DEPARTMENT OF HUMAN SERVICES

FALL 2006 FORECAST

DHS
oregon department
of human services

FINANCE & POLICY ANALYSIS
FORECASTING, RESEARCH & ANALYSIS
OCTOBER 2006

Executive Summary

DHS produces semi-annual forecasts of its caseload each spring and fall. The Fall 2006 forecasts predict continued moderate growth for most programs through the next biennium, 2007-09. With few exceptions, this closely aligns with the estimates from the Spring 2006 forecasts.

Background and Risks

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). In researching the national and state trends, it is predicted that Oregon's economy will cool, and experience slight to moderate growth after having experienced relatively rapid growth in the three years since the recession. Also, the higher uninsured rate is anticipated to continue with fewer employers providing health coverage. State demographers predict that Oregon's population will continue to increase moderately with relatively rapid increases in the elderly population. Finally, the number of Oregon's children and families in extreme poverty is anticipated to grow. These factors will likely act to increase DHS caseloads.

Changes in federal policy present major risks to the current estimates for a wide range of DHS programs - from Temporary Assistance for Needy Families (TANF) to Medicaid. Other risks to the forecasts include ramifications of significant demands on Community-Based treatment programs, particularly the 24-hour care/residential facilities, substance abuse treatment programs, and mental health treatment programs. While the lack of capacity may reduce the number of people for some programs, the inability to provide services leads to increasing caseloads and costs in other program areas. Additional risks beyond the inherent risk of forecasting years into the future include a possible flu pandemic or natural disaster, both of which would place upward pressure on demand for DHS services.

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 TANF and Food Stamps exhibit slight growth, reflecting an economy that is growing more slowly than in recent years.
>
> **Child Welfare** caseloads, on the other hand, continue to show substantial growth, though not as strong as has been experienced during the past two years. The one exception continues to be the "Child In Home" caseload,

which has experienced a rapid decline in recent years. Due to changes in Child Protective Service practices, it is anticipated that this group will begin to grow moderately in the upcoming years. Also, the latter part of 2005 saw a leveling off of the Foster Care caseload. However, given population growth and prior history of short periods of little growth, it is anticipated that the flattening is only temporary.

Vocational Rehabilitation caseload has remained fairly stable over the past two years, dropping slightly over the last few months. The projections are for continued stability at the most recent lower level.

Medical Assistance Programs: Medical Assistance programs consist of three major areas: OHP Plus, OHP Standard and "Other". Most programs are expected to moderately grow with a few exceptions. Also, most estimates are relatively close to the Spring 2006 forecasts.

Temporary Assistance for Needy Families Medical (TANF-M): Due to the improved economy, as well a several major changes in the TANF medical program, this population is leveling off, and is expected to decline in upcoming years. However, there are several major federal changes looming that make these forecasts more risky than usual.

Children's & Poverty Level Medical Women (PLMW) Programs: All children's and PLM women caseloads are anticipated to grow. The growth in the children caseload is mainly due to the changing the recertification interval from 6 months to 12 months for the Children's Health Insurance Program (CHIP).

Seniors & Disabled: The medical assistance programs for people with disabilities have experienced steady growth for a couple of years. This pattern is expected to continue. The caseload for seniors has recently declined from its previous trend of slight growth, likely due to the implementation of the Medicare drug benefit in January 2006. This decline is expected to continue, although the lack of historical experience with such a change imparts a high a degree of risk.

OHP Standard: Due to the closure to new enrollment of OHP Standard, the caseload has dropped over the past couple of years. However, it is not expected that the caseload will continue to decline at the same rate. This is because individuals are maintaining their enrollment for longer periods of time.

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 Long-Term Care caseload forecast is relatively unchanged from the Spring 2006 forecast for the 2005-07 and the 2007-09 biennia.

In-Home service caseload for the past three years has been relatively flat or slightly decreasing after severe budgetary cutbacks that occurred in 2003. That pattern is expected to continue.

Community-Based Care Facilities caseload also experienced declines after 2003, followed by a period of little or modest growth. Given issues regarding availability and capacity of these facilities, it is anticipated that only slight growth will occur through 2009.

Nursing Facilities caseload has steadily declined for several years. However, due to an aging population as well as the effects of LTC market dynamics in community-based settings, nursing facilities are expected to begin to rebound.

Mental Health: The Fall 2006 Mental Health forecast estimates mandated caseloads. The Criminally Committed (Aid and Assist; Psychiatric Security Review Board), and Civilly Committed (24 Hour Care, Acute care, and State Hospitals, excluding individuals Civilly Committed in community outpatient settings). Although these groups have been forecasted in the past, new data sources and forecasting methods preclude comparisons.

Criminally Committed caseload has fluctuated with periods of slight to rapid growth followed by shorter periods of decline. It is anticipated that the recent period of decline will follow this historical pattern, and will shift to one of slight growth through 2009.

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

Total DHS Caseload Biennial Average Comparison by Forecasts

Biennial Averages by Forecast (Rounded to the 10's)	2005-07 Biennium Spring 2006 to Fall 2006			2007-09 Biennium Spring 2006 to Fall 2006		
	Spring 06 Forecast 2005-07	Fall 06 Forecast 2005-07	*% Diff. Fall 06 to Spring 06 2005-07*	Spring 06 Forecast 2007-09	Fall 06 Forecast 2007-09	*% Diff. Fall 06 to Spring 06 2007-09*
Children, Adults and Families (CAF)						
Self-Sufficiency						
Food Stamps (Households)	223,740	221,690	-1.0%	234,620	231,160	-1.5%
Temporary Assistance for Needy Families (Families: Cash Asst.)	18,330	18,280	0.0%	18,900	18,530	-2.0%
Employment Related Daycare (Families)	9,700	9,580	-1.0%	9,770	9,740	-1.0%
Child Welfare (Children Served)						
Adoption Assistance	9,640	9,580	-1.0%	11,050	11,020	0.0%
Foster Care	10,820	10,480	-3.0%	12,130	11,640	-4.0%
Child In Home	4,500	3,930	-13.0%	4,700	3,890	-17.0%
Vocational Rehabilitation (Clients Served)	9,900	9,450	-5.0%	9,870	9,370	-5.0%
Medical Assistance Programs						
OHP Plus: Temporary Assistance to Needy Families (Medical)	137,560	134,700	-2.0%	139,390	128,400	-8.0%
OHP Plus: Children (PLMC & CHIP)	113,620	114,720	1.0%	118,880	127,690	7.0%
OHP Plus: Seniors & People w/ Disabilities	92,780	92,030	-1.0%	97,620	94,800	0.0%
OHP Plus: Poverty Level Medical Women	9,930	10,310	4.0%	10,700	11,830	11.0%
OHP Plus: Foster/Substitute Care	18,450	18,050	-2.0%	20,330	18,920	-7.0%
OHP Plus Total	**372,340**	**369,810**	-1.0%	**386,920**	**381,640**	-1.0%
Other Medical Assistance Programs	29,630	30,226	2.0%	29,600	30,390	3.0%
Seniors & People w/ Physical Disabilities - Long Term Care						
In-Home	11,620	11,630	0.0%	11,520	11,560	0.0%
Community-Based Care	11,100	10,920	-2.0%	11,150	11,070	-1.0%
Nursing Facilities	4,920	4,900	0.0%	4,740	4,830	2.0%
***Mental Health (State Hosp. & Community Residential Care)**						
Forensic (PSRB & Aid and Assist)	-	800	-	-	810	-
**Civil Commitment	-	1,170	-	-	1,300	-

*The Fall 2006 Mental Health forecast is significantly different than previous versions in both methodology and data development making comparisons to prior forecasts not feasible.
**Excludes civilly committed in community outpatient settings.

Table of contents

About the Forecast

The Department of Human Services (DHS) is the largest state agency, serving about one million Oregonians. 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.

The department predicts the number of clients, or the caseload, it will serve. The caseload forecast is one element of the agency's budgeting process. There are four groups of programs for which DHS forecasts caseloads. These groups are Children, Adults and Families Division (CAF), Division of Medical Assistance Programs (DMAP), Addictions and Mental Division (AMH), and Seniors and People with Disabilities Division (SPD).

Background and Risks

More than most other agencies in state government, the demand for DHS programs, and thus its caseload, is affected by a number of factors beyond its control. Demographics, social behavior, economic trends, and policy changes all influence the number of clients who will seek DHS services. The following outlines several major environmental factors that impact DHS caseloads.

Population Growth[1]

According to the US Census, Oregon's population growth has continued to outpace the national average – between 1990 and 2000 Oregon's population increased by 20.4 percent while nationally the population grew by only 13.1 percent. The Office of Economic Analysis (OEA) is projecting that Oregon's population will grow slightly by about 1.4 percent over the next few years. It has also been projected that the population will increase by 41.3 percent from 2000 through 2030. As the population continues to grow, so will the demand for many of the DHS programs.

Growing Number of Seniors

Elderly Oregonians are the fastest growing segment of the state population. The overall anticipated growth of elderly Oregonians is greater than the growth of other population groups. By 2010, it is expected that there will be a 13 percent increase in those over the age of 65 since 2000. By 2010, the 65-74 year old group is expected to increase by 23 percent, the greatest growth among elderly

[1] Sources for population estimates: US Census Bureau, State Interim Report, 2005; Office of Economic Analysis, 2006; Office of Economic Analysis, Short-term State Population Forecast through 2011, 2006

Oregonians. The 85 years and older segment is expected to grow by 18 percent during this same time period.

Economic Factors

The economies of the state and the nation have a large impact on the department. A downturn in the economy can affect the number and type of services needed by DHS clients. Conversely, a strong state economy reduces the percentage of the federal government's Medicaid match rate. Federal Funds provide about 60 percent of the revenue for DHS programs, and Medicaid is the largest of those programs. When Oregon's economy improves relative to the rest of the nation, the match rate changes so that Oregon contributes a larger share of the state General Fund to receive federal matching funds. Major programs like Food Stamps, Temporary Assistance for Needy Families (TANF), childcare assistance, public health, and the Oregon Health Plan are affected by the health of the economy. In addition, the indirect effects of economic changes may impact DHS services. For example, stress due to job or income loss can lead to increased child abuse and neglect, that can result in a greater demand for child welfare programs.

Employment[2]

As Oregon emerged from the recession, the job market grew substantially. However, Oregon has a higher unemployment rate than the national average. While job growth is expected to continue, it is predicted that the jobs will be added at a much slower rate than in previous years. The current estimate of annual job growth is just over 1 percent during both 2007 and 2008. Much of the job growth since the recession was in low-wage industries and it has been projected that the greatest job growth will continue in this area. Tied to slowing job growth, inflation is predicted to increase by 1.7 percent, by projected increases in the cost of living. These increases are projected to be faster than increases in income levels. For the next 8 years, economists project that Oregon's per capita income will remain below the U.S. average. These conditions are likely to stimulate even more people to seek DHS services.

[2] Most of the information was obtained from the Employment Department in 2006, and the Office of Economic Analysis' forecast 2006.

Poverty[3]

Poverty in Oregon is a complex problem fueled by many factors including unemployment or underemployment, disability, lack of education, low wages, unaffordable housing, and untreated mental health and substance abuse. Current figures estimate that the national poverty rate is 12.6 percent (U.S. Census Bureau, 2006); Oregon's rate is 12.1 percent as of 2005. In Oregon, the number of children living in poverty continues to increase at an alarming rate. The 2003 poverty level for 0-17 year old was 17.4 percent; over 20 percent of Oregon's children under age five lived in poor households (American Community Survey, 2005). In both Oregon and the U.S., the poverty rate for children is higher than it is for 18-64 year olds as well as those 65 and older (Oregon Housing and Community Services, Report on Poverty, 2004; U.S. Census Bureau, 2006.)

Abuse of Alcohol and Other Drugs

If any one specific factor leads to long-term demand for many of the department's services it is substance abuse. Dependence on public assistance, child abuse and neglect, and mental health problems can often be traced to alcohol and other drug abuse. In 1999, 15.2 percent of Oregonians were either dependent upon, or abused alcohol and/or drugs. More recent findings demonstrate a high rate of continued use of these substances, especially by adolescents. Given that early substance abuse is a definite risk factor for later problems, this increased level of substance abuse, will likely lead to greater demand for DHS services in the future.

Rising Cost of Health Care and Other Provider Costs[4]

Over the past decade, one of the fastest growing components of budgets in many states is the Medicaid program. This is partially due to federal program and eligibility changes, but a major factor is continued rising medical costs. These rising costs have led to a higher rate of uninsured individuals. Fewer employers are offering paid health insurance due to increased costs. Additionally, many employees whose employer offers health insurance cannot afford to pay for the coverage. There was a dramatic change in the rate of uninsured Oregonians from 2000-01 to 2004-05 (12.7 percent to 16.4 percent respectively). This increase represents one of the greatest increases in uninsured rates in the country. The 2004 Oregon Population Survey found that 17 percent of Oregonians were without health insurance coverage. This is about 1 out of every 6 people in the state. Oregon's rate of uninsured children is somewhat better than the national average at 10.4 percent in 2005. Nationally,

[3] Sources for poverty figures: US Census Bureau, 2006; American Community Survey, 2005; Oregon Housing and Community Services, Report on Poverty, 2004

[4] Sources for Health Care/Provider costs: Current Population Survey; Oregon Population survey; Employment Dept. Survey of Health Insurance by Employers.

11.2 percent of all children were without health insurance coverage in 2005, an increase of .4 percent from 2004. More troublesome was that in 2005, 19 percent of children living in poverty were without health care across the nation.

Actions by the Federal and State Government

The Deficit Reduction Act's TANF reauthorization of 2005, poses significant risks to many of the DHS caseload forecasts. There has been very little federal guidance on implementation, leaving the state and DHS with major policy decisions. In addition, about 60 percent of the resources for DHS programs come from the federal government, the majority of which is from the Medicaid (Title XIX) program. This dependence constrains the ability of the department to adjust to the needs of its clients if federal resources are reduced or the rules that accompany the funding are altered substantially. In recent years, the federal government has made significant reductions in the Title XX or Social Services Block Grant program which funds child welfare and day care programs in the department. The changes to, or enactments of, federal or state policies frequently have an unpredictable effect on the DHS caseload.

Other risks to the forecasts include ramifications of the significant demands on community-based treatment programs, particularly 24-hour care/residential facilities, substance abuse treatment programs, and mental health treatment programs. While the lack of capacity may reduce the number of people for some programs, the inability to provide services increases caseloads and costs in other program areas.

Other Considerations

There are considerations aside from those mentioned above that should be taken into account as possible factors that would have a likely impact on the DHS caseloads. It is difficult to predict the likelihood of certain events, particularly a flu pandemic or natural disaster, but the outcomes of such events can be anticipated and planned for. When events occur that endanger or compromise the health and safety of Oregonians, more resources are needed to mitigate the situation. Since these uncontrollable events directly impact the ability of DHS to assist people in becoming independent, healthy and safe, it is important to realize and acknowledge the types of scenarios that would likely result in a greater demand for DHS services.

Flu Pandemic

Flu pandemic would impact not only human health, but many facets of Oregon's economy as well. Additionally, providing flu vaccinations for other types of influenza outbreaks to safeguard human health could be costly for programs within DHS. Of particular concern in the event of flu pandemic would be those more susceptible DHS and Oregon populations including the elderly and young children. These populations would likely impact DHS by increasing demands for preventative services and flu vaccinations.

Natural Disasters

Natural disasters are difficult to predict yet generally increase demand for DHS services. When a natural disaster occurs, loss of life, jobs, and/or property damage may result. These types of occurrences may stress taxpayers and state agencies. In response, insurance premiums may rise and become unaffordable for some. This would likely lead to more individuals seeking DHS services.

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. The program caseloads included in the CAF Fall 2006 forecast appear in Exhibit A-1. Further details regarding each group will be detailed in each section.

Exhibit A-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	Subsidized Guardianship	
Employment Related Daycare	Foster Care	
Temporary Assistance for Domestic Violence Survivors		

Self-Sufficiency

The forecast for Self-Sufficiency programs falls into the following categories:

Food Stamps
This program supplements food budgets for low-income families, people receiving public assistance, low-income seniors and peoples with disabilities.

Temporary Assistance for Needy Families (TANF)
This program provides cash grants to very low-income families with children. The goal of the program is to help people become self-sufficient. It should be noted that families receiving TANF medical only are not in this caseload (see Medical Assistance Programs).

Employment Related Daycare (ERDC)
This program subsidizes daycare to help low-income working parents remain employed. This includes those who are transitioning off TANF as well as those who are at risk of ending up on TANF without affordable daycare.

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

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.

Given the expectation of modest growth in the Oregon population, together with a slowing economy, the forecast for Self-Sufficiency programs exhibit very modest growth. This represents the continuation of a trend that has existed over the past two years.

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

	2005-07 Biennium			2007-09 Biennium		
Comparison:	**Spring 2006 to Fall 2006**			**Spring 2006 to Fall 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 06 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*%Diff. Fall 06 to Spring 06 2005-07*	**Spring 06 Forecast 2007-09**	**Fall 06 Forecast 2007-09**	*%Diff. Fall 06 to Spring 06 2007-09*
SELF-SUFFICIENCY						
Food Stamps (Households)						
Children, Adults and Families	158,586	156,944	-1.0%	163,384	159,743	-2.2%
Seniors and People with Disabilities	65,149	64,749	-0.6%	71,242	71,422	0.3%
Total Food Stamps	**223,735**	**221,693**	-0.9%	**234,626**	**231,165**	-1.5%
Temporary Assistance for Needy Families (Families: Cash/Grants)						
Basic	17,284	17,296	0.1%	17,734	17,420	-1.8%
UN	1,048	979	-6.6%	1,168	1,108	-5.1%
Total TANF	**18,332**	**18,275**	-0.3%	**18,902**	**18,528**	-2.0%
Employment Related Daycare (Families)	**9,707**	**9,583**	-1.3%	**9,772**	**9,738**	-0.3%
Temp. Assist. for Dom. Violence Survivors (Families)	**601**	**540**	-10.1%	**642**	**549**	-14.5%

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 programs. Households entering the program through Children, Adults and Families Division 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 A-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 not grown at the predicted pace of the Spring 2006 forecast. Thus, the Fall 2006 forecast's 2005-07 biennial average for households of 156,940 is slightly lower (1 percent) than the spring estimate; and the 2007-09 biennial average for households of 159,740 is around 2 percent lower than the Spring 2006 forecast (Exhibit A-2). In contrast, the SPD Food Stamp population has only deviated slightly from its growth trend since the Spring 2006 forecast; hence, at about 64,750 in 2005-07; and about 71,420 households in 2007-09, the Fall 2006 forecast for SPD Food Stamps differs very little from the Spring 2006 forecast. Overall, the total Food Stamp caseload of

nearly 231,170 households predicted by the Fall 2006 forecast is around 2 percent below that for the Spring 2006 forecast for 2007-09 (Exhibit A-3).

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. There is some anecdotal evidence, however, that demand at food banks in Oregon has increased due to low-income individuals having less to spend on food due to rising housing and fuel costs. However, it is difficult to tell just how this might impact Food Stamp caseloads. Thus, any significant improvement or deterioration in the economy could result in the forecast being over- or understated, respectively.

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 (Exhibit A-3).

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.

Forecast

The TANF caseload experienced moderate growth during 2001 through the first part of 2005, accompanied by seasonal fluctuations (Exhibit A-4). However, since that time, with seasonal variation continuing, the caseload has been declining slightly. As shown in Exhibit A-2 the Fall 2006 forecast predicts an average 18,280 families for the 2005-07 biennium, which is nearly identical to the Spring 2006 forecast (only 0.3 percent lower). For the 2007-09 biennium, the Fall 2006 forecast of almost 18,530 families is 2 percent lower than the Spring 2006 forecast. Most of the difference for the 2007-09 biennium comes from TANF Basic, which at 17,420 families accounts for 94 percent of the caseload. The Fall

2006 forecast for TANF UN is approximately 1,110 families for the 2007-09 biennium, which is about 5 percent lower than the Spring 2006 forecast.

Risks and Assumptions

The Fall 2006 forecast assumes very little change in the economy, in keeping with the Office of Economic Analysis projections. 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 Deficit Reduction Act's TANF reauthorization passed in 2005, and signed into law in February of 2006 poses significant but uncertain risks to the TANF caseload forecast. There has been very little federal guidance on implementation, and the state and DHS have many major policy decisions to decide. Thus, this forecast is at significant risk.

Even without the above risks, historically, the TANF caseload has exhibited moderately high variability in the past. Given this historical pattern, future caseloads could average 5 percent higher or lower than the forecast for the 2007-09 biennium even without any impacts from changes in policies (Exhibit A-4).

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

As shown in Exhibit A-2 the Fall 2006 forecast for ERDC families for the 2005-07 and the 2007-09 biennia (9,580 and 9,770, respectively) are slightly lower as the Spring 2006 estimate. The reason for this is a temporary drop in caseload (about 4 percent) from February to April 2006. This was apparently caused by staff turnover as the result of layoffs, which created a situation where the staff could not handle the regular workload of applications, eligibility screening and caseload. However, the caseload seems to have recovered somewhat in May and June, which suggests that it will eventually catch up with the Spring 2006 forecast (Exhibit A-5).

Recently, the number of children per family increased, and has held steady for the past eight months. The Fall 2006 forecast reflects this increase, resulting in an increase in the number of children of around 3 percent.

Risks and Assumptions

As already described, the Fall 2006 forecast assumes that the decline in caseload from February to April 2006 was the result of staff turnover and is a temporary effect. If the ERDC caseload does not recover as predicted, then the forecast will be overestimated. Issues related to TANF such as TANF reauthorization and the economy also present significant risks to the ERDC forecast.

The large historical variability of the ERDC caseload creates a large range of variability for the forecast. For the 2007-09 biennium, the average actual caseload could fall above or below the forecast by about 15 percent, even without the significant risks of the TANF reauthorization policy changes (Exhibit A-6).

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

Historically, there is considerable variability in this population. At 540 cases for the 2005-07 biennium and 550 cases for 2007-09, the Fall 2006 forecast for this relatively small program falls considerably below the forecast from Spring 2006 (about 10 percent lower for 2005-07 and nearly 15 percent lower for 2007-09).

This reflects the fact that recent actual caseloads have been below the Spring 2006 forecast. A possible factor contributing to the decline in TA-DVS caseload is that the housing subsidy provided through TA-DVS to help fleeing victims move to a safe environment has not kept pace with the rising cost of housing. Unable to find affordable housing, families may wind up homeless, and thus, unable to benefit from the TA-DVS program.

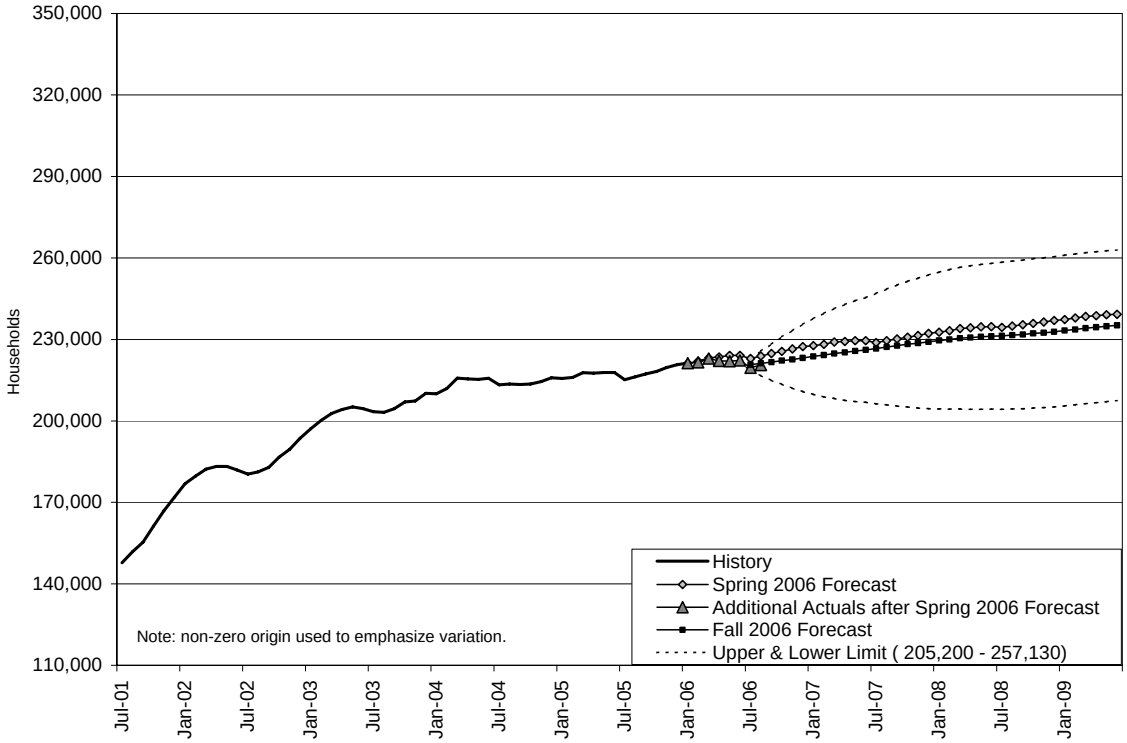
Risks and Assumptions

Historically, the TA-DVS caseload has exhibited a seasonal dip in September, with an increase in October and then a steady decline from October through February, with a steady increase approaching and through the summer months. Although the October increase did not manifest itself in 2005, the forecast assumes that the future pattern will be similar to the previous historical pattern.

Given the extreme variability of this caseload, it is difficult to tell whether movements represent permanent changes or random fluctuations. The Fall 2006 forecast assumes a flat trend centered about the range of recent values, but if

the long-term drift downward continues, the forecast will end up overestimating the caseload. In fact, based strictly on the historical volatility of this small caseload, the actual average for the 2007-09 biennium could easily deviate as much as 30 percent above or below the forecast (Exhibit A-7).

Exhibit A3: Total Food Stamps (Households)



Exhbit A4: Temporary Assistance for Needy Families (Families)

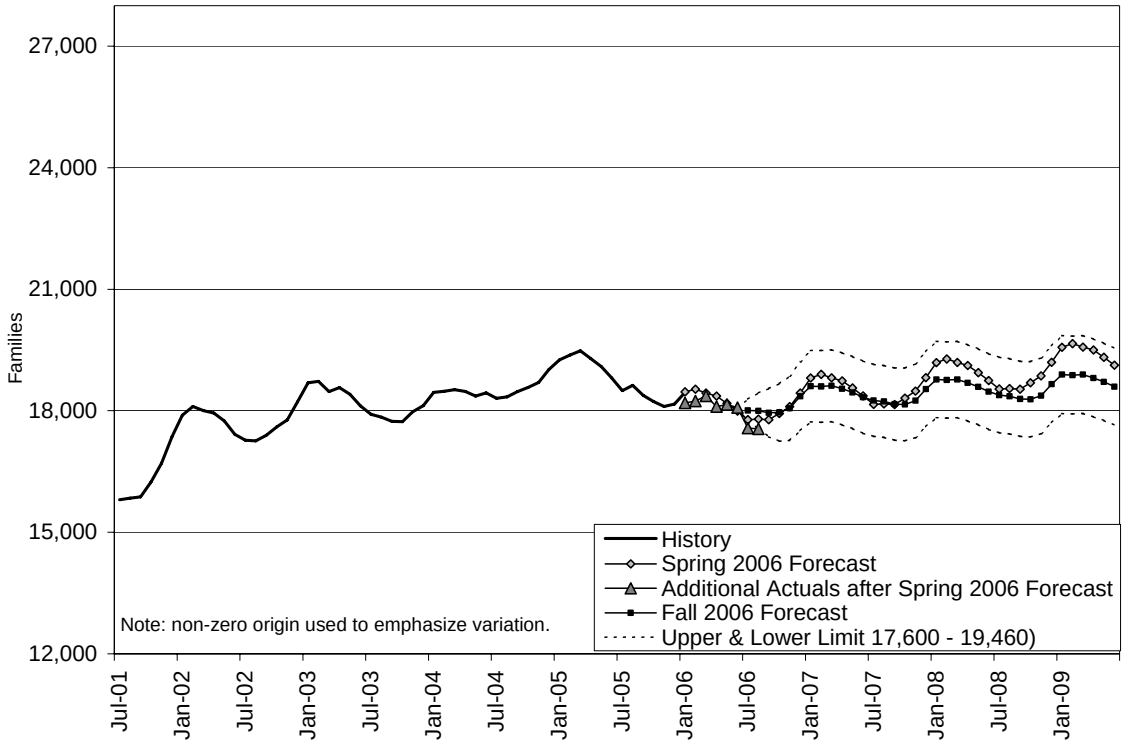


Exhibit A-5: Temporary Assistance for Needy Families - UN

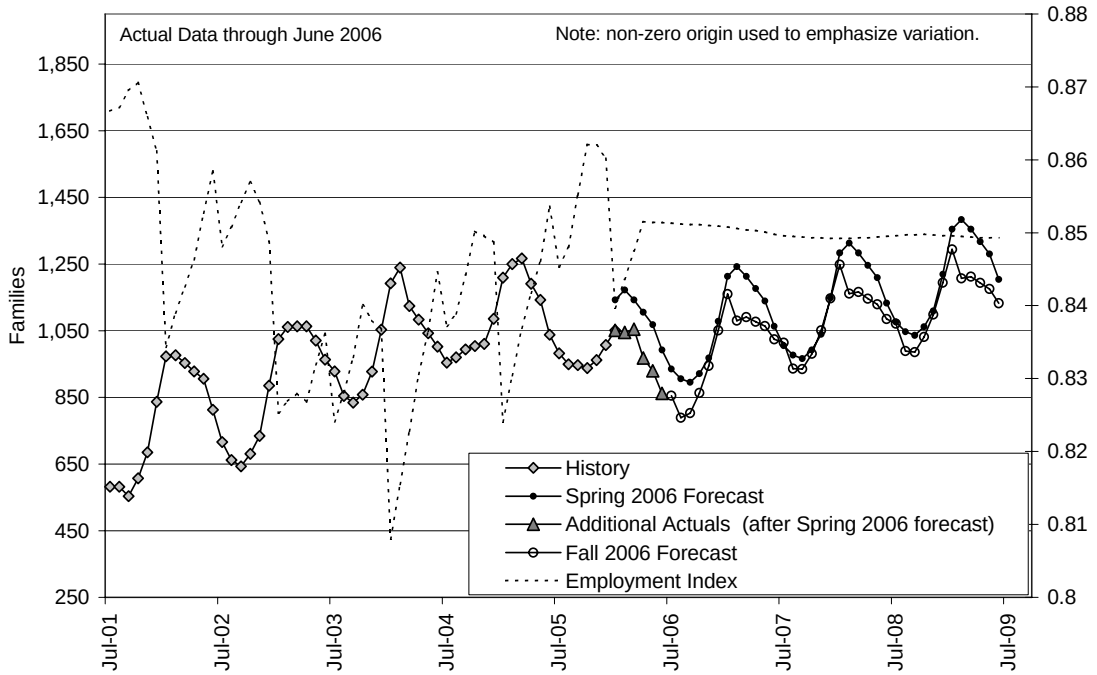
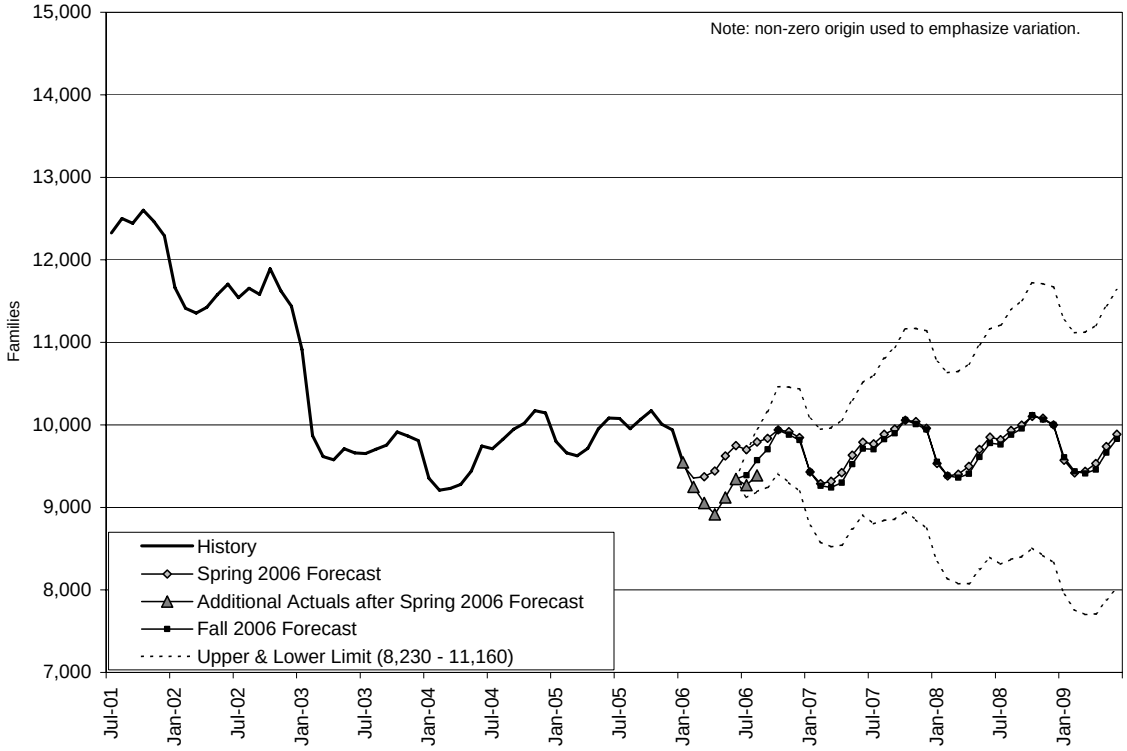
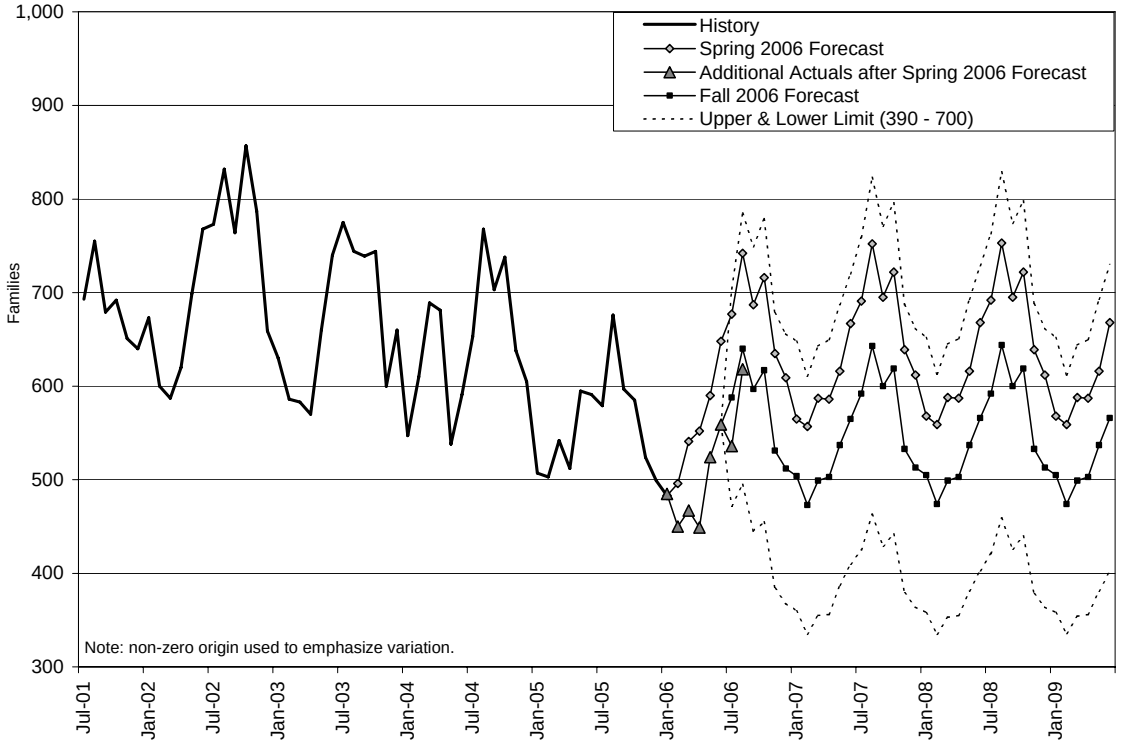


Exhibit A-6: Employment Related Daycare (Families)



Exhbit A-7: 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[5]:

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.

Foster Care provides temporary care for children who cannot be safely cared for by their birth parents.

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

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 absorbed most of this. Then around July 2005, the overall Child Welfare caseload flattened out. Although this is typical during the summer months, in September the growth trend did not resume, as one would expect. This stemmed from a combination of continued decreases in the Child In Home caseload and a leveling out of the Foster Care caseload. The Fall 2006 forecast for the 2005-07 biennium is approximately 24,560, which falls 4 percent below the Spring 2006 forecast (Exhibit A-8). For the 2007-09 biennium, the Fall 2006 forecast projects an average of 27,320 children, which is nearly 5 percent below the Spring 2006 forecast. The changes in the In-Home and Foster Care caseloads are due to multiple factors, ranging from increased parental substance abuse with decreased availability of treatment, to business practice changes in child

[5] The Child Welfare caseload excludes 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. The Spring 2006 forecast originally included Title IV-E Tribal Foster Care and Mutual Homes Recovering Families, but it has been restated to exclude these groups in order to make it comparable to the Fall 2006 forecast.

protective services designed to focus attention on the most critical cases. The overall Child Welfare caseload has varied moderately over the past few years. Given this historical variability, the actual average caseload for the 2007-09 biennium could end up above or below the forecast by about 4 percent (Exhibit A-9).

Exhibit A-8: Total Child Welfare Caseload Biennial Average Comparison by Forecasts

	2005-07 Biennium			2007-09 Biennium		
Comparison:	**Spring 2006 to Fall 2006**			**Spring 2006 to Fall 2006**		
Children, Adults and Families (CAF)						
Biennial Averages by Forecast	**Spring 06 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*%Diff. Fall 06 to Spring 06 2005-07*	**Spring 06 Forecast 2007-09**	**Fall 06 Forecast 2007-09**	*%Diff. Fall 06 to Spring 06 2007-09*
CHILD WELFARE (Children Served)						
Adoption Assistance	9,635	9,575	-0.6%	11,049	11,020	-0.3%
Subsidized Guardianship	582	576	-1.0%	762	764	0.3%
Foster Care	10,820	10,479	-3.2%	12,131	11,639	-4.1%
Child in Home	4,507	3,928	-12.8%	4,701	3,892	-17.2%
Total Child Welfare	**25,544**	**24,558**	-3.9%	**28,643**	**27,315**	-4.6%

Adoption Assistance Forecast

At 9,580 for the average number of children served in the 2005-07 biennium and 11,020 for the 2007-09 biennium, the Fall 2006 forecast differs very little from the Spring 2006 forecast (0.6 percent lower for 2005-07 and 0.3 percent lower for 2007-09), remaining close to the historical trend line.

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 plus or minus one percent of the average forecasted for the 2007-09 biennium (Exhibit A-10).

Subsidized Guardianship Forecast

The Fall 2006 forecast for this relatively small caseload (an average of 580 children served for the 2005-07 biennium and 760 for 2007-09) is slightly below the Spring 2006 forecast, but appears to have resumed its previous trend. Accordingly, the trend line for Fall 2006 forecast reconnects with the Spring 2006 forecast, resulting in a negligible difference in the biennial averages.

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 5 percent from the average forecasted for the 2007-09 biennium (Exhibit A-11).

Foster Care Forecast

The Fall 2006 forecast predicts that nearly 10,480 children will be served on average each month for the 2005-07 biennium, which is around 3 percent lower than the Spring 2006 forecast, while an average of 11,640 will be served in 2007-09, which is approximately 4 percent lower than the Spring 2006 forecast (Exhibit A-12). These differences are due to a flattening of the trend line from September 2005 through February 2006.

The Foster Care caseload has had periods of leveling off in the past, usually during the summer months when children are less likely to be in contact with a major group of mandatory reporters, teachers. A key exception to this is the period from October 2001 to May 2002. The March 2006 figure for Foster Care shows a slight up-tick. While this does not by itself constitute evidence of a resumption of the historical upward trend, it is at least consistent with such a pattern. Since there is no reason to expect a permanent suspension of the long-term growth in Foster Care, the Fall 2006 forecast assumes a trend line that puts the Fall 2006 forecast below but parallel to the Spring 2006 forecast.

The Foster Care caseload has experienced moderate volatility in the past. Given this historical variability, future caseloads could deviate from the forecast by an average of 3 percent up or down for the 2007-09 biennium.

Child In Home Forecast

The Fall 2006 forecast of around 3,930 for the 2005-09 biennium is down approximately 13 percent from the Spring 2006 forecast, which had assumed that the decline exhibited since early 2004 would subside and growth would return to its previous pattern (Exhibit A-13). At just over 3,890 for the 2007-09 biennium, the Fall 2006 forecast is about 17 percent lower than the Spring 2006 forecast. Since the Spring 2006 forecast, the Child In Home caseload has continued to fall, but appears to have leveled off in January 2006. The Fall 2006 forecast assumes that the long-term decline has abated and that the caseload will grow at a modest rate of about 2 percent per year.

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 paid 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, including a rule requiring face-to-face contact every 30 days 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 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[6].
- 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 is implementing comprehensive training starting in September of 2006 to implement some of the suggestions of the Holder Report. It is thought that this will lead to a more stable upward trend in the Child In Home caseload.

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 17 percent in either direction.

Risks and Assumptions

During 2004 and the first half of 2005, decreases in the Child In Home caseload were offset by increases in Foster Care. However, in September 2005, when one would have expected the seasonal easing of growth in the summer to give way to the increases normally exhibited in the fall, Foster Care remained flat even as the Child In Home caseload continued to experience decreases. Given the myriad of policy and procedural changes that have occurred recently, though, it would be ill advised to conclude that growth in the number of Oregon children requiring protection from abuse and neglect has subsided in any substantial way.

Accordingly, the Fall 2006 forecast makes the assumption that the overall Child Welfare caseload will resume its historical trend, albeit at a lower level than forecasted in Spring 2006. Should Child In Home continue its decline and Foster Care remain at its most recent level, the Fall 2006 forecast will end up overestimating these caseloads.

Another risk to the forecast relates to safety training that is occurring September through December 2006. If, through this training, staff became more convinced and confident that they can successfully manage cases in the home, this may cause a greater shift in caseload from Foster Care to Child In Home than estimated.

[6] 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.

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 A-9: Total Child Welfare

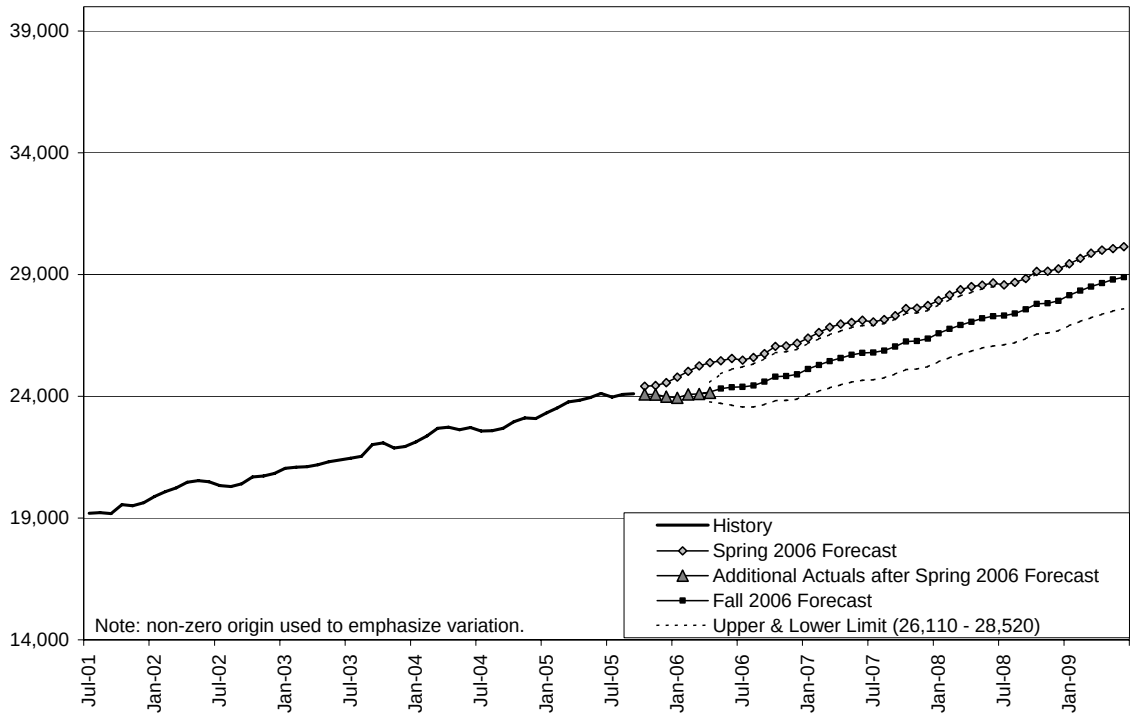


Exhibit A-10: Adoption Assistance

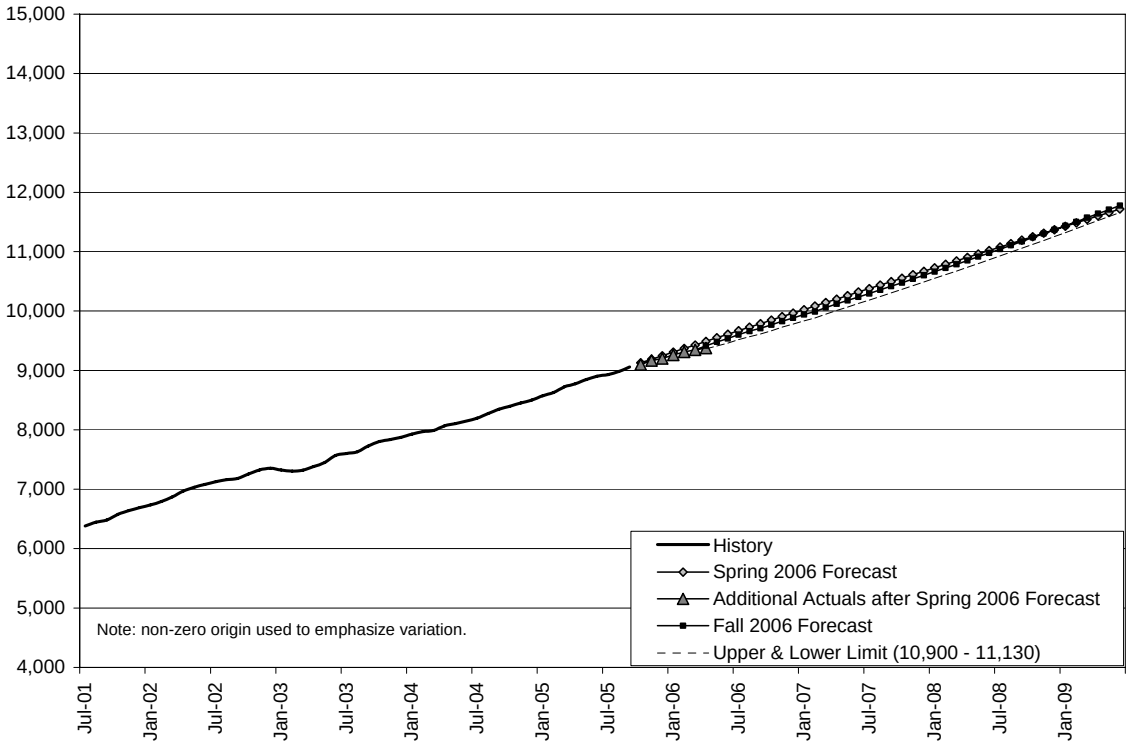


Exhibit A-11: Subsidized Guardianship

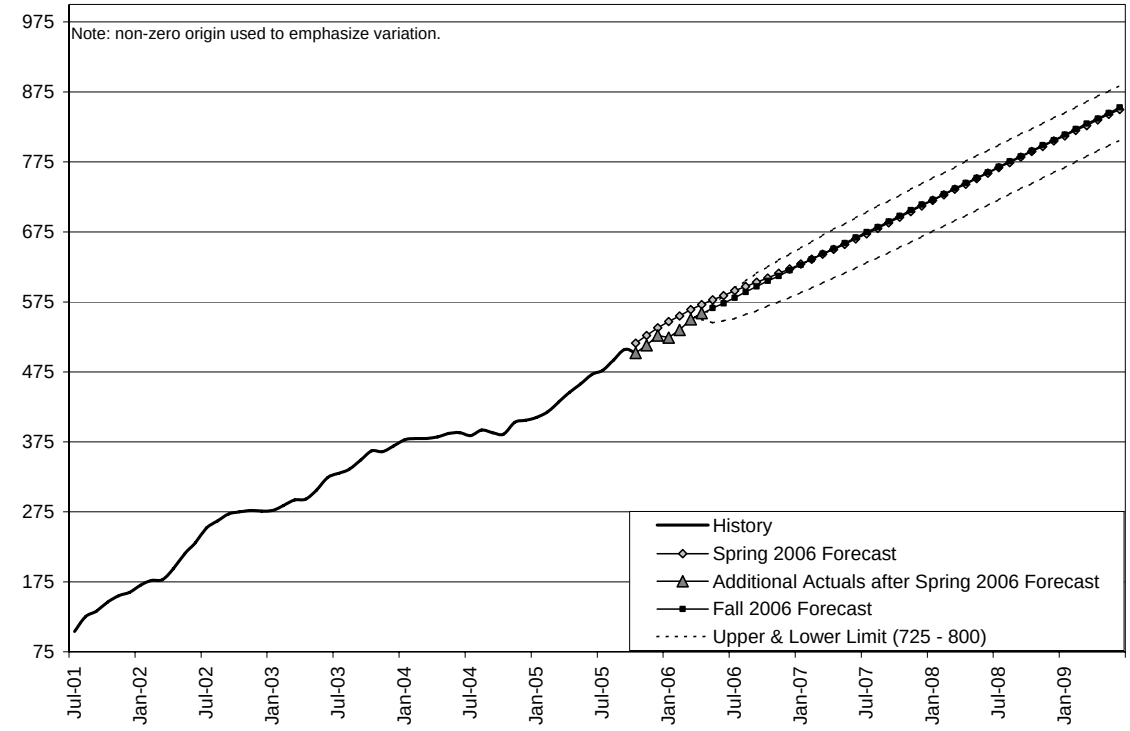


Exhibit A-12: Foster Care

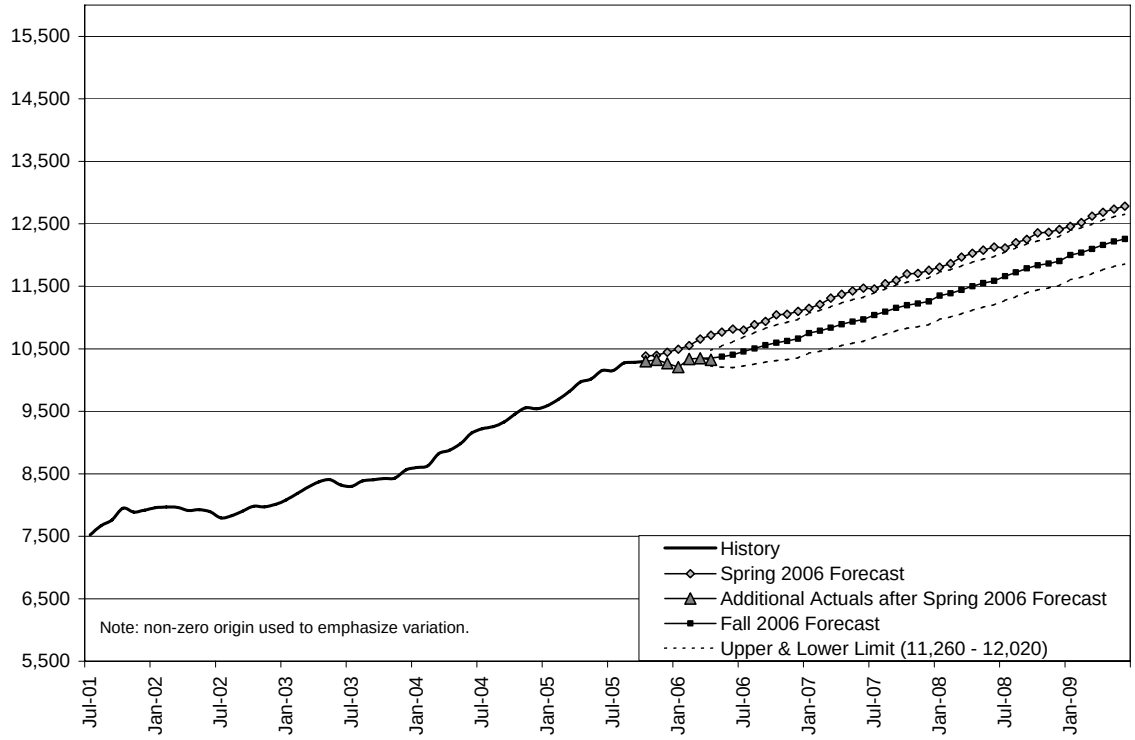
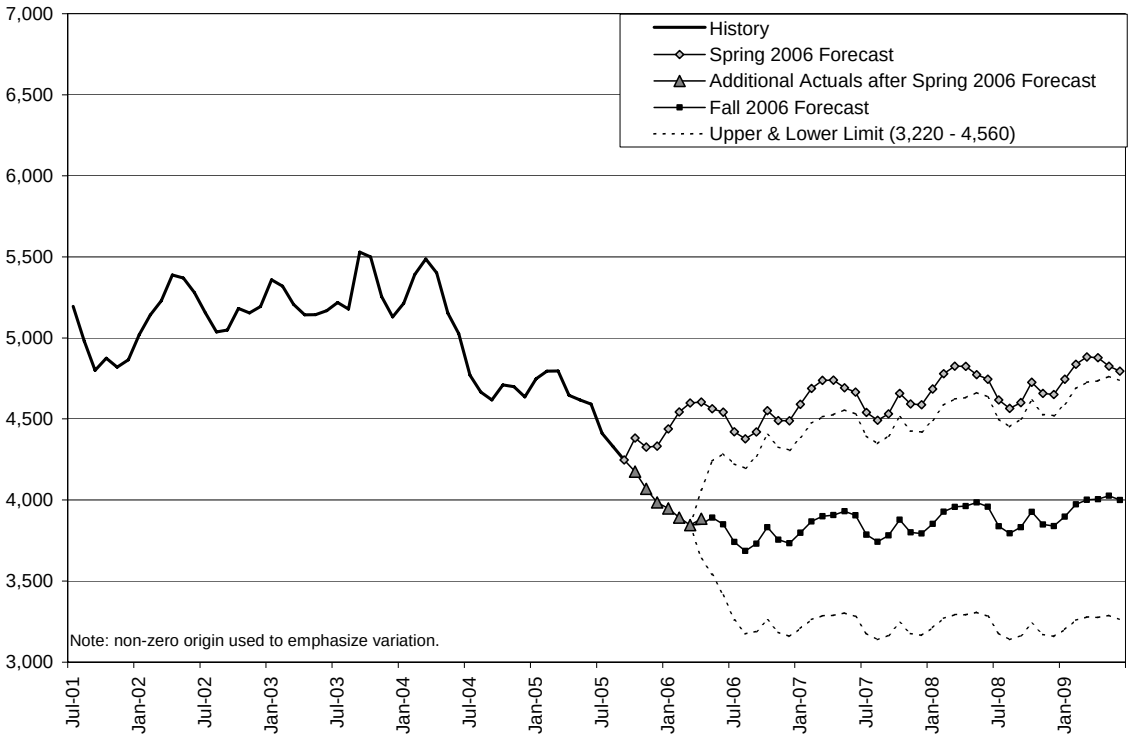


Exhibit A-13: Child In Home



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.

Forecast

The Fall 2006 forecast predicts an average of 9,450 Vocational Rehabilitation clients served per month for the 2005-07 biennium and approximately 9,370 for the 2007-09 biennium, which is about 5 percent lower than the Spring 2006 forecast (Exhibit A-14). The Fall 2006 forecast had assumed that the sharp decline in December 2005 represented a transient event, but subsequent data suggest that caseloads are holding at that new level.

Applications per month have historically been flat with variations caused by seasonality. However, around March 2003, applications fell and then held at a new lower level. Also, the overall caseload fell around this time (Exhibit A-15). This is consistent with national and regional trends. Although no universal explanation has been offered for the decline, a number of factors could have contributed to the falling caseloads experienced in Oregon:

- Over the past several years, as part of the DHS reorganization, many branch offices have been relocated and/or reconfigured. This may discourage some potential clients due to reduced visibility, poor accessibility to parking or public transportation, or reduced privacy in a cubicle office setting.
- There has been staff turnover, leading to less experienced staff that may not be able to work as efficiently or effectively as those with more experience specifically related to vocational rehabilitation. The average Full Time Equivalent (FTE) dropped from 245 in Federal Fiscal Year (FFY) 2002 to 2006 in FFY 2003, recovering to only 213 by FFY 2005. Average number of position vacancies went from four in Calendar Year (CY) 2002 to eight in CY 2003 and then six in CY 2004.
- There has been a reduction in the availability of mental health and substance abuse treatment services as result of budget cuts to the Oregon Health Plan. The cuts stressed the provider infrastructure, thereby reducing availability of services. Also, in early 2003, legislation removed support from the General Fund for ongoing supportive services for individuals with psychiatric disabilities.
- There is anecdotal evidence of an increasing availability of alternative services via special education programs and community colleges, which may lead to lower demand for vocational rehabilitation services via DHS.

Exhibit A-14: Total Vocation Rehabilitation Caseload Biennial Average Comparison by Forecasts

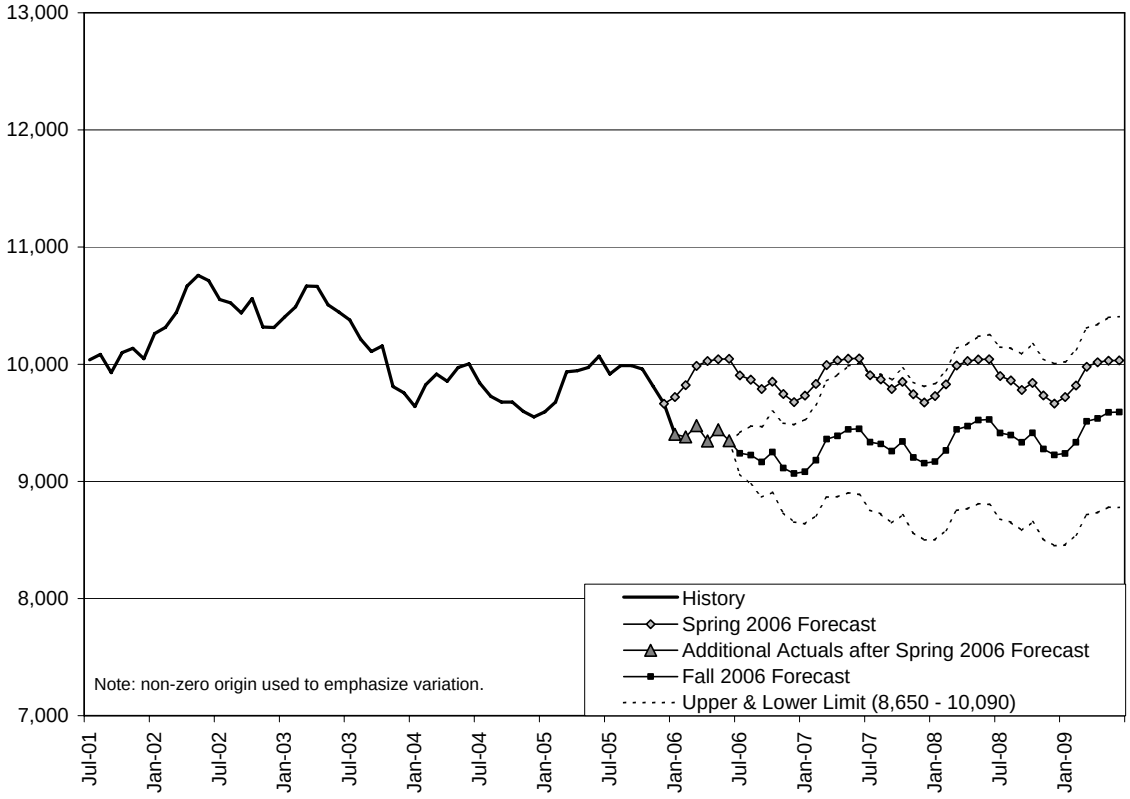
	2005-07 Biennium			2007-09 Biennium		
Comparison:	Spring 2006 to Fall 2006			Spring 2006 to Fall 2006		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 06 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*%Diff. Fall 06 to Spring 06 2005-07*	**Spring 06 Forecast 2007-09**	**Fall 06 Forecast 2007-09**	*%Diff. Fall 06 to Spring 06 2007-09*
Vocational Rehabilitation (Clients Served)	**9,895**	**9,445**	-4.5%	**9,869**	**9,369**	-5.1%

Risks and Assumptions

During the first half of 2006, the VR caseload remained flat instead of experiencing the seasonal growth has been historically normal for that time of year. The Fall 2006 forecast assumes that this pattern represents a shift to a new level. If the caseload returns to the level maintained during 2004 and 2005, the result would be an underestimation of the future caseload.

Besides the specific risks that may impact the accuracy of the forecast, 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. Based on the historical variability of the VR caseload, the average actual caseload for the 2007-09 biennium could easily deviate from the forecast by 8 percent in either direction.

Exhibit A-15: Vocational Rehabilitation



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 B-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 B-1 are discussed below.

Exhibit B-1: Division of Medical Assistance Programs benefit 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
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 B-2 provides comparisons between the two most recent semi-annual forecast, including the current forecast, for each of the thirteen DMAP programs. This table provides an overview of how the forecasts have changed over time given the change in the historical activity of individual programs.

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

	2005-07 Biennium						2007-09 Biennium		
Comparison:	**Spring 2005 to Fall 2006**			**Spring 2006 to Fall 2006**			**Spring 2006 to Fall 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*%Diff Spring 05 to Fall 06 2005-07*	**Spring 06 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*% Diff. Fall 06 to Spring 06 2005-07*	**Spring 06 Forecast 2007-09**	**Fall 06 Forecast 2007-09**	*% Diff. Fall 06 to Spring 06 2007-09*
OHP Plus									
TANF-Related Medical		95,114		96,056	95,114	-1.0%	96,881	92,784	-4.2%
TANF-Extended		39,595		41,507	39,595	-4.6%	42,508	35,623	-16.2%
TANF Medical - Subtotal	**129,208**	**134,709**	4.3%	**137,564**	**134,709**	**-2.1%**	**139,389**	**128,407**	-7.9%
Poverty Level Medical - Women	9,185	10,305	12.2%	9,926	10,305	3.8%	10,698	11,833	10.6%
Poverty Level Medical - Children	79,402	82,430	3.8%	82,380	82,430	0.1%	82,894	80,073	-3.4%
Aid to the Blind & Disabled	58,639	61,817	5.4%	61,912	61,817	-0.2%	64,811	65,093	0.4%
Old Age Assistance	31,574	30,217	-4.3%	30,872	30,217	-2.1%	32,805	29,706	-9.4%
Foster Care	16,390	18,050	10.1%	18,446	18,050	-2.1%	20,334	18,918	-7.0%
Children's Health Insurance Program	21,702	32,287	48.8%	31,235	32,287	3.4%	35,990	47,612	32.3%
OHP Plus- Subtotal	**346,100**	**369,815**	**6.9%**	**372,335**	**369,815**	**-0.7%**	**386,921**	**381,642**	**-1.4%**
Other Medical Assistance Programs									
Citizen-Alien Waived Emergency Medical	21,962	18,532	-15.6%	18,118	18,532	2.3%	17,118	17,299	1.1%
Qualified Medicare Beneficiary	9,835	11,377	15.7%	11,193	11,377	1.6%	12,012	12,647	5.3%
Breast & Cervical Cancer program	219	317	44.7%	320	317	-0.9%	468	441	-5.8%
Other - Subtotal	**32,016**	**30,226**	**-5.6%**	**29,630**	**30,226**	**2.0%**	**29,598**	**30,387**	2.7%

Total Medical Assistance Programs

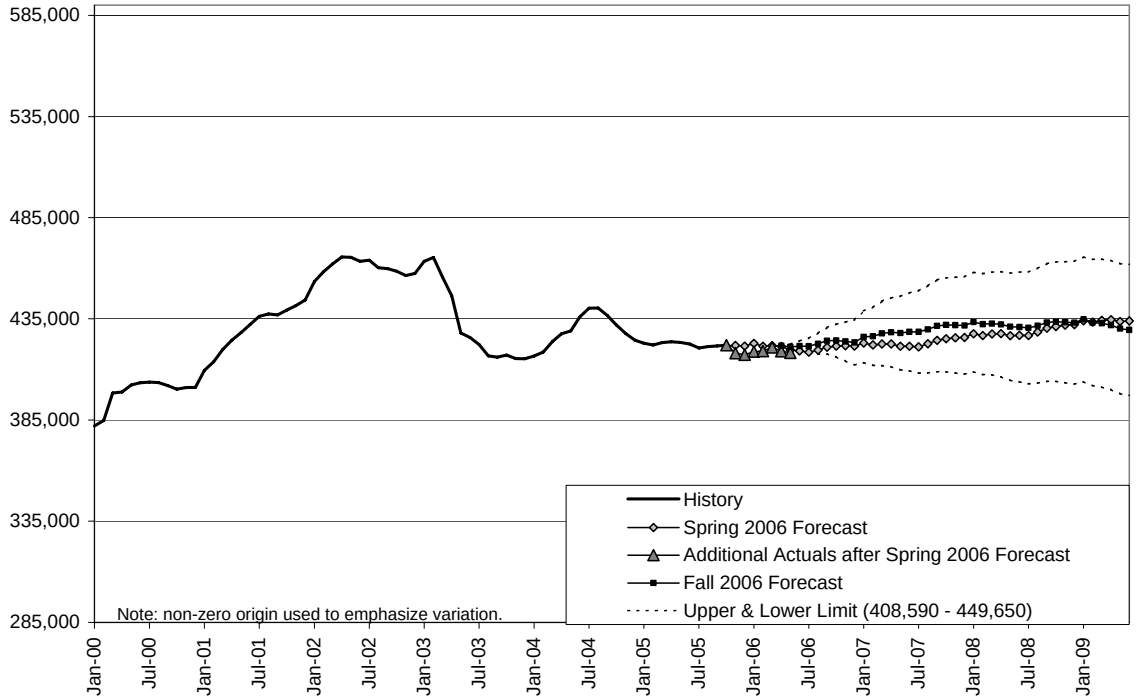
The total DMAP caseload was approximately 421,000 in March of 2006, the last month of complete data available for analysis. During the historical period shown in Exhibit B-3 caseload growth began to accelerate beginning in late 1999 resulting in a historical high of approximately 465,000 in the spring 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 management actions designed to address budgetary issues were implemented, such as the closure of some small medical assistance programs and the creation of OHP Plus/Standard programs followed by the reduction of certain benefits in the OHP Standard program (see Appendix II for timelines). One of the effects of the myriad actions 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 Standard program to new clients. A brief period of caseload growth in many OHP programs followed until the actual

closure to new clients in OHP Standard was implemented during the summer of 2004. Ultimately the total Standard population dropped from approximately 110,000 to a March 2006 figure of approximately 22,000.

Forecast

The Fall 2006 forecast for all DMAP programs (Exhibit B-3) anticipates a general growth pattern in the caseload through January of 2008 followed by a period of stabilization with a very slight downward trend by the end of the 2007-09 biennium. The Spring 2006 and Fall 2006 forecast DMAP total biennial averages for 2005-07 and for 2007-09 are very similar. 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 6 percent above or below the forecast in the 2007-09 biennium.

Exhibit B-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 the DHS 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 total OHP Plus population consists of eight categories listed below. They will be described in greater detail later.

- Temporary Assistance for Needy Families (TANF): Related Medical
- TANF: Extended
- Poverty Level Medical Women
- Poverty Level Medical Children
- Aid to the Blind & Disabled
- Old Age Assistance
- Foster/Substitute Care
- Children's Health Insurance Program

The OHP Plus population represents about 85 percent of total DMAP clients. During the full historical period (Exhibit B-4) increased growth began in January of 2001 reaching approximately 330,000 by April of 2002. Over the following 20 months, until December of 2003, the total caseload remained relatively stable. Beginning in January of 2004 the total Plus caseload grew once again until reaching a diminished growth plateau of between 366,000 and 368,000 in September of 2005 through March of 2006, the last month of historical data for the current forecast.

Forecast

The combined total forecast for the eight benefit groups within the OHP Plus program anticipates a slow growth pattern through the end of the 2007-2009 biennium. The Fall 2006 forecast biennial averages for the total Plus population is expected to be close to 370,000 for 2005-2007 and 380,000 in 2007-2009. Fall 2006 averages are slightly lower than Spring 2006 for 2005-2007 and approximately one percent lower than Spring 2006 for the 2007-2009 biennium.

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 due to changes in their financial circumstances related to increased employment income or child support payments. These clients may receive up to 12 months of transitional benefits if the increase in income is due to employment, or four months if the increase is due to child support payments.

The total TANF medical assistance caseload 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. Since that time, reflecting a return to economic expansion, the client population has leveled out at between 135,000 and 140,000 (Exhibit B-5).

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 program. 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 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 represented by a return to unemployment rates around 8 percent or higher. This second recessionary peak persisted with a slow decline too 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, has low wages, and/or do not provide health insurance coverage.

OHP Plus: Temporary Assistance for Needy Families-Related Medical

The TANF-RM client group makes up around 70 percent of the total TANF medical caseload. Since it is by far the larger of the two TANF groups, the historical growth and decline of TANF-RM 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 to approximately 95,000, with the average being around 96,000 (Exhibit B-6). The leveling of the population during this period is tied directly to improving economic conditions, as well as changes in DHS practices.

OHP Plus: Temporary Assistance for Needy Families-Extended

The TANF-EX benefit group is made up of clients who have left the TANF-RM group due to an increase 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[7] from TANF-RM, there is also a tendency for caseload changes to lag the changes in the other group. Recent growth in the TANF-EX population is reflected in the increase in absolute number of clients moving from TANF-RM. For example, TANF-EX currently has around 4,500 clients per month transferring from TANF-RM compared to roughly 3,000 per month prior to July of 2004. This increase in new clients is expected to slow as the economy (and especially the job market) slows.

Forecast

The forecast is for the total TANF medical assistance caseload to enter a period of decline lasting through the summer of 2009. The reasons for the projected decline lie with both the TANF-RM benefit group and the TANF-EX benefit group as discussed below.

The Fall 2006 forecast calls for a gradual decline in the TANF-RM population through the 2007-09 biennium, and a relatively large decline in the TANF-EX population. The Spring 2006 forecast called for relatively stable populations across the same period. The difference in these two forecasts is primarily due to the implementation of DHS policies/programs specific to the TANF-EX program, and to a lesser degree, changes in DHS business practices related to TANF-RM. These two benefit groups are programmatically tied since TANF-EX benefits require prior participation in TANF-RM. Of the clients leaving TANF-RM, approximately 50 percent exit to TANF-EX. Additionally, of the clients leaving the TANF-EX group, approximately one third return directly to TANF-RM. Thus, any influence resulting in caseload changes in one group has an effect in the other.

The specific changes to the TANF program relevant to the caseload were implemented in the spring and summer of 2006. Briefly, they include an

[7] These clients may serve as precursors of economic downturn as the income conditions resulting in their move to TANF Extended no longer pertain. The extent to which job loss or 'working poor' conditions (including changes in availability of employer-based health care coverage) contribute to the return to TANF may provide information about short-term trends in economic conditions.

automatic closure of some TANF cases; 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 are 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 is also expected as a result of the effects of moderate economic expansion in Oregon. Exhibits B-5 through B-7 display the histories and comparative forecast for these groups.

Risks and Assumptions

An assumption in the TANF forecasts, are that the economy, job growth and health insurance availability will follow the predicted trends in upcoming years, (i.e. moderate economic growth, 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.

Another more tangible risk to the forecasts for both of these groups lies with the Deficit Reduction Act that includes TANF reauthorization provisions through 2010. At this point, even though the Act became law in February of 2006, there is little guidance from the federal government, and many policy decisions are still outstanding that will have significant, but unknown effects on this caseload. Consequently, the TANF caseload forecasts have substantial risks associated with them.

Third, the changes to eligibility and review policy within TANF-EX and TANF-RM will have a direct and depressing affect on this group. While some effects of the changes have been incorporated in the forecast, not all of the effects are fully known. If the impact does not materialize as predicted, the forecast could be over or underestimated.

Even without the substantive risks listed above, these caseloads have a high degree of variability in the forecasts compared to the actual counts. This creates a high range of expected variability of plus/minus 9 percent for the 2007-09 biennium upper and lower limits (Exhibit B-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 varied monthly at around 8,500 clients. With the expansion from 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 March of 2006, the last month of complete historical data for the Fall 2006 forecast.

Forecast

The Fall 2006 forecast is higher than that expected in the Spring 2006 forecast. The current forecast biennial averages are a little greater than 10,000 during 2005-2007 increasing to close to 12,000 during 2007-2009. These averages represent an increase over the Spring 2006 forecast of approximately 4 percent for 2005-2007 and 11 percent for the 2007-2009 biennium. The addition of 6 months of actual data coupled with the persistence of aggressive growth across those months support a higher estimated caseload level than was anticipated in the spring of 2006. Exhibit B-8 displays the history and comparative forecasts for this group.

Relatively wide patterns of historical variability creates a level of general risk represented by the upper and lower limits that average about 6 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-RM program. About 50 percent of the TANF-RM caseload are children. 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 qualify for TANF-RM.

Forecast

The Fall 2006 forecast for PLMC projects a continued caseload growth reflective of the early months of 2006 until reaching a general plateau around 84,000 clients in the fall of 2006. The caseload is expected to decline in the spring of 2007 and to continue declining to approximately 77,000 cases by the summer of 2009. The variation and downturn, compared to the Spring 2006 forecast, is primarily the result of program and policy changes in the CHIP program, and to a lesser degree, to the TANF medical caseload discussed above. The Children's Health Insurance Program (CHIP) program changes are discussed in the CHIP section. Biennial average caseloads for the PLMC group are virtually identical for the Spring 2006 and Fall 2006 forecasts for the 2005-07 biennium at about 82,400. The Fall 2006 forecast biennial average for 2007-09 of about 82,100, however, is about 3 percent lower than the spring forecast. The upper and lower limits associated with this group are relatively small, and attest to the relative historical accuracy in estimating this group. It is estimated that the forecast could reasonably be about $\pm$ 3 percent above or below the actual average for 2007-09 (Exhibit B-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, causing a one-time increase in AB/AD. The GA program reopened in November 2003 with only a few hundred clients and then closed permanently 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 and Spring 2006 forecasted biennial averages are nearly identical for both the 2005-07 and 2007-09 biennia. The Fall 2006 forecast for this group projects an increase through the forecast horizon similar to that seen from July 2004 through March of 2006. This caseload is expected to grow from approximately 61,000 in March of 2006 to close to 63,400 in June of 2007 and nearly 67,000 by the end of the 2007-09 biennium. The upper and lower limits, which average 2 percent above and below the forecast, show anticipated stability in the continued growth of this program (Exhibit B-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). 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.

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 Fall 2006 forecast for this group projects a continued relatively steady population across the entire forecast horizon at approximately 30,000 clients. While the Spring 2006 forecast called for a gradually increasing caseload to around 33,000 by June of 2009, the current forecast estimates close to 30,000 for that same month. A more aggressive growth line was forecast in Spring 2006 as the result of an assumption that the continuing rapid increase in AB/AD would put upward pressure on the OAA group through aging into the program. All clients reaching age 65 who are active participants in the AB/AD program are automatically moved into this group. A more recent detailed analysis of age groupings within AB/AD has mitigated these earlier expectations through the short term (the 2007-2009 biennium). The current forecast calls for a 2005-2007 biennial average of around 30,200 compared to almost 30,900 estimated in the spring of 2006. Similarly, the current 2007-2009 biennial average for this group is expected to be approximately 29,700 compared to a much higher 32,800 estimate resulting from the Spring 2006 forecast (Exhibit B-2). The upper and lower limits average around 4 percent above and below the forecast for 2007-09.

OHP Plus: Foster/Substitute Care

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

The Foster/Substitute Care caseload has increased consistently since July of 1999 with brief, intermittent periods of flattening. An analysis of new clients entering this group reveals a pattern of slower growth from August 2004 through September 2005. Reasons for this pattern can be found in the Children, Adults and Families, Child Welfare portion of this publication.

Forecast

The Fall 2006 forecast for this group projects a continued increase, but not at the same rapid pace predicted in the Spring 2006 forecast due to a sustained period of slowing in the growth pattern in recent months (see, the Children, Adults, and Families, Child Welfare section of this report for more details on expectations for upcoming trends). This group has a history of growth followed by short periods of flattening. There remains a risk that the estimates for the 2007-09 biennium may be understated. The Fall 2006 forecast biennial averages some 400 cases lower than the spring of 2006 estimate (Fall 2006, 18,150: Spring 2006, 18,440). The 2007-09 biennium shows larger differences with the Fall 2006 forecast estimating a biennial average of 18,900 compared to the spring estimate of 20,300 (Exhibit B-12). The moderate range of upper and lower limits of plus or minus 5 percent reflect the variability of forecasts compared to actual historical counts.

OHP Plus: Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) covers uninsured children age zero through age 18 living in households with income up to 185 percent of the federal poverty level. Children from birth through 5 years are eligible if they live in households with family income between 133 and 185 percent of the federal poverty level, and those in the older age groups are eligible if family income falls between 100 and 185 percent of FPL.

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 2006 forecasted biennial average are approximately 32,300 for 2005-07, and 47,600 clients in the 2007-09 biennium. This is about 3 percent higher than the Spring 2006 estimate for 2005-07, but about a third higher for 2007-09. The caseload is expected to grow at a pace and in a pattern similar to that observed from July 2004 through January 2006. However, beginning in January of 2007, an extremely aggressive growth pattern is expected through early 2008 when a return to seasonal variation and slower growth is anticipated. 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 they need to recertify their eligibility, instead of six months. In effect, this policy change causes 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 will emanate.

Exhibit B-4: Total Oregon Health Plan Plus

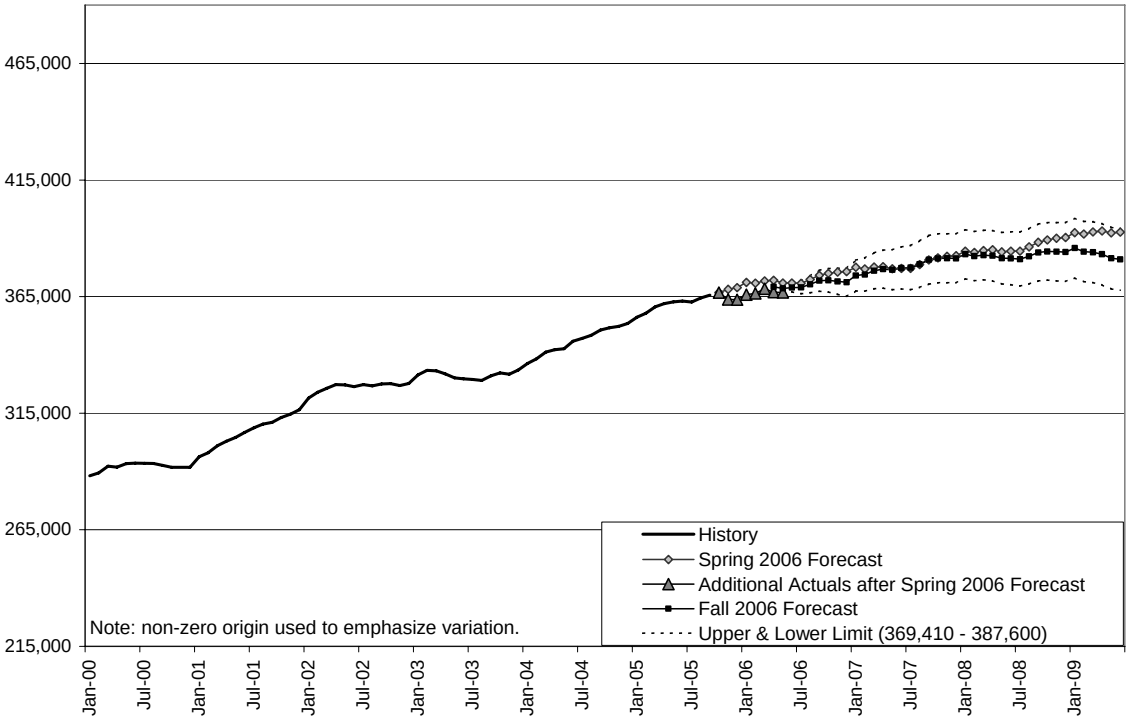


Exhibit B-5: Total Temporary Assistance for Needy Families

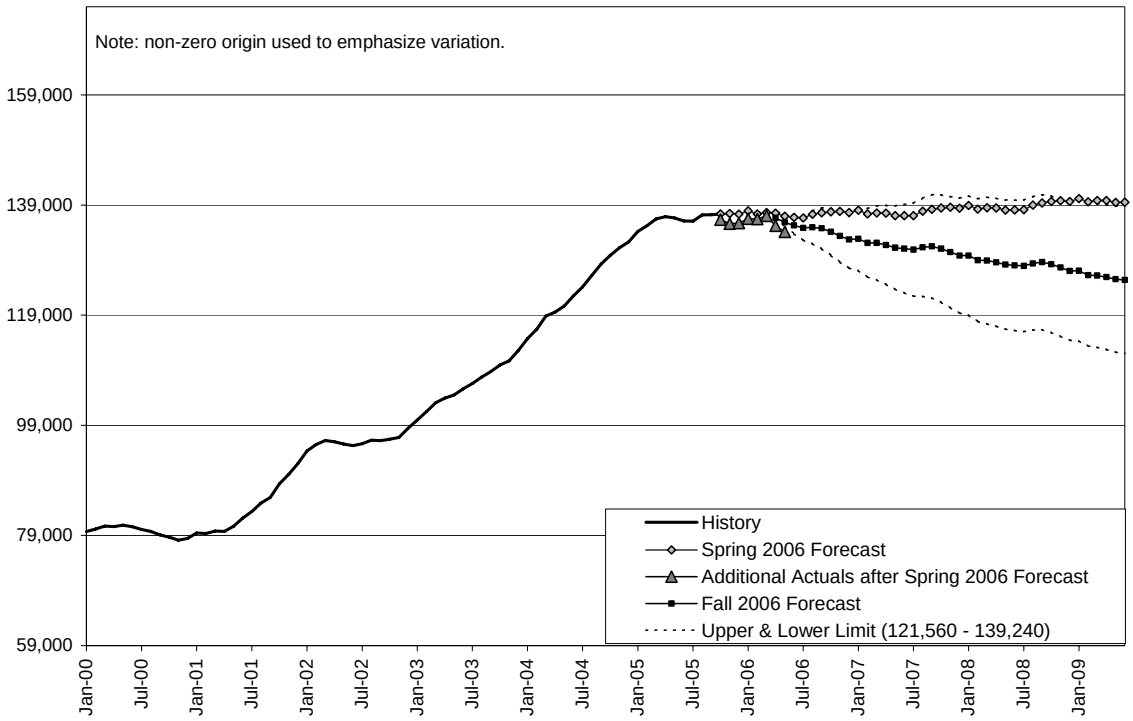


Exhibit B-6: Temporary Assistance for Needy Families-Related Medical

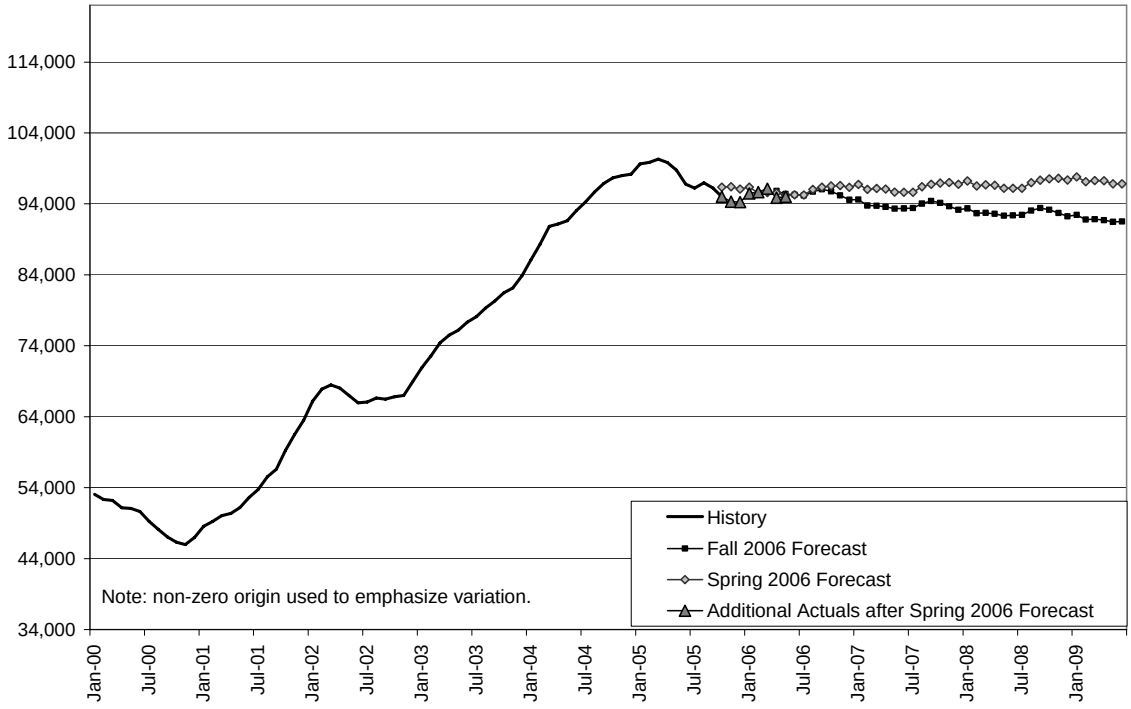


Exhibit B-7: Temporary Assistance for Needy Families-Extended

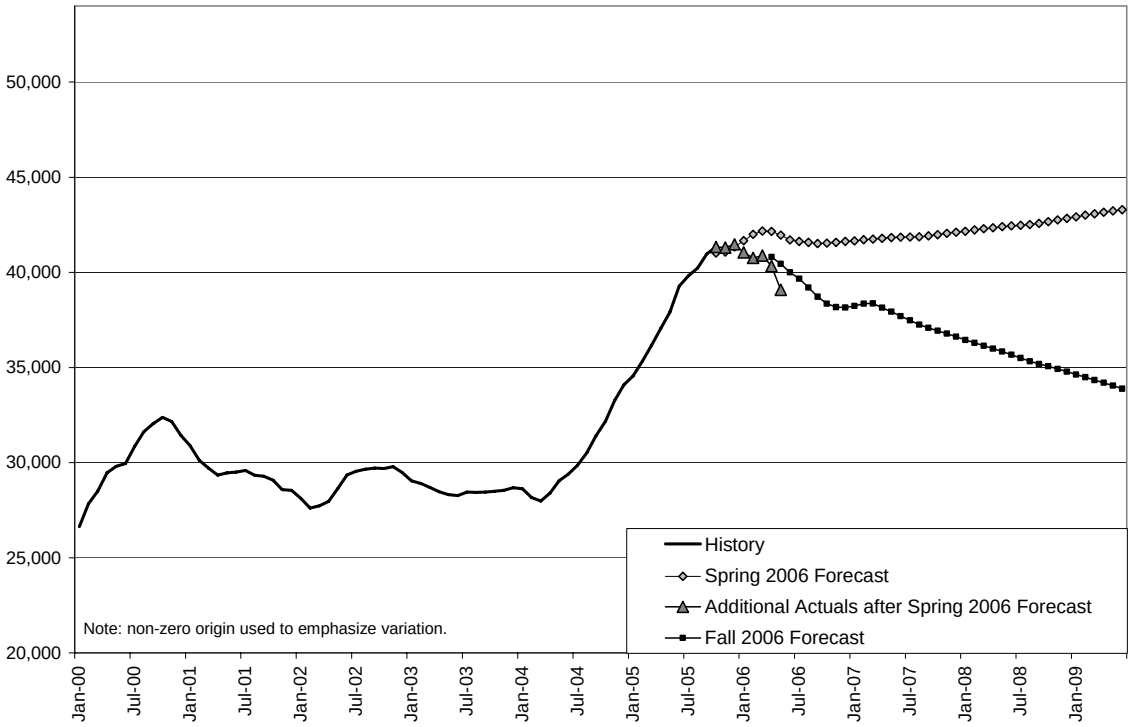


Exhibit B-8: Poverty-Level Medical Women

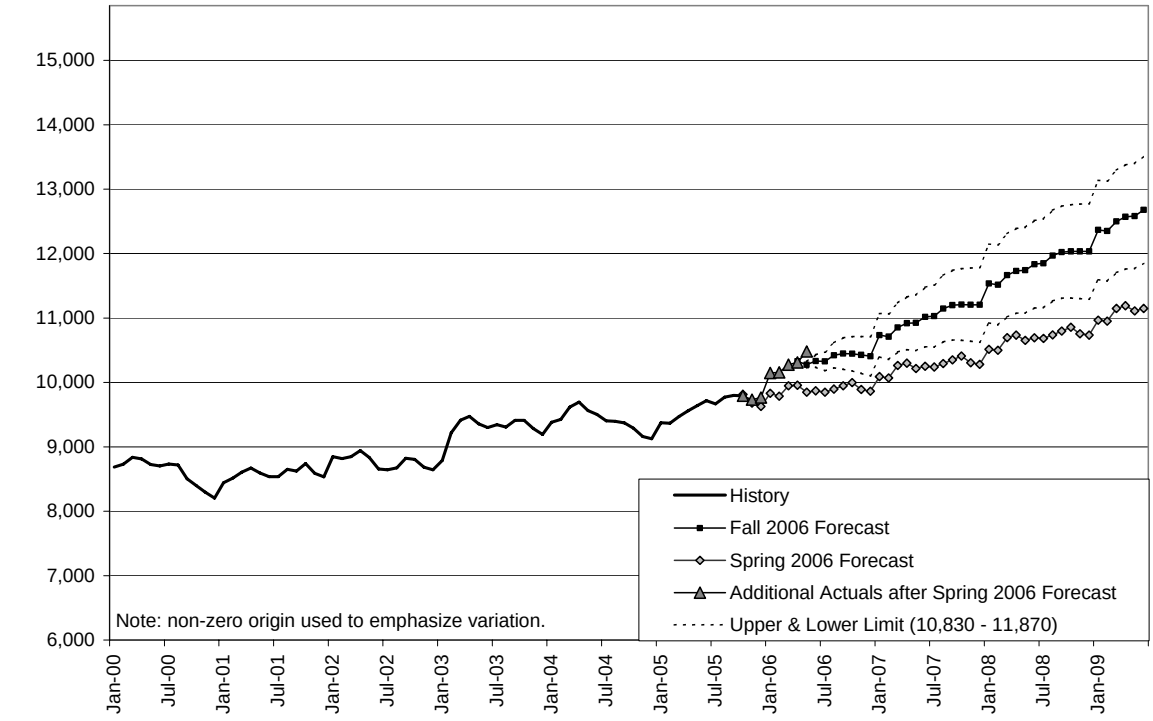


Exhibit B-9: Poverty-Level Medical Children

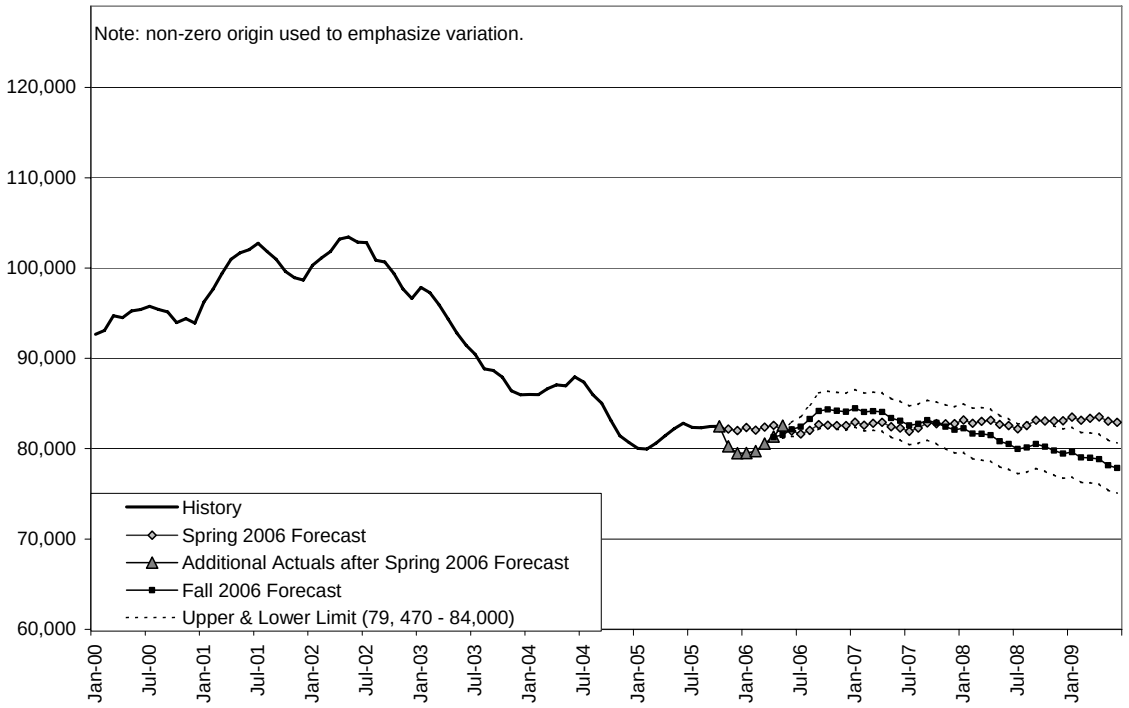


Exhibit B-10: Aid to the Blind and Disabled

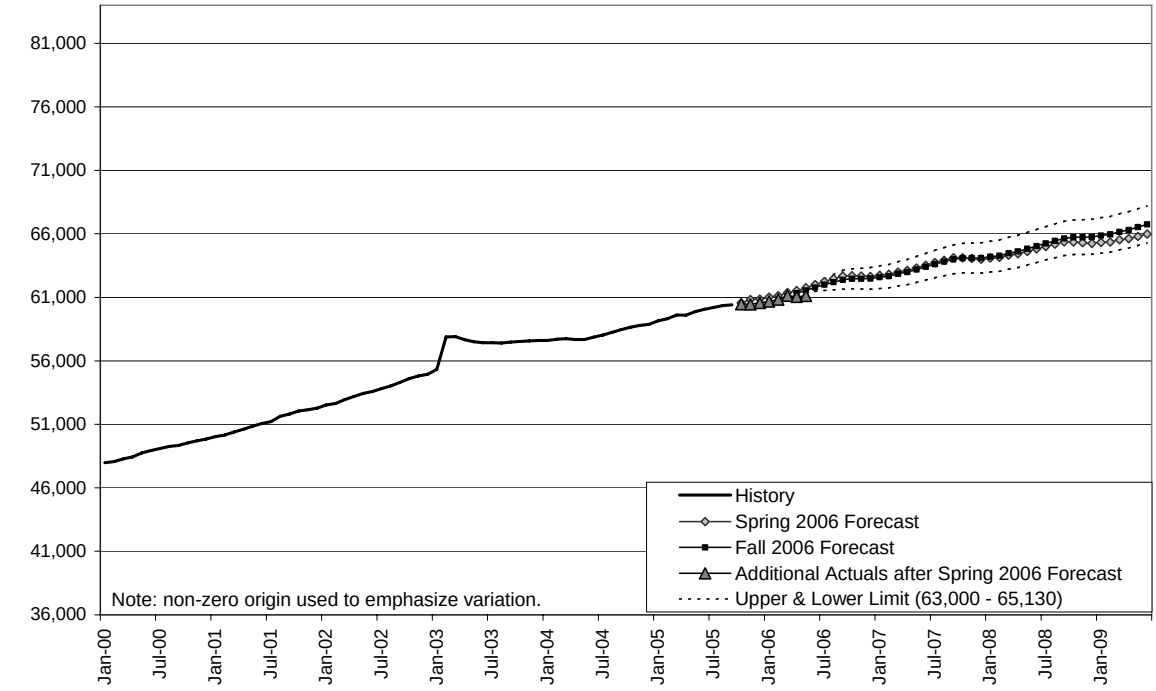


Exhibit B-11: Old Age Assistance

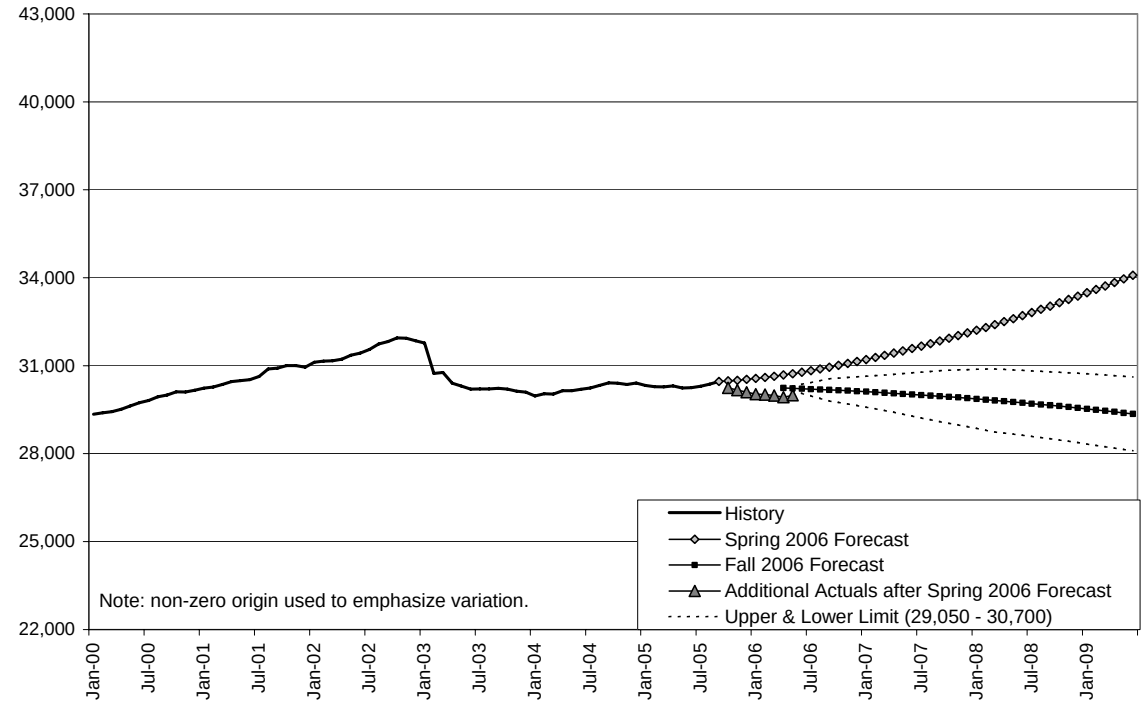


Exhibit B-12: Foster Care/Substitute Care

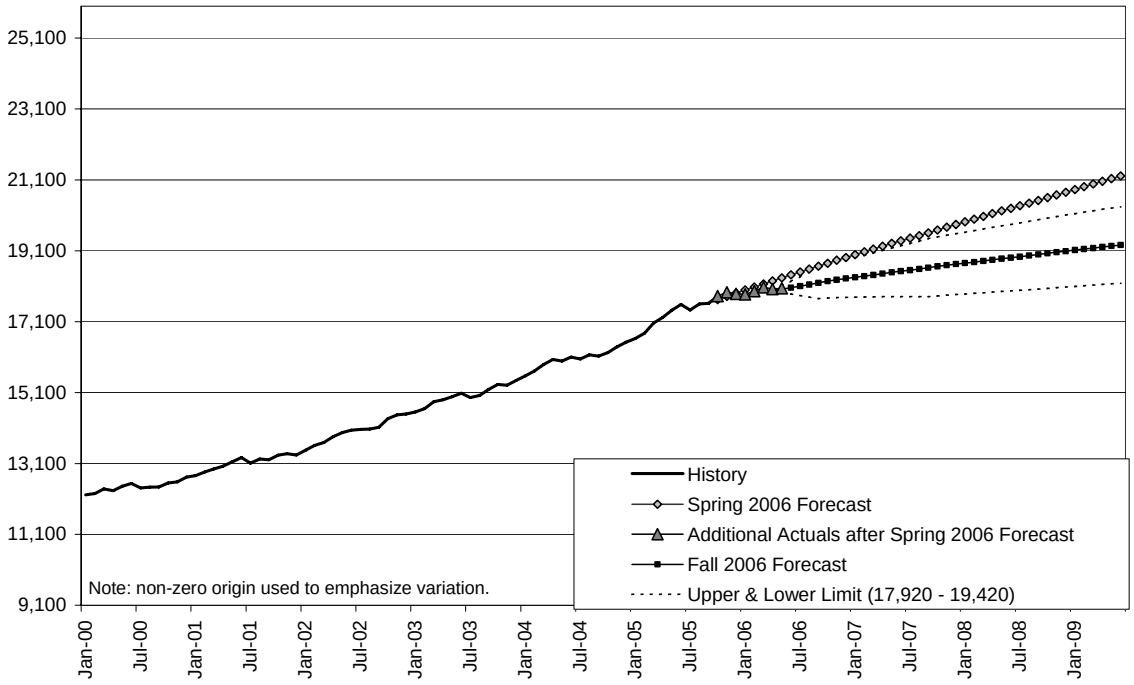
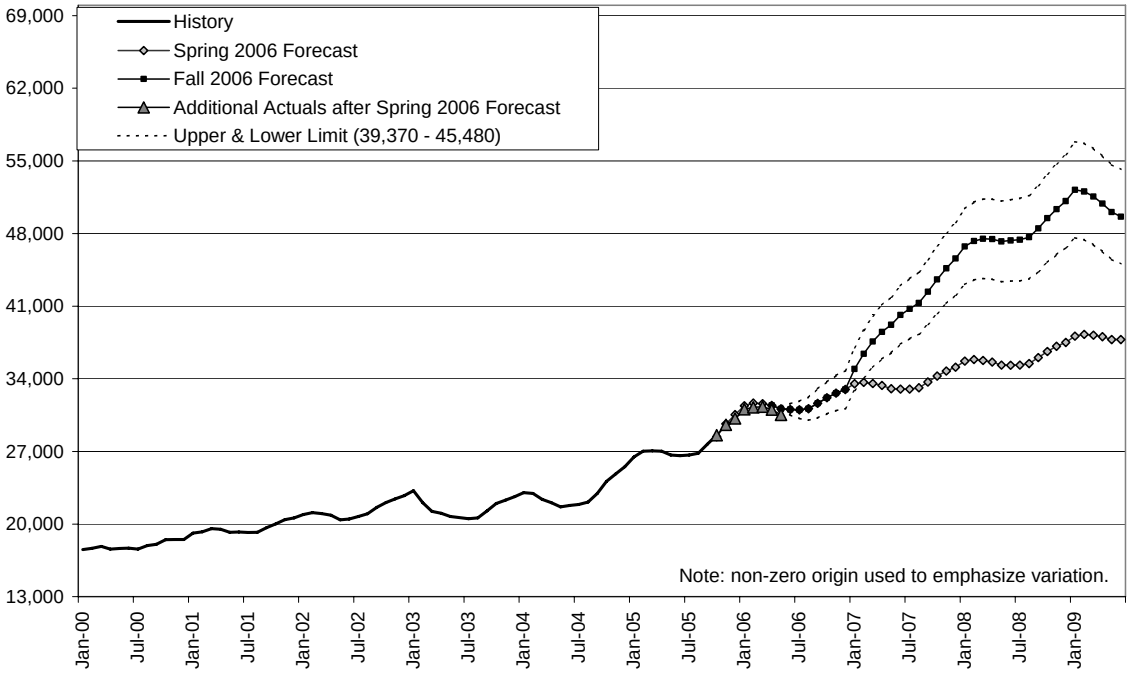


Exhibit B-13: Children's Health Insurance Program



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 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 programs were, and continue to be, allowed to transfer into OHP Standard, Families or Adults and Couples, 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 March 2006, the last month of complete historical data available for this forecast, the combined populations of these two groups averaged around 24,500 from the beginning of the biennium. The averages for Families and for Adults/Couples were around 7,170 and 17,300, 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.

Other Medical Assistance Programs (MAP)

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 (BCCP). The total number of clients in these groups has historically represented between 5 and 7 percent of the total DMAP client caseload; the Breast and Cervical Cancer program being by far the smallest caseload, representing less than 1 percent of the total of the three groups in September 2005. 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 DHS sponsored Long-Term Care services. DHS pays for Medicare Part A and Part B premiums as well as any applicable coinsurance and/or deductibles not exceeding the Department's fee schedule.

Forecast

The QMB caseload has undergone a significant shift. The closure of the Medically Needy program in February 2003 resulted in a shift of clients from that 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 increased slowly. However, growth has been accelerating since spring 2004 to the present. The most recent information, however, indicates an even more rapid pattern of growth beginning in September of 2006. This is most likely the result of outreach efforts regarding the Medicare Modernization Act, Part D, which provides a prescription drug benefit for Medicare beneficiaries.

The Fall 2006 forecast for the QMB benefit group projects a continuing increase in the caseload, over and above that projected in the spring 2006. While the 2005-07 biennial averages are relatively close in both forecasts (Spring 2006 average, 11,200: Fall 2006 average, 11,400), the greatest deviation occurs in the 2007-2009 biennium when the expected biennial averages rise from 12,010 in the Spring estimate to 12,650 for the current estimate. Upper and lower limits reflect the mean deviation from actual experience across historical forecasts. The upper and lower limits range on average for 2007-09 about 2 percent from the forecast.

Other: Citizen-Alien Waived Emergency Medical

The Citizen-Alien Waived Emergency Medical (CAWEM) program is a federal Mandated program that covers emergency care and childbirth services for non-citizens who are 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.

The CAWEM caseload increased rapidly from January 2000 through June 2002 with the implementation of the new computer tracking codes. Between July 2002 and January 2004, the caseload remained relatively stable. From January through July 2004, the caseload once again began to increase to a historical high of approximately 25,500 clients. From July 2004 through September 2005 the caseload decreased rapidly to about 19,000 clients. This caseload patterns starting in July of 2004, closely tracks that of the OHP Standard population after that program was closed to new clients. This is because applicants who would have met OHP Standard eligibility requirements except for citizenship were now required to meet the more restrictive eligibility requirements of OHP Plus, thus reducing the number of new clients entering this program.

Forecast

The Fall 2006 forecast for the CAWEM client population varies only slightly from the Spring 2006 estimates. A general continued decline is anticipated for this client group. The greatest forecast differences between spring 2006 and fall 2006 occur in the 2005-2007 biennium. The Fall 2006 forecast estimates a biennial average of approximately 18,500 in contrast to an earlier spring forecast estimate of approximately 18,100. The differences are attributable to the growth that started in January 2006 through the last month of complete history used for this forecast, March 2006. The growth continued through the summer of 2006 per the additional 'calculated estimates' from more recent months. The Fall 2006 forecast for the 2007-2009 biennium projects a biennial average of approximately 17,300. This is not substantially different from the Spring 2006 forecast of about 17,100. Exhibit B-16 displays the history and comparative forecasts for this group. The high historical variability in this group is demonstrated in the upper and lower limit estimates, which average nearly 20 percent above and below the forecast for 2007-09.

Other MAP: Breast and Cervical Cancer Program

The Breast and Cervical Cancer program (BCCP) began, in January 2002, to provide medical benefits for women who are diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Health Services through county health departments and tribal health clinics. After determining the eligibility, the client receives all Medicaid

services, including mental and dental health. A client is eligible until she reaches the age of 65, obtains creditable coverage or ends treatment. As of September 2005, the caseload had grown to 267 clients. While this group is quite small, the caseload increase has been consistent and rapid, although the most recent historical data have shown a slight slowing in growth.

Forecast

The fall 2006 forecast for the Breast and Cervical Cancer Program varies only slightly from the Spring 2006 forecasted estimates. The current forecast, while calling for continued aggressive growth in this population, estimates slightly fewer clients for the 2007-09 biennium with an average of 440. The Spring 2006 forecast estimated the 2007-09 biennial average for this group at approximately 470. Averages for the 2005-2007 biennium are virtually identical. The upper and lower limits show that for 2007-09, the actual counts could be expected to range 10 percent above or below the forecast.

Exhibit B-14: Total 'Other Medical Assistance Programs'

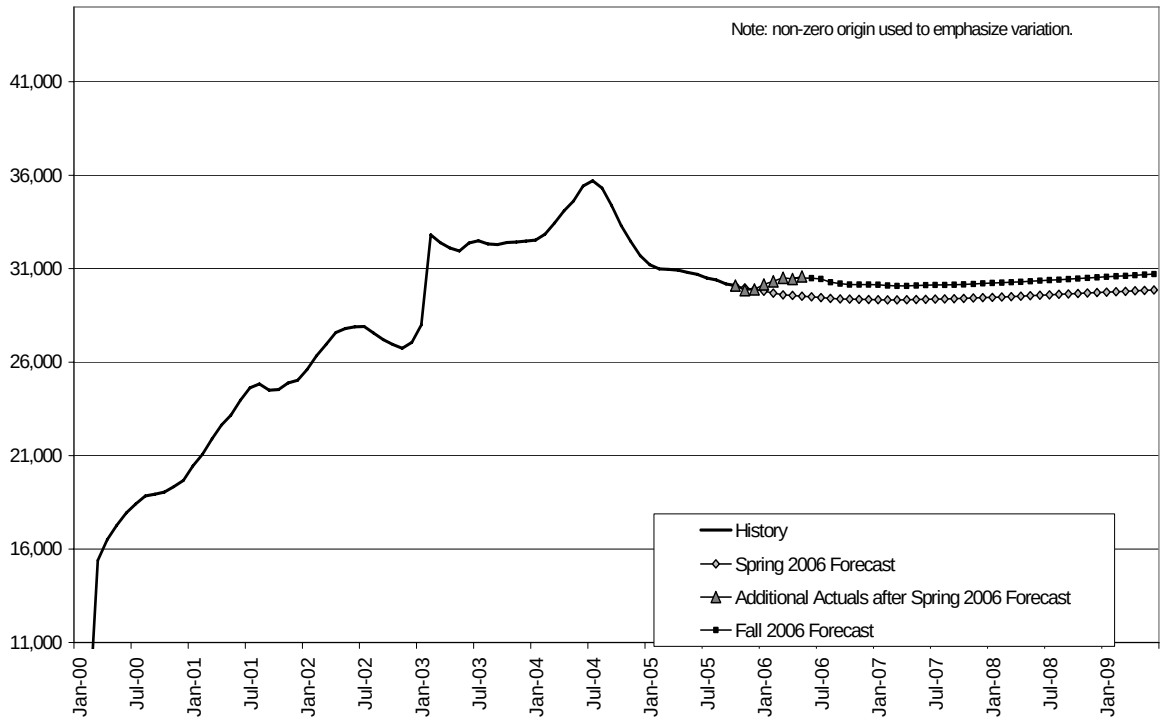


Exhibit B-15: Qualified Medicare Beneficiaries

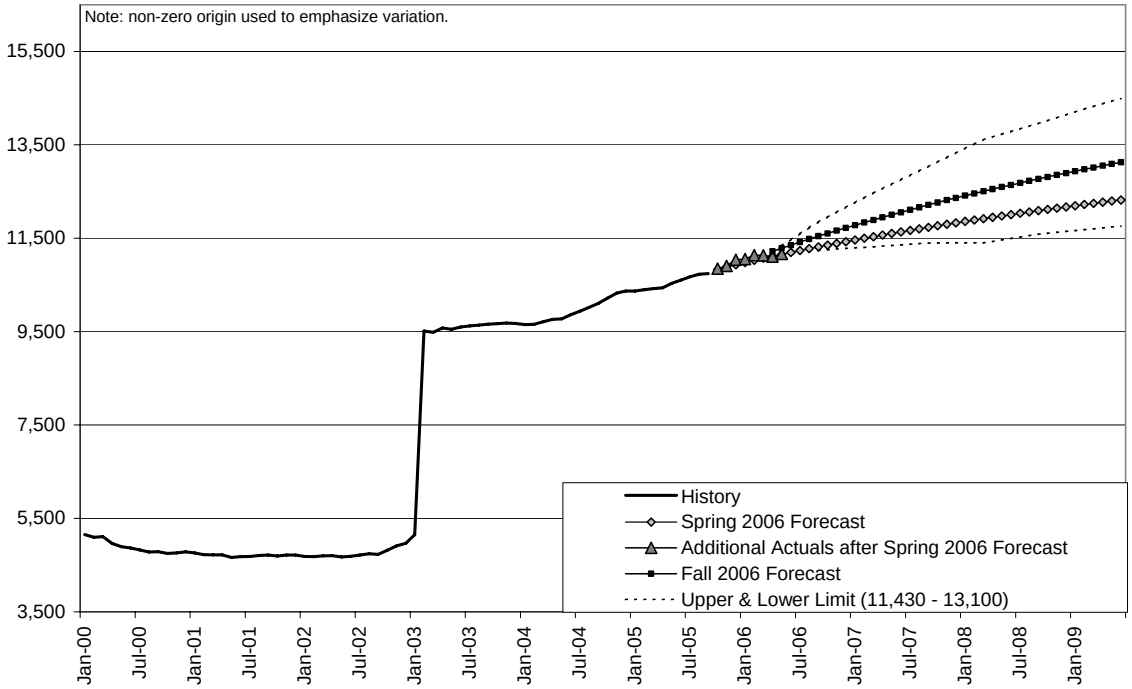


Exhibit B-16: Citizen / Alien Waived Emergency Medical

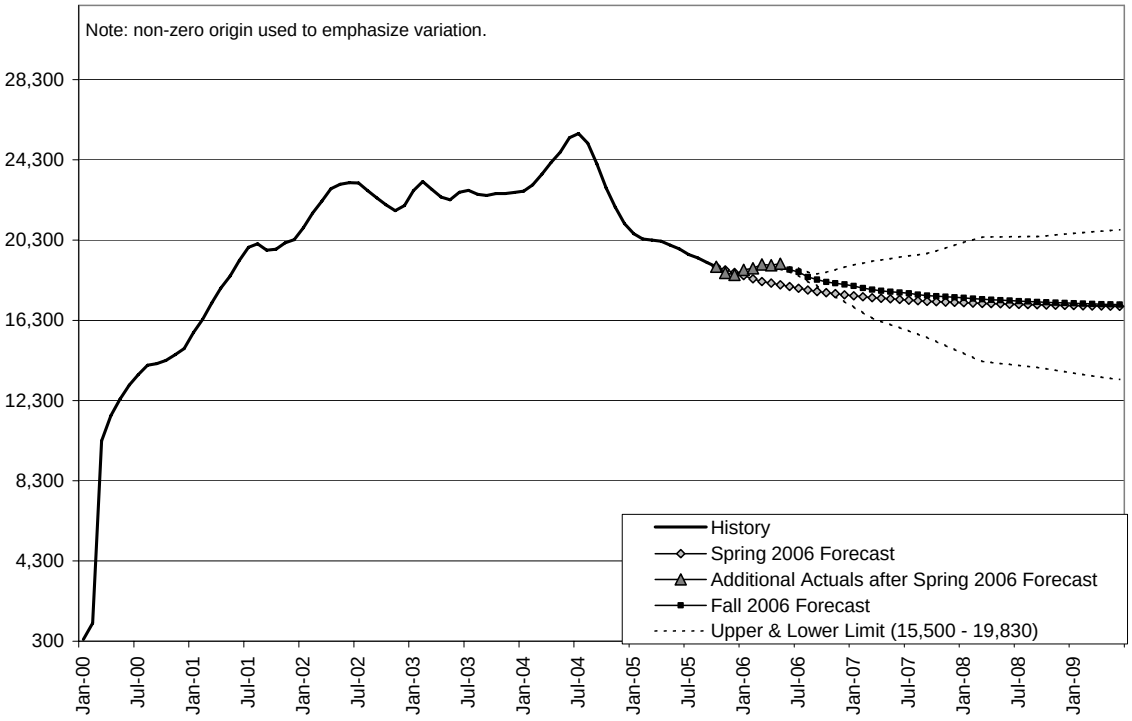
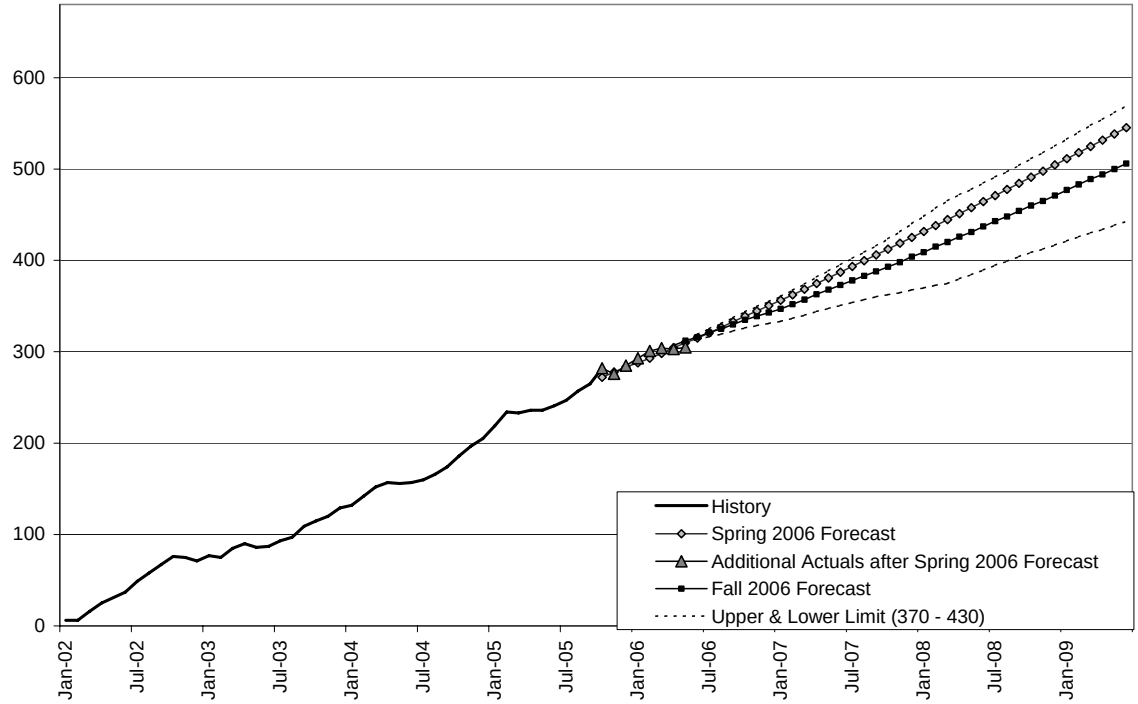


Exhibit B-17: Breast and Cervical Cancer Program



Risks to the Fall 2006 Forecast

Risks to the current Fall 2006 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.

Another systemic risk to the current forecast lies in the methamphetamine epidemic. By some accounts, the increasing foster/substitute care population is partially due to the effects of this epidemic. Children of individuals who are involved in methamphetamine use and/or manufacturing are routinely removed from the home and placed in foster care. If the epidemic and its effects were to increase at an unexpected rate, the Foster/Substitute care caseload would be underestimated.

The Medicare Modernization Act provides prescription drug coverage to elderly and disabled people who are enrolled in the Medicare programs. Approximately 264,000 Oregonians in the fall of 2005 were informed about their potential eligibility for low-income subsidies that would pay for this coverage. A subset of these individuals may be eligible for other State-funded benefits like the Oregon Health Plan. Another group may have the functional needs to qualify for Long-Term Care services. The Fall 2006 forecast assumes that the trends that have emerged since the MMA implementation will continue. However, given the relative newness of the program, coupled with continual changes in implementation, there is significant risk that forecasts for the Aid to the Blind/Disabled, Old Age Assistance and Qualified Medicare Beneficiary are over or under estimated.

Outreach efforts to identify individuals eligible for program services that are carried out by advocate groups, providers, and DHS programs present a risk to DHS client caseloads. Currently, there are efforts underway in various counties in targeting uninsured children. The effects of these efforts have the potential of increasing the CHIP and Poverty Level Medical Children caseloads above the forecast. This could also affect caseloads associated with the parents of these children. The most significant effect, however, would be expected in the groups focusing on benefits for children.

DHS continually reviews its processes for eligibility reviews, and implements program integrity efforts and process improvements as needed. Such efforts, while clearly valuable, do pose a risk to the forecasts since such efforts

frequently impact the numbers of new clients, transfers between programs and closures. A specific effort that poses risks to the forecast is the policy changes in criteria related to eligibility and review within TANF Extended and TANF Related Medical. While the effects of the changes have been incorporated in the forecast, the full impact is not fully known. If it does not materialize as predicted, the forecast could be over or underestimated.

Another policy risk to the forecasts for TANF medical, and other caseloads that are affected by changes in TANF, such as PLM children, is the Deficit Reduction Act that includes TANF reauthorization provisions through 2010. At this point, although the Act became law in February of 2006, there is little guidance from the federal government, and many policy decisions are still outstanding that will have significant, but unknown effects on this caseload. Consequently, the afore-mentioned caseload forecasts have substantial risks associated with them.

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 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; and 24 Hour Care, such as residential, foster care and acute hospital care. The community also provides supervision and treatment for persons under the jurisdiction of the Psychiatric Security Review Board.

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 to the Department as 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. Non-Mandated services are primarily provided in community outpatient settings. Only Mandated caseloads are forecasted (Exhibit C-1). Each will be discussed in detail in a later section.

Exhibit C-1: Mental Health Caseload Categories

Mandated	Criminally Committed	Civilly Committed
Criminally Committed	Aid and Assist	24 Hour Care
Civilly Committed	Psychiatric Security Review Board	Acute Care
		State Hospital

The Fall 2006 Mental Health forecast is significantly different from previous versions in both forecasting methodology and data development. It is the first to use data from the new Integrated Client Services Data Warehouse (ICS). This initial use of the ICS data represents the inaugural forecast of a new forecasting process. Formal definitions and business rules to create caseload categories are now finalized and standardized to ensure that caseload data can be developed efficiently and consistently. These data will then enable valid and appropriate

comparisons over time. Previous attempts to forecast the Mental Health caseloads relied on ad hoc manipulations of five databases so that developing reliable and consistent monthly counts of Mental Health clients was especially challenging. Because of these differences, comparisons among prior forecasts and the Fall 2006 forecast are inappropriate and problematic. Continued use of ICS numbers will provide stable historical data for more appropriate comparisons in future forecasts.

Exhibit C-2 compares the biennial averages of actual counts and forecasted caseload per the Fall 2006 forecast for the 2003-05, 2005-07, and 2007-09 biennia.

Exhibit C-2: Mental Health Biennial Average Comparisons

Numbers of Clients Served Per Month

Mandated Caseload Category:	Actuals 2003-2005	Forecast 2005-2007	03-05 to 05-07 Change	% Change	Forecast 2007-2009	05-07 to 07-09 Change	% Change
Aid and Assist	91	102	11	12.1%	103	1	1.0%
PSRB	687	700	13	1.9%	710	10	1.4%
Subtotal - Criminal Commitment	778	802	24	3.1%	813	11	1.4%
24 Hr Care	601	752	151	25.1%	902	150	19.9%
Acute Care	94	98	4	4.3%	99	1	1.0%
State Hospital	330	320	-10	-3.0%	307	-13	-4.1%
Subtotal - Civil Commitment*	1,025	1,170	145	14.1%	1,308	138	11.8%
Sum: Mandated Clients Served	1,803	1,972	169	9.4%	2,121	149	7.6%
Unduplicated Count, Mandated Clients Served	1,758	1,933	175	10.0%	2,079	146	7.6%

Average Daily Populations

Mandated Caseload Category:	Actuals 2003-2005	Forecast 2005-2007	03-05 to 05-07 Change	% Change	Forecast 2007-2009	05-07 to 07-09 Change	% Change
Aid and Assist	73	82	9	12.3%	82	0	0.0%
PSRB	681	697	16	2.3%	706	9	1.3%
Subtotal - Criminal Commitment	754	779	25	3.3%	788	9	1.2%
24 Hr Care	574	718	144	25.1%	858	140	19.5%
Acute Care	53	53	0	0.0%	54	1	1.9%
State Hospital	294	285	-9	-3.1%	290	5	1.8%
Subtotal - Civil Commitment*	921	1,056	135	14.7%	1,202	146	13.8%
Sum: Mandated Clients Served	1,675	1,835	160	9.6%	1,990	155	8.4%

*Excludes civilly committed in community outpatient settings.

Mandated Mental Health Caseload

Forecast

Overall, the Mandated caseload is predicted to continue to increase through June 2009 (Exhibit C-3). The 2007-09 biennial average is estimated to increase by 8.4 percent over that for 2005-07. 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 six percent over the forecasted interval.

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 people Mandated to Oregon State Hospital for assessment and treatment until they are fit for 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 declined relative to the growth exhibited in early 2003-05 (Exhibit C-4). The 2003-05 biennial average increased by 12 percent over that for 2001-03 biennium. In contrast, the biennial average for 2005-07 is expected to increase by 3 percent. This caseload will continue to decrease somewhat through the remainder of 2005-07, and then increase slightly through 2007-09. The level of variation in the historical data contributes to a rather high level of uncertainty for the forecast as future levels might vary by an average of 11 percent above or below the forecast through June 2009.

Aid and Assist Forecast

The Fall 2006 forecast estimates an 12 percent increase in the Aid and Assist caseload from the 2003-05 biennium (average monthly number of clients = 90) to the 2005-07 biennial average (100). The caseload remains constant with seasonal fluctuation through 2007-09 (average = 100) (Exhibit C-5). However, relatively large and consistent variation in the historical data creates an average risk of 38 percent above or below the forecasted values.

Psychiatric Security Review Board Forecast

We expect the total PSRB caseload to continue decreasing and then increase through 2007-09 (Exhibit C-6). The 2005-07 biennial monthly average (700 clients) is 1.9 percent greater than that for 2003-05 (690 clients). The average monthly forecast for 2007-09 (710 clients) shows an increase of 1.4 percent over that for 2005-07. Future actuals may vary by 11 percent around the forecast.

Civilly Committed

The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves or others or to be unable to care for themselves as a result of mental illness. Through this process, the individuals are mandated by court to treatment. People on this caseload are served in a variety of settings. For forecasting and budgeting, only that portion of the caseload that receives services in the State Hospital system and/or in 24-Hour community settings (adult residential, foster care, and enhanced care) are considered.

Forecast

The Fall 2006 forecast estimates that the combined Civilly Committed caseload will continue the growth of 2003-05 through 2005-07 and 2007-09 (Exhibit C-7). The Civilly Committed caseload may vary, on average, by eight percent above or below future actuals over the forecasted interval. This forecast excludes Civilly Committed in community outpatient settings.

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 C-8). The percent increases in the biennial averages over 2003-05, 2005-07, and 2007-09 are 14[7], 25, and 20 percent, respectively. Some of the more recent growth is due to placing some patients from the State Hospital into 24 Hour Care settings. Future actuals may vary by 13 percent around the forecast.

[7] 2001-03 Biennial average and percent growth not included in Exhibit C-2.

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 Civilly Committed Acute Care caseload is expected to remain constant through 2007-09 (Exhibit C-9). One of primary reasons for the flat caseload trend is that there is limited bed capacity in Acute Care facilities. No increase in the number of beds is anticipated at this time. However, the high degree of variation in the historical numbers contributes to a greater degree of uncertainty as future actuals might vary by an average of 35 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 are expected to decrease by an average of 23 from the 2003-05 value through June 2009 (Exhibit C-10). The State Hospitals have been at, if not above, their capacities. Thus, alternative treatment settings in the community (24 Hour Care) have to be found, which results in an increase in the forecast for Civilly Committed- 24 Hour Care caseload, and a reduction in the State Hospitals. The caseload may vary by an average of seven percent through 2009.

Risks and Assumptions

The 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 forecasts is that any factors that significantly affect the Mental Health programs or clients will remain unchanged through 2009, an assumption shared by Mental Health program staff.

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; changes at this point in the system could alter 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.[8]

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.

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 changes, then the caseload might change accordingly. Economic and behavioral issues can interact to affect this rate. Interactions among economic stressors, drug and alcohol dependence, and individual predispositions 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 may be minimal with a net result of reduced demand for services. During a recession, however, increased stress might contribute to a growing demand for services.

Specific Program and Policy Events: Program staff has no knowledge of significant, impending changes that would affect the forecasted caseloads.

Statistical Error: Besides the future risks mentioned above that may affect the accuracy of the forecasts, all forecasts have a risk that is based on normal error in the actual data that are used to create the forecasts. The farther out in time numbers are projected, the more influence this error has on the forecasted values. This results in an increasing probability that the forecast will deviate from what actually occurs in the future. The following graphs provide upper and lower limits that illustrate the effects of this probability on the forecasts.

[8]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.]

Exhibit C-3: Total Mandated

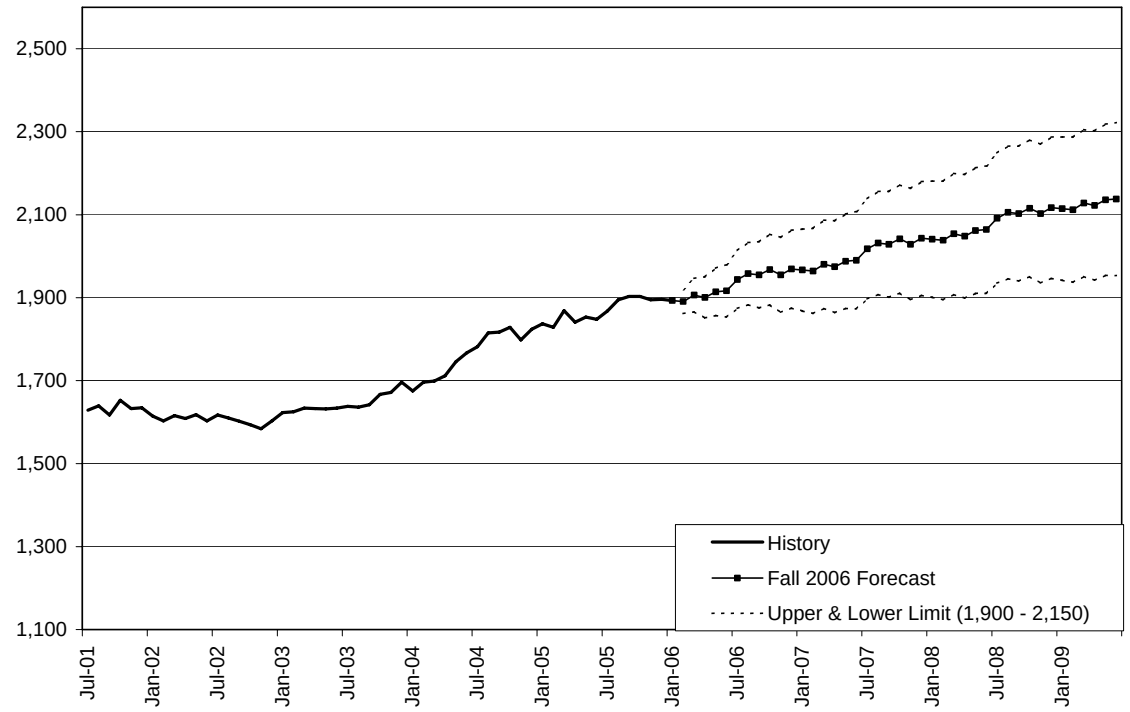


Exhibit C-4: Total Criminal Commitment

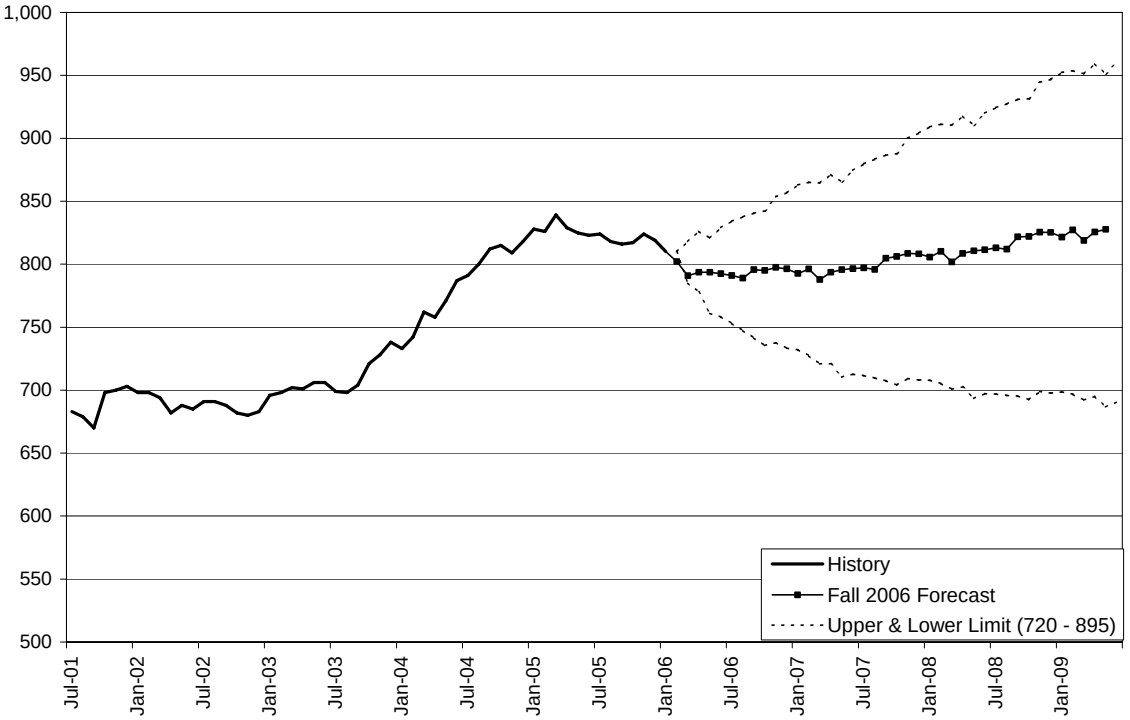


Exhibit C-5: Criminal Commitment - Aid and Assist

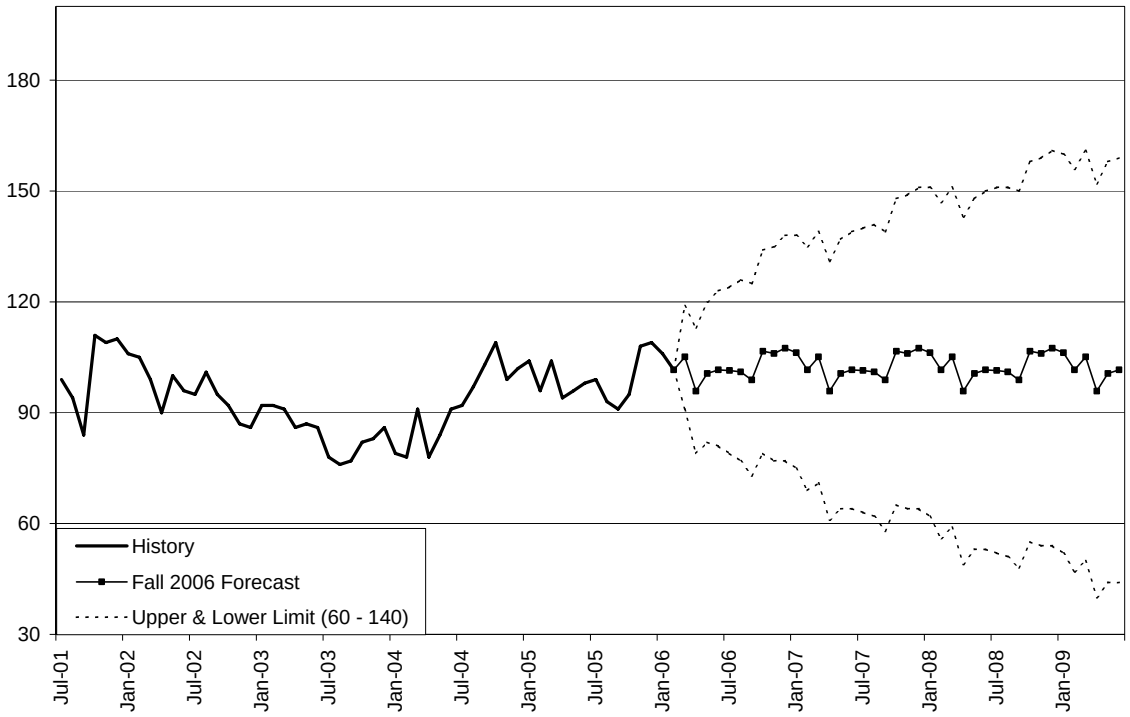


Exhibit C-6: Criminal Commitment - Psychiatric Security Review Board

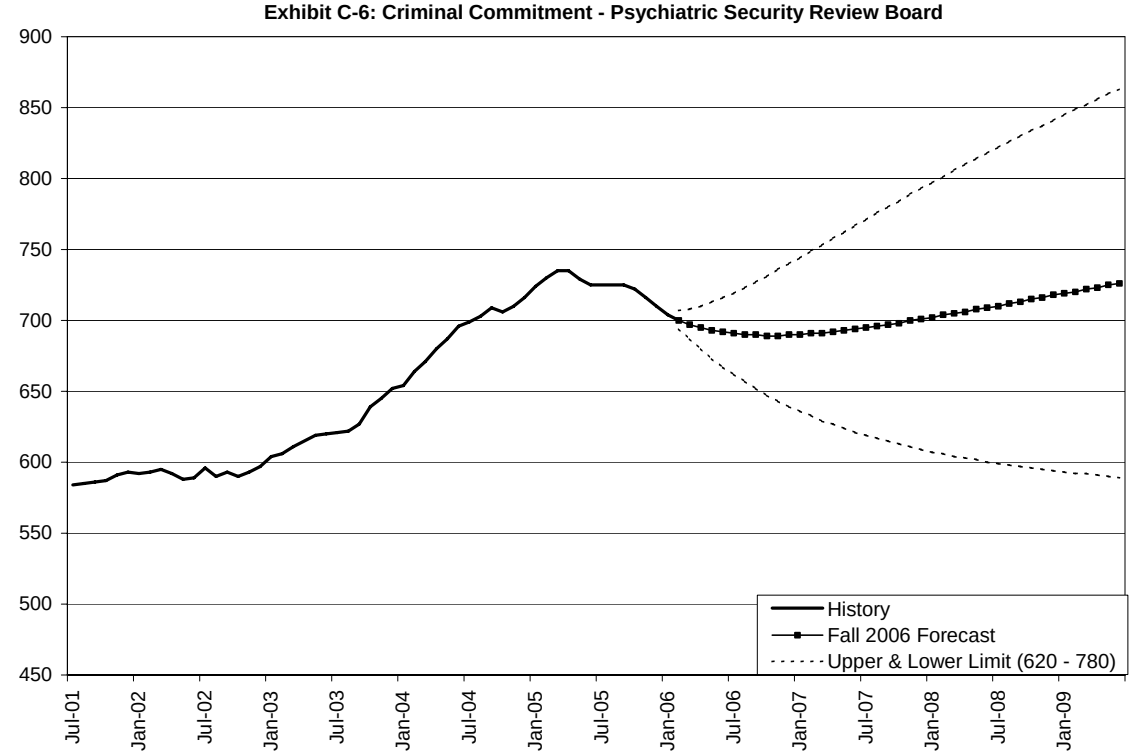


Exhibit C-7: Total Civil Commitment

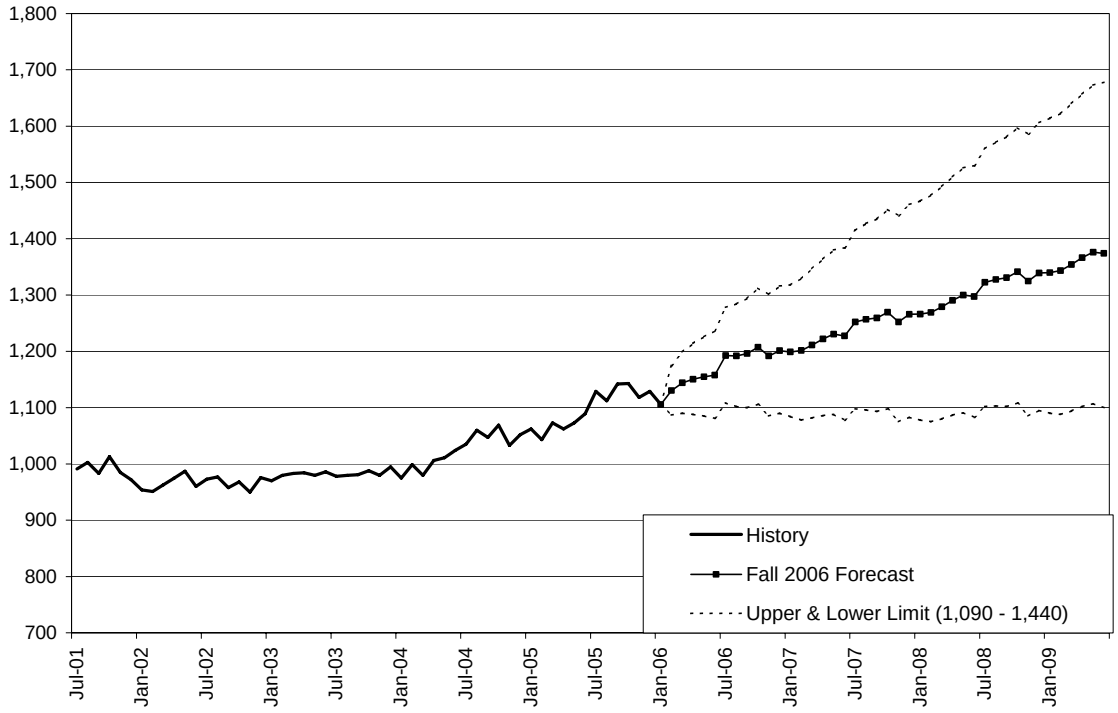


Exhibit C-8: Civil Commitment - 24 Hour Care

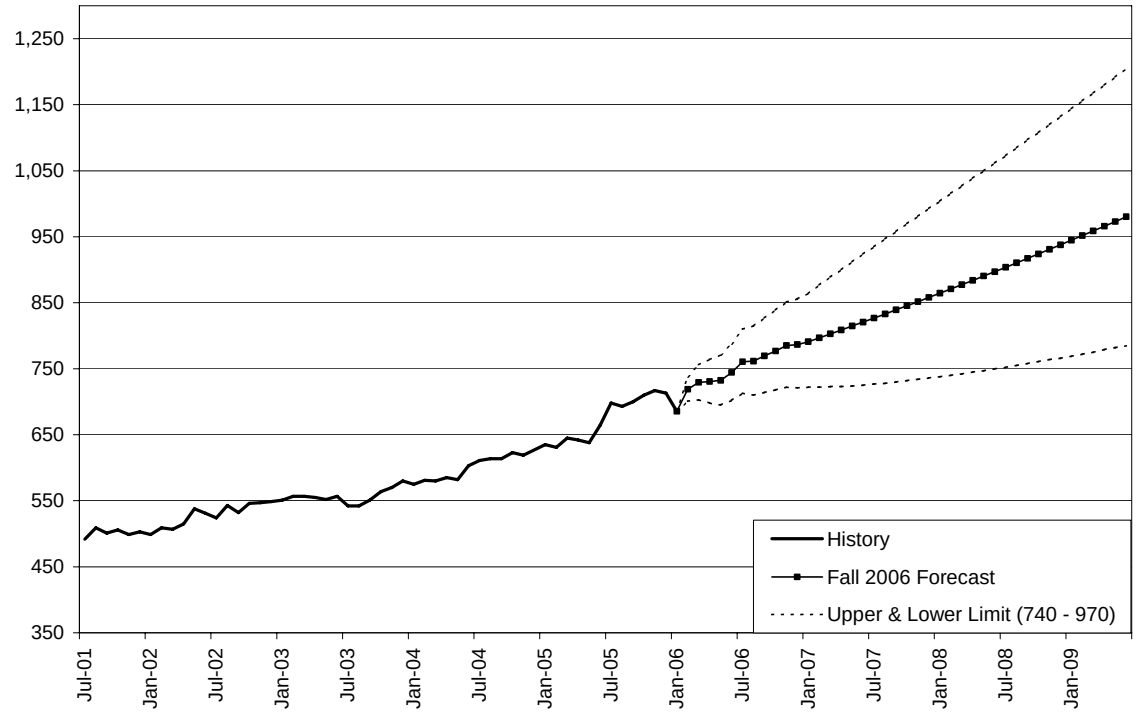


Exhibit C-9: Civil Commitment - Acute Care

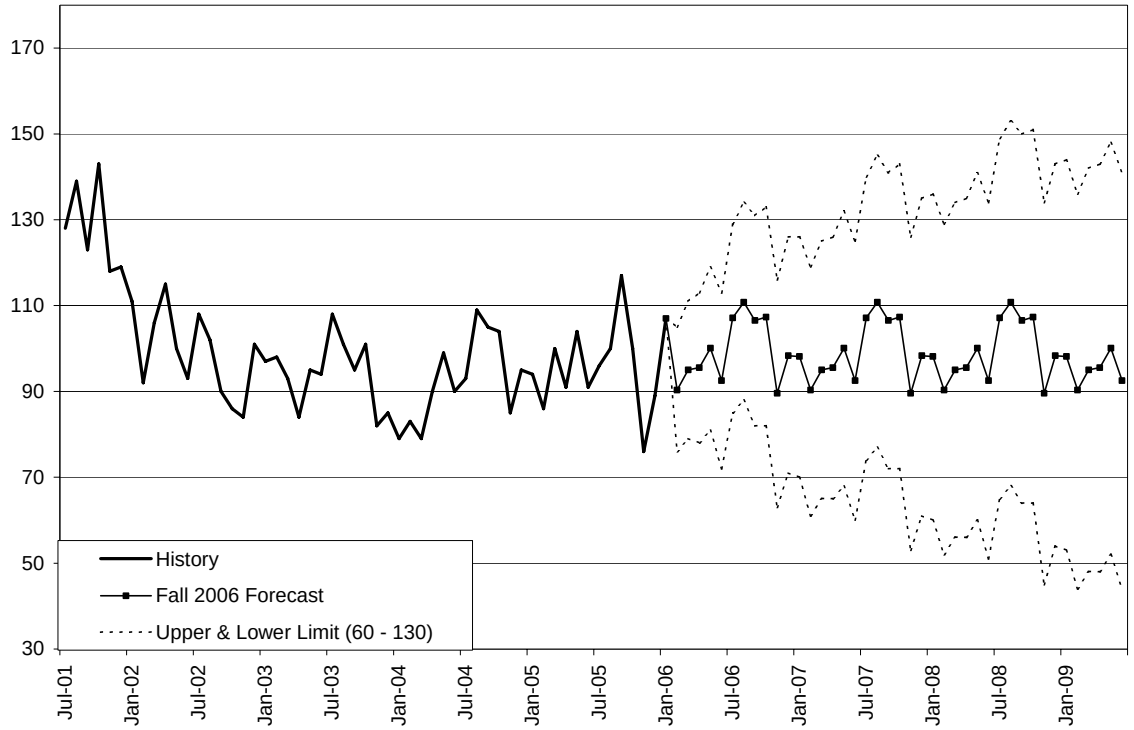
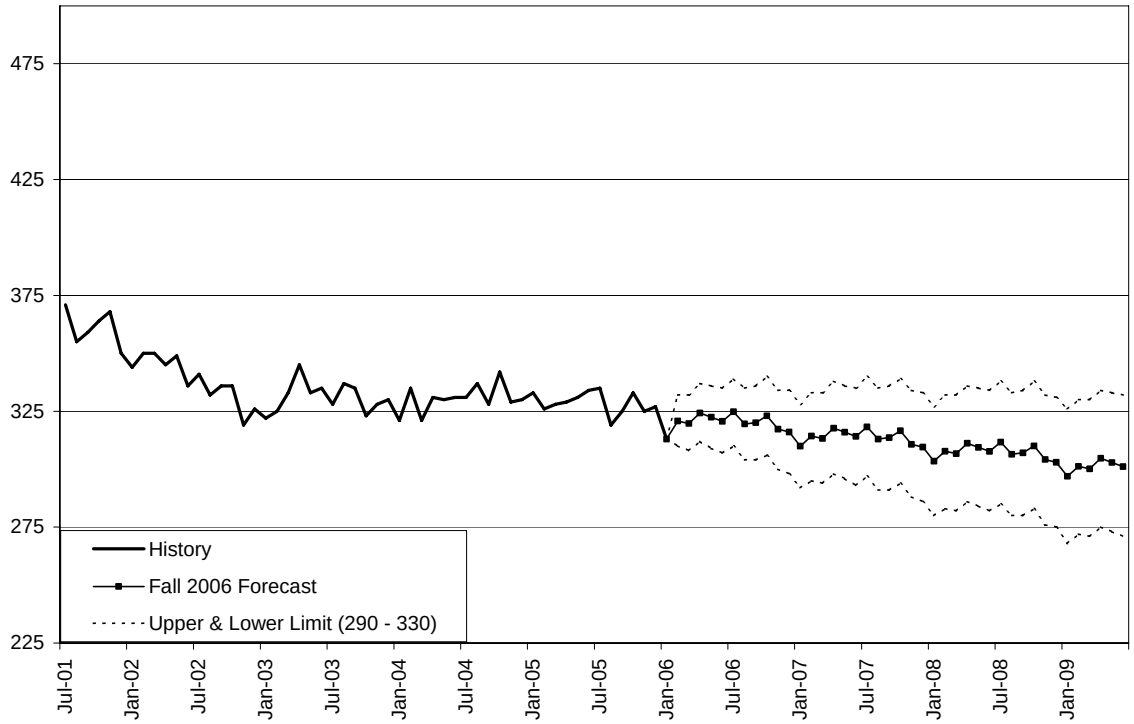


Exhibit C-10: Civil Commitment - State Hospital



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 D-1 shows the services included in each category.

Exhibit D-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
Not Included in Forecast:	Residential Care Facilities: Contract	**Other NF Services:**
Independent Choices	Assisted Living Facilities	Medicare Extended Care
	Specialized Living Facilities	OHP Post-Hospital Benefit
	Providence ElderPlace	Enhanced Care

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. However, they are not receiving Medicaid Long-Term Care services. OPI clients generally meet Medicaid eligibility, except in some cases they may have higher than allowable resource limits. Many choose not to enroll in Medicaid due to the state recovery requirement. OPI served about 3,130 clients in 2005.

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

Total Fall 2006 Caseload Forecast

The total Long-Term Care caseload forecast for Fall 2006 includes In-Home care, Community-Based Care and Nursing Facilities. Starting with the Spring 2006 forecast, the Other Nursing Facilities services such as Medicare Extended Care, Enhanced Care and the OHP Post-Hospital Benefit caseloads are included in the forecast. These Other Nursing Facilities caseloads are not rolled-up in the total Long-Term Care caseload so that the Fall 2006 caseloads can be compared to previous forecasts if needed. The Fall 2006 forecast for the Other Nursing Facilities caseloads can be compared to the Spring 2006 forecast.

Nursing Facilities make up about 18 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 D-2). The Other Nursing Facilities caseloads account for 1 percent of the total Long-Term Care caseload. Overall, this caseload distribution pattern has not changed significantly.

The biennial average Long-Term Care caseload population was 28,020 clients in the 2003-05 biennium. The average Long-Term Care caseload, measured as a biennial average, is forecasted to decrease to approximately 27,360 clients in the 2005-07 biennium. The total LTC caseload is anticipated to average 27,460 in the 2007-09 biennium.

As illustrated in Exhibit D-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[9].

For the 2005-07 biennium, the Fall 2006 forecast is about 1 percent lower than the Spring 2006 forecast; but slightly higher than the Spring 2006 forecast for the 2007-09 biennium. The lower caseload forecasts for the 2005-07 biennium are due to a decline in Community-Based Care Facilities. The higher caseload estimate for 2007-09 is due to higher estimates for the nursing facility caseload (Exhibit D-2).

[9] 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.

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

Forecasts compared:	2005-07 Biennium Spring 2006 to Fall 2006			2007-09 Biennium Spring 2006 to Fall 2006		
Aged and Physically Disabled **Biennial Averages by Forecast**	**Spring 06 Forecast 2005-07**	**Fall 06 Forecast 2005-07**	*% Diff. Spring 06 to Fall 06 2005-07*	**Spring 06 Forecast 2007-09**	**Fall 06 Forecast 2007-09**	*% Diff. Spring 06 to Fall 06 2007-09*
In-Home						
In-Home Hourly	10,260	10,261	0.0%	10,165	10,206	0.4%
In-Home Live-In	1,230	1,230	0.0%	1,218	1,223	0.4%
In-Home Spousal pay	135	135	0.0%	134	134	0.0%
Subtotal - In-Home	**11,624**	**11,626**	**0.0%**	**11,517**	**11,564**	**0.4%**
Community-Based Care						
Relative Adult Foster Care	1,524	1,533	0.6%	1,330	1,321	-0.7%
Commercial Adult Foster Care	2,496	2,495	0.0%	2,425	2,428	0.1%
Regular Residential Care	1,065	1,026	-3.7%	1,087	1,024	-5.8%
Contract Residential Care	1,195	1,162	-2.8%	1,340	1,352	0.9%
Assisted Living	3,986	3,906	-2.0%	4,098	4,066	-0.8%
Specialized Living	165	164	-0.6%	165	165	0.0%
Providence ElderPlace	668	633	-5.2%	700	715	2.2%
Subtotal - Community-Based Care	**11,098**	**10,919**	**-1.6%**	**11,145**	**11,071**	**-0.7%**
Nursing Facilities						
Basic Nursing Facility Care	4,503	4,497	-0.1%	4,342	4,419	1.8%
Complex Medical Add-On	344	342	-0.6%	328	337	2.7%
Pediatric Care	70	69	-1.4%	70	70	0.0%
Subtotal - Nursing Facilities	**4,917**	**4,907**	**-0.2%**	**4,740**	**4,825**	**1.8%**
Total Long-Term Care	**27,639**	**27,359**	**-1.0%**	**27,402**	**27,460**	**0.2%**
Extended Care NFC		139		142	173	
Enhanced Care		60		60	60	
Post-Hospital Benefit		6		6	6	
Other Nursing Facility Services		**201**		**204**	**235**	

Notes: Total In-Home caseload does not include Independent Choices and Oregon Project Independence caseloads.*
** Other Nursing Facilities Services are new caseload forecast (in the Spring 06 Forecast) and are not rolled up in the Total NFC and Total LTC caseloads.*
** Fall 2006 Forecast: Actual through March 2006.*
** Spring 2006 Forecast: Actual through September 2005.*
** Spring 2005 Forecast: Actual through September 2004.*

To summarize the comparison of Fall 2006 and the Spring 2006 forecasts, the following points can be made:

- The In-Home caseload forecast remains nearly identical in the 2005-2007 biennium, and the 2007-09 biennium compared with the Spring 2006 forecast.
- The Fall 2006 forecast for Community-Based Care caseloads is about 2 percent lower for the 2005-07 biennium and about 1 percent in the 2007-09 biennium compared with the Spring 2006 forecast.
- The Nursing Facilities forecast remains nearly identical in the 2005-07 biennium compared to Spring 2006. It is higher by 2 percent in the 2007-2009 biennium.

Risks and Assumptions

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

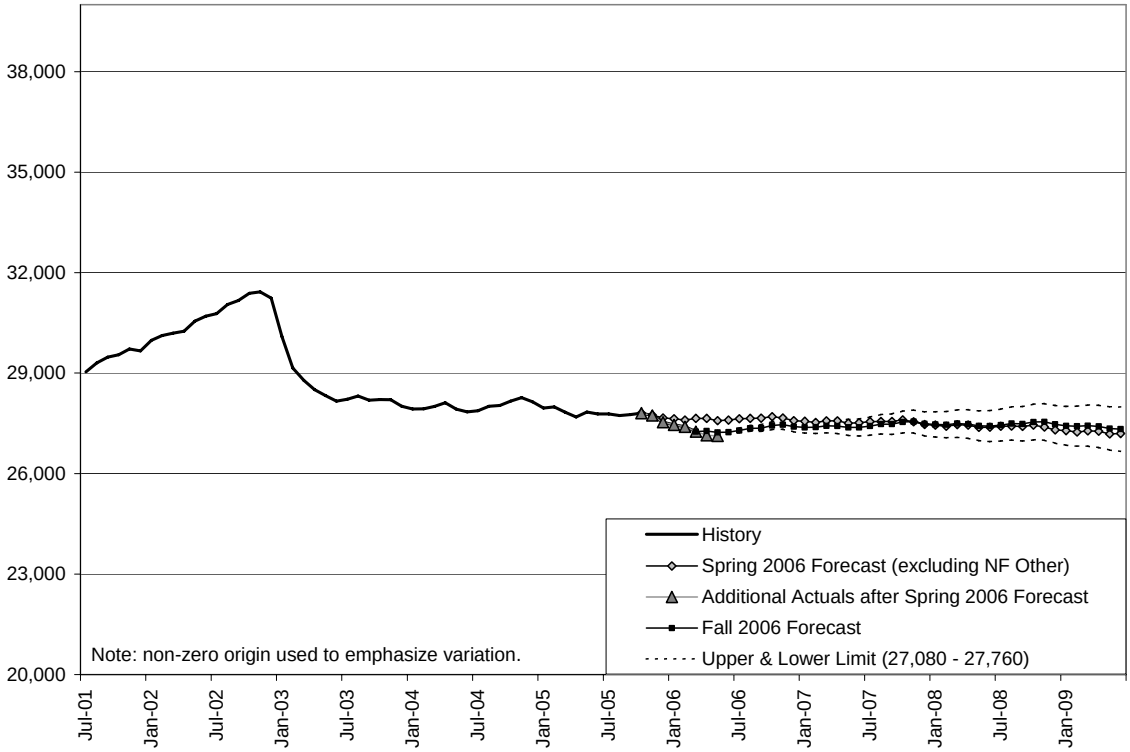
- The historical mix of current Medicaid services is assumed to remain constant throughout the forecast period
- Medicaid eligibility requirements will remain the same throughout the forecast period.
- The transition patterns on/off Long-Term Care services, and among the Medicaid LTC services will follow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

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

The growing elderly population in Oregon poses a risk to the forecast. Elderly Oregonians are among the fastest growing segments of the state population. Between 2005 and 2010, the total Oregon population is expected to increase 6 percent; the 65 and older group will grow by 10.5 percent. The 85 and older group will increase by 13 percent. 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).

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 3 percent in either direction for the 2007-09 biennium.

Exibit D-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 in Activities of Daily Living[10] (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. SPD manages entry into Personal Care for people who are aged, physically or developmentally disabled, or who qualify to

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

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 one percent of the total In-Home services caseload.

The same proportions across the three In-Home services are expected to remain for both the 2005-07 and 2007-09 forecast periods.

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.

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.

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 D-4. 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 the 2005-07 biennium, the total In-Home services caseload is forecasted to be 11,630 clients, which is nearly identical to the Spring 2006 forecast of 11,620 (Exhibit D-4). The total In-Home caseload is projected to average 11,560 in the 2007-09 biennium, which is also nearly identical to the Spring 2006 forecast.

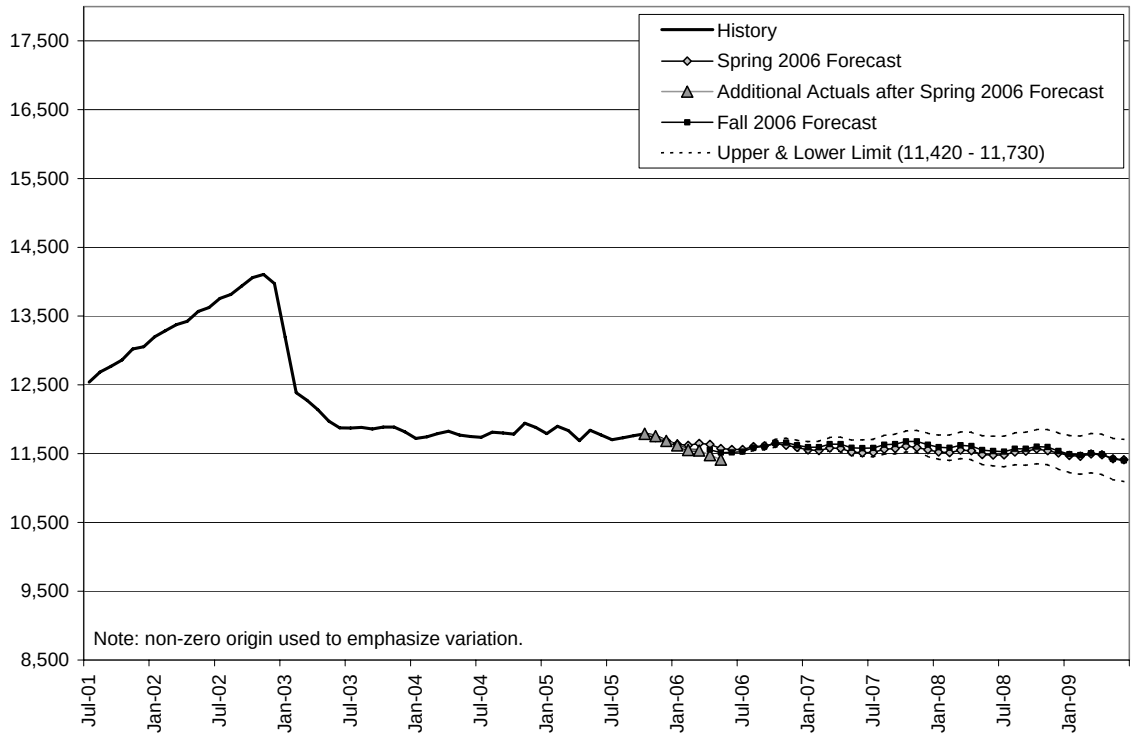
Risks to In-Home Forecast

The In-Home caseload may see decreases in this forecast horizon due to the full implementation of Medicare Modernization Act (MMA), which provides for the prescription drug coverage. Full implementation 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 historical fluctuation in this caseload, the forecast could vary 4 percent above or below the average forecast for the 2007-09 biennium.

Exihibt D-4: Total In-Home Care



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 are 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 average Community-Based Care caseload represents about two-fifths of the total Long-Term Care caseload. This total caseload is comprised of Adult Foster Care (37 percent), Assisted Living Facilities (36 percent) and Residential Care Facilities (20 percent). Specialized Living Facilities and Providence ElderPlace account for about 2 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
- Providence ElderPlace

Special Need Contract clients are a small group of clients that receive services in Community-Based Care facilities; however, they do have targeted special needs. They are included in the appropriate CBC caseloads. In March 2006, approximately 150 clients were being served under special need contracts in Residential Care, Adult Foster Care and Assisted Living 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.

The Fall 2006 total Community-Based Care caseload forecast for the 2005-07 biennium is about 2 percent lower than the Spring 2006 (10,920 versus 11,100). In the 2007-09 biennium, the total Community-Based Care caseload is about 1 percent lower than the Spring 2006 estimate (Exhibit D-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 37 percent of the total CBC caseload in the Fall 2006 forecast. It accounted for 41 percent of the CBC caseload in 2003-05 (Exhibit D-6). 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.

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 4,030) in the Fall 2006 forecast. As Exhibit D-7 shows, the AFC-Relative caseload has been declining at a rapid rate since January 2004.

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 more 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.

The AFC- Relative caseload forecast for Fall 2006 remain nearly unchanged from the Spring 2006 forecast for both the 2005-07 and 2007-09 biennia.

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 4,030) in the Fall 2006 forecast. The Adult Foster Care-Commercial caseload was increasing prior to 2003, but declined rapidly in the early part of the 2003. However, it has stabilized in the recent months leading up to the Fall 2006 forecast.

Forecast

The Fall 2006 Adult Foster Care-Commercial caseload forecast (2,500) is nearly identical to the Spring 2006 forecast for the 2005-07 biennium. This caseload is projected to average 2,430 in the 2007-09 biennium, which is also very close to the Spring 2006 forecast (Exhibit D-8).

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 the Spring 2006 forecast. It accounted for 19 percent of the CBC caseload in the 2003-05 biennium.

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 2,190). 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 D-10). One of the reasons for this decline has to do with the gradual increase of the RCF-Contract caseload (Exhibit D-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 Residential Facilities-Contract (Exhibit D-11).

Forecast

In the Fall 2006 forecast, the RCF-Regular caseload is projected to stabilize at a biennial average of 1,030 for 2005-07. This is about 4 percent lower than the Spring 2006 projection of 1,040 during the 2005-07 biennium. This caseload is projected to average 1,020 for 2007-09 biennium.

CBC: Residential Care - Contract

The Residential Care-Contract caseload is about 11 percent of the total CBC caseload, which accounts for 53 percent of the total RCF caseload (total average equals 2,190). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to continue to grow over the 2005-07 and 2007-09 biennia.

Forecast

The RCF-Contract caseload in the Fall 2006 is slightly lower than in the Spring 2006 and the Spring 2005 forecasts for the 2005-07 biennium (Exhibit D-11). It is forecasted to be at a biennial average of 1,160 clients in 2005-07, lower than the Spring 2006 forecast of 1,200 clients by about 4 percent. The RCF-Contract caseload is anticipated to average 1,350 per month in the next biennium (2007-09), which would increase its share of total Residential Care caseload to 57 percent from the current 53 percent.

CBC: Assisted Living Facilities

The Assisted Living Facilities (ALF) is 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 36 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 most recent months (January –March 2006) has shown some decline in this caseload. Nonetheless, growth in this caseload is expected to re-emerge, albeit at a slower pace, especially during the current biennium.

Forecast

The Fall 2006 forecast (3,900 biennial average) is about 2 percent lower than the Spring 2006 forecast of 3,990 (Exhibits D-12). Similarly, the caseload biennial average is projected to be slightly lower (biennial average 4,070) in the 2007-09 forecast period compared with the Spring 2006 forecast level of 4,100.

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.

Forecast

The SLF caseload forecast is anticipated to maintain the monthly average of 165 in the 2005-07 and the 2007-09 biennia. (No graph included because of the small number and relatively flat caseload).

CBC: Providence ElderPlace

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 verity of care settings. The Providence ElderPlace program is responsible for providing and coordinating their clients' full health and long-term care needs in all of these settings. Most clients served through Providence ElderPlace are dually eligible for both Medicare and Medicaid. At present, the Providence ElderPlace services are only available in Multnomah County, and account for 6 percent of the total CBC caseload.

Forecast

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

In the Fall 2006 forecast, the 2005-07 PEP caseload is estimated to be 630, which is lower than the Spring 2006 forecast of 670 by about 5 percent. The Fall 2006 caseload forecast for the 2007-09 period is about 2 percent higher than the Spring 2006 forecast (700). The 2007-09 forecast of 720 accounts for growth in this caseload due to a plan expansion of PACE services in Washington and Marion counties starting 2008.

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 market. In the CBC market, private pay residents in most cases, after spend–down, become Medicaid eligible. As a result, while the Adult Foster Care market is becoming increasingly Medicaid, other care providers such as ALF and RCF are succeeding competitively in the private pay market. This phenomenon may be attributed to the widening gap in recent years between relatively flat Medicaid reimbursement and the growing operating cost of doing business. If more CBC facilities reduce the number of Medicaid clients they accept, this may dampen growth in some CBC caseloads below estimates, while causing others such as AFC or Nursing Facilities to grow (since the overall numbers of people in need of Medicaid LTC facilities has not been reduced).

Providence ElderPlace has a projected plan for the service expansion in Washington County and rural Mid-Willamette valley starting in January 2008. The 4-year expansion rollup in the Washington County and in rural Oregon will increase its caseload by about 160. This may impact the current Medicaid caseloads in ALF, Foster Homes and some nursing homes.

The Community Based Care caseload, historically, has shown some volatility in response to changes in the program implementation and the CBC market forces (i.e., Medicaid reimbursement) 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 5 percent in either direction.

Exhibit D-5: Total Community-Based Care Facilities

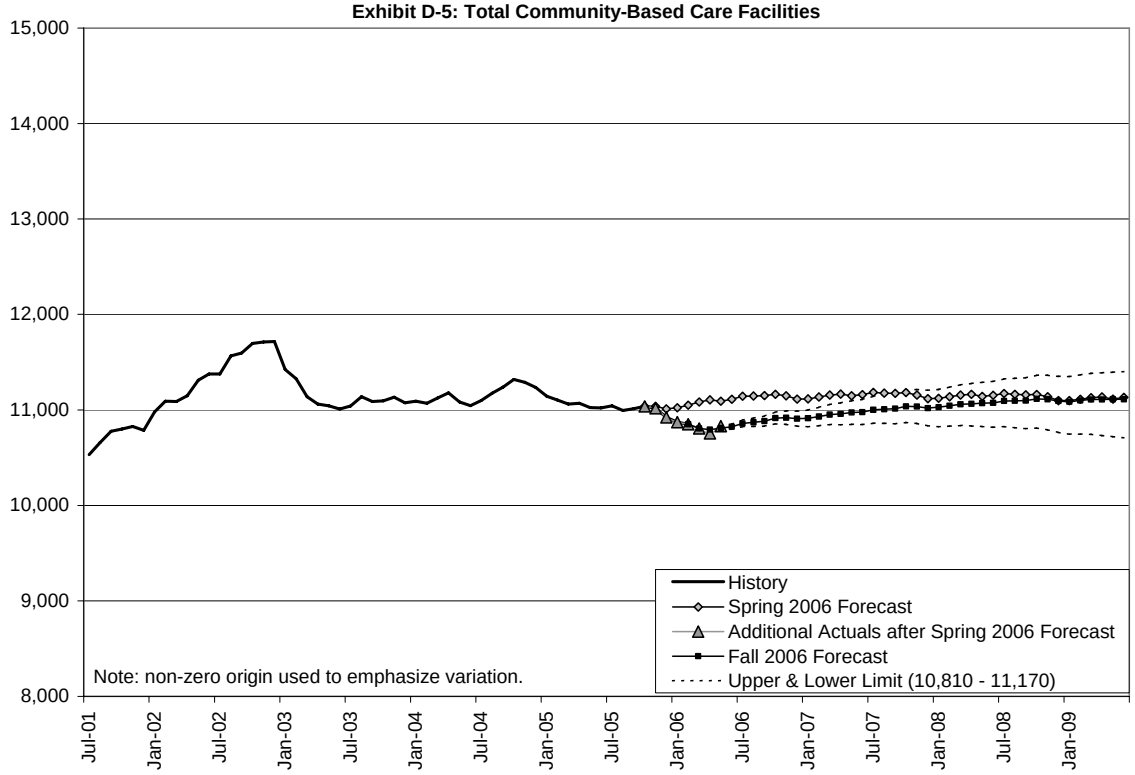


Exhibit D-6: Total Adult Foster Care

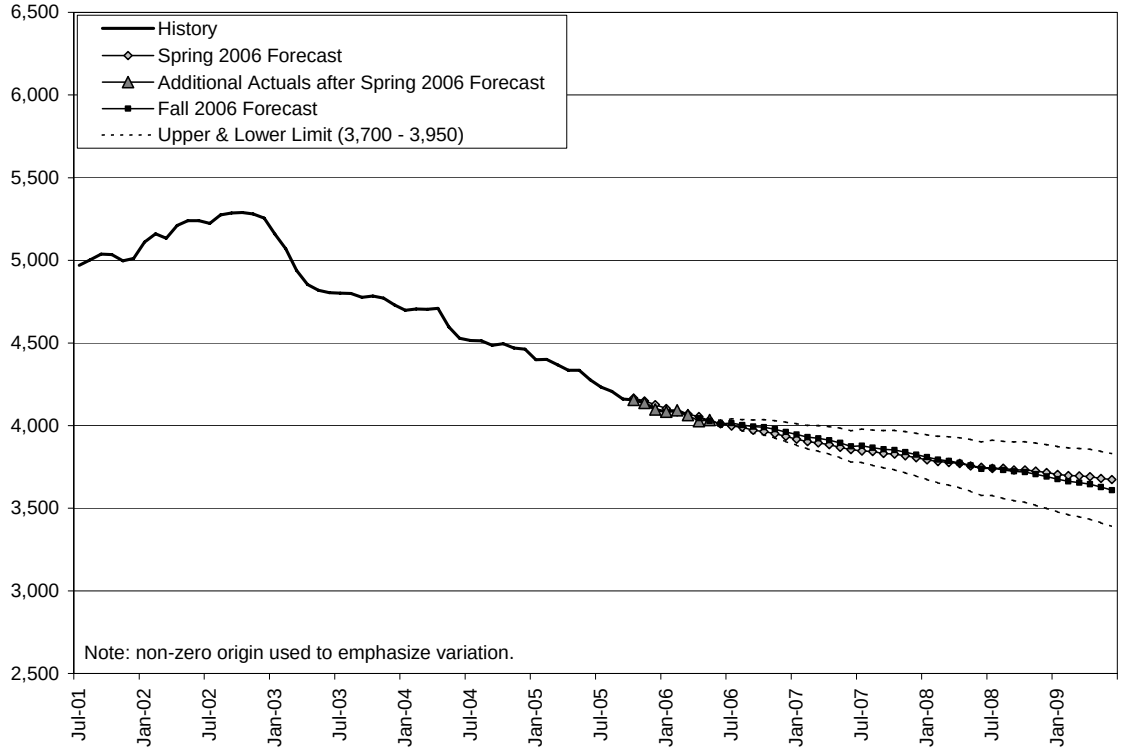


Exhibit D-7: Relative Adult Foster Care

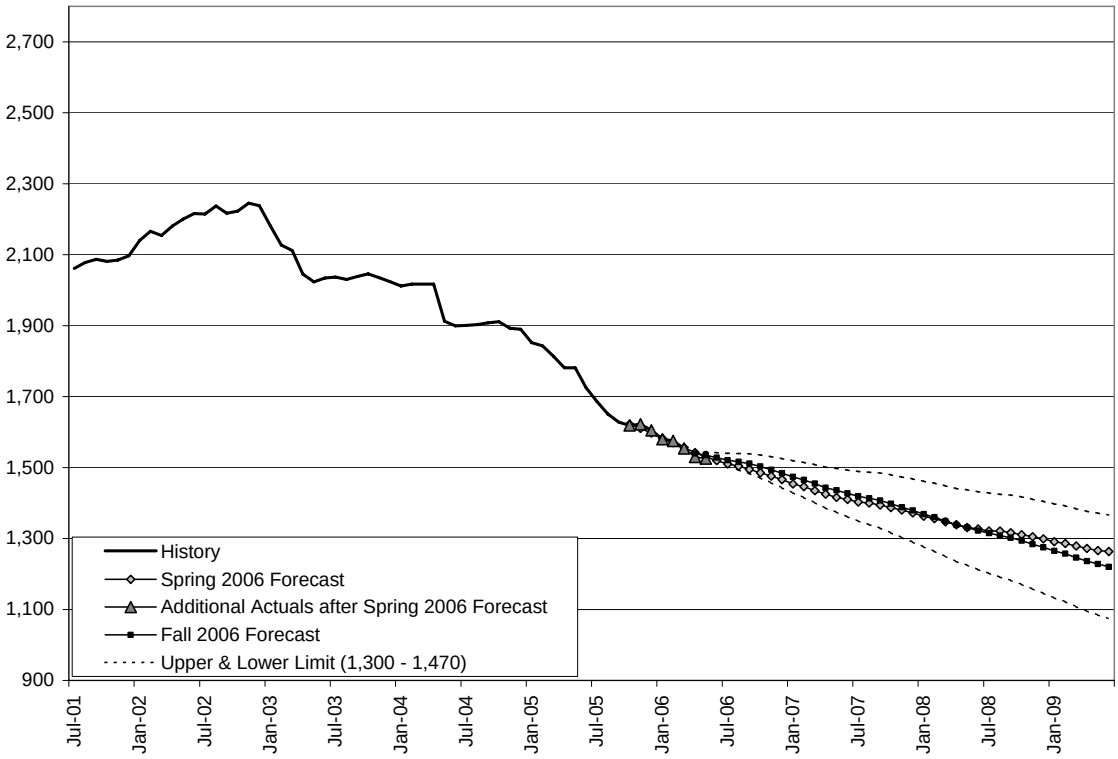


Exhibit D-8: Commercial Adult Foster Care

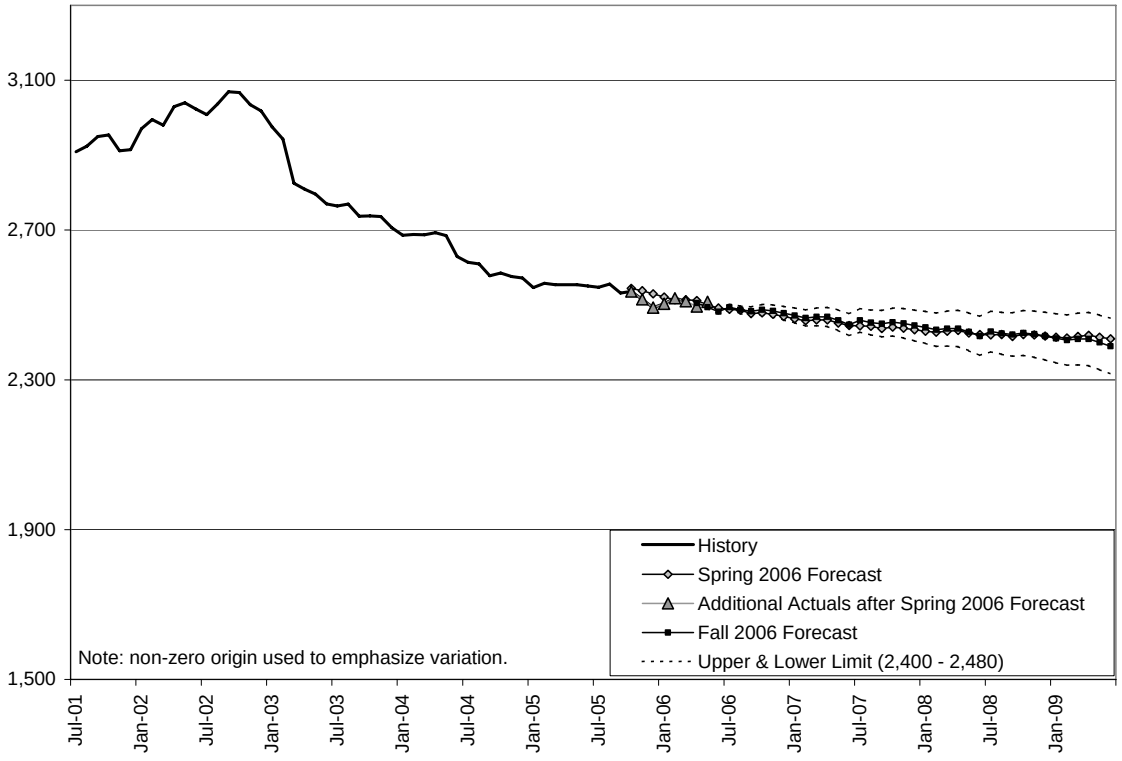


Exhibit D-9: Total Residential Care Facilities

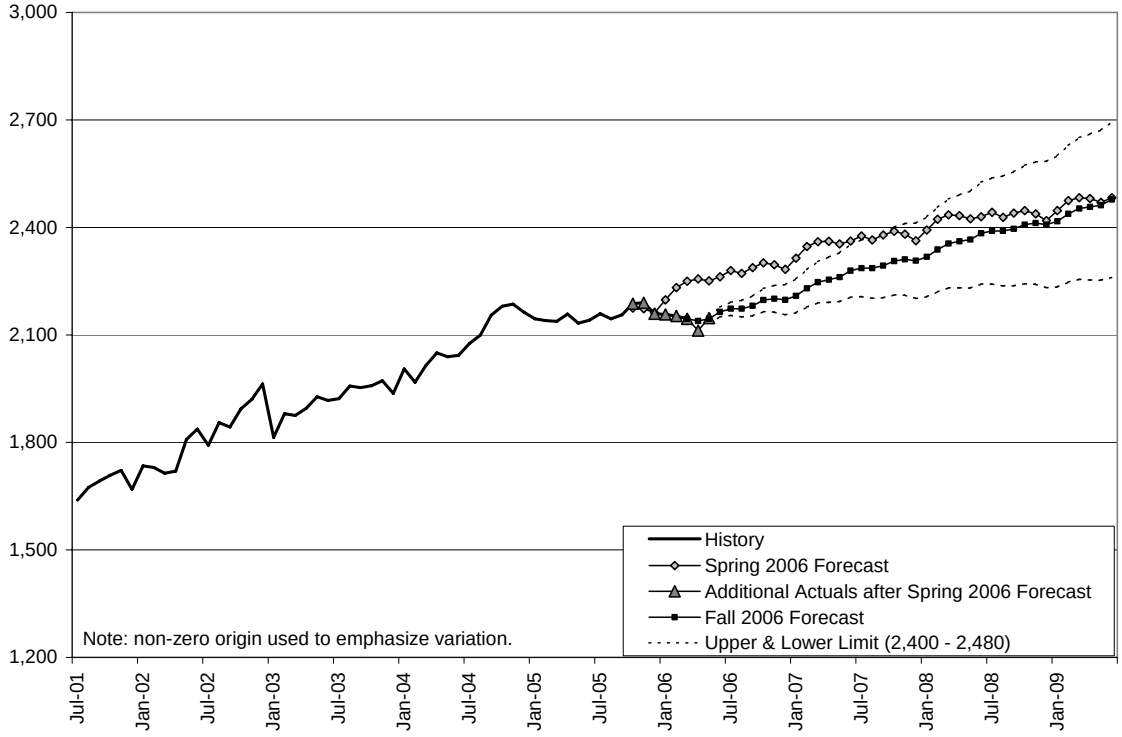


Exhibit D-10: Regular Residential Care

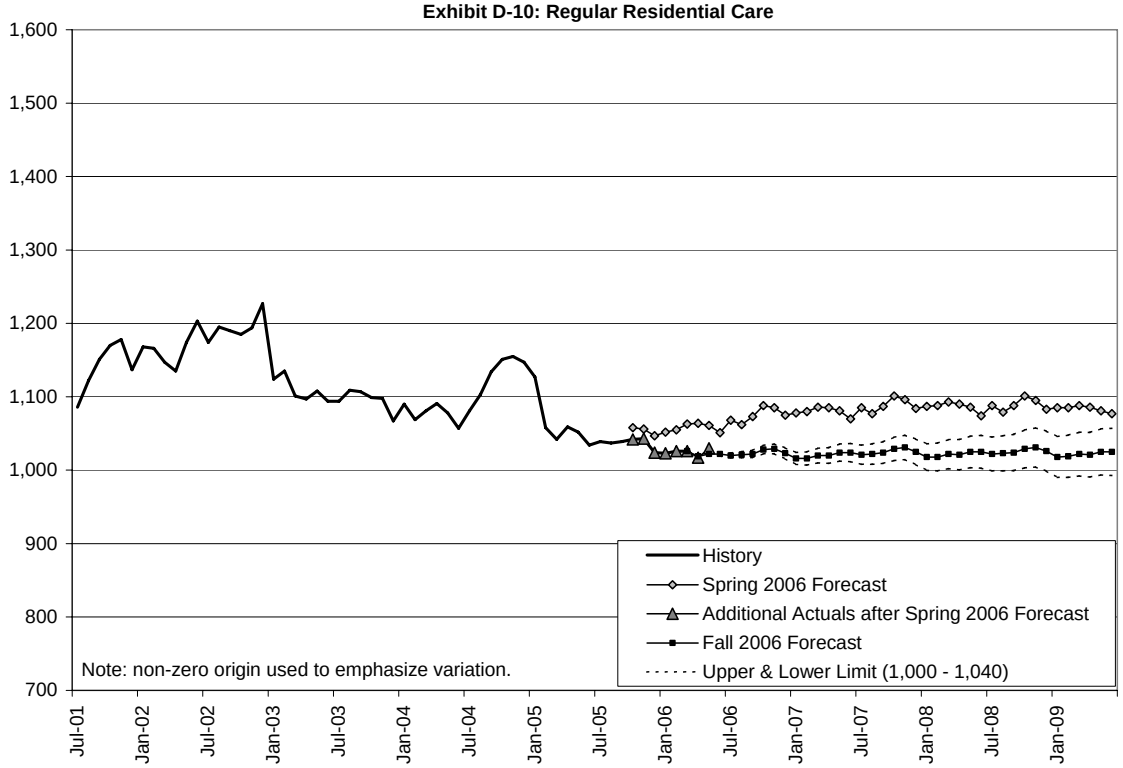


Exhibit D-11: Contract Residential Care

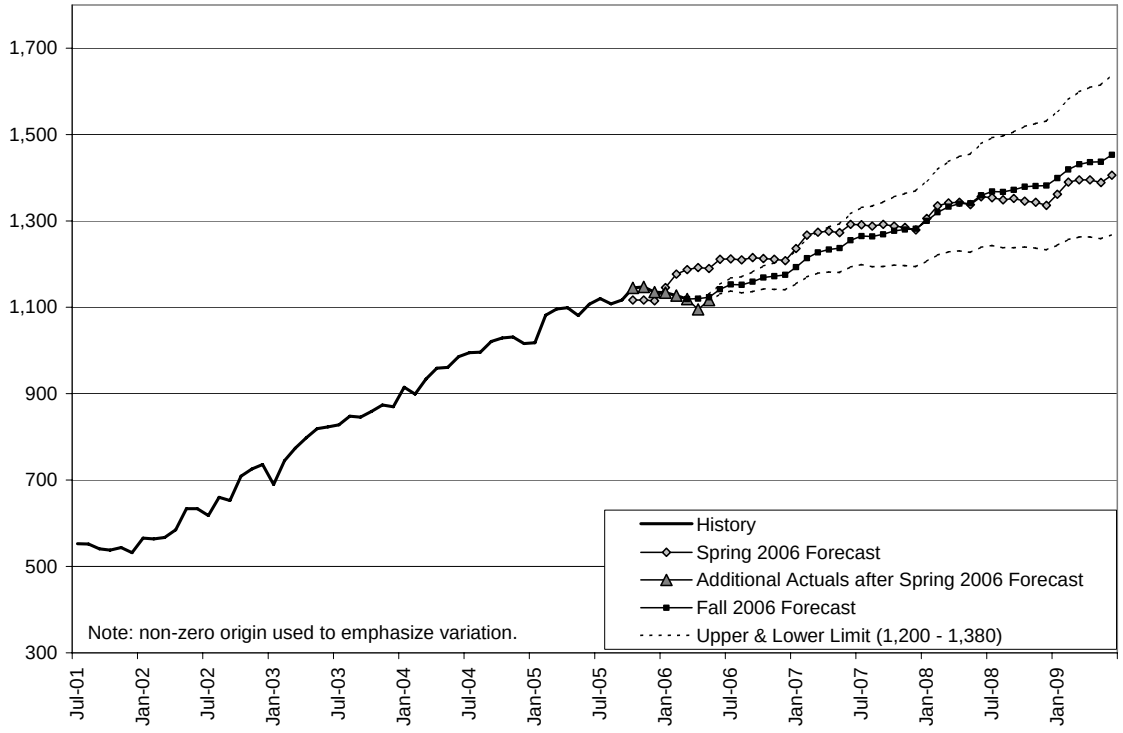


Exhibit D-12: Assisted Living Facilities

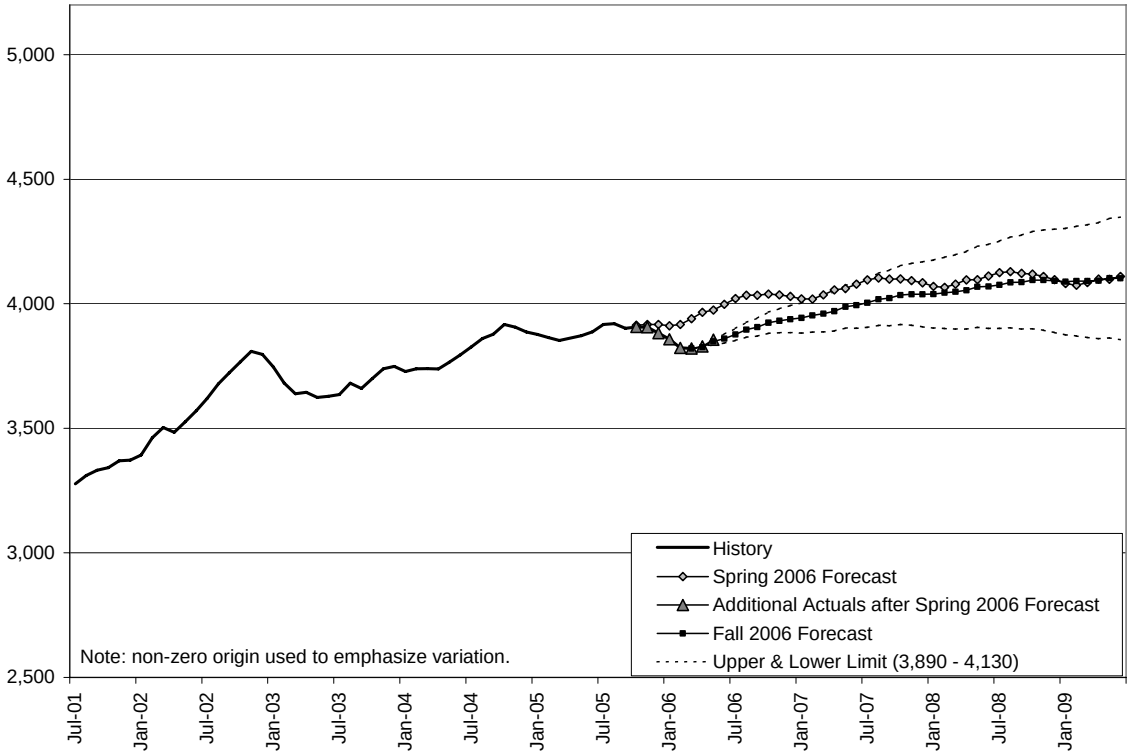
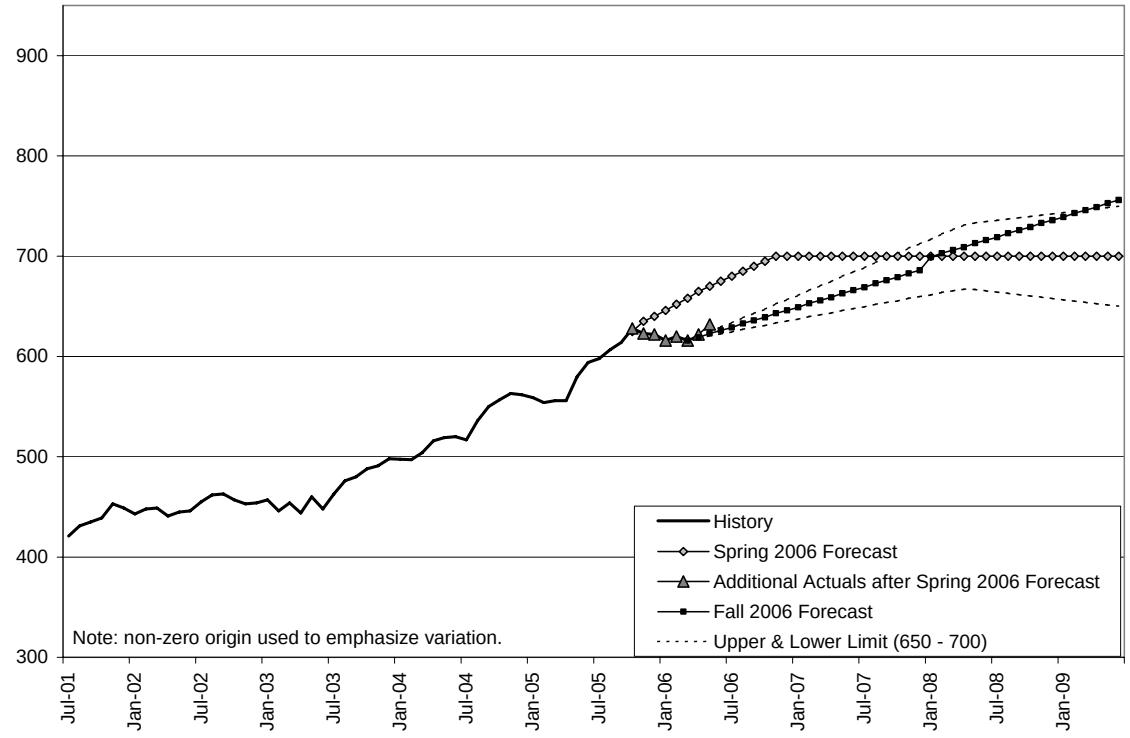


Exhibit D-13: Providence ElderPlace



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

Other Nursing Facilities Services:

- 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[11].

Forecast

In the Fall 2006 forecast, the total nursing facility caseload (excluding the three groups listed under the "Other NF Services") of 4,910 remain nearly unchanged from the Spring 2006 forecast. This caseload is, however, projected to average about 2 percent higher at 4,830 in the 2007-09 biennium (Exhibit D-14), than the Spring 2006 forecasted biennial average of 4,740.

Other Nursing Facilities Services:

Since the Spring 2006 forecast, the other Nursing Facility services are included in the NF caseload forecast. The other NF services include the Medicare Extended Care, Enhanced Care and OHP Post-Hospital Benefit. These three NF services have relatively small caseloads. Exhibit D-14 show total NF including the other Nursing Facility services caseload forecasts.

Nursing Facility Care: Basic

The Nursing Facility Care-Basic caseload includes about 88 percent of total Nursing Facility clients[12]. The clients in this caseload need 24-hour

[11] 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).
[12] 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.

comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care either due to age or physical disability.

Forecast

As noted earlier, this caseload has been decreasing gradually over time. However, the Fall 2006 NF Care-Basic caseload forecasts of about 4,500 remain at the level of Spring 2006. This caseload is projected to average 4,420 in the 2007-09 biennium, which is approximately 2 percent higher than the Spring 2006 as seen in Exhibit D-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 is projected to average 340 in the 2005-07 biennium and the average of 340 in the 2007-09 biennium (Exhibit D-16). Comparing the previous forecasts, the Fall 2006 Complex Medical Add-On forecast is nearly identical to the Spring 2006 forecast for the 2005-07 biennium, while it is about 3 percent higher for the 2007-09 biennium.

Other Nursing Facilities Services

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 nursing client population will remain at the capped level of 70 clients through the 2007-09 biennium.

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 is forecasted to remain at an average of 140 clients in the current (2005-07 biennium) and 170 clients in the next biennium (2007-09) as shown in Exhibits D-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.

In the 2005-07 and the 2007-09 biennia, the post-hospital care benefit caseload is forecasted to remain at the biennial average of 6 clients.

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 (220 in March 2006) 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 clients. 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 160 clients are being served in various Community-Based Care settings.

In the 2005-07 and the 2007-09 biennia, 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 with the market.

The nursing facilities caseload, historically, has shown some volatility in response to changes in the program implementation and the NFC market forces. Thus, the total nursing facilities caseload forecast could fall within the margin of 6 percent above or below the average forecast for the 2007-09 biennium.

Exhibit D-14: Total Nursing Facilities

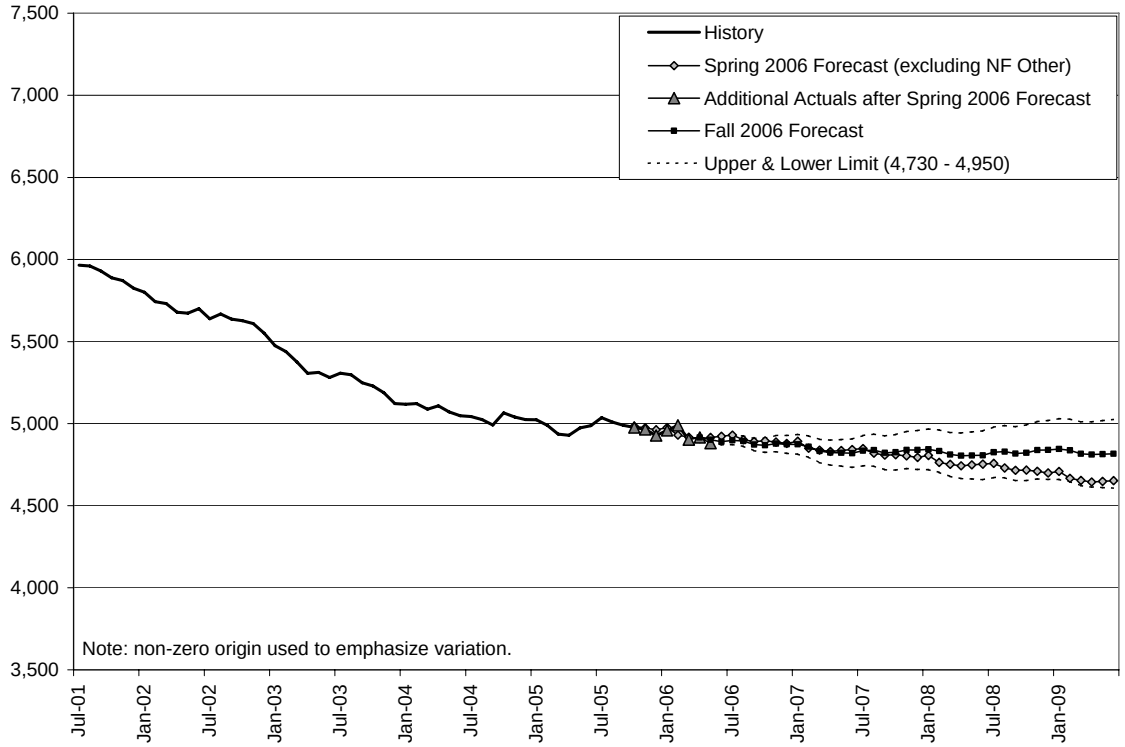


Exhibit D-15: Basic Nursing Facilities

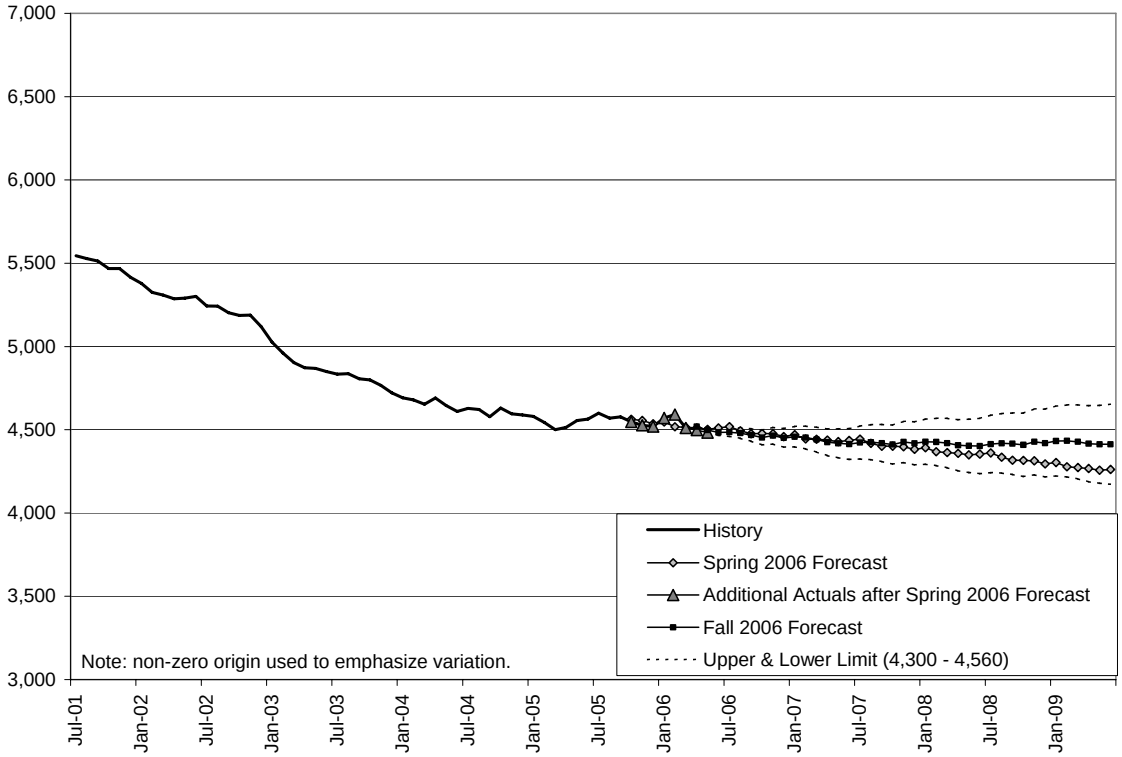


Exhibit D-16: Complex Medical Add-On Nursing Facilities

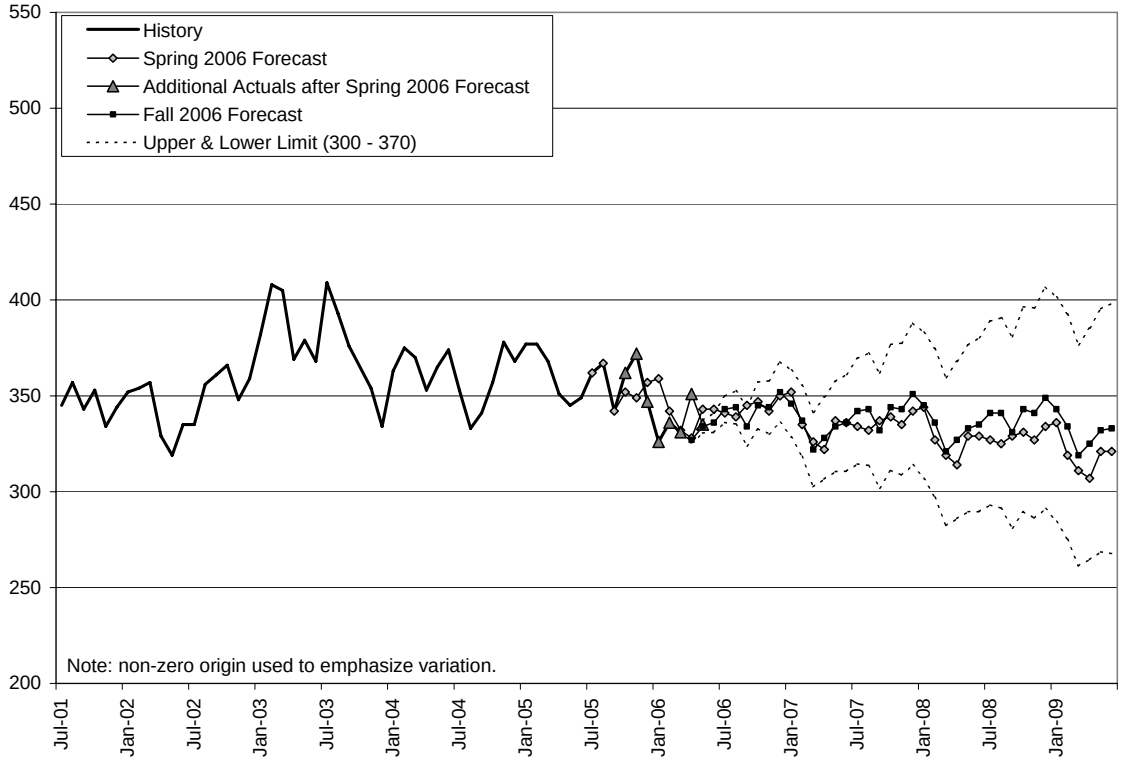
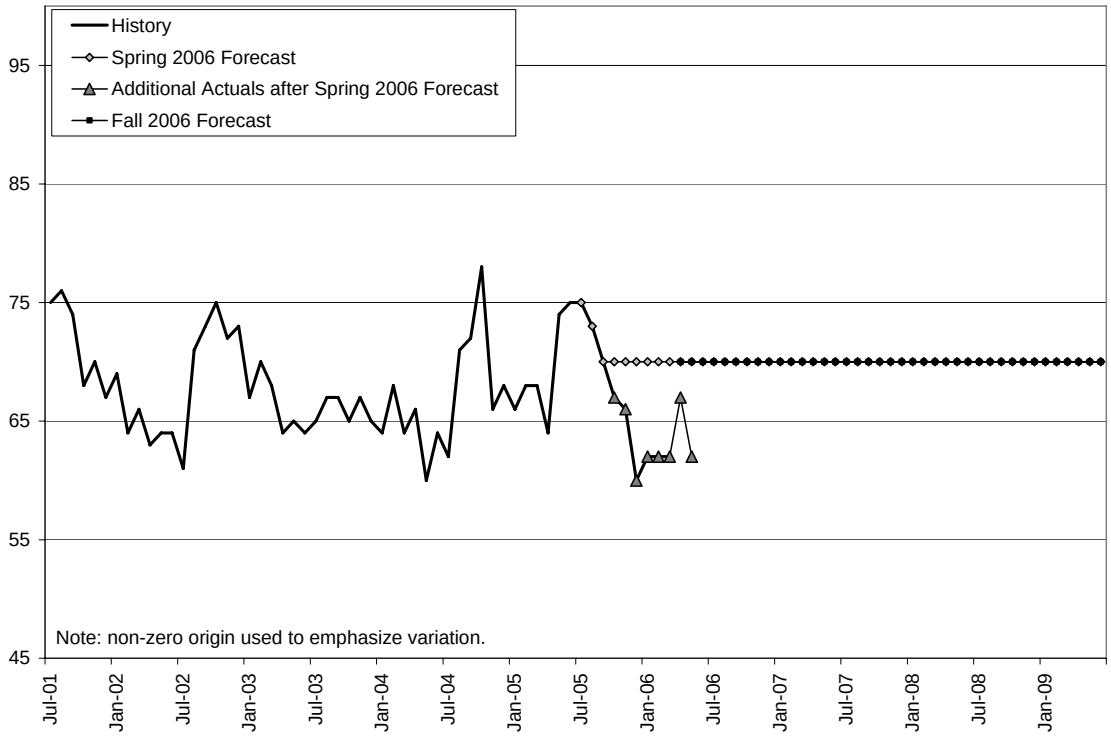


Exhibit D-17: Pediatric Nursing Facilities



Appendix I

Child Welfare Average Daily Population by Service Category

Service Categories

Besides projecting the number of children served, the Child Welfare forecast also provides projections of average daily population (ADP) for the following categories of services:

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[13] eligible children for whom returning home or adoption is not in their best interest.

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.

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 Office of Mental Health and Addiction Services (OMHAS).

[13] 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.

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.

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

Adoption Assistance

This service correlates very strongly with the Adoption Assistance caseload, so it presents a very similar historical trend. The Fall 2006 forecast of 10,460 for the 2007-09 biennium ADP exactly matches the Spring 2006 Forecast.

Subsidized Guardianship

This service has an even stronger correlation to its caseload counterpart than Adoption Assistance ADP has to its corresponding caseload. At 750, the Fall 2006 forecast for ADP in the 2007-09 biennium is only 0.4 percent lower than the Spring 2006 forecast.

Regular Paid Foster Care

The Foster Care caseload consists of individuals falling into three categories: Residential Treatment; Paid Foster Care; and Non-paid Foster Care. Regular Paid Foster Care relates to those in the Paid Foster Care category. As one might expect, the leveling off apparent in the Foster Care caseload since July 2005 is also evident in Regular Paid Foster Care ADP. Like the Foster Care caseload, Regular Paid Foster Care ADP is expected to return to the long-term trend in the Fall 2006 forecast. The 7,730 average forecasted for the 2007-09 biennium is nearly 8 percent lower than the Spring 2006 forecast.

Special Rates Foster Care

The individuals receiving special rate payments form a subset of the group receiving regular foster care payments. In the Spring 2006 forecast, the 2007-09 biennial average for Special Rates Foster Care equaled 46 percent of the average for Regular Paid Foster Care. The Fall 2006 forecast, however, has Special Rates Foster Care growing at a faster rate than Regular Paid Foster Care, raising the percentage to 50 percent. The result is that the Fall 2006

forecast's biennial average of 3,850 for Special Rates Foster Care is only 0.6 percent lower than the Spring 2006 forecast.

Residential Treatment

Like Regular Paid and Special Rates Foster Care, the flattening of the Foster Care caseload trend line has impacted Residential Treatment ADP. The 2007-09 biennial average of 560 for Total Residential Treatment falls nearly 11 percent below that for the Spring 2006 forecast. Regular Contract tends to be relatively stable since it relates to a contracted number of beds, so most of the deviation is in Special Contracts (about 22 percent lower than the Spring 2006 forecast) and Target Children (around 17 percent lower). However, Regular Contract does come out lower (by approximately 3 percent) for the Fall 2006 forecast due to expected changes in capacity utilization. The Spring 2006 forecast assumed that 98 percent utilization would be achieved by June 2006. Based on recent figures, though, this does not seem reasonably attainable, so the Fall 2006 forecast works from the assumption that utilization will reach 95 percent by June 2006 and then stay there.

Risks and Assumptions

As with the caseloads in terms of number served, the ADP forecasts for Fall 2006 assume steady trends in Adoption Assistance and Subsidized Guardianship and resumed growth in Foster Care, which impacts Regular Paid Foster Care, Special Rates, and Residential Treatment. The Fall 2006 forecast also assumes that Regular Contract Residential Treatment will reach a 95 percent utilization rate. Deviations from these assumptions will result in an inaccurate forecast.

Appendix II

Medical Assistance Program Timelines

The graphs in this section show Oregon Medical Assistance Programs caseload counts over the period from January 2000 through September 2005. They also note various events that occurred during this period that likely had an effect on the caseload. These graphs illustrate how major events, both internal and external to DHS, can contribute to an increase or decrease in caseloads.

The four graphs included here illustrate the following caseloads:

Total Oregon Health Plan Population
TANF Related Medical
TANF Extended
Poverty Level Medical Women
Poverty Level Medical Children
Aid to the Blind and Disabled
Old Age Assistance
Foster/Substitute Care
Children's Health Insurance Program
OHP Standard—Families
OHP Standard—Adults and Couples
Citizen-Alien Waived Emergency Medical

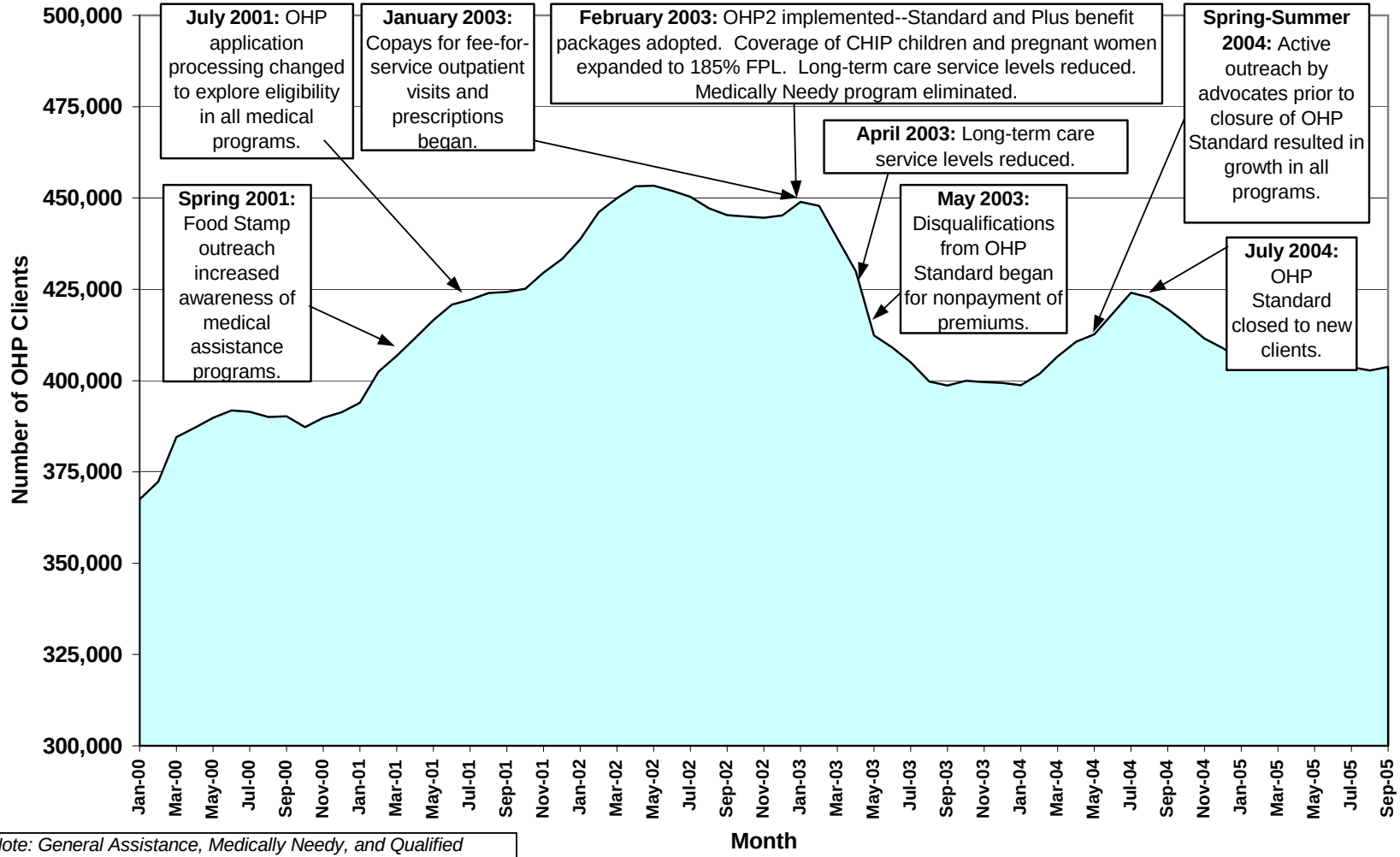
Oregon Health Plan Plus Population
TANF Related Medical
TANF Extended
Poverty Level Medical Women
Poverty Level Medical Children
Aid to the Blind and Disabled
Old Age Assistance
Foster/Substitute Care
Children's Health Insurance Program

Oregon Health Plan Standard Population
OHP Standard—Families
OHP Standard—Adults and Couples

Oregon Health Plan CHIP Population

Total Oregon Health Plan Population

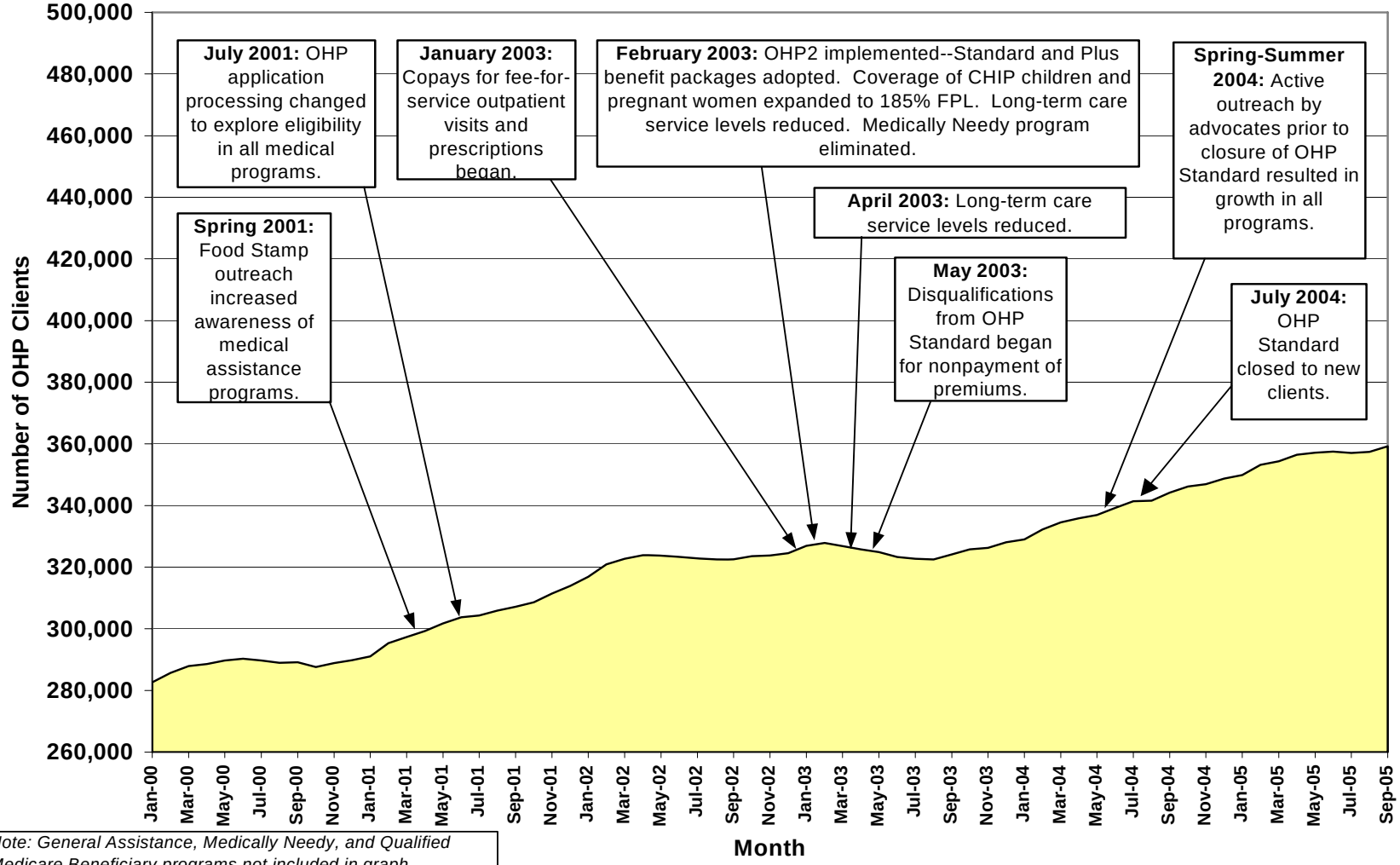
January 2000 through September 2005



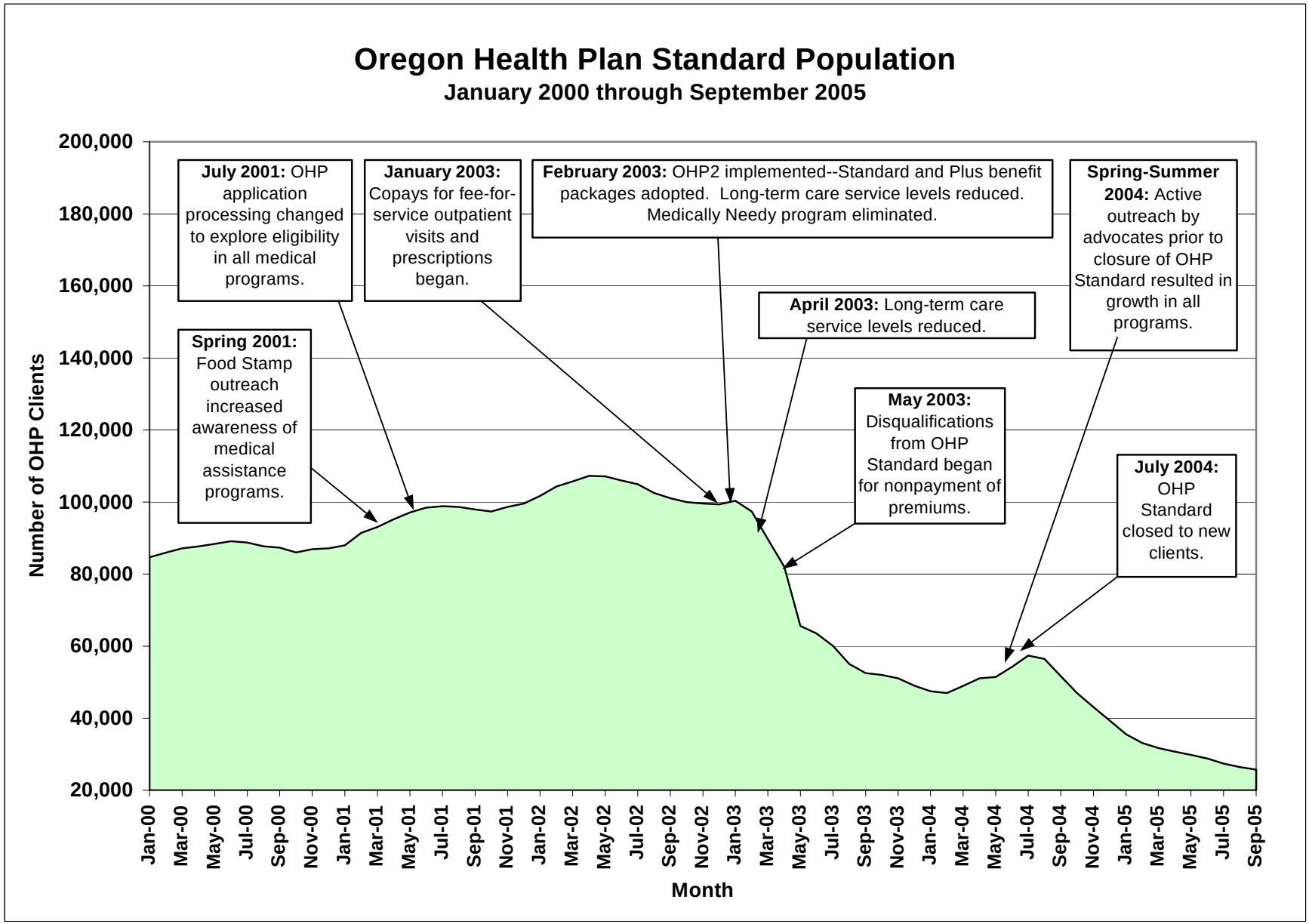
Note: General Assistance, Medically Needy, and Qualified Medicare Beneficiary programs not included in graph.

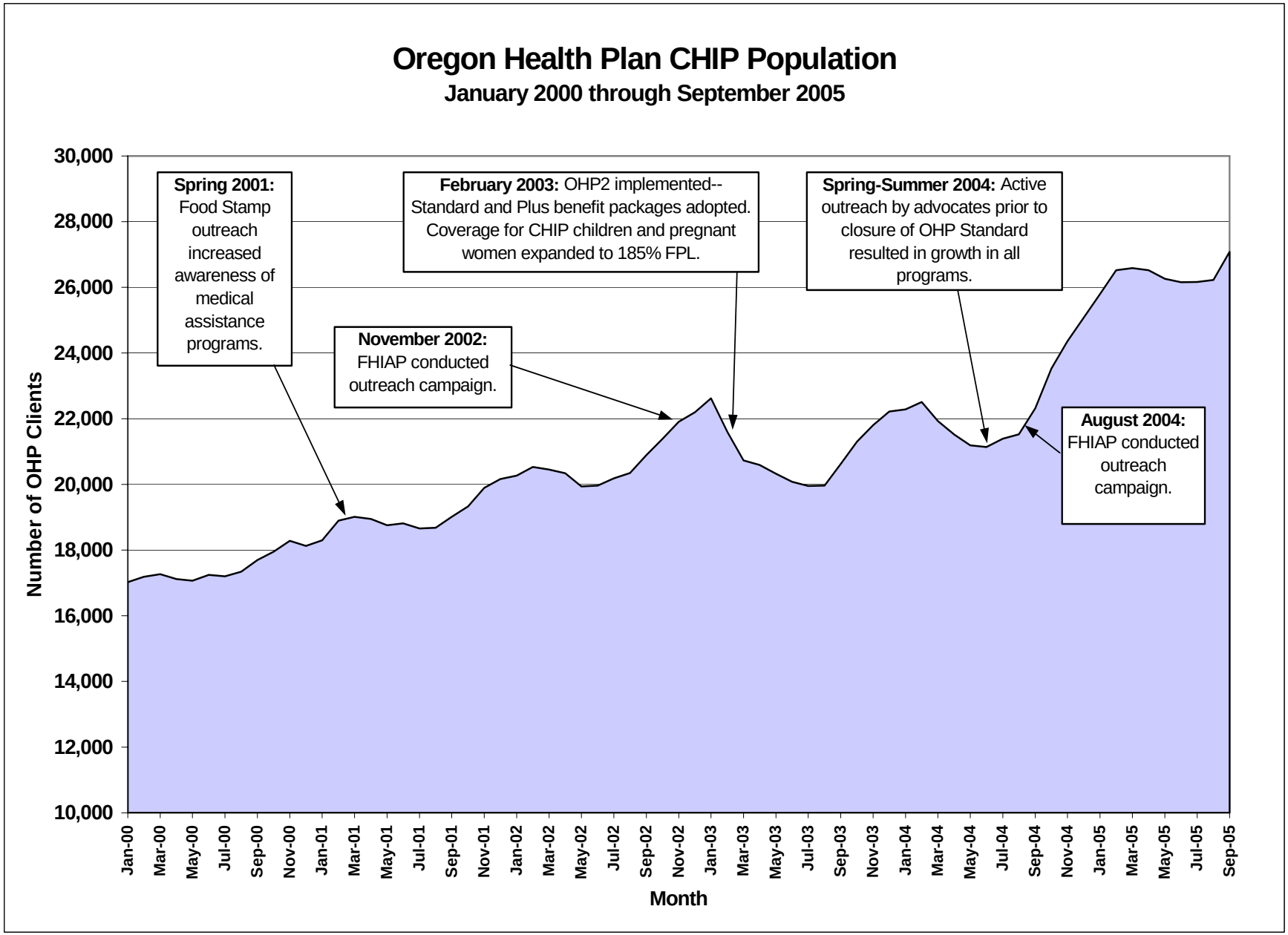
Oregon Health Plan Plus Population

January 2000 through September 2005



Note: General Assistance, Medically Needy, and Qualified Medicare Beneficiary programs not included in graph.


Oregon Health Plan Standard Population
January 2000 through September 2005
Number of OHP Clients
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
Jan-00
Mar-00
May-00
Jul-00
Sep-00
Nov-00
Jan-01
Mar-01
May-01
Jul-01
Sep-01
Nov-01
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05
Sep-05
Month
July 2001: OHP application processing changed to explore eligibility in all medical programs.
January 2003: Copays for fee-for-service outpatient visits and prescriptions began.
February 2003: OHP2 implemented--Standard and Plus benefit packages adopted. Long-term care service levels reduced. Medically Needy program eliminated.
Spring-Summer 2004: Active outreach by advocates prior to closure of OHP Standard resulted in growth in all programs.
April 2003: Long-term care service levels reduced.
Spring 2001: Food Stamp outreach increased awareness of medical assistance programs.
May 2003: Disqualifications from OHP Standard began for nonpayment of premiums.
July 2004: OHP Standard closed to new clients.


Oregon Health Plan CHIP Population
January 2000 through September 2005
Number of OHP Clients
30,000
28,000
26,000
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
Spring 2001: Food Stamp outreach increased awareness of medical assistance programs.
November 2002: FHIAP conducted outreach campaign.
February 2003: OHP2 implemented-- Standard and Plus benefit packages adopted. Coverage for CHIP children and pregnant women expanded to 185% FPL.
Spring-Summer 2004: Active outreach by advocates prior to closure of OHP Standard resulted in growth in all programs.
August 2004: FHIAP conducted outreach campaign.
Jan-00
Mar-00
May-00
Jul-00
Sep-00
Nov-00
Jan-01
Mar-01
May-01
Jul-01
Sep-01
Nov-01
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05
Sep-05
Month

Appendix III

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. The 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. Then, the forecaster 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, they are 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. A list of the group members is listed in Appendix III.
Another part of the forecasting process is a twice-yearly meeting of the Peer Review 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.

Lists of the members of the Steering committees, Community Provider Advisory group, DAS Review Team, and the Peer Review Group follow.

Notes on methods

To create the forecast, the forecaster how many clients it *has* served in the past and applies mathematical models to project how many it *will* serve 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 Children, Adults and Families Division 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.

CAF Steering Committee Members

Vic Todd, Administrator
Self-Sufficiency Programs, CAF
Department of Human Services

Sheila Baker, Budget Analyst
Legislative Fiscal Office
Oregon State Legislature

Ramona Foley, Assistant Director
Children, Adults & Families
Department of Human Services

Nancy Keeling, Administrator
Safety and Permanency for Children, CAF
Department of Human Services

Angela Long, Administrator
Program, Performance & Reporting, CAF
Department of Human Services

Elyssa Tran, CAF Budget Administrator
Finance & Policy Analysis
Department of Human Services

Judy Mohr-Peterson, Ph.D., Administrator
Forecasting, Research & Analysis
Department of Human Services

James Neely, Deputy Assistant
Director of Field Services, CAF
Department of Human Services

Stephaine Parrish Taylor, Administrator
of Vocational Rehabilitation Services
Children, Adults & Families
Department of Human Services

Michael Serice, Deputy Assistant
Director for Program & Policy
Children, Adults & Families
Department of Human Services

John Swanson, Deputy Assistant Director
Finance & Policy Analysis
Department of Human Services

Eric Moore, Budget Analyst
Budget and Management
Department of Administrative Services

Kevin Hamler-Dupras, Ph.D.,
Forecast Analyst
Children, Adults and Families Division
Forecasting, Research & Analysis
Department of Human Services

DMAP Steering Committee Members

John Britton, Budget Analyst
Legislative Fiscal Office
Oregon State Legislature

Eric Moore, Budget Analyst
Budget and Management
Department of Administrative Services

Jim Edge, Assistant Administrator
Division of Medical Assistance Programs
Department of Human Services

Deanna Hartwig, Administrator
Federal Resource & Financial Eligibility
Seniors & People with Disabilities
Department of Human Services

Karen House, Program Manager
CAF Medical Programs
Department of Human Services

Julia Huddleston, Manager
Office of Research & Planning
Seniors & People with Disabilities
Department of Human Services

Tina Kitchin, Medical Director
Seniors & Peoples with Disabilities
Department of Human Services

Judy Mohr-Peterson, Ph.D., Administrator
Forecasting, Research & Analysis
Department of Human Services

Jeanie Phillips, Deputy Administrator
Medical Assistance Programs
Department of Human Services

Lynn Read, Administrator
Medical Assistance Programs
Department of Human Services

Pam Ruddell, Operations Manager
Service Delivery Area 1
Department of Human Services

Roger Staples, Special Projects
Medical Assistance Programs
Department of Human Services

John Swanson, Deputy Assistant Director
Finance & Policy Analysis
Department of Human Services

Susan Violette, Fiscal Analyst
Finance & Policy Analysis, HS Budget
Department of Human Services

Michele Wallace, Program Manager
Field Services
Central Processing Branch
Department of Human Services

Nathan Warren, Fiscal Analyst
Finance & Policy Analysis, HS Budget
Department of Human Services

Dawn Werlinger, Administrator
Finance & Policy Analysis, HS Budget
Department of Human Services

Stephen Willhite, Ph.D.,
Forecast Analyst
Medical Assistance Programs
Forecasting, Research & Analysis
Department of Human Services

SPD Steering Committee Members

John Britton, Budget Analyst
Legislative Fiscal Office
Oregon State Legislature

Cathy Cooper, Deputy Asst. Director
Seniors & People with Disabilities
Department of Human Services

Marylee Fay, Administrator
Seniors & People with Disabilities
Department of Human Services

Cindy Hannum, Administrator
Licensing & Quality of Care
Seniors & People with Disabilities
Department of Human Services

Deanna Hartwig, Administrator
Federal Resource & Financial Eligibility
Seniors & People with Disabilities
Department of Human Services

Julia Huddleston, Manager
Office of Research & Planning
Seniors & People with Disabilities
Department of Human Services

Blake Johnson, Budget Analyst
Budget & Management Division
Department of Administrative Services

Susan Violette, Fiscal Analyst
Finance & Policy Analysis, DMAP Budget
Department of Human Services

Patricia Johnson, Fiscal Analyst
Finance & Policy Analysis, SPD Budget
Department of Human Services

Shelley Jones, Budget Administrator
Finance & Policy Analysis, SPD Budget
Department of Human Services

Debra McDermott, Manager
SPD Field Services
Department of Human Services

Judy Mohr-Peterson, Ph.D., Administrator
Forecasting, Research & Analysis
Department of Human Services

Chris Pascual, Fiscal Analyst
Seniors & People with Disabilities
Department of Human Services

John Swanson, Deputy Assistant Director
Finance and Policy Analysis
Department of Human Services

James Toews, Assistant Director
Seniors & People with Disabilities
Department of Human Services

Kush Shrestha, Ph.D.,
Forecast Analyst
Seniors and People with Disabilities Division
Forecasting, Research & Analysis
Department of Human Services

AMH Steering Committee

Madeline Olson, Deputy Asst. Director
Addictions & Mental Health
Department of Human Services

Mike Moore, Adult Coordinator
Addictions & Mental Health
Department of Human Services

Jon Collins, Ph.D.,
Manager of PAE
Addictions & Mental Health
Department of Human Services

Judy Mohr-Peterson, Ph.D., Administrator
Forecasting, Research & Analysis
Department of Human Services

Patrick McIntire, Ph.D.,
Forecast Analyst
Addictions and Mental Health
Forecasting, Research & Analysis
Department of Human Services

John Britton, Budget Analyst
Legislative Fiscal Office
Oregon State Legislature

Eric Moore, Budget Analyst
Budget and Management
Department of Administrative Services

DAS Forecast Review Team

Linda Ames, Deputy Administrator
Budget & Management Division
Department of Administrative Services

Steve Bender, Principal Legislative Analyst
Legislative Fiscal Office
Oregon State Legislature

Tom Potiowsky, Ph.D.
Oregon State Economist
Office of Economic Analysis
Department of Administrative Services

Kanhaiya Vaidya, Ph.D.
State Demographer
Office of Economic Analysis
Department of Administrative Services

Community Provider Advisory Group

Steve Allanketner
Options Counseling Services

Karl Brimner
Multnomah Co. MH & Addictions Serv.

Rhonda Busek
Lane Individual Practice Assoc.

Jim Carlson
Oregon Health Care Association

Barry Donenfeld
NW Senior & Disability Services

Kim Freeman
Mount Hood Comm. College

Craig Hostetler
Oregon Primary Care Assoc.

Judy Mohr-Peterson
Department of Human Services

Bill Murray
Doctors of the Oregon Coast

Bill Norris
Oregon Primary Care Assoc.

Claire Tranchese
Office of Rural Health

Forecast Peer Review Group

Art Ayre, Ph.D., Employment Economist
Oregon Employment Department

John Britton, Budget Analyst
Legislative Fiscal Office
Oregon State Legislature

Stephanie Brunell, Ph.D., Associate Prof.
School of Public Health
Oregon State University

Gwen Grams, Ph.D.,
Johnson, Bassin and Shaw
Silver Spring, Maryland

Laura Leete, Ph.D., Professor
Public Policy Research Center
Willamette University

Thomas Potiowsky, Ph.D.,
Oregon State Economist
Office of Economic Analysis
Department of Administrative Services

John Taponga, Research Economist
EcoNorthwest

Kanhaiya Vaidya,
State Demographer
Department of Administrative Services

Staff Participants

Judy Mohr-Peterson, Ph.D., Administrator
Forecasting, Research & Analysis
Department of Human Services

Kevin Hamler-Dupras, Ph.D.,
Forecast Analyst
Children, Adults and Families Division
Forecasting, Research & Analysis
Department of Human Services

Patrick McIntire, Ph.D.,
Forecast Analyst
Addictions and Mental Health
Forecasting, Research & Analysis
Department of Human Services

Kush Shrestha, Ph.D.,
Forecast Analyst
Seniors and People with Disabilities Division
Forecasting, Research & Analysis
Department of Human Services

Stephen Willhite, Ph.D.,
Forecast Analyst
Medical Assistance Programs
Forecasting, Research & Analysis
Department of Human Services

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

www.dhs.state.or.us

Oregon Department of Human Services
Finance and Policy Analysis
Forecasting, Research & Analysis