DEPARTMENT OF HUMAN SERVICES

SPRING 2007 FORECAST

FINANCE & POLICY ANALYSIS
FORECASTING, RESEARCH & ANALYSIS
MAY 2007

Executive Summary

DHS produces semi-annual forecasts of its caseload each spring and fall. The Spring 2007 forecast predict continued moderate growth for most programs through the next biennium, 2007-09. With few exceptions, such as Child Welfare and Medical Assistance Programs, this closely aligns with the estimates from the Fall 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 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 as the trend of fewer employers providing health coverage continues. 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 push DHS caseloads upward.

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/Oregon Health Plan. 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 Temporary Assistance for Needy Families and Food Stamps exhibit minimal growth, reflecting an economy that is growing, albeit more slowly than in recent years.

Child Welfare caseloads, which had exhibited strong growth during the two years preceding July 2005, have since leveled off, and have even slipped downward since July 2006. Child In-Home has been falling since 2004. Foster Care, which had been offsetting the losses in Child In-Home, began leveling off after July 2005 and fell after July 2006. Adoption Assistance, on the other hand, continues to maintain a strong upward trend. Since there is considerable uncertainty regarding the factors that might be driving the trends in Foster Care and Child In-Home, the forecasts for these caseloads assume modest growth but have a wide risk band.

Vocational Rehabilitation caseload fell steadily during 2006. The implementation of a 180-day standard for plan development in October 2006 caused an additional decline, which could continue during the first part of 2007 as older cases are resolved and closed out. The forecast assumes a leveling out, but with the recognition that this caseload could experience major drops due to the closing out of old cases.

Medical Assistance Programs: Medical Assistance programs consist of three major areas: Oregon Health Plan Plus, Oregon Health Plan Standard and "Other". The total Division of Medical Assistance Program (DMAP) caseload is expected to finish a short-term period of decline and resume a very moderate growth pattern. Most individual programs, with a few exceptions, are expected to grow moderately.

Temporary Assistance for Needy Families-Medical (TANF-M): Due to the improved economy, as well as several major changes in the TANF medical programs, this population is leveling off, and is expected to either remain stable or slightly decline in upcoming years. However, the instability due to the continued effects of the policy changes compiled with several major federal changes looming, makes these forecasts more risky than usual.

Children's Programs: Oregon children are served in two programs, depending primarily on level of poverty. The Poverty Level Medical Children's benefit group serves the most impoverished children. This group displayed a substantial decline between 2002 and 2005, but has been relatively stable or in a slow decline since that time. Expectations for this group to continue a very slow decline over the next biennium primarily related to the changes of the Children's Health Insurance Programs (CHIP). The CHIP program serves children up to 185% of the Federal Poverty Level, of poverty and has grown aggressively since summer of 2004. A change, as of June 2006, in recertification policy is expected to contribute to even more continuation of aggressive growth over the next biennium.

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 emerged from a brief period of decline likely due to the implementation of the Medicare drug benefit in January 2006. The return to slow growth is expected to continue for the foreseeable future.

OHP Standard: Due to the closure of OHP Standard programs to new clients in summer of 2004, the overall caseload has dropped substantially to a relatively stable level. The caseload has experienced recent increases, however, resulting from other program transfers. The primary contributor to these minor increases is client transfers from the TANF benefit group as economic conditions improve.

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

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

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

Seniors & Physically Disabled – **Long-Term Care (LTC)**: The Long-Term care forecast is divided into In-Home, Community-Based Care Facilities and Nursing Facilities. The overall Long-Term Care caseload forecast is slightly lower than the Fall 2006 forecast mainly due to caseload declines or slower growth in In-Home and Community-Based Care.

In-Home service caseload for the past three years has been relatively flat or slightly decreasing after severe budgetary cutbacks that occurred in 2003. This caseload is anticipated to experience continued decline due to ongoing client eligibility reviews and the implementation of Medicare Modernization Act. However, in the later part of the biennium, it is expected to stabilize and see slight growth in the caseload.

Community-Based Care Facilities caseload also experienced declines after 2003, followed by a period of little or modest growth, which will continue through 2009. The stagnant growth in community-based care caseload is, in part, due to Medicaid and private LTC market forces.

Nursing Facilities caseload has steadily declined for several years. In this forecast period, it is expected to slow down the rate of decline and stabilize the caseload. The combined effect of aging population and the changes in the LTC market dynamics in community-based care settings may see a rebound in nursing facilities caseload growth.

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

Total DHS Caseload Biennial Average Comparison by Forecasts

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast		
Comparison:	**Fall 2006 to Spring 2007**			**Fall 2006 to Spring 2007**			**2005 - 07 to 2007 - 09**		
Biennial Averages by Forecast	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*%Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*%Diff. Fall 06 to Spring 07 2007-09*	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*%Diff. Spring 07 2005-07 to 2007-09*
Children, Adults and Families (CAF)									
Self-Sufficiency									
Food Stamps (Households)	221,693	220,867	-0.4%	231,165	226,123	-2.2%	220,867	226,123	2.4%
Temporary Assistance for Needy Families (Families: Cash Assistance)	18,275	17,946	-1.8%	18,533	17,572	-5.2%	17,946	17,572	-2.1%
Employment Related Daycare (Families)	9,583	9,396	-2.0%	9,738	9,251	-5.0%	9,396	9,251	-1.5%
Child Welfare (Children Served)									
Child In Home	3,928	3,580	-8.9%	3,892	3,237	-16.8%	3,580	3,237	-9.6%
Foster Care	10,479	10,076	-3.8%	11,639	10,213	-12.3%	10,076	10,213	1.4%
Adoption Assistance	9,575	9,512	-0.7%	11,020	10,705	-2.9%	9,512	10,705	12.5%
Vocational Rehabilitation (Clients Served)	9,445	9,323	-1.3%	9,369	8,991	-4.0%	9,323	8,991	-3.6%
Medical Assistance Programs									
OHP Plus: Temporary Assistance to Needy Families (Medical)	134,709	128,330	-4.7%	128,407	115,045	-10.4%	128,330	115,045	-10.4%
OHP Plus: Children (PLMC & CHIP)	114,717	114,434	-0.2%	128,315	127,632	-0.5%	114,434	127,632	11.5%
OHP Plus: Seniors and People with Disabilities	92,034	91,713	-0.3%	94,799	94,489	-0.3%	91,713	94,489	3.0%
OHP Plus: Poverty Level Medical Women	10,305	10,270	-0.3%	11,833	10,987	-7.1%	10,270	10,987	7.0%
OHP Plus: Foster/Substitute Care	18,050	17,811	-1.3%	18,918	19,054	0.7%	17,811	19,054	7.0%
OHP Plus Total	**369,815**	**362,558**	**-2.0%**	**382,272**	**367,207**	**-3.9%**	**362,558**	**367,207**	**1.3%**
Other Medical Assistance Programs	30,226	30,039	-0.6%	30,387	29,771	-2.0%	30,039	29,771	-0.9%
Seniors and People with Disabilities - Long Term Care									
In Home	11,626	11,401	-1.9%	11,564	11,256	-2.7%	11,401	11,256	-1.3%
Community Based Care	10,919	10,848	-0.7%	11,071	10,939	-1.2%	10,848	10,939	0.8%
Nursing Facilities	4,907	4,939	0.7%	4,825	4,861	0.7%	4,939	4,861	-1.6%

More detailed descriptions of the caseloads, forecasts and risks to the forecast can be found in the Fall 2006 report.

Table of contents

About the Forecast

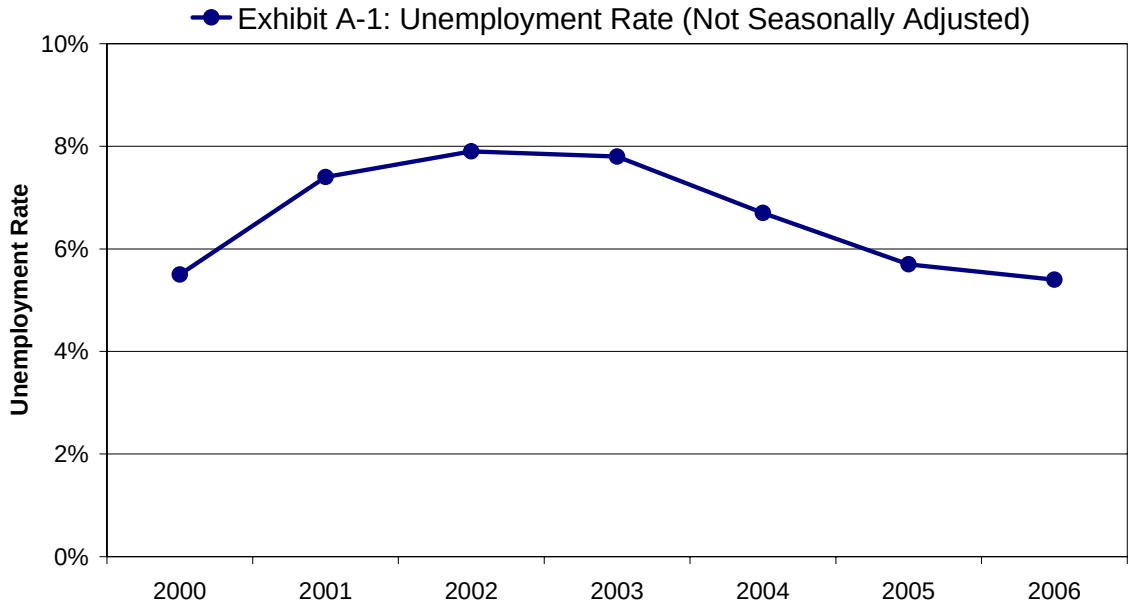
The Department of Human Services (DHS) provides a broad array of programs to thousands of Oregonians on a daily basis. Benefits and services are provided to children and families, seniors, people with developmental and/or physical disabilities, people with mental illness, people with substance abuse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

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

Key Economic Factors

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

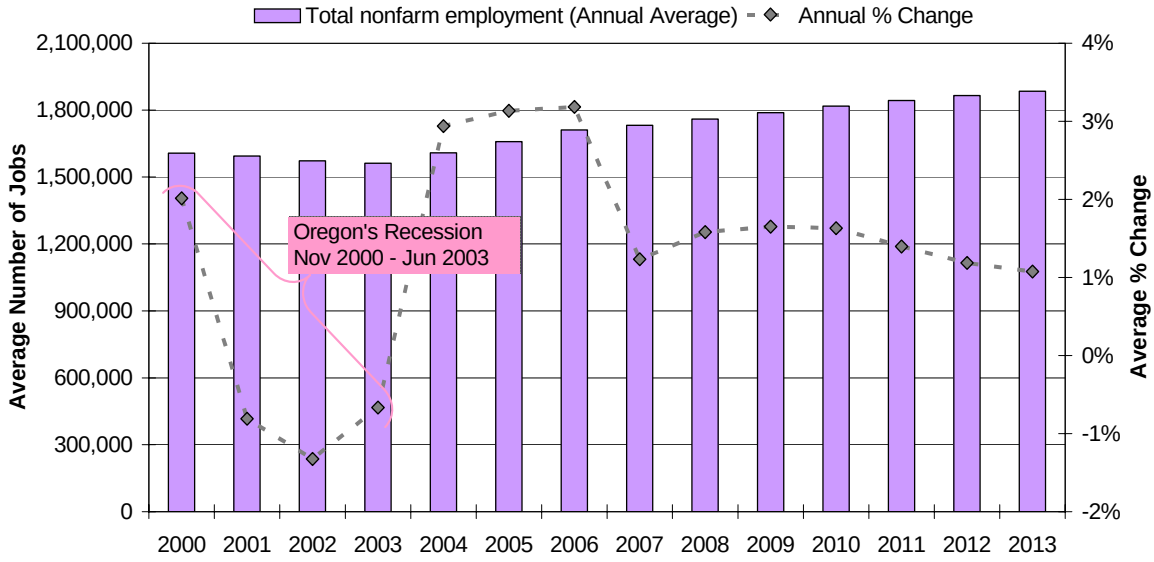
In researching the national and state trends, it is predicted that Oregon's economy will experience slight to moderate growth after having experienced relatively rapid growth in the three years since the recession.



Source: Oregon's Employment Department

After the recent recessionary period, job growth increased while the unemployment rate decreased. However, job growth is expected to slow down as evidenced by the anticipated average percentage change for 2007 (See Exhibit A-2).

Exhibit A-2: Average Number of Jobs and Annual % Change

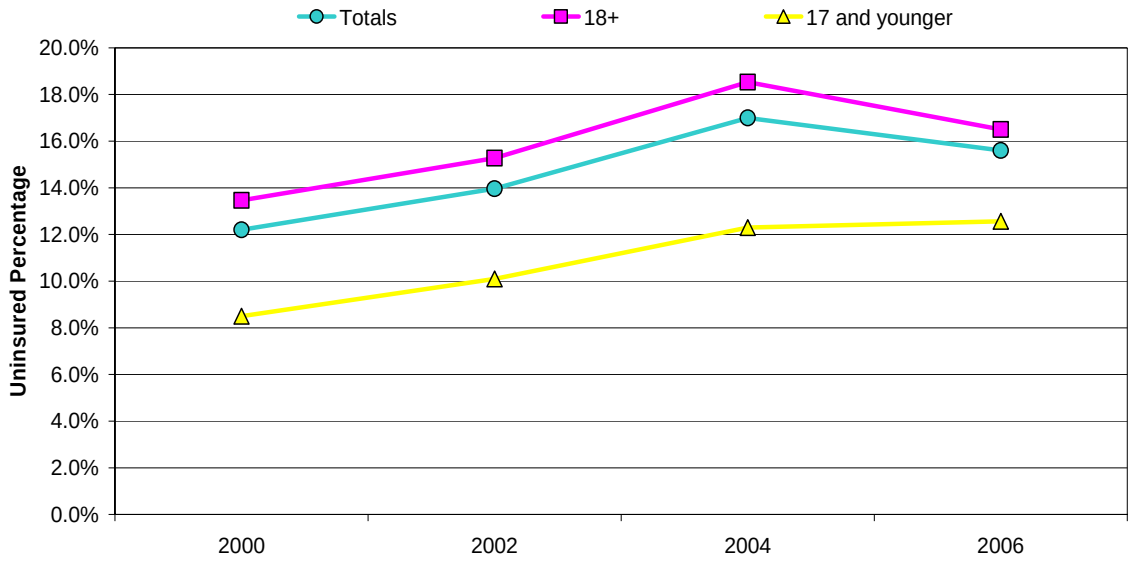


Source: Oregon's Office of Economic Analysis and Oregon's Employment Department

Health Care Factors

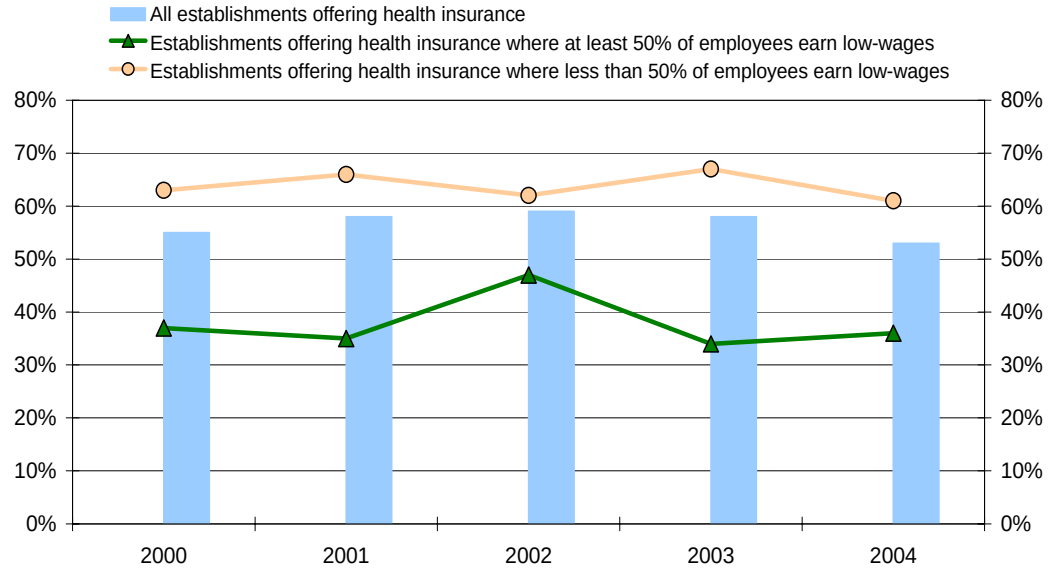
Not having health insurance prohibits individuals from seeking basic care from doctors, as well as limits their access to medicine, eyeglasses, and other services; services that are often taken for granted by people who have health insurance. Those who lack health care coverage are at higher risk of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

Exhibit A-3: Percentage of Uninsured Oregonians by Age Group, 2000-2006



The percentage of establishments offering health insurance seems to differ given whether the majority of employees earn low-wages. It seems fewer establishments where the majority of employees earn low-wages offer health insurance to their employees. (See Exhibit A-4). There has been an overall decline in the total percentage of establishments offering health care coverage since 2000.

Exhibit A-4: Percent of establishments offering health insurace by proportion of employees who earn low-wages



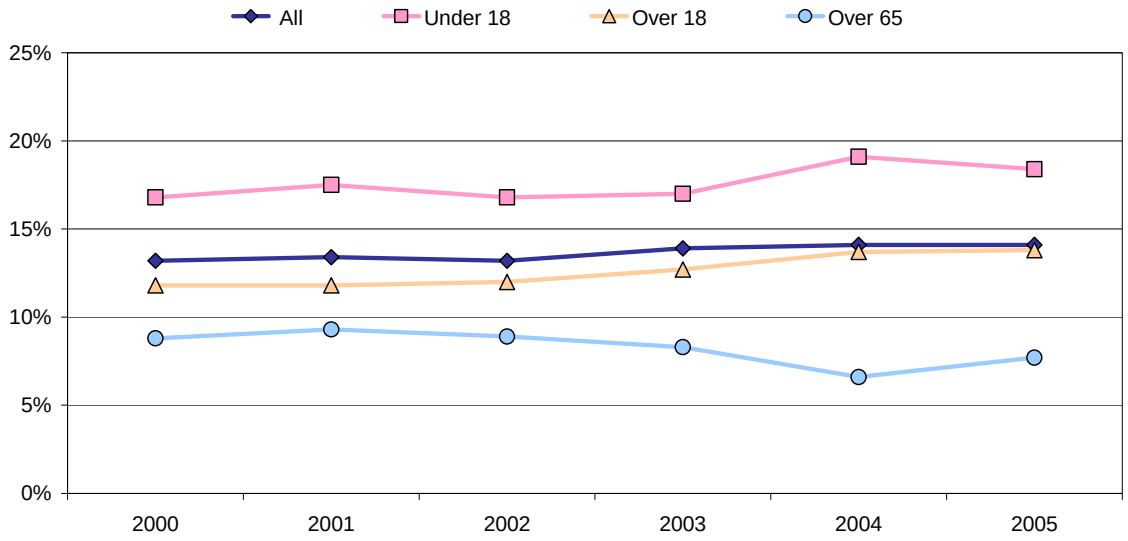
Source: United States Department of Health and Human Services: Agency for Healthcare, Research, and Quality: Medical Expenditure Panel Survey

Poverty

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

Oregonians under the age of 18 are at higher risk of living in poverty than are older Oregonians.

Exhibit A-5: Percentage of People Living in Poverty by Age Group



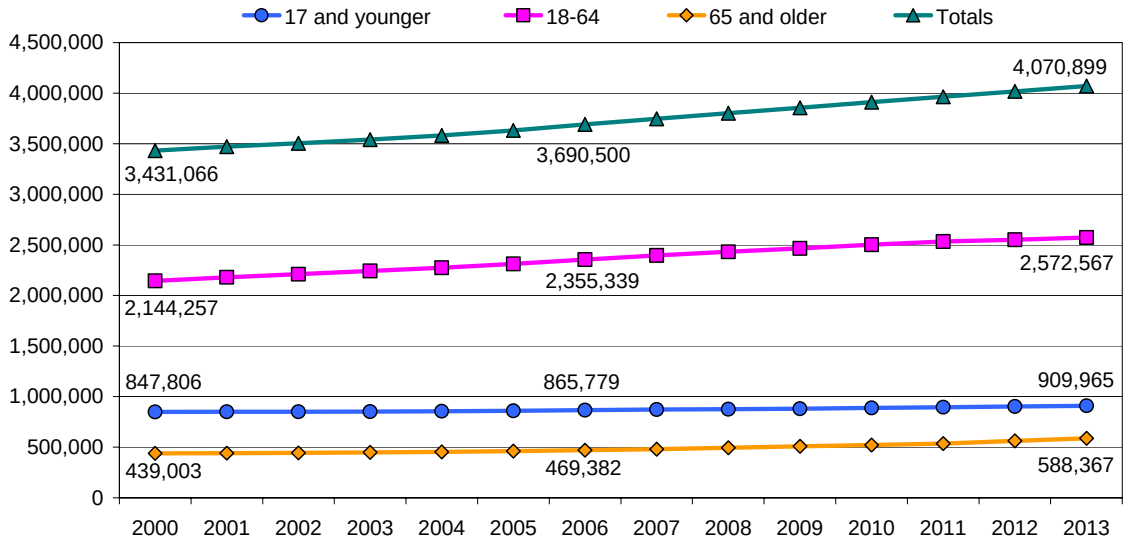
Source: U.S. Census Bureau: American Community Survey

Age Demographics

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

As of July of 2006, 23% of all Oregonians were children. Less than 13% of the total populations were individuals 65 and older. However, from 2007 through 2013, the population growth rates will be highest for seniors, 23% compared to 7% for those, ages 18-64, and 5% among children.

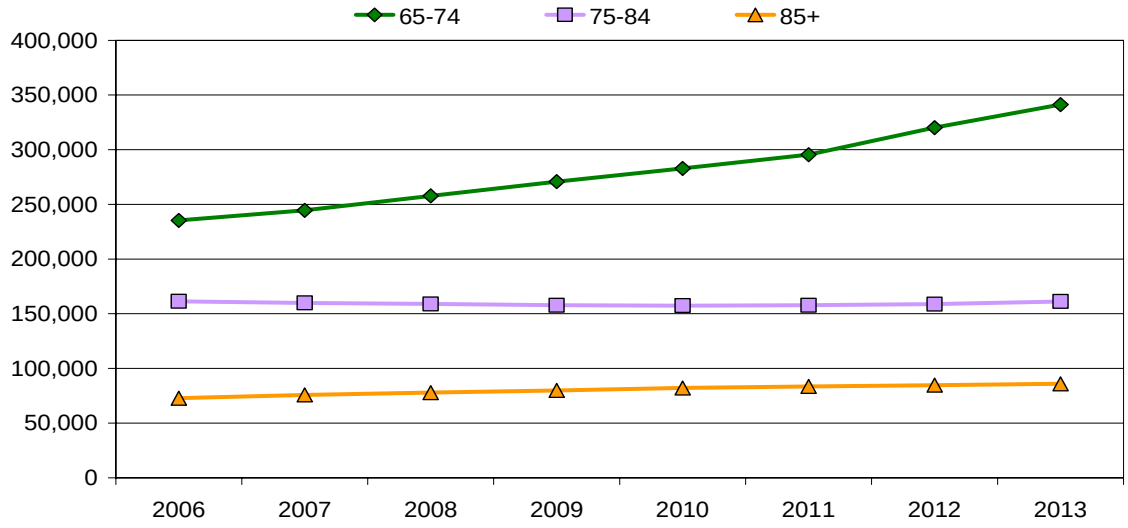
Exhibit A-6: Population by Age Group



Source: Oregon Department of Administrative Services, Office of Economic Analysis: Data Projection March 1, 2007

By 2030, it is anticipated that around 1 in 5 Oregonians will be 65 or older. From 2006 through 2013, the 65-74 year old population segment is projected to increase 45%. The 85 and older population segment is projected to increase 18% from 2006-2013, though there is a projected decline in the 75-84 year old population segment of .1%. The overall projected increase in Oregonians older than 65 is 25%, this is an outpace of the growth expected for Oregonians younger than 18 and among Oregonians 18-64.

Exhibit A-7: Forecasted Population for Oregonians Older than 65



Source: Oregon Department of Administrative Services, Office of Economic Analysis: Data Projection March 1, 2007

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 spring 2007 forecast appear in Exhibit B-1. Further details regarding each group will be detailed in each section.

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

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

Self-Sufficiency

The forecasts for Self-Sufficiency programs include 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. Since the most recent actual caseloads have fallen below the previous forecast, the current forecast has been adjusted downward accordingly.

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

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast		
Comparison:	Fall 2006 to Spring 2007			Fall 2006 to Spring 2007			2005 - 07 to 2007 - 09		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*%Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*%Diff. Fall 06 to Spring 07 2007-09*	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*%Diff. Spring 07 2005-07 to 2007-09*
SELF-SUFFICIENCY									
Food Stamps (Households)									
Children, Adults and Families	156,944	156,669	-0.2%	159,743	158,529	-0.8%	156,669	158,529	1.2%
Seniors and People with Disabilities	64,749	64,198	-0.9%	71,422	67,594	-5.4%	64,198	67,594	5.3%
Total Food Stamps	**221,693**	**220,867**	**-0.4%**	**231,165**	**226,123**	**-2.2%**	**220,867**	**226,123**	**2.4%**
Temporary Assistance for Needy Families (Families: Cash/Grants)									
Basic	17,296	17,046	-1.4%	17,425	16,752	-3.9%	17,046	16,752	-1.7%
UN	979	900	-8.1%	1,108	820	-26.0%	900	820	-8.9%
Total TANF	**18,275**	**17,946**	**-1.8%**	**18,533**	**17,572**	**-5.2%**	**17,946**	**17,572**	**-2.1%**
Employment Related Daycare (Families)	**9,583**	**9,396**	**-2.0%**	**9,738**	**9,251**	**-5.0%**	**9,396**	**9,251**	**-1.5%**
Temp. Assist. for Dom. Violence Survivors (Families)	**540**	**520**	**-3.7%**	**549**	**504**	**-8.2%**	**520**	**504**	**-3.1%**

Food Stamps

There are approximately a quarter of a million households that receive Food Stamps in Oregon, which translates to over 400,000 individuals who receive benefits through this program. The Food Stamp program supplements food budgets for low-income families and individuals, people receiving public assistance, and individuals enrolled with Seniors and People with Disabilities Division's (SPD) programs. Households entering the program through Children,

Adults and Families Division (CAF) are classified as CAF households, while those entering the program through Seniors and People with Disabilities Division are classified as SPD households. Both groups of recipients underwent relatively rapid growth from 2001 through 2004 (Exhibit B-3). However, in the past couple of years to the present, the CAF Food Stamp population has been leveling off, while the SPD program has grown slowly but steadily.

Forecast

Recently, the CAF Food Stamp caseload has not grown at the predicted pace of the Fall 2006 forecast. Most of the decrease occurred in July 2006, which was right after the announcement that proof of citizenship would be required for Medicaid eligibility; the announcement may have discouraged people from coming in for food stamps, although there could be other reasons for the decline. Accordingly, the Spring 2007 forecast 2007-09 biennial average for households of 158,529 is around one percent lower than the Fall 2006 forecast (Exhibit B-2). The Spring 2007 average caseload in households for 2005-07 is 156,669, which differs very little from the Fall 2006 forecast. The SPD Food Stamp population has also fallen below its growth trend since the Fall 2006 forecast. At 67,594 for 2007-09, it falls about 5 percent below the Fall 2006 forecast; for 2005-07, it averages 64,198, which is one percent below the Fall 2006 forecast. Overall, the total Food Stamp caseload of nearly 226,123 households predicted by the Spring 2007 forecast is around 2 percent below that for the Fall 2006 forecast for 2007-09, while the 220,867 for 2005-07 is just slightly below (less than one percent) that for the Fall 2006 forecast (Exhibit B-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 10 percent above or below the average forecast for the 2007-09 biennium.

Temporary Assistance for Needy Families

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

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

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

Forecast

The TANF caseload experienced moderate growth during 2001 through the first part of 2005, accompanied by seasonal fluctuations (Exhibit B-6). However, since that time, with seasonal variation continuing, the caseload has been declining slightly. An automated procedure to close overdue TANF cases was implemented around July 2006, and the sharp decline in caseload that month is most likely associated with a one-time clean-up of cases through the auto close procedure. As shown in Exhibit B-2, the Spring 2007 forecast predicts an average 17,572 families for the 2007-09 biennium, which is 5 percent lower than the corresponding forecast for Fall 2006. The Spring 2007 forecast for TANF UN is 820 families for the 2007-09 biennium, which is 26 percent lower than the Fall 2006 forecast. Although the difference is large percentage-wise, the UN caseload is small and accounts for only 5 percent of the TANF caseload, with TANF Basic averaging 16,752 families for the 2007-09 biennium. For the 2005-07 biennium, the Spring 2007 forecast of 17,946 families for total TANF is 2 percent lower than the Fall 2006 forecast.

Risks and Assumptions

The Spring 2007 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 (TANF Reauthorization), which was passed in 2005 and signed into law February 2006, poses a significant risk to the forecast. Although policy makers have identified many elements of the redesigned program, it is too soon to estimate the exact impact with any reasonable accuracy.

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 13 percent higher or lower than the forecast for the 2007-09 biennium even without any impacts from changes in policies (Exhibit B-6).

Employment Related Daycare

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

Forecast

As shown in Exhibit B-2, the Spring 2007 forecast of 9,251 ERDC families for the 2007-09 biennium is 5 percent below the Fall 2006 estimate. This caseload fell for much of 2006, and after a slight recovery, flattened out for the remainder of the year. The Spring 2007 forecast reflects this lower level and subdued seasonality. For the 2005-07 biennium, the Spring 2007 forecast of 9,396 families is 2 percent lower than the Fall 2006 forecast.

The flattening of the ERDC caseload around July 2006 may be due in part to the implementation of an administrative rule in April 2006 requiring children to meet the citizenship or alien status requirements of OAR 461-120-0110. Besides making certain children ineligible, this may have also had a chilling effect on parents or caretakers who do not meet the citizenship requirements but do not understand that the requirement only pertains to the child or fear of deportation if they come in. This may have been exacerbated by the regulation that went into effect July 1, 2006 requiring proof of citizenship for certain Medicaid programs.

Risks and Assumptions

The ERDC caseload has exhibited some extra volatility recently, which poses a risk to the forecast. For the 2007-09 biennium, the average actual caseload could fall above or below the forecast by about 6 percent (Exhibit B-9). Issues related to TANF such as TANF reauthorization and the economy present additional significant risks beyond the historical variability.

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 504 cases for the 2007-09 biennium, the Spring 2007 forecast for this relatively small program falls 8 percent below the forecast from Fall 2006. For 2005-07, the Spring 2007 forecast of 520 cases is around 4 percent lower than the Fall 2006 forecast.

The Spring 2007 forecast reflects the fact that actual caseloads since the Fall 2006 forecast have fallen short of that 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 become homeless, and 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 actual caseloads have fallen below the Fall 2006 forecast, the historical seasonal pattern has remained relatively intact. The Spring 2007 forecast assumes a continuation this pattern.

Given the extreme variability of this caseload, it is difficult to anticipate any change in the overall trend. Based on these historical fluctuations, the actual average for the 2007-09 biennium could deviate as much as 53 percent above or below the forecast (Exhibit B-10).

Exhibit B-3: Total Food Stamps

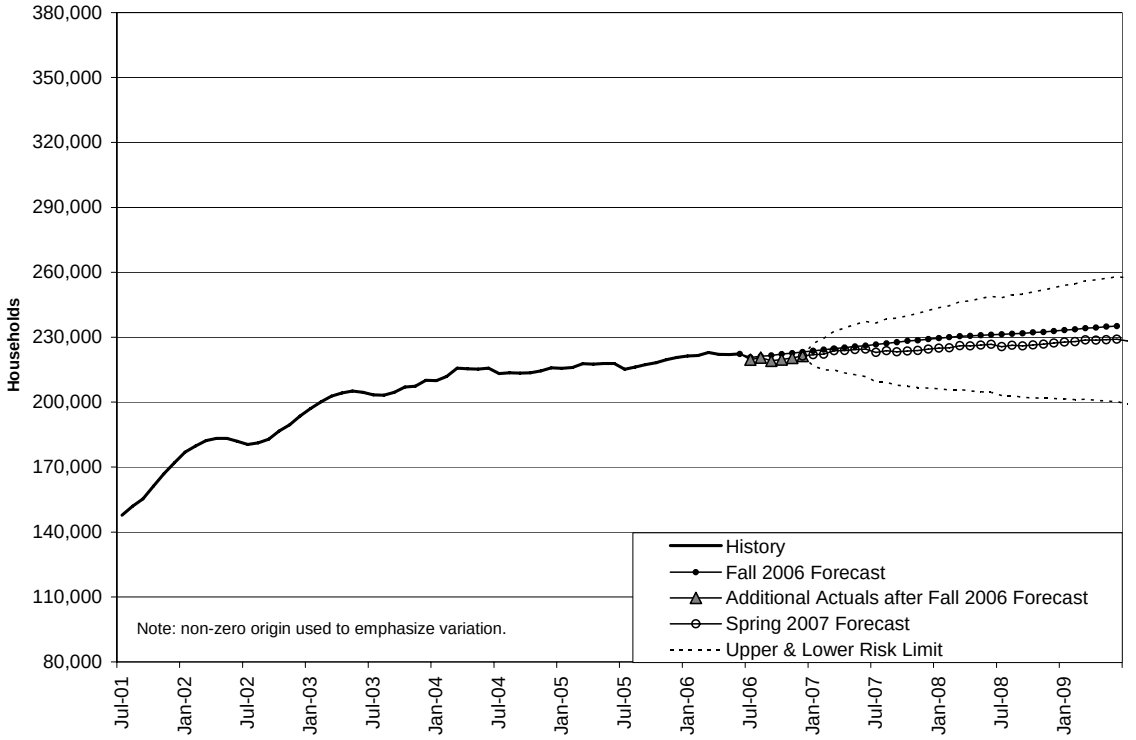


Exhibit B-4: Children, Adults and Families Food Stamps

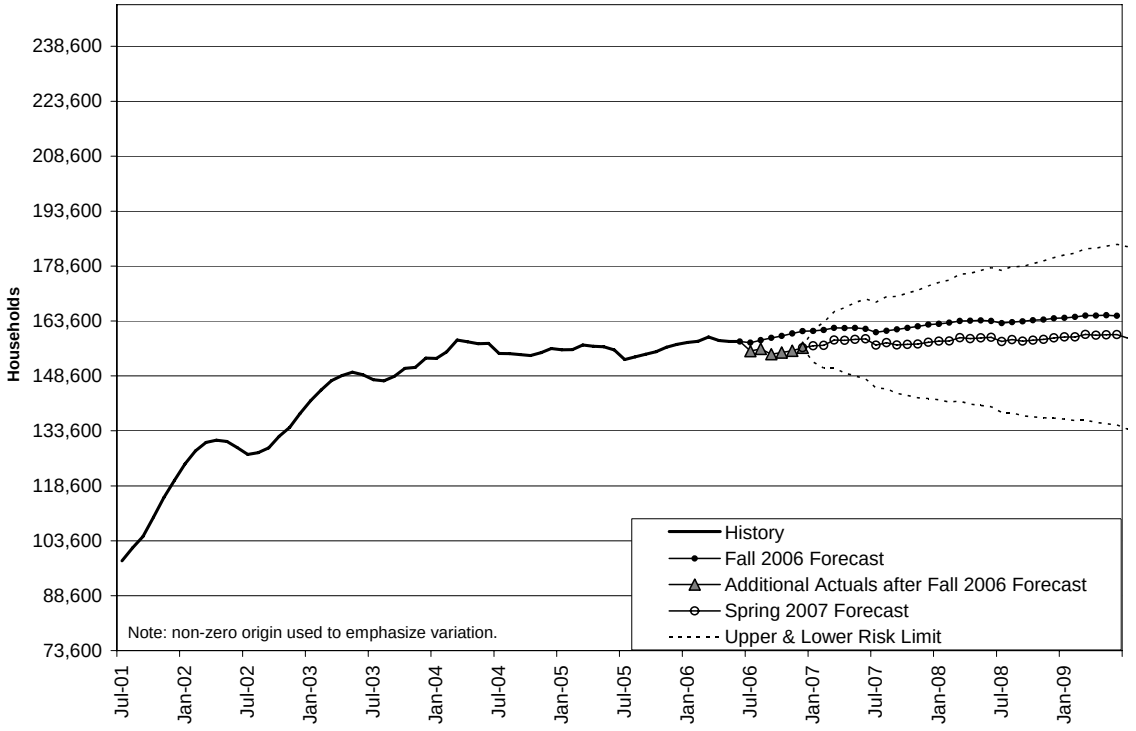


Exhibit B-5: Seniors & People with Disabilities Food Stamps

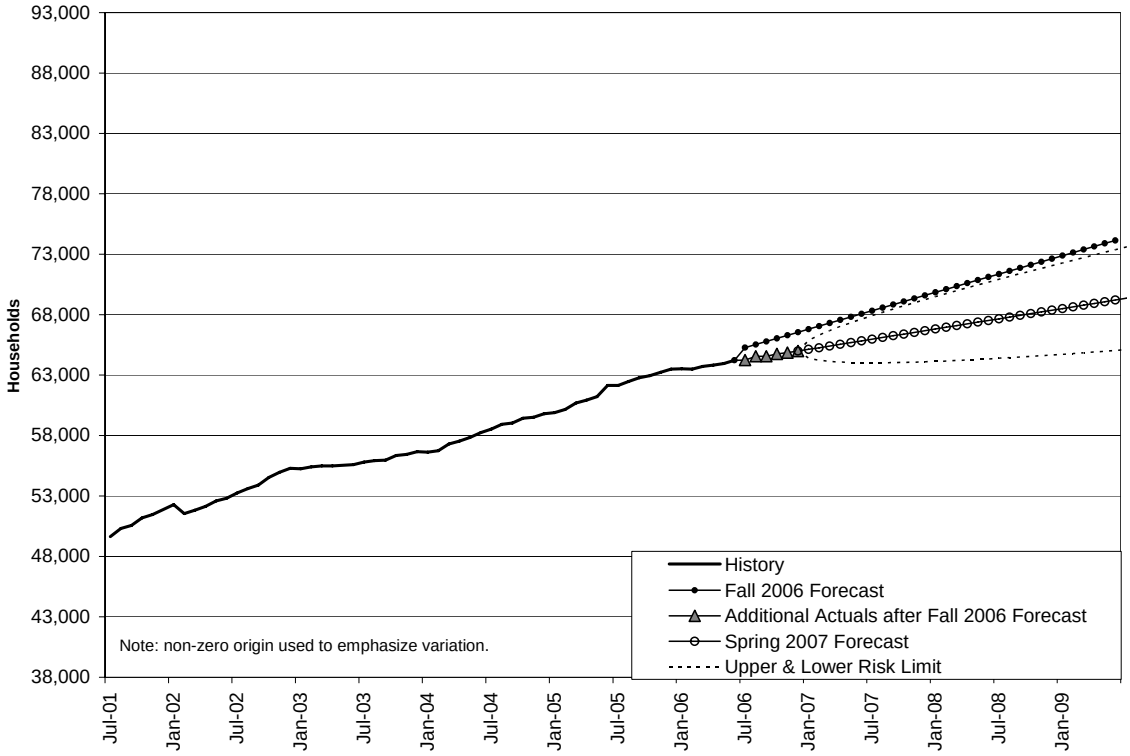


Exhibit B-6: Total Temporary Assistance for Needy Families

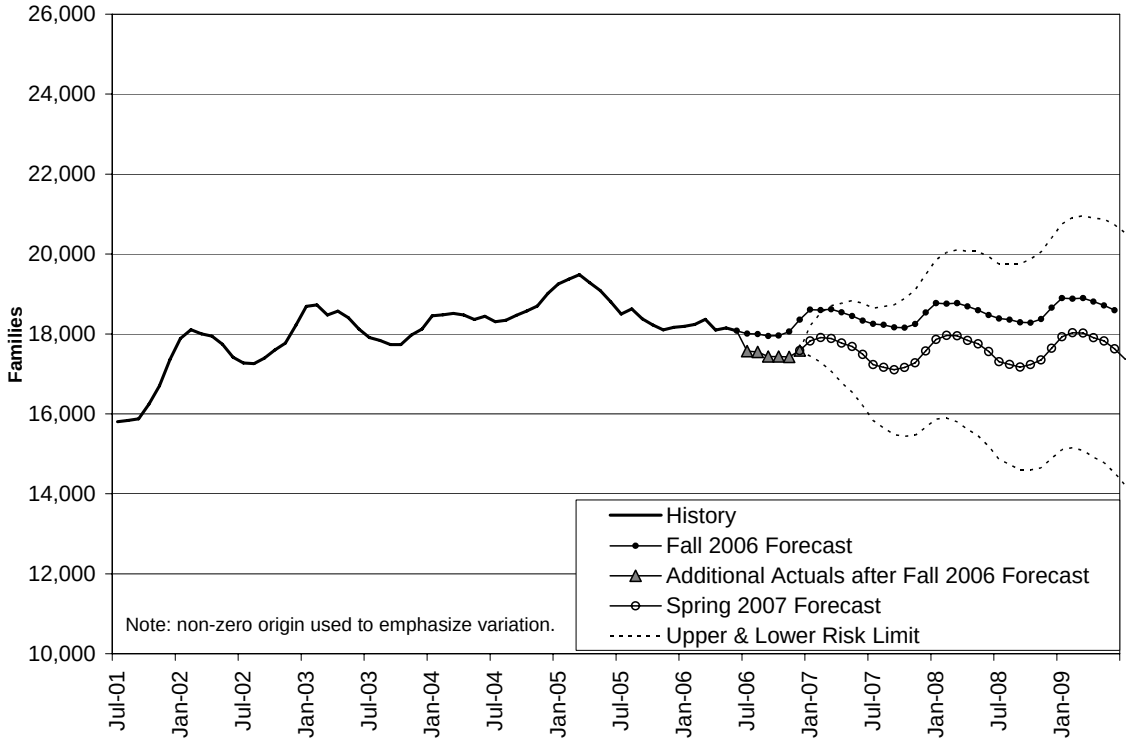


Exhibit B-7: Temporary Assistance for Needy Families - Basic

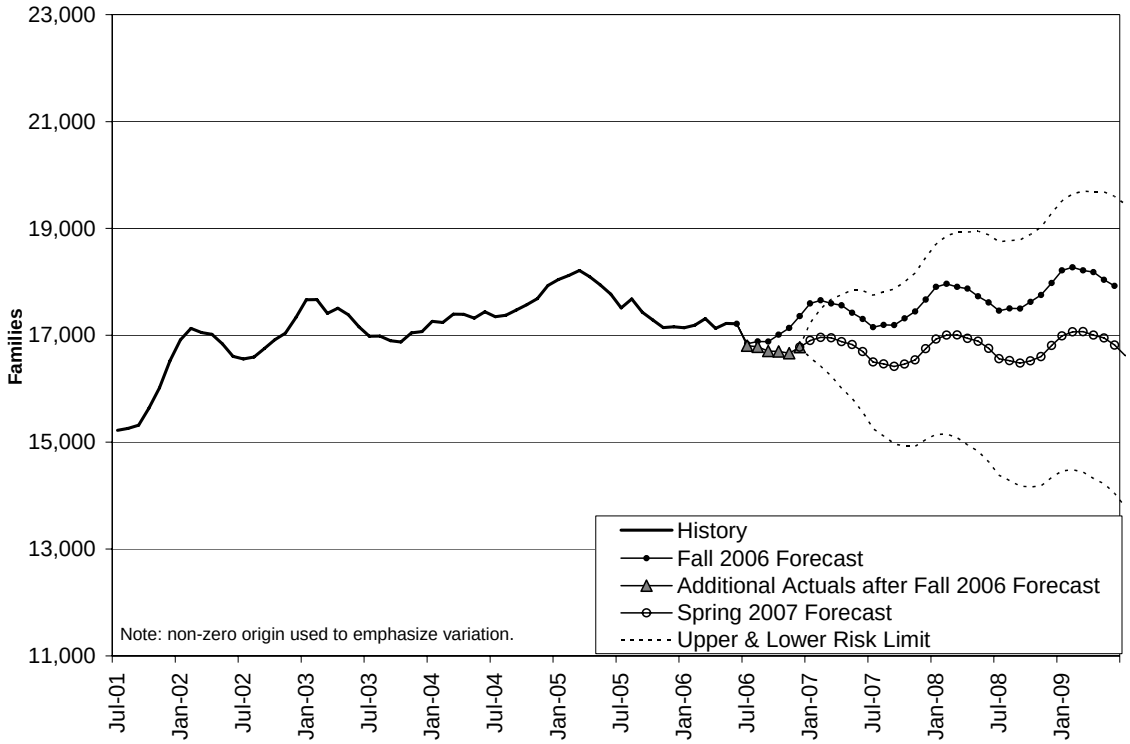


Exhibit B-8: Temporary Assistance for Needy Families - UN

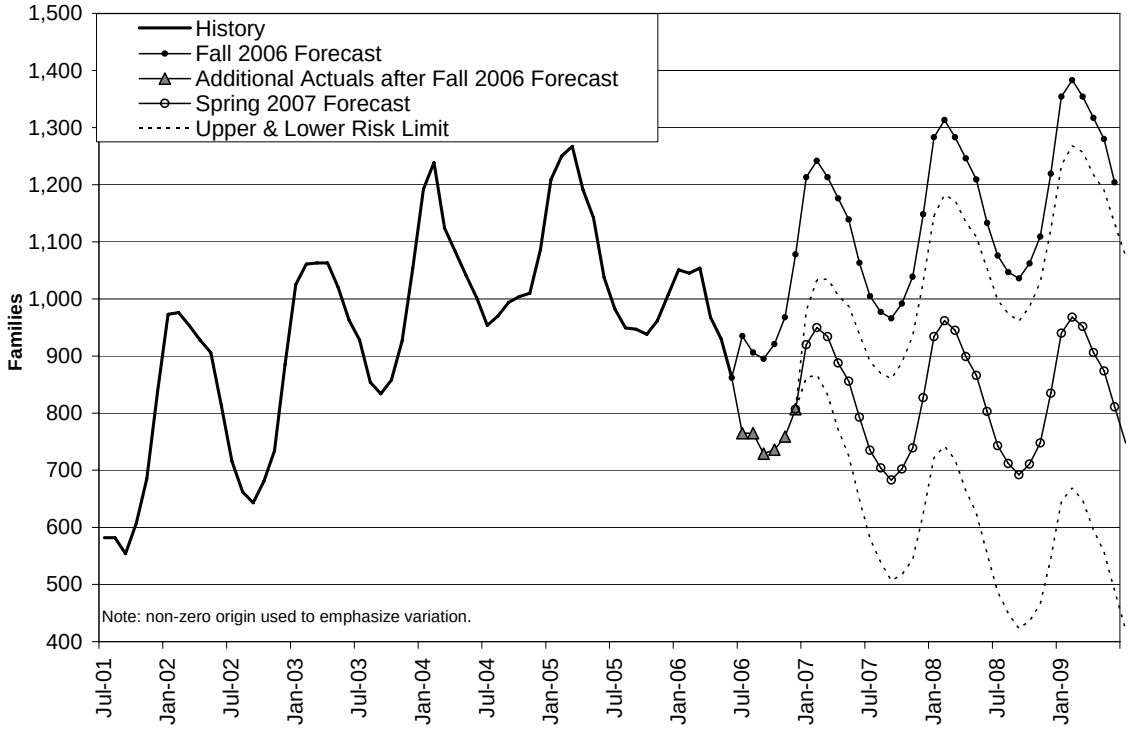


Exhibit B-9: Employment Related Daycare

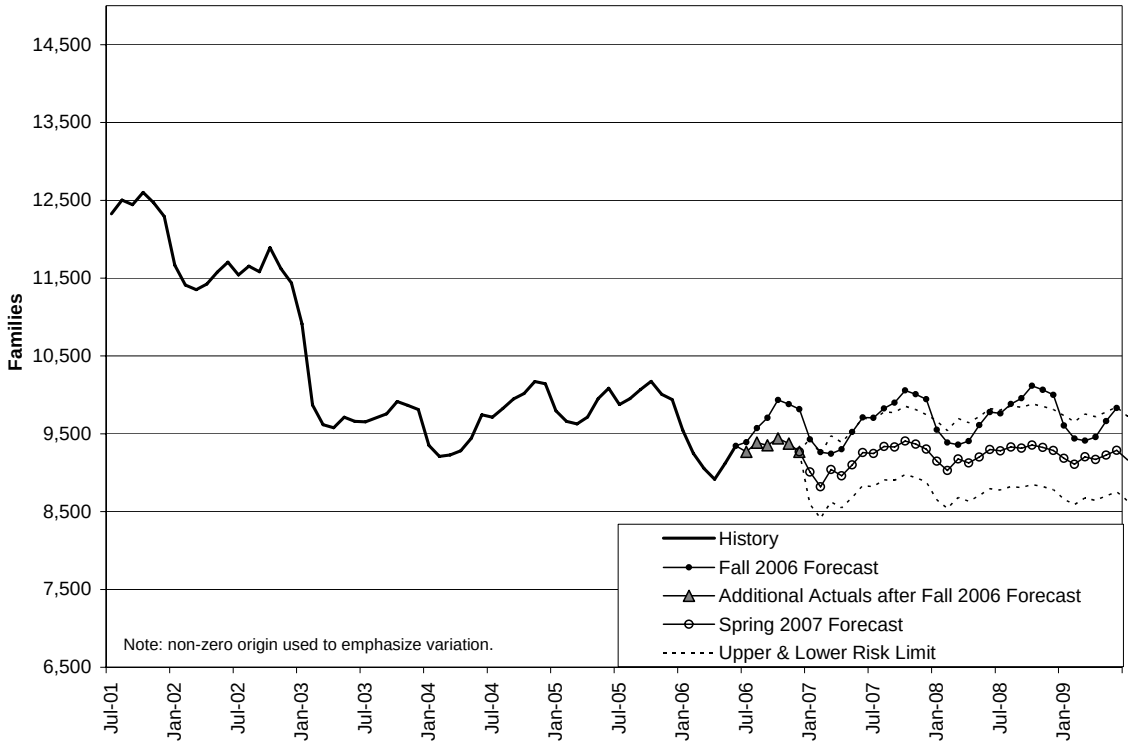
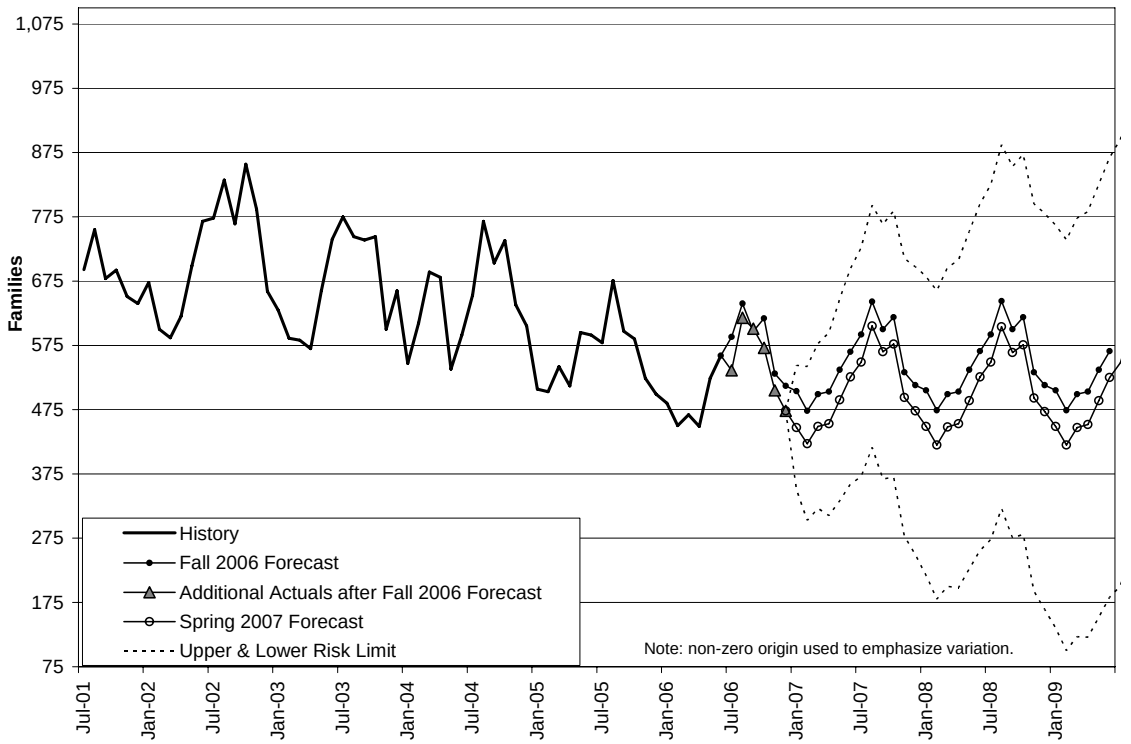


Exhibit B-10: Temporary Assistance for Domestic Violence Survivors



Child Welfare

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

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

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

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

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

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

Forecast

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

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

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

forecast takes a conservative approach by assuming that the Foster Care and Child In-Home caseloads will grow at the same rate that founded referrals have grown since 2003, which is 0.15 percent per month. The result is a Spring 2007 forecast of 24,924 children on the Child Welfare caseload for the 2007-09 biennium, which is 9 percent lower than the Fall 2006 forecast. The Spring 2007 forecast for the 2005-07 biennium is 23,751, which falls roughly 3 percent below the Fall 2006 forecast (Exhibit B-2). Given the high level of risk associated with this forecast, the average for the 2007-09 biennium could easily end up being off by as much as 7 percent in either direction.

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

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast		
Comparison:	**Fall 2006 to Spring 2007**			**Fall 2006 to Spring 2007**			**2005 - 07 to 2007 - 09**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*%Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*%Diff. Fall 06 to Spring 07 2007-09*	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*%Diff. Spring 07 2005-07 to 2007-09*
CHILD WELFARE (Children Served)									
Adoption Assistance	9,575	9,512	-0.7%	11,020	10,705	-2.9%	9,512	10,705	12.5%
Subsidized Guardianship	576	583	1.2%	764	769	0.7%	583	769	31.9%
Foster Care	10,479	10,076	-3.8%	11,639	10,213	-12.3%	10,076	10,213	1.4%
Child in Home	3,928	3,580	-8.9%	3,892	3,237	-16.8%	3,580	3,237	-9.6%
Total Child Welfare (Children Served)	**24,558**	**23,751**	**-3.3%**	**27,315**	**24,924**	**-8.8%**	**23,751**	**24,924**	**4.9%**
CHILD WELFARE (Average Daily Population)									
Adoption Assistance	8,986	8,934	-0.6%	10,461	10,240	-2.1%	8,934	10,240	14.6%
Subsidized Guardianship	566	574	1.4%	748	765	2.3%	574	765	33.3%
Regular Paid Foster Care	7,025	6,706	-4.5%	7,734	6,834	-11.6%	6,706	6,834	1.9%
Special Rates Foster Care	3,535	3,367	-4.8%	3,849	3,308	-14.1%	3,367	3,308	-1.8%
Residential Treatment	511	475	-7.0%	564	474	-16.0%	475	474	-0.2%
Residential Treatment - Regular Contract	335	328	-2.1%	343	343	0.0%	328	343	4.6%
Residential Treatment - Special Contract	112	90	-19.6%	141	83	-41.1%	90	83	-7.8%
Target Children	64	57	-10.9%	80	48	-40.0%	57	48	-15.8%
Total Child Welfare (Average Daily Population)	**21,134**	**20,531**	**-2.9%**	**23,920**	**22,095**	**-7.6%**	**20,531**	**22,095**	**7.6%**

Child In-Home Forecast

The Spring 2007 forecast of 3,237 for the 2007-09 biennium is down approximately 17 percent from the Fall 2006 forecast, which had assumed that the decline exhibited since early 2004 would subside and growth would return to its previous pattern (Exhibit B-11). At just over 3,580 for the 2005-07 biennium, the Spring 2007 forecast is about 9 percent lower than the Fall 2006 forecast. Since the Fall 2006 forecast, the Child In-Home caseload has continued to drop, but recent estimates give some indication that it may be flattening out.

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

- A number of administrative changes took place ranging from renewed attention to In-Home plans, closing inactive In-Home plan cases, and to more accurately reporting the type of plan a case was in. Additionally, several new

processes have been implemented, including, a rule requiring face-to-face contact every 30 days went into effect August 2004; and the implementation of the Guided Assessment Process for assessing referrals to child protective services that was fully implemented in late 2004.

- Staff turnover has led to a higher percentage of caseworkers with less experience. Anecdotally, it has been suggested that the less experienced caseworkers are less confident about managing cases in the home, which is supported by research on foster care and caseworker experience[2].
- Also, there has been decreased availability of mental health and substance abuse treatment services for many parents, making it more difficult to keep children in the home. The decrease in substance abuse and mental health treatment is tied to the budget cuts in the Oregon Health Plan in 2003, which had the effect of reducing providers' availability for some services.

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

Given the large historical variability of the Child In-Home caseload, future caseloads could deviate substantially from the forecast. Based on historical data, the average deviation over the 2007-09 biennium could be as great as 14 percent in either direction.

Foster Care Forecast

The Spring 2007 forecast predicts that 10,213 children will be served on average each month for the 2007-09 biennium, which is around 12 percent lower than the Fall 2006 forecast. An average of 10,076 will end up having been served in 2005-07, which is approximately 4 percent lower than the Fall 2006 forecast (Exhibit B-11). The Fall 2006 forecast had assumed that the rapid growth exhibited from the last half of 2002 to the first part of 2005 would resume following the flattening that occurred the latter part of 2005; however, actual caseloads observed since then show a continuation of the flat trend, and more recently a slight decrease (Exhibit B-13).

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

A great deal of uncertainty exists as to whether: a) the recent downturn will persist; b) the trend will stabilize into the flattened trend exhibited during the latter part of 2005 and first part of 2006; or c) the pattern will return to the aggressive growth seen during the two years preceding July 2005. Given this uncertainty, future caseloads could deviate from the forecast by an average of 10 percent up or down for the 2007-09 biennium.

Adoption Assistance Forecast

At 10,705 for the average number of children served in the 2007-09 biennium, the Spring 2007 forecast is 3 percent below the forecast from Fall 2006. For the 2005-07 biennium, the Spring 2007 forecast is less than one percent lower than the Fall 2006 forecast.

The growth in this caseload has remained relatively stable, leading to very little variability in the historical data. Thus, future caseloads for Adoption Assistance will most likely fall within slightly over one percent above or below the average forecasted for the 2007-09 biennium (Exhibit B-14).

Subsidized Guardianship Forecast

The Spring 2007 forecast for this relatively small caseload (an average of 583 children served for the 2005-07 biennium and 769 for 2007-09) is about one percent higher than the Fall 2006 forecast. Since variation in the Subsidized Guardianship caseload has been moderately high in the past, future caseloads could reasonably be expected to vary by plus or minus 9 percent from the average forecasted for the 2007-09 biennium (Exhibit B-15).

Risks and Assumptions

Lacking a definitive explanation for the relatively large swings that have occurred in the Foster Care and Child In-Home caseloads, one must be cautious in making assumptions about the future direction of these populations. Rather than assume a resumption of the strong growth experienced for most of the last several years or a continuation of the recent declines, the Spring 2007 forecast has taken a conservative approach, projecting very modest growth (almost flat) for Foster Care and Child In-Home based on the rate of growth in the founded cased from September 2003.

Another risk to the forecast relates to safety training that began September 2006 in advance of changes in policy and rules in response to the Holder Report. 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.

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

Exhibit B-12: Total Child Welfare

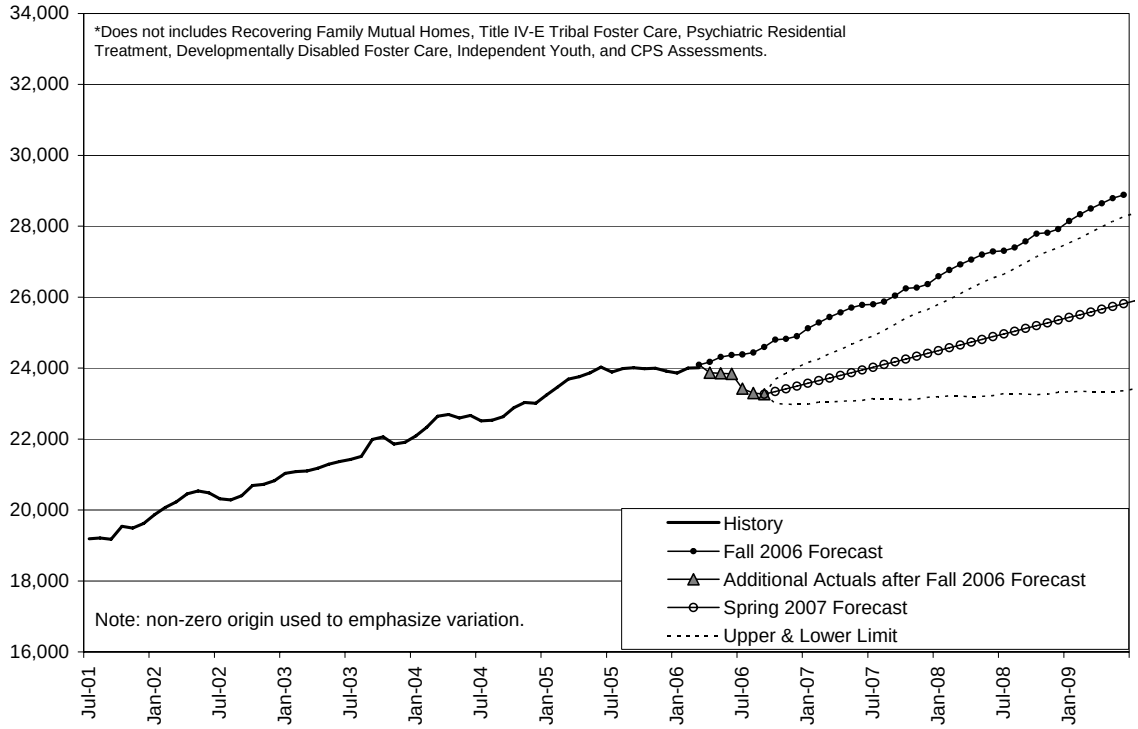


Exhibit B-13: Child In-Home

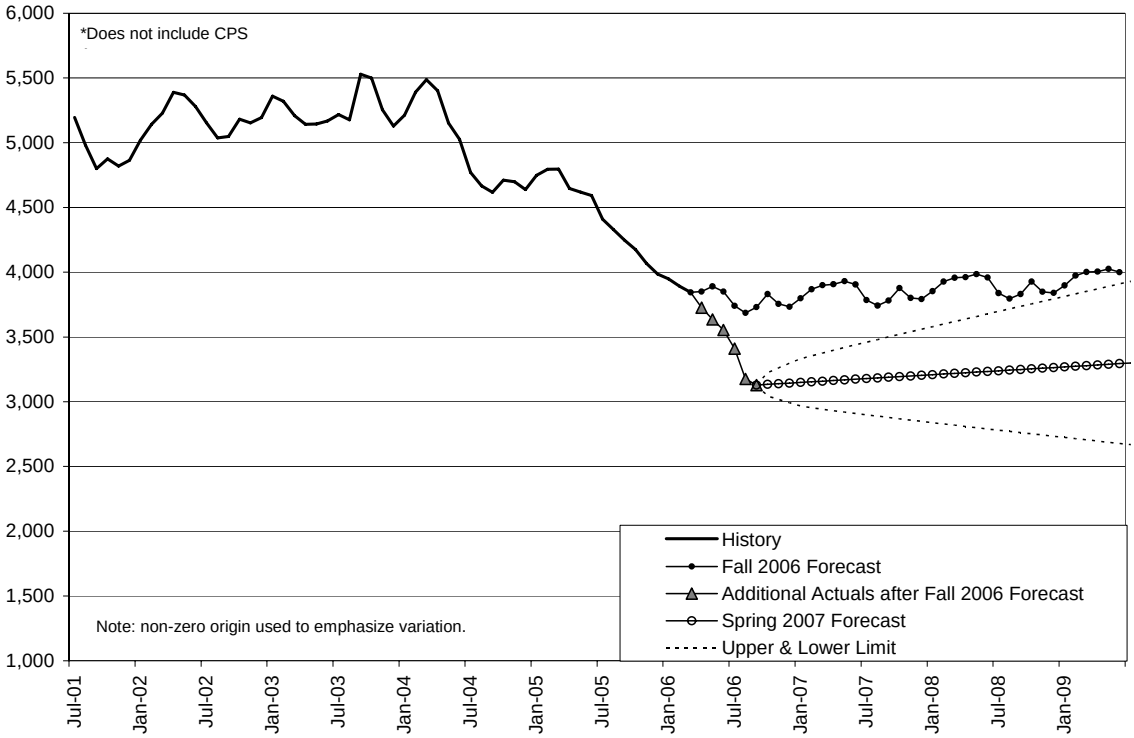


Exhibit B-14: Foster Care

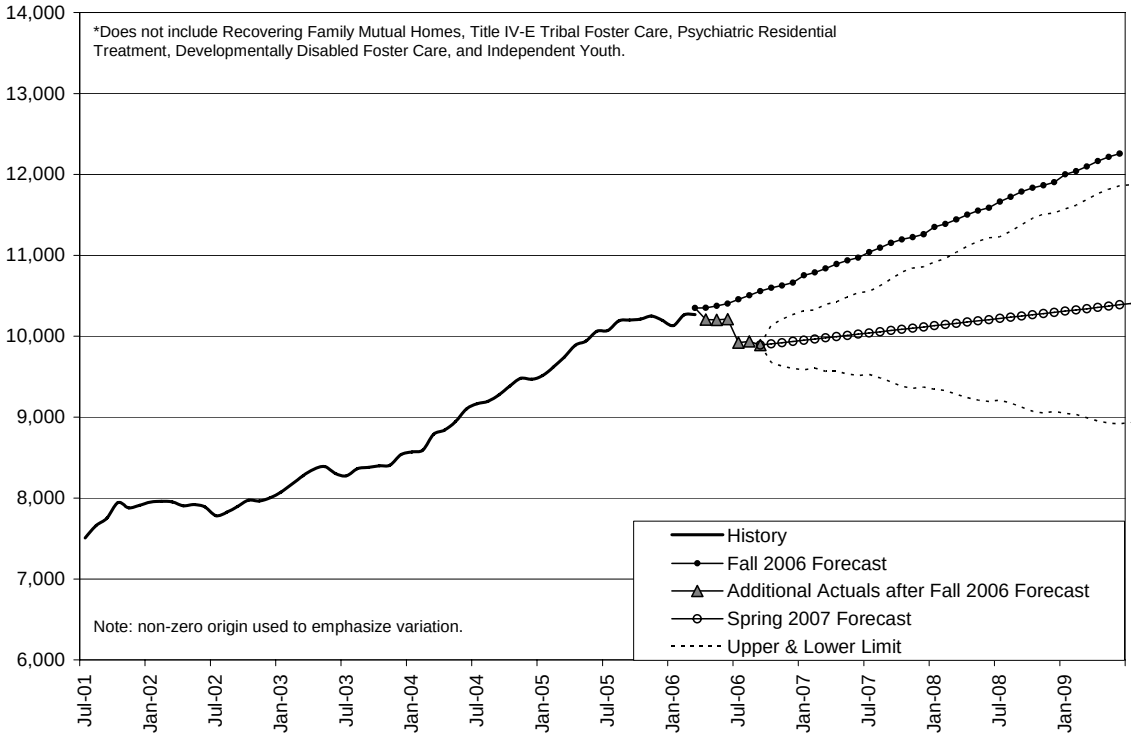


Exhibit B-15: Adoption Assistance

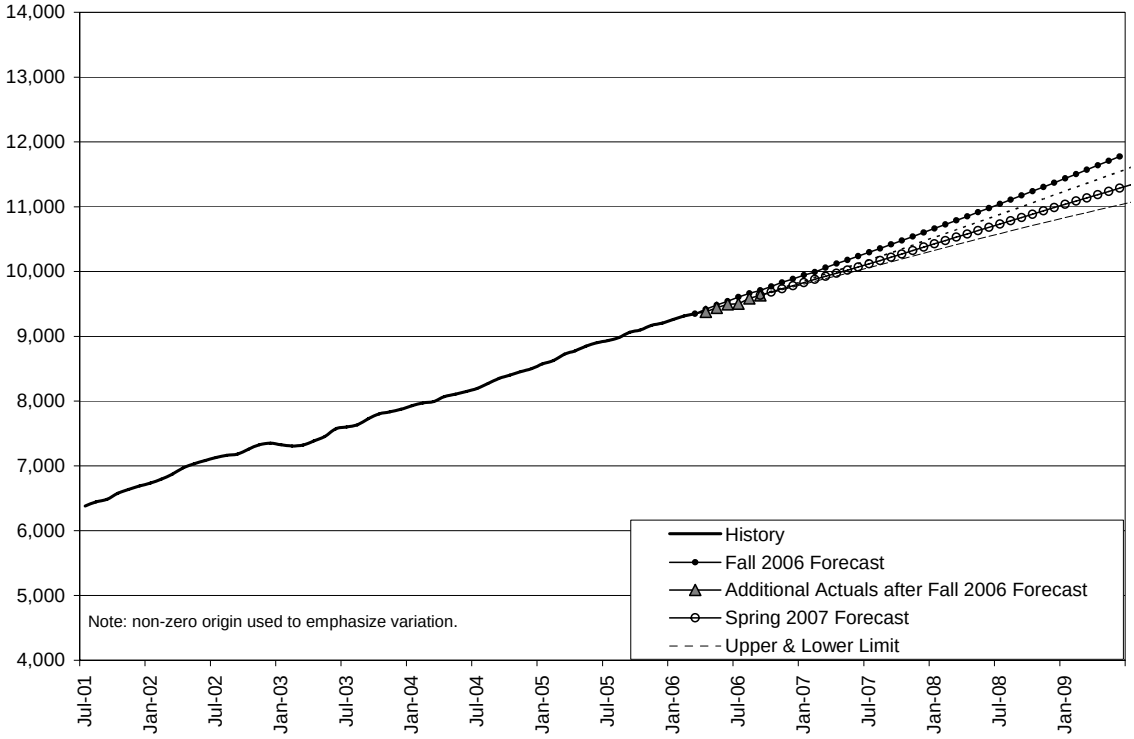
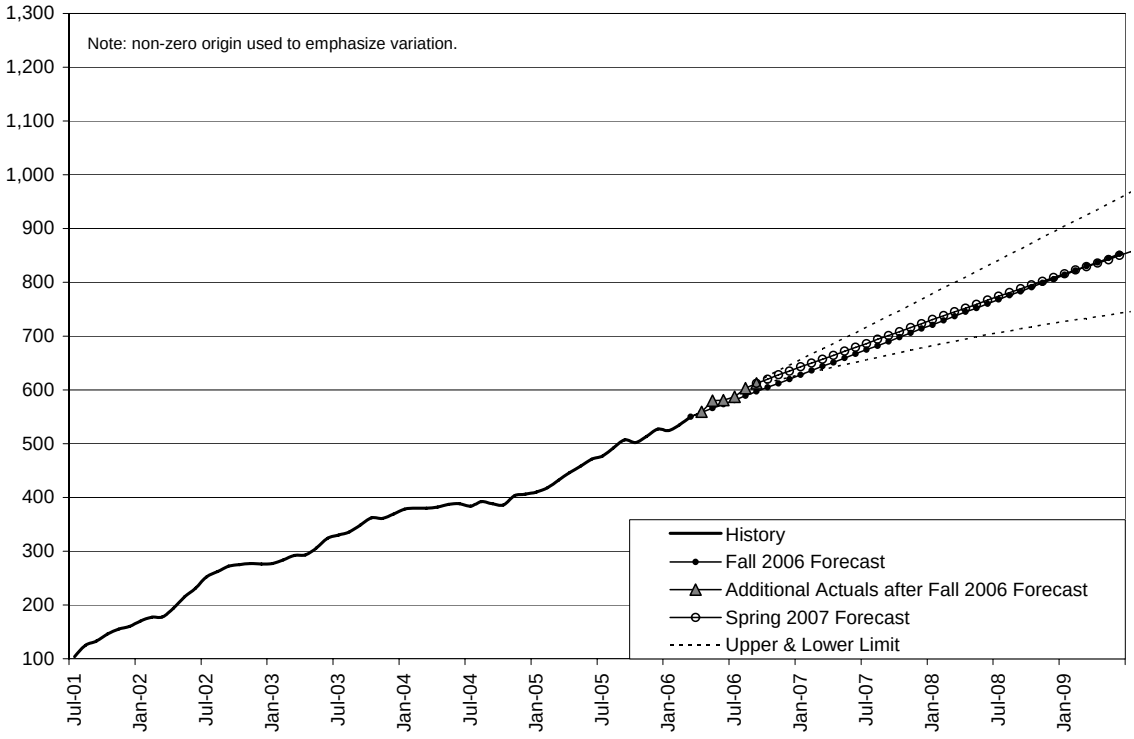


Exhibit B-16: Subsidized Guardianship



Vocational Rehabilitation

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

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

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast		
Comparison:	Fall 2006 to Spring 2007			Fall 2006 to Spring 2007			2005 - 07 to 2007 - 09		
Children, Adults and Families (CAF) Biennial Averages by Forecast	Fall 06 Forecast 2005-07	Spring 07 Forecast 2005-07	%Diff. Fall 06 to Spring 07 2005-07	Fall 06 Forecast 2007-09	Spring 07 Forecast 2007-09	%Diff. Fall 06 to Spring 07 2007-09	Spring 07 Forecast 2005-07	Spring 07 Forecast 2007-09	%Diff. Spring 07 2005-07 to 2007-09
Vocational Rehabilitation (Clients Served)	**9,445**	**9,323**	**-1.3%**	**9,369**	**8,991**	**-4.0%**	**9,323**	8,991	**-3.6%**

Forecast

The Spring 2007 forecast predicts an average of 8,991 Vocational Rehabilitation clients served per month for the 2007-09 biennium, which is 4 percent lower than the Fall 2006 forecast (Exhibit B-17). For the 2005-07 biennium, the Spring 2007 forecast of 9,323 is approximately one percent lower than the Fall 2006 forecast. In terms of recent trends, the caseload fell sharply in 2003 before leveling off in 2004, and then began another a steep decline January 2006 (Exhibit B-18). 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 a 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.

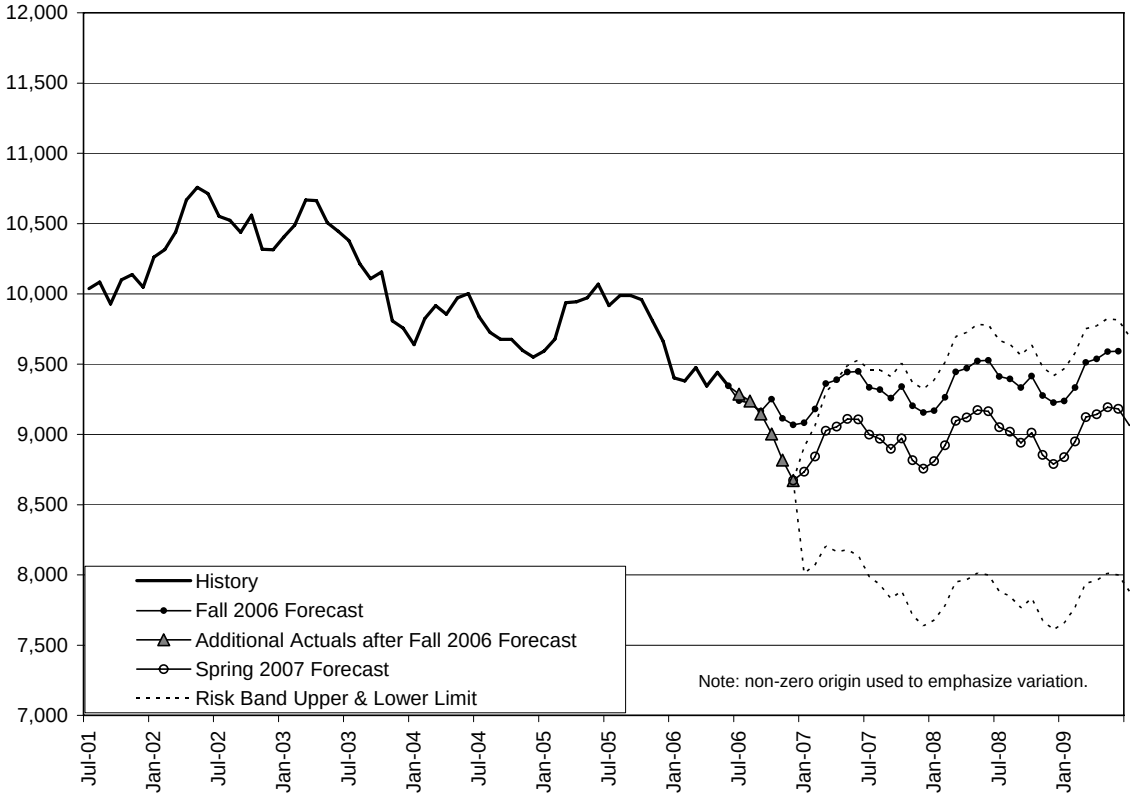
Besides the general downward trend, the caseload experienced additional downward pressure due to the implementation of a 180-day standard for plan development that became effective October 1, 2006. This standard, besides shortening caseload length of stay, has also prompted the closing out of pre-plan cases that result in little if any cost savings and have a low impact on counselor workload. This will most likely cause the caseload to continue to decline during the first part of 2007.

Risks and Assumptions

The Spring 2007 forecast assumes minimal growth (almost flat) after a downward shift caused by the implementation of the standard development of the180-day plan. However, given that the impact of this policy may not have played itself out, there is a high level of risk that the caseload could drop much lower, especially during the first part of 2007. Also, 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.

The greatest risk for the VR caseload forecast lies on the downside, with the average caseload for the 2007-09 biennium possibly falling 13 percent below the forecast. In the other direction, the average caseload could feasibly exceed the forecast by 7 percent.

Exhibit B-18: 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 C-1 along with the names of the individual programs within each group. For programs that are part of the Oregon Health Plan, benefits are defined by a Prioritized List of eligible medical services that is maintained by the Oregon Health Services Commission, a separate entity from DHS. Each of the thirteen programs listed in Exhibit C-1 is discussed below.

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

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

Comparisons of Forecasts Over Time

Exhibit C-2 provides comparison between the current forecast; Spring 2007 and the prior forecast; Fall 2006 for each of the thirteen DMAP programs.

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

	2005-07 Biennium			2007-09 Biennium			Spring 07 Forecast		
Comparison:	Fall 2006 to Spring 2007			Fall 2006 to Spring 2007			2005 - 07 to 2007 - 09		
Medical Assistance Programs **Biennial Averages by Forecast**	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*% Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*% Diff. Fall 06 to Spring 07 2007-09*	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*% Diff. Spring 07 2005-07 to 2007-09*
OHP Plus									
TANF-Related Medical	95,114	90,544	-4.8%	92,784	82,331	-11.3%	90,544	82,331	-9.1%
TANF-Extended	39,595	37,786	-4.6%	35,623	32,714	-8.2%	37,786	32,714	-13.4%
TANF Medical - Subtotal	**134,709**	**128,330**	**-4.7%**	**128,407**	**115,045**	**-10.4%**	**128,330**	**115,045**	**-10.4%**
Poverty Level Medical - Women	10,305	10,270	-0.3%	11,833	10,987	-7.1%	10,270	10,987	7.0%
Poverty Level Medical - Children	82,430	82,235	-0.2%	80,703	80,020	-0.8%	82,235	80,020	-2.7%
Aid to the Blind & Disabled	61,817	61,410	-0.7%	65,093	64,073	-1.6%	61,410	64,073	4.3%
Old Age Assistance	30,217	30,303	0.3%	29,706	30,416	2.4%	30,303	30,416	0.4%
Substitute Care & Adoption Serv.	18,050	17,811	-1.3%	18,918	19,054	0.7%	17,811	19,054	7.0%
Children's Health Insurance Program	32,287	32,199	-0.3%	47,612	47,612	0.0%	32,199	47,612	47.9%
OHP Plus Subtotal	**369,815**	**362,558**	**-2.0%**	**382,272**	**367,207**	**-3.9%**	**362,558**	**367,207**	**1.3%**
Other Medical Assistance Programs									
Citizen-Alien Waived Emergency Medical	18,532	18,387	-0.8%	17,299	16,778	-3.0%	18,387	16,778	-8.8%
Qualified Medicare Beneficiary	11,377	11,345	-0.3%	12,647	12,575	-0.6%	11,345	12,575	10.8%
Breast & Cervical Cancer program	317	307	-3.2%	441	418	-5.2%	307	418	36.2%
Other Subtotal	**30,226**	**30,039**	**-0.6%**	**30,387**	**29,771**	**-2.0%**	**30,039**	**29,771**	**-0.9%**
OHP Standard									
Biennial Average Sustainable Number	**24,000**	**24,000**	**0.0%**	**24,000**	**24,000**	**0.0%**	**24,000**	**24,000**	**0.0%**
Total Medical Assistance Programs	***424,041***	***416,597***	***-1.8%***	***436,659***	***420,978***	***-3.6%***	***416,597***	***420,978***	***1.1%***

Total Medical Assistance Programs

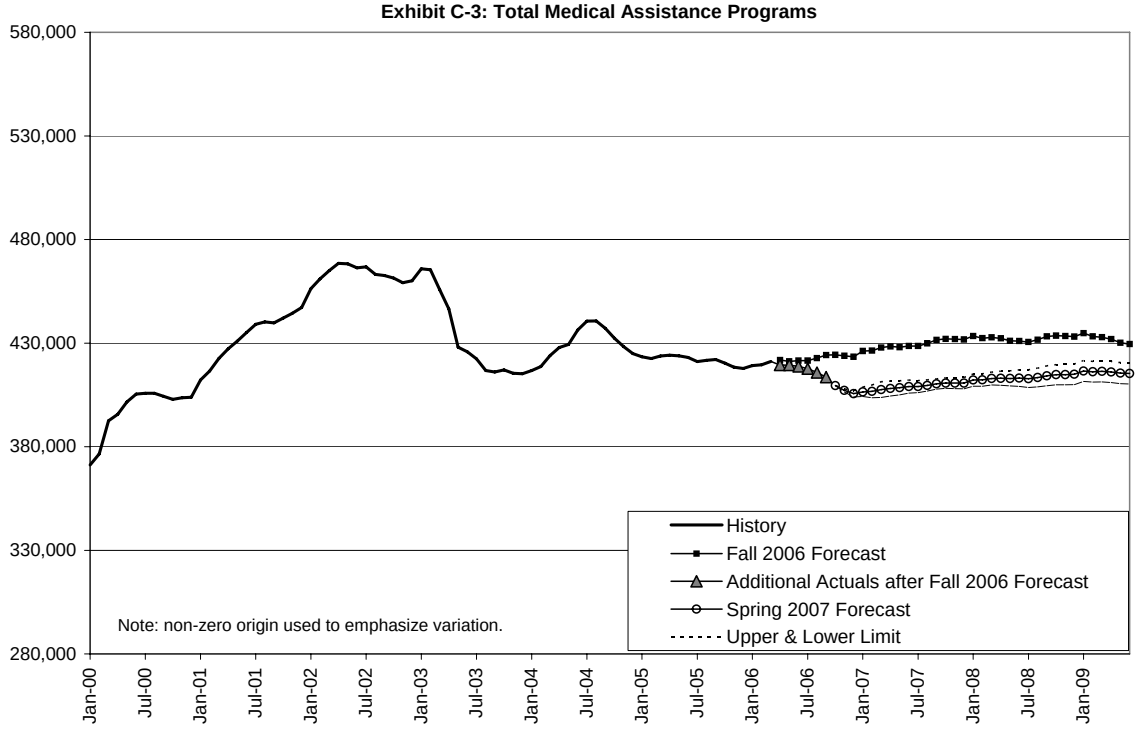
The total DMAP caseload was approximately 413,500 in September of 2006, the last month of complete data available for analysis. During the historical period shown in Exhibit C-3 caseload growth began to accelerate beginning in late 1999 resulting in a historical high of approximately 465,000 in the spring of 2002. Over the following ten months the population remained relatively stable. Beginning in March of that year the client population began a rapid decline that persisted through the end of 2003. It was during this period that a series of budget cuts occurred, such as the closure of some small medical assistance programs, the creation of OHP Plus/Standard benefit packages followed by the reduction of benefits in OHP Standard. 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 approximately 21,800 in September of 2006.

Forecast

The Fall 2006 forecast for all DMAP programs anticipated 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 2007 forecast (Exhibit C-3) continues to anticipate a slow growth pattern as the policy and environmental factors contributing to the long term decline are mitigated. 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 1 percent above or below the forecast in the 2007-09 biennium.

Exhibit C-3: Total Medical Assistance Programs



Oregon Health Plan Plus

The Oregon Health Plan Plus (OHP Plus) program represents one of the three broad program categories administered by DMAP. In February 2003, the Department replaced the original OHP Basic benefit package with the OHP Plus package. The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules. The OHP Plus population makes up about 87 percent of DMAP clients and is expected to reach 89 percent by the end of the 2007-2009 biennium.

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

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

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

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

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

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

The recent decline in this population is primarily due to policy changes implemented in the spring and summer of 2006. Briefly, they include an automatic closure of TANF cases that were overdue for review; increasing the time one needed to be in TANF-RM in order to qualify for TANF-EX; and increased financial reporting requirements for TANF-EX. All are part of ongoing program integrity efforts. These changes 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. The impact of these changes continues to work its way through the system and is not expected to be realized fully until into the 2007-2009 biennium.

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

The TANF-RM client group makes up around 71 percent of the total TANF medical caseload (September 2006). 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 in March of 2005 to nearly 88,000 in September of 2006 (Exhibit C-6).

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

The TANF-EX benefit group is made up of clients who have left the TANF-RM group due to a change in income (see earlier discussion of the total TANF client group). During the recession and while the TANF Related Medical client

population was dramatically increasing, this group remained relatively flat. Since this group comes only from TANF-RM, there is also a tendency for caseload changes to lag the changes in the other group. The longest period of growth in the TANF-EX population (April 2004 through December of 2005) is reflected in the increase in absolute number of clients moving from TANF-RM during that period. This group entered a period of rapid decline after March of 2006. This date corresponds to the implementation of eligibility reform; these were expected to have the effect of lowering the caseloads.

Forecast

The forecast for the total TANF medical assistance caseload is to emerge gradually from the negative effects of the policy changes and maintain a slowly declining to stable pattern through the 2007-2009 biennium. The Spring 2007 forecast for TANF-RM expects a similar pattern of gradual emergence to a stable, flat caseload. The Spring 2007 forecast for the TANF-EX caseload calls for a similar emergence from the main effects of the policy implementation but will continue to slowly decline through the 2007-2009 biennium. 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 40 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. Exhibits C-5 through C-7 displays the histories and comparative forecast for these groups.

Risks and Assumptions

An assumption in the TANF forecasts is that the economy, job growth and health insurance availability will follow the predicted trends in upcoming years (i.e. moderate economic growth, and job growth largely in the service sector with about the same levels of availability of health insurance). Changes in economic conditions create a high level of risk to the forecasts due to the high level of sensitivity of these groups to the economic environment.

Another more tangible risk to the forecasts for both of these groups lies with the Deficit Reduction Act of 2005 that includes TANF reauthorization provisions through 2010. At this point, the program is in the process of being redesigned. However, even after the new program structures are known, anticipating all of the effects is simply not possible. Consequently, the TANF caseload forecasts have substantial risks associated with them.

Third, the changes to eligibility and review policy within TANF-EX and TANF-RM will continue to have effects 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 to the magnitude or duration as predicted, the forecast could be over or underestimated.

Even without the substantive risks listed above these forecasts have a high degree of variability when compared to the actual counts. This creates a high range of expected variability of plus/minus 10 percent for the 2007-09 biennium upper and lower limits (Exhibit C-5).

OHP Plus: Poverty Level Medical Women

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

The Poverty Level Medical Women program group has had consistent, if intermittent, growth at least as far back as the beginning of 2001. During the two years from 2001 to 2003 the total client caseload varied monthly at around 8,500 clients. With the expansion of 170 percent to 185 percent FPL at the start of 2003, the caseload increased in a one-time shift to a new level of just below 9,500 cases. The pattern of moderate growth continued through January of 2005 when a more rapid growth pattern emerged. This rapid growth has continued through September of 2006, although the last four or five months are showing signs of some stability. Why recent growth: while no single factor has been identified for the growth that has occurred in 2005 and 2006, there is evidence that the birth rate has increased statewide; and that outreach efforts for enrolling pregnant women have been successful which has lead to increases.

Forecast

The Spring 2007 forecast is lower than in the Fall 2006 forecast. The current forecast biennial averages are approximately 10,300 during 2005-2007 increasing to approximately 11,000 for 2007-2009. These averages represent a decrease over the Fall 2006 forecast of less than 1 percent for 2005-2007, but close to 7 percent for the 2007-2009 biennium. The most recent historical stabilizing of the caseload had a moderating influence on the long term growth patterns expected for this group when compared to the information available at the time of the Fall 2006 forecast. Exhibit C-8 displays the history and comparative forecasts for this group.

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

OHP Plus: Poverty Level Medical Children

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

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

Forecast

The Fall 2006 forecast for PLMC projects a caseload pattern of general and slow decline through the end of the 2007-2009 biennium. The caseload is expected to decline to approximately 77,000 cases by late 2009. The gradual downturn 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 Fall 2006 and Spring 2007 forecasts for the 2005-07 biennium at about 82,000. The Fall 2006 forecast biennial average for 2007-09, however, is about 700 clients higher than the Spring 2007 forecast. The upper and lower limits associated with this group are relatively large, and attest to the relative historical variability and seasonality within this group. It is estimated that the forecast could reasonably be about $\pm$ 6 percent above or below the actual average for 2007-09 (Exhibit C-9).

OHP Plus: Aid to the Blind and Disabled

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

The AB/AD caseload increased substantially from July of 1999 through January 2003. During that period the caseload grew nearly 20 percent, from about 46,600 clients to 55,300 clients. In February 2003, approximately 2,500 clients entered this caseload after the closure of the General Assistance (GA) program.

At the time of the closure, clients were evaluated to determine if they were eligible for other programs. Many had disabilities and qualified for the AB/AD program, resulting in a one-time increase. The GA program reopened in November 2003 with only a few hundred clients and then closed again in October 2005.

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

Forecast

The Fall 2006 and Spring 2007 forecasted biennial averages for this group are nearly identical for 2005-07 and only slightly lower in the Spring for the 2007-09 biennia. The Spring 2007 forecast for this group projects an increase through the forecast horizon similar to that seen from November 2005 through September of 2006. This pattern of growth is similar to earlier growth periods but somewhat more moderated. This caseload is expected to grow from approximately 61,600 in September of 2006 to approximately 62,400 in June of 2007 and 66,000 by the end of the 2007-09 biennium. The upper and lower limits, which average 3 percent above and below the forecast, show anticipated stability in the continued growth of this program (Exhibit C-10).

OHP Plus: Old Age Assistance

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

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

Forecast

The Spring 2007 forecast for this group projects a continued relatively steady population across the entire forecast horizon at approximately 30,000 clients. While the Fall 2006 forecast called for a gradually decreasing caseload to around 29,300 by June of 2009, the current forecast estimates close to 30,500 for that same month. The current forecast calls for a 2005-2007 biennial average of around 30,300 compared to an almost identical 30,200 estimated in the fall of 2006. Similarly, the current 2007-2009 biennial average for this group is expected to be approximately 30,400 compared to a somewhat lower 29,700

estimate resulting from the Fall 2006 forecast (Exhibit C-2). The upper and lower limits average around 2 percent above and below the forecast for 2007-09.

OHP Plus: Foster/Substitute Care and Adoption Services

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

The Foster/Substitute Care and Adoption Services caseload has increased consistently since January of 2000 with brief, intermittent periods of flattening. The most recent period of no growth began in the summer of 2005 and has persisted to date. Reasons for this pattern are discussed in the Children, Adults and Families, Child Welfare portion of this publication.

Forecast

The Spring 2007 forecast for this group anticipates a near future return to patterns of continued growth (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 overstated, especially if the caseload fails to return to prior levels of growth as expected. The Spring 2007 forecast biennial averages for 2005-2007 are only marginally lower than the Fall 2006 forecast (Fall 2006, 18, 050: Spring 2007, 17,811). The 2007-09 biennium shows similar differences with the Fall 2006 forecast estimating a biennial average of 18,900 compared to the Spring 2007 estimate of 19,000 (Exhibit C-12). The moderate range of upper and lower limits of plus or minus 4 percent reflects the variability of historical forecasts compared to actual historical counts.

OHP Plus: Children's Health Insurance Program

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

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

Forecast

The Spring 2007 forecast estimates biennial averages for this group to approximately 32,200 for 2005-2007 and 47,600 for 2007-2009. The caseload is expected to grow at a similar pace and pattern to that observed from July 2004 through January 2006. However, beginning in December of 2006, 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 eligibility recertification, compared to six months prior to the policy change. In effect, this policy change is expected to initiate a rapid accumulation of clients to a much higher base level. It is from this new base that previous patterns of slow but persistent growth expected to re-emerge.

Exhibit C-4: Total Oregon Health Plan Plus

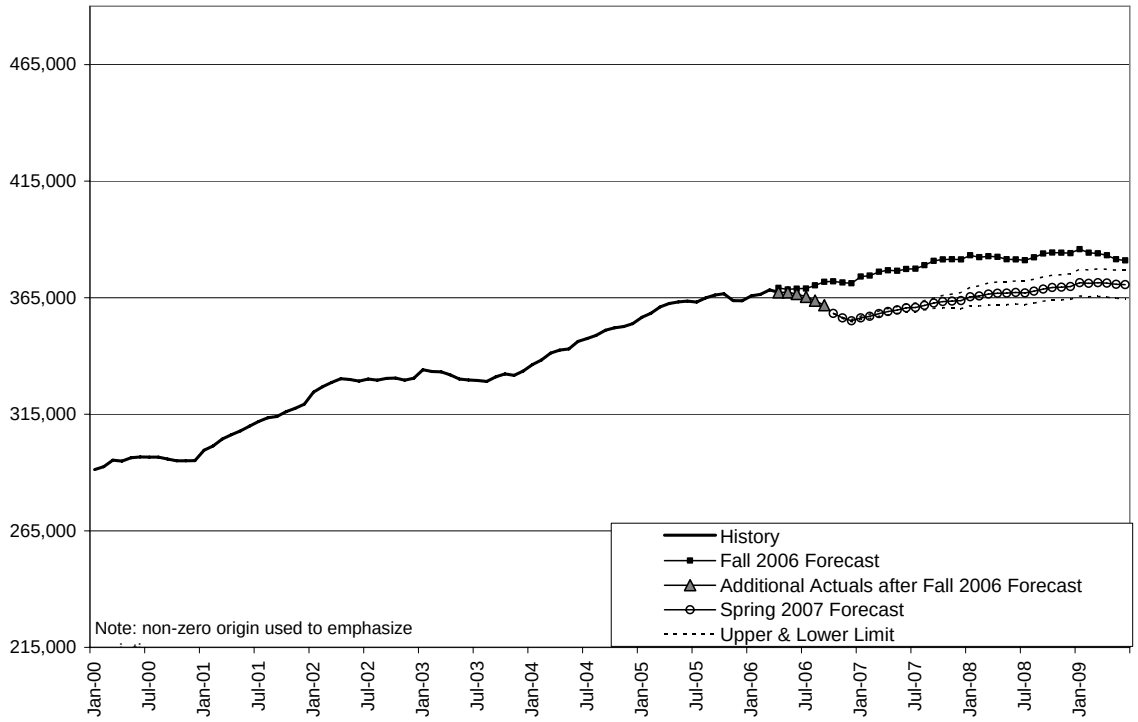


Exhibit C-5: Total Temporary Assistance for Needy Families

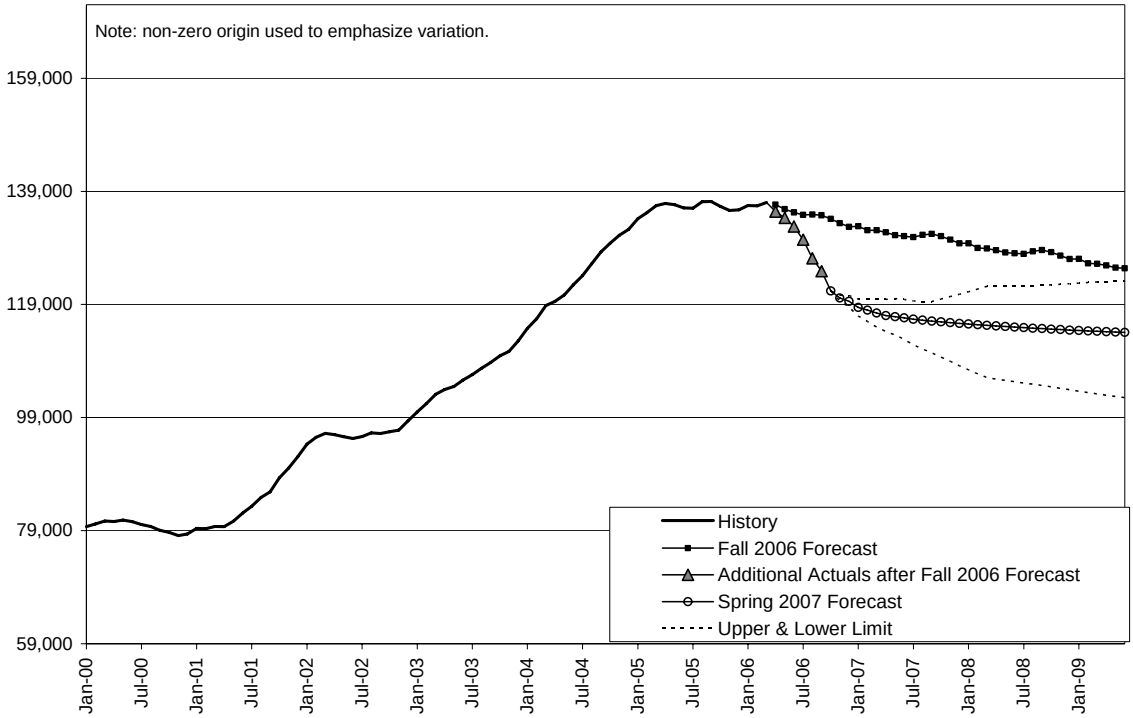


Exhibit C-6: Temporary Assistance for Needy Families-Related Medical

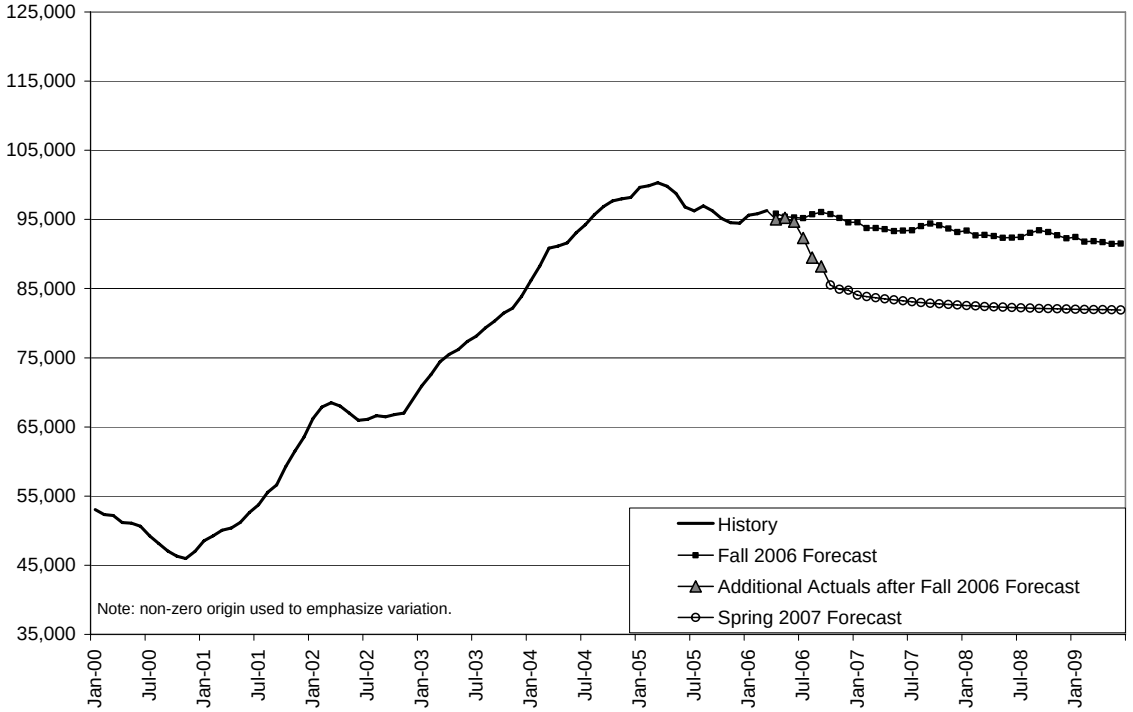


Exhibit C-7: Temporary Assistance for Needy Families-Extended

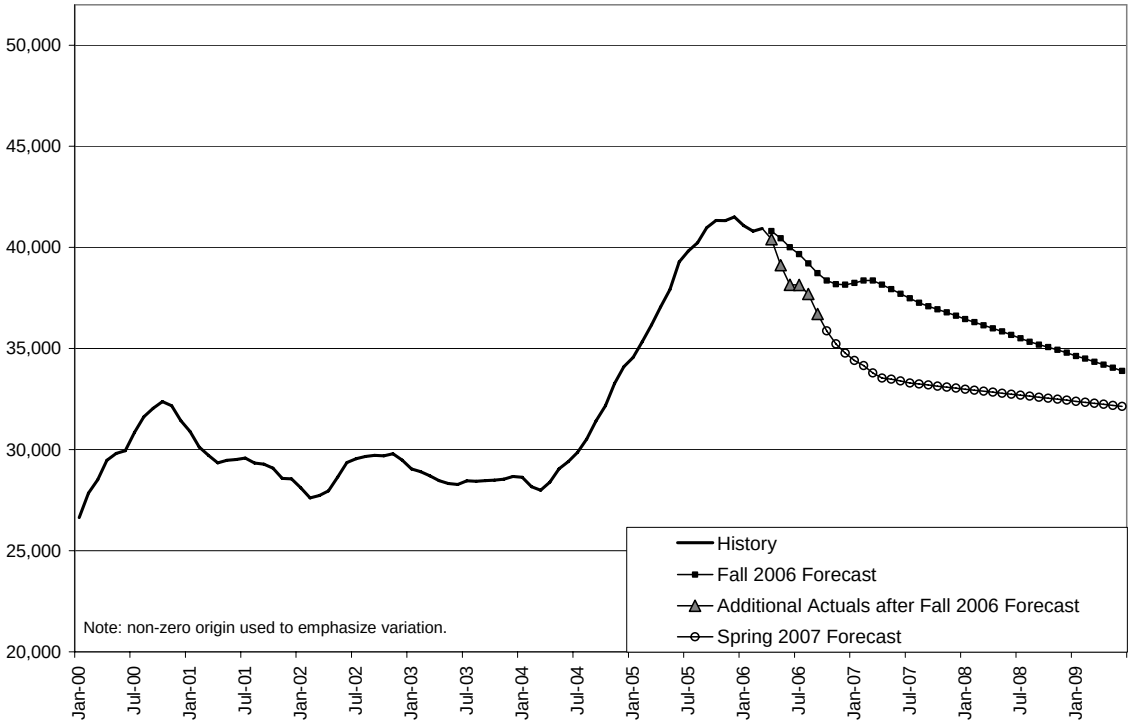


Exhibit C-8: Poverty-Level Medical Women

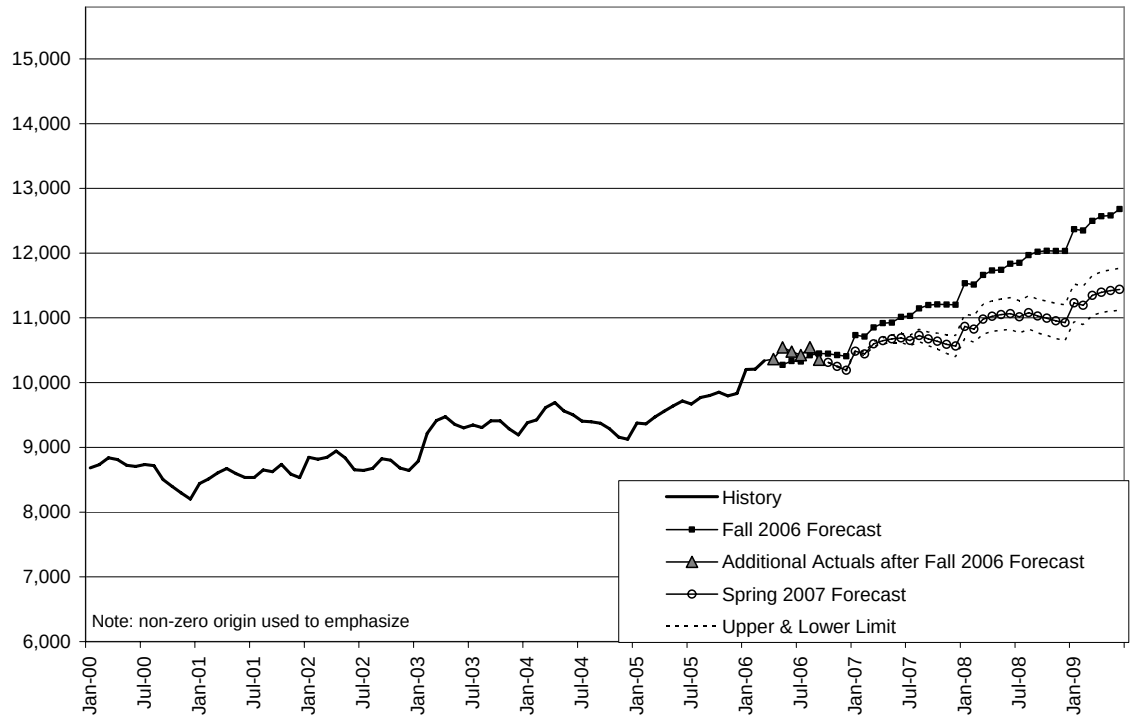


Exhibit C-9: Poverty-Level Medical Children

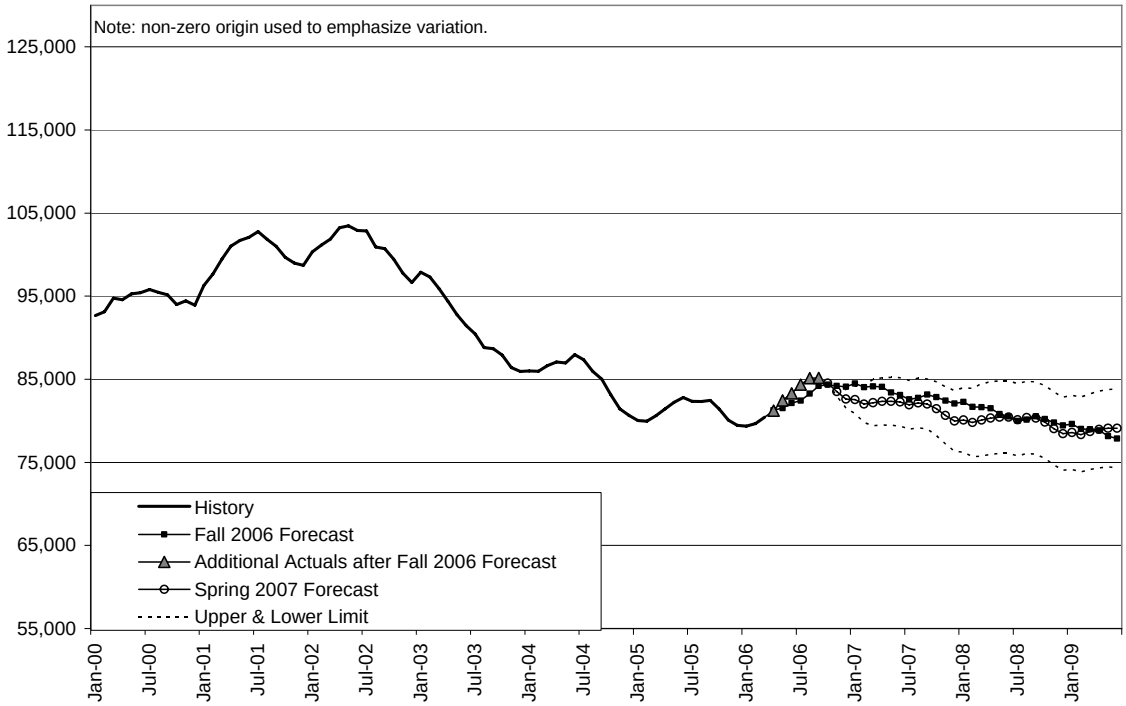


Exhibit C-10: Aid to the Blind and Disabled

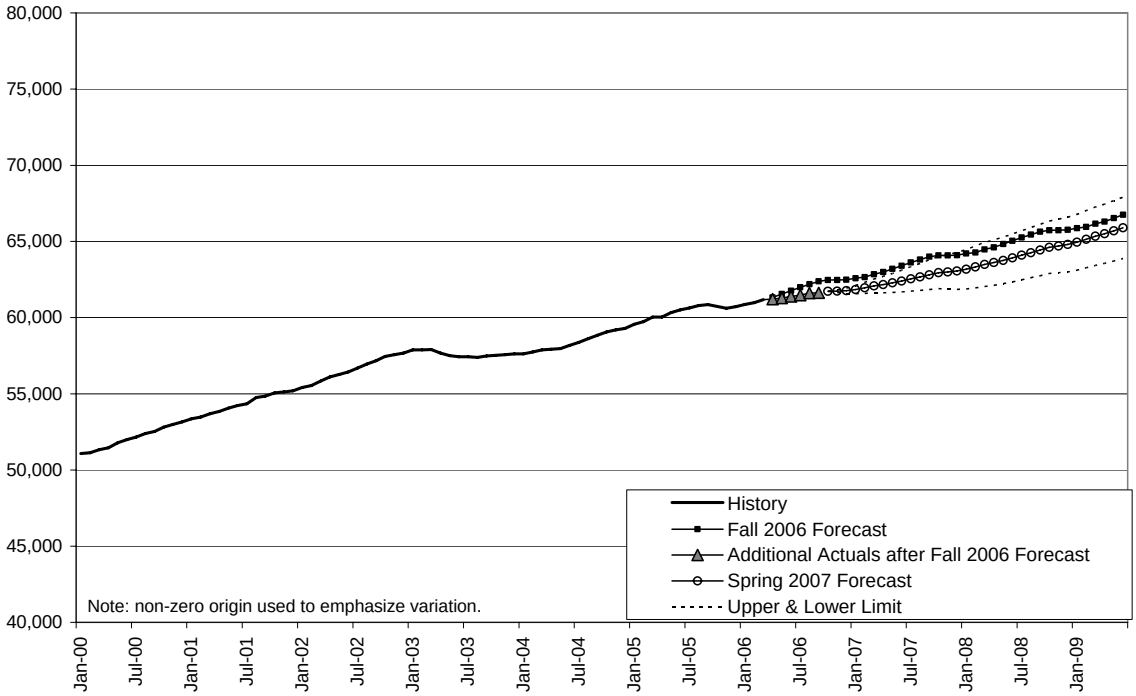


Exhibit C-11: Old Age Assistance

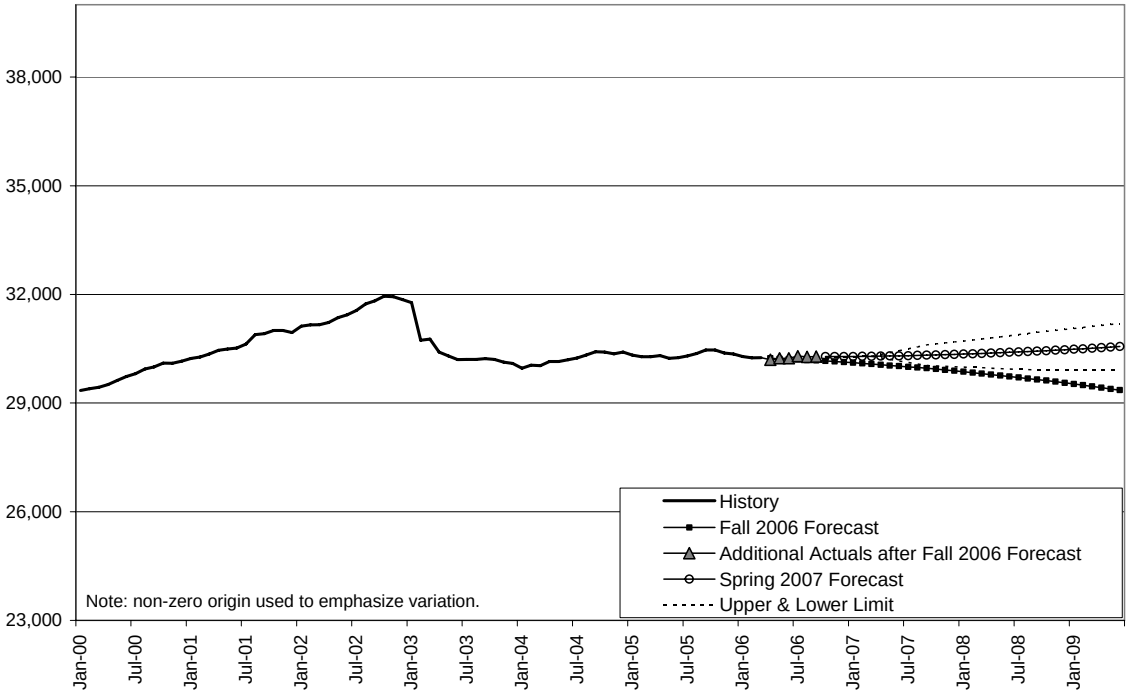


Exhibit C-12: Foster/Substitute Care & Adoption Services

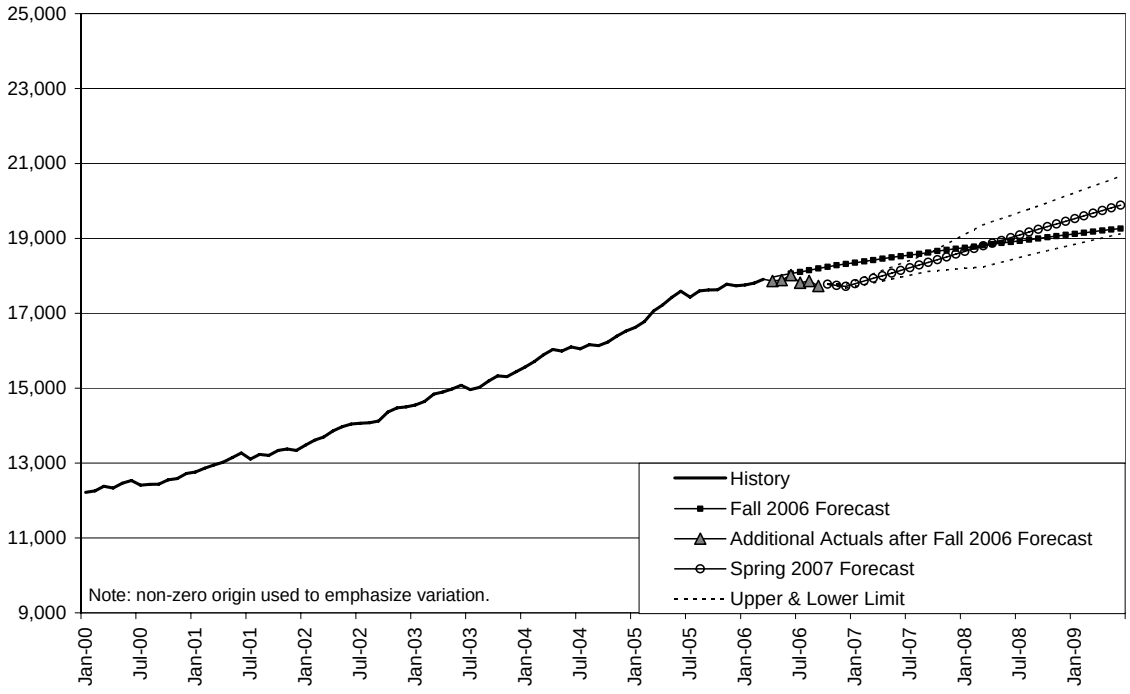
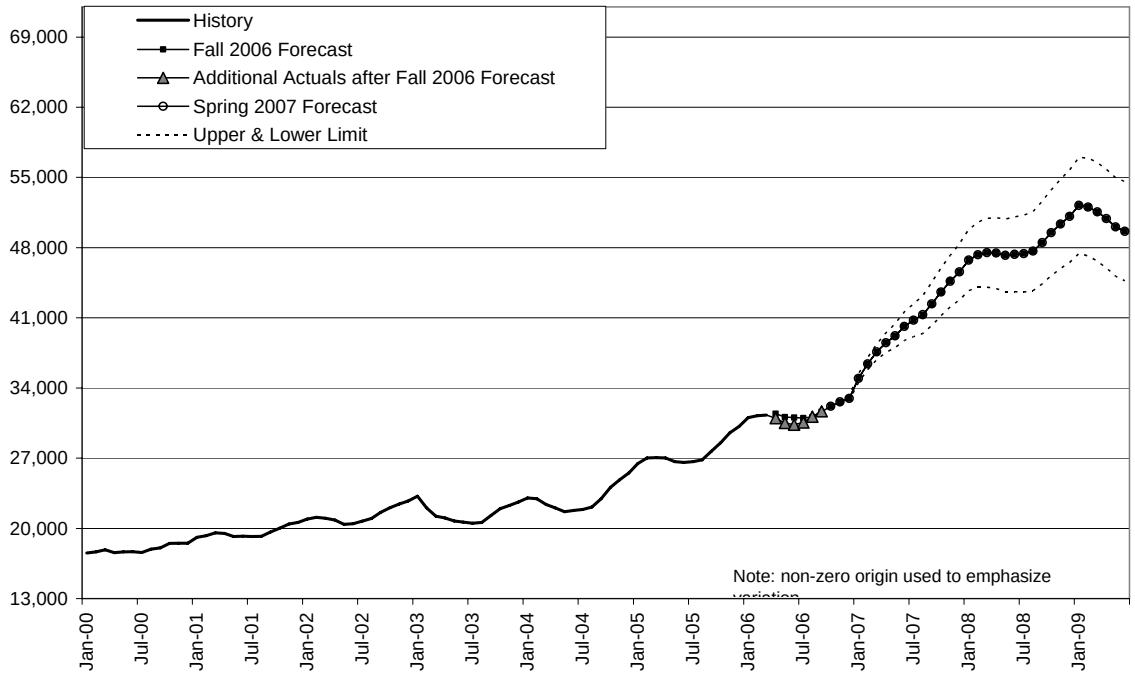


Exhibit C-13: Children's Health Insurance Program



Oregon Health Plan Standard

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

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

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

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

In January 2003, the combined population for these two groups was just over 100,000. In February 2004, after 13 months of rapidly decreasing caseloads associated with benefit reductions, increased co-payments and strict enforcement of premium payment requirements, the combined population was fewer than 48,000 clients. During the period immediately prior to closure of the program in July 2004, the caseload increased as a direct result of outreach by advocacy groups. The subsequent closure initiated a caseload decline that continued through early 2006. As of September 2006, the last month of complete historical data available for this forecast, the combined populations of these two groups averaged 23,350 from the beginning of the biennium. The averages for Families and for Adults/Couples were around 7, 200 and 16,150, 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

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 2006. 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 any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductibles not exceeding the Department's fee schedule.

Forecast

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

The Spring 2007 forecast for the QMB benefit group projects a continuation of caseload growth virtually identical to that anticipated in the Fall 2006 forecast. 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 3 percent from the forecast.

Other: Citizen/Alien Waived Emergency Medical

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

Once the caseload stabilized after the implementation the new eligibility and computer tracking codes. The caseload remained relatively stable through January 2004. 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 closely track that of the OHP Standard population right before and after that program was closed to new clients. The drop occurred because applicants who would have met OHP Standard eligibility requirements except for citizenship statewide 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 Spring 2007 forecast for the CAWEM client population represents a slight downward revision when compared to the Fall 2006 forecast. A general continued decline is anticipated for this client group. The Spring 2007 forecast estimates a biennial average of approximately 18,400 in contrast to the earlier Fall 2006 estimate of approximately 18,500. Exhibit C-15 displays the history and comparative forecasts for this group. The upper and lower limit estimates average nearly 3 percent above and below the forecast for 2007-09.

Other: Breast and Cervical Cancer Program

The Breast and Cervical Cancer program (BCCP) began in January 2002. This program provides medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Health Services through county health departments and tribal health clinics. After determining eligibility, the client receives all Medicaid services, including mental and dental health services. A client is eligible until reaching the age of 65, obtaining creditable coverage or ending treatment. As of September, the caseload had grown to 312 clients. While this group is quite small, the caseload increase has been consistent and rapid. The most recent available data, however, have indicated a slight slowing in the pattern of growth over the summer. This is due to the transition to a new standardized computer system by the BCCP county health programs that temporarily delayed entries. Once the IS system is back online, it is expected there will be a short time in which the backlog is cleared, followed by a resumption in the pattern of growth this program has experienced since its creation.

Forecast

The Spring 2007 forecast for the Breast and Cervical Cancer Program varies only slightly from the slightly higher Fall 2006 forecasted estimates. The current forecast, while calling for continued aggressive growth in this population, estimates slightly fewer clients for the 2005-2007 biennium with an average of 307. The Fall 2006 forecast, in contrast, estimated the 2005-2007 biennial average for this group at approximately 317. Averages for the 2007-2009 biennium differ only slightly more with the current forecast calling for an average of 418 compared to the prior forecast estimate of 441. The upper and lower limits show that for 2007-09, the actual counts could be expected to range approximately 4 percent above or below the forecast.

Exhibit C-14: Qualified Medicare Beneficiaries

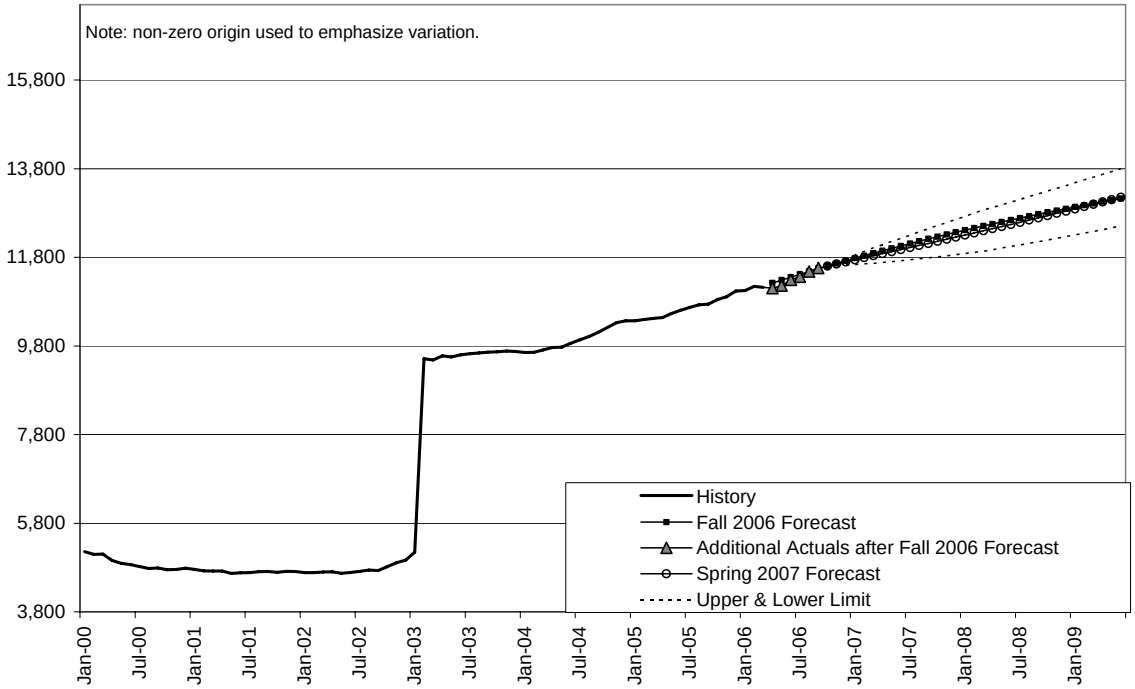


Exhibit C-15: Citizen / Alien Waived Emergency Medical

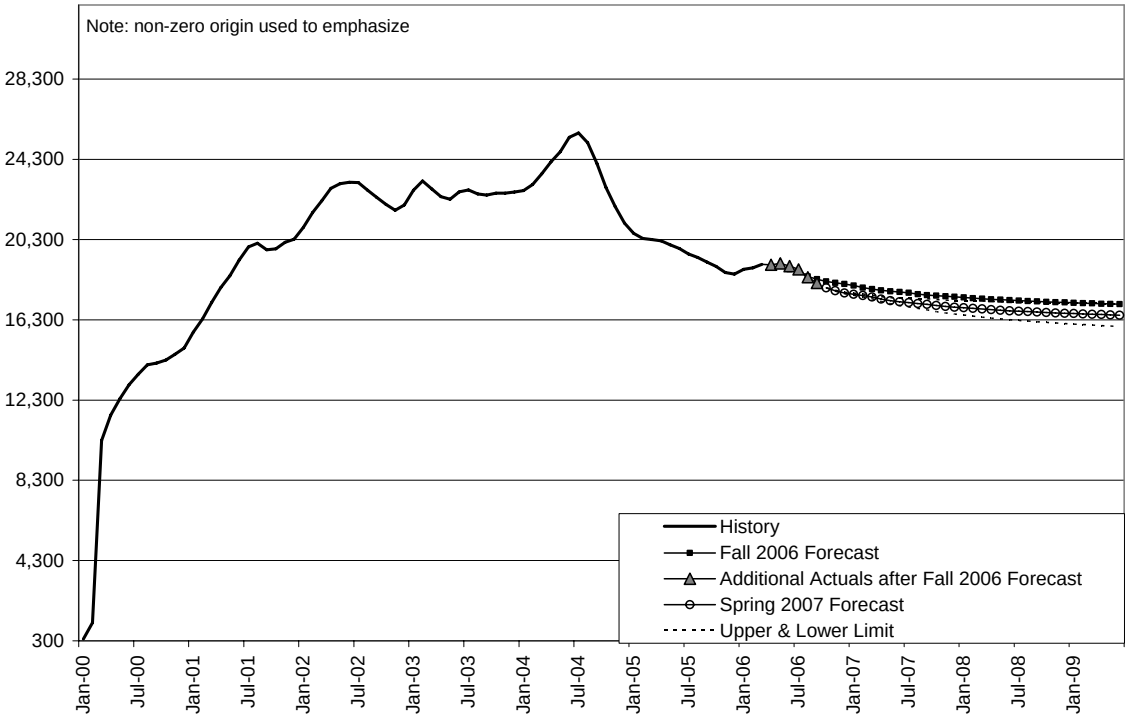
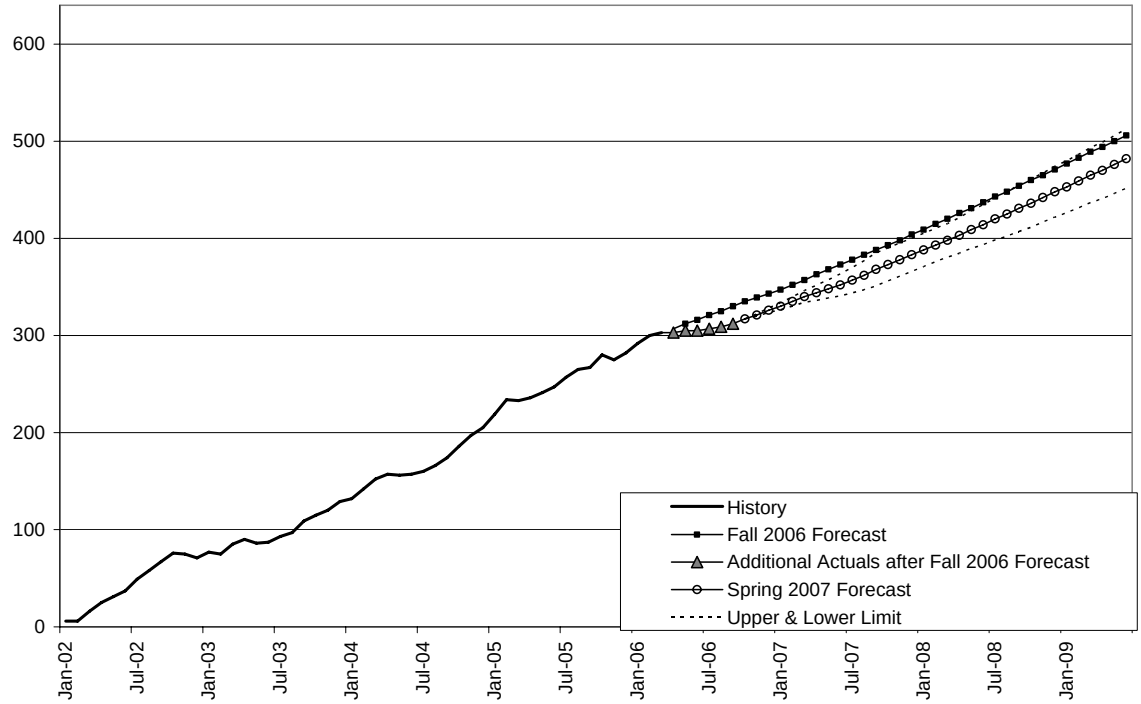


Exhibit C-16: Breast and Cervical Cancer Program



Additional Risks to the Spring 2007 Forecast

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

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

Another systemic risk to the current forecast lies in the methamphetamine epidemic. By some accounts, the historical increases in the Substitute Care and Adoption Services caseload are 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 Substitute Care and Adoption Services caseload would be underestimated.

The Medicare Modernization Act (MMA) 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 Spring 2007 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/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.

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 because they are a danger to themselves or others, including people who have been found guilty except for insanity.

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

Exhibit D-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 Spring 2007 Mental Health forecast continues the new forecasting process that was implemented in Fall 2006. We use historical data from the Integrated Client Services Data Warehouse (ICS). In the interim between these two forecasts, data definitions and business rules have been used to create caseload categories and have continued to evolve, resulting in slight to major differences in the monthly caseload numbers. For example, we now count and forecast Civilly Committed in community outpatient settings. We anticipate that data development will be finalized before the next forecast cycle. Because of these differences, comparisons between the Fall 2006 and present, Spring 2007,

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

Exhibit D-2 compares the biennial averages of actual counts and forecasted caseload per the Spring 2007 forecast for the 2005-07 and 2007-09 biennia.

Exhibit D-2: Mental Health Biennial Average Comparisons

Numbers of Clients Served per Month	**2005-07 Biennium**	**2007-09 Biennium**	**Spring 2007 Forecast**
	Spring 2007	**Spring 2007**	**2005-07 to 2007-09**
Addictions and Mental Health Programs **Biennial Averages**	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*% Diff. Spring 07 2005-07 to 2007-09*
Criminal Commitment			
Aid and Assist	168	214	27.4%
Psychiatric Security Review Board	716	723	1.0%
Total Criminal Commitment	**884**	**937**	**6.0%**
Civil Commitment			
24 Hour Care	976	1,141	16.9%
Acute Care	184	181	-1.6%
State Hospital	359	359	0.0%
Community Care	2,277	2,803	23.1%
Total Civil Commitment	**3,796**	**4,484**	**18.1%**
Total Mandated Care	**4,680**	**5,421**	**15.8%**
Unduplicated Count, Total Mandated Care	**3,970**	**4,516**	**13.8%**

Average Daily Populations	2005-07 Biennium	2007-09 Biennium	Spring 2007 Forecast
	Spring 2007	Spring 2007	2005-07 to 2007-09 % Dif.
Addictions and Mental Health Programs **Biennial Averages**	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	*Spring 07 2005-07 to 2007-09*
Criminal Commitment			
Aid and Assist	142	184	29.6%
Psychiatric Security Review Board	702	710	1.1%
Total Criminal Commitment	**844**	**894**	**5.9%**
Civil Commitment			
24 Hour Care	940	1,085	15.4%
Acute Care	79	78	-1.3%
State Hospital	310	310	0.0%
Community Care	2,113	2,595	22.8%
Total Civil Commitment	**3,442**	**4,068**	**18.2%**
Total Mandated Care	**4,286**	**4,962**	**15.8%**
Unduplicated Count, Total Mandated Care	**3,676**	**4,250**	**15.6%**

Mandated Mental Health Caseload

Forecast

Overall, the Mandated caseload is predicted to continue to increase through June 2009 (Exhibit D-3). The 2007-09 biennial average number of clients is estimated to increase by 14 percent over the 2005-07 biennium. A primary driver of this growth is the increasing Civilly Committed caseload. The upper and lower limits for the Mandated caseload may vary, on average, by three percent 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 individuals mandated to the Oregon State Hospital for assessment and treatment until they are fit to stand trial. A defendant can be tried only if he or she is able to understand and assist the attorney; fitness to proceed is sometimes called “Aid and Assist.” The **Psychiatric Security Review Board** has jurisdiction over people who have been found “guilty except for insanity” of a crime by a court. AMH is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital.

Forecast

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

Aid and Assist Forecast

The Spring 2007 forecast estimates a 27 percent increase in the Aid and Assist caseload from the 2005-07 biennium average monthly number of clients' is168 and in the 2007-09 biennia the average is 214. However, relatively large and consistent variation in the historical data creates an average risk of 16 percent above or below the forecasted values (Exhibit D-5).

Psychiatric Security Review Board Forecast

We expect the total PSRB caseload to remain level through the 2005-07 biennium and then to increase slightly through the 2007-09 biennium (Exhibit D-6). The average monthly forecast for the 2007-09 biennium (723 clients) shows an increase of one percent over the 2005-07 biennium. Future actuals may vary by 15 percent above or below the forecast.

Civilly Committed

The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves as a result of mental illness. Through this process, the individuals are mandated by court to treatment. People on this caseload are served in a variety of settings. Previously, only that portion of the caseload that received services in the State Hospital system and/or in 24-Hour community settings (adult residential, foster care, and enhanced care) were included in the forecast. However, we are now able to include Civilly Committed receiving community outpatient services in the caseload forecast as well.

Forecast

The Spring 2007 forecast estimates that the combined Civilly Committed caseload will continue the growth trend of 2001 through 2006 into the latter part of the decade (Exhibit D-7). The average monthly forecast for the 2007-09 biennium shows an increase of 18 percent over the 2005-07 biennium. The Civilly Committed caseload may vary, on average, by four percent above or below future actuals.

Civilly Committed - 24 Hour Care

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

Forecast

The current forecast estimates that the Civilly Committed - 24 Hour Care caseload will continue the growth exhibited since early 2002 (Exhibit D-8). The average monthly forecast for the 2007-09 biennium shows an increase of 17 percent for the 2005-07 biennium. Some of the more recent growth is due to placing some patients from the State Hospital into 24 Hour Care settings. Future actuals may vary by 10 percent above or below the forecast.

Civilly Committed - Acute Care

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

Forecast

The Civilly Committed Acute Care caseload is expected to remain constant through the 2007-09 biennium (Exhibit D-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 moderate degree of uncertainty as future actuals may vary by an average of eight 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 remain constant through June 2009 (Exhibit D-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 may result in an increase in

the forecast for Civilly Committed- 24 Hour Care caseload. The caseload may vary by an average of eight 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.

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

The following factors also pose risks to the forecasts:

Changes in laws and judicial processes: The forensic caseload is a function of the legal system that controls entries to and exits from treatment. If new laws are passed that expand forensic commitment or significantly change time in treatment, then the actual caseload might shift away from forecasted levels. Likewise, civil commitments rely on a legal process for the initial determination and changes at this point in the system could alter the caseload. Statewide policies regarding incarceration in jails versus civil commitment can further influence forensic and civil caseloads. Even variations in attorney behavior regarding the use of the insanity plea can affect the forensic caseload; jail sentences may shorten as jails reach maximum capacities so that attorneys would favor a regular jail sentence rather than a longer forensic or civil commitment.[3]

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

Changes in environmental factors: Demographic, economic, and behavioral trends can influence the Mental Health caseload. For example, a consistent proportion of mentally ill people in a growing Oregon population during the next

[3]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.]

few years will lead to a growing caseload. If this proportion were to change, the caseload may also respectively change. Economic and behavioral issues can interact to affect this rate. Interactions among economic stressors, drug and alcohol dependency, and an individual's predisposition for mental illness could result in corresponding fluctuations in caseload levels as each component changes over time. For example, during a growing economy and economic stress may be minimal which resulted in 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: All forecast have inherent error that increased with time; the longer the forecast period, the greater the error. The following graphs provide upper and lower limits that illustrate the effects of this probability on the forecasts.

Exhibit D-3: Total Mandated

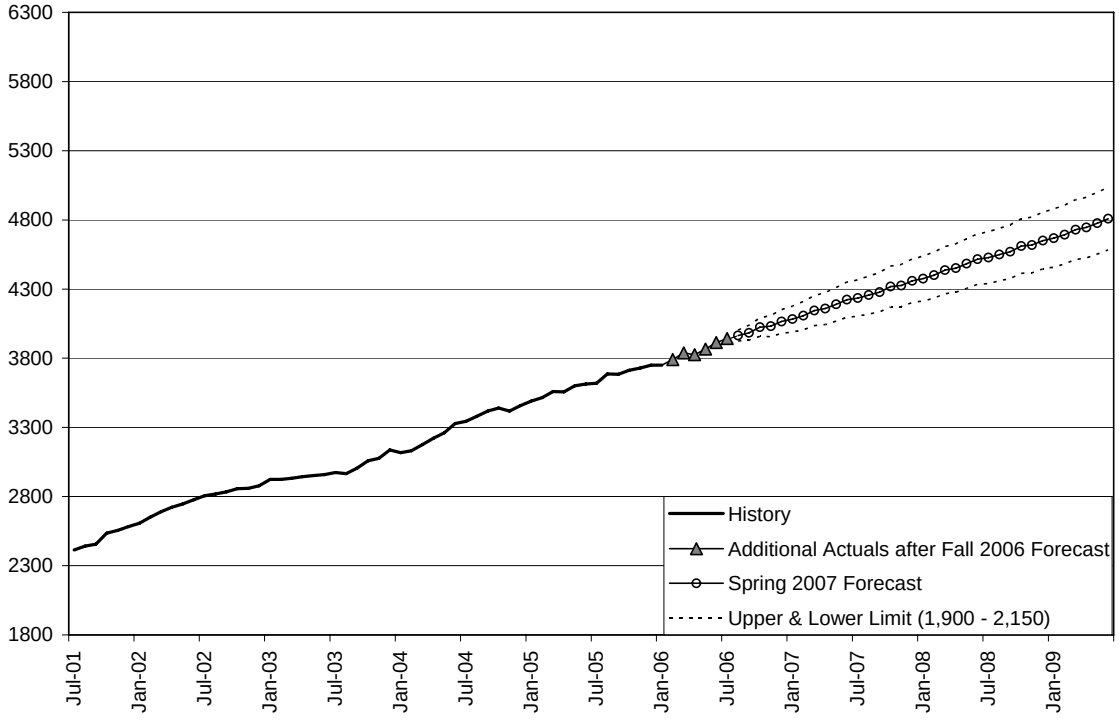


Exhibit D-4: Total Criminal Commitment

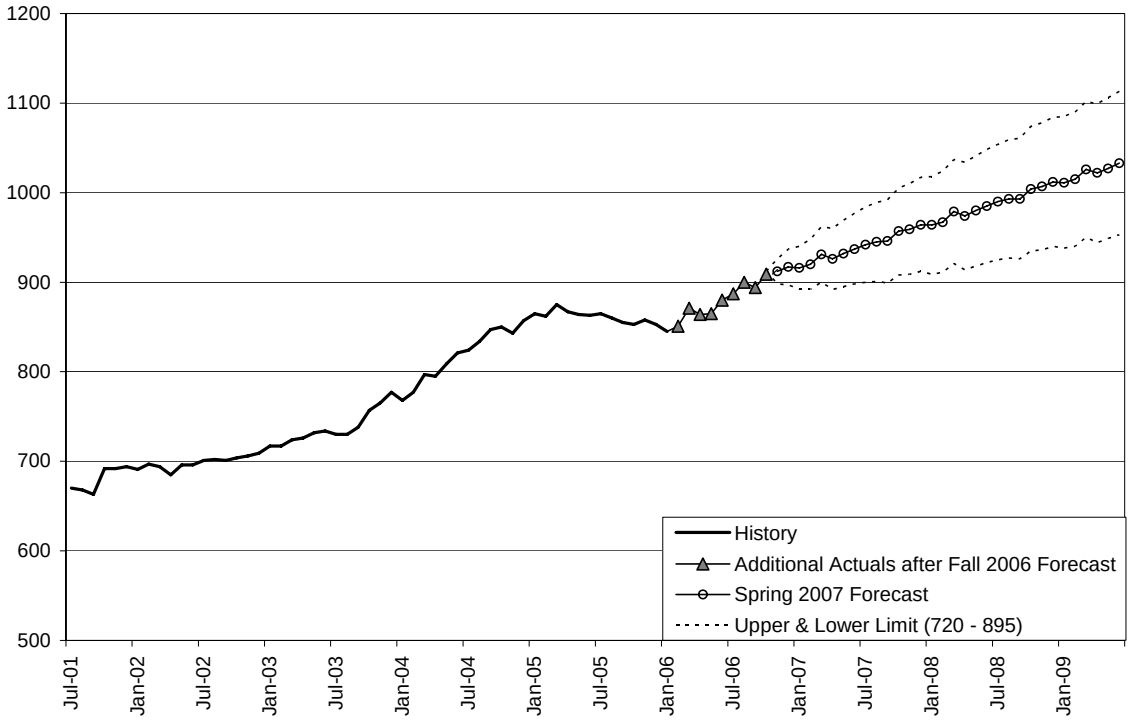


Exhibit D-5: Ciminal Commitment - Aid and Assist

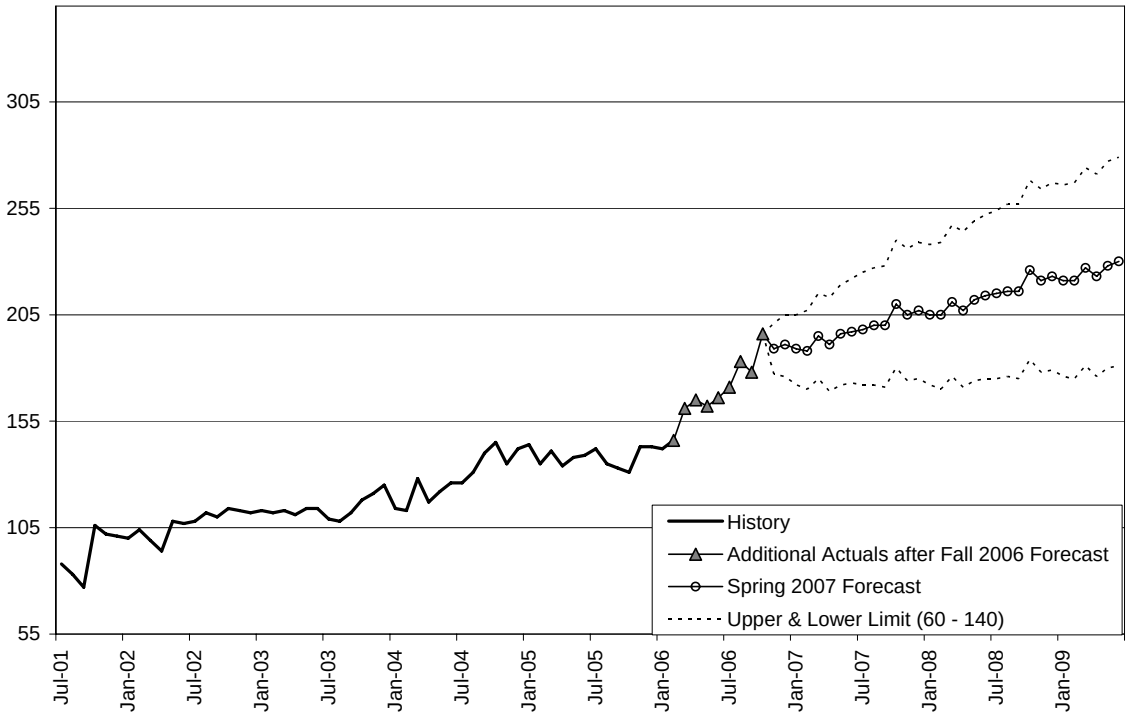


Exhibit D-6: Criminal Commitment - Psychiatric Security Review Board

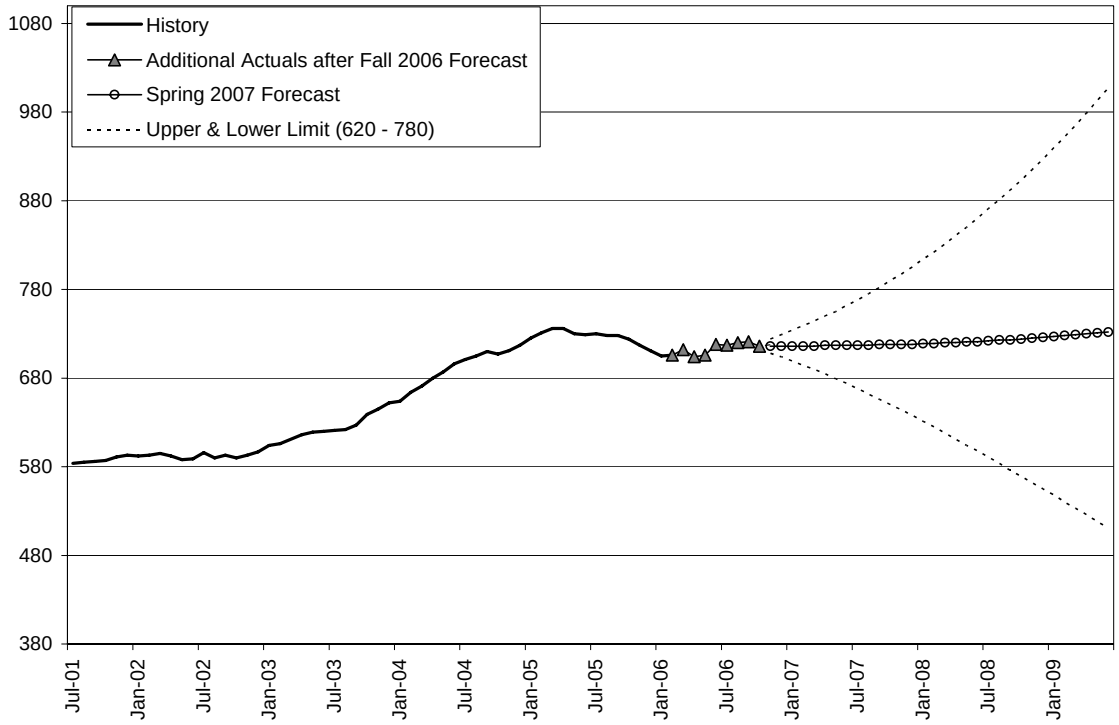


Exhibit D-7: Total Civil Commitment

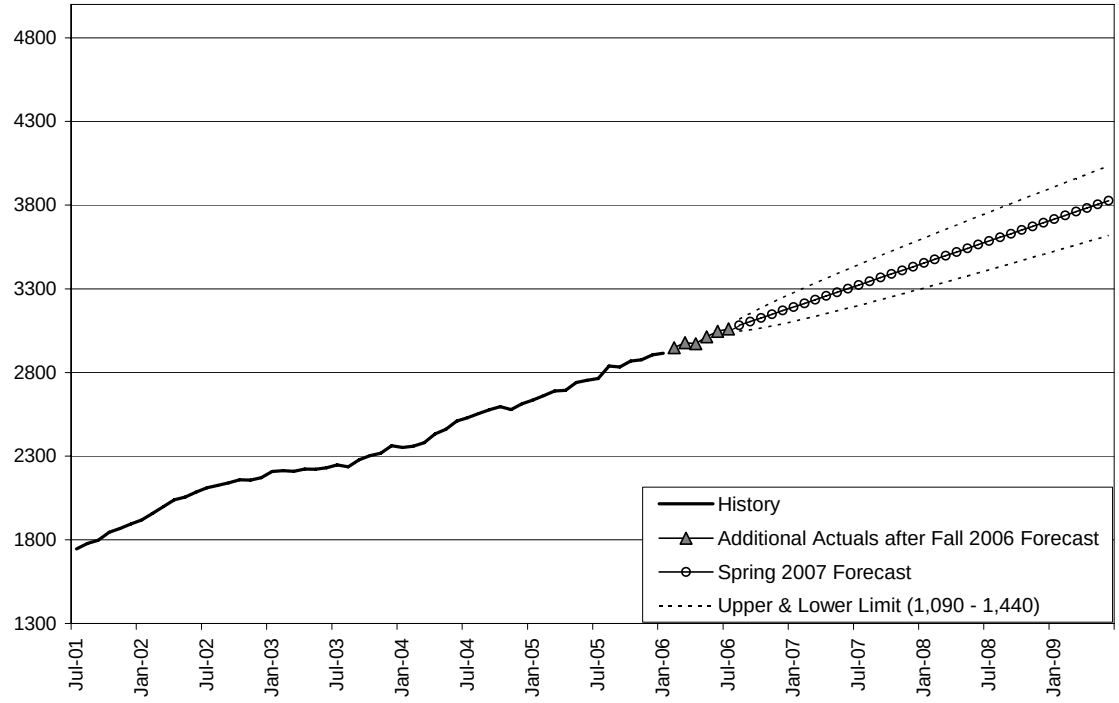


Exhibit D-8: Civil Commitment - 24 Hour Care

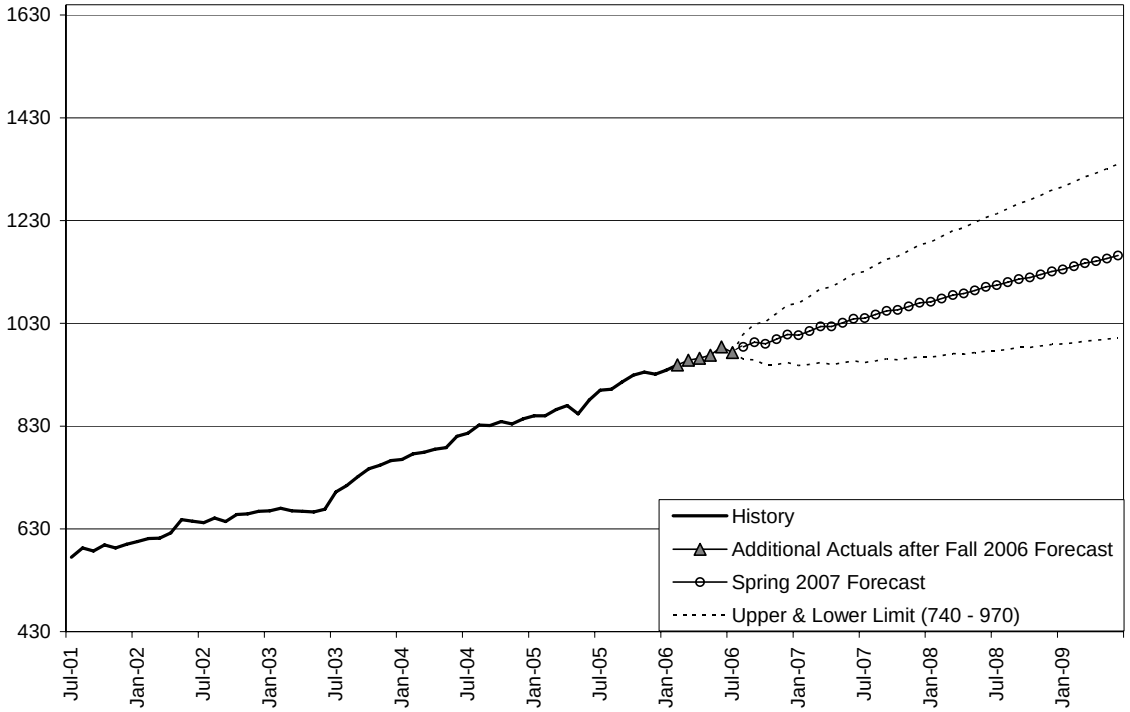


Exhibit D-9: Civil Commitment - Acute Care

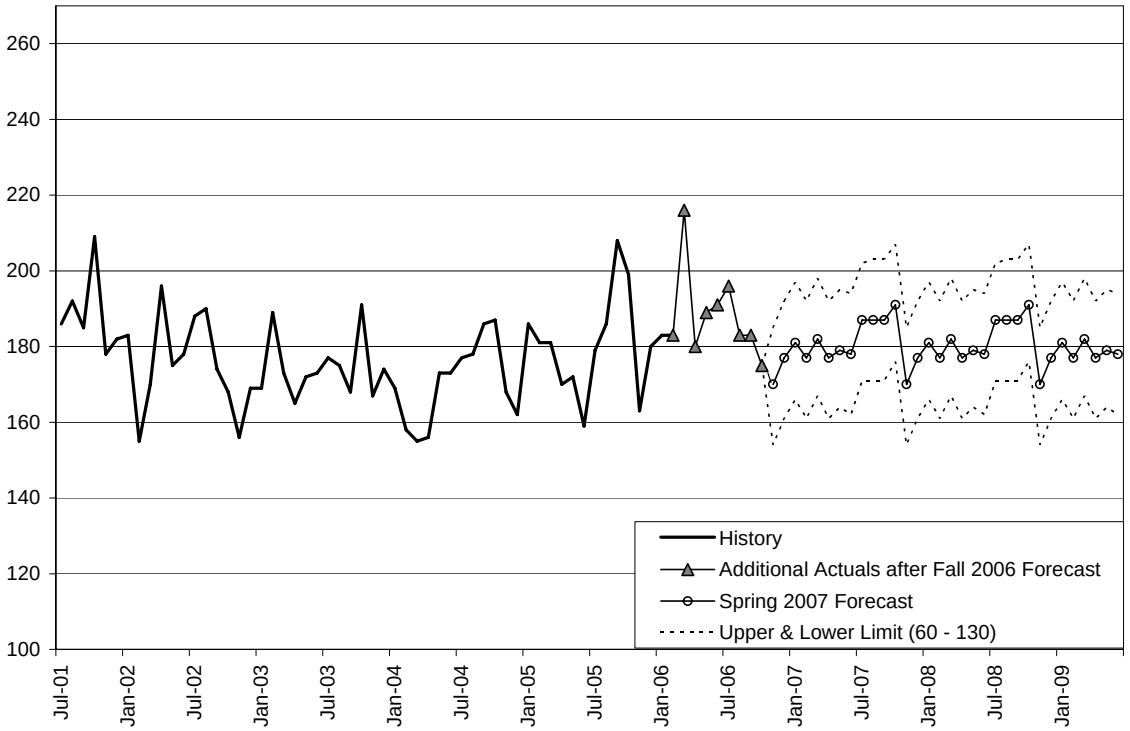
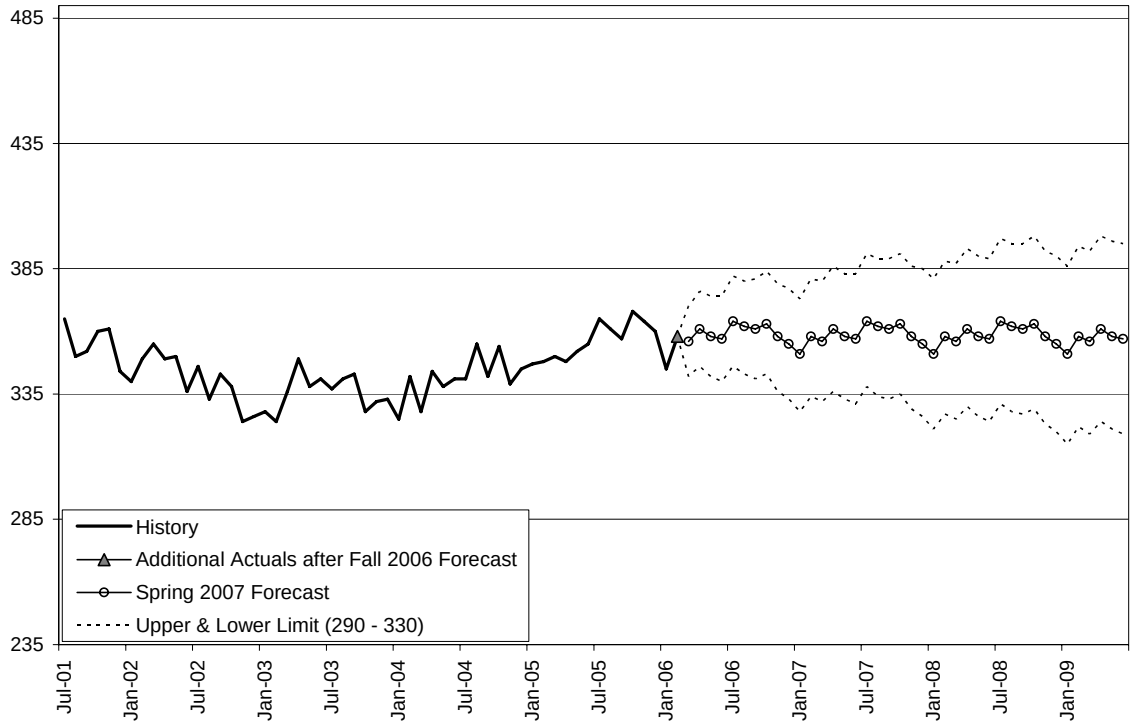


Exhibit D-10: Civil Commitment - State Hospital



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

Introduction

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

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

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

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

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

The OSIP Cash Assistance caseload is comprised of three main service groups:

Aid to the Blind (AB)
Aid to the Disabled (AD), and
Old Age Assistance (OAA)

The OSIP caseload forecast is a new category included in this document.

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 estate recovery requirement. OPI served an average of 3,400 clients a month in 2006.

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

Total Spring 2007 Caseload Forecast

The total Long-Term Care caseload forecast for Spring 2007 includes In-Home Care, Community-Based Care and Nursing Facilities. The Other Nursing Facilities services such as Medicare Extended Care, Enhanced Care and the OHP Post-Hospital Benefit caseloads are included beginning in the Spring 2006 forecast. These Other Nursing Facilities caseloads are rolled-up in the total Long-Term Care caseload.

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 E-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 Long-Term Care caseload population was 28,021 clients excluding the other NFC service category in the 2003-05 biennium. The Long-Term Care caseload, measured as a biennial average, is forecasted to decrease to 27,378 clients in the 2005-07 biennium. The total LTC caseload is anticipated to average 27,277 in the 2007-09 biennium including other NFC service caseload. The lower caseload forecast for Spring 2007 is due to a decline in In-Home and Community-Based Care Facilities, while the nursing facility caseload forecast is slightly higher.

As illustrated in Exhibit E-3, the overall Long-Term Care caseload in the first eight months of 2003 (November 2002-June 2003) declined about 10 percent, or by more than 3,000 cases. This was primarily due to the elimination of Long-

Term Care service priority level 12 through 17 implemented in February and April 2003[4].

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

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast		
Forecasts compared:	**Fall 2006 to Spring 2007**			**Fall 2006 to Spring 2007**			**2005 - 07 to 2007 - 09**		
Aged and Physically Disabled Biennial Averages by Forecast	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*% Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*% Diff. Fall 06 to Spring 07 2007-09*	**Spring 07 Forecast 2005-07**	**Spring 07 Forecast 2007-09**	**% Diff. Spring 07 2005 - 07 to 2007-09**
In-Home									
In-Home Hourly	10,261	10,063	-1.4%	10,206	9,934	-2.7%	10,063	9,934	-1.3%
In-Home Live-In	1,230	1,206	-1.5%	1,223	1,191	-2.6%	1,206	1,191	-1.2%
In-Home Spousal pay	135	132	-1.5%	134	131	-2.2%	132	131	-0.8%
Subtotal - In-Home	**11,626**	**11,401**	**-1.9%**	**11,564**	**11,256**	**-2.7%**	**11,401**	**11,256**	**-1.3%**
Community-Based Care									
Relative Adult Foster Care	1,533	1,543	0.7%	1,321	1,451	9.8%	1,543	1,451	-6.0%
Commercial Adult Foster Care	2,495	2,500	0.2%	2,428	2,498	2.9%	2,500	2,498	-0.1%
Regular Residential Care	1,026	1,015	-1.1%	1,024	997	-2.6%	1,015	997	-1.8%
Contract Residential Care	1,162	1,125	-3.2%	1,352	1,197	-11.5%	1,125	1,197	6.4%
Assisted Living	3,906	3,865	-1.0%	4,066	3,933	-3.3%	3,865	3,933	1.8%
Specialized Living	164	163	-0.6%	165	165	0.0%	163	165	1.2%
Providence ElderPlace	633	637	0.6%	715	698	-2.4%	637	698	9.6%
Subtotal - Community-Based Care	**10,919**	**10,848**	**-0.7%**	**11,071**	**10,939**	**-1.2%**	**10,848**	**10,939**	**0.8%**
Nursing Facilities									
Basic Nursing Facility Care	4,497	4,522	0.6%	4,419	4,452	0.7%	4,522	4,452	-1.5%
Complex Medical Add-On	342	351	2.6%	337	339	0.6%	351	339	-3.4%
Pediatric Care	69	66	-4.3%	70	70	0.0%	66	70	6.1%
Subtotal - Nursing Facilities	**4,907**	**4,939**	**0.7%**	**4,825**	**4,861**	**0.7%**	**4,939**	**4,861**	**-1.6%**
Other Nursing Facility Services									
Extended Care NFC	139	126	-9.4%	173	155	-10.4%	126	155	23.0%
Enhanced Care	60	57	-5.0%	60	60	0.0%	57	60	5.3%
Post-Hospital Benefit	6	4	-33.3%	6	6	0.0%	4	6	50.0%
Subtotal - Other Nursing Facility	**205**	**187**	**-8.8%**	**239**	**221**	-7.5%	187	221	**18.2%**
Total Long-Term Care	**27,657**	**27,375**	**-1.0%**	**27,699**	**27,277**	**-1.5%**	**27,375**	**27,277**	**-0.4%**
Oregon Supplemental Income Prgm. (OSIP)									
Aid to the Blind	595	598	0.5%	608	620	2.0%	598	620	3.7%
Aid to the Disabled	38,828	38,852	0.1%	40,250	40,311	0.2%	38,852	40,311	3.8%
Old Age Assistance	10,312	10,304	-0.1%	11,563	11,555	-0.1%	10,304	11,555	12.1%
Total OSIP	**49,735**	**49,754**	**0.0%**	**52,421**	**52,486**	**0.1%**	**49,754**	**52,486**	**5.5%**

Notes:
** Fall 2006 Forecast: Actuals through March 2006.*
** Spring 2007: Actuals through September 2006.*
** Total In-Home caseload does not include Independent Choices and Oregon Progject Independence caseloads.*
** OSIP Cash Assistance Program is a new caseload (counted as cases) forecast in the Spring 2007 Forecast.*

To summarize the comparison of Fall 2006 and the Spring 2007 forecasts, the following points can be made:

- The In-Home caseload forecast is lower in the 2005-2007 biennium by about 2 percent, and the 2007-09 biennium by about 2.7 percent compared with the Fall 2006 forecast.
- The Spring 2007 forecast for Community-Based Care caseloads is about 1 percent lower for the 2005-07 and the 2007-09 biennia compared with the Fall 2006 forecast.

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

- The Nursing Facilities forecast remains higher in the 2005-07 and 2007-09 biennia compared to the Fall 2006 forecast. It is higher by 1 percent in the 2007-2009 biennium.
- The Spring 2007 forecast for OSIP caseloads is nearly identical to Fall 2006 for 2005-07 and is slightly higher for the 2007-09 biennium. The Fall 2006 OSIP caseload forecast is taken from the SPD Rebalance for 2005-07.

Risks and Assumptions

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

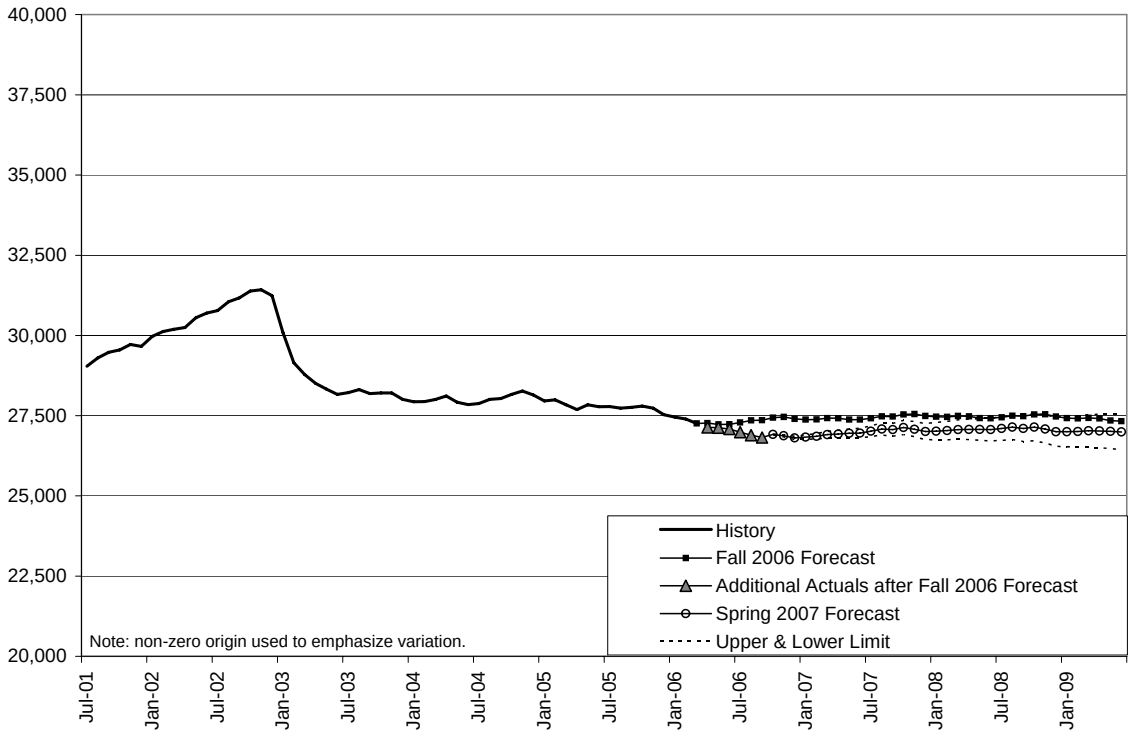
- The historical mix of current Medicaid services is assumed to remain constant throughout the forecast period.
- Medicaid eligibility requirements will remain the same throughout the forecast period.
- The transition patterns on/off Long-Term Care services and among the Medicaid LTC services will follow 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. More importantly, the 85 and older group will increase by 13 percent. Oregonians with multiple chronic conditions in the 85+ age group are also at risk of 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 non-competitive Medicaid reimbursement rates, 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 4 percent in either direction for the 2007-09 biennium.

Exibit E-3: Total Long Term Care



In-Home

The In-Home program provides personal assistance services that help people stay in their homes when they need assistance in Activities of Daily Living[5] (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

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

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 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. The Independent Choices program is set to be implemented statewide in later part of 2007.

Forecast

The total In-Home caseload was growing rapidly in 2001-03 with a biennial average of more than 13,000. This caseload averaged just over 11,800 in the 2003-05 biennium. In the first eight months of 2003-05 (November 2002 to June 2003), the In-Home services caseload declined by about 16 percent, or more than 2,200 cases as illustrated in Exhibit E-4. 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 11,401 clients, which is about 2 percent lower than the Fall 2006 forecast of 11,626 (Exhibit E-4). The total In-Home caseload is projected to average 11,256 in the 2007-09 biennium, which is about 3 percent lower than the Fall 2006 forecast.

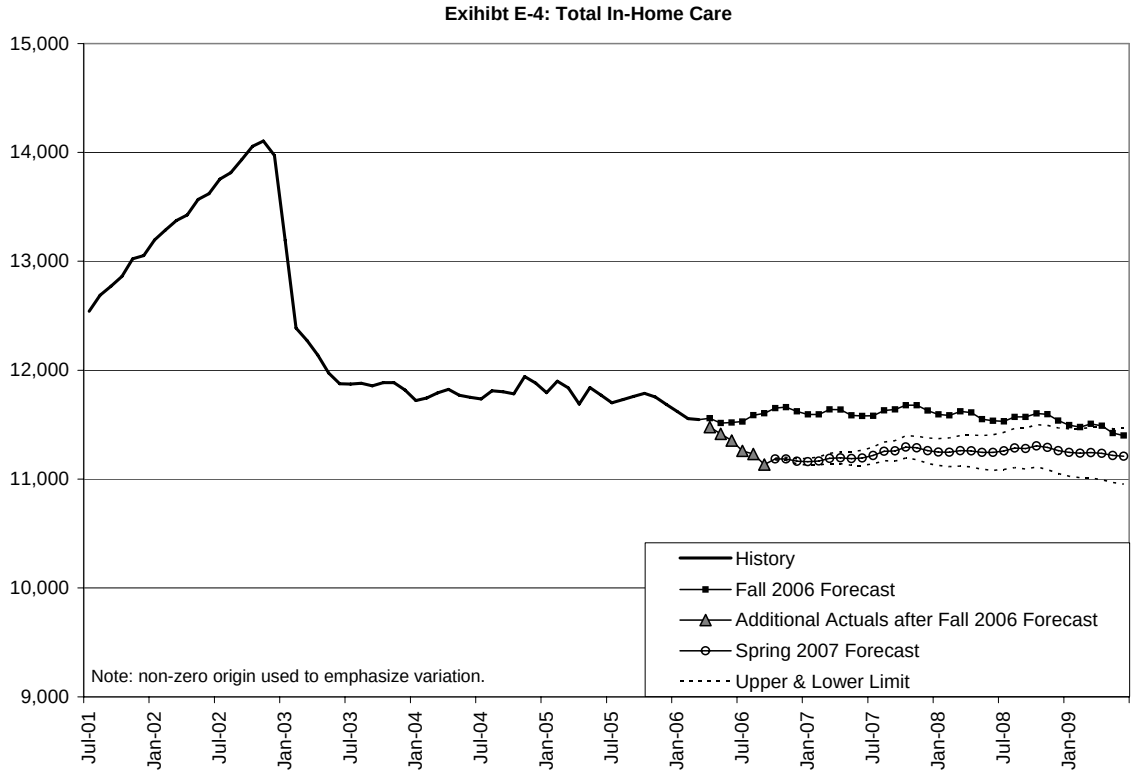
Risks to In-Home Forecast

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

The Medicare Modernization Act (MMA) implemented as of January 1, 2006, provides prescription drug coverage for people with Medicare. In the pre-MMA period, Medicare beneficiaries would have sought a few hours of In-Home services that would have qualified them for Oregon Health Plan prescription drug benefit. Those people may now drop the In-Home services. Furthermore, the dual eligible (Medicare and Medicaid) clients who have need for prescription medications and also qualify for Medicaid long-term care services may not choose to enroll for the few hours of In-home services to maintain the prescription drug coverage.

Independent Choices (IC) is being implemented statewide in coming years, which will exceed the current pilot program enrollment cap of 300 clients. 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.

In addition, field reviews and local office training on LTC service eligibility began in the later part of 2006 and will continue in 2007 and this will likely tighten up the new client entry into the In-Home services. 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.



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 (38 percent), Assisted Living Facilities (36 percent) and Residential Care Facilities (20 percent). Specialized Living Facilities and Providence ElderPlace account for about 1 percent and 5 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 Population clients are a small group of clients with targeted special medical or service needs (such as, mental health, traumatic brain injuries, AIDS, and ventilator-dependant clients). They receive services in Community-Based Care facilities. They are included in the appropriate CBC caseloads. **In January, 2007, approximately 264 clients** were being served under special need contracts in Residential Care, Adult Foster Care, and Assisted Living Facilities.

In addition, **63 clients** are receiving **Enhanced Care (EC)** services in various Community-Based Care facilities. Another **82 clients** receive **Enhanced Care Outreach Services (ECOS)** on a less intense basis in CBC as well as in Nursing Facilities. The Enhanced Care Services is a joint program between the SPD and Addiction and Mental Health Services, and it serves the most challenging placement populations generally from the state hospital. They are included in the appropriate CBC and NF caseloads. About 60 clients receiving Enhanced Care in Nursing Facilities are counted under the Other Nursing Facilities section.

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 Spring 2007 total Community-Based Care caseload forecast for the 2005-07 biennium is about 1 percent lower than the Fall 2006 (10,848 versus 10,919). In the 2007-09 biennium, the total Community-Based Care caseload is about 1 percent lower than the Fall 2006 estimate (Exhibit E-5).

CBC: Total Adult Foster Care

Adult Foster Care (AFC) provided by Adult Foster Homes, offers Long-Term Care in home-like settings licensed for five or fewer people. Adult Foster Homes represent 38 percent of the total CBC caseload in the Spring 2007 forecast. It accounted for 40 percent of the CBC caseload in 2003-05 (Exhibit E-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 4,078) in the Spring 2007 forecast. As Exhibit E-7 shows, the AFC-Relative caseload that has been declining steadily since January 2004 has stopped declining and is remaining steady around 1500.

During the 2001-03 biennium, the AFC-Relative caseload was increasing before the elimination of Service Priority Levels (SPL) 12-17. Since then, this caseload has experienced the risk of program elimination and uncertainty of budget cuts for the 2005-07 biennium. In addition, the elimination of the dual waiver option meant the developmentally disabled relative foster care clients were dropped from this caseload, and moved to Developmentally Disabled Foster Care 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 Spring 2007 remain slightly above the Fall 2006 forecast for the 2005-07, and significantly above the Fall 2006 for 2007-09 biennium. The growth in this caseload is anticipated due to recent trend of stabilization in this caseload as well as due to the clarification and enforcement of policy regarding the In-home and Relative AFC services. (Unlike In-Home clients, the Relative AFC clients stay with the relative care providers at their home).

CBC: Adult Foster Care - Commercial

The Adult Foster Care-Commercial caseload is 23 percent of the total Community-Based Care caseload, and it accounts for 62 percent of the total AFC caseload for the 2005-07 biennium (total average equals 4,043) in the Spring 2007 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 Spring 2007 forecast.

Forecast

The Spring 2007 Adult Foster Care-Commercial caseload forecast (2,500) is nearly identical to the Fall 2006 forecast for the 2005-07 biennium. This caseload is projected to average 2,498 in the 2007-09 biennium, which is about 3 percent above the Fall 2006 forecast (Exhibit E-8).

CBC: Total Residential Care Facilities

Residential Care Facilities (RCF) is 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 2007 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 that Contract Rates are more competitive in the RCF market place than the Regular Rates. However, neither RCF Regular nor RCF Contract caseloads are expected to grow rapidly (Exhibit E-9).

CBC: Residential Care Facilities - Regular

The **Residential Care Facilities-Regular** accounts for 9 percent of the total CBC caseload. It accounts for 48 percent of the total RCF caseload (total average equals 2,140). As with most other Long-Term Care caseloads, the RCF-Regular caseload was also growing prior to 2003. However, since that time it has been in gradual decline (Exhibit E-10). One of the reasons for this decline has to do with the gradual increase of the RCF-Contract caseload (Exhibit E-11). The RCF-Regular caseload bump between July 2004 and February 2005 indicates the increased RCF enrollment followed by the subsequent move of some RCF-Regular clients to Residential Facilities-Contract (Exhibit E-11).

Forecast

In the Spring 2007 forecast, the RCF-Regular caseload is projected to be lowered at a biennial average of 1,015 for 2005-07. This is about 1 percent lower than the Fall 2006 projection of 1,026 during the 2005-07 biennium. This caseload is projected to average 997 for 2007-09 biennium.

CBC: Residential Care - Contract

The Residential Care-Contract caseload is about 10 percent of the total CBC caseload, which accounts for 52 percent of the total RCF caseload (total average equals 2,144). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to grow at a slower pace than anticipated in the previous forecast (Fall 2006), over the 2005-07 and 2007-09 biennia.

Forecast

The RCF Contract caseload in the Spring 2007 is lower than in the Fall 2006 forecast for the 2005-07 biennium (Exhibit E-11). It is forecasted to be at a biennial average of 1,125 clients in 2005-07, lower than the Fall 2006 forecast of 1,162 clients by about 3 percent. The RCF-Contract caseload is anticipated to

average 1,197 per month in the next biennium (2007-09), which will be about 12 percent lower than the previously forecast (Fall 2006). This forecast reflects the lower rate of growth in this caseload over the 2007-09 biennium due primarily to the less than the competitive Medicaid reimbursement.

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. Thus, the Spring 2007 forecast reflect the downward adjustment of this caseload by 1 percent over the previous (Fall 2006) forecast.

Forecast

The Spring 2007 forecast (3,865 biennial average) is about 1 percent lower than the Fall 2006 forecast of 3,906 for 2005-07 (Exhibits E-12). Similarly, the caseload is projected to be lower (biennial average 3,933) in the 2007-09 forecast period compared with the Fall 2006 forecast level of 4,066.

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 traumatic brain injuries. The clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or 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 E-13).

In the Spring 2007 forecast, the 2005-07 PACE caseload is estimated to be 637. The Spring 2007 caseload forecast (698) for the 2007-09 period is about 2 percent lower than the Fall 2006 forecast of 715.

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 often spend–down and 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 is planning for a possible 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 would increase the current caseload by about 160. This may also impact the current Medicaid caseloads in ALF, Foster Homes and some nursing homes.

Historically, the Community Based Care caseload 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 E-5: Total Community-Based Care Facilities

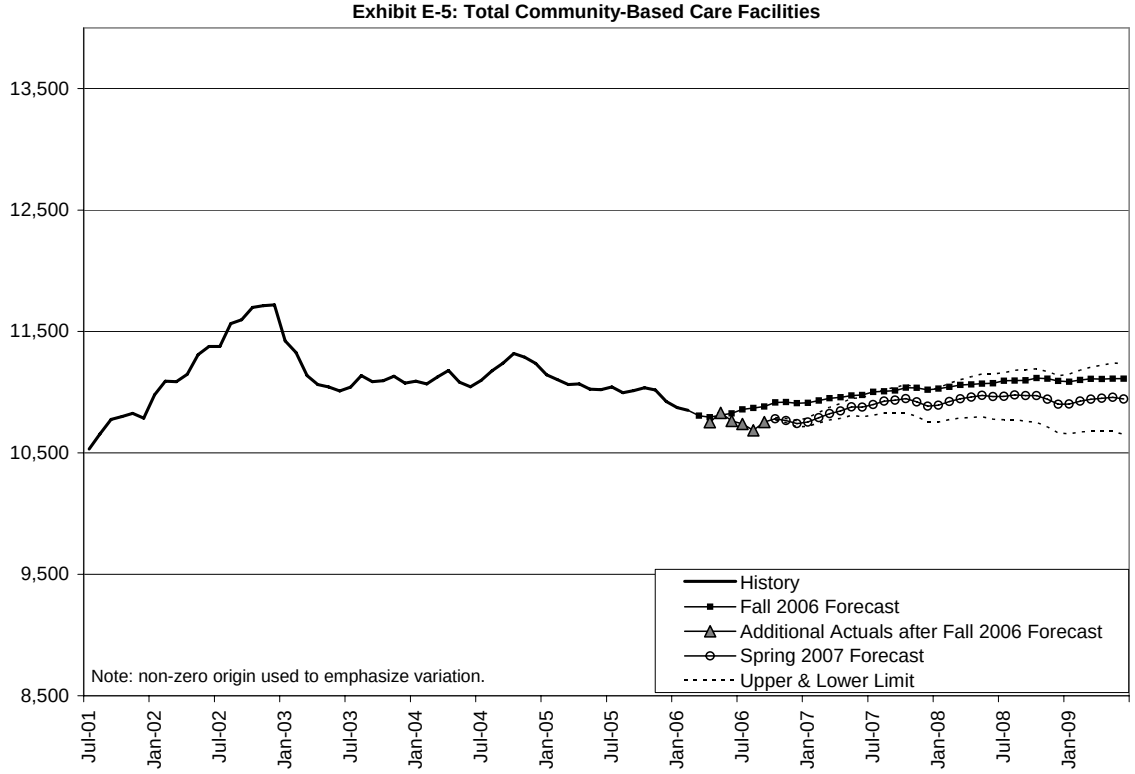


Exhibit E-6: Total Adult Foster Care

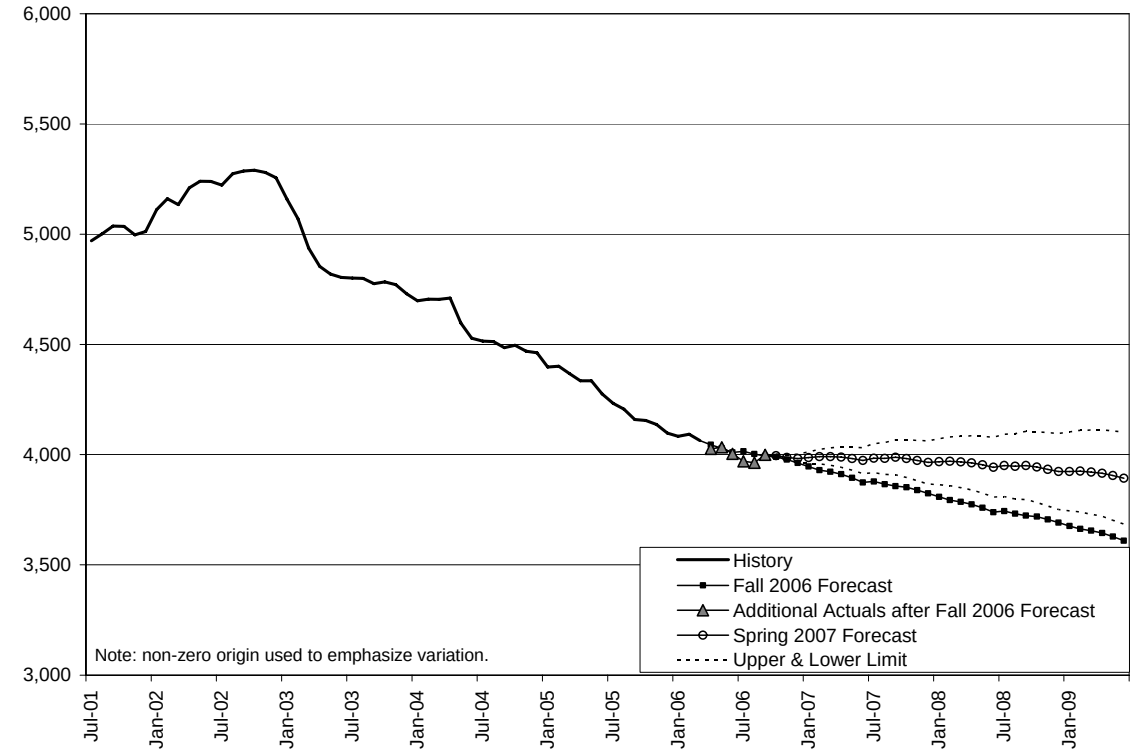


Exhibit E-7: Relative Adult Foster Care

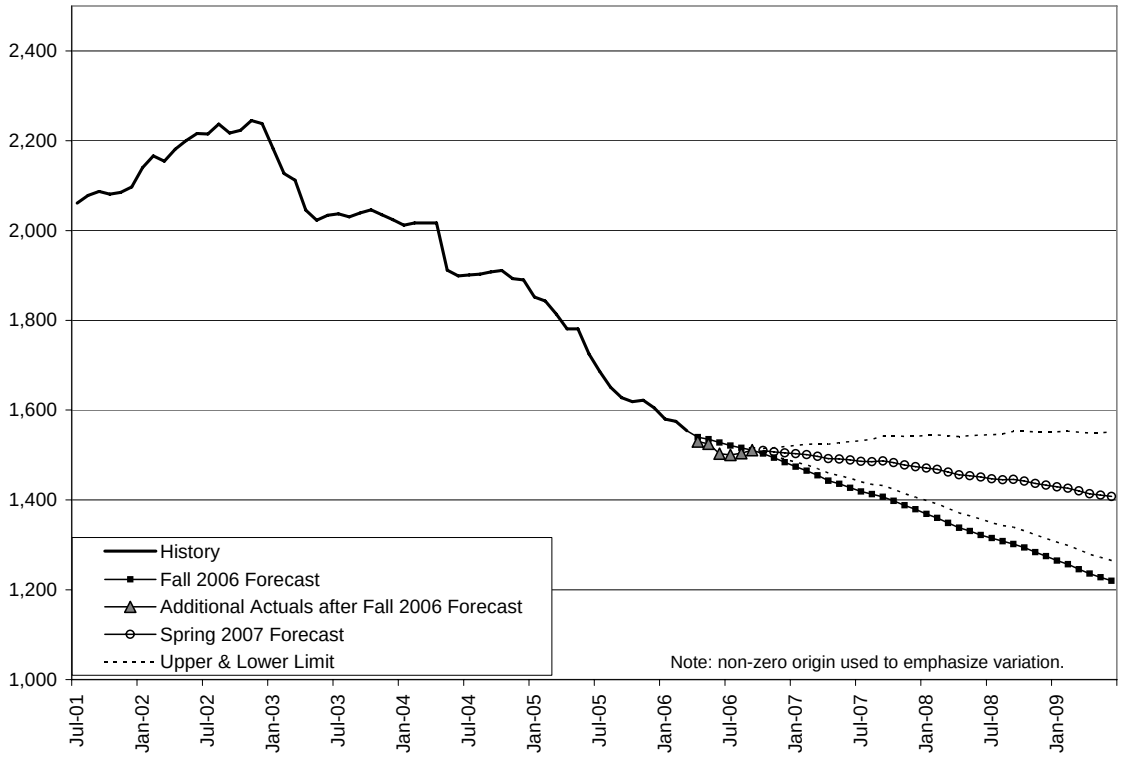


Exhibit E-8: Commercial Adult Foster Care

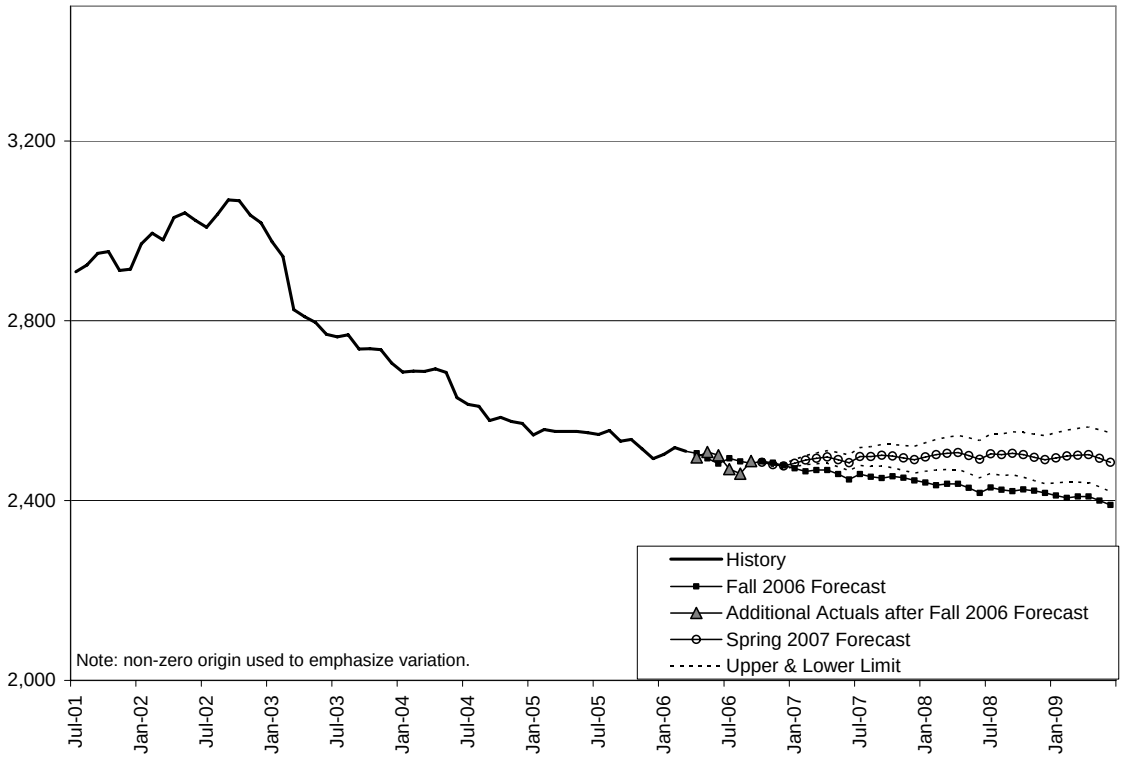


Exhibit E-9: Total Residential Care Facilities

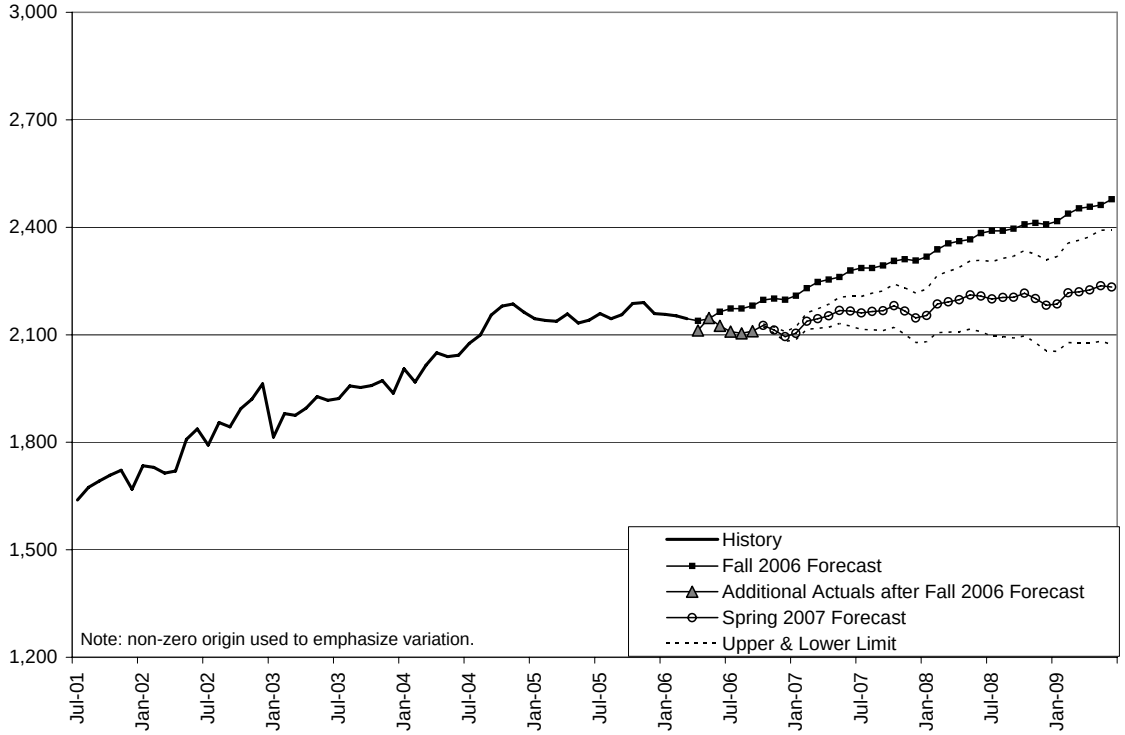


Exhibit E-10: Regular Residential Care

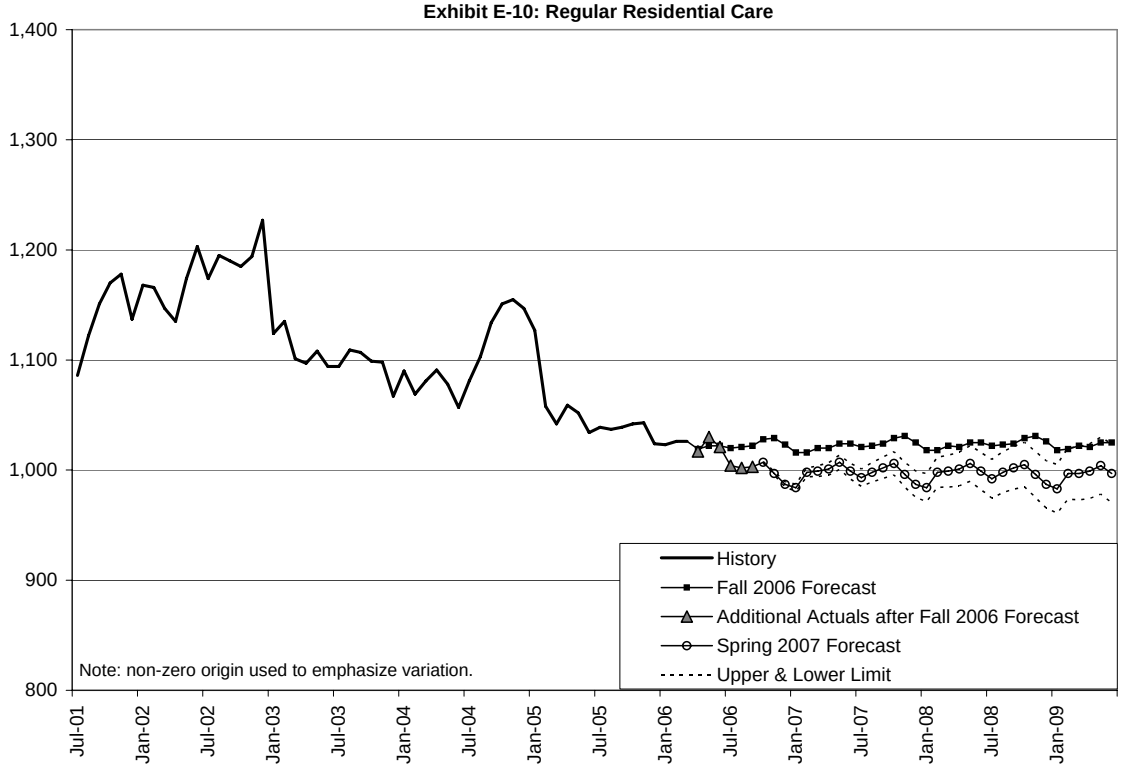


Exhibit E-11: Contract Residential Care

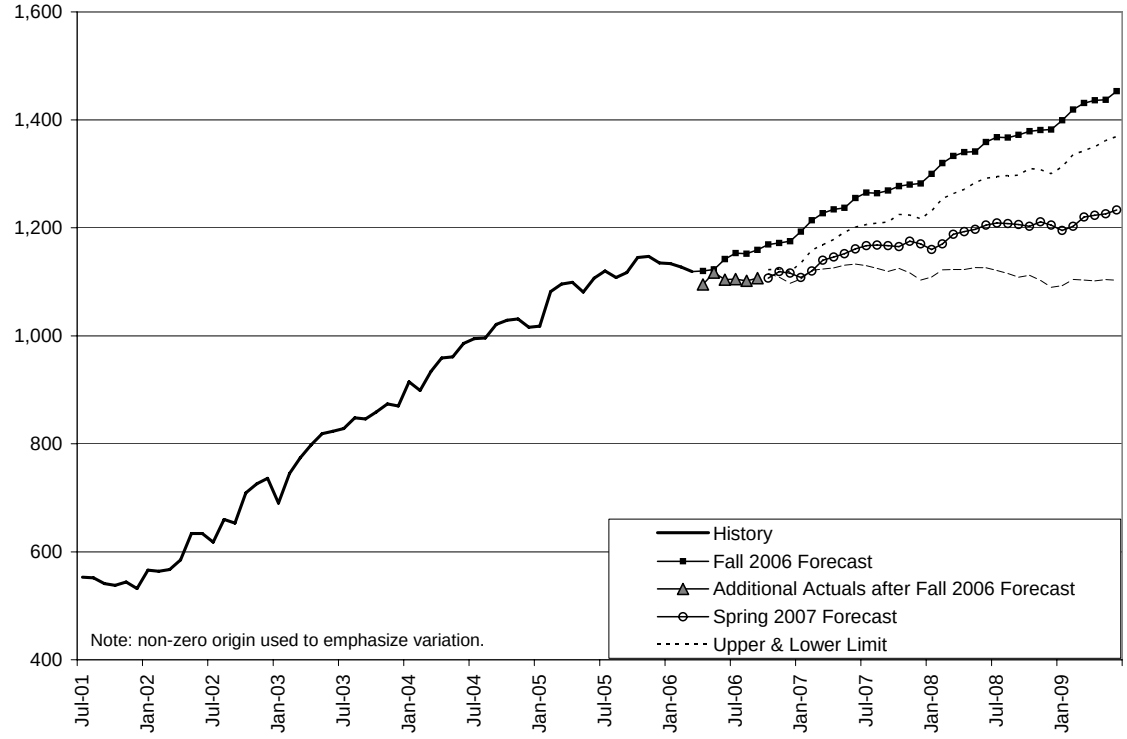


Exhibit E-12: Assisted Living Facilities

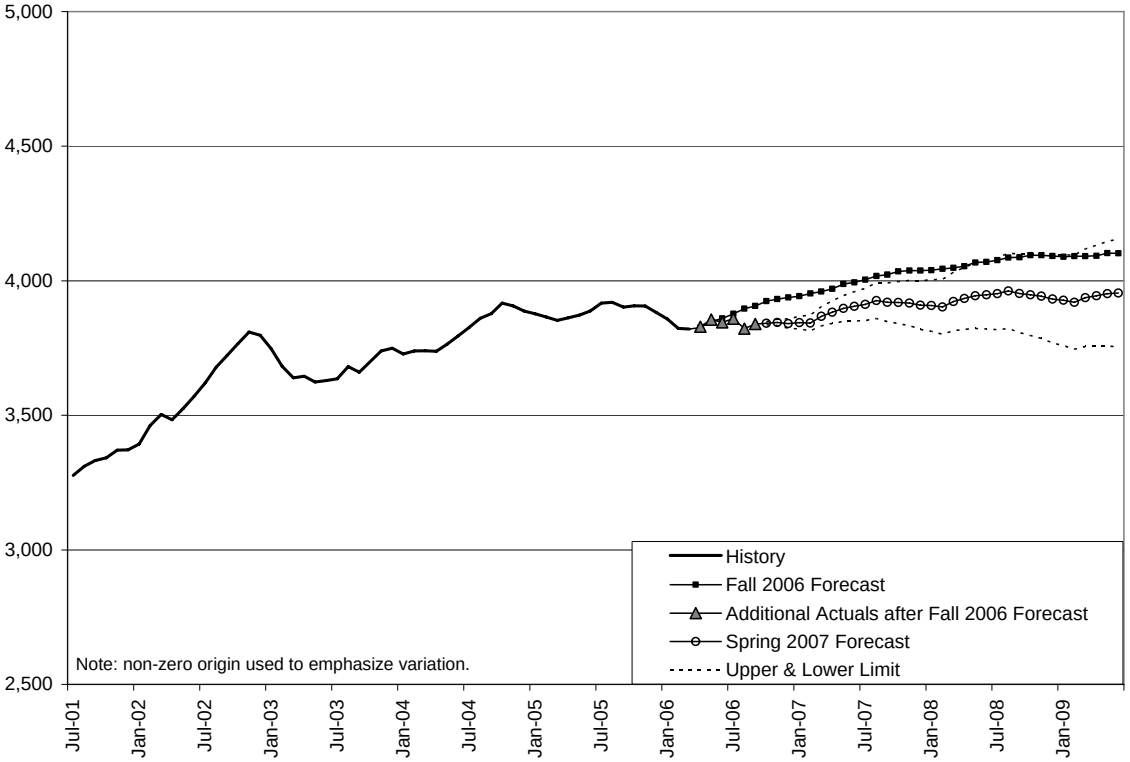
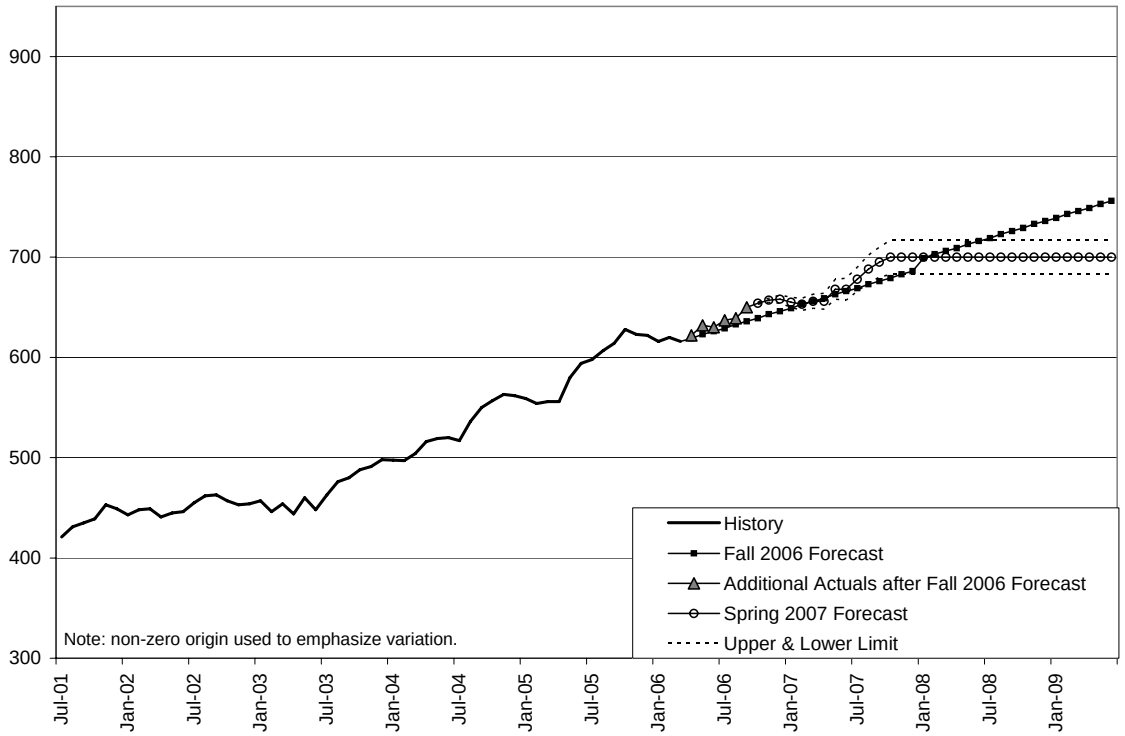


Exhibit E-13: Providence ElderPlace



Nursing Facilities

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

- Basic Care
- Complex Medical Add-On
- Pediatric Care

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[6].

[6] 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).

Forecast

In the Spring 2007 forecast, the total nursing facility caseload (excluding the three groups listed under the "Other NF Services") of 4,939 is slightly higher than the Fall 2006 forecast. This caseload is, however, projected to average about 1 percent higher at 4,861 in the 2007-09 biennium (Exhibit E-14), than the Fall 2006 forecasted biennial average of 4,825.

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 E-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[7]. The clients in this caseload need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care either due to age or physical disability.

Forecast

As noted earlier, this caseload has been decreasing gradually over time. The Spring 2007 NF Care-Basic caseload for 2005-07 biennium is estimated to be about 4,522. This caseload is projected to average 4,452 in the 2007-09 biennium, which is approximately 1 percent higher than the Fall 2006 forecast as seen in Exhibit E-15.

Nursing Facilities: Complex Medical Add-On

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

Forecast

The Complex Medical Add-On caseload is projected to average 351 in the 2005-07 biennium and the average of 339 in the 2007-09 biennium (Exhibit E-16). Comparing the previous forecasts, the Spring 2007 Complex Medical Add-On

[7] 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.

forecast is slightly higher than the Fall 2006 forecast for the 2005-07 biennium, and is nearly identical 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 forecast will remain at 70 clients through the 2007-09 biennium.

Medicare Extended Care

People receiving NF Medicare Extended Care (or extended skilled nursing care) is 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 extended care caseload is forecasted to remain at an average of 126 clients in the current (2005-07 biennium) and 155 clients in the next biennium (2007-09) as shown in Exhibits E-2.

Post-Hospital Benefit

The OHP post-hospital benefit is an Oregon Health Plan (OHP) extended skilled nursing care service. The OHP benefit pays for a maximum of 20 days of post-hospital extended skilled nursing care. In order to be eligible for the NF post-hospital benefit, people who are <u>not</u> 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 (206 in September 2006) for Enhanced Care services in various community care settings and Nursing Facilities. A new facility with 16 beds is planned to open in late 2007. The caseloads in the various Community-Based 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.

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 up 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 7 percent above or below the average forecast for the 2007-09 biennium.

Exhibit E-14: Total Nursing Facilities

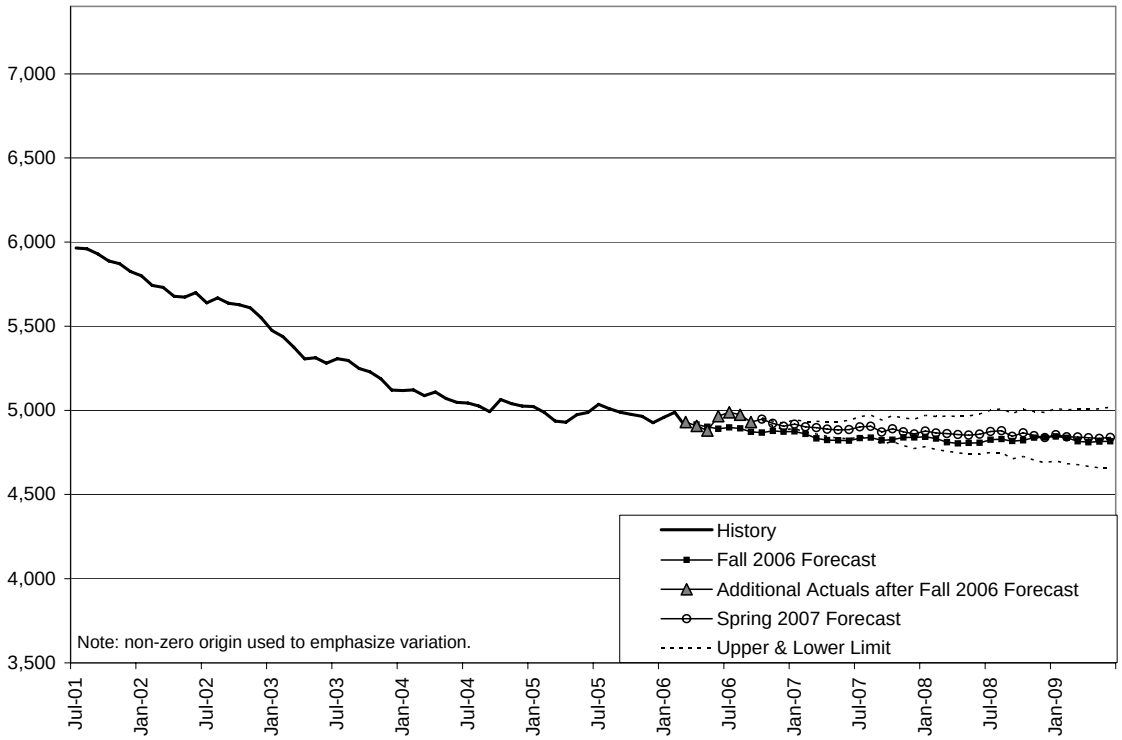


Exhibit E-15: Basic Nursing Facilities

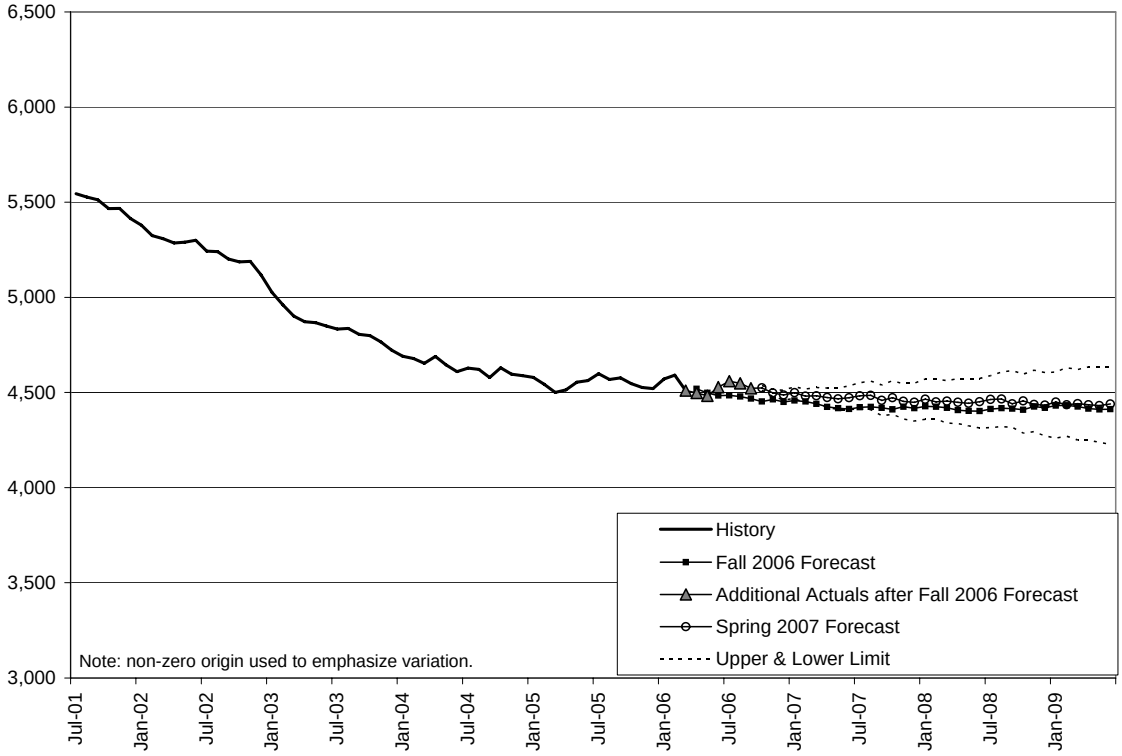
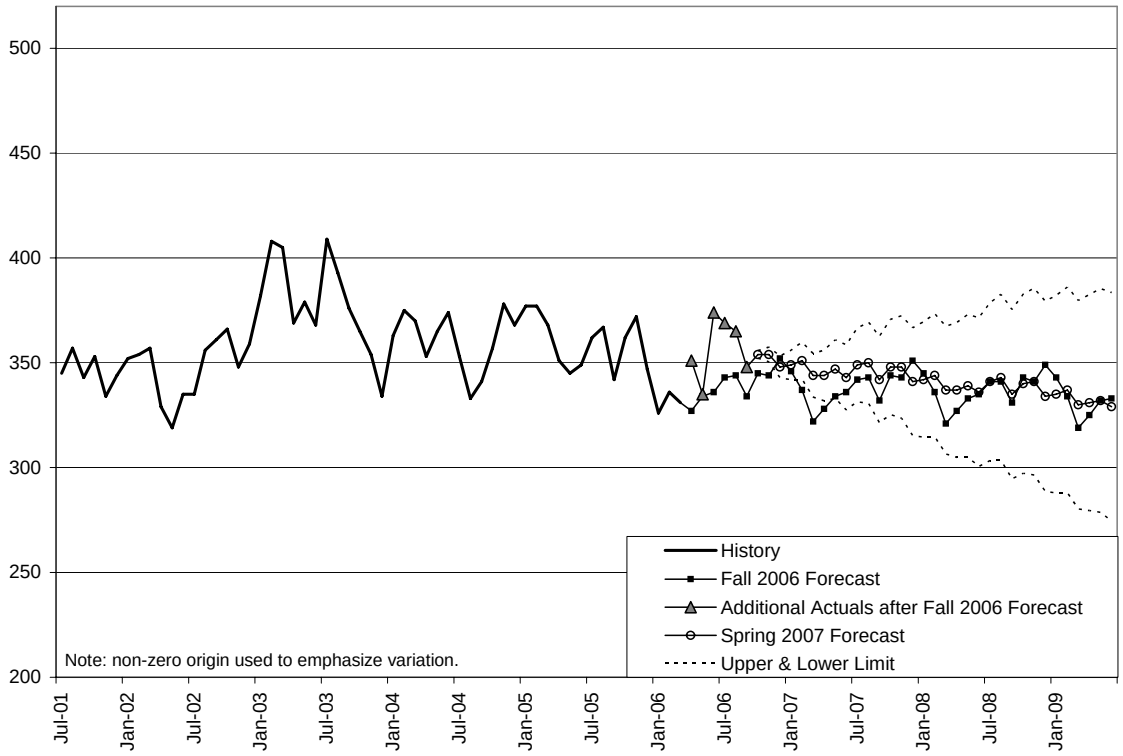


Exhibit E-16: Complex Medical Add-On Nursing Facilities



Public Health Division

CAREAssist Program

Introduction

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

Exhibit F-1 compares the biennial averages of actual individual counts and forecasted caseload per the Spring 2007 forecast for the 2005-07, and 2007-09 biennia.

Exhibit F-1: CAREAssist Biennial Average Comparisons

	2005-07 Biennium			2007-09 Biennium			Spring 2007 Forecast Comparison
	Spring 2007			Spring 2007			2005-07 to 2007-09
CAREAssist (ADAP) Program Biennial Averages	**Fall 06 Forecast 2005-07**	**Spring 07 Forecast 2005-07**	*% Diff. Fall 06 to Spring 07 2005-07*	**Fall 06 Forecast 2007-09**	**Spring 07 Forecast 2007-09**	*% Diff. Fall 06 to Spring 07 2007-09*	*% Diff. Spring 07 2005-07 to 2007-09*
CAREAssist	1,561	1,501	-3.8%	2,061	1,894	-8.1%	26.2%

CAREAssist Caseload

Forecast

Overall, the CAREAssist caseload is predicted to increase through June 2009 (Exhibit F-2). The 2007-09 biennial average is estimated to increase by 26 percent over that for 2005-07. Recent actuals for the last six months of 2006 were lower than those predicted by the Fall 2006 forecast. As a result, the current 2005-07 biennial average is four percent lower than the previous number and the 2007-09 biennial average is eight percent lower.

Risks and Assumptions

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

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

The following factors pose risks to the forecast:

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

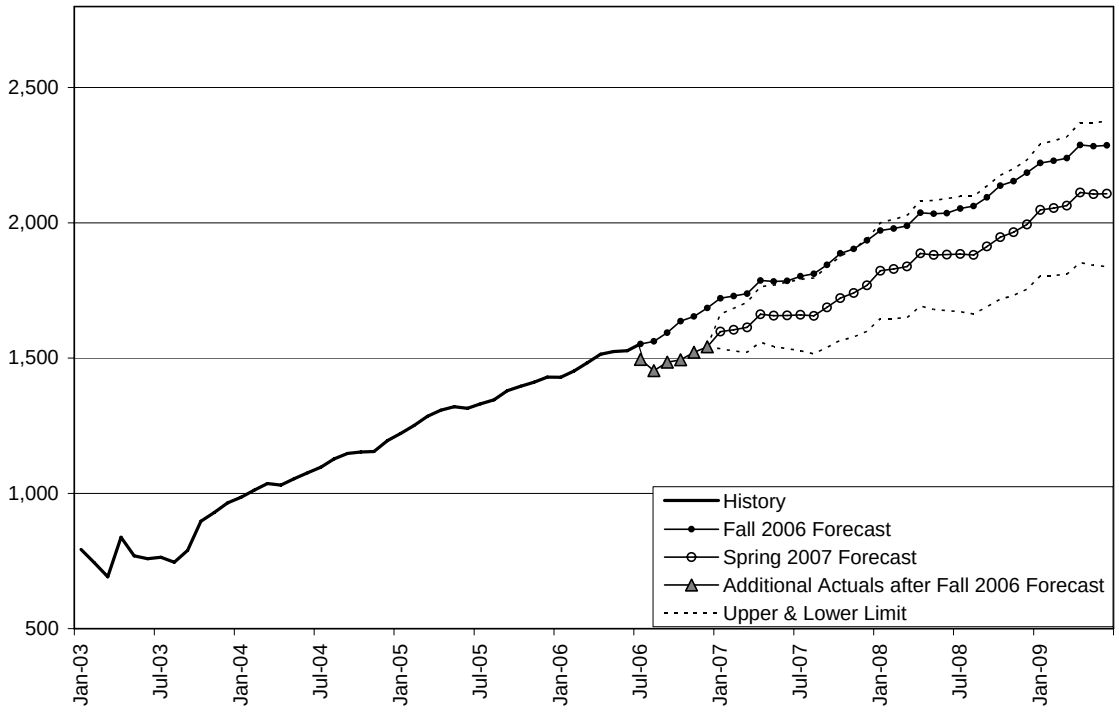
Changes in program resources: Fluctuations in federal funding affect the numbers of client receiving services and benefits from the CAREAssist program.

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

Specific Program and Policy Events: Changes in eligibility requirements or other guidelines can affect the observed caseloads.

Statistical Error: All forecasts have inherent error that increases with time; the longer the forecast period, the greater the error. The following graph incorporates upper and lower limits that illustrate the effects of this error on the forecast. Based on the historical fluctuation in the caseload, the future actuals could vary 10 percent above or below the average monthly forecast for the 2007-09 biennium.

Exhibit F-2: CAREAssist



Appendix I

Child Welfare Average Daily Population by Service Category

Service Categories

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

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

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

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

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

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

Residential Treatment consists of three major types of service:

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

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

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

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

Forecast

Regular Paid Foster Care

The Foster Care caseload consists of individuals falling into three categories: Residential 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 and subsequent decrease apparent in the Foster Care caseload since July 2005 is also evident in Regular Paid Foster Care ADP. The 6,834 average forecasted for the 2007-09 biennium is nearly 12 percent lower than the Fall 2006 forecast. This is similar to the situation with number served, where the Spring 2007 figure is about 12 percent lower than that for the Fall 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 Fall 2006 forecast, the 2007-09 biennial average for Special Rates Foster Care equaled 50 percent of the average for Regular Paid Foster Care; the Spring 2006 forecast had this percentage at 46. The Spring 2007 forecast has Special Rates Foster Care at 48 percent of Regular Paid Foster Care for the 2007-09 biennial average. The Spring forecast's biennial average of 3,308 for Special Rates Foster Care is 14 percent lower than the Fall 2006 forecast.

Adoption Assistance

This service correlates strongly with the Adoption Assistance caseload in terms of number served, so it presents a similar historical trend. The Spring 2007 forecast of 10,240 for the 2007-09 biennium ADP is around 2 percent lower than the Fall 2006 forecast. This is consistent with the difference between number served for the Spring 2007 and Fall 2006 forecasts, where the Spring 2007 forecast is about 3 percent lower than the Fall 2006 forecast for the 2007-09 biennium.

Subsidized Guardianship

This service has a strong correlation to its number served counterpart. At 765, the Spring 2007 forecast for ADP in the 2007-09 biennium is slightly over 2 percent higher than the Fall 2006 forecast. The number served figure is almost one percent higher for the Spring 2007 forecast compared to Fall 2006.

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 474 for Total Residential Treatment falls 16 percent below that for the Fall 2006 forecast. Regular Contract tends to be relatively stable since it relates to a contracted number of beds, so at 343 the forecast shows no deviation from the Fall 2006 forecast, remaining with the assumption of 95 percent utilization. The deviation, then, is attributable to Special Contracts (about 41 percent lower than the Spring 2006 forecast) and Target Children (around 40 percent lower).

Risks and Assumptions

As with the caseloads in terms of number served, the Adoption Assistance and Subsidized Guardianship ADP forecasts for Spring 2007 assume a continuation of the upward trends exhibited historically. Given the relative stability of these trends, the associated forecasts present very little risk.

Foster Care, on the other hand, has exhibited a leveling off and recent decrease in terms of both number served and ADP that one cannot readily explain. This creates uncertainty as to whether: a) the recent downturn will persist; b) the trend will stabilize into the flattened trend exhibited during the latter part of 2005 and first part of 2006; or c) the pattern will return to the aggressive growth seen during the two years preceding July 2005. This uncertainty extends to the ADP forecasts for Regular Paid Foster Care, Special Rates Foster Care, and Residential Treatment, all of which link closely to the number served in Foster Care. The forecast assumes that the Foster Care caseload in terms of number served will grow at the same rate that founded referrals have grown since 2003, which is 0.15 percent per month.

Appendix II

Forecast Process and Methodology

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

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

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

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

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

Notes on methods

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

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

www.dhs.state.or.us

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