DEPARTMENT OF HUMAN SERVICES

FALL 2007 FORECAST

FINANCE & POLICY ANALYSIS
FORECASTING, RESEARCH & ANALYSIS
APRIL 2008

Executive Summary

Background and Risks

Summary of DHS forecasts

Children, Adults and Families (CAF): CAF is made up of Self-Sufficiency, Child Welfare and Vocational Rehabilitation programs.

Self Sufficiency programs such as Temporary Assistance for Needy Families (TANF) and Food Stamps exhibit some underlying growth, reflecting an economy that is growing, albeit more slowly than in recent years. A restructuring of the TANF program is expected to create a gradual decline in the TANF caseload during the 2007-09 biennium, with an associated (but not as large) increase in Employment Related Daycare. The recent flood and storm damage will have an impact on Food Stamps. Given the restructuring of TANF and ERDC, the uncertain economy and natural disasters that affected several Oregon counties there is considerable risk associated with the forecast.

Child Welfare caseloads, which had exhibited strong growth during the two years preceding July 2005, have since leveled off, and even slipped downward from July to September 2006 before flattening out again. Child Protective Services caseload had been falling since 2004, but recently leveled off and has even shown some increases. Out of Home Care (e.g. Foster Care), which had been increasing for several years, began leveling off after July 2005 and fell after July 2006. Adoption Assistance and Subsidized Guardianship, on the other hand, continue to maintain strong upward trends, which are maintained in the forecasts. Since there is considerable uncertainty regarding the factors that might be driving the trends in Out of Home Care and Child In Home, these forecasts are bounded by wide risk bands; the forecasts for these caseloads assume an easing of the downward trend in Out of Home Care and modest growth in Child In Home.

Vocational Rehabilitation caseload fell steadily during 2006. The implementation of a 180-day standard for planed development became effective October 1, 2006 shortened caseload length of stay, and prompted the closing of some pre-plan cases. These created some volatility. However, since the number of new applications and active cases did not subside, this resulted in low impact on counselor workload. The caseload resumed its previous trend in May 2006, which the forecast assumes will continue.

Medical Assistance Programs: Medical Assistance programs consist of three major areas: Oregon Health Plan (OHP) Plus, OHP Standard and "Other". The total Division of Medical Assistance Program (DMAP) caseload is expected to grow dramatically as new policies and procedures are implemented within the 2007-2009 biennium. The three major influences on future DMAP populations as incorporated into the current forecast include the planned re-opening of OHP Standard program; the implementation of the provisions of HB2469 (provides for both restructuring and expansion of program related to TANF) which is expected to add several thousands of clients to the TANF Medical caseload beginning in October of 2008, and; implementation of the provisions of HB2406 (relating to home care for medically involved children) which is expected to add approximately 200 clients to the AB/AD caseload over the course of the current biennium (2007-2009).

Temporary Assistance for Needy Families-Medical (TANF-M): Due to the somewhat stable economy, as well as the diminished effect of prior policy changes which led to a dramatic reduction in these caseloads, both of these groups recently showed signs of stability. When the policy changes discussed above are each of these populations are expected to grow dramatically as clients move between eligibility groups. Given the lack of historical data regarding the policy changes and the uncertain economy in the upcoming years, there is considerable risk associated with the forecast.

Children's Programs: Oregon children are served in two programs, depending primarily on level of poverty. The Poverty Level Medical Children's benefit group serves the most impoverished children. This group displayed a substantial decline between 2002 and 2005, but has been relatively stable since that time. Expectations are for this group to add caseload slowly over the next biennium.

The CHIP program serves children up to 185% of the Federal Poverty Level of poverty and has grown aggressively since summer of 2004. A change as of June 2006, in recertification policy had significant influence on the aggressive growth pattern in this group. The current expectation is for growth pattern to remain high, but substantially lower rate than prior forecasts.

Poverty Level Medical Women:

The Poverty Medical Level – Women caseload has continued to increase with intermittent periods of stability across the entire historical period. A regular and seasonal pattern of caseload growth has emerged since the beginning of 2006. This pattern is expected to continue.

Seniors & Disabled: The medical assistance programs for people with disabilities have experienced steady growth for several years. This pattern is expected to continue. The caseload for seniors has recently emerged from a brief period of decline likely due to the implementation of the Medicare drug benefit in January 2006. The return to slow growth is expected to continue for the foreseeable future.

OHP Standard: In July of 2004 the OHP Standard program was closed to new clients while remaining open to clients transiting from other eligibility categories. One result of the closure was to reduce dramatically the number of clients enrolled in the two groups (Families and Adults and Couples). Together these two groups declined from a total caseload of around 57,000 in July of 2004 to approximately 19,000 in June of 2007. Absent policy change this eligibility group would be expected to maintain an extremely slow decline in caseload through the forecast horizon.

There are plans to reopen the OHP Standard program. The implementation plans will determine how long it will remain open. Policy impact assessments indicate that the total Standard caseload should approximate an average of 28,000 clients across the 2007-2009 biennium.

Mental Health: The Fall 2007 Mental Health forecast is composed of the following mandated caseloads: Criminally Committed (Aid and Assist; Psychiatric Security Review Board (PSRB)), and Civilly Committed (24 Hour Care, Acute Care, and State Hospitals). Civilly Committed and PSRB individuals in community outpatient settings are included in the Fall 2007 forecast. Continued refinements of the data since the last forecast do not allow comparisons with previous forecasts.

Criminally Committed caseload has fluctuated with periods of growth followed by short periods of decline. It is anticipated that the recent period of growth will continue through 2009.

Civilly Committed caseload has steadily grown during the past three years. This trend is expected to continue through the 2007-09 biennium.

Seniors & Physically Disabled – **Long-Term Care (LTC)**: The Long-Term care forecasts are divided into In-Home, Community-Based Care Facilities and Nursing Facilities. The Fall 2007 Long-Term Care caseload forecast is estimated to be lowered from the Spring 2007 forecast for the 2007-09 biennium.

In-Home care caseload for the past three years has been relatively flat or slightly decreasing after severe budgetary cutbacks that occurred in 2003. The caseload is anticipated to experience continued decline due to ongoing client eligibility reviews and the implementation of Medicare

Modernization Act. The decline observed in this caseload is expected to continued, however, in a slower pace.

Community-Based Care Facilities caseload has also experienced steady declined after 2003, followed by a period of little or modest growth. Given issues regarding gradual withdrawal from Medicaid contracts in Assisted Living and Contract Residential Care services (due primarily to lower Medicaid reimbursement), and as a result, it is anticipated to continue decline to occur through 2009.

Nursing Facilities caseload has steadily declined for several years. The decline in this caseload slow downed and stabilized in 2006 and it has moderately increased in recent months. In this forecast period, it is expected to continue the moderate growth. The combined effect of aging population and the changes in the LTC market dynamics in community-based settings, including the SPD's Money Follows the Person and other relocation initiatives, may see a slower rebound in nursing facilities caseload growth.

Oregon Supplemental Income Program (OSIP) caseload is expected to moderately grow through 2007-09 biennium.

Total DHS Caseload Biennial Average Comparison by Forecasts

	2007-09 Biennium				Fall Forecast		
Comparison:	Spring 07 to Fall 07				2007-09 to 2009-11		
Biennial Averages by Forecast	**Spring 07 Forecast 2007-09**	***LAB 2007 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*%Diff. LAB 07 to Fall 07 2007-09*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*% Diff. Fall 07 2007-09 to 2009-11*
Children, Adults and Families (CAF)							
Self-Sufficiency							
Food Stamps (Households)	226,123	226,123	227,410	0.6%	227,410	233,056	2.5%
Temporary Assistance for Needy Families (Families: Cash Assistance)	17,572	15,821	16,977	7.3%	16,977	15,159	-10.7%
Employment Related Daycare (Families)	9,251	10,502	9,840	-6.3%	9,840	10,859	10.4%
Child Welfare (Children Served)							
Child In Home	3,237	3,237	3,056	-5.6%	3,056	3,140	2.7%
Out of Home Care	10,213	10,213	8,596	-15.8%	8,596	8,456	-1.6%
Adoption Assistance	10,705	10,705	10,678	-0.3%	10,678	11,919	11.6%
Vocational Rehabilitation (Clients Served)	8,991	8,991	9,181	2.1%	9,181	9,367	2.0%
Medical Assistance Programs							
OHP Plus: Temporary Assistance to Needy Families (Medical)	115,045	117,299	116,091	-1.0%	116,091	123,460	6.3%
OHP Plus: Children (PLMC & CHIP)	127,632	127,632	125,971	-1.3%	125,971	131,864	4.7%
OHP Plus: Seniors and People with Disabilities	94,489	95,152	95,220	0.1%	95,220	100,345	5.4%
OHP Plus: Poverty Level Medical Women	10,987	11,324	10,825	-4.4%	10,825	11,380	5.1%
OHP Plus: Substitute Care & Adoption Serv.	19,054	19,054	17,667	-7.3%	17,667	18,104	2.5%
OHP Plus Total	**367,207**	**370,461**	**365,774**	-1.3%	**365,774**	**385,153**	**5.3%**
Other Medical Assistance Programs	29,771	30,033	30,910	2.9%	30,910	33,470	8.3%
Seniors and People with Disabilities - Long Term Care							
In Home	11,256	11,256	10,690	-5.0%	11,256	10,502	-6.7%
Community Based Care	10,939	10,939	10,550	-3.6%	10,939	10,435	-4.6%
Nursing Facilities	4,861	4,861	5,135	5.6%	4,861	5,205	7.1%

* Spring 2007 Forecast and 2007-09 Legislative Actions.

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Forecast: Economic and Demographic Background

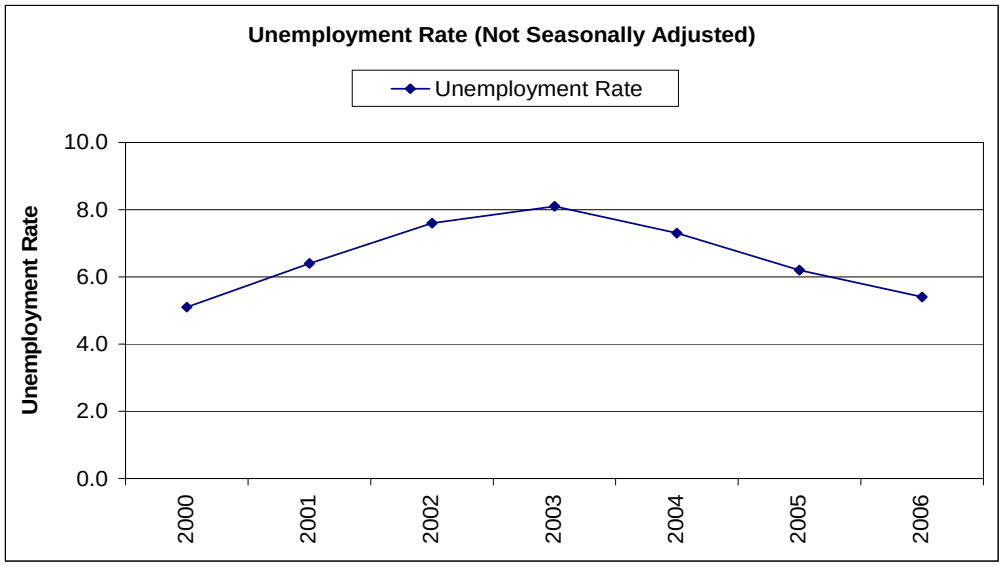
The Department of Human Services (DHS) provides a broad array of programs to thousands of Oregonians on a daily basis. Benefits and services are provided to children and families, seniors, people with developmental and/or physical disabilities, people with mental illness, people with substance abuse problems, and people in poverty.

DHS programs are affected by a number of environmental factors that contribute to the demand for benefits and services (such as the economy and changing demographics). The following information is a snapshot of a few common factors that influence the number of Oregonians seeking DHS services.

Key Economic Factors

The overall health of an economy is a function of many components including (un)employment rates, cost of living, and per capita income. Simplistically, a strong economy makes such things as housing, food, health care, and other daily and essential needs more affordable.

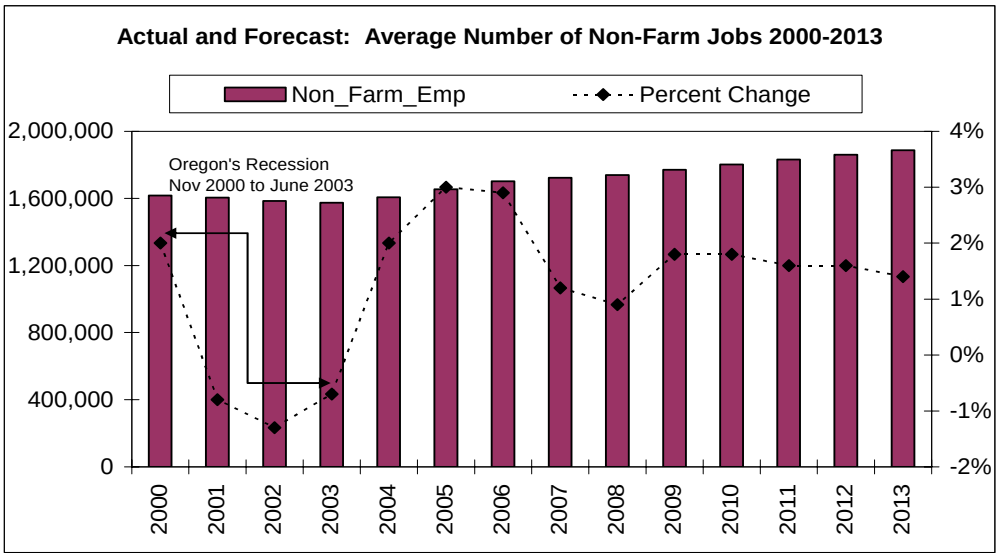
- In researching the national and state trends, it is predicted that Oregon's economy will experience slight to moderate growth after having experienced relatively rapid growth in the three years since the recession.



Source: Oregon Employment Department

After the recent recessionary period of November 2000 to June 2003, job growth increased while the unemployment rate decreased. However, job growth is expected to decline in the near future as evidenced by weak job growth for the nation at the end of 2007 and increased risk of recession stemming primarily

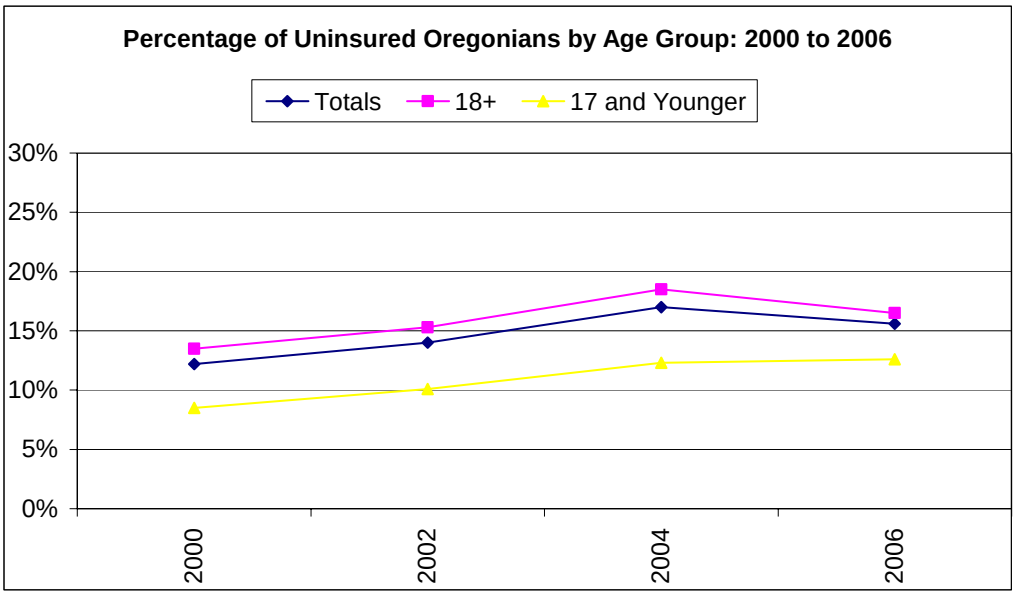
from the collapse of the sub-prime mortgage market which has created a tightening of financial credit throughout the U.S.



Source: Oregon's Office of Economic Analysis: Economic Forecast and Oregon Employment Department

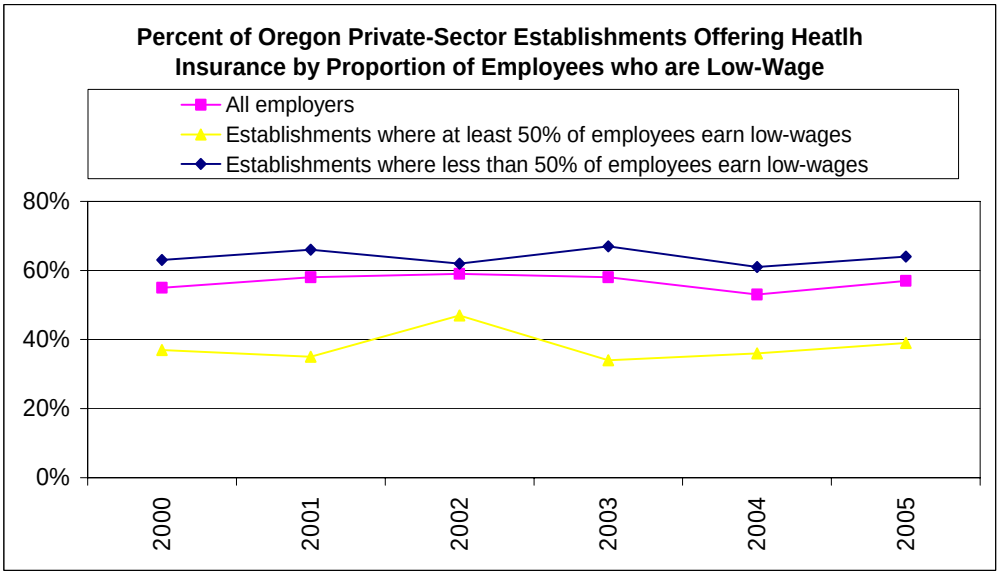
Health Care Factors

Not having health insurance prohibits individuals from seeking basic care from doctors, as well as limits their access to medicine, eyeglasses, and other services; services that are often taken for granted by people who have health insurance. Those who lack health care coverage are at higher risk of needing expensive emergency procedures for otherwise treatable illnesses and injuries. Unfortunately, health care costs have increased substantially over time leading to an increase in the number of people living without heath insurance. It is anticipated that Oregonians will continue to experience higher rates of being uninsured.



Source: Oregon Health Policy and Research; 2006 Oregon Population Survey

Recent data suggests that the total percentage of employers offering health care coverage has declined since 2000 with a slight increase in 2005. However, there has also been a slight increase in the number of establishments where at least 50 percent of all employees earn low-wages from 2003 to 2005.

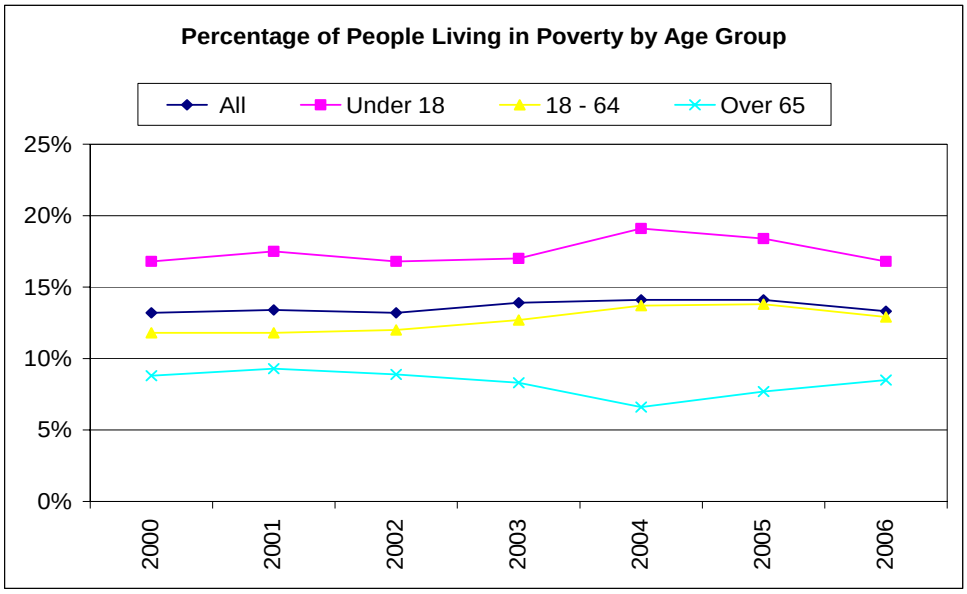


Source: United States Department of Health and Human Services: Agency for Healthcare, Research, and Quality: Medical Expenditure Panel Survey

Poverty

The income level of an individual or a family is the main criterion when determining one's poverty status. It is often said that an individual or family is living below or above the federal poverty limit (FPL). The FPL is determined each year by the federal government. Individuals and families who live in poverty face barriers to health care, food, shelter, education, employment, and other important factors that affect their quality of life.

Oregonians under the age of 18 are at higher risk of living in poverty than are older Oregonians. In 2006, children and adults ages 18 to 64 witnessed a slight decrease in the percent living in poverty. Conversely, those older than 65, though comprising a smaller proportion of the population, have seen the percent living in poverty increase since 2004.



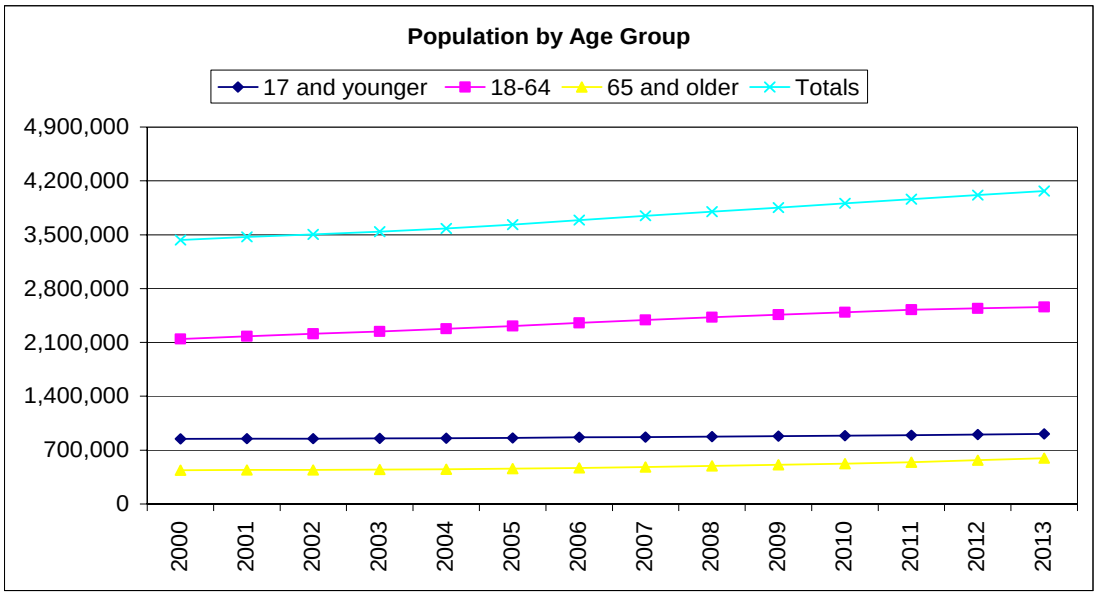
Source: U.S. Census Bureau: American FactFinder

Age Demographics

Peoples' needs often differ based on age. Children's needs are different than those of the elderly. State demographers anticipate moderate population growth in Oregon with relatively rapid increases in the elderly population. As Oregon's population and age composition is expected to change over time, the focus of DHS services has and will continue to change to reflect changing age demographics.

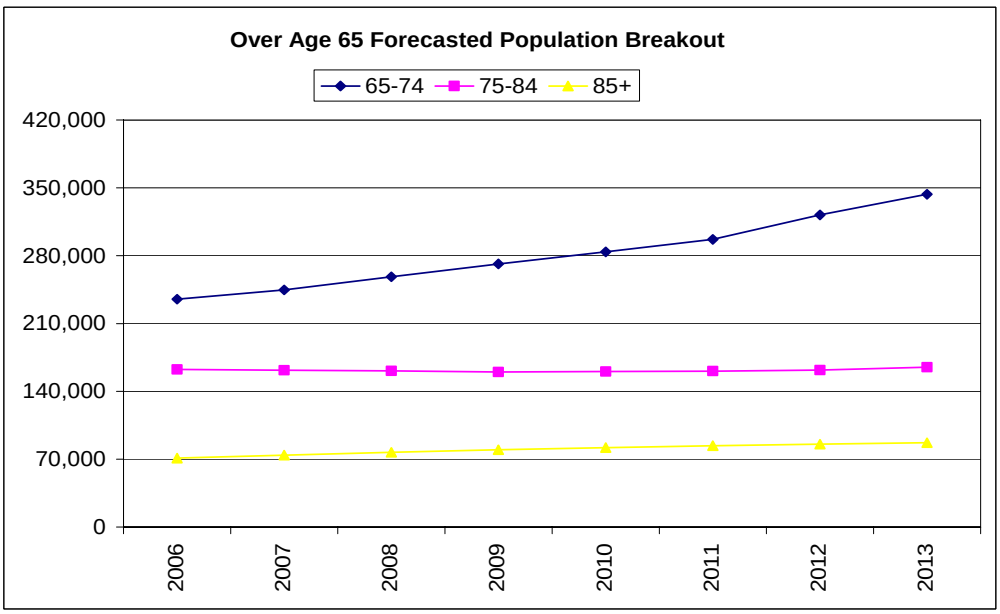
As of September of 2006, roughly 23 percent of all Oregonians were children. Less than 13 percent of the total population was individuals 65 and older. However, from 2007 through 2013, the population growth rates will be highest for

seniors, 23 percent compared to 7 percent for those 18-64 and 5 percent among children.



Source: Oregon Department of Administrative Services, Office of Economic Analysis: Short-Term State Population Forecast

By 2030 around 1 in 5 Oregonians will be 65 or older. The growth rate among the youngest segment of this population, 65-74 year olds, is projected to increase 45 percent from 2006 through 2013, for those 75-84 the growth rate will remain almost constant with a decline of 0.2 percent. Lastly, there is projected to be an increase of 18 percent for those 85 and older.



Source: Oregon Department of Administrative Services, Office of Economic Analysis, Short-Term State Population Forecast

Children, Adults and Families Division

Introduction

The Children, Adults and Families Division (CAF) administer programs to protect abused and neglected children and to help Oregon families achieve self-sufficiency. These two areas of service are identified as Child Welfare and Self-Sufficiency, respectively. In addition, CAF operations include the Office of Vocational Rehabilitation Services (OVRS), which assists individuals with disabilities in getting and keeping a job.

Exhibit B-1: Children, Adults and Families Division program caseload

Self Sufficiency	Child Welfare	Vocational Rehabilitation
Food Stamps	Adoption Assistance	Vocation Rehabilitation
Temporary Assistance for Needy Families (TANF)	Subsidized Guardianship	
Employment Related Daycare (ERDC)	Out of Home Care (Foster Care)	
Temporary Assistance for Domestic Violence Survivors (TADVS)	Child In-Home	

Self-Sufficiency

Self-Sufficiency caseloads are measured in both number of clients and number of cases. For Food Stamps, a case means a household. For TANF, ERDC and TA-DVS, a case equates to a family.

Exhibit B-2: Total Self-Sufficiency Caseload Biennial Average Comparison by Forecasts (Cases)

	2007-09 Biennium				Fall Forecast		
Comparison:	Spring 07 to Fall 07				2007-09 to 2009-11		
Children, Adults & Families Division **Biennial Averages by Forecast**	**Spring 07 Forecast 2007-09**	***LAB 2007 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*%Diff. LAB 07 to Fall 07 2007-09*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*Fall 07 2007-09 to 2009-11*
SELF-SUFFICIENCY							
Food Stamps (Households)							
Children, Adults and Families	158,529	158,529	158,247	-0.2%	158,247	158,239	0.0%
Seniors and People with Disabilities	67,594	67,594	69,163	2.3%	69,163	74,817	8.2%
Total Food Stamps	**226,123**	**226,123**	**227,410**	**0.6%**	**227,410**	**233,056**	**2.5%**
Temporary Assistance for Needy Families (Families: Cash/Grants)							
Basic	16,752	15,103	16,056	6.3%	16,056	14,351	-10.6%
UN	820	718	921	28.3%	921	808	-12.3%
Total TANF	**17,572**	**15,821**	**16,977**	**7.3%**	**16,977**	**15,159**	**-10.7%**
Employment Related Daycare (Families)	9,251	10,502	9,840	-6.3%	9,840	10,859	10.4%
Temp. Assist. For Dom. Violence Survivors (Families)	504	504	523	3.8%	523	528	1.0%

* Spring 2007 Forecast and 2007-09 Legislative Actions

Food Stamps

There are approximately a quarter of a million households that receive Food Stamps in Oregon, which translates to over 400,000 individuals who receive benefits through this program. The Food Stamp program supplements food budgets for low-income families and individuals, people receiving public assistance, and individuals enrolled with Seniors and People with Disabilities Division's (SPD) programs. Households entering the program through Children, Adults and Families Division (CAF) are classified as CAF households, while those entering the program through Seniors and People with Disabilities Division are classified as SPD households. Both groups of recipients underwent relatively rapid growth from 2001 through 2004 (Exhibit B-3). However, in the past couple of years to the present, the CAF Food Stamp population has been leveling off, while the SPD program has grown slowly but steadily.

Forecast

Recently, the CAF Food Stamp caseload has tracked fairly well with the Spring 2007 forecast, which was used for the Legislatively Approved Budget (LAB) and is referred to in Exhibit B-2 as the "LAB 2007" forecast. Accordingly, the Fall 2007 forecast 2007-09 biennial average for households of 158,247 is quite close to the forecast for Spring 2007 (Exhibit B-2). The SPD Food Stamp population has grown somewhat faster than predicted by the Spring 2007 forecast, leading to a steeper trend for Fall 2007. At a biennial average of 69,163 for 2007-09, it is about two percent higher than the Spring 2007 forecast. Overall, the total Food Stamp caseload of 227,410 households predicted by the Fall 2007 forecast is only about a half percent higher than the Spring 2007 forecast for 2007-09 (Exhibit B-2).

Risks and Assumptions

The forecast is based on the assumption that the Food Stamp Program will continue in its present form with no substantial changes in policy or legislation, as well as little change in the economy. A recently obtained grant for outreach efforts to seniors could potentially increase the SPD Food Stamps caseload, but this has not been incorporated in the Fall 2007 forecast.

In the past, the Food Stamp caseload experienced substantial volatility due to fluctuations in the economy, outreach efforts and changes in policy. With that degree of historical variability, the forecast could average 11 percent above or below the average forecast for the 2007-09 biennium.

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program provides services and cash grants to low-income families with children to help them become self-sufficient. It should be noted that families with TANF medical benefits only are not in this caseload (see Medical Assistance Programs). TANF families are divided into two main categories:

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

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

For TANF reauthorization, the program has undergone significant changes that became effective October 1, 2007. Since no data are available under the new

system, the Fall 2007 forecast was developed under the old categories, and then modified for the estimated effects. The new categories are as follows:

Pre-TANF is a category previously known as "TANF Assessments," in which a family may receive benefits while undergoing assessment for TANF eligibility. It was not part of the TANF caseload forecast under the old methods.

Pre-SSI TANF encompasses families classified as TANF Basic or UN under the old system who have applied for Social Security Insurance (SSI). Once they qualify for SSI, the SSI payments they receive retroactively will be used to pay back the TANF benefits they received.

TANF Basic consists of the former TANF Basic category with Pre-SSI families excluded.

TANF UN includes only UN families that do not have difficulty meeting the federal job participation requirements and do not come under Pre-SSI.

State-Only TANF is made up of those UN families that have difficulty meeting the federal job participation requirements and do not come under Pre-SSI. Placing them in a state-funded-only program helps DHS meet the Maintenance Of Effort (MOE) required by federal law.

Post-TANF is a new category that includes families not counted under the old TANF forecast. Benefits are provided to keep families who are no longer eligible for TANF from returning to the TANF caseload.

Forecast

The TANF caseload experienced moderate growth during 2001 through the first part of 2005, accompanied by seasonal fluctuations (Exhibit B-6). In contrast, the latter part of 2005 and all of 2006 saw a slight decline, possibly due to the improving economy. During 2007, however, the caseload gradually edged upward, moving it away from the Spring 2007 forecast. The Fall 2007 forecast without adjustment for policy changes due to TANF Reauthorization reflects this slight upward trend.

With the implementation of new policies and programs under TANF Reauthorization, strides in helping clients gain and maintain employment should cause TANF Basic and UN caseloads (under the old definition) to fall. For the 2007-09 LAB forecast, the Spring 2007 forecast was adjusted for the expected impact of the TANF Reauthorization on the TANF caseload. These adjustments were used for the Fall 2007 forecast. As shown in Exhibit B-2, the Fall 2007 forecast predicts an average 16,977 families for the 2007-09 biennium, which is 7 percent higher than the LAB 2007 forecast. The Fall 2007 forecast for TANF UN is 921 families for the 2007-09 biennium, which is 28 percent higher than the LAB

2007 forecast. Although the difference is large percentage-wise, the UN caseload is small and accounts for only 5 percent of the TANF caseload, with TANF Basic averaging 16,056 families for the 2007-09 biennium under the Fall 2007 forecast.

Risks and Assumptions

The Fall 2007 forecast assumes very little change in the economy, in keeping with the Office of Economic Analysis projections of October 2007. However, major changes in the economy could affect the TANF population, in particular TANF UN, where the employment status of the parents can impact eligibility.

In addition, the estimates for the impact of policy and program changes related to the TANF Reauthorization are only best guesses at what might happen. The possibility that these changes may not impact the caseload as expected presents a substantial risk to the forecast.

Even without the above risks, historically the TANF caseload has exhibited moderately high variability in the past. Combining this historical volatility with the risks posed by the TANF Reauthorization, future caseloads could average 13 percent below or 29 percent above the forecast for the 2007-09 (Exhibit B-6).

Employment Related Daycare

Employment Related Daycare (ERDC) subsidizes daycare to help low-income working parents remain employed while they transition from TANF, or while they are at the risk of entering TANF.

Forecast

The changes related to TANF Reauthorization are expected to increase ERDC caseloads by 50 percent of the TANF impact. This result in the Fall 2007 forecast for ERDC rising sharply from January 2008 to June 2009 and then leveling off (Exhibit B-7). The 50 percent factor is a best guess estimate, since adequate data are not available. Data will be captured in the coming months to get a better idea of the impact of TANF Reauthorization.

In addition to the TANF Reauthorization, ERDC has undergone changes in co-pay, rate and FPL eligibility levels effective October 1, 2007. These are expected to further increase the Fall 2007 forecast for ERDC. The Fall 2007 forecast also reflects the phasing out of DHS involvement with the Student Block Grant, although this represents an insignificant portion of the caseload.

As shown in Exhibit B-2, the Fall 2007 forecast of 9,840 ERDC families for the 2007-09 biennium is 6 percent below the LAB 2007 forecast. Since both the Fall 2007 and LAB 2007 forecasts incorporate the estimated impacts of the TANF

Reauthorization, the difference is driven by both the changes in the Student Block Grant, co-pay, rate and FPL eligibility level, and by the fact that recent actuals have fallen below the original Spring forecast before adjustments.

Risks and Assumptions

Given the historical variability of the ERDC caseload and the uncertain impact of various policy and program changes that have been implemented, the average caseload for the 2007-09 biennium could increase to 9 percent above or 19 percent below the forecast (Exhibit B-9).

Temporary Assistance for Domestic Violence Survivors

Temporary Assistance for Domestic Violence Survivors (TA-DVS) provides short-term financial assistance (up to 90 days) for individuals fleeing an abusive partner or family member.

Forecast

Recent actuals for this caseload have tracked very closely to the LAB 2007 forecast (no adjustments were made to the Spring 2007 forecast in developing the LAB). Therefore, the Fall 2007 forecasted 2007-09 biennial average of 523 is just 4 percent high than the LAB 2007 forecast.

Risks and Assumptions

Given the extreme variability of this relatively small caseload, it is difficult to anticipate any change in the overall trend. Based on these historical fluctuations, the actual average for the 2007-09 biennium could deviate as much as 25 percent above or 21 percent below the forecast (Exhibit B-10).

Exhibit B-3: Total Food Stamps (Households)

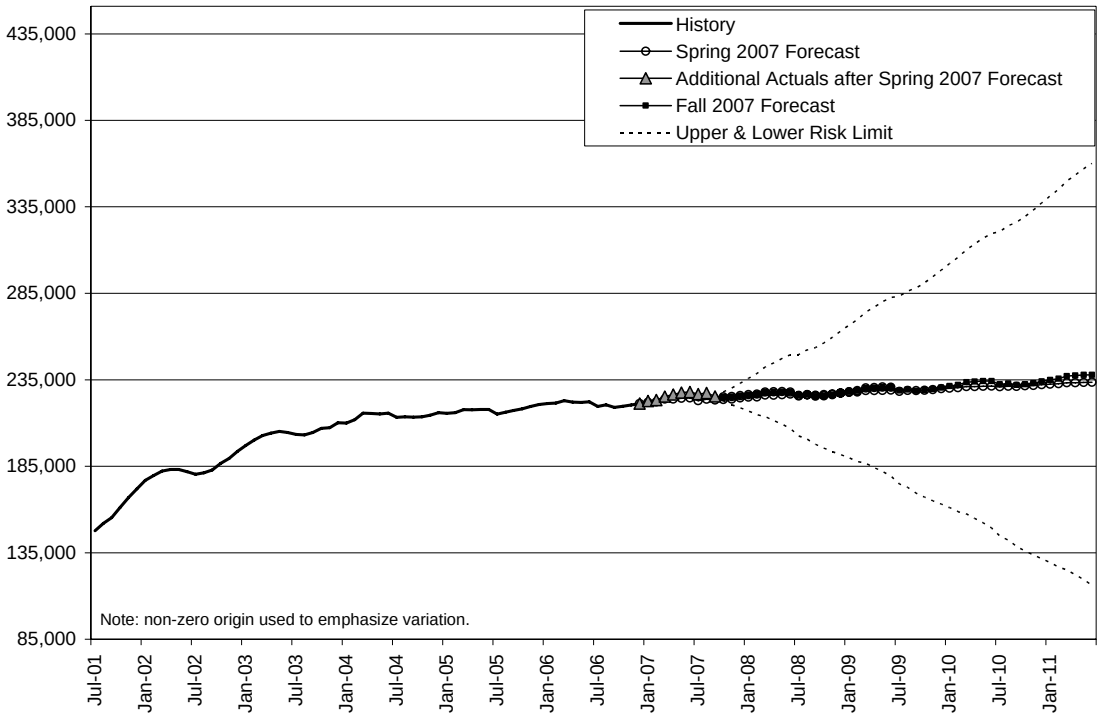


Exhibit B-4: CAF Food Stamps (Households)

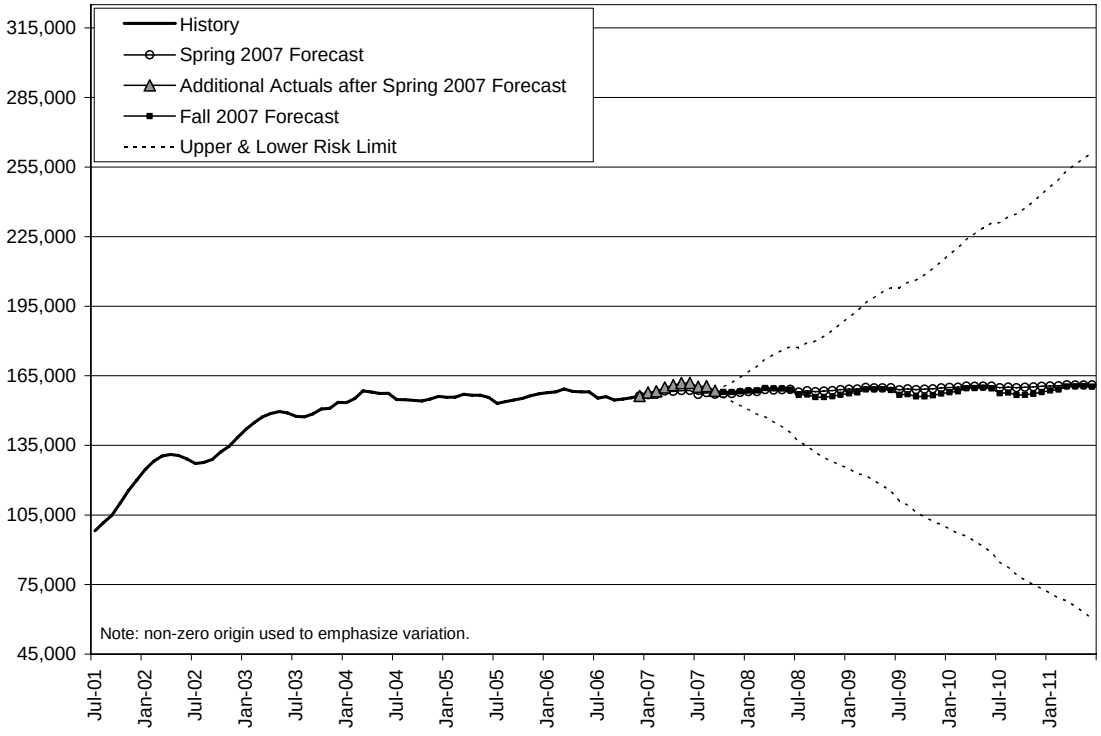


Exhibit B-5: SPD Food Stamps (Households)

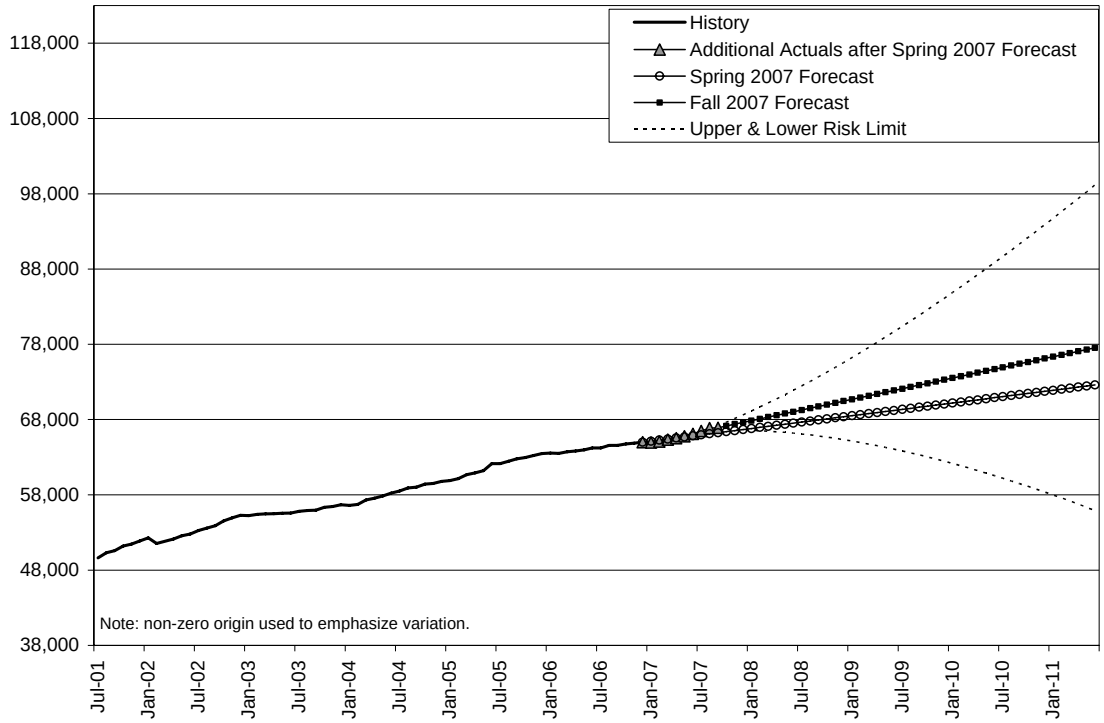


Exhibit B-6: Temporary Assistance for Needy Families (Families)

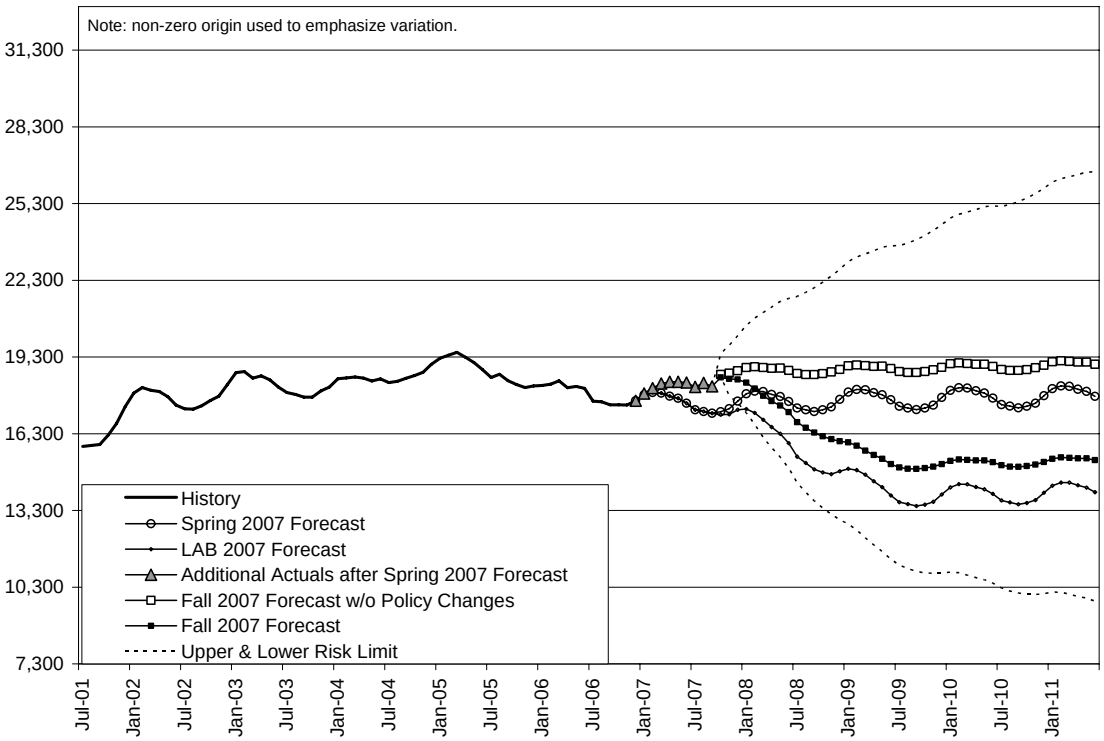


Exhibit B-7: Temporary Assistance for Needy Families Basic (Families)

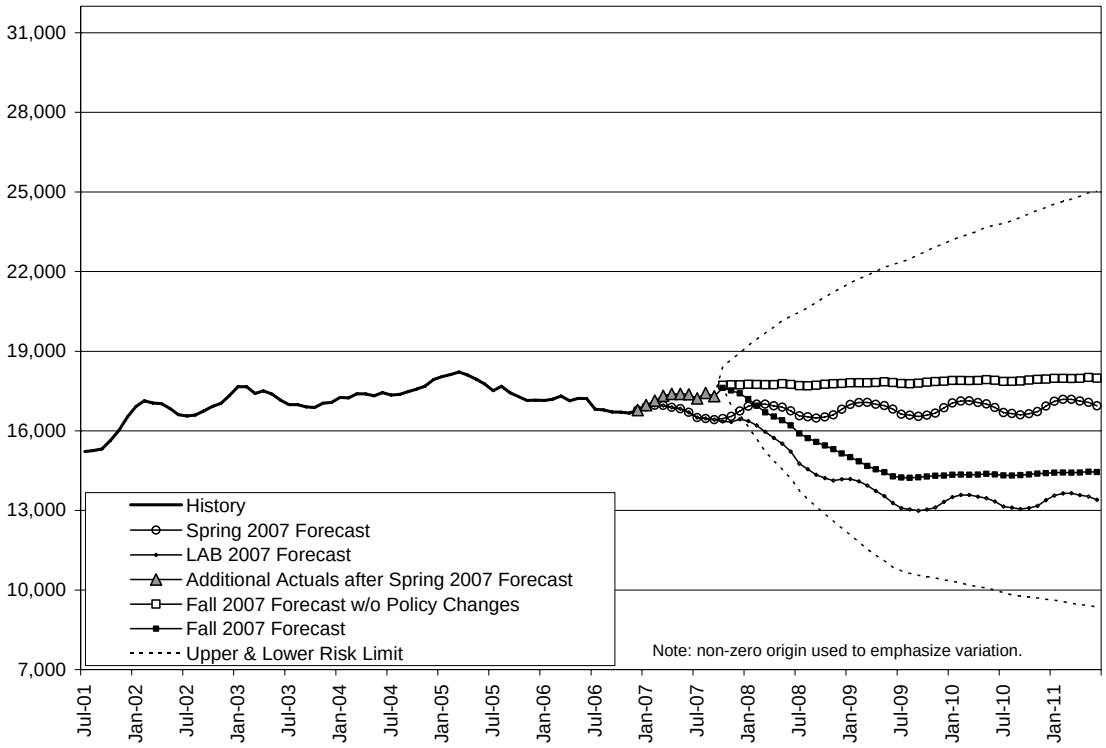


Exhibit B-8: Temporary Assistance for Needy Families UN (Families)

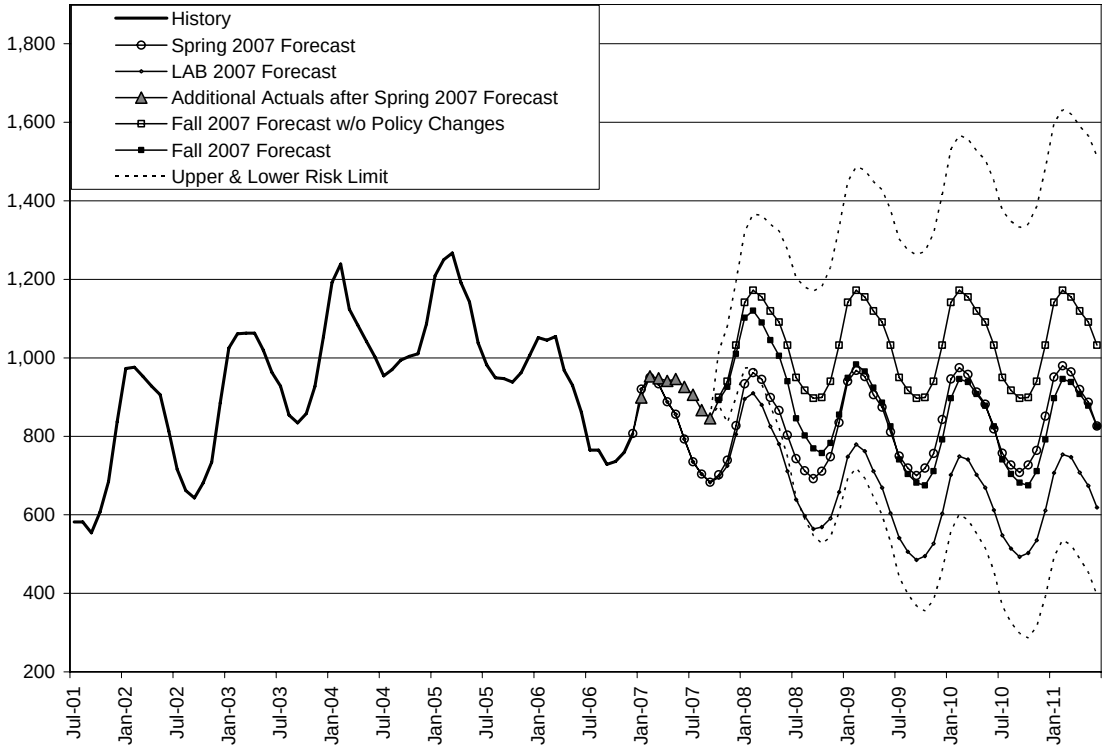


Exhibit B-9: Employment Related Daycare (Families)

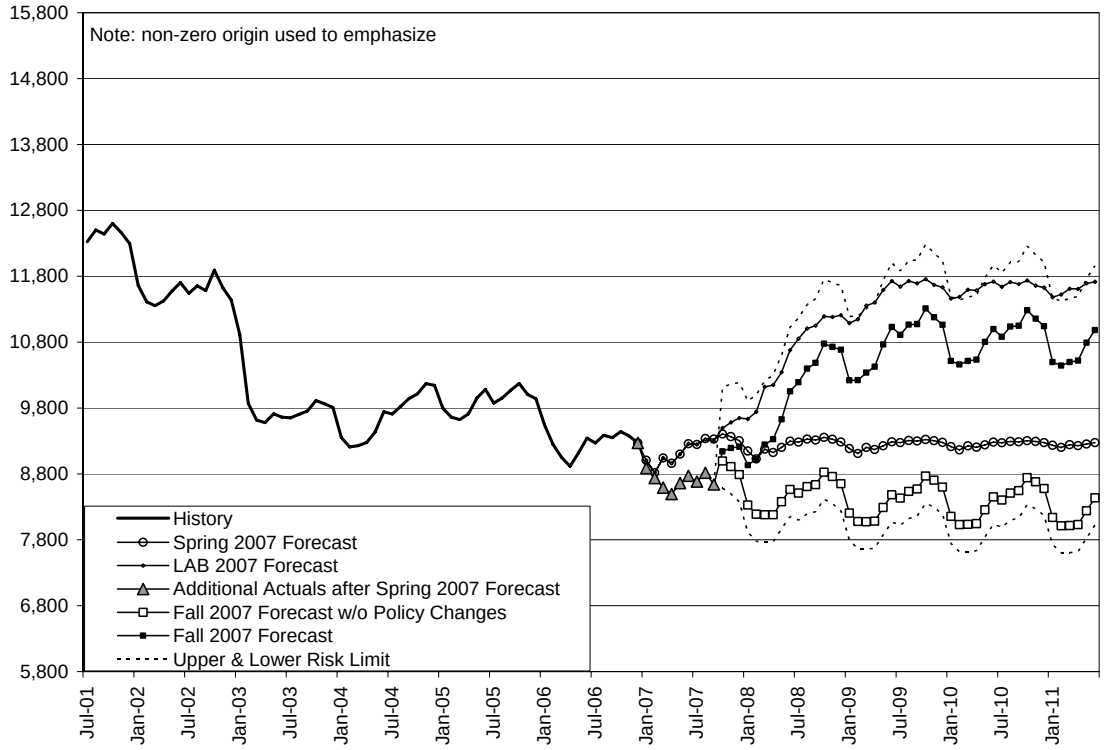
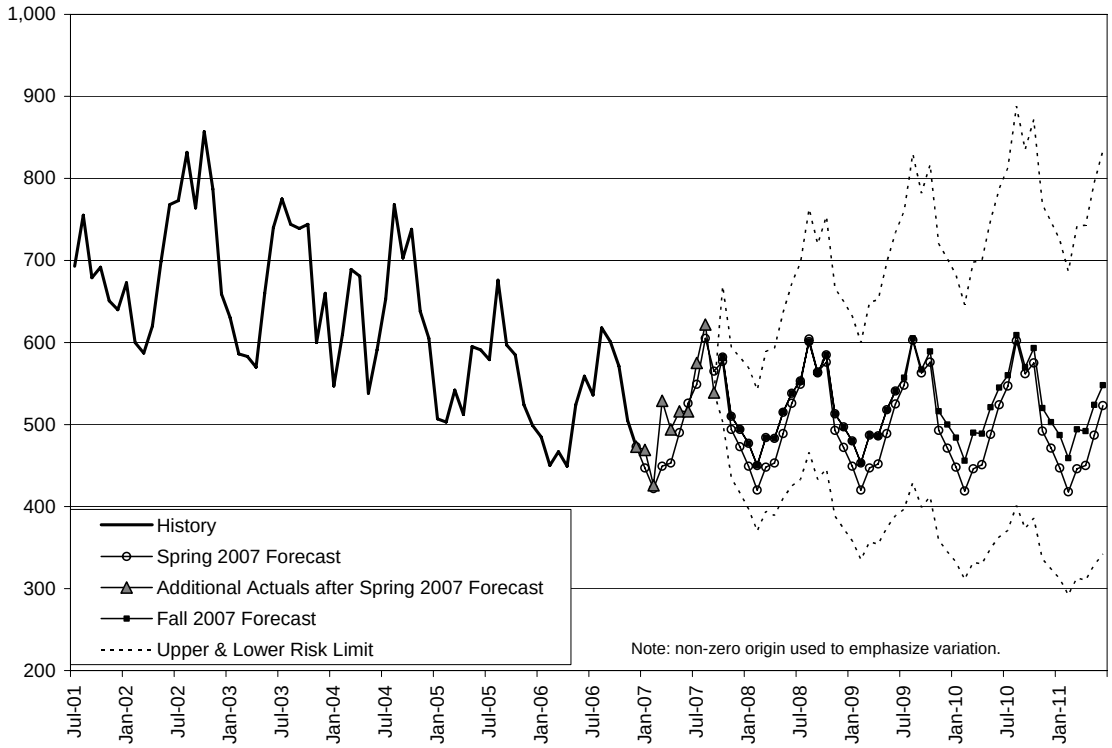


Exhibit B-10: Temporary Assistance for Domestic Violence Survivors (Families)



Child Welfare

The Child Welfare system provides services to protect abused and neglected children. The forecast projects the number of children who are served in a given month, divided into the following categories[1]:

Child In Home includes children who have an open plan but are in the custody of their parents.

Out of Home provides temporary care for children who cannot be safely cared for by their birth parents. This includes various forms of substitute care, including foster homes and residential care facilities.

Adoption Assistance provides support to help remove financial barriers to achieving and sustaining adoptions for special needs children. This can include payments and/or non-cash assistance such as medical benefits.

Subsidized Guardianship helps remove financial barriers for individuals who do not wish to adopt but would like to offer a permanent home for children who would otherwise be in foster care.

For budget purposes, the forecast also includes projections of Average Daily Population for key services. These appear in Appendix I.

Forecast

Overall, the Child Welfare caseload in terms of number of children served was on an upward trend for several years, increasing approximately 5 or 6 percent each year from July 2001 to July 2005. In early 2005, the Child In Home caseload began to decline, but increased growth in Foster Care counter balanced most of this. Then around July 2005, the overall Child Welfare caseload flattened out. This stemmed from a combination of continued decreases in the Child In Home caseload and a leveling out of the Out of Home Care caseload. Toward the middle of 2006, the Out of Home Care caseload began to decline, causing the overall Child Welfare caseload to decline as well.

The changes starting in July 2005 may be in part from improved practice in terms of keeping children safe in their own homes and the avoidance of opening cases where the child is not truly in danger; however, the available data is not adequate to confirm the validity of these possible explanations. Due to the high level of uncertainty surrounding the Out of Home Care and Child In Home caseloads, the

[1] The Child Welfare caseload does not include counts of assessments done by Child Protective Services, Mutual Homes Recovering Families, Independent Youth, Title IV-E ("Other"), Tribal Foster Care, Psychiatric Residential Treatment, and Developmentally Disabled Foster Care.

forecast takes a conservative approach by assuming an easing of the downward trend in Out of Home Care and modest growth in Child In Home. Combined with strong projected growth in Adoption Assistance and Subsidized Guardianship, the result is a Fall 2007 forecast of 23,286 children on the Child Welfare caseload for the 2007-09 biennium, which is 7 percent lower than the Spring 2007 forecast used for the Legislatively Approved Budget (referred to as the "LAB 2007" forecast). Given the high level of risk associated with this forecast, the average for the 2007-09 biennium could easily end up being off by as much as 13 or 14 percent in either direction.

Exhibit B-11: Total Child Welfare Caseload Biennial Average Comparison by Forecasts (Cases)

	2007-09 Biennium				Fall Forecast		
Comparison:	Spring 07 to Fall 07				2007-09 to 2009-11		
Children, Adults & Families Division **Biennial Averages by Forecast**	**Spring 07 Forecast 2007-09**	***LAB 2007 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*%Diff. LAB 07 to Fall 07 2007-09*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*% Diff. Fall 07 2007-09 to 2009-11*
CHILD WELFARE (Children)							
Adoption Assistance	10,705	10,705	10,678	-0.3%	10,678	11,919	11.6%
Subsidized Guardianship	769	769	956	24.3%	956	1,338	40.0%
Out of Home Care	10,213	10,213	8,596	-15.8%	8,596	8,456	-1.6%
Child In-Home	3,237	3,237	3,056	-5.6%	3,056	3,140	2.7%
Total Child Welfare[1]	**24,924**	**24,924**	**23,286**	**-6.6%**	**23,286**	**24,853**	**6.7%**

1. Excludes Child Protective Services Assessments, Recovering Family Mutual Homes, Independent Youth, Title IV-E Tribal Foster Care, Psychiatric Residential Treatment, and Developmentally Disabled Foster Care.

Child In Home Forecast

The Fall 2007 forecast of 3,056 for the 2007-09 biennium is down approximately 6 percent from the LAB 2007 forecast, which had assumed modest growth (Exhibit B-11). Since the LAB 2007 forecast, the Child In Home caseload has shown signs of flattening out and even possibly growing.

A number of factors could have contributed to the decline in the Child In Home caseload:

- A number of administrative changes took place ranging from renewed attention to In-Home plans, closing inactive In-Home plan cases, and to more accurately reporting the type of plan a case was in. Additionally, several new processes have been implemented, including a rule requiring face-to-face contact every 30 days that went into effect August 2004; and the implementation of the Guided Assessment Process for assessing referrals to child protective services that was fully implemented in late 2004.
- Staff turnover has led to a higher percentage of caseworkers with less experience. Anecdotally, it has been suggested that the less experienced

caseworkers are less confident about managing cases in the home, which is supported by research on foster care and caseworker experience[2].

- Also, there has been decreased availability of mental health and substance abuse treatment services for many parents, making it more difficult to keep children in the home. The decrease in substance abuse and mental health treatment is tied to the budget cuts in the Oregon Health Plan in 2003, which had the effect of reducing providers' availability for some services.

Another significant occurrence during 2003-2005 includes the review of DHS child welfare practices by the National Resource Center for Child Protective Services (NRCCPS) in May 2005 ("Holder Report"). DHS began training in September of 2006 to implement some of the suggestions of the Holder Report. This training emphasizes the Oregon Child Welfare Safety Model, which provides well-defined procedures for assessing whether a child is safe in the home. Without such training, a caseworker might tend to err unnecessarily on the side of caution and place a child in foster care when in fact the situation does not warrant it. By reducing the occurrence of this, the training should eventually produce a stabilization of the Child In Home caseload into a slightly upward trend.

Given the large historical variability of the Child In Home caseload, future caseloads could deviate substantially from the forecast. Based on historical data, the average deviation over the 2007-09 biennium could be as great as 42 percent above or 35 percent below the forecast.

Out of Home Care Forecast

The Fall 2007 forecast predicts that 8,596 children will be served on average each month for the 2007-09 biennium, which is around 16 percent lower than the LAB 2007 forecast (Exhibit B-11). The LAB 2007 forecast had assumed moderate growth, but recent actuals have indicated a continuation of the previous downward trend (Exhibit B-13).

A great deal of uncertainty exists as to whether: a) the recent downturn will persist; b) the trend will stabilize into the flattened trend exhibited during the latter part of 2005 and first part of 2006; or c) the pattern will return to the aggressive growth seen during the two years preceding July 2005. Given this uncertainty, future caseloads could deviate from the forecast by an average of 16 or 17 percent up or down for the 2007-09 biennium.

[2] Studies have shown that children are more likely to be returned home safely within 12 months as well as to remain safely in the home with more experienced foster care caseworkers.

Adoption Assistance Forecast

At 10,678 for the average number of children served in the 2007-09 biennium, the Fall 2007 forecast varies very little from the LAB 2007 forecast. The growth in this caseload has remained relatively stable, leading to very little variability in the historical data. Thus, future caseloads for Adoption Assistance will most likely fall within three percent above or below the average forecasted for the 2007-09 biennium (Exhibit B-14).

Subsidized Guardianship Forecast

The Fall 2007 forecasted average of 956 children served for 2007-09 is about 24 percent higher than the LAB 2007 forecast. This is driven by increased growth that may be due to a keener awareness of the usefulness of this program as a path to permanency. This is a relatively small caseload, and hence small changes in absolute terms can generate large percentage changes. Given this, and since variation in the Subsidized Guardianship caseload has been moderately high in the past, future caseloads could reasonably be expected to vary by plus or minus 23 percent from the average forecasted for the 2007-09 biennium (Exhibit B-15).

Risks and Assumptions

Lacking a definitive explanation for the relatively large swings that have occurred in the Out of Home Care and Child In Home caseloads, one must be cautious in making assumptions about the future direction of these populations. Also, it is still unclear what impact safety training will have on these caseloads.

Besides specific risks that may impact the accuracy of the forecast, such as known policy changes or environmental factors, each forecast carries an inherent risk that is based on unexplained variability in the actual caseload data. The farther out the projection, the greater the risk that it will deviate from what actually occurs in the future.

Exhibit B-12: Total Child Welfare - Number Served

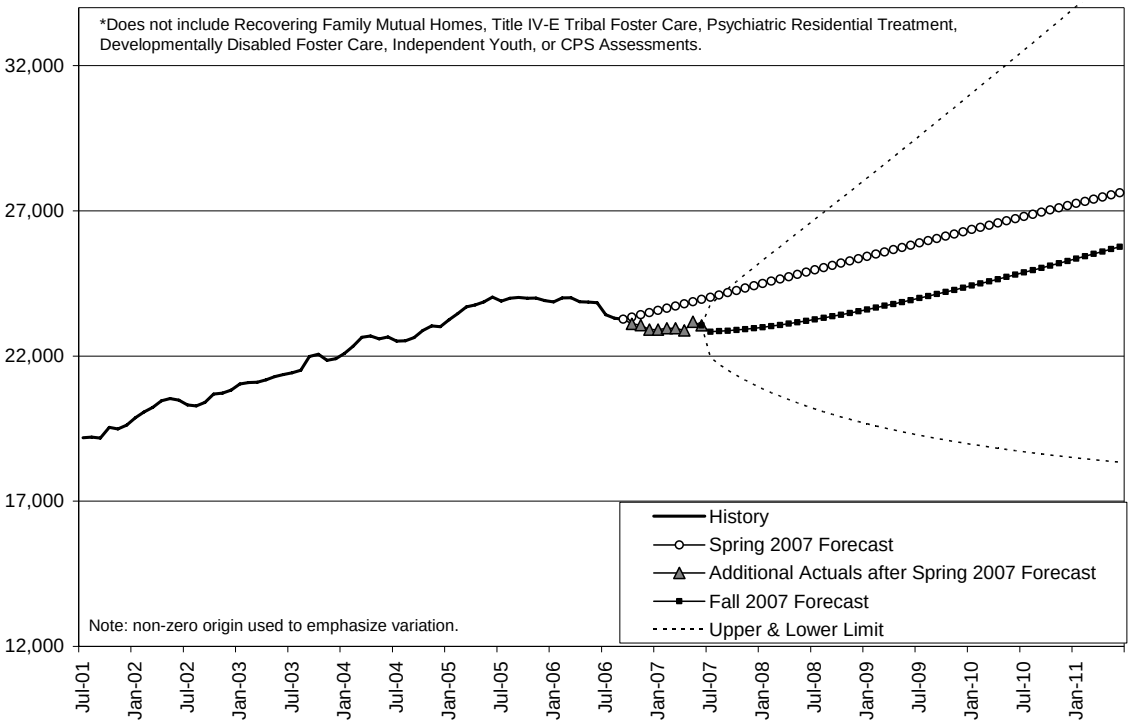


Exhibit B-13: Child In Home - Number Served

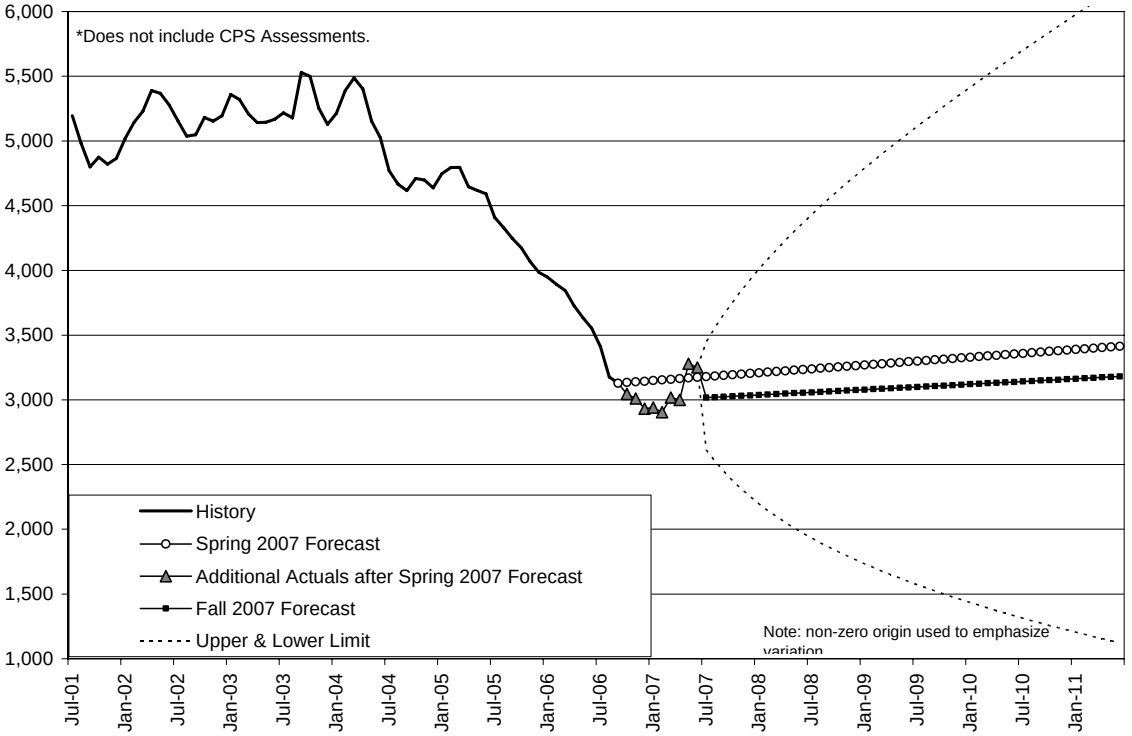


Exhibit B-14: Out of Home Care - Number Served

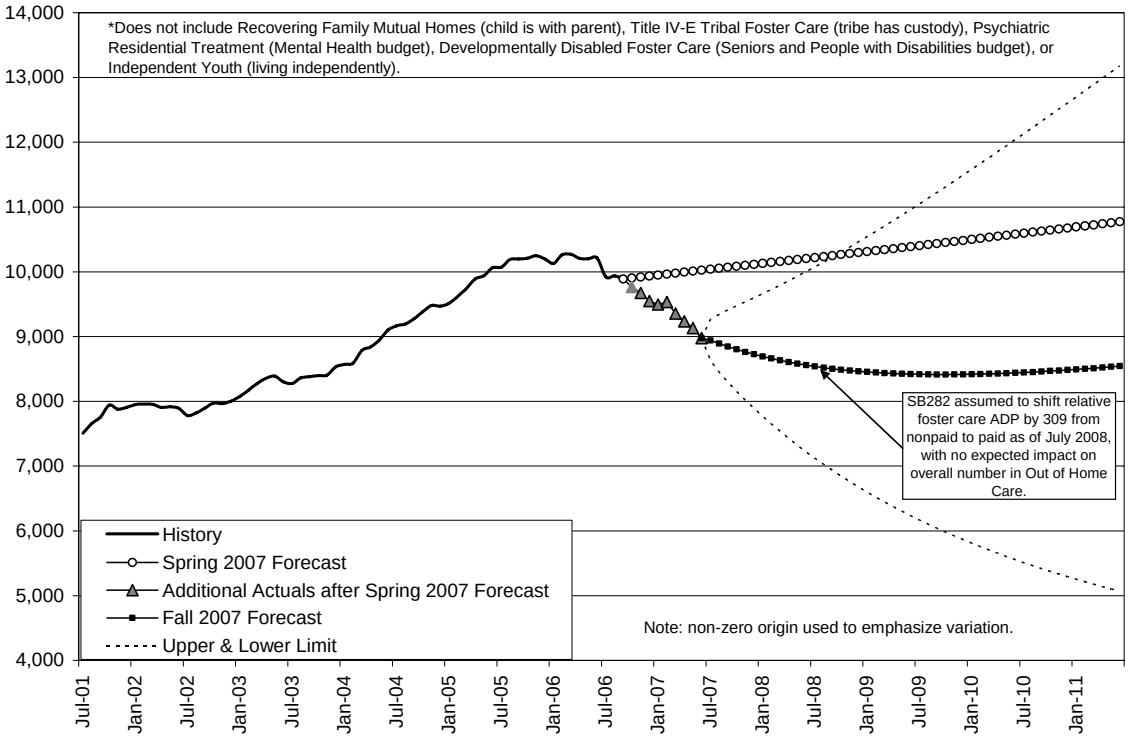


Exhibit B-15: Adoption Assistance - Number Served

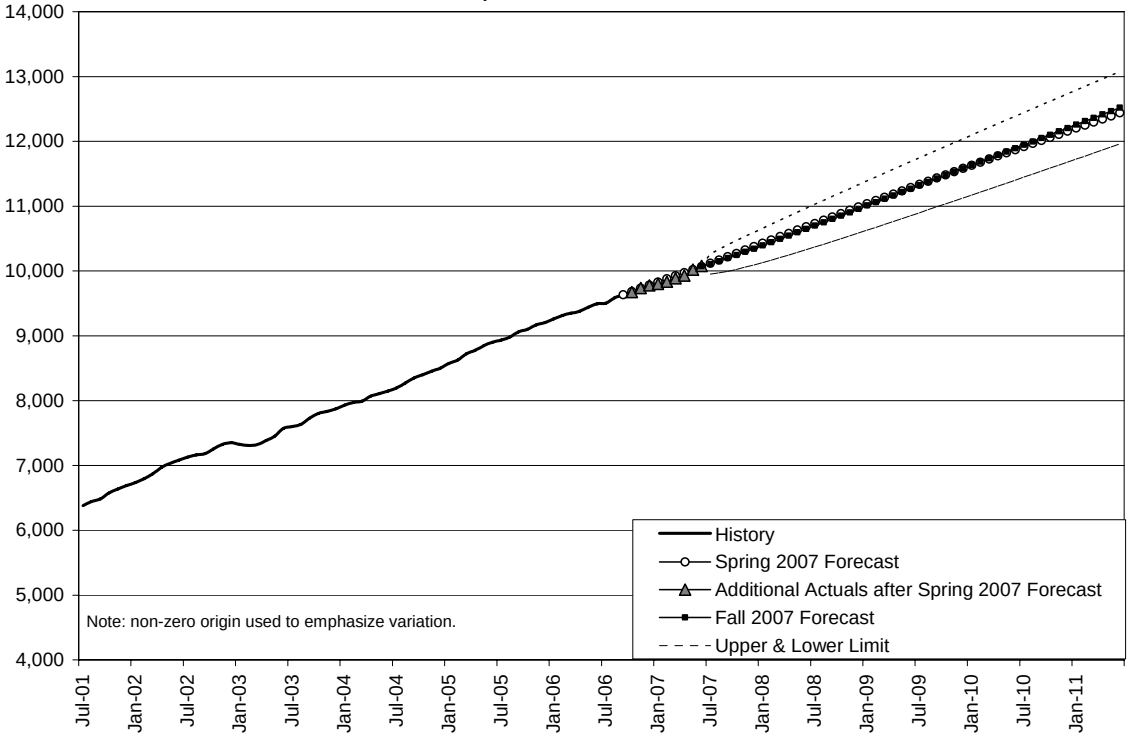
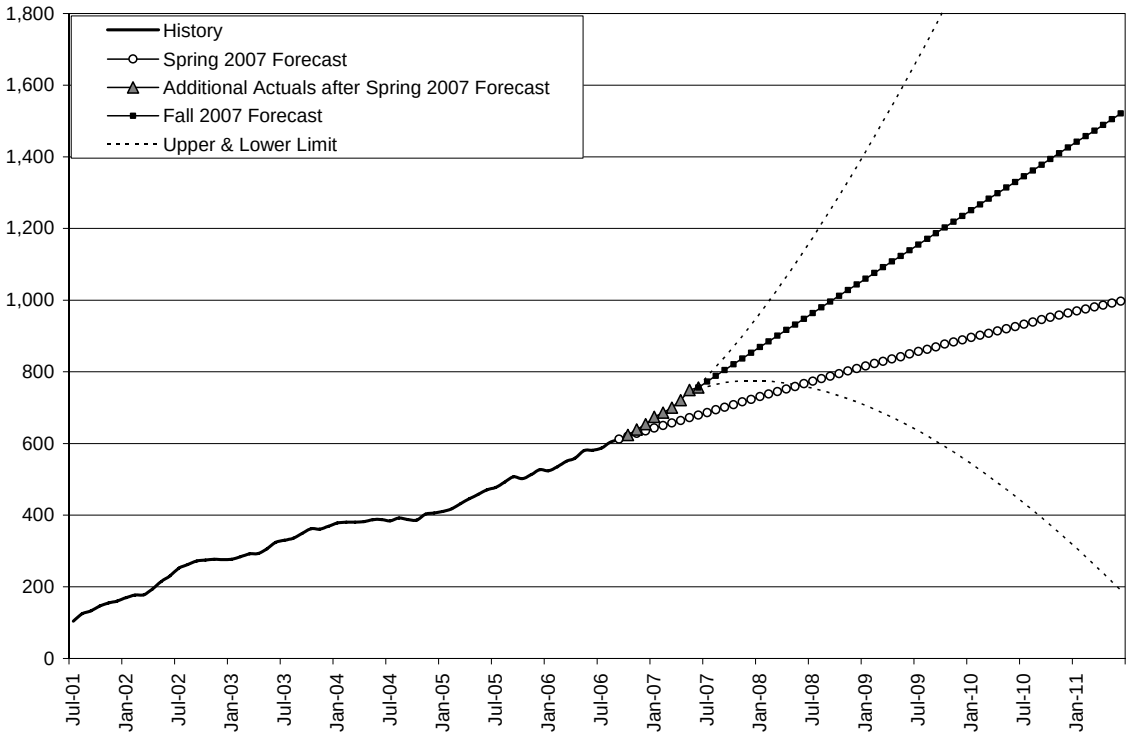


Exhibit B-16: Subsidized Guardianship - Number Served



Vocational Rehabilitation

The Office of Vocational Rehabilitation Services (OVRS) helps individuals with disabilities get and keep a job. It partners with community resources, and purchases training and services from a range of local providers.

Exhibit B-17: Vocational Rehabilitation Caseload Biennial Average Comparison by Forecasts (Clients)

	2007-09 Biennium				Fall Forecast		
Comparison:	Spring 07 to Fall 07				2007-09 to 2009-11		
Children, Adults & Families Division **Biennial Averages by Forecast**	**Spring 07 Forecast 2007-09**	***LAB 2007 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*%Diff. LAB 07 to Fall 07 2007-09*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*% Diff. Fall 07 2007-09 to 2009-11*
VOCATIONAL REHABILITATION (Clients)	8,991	8,991	9,181	2.1%	9,181	9,367	2.0%

*Spring 2007 Forecast and 2007-09 Legislative Policy Actions

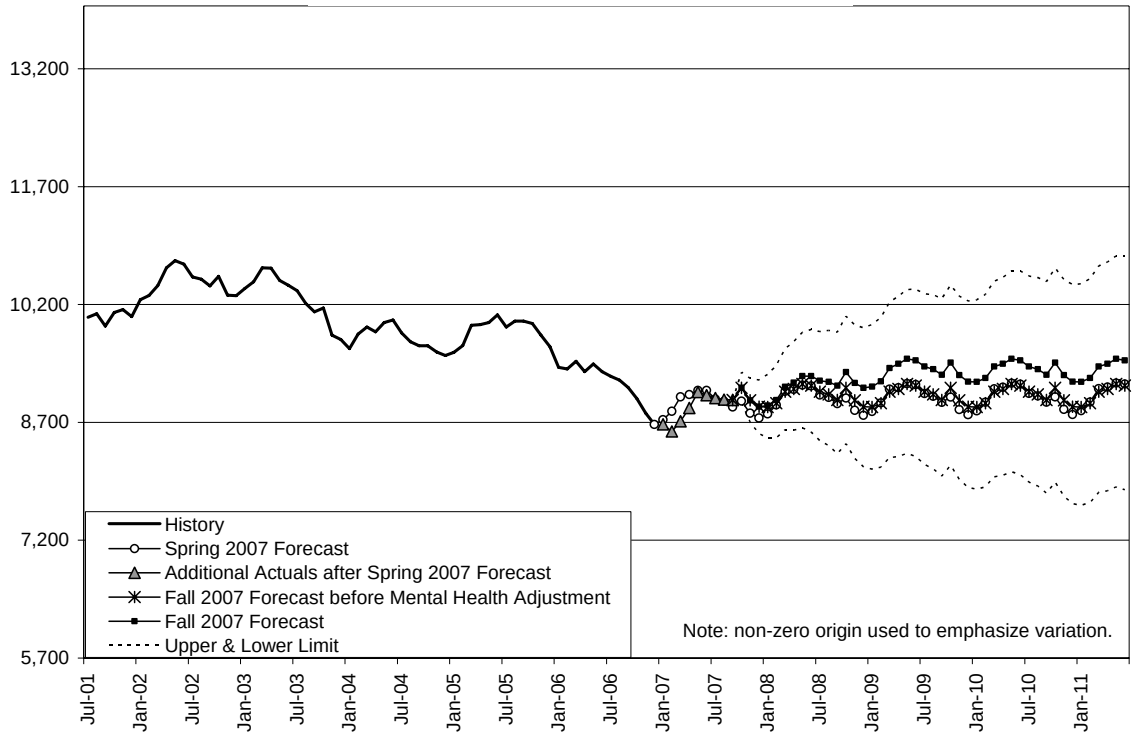
Forecast

The Fall 2007 forecast predicts an average of 9,181 Vocational Rehabilitation clients served per month for the 2007-09 biennium, which is very close to the LAB 2007 forecast (Exhibit B-17). The implementation of a 180-day standard for plan development that became effective October 1, 2006 shortened caseload length of stay, and prompted the closing out of pre-plan cases, which created some volatility. However, since the level of new applications and plans being worked did not subside, this resulted in low impact on counselor workload. The caseload resumed its previous trend in May 2006. The forecast is based on the assumption that this need will continue with some additional growth expected from an expansion of the Mental Health program for Supported Employment Evidenced Based Practices.

Risks and Assumptions

The expansion of the Mental Health program for Supported Employment Evidenced Based Practices could have a greater or lesser impact than the estimate used for the Fall 2007 forecast. Also, this caseload could be influenced by changes in the economy and in the availability of services through other organizations. Besides the specific risks that may impact the accuracy of the forecast, each forecast also carries an inherent risk that is based on unexplained variability in the actual caseload data. The farther out the projection, the greater the risk that it will deviate from what actually occurs in the future. Given the historical variability of the data, the average for the 2007-09 biennium could fall 8 percent above or 6 percent below the Fall 2007 forecast.

Exhibit B-18: Vocational Rehabilitation - Number Served



Division of Medical Assistance Programs

Introduction

The Division of Medical Assistance Programs (DMAP) provides health insurance coverage for low-income Oregonians. DMAP programs are divided into three major categories: Oregon Health Plan Plus (OHP Plus), Oregon Health Plan Standard (OHP Standard), and "Other" Medical Assistance Programs. These three groups are shown in Exhibit C-1 along with the names of the individual programs within each group. For programs that are part of the Oregon Health Plan, benefits are defined by a Prioritized List of eligible medical services that is maintained by the Oregon Health Services Commission, a separate entity from DHS. Each of the thirteen programs listed in Exhibit C-1 is discussed below.

Exhibit C-1: Division of Medical Assistance Programs benefits groups within program categories.

OHP Plus	OHP Standard	Other Medical Assistance Programs
Temporary Assistance for Needy Families - Related Medical	Adults & Couples	Qualified Medicare Beneficiary
Temporary Assistance for Needy Families - Extended	Families	Citizen-Alien Waived Emergency Medical
Poverty Level Medical Women		Breast & Cervical Cancer Program (Medical)
Poverty Level Medical Children		
Aid to the Blind & Disabled		
Old Age Assistance		
Foster/Substitute Care		
Children's Health Insurance Program		

Comparisons of Forecasts Over Time

Exhibit C-2 provides comparison between the current Fall 2007 forecast and the prior Spring 2007 forecast for each of the thirteen DMAP programs.

Exhibit C-2: Total Medical Assistance Programs Biennial Average Comparison by Forecasts

	2007-09 Biennium				Fall Forecast		
Comparison:	Spring 07 to Fall 07				2007-09 to 2009-11		
Medical Assistance Programs **Biennial Averages by Forecast**	**Spring 07 Forecast 2007-09**	***LAB 2007 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*% Diff. LAB 07 to Fall 07*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*% Diff. Fall 07 to Fall 11*
OHP Plus							
TANF-Related Medical	82,331	84,507	87,499	3.5%	87,499	93,019	6.3%
TANF-Extended	32,714	32,792	28,592	-12.8%	28,592	30,441	6.5%
TANF Medical - Subtotal	**115,045**	**117,299**	**116,091**	-1.0%	**116,091**	**123,460**	**6.3%**
Poverty Level Medical - Women	10,987	11,324	10,825	-4.4%	10,825	11,380	5.1%
Poverty Level Medical - Children	80,020	80,020	83,407	4.2%	83,407	84,754	1.6%
Aid to the Blind & Disabled	64,073	64,666	64,733	0.1%	64,733	68,906	6.4%
Old Age Assistance	30,417	30,486	30,487	0.0%	30,487	31,439	3.1%
Substitute Care & Adoption Serv.	19,054	19,054	17,667	-7.3%	17,667	18,104	2.5%
Children's Health Insurance Program	47,612	47,612	42,564	-10.6%	42,564	47,110	10.7%
OHP Plus Subtotal	**367,208**	**370,461**	**365,774**	**-1.3%**	**365,774**	**385,153**	**5.3%**
Other Medical Assistance Programs							
Citizen-Alien Waived Emergency Medical	16,778	16,778	17,573	4.7%	17,573	18,129	3.2%
Qualified Medicare Beneficiary	12,575	12,837	12,965	1.0%	12,965	14,829	14.4%
Breast & Cervical Cancer program	418	418	372	-11.0%	372	512	37.6%
Other Subtotal	**29,771**	**30,033**	**30,910**	**2.9%**	**30,910**	**33,470**	**8.3%**
OHP Standard							
Biennial Average Sustainable Number	**24,000**	**24,000**	**24,000**	**0.0%**	**24,000**	**24,000**	**0.0%**
Total Medical Assistance Programs	***420,979***	***424,494***	***420,684***	**-0.9%**	***420,684***	***442,623***	***5.2%***

*Spring 2007 Forecast and 2007-09 Legislative Policy Actions

Total Medical Assistance Programs

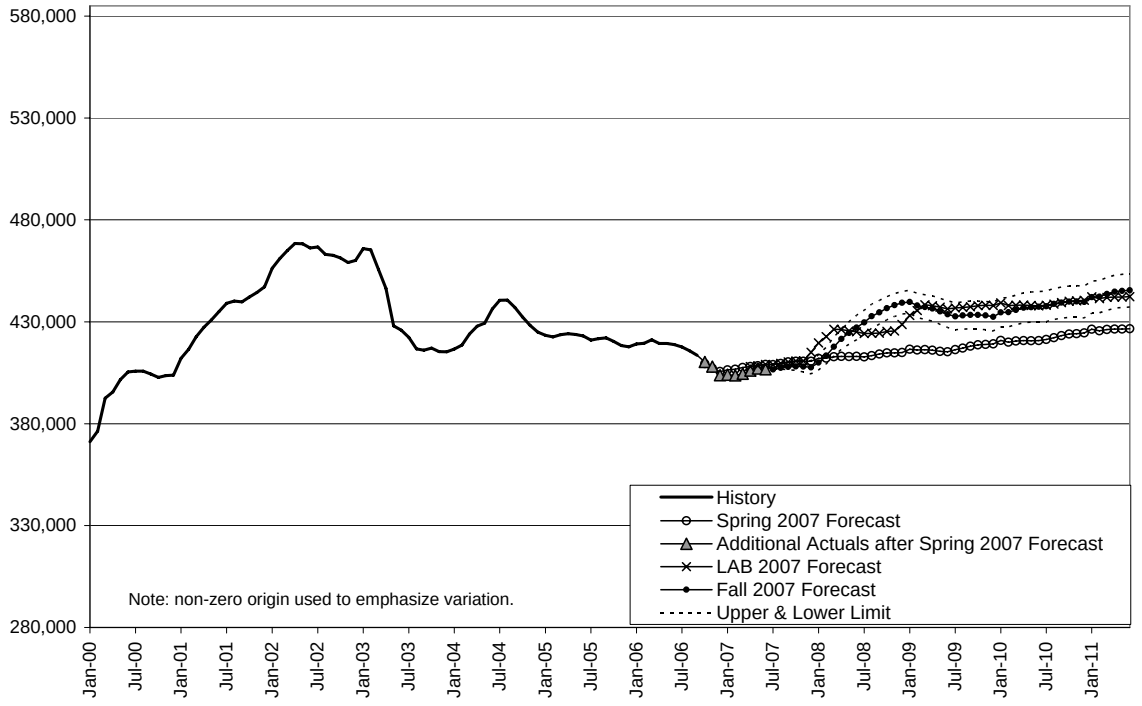
The total DMAP caseload was approximately 406,800 in June of 2007, the last month of complete data available for forecast and analysis. The historical period shown in Exhibit C-3, caseload growth began to accelerate beginning in late 1999 resulting in a historical high of approximately 465,000 in the spring of 2002. Over the following ten months the population remained relatively stable. Beginning in March of that year the client population began a rapid decline that persisted through the end of 2003. It was during this period that a series of budget cuts occurred, such as the closure of some small medical assistance programs, the creation of OHP Plus/Standard benefit packages that included the reduction of benefits in OHP Standard coupled with increased cost sharing and stricter enforcement of co-pays on monthly premiums. One of the effects was to decrease the OHP Standard population by approximately 50,000 clients. Beginning in early 2004 advocates began aggressive out reach efforts in

response to DHS planned closure of the OHP Standard program to new clients in July 2004. A brief period of caseload growth in many OHP programs followed. Ultimately the total Standard population dropped from approximately 110,000 to approximately 19,100 in June of 2007.

Forecast

The prior Spring 2007 forecast for all DMAP programs anticipated a general growth pattern in the caseload through the end of the 2009-2011 biennium. The current Fall 2007 forecast adds to the anticipated growth as a result of several legislative actions and policy changes. The current forecast estimates for the 2007-09 biennial average of 424,600 clients. The previous forecast was lower by approximately 11,600 clients. The upper and lower limits around the total DMAP caseload reflect the expected variation of the forecast from the actual counts of the aggregated program components. It is estimated that the total counts could reasonably vary an average of less than 2 percent above or below the forecast in the 2007-09 biennium without taking into consideration other risks to the forecast as described at the end of this section.

Exhibit C-3: Total Medical Assistance Programs



Oregon Health Plan Plus

The Oregon Health Plan Plus (OHP Plus) program represents one of the three broad program categories administered by DMAP. In February 2003, the Department replaced the original OHP Basic benefit package with the OHP Plus package. The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules. The OHP Plus population made up 87.8 percent of DMAP clients in June of 2007 and is expected to reach 88.2 percent by the end of the 2007-2009 biennium.

The total OHP Plus population consists of eight caseload categories listed below, which will be described in greater detail later.

- Temporary Assistance for Needy Families: Related Medical (TANF-RM)
- Temporary Assistance for Needy Families: Extended (TANF-EX)
- Poverty Level Medical Women (PLMW)
- Poverty Level Medical Children (PLMC)
- Aid to the Blind & Disabled (AB/AD)
- Old Age Assistance (OAA)
- Foster/Substitute Care & Adoption Services (FSC/AS)
- Children's Health Insurance Program (CHIP)

OHP Plus: Temporary Assistance for Needy Families (Medical & Extended)

The TANF medical program is made up of two groups, TANF Related Medical (TANF-RM) and TANF Extended (TANF-EX). These caseloads are inter-related programmatically, but differ in their characteristics. Clients in the TANF-RM program are those who meet the criteria to receive TANF cash grants. However, they may choose to receive both cash and medical benefits, or medical benefits only. Clients in the TANF Extended caseload are individuals who have left TANF Related Medical when they are over income limits. These clients may receive up to 12 months of transitional medical benefits if the increase in income is due to employment or up to four months if the increase is due to child support payments.

The total TANF medical assistance caseload (TANF Related Medical plus TANF-Extended) grew rapidly from the beginning of 2001 for about one year, leveled off, and grew again rapidly in 2003. The earliest period of growth lasted for about 15 months until the spring of 2002. The sustained rapid growth of the total TANF caseload peaked in the spring of 2005. For the next twelve months the total caseload remained relatively stable between 135,000 and 140,000 clients. However, since March 2006 and continuing through September of 2006, the combined caseloads have significantly dropped to approximately 125,000 clients.

The rapid increase of the client population during 2001 and 2003 was largely due to the beginning of the Oregon recession, as well as internal DHS program integrity efforts to place clients in the correct and appropriate Medical Assistance programs. The hiatus in growth from the spring of 2002 to the beginning of 2003 corresponds with a 'dip' in the unemployment rate from greater than 8.5 percent to a low of less than 7 percent in the same time period. While the unemployment rate alone does not explain all of the changes to TANF populations, it is highly correlated and is an effective indicator of the economic conditions necessary to contribute to an increase in TANF caseloads. Following the unemployment low in September of 2002, a second recessionary peak occurred including a return to unemployment rates around 8 percent or higher. This second recessionary peak slowly declined to much lower unemployment rates by the end of 2004. Under-employment also created conditions that contributed to an increase in TANF caseloads, since 'under-employed' clients may be working in jobs that are part-time, have low wages, and/or do not provide health insurance coverage.

The recent decline in this population is primarily due to policy changes implemented in the spring and summer of 2006. Briefly, they include an automatic closure of TANF cases that were overdue for review; increasing the time one needed to be in TANF-RM in order to qualify for TANF-EX; and increased financial reporting requirements for TANF-EX. All are part of ongoing program integrity efforts. These changes were expected to exert downward pressure on each of the TANF-RM and TANF-EX caseloads and, by virtue of their programmatic interactions, create downward effects on each other. This downward trend was also expected as a result of the effects of moderate economic expansion in Oregon. Evidence from recent months would indicate that these effects have worked their way through the system with both component programs showing a slowed decline or an increase for the first time since March of 2006.

OHP Plus: Temporary Assistance for Needy Families-Related Medical (TANF-RM)

The TANF-RM client group makes up around 77.5 percent of the total TANF medical caseload (June 2007). Since it is by far the larger of the two TANF groups, the historical growth and decline of TANF-RM generally parallels that described above in the total TANF. This benefit group experienced a sustained period of growth between the fall of 2002 and spring of 2005. However, since that time the caseload for this group has dropped from a high of approximately 100,000 clients in March of 2005 to nearly 87,600 in June of 2007 (Exhibit C-6). Estimated caseloads since June of 2007 would indicate that this population, may have, settled into a stable, seasonal pattern.

OHP Plus: Temporary Assistance for Needy Families-Extended (TANF-EX)

The TANF-EX benefit group is made up of clients who have left the TANF-RM group due to a change in income (see earlier discussion of the total TANF client group). During the recession and while the TANF Related Medical client population was dramatically increasing, this group remained relatively flat. Since this group comes only from TANF-RM, there is also a tendency for caseload changes to lag the changes in the other group. The longest period of growth in the TANF-EX population (April 2004 through December of 2005) is due to the increase in absolute number of clients moving from TANF-RM to TANF- Ex during that period. This group entered a period of rapid decline after March of 2006. This date corresponds to the implementation of eligibility reform described earlier. Recent months actuals indicate that the period of policy-driven decline is may be over. The caseload for this group 'bottomed-out' in May of 2007 and has exhibited a pattern of slow increase since that time.

Forecast

Since the Spring 2007 forecast, two policy changes have or will be enacted. The most significant is represented in TANF Reauthorization legislation, HB2469. This legislation is forecast to add an average of 2,620 cases per month to TANF Related Medical from October of 2008 through June of 2009. The reopening of OHP Standard to new clients sometime in early 2008 will add approximately 174 additional cases to the TANF-RM caseload through the end of the 2007-2009 biennium.

Since TANF Extended and TANF Related Medical are programmatically tied any change to TANF Related Medical results in TANF Extended caseload changes. Of the clients leaving TANF-RM, approximately 40 percent exit to TANF-EX. Additionally, of the clients leaving the TANF-EX group, approximately one third return directly to TANF-RM. The current Fall 2007 forecast calls for strong growth in the TANF-Ex population driven by changes to TANF Related Medical. (See exhibits C-5 through C-7)

The Fall 2007 forecast for both groups combined estimates a 2007-2009 biennial average of approximately 116,000 cases. This is compared to 115,000 cases estimated in the Spring 2007 LAB forecast.

Risks and Assumptions

An assumption in the TANF forecasts is that the economy, job growth and health insurance availability will follow the predicted trends in upcoming years (i.e. moderate economic growth, and job growth largely in the service sector with about the same levels of availability of health insurance). Changes in economic

conditions create a high level of risk to the forecasts due to the high level of sensitivity of these groups to the economic environment. Since the forecast was completed the Oregon economists have presented a gloomier outlook in the upcoming years, which if it occurs, would present a risk that the forecast has understated the number of people expected.

Another more tangible risk to the forecasts for both of these groups is the TANF reauthorization, HB2469. While the new program structures are known, anticipating all of the effects is simply not possible. Consequently, the TANF caseload forecasts have substantial risks associated with them.

Even without the substantive risks listed above these forecasts have a high degree of variability when compared to the actual counts. This creates a high range of expected variability of plus/minus 4.5 percent for the 2007-09 biennium (Exhibit C-5).

OHP Plus: Poverty Level Medical Women

The Poverty Level Medical Women (PLMW) program provides medical insurance coverage to pregnant women with income levels up to 185 percent of the federal poverty level (FPL). Coverage is extended for 60 days after childbirth. The income eligibility limit was increased from 170 percent to 185 percent of FPL in February 2003.

The Poverty Level Medical Women program group has had consistent, if intermittent, growth at least as far back as the beginning of 2001. During the two years from 2001 to 2003 the total client caseload averaged 8,500 clients. With the expansion of 170 percent to 185 percent FPL at the start of 2003, the caseload increased in a one-time shift to a new level of just below 9,500 cases. The pattern of moderate growth continued through January of 2005 when a more rapid growth pattern emerged. This rapid growth has continued through June of 2007. The growth rate parallels the number of births statewide.

Forecast

The Fall 2007 forecast is slightly lower than the Spring 2007 forecast. The current forecast biennial averages are approximately 10,800 during 2007-2009 increasing to approximately 11,380 for 2009-2011. These averages represent a decrease over the Spring 2007 forecast of less than 1.5 percent for 2007-2009. Exhibit C-8 displays the history and comparative forecasts for this group.

The historical variability and seasonality creates a level of general risk represented by the upper and lower limits that average about 3 percent for 2007-09 above and below the forecast.

OHP Plus: Poverty Level Medical Children

The Poverty Level Medical Children (PLMC) benefit group provides medical insurance coverage for children ages 0 through 5 in households with incomes up to 133 percent of the federal poverty level (FPL), and for children ages 6 through 18 in households with incomes up to 100 percent of the FPL.

Since January of 2005, the PLMC caseload has fluctuated by several thousand cases around an average caseload of approximately 81,000 clients. Prior to this period the caseload dropped rapidly beginning around July of 2002, and did not bottom out until January of 2005. This is largely due to the inter-relationship with the TANF programs. (Approximately 50% of the total TANF medical population is under the age of 13 and the CHIP children caseload). During the rapid growth of the TANF-RM program, many children were transferred from the PLMC caseload to the TANF-RM caseload because their parent/guardian now qualified for TANF-RM.

Forecast

The prior Spring 2007 forecast for PLMC projected a caseload pattern of general and slow decline through the end of the 2007-2009 biennium. The caseload was expected to decline to approximately 77,000 cases by late 2009. The current Fall 2007 forecast expects a reversal of this trend to one of slow growth punctuated by expected seasonal variation. By June of 2009 the population is expected to approximate 84,000. The upper and lower limits associated with this group attest to the relative historical variability and seasonality within this group. It is estimated that the forecast could reasonably be about $\pm$ 2.5 percent above or below the actual average for 2007-09 (Exhibit C-9).

OHP Plus: Aid to the Blind and Disabled

The Aid to the Blind and Disabled Program (AB/AD) provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). Aged, blind and disabled populations meeting Long-Term Care criteria are eligible up to 300 percent of the SSI level (which is equivalent to approximately 225 percent of the FPL); otherwise, these populations are eligible up to 100 percent of the SSI level.

The AB/AD caseload increased substantially from July of 1999 through January 2003. During that period the caseload grew nearly 20 percent, from about 46,600 clients to 55,300 clients. In February 2003, approximately 2,500 clients entered this caseload after the closure of the General Assistance (GA) program. At the time of the closure, clients were evaluated to determine if they were eligible for other programs. Many had disabilities and qualified for the AB/AD program, resulting in a one-time increase. The GA program reopened in

November 2003 with only a few hundred clients and then closed again in October 2005.

After the entrance of the GA clients, the AB/AD caseload remained stable until it began increasing in July 2004. Since that time, the caseload has continued to increase moderately.

Forecast

The Fall 2007 forecast for this group calls for a continuation of sustained growth through the end of the 2009-2011 biennium at a level somewhat higher than anticipated in the Spring of 2007. The Spring 2007 forecast estimated a 2007-2009 biennial average of approximately 64,000 while the current biennial average estimate is close to 64,700. In addition to the 'natural' growth associated with this caseload, upward pressure is exerted by the planned re-opening of the Standard groups to new clients in Spring of 2008, and the passage of HB2406. The re-opening of the Standard groups is expected to contribute cases to AB/AD through inter-category transfers. HB2406 has the direct effect of increasing the AB/AD population by approximately 200 clients through the end of the next 2009-2011 biennium. The upper and lower limits, which average less than one percent above and below the forecast, show anticipated stability in the continued growth of this program (Exhibit C-10).

OHP Plus: Old Age Assistance

The Old Age Assistance (OAA) benefit group provides medical insurance coverage through Medicaid for individuals who are age 65 or over and eligible for federal Supplemental Security Income (SSI).

Prior to February 2003, the OAA caseload increased at a steady pace. However, in February 2003, it declined due to the elimination of coverage for Service Priority Levels 15-17 on the Activities of Daily Living list. This change also reduced the number of potential clients who could enter the program, which has resulted in a stable caseload of approximately 30,000 clients.

Forecast

The Spring 2007 forecast for this group projected a continued relatively steady population across the entire forecast horizon at approximately 30,000 clients. The current forecast calls for a 2007-2009 biennial average of around 30,500 compared to an almost identical 30,417 estimated in the spring of 2007 (Exhibit C-2). The upper and lower confidence limits average around 1 percent above and below the forecast for 2007-09.

OHP Plus: Foster/Substitute Care and Adoption Services

The Foster/Substitute Care and Adoption Services benefit group provides medical insurance coverage through Medicaid for children in foster care and children whose adoptive families are receiving adoption assistance services.

The Foster/Substitute Care and Adoption Services caseload increased consistently from January of 2000 through January of 2006. Since that time this client population has stabilized around an average caseload of approximately 17,750.

Forecast

The previous Spring 2007 forecast for this group anticipated a return to patterns of continued growth consistent with Children, Adults, and Families, Child Welfare forecast. This group has a history of growth followed by short periods of flattening. The risk that the Spring 2007 estimates were overstated was realized in that the expected return to growth did not materialize. In fact, the client population stabilized and even showed a recent slight downturn. Currently it is expected that this population will exhibit a long period of stabilization with slight increases over the forecast horizon. The Fall 2007 forecast estimates a 2007-2009 biennial average of 17,667 compared to the much higher prior estimate of approximately 19,054. The range of upper and lower limits of plus or minus 2.2 percent reflects the variability of historical forecasts compared to actual historical counts.

OHP Plus: Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) covers uninsured children from birth through age 18 living in households with income up to 185 percent of the federal poverty level.

The total CHIP caseload has grown in different patterns over the years. From July of 1999 through November 2001, the CHIP caseload increased slowly but steadily to a total of approximately 20,430. From November 2001 through August 2002, the caseload growth slowed. Beginning around September 2002 and continuing through September 2004, a seasonal pattern of caseload growth and decline with high points occurring near January of each year emerged. In keeping with seasonal patterns, a short period of stabilization appeared in the summer months before a return to a steady increase.

Forecast

The Fall 2007 forecast estimates biennial averages for this group to approximate 42,500 for 2007-2009. This current forecast calls for a moderation of the aggressive growth pattern in the Spring 2007 estimate.

The main driver for the increase is a major policy change that was implemented in June of 2006. CHIP clients now have 12 months of coverage before eligibility recertification, compared to six months prior to the policy change. In effect, this policy change is expected to initiate a rapid accumulation of clients to a much higher base level. It is from this new base that previous patterns of slow but persistent growth are expected to re-emerge.

Exhibit C-4: Total Oregon Health Plan Plus

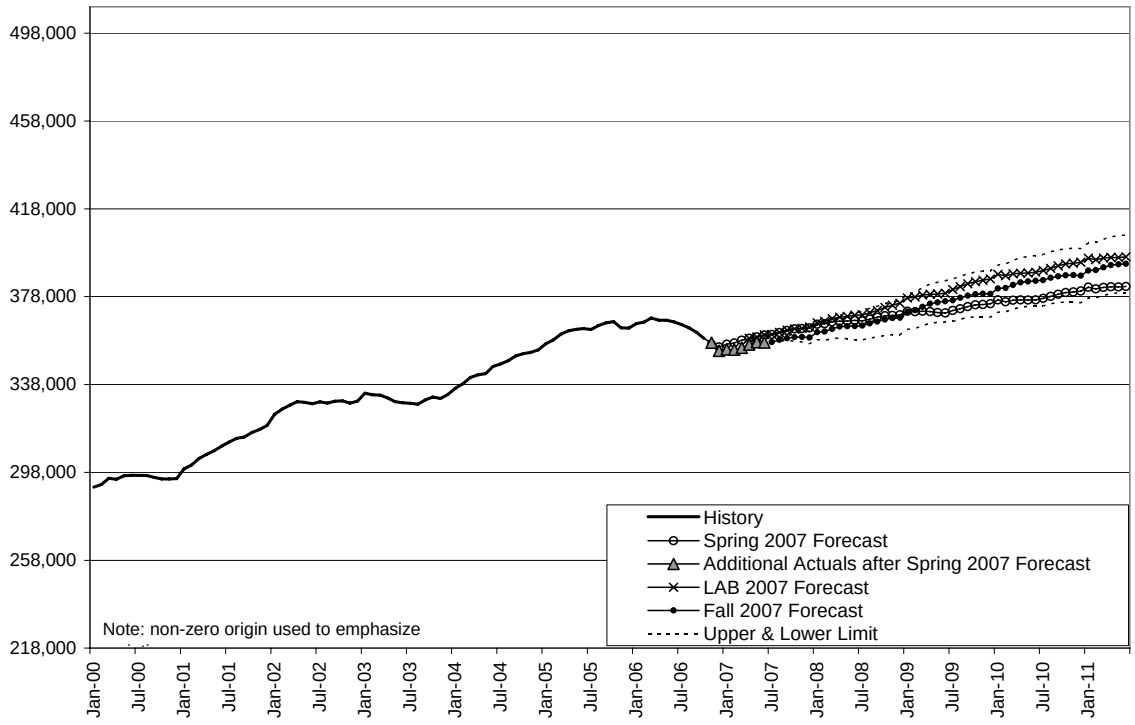


Exhibit C-5: Total Temporary Assistance for Needy Families

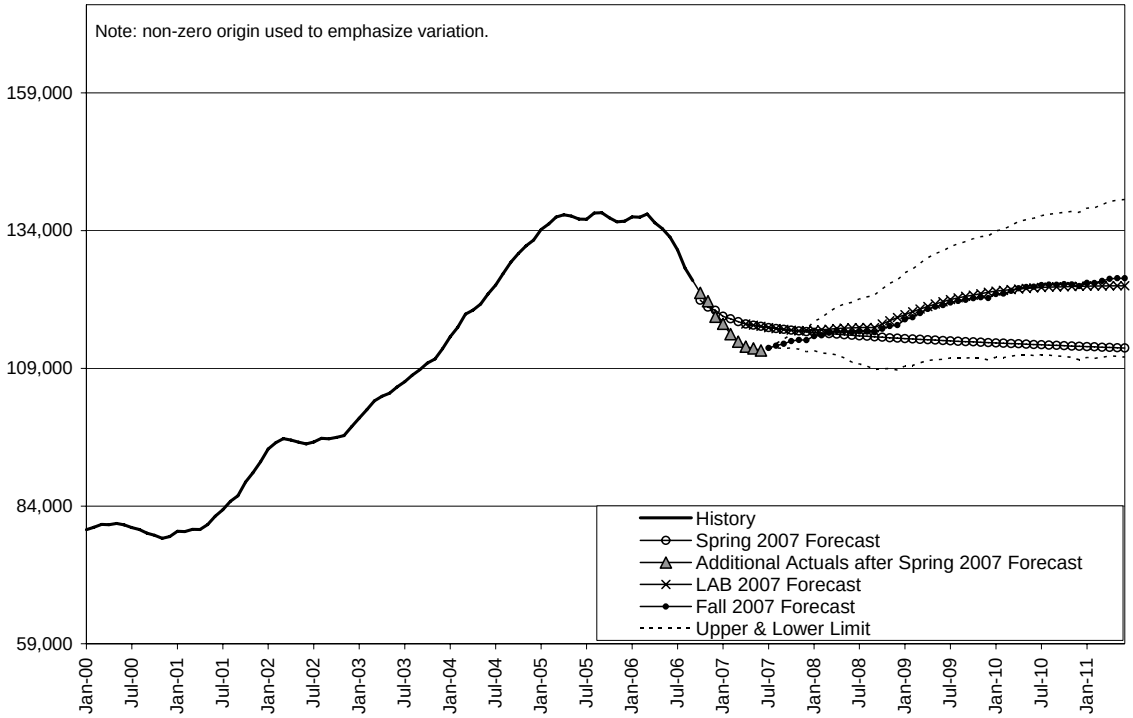


Exhibit C-6: Temporary Assistance for Needy Families-Related Medical

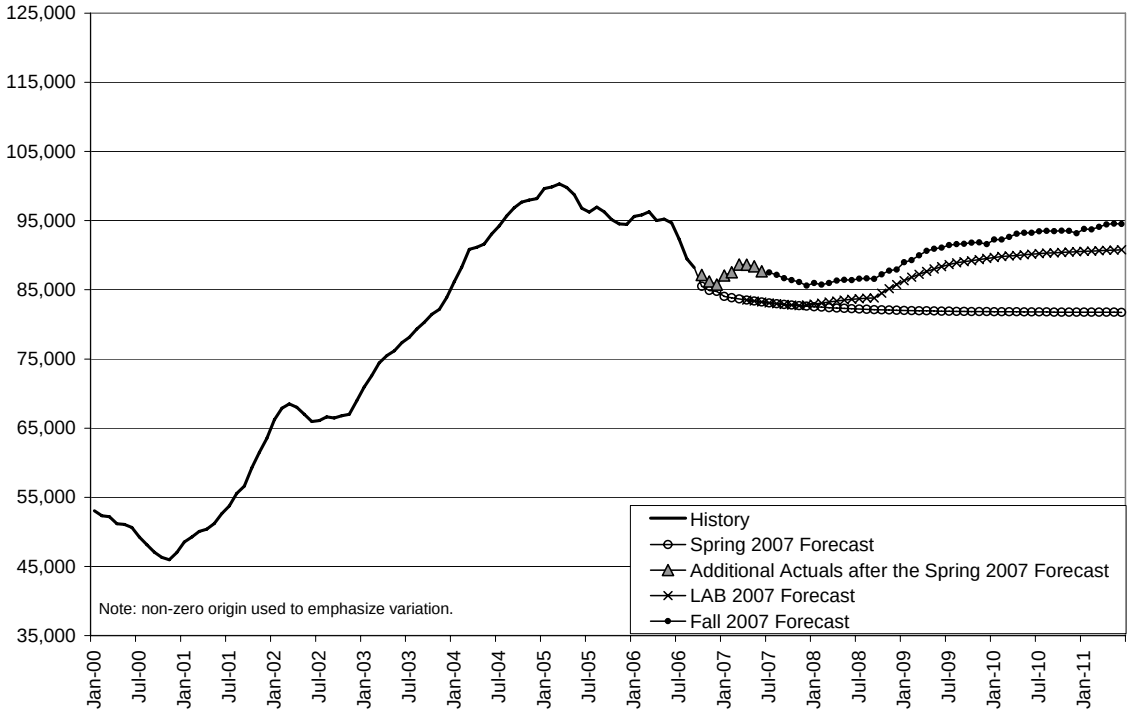


Exhibit C-7: Temporary Assistance for Needy Families-Extended

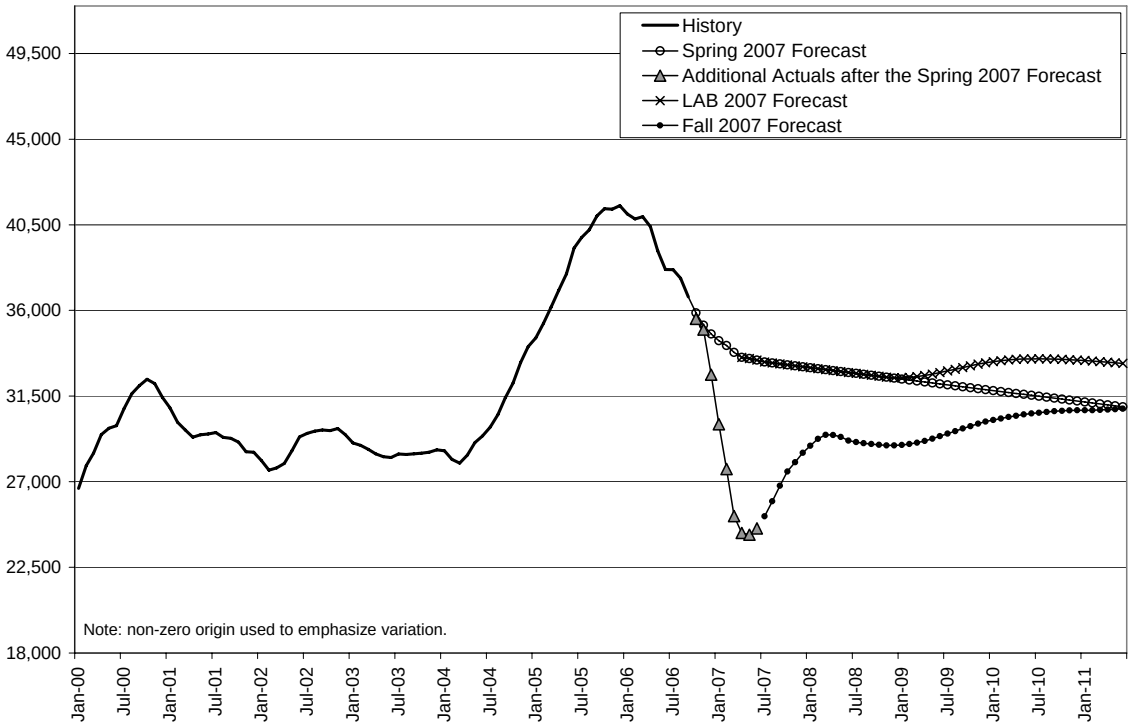


Exhibit C-8: Poverty-Level Medical Women

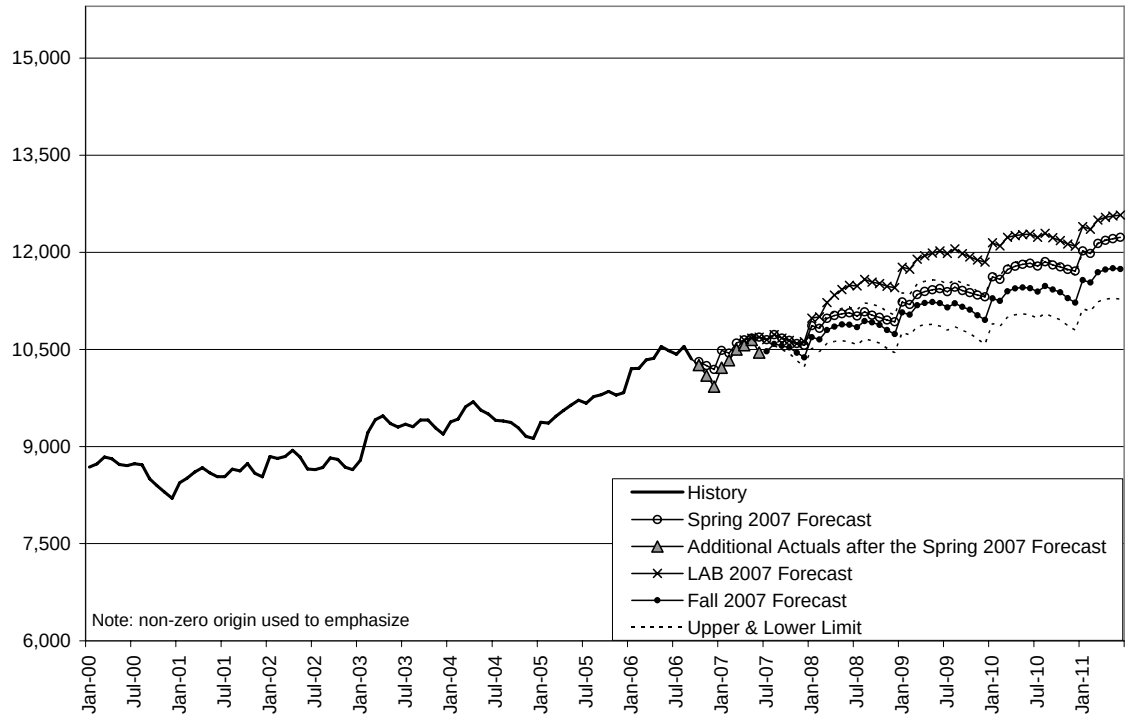


Exhibit C-9: Poverty-Level Medical Children

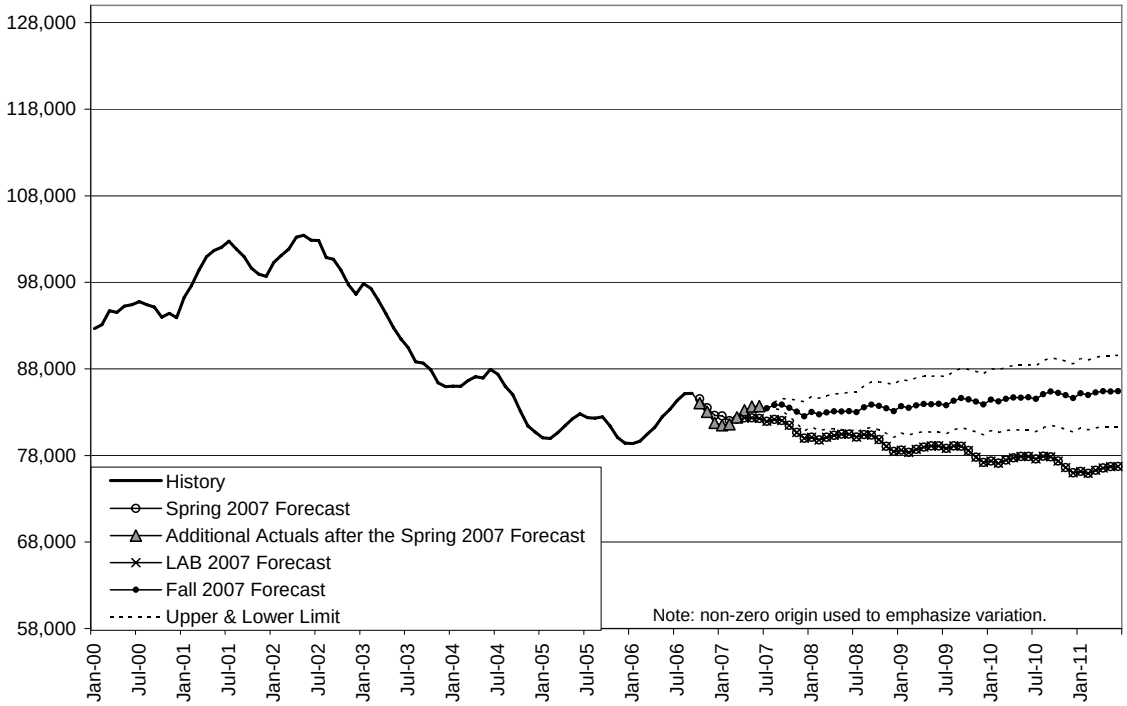


Exhibit C-10: Aid to the Blind and Disabled

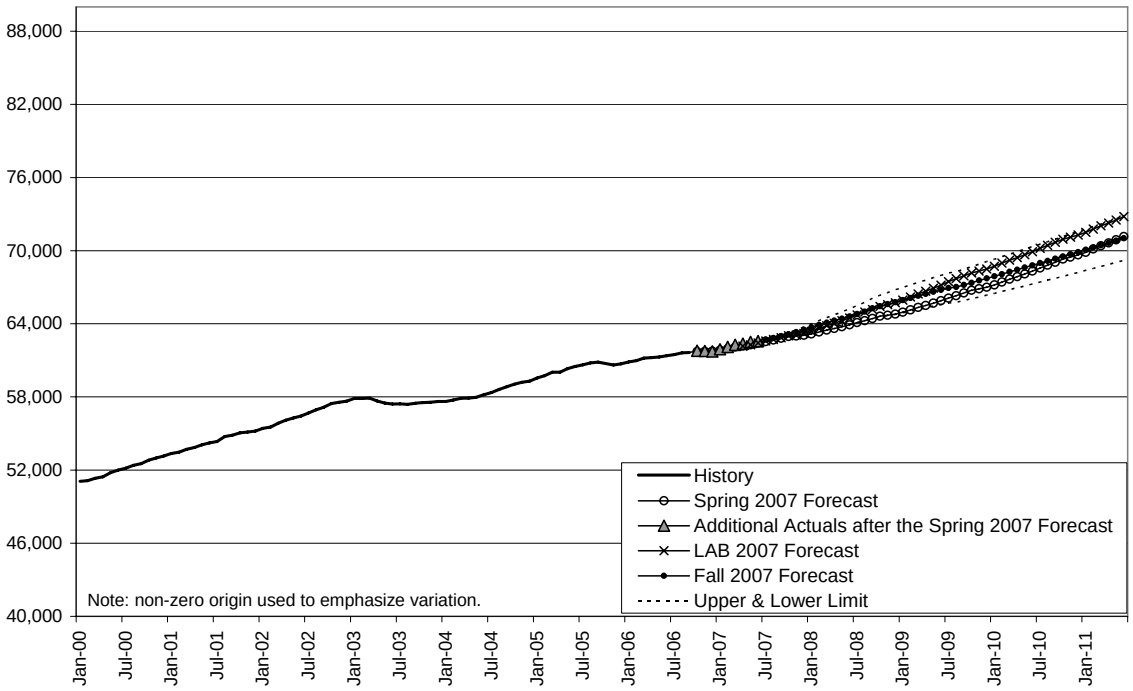


Exhibit C-11: Old Age Assistance

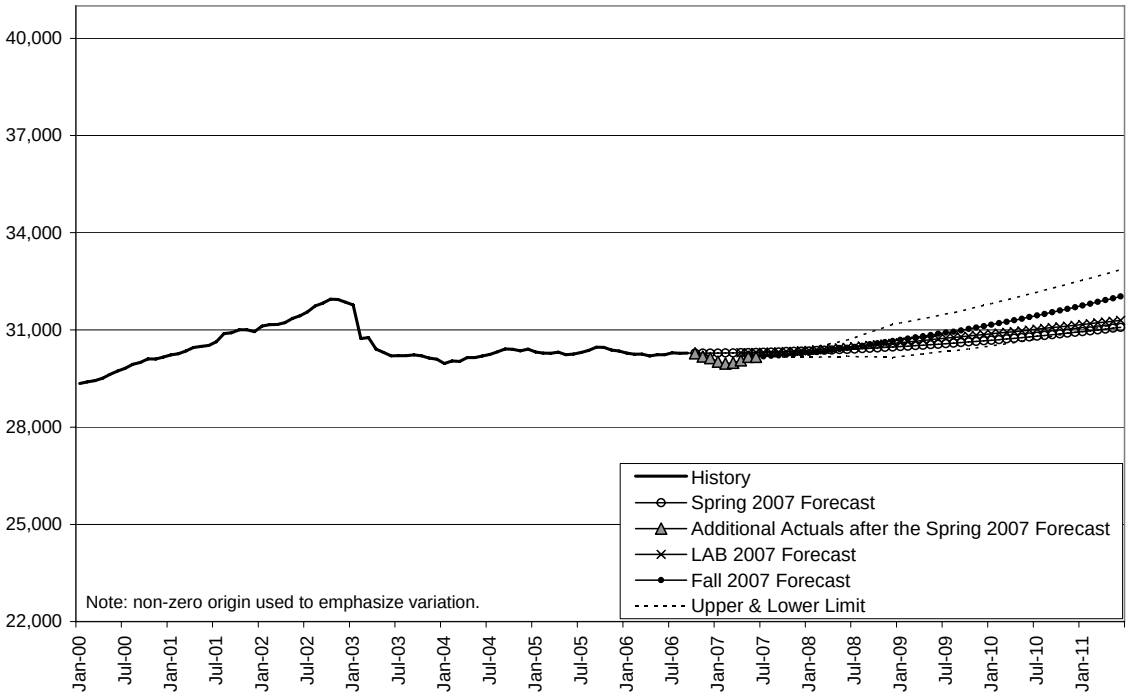


Exhibit C-12: Substitute Care & Adoption Services

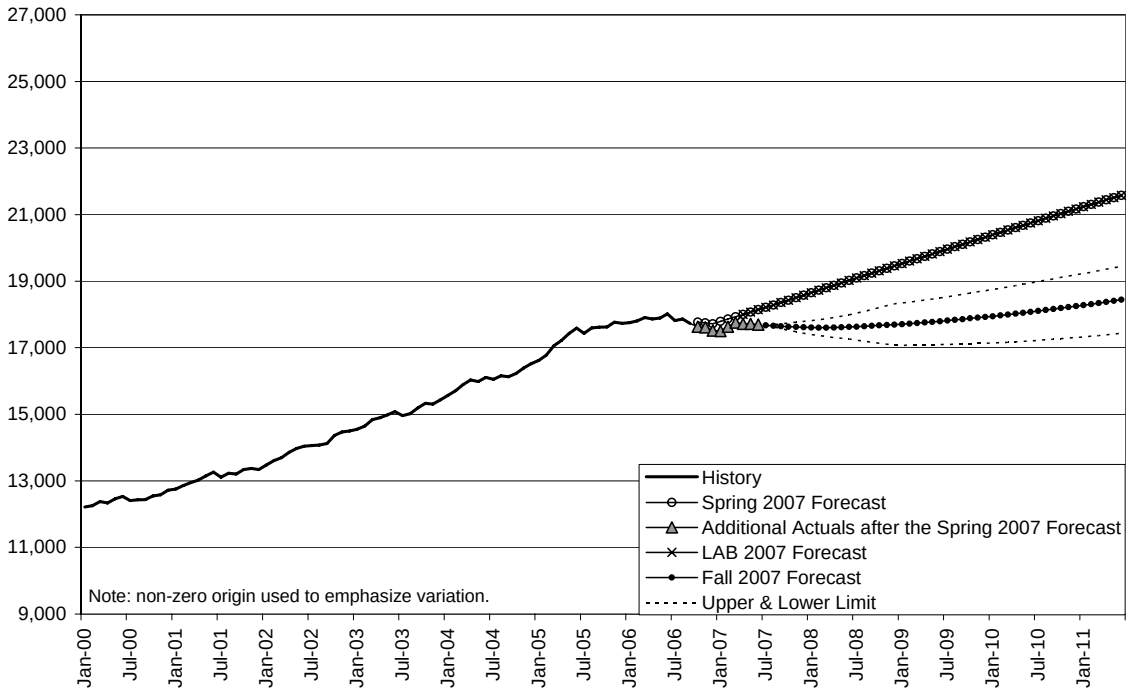
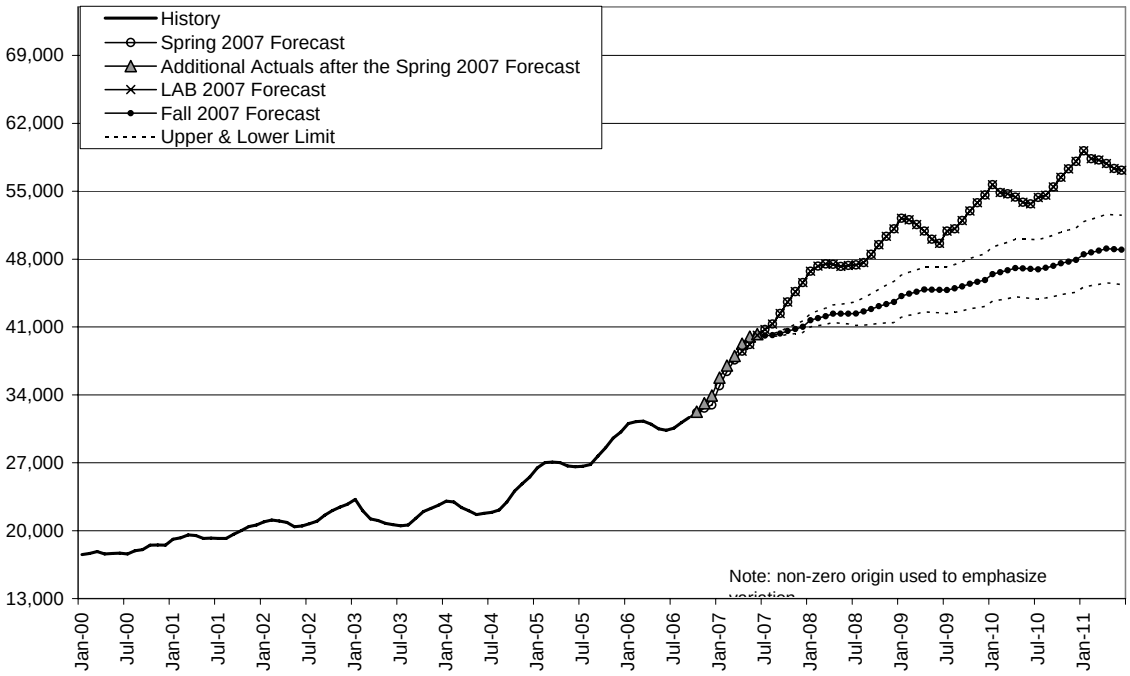


Exhibit C-13: Children's Health Insurance Program



Oregon Health Plan Standard

The OHP Standard program was created in February 2003 with a reduced package of covered medical services compared to the OHP Plus program. This program incorporated clients from other OHP programs that were part of the original 1994 OHP expansion. The OHP Standard program also required that participants share some of the costs of their medical coverage through the institution of premiums and co-payments. The clients in OHP Standard are not eligible for traditional Medicaid programs under Federal rules and represent an expansion under the Oregon Health Plan. The OHP Standard program consists of two benefit groups:

Families (Parents): Adults whose income is up to 100 percent of the federal poverty level, who have children, but do not qualify for traditional Medicaid programs.

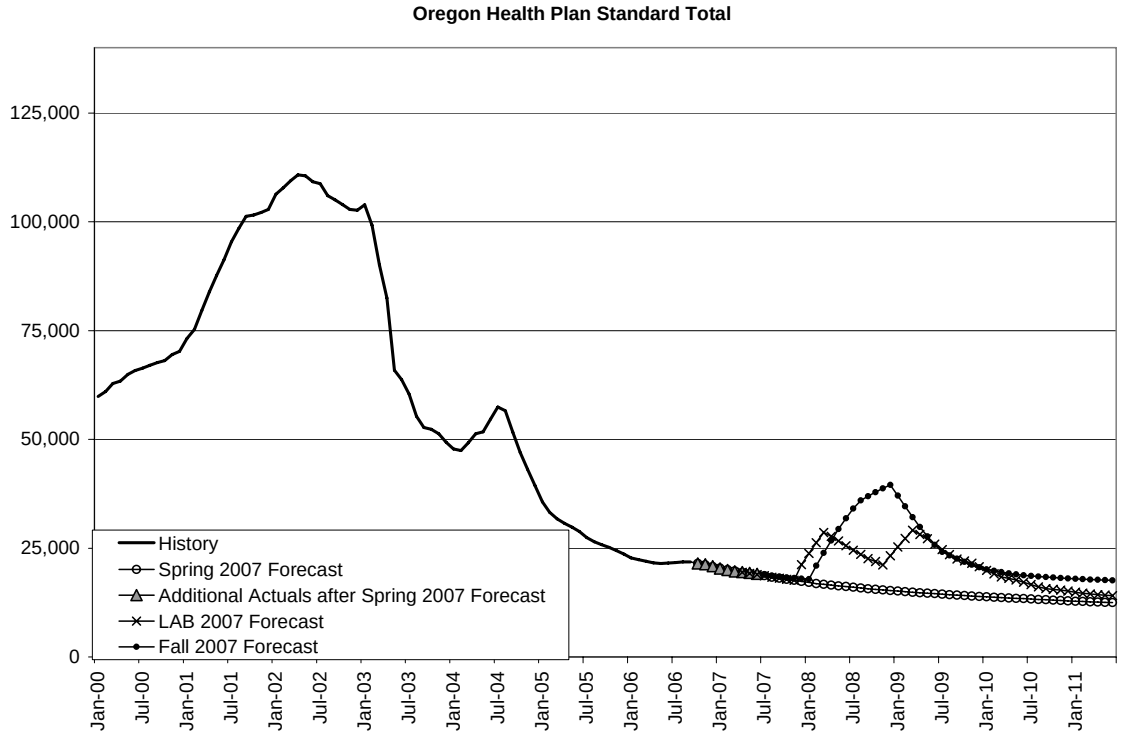
Adults and Couples: Adults with income up to 100 percent of the federal poverty level, who do not have children, and do not qualify for traditional Medicaid programs.

From the start of the program, OHP Standard program clients have been subject to a variety of benefit cuts and restorations. Also, as of July 2004, this program was closed to new clients. However, individuals already participating in other OHP Plus programs were, and continue to be, allowed to transfer into OHP Standard, if they meet OHP Standard eligibility criteria.

In January 2003, the combined population for these two groups was just over 100,000. In February 2004, after 13 months of rapidly decreasing caseloads associated with benefit reductions, increased co-payments and strict enforcement of premium payment requirements, the combined population was fewer than 48,000 clients. During the period immediately prior to closure of the program in July 2004, the caseload increased as a direct result of outreach by advocacy groups. The subsequent closure initiated a caseload decline that continued through early 2006. As of June 2007, the last month of complete historical data available for this forecast, the combined populations of these two groups stood at approximately 19,100. The June 2007 caseloads for Families and for Adults/Couples were around 7,300 and 11,800, respectively.
All state General Fund support for the Standard program was eliminated during the 2003 legislative session. However, a tax package was proposed by the legislature that would have funded the program. In February 2004 a referendum, Measure 30, was put before voters and defeated, overturning the Legislature's proposed tax package and leaving the Standard program without funding. Subsequently, the program was funded through provider taxes assessed on health care organizations that provide services for OHP clients. In early 2005, an analysis of available revenue indicated that the Standard program could provide

benefits for a maximum 2005-07 biennial average of about 24,000 total clients, 17,000 Adults/Couples and 7,000 Families.

The Spring 2007 forecast for the total standard population, absent a reopen program, called for a gradual decline of the population over time. The current Fall 2007 forecast includes the effects of reopening the Standard program (Families and Adults and Couples) to a fixed monthly number of new clients from Spring 2008 through the end of the 2008 calendar year.[3] Families generally make up approximately 40% of the total Standard program. Contributions from this program to other eligibility groups via the normal eligibility transfer process are expected and have been taken into consideration when forecasting the affected groups.



[3] The implementation of the Standard re-open plan is subject to change.

Other Medical Assistance Programs

Three DMAP benefit groups comprise the remaining portion of the forecast. They are the Qualified Medicare Beneficiary (QMB), Citizen-Alien Waived Emergency Medical (CAWEM), and Breast & Cervical Cancer Program - Medical (BCCP-M). The total number of clients in these groups has historically represented between 5 and 8 percent of the total DMAP client caseload; the Breast and Cervical Cancer Program - Medical being by far the smallest caseload, representing less than 2 percent of the total of the three groups in June of 2007. Each of these programs is discussed separately below.

Other: Qualified Medicare Beneficiary

Qualified Medicare Beneficiary (QMB) clients meet the criteria for both Medicare and Medicaid participation. The clients included in this caseload have incomes below 100 percent FPL, but above 100 percent of SSI, which is approximately 67 percent FPL. In addition, they do not meet the criteria for medical covered long-term care services. DHS pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductibles not exceeding the Department's fee schedule.

Forecast

The closure of the Medically Needy program in February 2003 resulted in a one-time shift of clients from the Medically Needy program into the QMB group. This occurred because the majority of Medically Needy clients had Medicare, and met the QMB eligibility criteria. The one-time shift increased the caseload by approximately 4,400 clients. Since the shift, the caseload has increased steadily. However, growth has been accelerating since spring 2004 to the present.

The previous Spring 2007 forecast for the QMB benefit group projected a continuation of caseload growth virtually identical to that anticipated in earlier forecasts. The current Fall 2007 forecast continues the growth expectation but at a more aggressive level than previously anticipated. The Fall 2007 forecast expects a 2007-2009 biennial average of nearly 13,000 clients compared to approximately 12,600 in the previous forecast. The upper and lower limits reflect the average variation compared actual forecasts. The upper and lower limits range on average for 2007-2009 about 1.5 percent from the forecast.

Other: Citizen/Alien Waived Emergency Medical

The Citizen/Alien Waived Emergency Medical (CAWEM) program is a federally mandated program that covers emergency care and childbirth services for non-citizens otherwise eligible for Medicaid services. CAWEM beneficiaries became identifiable as a group in January 2000 when separate computer codes were developed to track this population.

Historically this group had large swing in total caseload peaking in July of 2004 with approximately 25,600 clients followed by a precipitous decline to approximately 18,600 in December of 2005. This pattern of decline closely tracks that of the OHP Standard population right before and after that program was closed to new clients. The drop occurred because applicants who would have met OHP Standard eligibility requirements except for citizenship (CAWEM clients) were now required to meet the more restrictive eligibility requirements of OHP Plus, thus reducing the number of new clients entering this program. Beginning with January of 2006 this caseload began to rebound, showing a recovery from the Standard closure effects. As of this writing the overall caseload pattern appears to be one of stabilization with potential for a pattern of slow seasonal growth.

Forecast

The Fall 2007 forecast for the CAWEM client is higher than the Spring 2007 forecast. The Fall 2007 forecast estimates a biennial average of approximately 17,573 in contrast to the earlier Spring 2007 estimate of approximately 16,800. Exhibit C-15 displays the history and comparative forecasts for this group. The upper and lower limit estimates average close to 2 percent above and below the forecast for 2007-09.

Other: Breast and Cervical Cancer Program

The Breast and Cervical Cancer Program - Medical (BCCP-M) began in January 2002. This program provides medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Public Health through county health departments and tribal health clinics. After determining eligibility, the client receives all Oregon Health Plan Plus medical insurance benefits including mental and dental health services. A client is eligible until reaching the age of 65, obtaining creditable coverage or ending treatment. As of January of 2007, the caseload had grown to 334 clients. While this group is quite small, the caseload increase has generally been consistent and rapid. Only in the first half of calendar 2007 has the caseload shown a tendency to decline, primarily as a result of short-term administrative change, the impact of which is anticipated to be short-lived. Additional caseload information since June of 2007 would indicate a return to consistent and aggressive growth

Forecast

The Fall 2007 forecast for the Breast and Cervical Cancer caseload varies from the higher Spring 2007 forecasted estimates primarily due to the recent, short period of caseload decline. The current forecast, while calling for continued aggressive growth in this population, estimates slightly fewer clients for the 2007-2009 biennium with an average of 372. Compared to the Spring 2007, the 2007-2009 biennial average is approximately 418. The upper and lower limits show that for 2007-09, the actual counts could be expected to range an average of 3.3 percent above or below the forecast.

Additional Risks to the Spring 2007 Forecast

Risks to the current Spring 2007 forecast may be grouped into two broad categories: systemic/behavioral and policy related.

Many DMAP caseloads are sensitive to both available economic resources and access to health care systems. Systemic changes in economic conditions, especially the availability of jobs, exert upward or downward pressure on these caseloads. If the economy does not continue on its predicted path, the TANF, PLMC, and CHIP caseloads, in particular, are at risk of being incorrectly estimated.

Perhaps the greatest risk to the current Fall 2007 forecast lies with the estimates of the impacts of HB2469 which will increase the TANF Related Medical population as well as TANF Extended and the re-opening of the Standard groups to new clients. These two policies are expected to add thousands of clients to the existing caseloads. Both are subject to a wide variety of unknowns and therefore represent a substantial risk to the current forecast.

Exhibit C-14: Qualified Medicare Beneficiaries

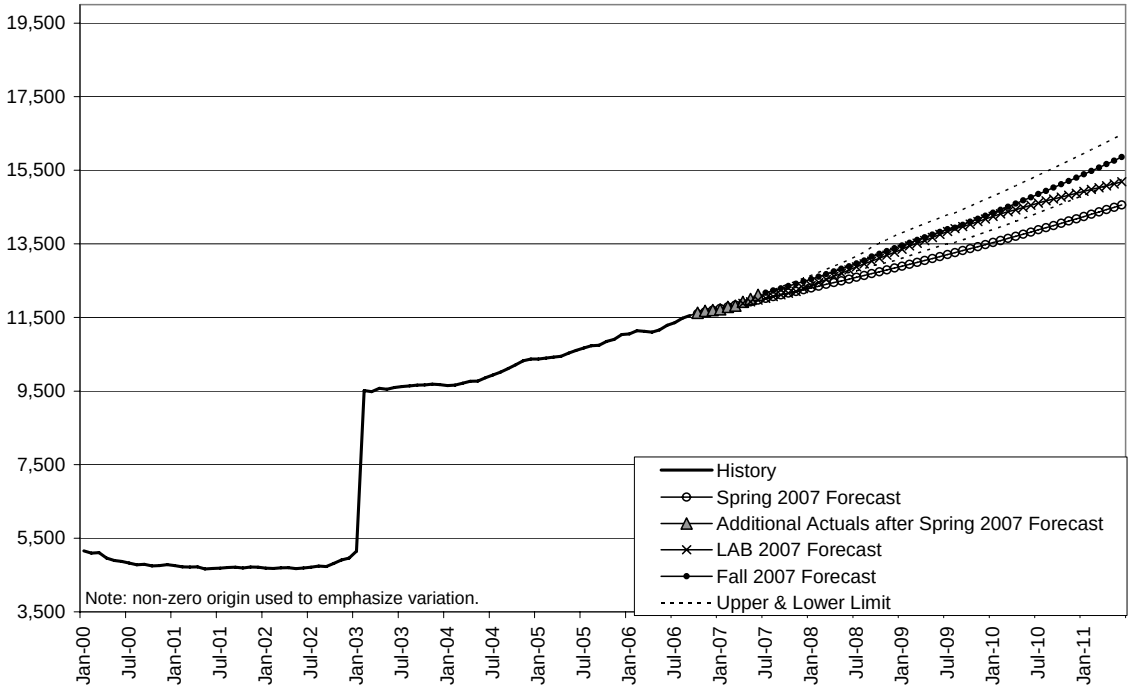


Exhibit C-15: Citizen / Alien Waived Emergency Medical

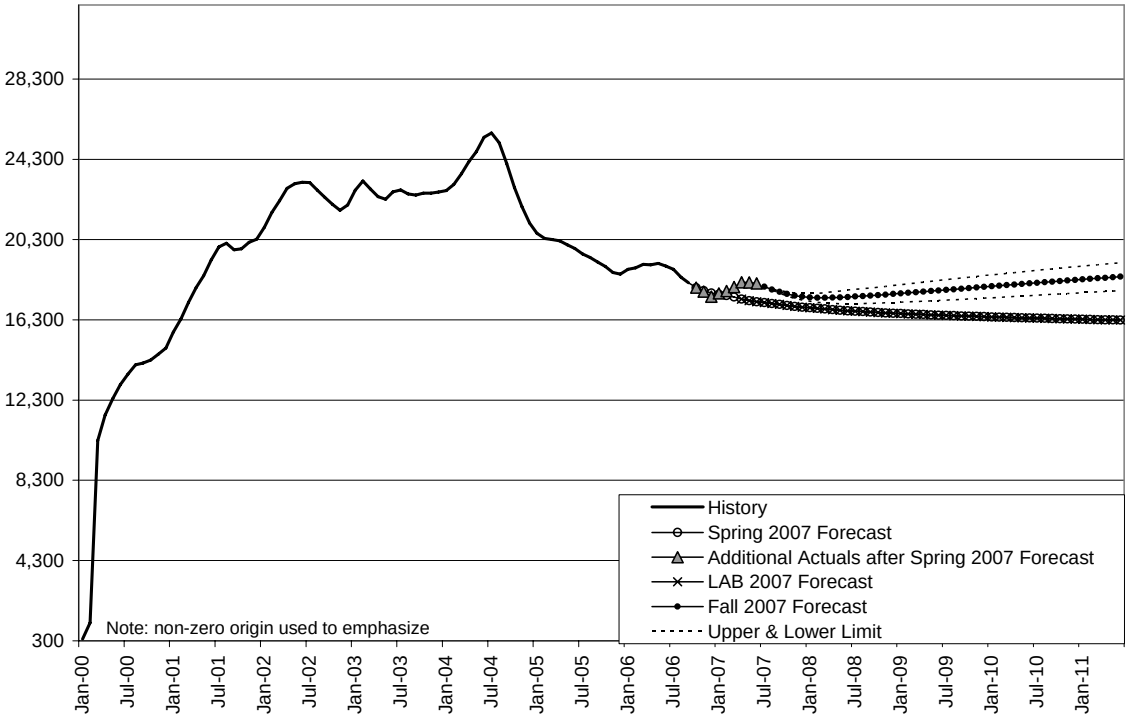
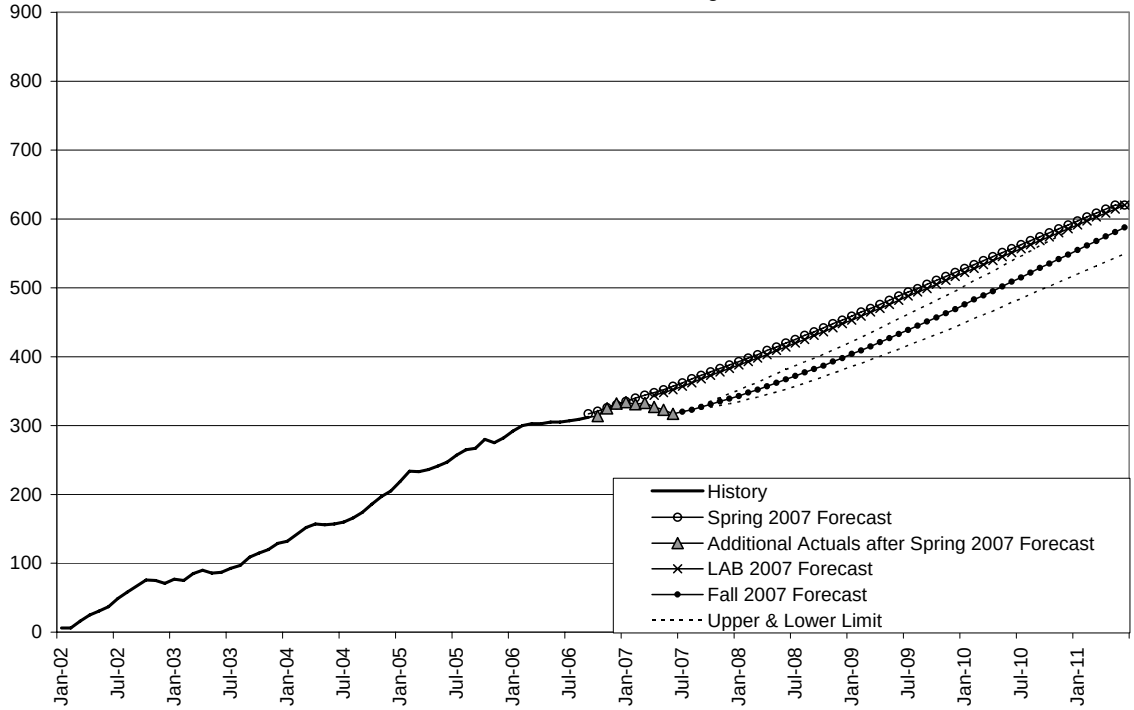


Exhibit C-16: Breast and Cervical Cancer Program - Medical



Addictions and Mental Health Division

Introduction

This forecast focuses on mental health services provided by the Addictions and Mental Health Division (AMH). Services primarily fall into two categories: Community Services, including Residential Care, and the State Hospital system. Community programs provide outpatient services including community/outpatient intervention and therapy, case management, child and adolescent day treatment, supported employment crisis and pre-commitment services. Residential 24 Hour Care includes placements in Secure Adult Facilities and Adult Foster Care. In addition, AMH services include acute hospital care.

The State Hospitals – located in Salem, Portland and Pendleton – 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.

For budgeting purposes, the Mental Health caseload is divided into two client groups: Mandated and Non-Mandated. Mandated populations are required to receive mental health services by Oregon law, and include care of both Criminally and Civilly-Committed patients. Services for the Mandated populations occur in community settings and State Hospitals (Exhibit D-1). Non-Mandated services are primarily provided in community outpatient settings. Only Mandated caseloads are forecasted. Each will be discussed in detail in a later section.

Exhibit D-1: Mandated Mental Health Caseload Categories by Setting

Setting	Criminally Committed		Civilly Committed
	Aid and Assist	Psychiatric Security Review Board	
State Hospitals	X		X
Acute Care Hospitals			X
24 Hour Care			X
Community Services			X
TOTAL	X	X	X

The Fall 2007 Mental Health forecast continues the new forecasting process that was implemented in Fall 2006. We use historical data from the Integrated Client Services Data Warehouse (ICS). Data definitions and business rules that have been used to create caseload categories have continued to evolve, resulting in slight to major differences in the monthly caseload numbers over this interval. For example, we now count and forecast Civilly Committed in community outpatient settings. Because of these differences, most comparisons between the Spring

2007 and Fall 2007 forecasts are problematic. Continued use of ICS numbers will eventually provide stable historical data for more appropriate comparisons in future forecasts.

Exhibit D-2 compares the biennial averages of actual counts and forecasted caseload per the Fall 2007 forecast for the 2007-09 and 2009-11 biennia.

Exhibit D-2: Mental Health Biennial Average Comparisons

Numbers of Clients Served per Month			
Addictions and Mental Health Programs **Biennial Averages**	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-011**	*% Diff. Spring 07 2007-09 to 2009-11*
Criminal Commitment			
Aid and Assist	177	200	13.0%
Psychiatric Security Review Board	781	846	8.3%
Total Criminal Commitment	**958**	**1,046**	**9.2%**
Civil Commitment			
24 Hour Care	1,420	1,725	21.5%
Acute Care	168	169	0.6%
State Hospital	316	316	0.0%
Community Care	2,792	3,260	16.8%
Total Civil Commitment	**4,696**	**5,470**	**16.5%**
Total Mandated Care	**5,654**	**6,516**	**15.2%**
Unduplicated Count, Total Mandated Care	**4,488**	**5,117**	**14.0%**

Mandated Mental Health Caseload

Forecast

Overall, the Mandated caseload is predicted to continue to increase through June 2009 (Exhibit D-3). The 2007-09 biennial average number of clients is estimated to increase by thirteen percent over the 2005-07 biennium. A primary driver of this growth is the increasing Civilly Committed caseload. The upper and lower limits for the Mandated caseload may vary, on average, by three percent through June 2009.

Criminally Committed

The Criminal Commitment (Forensics) caseload is composed of two separate categories: (1) **Aid and Assist** and (2) **Psychiatric Security Review Board** (PSRB). **Aid and Assist** are individuals placed in the Oregon State Hospital for assessment and treatment until they are fit to stand trial. A defendant can be tried only if he or she is able to understand and assist the attorney; fitness to proceed is sometimes called "Aid and Assist." The **Psychiatric Security Review Board** has jurisdiction over people who have been found "guilty except for insanity" of a crime by a court. AMH is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital.

Forecast

Recent levels of the total forensic caseload have increased after exhibiting a slight decline through 2005 and the first half of 2006 (Exhibit D-4). This caseload is expected to continue this rate of growth. The biennial average for the 2007-09 biennium is expected to increase by eleven percent over the 2005-07 biennium. The level of variation in the historical data contributes to a moderate level of uncertainty for the forecast as future levels might vary by an average of five percent above or below the forecast through June 2009.

The 2007 Legislature funded a comprehensive package of community-based services relating to the construction of new State Hospital facilities. Included in the bill were several strategies for "front end" services that would either mitigate the need for placement into the State Hospital or help to minimize some lengths-of-stay in the State Hospital. One such strategy, called "Jail Bridge Services" provides intensive case-management services to persons coming out of jail or being diverted from jail. The pilot program will serve up to 60 or more clients. If successful, this program would slow the rate of growth of the forensic caseload throughout the remainder of the biennium and thus serve as a risk to the forecast.

In addition, AMHD staff has developed a plan for accelerated placements of State Hospital forensic and civilly-committed patients into new residential treatment facilities in various communities. These numbers have been incorporated into the appropriate forecasts. Successful development of these residential facilities, however, requires the cooperation of local governments. Failure to cooperate in developing these residential facilities could jeopardize this plan and thus the forecasts.

Aid and Assist Forecast

The Spring 2007 forecast estimates a 34 percent increase in the Aid and Assist caseload; the 2005-07 biennial average of 132 increases to 177 in the 2007-09

biennium. However, relatively large and consistent variation in the historical data creates an average risk of 14 percent above or below the forecasted values (Exhibit D-5).

Psychiatric Security Review Board Forecast

We expect the total PSRB caseload to increase through the 2007-09 biennium (Exhibit D-6). The average monthly forecast for the 2007-09 biennium (781 clients) shows an increase of nine percent over the 2005-07 biennium. Future actuals may vary by eleven percent above or below the forecast.

Civilly Committed

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. Through this process, the individuals are mandated by a court to treatment. People on this caseload are served in a variety of settings. Previously, only that portion of the caseload that received services in the State Hospital system and/or in 24-Hour community settings (adult residential, foster care, and enhanced care) were included in the forecast. However, we are now able to include Civilly Committed receiving community outpatient services in the caseload forecast as well.

Forecast

The Fall 2007 forecast estimates that the combined Civilly Committed caseload will continue the growth trend of 2001 through 2007 into the latter part of the decade (Exhibit D-7). The average monthly forecast for the 2007-09 biennium shows an increase of 13 percent over the 2005-07 biennium. The Civilly Committed 2007-09 caseload may vary, on average, by four percent above or below future actuals.

Civilly Committed - 24 Hour Care

The Civilly Committed - 24 Hour Care caseload includes patients who have been Civilly Committed to treatment and reside in community residential settings that are not hospitals. These include Adult Residential, Secure Adult Residential, and Adult Foster Care facilities.

Forecast

The current forecast estimates that the Civilly Committed - 24 Hour Care caseload will continue the growth exhibited since early 2002 (Exhibit D-8). The average monthly forecast for the 2007-09 biennium shows an increase of 22 percent over that the 2005-07 biennium. Some of the more recent growth is due to placing some patients from the State Hospital into 24 Hour Care settings;

relocations from the State Hospital into the community are expected to continue and have been accounted for in the forecast. Future actuals may vary by nine percent above or below the forecast.

Civilly Committed - Acute Care

The Civilly Committed Acute Care caseload includes people that have been Civilly Committed and reside in Acute Care hospitals other than the State Hospitals.

Forecast

The 2007-09 Civilly Committed Acute Care caseload is expected to decrease slightly from the 2005-07 level (Exhibit D-9). However, the high variation in the historical numbers contributes to a greater degree of uncertainty as future actuals may vary by an average of 20 percent above or below the forecast

Civilly Committed – State Hospitals

The Civilly Committed State Hospital caseload includes those people that have been Civilly Committed and reside in one of Oregon's three State Hospital campuses. The State Hospital system provides 24-hour supervised care to people with the most severe mental health disorders.

Forecast

The numbers of Civilly Committed clients in the State Hospitals have declined in recent months but are expected to remain constant through June 2009 (Exhibit D-10). Also, the planned expansion of alternative treatment settings in the community (24 Hour Care) would allow for more relocations from the State Hospital. Staff expects that transfers to the State Hospitals from acute care hospitals will maintain a constant number of patients. The caseload may vary by an average of eight percent through 2009.

Risks and Assumptions

The base forecasts were developed using common statistical methods. These methods rely on the relative month-to-month change in the caseload history. Assumed changes in significant environmental factors such as future population growth or program policies do not influence the predicted levels, but they may have shaped the historic caseload levels. Thus, the primary assumption of these base forecasts is that any factors that significantly affect the Mental Health programs or clients will remain unchanged through 2009. Base forecasts may be adjusted to correspond to the expected outcomes of program and policy changes.

Conversely, risks are those events or conditions that cause the real numbers of clients to differ substantially from the forecasted numbers. Examples would include an unexpected increase in the rate of mental illness and subsequent demand for services throughout Oregon.

The following factors also pose risks to the forecasts:

Changes in laws and judicial processes: The forensic caseload is a function of the legal system that controls entries to and exits from treatment. If new laws are passed that expand forensic commitment or significantly change time in treatment, then the actual caseload might shift away from forecasted levels. Likewise, civil commitments rely on a legal process for the initial determination, and changes at this point in the system could alter the caseload. Statewide policies regarding incarceration in jails versus civil commitment can further influence forensic and civil caseloads. Even variations in attorney behavior regarding the use of the insanity plea can affect the forensic caseload; jail sentences may shorten as jails reach maximum capacities so that attorneys would favor a regular jail sentence rather than a longer forensic or civil commitment.[4]

Changes in capacities and resources: Capacity issues, like the availability of beds in hospitals and community settings, as well as resources in general, can affect the tendency of courts to decide on civil commitment. In addition, the available capacities of different types of settings, e.g. State Hospitals vs. various residential facilities, can influence client placement and the resulting caseloads.

Changes in environmental factors: Demographic, economic, and behavioral trends can influence the Mental Health caseload. For example, a consistent proportion of mentally ill people in a growing Oregon population during the next few years will lead to a growing caseload. If this proportion were to change, the caseload may also respectively change. Economic and behavioral issues can interact to affect this rate. Interactions among economic stressors, drug and alcohol dependency, and an individual's predisposition for mental illness could result in corresponding fluctuations in caseload levels as each component changes over time. For example, during a growing economy, economic stress would be minimal with a reduced demand for services. During a recession, however, increased stress might contribute to a growing demand for services.

Specific Program and Policy Events: As previously stated, the 2007 Legislature strengthened several components of community-based mental health services. The mental health forecasts are based on staff's assessment of the outcomes of these new funding levels. These new programs require complex coordination of, and full cooperation by, several public and private entities. The forecast assumes

[4]M.N. Schaefer and J.D. Bloom. 2005. The Use of the Insanity Defense as a Jail Diversion Mechanism for Mentally Ill Persons Charged with Misdemeanors. J Am Acad Psychiatry Law 33:79-84. [Focuses on Oregon's PSRB system.]

that these positive outcomes will happen. For example, if local entities deny the development of additional residential facilities in communities, then the relocation of patients from the State Hospital would be at lower levels than expected, and the caseload would not be at forecasted levels. Therefore, forecasts that assume a successful outcome are inherently at risk.

Statistical Error: All forecasts have inherent error that increases with time; the longer the forecast period, the greater the error. The following graphs provide upper and lower limits that illustrate the effects of this error on the forecasts.

Exhibit D-3: Total Mandated

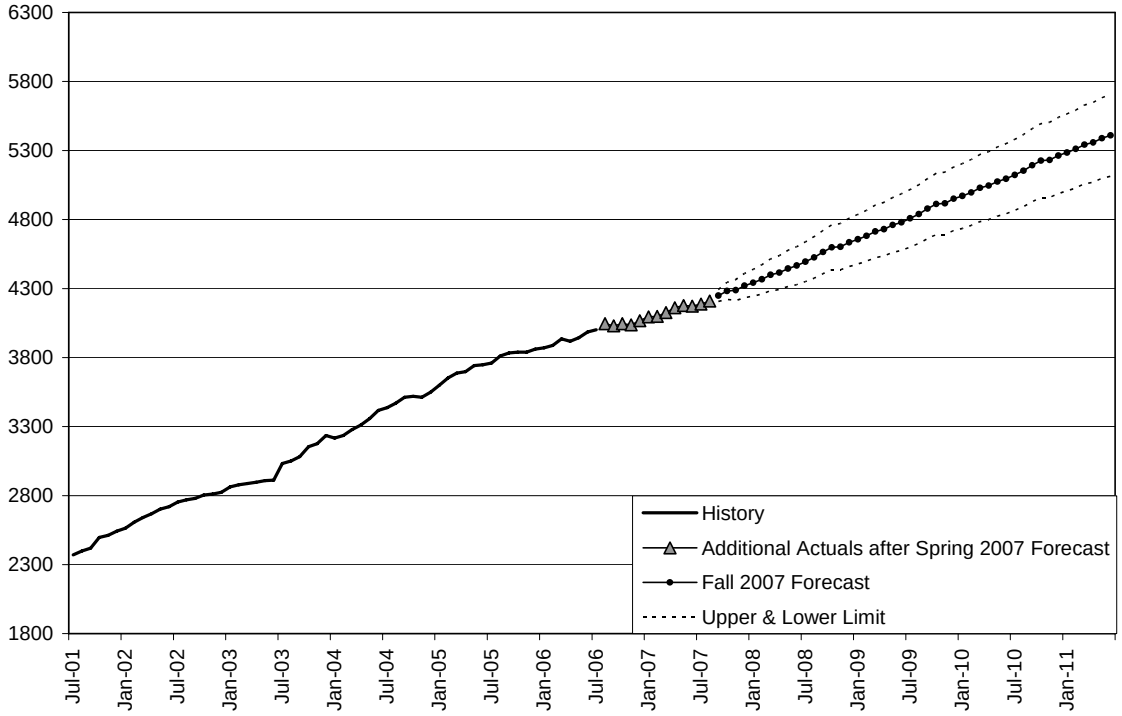


Exhibit D-4: Total Criminal Commitment

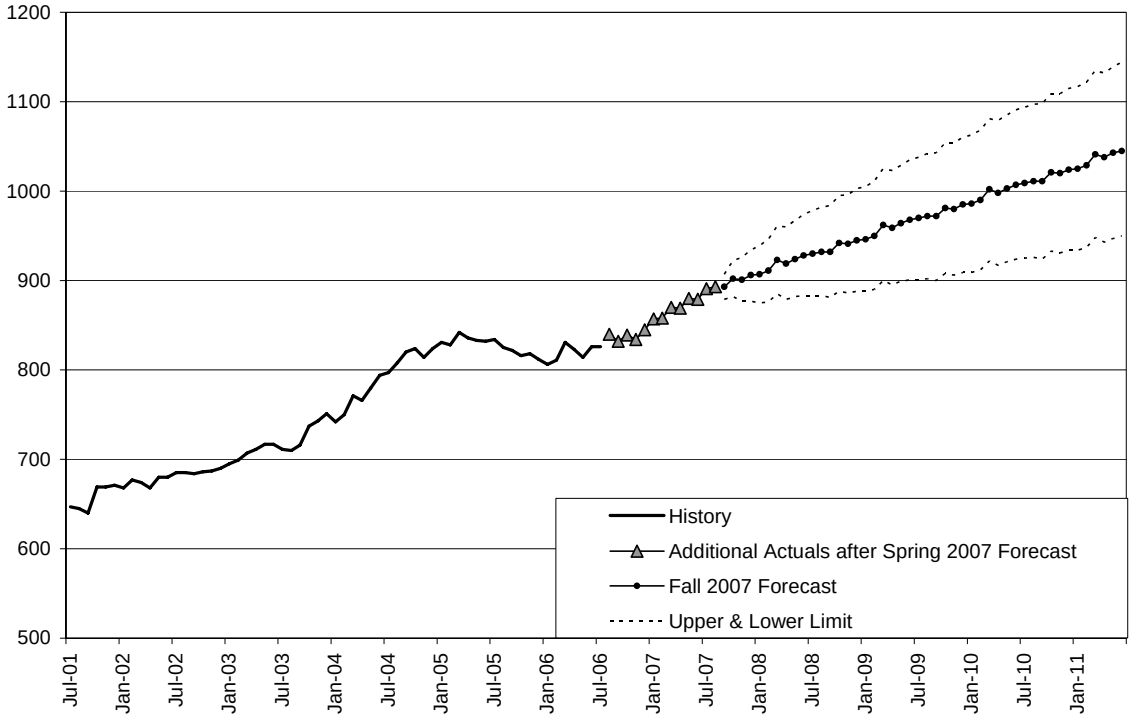


Exhibit D-5: Ciminal Commitment - Aid and Assist

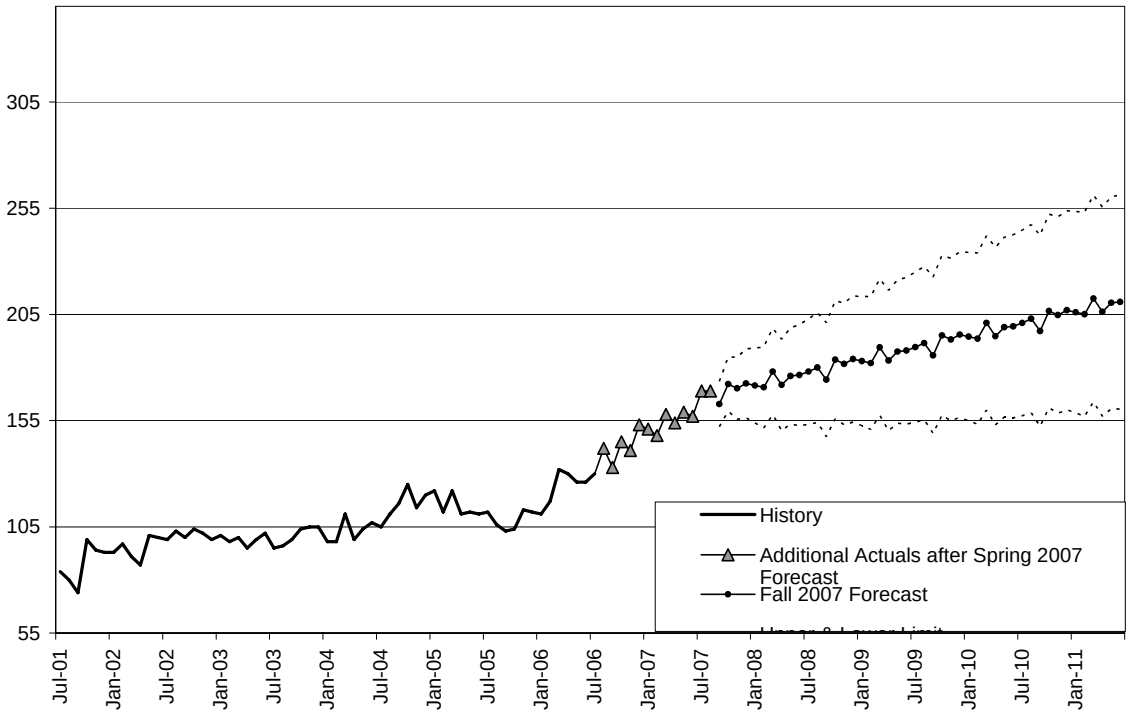


Exhibit D-6: Criminal Commitment - Psychiatric Security Review Board

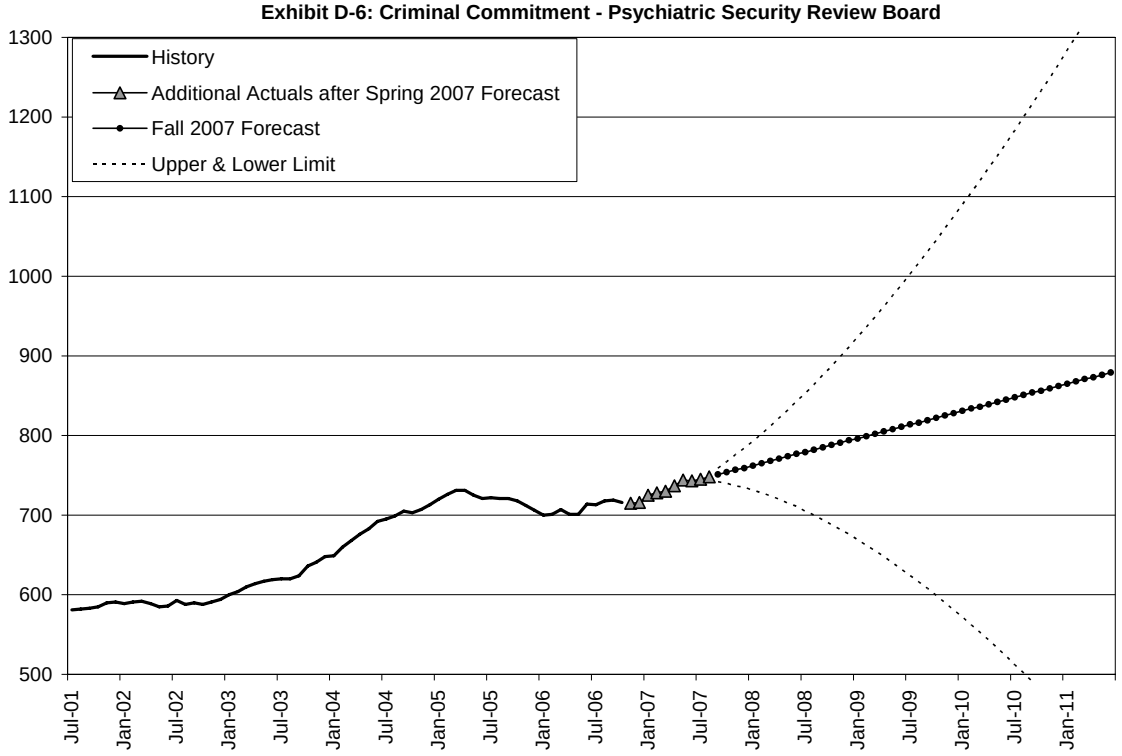


Exhibit D-7: Total Civil Commitment

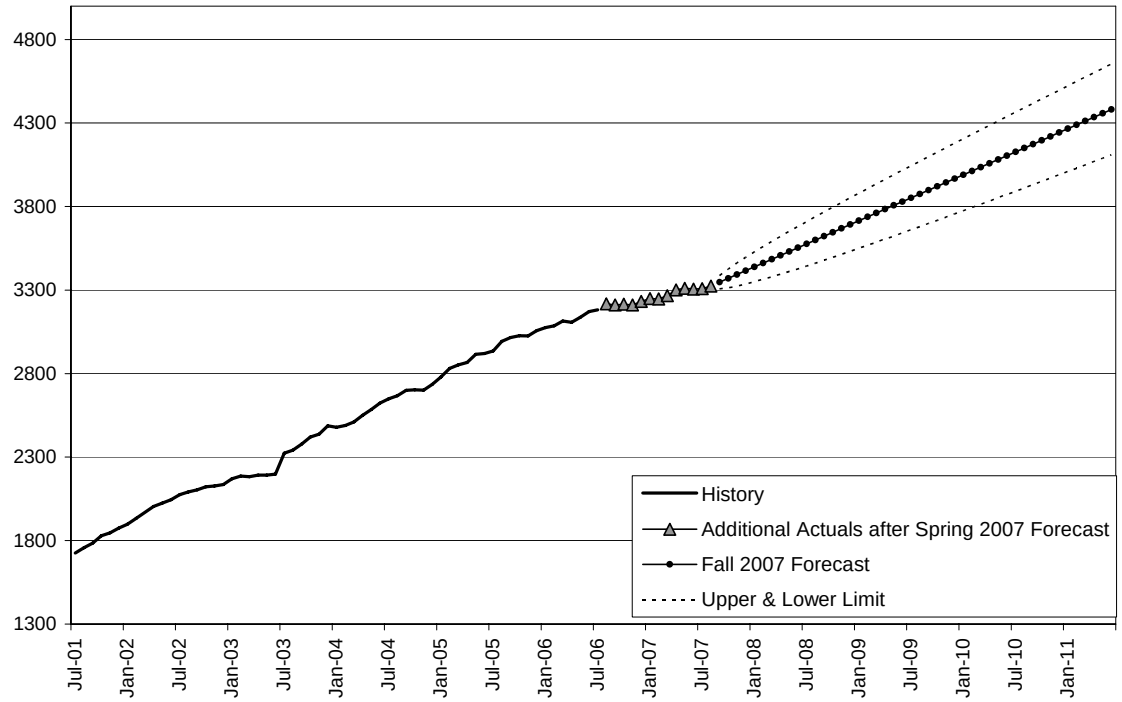


Exhibit D-8: Civil Commitment - 24 Hour Care

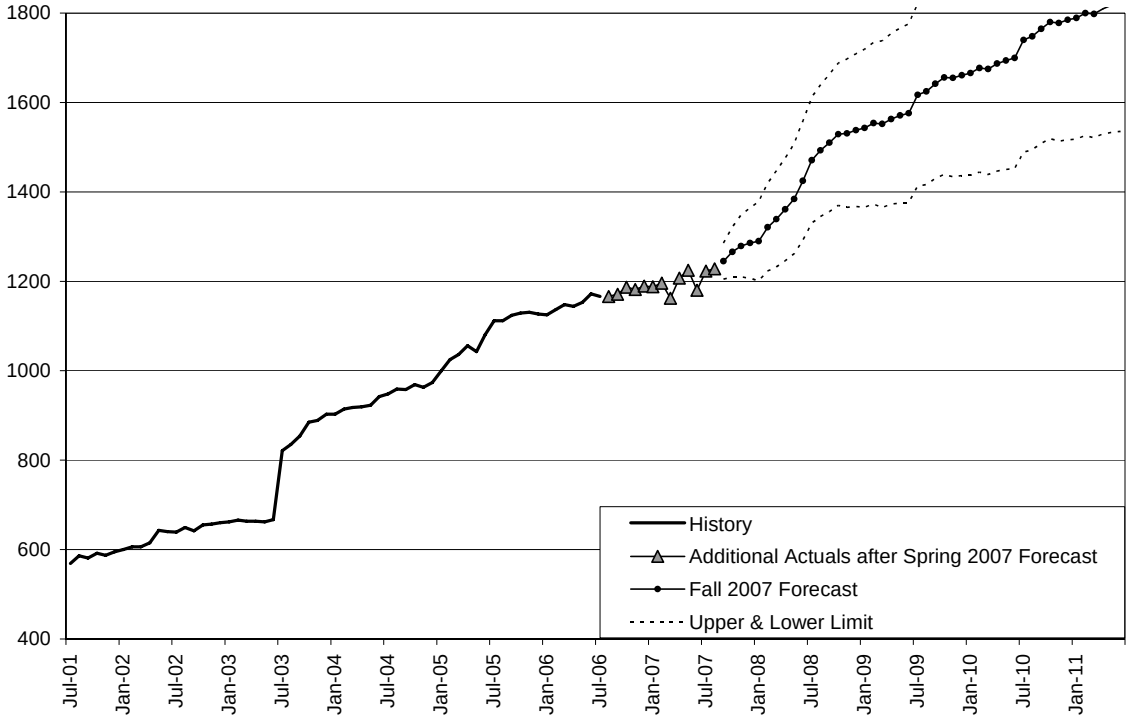


Exhibit D-9: Civil Commitment - Acute Care

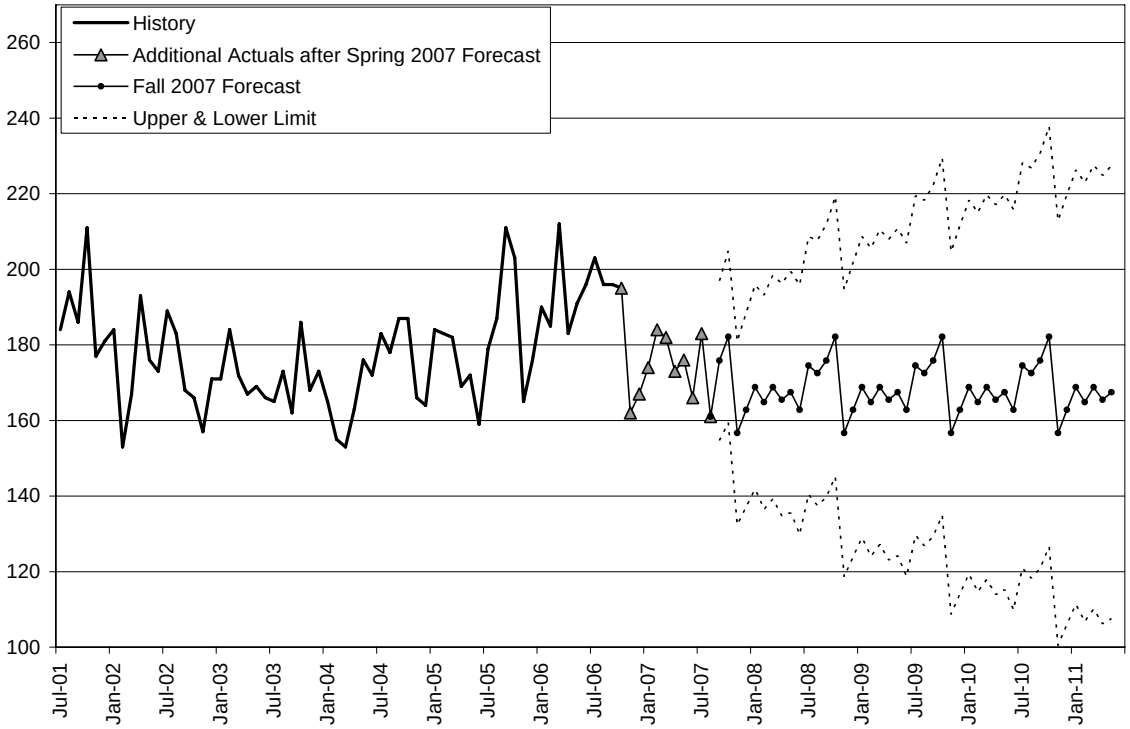
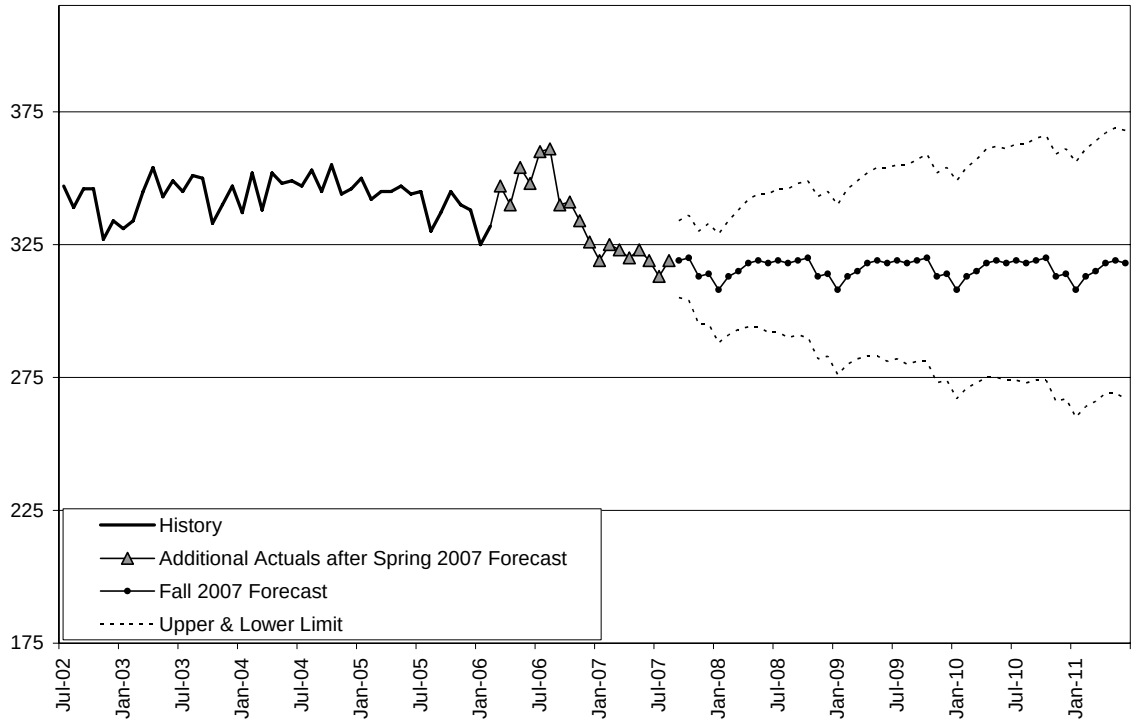


Exhibit D-10: Civil Commitment - State Hospital



Seniors and People with Disabilities Division:
Long-term Care for Seniors and People with Physical Disabilities

Introduction

The Seniors and People with Disabilities Division (SPD) provides Long-Term Care services to people who, due to their age or disabilities, require these services to live in a safe and healthy environment. Long-Term Care (LTC) services can be provided in institutional settings such as nursing facilities, in community-based care settings like residential care facilities and adult foster homes, or in the person's own home.

The forecast projects the Long-Term Care caseloads for the three main service categories: In-Home, Community-Based Care Facilities (also referred to as Licensed Community Facilities), and Nursing Facilities. Exhibit E-1 shows the services included in each category.

Exhibit E-1: Long-Term Care Program Categories.

In-Home Care	Community-Based Care Facilities	Nursing Facilities
In-Home: Hourly	Adult Foster Care: Relative	Basic Care
In-Home: Live-In	Adult Foster Care: Commercial	Complex Medical Add-On
In-Home: Spousal-Pay	Residential Care Facilities: Regular	Pediatric Care
	Residential Care Facilities: Contract	Medicare Extended Care
	Assisted Living Facilities	OHP Post-Hospital Benefit
	Specialized Living Facilities	Enhanced Care
	Providence ElderPlace	

Oregon Supplemental Income Program (OSIP) provides cash and medical assistance to Oregonians who are age 65 and older, physically or mentally disabled or blind as determined by the Social Security Administration. The medical and cash assistance is based on a means test, which includes income limit of Supplemental Security Income (SSI) of ($623 in 2007;$637 in 2008) per month. The SSI eligibles receive a mandatory supplemental income of $20.40 per year from the State of Oregon.

The OSIP Cash Assistance caseload is comprised of three main service groups:
Aid to the Blind (AB)
Aid to the Disabled (AD), and
Old Age Assistance (OAA).

It should be noted that the program, **Oregon Project Independence (OPI)**, is not part of the Long-Term Care caseload forecast. OPI is a safety net, pre-Medicaid program for individuals who are 60 years of age or older or who have been diagnosed with Alzheimer's disease or a related disorder, and meet the requirement of Long-Term Care service priority rules. OPI clients generally meet Medicaid eligibility, except in some cases they may have higher than allowable resource limits, and many choose not to enroll in Medicaid due to the state recovery requirement. OPI served about 3,600 clients in 2007.

The Long-Term Care services mentioned above in Exhibit E-1 will be described at appropriate sections in the forecast book.

Total Fall 2007 Caseload Forecast

The total Long-Term Care caseload forecast for Fall 2007 includes In-Home Care, Community-Based Care and Nursing Facilities (including the Other Nursing Facilities services such as Medicare Extended Care, Enhanced Care and the OHP Post-Hospital Benefit caseloads).

Nursing Facilities make up about 19 percent of the total Long-Term Care caseload, while the In-Home and Community-Based Care Facilities account for 42 and 40 percent respectively (Exhibit E-2). Overall, this caseload distribution pattern has not changed significantly.

The biennial average Long-Term Care caseload population was 28,021 clients in 2003-05. This population decreased to 27,160 clients in the 2005-07 biennium. The average Long-Term Care caseload, measured as a biennial average, is forecasted to decrease to approximately 26,375 clients, or about 2.9 percent in the 2007-09 biennium from the 2005-07 level.

As illustrated in Exhibit E-3, the overall Long-Term Care caseload in the first eight months of 2003 (November 2002-June 2003) declined about 10 percent, or by more than 3,000 cases. This was primarily due to the elimination of Long-Term Care service priority level 12 through 17 implemented in February and April 2003[5].

The Fall 2007 forecast is about 3 percent lower than the Spring 2007 forecast for the 2007-09 biennium. The lower caseload forecasts for the 2007-09 biennium is due to continued decline in In-Home and Community-Based Care Facilities. The Nursing Facility caseload, however, is maintaining the moderate growth (Exhibit E-2).

[5] Long-Term Care service for people in service priority levels 15-17 was eliminated on February 1, 2003 and levels 12, 13 and 14 were eliminated on April 1, 2003. Services were restored for levels 12 and 13 effective July 1, 2004.

The OSIP caseload population as a biennial average was 46,669 for the 2003-05 and 49,754 for the 2005-07 biennium. This caseload is estimated to be slightly higher (52,766) for the 2007-09 biennium in the Fall 2007 forecast compared to the Spring 2007 forecast.

Exhibit E-2: Total Long-Term Care Caseload Biennial Average Comparison by forecasts

	2007-09 Biennium			2009-11 Biennium			Fall Forecast		
Forecasts compared:	Spring 2007 to Fall 2007			Spring 2007 to Fall 2007			2007-09 to 2009-11		
Aged and Physically Disabled biennial averages by forecast	**Spring 07 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	% Diff. Spring 07 to Fall 07 2007-09	**Spring 07 Forecast 2009-11**	**Fall 07 Forecast 2009-11**	% Diff. Spring 07 to Fall 07 2009-11	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	% Diff. Fall 07 2007-09 to 2009-11
In-Home Hourly	9,934	9,436	-5.0%	9,805	9,269	-5.5%	9,436	9,269	-1.8%
In-Home Live-In	1,191	1,131	-5.0%	1,175	1,111	-5.4%	1,131	1,111	-1.8%
In-Home Spousal pay	131	124	-5.3%	129	122	-5.4%	124	122	-1.6%
Subtotal - In-Home	11,256	10,690	-5.0%	11,109	10,502	-5.5%	10,690	10,502	-1.8%
Relative Adult Foster Care	1,451	1,456	0.3%	1,366	1,374	0.6%	1,456	1,374	-6.0%
Commercial Adult Foster Care	**2,498**	**2,551**	**2.1%**	**2,472**	**2,558**	**3.5%**	2,551	2,558	0.3%
Regular Residential Care	**997**	**957**	**-4.0%**	**992**	**944**	**-4.8%**	957	944	-1.4%
Contract Residential Care	1,197	1,102	-7.9%	1,242	1,103	-11.2%	1,102	1,103	0.1%
Assisted Living	3,933	3,615	-8.1%	3,918	3,500	-10.7%	3,615	3,500	-3.3%
Specialized Living	165	165	0.0%	165	165	0.0%	165	165	0.0%
ElderPlace (PACE)	698	704	0.9%	700	791	13.0%	704	791	11.0%
Subtotal - Community-Based Care	**10,939**	**10,550**	**-3.6%**	**10,855**	**10,435**	**-3.9%**	**10,550**	**10,435**	**-1.1%**
Basic Nursing Facility Care	4,452	4,529	1.7%	4,430	4,595	3.7%	4,529	4,595	1.4%
Complex Medical Add-On	339	348	2.7%	325	334	2.8%	348	334	-4.2%
Pediatric Care	70	56	-20.0%	70	56	-20.0%	56	56	0.0%
Extended Care NFC	155	136	-12.3%	180	154	-14.4%	136	154	11.7%
Enhanced Care	60	60	0.0%	60	60	0.0%	60	60	0.0%
Post-Hospital Benefit	6	6	0.0%	6	6	0.0%	6	6	0.0%
Subtotal-Nursing Facility	**5,082**	**5,135**	**1.0%**	**5,071**	**5,205**	**2.6%**	**5,135**	**5,205**	**1.3%**
Total Long-Term Care	**27,277**	**26,375**	**-3.3%**	**27,035**	**26,142**	**-3.3%**	**26,375**	**26,142**	**-0.9%**
Aid to the Blind	620	621	0.2%	637	647	1.6%	621	647	4.0%
Aid to the Disabled	40,311	40,494	0.5%	41,772	42,110	0.8%	40,494	42,110	3.8%
Old Age Assistance	11,555	11,651	0.8%	12,821	12,994	1.3%	11,651	12,994	10.3%
Total Oregon Suplemental Income Program (OSIP)	**52,486**	**52,766**	**0.5%**	**55,229**	**55,751**	**0.9%**	**52,766**	**55,751**	**5.4%**

Notes:

** Fall 06 Forecast: Actual through March 2006.*

** Spring 2007 Forecast: Actual through September 2006.*

** Fall 2007 Forecast: Actual through June 2007.*

** Total In-Home caseload does not include In-Home Agency, Independent Choices & Oregon Project Independence caseloads.*

To summarize the comparison of Fall 2007 and the Spring 2007 forecasts, the following points can be made:

- The In-Home caseload was 11,275 in the 2005-2007 biennium. The In-Home caseload forecast for 2007-09 is 5 percent lower in the Fall 2007 forecast compared with the Spring 2007 forecast.
- Community-Based Care caseloads averaged 10,771 for the 2005-07 biennium. The Fall 2007 forecast for Community-Based Care caseloads is about 4 percent lower for the 2007-09 compared with the Spring 2007 forecast.

- The Nursing Facilities caseload was 5,116 in 2005-07 biennium. The Fall 2007 Nursing Facilities caseload forecast remains to be 1 percent higher for the 2007-09 compared with the Spring 2007 forecast.
- The Oregon Supplemental Income Program (OSIP) Fall 2007 caseload forecast is also slightly higher in Fall 2007 for 2007-09 biennium.

Risks and Assumptions

The following summarizes the major assumptions made for the Long-Term Care service caseload forecasts:

- The historical mix of current Medicaid services is assumed to remain constant throughout the forecast period,
- Medicaid eligibility requirements will remain the same throughout the forecast period,
- The transition patterns on/off Long-Term Care services and among the Medicaid LTC services will follow historical patterns.

If these assumptions do not hold true over the upcoming years, then the forecasts will be over or under estimated.

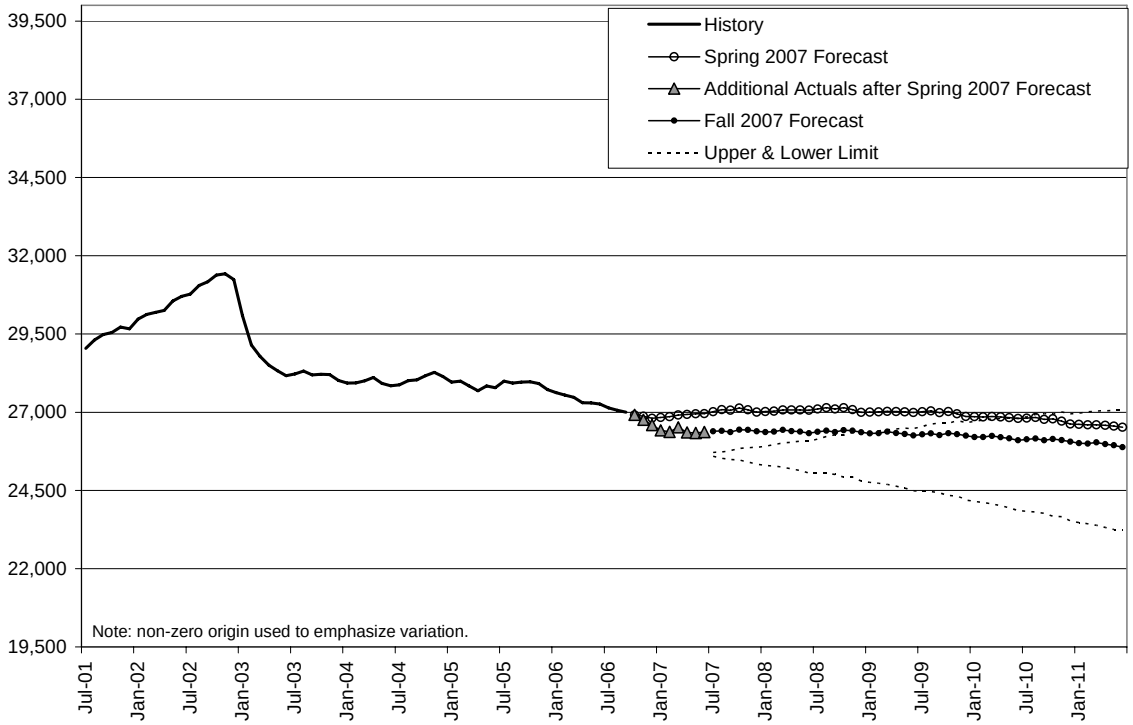
Oregon Demographic Shift: In addition, a series of external as well as internal factors will change the forecast estimates. As the Oregon demographic shifts toward elderly population as a percentage of its total population, it poses a risk to the forecast. Elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85+ age group also risk depleting their resources. If they do, then they will likely become eligible for the DHS Medicaid and Long-Term Care programs. If this occurs at a faster pace than projected, along with the changing dynamics of Long-Term Care market forces in terms of service capacity and competitive Medicaid reimbursement rate, it poses a serious risk to the forecast. (For the details, please see SPD Caseload Forecast Risks and Assumptions Section, in the DHS Spring 2006 Forecast).

New CBC Initiatives: In 2008, SPD is planning several program initiatives to address the growing Medicaid contract withdrawals from providers in favor of private pay market in the Community-Based Care settings (including the independent assessment of CBC private rate structure as well as Medicaid reimbursement rate bump for Assisted Living, Commercial Foster Care and Residential Care services). SPD is also strengthening its ability to reduce Medicaid clients' reliance on high cost Nursing Facilities through various relocation and diversion approaches, including the Money Follows the Person (MFP) project. The diversion initiative targets those at risk of placement in a nursing facility as a Medicaid client; MFP focuses on those Medicaid clients currently living in nursing facilities. In both initiatives. SPD will increase case

management and provider network supports as needed to ensure that people receive needed long-term care services in their homes and communities.

The total Long-Term Care caseload, since the service priority level elimination in early 2003, has slowly declined with some historical fluctuations. Based on the historical variability of the LTC caseload, the forecast has inherent risk the further out the projections. Thus, the average LTC caseload forecast could reasonably be expected to vary by as much as 4 percent in either direction for the 2007-09 biennium.

Exibit E-3: Total Long Term Care



In-Home

The In-Home program provides personal assistance services that help people stay in their homes when they need assistance with Activities of Daily Living[6] (ADLs). Home care workers are hired directly by clients to provide the In-Home services. Historically, the average In-Home services caseload represented approximately two-fifths of the total Long-Term Care caseload.

The total In-Home care population includes the three major service categories:

- In-Home: Hourly
- In-Home: Live-In
- In-Home: Spousal-Pay

The **In-Home Services Hourly** caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks. The In-Home hourly caseload accounts for approximately 88 percent of the total In-Home services caseload.

A small percentage of the In-Home hourly caseload includes Personal Care services. These are essential supportive services that enable clients to move into and/or remain in their own homes, such as basic personal hygiene, toileting, mobility, transfer, nutrition and meal preparation, and medication management. SPD manages entry into Personal Care for people who are aged, physically or developmentally disabled, or who qualify to receive the service based on mental health care needs. Personal Care services are available to people who are Medicaid eligible but not eligible for waivered services. Services are limited to no more than 20 hours a month.

The **Live-In Provider** caseload includes clients who hire a live-in home care worker to provide 24-hour care. In-Home live-in care comprises about 11 percent of the total In-Home services caseload.

The **Spousal Pay** caseload includes those clients who choose to have their care provided by their spouse. Spousal Pay accounts for 1 percent of the total In-Home services caseload.

The same proportions across the three In-Home services are expected to remain for the 2007-09 forecast period.

In-Home clients may also receive other support services, such as adult day care, In-Home agency provider, home delivered meals and minor home adaptations.

[6] The Activity of Daily Living includes: Mobility, eating, bathing, dressing, grooming, toileting, and bowel and bladder care.

Not included in the forecast is **Independent Choices (IC)**, a 5-year demonstration waiver approved by the Centers for Medicare and Medicaid Services. Independent Choices provide clients more freedom, flexibility and self-direction with regard to how they receive their In-Home services. It has been in operation since November 2001 in Clackamas, Coos and Jackson/Josephine counties. The program serves a maximum of **300** people. Since it is a pilot project with a maximum enrollment limit, the IC caseload is not included in the LTC caseload forecast.

Additionally, **In-Home Agency Provider** is another In-Home service that is not included in the forecast. The agencies, licensed through DHS, provide hourly In-Home services to In-Home clients through their staff. On an average **434** clients received In-Home care services in 2007. In many instances, such services are in addition to regular In-Home services mentioned above.

Forecast

The total In-Home caseload was growing rapidly in 2001-03 with a biennial average of more than 13,000. This caseload averaged just over 11,800 in the 2003-05 biennium. In the first eight months of 2003-05 (November 2002 to June 2003), the In-Home services caseload declined by about 16 percent, or more than 2,200 cases as illustrated in Exhibit E-4. The In-Home caseload decreased to 11,275 in 2005-07 biennium. This caseload decline is primarily due to the elimination of the Long-Term Care service priority levels 12 through 17 that were implemented in February and April 2003.

The total In-Home caseload is projected to average 10,690 in the 2007-09 biennium, which is about 5 percent lower than the Spring 2007 forecast. (Exhibit E-4).

Risks to In-Home Forecast

The In-Home caseload may see continued decline in this forecast horizon due to the combination of following actions:

SPD has implemented aggressive LTC client eligibility and field reviews.

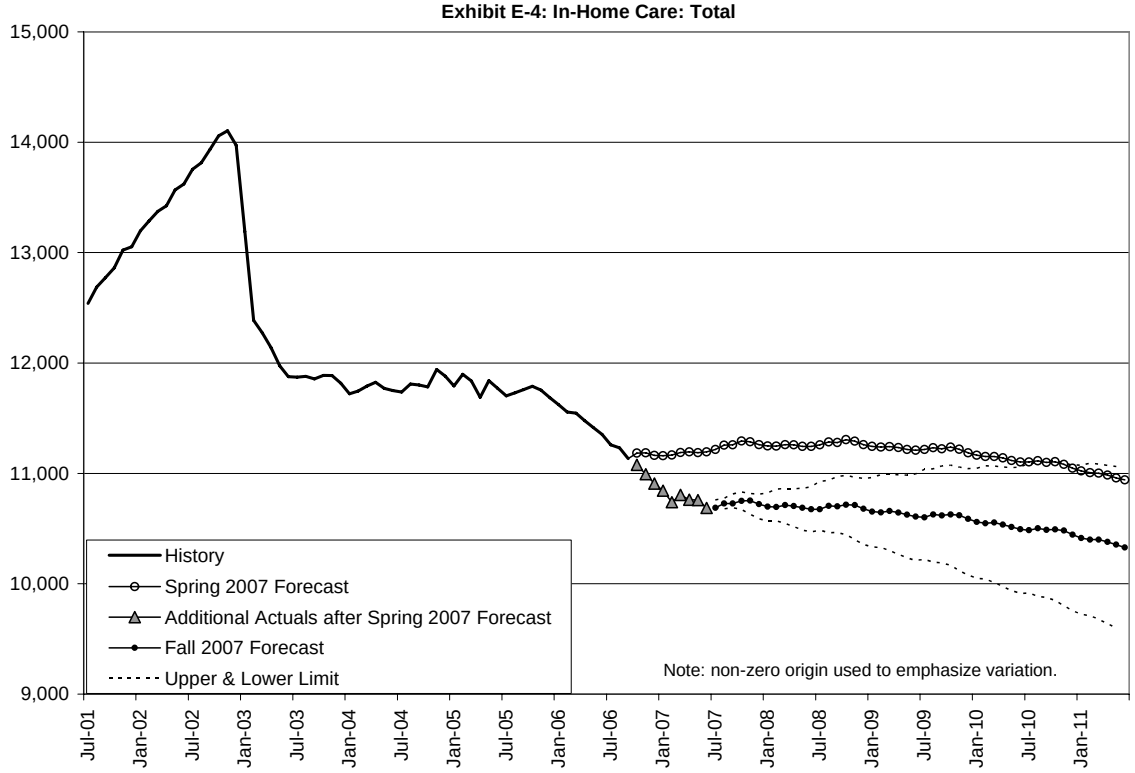
The full implementation of Medicare Modernization Act (MMA), which provides for prescription drug coverage, may create incentives for those In-Home clients who were only maintaining a few hours of in-home services in order to obtain the prescription drug benefit in the pre-MMA period, to now drop out of the In-Home services.

In addition, there are plans to expand Independent Choices (IC) statewide in the upcoming years. If so, it will exceed the capped enrollment of 300 over several

years of expansion of this program. This may draw some of the current In-Home clients into the IC program, as well as increase new enrollees in this program, especially younger clients who have disabilities.

The forecast has inherent risks the farther out the projections. Based on the normal historical fluctuation in this caseload, the forecast could vary 3 percent above or below the average forecast for the 2007-09 biennium.

Exhibit E-4: In-Home Care: Total



Community-Based Care Facilities

The Community-Based Care caseload (also referred to as Licensed Community Facilities) includes clients receiving Long-Term Care services in licensed Community-Based Care settings. Such Community-Based Care (CBC) facilities are located throughout Oregon and serve both Medicaid and non-Medicaid clients. Even though each type of Community-Based Care facilities is licensed differently, each facility can provide care for all Long-Term Care clients, except when a client needs specialized services. Thus, some LTC clients can and do change their care settings over time.

The Community-Based Care caseload represents about two-fifths of the total Long-Term Care caseload. This total caseload is comprised of Adult Foster Care (38 percent), Assisted Living Facilities (35 percent) and Residential Care Facilities (20 percent). Specialized Living Facilities and PACE account for about 1 percent and 6 percent of the total Community-Based Care caseload.

The total Community-Based Care population includes seven major service categories:

- Adult Foster Care: Relative and Commercial
- Residential Care: Regular and Contract
- Assisted Living Facilities
- Specialized Living Facilities
- PACE (Program of All-Inclusive Care for the Elderly)

Special Need Population clients are a small group of clients with targeted special medical or service needs (such as, mental health, traumatic brain injuries, AIDS, and ventilator-dependant clients). They receive services in Community-Based Care facilities. They are included in the appropriate CBC caseloads. In 2007, approximately **260** clients were being served under special need contracts in Residential Care, Adult Foster Care and Assisted Living Facilities.

In addition, **60** clients are receiving **Enhanced Care (EC)** services in various Community-Based Care facilities. Another **86** clients receive **Enhanced Care Outreach Services (ECOS)** on a less intense basis in CBC as well as in Nursing Facilities. The Enhanced Care Services is a joint program between the SPD and Addiction and Mental Health Services, and it serves the most challenging placement populations often from the state hospital. They are included in the appropriate CBC and NF caseloads. About 60 clients receiving Enhanced Care in Nursing Facilities are counted under the Other Nursing Facilities section. Overall, there are 206 fixed placements available for Enhanced Care services in various community care settings and Nursing Facilities.

Forecast

A large drop in the total Community-Based Care caseload occurred between November 2002 to June 2003, resulting in a decline of about 6 percent, or 700 clients. This caseload decline is primarily due to the elimination of the Long-Term Care service priority levels 12 through 17 that were implemented in February and April 2003.

In 2003-05, the total caseload in Community-Based Care facilities averaged 11,123. However, this caseload declined to a biennial average of 10,771 in 2005-07. The Fall 2007 total Community-Based Care caseload forecast for the 2007-09 biennium is about 4 percent lower than the Spring 2007 (10,550 versus 10,939) (Exhibit E-5).

CBC: Total Adult Foster Care

Adult Foster Care (AFC) provided by Adult Foster Homes, offers Long-Term Care in home-like settings licensed for five or fewer unrelated people. Adult Foster Homes represent 38 percent of the total CBC caseload in 2005-07. Foster homes may be "**Commercial**" and open to members of the public who are not related to the care provider or "**Relative**" and only provide care for people who are related to the care provider. Some foster homes provide specialized services to residents who are dependent on ventilators. Relative AFC clients receive services at their relative care takers' home.

CBC: Adult Foster Care - Relative

The Adult Foster Care-Relative caseload constitutes 14 percent of the total Community-Based Care caseload and 38 percent of the total AFC caseload (AFC total equals 4,043 in the 2005-07 biennium) in the Fall 2007 forecast. As Exhibit E-6 shows, the AFC-Relative caseload that has been declining at a rapid rate since January 2004, has stopped its precipitous drop, and is remaining around 1540.

During the 2001-03 biennium, the AFC-Relative caseload was increasing before the elimination of Service Priority Levels (SPL) 12-17. Since then, this caseload has experienced the risk of program elimination and uncertainty of budget cuts for the 2005-07 biennium. In addition, the elimination of the dual waiver option meant the developmentally disabled relative foster care clients were dropped from this caseload, and moved to the Developmentally Disabled caseload. Also, disallowance of Medicaid reimbursement for informal supports and the lack of market promotion led to rapid decline in the AFC-Relative caseload.

Forecast

The AFC Relative caseload forecast (1456) for the Fall 2007 is slightly above the Spring 2007 forecast for 2007-09 biennium. This caseload has exhibited considerable stabilization over the previous biennium and is expected to remain stabilized or decline very slowly due to the clarification and enforcement of policy regarding the In-home and Relative AFC services. (Unlike In-Home clients, the Relative AFC clients stay with the relative care providers at their home).

CBC: Adult Foster Care - Commercial

The Adult Foster Care-Commercial caseload is 23 percent of the total Community-Based Care caseload, and it accounts for 62 percent of the total AFC caseload (total average equals 4,043 in the 2005-07 biennium). The Adult Foster Care-Commercial caseload was increasing prior to 2003, but declined rapidly in the early part of the 2003. However, it has considerably stabilized in the 2005-07 period and in most recent months since January 2007 it has shown upward trend leading up to the Fall 2007 forecast.

Forecast

The Fall 2007 Adult Foster Care-Commercial caseload forecast with a biennial average of 2,551 is about 2 percent higher than the previous biennium (2,496). This caseload is projected to average about 2 percent in the 2007-09 biennium.

CBC: Total Residential Care Facilities

Residential Care Facilities (RCF) are licensed 24-hour care settings serving six or more residents. Facilities range in size from six beds to over 100. Different types of residential care include 24-hour residential care for adults as well as specialty Alzheimer care facilities. Overall, the total residential care caseload accounts for 20 percent of all CBC caseloads in 2005-07.

The total RCF caseload is projected to grow in the 2005-07 and 2007-09 forecast periods. Over the next three to four years, the contract rate RCF caseload is expected to continue to gain a larger share of the total RCF caseload. One of the reasons for this trend is due to the fact that the Medicaid contract rates are more competitive in the RCF market place (Exhibit D-9).

CBC: Residential Care Facilities - Regular

The **Residential Care Facilities-Regular** accounts for 9 percent of the total CBC caseload. It accounts for 47 percent of the total RCF caseload (total average equals 2,116 in 2005-07). As with most other Long-Term Care caseloads, the RCF-Regular caseload was also growing prior to 2003. However, since that time it has been in gradual decline (Exhibit E-10). One of the reasons for this decline has to do with the gradual increase of the RCF-Contract caseload in 2005-07 (Exhibit E-11). The RCF-Regular caseload bump between July 2004 and

February 2005 indicates the increased RCF enrollment followed by the subsequent move of some RCF- Regular clients to RCF-Contract (Exhibit E-11). However in 2007, the Contract RCF caseload declined primarily due to RCF providers that have chosen to withdraw from the Medicaid contracts, and thus not taking in new Medicaid clients.

Forecast

The RCF-Regular caseload averaged 1000 in 2005-07. This caseload is projected to average 957 for 2007-09. It is about 4 percent lower than the Spring 2007 projection of 997.

CBC: Residential Care - Contract

The Residential Care-Contract caseload is about 10 percent of the total CBC caseload, which accounts for 53 percent of the total RCF caseload (total average equals 2,116). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to grow in a slower pace than anticipated in the previous forecast (Spring 2007) in the 2007-09 biennium.

Forecast

The RCF-Contract caseload in the Fall 2007 is lower than in the Spring 2007 forecast for the 2005-07 biennium (Exhibit E-11). The RCF-Contract caseload is anticipated to average 1,102 per month in the 2007-09 biennium, which is about 8 percent lower than the previous forecast (Spring 2007). This forecast reflects the lower rate of growth in this caseload over the 2007-09 biennium due primarily to the less than competitive Medicaid reimbursement and gradual withdrawals of providers from the Medicaid contracts.

CBC: Assisted Living Facilities

The Assisted Living Facilities (ALF) are licensed 24-hour care settings for six or more residents that include private apartments. Services are comparable to residential care facilities but have special focus on resident independence and choice. Also, registered nurse consultation services are required by regulation. ALF constitutes 35 percent of the total CBC caseload.

The ALF caseload was growing rapidly prior to the elimination of Long-Term Care service priority levels 12-17 in 2003 at which point there was a one-time drop in the caseload. Since that time, the ALF caseload has experienced gradual growth. However, in the last nine months (October 2006 –June 2007) since the Spring forecast, there has been a decline in this caseload. In the 2005-07 biennium, the ALF caseload averaged at 3,816. The growth in this caseload is not expected to re-emerge, due to the gradual withdrawal from the Medicaid contracts by providers in favor of private market clients. Thus, the Fall 2007 forecast reflects the downward adjustment of this caseload over the Spring 2007 forecast.

Forecast

The ALF caseload forecast of 3,615 is expected to be about 8 percent lower than the Spring 2007 forecast of 3,933 in the 2007-09 forecast period (Exhibits E-12).

CBC: Specialized Living Facilities

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

The SLF caseload maintained the monthly average of 161 in 2005-07 biennium.

Forecast

The SLF caseload forecast is anticipated to maintain the monthly average of 165 in the 2007-09 biennium. (No graph included because of the small number and relatively flat caseload).

CBC: PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated Medicare/Medicaid program that provides acute health and long-term care services. Senior served in this program generally attends adult daycare services and live in a variety of care settings. The PACE is responsible for providing and coordinating their clients' full health and long-term care needs in all of these settings. Most clients served are dually eligible for both Medicare and Medicaid. At present, Providence ElderPlace serves only Multnomah County, and PACE accounts for 6 percent of the total CBC caseload.

In 2005-07 biennium, PACE caseload averaged to 635, which is an increase of 21 percent over the 2003-05 period. The PACE caseload is expected to keep the growth trend.

Forecast

Since mid-2003, this caseload has been growing as the capacity of Providence ElderPlace to serve additional clients has increased (Exhibit E-13).

In the Fall 2007 forecast, the 2007-09 PACE caseload is estimated to be 704. The Fall 2007 caseload forecast for the 2007-09 period is about 1 percent higher than the Spring 2007 forecast (698).

Risks to the Community-Based Care Forecast

The CBC services, with the exception of Adult Foster Care, rely generally on private-pay clients rather than on the Medicaid clients. In the CBC market, private pay residents spend–down and then become Medicaid eligible. While the Adult Foster Care market has become increasingly Medicaid, CBC providers such as ALF and RCF have been more successful in a highly competitive private pay market. In addition, a wider gap between relatively flat Medicaid reimbursement and the growing operating cost of doing business in the CBC market has persisted over several years. As more CBC providers (among the residential care and ALFs) are applying for the gradual contract withdrawals from the Medicaid and new CBC licensing moratorium remains through the end of the current biennium, it reduces the access for the Medicaid clients in the CBC services. As a result, this may dampen growth in some CBC caseloads below estimates, while causing corresponding growth in Nursing Facilities caseload, since the overall numbers of people in need of Medicaid LTC facilities has not been reduced.

PACE has a projected plan for the service expansion in Portland Metro in 2008. The expansion of PACE program will increase its caseload to more than 700 in the second half of the current biennium.

The Community Based Care caseload, historically, has shown some volatility in response to changes in the program implementation and the CBC market forces resulting in the recent onset of decline in the CBC caseloads. Given the historical pattern, the total CBC caseload forecast could deviate from the average forecast for the 2007-09 biennium by 3 percent in either direction. However, there is a strong risk, as noted above that the forecast could vary much more than the historical pattern suggest.

Exhibit E-5: Community-Based Care Facilities: Total

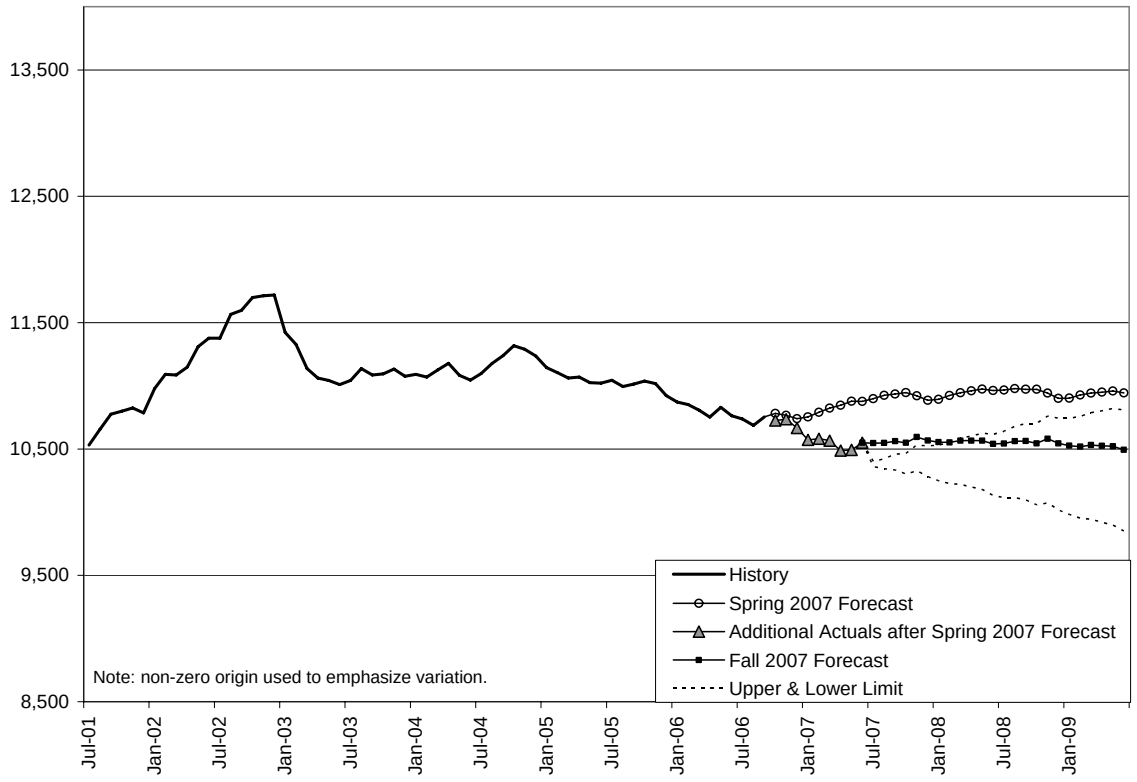


Exhibit E-6: Total Adult Foster Care

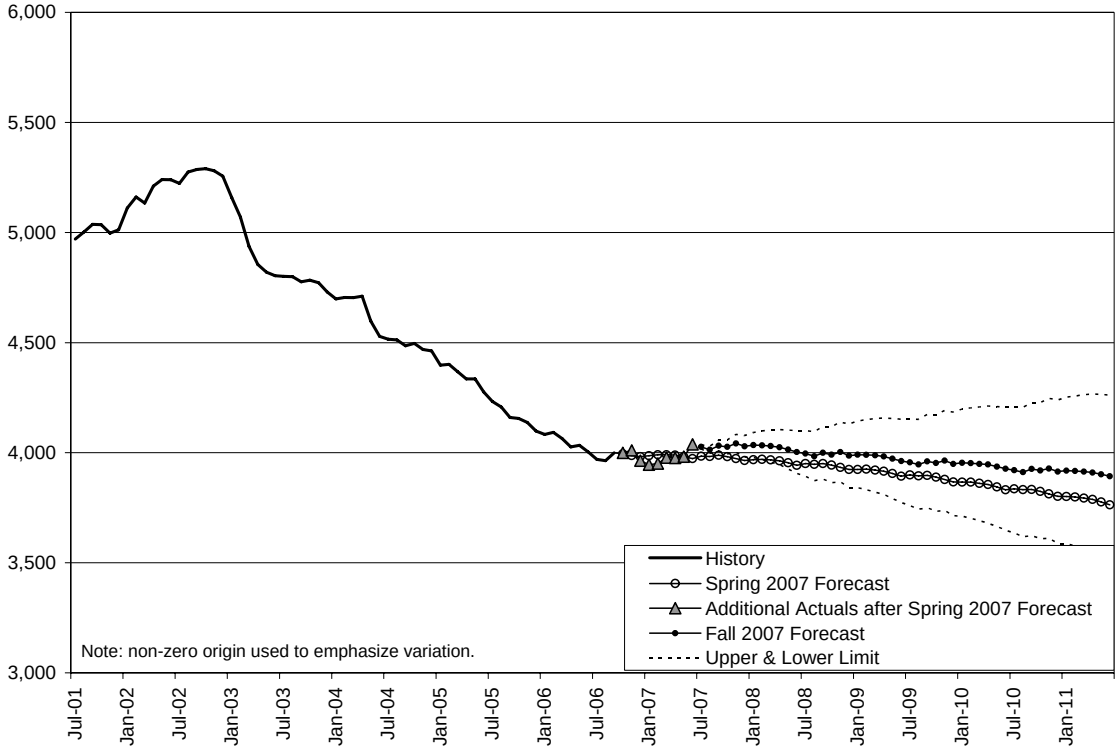


Exhibit E-7: Relative Adult Foster Care

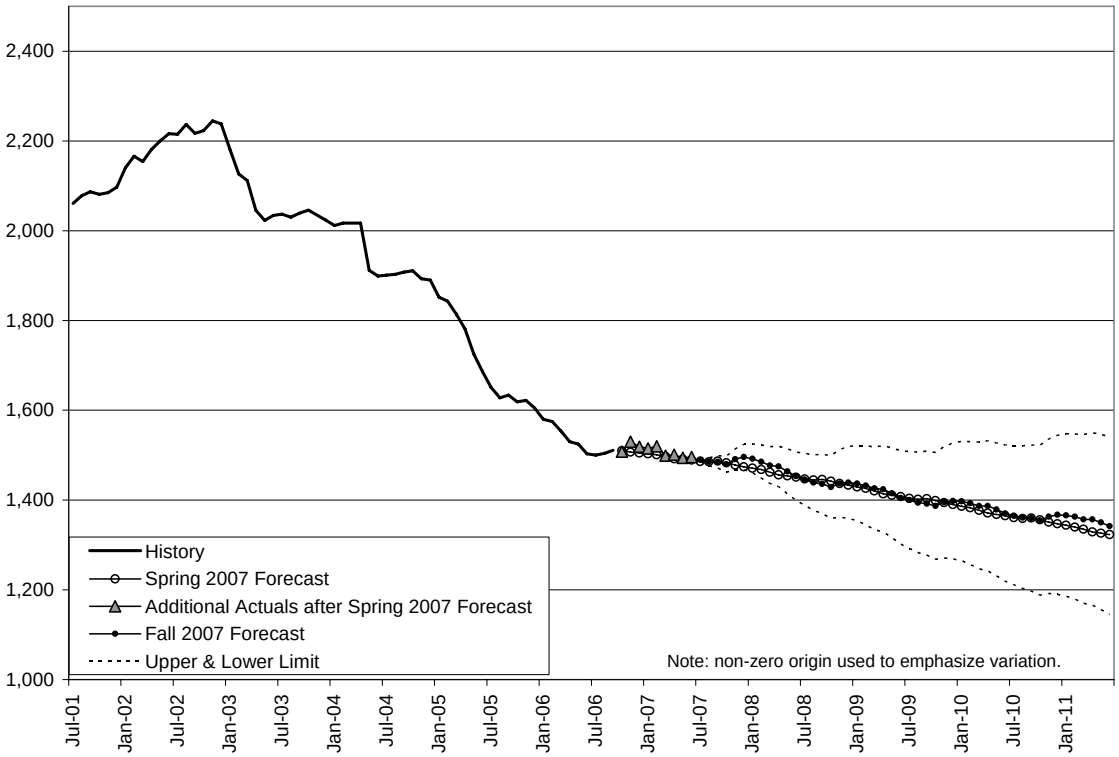


Exhibit E-8: Commercial Adult Foster Care

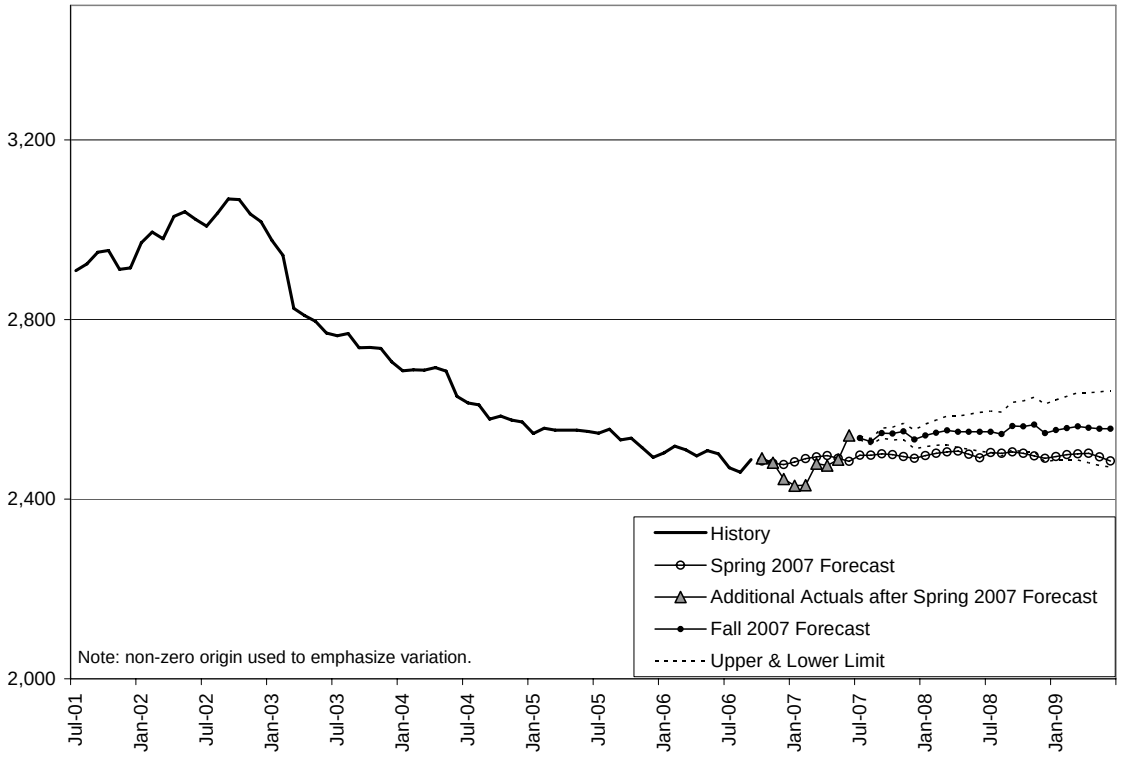


Exhibit E-9: Total Residential Care Facilities

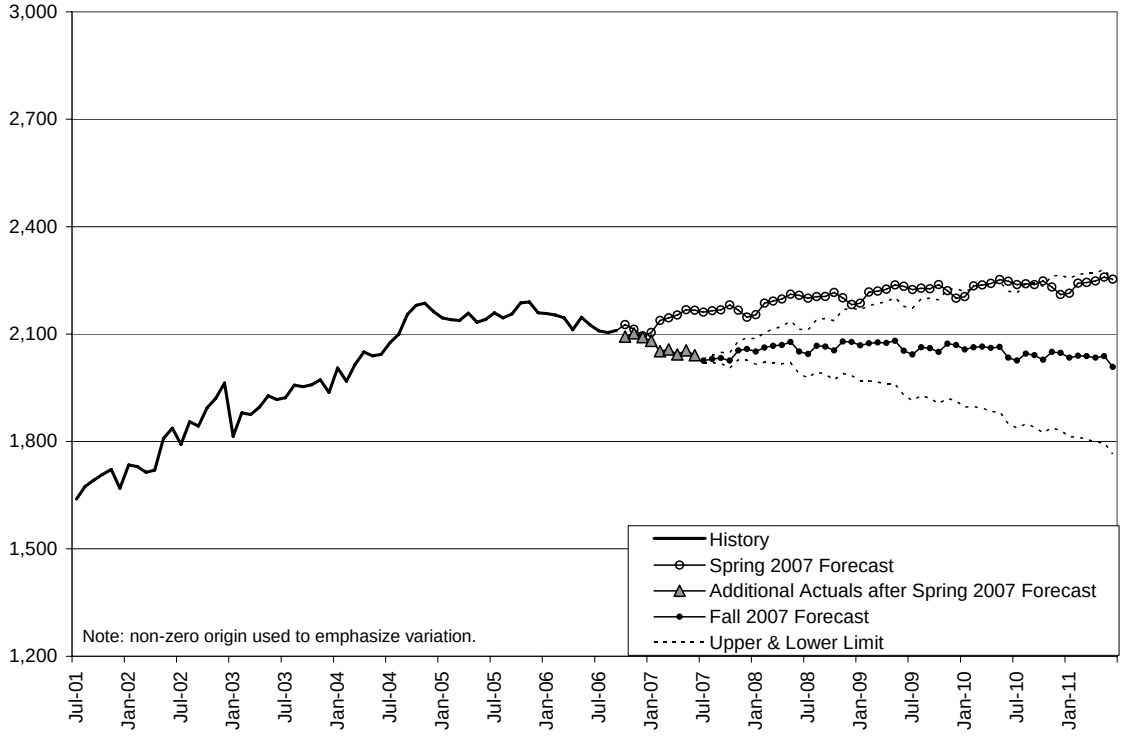


Exhibit E-10: Regular Residential Care

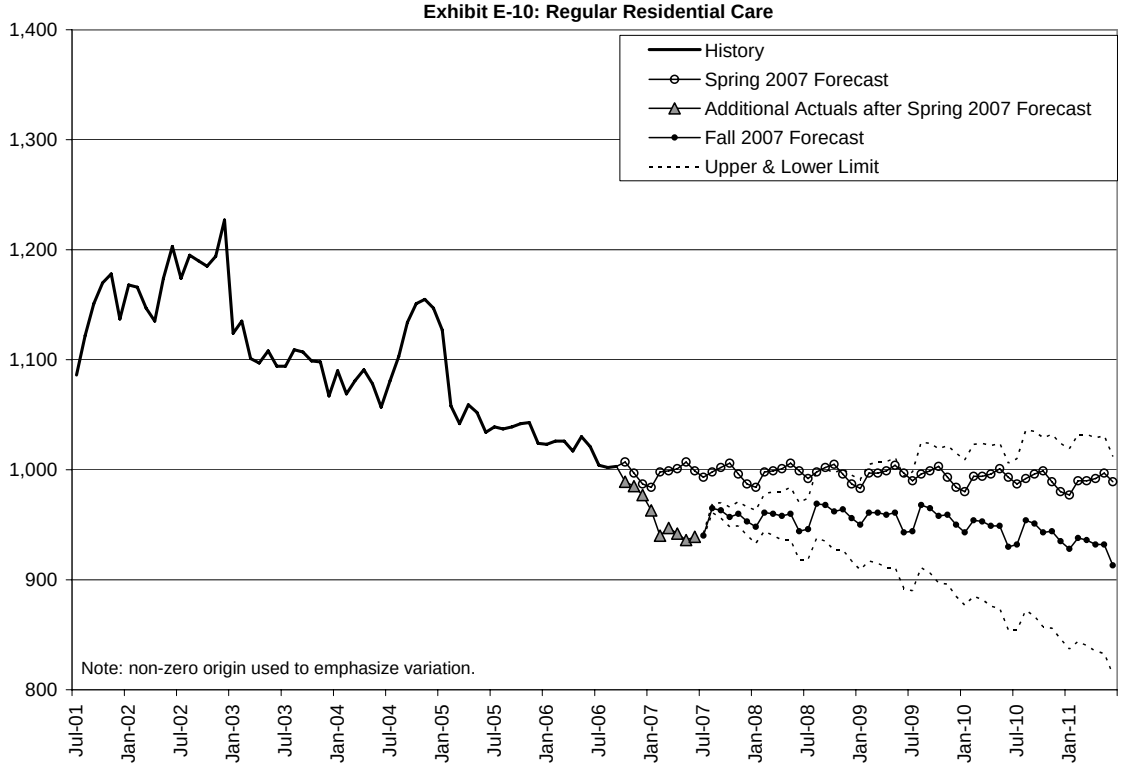


Exhibit E-11: Contract Residential Care

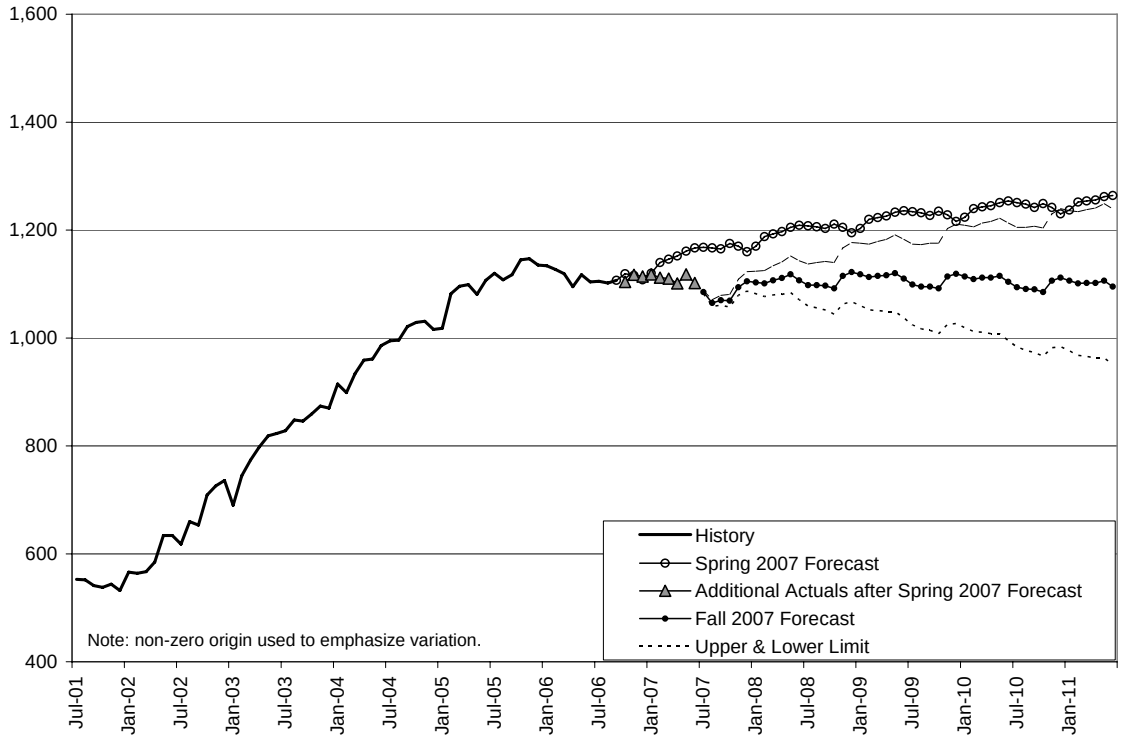


Exhibit E-12: Assisted Living Facilities

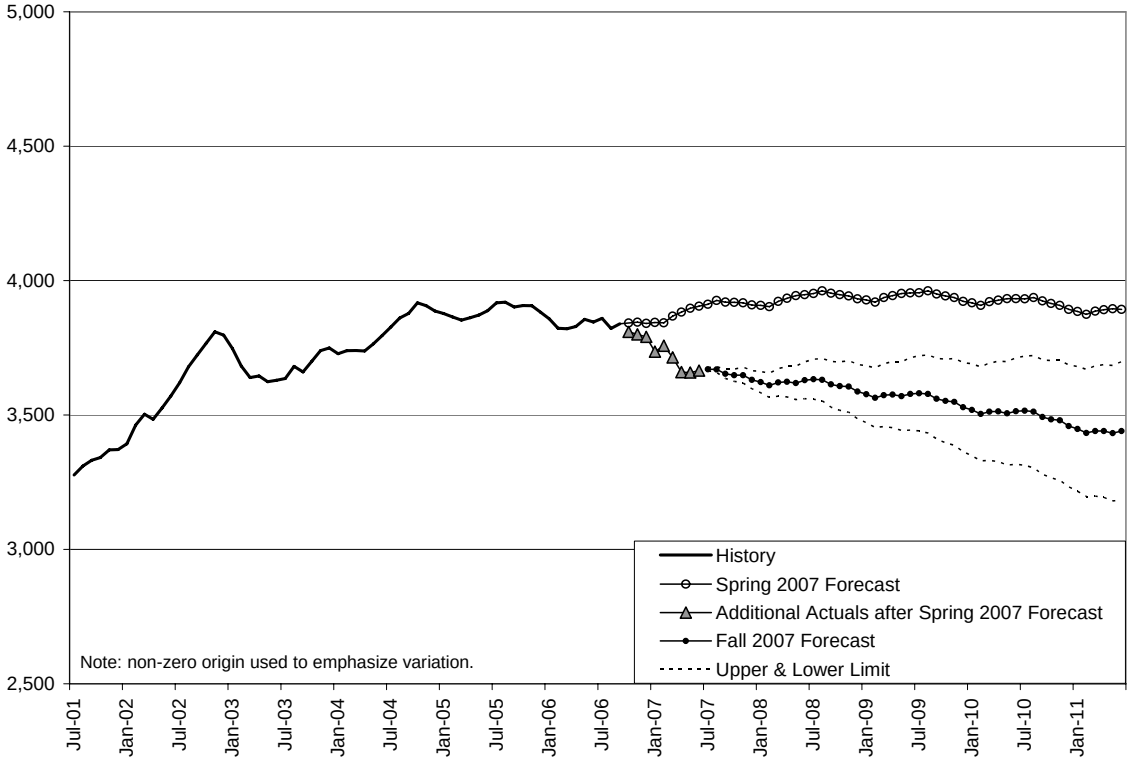
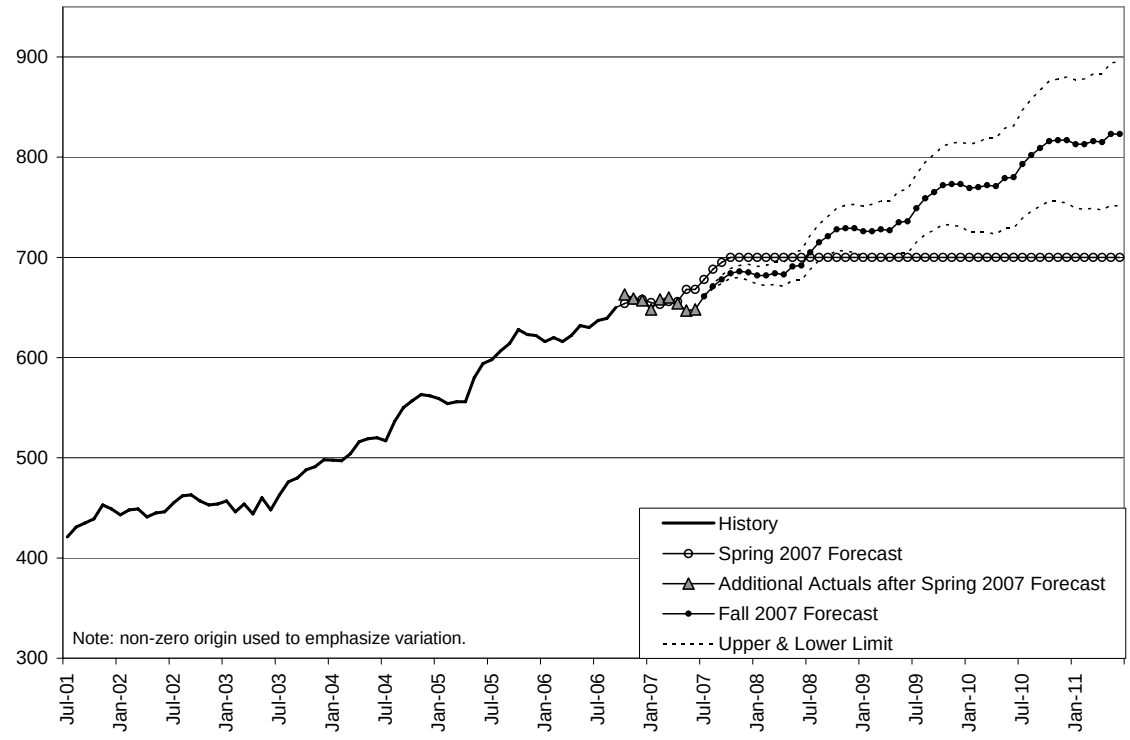


Exhibit E-13: Providence ElderPlace



Nursing Facilities

The Nursing Facilities (NF) clients comprise approximately one-fifth of the total Long-Term Care caseload. The Nursing Facility client population falls into six service categories:

- Basic Care
- Complex Medical Add-On
- Pediatric Care
- Medicare Extended Care
- OHP Post-Hospital Benefit
- Enhanced Care

Historically, the Nursing Facilities caseload has steadily declined. This is the result of the promotion of In-Home and CBC services as an alternative to institutional care. Some of the decline may also be attributed to the gradual decrease in the average length of time people stay in a nursing facility[7]. However, it is worth noting that about half of the Medicaid NF residencies are used by Medicaid clients for longer than 6 months.

Forecast

In 2003-05, total nursing facility caseload averaged 5,082 per month. In 2005-07, the NFC caseload that includes other small nursing facility services, such as Medicare Extended Care, OHP Post-Hospital Benefit and Enhanced Care, averaged 5,116 per month.

In the Fall 2007 forecast, the total nursing facility caseload (including the Medicare Extended Care, OHP Post-Hospital Benefit and Enhanced Care) was 5,082 in the Spring 2007. This caseload is projected to average about 1 percent higher at 5,135 in the Fall 2007 forecast 2007-09 biennium (Exhibit E-14),

Nursing Facility Care: Basic

The Nursing Facility Care-Basic caseload includes about 89 percent of total Nursing Facility clients[8]. The clients in this caseload need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care either due to age or physical disability.

[7] The annual survey data of Oregon Nursing Facilities, from Oregon Health Plan Policy Research, show an average decline in the length of stay in Oregon nursing facilities in the last ten-year period (1994-2004).
[8] Basic NF caseload share is 92 percent, if the newly forecast groups (Medicare Extended Care, OHP Post-Hospital Benefit and Enhanced Care) are not included.

As noted earlier, this caseload has been decreasing gradually over time. In 2005-07 biennium, it has averaged at 4,532. In most recent months, this caseload has shown a growth and that is reflected in the forecast.

Forecast

This caseload is projected to average 4,529 in the 2007-09 biennium, which is about 2 percent higher than the Spring 2007 as seen in Exhibit E-15.

Nursing Facilities: Complex Medical Add-On

The NF Complex Medical Add-On caseload includes about 7 percent of total Nursing Facility clients. Clients in this caseload have medical conditions and needs that require additional nursing services and staff assistance beyond the basic care.

Forecast

The Complex Medical Add-On caseload remained at 350 in previous biennium 2005-07. This caseload is projected to average slightly lower in the 2007-09 at 348 and it (Exhibit E-16) is expected to remain slightly higher than the Spring 2007 forecast.

Pediatric Care

Children under 21 who receive care in the state's pediatric nursing facility units are included in the pediatric care caseload. There are 70 pediatric facility placements available in Oregon. The pediatric clients averaged 61 in 2005-07 biennium. In the first nine months of 2007, pediatric clients averaged at 56.

The pediatric nursing client population is projected to remain at monthly average of 56. It is expected that some of pediatric clients will be diverted into the community–based care or in-home services in the current biennium. (No graph included because of the small number and relatively flat caseload).

Medicare Extended Care

People receiving NF Medicare Extended Care (or extended skilled nursing care) are both Medicare and Medicaid eligible. They are placed in a nursing facility after a Medicare-qualifying hospital stay. Medicare pays in full for the first 20 days of the extended skilled nursing care services but only pays the co-payments from days 21 to 100; Medicaid covers the balance. Medicare controls these clients' extended skilled nursing care stays. (The outlier data in the months of July and August in 2004 is a data error that has been accounted for in the forecast).

The extended care caseload was 113 in 2005-07 and is forecasted to remain at an average of 136 clients in the current (2007-09 biennium) Exhibits E-2.

Post-Hospital Benefit

The OHP post-hospital benefit is an Oregon Health Plan (OHP) extended skilled nursing care service. The OHP benefit pays for a maximum of 20 days of post-hospital extended skilled nursing care. In order to be eligible for the NF post-hospital benefit, people who are not Medicare eligible must meet state program criteria. These include: receiving Acute Care benefits through OHP; have a qualifying stay in the OHP paid hospital bed; admitted to a nursing facility within 30 days of a hospital discharge; and need daily skilled nursing or rehabilitative services that can only be supplied in a nursing facility.

The post-hospital care benefit caseload remain at 2 clients as the biennial average for the 2005-07 biennium, and is forecasted to remain at the biennial average of 6 clients in 2007-09 biennium.

Nursing Facilities: Enhanced Care

The NF Enhanced Care services help support clients whose demonstrated behavior makes them hard to place in regular Long-Term Care services. This behavior can include self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs.

There are fixed placements available (206 in November 2007) for Enhanced Care services in various community care settings and Nursing Facilities. The caseloads in the various community care settings already count these Enhanced Care and ECOS clients, as noted earlier in the Community-Based Care section. The Enhanced Care caseload served in nursing facilities is reported in this Nursing Facility Enhanced Care section.

Approximately 60 clients are being served under Enhanced Care services in nursing facilities. Additionally, an average of 145 clients are being served in various Community-Based Care settings.

In the 2007-09 biennium, the Nursing Facility Enhanced Care caseload is forecasted to remain at the biennial average of 60 clients.

Risks to Nursing Facilities Forecast

Nursing Facilities may be experiencing increased caseload due to higher post-hospital discharges and an inadequate relocation plan for them in other alternative care settings.

In addition, the higher NF Medicaid reimbursement rate may encourage enrollment of Medicaid clients in NF relative to the Community Based Care market, where the Medicaid reimbursement has not kept up with the market.

Money Follows the Person: Starting in 2008, SPD is implementing the Money Follows the Person (MFP) demonstration program through a federal Center for Medicare and Medicaid Services grant. Between 2008 and September 2011, SPD plans to move as many as 1,000 nursing facility clients back into their home and communities. The majority of people who will be moved are adults (ages 18 through 64) with disabilities.

In addition, SPD is also implementing Medicaid client relocation initiatives that will impact the new nursing facility certified Medicaid clients to be served in the lower cost care settings in the various community-based care and In-home settings.

The nursing facilities caseload, historically, has shown some volatility in response to changes in the CBC program implementation and the NFC market forces. Thus, the total nursing facilities caseload forecast could be expected to vary 5 percent above or below the average forecast for the 2007-09 biennium, even without the risks described above.

Exhibit E-14: Nursing Facilities: Total

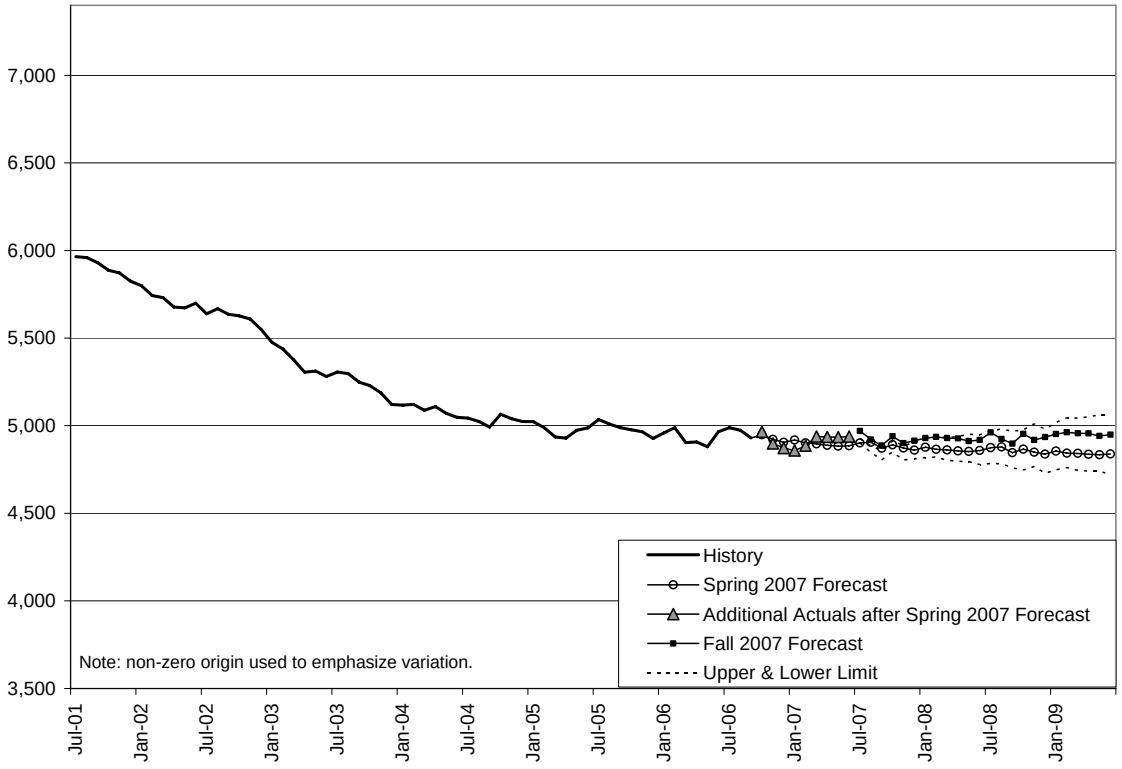


Exhibit E-15: Basic Nursing Facilities

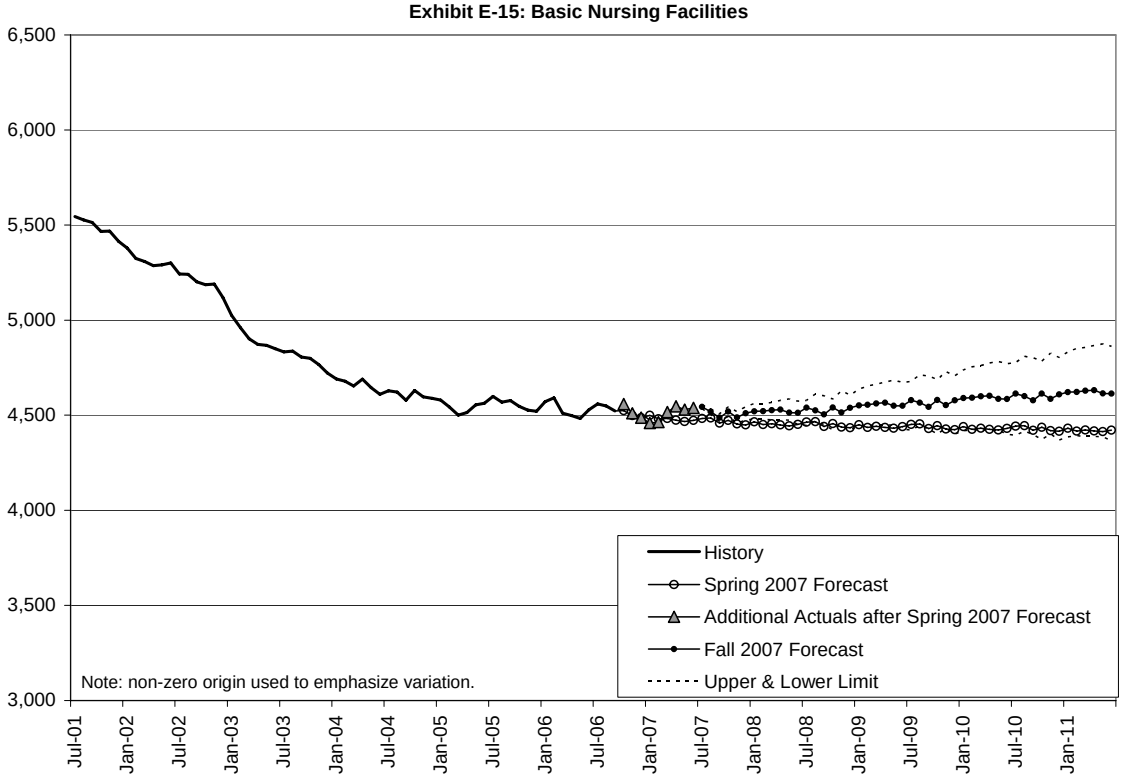
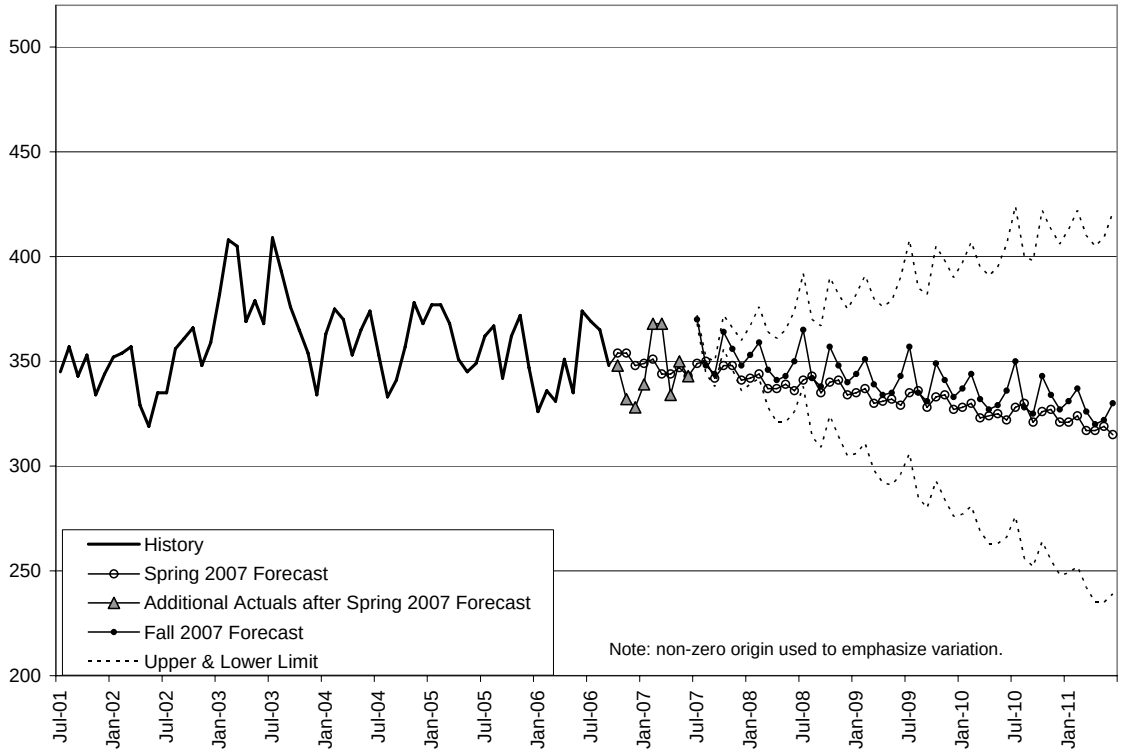


Exhibit E-16: Complex Medical Add-On Nursing Facilities



Public Health Division

CAREAssist Program

Introduction

This forecast focuses on clients who receive services from the CAREAssist program within the Public Health Division. CAREAssist, formerly know as the Community Health Insurance Program /AIDS Drug Assistance Program (ADAP), is for people living with HIV or AIDS who need help paying for medical care expenses. The program helps qualified Oregon residents buy health insurance premiums and prescription drugs. Funding for CAREAssist comes from the federal government under the Ryan White Care Act. CAREAssist provides services to the extent that funding allows and may stop services as necessary based on a lack of funds. Clients are assigned to one of three groups based on their incomes; services and benefits vary by group. This forecast uses the total number of clients over all three groups combined.

Exhibit F-1: CAREAssist Biennial Average Comparisons

	2007-09 Biennium			Fall Forecast		
Comparison:	**Spring 07 to Fall 07**			**2007-09 to 2009-11**		
CAREAssist (ADAP) Program Biennial Averages	**Spring 07 Forecast 2007-09**	**Fall 07 Forecast 2007-09**	*% Diff. Spring 07 to Fall 07*	**Fall 07 Forecast 2007-09**	**Fall 07 Forecast 2009-11**	*% Diff. Fall 07 2007-09 to 2009-11*
CAREAssist (ADAP) Program	1,894	1,881	-0.7%	1,881	2,306	22.6%

CAREAssist Caseload

Forecast

Overall, the CAREAssist Fall 2007 and the Spring 2007 forecasts for 2007-09 are quite similar (Exhibit F-1). This caseload is predicted to increase through June 2009 (Exhibit F-2). The 2007-09 biennial average is estimated to increase by 26 percent over that for 2005-07. Future actuals may vary by eight percent above or below the forecast through 2009.

Risks and Assumptions

The forecast was developed using common statistical methods. These methods rely on the relative month-to-month change in the caseload history. Assumed changes in significant environmental factors such as future population growth or program policies do not influence the predicted levels, but they may have shaped the historic caseload levels. Thus, the primary assumption of this forecast is that any factors that significantly affect the CAREAssist program or its clients will remain unchanged through 2009.

Conversely, risks are those events or conditions that cause the real numbers of clients to differ substantially from the forecasted numbers. Examples would include an unexpected increase or decrease in the prevalence of HIV, and subsequent demand for services, throughout Oregon.

The following factors pose risks to the forecast:

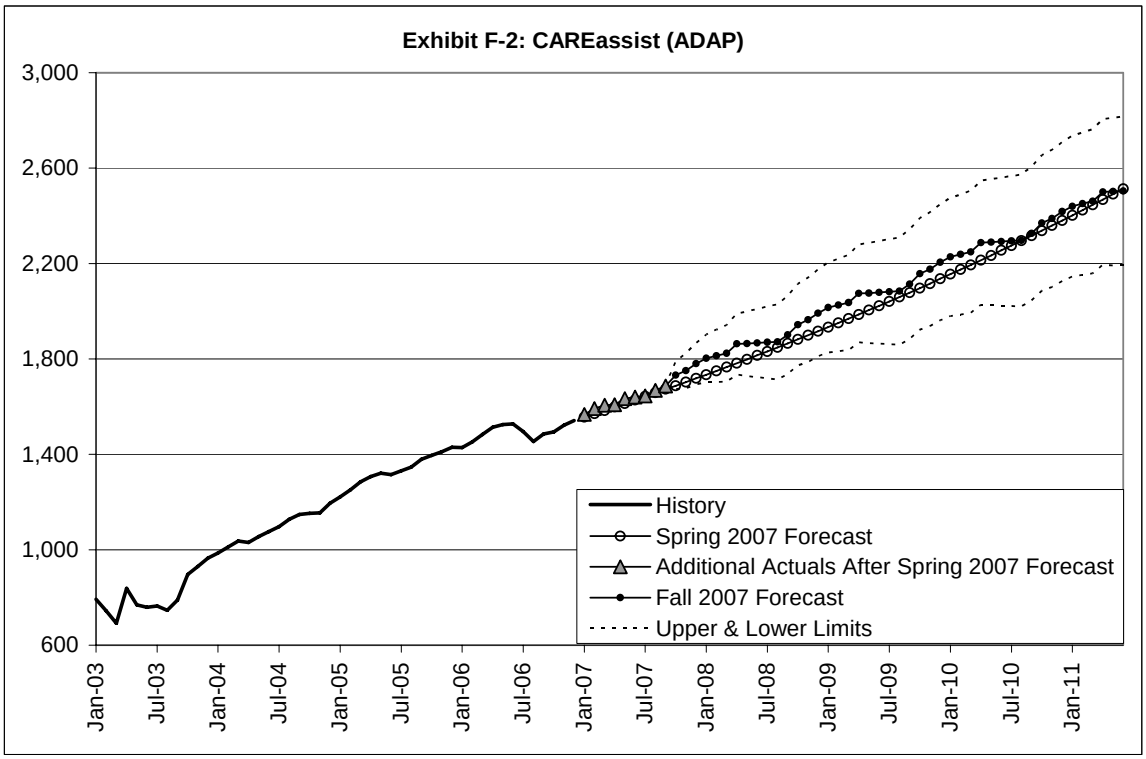
Changes in medical practices and/or medications: The rapid development of successful treatments could accelerate recovery and cause a decline in the observed caseload.

Changes in program resources: Fluctuations in federal funding affect the numbers of client receiving services and benefits from the CAREAssist program.

Changes in environmental factors: Demographic, economic, and behavioral trends can influence the CAREAssist caseload as resources allow. For example, a constant rate of HIV infection in a growing Oregon population during the next few years will lead to a growing caseload. Because eligibility is based on income, economic variability can result in caseload fluctuations as the number of jobs, especially those that provide access to affordable health insurance, increase or decrease over time. Also, economic and behavioral issues can interact to change the CAREAssist caseload. Interactions among economic stressors, drug and alcohol dependence, and individual behaviors can result in corresponding changes in caseload levels as each component changes over time.

Specific Program and Policy Events: Changes in eligibility requirements or other guidelines can affect the observed caseloads. For example, the Standard program of the Oregon Health Plan will be opened to new enrollees in January 2008. Staff plans to increase enrollment to maintain a biennial average of 28,000 clients through the 2007-09 biennium. When Standard reopens, CAREAssist staff will refer new applicants with incomes at or below 100% of the federal poverty level to the Standard program. This action would no doubt affect the CAREAssist caseload forecast; future monthly levels might be lower than expected in the current forecast.

Statistical Error: All forecasts have inherent error that increases with time; the longer the forecast period, the greater the error. The following graph incorporates upper and lower limits that illustrate the effects of this error on the forecast. Based on the historical fluctuation in the caseload, the future actuals could vary eight percent above or below the average monthly forecast for the 2007-09 biennium.



Appendix I

Child Welfare Average Daily Population by Service Category

Service Categories

The Child Welfare forecast provides projections for the average daily population for various categories of Child Welfare services. Average Daily Population (ADP) is the sum of the daily populations divided by the number of days in the month. ADP is calculated by adding days of service for the entire month (person days) and dividing by the number of days in the month. This method is used because children may be receiving multiple services during a month.

Regular Paid Foster Care: The ADP for Regular Paid Foster Care includes regular payments made for the costs of children placed in foster homes.

Special Rates Foster Care: The ADP for Special Rates Foster Care includes payments made at a special rate to address special needs that cannot be accommodated by the regular foster care payment.

Adoption Assistance: The ADP for Adoption Assistance includes payments made to provide support to help remove financial barriers to achieving and sustaining adoptions for special needs children, and excludes those receiving non-cash assistance only.

Subsidized Guardianship: The ADP for Subsidized Guardianship includes payments made to remove financial barriers in achieving permanency for Title IV-E[1] eligible children for whom returning home or adoption is not in their best interest.

Residential Treatment: The ADP for Residential Treatment includes payments made to provide intense supervision and therapy to children who have experienced severe abuse or neglect. This also includes payments made to professional shelters that accept children any time of day or night and provide special services. The forecast presented here includes only Behavioral Rehabilitation Services (BRS) and not Psychiatric Residential Treatment, which is included in the services provided by the Addictions and Mental Health Division.

Residential Treatment consists of three major types of service:

Regular Contract, which relates to a specific number of contracted beds for children with behavioral and emotional problems.

[1] Title IV-E is part of the federal Social Security Act and provides reimbursement for the costs of children placed in foster homes or other types of out-of-home care.

Special Contract (also known as Emergency Contract), which involves a contract written for an individual child with behavioral and emotional problems who is in need of emergency placement when no other placement is available.

Target Children, who are children with multiple handicapping conditions who cannot be served in a regular foster care or residential bed.

Forecast

Regular Paid Foster Care

The Foster Care caseload consists of individuals falling into three categories: Residential Care; Paid Foster Care; and Non-paid Foster Care. Regular Paid Foster Care is a subset of the Paid Foster Care category. As one might expect, the leveling off and subsequent decrease apparent in the Foster Care caseload since July 2005 is also evident in Regular Paid Foster Care ADP. The 5,880 average forecasted for the 2007-09 biennium is 14 percent lower than the forecast prepared for the Legislatively Adopted Budget (LAB) in Spring 2007. Another factor influencing this caseload is SB 282, which provides for making foster care payments to relatives. This results in a shift of 309 from Non-paid Relative Foster Care to Paid Relative Foster Care.

Special Rates Foster Care

The individuals receiving special rate payments form a subset of the group receiving regular foster care payments. On average, half of those receiving foster care payments also receive special rate payments. The Fall 2007 forecast's biennial average of 2,949 for Special Rates Foster Care is approximately 11 percent lower than the Spring 2007 (LAB) forecast. The Special Rates category is also expected to be impacted by SB 282, but by half the expected impact to Regular Paid Foster Care.

Paid Adoption Assistance

This service correlates strongly with the Adoption Assistance caseload in terms of number served, so it presents a similar historical trend. The Fall 2007 forecast of 10,119 for the 2007-09 biennium ADP is around 1 percent lower than the Spring 2007 (LAB) forecast.

Paid Subsidized Guardianship

As with its number served counterpart, Subsidized Guardianship ADP has shown an increase in growth recently, due possibly to more emphasis being placed on this path to permanency. The Fall 2007 forecast reflects this; at 936, it exceeds the Spring 2007 (LAB) forecast for the 2007-09 biennium by over 22 percent.

Residential Care

Like Regular Paid and Special Rates Foster Care, the flattening of the Foster Care caseload trend line has impacted Residential Care ADP. The 2007-09 biennial average of 457 for Total Residential Care falls nearly 4 percent below that for the Spring 2007 (LAB 2007) forecast. For Regular Contract, the LAB 2007 forecast assumed 95 percent utilization. The additional actuals show that this level of utilization has not been achieved; however, the contracts will be reconfigured in the coming year to only pay for filled beds, which should create a shift from special contract beds to regular contract beds until 95% utilization is achieved.

Risks and Assumptions

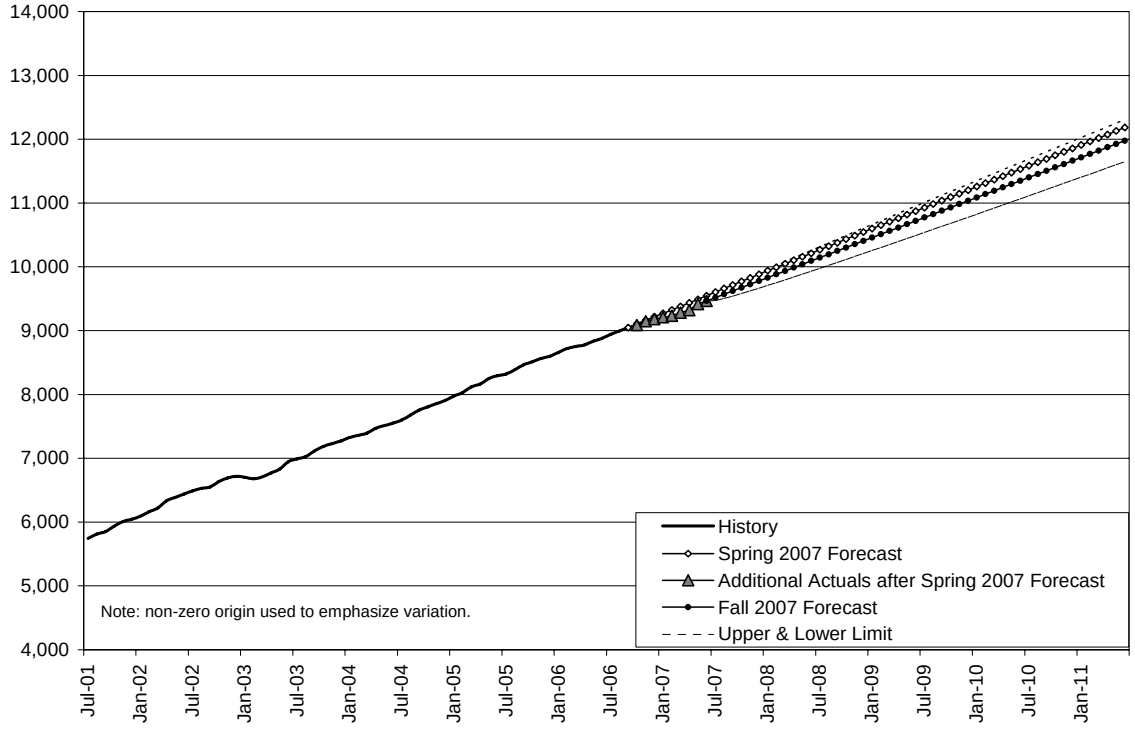
The Fall 2007 forecasts for Regular Paid and Special Rates Foster Care pose the greatest risk, since it is difficult to determine exactly why they have fallen over the past year. As discussed in the section on number served, the decline in Foster Care may be in part from improved practice in terms of keeping children safe in their own homes, but this is by no means certain.

As with its corresponding caseload in terms of number served, the Paid Adoption Assistance ADP forecast for Fall 2007 assumes a continuation of the upward trend exhibited historically. Given the relative stability of this trend, the forecast presents very little risk.

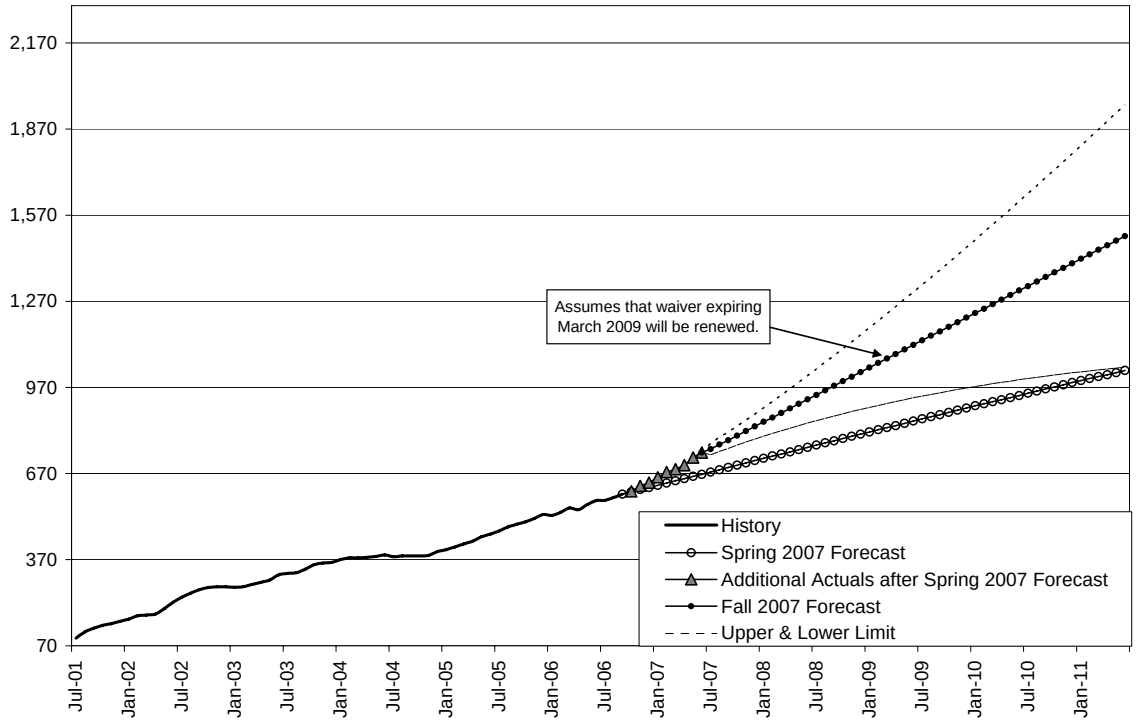
The Paid Subsidized Guardianship forecast has a specific risk from two sources. First, the waiver associated with this program is scheduled to expire March 2009; if it is not renewed, no new entries would be allowed. The Fall 2007 forecast assumes that the program will be renewed and continue in its current form. A second risk stems from the fact that this caseload has deviated from its previous historical trend recently, and it is uncertain whether this is a permanent change or merely temporary.

The Fall 2007 forecast for Residential Care ADP poses a risk mostly in terms of the split between regular and special contract beds. This is due to the difficulty of estimating exactly how the reconfiguration of residential care contracts will impact the utilization of regular contract beds.

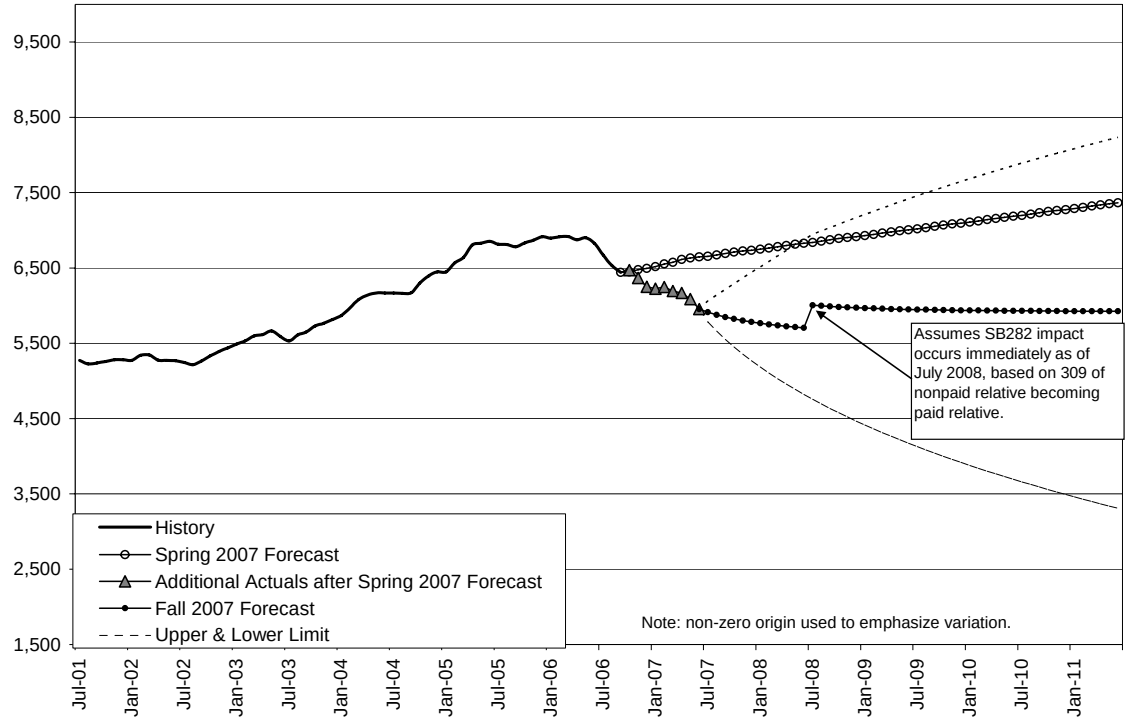
Paid Adoption Assistance - Average Daily Population



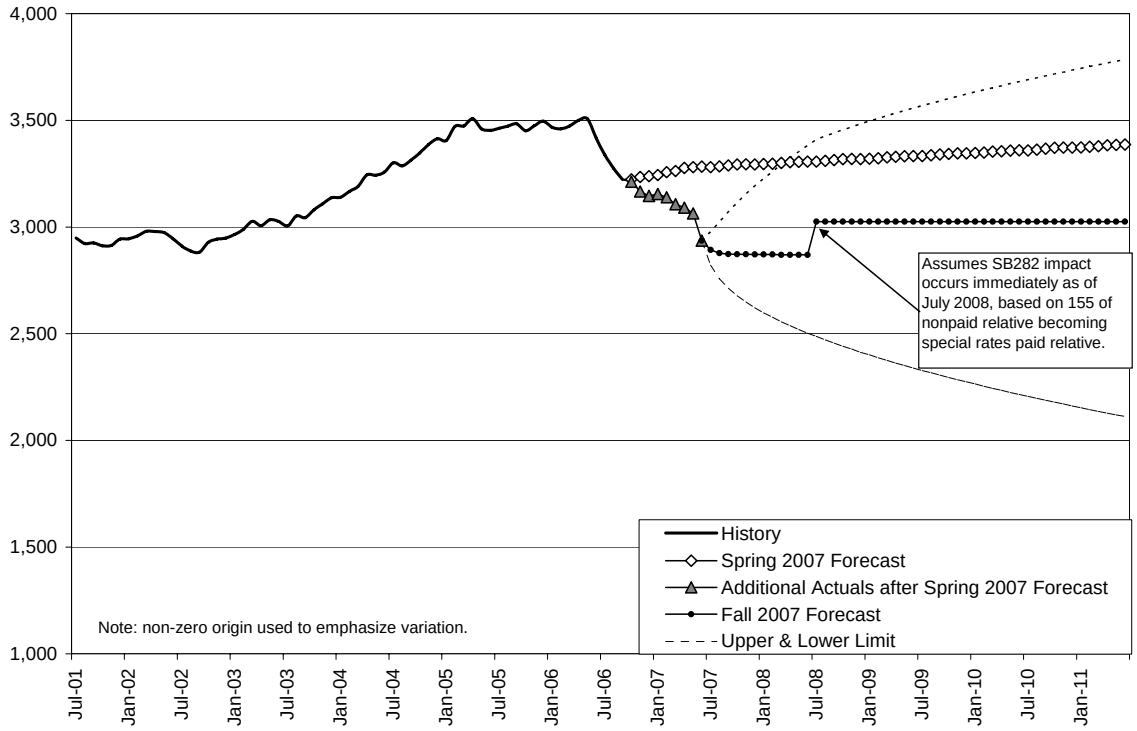
Paid Subsidized Guardianship - Average Daily Population



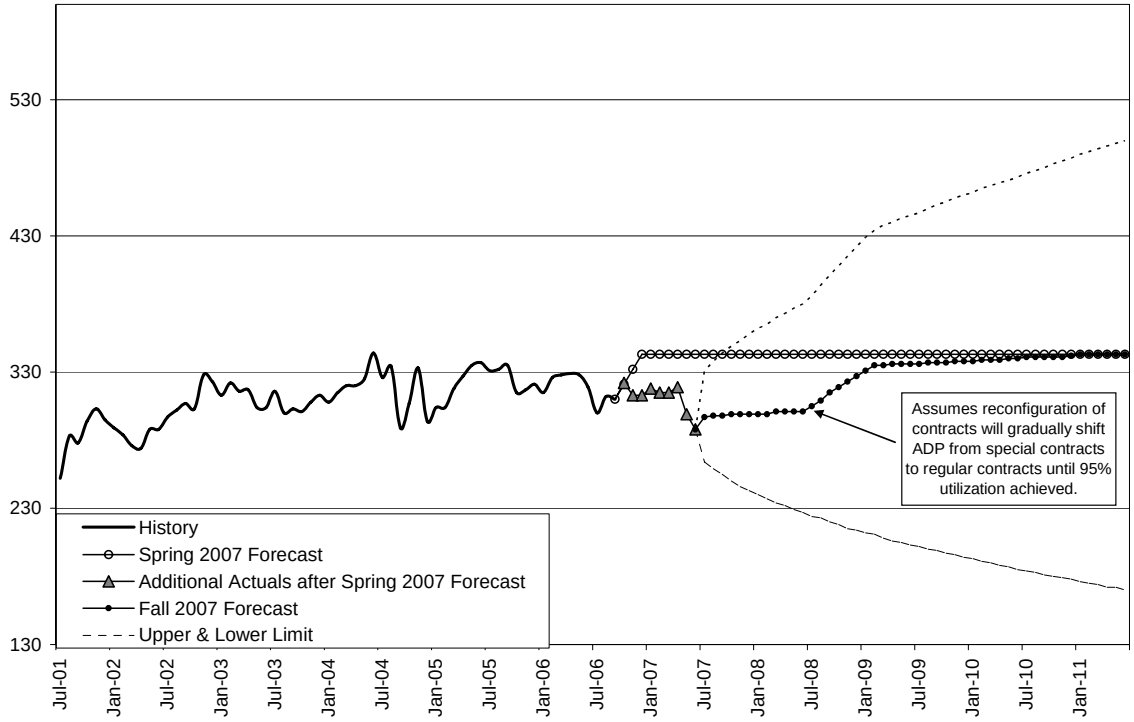
Regular Paid Foster Care - Average Daily Population



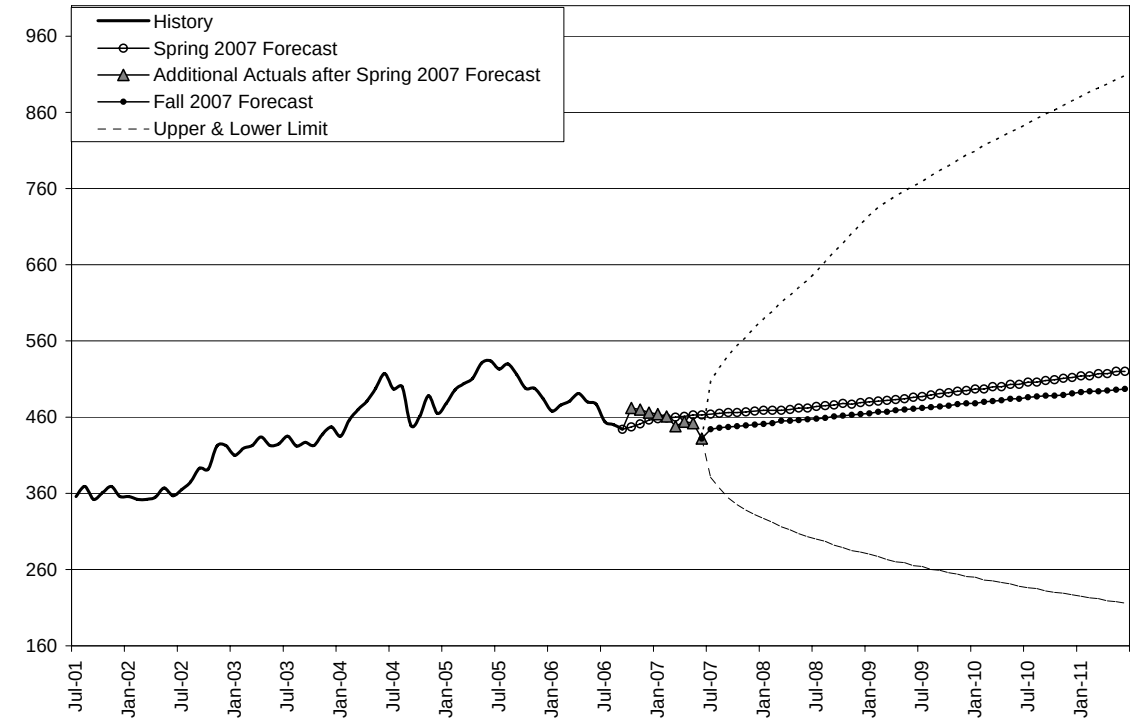
Special Rates Foster Care - Average Daily Population



Regular Contract Residential Care - Average Daily Population



Total Residential Care - Average Daily Population



Appendix II

Forecast Process and Methodology

Each program's forecast is prepared twice a year in two steps. The process begins with each program's steering committee creating a forecast agreement with the forecasting team. The agreement outlines the specific caseloads that will be forecast. A steering committee is composed of:

DHS program experts
DHS budget analysts
Legislative Fiscal Office (LFO) analysts
Department of Administrative Services' (DAS) Budget and Management Office (BAM) analysts.

Once the forecast agreement is final, the forecaster uses mathematical models to produce preliminary forecasts. The forecaster then discusses the preliminary forecasts with the program's steering committee. The steering committee provides information about past and future policy changes and their effects. A new addition to this process is review of the forecast, and discussion of trends and events in the community that may affect DHS caseloads by the Community Provider Advisory group. The forecaster incorporates events and the feedback into the forecast. The Steering committee agrees on a final forecast.

After finalized by the Steering committee, there is a review of the forecast and methods by the DAS Forecast Review Team, and review and sign-off of the forecasts by the DAS and DHS Directors. The DAS Forecast Review team consists of representatives from LFO, BAM, and the Office of Economic Analysis. This review occurs after the steering committee review and provides another review of the forecast.

Another part of the forecasting process is a twice-yearly meeting of the Technical Forecasting Advisory Group. This group of experts from other Oregon state agencies, the Oregon universities, and private industry provides advice on the forecasting methodology and how to improve it. The list of participants for the various steering committees and advisory committees are available upon request.

Notes on methods

To create the forecast, the forecaster must know how many clients *have been* served in the past and they apply the mathematical models to project how many *will* be served in the future. There are counts of clients for each month and the forecast predicts a number of clients for each future month of the forecast. The DMAP and SPD forecasts use the number of people entering those programs' services, how long they receive services, and the patterns of people transferring between programs to forecast. The CAF, MH and CareAssist caseload forecasts differ from the DMAP and SPD somewhat. They are created by applying statistical methods to historical caseload data, accounting for long-term trends, seasonality, and changes in policies and/or programs. Further details of the methodologies used are available in technical documents upon request.

For additional copies, information or to receive information in an alternate format call (503) 947-5185.

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