

DEPARTMENT OF HUMAN SERVICES

FALL 2008 FORECAST



BUDGET PLANNING AND ANALYSIS
FORECASTING, RESEARCH & ANALYSIS
SEPTEMBER 2008

Executive Summary

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). Through August 2008, Oregon has experienced a growing unemployment rate and overall slowing of the economy. Economists predict that Oregon will experience further job losses across most sectors throughout 2008 and into 2009, after having experienced moderate to rapid growth in the five years since the last recession. The rate of growth of personal income in Oregon has been declining since the fourth quarter of 2006. There was a large increase in the second quarter of 2008, largely due to federal rebate checks. However, the rate of growth in personal income is expected to slow dramatically in the third quarter of 2008 while rebounding to average levels through 2012.

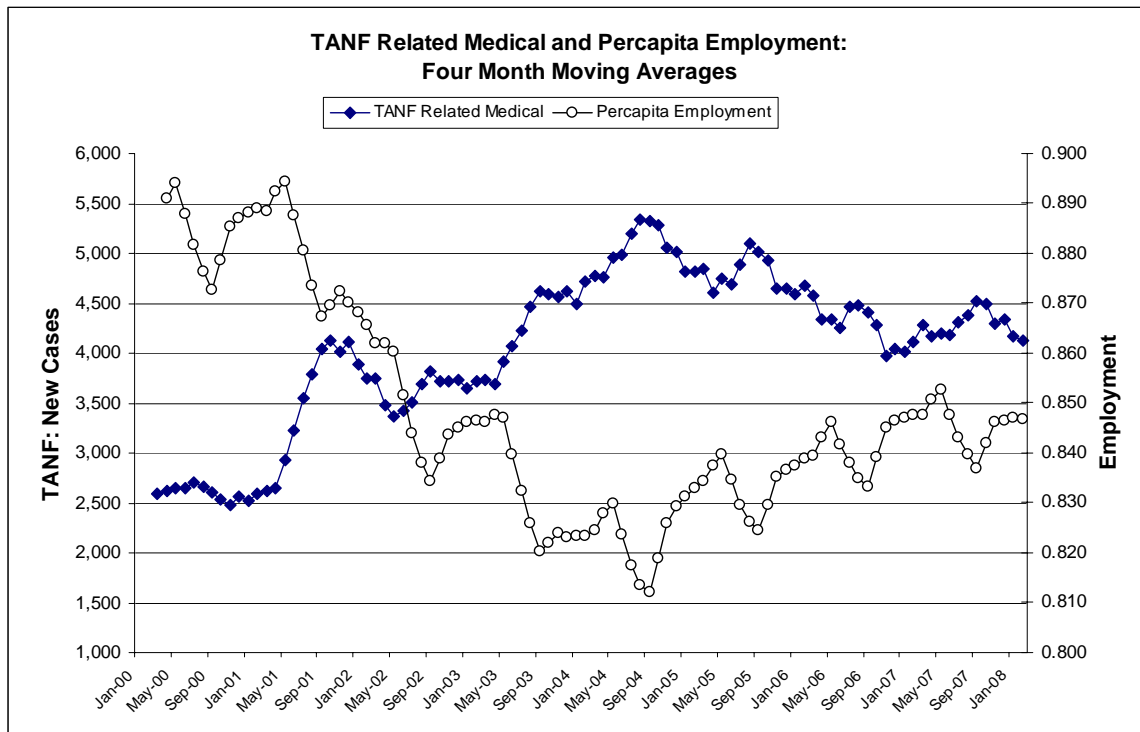


Figure One illustrates the overall relationship between employment (jobs) and DHS caseload. In this case, we are showing the number of new clients entering the TANF Medical program; these clients have the lowest income-eligibility limits of any Oregon Health Plan group and are sensitive to fluctuations in the economy. The graph shows that as jobs decrease over time, the TANF Medical caseload increases, and vice-versa.

The rate of job growth has also been in decline since the end of 2007 and is expected to continue this trend throughout 2008 as both the national and state

economies soften further. Currently, the seasonally adjusted unemployment rate rose from 5.5 percent in June to 6.0 percent in July. Even though unemployment has increased marginally as a state, 10 counties have seen their unemployment rates rise by more than 1.5 percent, and 14 have seen the rate rise by more than 1 percent as of March 2008. The counties most affected by the economic downturn are those in the central and eastern parts of the state.

Also, the higher uninsured rate is anticipated to continue with fewer employers providing health coverage. State demographers predict that Oregon's population will continue to increase moderately with relatively rapid increases in the elderly population. Finally, the number of Oregon's children and families in extreme poverty is anticipated to grow. These factors will likely exert significant upward pressure on several DHS caseloads.

Changes in federal policy present major risks to the current estimates for a wide range of DHS programs - from Temporary Assistance for Needy Families (TANF) to Medicaid.

To help improve the accuracy of the Fall 2008 caseload forecasts, OFRA forecasters included known economic effects and expert opinion into the forecast models to produce "recession-based" forecasts for select caseload groups. These forecasts predicted caseloads that are larger than those produced by traditional methods and grow at substantially faster rates than those of the Spring 2008 forecasts. For example, for the 2007-09 biennium, the total Oregon Health Plan (Medicaid) forecast grows at a rate that is over twice as fast as the Spring 2008 forecast, and the difference in growth over the 2009-11 biennium is nearly the same. The Fall 2008 Poverty Level Medical – Children forecast has 16 times the growth rate over 2007-09 than that for the Spring 2008 forecast!

OFRA analysts also conducted a telephone survey of the Community Provider Advisory Group and additional community-based non-profit agencies to help interpret the forecasts and aid in selecting the final estimates. Providers were asked to share their observations of (1) the current demand for services as well as reasons for potential demand increase over the next 6 to 12 months, (2) DHS program interactions, and (3) client trends in local communities. The majority of providers reported an increase in individuals and families living in poverty across all DHS program areas and geographic regions. Several providers also reported an increase in two- and three- income families, those with moderate income, and the "working poor" seeking assistance from DHS programs.

Nearly all providers observed an increase in the current need for services. They cited the high cost of necessities (food, gasoline, healthcare and housing) combined with general unemployment and industry-specific job cuts as the primary cause of the increase. Providers also reported increasing social conditions resulting from economic decline (alcohol and drug addiction, domestic violence, homelessness). The majority of providers expect demand to increase or remain steady between January 2009 and July 2009. Contributing factors include the increase in healthcare expenses combined with the rising uninsured and underinsured population; the increasing price of gasoline and lack of affordable,

reliable transportation; unemployment and the lack of sustainable, full-time, local jobs; the projected record heating utility costs for in the upcoming fall and winter months; and the effect of affordable housing shortages on migration, transitional housing, and homelessness.

Summary of DHS forecasts

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

Self Sufficiency programs such as Temporary Assistance for Needy Families (TANF) and Food Stamps have exhibited strong growth since late 2007. This growth is believed to be the result of a weakening economy. Oregon experienced an employment decline during the second quarter of 2008. In its September 2008 *Oregon Economic and Revenue Forecast*, the Office of Economic Analysis (OEA) expects quarterly employment declines to continue through the end of 2008. OEA expects a slow recovery beginning in 2009 with significant year over year employment gains beginning in 2010. Given this economic outlook and the economy's historical effect on Self-Sufficiency caseloads, the Food Stamp and TANF caseloads are forecast to increase through the end of 2009. The 2007 TANF Reauthorization created new policies and programs that were expected to create a gradual decline in the TANF caseload during the 2007-09 and 2009-11 biennia. However, the effects of the TANF Reauthorization on the caseload have heretofore been overshadowed by economic pressures.

Child Welfare caseloads exhibited strong growth during the two years prior to July 2005. The total caseload was stable in the following year, and then it declined in nearly every month between July 2006 and April 2008. The downward trend was caused by declines in both the Child in Home and Out of Home caseloads. Various theories have been offered as to why these caseloads declined including more efficient screening, improved practices that allow more children to remain in their homes, the decline in methamphetamine labs, and the phasing-out of non-paid foster care. Both caseloads show recent signs that the period of large decreases has ended. Child in Home care is expected to undergo a moderate increase, while Out of Home care is expected to decline a bit more before stabilizing. Since there is considerable uncertainty regarding the exact factors that might be driving the trends in these two caseloads, their forecasts are bounded by wide risk bands. Adoption Assistance and Subsidized Guardianship, on the other hand, have maintained upward trends, and those trends are continued in the forecast through 2009-11.

Vocational Rehabilitation caseload fell steadily during 2006 and trended upward through May 2007. Since then the caseload has been stable with seasonal fluctuations. This caseload is expected to increase due to growth in referrals from the Mental Health program for Supported Employment Evidenced Based Practices.

Medical Assistance Programs: consist of three major areas: Oregon Health Plan (OHP) Plus, OHP Standard and "Other". The total Division of Medical Assistance Program (DMAP) caseload is expected to grow dramatically as new policies and procedures are, or have been, implemented within the 2007-2009 biennium and as the ongoing economic downturn worsens through mid-2009. Caseload growth is expected to continue through 2009-11. The potential influences on future DMAP populations as incorporated into the current forecast include: (1) the managed re-opening of the OHP Standard program in the spring of 2008; (2) the implementation of the provisions of HB 2469 (provides for both restructuring and expansion of programs related to TANF); (3) the extension of eligibility re-determination periods from six to twelve months for Poverty Level Medical Children and TANF children; and (4) continued economic slowdown through the middle of calendar 2009.

Temporary Assistance for Needy Families-Medical (TANF-M): Due to the effects of prior policy changes coupled with a relatively stable economic period this eligibility group experienced a substantial drop in caseload from 2005 through 2006 followed by a flattening through the end of 2007. Since that time a worsening economy has contributed to significant increases in monthly caseloads. The sensitivity of this group to economic conditions coupled with eligibility review changes for children is expected to result in rapidly increasing caseloads through the end of 2009. Considerable risk is associated with the forecast for this group and is primarily associated with economic change.

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 in caseload between 2002 and 2005 followed by a relatively stable period through 2006. This group is also sensitive to changing economic conditions. Dramatic increases in caseload since the beginning of 2007 coupled with a planned policy change to eligibility re-determination periods in 2009 result in a rapid and sustained caseload growth through the end of the 2009-2011 biennium.

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

growth pattern to continue at its historical pace exacerbated by worsening economic conditions.

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

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

OHP Standard: In July 2004, the OHP Standard program was closed to new clients while remaining open to clients transitioning from other eligibility categories. One result of the closure was to reduce dramatically the number of clients enrolled in the two groups (Families and Adults and Couples). Together these two groups declined from a total caseload of around 57,000 in July 2004 to approximately 18,800 in September 2007. Absent policy change this eligibility group would be expected to maintain an extremely slow decline in caseload through the forecast horizon.

The Standard program was re-opened to a fixed number of new clients (via random selection) in March 2008. The caseloads for this program (Families and Adults and Couples) are currently being managed within budgetary parameters. The current expectation is that the caseload should approximate an average of 24,000 clients across the 2007-2009 biennium.

Mental Health: The Spring 2008 Mental Health forecast is composed of the following mandated caseloads: Criminally Committed (Aid and Assist; Psychiatric Security Review Board (PSRB)), and Civilly Committed (24 Hour Care, Acute Care, State Hospitals, and Non-residential Community). Civilly Committed and PSRB individuals in community outpatient settings are included in the Spring 2008 forecast. In the past, data development issues did not allow comparisons between forecasts. Because these data issues have been largely resolved, we can now compare the Spring 2008 forecast with that for Fall 2007.

Criminally Committed caseload has fluctuated with periods of growth followed by decline in 2005-06 and growth in 2007. We anticipate that the recent growth will continue through 2011.

Civily Committed caseload has steadily grown through 2006 but has recently leveled off. Thus, only slight growth is expected through the 2009-11 biennium.

Seniors & Physically Disabled – Long-Term Care (LTC): The Long-Term Care forecasts are divided into In-Home, Community-Based Care Facilities and Nursing Facilities. The Fall 2008 Long-Term Care caseload forecast remains slightly below the Spring 2008 forecasted level for the 2007-09 and 2009-11 biennia.

In-Home Care caseload was relatively flat or slightly decreasing after severe budget cutbacks in 2002. However, the caseload has continued to decline due to ongoing client eligibility reviews and the implementation of the Medicare Modernization Act. This decline has stabilized in recent months.

Community-Based Care Facilities caseload also declined in 2002, but grew modestly in 2003 and early 2004. The gradual withdrawal from Medicaid contracts by Assisted Living and Contract Residential Care providers (due primarily to lower Medicaid reimbursement) has slowed down. This factor coupled with various program initiatives including the CBC Rate increase, new licensing requirements and eligibility determinations results in a modest growth trend through this forecast period.

Nursing Facilities caseload is declining in most recent months. As a result, we expect a slight decline through 2009-11. The combined effect of an aging population and the persistent volatility in LTC market dynamics in community-based settings, as well as SPD's Oregon on the Move (Money Follows the Person) and other diversion initiatives, may result in a slower decline in Nursing Facilities caseload.

Oregon Supplemental Income Program (OSIP) caseload is expected to moderately grow through the 2009-11 biennia.

Total DHS Caseload Biennial Average Comparison by Forecasts

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	% Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
Biennial Averages by Forecast									
Children, Adults and Families (CAF)									
Self-Sufficiency									
Food Stamps (Households)	227,410	245,721	8.1%	238,130	245,721	3.2%	245,721	273,532	11.3%
Temporary Assistance for Needy Families (Families: Cash Assistance) Basic & UN	16,977	19,468	14.7%	18,716	19,468	4.0%	19,468	20,214	3.8%
Employment Related Daycare (Families)	9,840	10,100	2.6%	10,435	10,100	-3.2%	10,100	11,638	15.2%
Child Welfare (Children Served)									
Child In Home	3,056	2,813	-8.0%	3,036	2,813	-7.3%	2,813	2,841	1.0%
Out of Home Care	8,596	7,404	-13.9%	8,187	7,404	-9.6%	7,404	6,978	-5.8%
Adoption Assistance	10,678	10,565	-1.1%	10,641	10,565	-0.7%	10,565	11,541	9.2%
Vocational Rehabilitation (Clients Served)									
	9,181	9,201	0.2%	9,111	9,201	1.0%	9,201	9,362	1.7%
Medical Assistance Programs									
OHP Plus: Temporary Assistance to Needy Families (Medical)									
	116,091	115,829	-0.2%	114,618	115,829	1.1%	115,829	132,663	14.5%
OHP Plus: Children (PLMC & CHIP)									
	125,971	138,674	10.1%	126,481	138,674	9.6%	138,674	170,810	23.2%
OHP Plus: Seniors and People with Disabilities									
	95,220	96,518	1.4%	95,908	96,518	0.6%	96,518	105,025	8.8%
OHP Plus: Poverty Level Medical Women									
	10,825	11,083	2.4%	10,825	11,083	2.4%	11,083	12,034	8.6%
OHP Plus: Substitute Care & Adoption Serv.									
	17,667	17,833	0.9%	17,361	17,833	2.7%	17,833	18,360	3.0%
OHP Plus Total	365,774	379,937	3.9%	365,193	379,937	4.0%	379,937	438,892	15.5%
Other Medical Assistance Programs									
	30,910	32,134	4.0%	30,899	32,134	4.0%	32,134	34,725	8.1%
Seniors and People with Disabilities - Long Term Care									
In Home	10,691	10,488	-1.9%	10,570	10,488	-0.8%	10,488	10,345	-1.4%
Community Based Care	10,550	10,538	-0.1%	10,509	10,538	0.3%	10,538	10,548	0.1%
Nursing Facilities	5,135	5,215	1.6%	5,293	5,215	-1.5%	5,215	5,284	1.3%
Addictions and Mental Health (AMH)									
Criminal Commitment									
Aid and Assist	177	139	-21.5%	148	139	-6.1%	139	154	10.8%
Psychiatric Security Review Board	781	767	-1.8%	765	767	0.3%	767	811	5.7%
Total Criminal Commitment	958	906	-5.4%	913	906	-0.8%	906	965	6.5%
Civil Commitment									
24 Hour Care	1,420	1,387	-2.3%	1,295	1,387	7.1%	1,387	1,643	18.5%
Acute Care	168	173	3.0%	168	173	3.0%	173	177	2.3%
State Hospital	316	320	1.3%	317	320	0.9%	320	322	0.6%
Non-residential Community Care	2,792	3,094	10.8%	2,649	3,094	16.8%	3,094	3,653	18.1%
Total Civil Commitment	4,696	4,974	5.9%	4,429	4,974	12.3%	4,974	5,795	16.5%
Total Mandated Care	5,654	5,880	4.0%	5,342	5,880	10.1%	5,880	6,760	15.0%
Unduplicated Count, Total Mandated Care	4,488	4,738	5.6%	4,302	4,738	10.1%	4,738	5,434	14.7%

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I. CHILD WELFARE AVERAGE DAILY POPULATION

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Forecast: Economic and Demographic Background

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

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

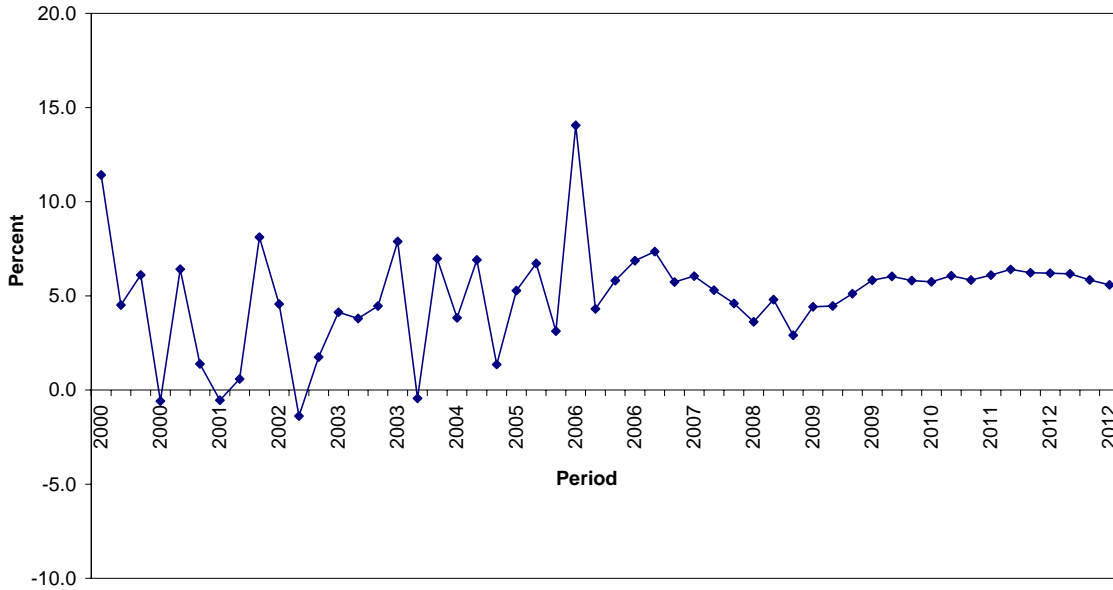
Key Economic Factors

The overall health of an economy is a function of many components including unemployment rates, cost of living, and per capita income. Simplistically, a strong economy increases people's standard of living by making such things as housing, food, health care, and other essential needs more affordable and available.

Through August 2008, Oregon has experienced a growing unemployment rate and overall slowing of the economy. Based on national and state economic trends, economists predict that Oregon will experience further job losses across most sectors throughout 2008 and into 2009. The current economic slowdown stems from two primary sources: (1) persistent troubles in the mortgage market which continues to strain financial credit; and (2) dramatic increases in the price of energy and food. Combined, these effects will help to constrain consumer spending and economic growth throughout the rest of 2008 and into 2009. It should be noted however, that Oregon is expected to fair better than the national economy during the current slowdown.

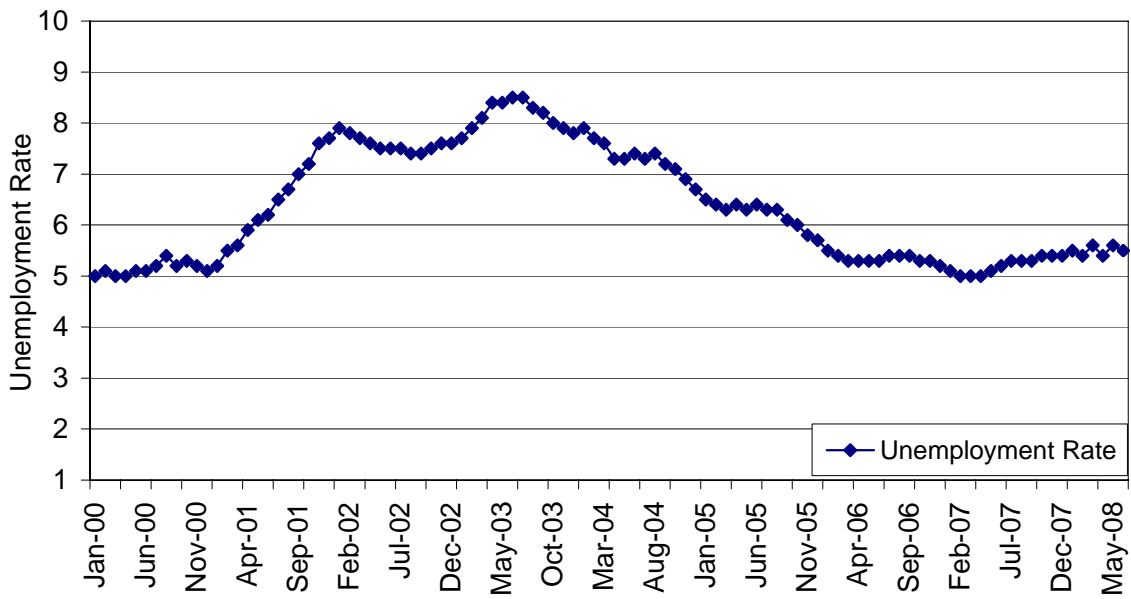
The rate of growth of personal income in Oregon, displayed in Exhibit A-1, has been declining since the first quarter of 2007. There was an increase in the second quarter of 2008, largely due to federal rebate checks. However, the rate of growth in personal income is expected to slow dramatically in the third quarter of 2008 while rebounding to average levels through 2012.

Exhibit A-1: Percent Change in Oregon Personal Income



Source: Oregon's Office of Economic Analysis: Economic Forecast

Exhibit A-2: Unemployment Rate (Seasonally Adjusted)



Source: Oregon Employment Department

Job Growth

The rate of job growth has also been in decline since the end of 2006 and is expected to continue this trend throughout 2008 as both the national and state economies soften further (Exhibit A-3). Currently, the seasonally adjusted unemployment rate rose from 5.9 percent in July to 6.5 percent in August (Exhibit A-2). Unemployment has increased drastically as a state, 10 counties have seen their unemployment rates rise by more than 1.5 percent, and 14 have seen the rate rise by more than 1 percent as of March 2008. The counties most affected by the economic downturn are those in the central and eastern parts of the state.

DHS clients are employed in a variety of industries with the most prevalent being: professional and business services, retail, leisure and hospitality, and education and health services. Overall, growth in employment of these industries is expected to increase during the third and fourth quarters of 2008 but at a much lower rate. Professional and business services are expected to grow in the third and fourth quarters of 2008 albeit at a slower pace. Retail trade is expected to decrease in the third quarter of 2008 then resume making employment gains thereafter. Leisure and Hospitality will continue to make modest employment gains through the rest of 2008 and then slow through 2009, largely as a result of higher costs for energy. Last, education and health services are expected to make positive gains in employment through 2009 primarily as a result of positive growth in health services.

Exhibit A-3: Actual and Forecast: Average Number of Non-Farm Jobs 2000-2013

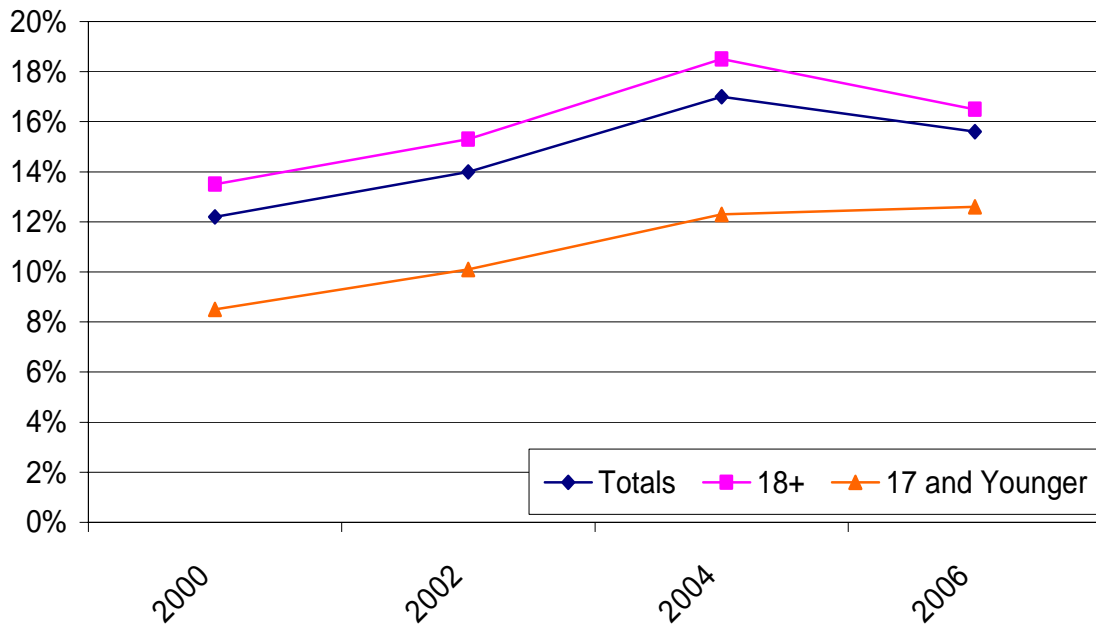


Source: Oregon's Office of Economic Analysis: Economic Forecast and Oregon Employment Department

Health Care Factors

The lack of health insurance limits individuals' access to doctors, medicine, eyeglasses and other services. 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 health insurance (Exhibit A-4). It is anticipated that Oregonians will continue to experience higher rates of being uninsured.

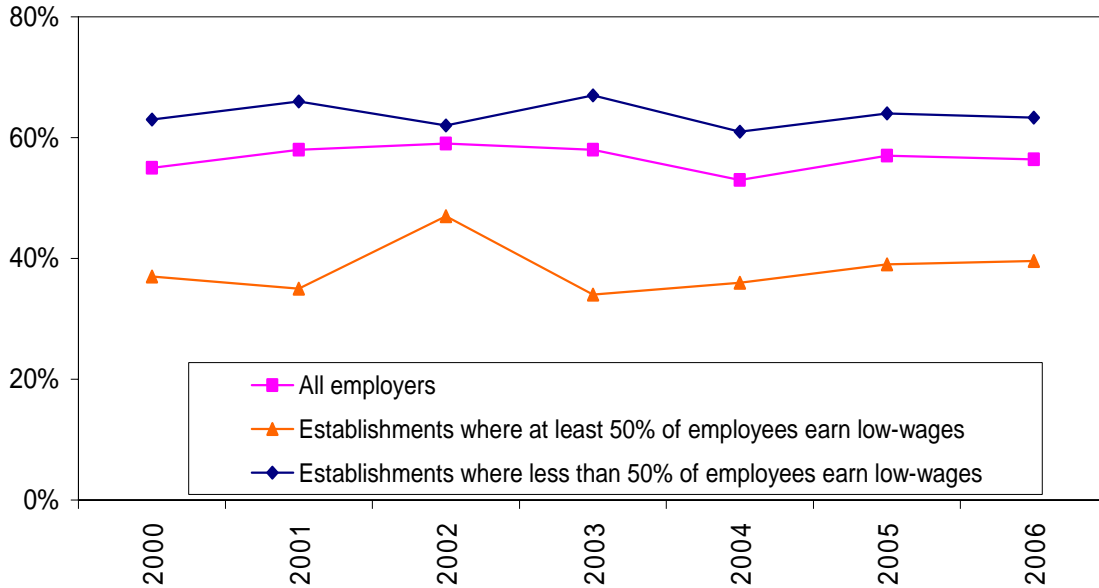
**Exhibit A-4: Percentage of Uninsured Oregonians by Age Group:
2000 to 2006**



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

Of the industries where DHS clients are most prevalent, educational and health services are among the industries most likely to offer employees health insurance. On the other hand, leisure and hospitality, ranks far behind any other industry in offering health insurance. Business services also lags behind other industries while professional services ranks near the top.

Exhibit A-5: Percent of Oregon Private-Sector Establishments Offering Health Insurance by Proportion of Employees who are Low-Wage



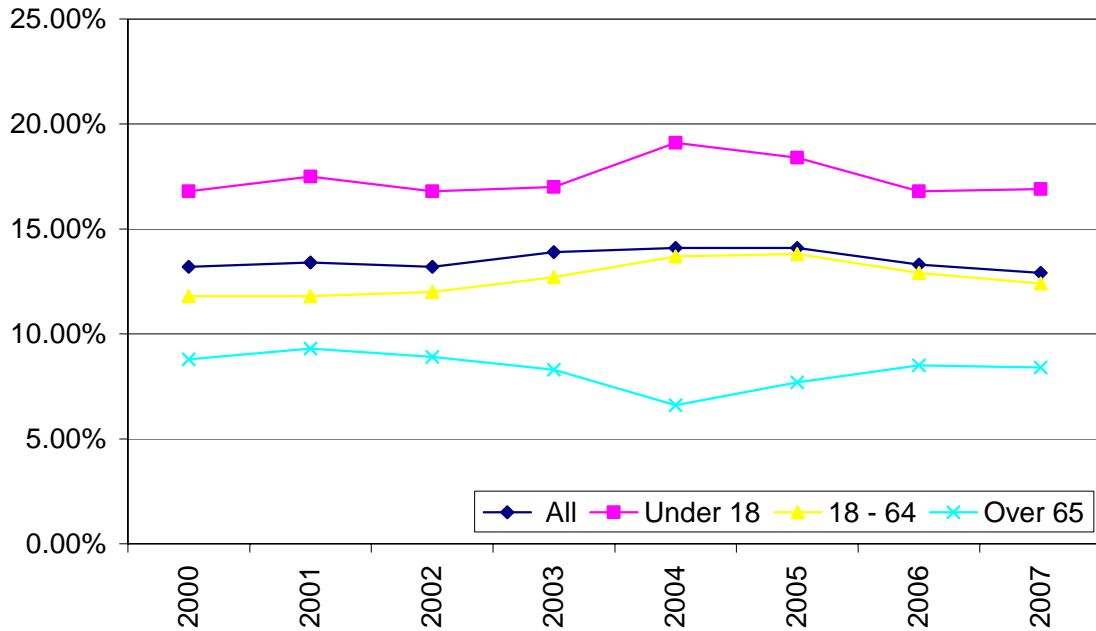
Source: United States Department of Health and Human Services: Agency for Healthcare, Research, and Quality: Medical Expenditure Panel Survey

Poverty

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

Oregonians under the age of 18 are at higher risk of living in poverty than are older Oregonians. In 2007, adults ages 18 to 64 experienced a half percent decrease in the percent living in poverty while those under the age of 18 experienced an increase. Those older than 65, though comprising a smaller proportion of the population, have seen the percent living in poverty increase since 2004 by almost two percent (Exhibit A-5).

Exhibit A-6: Percentage of People Living in Poverty by Age Group



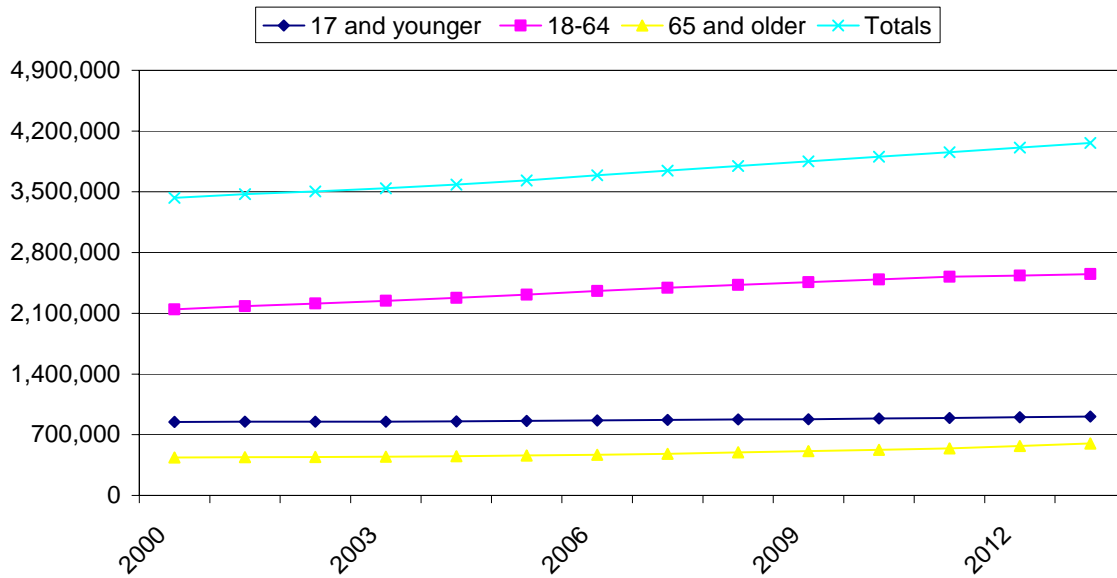
Source: U.S. Census Bureau: American FactFinder

Age Demographics

Peoples' needs often differ by 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 composition changes over time, the focus of DHS services has and will continue to reflect changing age demographics.

As of June of 2008, roughly 23 percent of all Oregonians were children. As shown in Exhibit A-6, less than 13 percent of the total population was individuals 65 and older. However, from 2008 through 2013, the population growth rates will be highest for seniors at 23 percent compared to 7 percent for those 18-64 and 5 percent among children.

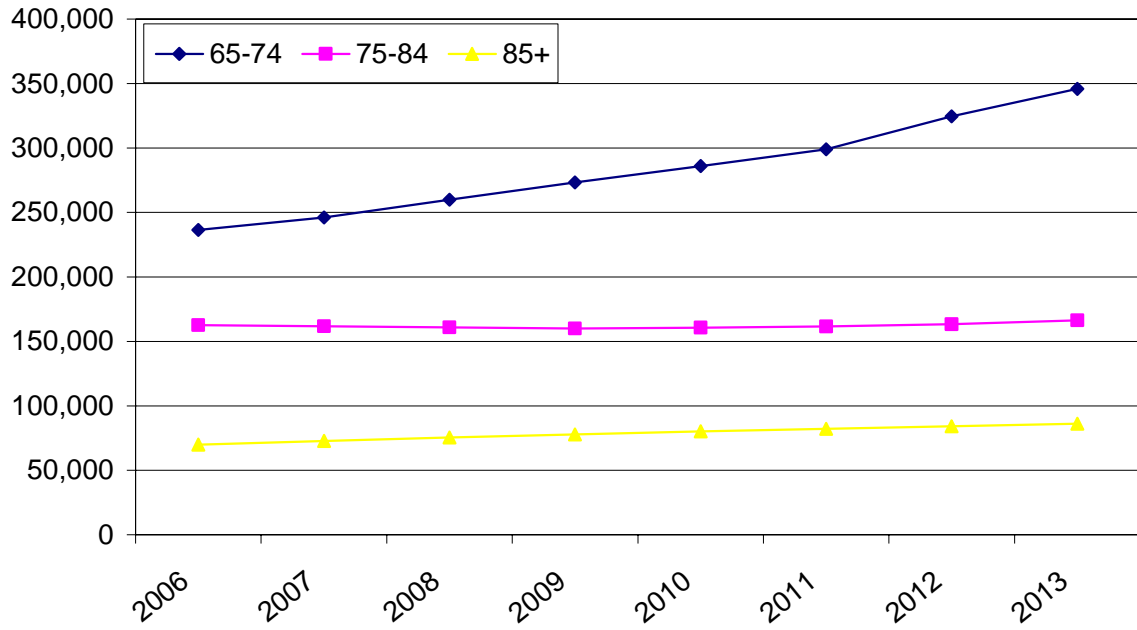
Exhibit A-7: Population by Age Group



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

By 2030 around one in five Oregonians will be 65 or older. The growth rate among the youngest segment of this population, 65-74 year olds, is projected to increase 45 percent from 2006 through 2013; for those 75-84 the growth rate will remain almost constant with a decline of 0.2 percent (Exhibit A-7). Lastly, there is projected to be an increase of 18 percent for those 85 and older (Exhibit A-8).

Exhibit A-8: Over Age 65 Forecasted Population Breakout



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

Children, Adults and Families Division

Introduction

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

Exhibit B-1: Children, Adults and Families Division program caseload		
Self Sufficiency	Child Welfare	Vocational Rehabilitation
Food Stamps	Adoption Assistance	Vocation Rehabilitation
Temporary Assistance for Needy Families (TANF)	Subsidized Guardianship	
Employment Related Daycare (ERDC)	Out of Home Care (Foster Care)	
Temporary Assistance for Domestic Violence Survivors (TADVS)	Child In-Home	

Self-Sufficiency

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

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

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
Children, Adults & Families Division	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
SELF-SUFFICIENCY									
Food Stamps (Households)									
Children, Adults and Families	158,247	175,254	10.7%	168,380	175,254	4.1%	175,254	194,944	11.2%
Seniors and People with Disabilities	69,163	70,467	1.9%	69,750	70,467	1.0%	70,467	78,588	11.5%
Total Food Stamps	227,410	245,721	8.1%	238,130	245,721	3.2%	245,721	273,532	11.3%
Temporary Assistance for Needy Families (Families: Cash/Grants)									
Basic	16,056	18,204	13.4%	17,696	18,204	2.9%	18,204	18,730	2.9%
UN	921	1,264	37.2%	1,020	1,264	23.9%	1,264	1,484	17.4%
Total TANF	16,977	19,468	14.7%	18,716	19,468	4.0%	19,468	20,214	3.8%
*Pre-SSI	1,895	777	-59.0%	1,603	777	-51.5%	777	1,196	53.9%
*Post-TANF	2,523	2,444	-3.1%	2,489	2,444	-1.8%	2,444	4,517	84.8%
Employment Related Daycare (Families)	9,840	10,100	2.6%	10,435	10,100	-3.2%	10,100	11,638	15.2%
Temp. Assist. For Dom. Violence Survivors (Families)	523	557	6.5%	562	557	-0.9%	557	571	2.5%

*Note: The Pre-SSI and Post-TANF are new programs as of October 2007 (created under TANF Reauthorization). The Pre-SSI population was a subset of the TANF Basic and UN, and thus included in prior forecasts. However, the Post-TANF is a new caseload group.

Food Stamps

There are nearly a quarter of a million households receiving Food Stamps in Oregon. This translates to over 480,000 individuals currently receiving 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 the 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. Growth in the CAF program slowed from 2004 through mid-2007 while the SPD program continued to grow steadily. In the latter part of 2007, the CAF program began to grow quite rapidly, adding more than 20,000 cases and 44,000 individuals between September 2007 and July 2008 (Exhibit B-4). Food Stamp caseloads around the nation are growing, and their growth is generally attributed to a sagging economy and higher food and fuel prices.

Forecast

For the CAF Food Stamp caseload, the 2007-09 biennial average is forecast to be 175,254, 4.1 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 194,944, 11.0 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

For the SPD Food Stamp caseload, the 2007-09 biennial average is forecast to be 70,467, 1.0 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 78,588, 11.5 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

The current forecast calls for a biennial average caseload of 245,721 for the combined programs in the 2007-09 biennium. This is 3.2 percent higher than the Spring 2008 forecast for the same period. The 2009-11 biennial average is forecast to be 273,532, 11.0 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

The Spring 2008 CAF Food Stamp forecast called for the strong growth experienced during the fall of 2007 to slow through the spring and summer months in accordance with the caseload's normal seasonal fluctuation. Thereafter the caseload was forecasted to grow at the same rate as observed between 2001 and 2004. The Fall 2008 forecast takes into account the Office of Economic Analysis' (OEA) September 2008 *Oregon Economic and Revenue Forecast* and the effects of Oregon's prior recession (November 2000 to June 2003) on the Food Stamp caseload.

Oregon experienced an employment decline during the second quarter of 2008. OEA expects quarterly employment declines to continue through the end of 2008 with a slow recovery beginning in 2009. Significant year over year employment gains are expected in 2010. As a result the Food Stamp caseload is expected to grow until 2010. If the economic slowdown continues past next spring, the caseload could grow higher than predicted. Conversely, if the recovery begins sooner than expected, the caseload could decline or stabilize prior to 2010.

Growth in the SPD Food Stamp population slightly outpaced the previous forecast. The economy is believed to have some effect on this caseload. For example, persons 65 or older who seek Food Stamps due to lost or curtailed employment would be considered part of the SPD Food Stamp caseload. In addition, OEA forecasts annual growth ranging from 3.0 to 5.4 percent for this age group through 2015.

The forecast is based on the additional assumption that the Food Stamp Program will continue in its present form with no substantial changes in policy or legislation. 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 average caseload could be 4.2 percent above or below the forecast average for the 2007-09 biennium. The average caseload could be 26.7 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-3).

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program provides services and cash grants to low-income families with children to help them become self-sufficient. It should be noted that families with TANF medical benefits only are not on 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.

The program underwent significant changes effective October 1, 2007, as part of its reauthorization. Some new service categories were created:

State-Only TANF is made up of those UN families that have difficulty meeting the federal job participation requirements and do not come under Pre-SSI.

Pre-SSI encompasses families who have applied for Social Security Insurance (SSI). They receive TANF benefits while they are waiting for their SSI benefits. Once they qualify for SSI, the retroactive SSI payments they receive will be used to pay back the TANF benefits.

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

Post-TANF is a new category that includes families not counted in the previous TANF forecasts. Temporary benefits are provided to keep families from returning to the TANF caseload once are no longer eligible for TANF.

The TANF caseload experienced significant growth during the 2000-03 recession and moderate growth through the first part of 2005. In contrast, during the latter part of 2005 and all of 2006 the caseload declined, possibly due to the improving

economy. During 2007 the caseload gradually began to increase. After leveling off in the summer months the TANF caseload, like the Food Stamps caseload, sharply increased. With nearly 20,000 families the TANF caseload is at its highest level since July 2000 (Exhibit B-6).

Forecast

The Fall 2008 forecast predicts a biennial average caseload of 18,204 families for TANF Basic. This is 2.9 percent higher than the previous forecast. The biennial average for the much smaller TANF UN caseload is predicted to be 1,264, 23.9 percent higher than was called for in the previous forecast. For total TANF, the current forecast predicts an average of 19,468 families for the 2007-09 biennium, 4.0 percent higher than predicted in the previous forecast. The 2009-11 biennial average for total TANF is forecast to be 20,214, 3.8 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Pre-SSI and Post-TANF are forecast for the first time in this edition. The average Pre-SSI caseload forecast for the current biennium is 777. The 2009-11 biennial average is forecast to be 1,196, 53.9 percent higher than the forecast average for the 2007-09 biennium. The average Post-TANF caseload forecast for the current biennium is 2,444. The 2009-11 biennial average is forecast to be 4,517, 84.8 percent higher than the forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

The Spring 2008 forecast called for higher growth in the caseload through July 2009, but it was adjusted downward for the expected impact of the TANF reauthorization. As of July 2008, the effect of the reauthorization on the caseload has been overshadowed by continued caseload increases. As with Food Stamps, Oregon's weakening economy is believed to be behind the increase in TANF caseloads. The Fall 2008 TANF forecast takes into account OEA's September 2008 forecast and the effect of Oregon's previous recession on TANF caseloads. Under this scenario, caseload growth continues until 2010 (Exhibit B-6).

The risks associated with the current TANF forecast are significant. As with Food Stamps, continued weakness in the economy past next spring could lead to continued caseload growth into 2010. Conversely, a quicker recovery could cause an earlier decline in the caseload. The TANF caseload historically has exhibited moderately high variability. Given its history, the average caseload for the 2007-09 biennium could be 5.3 percent above or 5.0 percent below the forecast average for that period. For the 2009-11 biennium, the average caseload could be 29.9 percent above or 26.1 percent below the forecast average (Exhibit B-6).

The major risks to the forecasts for the new programs of Pre-SSI and Post-TANF stem from the fact that there are currently only nine months of available history. Specifically, there is great uncertainty as to the length of time on the caseload that will be typical of Pre-SSI cases. For Post-TANF, greater or lesser program participation than is currently envisioned represents the major identified risk. For the Pre-SSI program, the average caseload for the 2007-09 biennium could be 53.9 percent above or 19.5 percent below the forecast average for that period. For the 2009-11 biennium, the average caseload could be 162.4 percent above or 59.6 percent below the forecast average (Exhibit B-9). For the Post-TANF program, the average caseload for the 2007-09 biennium could be 27.7 percent above or 20.8 percent below the forecast average for that period. For the 2009-11 biennium, the average caseload could be 68.8 percent above or 49.1 percent below the forecast average (Exhibit B-10).

Employment Related Daycare

Employment Related Daycare (ERDC) subsidizes daycare to help low-income working parents remain employed. Stable and affordable child care is an important component in maintaining self-sufficient families and minimizing their risk of entering or re-entering TANF.

The changes related to the TANF reauthorization were expected to increase the number of families participating in ERDC. In addition, changes were made to income eligibility, co-pays, and provider reimbursement rates during the 2007 legislative session. These changes also were expected to increase the caseload, and it has increased since they took effect in October 2007. At 10,435 cases ERDC is at its highest level since January 2003 when budget cuts forced a program reduction.

Forecast

The current forecast of 10,100 ERDC families for the 2007-09 biennium is 3.2 percent below the previous forecast. Significant growth is expected over the next two years, particularly in 2010. Thereafter the growth rate declines (Exhibit B-11). The 2009-11 biennial average is forecast to be 11,638, 15.2 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

Recent policy changes appear to have had the intended effect on the ERDC caseload. However, these changes are still in the early stages of implementation. Given the historical variability of the ERDC caseload, the uncertain impact of the various policy changes over time, and possible economic effects, the average caseload for the 2007-09 biennium could be 4.9 percent above or 8.9 percent below the forecast average for that period. The average caseload for the 2009-11

biennium could be 20.1 percent above or 33.9 percent below the forecast average for that period (Exhibit B-11).

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

The Spring 2008 forecast tracked well with the actual caseload. Therefore there is little difference in the Fall 2008 forecast. The Fall 2008 forecast calls for a 2007-09 biennial average of 557, 0.9 percent lower than called for the previous forecast. The 2009-11 biennial average is forecast to be 571, 2.5 percent higher than the currently forecast average for the 2007-09 biennium.

Risks and Assumptions

This caseload experiences seasonal fluctuation and significant variability over time. Based on these historical fluctuations and the relatively small size of the caseload, the average caseload for the 2007-09 biennium could be 13.7 percent above or 14.4 percent below the forecast average for that period. The average caseload for the 2009-11 biennium could be 40 percent above or below the forecast average for that period (Exhibit B-12).

Exhibit B-3: Total Food Stamps (Households)

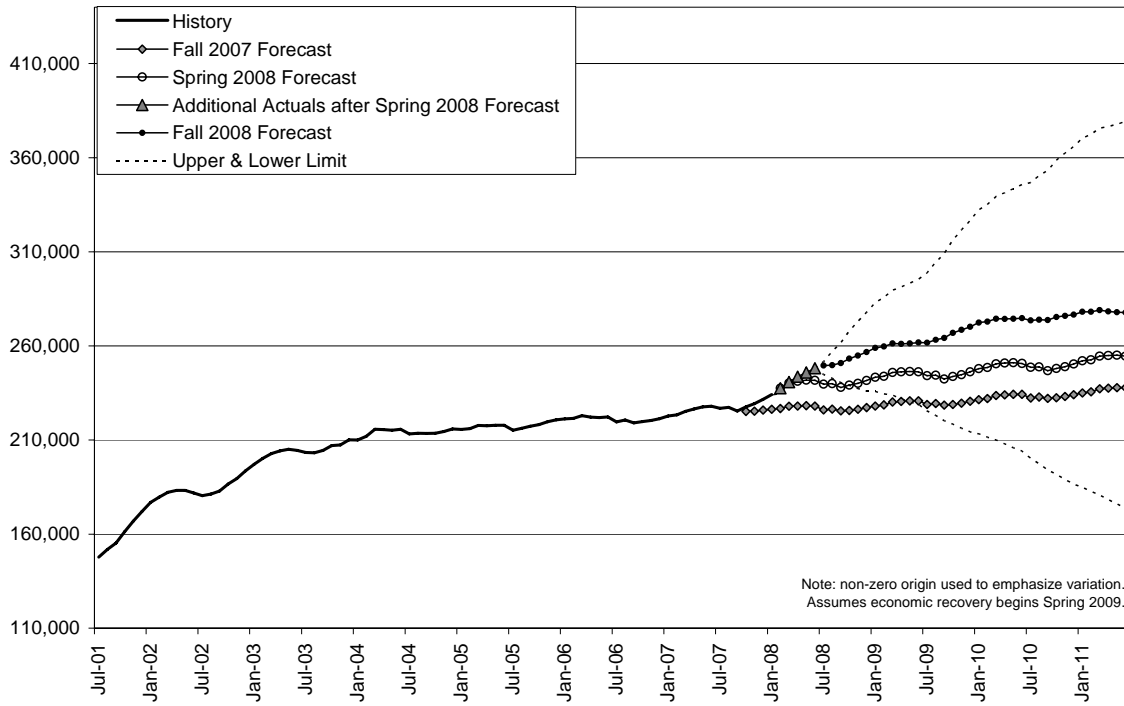


Exhibit B-4: CAF Food Stamps (Households)

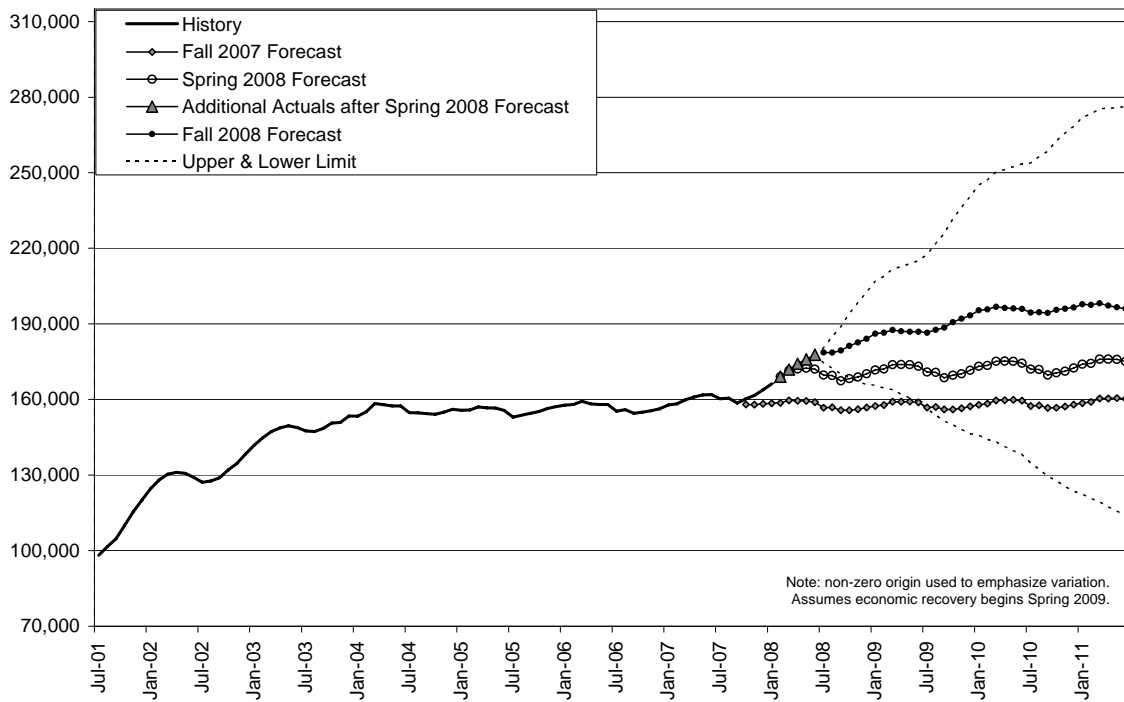


Exhibit B-5: SPD Food Stamps (Households)

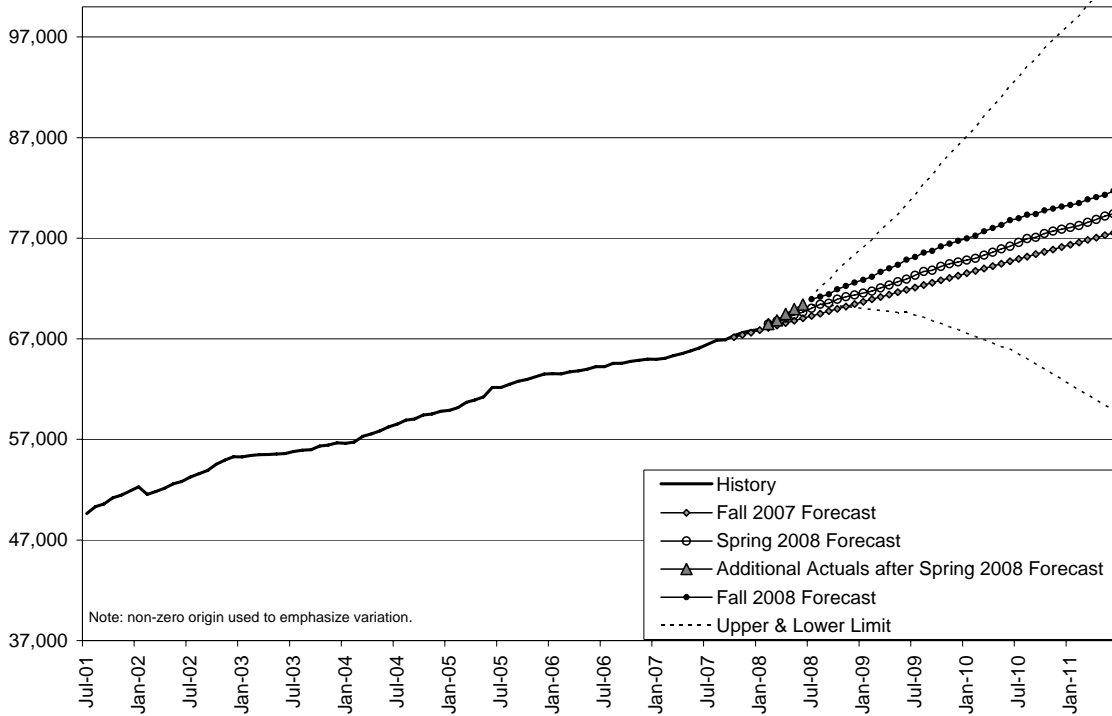


Exhibit B-6: Temporary Assistance for Needy Families Basic & UN (Families)

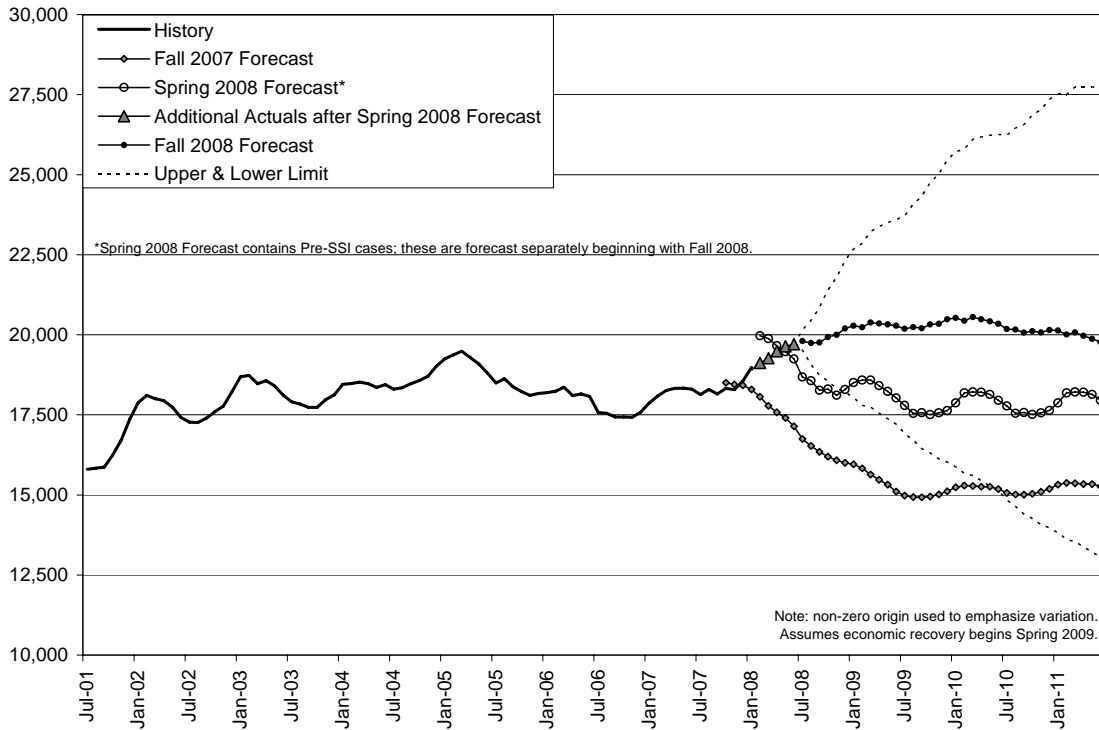


Exhibit B-7: Temporary Assistance for Needy Families - Basic (Families)

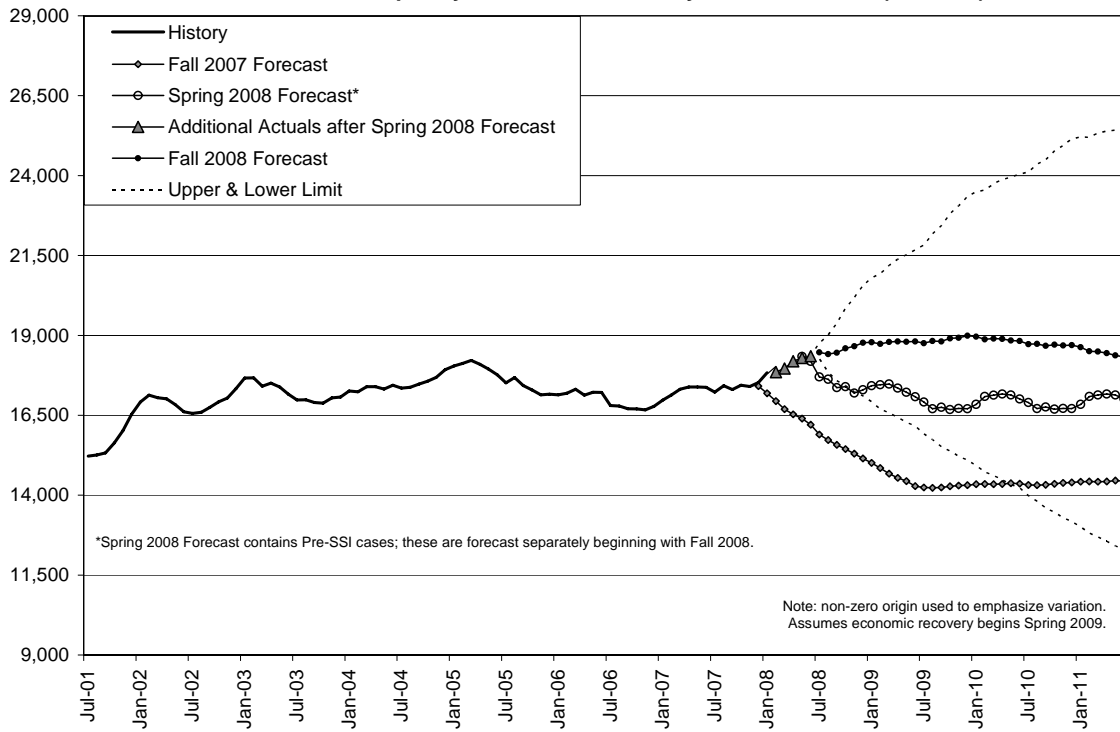


Exhibit B-8: Temporary Assistance for Needy Families - UN (Families)

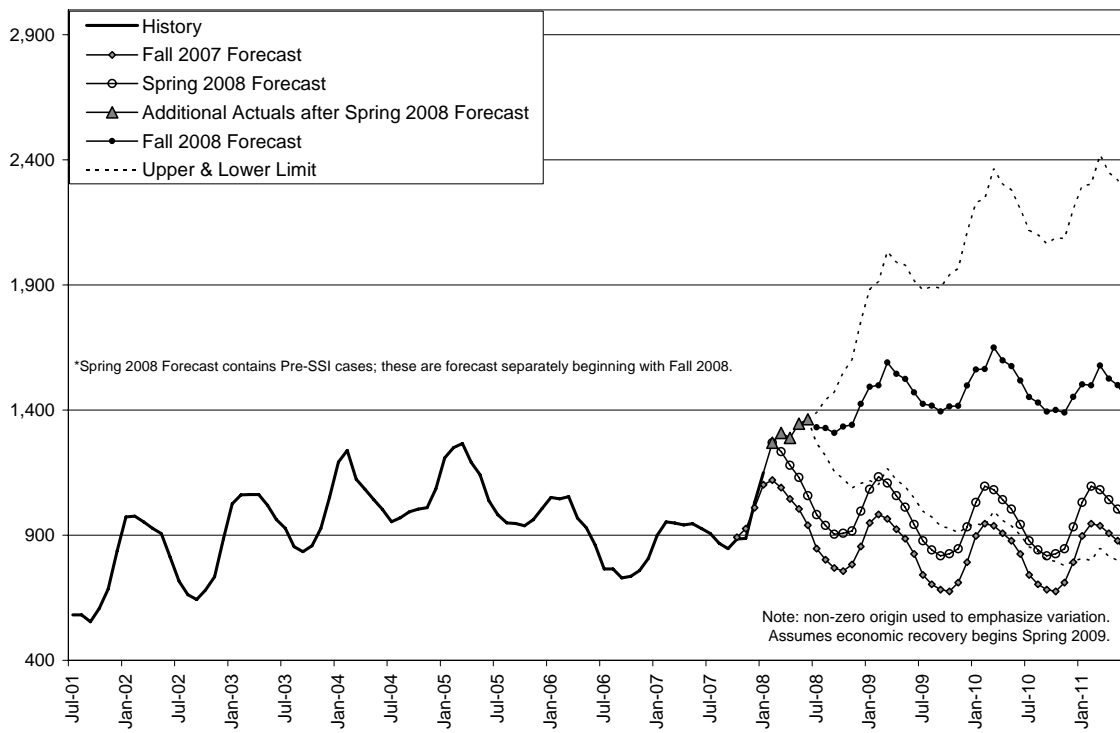


Exhibit B-9: Pre-SSI (Families)

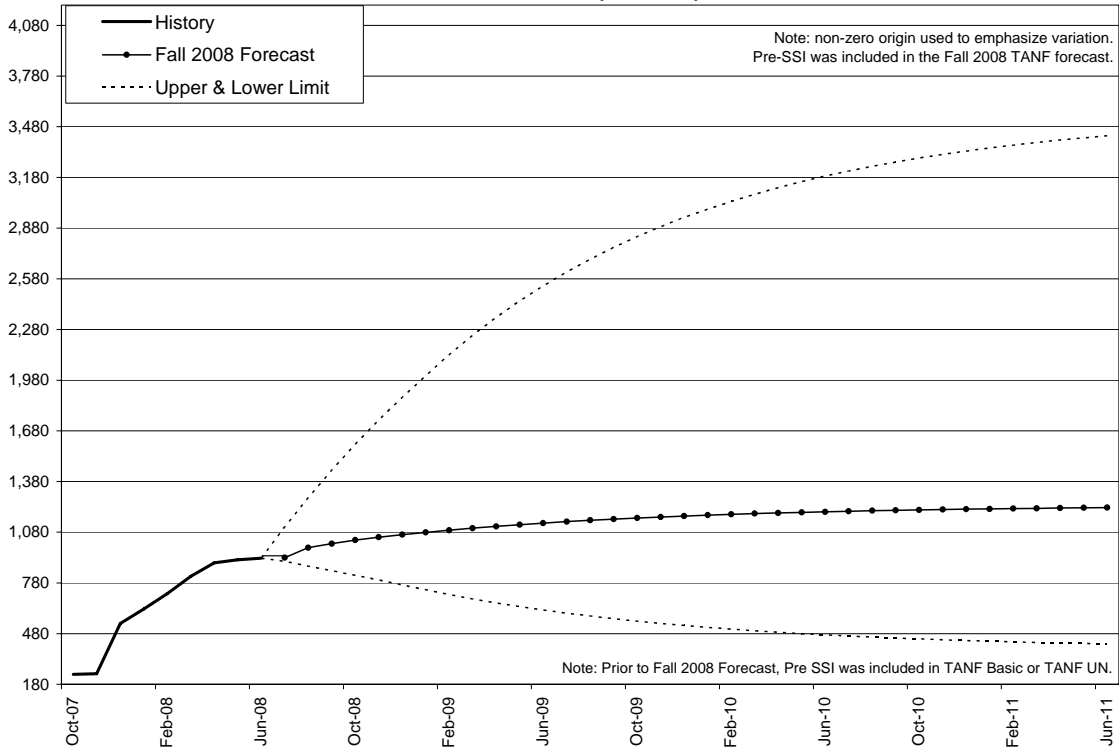


Exhibit B-10: Post Temporary Assistance for Needy Families (Families)

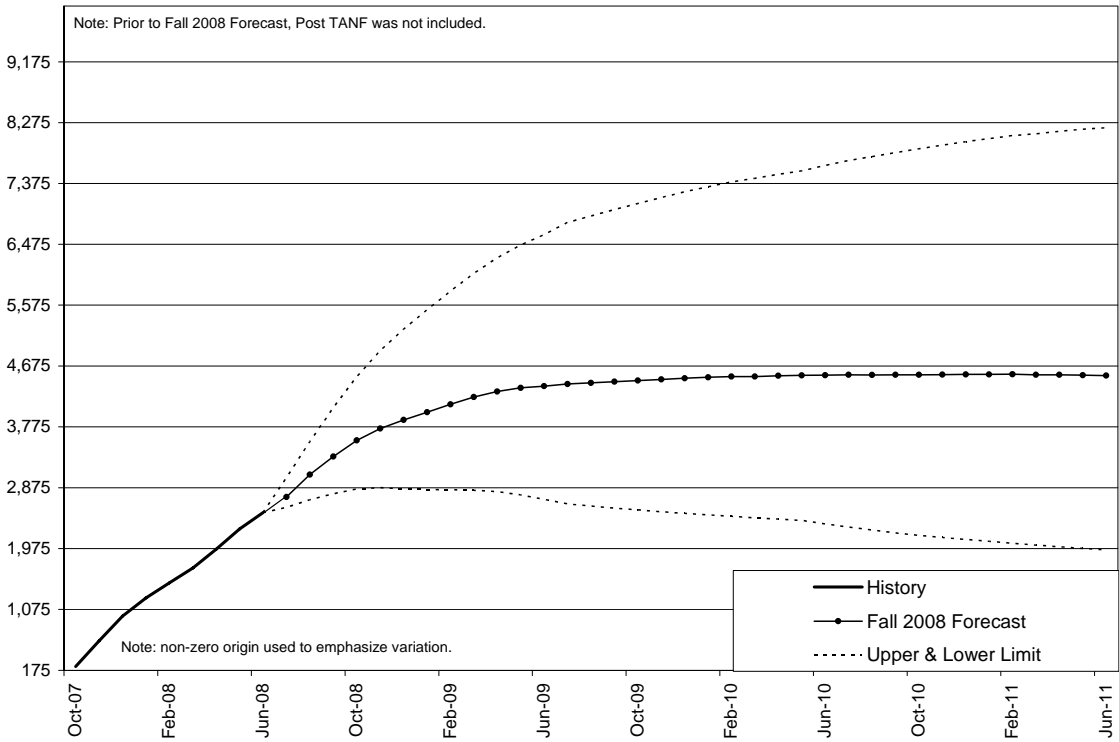


Exhibit B-11: Employment Related Daycare (Families)

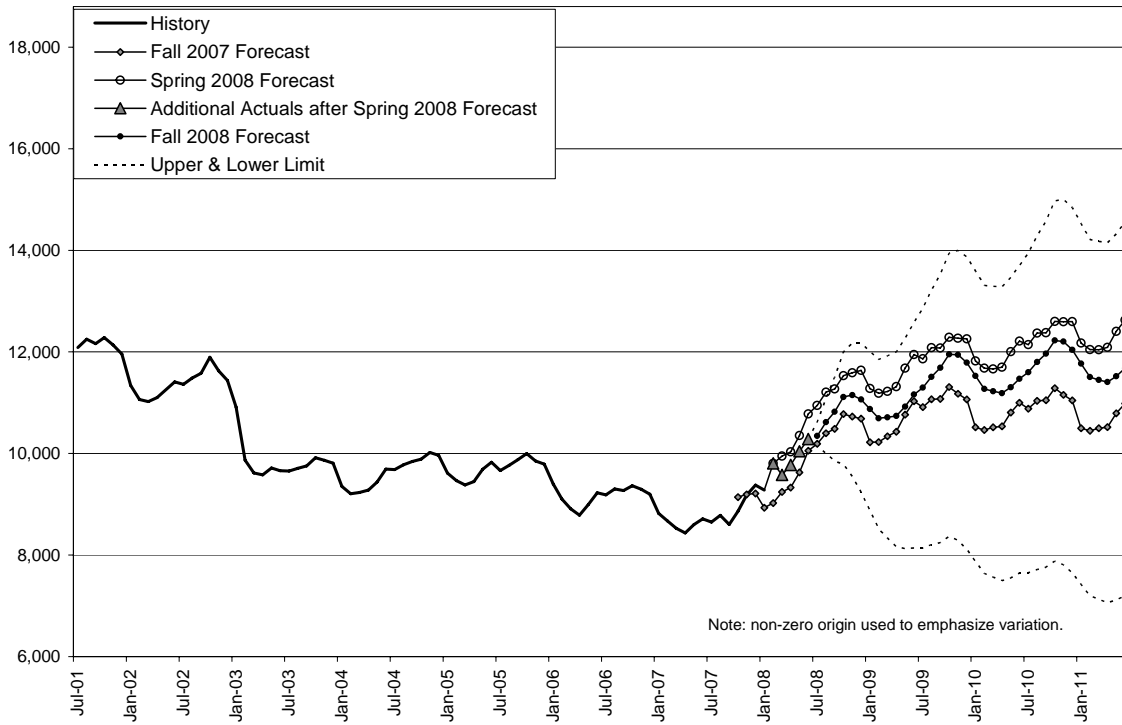
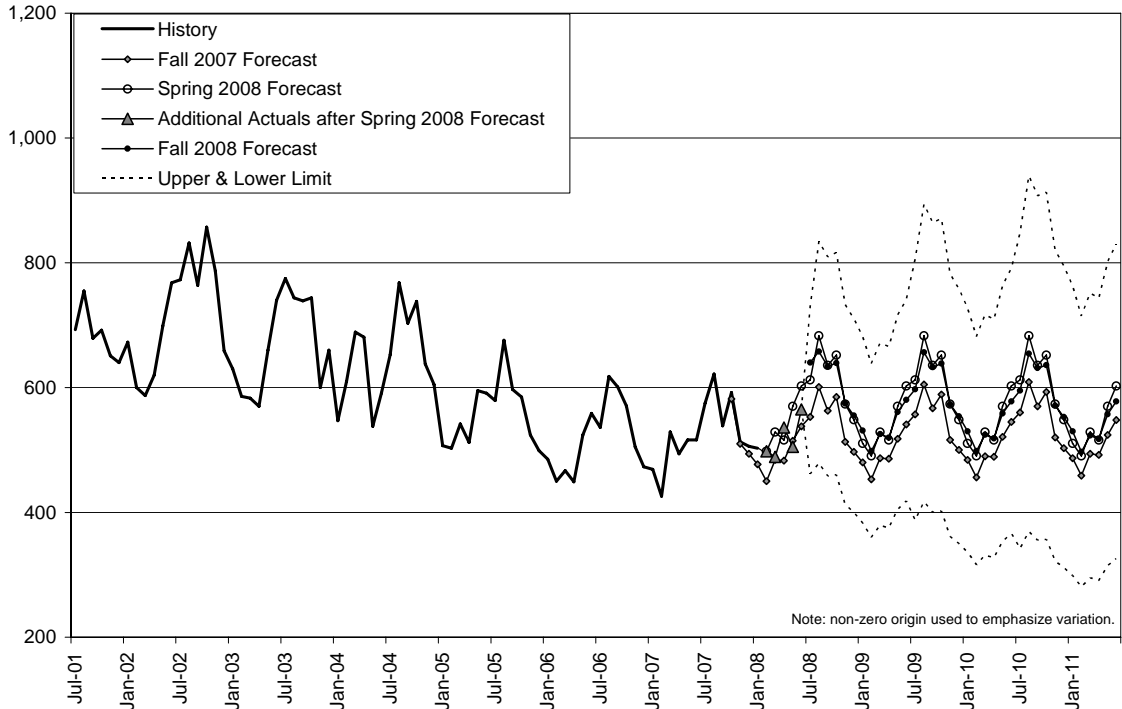


Exhibit B-12: Temporary Assistance for Domestic Violence Survivors (Families)



Child Welfare

The Child Welfare system provides services to protect abused and neglected children. The forecast projects the number of children who are served in a given month, divided into the following categories¹:

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.

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

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

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

Total Child Welfare

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 annually from July 2001 to July 2005. In early 2005 the Child in Home caseload began to decline. The overall caseload continued to grow because of increased growth in Out of Home care. In mid-2006 the Out of Home caseload also began to decline. The combination of these two large caseloads in decline caused the overall Child Welfare caseload to decline as well. With the exception of a short period in spring 2007, the decline in the Child Welfare caseload has extended into 2008.

Forecast

The Fall 2008 forecast calls for an average Child Welfare caseload of 21,685 for the 2007-09 biennium. This is 5.1 percent lower than the previous forecast. The caseload is expected to grow, and the average caseload for the 2009-11

¹The 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.

biennium is forecast to be 22,553. This is 4.0 percent higher than the currently forecast average for 2007-09 (Exhibit B-13).

Risks and Assumptions

The decline in caseload that started 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. One theory regarding the decline in Out of Home care stems from ending over the counter sales of pseudo ephedrine and the resulting sharp decline in methamphetamine labs. Societal focus on methamphetamine abuse and its effect on child neglect may have led more parents to seek help for their addiction before their children were removed from their homes. A more recent cause of decline in the Out of Home caseload was the phase-out of non-paid foster care in Fiscal Year 2008. Non-paid foster care declined more quickly and to a greater extent than it was replaced by paid foster care. As of April 2008 this change appears to have largely run its course. The Child in Home caseload increased during spring 2008, and it appears to be entering a period of stability with seasonal fluctuation. This was the typical pattern prior to the period of uninterrupted decline that occurred between March 2005 and December 2006.

It is simple mathematical reality that changes in caseload are determined by the number of cases opened versus closed. The difficulty lies in identifying the societal and programmatic causes that drive increases in case openings or closings. While the above theories are plausible, the available data are not adequate to confirm their validity nor to what extent each cause contributed to caseload change.

The forecast assumes that the long term declines in the Out of Home Care and Child in Home caseloads have mostly ended, and that these caseloads will be stable with seasonal fluctuations over the foreseeable future. Out of Home Care is expected to stabilize at around 7,000 cases, and modest growth is expected in the Child in Home caseload. Consistent growth is projected in Adoption Assistance and Subsidized Guardianship.

As noted above, this caseload has been subject to historical volatility and has only just begun to exhibit signs of stability. Given the high level of risk associated with this forecast, the average caseload for the 2007-09 biennium could be 4.2 percent above or 4.5 percent below the forecast average for that period. The average caseload for the 2009-11 biennium could be 17.8 percent above or 16.3 percent below the forecast average for that period (Exhibit B-14).

Exhibit B-13: Total Child Welfare Caseload Biennial Average Comparison by Forecasts (Numbers Served)

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
Children, Adults & Families Division	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
CHILD WELFARE (Children)									
Adoption Assistance	10,678	10,565	-1.1%	10,641	10,565	-0.7%	10,565	11,541	9.2%
Subsidized Guardianship	956	903	-5.5%	937	903	-3.6%	903	1,193	32.1%
Out of Home Care	8,596	7,404	-13.9%	8,187	7,404	-9.6%	7,404	6,978	-5.8%
Child In-Home	3,056	2,813	-8.0%	3,036	2,813	-7.3%	2,813	2,841	1.0%
Total Child Welfare¹	23,286	21,685	-7.4%	22,801	21,685	-5.1%	21,685	22,553	4.0%

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

Adoption Assistance Forecast

The Fall 2008 forecast calls for an average caseload of 10,565 for the 2007-09 biennium. This is 0.7 percent (82 cases) lower than the Spring 2008 forecast. The average caseload for the 2009-11 biennium is forecast to be 11,541, 9.3 percent higher than the average forecast for 2007-09 (Exhibit B-13).

Risks and Assumptions

Caseload growth has been slowing gradually over the last few years, and this is reflected in a slightly lower forecast. Even with the slowing rate of growth, this caseload has exhibited a consistent pattern that leads to narrow confidence bands. The average caseload for the 2007-09 biennium could be 1.8 percent above or below the forecast average for that period. The average caseload for the 2009-11 biennium could be 7.0 percent above or below the forecast average for that period (Exhibit B-15).

Subsidized Guardianship Forecast

The Fall 2008 forecast calls for an average caseload of 903 for the 2007-09 biennium. This is 3.6 percent (36 cases) lower than the Spring 2008 forecast. The average caseload for the 2009-11 biennium is forecast to be 1,193, 32.4 percent higher than the average forecast for 2007-09 (Exhibit B-13).

Risks and Assumptions

In this relatively small caseload small changes in absolute terms can generate large percentage changes. Given its size and the historical variation, the average caseload for the 2007-09 biennium could be 7.5 percent above or 2.9 percent below the forecast average for that period. The average caseload for the

2009-11 biennium could be 35.3 percent above or 18.9 percent below the forecast average for that period (Exhibit B-16).

Out of Home Care Forecast

The Fall 2008 forecast predicts an average of 7,404 cases for the 2007-09 biennium. This is 9.6 percent (783 cases) lower than the Spring 2008 forecast. The average caseload for the 2009-11 biennium is forecast to be 6,978, 5.8 percent lower than the average forecast for 2007-09 (Exhibit B-13).

Risks and Assumptions

The Spring 2008 forecast assumed that the transition from non-paid to paid foster care would not affect the overall caseload. This was not the case, and non-paid foster care declined more than paid foster care increased. Now that this transition appears to be mostly complete, the Fall 2008 forecast calls for the caseload to gradually stabilize at around 7,000 cases (Exhibit B-17).

Other than the transition from non-paid to paid foster care, a great deal of uncertainty exists as to exactly why the Out of Home caseload exhibited such a steep decline in 2006 and 2007. This in turn inhibits the ability to determine whether or not the decline will continue. Given this uncertainty, the average caseload for the 2007-09 biennium could be 5.4 percent above or 7.1 percent below the forecast average for that period. The average caseload for the 2009-11 biennium could be 27.6 percent above or below the forecast average for that period (Exhibit B-17).

Child in Home Forecast

The Fall 2008 forecast predicts an average of 2,813 cases over the 2007-09 biennium. This is 7.3 percent (223 cases) lower than the Spring 2008 forecast. The average caseload for the 2009-11 biennium is forecast to be 2,841, 1.0 percent higher than the average forecast for 2007-09 (Exhibit B-13).

Risks and Assumptions

The Child in Home caseload continues to show signs of stability, but given its historical variability future caseloads could deviate substantially from the forecast. Based on historical data, the average caseload for the 2007-09 biennium could be 9.1 percent above or 8.1 percent below the forecast average for that period. The average caseload for the 2009-11 biennium could be 30.6 percent above or 24.8 percent below the forecast average for that period (Exhibit B-18).

Exhibit B-14: Total Child Welfare - Number Served

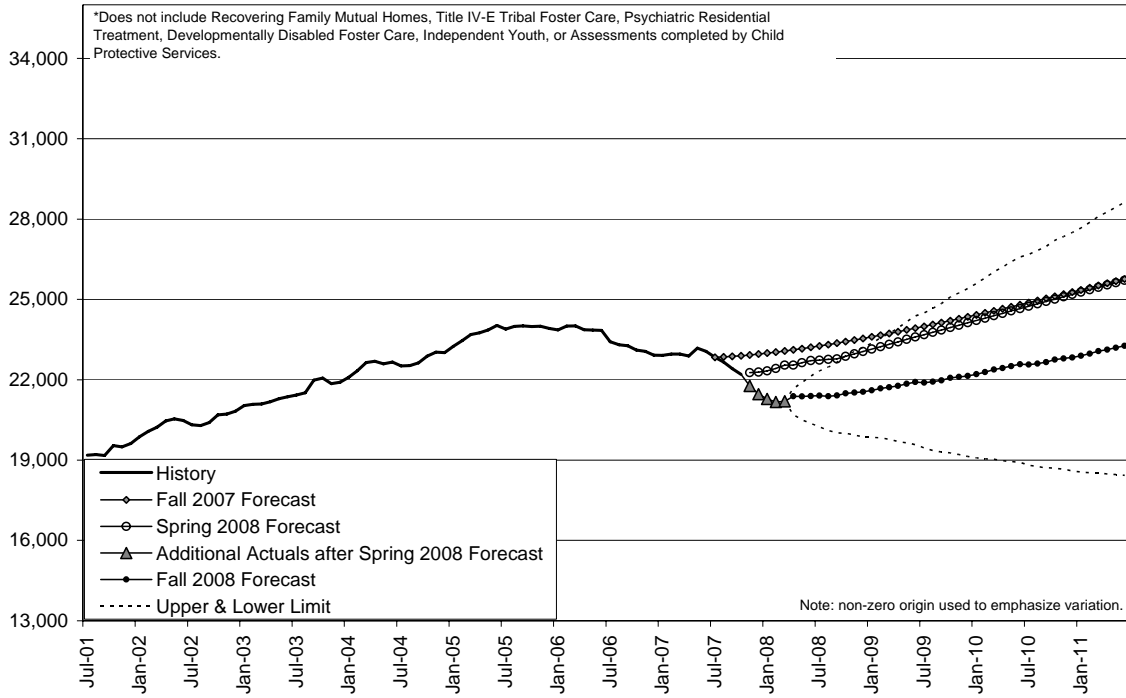


Exhibit B-15: Adoption Assistance - Number Served

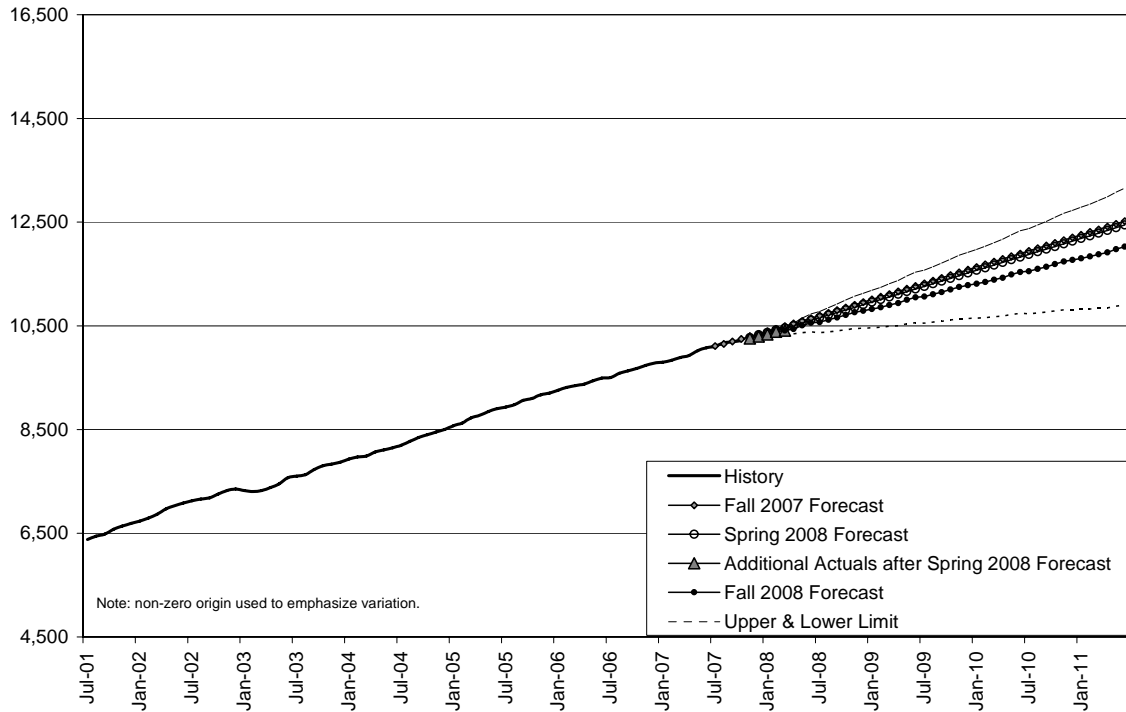


Exhibit B-16: Subsidized Guardianship - Number Served

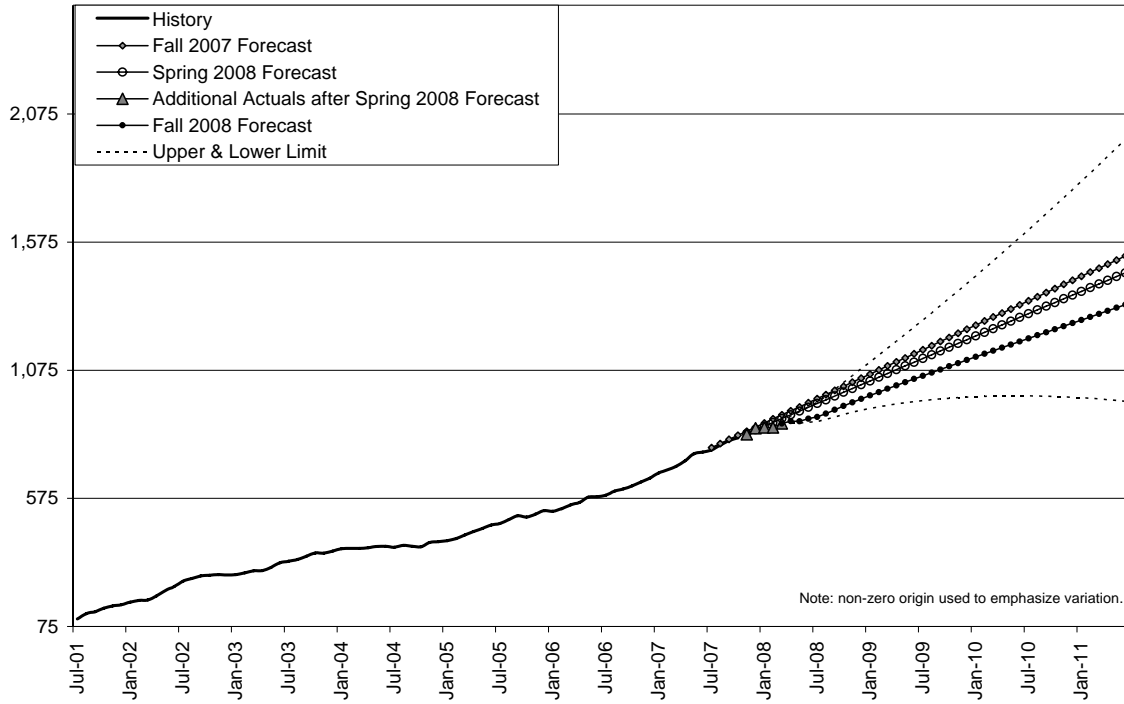


Exhibit B-17: Out of Home Care - Number Served

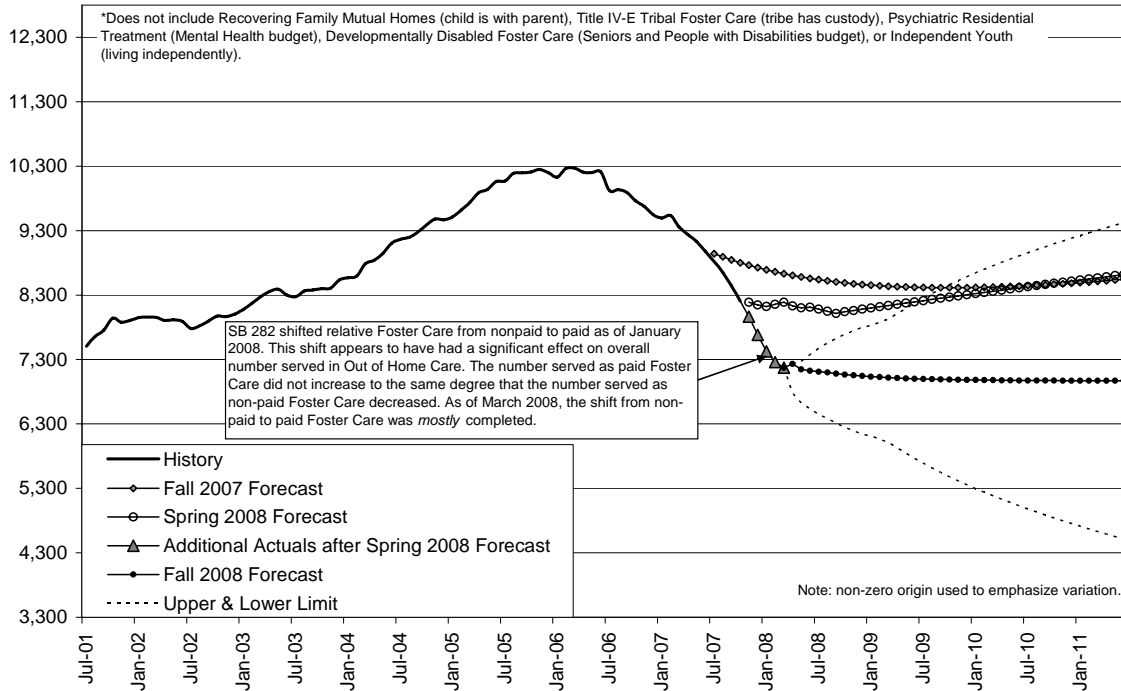
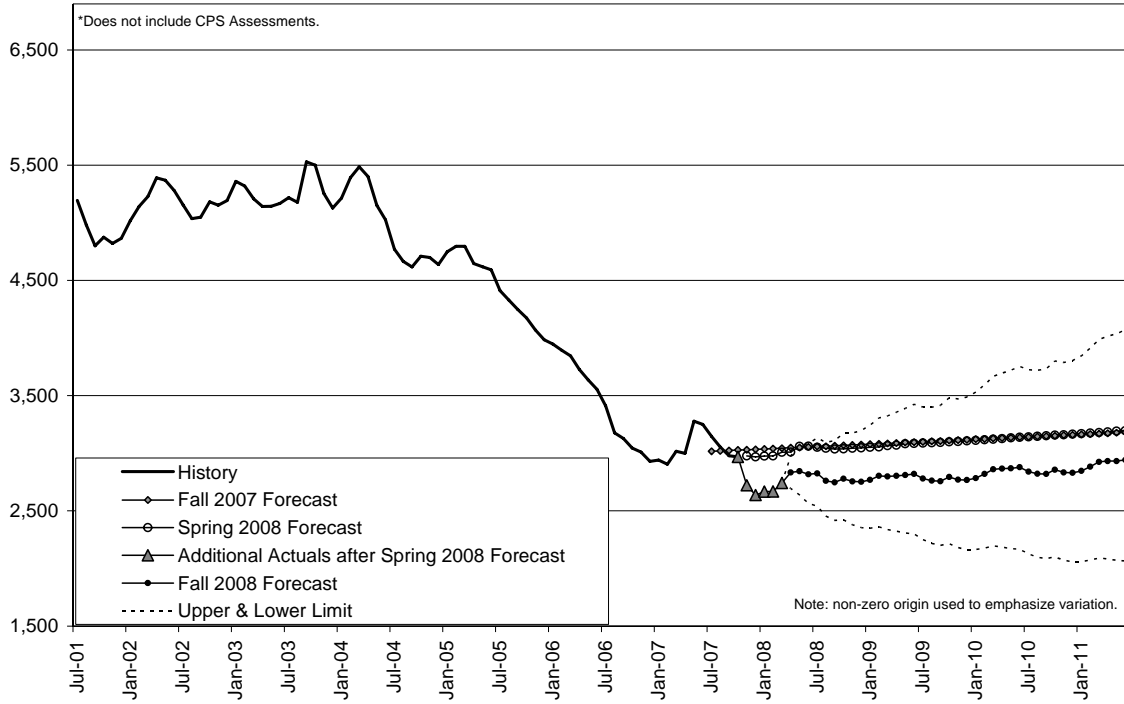


Exhibit B-18: Child In Home - Number Served



Vocational Rehabilitation

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

Exhibit B-19: Vocational Rehabilitation Caseload Biennial Average Comparison by Forecasts (Clients)

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
Children, Adults & Families Division Biennial Averages by Forecast	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007- 09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007- 09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
VOCATIONAL REHABILITATION (Clients)	9,181	9,201	0.2%	9,111	9,201	1.0%	9,201	9,362	1.7%

Forecast

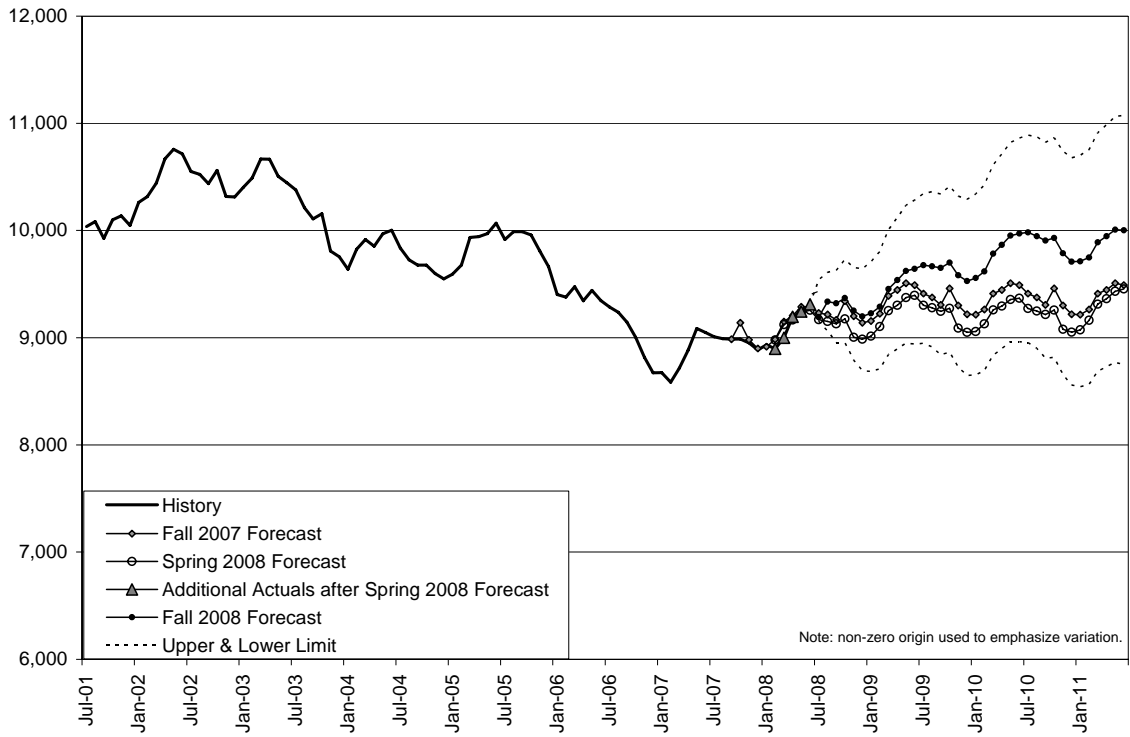
The Fall 2008 forecast predicts a biennial average of 9,201 Vocational Rehabilitation clients served for the 2007-09 biennium. This is 1.0 percent (67 cases) higher than the Spring 2008 forecast. The average caseload for the 2009-11 biennium is forecast to be 9,362, 2.0 percent higher than the average forecast for 2007-09 (Exhibit B-19).

Risks and Assumptions

Most of the difference between the current and previous forecasts is due to a change in assumptions regarding the number of clients that will be referred by the Mental Health program for Supported Employment Evidenced Based Practices. Based on experience so far, the caseload for this program is expected to average 531 cases during the 2009-11 biennium. This compares to an average of 96 cases in the previous forecast for the same period.

The expansion of the Mental Health program for Supported Employment Evidenced Based Practices could have a greater or lesser impact than the current estimate because the program is in its very early stages. The overall caseload also can be influenced by economic conditions and the availability of services through other organizations. Given the historical variability, future caseloads could be 2.4 percent above or 2.7 percent below the forecast average the 2007-09 biennium. The average caseload for the 2009-11 biennium could be 9.0 percent above or 10.4 percent below the forecast average for that period (Exhibit B-20).

Exhibit B-20: 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 (Medical)
Poverty Level Medical Children		
Aid to the Blind & Disabled		
Old Age Assistance		
Foster/Substitute Care		
Children’s Health Insurance Program		

Comparisons of Forecasts Over Time

Exhibit C-2 provides comparison between the current Spring 2008 forecast and the prior Fall 2007 forecast for each of the thirteen DMAP programs.

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

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
Medical Assistance Programs									
Biennial Averages by Forecast									
OHP Plus									
TANF-Related Medical	87,499	93,033	6.3%	88,728	93,033	4.9%	93,033	107,278	15.3%
TANF-Extended	28,592	22,796	-20.3%	25,890	22,796	-12.0%	22,796	25,385	11.4%
TANF Medical - Subtotal	116,091	115,829	-0.2%	114,618	115,829	1.1%	115,829	132,663	14.5%
Poverty Level Medical - Women	10,825	11,083	2.4%	10,825	11,083	2.4%	11,083	12,034	8.6%
Poverty Level Medical - Children	83,407	92,536	10.9%	84,680	92,536	9.3%	92,536	114,731	24.0%
Aid to the Blind & Disabled	64,733	65,956	1.9%	65,362	65,956	0.9%	65,956	73,405	11.3%
Old Age Assistance	30,487	30,562	0.2%	30,546	30,562	0.1%	30,562	31,620	3.5%
Substitute Care & Adoption Serv.	17,667	17,833	0.9%	17,361	17,833	2.7%	17,833	18,360	3.0%
Children's Health Insurance Program	42,564	46,138	8.4%	41,801	46,138	10.4%	46,138	56,079	21.5%
OHP Plus Subtotal	365,774	379,937	3.9%	365,193	379,937	4.0%	379,937	438,892	15.5%
Other Medical Assistance Programs									
Citizen-Alien Waived Emergency Medical	17,573	18,693	6.4%	17,501	18,693	6.8%	18,693	19,009	1.7%
Qualified Medicare Beneficiary	12,965	13,072	0.8%	13,026	13,072	0.4%	13,072	15,233	16.5%
Breast & Cervical Cancer program	372	369	-0.8%	372	369	-0.8%	369	483	30.9%
Other Subtotal	30,910	32,134	4.0%	30,899	32,134	4.0%	32,134	34,725	8.1%
OHP Standard									
<i>Biennial Average Sustainable Number</i>	24,000	25,726	7.2%	24,000	25,726	7.2%	25,726	25,842	0.5%
Total Medical Assistance Programs	420,684	437,797	4.1%	420,092	437,797	4.2%	437,797	499,459	14.1%

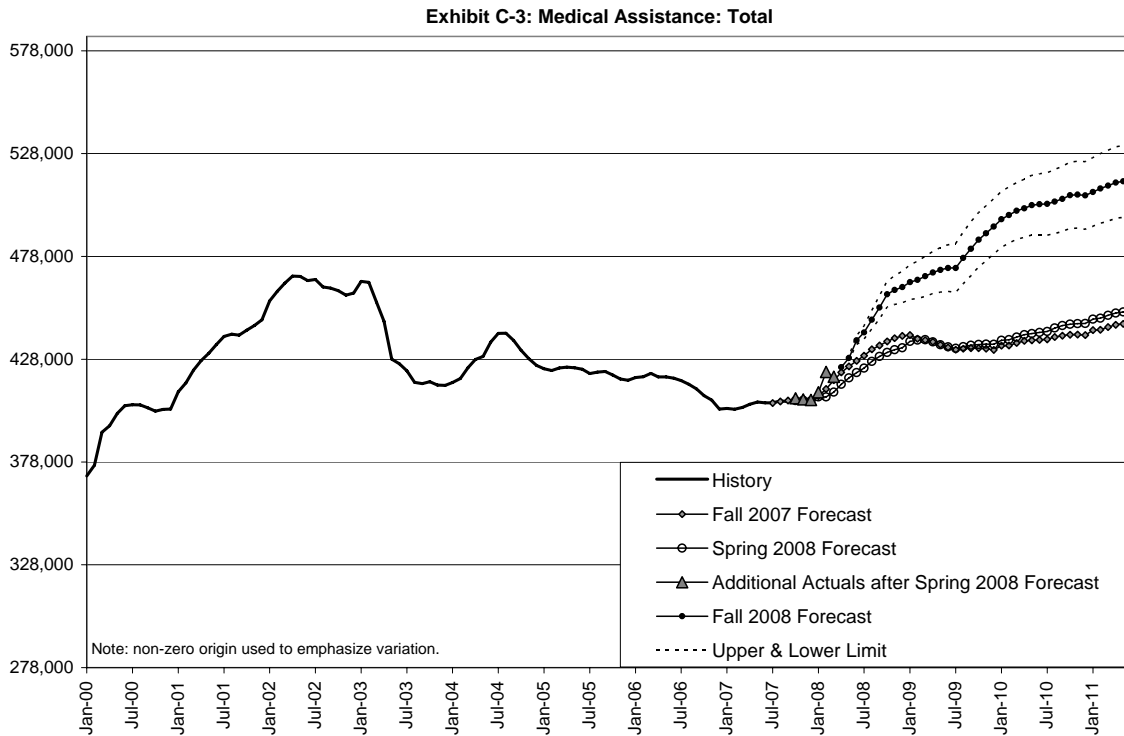
*Note: OHP Standard Biennial Average Sustainable Number (includes FHIAP clients) for 2007-09 (1,726) and 2009-11 (1,842) for the Fall 2008 Forecast.

Total Medical Assistance Programs

The total DMAP caseload was approximately 419,500 in March 2008, the last month of complete data available for forecast and analysis. Within 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 same period that a series of budget reduction policies were implemented. These policies included such items as the closure of a small medical assistance program (Medically Needy), the creation of a reduced OHP Plus/Standard benefit package, increases in OHP Standard cost sharing, and stricter enforcement of co-pays on monthly premiums with participation sanctions for non-compliance. One of the effects was to decrease the OHP Standard population by approximately 50,000 clients. Beginning in early 2004 advocates began aggressive outreach efforts in response to DHS planned closure of the OHP Standard program to new clients in July 2004. A brief period of caseload growth in many OHP programs followed. Ultimately the total Standard population dropped from approximately 110,000 to approximately 18,840 in September 2007.

Forecast

The prior Spring 2008 forecast for total DMAP programs anticipated a slow growth pattern in the caseload through the end of the 2009-2011 biennium. The current Fall 2008 greatly increases the anticipated growth from the earlier forecast. The current forecast estimates a 2007-09 biennial average of 437,797 clients. The previous forecast was lower by an average of 16,800 clients. The 2009-2011 biennial differences are even greater with the current forecast expecting an average of 499,459 clients compared to 420,092 in the Spring 2008 forecast. 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 by an average of less than 1.5 percent above or below the forecast in the 2007-09 biennium and 3 percent in 2009-2011. These variances do not take into consideration other risks to the forecast as described at the end of this section.



Oregon Health Plan Plus

The Oregon Health Plan Plus (OHP Plus) program represents one of the three broad program categories administered by DMAP. In February 2003, the Department replaced the original OHP Basic benefit package with the OHP Plus package. The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules. The OHP Plus population made up 88 percent of DMAP clients in September 2007 and is expected to be constant through the end of the 2007-2009 biennium.

The total OHP Plus population consists of the eight caseload categories listed below. A discussion of each follows.

- 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. In general, current policy is that clients transiting into TANF Extended from TANF Related Medical must have been enrolled in TANF Related Medical for three of the prior six months in order to receive extended benefits. Historically, between 30 and 40 percent of clients leaving TANF Extended in any given month have returned to TANF Related Medical.

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 during the Oregon recession period of November 2000 through June 2003. The sustained rapid growth of the total TANF caseload peaked in the spring of 2005 after a post-recessionary growth across some 24 months. For the next twelve months the total caseload remained relatively stable between 135,000 and 140,000 clients. Beginning in March 2006, however, and continuing through late fall of 2007, the combined caseloads significantly dropped to approximately 112,000 clients. Since the beginning of 2008 the caseload has exhibited a pattern of growth assumed to be associated with the onset of worsening economic conditions.

The rapid increase of the client population during 2001 and 2003 was largely due to the Oregon recession, as well as internal DHS program integrity efforts to place clients in the appropriate Medical Assistance programs. The hiatus in growth from the spring of 2002 to the beginning of 2003 corresponds with a 'dip' in the unemployment rate from greater than 8.5 percent to a low of less than 7 percent in the same time period. While the unemployment rate alone does not explain all of the changes to TANF populations, it is highly correlated and is an effective indicator of the economic conditions necessary to contribute to an increase in TANF caseloads. Following the unemployment low in September 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 (until the spring of 2008) is primarily due to policy changes implemented in the spring and summer of 2006. Briefly, they include an automatic closure of TANF cases that were overdue for review; increasing the time one needed to be in TANF-RM in order to qualify for TANF-EX; and increased financial reporting requirements for TANF-EX. All are part of ongoing program integrity efforts. These changes were expected to exert downward pressure on each of the TANF-RM and TANF-EX caseloads and, by virtue of their programmatic interactions, create downward effects on each other. This downward trend was also expected as a result of the effects of moderate economic expansion (since stagnant) in Oregon. Evidence from recent months would indicate that these effects have worked their way through the system with both component programs showing a slowing in caseload decline or increase for the first time since March 2006.

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

The TANF-RM client group makes up around 82 percent of the total TANF medical caseload (March 2008). Since it is the larger of the two TANF groups, the historical growth and decline of TANF-RM generally parallels that described above in the total TANF. This benefit group experienced a sustained period of growth between the fall 2002 and spring 2005. However, since that time the caseload for this group has dropped from a high of approximately 100,000 clients in March 2005 to approximately 86,800 in September of 2007. Since that time, however, the caseload has grown to approximately 93,033 clients as the effects of economic change began to be realized. (Exhibit C-6).

Two specific effects drive the caseload estimates for the Fall 2008 forecast. First, beginning in January 2009 the eligibility re-determination period of 6 months for TANF Related Medical children will be extended to 12 months. This

policy change will have the effect of dramatically increasing the ongoing caseload for this group. Secondly, this group is demonstrably sensitive to economic change as seen in the extreme caseload growth occurring during the prior recession and the 2 year post-recessionary period. The current forecast for this group factors in both policy and economic contraction effects.

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 2005) due to the increase in absolute number of clients moving from TANF-RM to TANF- Ex during that period. This group entered a period of rapid decline after March 2006. This date corresponds to the implementation of eligibility reform described earlier. Recent month's actuals indicate that the period of policy-driven decline may be over. The caseload for this group 'bottomed-out' in March 2008 with subsequent information indicating an emerging pattern of slow growth.

Forecast

Since the Spring 2008 forecast, two additional policy changes have or will be enacted: the TANF Reauthorization legislation (HB 2469) and the reopening of OHP Standard to new clients in March 2008. Both are expected to add cases to the TANF-RM caseload through the end of the 2007-2009 biennium.

Since TANF Extended and TANF Related Medical are programmatically tied, any change to TANF Related Medical results in TANF Extended caseload changes. Of the clients leaving TANF-RM, approximately 40 to 50 percent exit to TANF-EX. Additionally, of the clients leaving the TANF-EX group, approximately one in three return directly to TANF-RM. The current Fall 2008 forecast calls for substantial growth in the TANF Related Medical population with mild growth in TANF Extended driven by changes to TANF Related Medical (See exhibits C-5 through C-7).

The Fall 2008 forecast for both groups combined estimates a 2007-2009 biennial average of 115,829 cases rising to 132,663 in the 2009-2011 biennium. The Spring 2008 forecast estimated corresponding averages of 114,618 and 123,600.

Risks and Assumptions

The assumptions for TANF estimates in the Spring 2008 forecast were that the economy, job growth and health insurance availability would follow 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). Since that time, however, the economy slowed with higher unemployment rates and inflation across energy, food, and health care costs. 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 economy.

More tangible risks to the forecasts for both of these groups include the TANF reauthorization (HB 2469) and the planned extension of eligibility re-determination from 6 to 12 months for TANF Related Medical children. While the new program structures are known, anticipating the full range of effects is problematic. As a consequence, the TANF caseload forecasts have a substantial level of associated risk. Current estimates are for these changes to account for an average monthly increase of approximately 4,117 clients across the 2009-2011 bienniums.

Even without the substantive risks noted 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 2.6 percent for the 2007-09 biennium and 8.4 percent for the 2009-2011 biennium (Exhibit C-5).

As of this writing the monitored TANF Related Medical and TANF Extended caseloads have shown extreme changes in direction and magnitude when compared to previous expectations. While the total TANF estimates are within tolerances, the group specific differences are not. This provides an effective example of the types of risk associated with forecasting for these two groups.

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 growth at least as far back as the beginning of 2001. During the two years from 2001 to 2003 the total client caseload averaged 8,500 clients. With the expansion of 170 percent to 185 percent FPL at the start of 2003, the caseload increased in a one-time shift to a new level of just below 9,500 cases. The pattern of moderate growth continued through January 2005. Since this time, rapid growth has

continued through March 2008. The growth rate also generally parallels the number of births statewide.

Forecast

The Fall 2008 forecast is slightly higher than that expected in the Spring 2008 forecast. The current forecast calls for biennial averages of approximately 11,083 during 2007-2009 increasing to approximately 12,034 for 2009-2011. These averages represent an increase over the Spring 2008 forecast of less than 2.4 percent for 2007-2009 increasing to 5.7 percent difference in 2009-2011. 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. This variance increases to 5.3 percent for the 2009-2011 biennium.

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.

Beginning with January 2005 and continuing through spring 2008, the PLMC caseload has fluctuated by several thousand cases around an average caseload of approximately 81,000 clients. High caseloads early in the decade are correlated with the Oregon recession of November 2000-June 2003 as this group is also sensitive to systemic economic change. Following these high caseload levels a rapid drop occurred beginning July 2002 and ending January 2005. This is largely due to the inter-relationship with the TANF programs. 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 (Approximately 50% of the total TANF medical population is under the age of 13).

Forecast

Three specific factors contribute to the Fall 2008 forecast for this group. First, beginning in July 2009 the current eligibility re-determination period of 6 months will be shifted to 12 months. This policy shift will have the effect of pushing monthly caseloads much higher than normal as continuity of health care coverage is increased over the current policy. Second, this group is sensitive to changes in economic conditions as seen in the early part of the decade. Economic recessionary effects are factored into the current estimates for this group. Finally, the truncated re-opening of Standard is expected to bring in a

number of children who would not necessarily have otherwise become clients within the same time-frame.

The prior Spring 2008 forecast for PLMC projected a caseload pattern of general and slow increase through the end of the 2009-2011 biennium. The caseload was expected to increase to an average of 84,680 average cases for the 2007-2009 biennium and 86,300 in the following 2009-2011 biennium. The current Fall 2008 forecast substantially increases those estimates by factoring the above mentioned effects, none of which were considered in earlier forecasts. The Fall 2008 forecast anticipates a 2007-2009 biennial average of 92,536 clients, a 9.3 percent increase over spring 2008. The estimates for the 2009-2011 biennium are for 114,731 clients, a full 33 percent higher than Spring 2008. Policy change and economic factors drive the differences in these two forecasts. The upper and lower limits associated with this group attest to the relative historical variability and seasonality within this group. It is estimated that the forecast could reasonably be about ± 2 percent above or below the actual average for 2007-09. This increases to 6 percent during the 2009-2011 biennium. Note that there is substantial risk associated with the forecast for this group as uncertainty of economic change (both decline and recovery) and policy implementation is relevant to ultimate caseloads. (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 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 Spring 2008 forecast for this group calls for a continuation of sustained, strong growth through the end of the 2009-2011 biennium. The Spring 2008 forecast estimated a 2007-2009 biennial average of 65,362 while the current biennial average estimate is 65,956. In addition to the 'natural' growth associated with this caseload, upward pressure is exerted by the re-opening of the Standard groups to new clients in spring 2008, and the passage of HB 2406. The re-opening of the Standard groups is expected to contribute cases to AB/AD through inter-category transfers and through secondary effects of appropriate program screening of Standard applicants. HB 2406 has the direct effect of increasing the AB/AD population by approximately 200 clients through the end of the 2009-2011 biennium. The upper and lower limits, which average less than two percent above and below the forecast through the 2009-2011 biennium, 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 2008 forecast for this group projected a slowly growing population across the entire forecast horizon. The current forecast calls for a similar pattern of growth resulting in an average of 16 more clients expected in the 2007-2009 biennium with an average of 65 more clients during the 2009-2011 biennium. The upper and lower confidence limits average around 1 percent above and below the forecast for the 2007-09 biennium and 3 percent for 2009-2011.

OHP Plus: Foster/Substitute Care and Adoption Services

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

The Foster/Substitute Care and Adoption Services caseload increased consistently from January 2000 through June 2006. Since that time this client population has exhibited has a variable, but stable, pattern with a return to moderate growth in recent months.

Forecast

The previous Spring 2008 forecast for this group anticipated a return to patterns of continued growth consistent with Children, Adults and Families (CAF), Child Welfare forecast. This group has a history of growth followed by short periods of flattening. Currently it is expected that this population will exhibit a long period of stabilized slow growth at a level higher than anticipated in the Spring 2008 forecast. The Fall 2008 forecast estimates a 2007-2009 biennial average of 17,833 compared to the somewhat lower prior estimate of approximately 17,361. The range of upper and lower limits of plus or minus 2 percent for 2009-2011 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 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 emerged for both new client entry and caseload growth and decline with high points occurring near January of each year. In keeping with seasonal patterns, a short period of stabilization appeared in the summer months before a return to steady increases. This pattern continues unabated in the historical data.

Forecast

The Fall 2008 forecast for this group is substantially higher than the earlier Spring 2008 forecast. Several factors contribute to the current CHIP caseload estimates in the current forecast. First, the number of new clients entering the program is gradually increasing. This is most likely tied to the contracting economy. Secondly, there are clear indications that CHIP clients are not leaving the program as they were prior to the spring of 2008. These two effects result in caseloads that are higher than anticipated in the Spring 2008 forecast. Additional clients are expected to receive services from the re-opening of the Standard program.

The Fall 2008 forecast estimates the biennial averages for this group to approximate 46,138 for 2007-2009 and 56,079 for the 2009-2011 biennium. These estimates represent a 10.4 and 21.5 percent increase respectively when compared to the earlier estimates. The current forecast calls for a continuation of the aggressive growth pattern seen historically. One main driver for the

increases between July 2006 and July 2007 was a major policy change implemented in June 2006. Eligibility re-determination was changed from 6 to 12 months for this group. In effect, this policy change was expected to initiate a rapid accumulation of clients as may be seen in the historical data. Historical forecast variability indicates a 2.6 percent confidence limit range for the 2007-2009 biennium rising to 6.6 percent in 2009-2011.

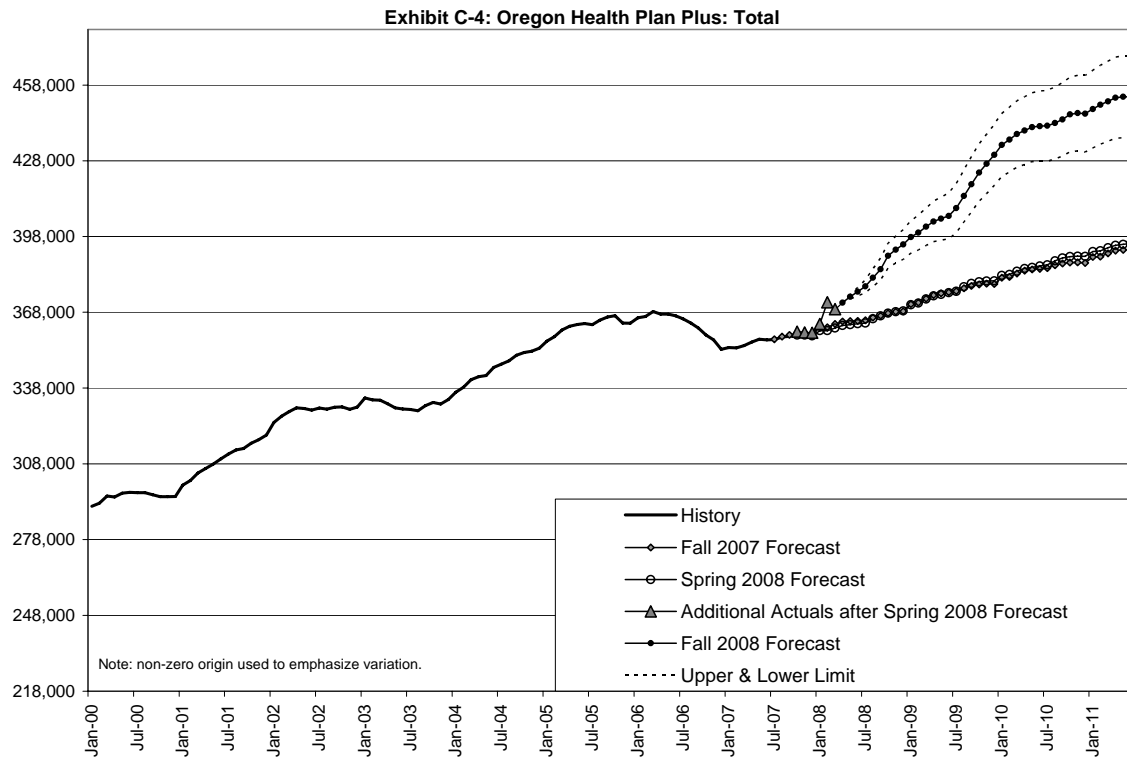


Exhibit C-5: Temporary Assistance for Needy Families: Total

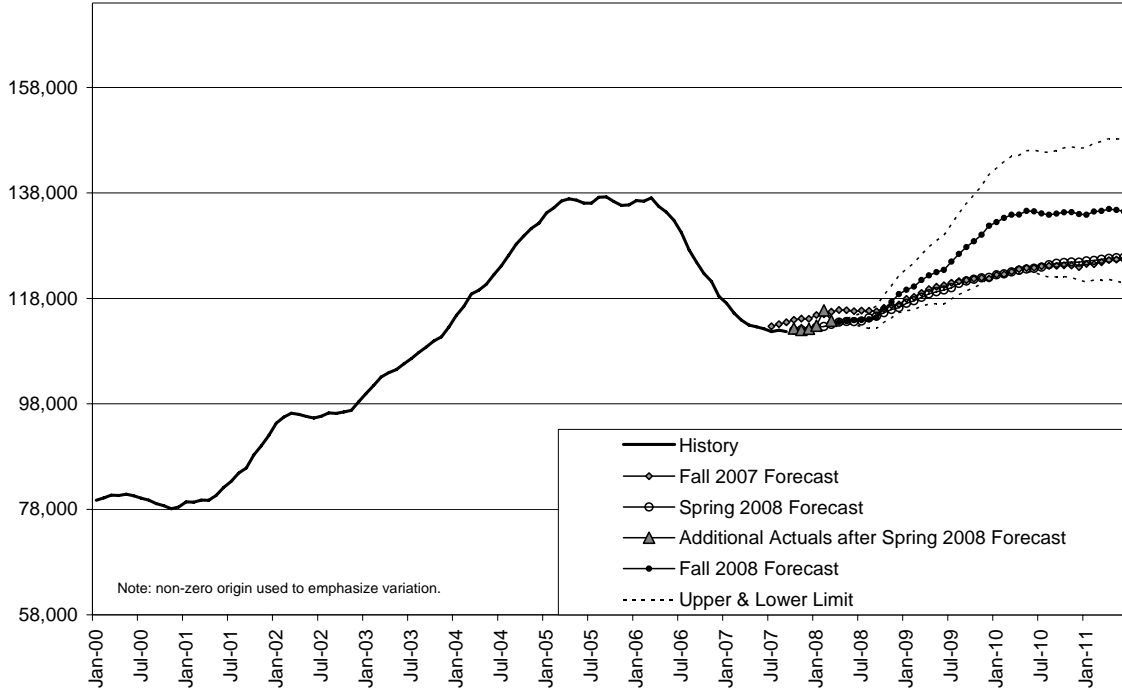


Exhibit C-6: Temporary Assistance for Needy Families-Related Medical

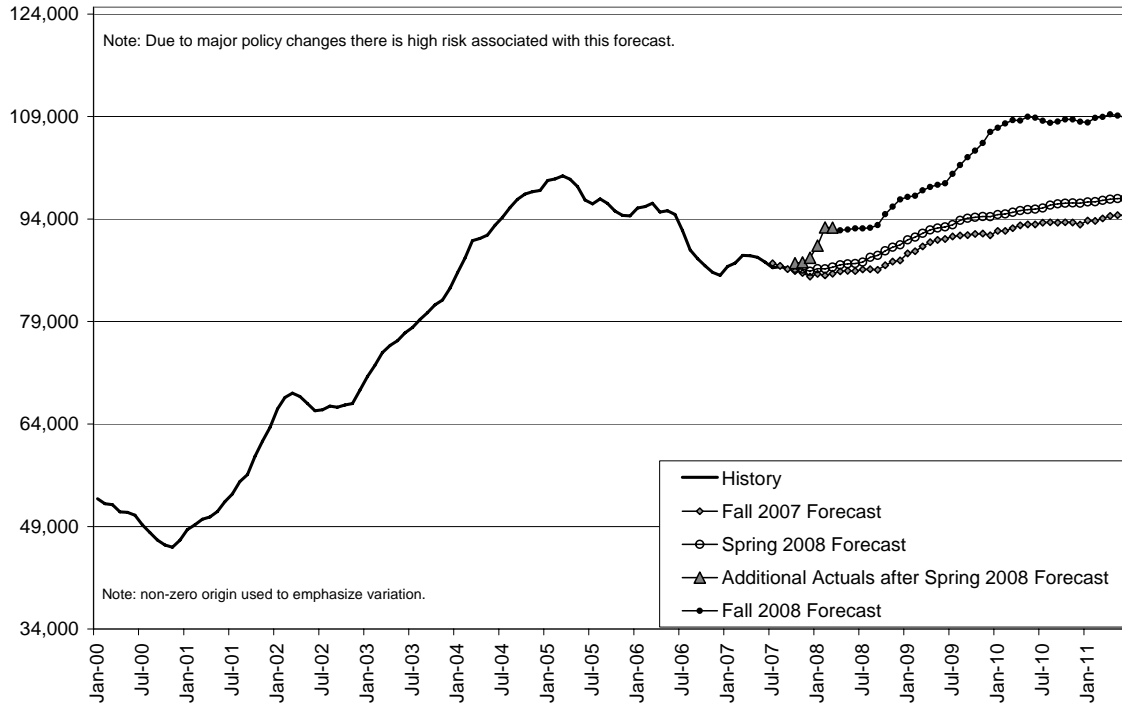


Exhibit C-7: Temporary Assistance for Needy Families-Extended

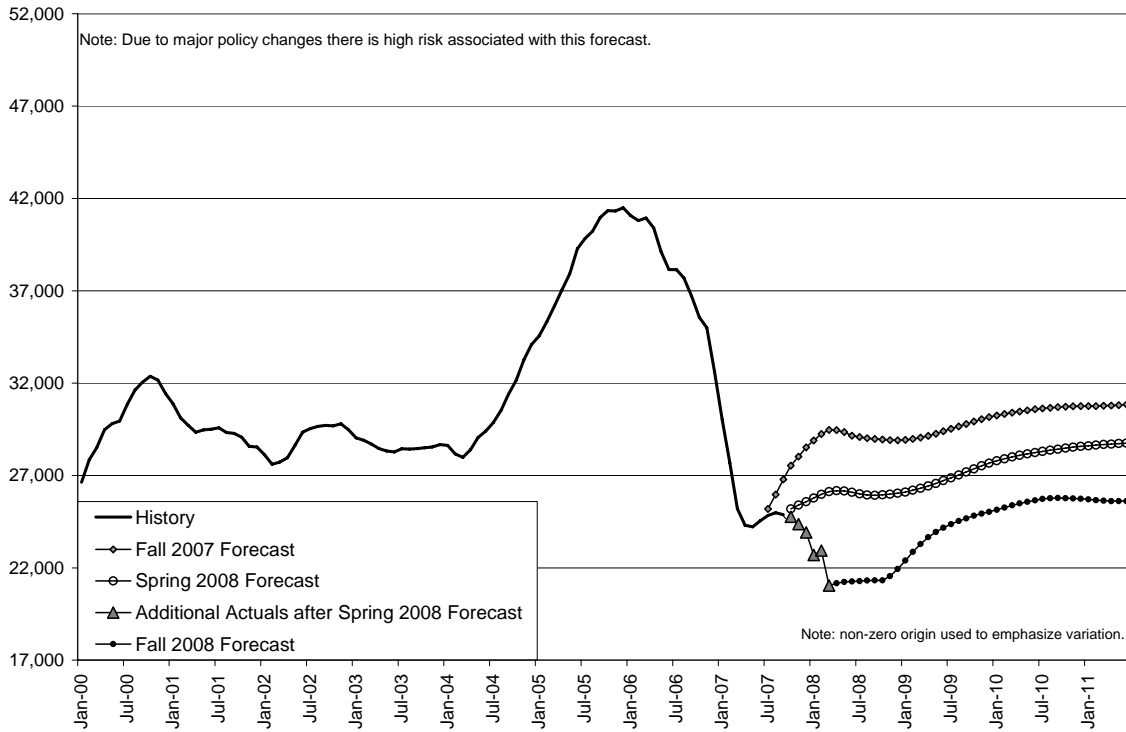


Exhibit C-8: Poverty-Level Medical Women

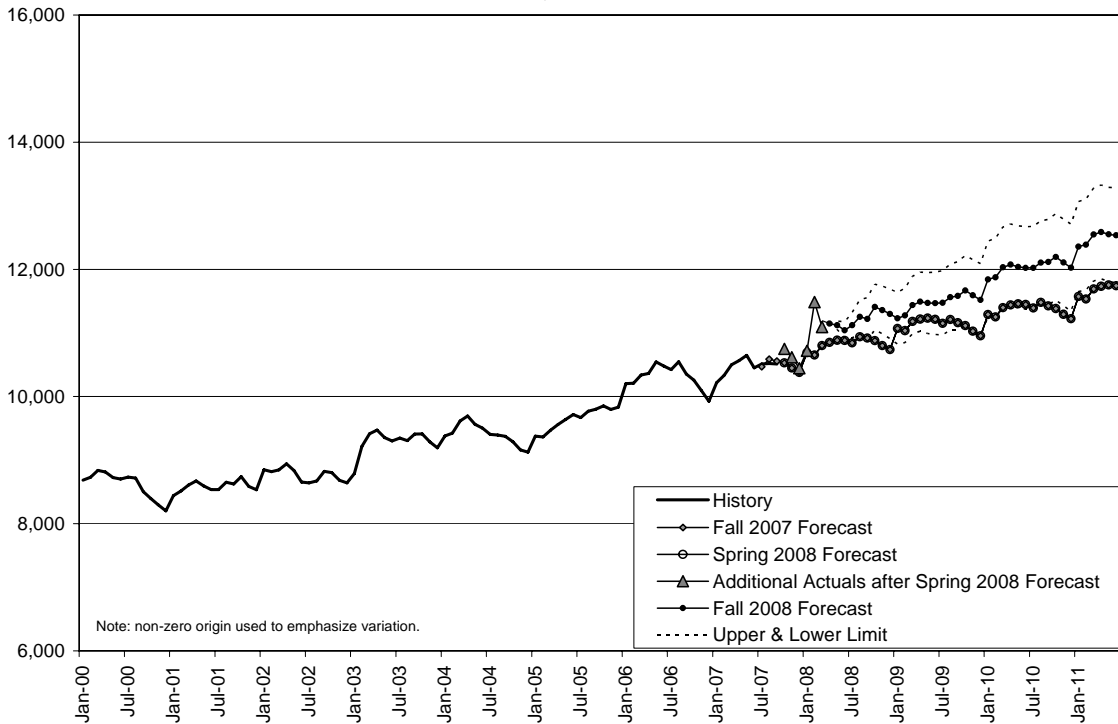


Exhibit C-9: Poverty-Level Medical Children

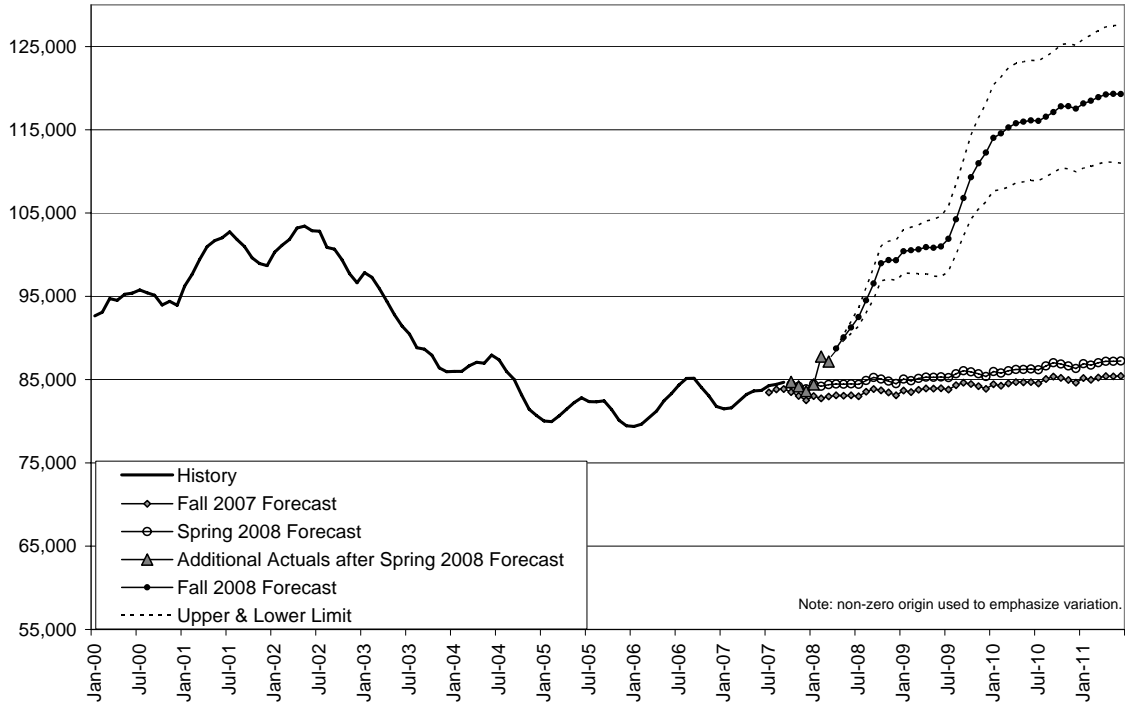


Exhibit C-10: Aid to the Blind and Disabled

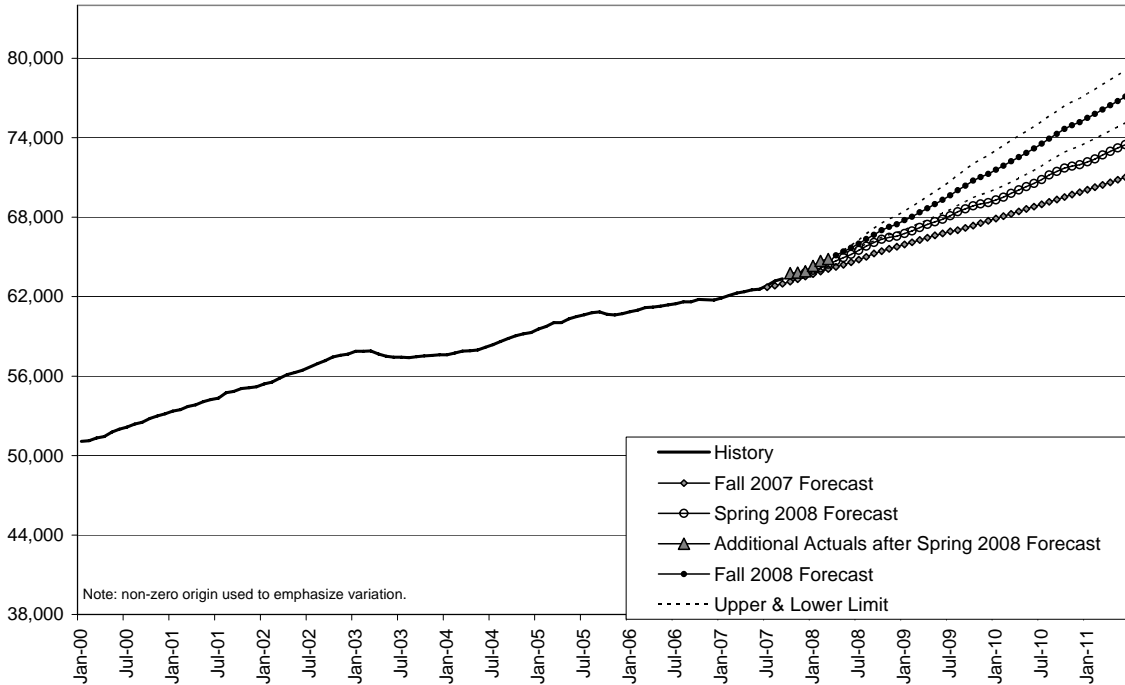


Exhibit C-11: Old Age Assistance

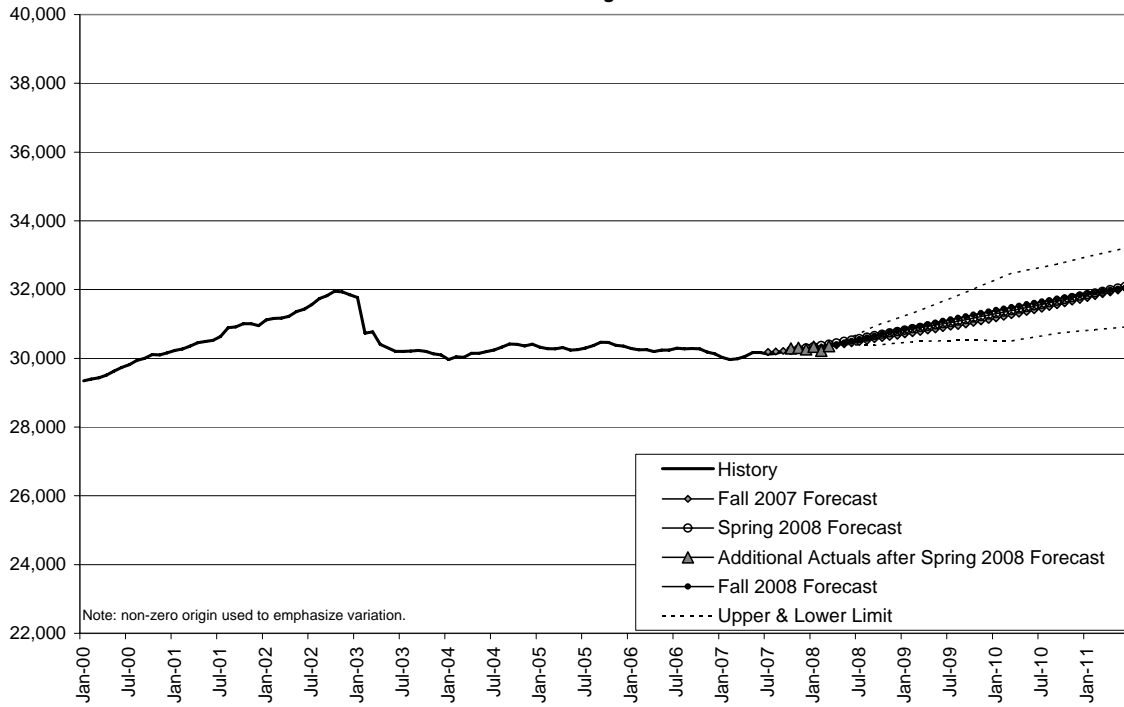


Exhibit C-12: Substitute Care & Adoption Services

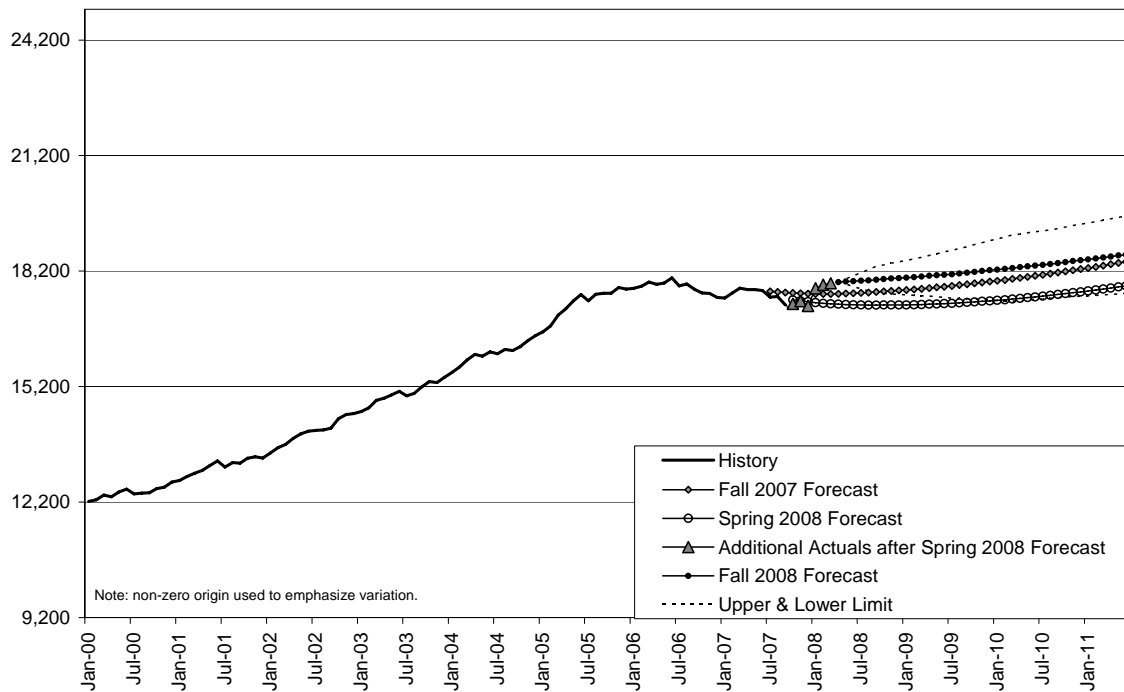
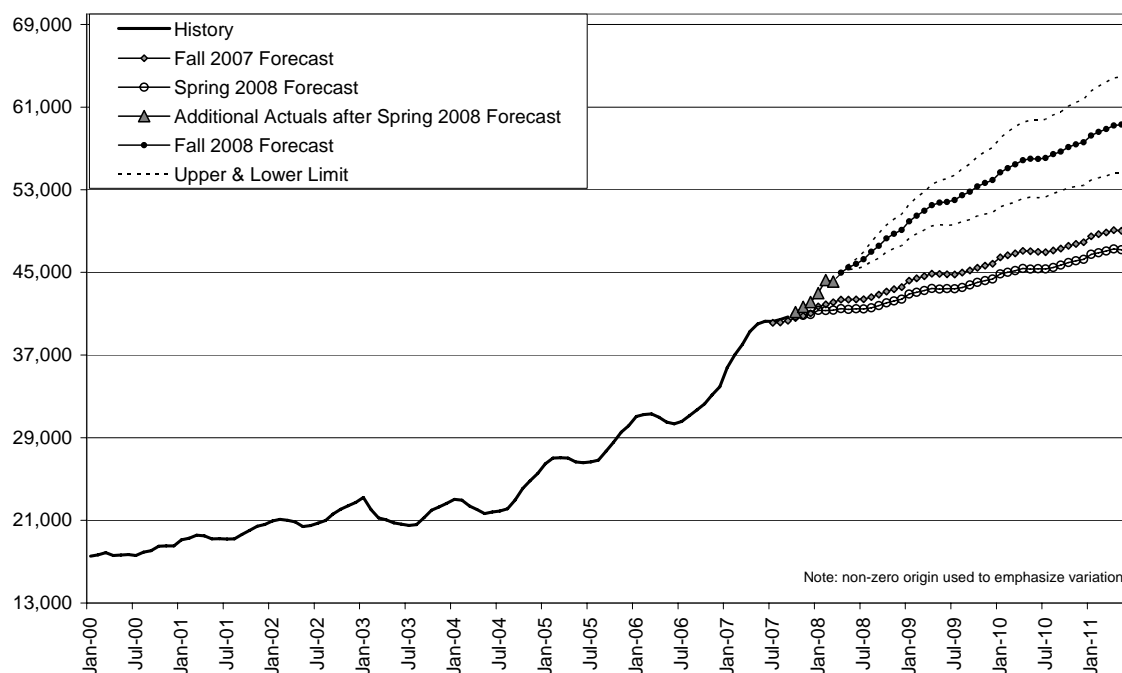


Exhibit C-13: Children's Health Insurance Program



Oregon Health Plan Standard

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

Families (Parents): Adults whose incomes 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 March 2008, the last month of complete historical data available for this forecast, the combined populations of these two groups stood at approximately 18,870. The March 2008 caseloads for Families and for Adults/Couples were around 7,500 and 11,350, respectively.

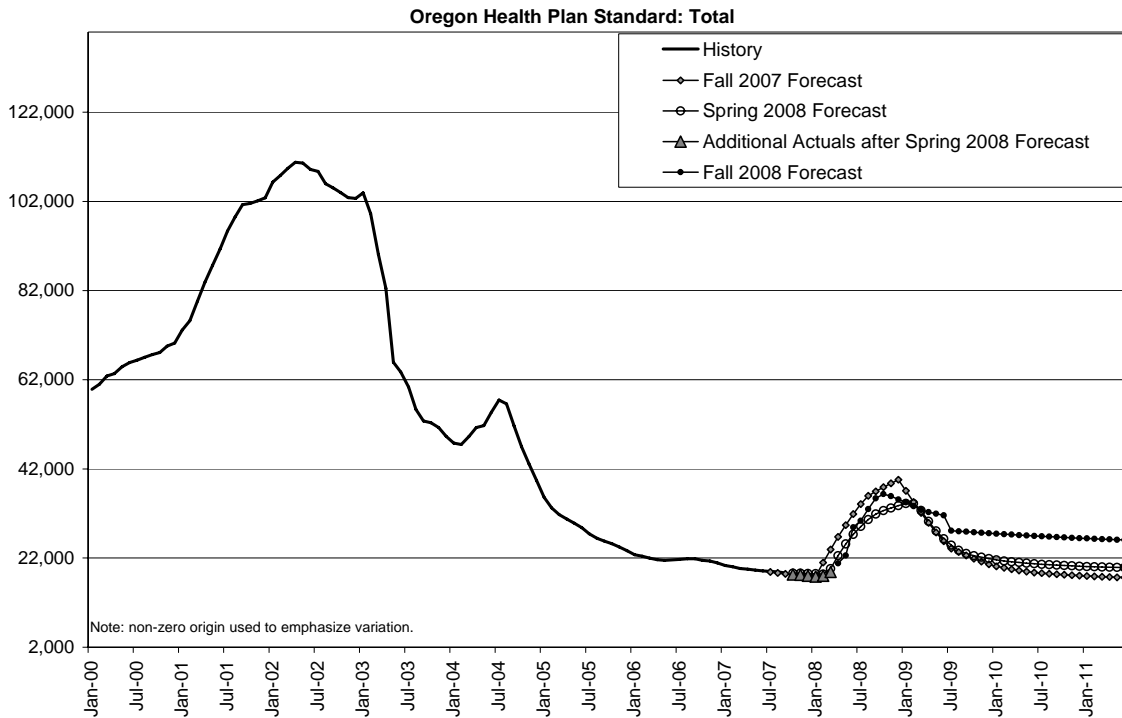
All state General Fund support for the Standard program was eliminated during the 2003 legislative session. However, a tax package was proposed by the legislature that would have funded the program. In February 2004, a referendum, Measure 30, was put before voters and defeated, overturning the Legislature's 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 2007-2009 biennial average of about 24,000 clients.

During February 2008 DHS invited Oregonians to place their name on a potential client list for possible enrollment in the Standard program. This list, which was opened for the month of February only, collected more than 90,000 names. Individuals on this list were self-selected and not vetted for eligibility. Subsequent to the closure of the list, a randomly selected number of individuals were, or will be, sent application forms each month. The number of individuals selected is related to estimates of final enrollment with a biennial average caseload of 24,000 as the target. This program of random selection and enrollment is ongoing. It should be noted that randomly selected applicants may qualify for OHP programs other than Standard. Limited experience thus far indicates that Poverty Level Medical Children and CHIP are the most likely non-Standard programs to see increased caseloads as a result of the random application process.

The current Fall 2008 forecast includes the estimated effects of reopening the Standard program (Families and Adults and Couples) to a fixed, but variable, monthly number of new clients from spring 2008 through the end of the 2008 calendar year.² Families generally make up approximately 40% of the total Standard program. Contributions from this program to other eligibility groups via the normal eligibility transfer process are expected and have been taken into

² The implementation of the Standard re-open plan is subject to change. As of this writing applications for enrollment will end with October of 2008.

consideration when forecasting the affected groups. Additionally, approximately 3,800 clients were transferred into the Standard program from FHIAP (Family Health Insurance Assistance Program) as part of the re-opening plan.



Other Medical Assistance Programs

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

Other: Qualified Medicare Beneficiary

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

Forecast

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

The previous Spring 2008 forecast for the QMB benefit group projected a continuation of caseload growth virtually identical to that anticipated in earlier forecasts. The current Fall 2008 forecast continues the growth expectation but at a slightly more aggressive level than earlier anticipated. The Fall 2008 forecast expects a 2007-2009 biennial average of approximately 13,072 clients compared to 13,026 in the previous forecast. The upper and lower limits reflect the average variation produced by historical forecasts. The upper and lower limits range on average approximately 2 percent from the forecast for the 2007-2009 biennium.

Other: Citizen/Alien Waived Emergency Medical

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

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

Forecast

The Fall 2008 forecast for the CAWEM client caseload is substantially higher in the 2007-2009 biennium than the Spring 2008 forecast for two reasons. First, this group, not unlike the TANF Related Medical group, is sensitive to economic change. As the current economic contraction continues it is expected that this population will increase. Second, the reopening of Standard (albeit in a limited way) is expected to contribute additional clients to this group. The reopening of the Standard eligibility groups to new clients, however, does not constitute an

expansion of eligibility for CAWEM clients. The Fall 2008 forecast estimates a 2007-2009 biennial average approximately 1,200 cases higher when compared to the Spring 2008 estimate. The differences decline, however, to approximately 375 cases in 2009-2011. The closing of the difference gap is due to the diminishing effects of the reopening of Standard and the anticipated economic recovery during the 2009-2011 biennium. Exhibit C-15 displays the history and comparative forecasts for this group. The upper and lower limit estimates average close to 1.2 percent above and below the forecast for 2007-09.

Other: Breast and Cervical Cancer Program

The Breast and Cervical Cancer Program - Medical (BCCP-M) began in January 2002. This program provides medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Public Health through county health departments and tribal health clinics. After determining eligibility, the client receives all Oregon Health Plan Plus medical insurance benefits including mental and dental health services. A client is eligible until reaching the age of 65, obtaining coverage or ending treatment. As of March 2008, the caseload had grown to 355 clients. While this group is quite small, the caseload increase has generally been consistent and rapid. Only in the first half of calendar year 2007 did the caseload shown a tendency to decline, primarily as a result of short-term administrative change.

Forecast

The Fall 2008 forecast for the Breast and Cervical Cancer caseload is virtually identical to that of Spring 2008 for the 2007-2009 biennium. Current estimates call for approximately 30 fewer average cases in 2009-2011. The upper and lower limits show that for 2007-2009, the actual counts could be expected to range an average of 3 percent above or below the forecast. This variance increases to 6 percent during the 2009-2011 biennium.

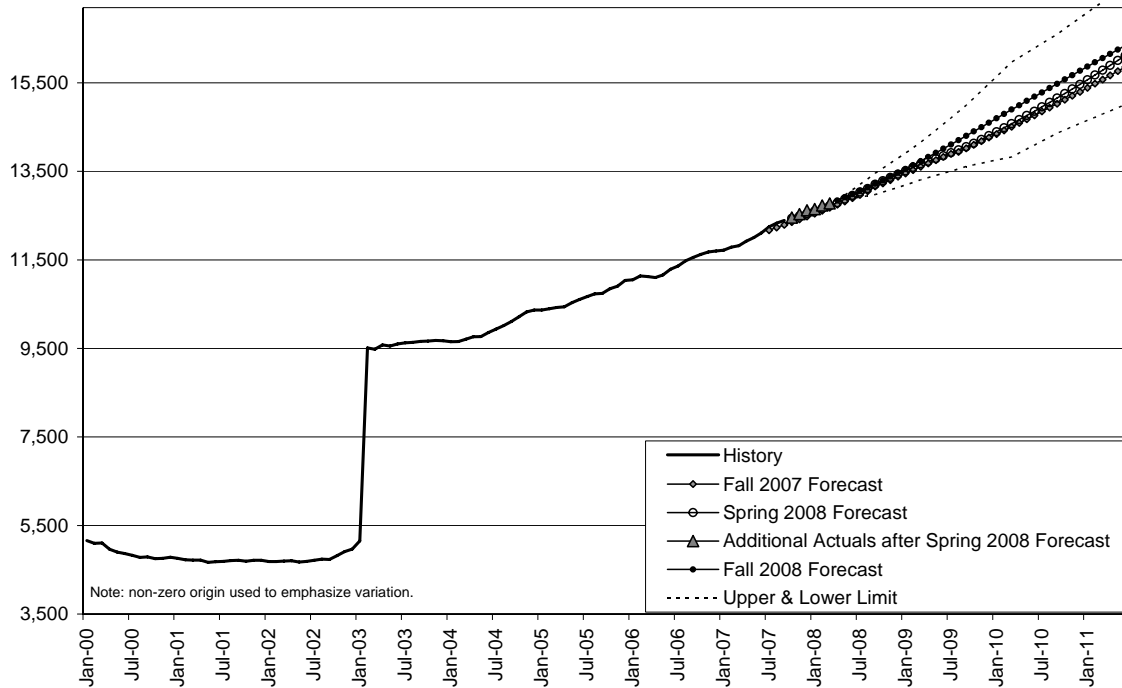
Additional Risks to the Spring 2008 Forecast

Risks to the current Spring 2008 forecast may be grouped into two broad categories: systemic/behavioral and policy related.

Many DMAP caseloads are sensitive to both the economy and access to health care. 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. As of this writing the U.S. economy continues to contract with energy, food, and health care costs showing substantial inflation. As these effects generalize to the wider U.S. economy and

to Oregon in particular, it is expected that DHS caseloads will grow. Current forecasts from the Oregon Department of Administrative Services, Office of Economic Analysis are for a continuation of economic contraction through mid-2009 with slow recovery beginning in the latter part of that year³.

Exhibit C-14: Qualified Medicare Beneficiaries



³ Oregon Economic Forecast. Oregon Department of Administrative Services. Office of Economic Analysis. 28 August 2008.

Exhibit C-15: Citizen / Alien Waived Emergency Medical

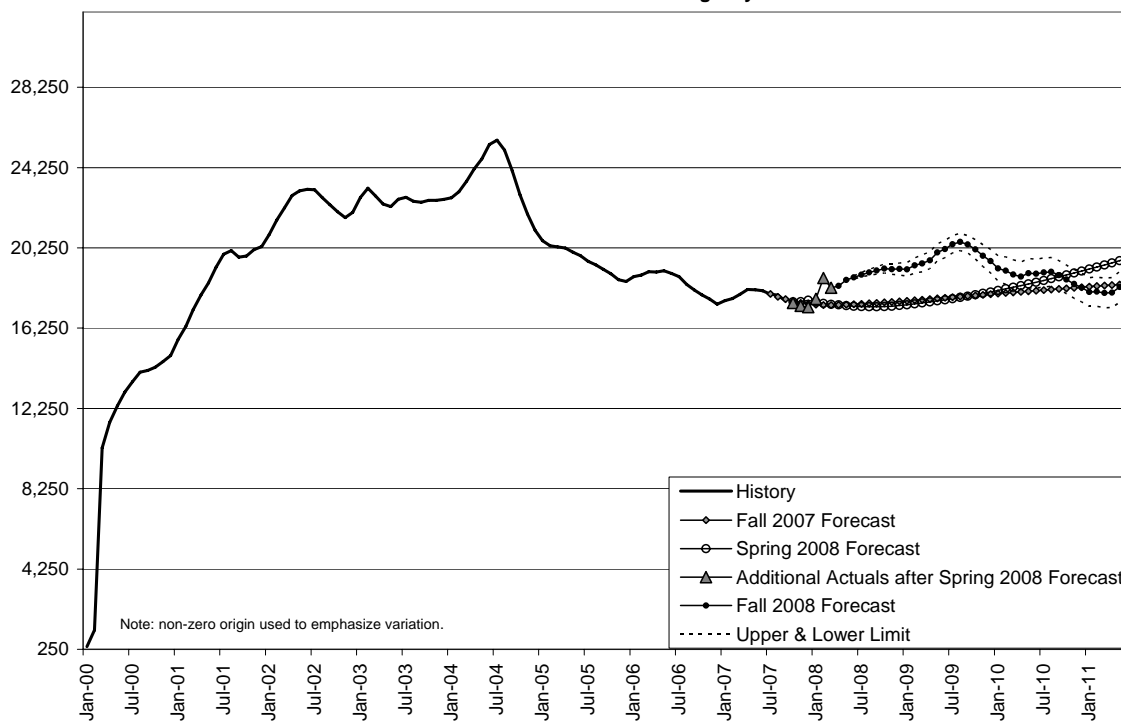
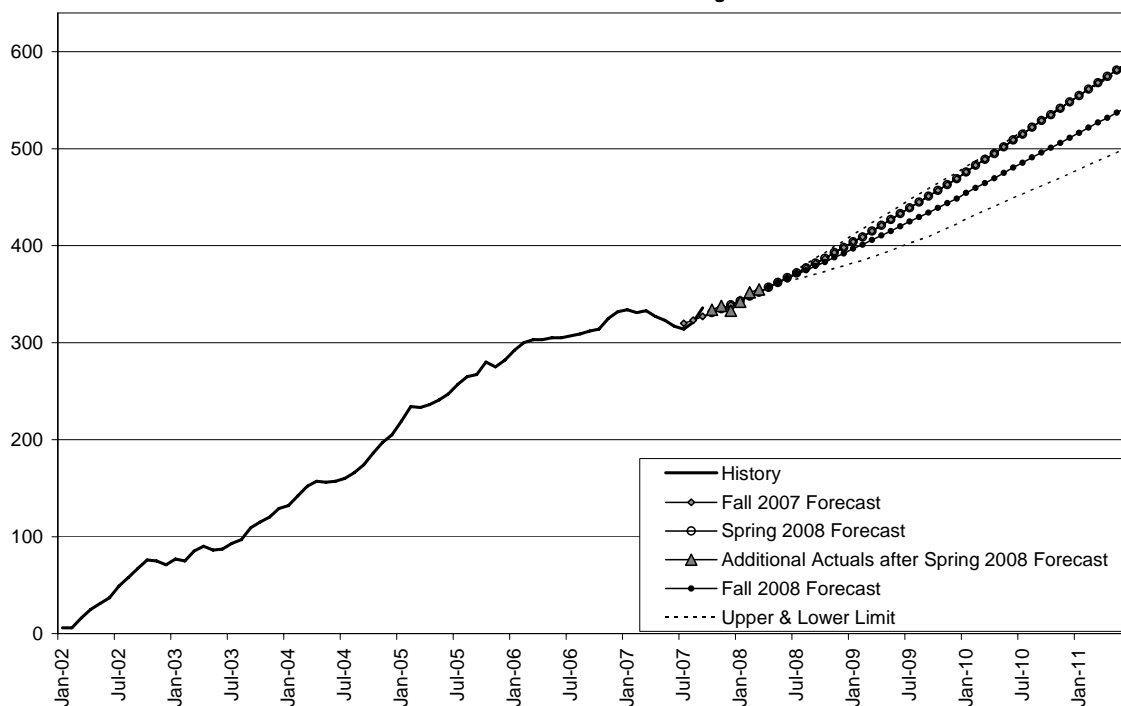


Exhibit C-16: Breast and Cervical Cancer Program-Medical



Addictions and Mental Health Division

Introduction

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

The State Hospitals – located in Salem, Portland and Pendleton – provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

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

Exhibit D-1: Mandated Mental Health Caseload within program categories	
Criminally Committed	Civilly Committed
Aid & Assist	24 Hour Care
Psychiatric Security Review Board	Acute Care
	State Hospital
	Non-Residential Community Care

The Fall 2008 Mental Health forecast continues the forecasting process that was implemented in Fall 2006. We use historical data from the Integrated Client Services Data Warehouse (ICS). Data definitions and business rules used to create caseload categories have largely reached a state of consistency, thereby allowing a comparison between the Fall 2008 and Spring 2008 forecasts.

Exhibit D-2 compares the biennial averages of actual counts and forecasted caseload between the Fall 2008 and Spring 2008 forecasts for the 2007-09 biennium as well as the Fall 2008 forecasts 2007-09 and 2009-11 biennia.

Exhibit D-2: Mental Health Biennial Average Comparisons

Numbers of Clients Served per Month	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
Addictions and Mental Health Programs									
Biennial Averages									
Criminal Commitment									
Aid and Assist	177	139	-21.5%	148	139	-6.1%	139	154	10.8%
Psychiatric Security Review Board	781	767	-1.8%	765	767	0.3%	767	811	5.7%
Total Criminal Commitment	958	906	-5.4%	913	906	-0.8%	906	965	6.5%
Civil Commitment									
24 Hour Care	1,420	1,387	-2.3%	1,295	1,387	7.1%	1,387	1,643	18.5%
Acute Care	168	173	3.0%	168	173	3.0%	173	177	2.3%
State Hospital	316	320	1.3%	317	320	0.9%	320	322	0.6%
Non-residential Community Care	2,792	3,094	10.8%	2,649	3,094	16.8%	3,094	3,653	18.1%
Total Civil Commitment	4,696	4,974	5.9%	4,429	4,974	12.3%	4,974	5,795	16.5%
Total Mandated Care	5,654	5,880	4.0%	5,342	5,880	10.1%	5,880	6,760	15.0%
Unduplicated Count, Total Mandated Care	4,488	4,738	5.6%	4,302	4,738	10.1%	4,738	5,434	14.7%

Mandated Mental Health Caseload

Forecast

As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is 10.1 percent higher than that for the Spring 2008 forecast.

Overall, the Mandated caseload is predicted to continue to increase through June 2011 (Exhibit D-3). The 2009-11 biennial average number of clients is estimated to increase by 16.5 percent over that for the 2007-09 biennium. The upper and lower limits for the Mandated caseload may vary, on average, by 4.0 percent over the 2009-11 biennium.

Criminally Committed

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

treatment and supervision for these individuals, either in the community or in a State Hospital.

Forecast

Recent levels of the total forensic caseload have fluctuated with periods of growth followed by decline in 2005-06 and growth in 2007. We anticipate that the recent growth will continue through 2011(Exhibit D-4). As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is 0.8 percent lower than that for the Spring 2008 forecast. For the Fall 2008 forecast, the average caseload for the 2009-11 biennium is expected to increase by 6.5 percent over the 2007-09 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 8 percent above or below the forecast over the 2009-11 biennium.

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

In addition, AMHD staff developed a plan for accelerated placements of State Hospital forensic and civilly-committed patients into new residential treatment facilities in various communities. The successful development of these residential facilities requires the cooperation of local governments and thus is a risk to the forecast.

Aid and Assist Forecast

Recent levels of the Aid and Assist caseload have increased through 2008. We anticipate that this growth will continue through 2011(Exhibit D-5). As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is 6.1 percent lower than that for the Spring 2008 forecast. For the Fall 2008 forecast, the average caseload for the 2009-11 biennium is expected to increase by 10.8 percent over the 2007-09 biennium. However, relatively large and consistent variation in the historical data creates an average risk of 29 percent above or below the forecasted values (Exhibit D-5) over the 2009-11 biennium.

Psychiatric Security Review Board Forecast

Recent levels of the PSRB caseload have increased through 2007 after declining in 2005-06. We anticipate that this growth will continue through 2011 (Exhibit D-6). As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is essentially the same as the Spring 2008 forecast; for 2009-11. For the Fall 2008 forecast, the average caseload for the 2009-11 biennium is expected to increase by 5.7 percent over the 2007-09 biennium. We expect the total PSRB caseload to increase through the 2009-11 biennium (Exhibit D-6). Future actuals may vary by an average of 29 percent above or below the forecast.

Civilly Committed

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

Forecast

The Fall 2008 forecast estimates that the combined Civilly Committed caseload will continue to increase through the end of the 2009-11 biennia (Exhibit D-7). As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is 12.3 percent higher than that for the Spring 2008 forecast. Much of this increase can be attributed to an update of the historical counts obtained from the ICS. For the Fall 2008 forecast, the average caseload for the 2009-11 biennium is expected to increase by 16.5 percent over the 2007-09 biennium. The Civilly Committed 2009-11 caseload may vary, on average, by 4 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). As shown in Exhibit D-2, the Fall 2008 biennial average for the 2007-09 biennium is 7.1 percent higher than that for the Spring 2008 forecast. For the Fall 2008 forecast, the average caseload for the 2009-11 biennium is expected to increase by 18.5 percent over the 2007-09 biennium. Some of the more recent growth is due to placing some patients from the State Hospital into 24 Hour Care settings; additional relocations from the State Hospital into community settings are expected to continue but have not been incorporated into the Fall 2008 forecast due to the delayed development of appropriate residential facilities. Future actuals may vary by 11 percent above or below the forecast.

Civilly Committed - Acute Care

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

Forecast

The 2007-09 and 2009-11 Civilly Committed Acute Care caseloads are expected to remain fairly constant as illustrated by (Exhibit D-9). The Fall 2008 forecast though, is expected to increase 3.0 percent over the Spring 2008 2007-09 biennia. Also, the Fall 2008 forecast average for 2009-11 is expected to be 2.3 percent higher than for 2007-09. High variation in the historical numbers for Acute Care contributes to a greater degree of uncertainty as future actuals may vary by an average of 31 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, after a period of decline, have increased in recent months but are expected to remain constant through June 2011 (Exhibit D-10). As shown in Exhibit D-2, the Fall 2008 for 2007-09 biennial average is practically identical to that for the Spring 2008 forecast. For the Fall 2008 forecast, the forecast remains constant across the biennia. Also, the planned expansion of alternative treatment settings in the community (24 Hour Care) has not yet occurred. Staff expect that transfers to the State Hospitals from acute care hospitals would maintain a constant number of patients even when new facilities become available. The caseload may vary by an average of 12 percent through 2011.

Risks and Assumptions

The base forecasts were developed using common statistical methods. These methods rely on the relative month-to-month change in the caseload history. Assumed changes in significant environmental factors such as future population growth or program policies do not influence the predicted levels, but they may have shaped the historic caseload trends. Thus, the primary assumption of these base forecasts is that any factors that significantly affect the Mental Health programs or clients will remain unchanged through 2011. Base forecasts may be adjusted to correspond to the expected outcomes of program and policy changes.

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

The following factors also pose risks to the forecasts:

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

would favor a regular jail sentence rather than a longer forensic or civil commitment.⁴

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

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

Specific Program and Policy Events: As previously stated, the 2007 Legislature strengthened several components of community-based mental health services. The mental health forecasts are based on staff's assessment of the outcomes of these new funding levels. These new programs require complex coordination of and full cooperation by, several public and private entities. The Fall 2008 forecast, unlike the Fall 2007 forecast, does not assume that all of these positive outcomes will happen. For example, if local entities deny the development of additional residential facilities in communities, then fewer than expected patients would be relocated from the State Hospital, and the caseload would not be at forecasted levels. Therefore, forecasts that assume successful outcomes are inherently at risk.

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

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

Exhibit D-3: Mandated: Total

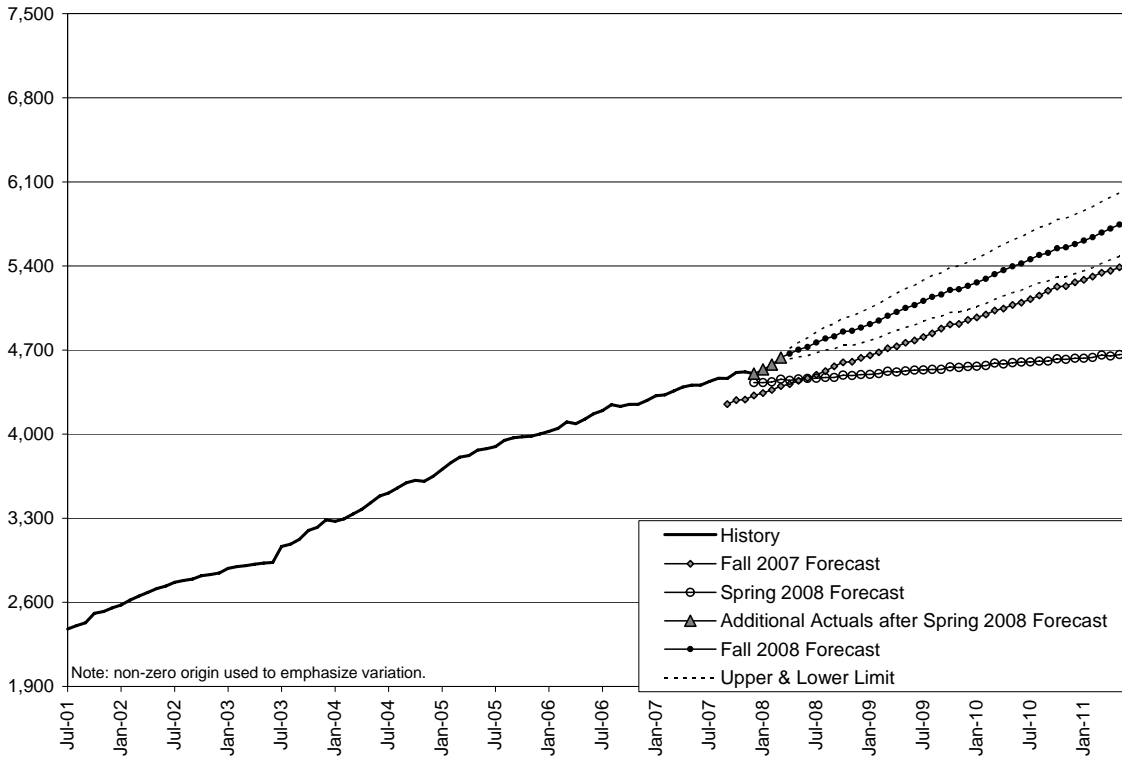


Exhibit D-4: Criminally Committed: Total

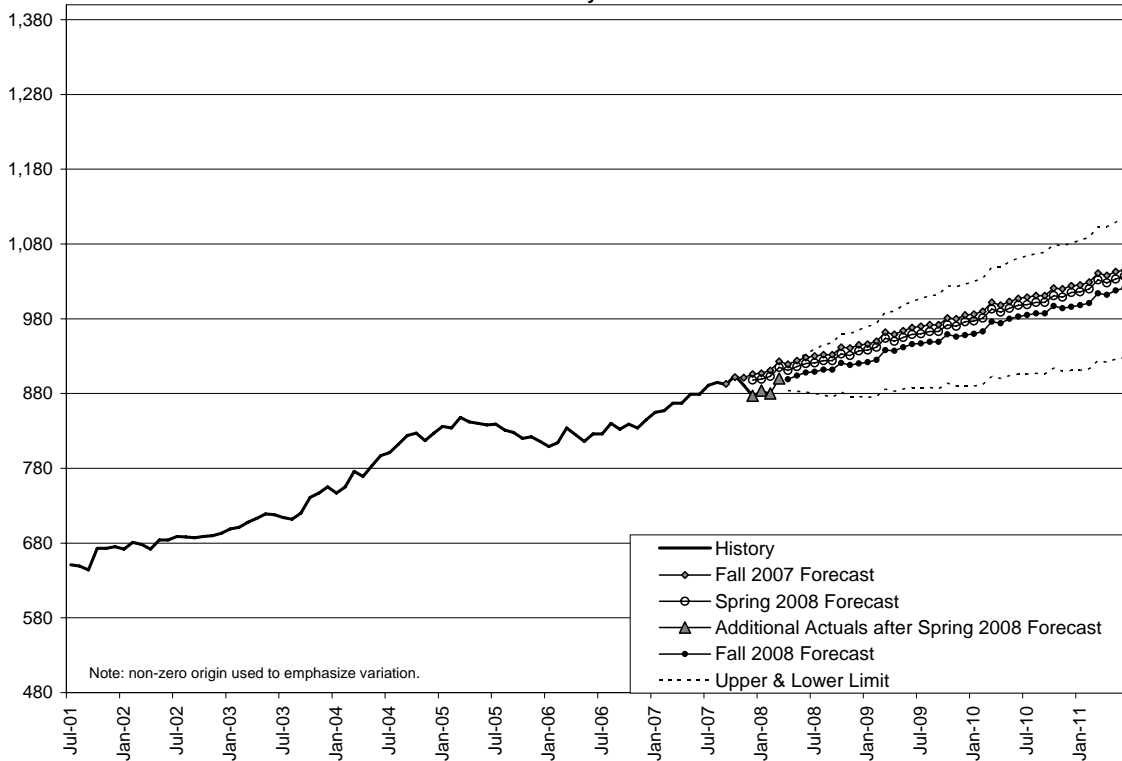


Exhibit D-5: Aid & Assist

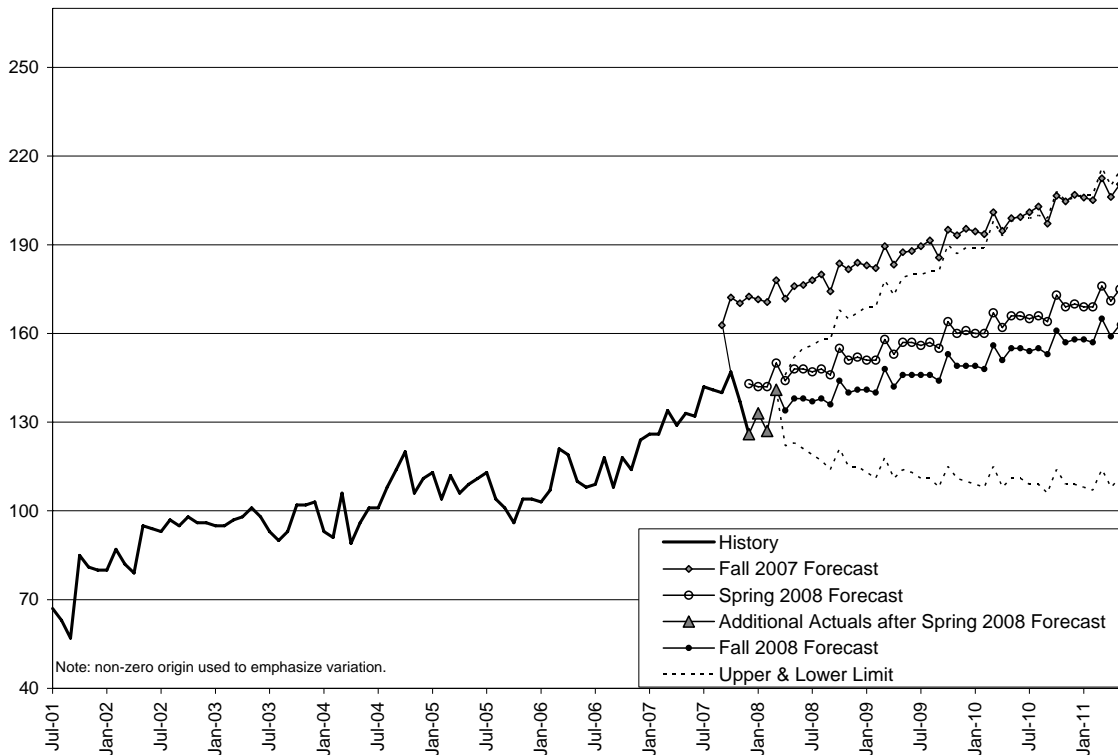


Exhibit D-6: Psychiatric Security Review Board: Total

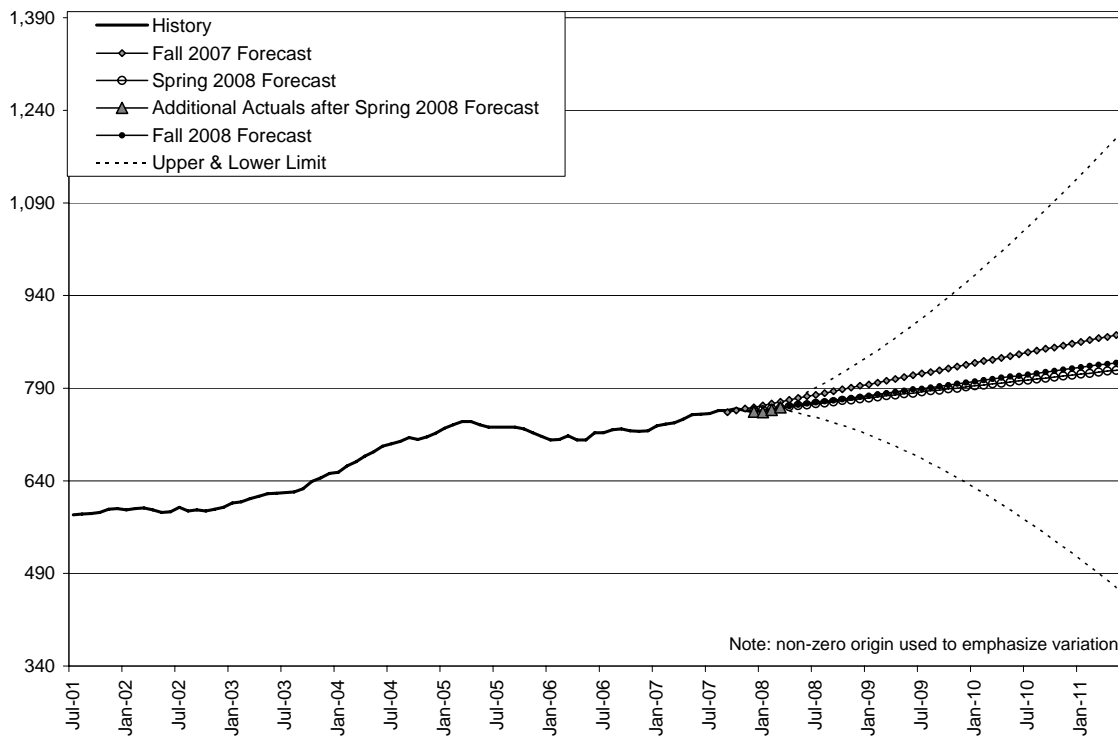


Exhibit D-7: Civilly Committed: Total

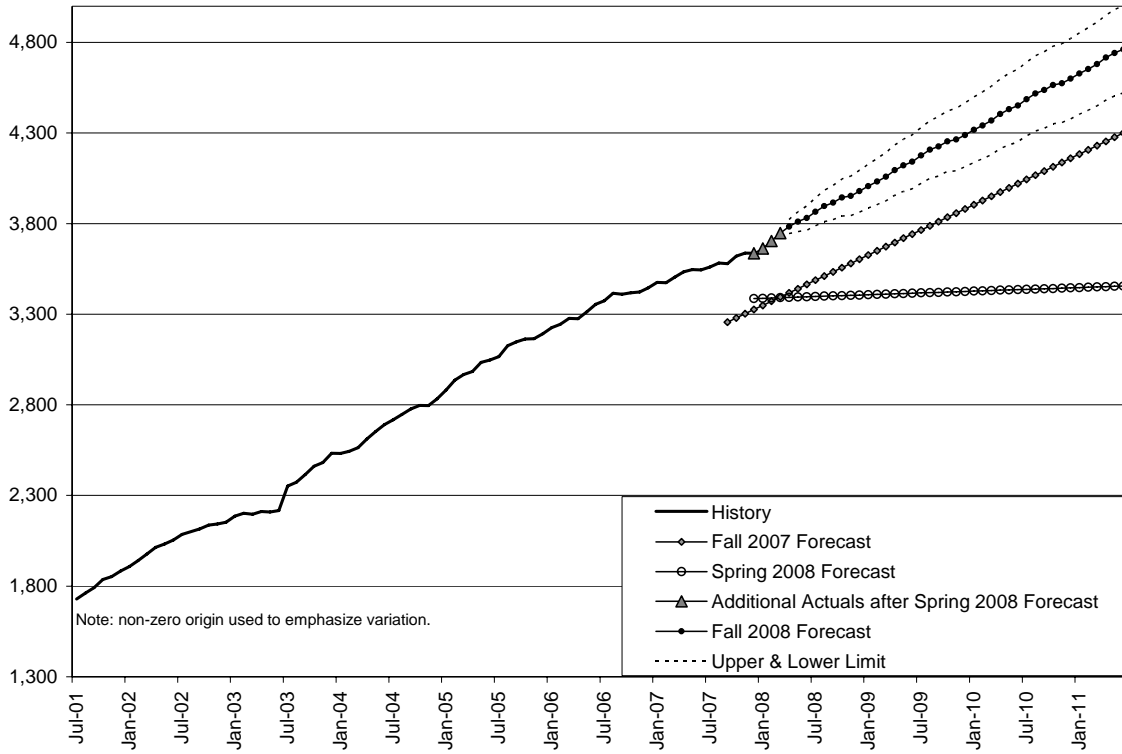


Exhibit D-8: Civilly Committed: 24 Hour Care

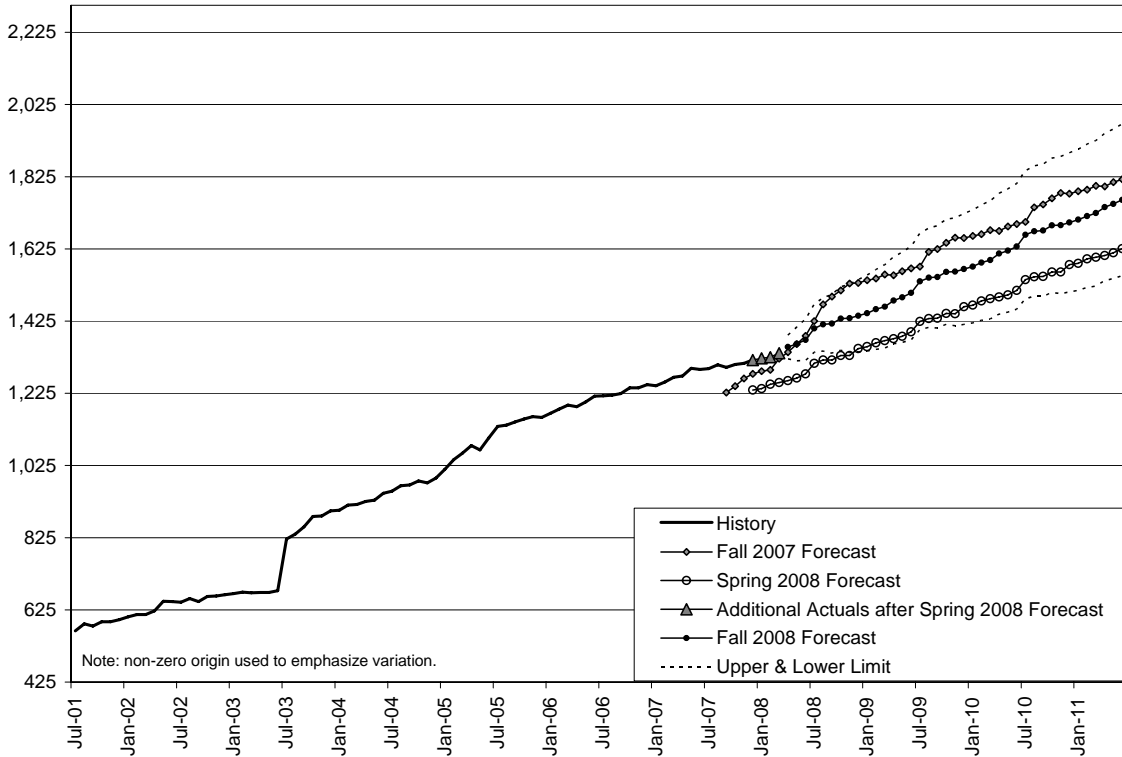


Exhibit D-9: Civilly Committed: Acute Care

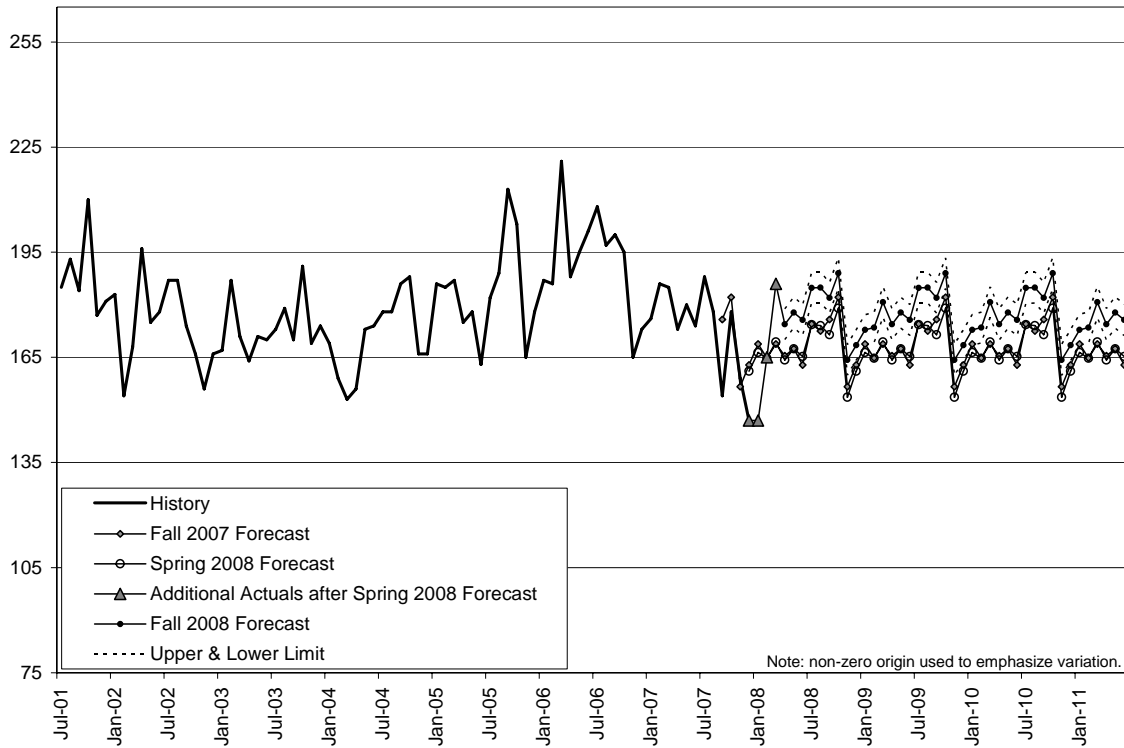
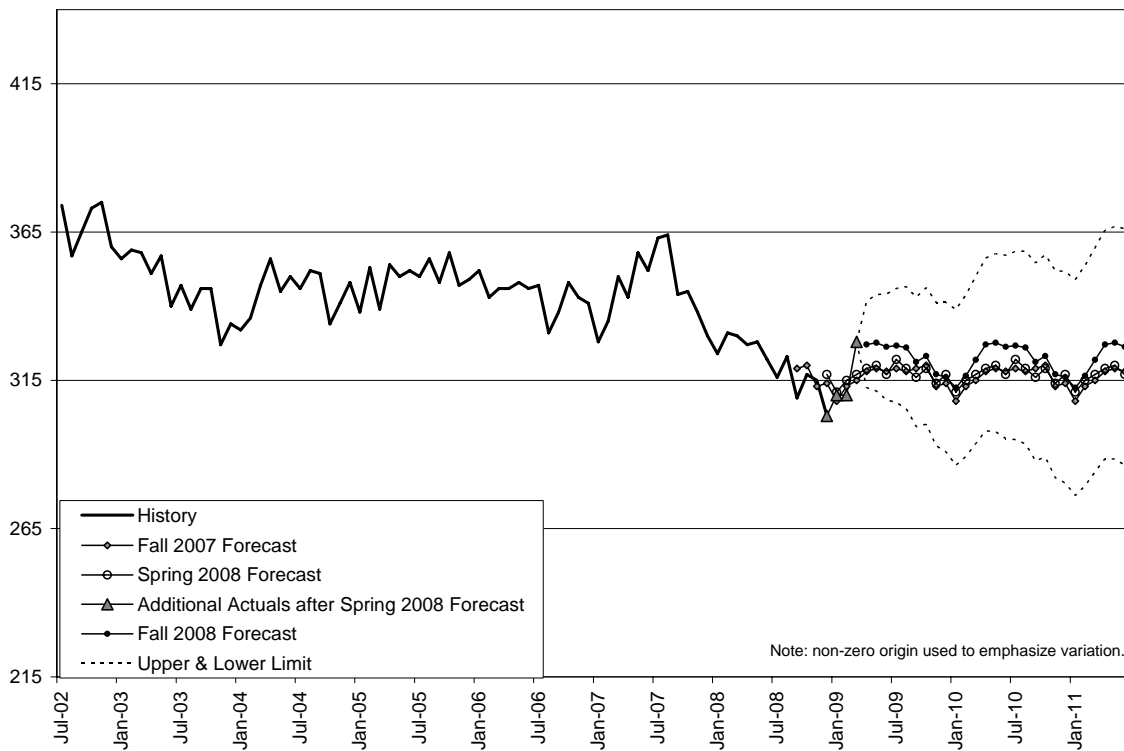


Exhibit D-10: Civilly Committed: State Hospital



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 (LTC) services to people who, due to their age or disabilities, require these services to live in a safe and healthy environment. Long-Term Care 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.

This forecast projects the Long-Term Care caseloads for 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

The 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 the income limit of Supplemental Security Income (SSI) (\$637 per month). The SSI eligibles receive a mandatory supplemental income of \$2,040 per year from the State of Oregon.

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

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

It should be noted that 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 Long-Term Care service priority rules. OPI clients generally meet Medicaid eligibility, except in some cases they may have higher than allowable resource limits, and many choose not to enroll in Medicaid due to the state recovery requirement. OPI served about 3,600 clients in 2007.

Total Fall 2008 Caseload Forecast

The total Long-Term Care caseload forecast for Fall 2008 includes In-Home Care, Community-Based Care and Nursing Facilities (including the Other Nursing Facilities services such as Medicare Extended Care, Enhanced Care and the OHP Post-Hospital Benefit caseloads).

Nursing Facilities make up about 20 percent of the total Long-Term Care caseload, while the In-Home and Community-Based Care Facilities account for 40 percent respectively (Exhibit E-2). Overall, this caseload distribution pattern has not changed significantly.

The average monthly Long-Term Care caseload, measured as a biennial average, was 28,021 clients (28,129 clients with all NFC services included) in 2003-05. This population decreased by 4.0 percent to 27,162 clients in the 2005-07 biennium, and it is forecasted to decrease 3.0 percent to an average of 26,241 clients in the 2007-09 biennium from the 2005-07 level. The Fall 2008 LTC caseload forecast for 2007-09 is forecasted to be slightly lower than the Spring 2008 forecasts.

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 10.0 percent, or more than 3,000 cases. This was primarily due to the elimination of Long-Term Care service priority levels 12 through 17 in February and April 2003⁵.

The Fall 2008 forecast is 0.5 percent lower than the Spring 2008 forecast for the 2007-09 biennium. The total caseload forecast for the 2009-11 biennium, compared to that for 2007-09, is lower by 0.2 percent. The lower Long-Term

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

Care caseload forecast for the 2009-11 biennium is due to a net decline in the In-Home caseload and an increase in the Nursing Facilities caseload while the Community-Base Care caseload remains unchanged (Exhibit E-2).

The total OSIP caseload averages 49,750 for the 2005-07 biennium. This caseload is expected to be slightly higher (53,142) for the 2007-09 biennium, and similarly, it is expected to remain higher (56,186) for the 2009-11 biennium.

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

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007-09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007-09 to 2009-11
Aged and Physically Disabled									
Biennial Averages by Forecast									
In-Home Hourly	9,436	9,296	-1.5%	9,329	9,296	-0.4%	9,296	9,194	-1.1%
In-Home Live-In	1,131	1,062	-6.1%	1,118	1,062	-5.0%	1,062	1,019	-4.0%
In-Home Spousal Pay	124	130	4.8%	123	130	5.7%	130	132	1.5%
Subtotal In-Home	10,691	10,488	-1.9%	10,570	10,488	-0.8%	10,488	10,345	-1.4%
Relative Adult Foster Care	1,456	1,475	1.3%	1,457	1,475	1.2%	1,475	1,399	-5.2%
Commercial Adult Foster Care	2,551	2,485	-2.6%	2,510	2,485	-1.0%	2,485	2,510	1.0%
Regular Residential Care	957	962	0.5%	953	962	0.9%	962	968	0.6%
Contract Residential Care	1,102	1,106	0.4%	1,126	1,106	-1.8%	1,106	1,099	-0.6%
Assisted Living	3,615	3,672	1.6%	3,603	3,672	1.9%	3,672	3,657	-0.4%
Specialized Living	165	164	-0.6%	165	164	-0.6%	164	165	0.6%
ElderPlace (PACE)	704	674	-4.3%	695	674	-3.0%	674	750	11.3%
Subtotal Community-Based Care	10,550	10,538	-0.1%	10,509	10,538	0.3%	10,538	10,548	0.1%
Basic Nursing Facility Care	4,529	4,594	1.4%	4,666	4,594	-1.5%	4,594	4,668	1.6%
Complex Medical Add-On	348	378	8.6%	377	378	0.3%	378	361	-4.5%
Pediatric Care	56	55	-1.8%	56	55	-1.8%	55	56	1.8%
Extended Care NFC	136	124	-8.8%	130	124	-4.6%	124	133	7.3%
Enhanced Care	60	59	-1.7%	59	59	0.0%	59	60	1.7%
Post-Hospital Benefit	6	5	-16.7%	5	5	0.0%	5	6	20.0%
Subtotal Nursing Facilities	5,135	5,215	1.6%	5,293	5,215	-1.5%	5,215	5,284	1.3%
Total Long-Term Care	26,376	26,241	-0.5%	26,372	26,241	-0.5%	26,241	26,177	-0.2%
Aid to the Blind	621	611	-1.6%	611	611	0.0%	611	638	4.4%
Aid to the Disabled	40,494	40,911	1.0%	40,673	40,911	0.6%	40,911	42,630	4.2%
Old Age Assistance	11,651	11,620	-0.3%	11,623	11,620	0.0%	11,620	12,918	11.2%
Total Oregon Supplemental Income Prgm (OSIP)	52,766	53,142	0.7%	52,907	53,142	0.4%	53,142	56,186	5.7%
<small>Notes: * Spring 2008 Forecast: Actual through October 2007. * Fall 2007 Forecast: Actual through June 2007. * Total In-Home caseload does not include In-Home Agency, Independent Choices & Oregon Project Independence caseload.</small>									

To summarize the comparison of the Fall 2008 and the Spring 2008 forecasts, the following points can be made:

- The In-Home caseload was 11,275 in the 2005-07 biennium. The In-Home caseload forecast is 0.8 percent lower in the Fall 2008 forecast compared with the Spring 2008 forecast for both 2007-09 and 2009-11 periods. This caseload decrease by 1.4 percent through 2009-11 biennium.
- Community-Based Care caseloads averaged 10,771 for the 2005-07 biennium. The Fall 2008 forecast for Community-Based Care caseloads is slightly higher than the Spring 2008 forecasts for both the 2007-09 and 2009-11 periods. It is expected to remain stable throughout the 2007-09 and the 2009-11 biennia.
- The Nursing Facilities caseload averaged 5,116 in the 2005-07 biennium. The Nursing Facilities caseload forecast is 1.5 percent lower in the Fall 2008 forecast compared with the Spring 2008 forecast for both the 2007-09 and 2009-11 forecasts.

Risks and Assumptions

The following are the major assumptions of the Long-Term Care 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 among the Medicaid LTC services will follow historical patterns.

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

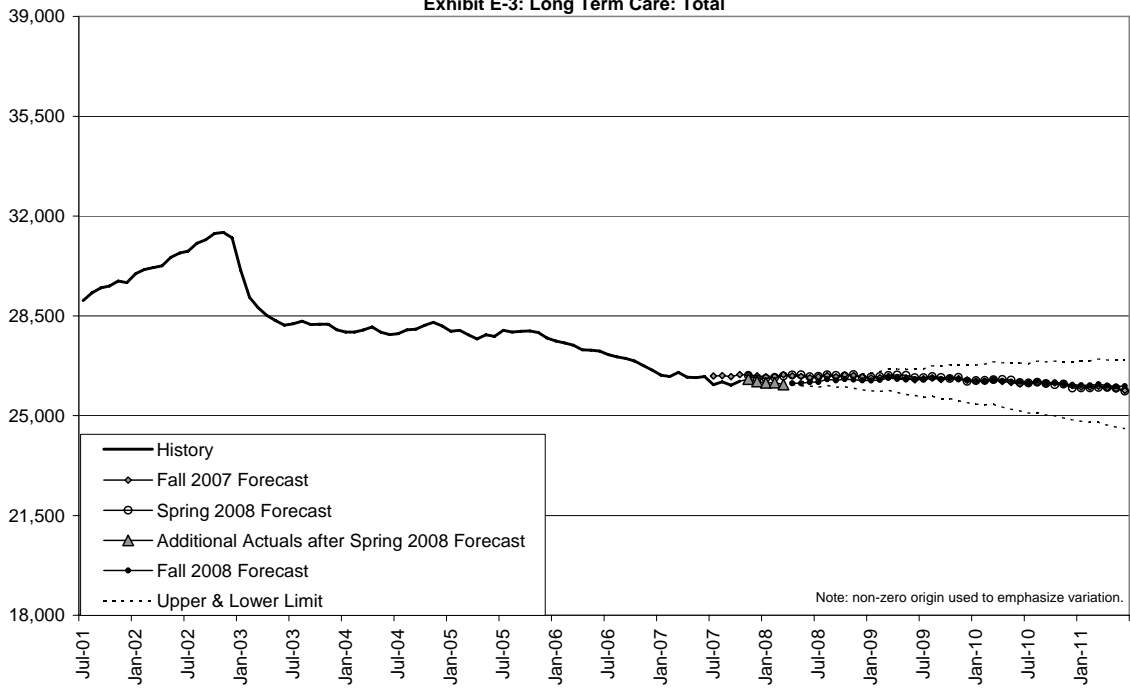
Oregon Demographic Shift: In addition, a series of external as well as internal factors will change the forecast estimates. The shift toward the elderly population as a percentage of the total is a risk to the forecast. Elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85+ age group also risk depleting their resources. If they do, then they will likely become eligible for the DHS Medicaid and Long-Term Care programs. Also, the changing dynamics of Long-Term Care market forces pose a serious risk to the forecast. (For details, please see SPD Caseload Forecast Risks and Assumptions Section, in the DHS Spring 2006 Forecast).

New CBC Initiatives: In addition, SPD is also set to implement other administrative actions that will ensure that more Medicaid clients (including spent-down clients) will be served in the CBC as a part of renewal of licensing agreement and/ or lifting of moratorium on construction of new ALFs and RCFs in Oregon. SPD is also working on offering several types of Medicaid contracts by making Medicaid participation more attractive to providers while actively seeking to recruit new CBC providers in underserved areas with low Medicaid community-based care capacity levels. However, these efforts may be discouraged by the slowdown in the housing market and decline in the value of homes which in turn make investors less enthusiastic about their investment in this sector and/ or that spend-down population delay entry into the supportive housing settings (i.e., ALFs & RCFs).

SPD has also examined the current acuity plus add-on CBC rate structure. The new proposal accounts for client acuity, prevailing market rates, as well as the Medicaid participation; doing so this will close the prevailing gap between Medicaid and Private Market reimbursement levels. As part of the comprehensive rate restructure plan, the current CBC base rate has been adjusted by \$260 per client per month effective July 1, 2008 and it is likely to stabilize the declining trends in the Medicaid caseloads in the near-term, while help increase the Medicaid access in the CBC market.

The total Long-Term Care caseload since 2002-03 has slowly declined with some fluctuations. Based on the historical variability as well as the current state of long-term care market volatility, the LTC forecast has inherent risk the farther out the projections. Thus, the average LTC caseload forecast may vary by as much as 5 percent in either direction for the 2007-11 biennia.

Exhibit E-3: Long Term Care: Total



In-Home

The In-Home program provides services that help people stay in their homes when they need assistance with Activities of Daily Living⁶ (ADLs). Home care workers are hired directly by clients to provide the In-Home services. Historically, the average In-Home services caseload makes up approximately two-fifths of the total Long-Term Care caseload.

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

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

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

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

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

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

The same proportions across the three In-Home services are expected to remain for the 2007-09 & 2009-11 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.

⁶ Activities of Daily Living include: mobility, eating, bathing, dressing, grooming, toileting, and bowel and bladder care.

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

Additionally, In-Home Agency Provider is another In-Home service that is not included in the forecast. The agencies, licensed through DHS, provide hourly In-Home services to In-Home clients through their staff. On average 401 clients received In-Home care services through the In-Home Agency Providers in 2008. In many instances, such services are in addition to the regular In-Home services mentioned above.

Forecast

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

The Total In-Home caseload forecast for the current biennium is lower by 0.8 percent compared to the Spring 2008 forecast. The forecast for 2009-11, compared to that for 2007-09 forecast, is 1.4 percent lower (10,488 versus 10,345).

Risks to In-Home Forecast

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

SPD has implemented aggressive LTC client eligibility and field reviews.

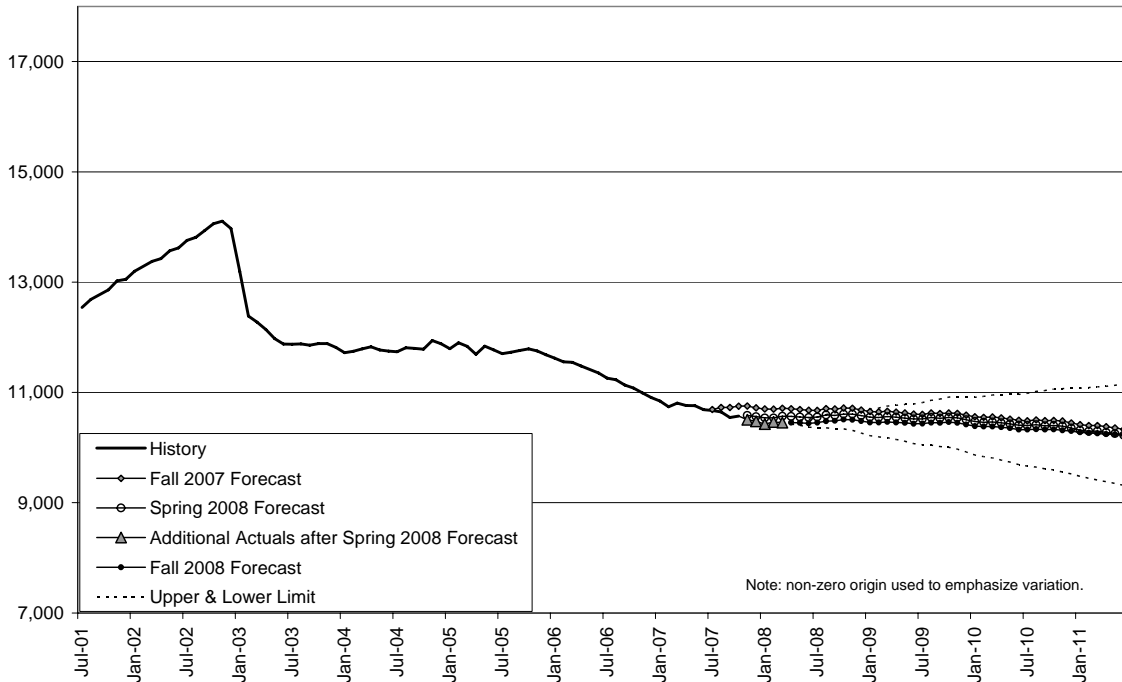
The full implementation of the Medicare Modernization Act (MMA), which provides prescription drug coverage, may have induced those In-Home clients who were only using services to obtain the Medicaid prescription drug benefit in the pre-MMA period to now drop out of In-Home services. In addition, there are plans to expand Independent Choices (IC) statewide in the upcoming years. If so, it will exceed the capped enrollment of 300 over several

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

In-Home Care Providers are represented and receive benefits for their full-time work. As a result, the In-Home care is being competitive with CBC services mainly with the Relative Adult Foster Care, and it may cause the lowering effect on this caseload.

The forecast has inherent risks the farther out the projections. Based on normal historical fluctuation in this caseload, the forecast could vary 10 percent above or below the average forecast for the 2007-11 biennia.

Exhibit E-4: In-Home Care: Total



Community-Based Care Facilities

The Community-Based Care caseload (also referred to as Licensed Community Facilities) includes clients receiving Long-Term Care (LTC) 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 facility is licensed differently, each facility can provide care for all Long-Term Care clients, except when a client needs specialized services. Thus, some LTC clients can and do change their care settings over time.

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

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

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

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

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

Forecast

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

In 2003-05, the total caseload in Community-Based Care facilities averaged 11,123. However, this caseload declined to a biennial average of 10,771 in 2005-07. The Fall 2008 total Community-Based Care caseload forecast for 2007-09 biennium is slightly higher than the Spring 2008 forecast. The forecast for the next biennium (2009-11) is also higher by 1 percent

The total CBC caseload forecast for the 2007-09 biennium is slightly higher than that of the Spring 2008 forecast. The total CBC caseload forecast for the next biennium 2009-11, compared to the 2007-09 forecast, remains about identical (10,538 versus 10,548) (Exhibit E-5).

CBC: Total Adult Foster Care

Adult Foster Care (AFC), provided by Adult Foster Homes, offers Long-Term Care in home-like settings licensed for five or fewer unrelated people. Adult Foster Homes represented 38 percent of the total CBC caseload in 2005-07. Foster homes may be Commercial and open to members of the public who are not related to the care provider or Relative and only provide care for people who are related to the care provider. Some foster homes provide specialized services to residents who are dependent on ventilators. Relative AFC clients receive services at their relative care takers' home. Total Adult Foster Care caseload is expected to decline slightly through 2009-11 (Exhibit E-6).

CBC: Adult Foster Care - Relative

The Adult Foster Care-Relative caseload constitutes 14 percent of the total Community-Based Care caseload and 37 percent of the total AFC caseload in the Fall 2008 forecast. As Exhibit E-7 shows, the AFC-Relative caseload that has been declining at a rapid rate since January 2004 has stopped its precipitous drop and is maintaining a slower pace of growth.

During the 2001-03 biennium, the AFC-Relative caseload was increasing before the elimination of Service Priority Levels (SPL) 12-17. Since then, this caseload has experienced the risk of program elimination and uncertainty of budget cuts for the 2005-07 biennium. In addition, the elimination of the dual waiver option meant the developmentally disabled relative foster care clients were dropped

from this caseload, and moved to the Developmentally Disabled caseload. Also, disallowance of Medicaid reimbursement for informal supports and the lack of market promotion led to rapid decline in the AFC-Relative caseload.

Forecast

The AFC Relative caseload forecast (1,475) for the Fall 2008 is 1.2 percent higher than the Spring 2008 forecast for 2007-09 biennium, and it is forecasted to average 1,399 for 2009-11. This caseload has exhibited considerable stabilization over the previous biennium and is expected to remain stabilized or grow very slowly due to the clarification and enforcement of policy regarding the In-home and Relative AFC services. (Unlike In-Home clients, the Relative AFC clients stay with the relative care providers at their home).

CBC: Adult Foster Care - Commercial

The Adult Foster Care-Commercial caseload is 24 percent of the total Community-Based Care caseload, and it accounts for 63 percent of the total AFC caseload (total average equals 4,043 in the 2005-07 biennium). The Adult Foster Care-Commercial caseload was increasing prior to 2003, but declined rapidly in the early part of the 2003. However, it has considerably stabilized in the 2005-07 period and remains stabilized with slower rate of growth in most recent months leading up to the Fall 2008 forecast.

Forecast

The Fall 2008 Adult Foster Care-Commercial caseload forecast averages 2,485 in the 2007-09 period and is 1.0 percent lower than the Spring 2008 forecast. This caseload is projected to average around 2,510 in the 2009-11 biennium (Exhibit E-8).

CBC: Total Residential Care Facilities

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

The total RCF caseload is projected to grow in the 2005-07 and 2007-09 forecast periods. Over the next three to four years, the contract rate RCF caseload is expected to continue to gain a larger share of the total RCF caseload; however, the rate of growth has been slower than in 2005-07. One of the reasons for this

trend is that the Medicaid contract rates that were more competitive a few years back in the long-term care market are not as competitive currently (Exhibit D-9).

CBC: Residential Care Facilities - Regular

The Residential Care Facilities-Regular accounts for 9 percent of the total CBC caseload. It accounts for 47 percent of the total RCF caseload (total average equals 2,116 in 2005-07, is 2,068 in 2007-09). As with most other Long-Term Care caseloads, the RCF-Regular caseload was also growing prior to 2003.

However, since that time it has been in gradual decline (Exhibit E-10). One of the reasons for this decline has to do with the gradual increase of the RCF-Contract caseload in 2005-07 (Exhibit E-11). The RCF-Regular caseload bump between July 2004 and February 2005 indicates the increased RCF enrollment followed by the subsequent move of some RCF- Regular clients to RCF-Contract (Exhibit E-11). In 2007, the Contract RCF caseload declined primarily due to some RCF providers withdrawing from Medicaid contracts, and thus not taking in new Medicaid clients.

Forecast

The RCF-Regular caseload averaged 1,000 in 2005-07. This caseload is projected to average 962 for 2007-09, and 968 for the next biennium. It is about 0.6 percent higher than the Spring 2008 projection.

CBC: Residential Care - Contract

The Residential Care-Contract caseload is about 10 percent of the total CBC caseload and 53 percent of the total RCF caseload (total average equals 2,116). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to decline at a slower pace in the 2007-09 and 2009-11 biennia.

Forecast

The RCF-Contract caseload in the Fall 2008 is slightly lower than in the Spring 2008 forecast for the 2007-09 and 2009-11 biennia (Exhibit E-11). The RCF-Contract caseload is anticipated to average 1,106 in the 2007-09 biennium, which is about 1.8 percent lower than the Spring 2008 forecast. This caseload, however, is expected to grow more slowly over the 2009-11 biennium due primarily to the gradual withdrawal of providers from Medicaid contracts.

CBC: Assisted Living Facilities

The Assisted Living Facilities (ALF) is a 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. ALF constitutes 35 percent of the total CBC caseload.

The ALF caseload was growing rapidly prior to the elimination of Long-Term Care service priority levels 12-17 in 2003 at which point there was a one-time drop in the caseload. Since that time, this caseload has experienced gradual growth. However, the ALF caseload has been in decline for over a year. The ALF caseload is expected to average 3,672 per month in 2007-09 biennium, and will remain around 3,650 for 2009-11. The most recent month's actual counts show gradual growth in this caseload in spite of the gradual withdrawal from the Medicaid contracts by some providers in favor of private clients. Thus, the Fall 2008 forecast reflects the upward adjustment of this caseload over the Spring 2008 forecast.

Forecast

The Fall 2008 ALF caseload forecasts of 3,672 for 2007-09 and 3,657 for 2009-11 are 2 and 5 percent higher than the Spring 2008 forecasts (Exhibit E-12).

CBC: Specialized Living Facilities

Specialized Living Facilities (SLF) provides care in a home-like environment for clients with specialized needs such as quadriplegics or clients with acquired brain injuries. The clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or are served in other Community-Based Care facilities. The SLF caseload maintained the monthly average of 161 in 2005-07 biennium.

Forecast

The SLF caseload forecast is anticipated to maintain an average of 165 in the 2007-09 and 2009-11 biennia (Exhibit E-13).

CBC: Providence ElderPlace

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

In 2005-07 biennium, PACE caseload averaged 635, which is an increase of 21 percent over the 2003-05 period. The PACE caseload is expected to keep this growth trend (Exhibit E-14).

Forecast

Since mid-2003, this caseload has been growing as the capacity of Providence ElderPlace to serve additional clients has increased (Exhibit E-14).

In the Spring 2008 forecast, the 2007-09 PACE caseload is estimated to be 695 clients per month. The Fall 2008 caseload forecast is adjusted downward by 3.0 percent for the 2007-09 (with a biennial average of 674), and is about 3.0 percent lower than the Spring 2008 forecast for the 2009-11 biennium.

Risks to the Community-Based Care Forecast

The CBC providers, with the exception of Adult Foster Care, generally rely on private-pay clients rather than on Medicaid clients. In the CBC market, private pay residents spend-down and then become Medicaid eligible. While the Adult Foster Care market has become increasingly Medicaid, CBC providers such as ALF and RCF have been more successful in the competitive private pay market. In addition, a gap between relatively flat Medicaid reimbursement rates and growing operating costs in the CBC market has persisted over several years. As more residential care and ALFs withdraw from Medicaid, capacity for Medicaid clients in CBC facilities is reduced. This situation may be compounded by slowdown in the housing market and decline in the value of homes. As a result of this many new eligible seniors may choose to delay their transition into a supportive housing setting, and this will result in fewer new admissions and lower spend-down population. A majority of them become Medicaid-eligible in future. As a result, this may dampen growth in some CBC caseloads below estimates, while causing corresponding growth in Nursing Facilities caseload since the total number of people in need of Medicaid LTC facilities will not be reduced.

PACE has begun to implement its plan for expansion in Multnomah County. The expansion of the PACE program should increase its caseload to more than 700 clients starting in the second half of the current biennium.

The Community Based Care caseload, historically, has shown some volatility in response to changes in program implementation and CBC market forces resulting in the recent decline in the CBC caseloads. Given the historical pattern, the total CBC caseload forecast could deviate from the average forecast for the 2007-11 biennia by 6 percent in either direction. However, there is a strong risk, as noted above, that the forecast could vary much more than the historical pattern suggests.

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

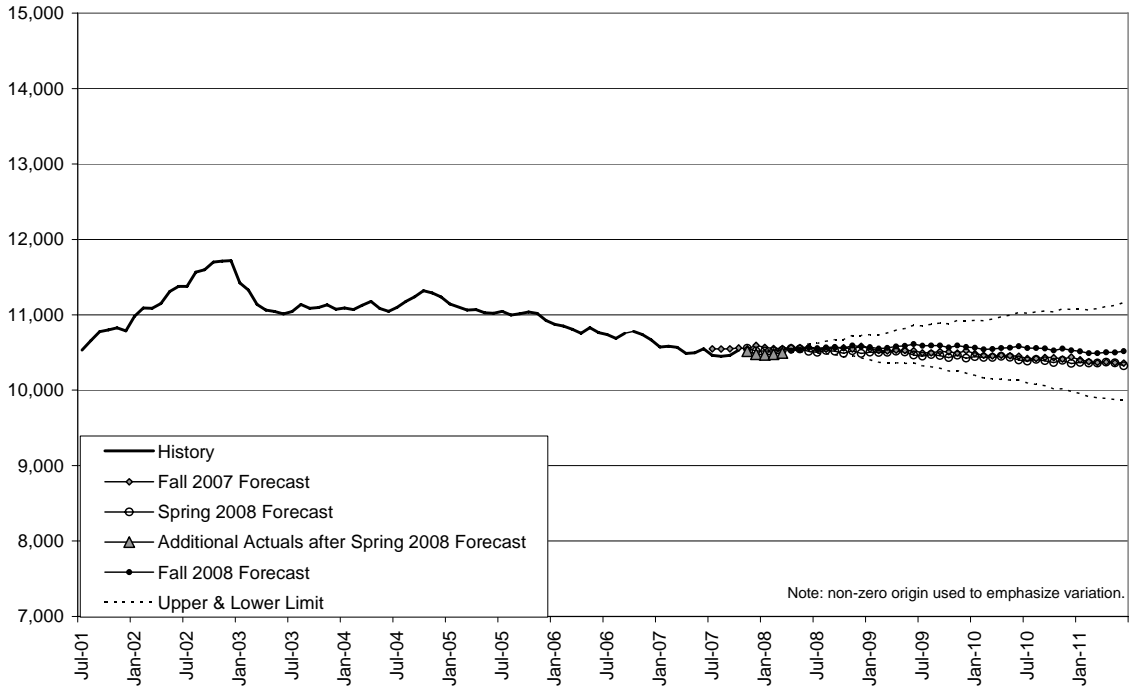


Exhibit E-6: Adult Foster Care: Total

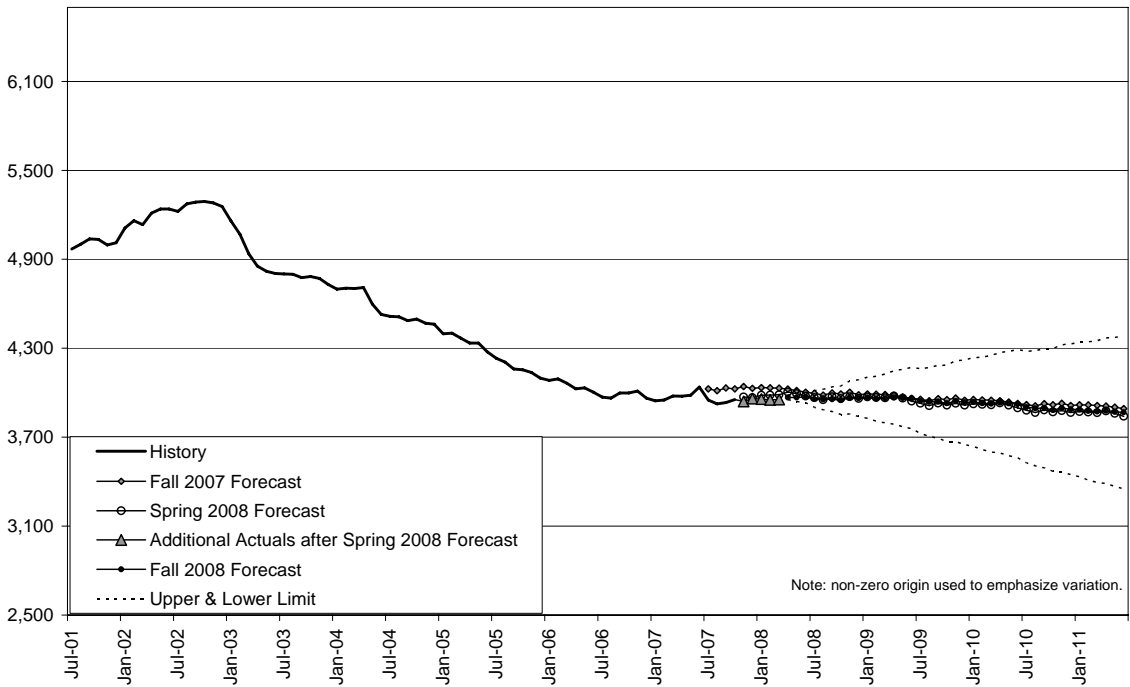


Exhibit E-7: Relative Adult Foster Care

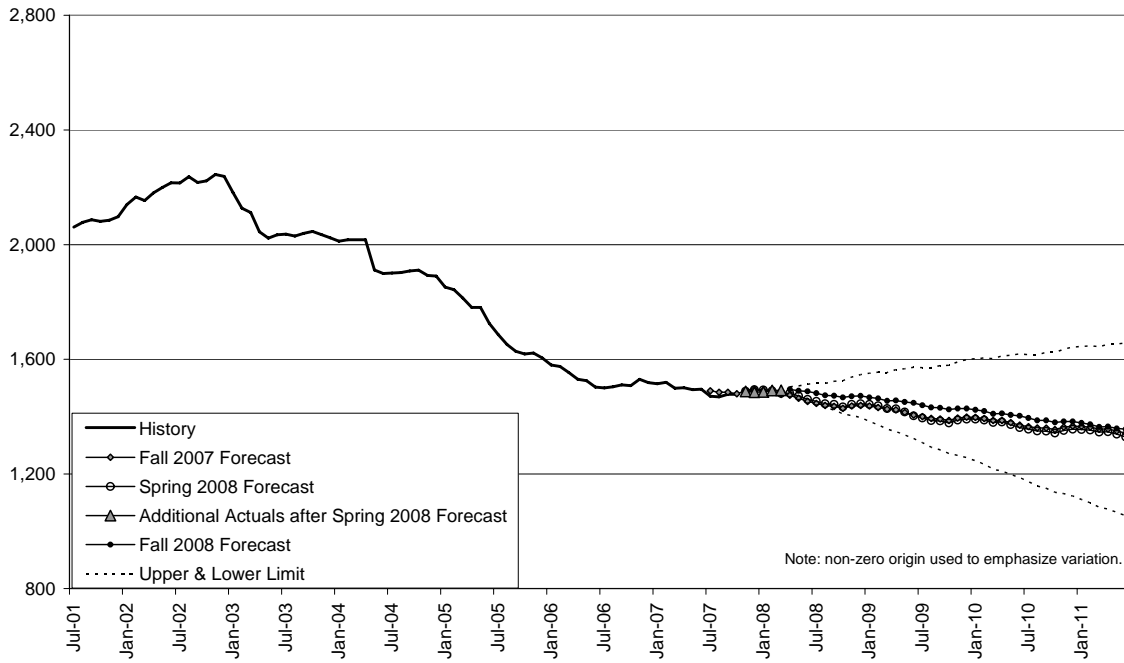


Exhibit E-8: Commercial Adult Foster Care

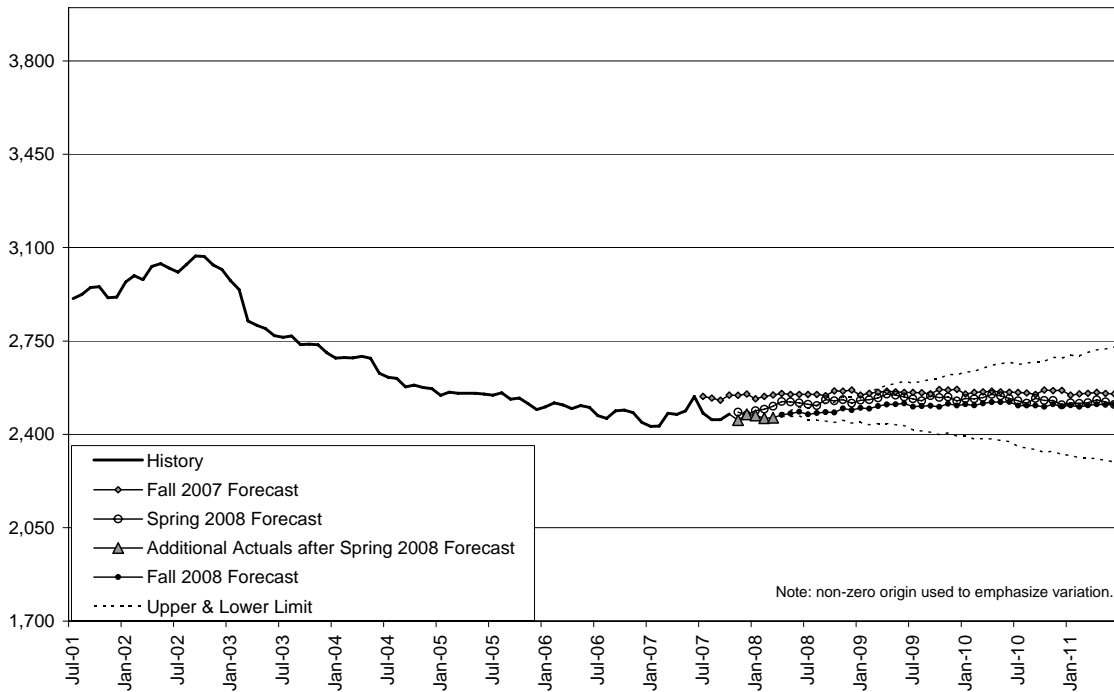


Exhibit E-9: Residential Care Facilities: Total

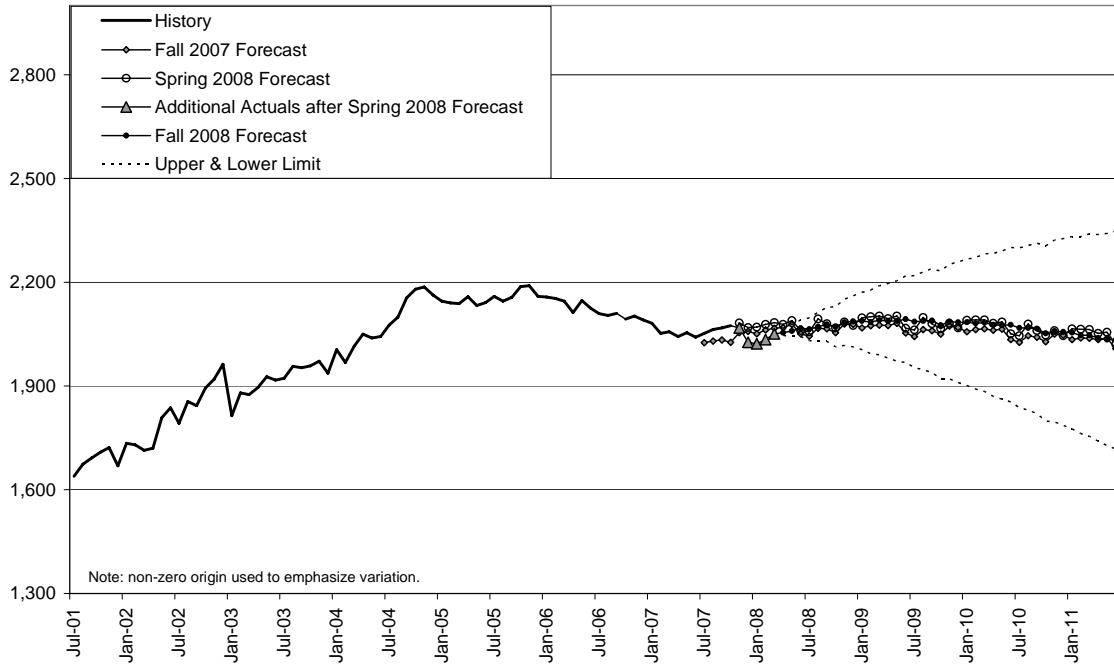


Exhibit E-10: Regular Residential Care

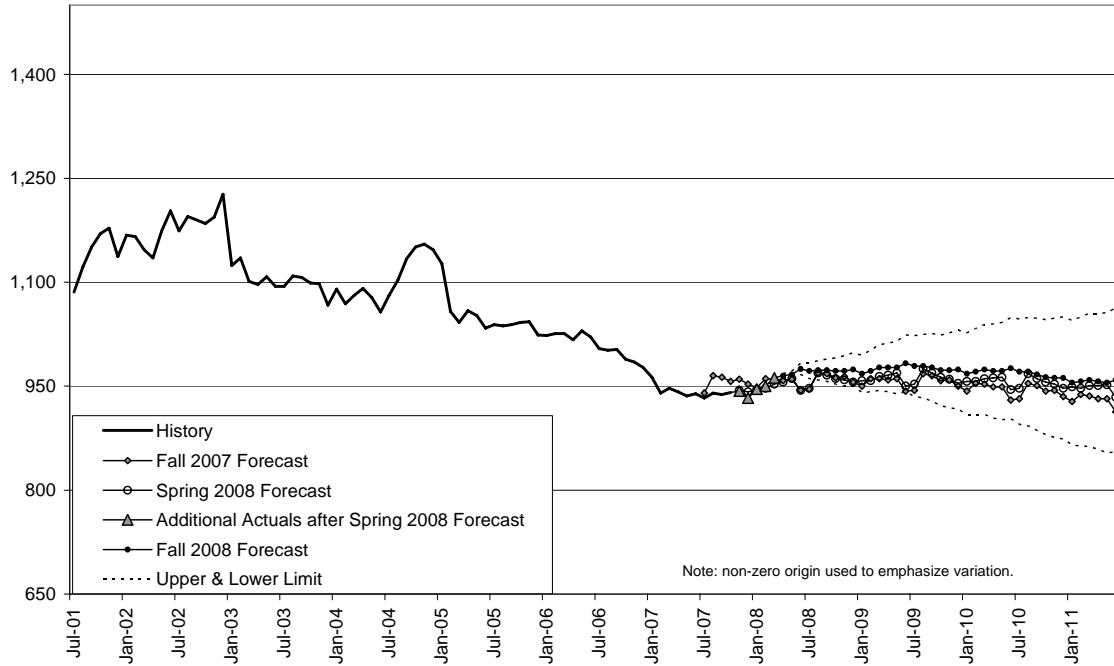


Exhibit E-11: Contract Residential Care

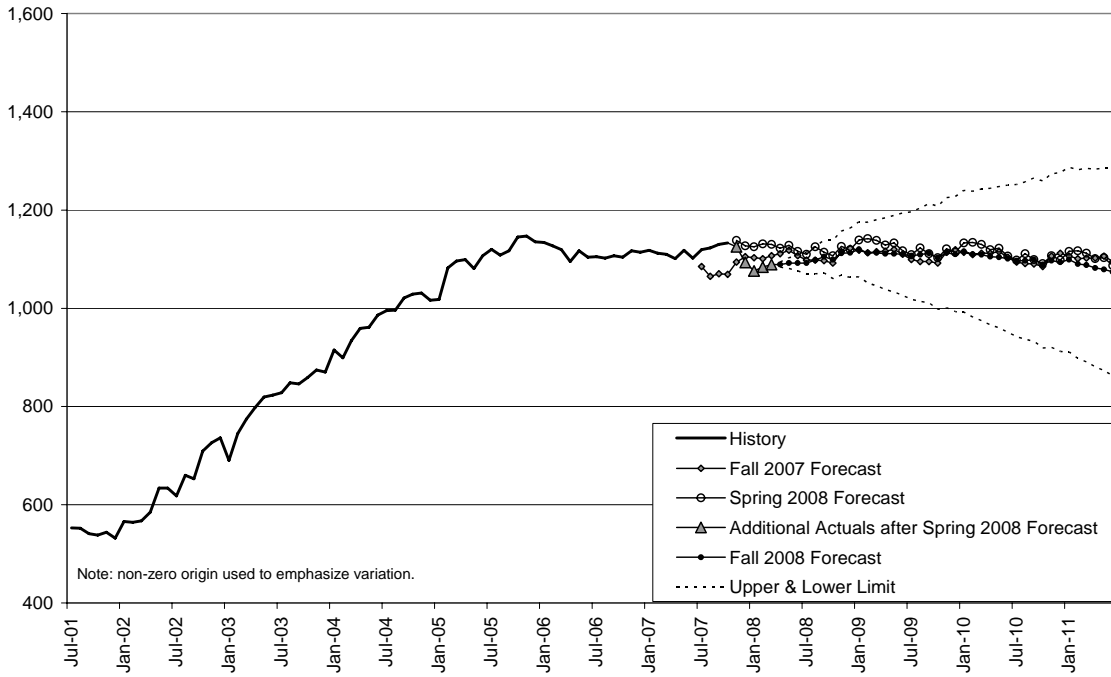


Exhibit E-12: Assisted Living Facilities

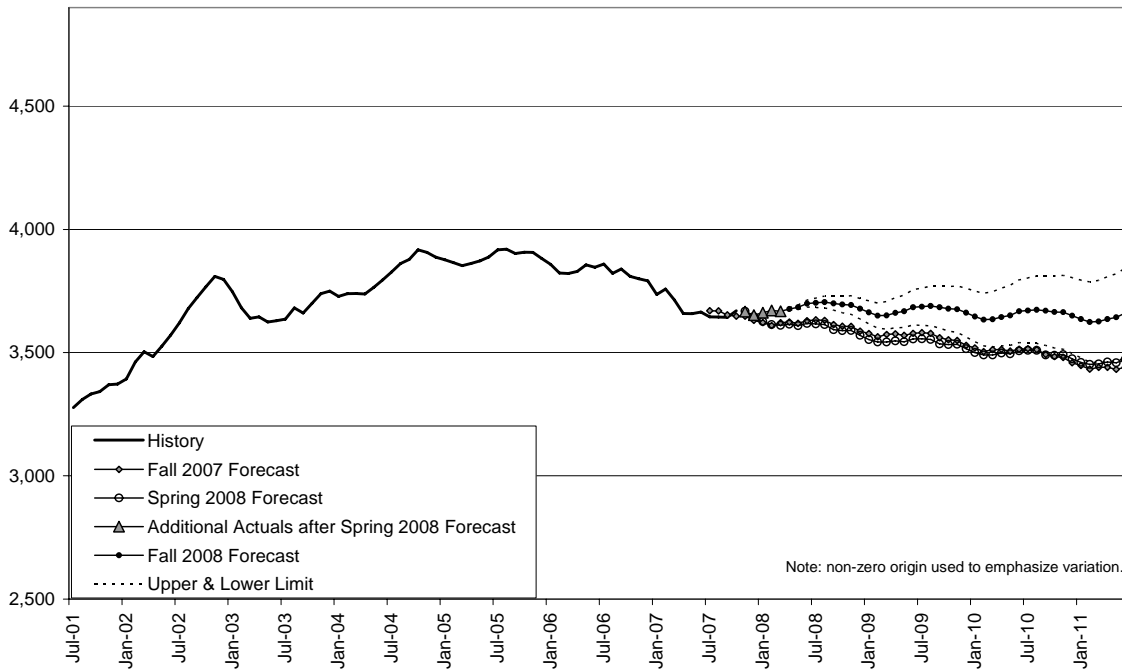


Exhibit E-13: Specialized Living Programs

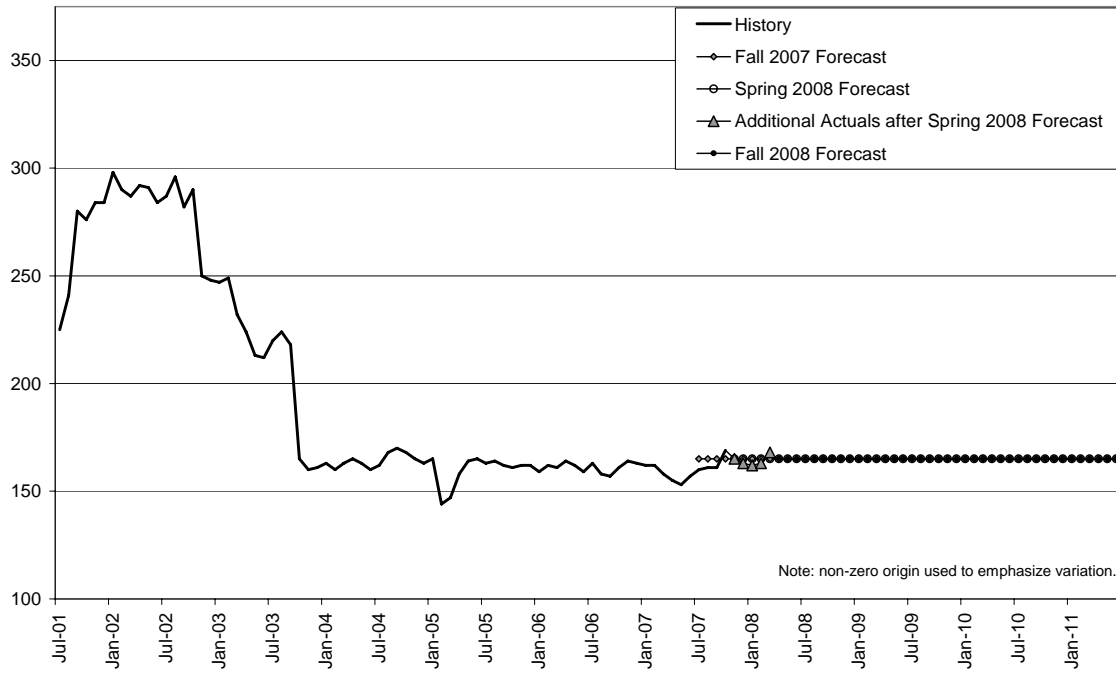
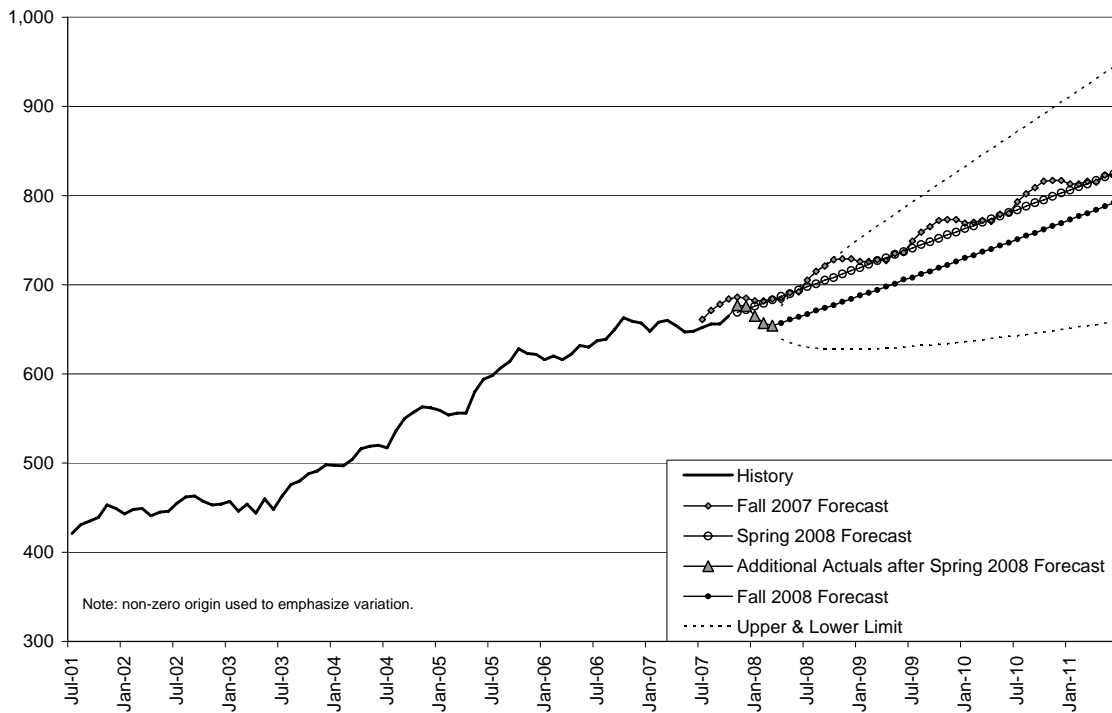


Exhibit E-14: Providence ElderPlace



Nursing Facilities

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

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

Historically, the Nursing Facilities caseload has steadily declined. This is the result of the promotion of In-Home and CBC services as an alternative to institutional care. Some of the decline may also be attributed to the gradual decrease in the average length of time people stay in a nursing facility⁷. However, it is worth noting that about half of the Medicaid NF beds are used by Medicaid clients for longer than 6 months.

Forecast

In 2003-05, the total nursing facility caseload averaged 5,082 per month. In 2005-07, the NF caseload averaged 5,116 per month.

The Total NFC caseload (including Medicare Extended Care, OHP Post-Hospital Benefit and Enhanced Care) forecast for the current biennium is lower by an average of 1.5 percent compared to the Spring 2008 forecast (5,215 versus 5,293). The total NFC caseload forecast for the 2009-11 biennium, compared to the 2007-09 forecast is about 1.3 percent higher (5,215 versus 5,284) (Exhibit E-15).

Nursing Facility Care: Basic

The Nursing Facility Care-Basic caseload includes about 88 percent of the total Nursing Facility clients⁸. These clients need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care due to either age or physical disability.

As noted earlier, this caseload has been decreasing gradually over time. In 2005-07, it has averaged 4,532 clients. This caseload grew in the first half of the 2007-

⁷ The annual survey data of Oregon Nursing Facilities, from Office of Health Policy and Research, show an average decline in the length of stay in Oregon nursing facilities in the last ten-year period (1994-2004).

⁸ Basic NF caseload share is 92 percent, if the NFC forecast groups (Medicare Extended Care, OHP Post-Hospital Benefit and Enhanced Care) are not included.

09 period but in recent months, however, this caseload has shown a downward trend that is reflected in the forecast (Exhibit E-16).

Forecast

This caseload is projected to average 4,594 in 2007-09 and 4,668 in 2009-11, which is about 1.5 percent lower than the Spring 2008 forecast.

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 basic care.

Forecast

The Complex Medical Add-On caseload averaged 350 clients per month in 2005-07. This caseload is projected to remain stable at 378 in the 2007-09 period and at 361 in the next biennium (Exhibit E-17).

Nursing Facilities: 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 caseload averaged 61 clients in the 2005-07 biennium, and is expected to average 56 clients per month through 2011.

The pediatric care population is projected to remain at a monthly average of 56. It is expected that some pediatric clients will be diverted into community-based care or in-home services in the current biennium as part of the Money Follows the Person grant (Exhibit E-18).

Nursing Facilities: Medicare Extended Care

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

The extended care caseload averaged 113 in 2005-07 and is forecasted to remain at an average of 124 and 133 clients in the 2007-09 and 2009-11 biennia (Exhibit E-2).

Nursing Facilities: Post-Hospital Benefit

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

The post-hospital care benefit caseload is forecasted to remain at a biennial average of 6 clients in 2007-09 biennium.

Nursing Facilities: Enhanced Care

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

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

Approximately 60 clients are being served under Enhanced Care services in nursing facilities.

In the 2007-09 and 2009-11 biennia, the Nursing Facility Enhanced Care caseload is forecasted to remain at the biennial average of 60 clients.

Risks to Nursing Facilities Forecast

After a stretch of stable growth, the Nursing Facilities caseload began to decline in the most recent months. In spite of such decline especially among the Basic NFC services caseload, Nursing Facilities may experience slower growth due to higher post-hospital discharges and an inadequate relocation plan for these clients in other alternative care settings.

In addition, the higher NF Medicaid reimbursement rate may encourage enrollment of Medicaid clients in NF rather than Community Based Care facilities, where Medicaid reimbursement rates have not kept up with the market.

Money Follows the Person: Starting in 2008, SPD is implementing the Money Follows the Person (MFP, also know as Oregon on the Move) demonstration program through a Center for Medicare and Medicaid Services grant. Between 2008 and September 2011, SPD plans to move as many as 1,000 nursing facility clients back into their homes and communities. The majority of these clients are adults (ages 18 through 64) with disabilities.

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

The nursing facilities caseload, historically, has shown some volatility in response to changes in the CBC program as well as NFC market forces. Thus, the total nursing facilities caseload forecast might vary by 9 percent above or below the average forecast for the 2007-11 forecast periods, even without the risks described above.

Exhibit E-15: Nursing Facilities: Total

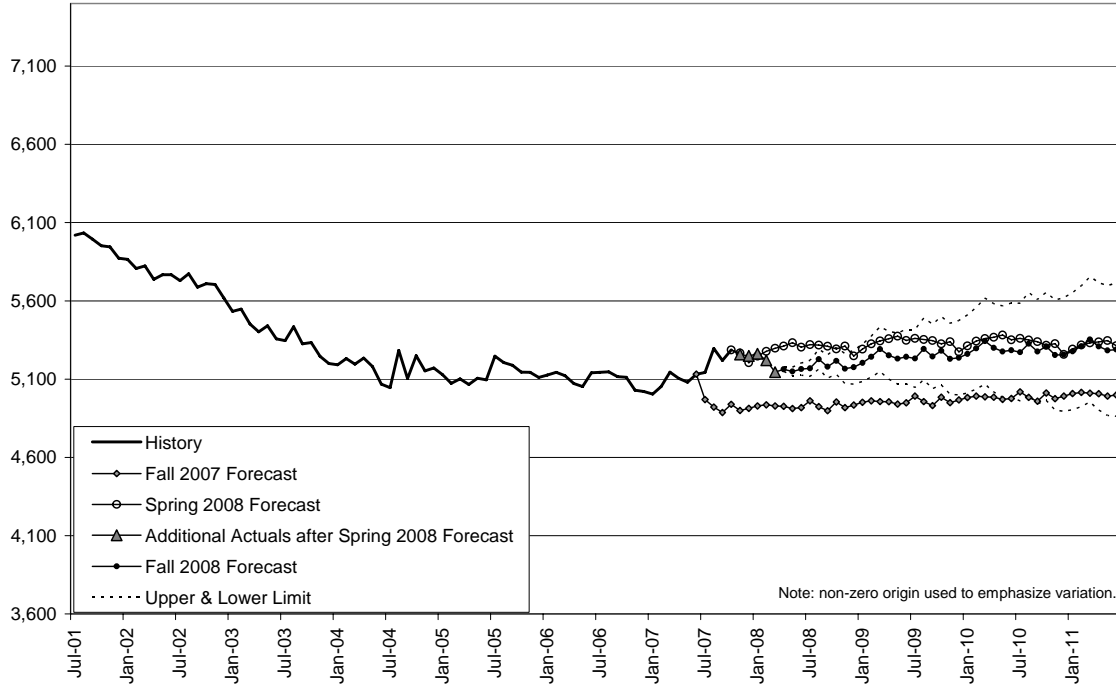


Exhibit E-16: Basic Nursing Facilities

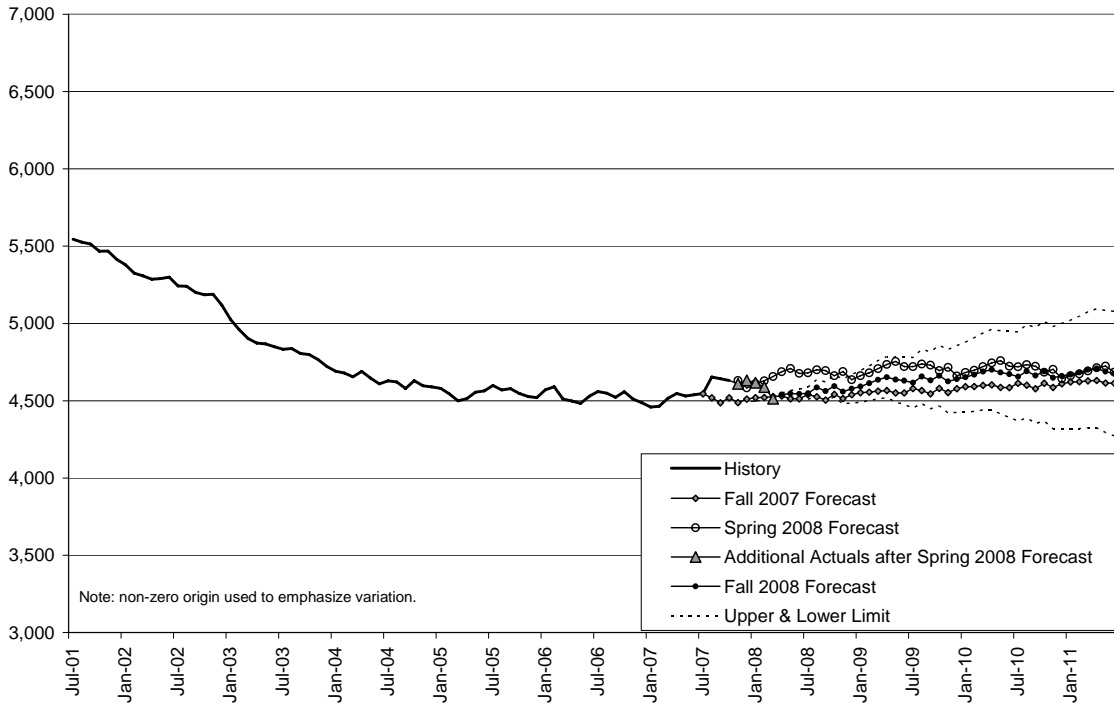


Exhibit E-17: Complex Medical Add-On Nursing Facilities

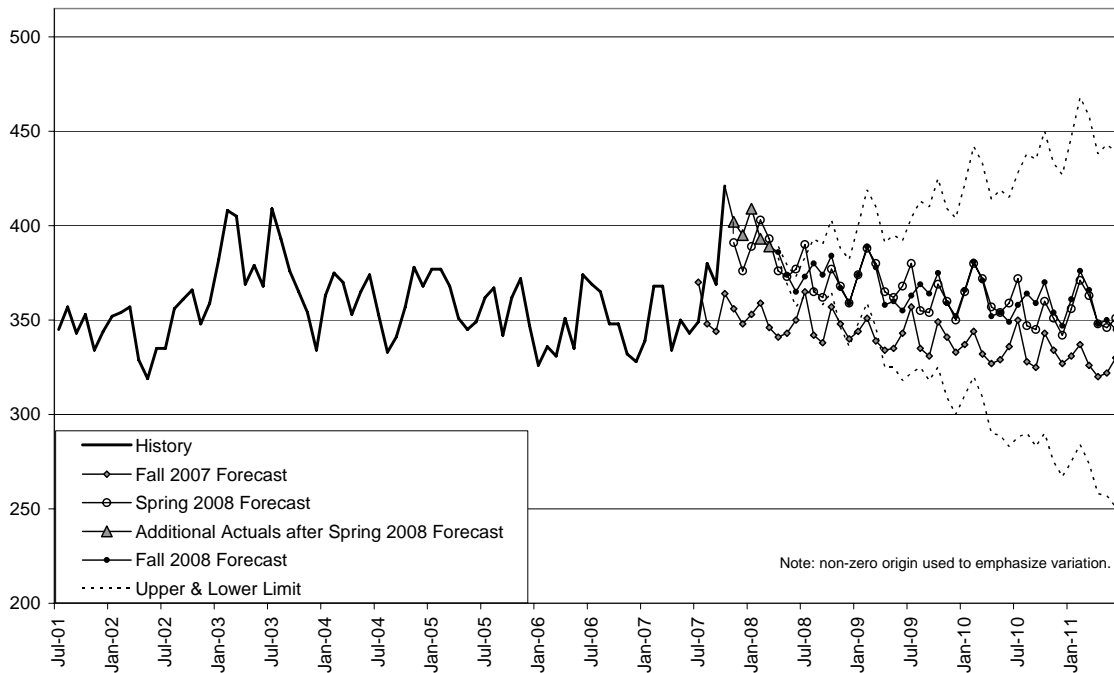
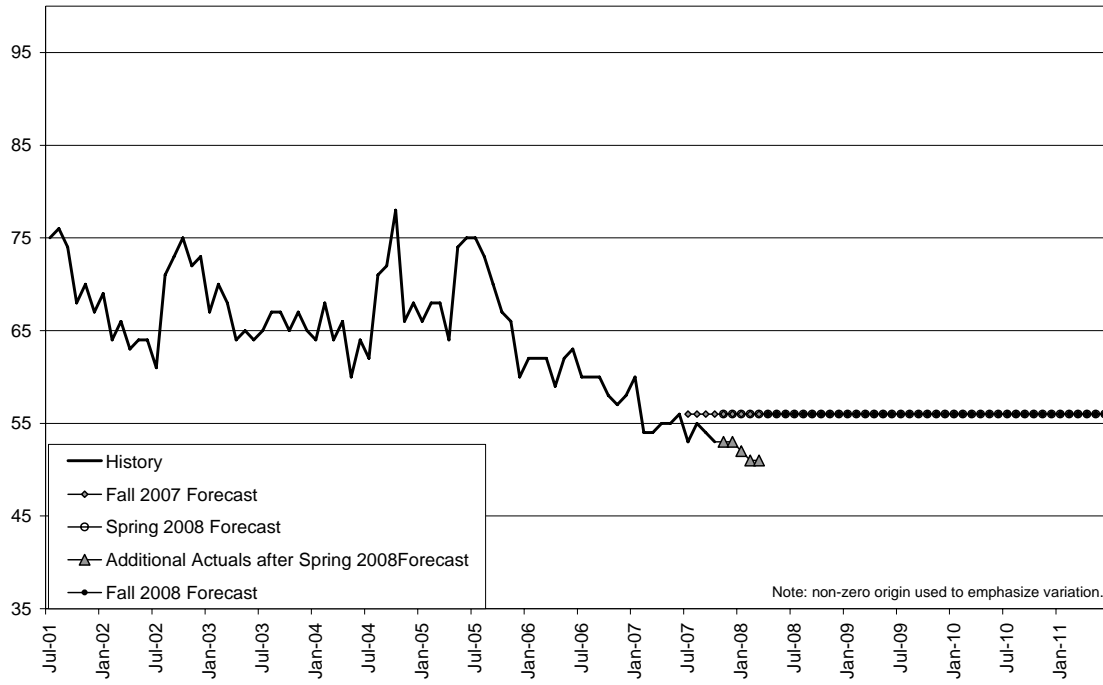


Exhibit E-18: Pediatric Nursing Facilities



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

Exhibit F-1: CAREAssist Biennial Average Comparisons

Comparison:	2007-09 Biennium			2007-09 Biennium			Fall 2008 Forecast		
	Fall 07 to Fall 08			Spring 08 to Fall 08			2007-09 to 2009-11		
Public Health Biennial Averages by Forecast	Fall 07 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Fall 07 to Fall 08 2007- 09	Spring 08 Forecast 2007-09	Fall 08 Forecast 2007-09	%Diff. Spring 08 to Fall 08 2007-09	Fall 08 Forecast 2007-09	Fall 08 Forecast 2009-11	% Diff. Fall 08 2007- 09 to 2009- 11
CAREAssist	1,881	1,882	0.1%	1,868	1,882	0.7%	1,882	2,063	9.6%

CAREAssist Caseload

Overall, the CAREAssist forecast for Fall 2008 is 1 percent larger than the Spring 2008 forecast for the 2007-09 biennia (Exhibit F-1). This caseload is predicted to increase through June 2011 (Exhibit F-2). The 2009-11 biennial average for the Fall 2008 forecast is estimated to increase by 23 percent over that for 2007-09. Future actuals may vary by 11 percent above or below the forecast through 2011.

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 2011.

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

The following factors pose risks to the forecast:

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

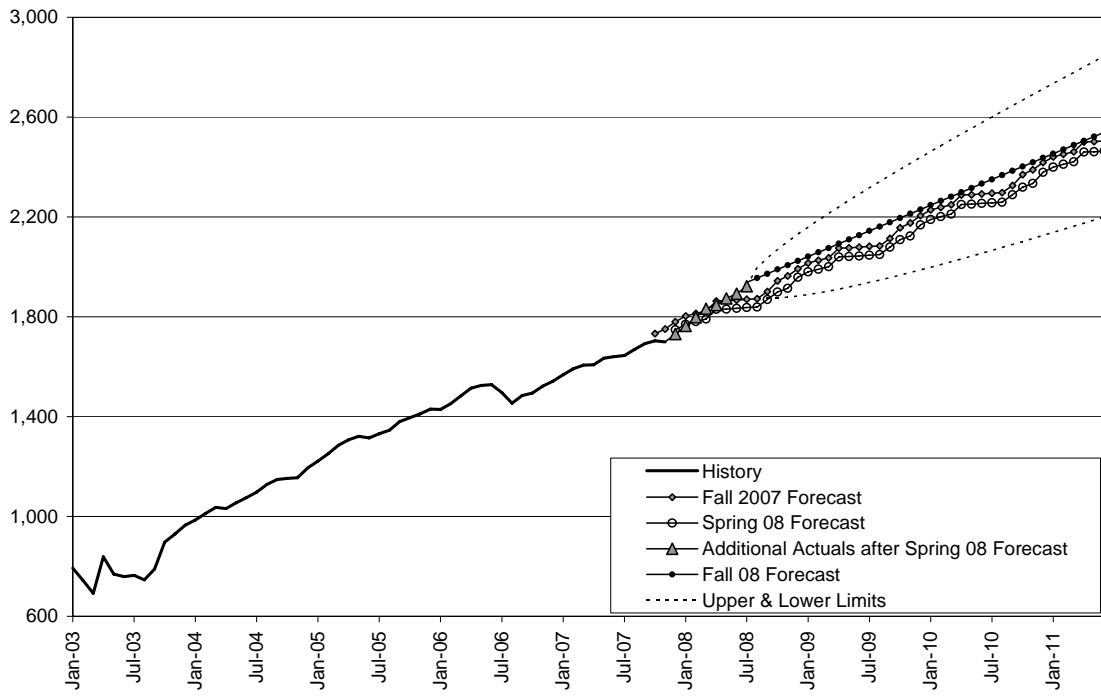
Changes in program resources: Fluctuations in federal funding affect the numbers of client receiving services and benefits from the CAREAssist program.

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

Specific Program and Policy Events: Changes in eligibility requirements or other guidelines can affect the observed caseloads. For example, the Standard program of the Oregon Health Plan opened to new enrollees in January 2008. Staff plans to increase enrollment to maintain a biennial average of 24,000 clients through the remainder of the 2007-09 biennium and into 2009-11. CAREAssist staff will refer new applicants with incomes at or below 100% of the federal poverty level to the Standard program. So far, very few CAREAssist clients have transferred to OHP Standard.

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 11 percent above or below the average monthly forecast for the 2007-09 biennium.

CAREAssist



Appendix I

Child Welfare Average Daily Population by Service Category

Service Categories

The Child Welfare forecast provides projections of 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 that sum by the number of days in the month. This method is used because children may receive 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 needs that cannot be accommodated by the regular foster care payment.

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

Subsidized Guardianship: The ADP for Subsidized Guardianship includes payments made for removing financial barriers to achieving permanency for Title IV-E¹ eligible children for whom returning home or adoption is not in their best interest.

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

Residential Treatment consists of three major types of service:

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

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

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

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

Forecast

Regular Paid Foster Care

The Foster Care caseload consists of individuals falling into three categories: Residential Care, Paid Foster Care, and Non-paid Foster Care. Regular Paid Foster Care is a subset of the Paid Foster Care category. The leveling and subsequent decrease apparent in the number-served Foster Care caseload since July 2005 is also evident in the Regular Paid Foster Care ADP. The average caseload forecast for the 2007-09 biennium is 5,735, 0.3 percent lower than the Spring 2008 forecast for the same period. The caseload is expected to average 5,808 during the 2009-11 biennium, 1.3 percent higher than the average forecast for 2009-07. Another influence on this caseload is SB 282 which was passed during the 2007 legislative session. This law provides for foster care payments to relatives. The result is a phase-out of Non-Paid Relative Foster Care and an increase of approximately 385 cases in Paid Relative Foster Care.

Special Rates Foster Care

The individuals receiving special rate payments form a subset of the group receiving regular foster care payments. On average, half of those receiving foster care payments also receive special rate payments. The Fall 2008 forecast calls for a 2007-09 biennial average of 2,709 for Special Rates Foster Care. This is 7.6 percent lower than the Spring 2008 forecast. The caseload is expected to average 2,696 during the 2009-11 biennium, 0.5 percent lower than the average forecast for 2009-07. The Special Rates category was also expected to increase as a result of SB 282. However, any noticeable increase in the ADP may have been masked by other changes to Special Rates care.

Paid Adoption Assistance

This service correlates strongly with the Adoption Assistance number-served caseload, so it presents a similar historical trend. The average caseload forecast for the 2007-09 biennium is 9,941, 1.0 percent lower than the Spring 2008 forecast for the same period. The caseload is expected to average 10,939 during the 2009-11 biennium, 10.0 percent higher than the average forecast for 2009-07.

Paid Subsidized Guardianship

As with its number-served counterpart, Subsidized Guardianship ADP has been growing. The average caseload forecast for the 2007-09 biennium is 885, 3.8 percent lower than the Spring 2008 forecast for the same period. The caseload is expected to average 1,171 during the 2009-11 biennium, 32.3 percent higher than the average forecast for 2009-07.

Residential Care

The volatility of the Foster Care caseload slightly impacted the Residential Care ADP. The average caseload forecast for the 2007-09 biennium is 445, 1.8 percent higher than the Spring 2008 forecast for the same period. The caseload is expected to average 462 during the 2009-11 biennium, 3.8 percent higher than the average forecast for 2009-07. The forecast assumes 95 percent utilization for Regular Contract beds. Contracts are being reconfigured to pay only for filled beds. This should create a shift from special contract beds to regular contract beds until 95% utilization is achieved.

Risks and Assumptions

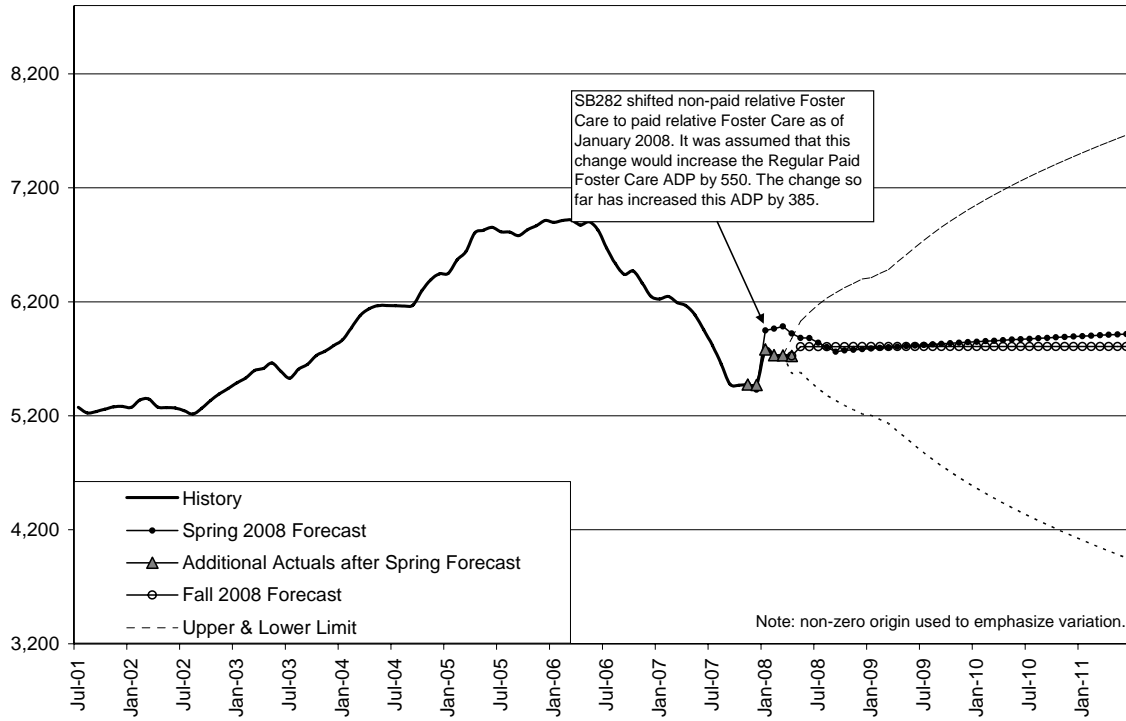
The Spring 2008 forecasts for Regular Paid and Special Rates Foster Care pose the greatest risk, since it is difficult to determine exactly why they have fallen over the past two years. As discussed in the section on number served, there are several factors that may have led to the decline in Foster Care. However, the data are not adequate to quantify the relative contribution of each factor. This uncertainty in turn leads to greater forecast risk.

As with its corresponding number-served caseload, the Paid Adoption Assistance ADP forecast for Fall 2008 assumes a continuation of the historical upward trend. Given the relative stability of this trend, the forecast presents little risk.

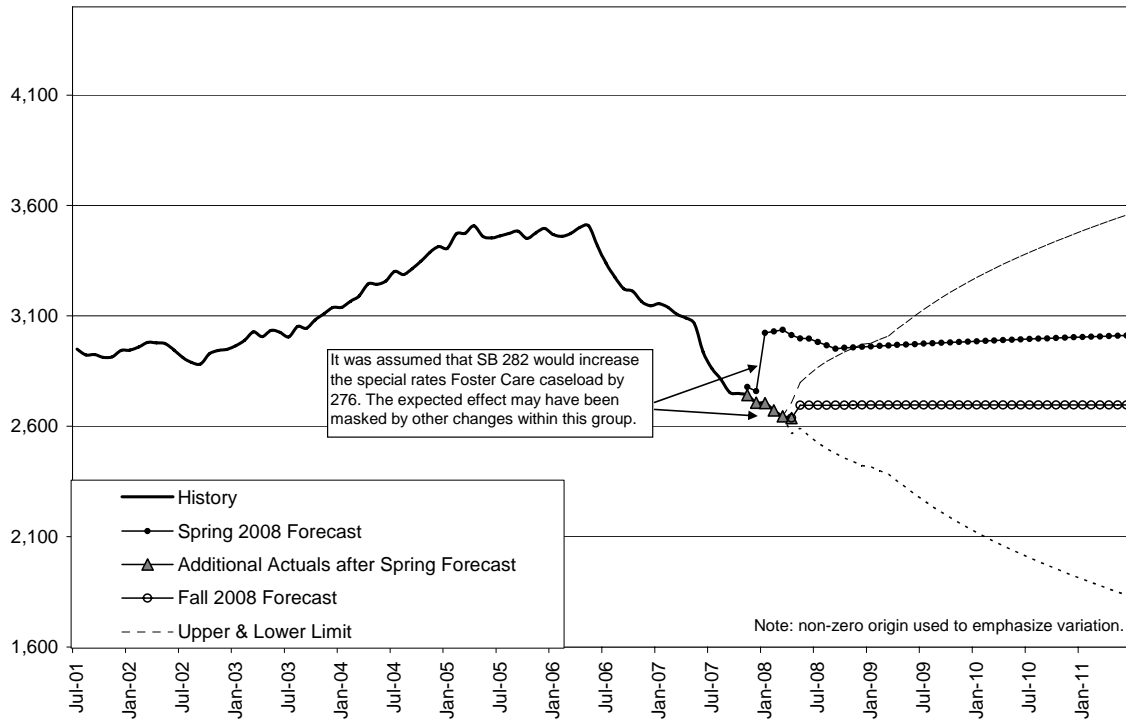
The Paid Subsidized Guardianship forecast has a specific policy risk. The waiver associated with this program is scheduled to expire March 2009. If it is not renewed no new entries will be allowed. The Fall 2008 forecast assumes that the program will be renewed and continue in its current form.

The Fall 2008 forecast for Residential Care ADP poses a risk mostly in terms of the split between regular and special contract beds. This is due to the difficulty of estimating exactly how the reconfiguration of residential care contracts will impact the utilization of regular contract beds.

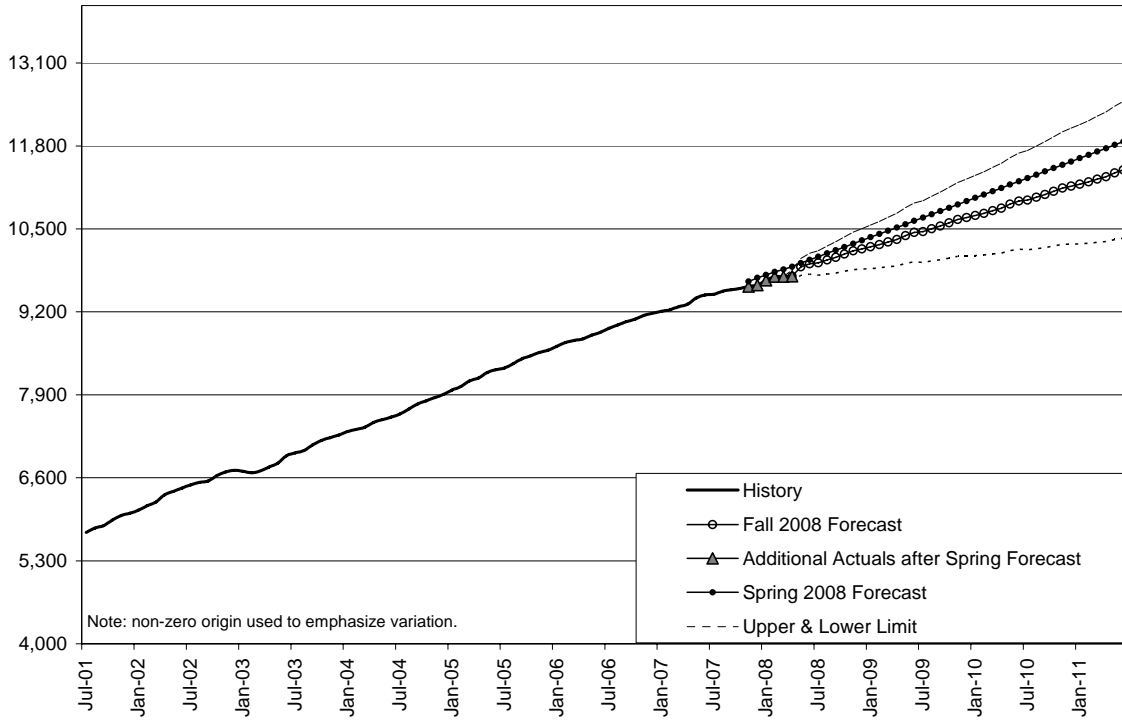
Regular Paid Foster Care - Average Daily Population



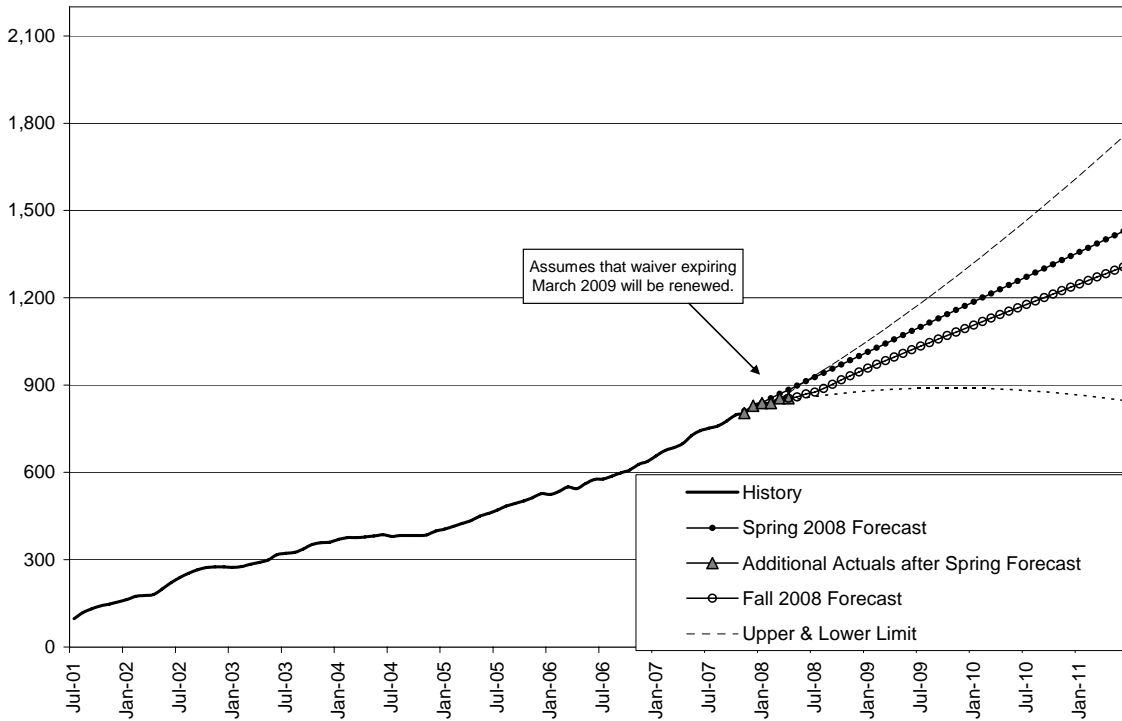
Special Rates Foster Care - Average Daily Population



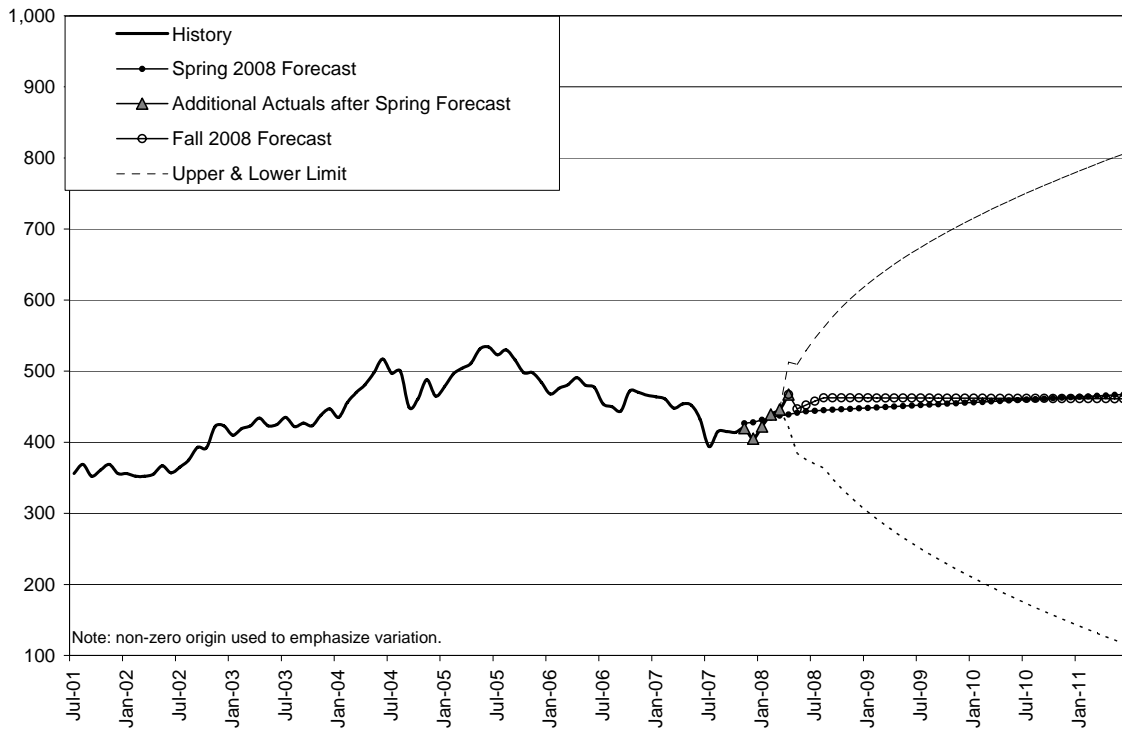
Paid Adoption Assistance - Average Daily Population



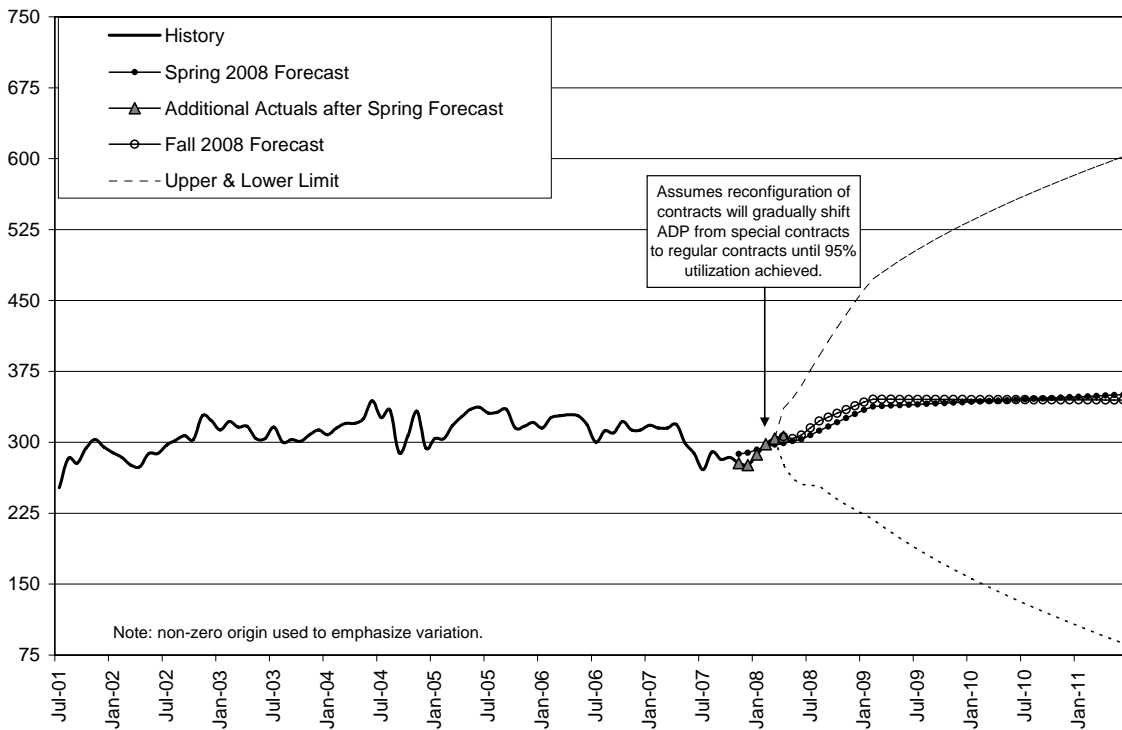
Paid Subsidized Guardianship - Average Daily Population



Total Residential Care - Average Daily Population



Regular Contract Residential Care - Average Daily Population



Appendix II

Provider Survey

Members of the Community Provider Advisory Group (CPAG) and community non-profit organizations that serve the economically disadvantaged participated in a survey about current and future demand for DHS services. The Office of Forecasting, Research and Analysis conducted the survey in August 2008. Four CPAG members and fifteen non-profit organizations participated for a response rate of 54% (19 of 35).

Providers answered semi-structured phone survey questions about their organization's services, current demand, and estimates for future demand. Providers also suggested contact information for other organizations. This "snowball" style sampling identified community service providers that otherwise might be missed. Analysts sorted the content of the answers, grouped the responses by category, and listed the categories in order of frequency.

Providers offer a range of services (Table 1). Some organizations directly provide services to clients. Other organizations provide funding or support to direct providers, or referral services to the community. Some providers offer more than one type of service.

Table 1 - Community Provider Services

Service	Number	Percentage
Food/Clothing Bank	7	37%
Indirect Services	5	26%
Housing and Utility Assistance	4	21%
Domestic Abuse (family, children, spouse or elder)	4	21%
Healthcare	4	21%
Child Care/Child Advocacy	4	21%
Employment	3	16%
Counseling	3	16%
Senior services (care giving, health care, long term care)	1	5%

Most providers work with CAF programs and clients. This may be related to CAF outreach efforts to a broad client population, frequent contact with community providers, and contact with other DHS program divisions. SPD was the least reported division, which may be due to the lack of SPD providers in the sample. Some providers serve seniors in their community, but have no programs specifically related to SPD services.

Every provider observed their current demand for service increasing or remaining steady. Every provider also cited the declining economy as a cause of the increasing or steady demand. Providers did, however, report different attributes of the economy (Table 2). These attributes can be summarized in four main categories:

- High cost of necessities
(Food, gasoline/transportation, housing and healthcare),
- Income Decline and Unemployment
(Layoffs, fewer job opportunities, low wages and increase in employers that do not offer healthcare benefits)
- Social and behavioral trends associated with economic struggle
(Domestic abuse, drug and alcohol addiction, homelessness and migration patterns)
- Decline in donations and DHS program limits
(Reduced donations from community, fewer Oregonians qualifying for DHS assistance programs under new policies)
- Improved life expectancy and the growing senior population

Table 2 – Factors Increasing Current Demand

Category	Number	Percentage
High Cost of Necessities	12	63%
Income/Employment Decline	10	53%
Social, Behavioral Trends Related to Economy	7	37%
Donor and State Funding Cuts	2	11%
Growing Senior Population/Improved Life Expectancy	2	11%

Members of the Community Provider Advisory Group were asked about their observations of demand in community non-profit services. They specifically reported increases in food bank, health care and prescription assistance demand. One provider noted the increase in non-profit demand resulting from Medicaid programs' citizenship document requirements. Low income populations sometimes face barriers accessing accurate birth certificates, immigration documents, social security cards, and passports. They access non-profit services because they cannot qualify for Medicaid-related DHS services without citizenship documents. The Oregon Health Fund Board confirmed this impact in a July 21st 2008 draft report to the Oregon Congressional Delegation.¹⁰

¹⁰ Oregon Health Fund Board—Federal Laws Committee. "Draft Report to Oregon's Congressional Delegation" July 21st, 2008. p10-12.
<http://www.oregon.gov/OHPPR/HFB/docs/Federal_Laws_Final.pdf>

Providers reported a variety of groups increasing demand (Table 3). The most frequently reported groups were low income individuals and families; minorities and people of color; single parent families; middle income/working poor¹¹ individuals and families; people speaking English as a second language; and professions related to millwork, contracting, and commercial fishing. Food bank and housing/utility assistance providers noted an increase in two-parent families, seniors and people with disabilities, the working poor and first-time cases.

Table 3 - Increases by Group

Group	Number	Percentage
Low income/Impoverished	10	53%
Minorities/People of Color	7	37%
Single Parent Families	4	21%
Seniors, Disabled	4	21%
Mid-Income/Working Poor	3	16%
Children Under 18	3	16%
ESL - Spanish (3), Eastern European (2), Somali, Ethiopian, Vietnamese (1)	3	16%
Region-Specific Professions - Mill (3), Contractors, Commercial Fishermen (1)	3	16%
First-Time Clients	3	16%
Two Parent Families	2	11%

All providers thought that demand would increase or remain steady through March 2009. They cited the economy, DHS and Medicaid program limitations, and the impending cold season (Table 4).

Table 4 - Factors Causing Future Demand Increase

Category	Number	Percentage
Cost of Healthcare	10	53%
Projected Cost of Necessities	8	42%
Economically Related Social Conditions, Behaviors	7	37%
Income Decline and Unemployment	6	32%
DHS and Medicaid Program Limitations	6	32%
Winter Utility Costs	5	26%

¹¹ Providers defined characteristics of this group as making \$25,000 or more a year, having more than one income source in the family, or having an income level just above the cut-off for DHS assistance programs.

Providers noted that these categories are often interrelated:

- Cost of Healthcare
 - Paying existing hospital bills, being uninsured/underinsured, prescription costs, OHP Standard opening to invitation enrollment.
- Projected Cost of Necessities
 - The increasing need to commute further distances to available employment
 - The increasing price of gasoline and lack of affordable, reliable transportation
 - The effect of affordable housing shortages on migration, transitional housing, and homelessness
- Income Decline and Unemployment
 - Unemployment and the lack of sustainable local jobs that offer healthcare benefits
- Winter Utility Costs

Forecast Summary

Community providers observed an increasing demand for their services and expect this demand to remain steady or increase through March 2009. Providers expect declining economic conditions –unemployment, high cost of fuel and food, longer commutes, and the rising cost of healthcare for the uninsured and underinsured – to contribute to this increased demand. These community-level observations correspond with the increases in economically-related DHS caseloads, supporting trends in the Fall 2008 forecasts and expected increases for the remainder of the 2007-2009 biennium.

Appendix III

Forecast Process and Methodology

Each program's forecast is prepared twice a year in two steps. The process begins with each program's steering committee creating a forecast agreement with the forecasting team. The agreement outlines the specific caseloads that will be forecast. 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 and others. The forecaster incorporates events and the feedback into the forecast. The Steering committee agrees on a final 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, private industry provides advice on the forecasting methodology and how to improve it. We especially seek input and guidance from economists of the Office of Economic Analysis and the Oregon Employment Department. The lists 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 then 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.

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