DEPARTMENT OF HUMAN SERVICES

SPRING 2009 FORECAST

BUDGET PLANNING AND ANALYSIS
FORECASTING, RESEARCH & ANALYSIS
APRIL 2009

Executive Summary

Background and Risks

Department of Human Services (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 March 2009, 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 2009 after having experienced moderate to rapid growth in the 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.

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. Currently, the seasonally adjusted unemployment rate rose from 6.4 percent in September to 12.1 percent in March 2009. Over this time period 15 counties have seen the rate rise by more than 1.0 percent. Although Oregon as a whole has seen large increases in unemployment, the counties most affected are located in the eastern and southwestern 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 Spring 2009 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.

Forecasting, Research and Analysis (OFRA) analysts conducted a survey of the DHS Community Provider Advisory Group and additional community-based agencies to help interpret the base forecasts and aid in selecting the final estimates. Stakeholders were asked to share their observations of: (1) the

current demand for services as well as reasons for potential demand increasing over the next 6 months; (2) the local need for DHS services; and (3) client trends in local communities.

The majority of respondents reported an increase in individuals and families living in poverty across all DHS program areas and geographic regions. Several respondents also reported an increase in two- and three- income families, those with moderate income, and the "working poor" seeking assistance from DHS programs. The majority of respondents expected increased demand for assistance by June 2009.

Most respondents reported increased demand because of economic decline (increasing cost of necessities combined with decreasing incomes, reduced access to medical coverage and providers) and client behaviors related to the recession (family stress and substance addiction related to economic stressors, more clients needing treatment for mental illness). Respondents noted clients' treatable situations becoming urgent, severe and expensive due to lack of assistance. Several respondents expressed concern about enacted and proposed budget cuts, capacity limits, and the reduced availability of DHS services increasing stakeholder demand. See individual programs for survey results.

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 been growing since late 2007. Caseload growth accelerated in the fourth quarter of 2008 along with job loss in Oregon. The Office of Economic Analysis (OEA) expects quarterly employment declines to continue through the end of 2009. OEA expects a slow recovery beginning in 2010 with significant annual employment gains beginning in 2011. 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 2010.
>
> **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.

The **Vocational Rehabilitation** caseload fell steadily during 2006. Since that time it has been growing at a moderate rate with seasonal fluctuations. This caseload is expected to increase due to growth in referrals from the Addictions and Mental Health Division program for Supported Employment Evidenced Based Practices. The Office of Vocational Rehabilitation Services (OVRS) began operating under an Order of Selection in January 2009. This will limit the number of clients who can receive rehabilitation and post-employment services at any given time. There is insufficient history to estimate the impact of the Order of Selection on the OVRS caseload, but it poses a significant risk to the forecast.

Medical Assistance Programs: consist of three major areas: Oregon Health Plan (OHP) Plus, OHP Standard and "Other". The total Division of Medical Assistance Programs (DMAP) caseload is expected to grow dramatically as new policies and procedures are, or have been, implemented within the current 2007-09 biennium and as the ongoing economic downturn worsens through 2009 and into 2010. 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 extension of eligibility re-determination periods from six to twelve months for Poverty Level Medical Children beginning in January 2009; (2) the continued closure of the Standard program to new clients after October 2008; and (3) expected continuation of an economic slowdown with subsequent elevated unemployment levels through calendar 2009 and 2010.

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 is expected to result in rapidly increasing caseloads through the end of the 2009-11 biennium. Considerable risk, due to the economy, is associated with this forecast.

Children's Programs: Oregon children are primarily served in two specific programs, depending on age and level of poverty. Of these two programs, 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 2009-11 biennium.

The CHIP program serves children up to 185 percent 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. We expect continued growth exacerbated by worsening economic conditions but moderated somewhat from earlier expectations as movement of clients into CHIP from Poverty Level Medical Children are expected to decline due to extended lengths of stay in that group.

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. A steady pattern of growth is expected in these caseloads with upward pressure coming from a combination of demographic changes and economic downturn.

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.

The Standard program was re-opened to a fixed number of new clients (via random selection) in March 2008 with closure to new clients effective November 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 average 24,000 clients across the 2007-09 biennium.

Mental Health: The Spring 2009 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 2009 forecast.

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.

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

Aged & Physically Disabled – Long-Term Care (LTC): The Long-Term Care forecasts are divided into In-Home, Community-Based Care Faculties, and Nursing Facilities. The Spring 2009 caseload forecast is estimated to remain slightly above the Fall 2008 forecasted level for 2007-09 and 2.3 percent higher for 2009-11, with a net increase of 1.8 percent between the 2007-09 and 2009-11 biennia.

Historically, the Long-Term Care caseload averaged more than 28,000 before the elimination of LTC service priority levels 12 through 17 in 2001-03. The LTC caseload declined about 10.0 percent, or more than 3,000 cases, during the 8 month period ending June 2003. This population decreased by 4.0 percent in the 2005-07 biennium. However, total LTC caseload is expected to increase slightly over the previous forecast for the current biennium, and over 2.0 percent in 2009-11 compared to 2007-09 due to caseload growth in In-Home and Community-Based Care services.

The growth in the Long-Term Care caseload can be attributed to a combination of several program initiatives that were implemented in 2008: Medicaid contracts designed to increase Medicaid participation in Community-Based Care, increased CBC rates for providers, diversion and transition of clients from Nursing Facilities, and expansion of the all-inclusive Elder Place Program. Although the current economic recession does not seem to have a direct or

primary effect on LTC caseload growth, it may have secondary and delayed effects.

In-Home Care caseload was relatively flat or slightly decreasing after severe budgetary cutbacks in 2002. This caseload continued to decline due to ongoing client eligibility reviews and the implementation of the Medicare Modernization Act. However, the caseload has stabilized in recent months and is expected to increase slightly in 2007-09; it should be 2.9 percent higher than the previous forecast in 2009-11, and it is expected to be about 1.0 percent greater than that for 2007-09.

Community-Based Care Facilities (CBC) caseload also declined in 2002, but grew modestly in 2003 and early 2004. Since the decreasing withdrawal from Medicaid contracts by Assisted Living and Contract Residential Care providers (due primarily to lower Medicaid reimbursement), and the implementation of various program initiatives including the CBC rate increase, new licensing requirements, and revised eligibility determinations, we've observed a modest growth in most of the CBC services that should continue in the current biennium while greater growth is expected in 2009-11 The total 2009-11 CBC caseload is expected to be 5.0 percent greater than that for 2007-09.

Nursing Facilities caseload has steadily declined for several years, but moderately increased in 2006-07. However, the NFC Basic caseload has declined in the most recent months. The total NFC caseload for 2007-09 is expected to decline by 2.4 percent, and by 7.2 percent in 2009-11, when compared to the previous forecast. Considering the current forecast, the total NFC caseload is expected to decrease by 3.9 percent in 2009-11. Active diversion and transition programs are contributing to this decline.

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

Total DHS Biennial Average Forecast Comparison

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	**Fall 08 to Spring 09**			**Fall 08 to Spring 09**			**2007-09 to 2009-11**		
Biennial Averages by Forecast	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
Children, Adults and Families (CAF)									
Self-Sufficiency									
Food Stamps (Households)	245,721	254,832	3.7%	273,181	328,628	20.3%	254,832	328,628	29.0%
Temporary Assistance for Needy Families (Families: Cash Assistance) Basic & UN	19,468	20,413	4.9%	20,209	25,234	24.9%	20,413	25,234	23.6%
Employment Related Daycare (Families)	10,100	10,032	-0.7%	11,638	11,616	-0.2%	10,032	11,616	15.8%
Child Welfare (Children Served)									
Adoption Assistance	10,531	10,485	-0.4%	11,541	11,633	0.8%	10,485	11,633	10.9%
Out of Home Care	-	8,315	-	-	7,710	-	8,315	7,710	-7.3%
Child In Home	2,811	2,875	2.3%	2,840	2,915	2.6%	2,875	2,915	1.4%
Vocational Rehabilitation (Clients Served)	9,201	9,225	0.3%	9,797	9,736	-0.6%	9,225	9,736	5.5%
Medical Assistance Programs									
OHP Plus: Temporary Assistance to Needy Families (Medical)	115,829	117,770	1.7%	132,663	165,514	24.8%	117,770	165,514	40.5%
OHP Plus: Children (PLMC & CHIP)	138,674	136,015	-1.9%	170,810	165,471	-3.1%	136,015	165,471	21.7%
OHP Plus: Seniors and People with Disabilities	96,518	96,476	0.0%	105,025	105,671	0.6%	96,476	105,671	9.5%
OHP Plus: Poverty Level Medical Women	11,083	10,909	-1.6%	12,034	11,835	-1.7%	10,909	11,835	8.5%
OHP Plus: Substitute Care & Adoption Serv.	17,833	17,807	-0.1%	18,360	18,360	0.0%	17,807	18,360	3.1%
OHP Plus Total	**379,937**	**378,977**	**-0.3%**	**438,892**	**466,851**	**6.4%**	**378,977**	**466,851**	**23.2%**
Other Medical Assistance Programs	32,134	31,973	-0.5%	34,725	35,016	0.8%	31,973	35,016	9.5%
Seniors and People with Disabilities - Long Term Care									
In Home	10,488	10,516	0.3%	10,345	10,643	2.9%	10,516	10,643	1.2%
Community Based Care	10,535	10,679	1.4%	10,548	11,218	6.4%	10,679	11,218	5.0%
Nursing Facilities	5,174	5,050	-2.4%	5,231	4,855	-7.2%	5,050	4,855	-3.9%
Addictions and Mental Health (AMH)									
Criminal Commitment									
Aid and Assist	139	142	2.2%	154	154	0.0%	142	154	8.5%
Psychiatric Security Review Board	767	754	-1.7%	811	785	-3.2%	754	785	4.1%
Total Criminal Commitment	**906**	**896**	**-1.1%**	**965**	**939**	**-2.7%**	**896**	**939**	**4.8%**
Civil Commitment									
24 Hour Care	1,387	1,422	2.5%	1,643	1,704	3.7%	1,422	1,704	19.8%
Acute Care	173	173	0.0%	177	178	0.6%	173	178	2.9%
State Hospital	320	318	-0.6%	322	313	-2.8%	318	313	-1.6%
Non-residential Community Care	3,094	3,150	1.8%	3,653	3,761	3.0%	3,150	3,761	19.4%
Total Civil Commitment	**4,974**	**5,063**	**1.8%**	**5,795**	**5,956**	**2.8%**	**5,063**	**5,956**	**17.6%**
Unduplicated Count, Total Mandated Care	**4,738**	**4,752**	**0.3%**	**5,433**	**5,477**	**0.8%**	**4,752**	**5,477**	**15.3%**

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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.

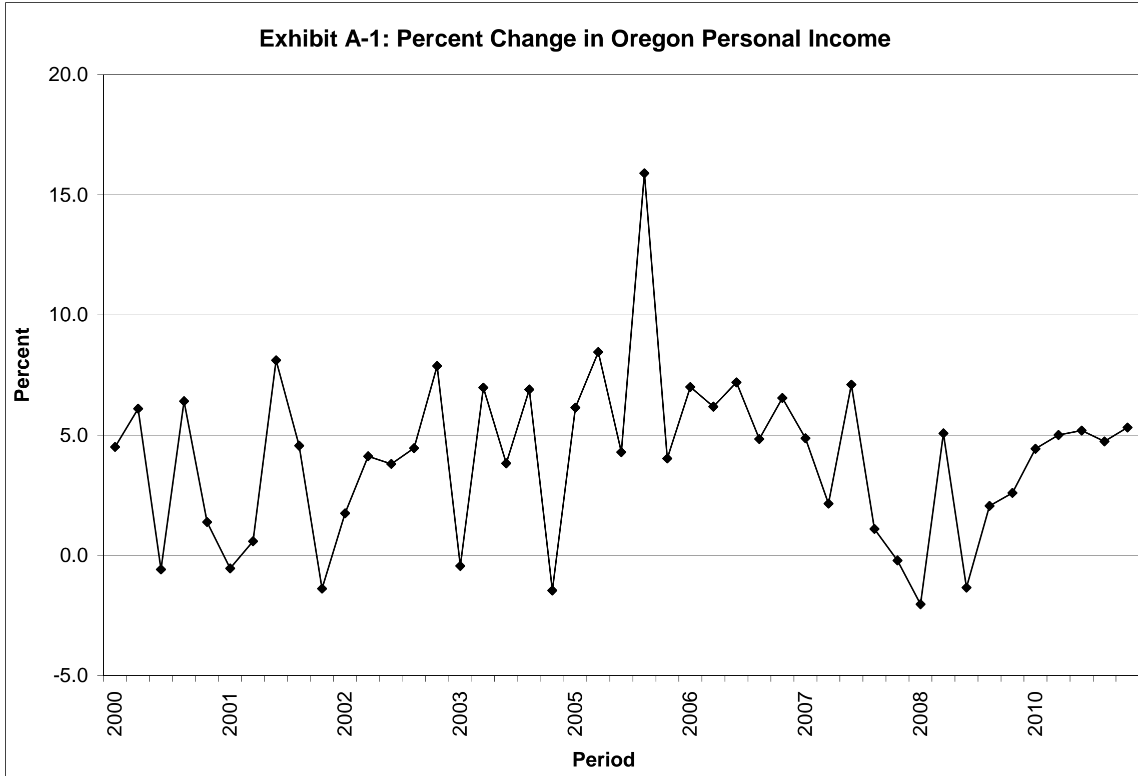
DHS programs are affected by a number of environmental factors that contribute to the demand for benefits and services (such as the economy and changing demographics). The following information is a snapshot of a few common factors that influence the number of Oregonians seeking DHS services.

Key Economic Factors and Outlook

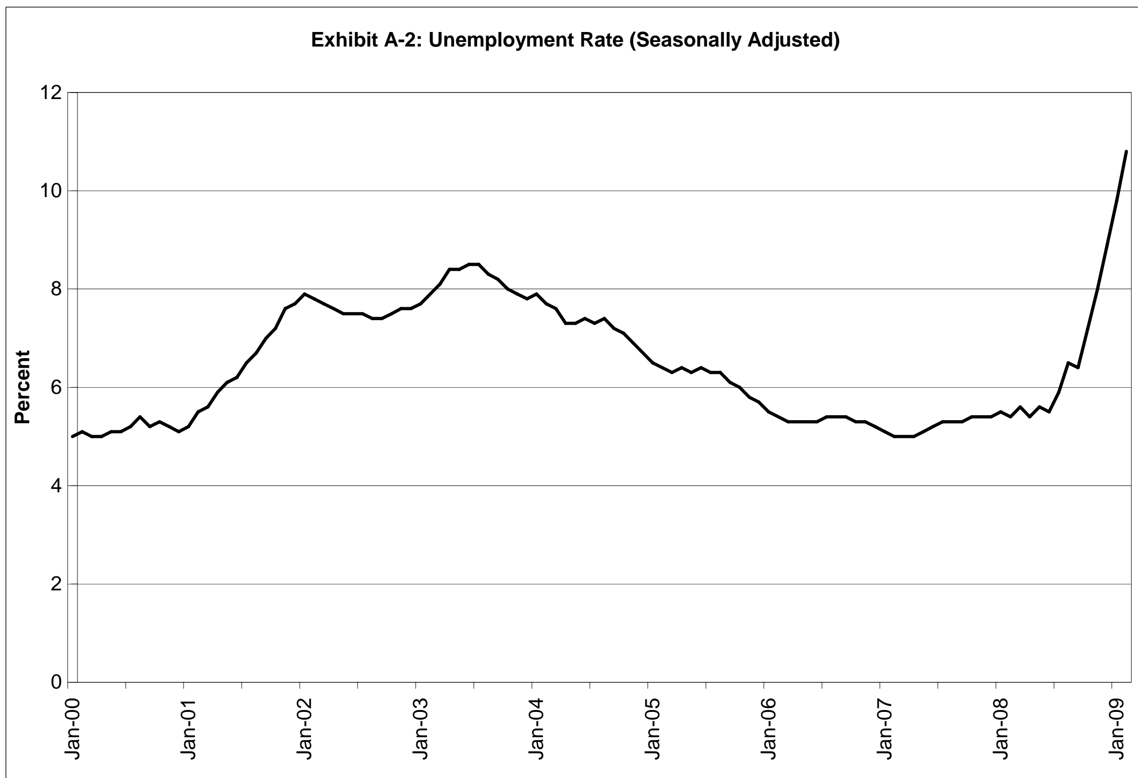
The overall health of an economy is a function of many components including unemployment rates, cost of living, and per capita income. Simplistically, a strong economy increases people's standard of living by making such things as housing, food, health care, and other essential needs more affordable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

Through February 2009, Oregon has experienced a drastically 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 2009. Persistent troubles in the housing and financial sectors have spilled over into the overall economy. Drastic price increases in food and energy have subsided but consumption, which accounts for two thirds of the U.S. economy, has dropped off considerably as job losses continue to mount. The Oregon economy is not expected to show positive growth until the later half of 2010.

The rate of growth of personal income in Oregon, displayed in Exhibit A-1, has been declining since the fourth quarter of 2006 and even went into negative territory during the last two quarters of 2008. It is expected that personal income growth will increase in the second quarter of 2009 and then become negative again in the third quarter of 2009.



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

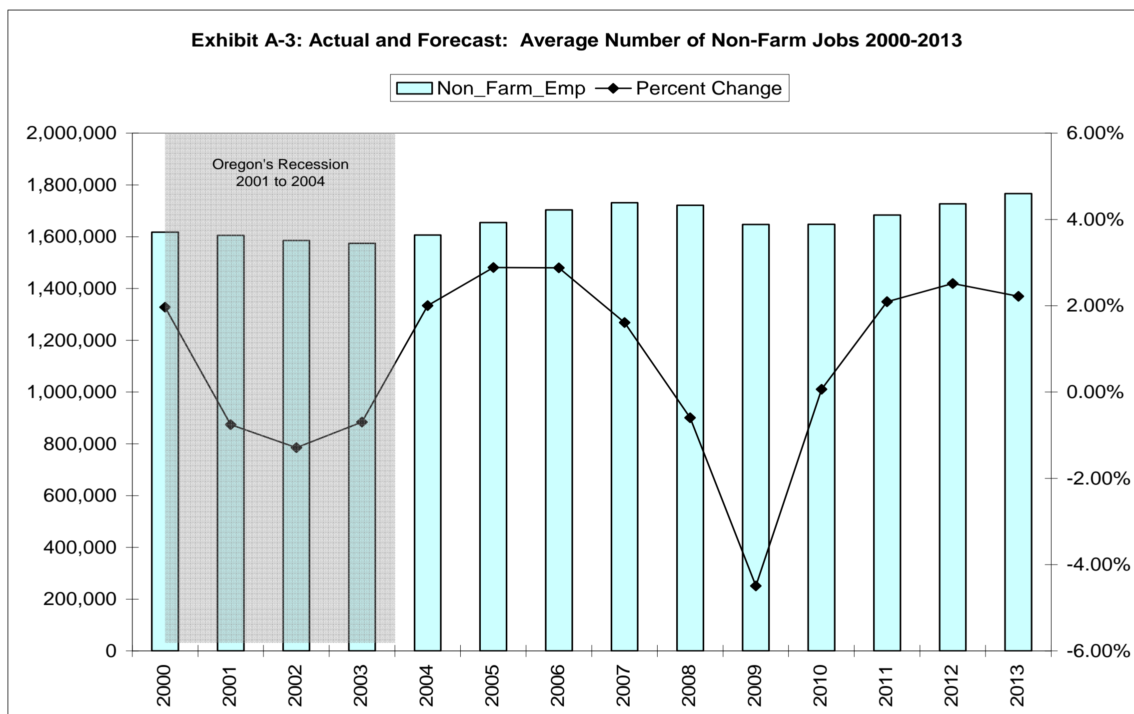


Source: Oregon Employment Department

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 2009 as both the national and state economies soften further (Exhibit A-3). Currently, the seasonally adjusted unemployment rate rose from 6.4 percent in September to 10.8 percent in February 2009 (Exhibit A-2). Unemployment has increased sharply as a state from January to February 2009. Over this time period 15 counties have seen the rate rise by more than 1.0 percentage point. Although Oregon as a whole has seen large increases in unemployment, the counties most affected are located in the eastern and southwestern 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 decrease throughout the rest of 2009 with a slight recovery in 2010. Professional and business services are expected to decrease dramatically in 2009 with a mild recovery in 2010. Retail trade is expected to decrease in 2009 then resume making employment gains thereafter. Leisure and Hospitality made modest employment gains in 2008 and but is predicted to decline through 2009 with a rebound in 2010. Last, education and health services are expected to make positive gains in employment through 2009 and 2010 primarily as a result of positive growth in health services.

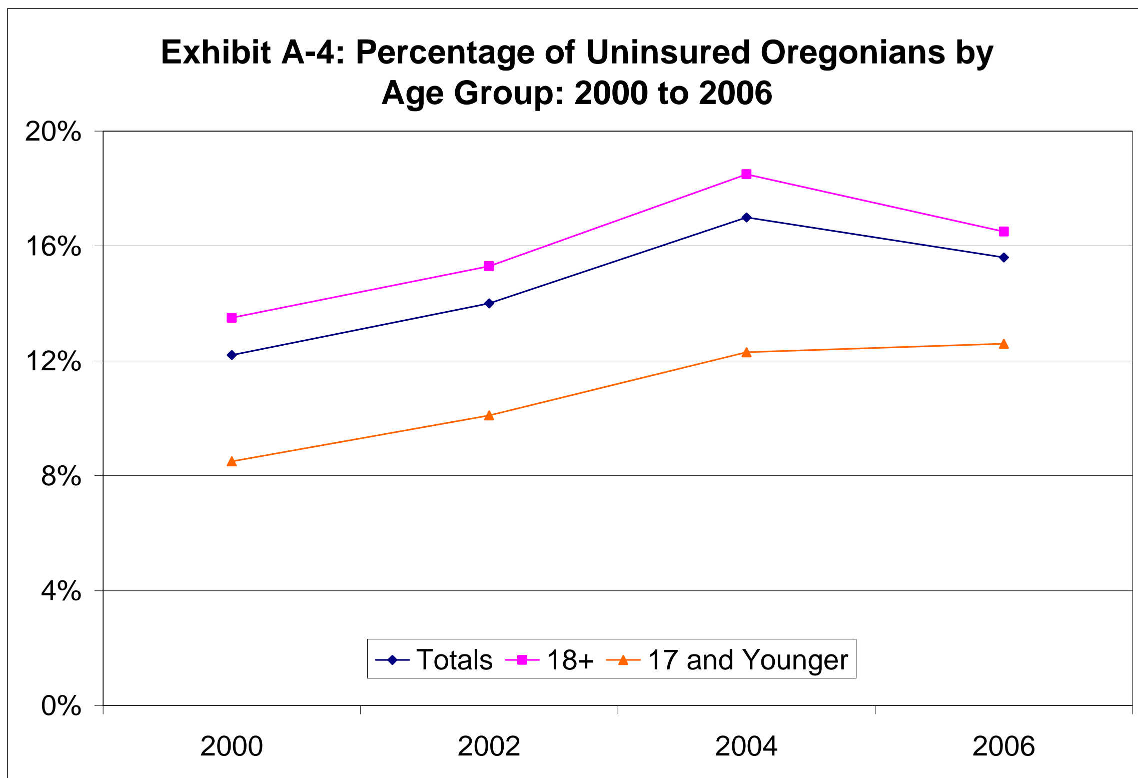


Source: Oregon's Office of Economic Analysis: Economic Forecast and Oregon Employment Department

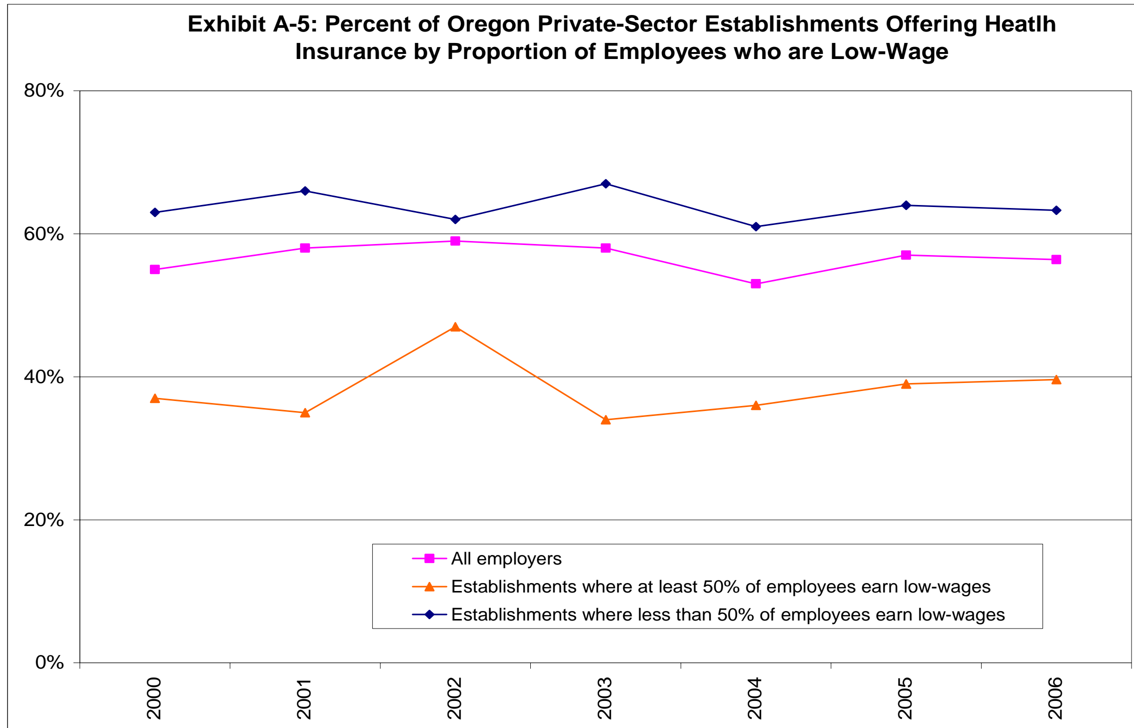
Health Care Factors

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 heath insurance (Exhibit A-4). It is anticipated that Oregonians will continue to experience higher rates of being uninsured, especially low-wage earners (Exhibit A-5).

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.



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

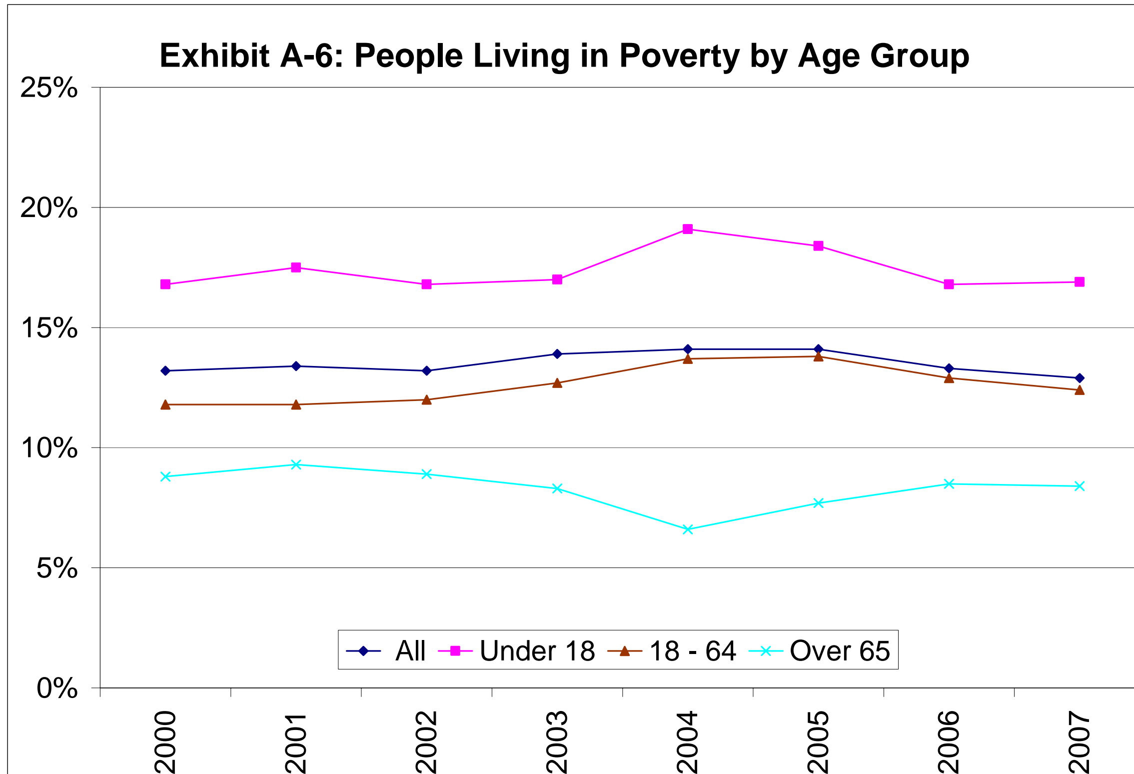


Source: United States Department of Health and Human Services: Agency for Healthcare, Research, and Quality: Medical Expenditure Panel Survey

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). 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, the most recent year for which data is available, 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-6).



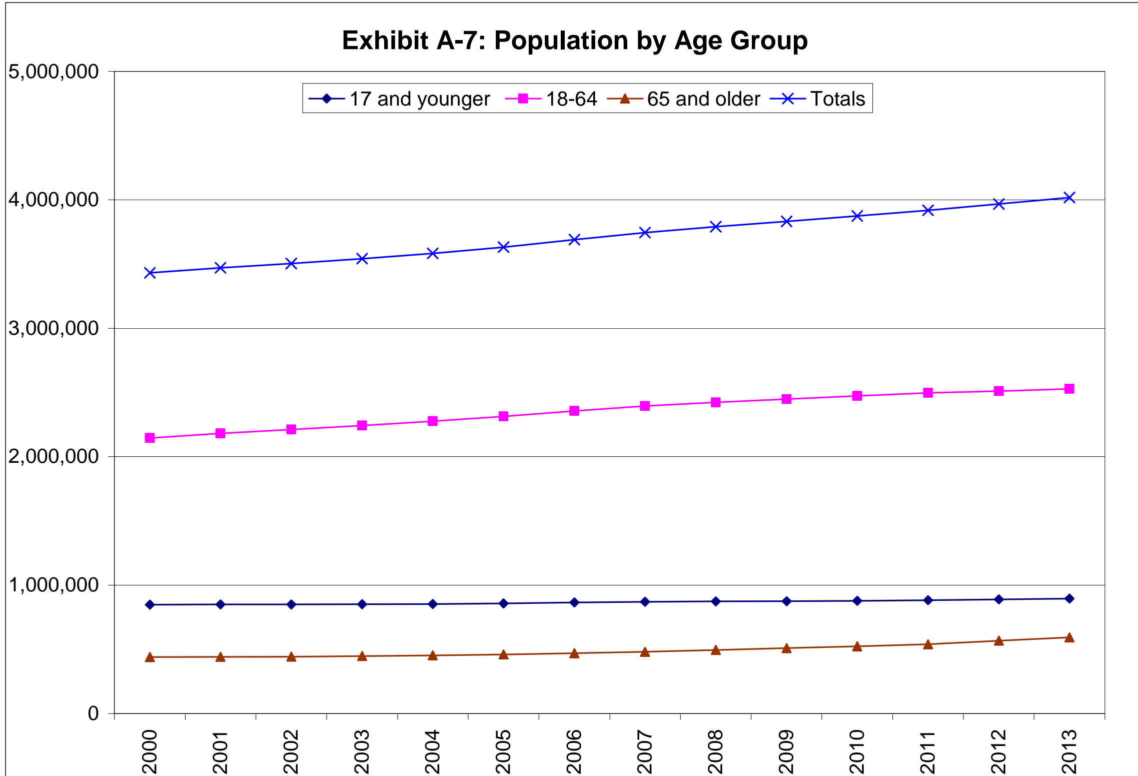
Source: U.S. Census Bureau: American FactFinder

Age Demographics

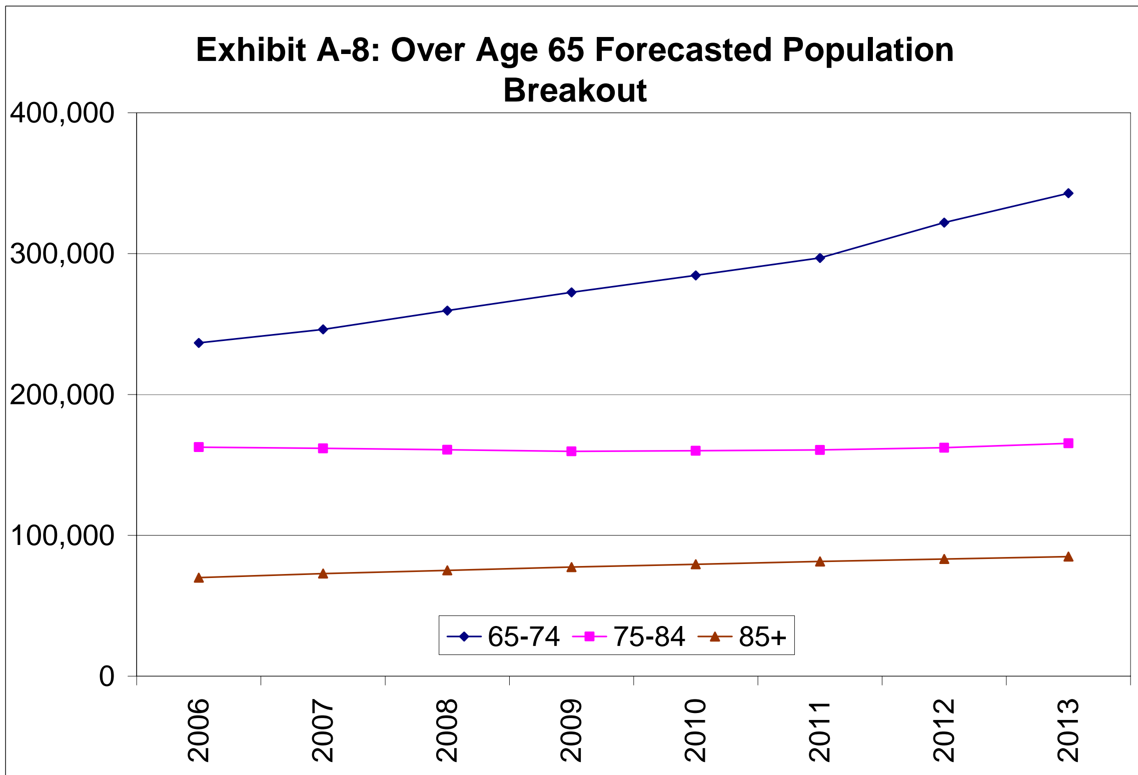
Peoples' needs often differ by age. Children's needs are different than those of the elderly. State demographers anticipate moderate population growth in Oregon with relatively rapid increases in the elderly population. As Oregon's population composition changes over time, the focus of DHS services has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

As of February 2009, roughly 23.0 percent of all Oregonians were children. As shown in Exhibit A-7, less than 13.0 percent of the total population was individuals 65 and older. However, from 2009 through 2013, the population growth rates will be highest for seniors at 23.0 percent compared to 7.0 percent for those 18-64 and 5.0 percent among children (Exhibit A-7).

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 45.0 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-8). Lastly, there is projected to be an increase of 18.0 percent for those 85 and older (Exhibit A-8).



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



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) administers 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 (OVRS) which assists individuals with disabilities to obtain and keep 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 means a family.

Some Food Stamps and TANF caseloads exhibit a strong relationship to Oregon's economy. A decrease in employment translates to an increase in families seeking some types of public assistance. This was especially apparent during 2008. Oregon's seasonally adjusted unemployment rate increased by 5.5 percentage points between January 2008 and February 2009, going from 5.3 to 10.8 percent. Most of that gain has occurred since October 2008. Likewise, TANF and Food Stamp caseloads grew throughout that period, but the rate of growth has accelerated since the fourth quarter of 2008. Based on historical observations, we developed statistical associations between these caseloads and per-capita employment to incorporate into our forecasting models.

The Spring 2009 forecast is based in part on Oregon's official economic forecast which is produced by the Office of Economic Analysis (OEA). The March 2009

edition of the *Oregon Economic and Revenue Forecast* calls for substantial job losses during 2009, particularly during the first half of the year. The Spring 2009 Self-Sufficiency forecast also takes into account estimates of Oregon jobs to be created by the 2009 American Recovery and Reinvestment Act (ARRA). Given OEA's forecast and the ARRA estimate, modest job gains are expected to begin in 2010. However, Oregon may not reach the rate of employment it saw in early 2007 until the end of 2013. This economic outlook underlies the Spring 2009 TANF and Food Stamp forecasts.

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

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	Fall 08 to Spring 09			Fall 08 to Spring 09			2007-09 to 2009-11		
Children, Adults & Families Division **Biennial Averages by Forecast**	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
SELF-SUFFICIENCY									
Food Stamps (Households)									
Children, Adults and Families	175,254	183,799	4.9%	194,593	245,727	26.3%	183,799	245,727	33.7%
Seniors and People with Disabilities	70,467	71,033	0.8%	78,588	82,901	5.5%	71,033	82,901	16.7%
Total Food Stamps	**245,721**	**254,832**	**3.7%**	**273,181**	**328,628**	**20.3%**	**254,832**	**328,628**	**29.0%**
Temporary Assistance for Needy Families (Families: Cash/Grants)									
Basic	18,204	18,887	3.8%	18,730	22,551	20.4%	18,887	22,551	19.4%
UN	1,264	1,526	20.7%	1,479	2,683	81.4%	1,526	2,683	75.8%
Total TANF	**19,468**	**20,413**	**4.9%**	**20,209**	**25,234**	24.9%	**20,413**	**25,234**	**23.6%**
***Pre-SSI**	777	755	-2.8%	1,196	1,143	-4.4%	755	1,143	51.4%
***Post-TANF**	2,444	2,021	-17.3%	4,517	3,119	-30.9%	2,021	3,119	54.3%
Employment Related Daycare (Families)	10,100	10,032	-0.7%	11,638	11,616	-0.2%	10,032	11,616	15.8%
Temp. Assist. For Dom. Violence Survivors (Families)	557	542	-2.7%	571	560	-1.9%	542	560	3.3%

*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

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 (SPD) are classified as SPD households.

There are more than 287,000 households and over 550,000 individuals receiving Food Stamps in Oregon. This translates to about 15 percent of all Oregonians currently receiving benefits through this program. The Food Stamp caseload is at its highest level since 1995, prior to welfare reform. The CAF and SPD caseloads 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. The CAF program has grown very rapidly since late 2007. Between September 2007 and February 2009 the number of cases grew by 34 percent (54,115) and the number of persons grew by 30 percent (109,272) (Exhibit B-4).

Forecast

The CAF Food Stamp biennial average caseload for 2007-09 is forecast to be 183,799, 4.9 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 245,727, 26.3 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 33.7 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

The SPD Food Stamp biennial average caseload for 2007-09 is forecast to be 71,033, 0.8 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 82,901, 5.5 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 16.7 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

The combined CAF and SPD biennial average caseload for 2007-09 is forecast to be 254,832, 3.7 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 328,628, 20.3 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 29 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

Economic performance and outlook have deteriorated significantly since September, and Food Stamp caseloads are at the highest levels in more than a decade. Food Stamp caseloads, especially CAF, have been increasing at an accelerated rate since October 2008. This corresponds with the steep and sudden economic deterioration that began at the same time. The difference between the Spring 2009 and Fall 2008 forecasts stems from economic deterioration beyond what was anticipated last fall.

The Office of Economic Analysis expects quarterly employment declines to continue through the end of 2009, though the rate of decline is expected to slow. Employment gains will begin gradually in 2010 and build throughout the next few years. As a result, the Food Stamp caseload is expected to grow through the end of 2010 and then start to decline in 2011. If the job loss continues beyond 2009 or if the loss is steeper than currently anticipated, the caseload could grow higher than predicted. Conversely, if the recovery begins sooner than (or the recession is not as deep as) expected, the caseload could decline or stabilize prior to 2011.

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. The Food Stamp caseload has experienced substantial volatility due to outreach efforts and changes in policy as well as economic changes. With that degree of historical variability, the average caseload could be 1.0 percent above or below the forecast average for the remainder of the 2007-09 biennium. The average caseload could be approximately 11.2 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 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.

There are more than 23,000 families and nearly 60,000 individuals enrolled in the TANF Basic and UN programs in Oregon, the highest levels this decade. The

caseload experienced significant growth during the 2001-03 recession and moderate growth through the first part of 2005. During the latter part of 2005 and all of 2006 the caseload declined, likely due to the improving economy. During 2007 the caseload gradually began to increase. Like Food Stamps, the TANF caseload increased sharply beginning in late 2007. Between November 2007 and February 2009 the number of cases grew by 28.3 percent (5,180) and the number of persons grew by 34.6 percent (15,115) (Exhibit B-6).

Forecast

The TANF Basic biennial average caseload for 2007-09 is forecast to be 18,887, 3.8 percent higher than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 22,551, 20.4 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 19.4 percent higher than the currently forecast average for the 2007-09 biennium.

The TANF UN biennial average caseload for 2007-09 is forecast to be 1,526, 20.7 percent higher than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 2,683, 81.4 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 75.8 percent higher than the currently forecast average for the 2007-09 biennium.

The total TANF biennial average caseload for 2007-09 is forecast to be 20,413, 4.9 percent higher than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 25,235, 24.9 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 23.6 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

The Pre-SSI biennial average caseload for 2007-09 is forecast to be 755, 2.8 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 1,143, 4.4 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 51.4 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

The Post-TANF biennial average caseload for 2007-09 is forecast to be 2,021, 17.3 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 3,119, 30.9 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 54.3 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

The risks to TANF are identical to those specified in the Food Stamps section, above. The degree and timing of growth and decline in the TANF caseload is dependent on the degree and timing of Oregon's economic growth and decline. Continued job loss beyond 2009 could lead to continued caseload growth into 2011. Conversely, a quicker recovery could cause an earlier decline in the caseload. In addition, the forecast assumes that current policies and practices remain in place through the next biennium. Given the history of the TANF caseload, the biennial average for 2007-09 could be approximately 1.4 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 16.6 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-6).

Pre-SSI is still relatively new. While a small number of families enter the program each month, it appears that a significant portion of those families' SSI applications will take more than a year to resolve. As long as there are more families joining than leaving the Pre-SSI caseload, it will continue to grow. Given the short history of this program, the biennial average for 2007-09 could be approximately 1.3 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 27.0 percent above or 18.6 percent below the forecast average for the 2009-11 biennium (Exhibit B-9).

The Post-TANF caseload is also relatively new. In the previous forecast, the assumptions as to how many clients would enter the Post-TANF caseload were too high. These have been adjusted in the current forecast. Even so, growth and decline in the TANF caseload will eventually lead to growth and decline in the Post-TANF caseload, all else being equal. That dynamic drives the Post-TANF forecast during the 2009-11 biennium. Given the short history of this program, the biennial average for 2007-09 could be approximately 2.6 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 31.2 percent above or below the forecast average for the 2009-11 biennium (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.

Several changes were made to ERDC during the 2007 legislative session that allowed more families to access the program and remain longer on the caseload. These changes included raising income eligibility and provider reimbursement rates. The ERDC caseload has grown fairly consistently since September 2007.

The caseload is highly seasonal and typically peaks in October. It reached 11,015 in October 2008. This is the highest level since December 2002, just prior to the imposition of budget cuts that forced a program reduction.

Forecast

The ERDC biennial average caseload for 2007-09 is forecast to be 10,032, 0.7 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 11,616, 0.2 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 15.8 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

Risks and Assumptions

The ERDC forecast assumes that current policies and practices continue through the coming biennium and that the caseload is not subject to budget reductions. So far, the economic downturn does not appear to have had any direct effect on the caseload. Any historical economic effects are difficult to disentangle from budget reductions (2003) or program enhancements (2007). Given the caseload's historical fluctuation, the biennial average for 2007-09 could be approximately 1.3 percent above or below the forecast average for the remainder of the biennium. The average caseload could be 16.1 percent above or 20.2 percent below the forecast average for the 2009-11 biennium (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.

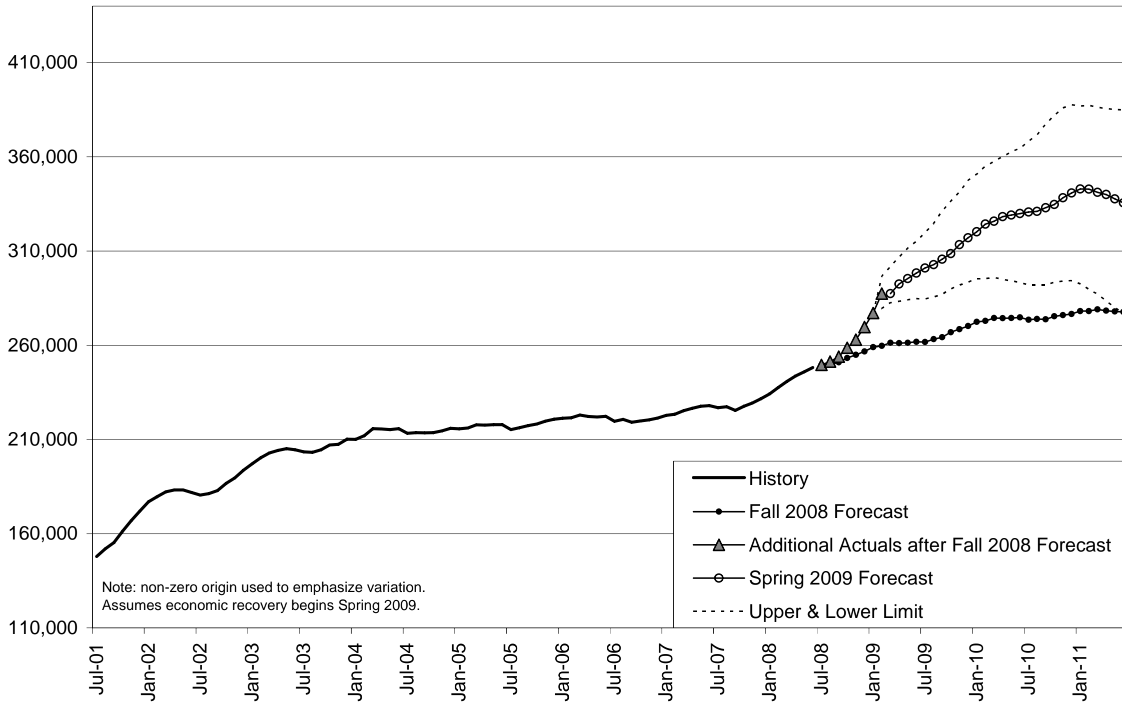
Forecast

The TA-DVS biennial average caseload for 2007-09 is forecast to be 542, 2.7 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 560, 1.9 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 3.5 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-2).

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 biennial average for 2007-09 could be approximately 4.6 percent above or below the forecast average for the remainder of the biennium. The

average caseload could be 32.5 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-12).



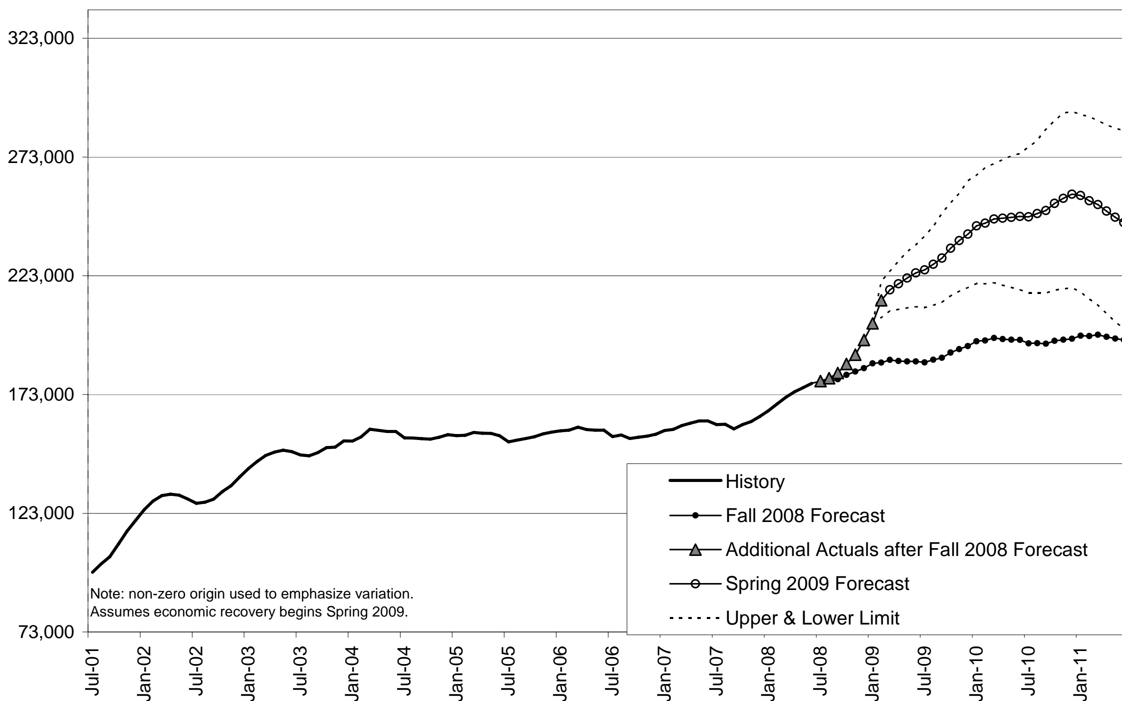


Exhibit B-5: SPD Food Stamps (Households)

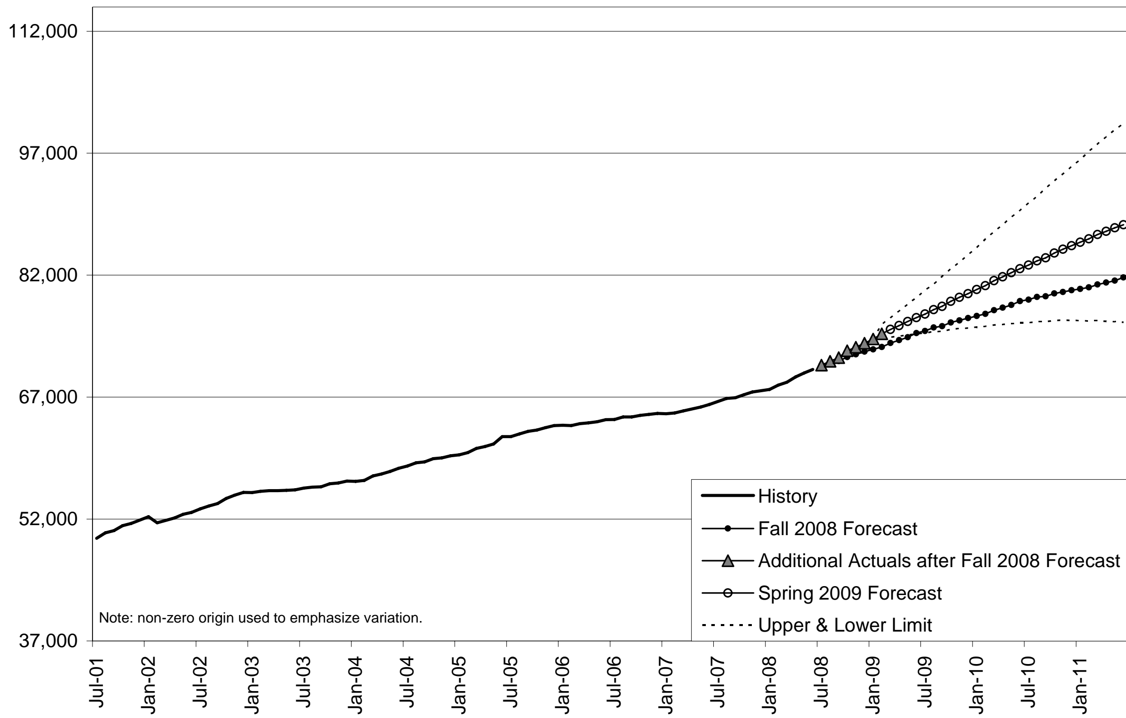
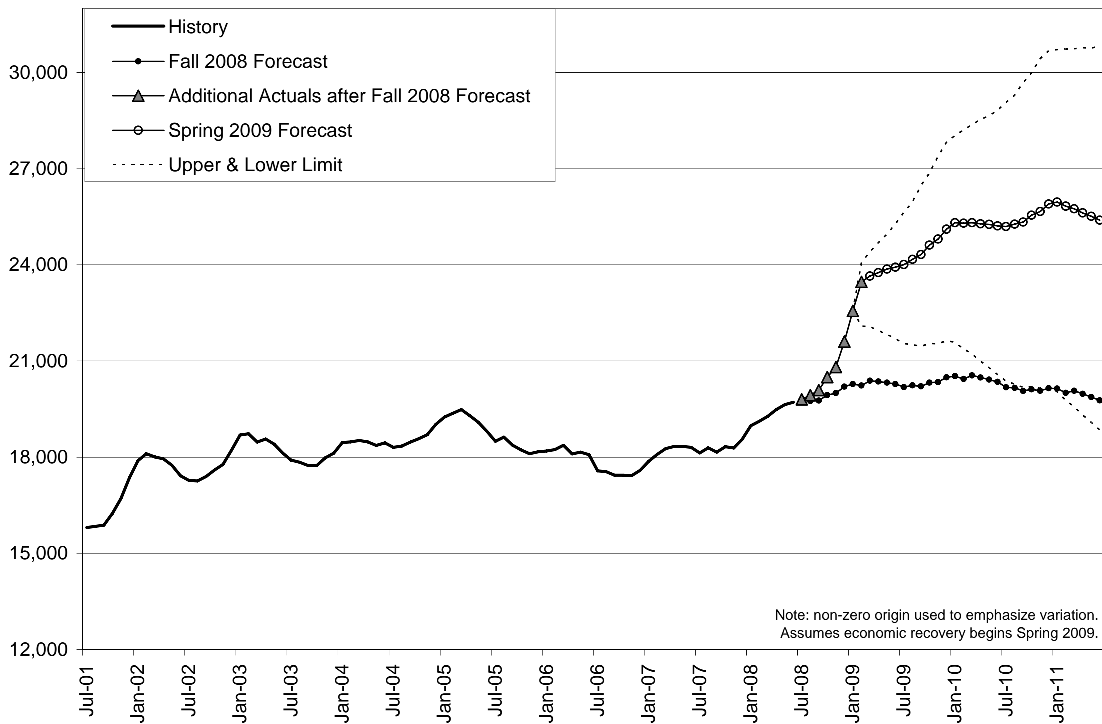


Exhibit B-6: Temporary Assistance for Needy Families Basic & UN (Families)



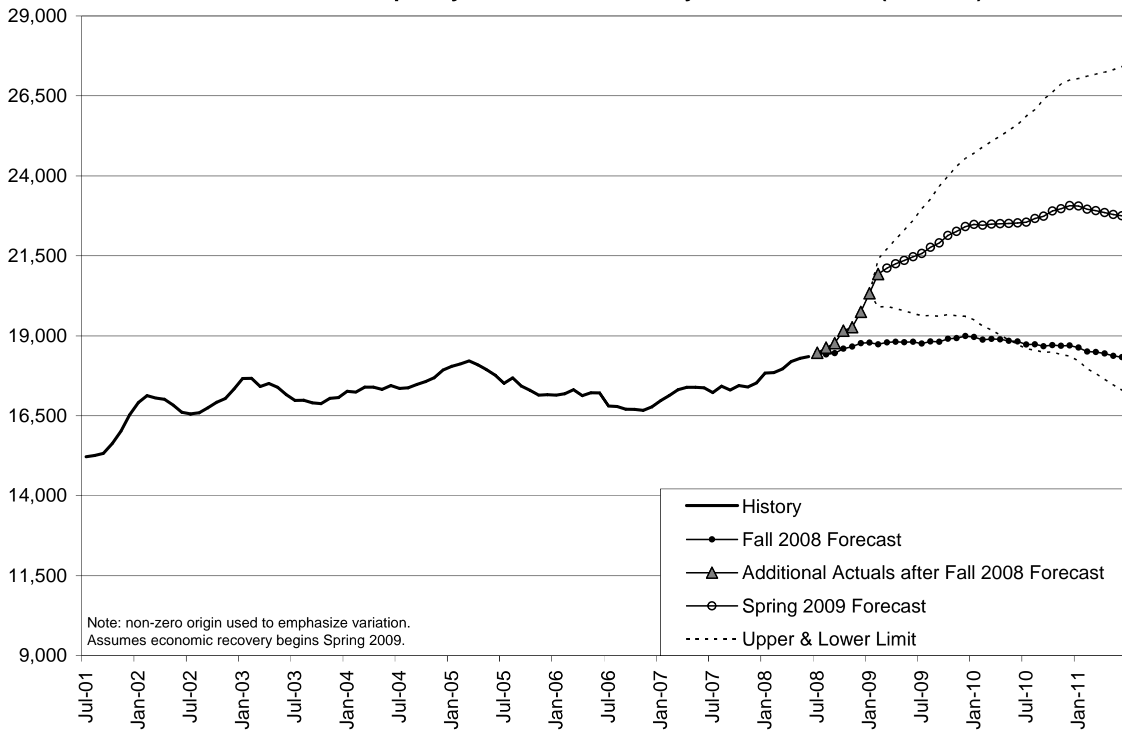


Exhibit B-7: Temporary Assistance for Needy Families - Basic (Families)
29,000
26,500
24,000
21,500
19,000
16,500
14,000
11,500
9,000
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Assumes economic recovery begins Spring 2009.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

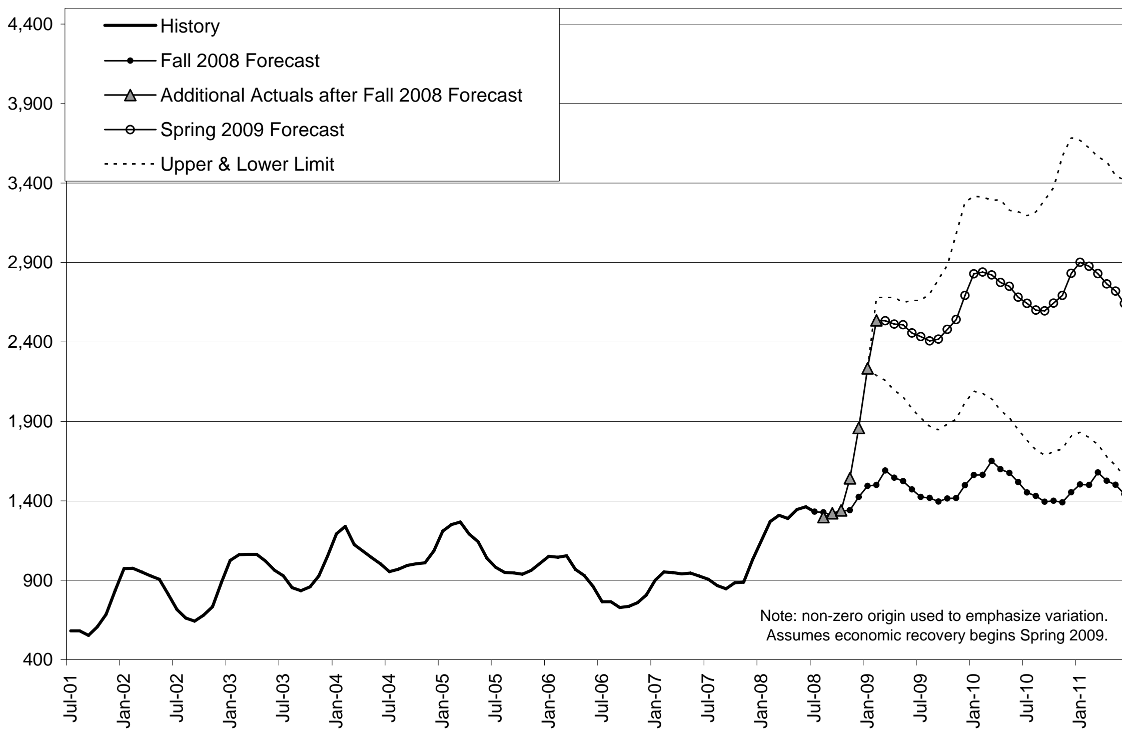


Exhibit B-8: Temporary Assistance for Needy Families - UN (Families)
4,400
3,900
3,400
2,900
2,400
1,900
1,400
900
400
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Assumes economic recovery begins Spring 2009.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

Exhibit B-9: Pre-SSI (Families)

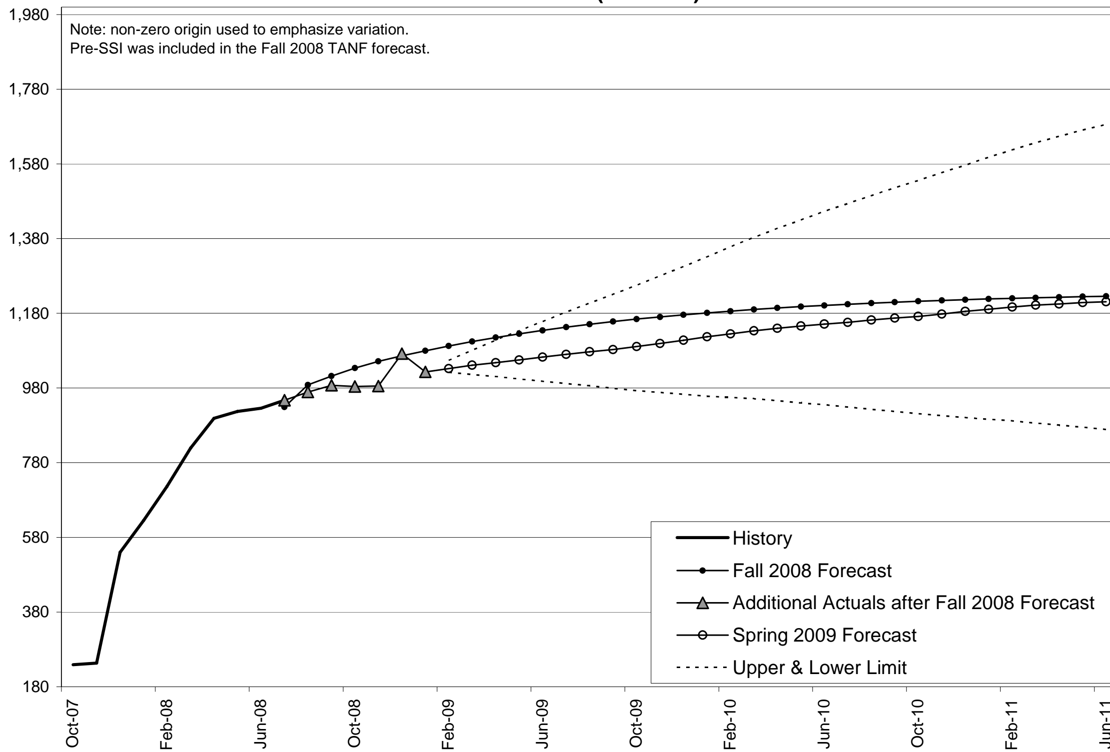


Exhibit B-10: Post Temporary Assistance for Needy Families (Families)

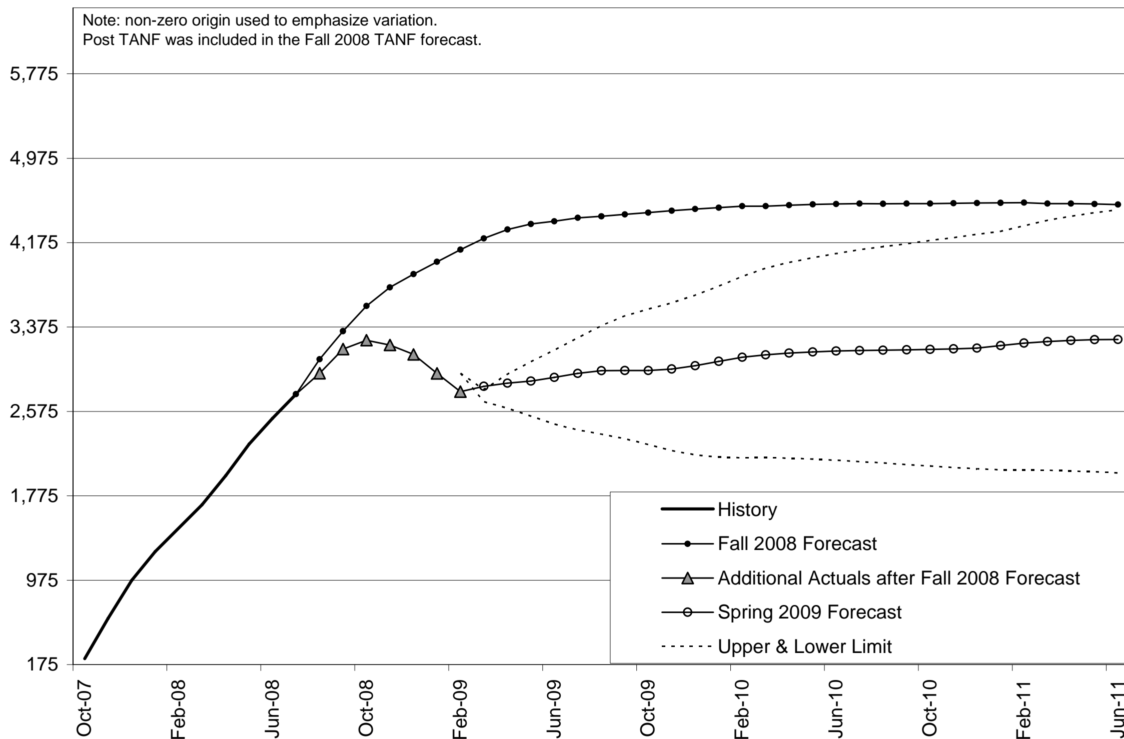


Exhibit B-11: Employment Related Daycare (Families)

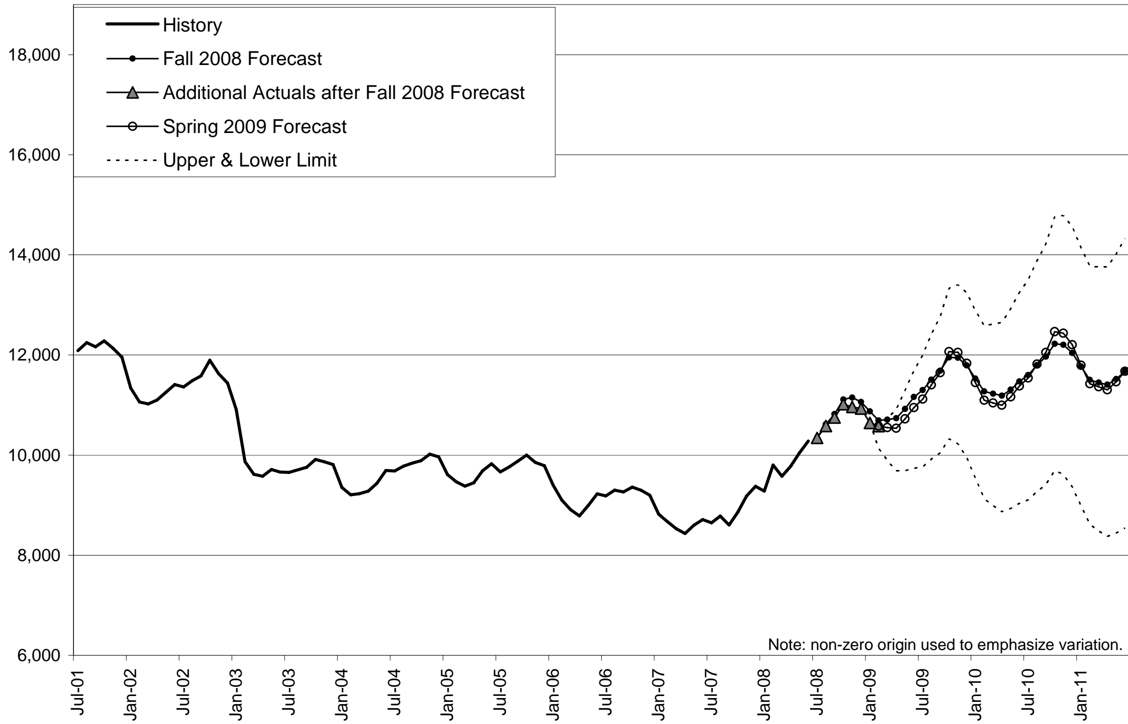
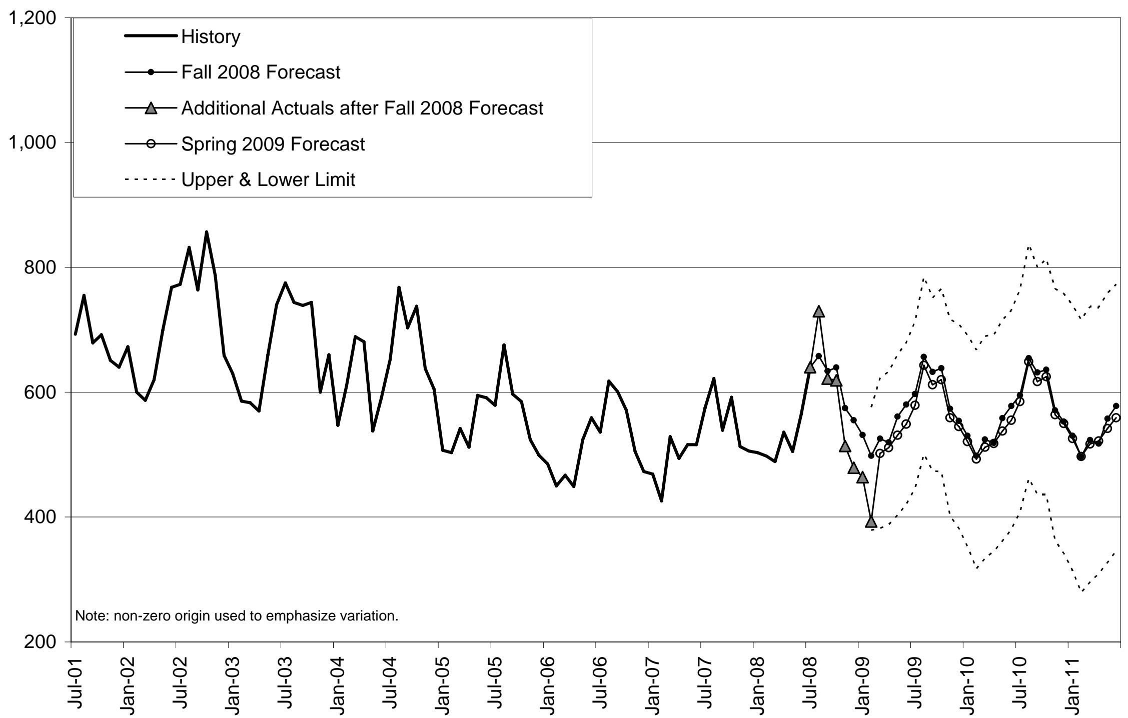
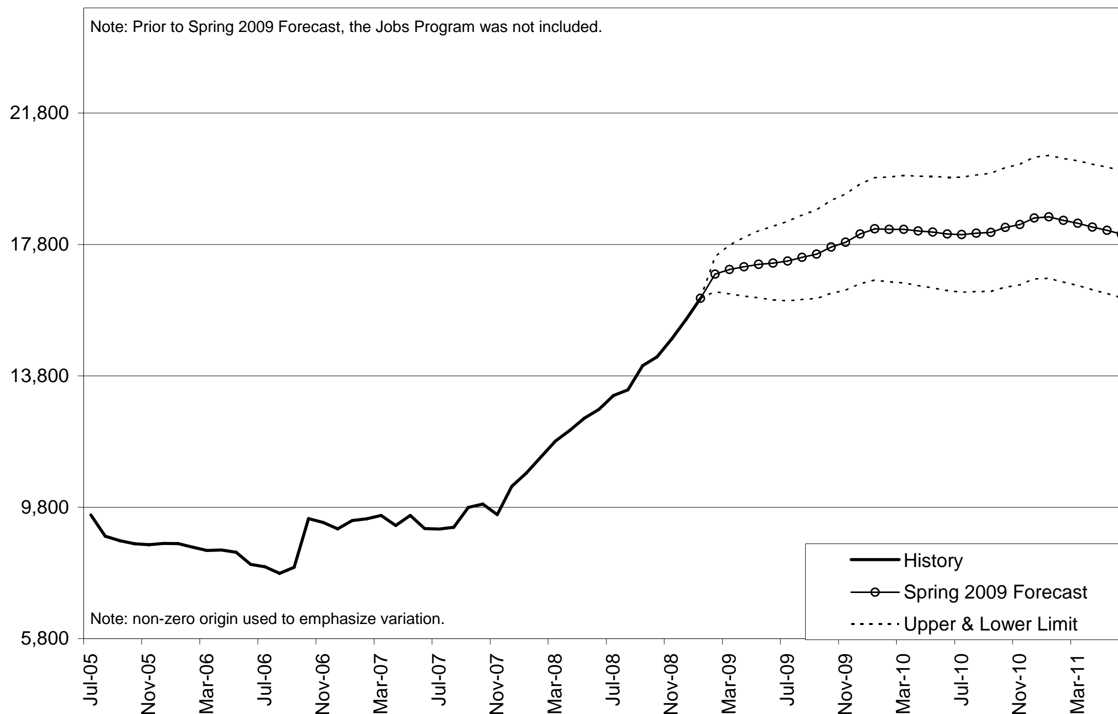


Exhibit B-12: Temporary Assistance for Domestic Violence Survivors (Families)





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, separated into the following categories[1]:

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.

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

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 percent 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. The Child Welfare caseload has been stable since the beginning of 2008.

Forecast

The currently forecast average for 2009-11 is 3.6 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-14).

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 pseudoephedrine 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. The decline appears to have run its course as of 2008. The Child In Home caseload 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.

Simple arithmetic dictates that changes in caseload are determined by the number of cases minus the number of cases 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 neither to confirm their validity nor determine to what extent each cause contributed to caseload change. The forecast assumes that the large and long term declines in the Out of Home Care and Child In Home caseloads have ended. Current practices are assumed to continue throughout the coming biennium, and expected overall population growth for children has been incorporated.

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 biennial average for 2007-09 could be approximately 1.3 percent above or below the forecast average for the remainder of the biennium. The average caseload could be 13.5 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-14).

Exhibit B-14: Total Child Welfare Caseload Biennial Average Comparison by Forecasts (Numbers Served)

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	Fall 08 to Spring 09			Fall 08 to Spring 09			2007-09 to 2009-11		
Children, Adults & Families Division Biennial Averages by Forecast	Fall 08 Forecast 2007-09	Spring 09 Forecast 2007-09	*%Diff. Fall 08 to Spring 09 2007-09*	Fall 08 Forecast 2009-11	Spring 09 Forecast 2009-11	*%Diff. Fall 08 to Spring 09 2009-11*	Spring 09 Forecast 2007-09	Spring 09 Forecast 2009-11	*% Diff. Spring 09 2007-09 to 2009-11*
CHILD WELFARE (Children)									
Adoption Assistance	10,531	10,485	-0.4%	11,541	11,633	0.8%	10,485	11,633	10.9%
Subsidized Guardianship	903	893	-1.1%	1,193	1,118	-6.3%	893	1,118	25.2%
Out of Home Care	-	8,315	-	-	7,710	-	8,315	7,710	-7.3%
Child In-Home	2,811	2,875	2.3%	2,840	2,915	2.6%	2,875	2,915	1.4%

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 Adoption Assistance biennial average caseload for 2007-09 is forecast to be 10,485, 0.4 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 11,633, 0.8 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 10.9 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-14).

Risks and Assumptions

Caseload growth has consistent for several years, and that consistent pattern leads to a higher degree of confidence in the forecast. The biennial average for 2007-09 could be approximately 0.3 percent above or below the forecast average for the remainder of the biennium. The average caseload could be 4.3 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-15).

Subsidized Guardianship Forecast

The Subsidized Guardianship biennial average caseload for 2007-09 is forecast to be 893, 1.1 percent lower than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 1,118, 6.3 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 25.2 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-14).

Risks and Assumptions

In this relatively small caseload small changes in absolute terms can generate large percentage changes. The rate of growth in this caseload has slowed over the last year, and this pattern is reflected forward in the forecast. The biennial average for 2007-09 could be approximately 3.6 percent above or 1.9 percent below the forecast average for the remainder of the biennium. The average caseload could be 35.8 percent above or 17.1 percent below the forecast average for the 2009-11 biennium (Exhibit B-17).

Out of Home Care Forecast

An error was discovered in the previous Out-of-Home Care monthly counts used for forecasting. A revised data series was used for the current forecast. Therefore, comparisons between the current and previous Out-of-Home forecasts are inappropriate. The Out-of-Home Care biennial average caseload for 2007-09 is forecast to be 8,315, and the 2009-11 biennial average caseload is forecast to be 7,710. The currently forecast average for 2009-11 is 7.3 percent lower than the currently forecast average for the 2007-09 biennium (Exhibit B-14).

Risks and Assumptions

The exact causes of the steep caseload decline in 2006 and 2007 are unknown. This in turn inhibits the ability to determine whether or not the decline will return. Program staff anticipates that the full implementation of the Oregon Child Safety Model may result in a smaller foster care caseload and larger Child-in-Home caseload, but it is too soon to incorporate any such assumption into the forecast. Given the volatility of this caseload, the average for 2007-09 could be approximately 1.6 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 18.7 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-18)

Child In Home Forecast

The Child In Home biennial average caseload for 2007-09 is forecast to be 2,874, 2.3 percent higher than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 2,915, 2.6 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 1.4 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-14).

Risks and Assumptions

The Child In Home caseload has been stable in 2008, but that stability follows a nearly uninterrupted three-year span of decline. The longer-term pattern of

decline increases the probability that caseloads could deviate substantially from the forecast. The average for 2007-09 could be approximately 3.7 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 31.3 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-19).

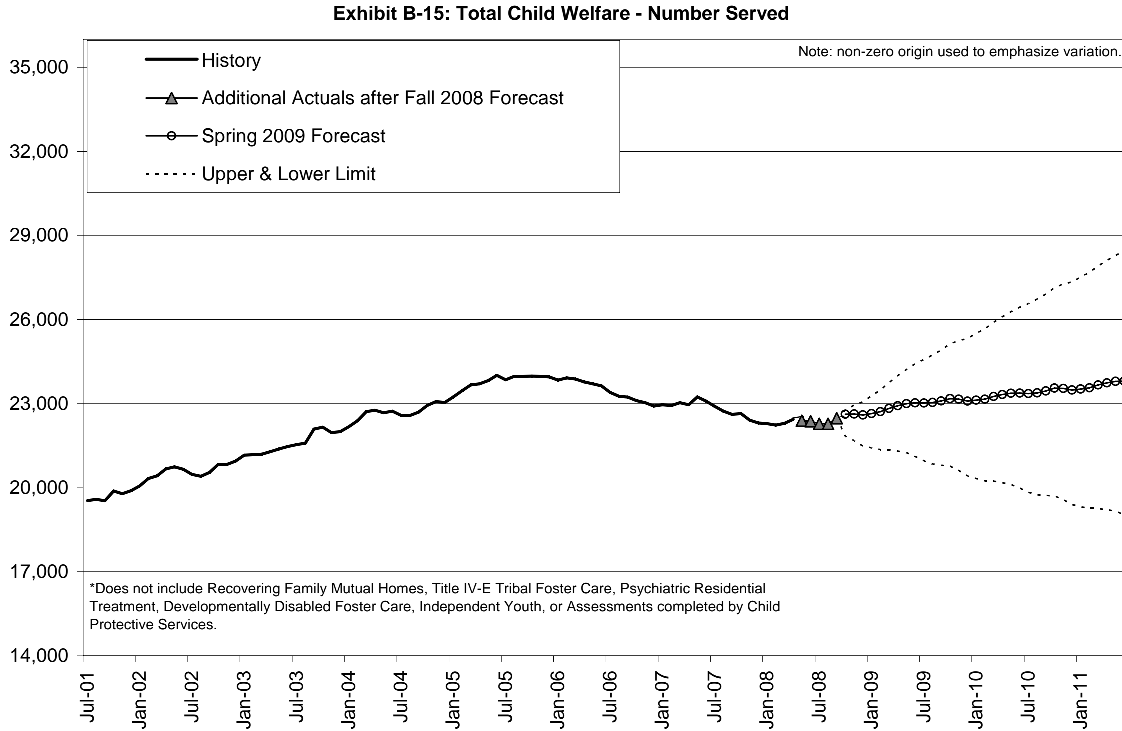


Exhibit B-16: Adoption Assistance - Number Served

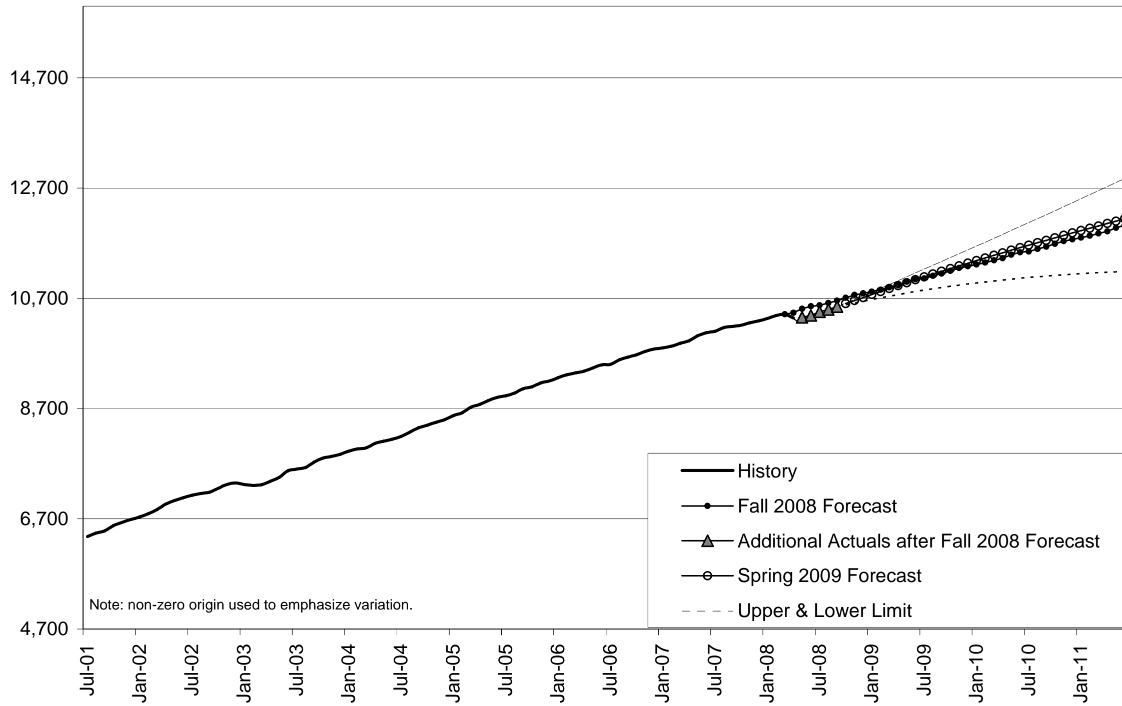
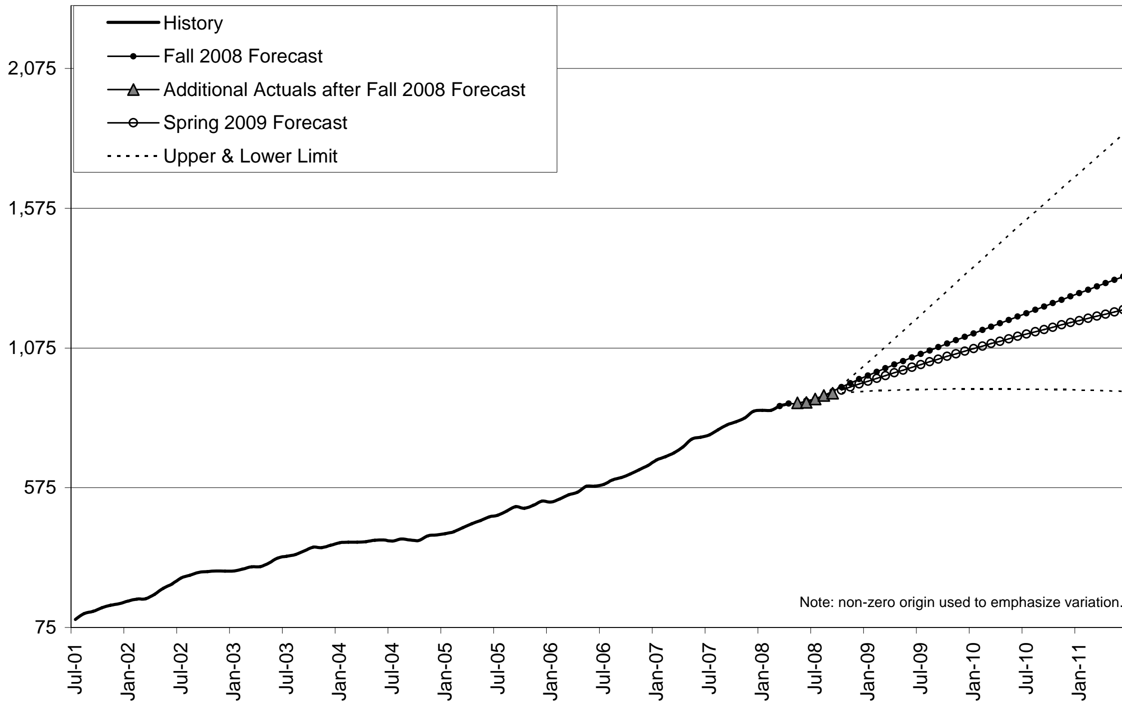


Exhibit B-17: Subsidized Guardianship - Number Served



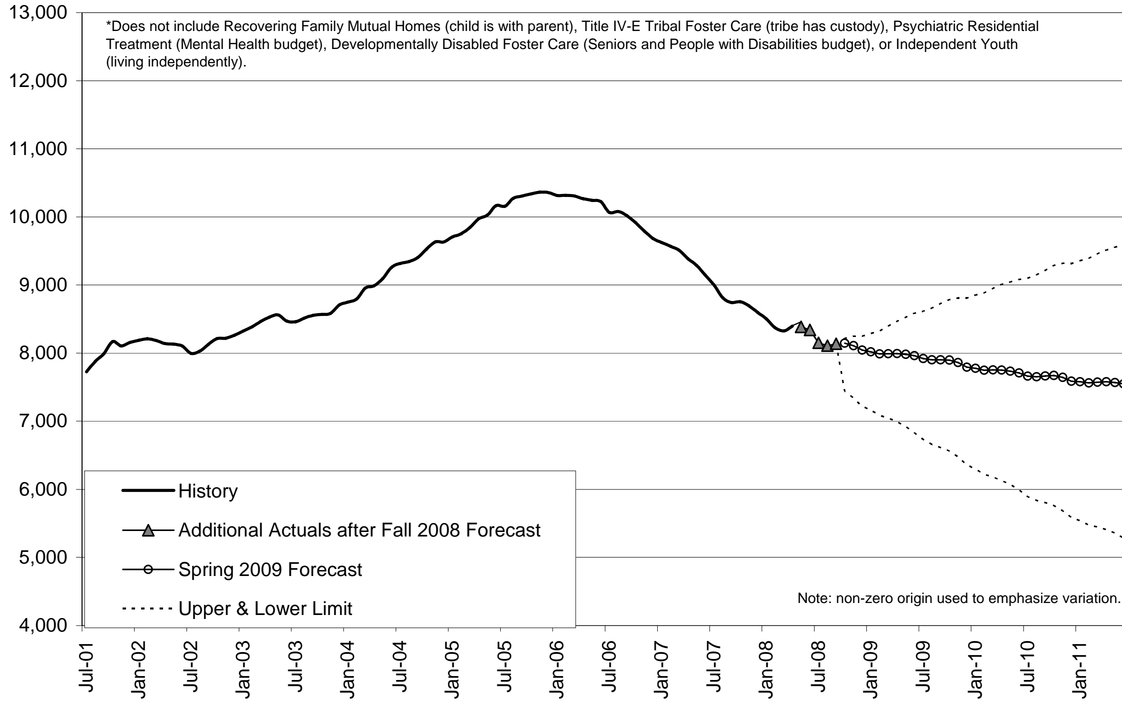


Exhibit B-18: Out of Home Care - Number Served
*Does not include Recovering Family Mutual Homes (child is with parent), Title IV-E Tribal Foster Care (tribe has custody), Psychiatric Residential Treatment (Mental Health budget), Developmentally Disabled Foster Care (Seniors and People with Disabilities budget), or Independent Youth (living independently).
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
5,000
4,000
History
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

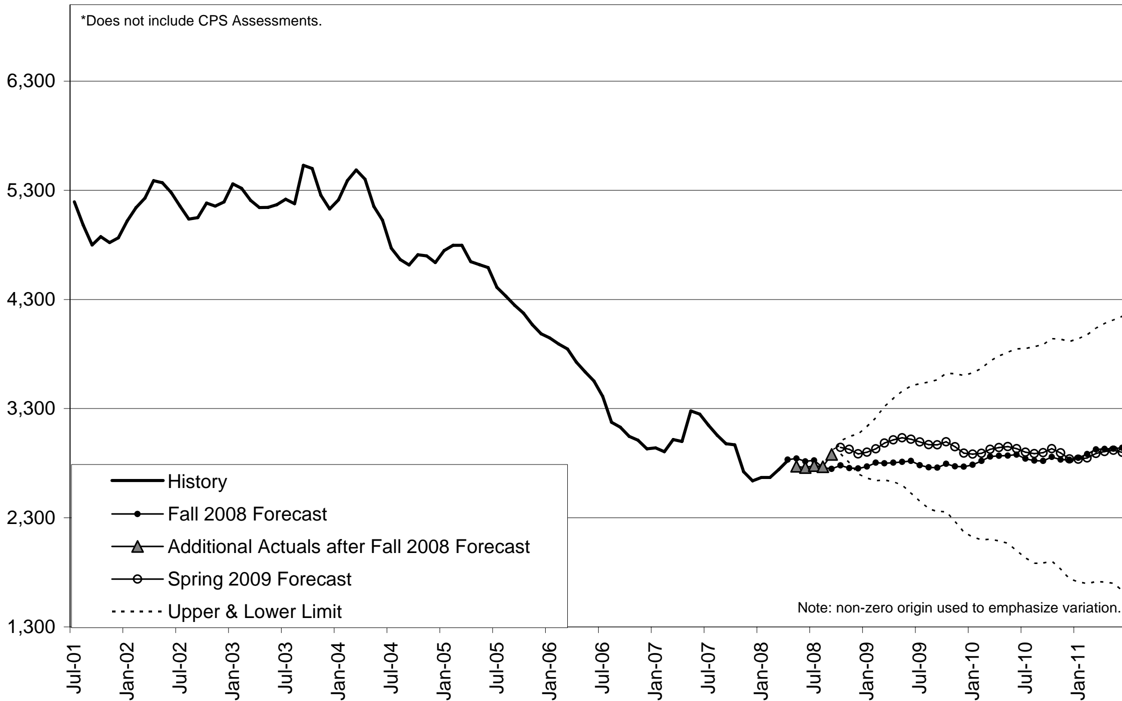


Exhibit B-19: Child In Home - Number Served
*Does not include CPS Assessments.
6,300
5,300
4,300
3,300
2,300
1,300
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

Vocational Rehabilitation

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

Exhibit B-20: Vocational Rehabilitation Caseload Biennial Average Comparison by Forecasts (Clients)

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	Fall 08 to Spring 09			Fall 08 to Spring 09			2007-09 to 2009-11		
Children, Adults & Families Division Biennial Averages by Forecast	Fall 08 Forecast 2007-09	Spring 09 Forecast 2007-09	*%Diff. Fall 08 to Spring 09 2007-09*	Fall 08 Forecast 2009-11	Spring 09 Forecast 2009-11	*%Diff. Fall 08 to Spring 09 2009-11*	Spring 09 Forecast 2007-09	Spring 09 Forecast 2009-11	*% Diff. Spring 09 2007-09 to 2009-11*
VOCATIONAL REHABILITATION (Clients)	9,201	9,225	0.3%	9,797	9,736	-0.6%	9,225	9,736	5.5%

Forecast

The OVRS biennial average caseload for 2007-09 is forecast to be 9,225, 0.3 percent higher than was predicted in the previous forecast. The 2009-11 biennial average caseload is forecast to be 9,736, 0.6 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 5.5 percent higher than the currently forecast average for the 2007-09 biennium (Exhibit B-20).

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 Addictions and Mental Health Division program for Supported Employment Evidenced Based Practices. Based on experience so far, the caseload for this program is expected to average 208 cases during the 2009-11 biennium. This compares to an average of 531 cases in the previous forecast for the same period. In addition, the additional adjustment for the Youth Transition Program is assumed to be complete. The previous forecast included an addition of 70 cases per month for this program during the 2009-11 biennium.

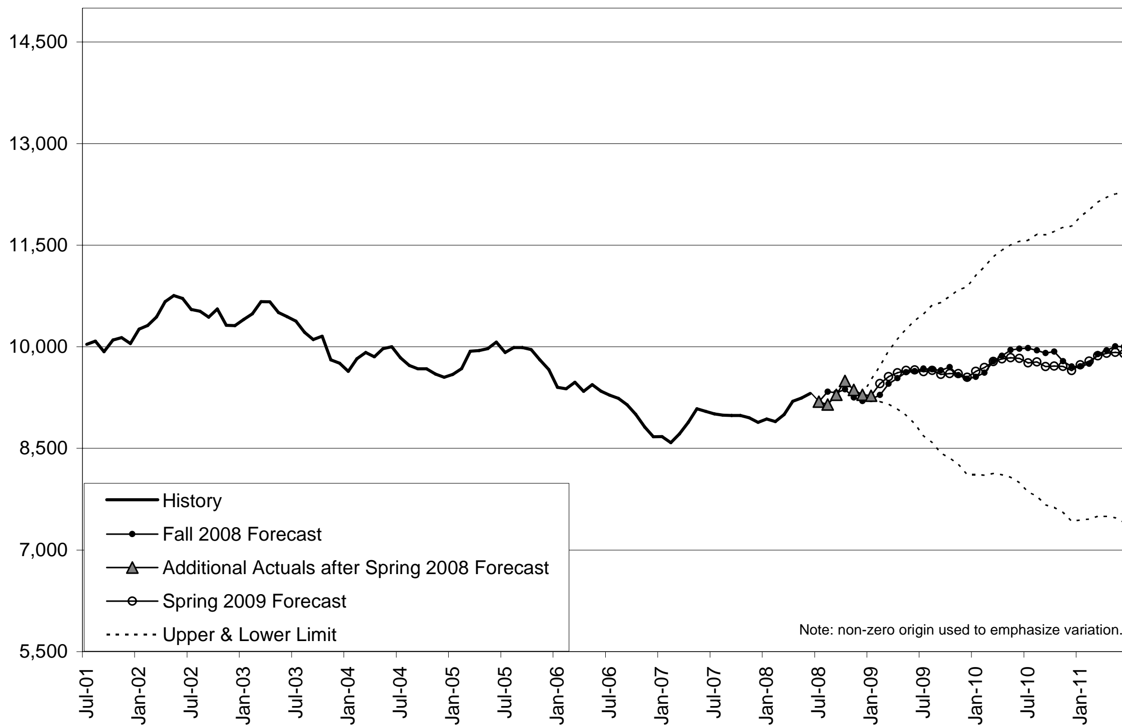
OVRS began to operate under an Order of Selection in mid-January 2009. When a state agency is not able provide the full range of rehabilitation services as identified in federal law, the agency must operate with an Order of Selection. The order is a legal prioritization of clients. Under the order, clients with the highest priority must be served before clients with lower priorities. Clients who cannot receive services immediately are placed on a waiting list.

It is possible that the Order of Selection will have a significant effect on the OVRS caseload, but it is too soon to tell. Serving fewer clients for longer periods of time might result in no change to caseload size. Conversely, a large waiting list

could increase the number of clients whose plans have been developed but cannot yet be implemented due to the order. More time and experience with the order will enable us to make some assumptions as to how the order will affect the future size of caseload.

The OVRS caseload has experienced moderate variability in the past which increases the probability that the caseload could deviate substantially from the forecast. The average for 2007-09 could be approximately 1.2 percent above or below the forecast average for the remainder of the biennium. The average caseload could be approximately 18.3 percent above or below the forecast average for the 2009-11 biennium (Exhibit B-21).

Exhibit B-21: Vocational Rehabilitation



STAKEHOLDER SURVEY RESULTS FOR CHILDREN, ADULTS & FAMILIES

Community Demand for Stakeholder Services

- Nearly every CAF stakeholder observed demand for stakeholder and DHS services increasing. 100 percent expected demand for stakeholder and DHS services to increase by Fall 2009.

- Most CAF stakeholders reported the increase in demand among low-income clients, single parent families, and mid-income and first-time clients.

Reasons for Increased Demand and Need

Most CAF stakeholders observed the reasons for increased demand rooted in economic stressors and client behaviors related to the economy. Several CAF stakeholders discussed the link between economic conditions and family stability; clients having difficulty accessing DHS services due to policy and eligibility restrictions; and clients utilizing support services but still having difficulty meeting their family needs. Most observed the cost of living increasing as income becomes scarce. Some CAF stakeholders also noted difficulty meeting demand due to a shortage of resources (funding, donations), and local shortages of DHS staff.

Stakeholders frequently mentioned the following client issues when discussing increased demand:

- **Cost of Living – Necessities.** Food, housing, heating fuel, health care expenses, prioritizing needs and expenses, asking for social assistance (food banks, rent and utility assistance) to make ends meet.

- **Unemployment.** Layoffs, shortage of positions, reduced hours and wages, reduced or eliminated benefits, unemployment "burnout" (people stop looking). Stakeholder report TANF clients taking longer to return to work due to lack of child care and other resources.

- **Family Stress.** Economic stress, family instability, increased child welfare caseload, need for counseling and advocacy services.

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 2009 forecast and the prior Fall 2008 forecast for each of the thirteen DMAP programs.

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

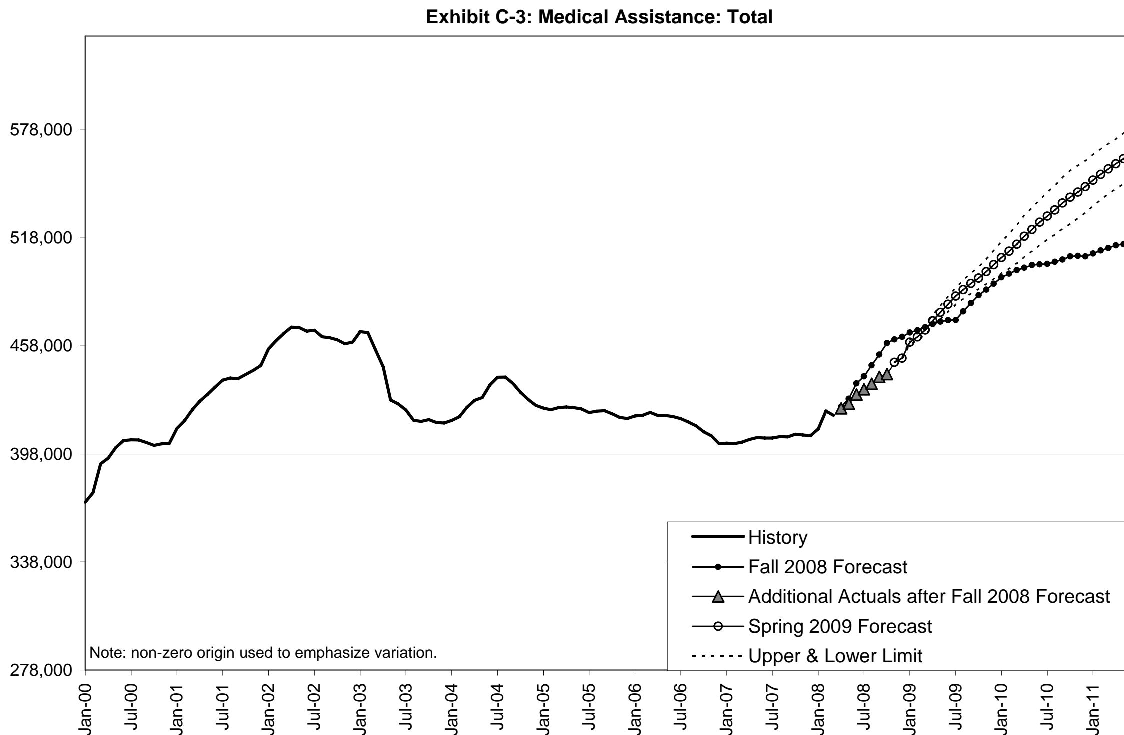
	2007-09 Biennium			**2009-11 Biennium**			**Spring 2009 Forecast**		
Comparison:	**Fall 08 to Spring 09**			**Fall 08 to Spring 09**			**2007-09 to 2009-11**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
OHP Plus									
TANF-Related Medical	93,033	94,157	1.2%	107,278	136,510	27.2%	94,157	136,510	45.0%
TANF-Extended	22,796	23,613	3.6%	25,385	29,004	14.3%	23,613	29,004	22.8%
TANF Medical - Subtotal	**115,829**	**117,770**	**1.7%**	**132,663**	**165,514**	**24.8%**	**117,770**	**165,514**	**40.5%**
Poverty Level Medical - Women	11,083	10,909	-1.6%	12,034	11,835	-1.7%	10,909	11,835	8.5%
Poverty Level Medical - Children	92,536	91,459	-1.2%	114,731	116,470	1.5%	91,459	116,470	27.3%
Aid to the Blind & Disabled	65,956	65,937	0.0%	73,405	73,162	-0.3%	65,937	73,162	11.0%
Old Age Assistance	30,562	30,539	-0.1%	31,620	32,509	2.8%	30,539	32,509	6.5%
Substitute Care & Adoption Serv.	17,833	17,807	-0.1%	18,360	18,360	0.0%	17,807	18,360	3.1%
Children's Health Insurance Program	46,138	44,556	-3.4%	56,079	49,001	-12.6%	44,556	49,001	10.0%
OHP Plus Subtotal	**379,937**	**378,977**	**-0.3%**	**438,892**	**466,851**	**6.4%**	**378,977**	**466,851**	**23.2%**
Other Medical Assistance Programs									
Citizen-Alien Waived Emergency Medical	18,693	18,481	-1.1%	19,009	19,548	2.8%	18,481	19,548	5.8%
Qualified Medicare Beneficiary	13,072	13,122	0.4%	15,233	14,985	-1.6%	13,122	14,985	14.2%
Breast & Cervical Cancer program	369	370	0.3%	483	483	0.0%	370	483	30.5%
Other Subtotal	**32,134**	**31,973**	**-0.5%**	**34,725**	**35,016**	**0.8%**	**31,973**	**35,016**	**9.5%**
OHP Standard	*25,726*	*24,288*	**-5.6%**	*25,842*	*24,933*	-3.5%	24,288	*24,933*	2.7%
Total Medical Assistance Programs	**437,797**	**435,238**	**-0.6%**	**499,459**	**526,800**	**5.5%**	**435,238**	**526,800**	**21.0%**

Total Medical Assistance Programs

The total DMAP caseload was 442,372 in October 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 to enroll new clients in response to the planned closure of the OHP Standard program 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 18,840 in September 2007.

Forecast

The prior Fall 2008 forecast for total DMAP programs anticipated an aggressive pattern of caseload growth through 2009-11 that was based on known recessionary effects. The current Spring 2009 forecast slightly moderates these increases for the remainder of the 2007-09 biennium. The current forecast estimates a 2007-09 biennial average of 435,238 clients. The previous forecast was slightly higher by an average of 3,543 clients. The 2009-11 biennial differences, however, are substantial with the current forecast expecting an average of 526,800 clients compared to 499,459 in the Fall 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 1.0 percent above or below the forecast for the remainder of the 2007-09 biennium and 2.0 percent in 2009-11. 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 86 percent of DMAP clients in October 2008 and is expected to be constant through the end of the 2007-09 biennium. This ratio is expected to increase to 89 percent by the end of the 2009-11 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-RM (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-EX caseload are individuals who have left TANF-RM 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 transitioning into TANF-EX from TANF-RM must have been enrolled in TANF-RM for three of the prior six months in order to receive extended benefits. Historically, 30 to 40 percent of clients leaving TANF-EX in any given month have returned to TANF-RM.

The total TANF medical assistance caseload (TANF-RM plus TANF-EX) grew rapidly from the beginning of 2001 for about one year, leveled off, and grew again in 2003. The earliest period of growth lasted for about 15 months until spring 2002 during the Oregon recession (November 2000 through June 2003). The sustained and rapid growth of the total TANF caseload peaked in spring

2005 after a post-recessionary growth across 24 months. For the next twelve months, the total caseload remained between 135,000 and 140,000 clients. Beginning in March 2006, however, and continuing through late fall of 2007, the combined caseloads dropped to approximately 112,000 clients. Since the beginning of 2008, the caseload has remained flat.

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

The TANF-RM client group makes up around 80 percent of the total TANF medical caseload (October 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. The caseload for this group dropped from a high of approximately 100,000 clients in March 2005 to approximately 86,800 in September 2007. Since that time, however, the caseload has grown to approximately 92,000 clients (Exhibit C-6).

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 the expected severity and duration of the recession as estimated by the Oregon Office of Economic Analysis.

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-RM 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) is due to the increase in absolute number of clients moving from TANF-RM to TANF- EX during that period. This group entered a period of rapid decline after March 2006. Recent caseload counts 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 growth pattern ultimately driven by the substantial increases in the TANF-RM caseload.

Forecast

Since TANF-EX and TANF-RM are programmatically tied, any change to TANF-RM results in TANF-EX caseload changes. Of the clients leaving TANF-RM, approximately 40 to 50 percent exit to TANF-EX. Additionally, the clients leaving the TANF-EX group, approximately one in three returns directly to TANF-RM. The current Spring 2009 forecast calls for substantial growth in the TANF-RM population with mild growth in TANF-EX driven by changes to TANF-RM (See exhibits C-5 through C-7). The effects of enhanced unemployment rates are expected to increase new clients to TANF-RM by 25 percent in 2009 over 2008 with slight declines of 5 percent and 2 percent in the following years. These estimates are tied to recession duration expectations delineated by the Oregon Office of Economic Analysis.

The Spring 2009 forecast for both groups combined estimates a 2007-09 biennial average of 117,770 cases rising to 165,514 in the 2009-11 biennium. The Fall 2008 forecast estimated corresponding averages of 115,829 and 132,663.

Risks and Assumptions

The assumptions for TANF estimates in the Fall 2008 forecast were that the economy, job growth and health insurance availability would decline in keeping with the then-developing economic recession. While the expected recession effects did not materialize in magnitude as forecast, the economy has continued to slow with even higher unemployment rates. The dynamics and volatility in economic conditions create a high level of risk to the forecasts due to the substantial level of sensitivity of these groups to the economy.

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 1.0 percent for the 2007-09 biennium and 7.6 percent for the 2009-11 biennium (Exhibit C-5).

As of this writing the monitored TANF-RM and TANF-EX caseloads have shown similar 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 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 Spring 2009 forecast is slightly lower than that expected in the Fall 2008 forecast. The current forecast calls for biennial averages of approximately 10,909 during 2007-09 increasing to approximately 11,835 for 2009-11. These averages represent a decrease over the Fall 2008 forecast of less than 1.6 percent for 2007-09 with a 1.7 percent difference in 2009-11. 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 1.4 percent for 2007-09 above and below the forecast. This variance increases to 2.9 percent for the 2009-11 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.

PLMC caseloads exceeding 100,000 per month early in the decade are reflective of the Oregon recession of November 2000-June 2003 as this group is also sensitive to 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 70 percent of the total TANF medical population is under the age of 18).

Forecast

Two specific factors contribute to the Spring 2009 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.

The prior Fall 2008 forecast for PLMC projected a caseload pattern of substantial increase through the end of the 2009-11 biennium. The caseload was expected to increase to an average of 92,536 average cases for the 2007-09 biennium and 114,731 in the following 2009-11 biennium. The current Spring 2009 forecast increases those estimates by factoring in the above mentioned effects. The Spring 2009 forecast anticipates a 2007-09 biennial average of 91,459 clients, a 1.2 percent decrease over Fall 2008. The estimates for the 2009-11 biennium are for 116,470 clients, or 1.5 percent increase when compared to Fall 2008. Policy change, economic factors, and recession timing 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 1.0 percent above or below the actual average for 2007-09. This increases to 2.7 percent during the 2009-11 biennium (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 20.0 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 2009 forecast for this group calls for a continuation of sustained, strong growth through the end of the 2009-11 biennium. The Fall 2008 forecast

estimated a 2007-09 biennial average of 65,956 while the current biennial average estimate is 65,937. 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. The temporary re-opening of the Standard groups was expected to contribute cases to AB/AD through inter-category transfers and through secondary effects of appropriate program screening of Standard applicants. The upper and lower limits, which average 0.2 percent above and below the forecast through the 2009-11 biennium, show anticipated stability in the continued growth of this program (Exhibit C-10).

OHP Plus: Old Age Assistance

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 Fall 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 23 fewer clients expected in the 2007-09 biennium with a more significant average of 890 more clients during the 2009-11 biennium. The upper and lower confidence limits average of less than 1.0 percent above and below the forecast for the 2007-09 biennium and 1.0 percent for 2009-11.

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 Fall 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 equal to that anticipated in the Fall 2008 forecast. The Spring 2009 forecast estimates a 2007-09 biennial average of 17,807 compared to the prior estimate of approximately 17,833. The range of upper and lower limits of plus or minus 0.1 percent for 2009-11 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.

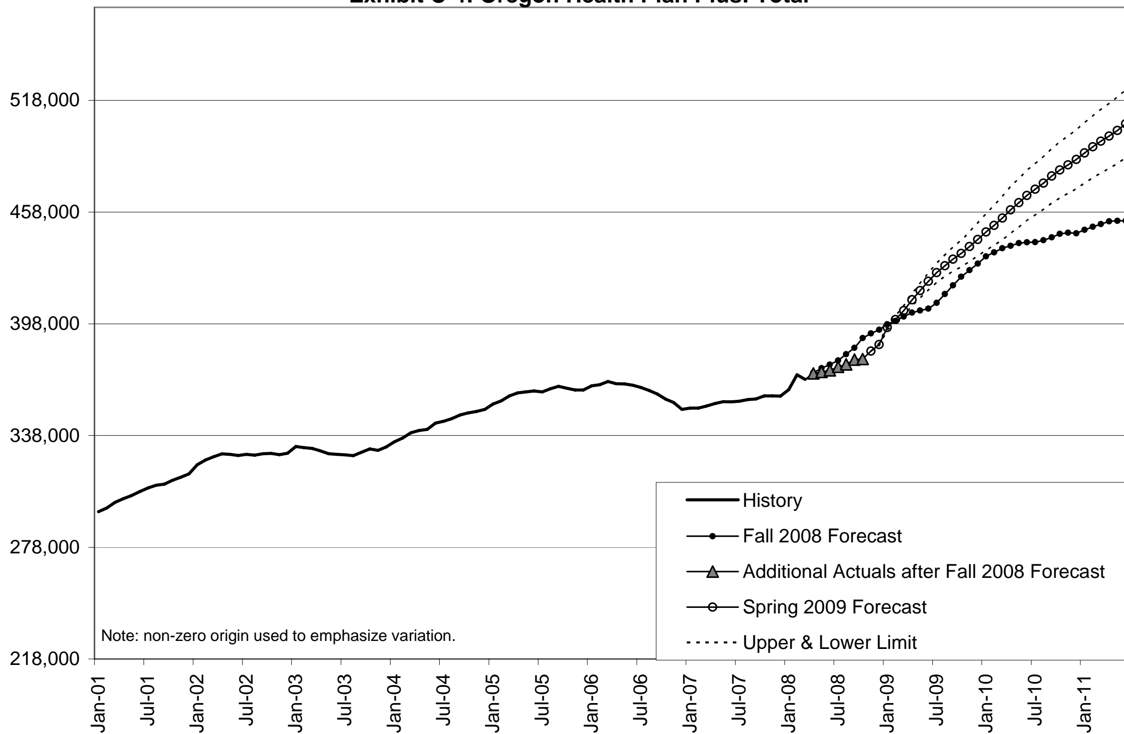
The total CHIP caseload has grown in different patterns over the years. From July 1999 through November 2001, the CHIP caseload increased slowly but steadily to a total of 20,430. From November 2001 through August 2002, growth slowed. Beginning around September 2002 and continuing through September 2004, 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.

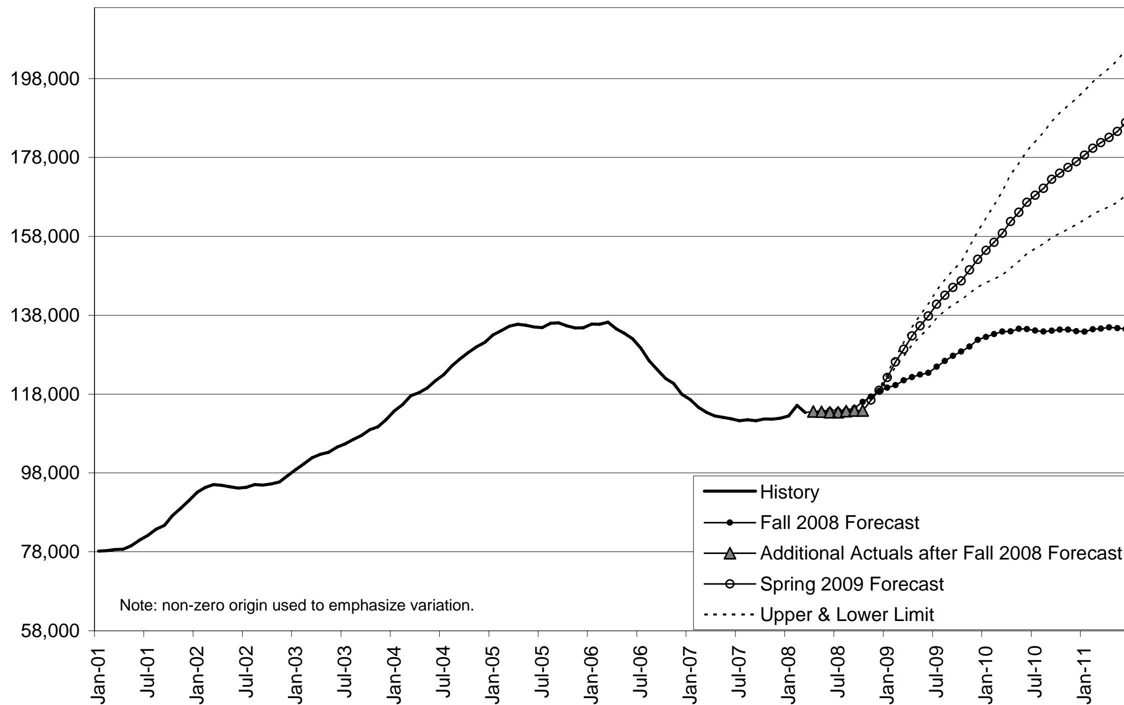
Forecast

The Spring 2009 forecast for this group is somewhat lower than the earlier Fall 2008 forecast. Several factors contribute to the CHIP caseload estimates in the current forecast. While the number of new clients entering the program is gradually increasing with lengths of stay increasing as well, the greater contribution to this lower estimate is tied to the eligibility review extension of Poverty Level Medical Children. As these latter children are retained longer in the PLMC caseload, there are fewer opportunities to transfer into CHIP resulting in lower estimates.

The Spring 2009 biennial averages for this group are 44,556 for 2007-09 and 49,001 for the 2009-11 biennium. These estimates represent a 3.4 and 12.6 percent decrease, respectively, when compared to those for Fall 2008. The current forecast calls for a continuation of the aggressive growth seen historically, but at a lower level. 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 with resultant rapid accumulation of clients and increasing caseload. Historical

forecast variability indicates a 1.0 percent confidence limit range for the 2007-09 biennium rising to 3.0 percent in 2009-11.





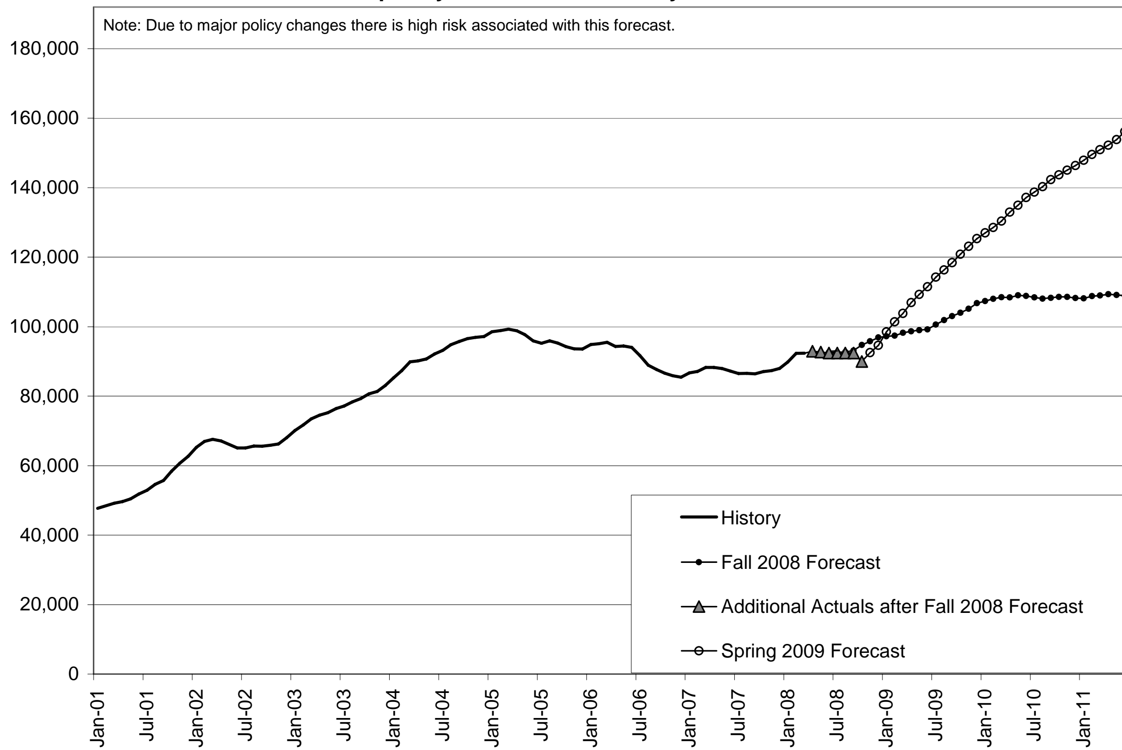


Exhibit C-6: Temporary Assistance for Needy Families-Related Medical
Note: Due to major policy changes there is high risk associated with this forecast.
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

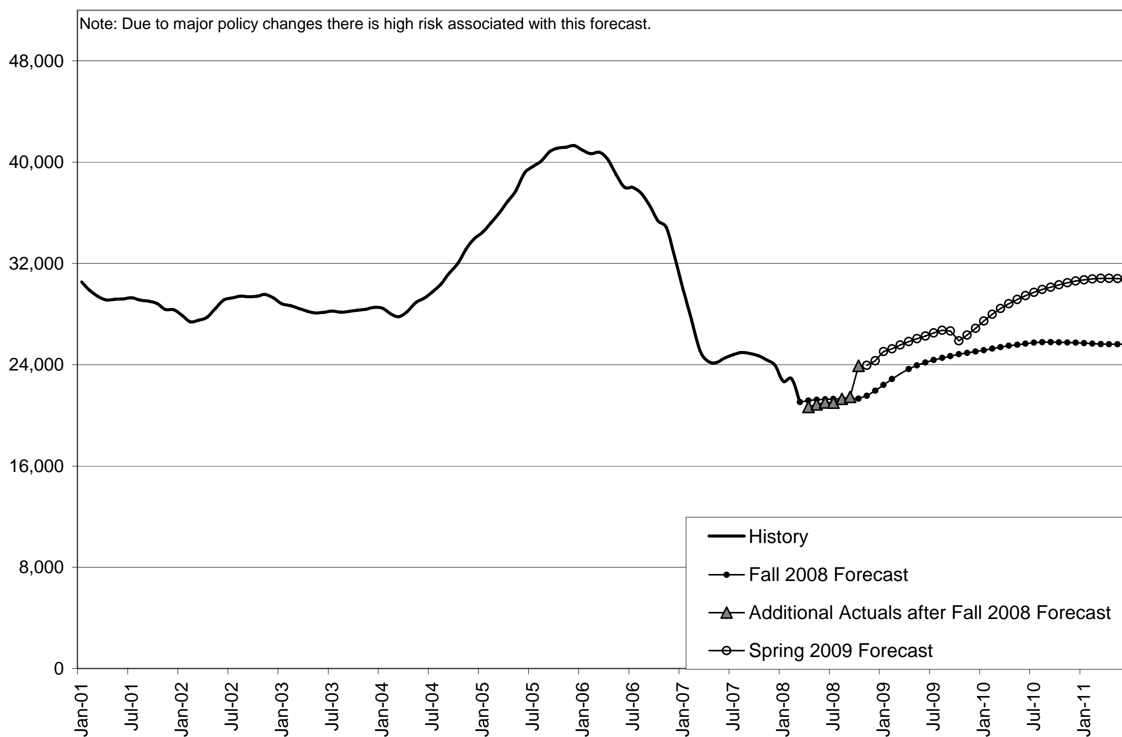


Exhibit C-7: Temporary Assistance for Needy Families-Extended
Note: Due to major policy changes there is high risk associated with this forecast.
48,000
40,000
32,000
24,000
16,000
8,000
0
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

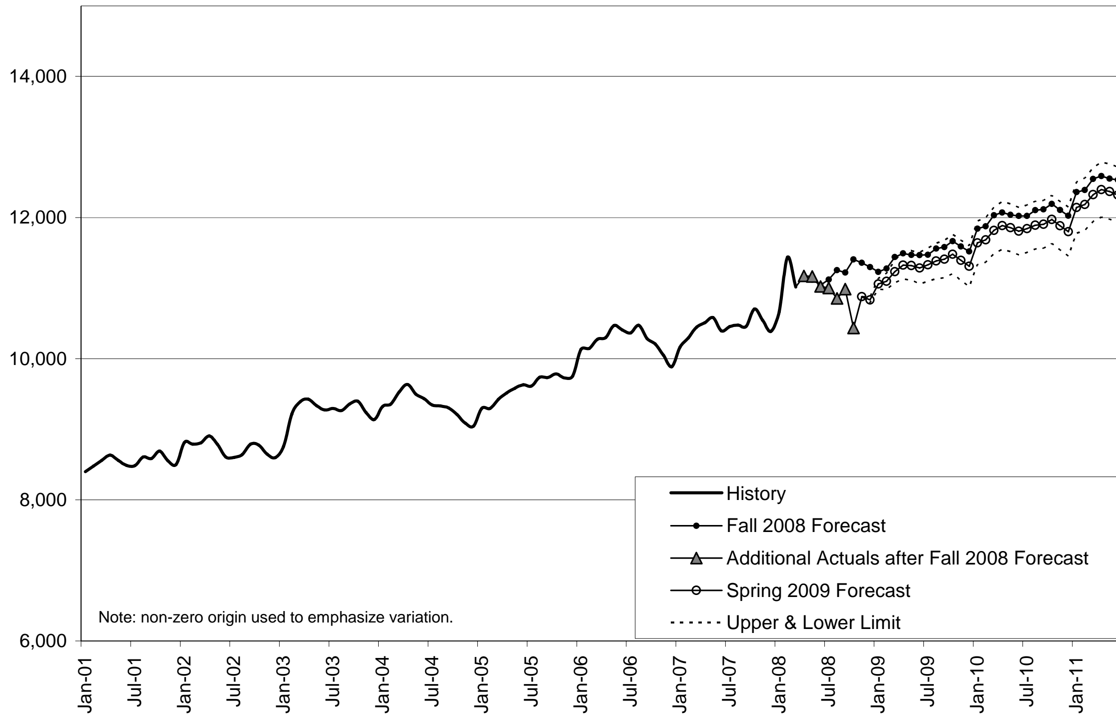


Exhibit C-8: Poverty-Level Medical Women
14,000
12,000
10,000
8,000
6,000
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

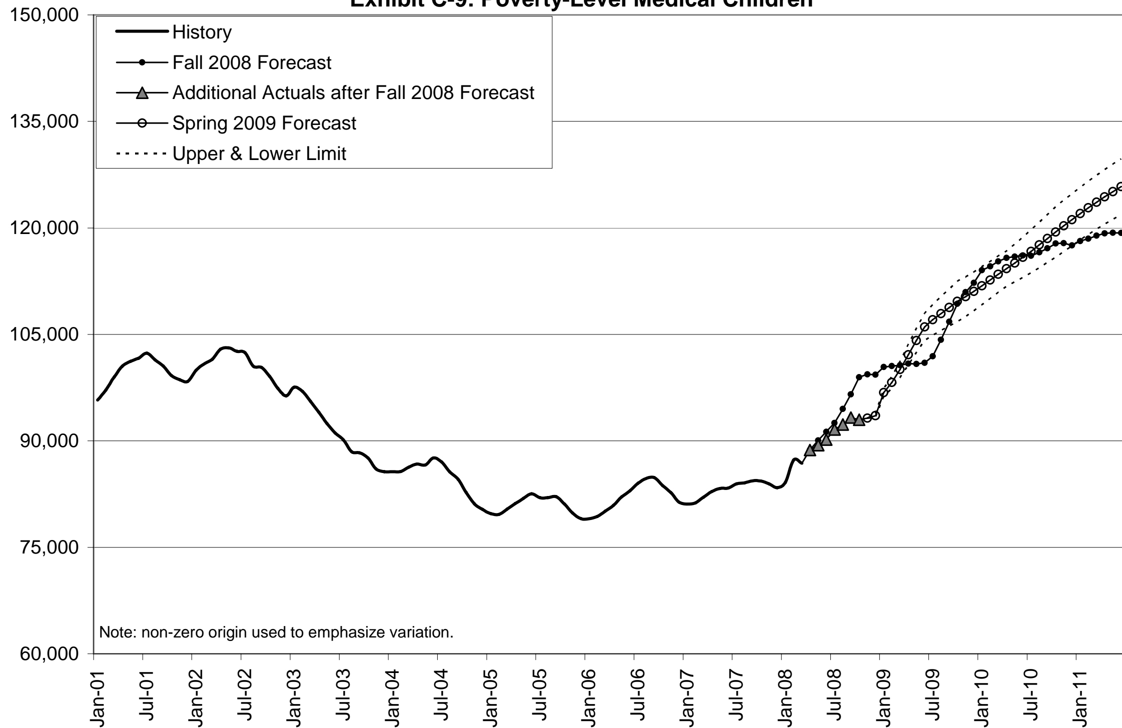


Exhibit C-9: Poverty-Level Medical Children
150,000
135,000
120,000
105,000
90,000
75,000
60,000
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

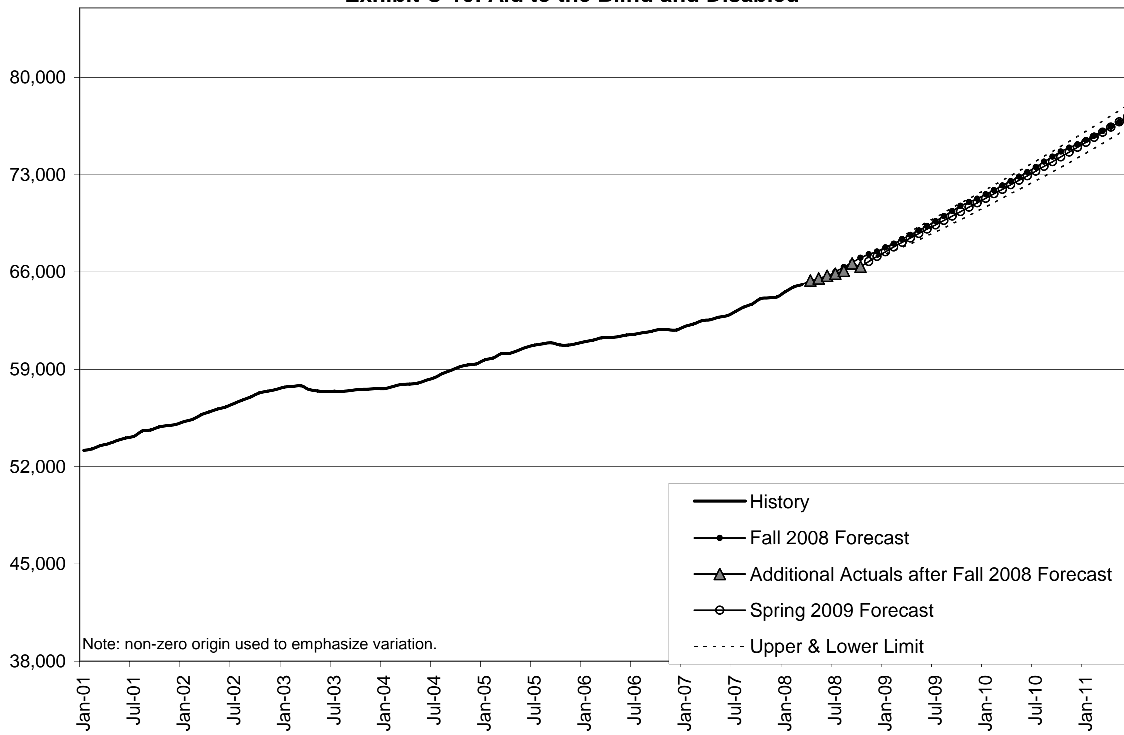


Exhibit C-10: Aid to the Blind and Disabled
80,000
73,000
66,000
59,000
52,000
45,000
38,000
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
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Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

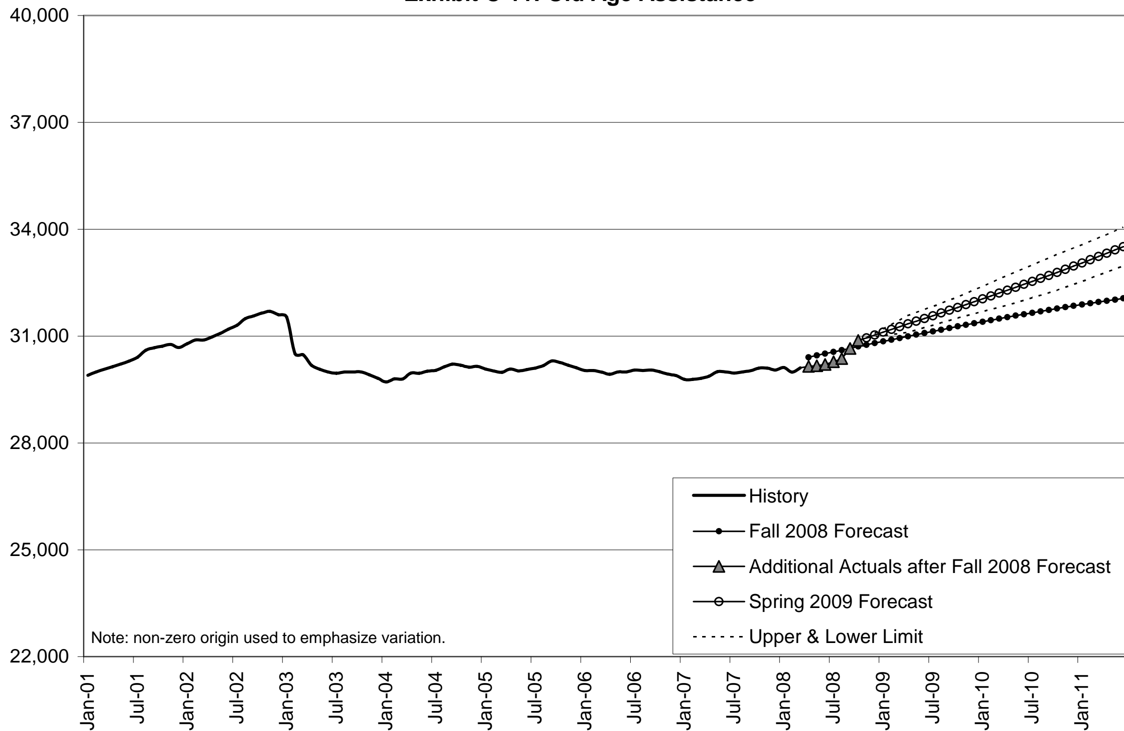
Exhibit C-11: Old Age Assistance
40,000
37,000
34,000
31,000
28,000
25,000
22,000
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
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Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

Exhibit C-12: Substitute Care & Adoption Services

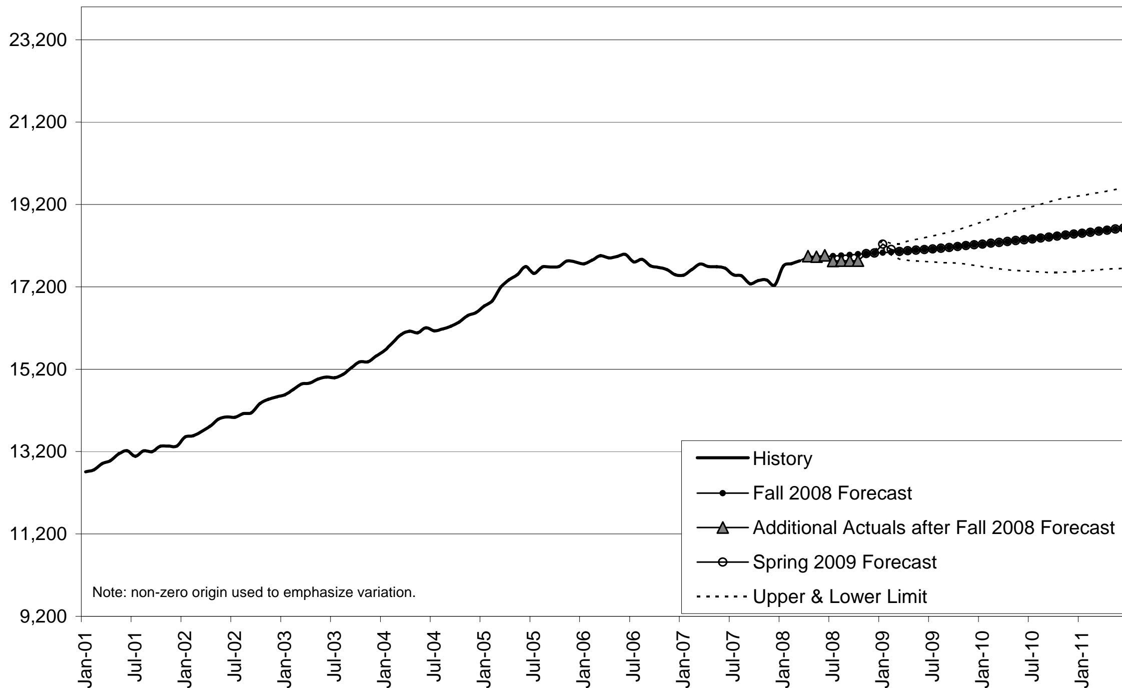
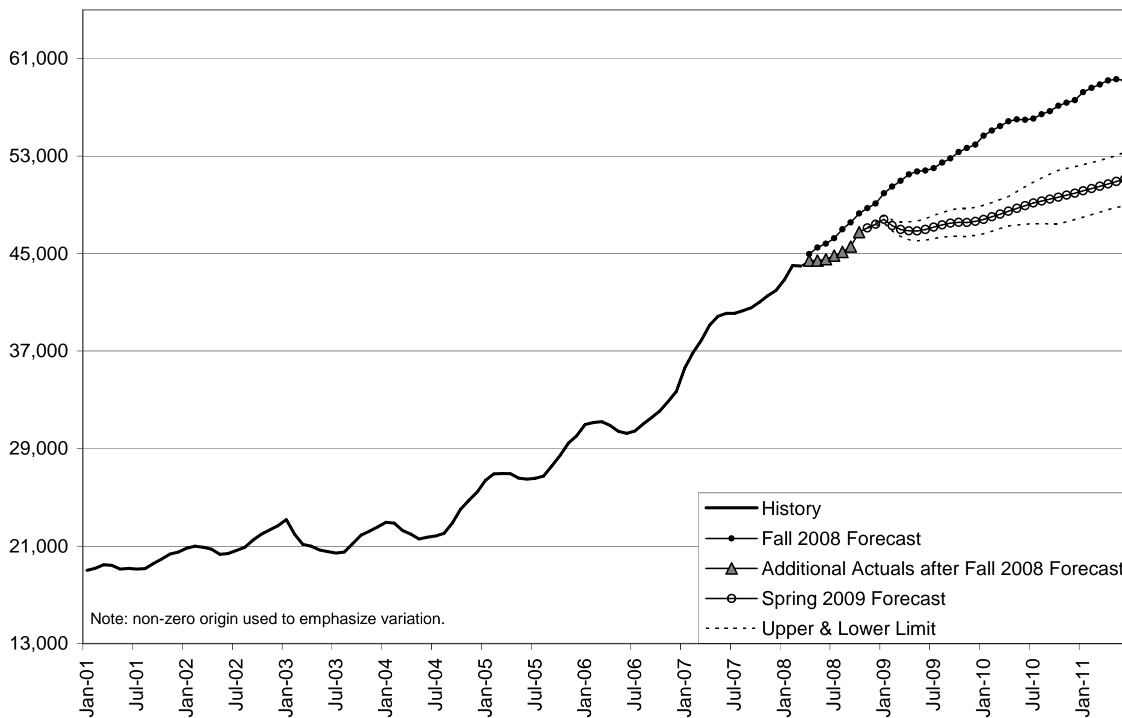


Exhibit C-13: Children's Health Insurance Program



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 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.

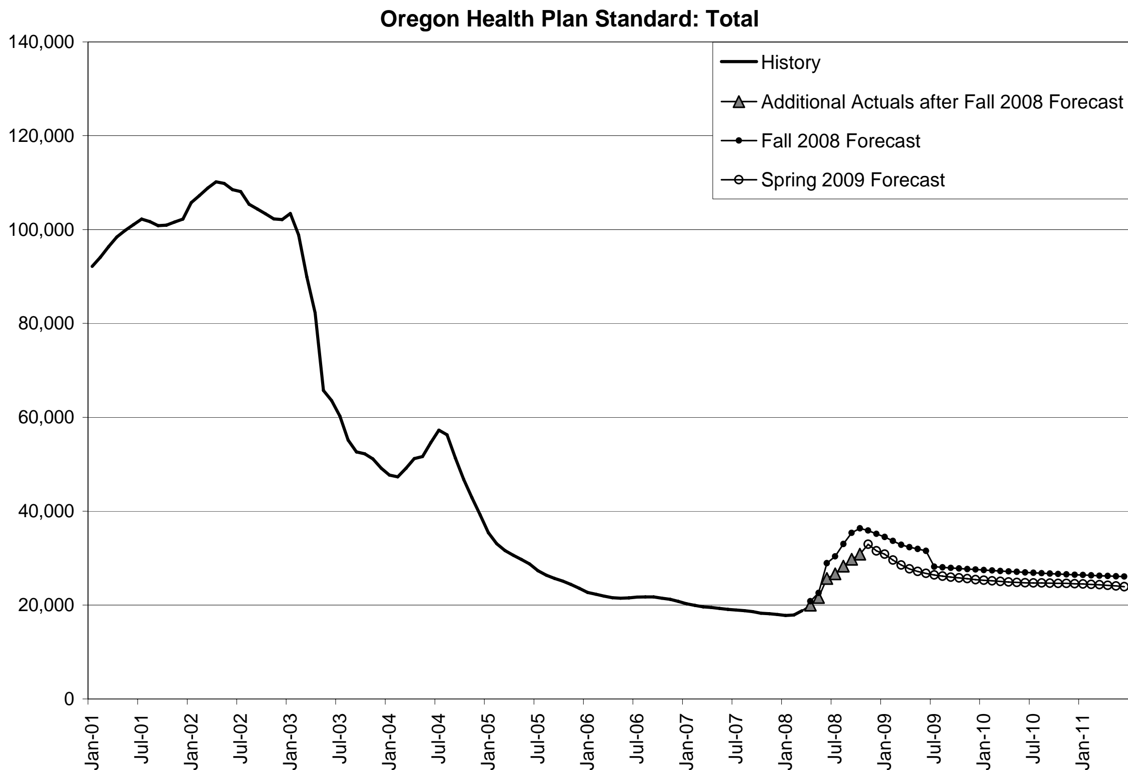
In January 2003, the combined population for these two groups was just over 100,000. In February 2004, after 13 months of rapidly decreasing caseloads associated with benefit reductions, increased co-payments and strict enforcement of premium payment requirements, the combined population was fewer than 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.

All state General Fund 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 2007-09 biennial average of about 24,000 clients.

During February 2008, DHS invited Oregonians to place their name on a 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 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. Random selection and enrollment continued through October 2008 at which point the program was again closed to new clients. It should be noted that randomly selected applicants may have qualified for OHP programs other than Standard. Limited experience thus far indicates that Poverty Level Medical Children and CHIP were the most likely non-Standard programs to see increased caseloads as a result of the random application process.

The current Spring 2009 forecast includes the historical effects of reopening the Standard program (Families, and Adults and Couples) to a pre-determined monthly number of new clients from spring 2008 through October. Families make up approximately 40 percent of the total Standard program. Contributions from this program to other eligibility groups via the normal eligibility transfer process are expected and have been taken into consideration when forecasting the affected groups. 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. The Spring 2009 forecast estimates a gradual decline in this population through the end of the 2009-11 biennium. Given length of stay estimates for program participants the total Standard population is expected to drop from 30,843 in October 2008 to 23,886 by June 2011.



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 5.0 and 8.0 percent of the total DMAP client caseload; the Breast and Cervical Cancer Program - Medical is by far the smallest caseload, representing less than 2.0 percent of the total. 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.

The current Spring 2009 forecast continues the growth of last fall. The Spring 2009 forecast predicts a 2007-09 biennial average of 13,122 clients compared to 13,072 in the previous forecast. Spring estimates for the 2009-11 biennium remain at 14,985, slightly lower than the 15,233 estimate in Fall 2008. The upper and lower limits reflect the average variation produced by the historical forecasts. The upper and lower limits range on average from less than 1.0 percent from the forecast for the 2007-09 biennium extending to 1.0 percent in 2009-11.

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; it peaked in July 2004 with approximately 25,600 clients and fell to 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 Spring 2009 forecast for the CAWEM caseload is slightly lower in the 2007-09 biennium than the Fall 2008 forecast and slightly higher in the 2009-11 biennium. The Fall 2008 forecast estimated a 2007-09 biennial average approximately 212 cases higher when compared to the Spring 2009 estimate. For 2009-11, however, the current Spring 2009 forecast calls for a biennial average increase of 539 clients. Exhibit C-15 displays the history and comparative forecasts for this group. The upper and lower limit estimates average less than 1.0 percent above and below the forecast for 2007-09, extending to 3.0 percent by 2009-11.

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 of 2007 the caseloads show a tendency to decline, primarily as a result of short-term administrative change.

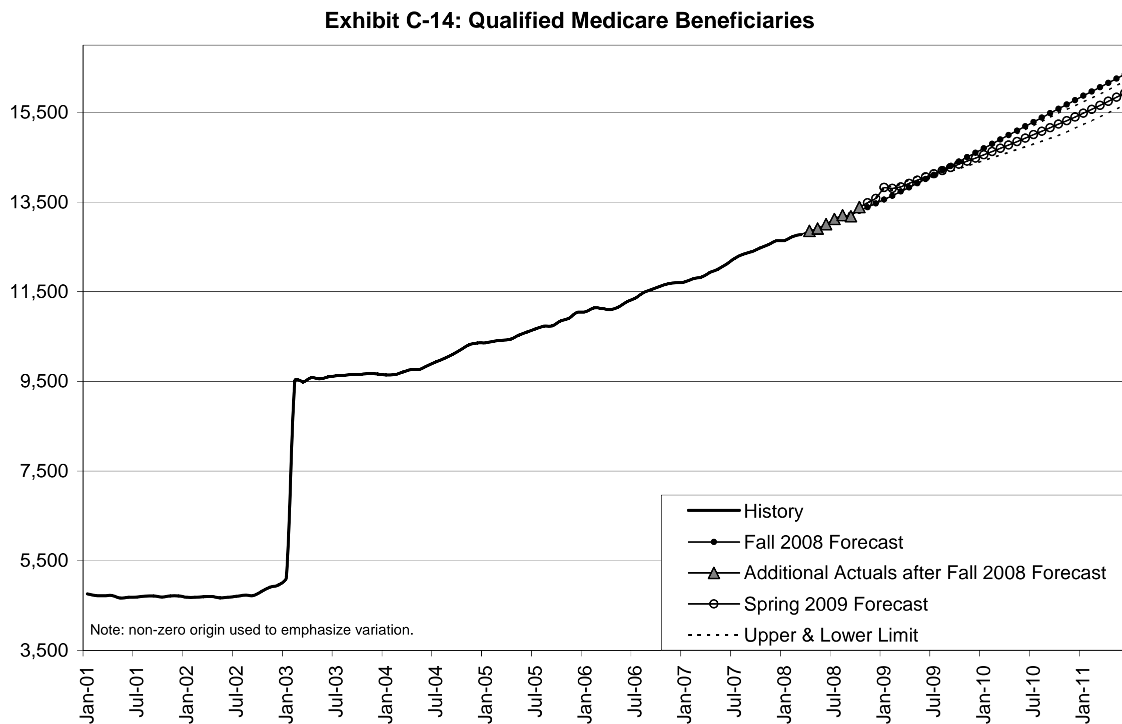
Forecast

The Spring 2009 forecast for the Breast and Cervical Cancer caseload is virtually identical to that of Fall 2008 for both the 2007-09 and 2009-11 biennia. The upper and lower limits show that for 2007-09, the actual counts could be expected to range an average of 3.0 percent above or below the forecast. This variance increases to 6.0 percent during the 2009-11 biennium.

Additional Risks to the Fall 2009 Forecast

Risks to the current Fall 2009 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 employment rates and other economic indicators declining over time. 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 the end of 2009 with slow recovery beginning in the following year[2].



[2] Oregon Economic Forecast. Oregon Department of Administrative Services. Office of Economic Analysis. February 2009.

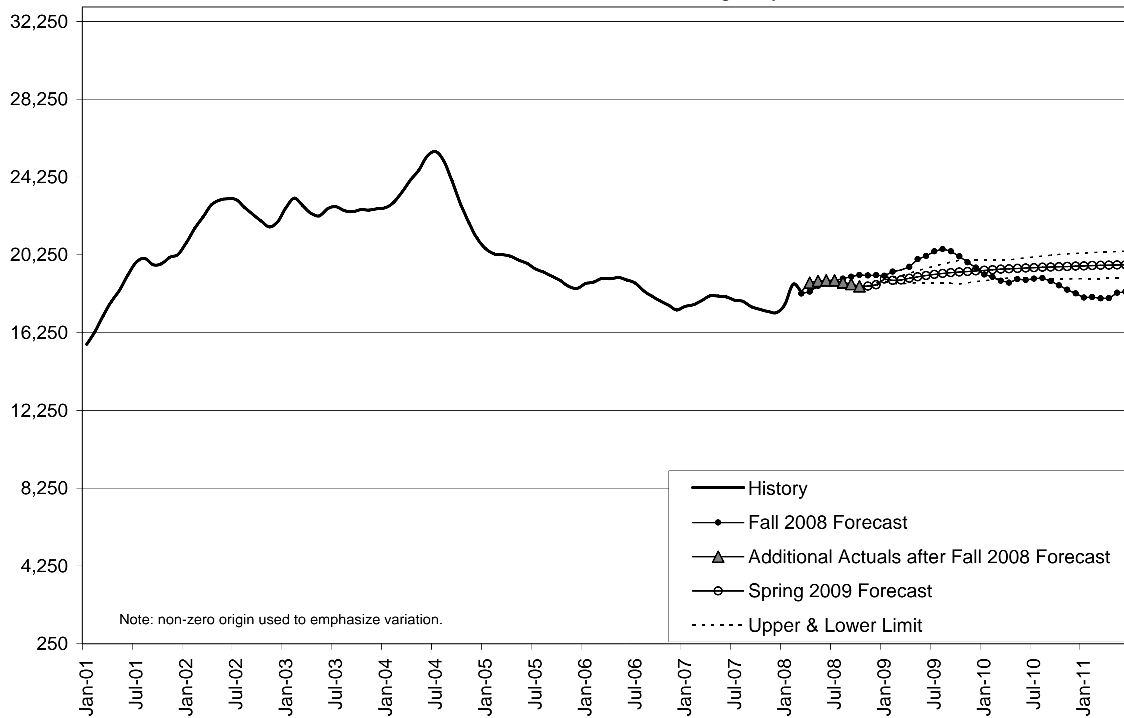


Exhibit C-15: Citizen / Alien Waived Emergency Medical
32,250
28,250
24,250
20,250
16,250
12,250
8,250
4,250
250
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
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Jul-09
Jan-10
Jul-10
Jan-11

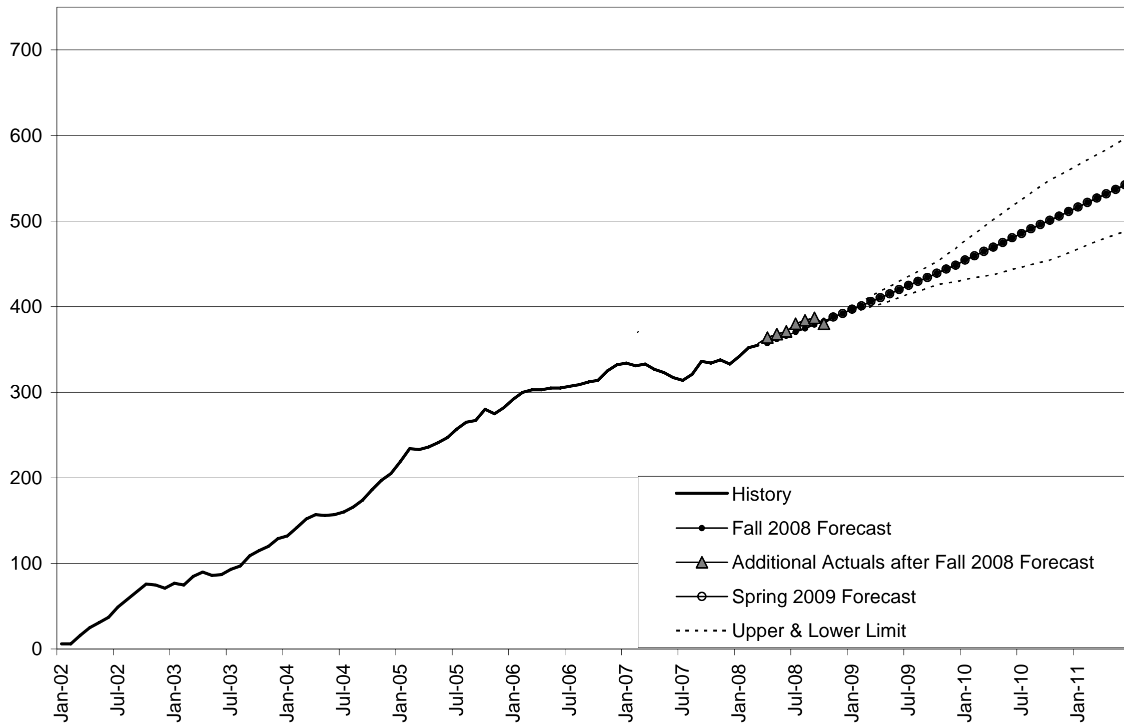
Exhibit B-16: Breast and Cervical Cancer Program-Medical
700
600
500
400
300
200
100
0
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

STAKEHOLDER SURVEY RESULTS FOR DIVISION OF MEDICAL ASSISTANCE PROGRAMS

Community Demand for Stakeholder Services

- The majority of DMAP stakeholders observed demand for stakeholder and DHS services increasing. Nearly every respondent expected demand for stakeholder and DHS services to increase by Fall 2009.

- The majority of DMAP stakeholders reported the increase in demand among low-income and mid-income clients, clients speaking a primary language other than English, single parent families, first-time clients, and seniors.

Reasons for Increased Demand and Need

Several DMAP stakeholders noted reduced client access to medical services because of local provider shortages, rural isolation, and client difficulties obtaining and navigating health care coverage. DMAP stakeholders expressed concern about Oregon Health Plan enrollment and coverage policies limiting access to health care. Stakeholders also noted social discrimination in their communities causing need and preventing access to services. Most observed the cost of living and health care increasing as income and health care benefits become scarce.

Stakeholders frequently mentioned the following client issues when discussing increased demand:

- **Access to Health Care.** Lack of health insurance coverage (employer or private), OHP enrollment limits, shortage of local health care providers, unaffordable out-of-pocket medical costs, neglected preventative care becoming emergency conditions, rural provider and client isolation.

- **Unemployment.** Layoffs, shortage of positions, reduced hours and wages, reduced or eliminated benefits, unemployment "burnout" (people stop looking).

- **Family Stress.** Economic stress, family instability, situational depression, increased child welfare caseload, need for counseling and advocacy services.

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 Spring 2009 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 Spring 2009 and Fall 2008 forecasts.

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

Exhibit D-2: Mental Health Biennial Average Comparisons

Numbers of Clients Served per Month	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
	Fall 08 to Spring 09			Fall 08 to Spring 09			2007-09 to 2009-11		
Addictions and Mental Health Programs **Biennial Averages**	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
Criminal Commitment									
Aid and Assist	139	142	2.2%	154	154	0.0%	142	154	8.5%
Psychiatric Security Review Board	767	754	-1.7%	811	785	-3.2%	754	785	4.1%
Total Criminal Commitment	**906**	**896**	**-1.1%**	**965**	**939**	**-2.7%**	**896**	**939**	**4.8%**
Civil Commitment									
24 Hour Care	1,387	1,422	2.5%	1,643	1,704	3.7%	1,422	1,704	19.8%
Acute Care	173	173	0.0%	177	178	0.6%	173	178	2.9%
State Hospital	320	318	-0.6%	322	313	-2.8%	318	313	-1.6%
Non-residential Community Care	3,094	3,150	1.8%	3,653	3,761	3.0%	3,150	3,761	19.4%
Total Civil Commitment	**4,974**	**5,063**	**1.8%**	**5,795**	**5,956**	**2.8%**	**5,063**	**5,956**	**17.6%**
Total Mandated Care	**5,880**	**5,959**	**1.3%**	**6,760**	**6,895**	**2.0%**	**5,959**	**6,895**	**15.7%**
Unduplicated Count, Total Mandated Care	**4,738**	**4,752**	**0.3%**	**5,433**	**5,477**	**0.8%**	**4,752**	**5,477**	**15.3%**

Mandated Mental Health Caseload

Forecast

As shown in Exhibit D-2, the Spring 2009 biennial average for the 2007-09 biennium is virtually unchanged from that for the Fall 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 15.7 percent over that for the 2007-09 biennium. The upper and lower limits for the Mandated caseload may vary, on average, by 4 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 in 2007 followed by a leveling off and then a slight decline in 2008. We anticipate that the recent leveling off will contribute to a lower growth path through 2011 (Exhibit D-4). As shown in Exhibit D-2, the Spring 2009 biennial average for the 2007-09 biennium is 1.1 percent lower than that for the Fall 2008 forecast. For the Spring 2009 forecast, the average caseload for the 2009-11 biennium is expected to increase 4.8 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 10 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 has developed a plan for accelerated placements of State Hospital forensic and civilly-committed patients into new residential treatment facilities in various communities. These numbers were used to adjust the base Fall 2007 forecast. At that time, we stated that the successful development of these residential facilities would require the cooperation of local governments and thus was a risk to the forecast. These facilities are still being planned so that the adjusted caseload numbers have not been realized to date and have not been incorporated into the current forecast.

Aid and Assist Forecast

Recent levels of the Aid and Assist caseload have witnessed a sharp increase followed by a sharp decrease from March 2008 through September 2008. We anticipate however that this caseload will continue an upward trend through 2011(Exhibit D-5). As shown in Exhibit D-2, the Spring 2009 biennial average for the 2007-09 biennium is 2.2 percent higher than that for the Fall 2008 forecast. For the Spring 2009 forecast, the average caseload for the 2009-11 biennium is expected to increase by 8.5 percent over the 2007-09 biennium. However, relatively large and consistent variation in the historical data creates an average risk of 42 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 slightly decreased through 2008 after a slight increase during 2006-07. We anticipate that this trend will continue for some time in 2009 then continuing an upward trend through 2011(Exhibit D-6). As shown in Exhibit D-2, the Spring 2009 biennial average for the 2007-09 biennium is expected to decrease by 1.7 percent than that for the Fall 2008 forecast; for 2009-11. For the Spring 2009 forecast, the average caseload for the 2009-11 biennium is expected to increase by 4.1 percent over the 2007-09 biennium. We expect the total PSRB caseload to level off over the 2009-11 biennium (Exhibit D-6). Future actuals may vary by an average of 4 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 Spring 2009 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 Spring 2009 biennial average for the 2007-09 biennium is virtually unchanged than that for the Fall 2008 forecast. For the Spring 2009 forecast, the average caseload for the 2009-11 biennium is expected to increase by 17.6 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 Spring 2009 biennial average for the 2007-09 biennium is 2.5 percent higher than that for the Fall 2008 forecast. For the Spring 2009 forecast, the average caseload for the 2009-11 biennium is expected to increase by 19.8 percent over the 2007-09 biennium. Much 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 10 percent above or below the forecast.

Civilly Committed - Acute Care

The Civilly Committed Acute Care caseload includes people that have been Civilly Committed and 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 Spring 2009 forecast though, is expected to remain unchanged from that for the Fall 2008 for the 2007-09 biennium. Also, the Spring 2009 forecast average for 2009-11 is expected to be 2.9 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 17 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 dropped off sharply from May 2008 through September 2008 (Exhibit D-10). As shown in Exhibit D-2, the Spring 2009 for 2007-09 biennial average is nearly identical to that for the Fall 2008 forecast. For the Spring 2009 forecast, we expect a decrease of 1.6 percent from 2007-09 to 2009-11. Also, the planned expansion of alternative treatment

settings in the community (24 Hour Care) has not yet occurred. Staff expects 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 15 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.[3]

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

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

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.

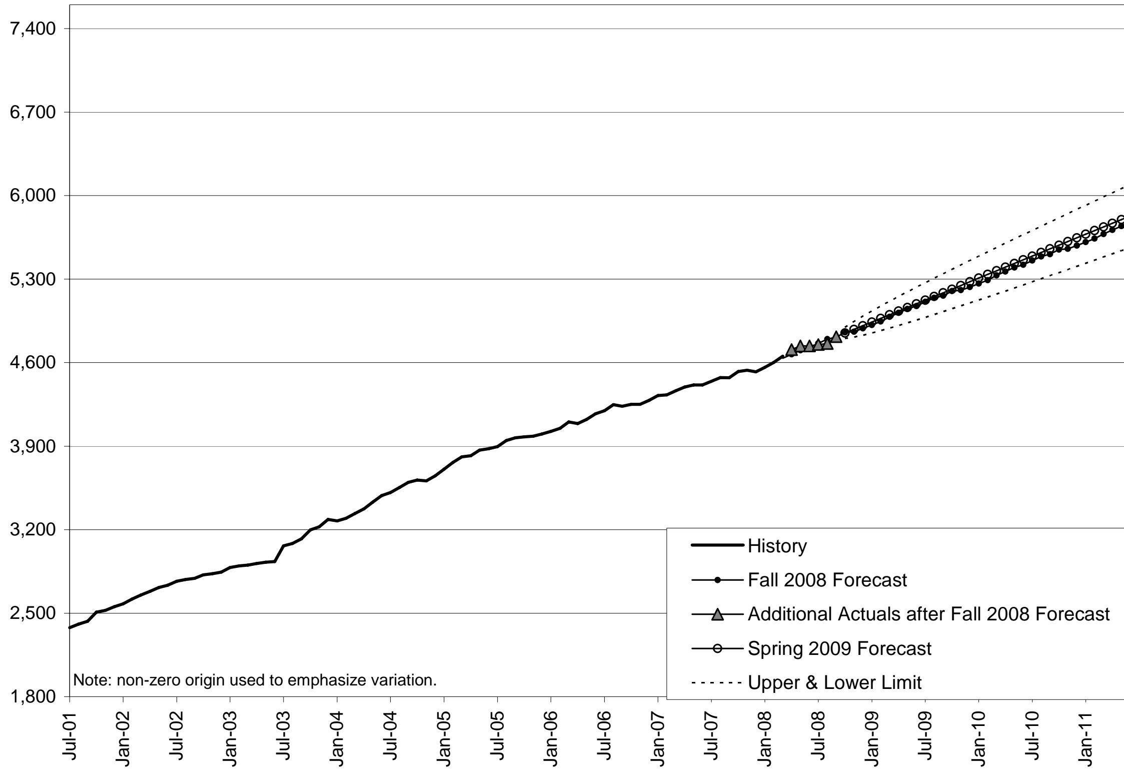
Exhibit D-3: Mandated: Total
7,400
6,700
6,000
5,300
4,600
3,900
3,200
2,500
1,800
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

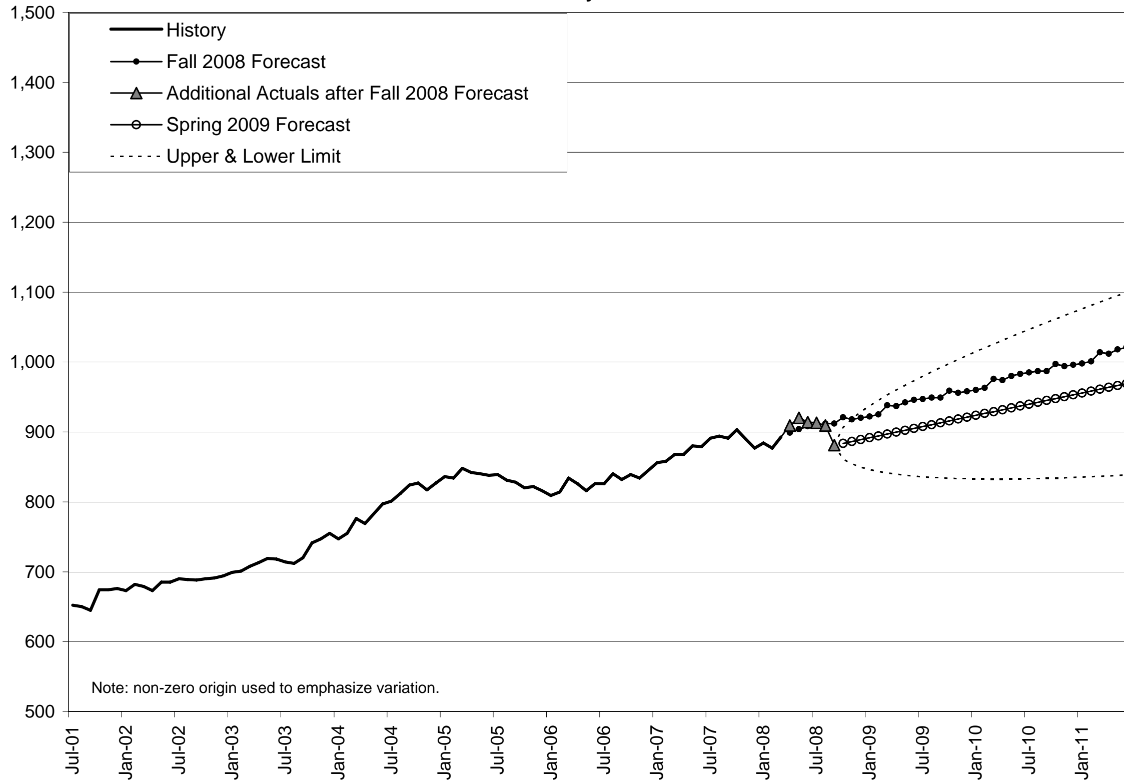
Exhibit D-4: Criminally Committed: Total
1,500
1,400
1,300
1,200
1,100
1,000
900
800
700
600
500
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

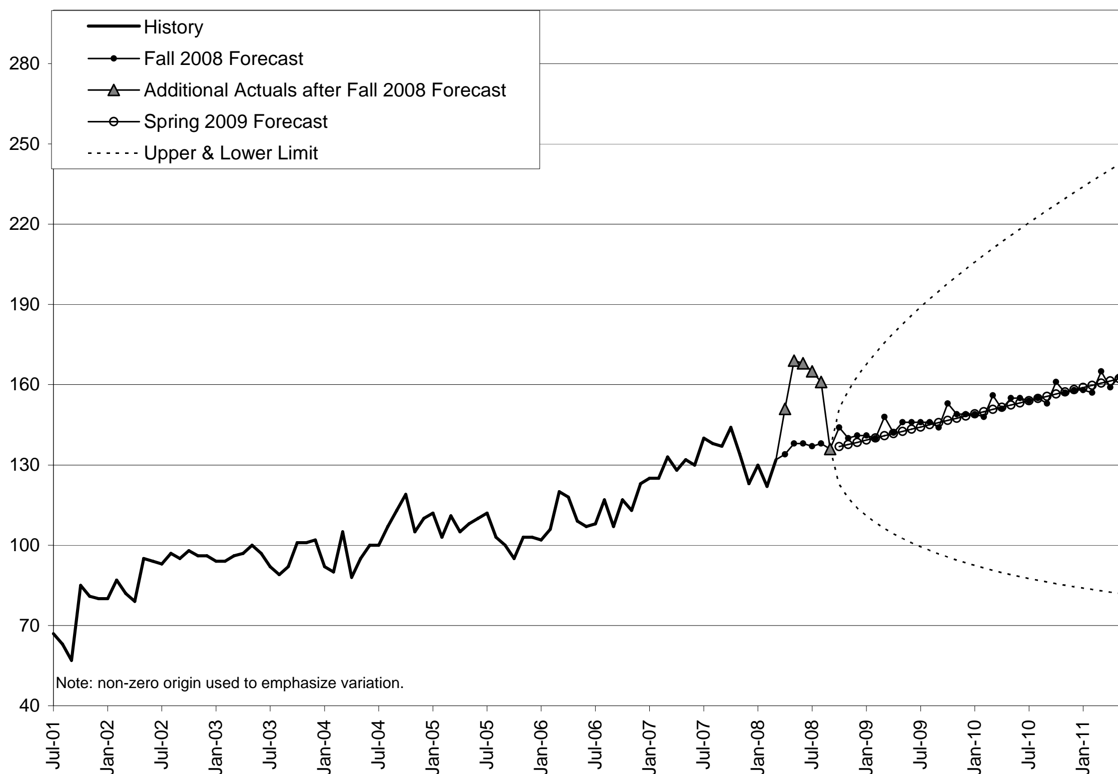
Exhibit D-5: Aid & Assist
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
280
250
220
190
160
130
100
70
40
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

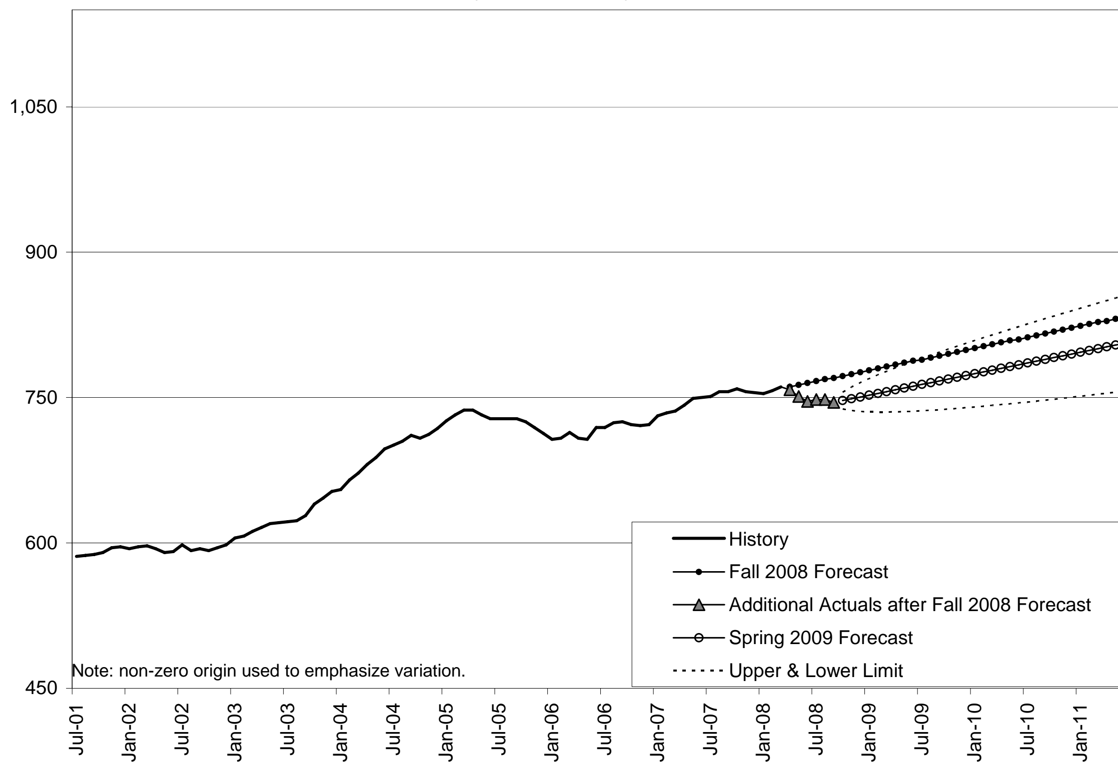
Exhibit D-6: Psychiatric Security Review Board: Total
1,050
900
750
600
450
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

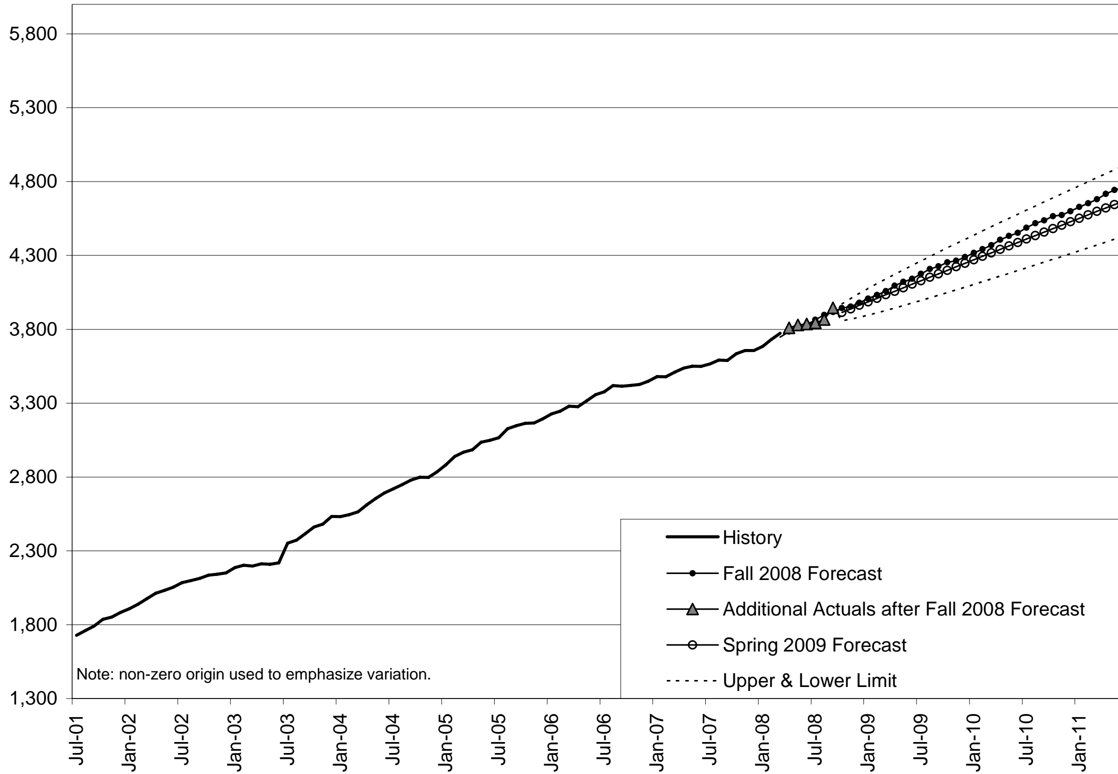
Exhibit D-7: Civilly Committed: Total
5,800
5,300
4,800
4,300
3,800
3,300
2,800
2,300
1,800
1,300
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
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Jan-10
Jul-10
Jan-11

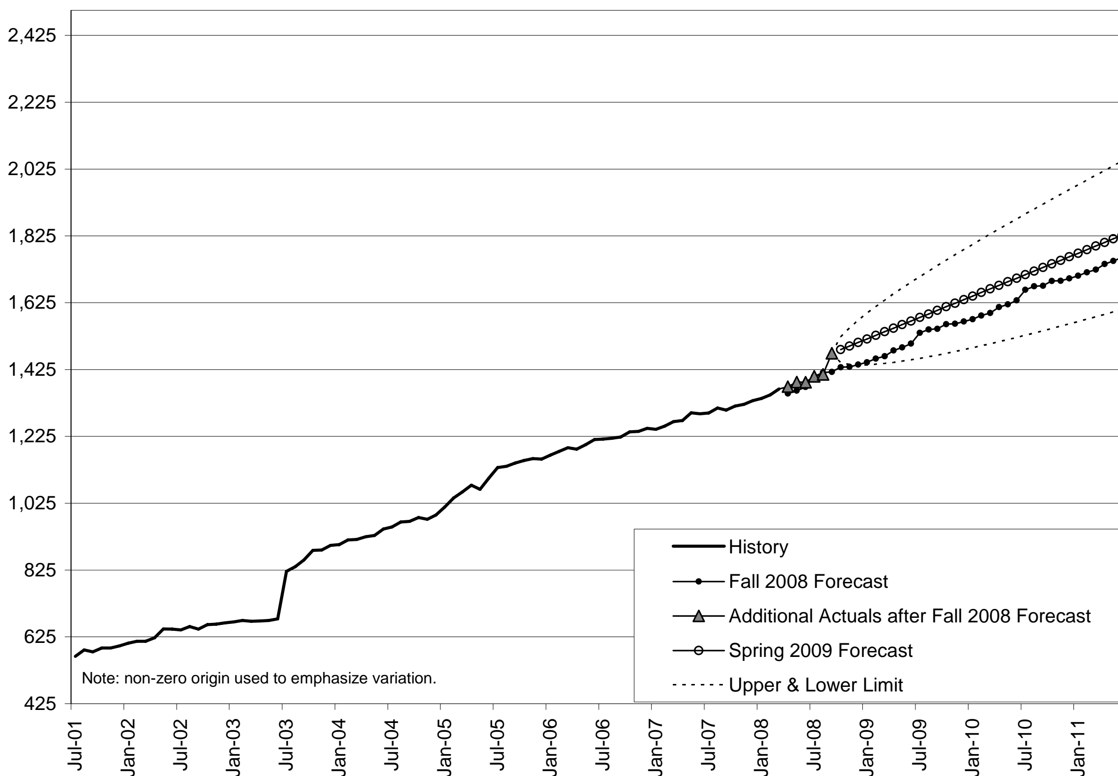
Exhibit D-8: Civilly Committed: 24 Hour Care
2,425
2,225
2,025
1,825
1,625
1,425
1,225
1,025
825
625
425
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
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Jan-10
Jul-10
Jan-11

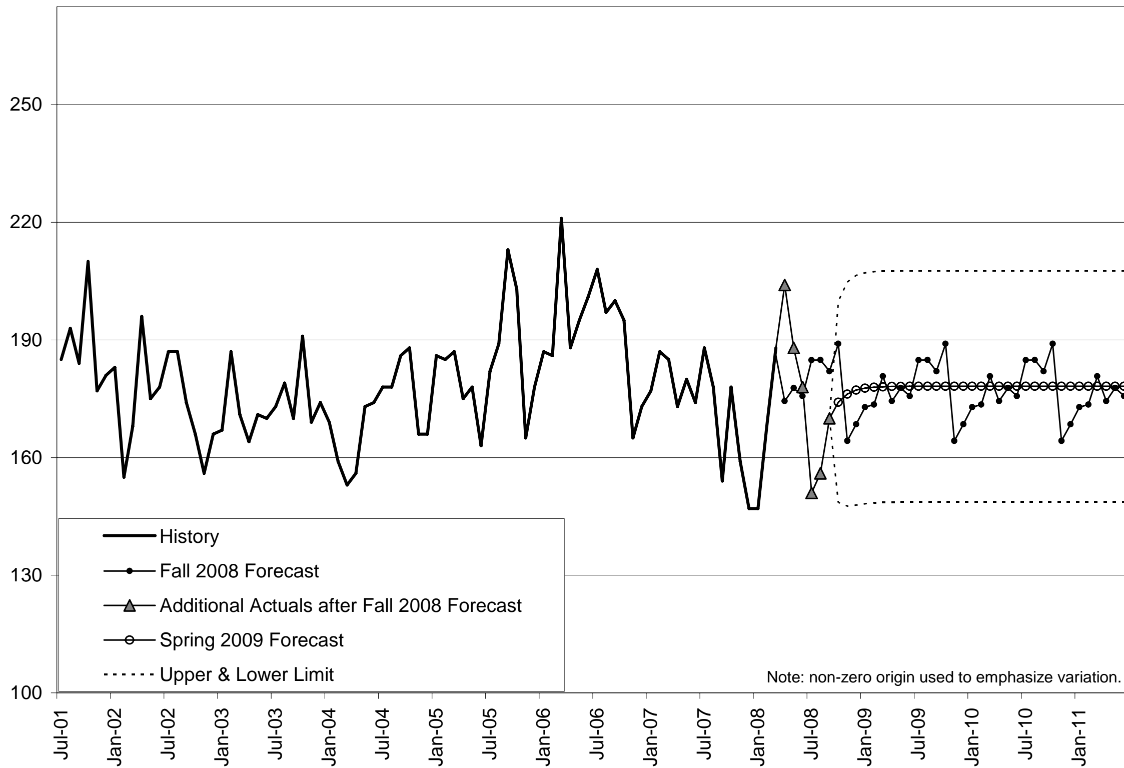
Exhibit D-9: Civilly Committed: Acute Care
250
220
190
160
130
100
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
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Jan-10
Jul-10
Jan-11

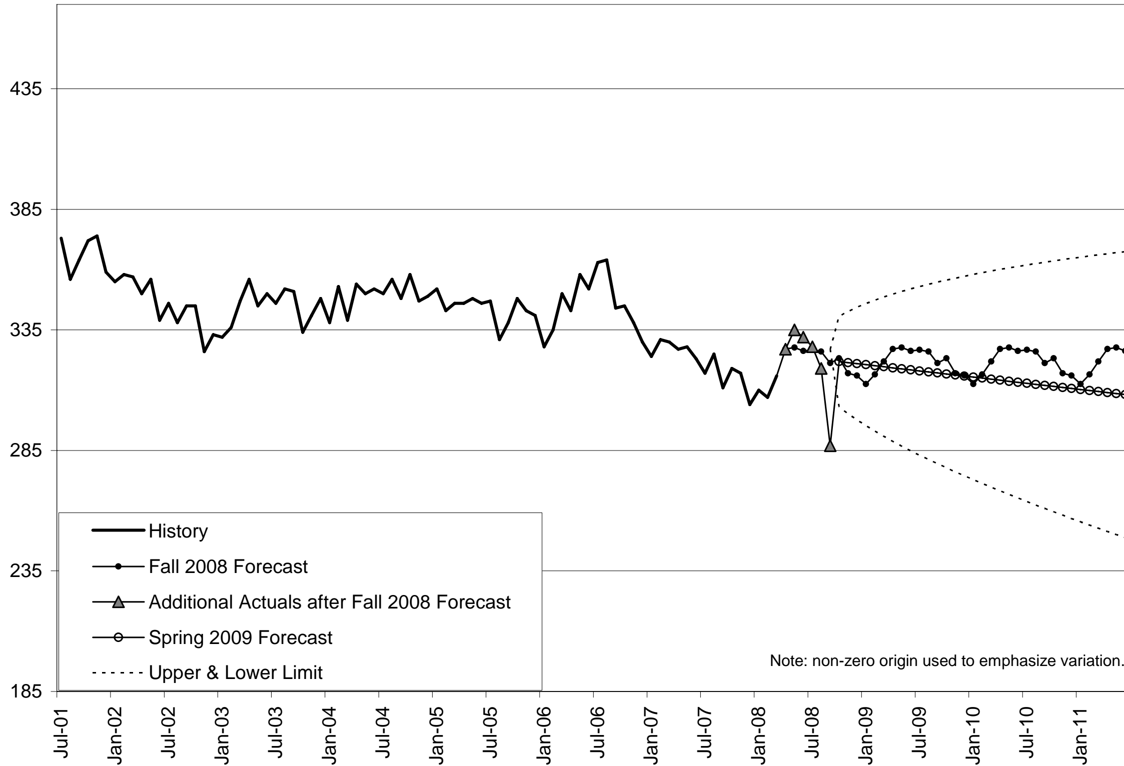


Exhibit D-10: Civilly Committed: State Hospital
435
385
335
285
235
185
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

STAKEHOLDER SURVEY RESULTS FOR ADDICTIONS AND MENTAL HEALTH

Community Demand for Stakeholder Services

- The majority of AMH stakeholders observed demand for stakeholder and DHS services increasing. Most stakeholders expected demand for stakeholder and DHS services to increase by Fall 2009.

- Most AMH stakeholders reported increased demand for their services among low-income and first-time clients. The majority reported low-income, repeat clients, and mid-income/working poor clients increasing their need for DHS services.

Reasons for Increased Demand and Need

Most AMH stakeholders observed demand increasing because of economic stressors and client behaviors related to the economy. Their clients often cannot afford community services, and accessing OHP and providers takes time. AMH stakeholders expressed concern over proposed budget cuts and OHP policy changes affecting local providers' abilities to deliver treatment services, and several stakeholders noted their clients' treatable situations and mental health conditions worsening because of failing human services and social safety nets. Stakeholders also noted social discrimination in their communities causing need and preventing access to services.

Stakeholders frequently mentioned the following client issues when discussing increased demand:

- **Substance Addiction, Mental Illness and Family Stress.** Substance use as a coping mechanism, under-funded local treatment programs, delayed treatment leading to more serious conditions, lack of affordable health care and local support services, situational depression, increased incidence of diagnosed and undiagnosed mental illness. Economic stress causing family instability, increased child welfare caseload, need for family counseling and advocacy services.

- **Unemployment.** Layoffs, shortage of positions, reduced hours and wages, reduced or eliminated benefits, unemployment "burnout" (people stop looking). AMH stakeholders report clients taking longer to return to work due to lack of resources (child care, job training or apprenticeship programs).

- **Cost of Living – Necessities.** Food, housing, heating fuel, prioritizing needs and expenses, asking for assistance (food banks, rent and utility assistance) to make ends meet.

Seniors and People with Disabilities Division:
Aged and Physically Disabilities & Long-Term Care

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) ($674 per month in 2009). The SSI eligibles receive a mandatory supplemental income of $20.40 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 resources. Many choose not to enroll in Medicaid due to the state recovery requirement. OPI served about 3,612 clients in 2008.

Total Spring 2009 Caseload Forecast

The total Long-Term Care caseload forecast for Spring 2009 includes In-Home Care, Community-Based Care and Nursing Facilities (including the Other Nursing Facilities services such as Medicare Extended Care, Enhanced Care and OHP Post-Hospital Benefit).

Nursing Facilities make up about 19.0 percent of the total Long-Term Care caseload, while the In-Home and Community-Based Care Facilities account for 42 and 40 percent respectively (Exhibit E-2). Overall, this caseload distribution pattern has not changed significantly in recent years.

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 27,127 clients in the 2005-07 biennium, and it is forecasted to increase to an average of 26,245 clients in the 2007-09 biennium from the 2005-07 level. The Spring 2009 LTC caseload forecast for 2007-09 is forecasted to be slightly higher than the Fall 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 2003[4].

The total caseload forecast for the 2009-11 biennium, compared to that for 2007-09, however, is higher by 1.8 percent. This is due to a net increase in both In-

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

Home and Community-based Care caseloads and a decrease in the Nursing Facilities caseload (Exhibit E-2).

The total OSIP cash assistance caseload averaged 49,750 for the 2005-07 biennium. This caseload is expected to be slightly higher (53,142) for the 2007-09 biennium, and it is expected to remain higher (56,186) for the 2009-11 biennium. This forecast is kept at the Fall 2008 level since OFRA is in the process of adopting a new methodology to count clients receiving these services.

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

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	Fall 08 to Spring 09			Fall 08 to Spring 09			2007-09 to 2009-11		
Aged and Physically Disabled **Biennial Averages by Forecast**	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
In-Home Hourly	9,296	9,321	0.3%	9,194	9,459	2.9%	9,321	9,459	1.5%
In-Home Live-In	1,062	1,065	0.3%	1,019	1,048	2.8%	1,065	1,048	-1.6%
In-Home Spousal Pay	130	130	0.0%	132	136	3.0%	130	136	4.6%
Subtotal In-Home	**10,488**	**10,516**	**0.3%**	**10,345**	**10,643**	**2.9%**	**10,516**	**10,643**	**1.2%**
Relative Adult Foster Care	1,475	1,501	1.8%	1,399	1,547	10.6%	1,501	1,547	3.1%
Commercial Adult Foster Care	2,482	2,514	1.3%	2,510	2,645	5.4%	2,514	2,645	5.2%
Regular Residential Care	962	921	-4.3%	968	908	-6.2%	921	908	-1.4%
Contract Residential Care	1,106	1,143	3.3%	1,099	1,276	16.1%	1,143	1,276	11.6%
Assisted Living	3,672	3,739	1.8%	3,657	3,886	6.3%	3,739	3,886	3.9%
Specialized Living	164	165	0.6%	165	165	0.0%	165	165	0.0%
ElderPlace (PACE)	674	696	3.3%	750	791	5.5%	696	791	13.6%
Subtotal Community-Based Care	**10,535**	**10,679**	**1.4%**	**10,548**	**11,218**	**6.4%**	**10,679**	**11,218**	**5.0%**
Basic Nursing Facility Care	4,594	4,467	-2.8%	4,668	4,285	-8.2%	4,467	4,285	-4.1%
Complex Medical Add-On	378	387	2.4%	361	368	1.9%	387	368	-4.9%
Pediatric Care	55	53	-3.6%	56	56	0.0%	53	56	5.7%
Extended Care NFC	83	83	0.0%	80	80	0.0%	83	80	-3.6%
Enhanced Care	59	56	-5.1%	60	60	0.0%	56	60	7.1%
Post-Hospital Benefit	5	4	-20.0%	6	6	0.0%	4	6	50.0%
Subtotal Nursing Facilities	**5,174**	**5,050**	**-2.4%**	**5,231**	**4,855**	**-7.2%**	**5,050**	**4,855**	**-3.9%**
Total Long-Term Care	**26,197**	**26,245**	**0.2%**	**26,124**	**26,716**	**2.3%**	**26,245**	**26,716**	**1.8%**
Aid to the Blind	611	611	0.0%	638	638	0.0%	611	638	4.4%
Aid to the Disabled	40,673	40,911	0.6%	42,300	42,630	0.8%	40,911	42,630	4.2%
Old Age Assistance	11,623	11,620	0.0%	12,938	12,918	-0.2%	11,620	12,918	11.2%
Total Oregon Supplemental Income Prgm (OSIP)	**52,907**	**53,142**	**0.4%**	**55,876**	**56,186**	**0.6%**	**53,142**	**56,186**	**5.7%**

Notes:

* *Spring 2009 Forecast: Actual through October 2008 (Actual through September 08 for NFC Basic & Complex Add-On).*
* *Fall 2008 Forecast: Actual through March 2008.*
* *NFC Extended Care caseload counts are based on paid claims instead of previously reported payment data (Spring 2009).*
* *Total In-Home caseload does not include In-Home Agency, Independent Choices & Oregon Project Independence caseloads.*

The following points summarize the comparison of the Spring 2009 and Fall 2008 forecasts:

- The In-Home caseload averaged 11,275 in 2005-07. The In-Home caseload forecast is slightly higher for the Spring 2009 forecast compared with the Fall 2008 forecast for 2007-09, and is projected to be 2.9 percent higher in 2009-11.

- Community-Based Care caseload averaged 10,771 for the 2005-07 biennium. The Spring 2009 forecast for Community-Based Care is higher than the Fall 2008 forecast for both 2007-09 (+1.4 percent), and 2009-11 (+6.4 percent).

- The Nursing Facilities caseload averaged 5,088 in the 2005-07 biennium. This forecast is 2.4 percent lower in the Spring 2009 forecast compared with the Fall 2008 forecast for the 2007-09; this caseload is projected to be lower by 7.2 percent in 2009-11 with a net decrease of 3.9 percent between 2007-09 and 2009-11.

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.

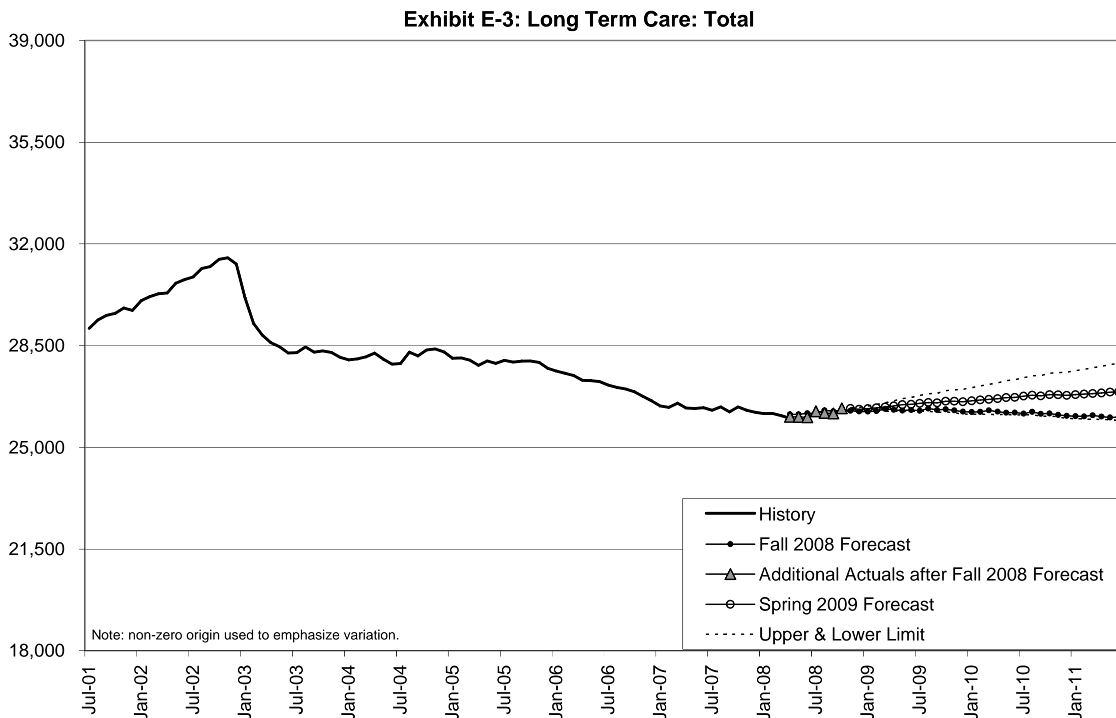
If these assumptions do not hold over the upcoming years, then the forecasts will be over or under estimated.

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.

New CBC Initiatives: In addition, SPD has implemented other administrative actions that will ensure that more Medicaid clients will be served in CBC as a part of reviewing licensing agreements and/or lifting moratoriums 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. However, these efforts may be discouraged by the slowdown in the housing market and decline in the value of homes which, in turn, inhibit investments and spend-down population.

SPD has also examined the current CBC rate structure. The new proposal accounts for client acuity, prevailing market rates and Medicaid participation. As part of the comprehensive rate-restructure plan, the current CBC base rate has been adjusted upward by $260 per client per month effective July 1, 2008. The new rate may help stabilize the declining Medicaid caseload in the near-term by increasing Medicaid access in the CBC market.

The LTC caseload forecast may vary by as much as 4.0 percent in either direction for the 2009-11 biennium (Exhibit E-3).



In-Home

The In-Home program provides services that help people stay in their homes when they need assistance with Activities of Daily Living[5] (ADLs). Home care workers are hired directly by clients to provide In-Home services. Historically, the average In-Home caseload makes up approximately two-fifths of the total Long-Term Care caseload.

The total In-Home care population includes 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 88.0 percent of the total In-Home services caseload.

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

The Live-In Provider caseload includes clients who hire a live-in home care worker to provide 24-hour care. In-Home live-in care comprises about 11.0 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 1.0 percent of the total In-Home services caseload.

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

Not included in the forecast is Independent Choices (IC), a 5-year demonstration waiver approved by the Centers for Medicare and Medicaid Services. Independent Choices provide clients more freedom, flexibility and self-direction with regard to how they receive their In-Home services. It has been in operation

[5] Activities of Daily Living include: mobility, eating, bathing, dressing, grooming, and toileting.

since November 2001 in Clackamas, Coos and Jackson/Josephine counties. SPD has expanded this program statewide in October 2008. Currently the Independent Choices program serves about 300 people. 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 16.0 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 forecast for the current biennium is slightly higher than the Fall 2008 forecast. The Spring 2009 forecast for 2009-11, compared to that for 2007-09, is 1.2 percent higher (10,516 versus 10,643).

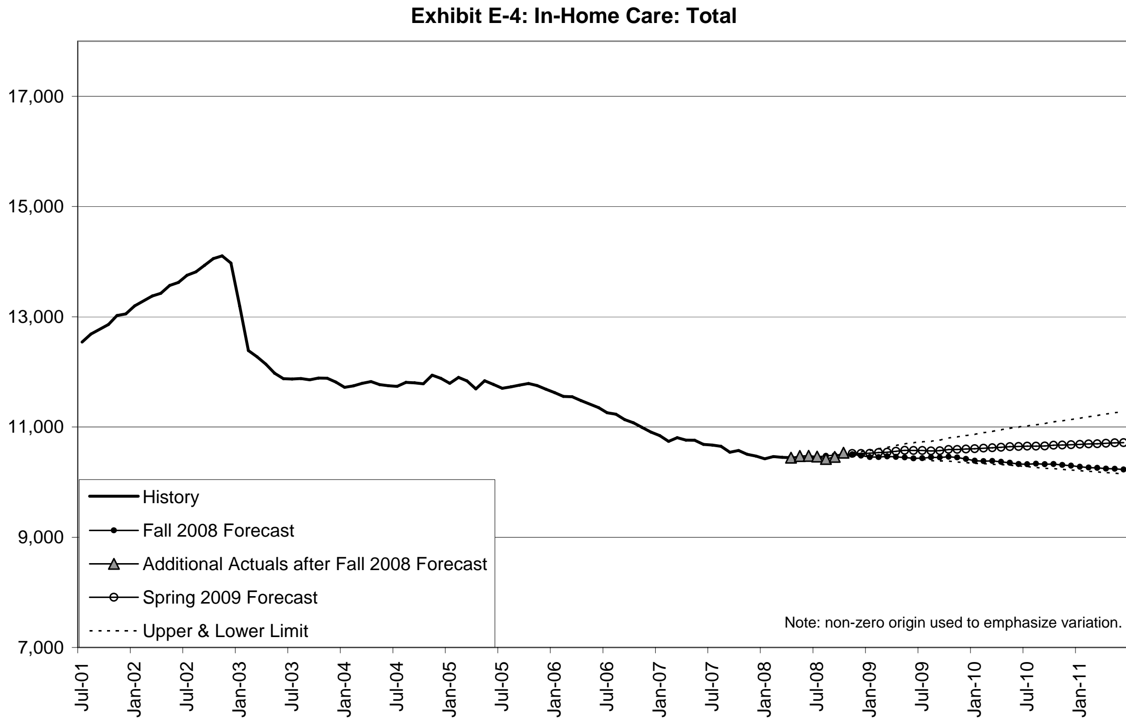
Risks to the In-Home Forecast

Reversing the previous trend, the forecasted In-Home caseload is gradually growing over the forecast period due to a combination of the following actions:

- SPD is continuing the LTC client eligibility and field reviews.
- Statewide implementation of Independent Choices may draw some of the current In-Home clients into the IC program, as well as increase new enrollees, 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.

In addition, if the Oregon Project Independence (OPI) program were to close, many of its recipients may qualify for the Medicaid services and enroll in the In-Home program, increasing the potential new client inflow to this program.

The forecast has inherent risks than farther out the projections. Based on normal historical fluctuation in this caseload, the forecast could vary by 6.0 percent above or below the average forecast for the 2009-11 biennium (Exhibit E-4).



Community-Based Care Facilities

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

This caseload represents about two-fifths of the total Long-Term Care caseload and is composed of Adult Foster Care (38.0 percent), Assisted Living Facilities (35.0 percent) and Residential Care Facilities (19.0 percent). Specialized Living Facilities and PACE account for about 2.0 percent and 7.0 percent, respectively.

The total Community-Based Care population includes seven 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 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 2008, approximately 240 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. Enhanced Care Services is a joint program between the SPD and Addiction and Mental Health Services, and it serves the most challenging placement populations. 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 180 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 6.0 percent, or

700 clients. This caseload decline is primarily due to the elimination of the Long-Term Care service priority levels 12 through 17.

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 Spring 2009 total Community-Based Care forecast for 2007-09 biennium is 1.4 percent higher than the Fall 2008 forecast. The forecast for the next biennium (2009-11) is higher by 6.4 percent

The current CBC caseload forecast for the 2007-09 biennium is higher than that of the Fall 2008 forecast. The CBC caseload forecast for 2009-11, compared to the 2007-09 forecast, is higher by 5.1 percent (10,679 versus 11,218) (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 38.0 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 increase through 2009-11 (Exhibit E-6).

CBC: Adult Foster Care - Relative

The Adult Foster Care-Relative caseload constitutes 14.0 percent of the total Community-Based Care caseload and 38.0 percent of the total AFC caseload in the Spring 2009 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. The elimination of the dual waiver option meant that the developmentally disabled clients were dropped from this caseload and moved to the Developmentally Disabled caseload. In addition, disallowance of Medicaid reimbursement for informal supports and the lack of market promotion led to rapid decline in the AFC-Relative caseload. However, this caseload has stabilized and actually grown in the recent months leading up to the current forecast.

Forecast

The AFC Relative caseload forecast (1,501) for the Spring 2009 is 1.8 percent higher than the Fall 2008 forecast for 2007-09 biennium, and it is forecast to average 1,547 for 2009-11. This is a 10.6 percent increase over the Fall 2008 forecast for 2009-11. This caseload has exhibited considerable stabilization over the previous biennium and is expected to grow. This growth is associated with the implementation of diversion and transition initiatives as well as clarification and enforcement of policy regarding the In-home and Relative AFC services.

CBC: Adult Foster Care - Commercial

The Adult Foster Care-Commercial is 24.0 percent of the total Community-Based Care caseload, and it accounts for 63.0 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 the slower rate of growth in the most recent months leading up to the Spring 2009 forecast.

Forecast

The Spring 2009 Adult Foster Care-Commercial forecast averages 2,514 in the 2007-09 period and is 1.3 percent higher than the Fall 2008 forecast. This caseload is projected to average around 2,645 in the 2009-11 biennium –an increase of 5.4 percent over the Fall 2008 forecast (Exhibit E-8).

CBC: Total Residential Care Facilities

Residential Care Facilities (RCF) are licensed 24-hour care settings serving six or more residents. Facilities range in size from six beds to over 100. Different types of residential care include 24-hour residential care for adults as well as specialty Alzheimer care facilities. Overall, the total residential care caseload accounts for 23.0 percent of all CBC caseloads in 2005-07.

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 ago and are not as competitive now (Exhibit D-9).

CBC: Residential Care Facilities - Regular

The Residential Care Facilities-Regular accounts for 9.0 percent of the total CBC caseload. It accounts for 47.0 percent of the total RCF caseload (total average

equals 2,116 in 2005-07, is 2,064 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 2007-08, 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 921 for 2007-09 that is a 4.3 percent lower than the Fall 2008 forecast. Similarly, the RCF-Regular caseload is lowered by 6.2 percent (N=908) for the next biennium.

CBC: Residential Care - Contract

The Residential Care-Contract caseload is about 10.0 percent of the total CBC caseload and 53.0 percent of the total RCF caseload (total average equals 2,116). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to grow in the 2007-09 and 2009-11 biennia.

Forecast

The RCF-Contract caseload for the Spring 2009 forecast is slightly higher than in the Fall 2008 forecast for the 2007-09 and 2009-11 biennia (Exhibit E-11). The RCF-Contract caseload is anticipated to average 1,143 in the 2007-09 biennium, which is about 3.3 percent higher than the Fall 2008 forecast. This caseload, however, is expected to grow higher over the 2009-11 biennium with a biennial average of 1,276.

CBC: Assisted Living Facilities

The Assisted Living Facilities (ALF) are licensed 24-hour care settings for six or more residents that include private apartments. Services are comparable to residential care facilities but have special focus on resident independence and choice. Also, registered nurse consultation services are required. ALF constitutes 35.0 percent of the total CBC caseload.

The ALF caseload has been in decline in 2007 mainly due to gradual withdrawal from Medicaid contracts by some providers in favor of private clients. However,

the most recent month's actual counts show gradual growth in this caseload. Thus, the Spring 2009 forecast reflects the upward adjustment of this caseload over the Fall 2008 forecast.

Forecast

The Spring 2009 ALF caseload forecasts of 3,739 for 2007-09 is about 1.8 percent higher and 3,886 for 2009-11 is about 6.3 percent higher than the Fall 2008 forecasts (Exhibit E-12).

CBC: Specialized Living Facilities

Specialized Living Facilities (SLF) provide care in a home-like environment for clients with specialized needs.

Forecast

The SLF caseload forecast is anticipated to maintain an average of 165 in 2007-09 and 2009-11 (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 6.0 percent of the total CBC caseload.

In 2005-07 biennium, PACE caseload averaged 635, which is an increase of 21.0 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 has increased (Exhibit E-14).

In the Spring 2009 forecast, the 2007-09 PACE caseload is estimated to be 696 clients per month. The Spring 2009 forecast is adjusted upward by 3.3 percent for the 2007-09, and is 5.5 percent higher than the Fall 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 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 a corresponding decline in the value of homes. As a result of this many newly 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. Some of these potential clients may defer services until their conditions warrant care in nursing facilities causing corresponding growth in Nursing Facilities caseload.

PACE has begun to implement its plan for expansion in Multnomah County. The expansion of the PACE program should increase its caseload and maintain a biennial average of more than 700 clients through the next biennium.

The Community Based Care caseload, historically, has shown some volatility in response to changes in program implementation and CBC market. Given the historical pattern, the total CBC caseload forecast could deviate from the average forecast for the 2007-11 biennia by 6.0 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.

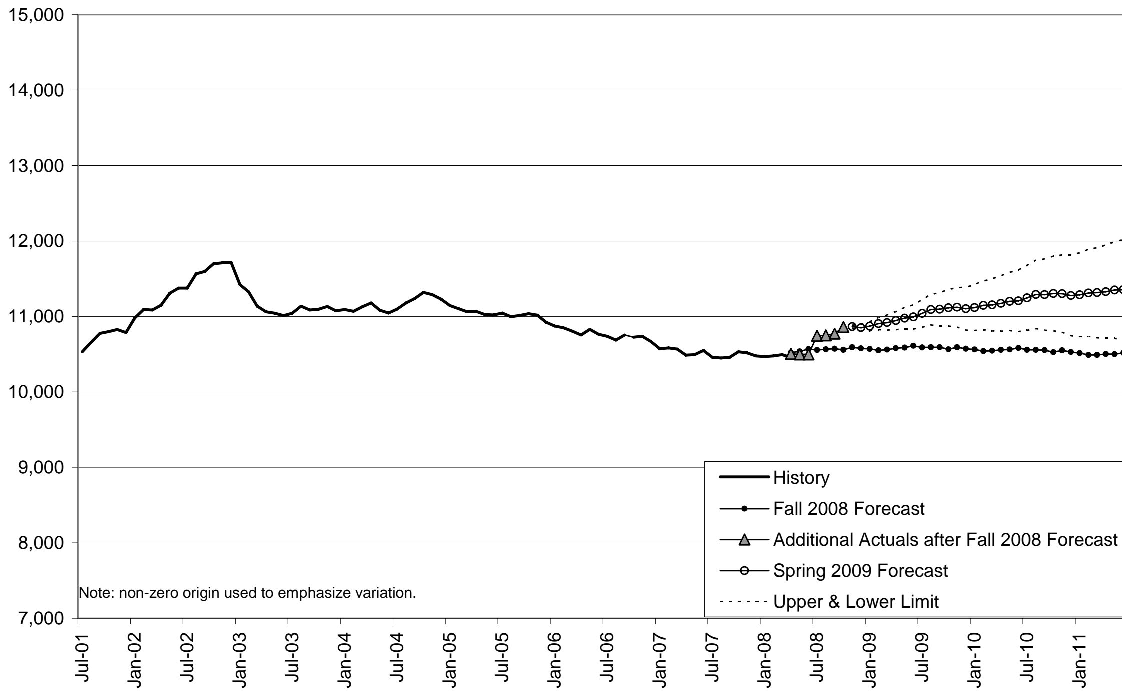


Exhibit E-5: Community-Based Care Facilities: Total
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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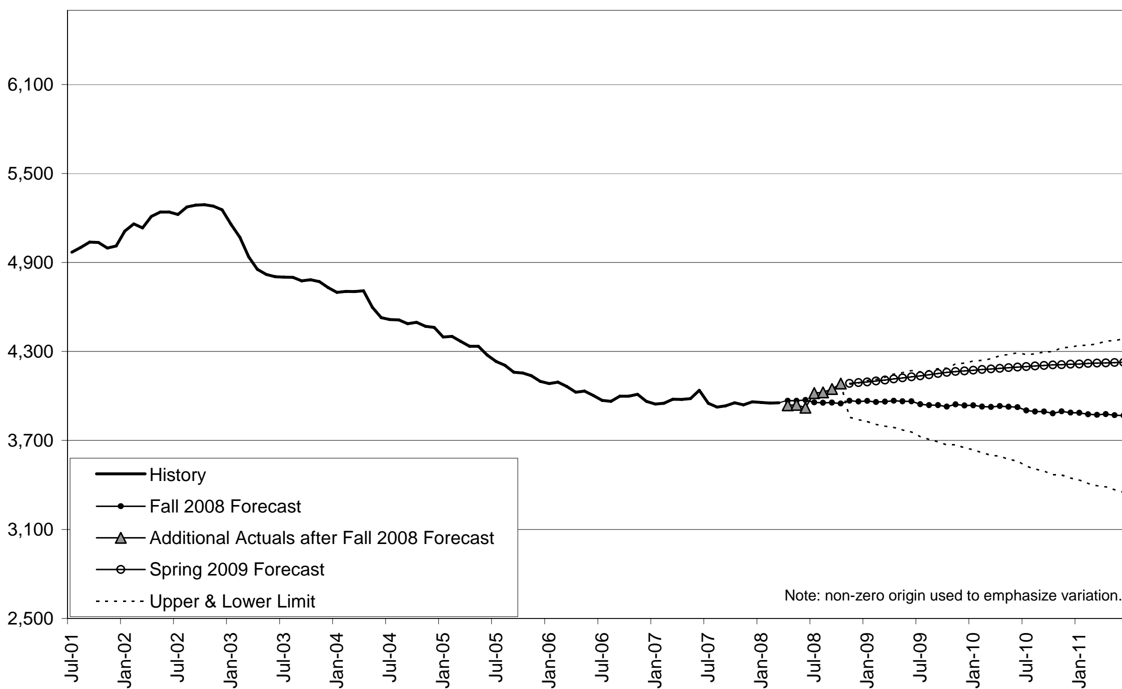
Exhibit E-6: Adult Foster Care: Total
6,100
5,500
4,900
4,300
3,700
3,100
2,500
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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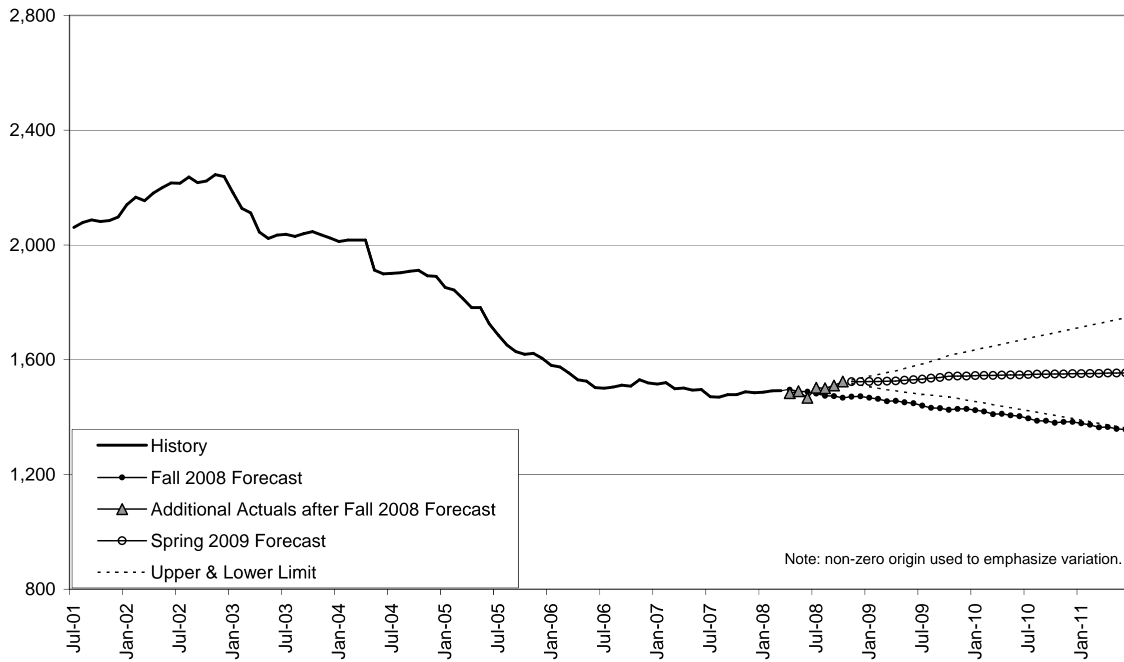
Exhibit E-7: Relative Adult Foster Care
2,800
2,400
2,000
1,600
1,200
800
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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Jan-03
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Jan-11

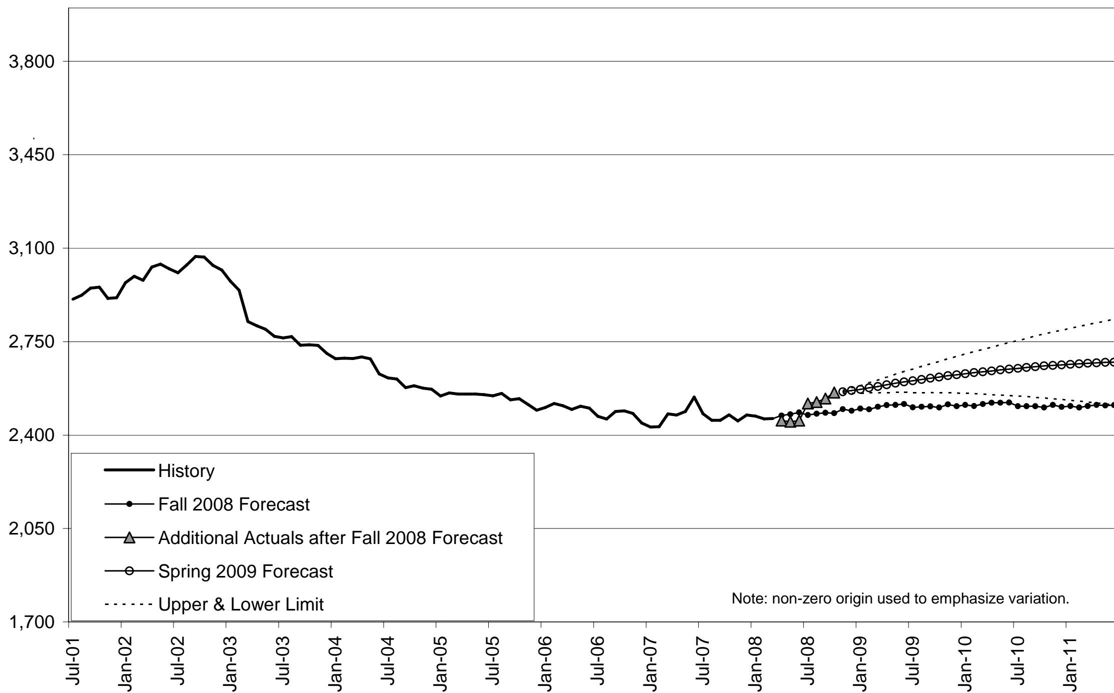
Exhibit E-8: Commercial Adult Foster Care
3,800
3,450
3,100
2,750
2,400
2,050
1,700
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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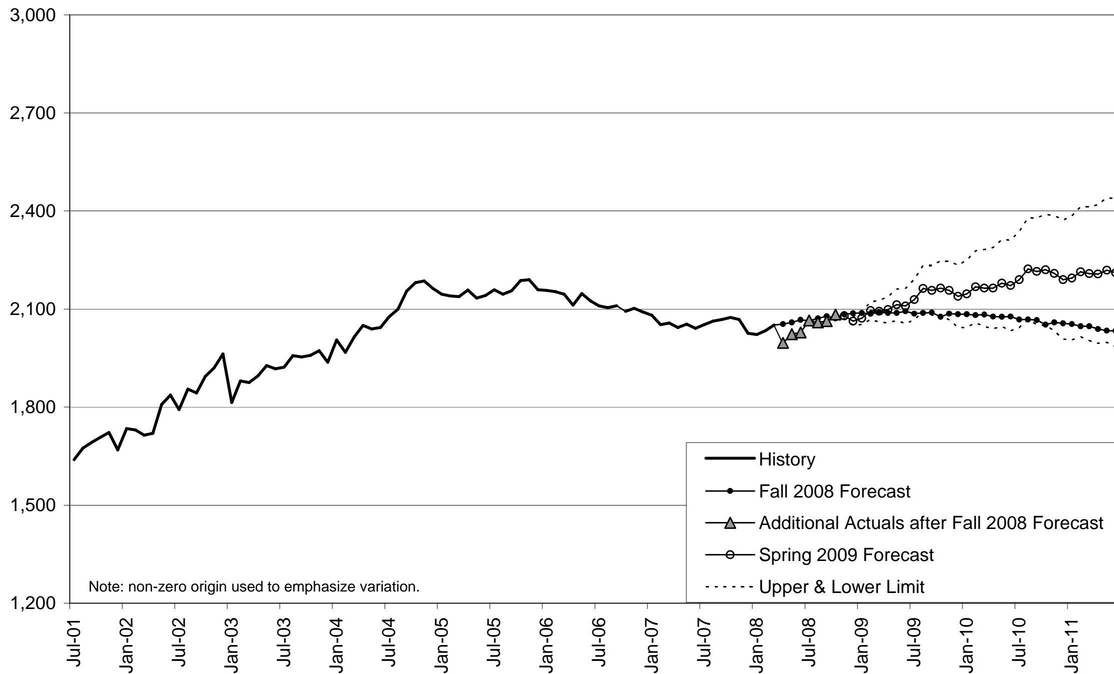
Exhibit E-9: Residential Care Facilities: Total
3,000
2,700
2,400
2,100
1,800
1,500
1,200
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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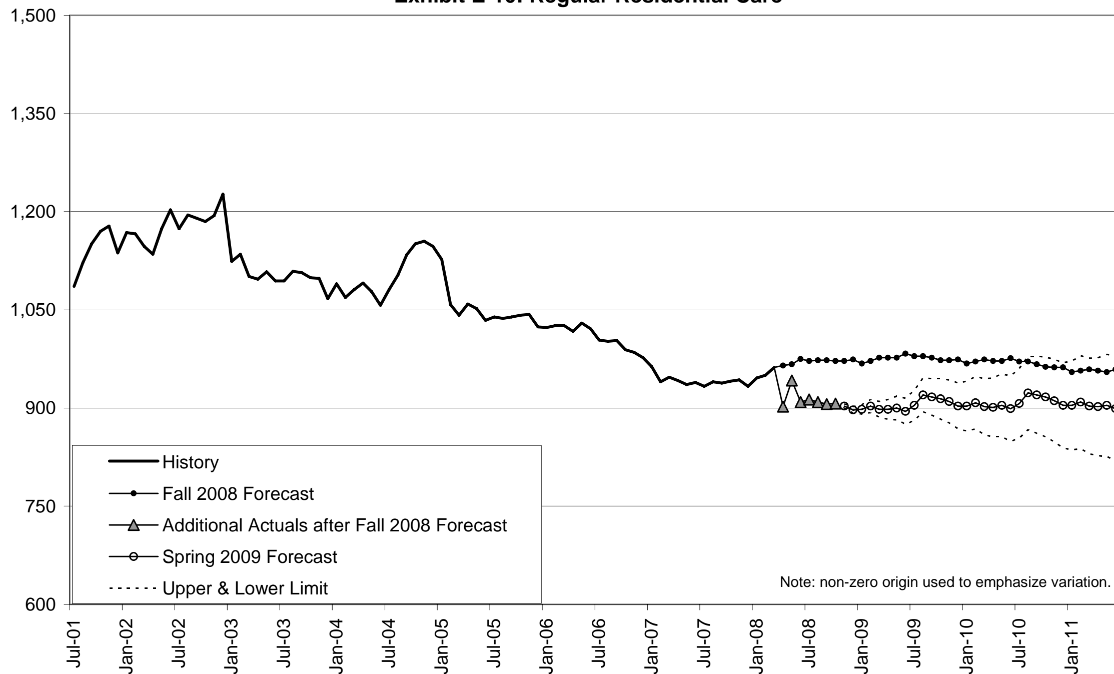
Exhibit E-10: Regular Residential Care
1,500
1,350
1,200
1,050
900
750
600
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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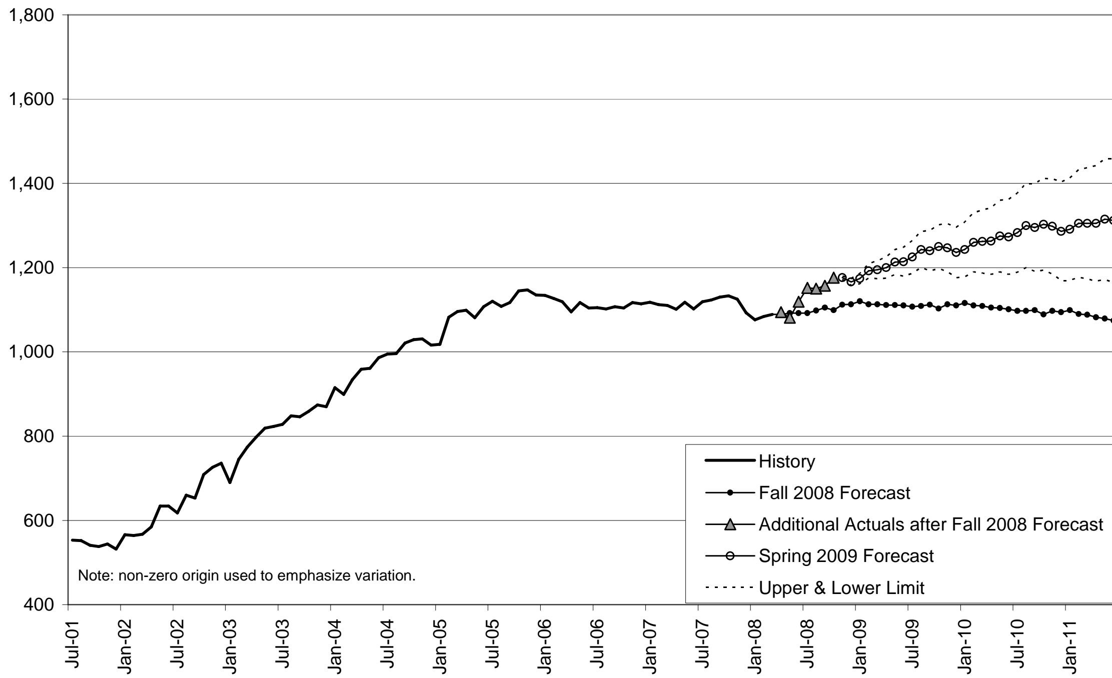
Exhibit E-11: Contract Residential Care
1,800
1,600
1,400
1,200
1,000
800
600
400
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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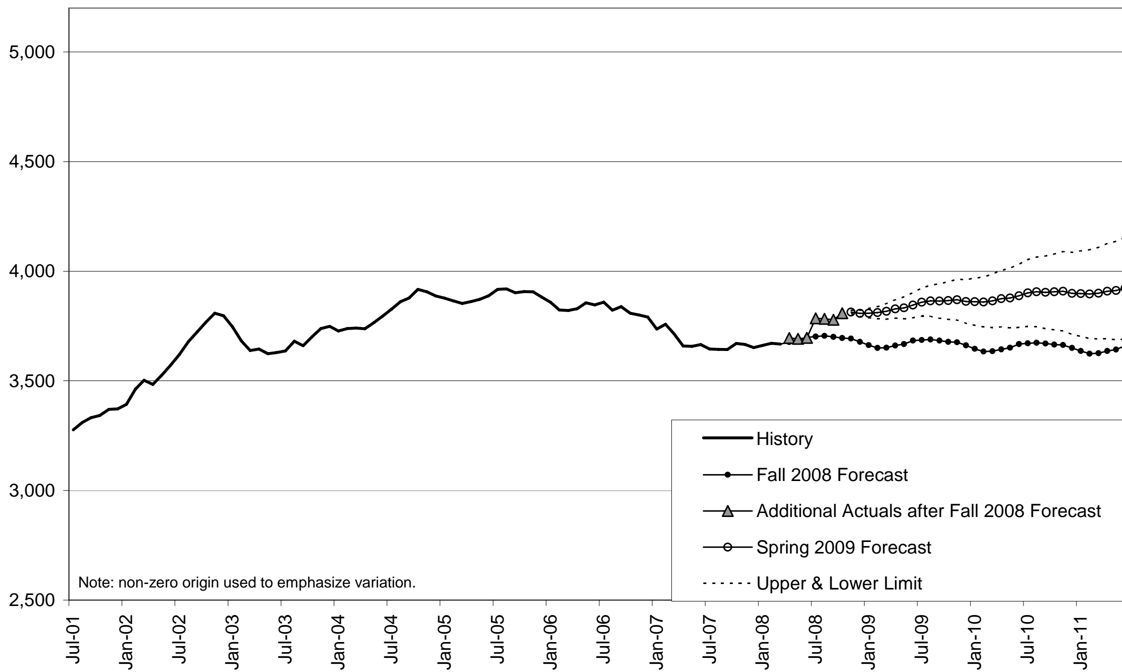
Exhibit E-12: Assisted Living Facilities
5,000
4,500
4,000
3,500
3,000
2,500
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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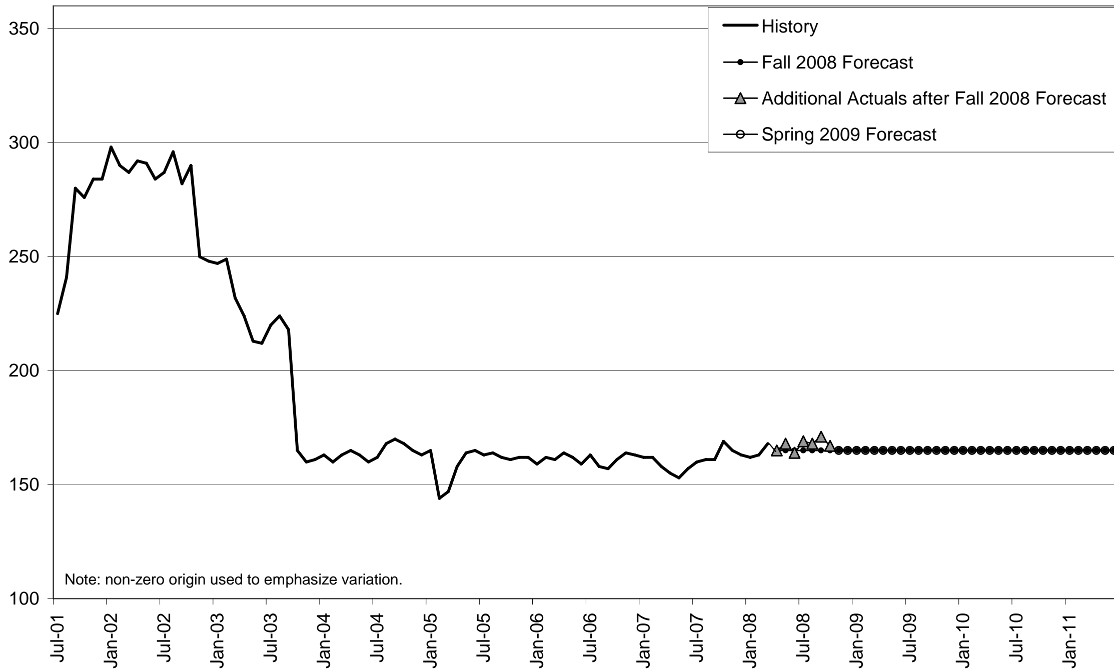
Exhibit E-13: Specialized Living Programs
350
300
250
200
150
100
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Note: non-zero origin used to emphasize variation.
Jul-01
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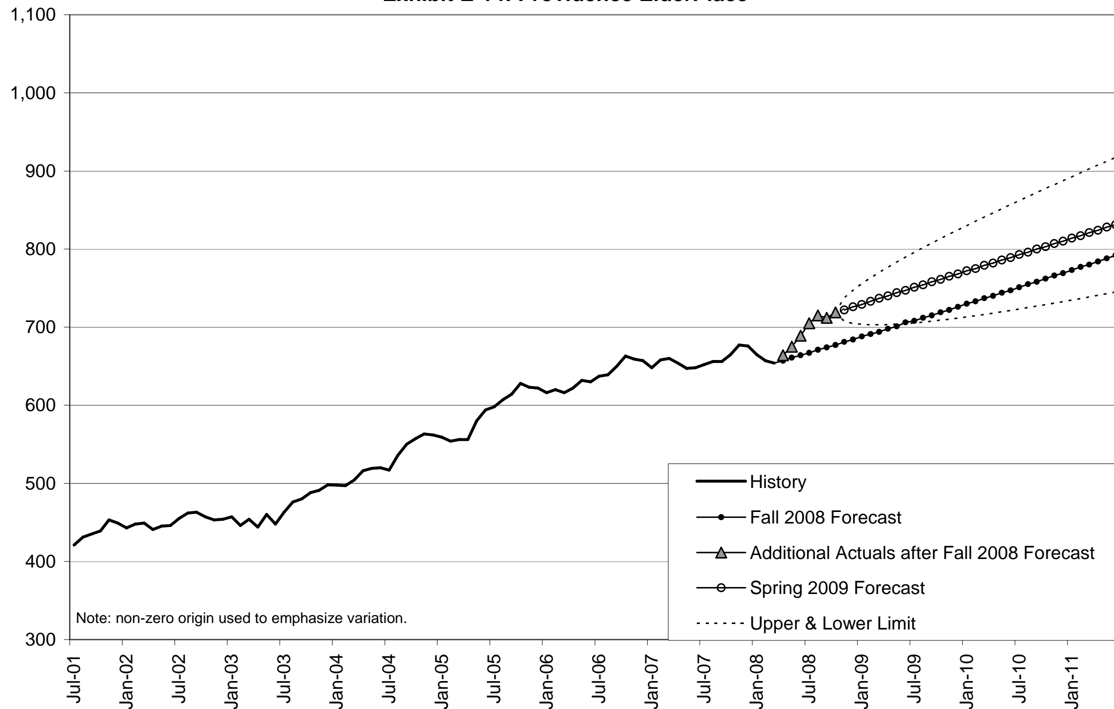
Exhibit E-14: Providence ElderPlace
1,100
1,000
900
800
700
600
500
400
300
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
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Nursing Facilities

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

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

Historically, the Nursing Facilities caseload has steadily declined. This is the result of the promotion of In-Home and CBC services as an alternative to institutional care. Some of the decline may also be attributed to the gradual decrease in the average length of time people stay in a nursing facility[6]. 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 5,081 per month. In 2005-07, the NF caseload averaged 5,088[7] 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 2.4 percent compared to the Fall 2008 forecast (5,050 versus 5,174). The total NFC forecast for the 2009-11 biennium, compared to 2007-09, is about 3.9 percent lower (4,855 versus 5,050) (Exhibit E-15).

Nursing Facility Care: Basic

The Nursing Facility Care-Basic caseload includes about 88 percent of the total Nursing Facility clients[8]. These clients need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care due to and/or 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-

[6] 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).
[7] NFC Total is adjusted from previously reported average of 5,088 due to change in the methodology of counting the NFC Extended Care clients.
[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 4,467 (2.8 percent lower than Fall 2008) in 2007-09 and 4,285 (8.2 percent lower) in 2009-11.

Nursing Facilities: Complex Medical Add-On

The NF Complex Medical Add-On caseload includes about 7.0 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 387 in 2007-09 and at 368 in 2009-11 (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.

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 care but only pays the co-payments from days 21 to 100; Medicaid covers the balance. Medicare controls these clients' extended care stays.

Starting Spring 2009, a new method of counting clients receiving NF Medicare Extended Care service has been adopted. The new method is consistent with all the other LTC caseload groups. The count based on the claims data is about 37 FTE less than the previous payment based data. Under the new count, the extended care caseload averaged 78 in 2005-07 and is forecasted to remain at

an average of 83 and 80 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 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 forecast 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 forecast to remain at the biennial average of 60 clients.

Risks to Nursing Facilities Forecast

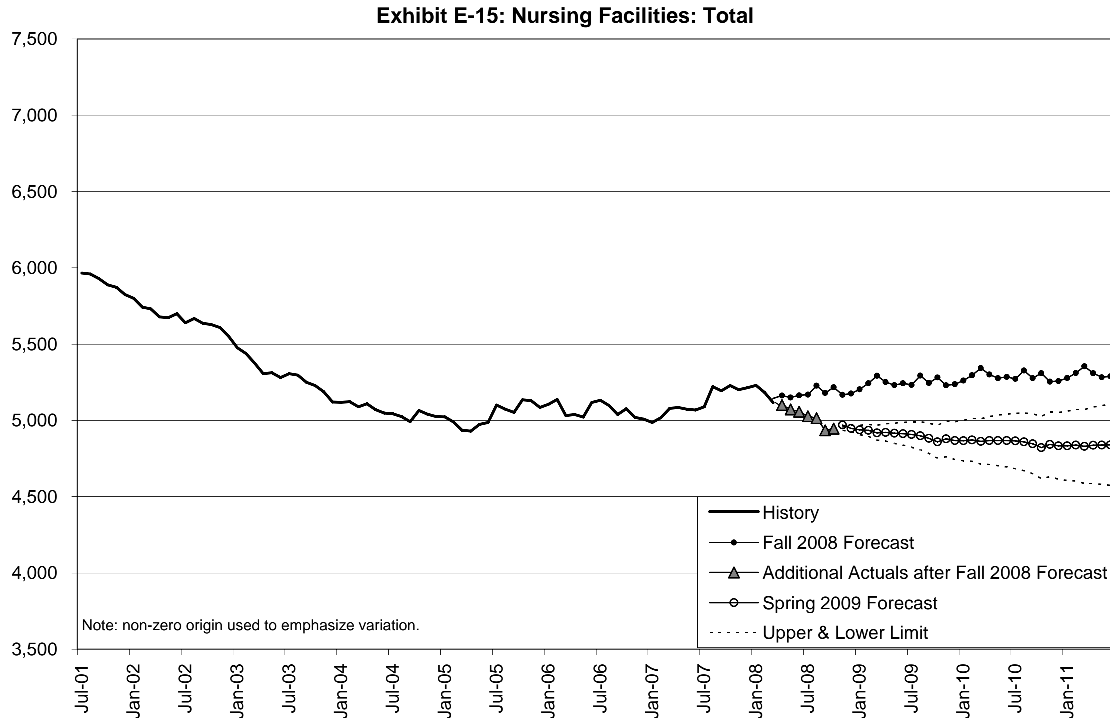
After a period of stable growth, the Nursing Facilities caseload began to decline in recent months. In spite of such decline especially among the Basic NFC services caseload, Nursing Facilities may experience slower growth due to higher post-hospital discharges and an inadequate relocation plan for these 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 in spite of $260 rate increase.

Money Follows the Person: In 2008, SPD implemented 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 actively implementing other relocation initiatives (diversion and transition) that will affect 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. Under the diversion and transition initiatives, clients with skilled care admission in NFC within the first 20 days (in case of diversion) and within the first 30 days in case of transition) will be redirected to alternative care settings with the informed consent of clients and or client's family or guardian and with the transition plan in place.

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 6.0 percent above or below the average forecast for the 2007-11 forecast periods, even without the risks described above.



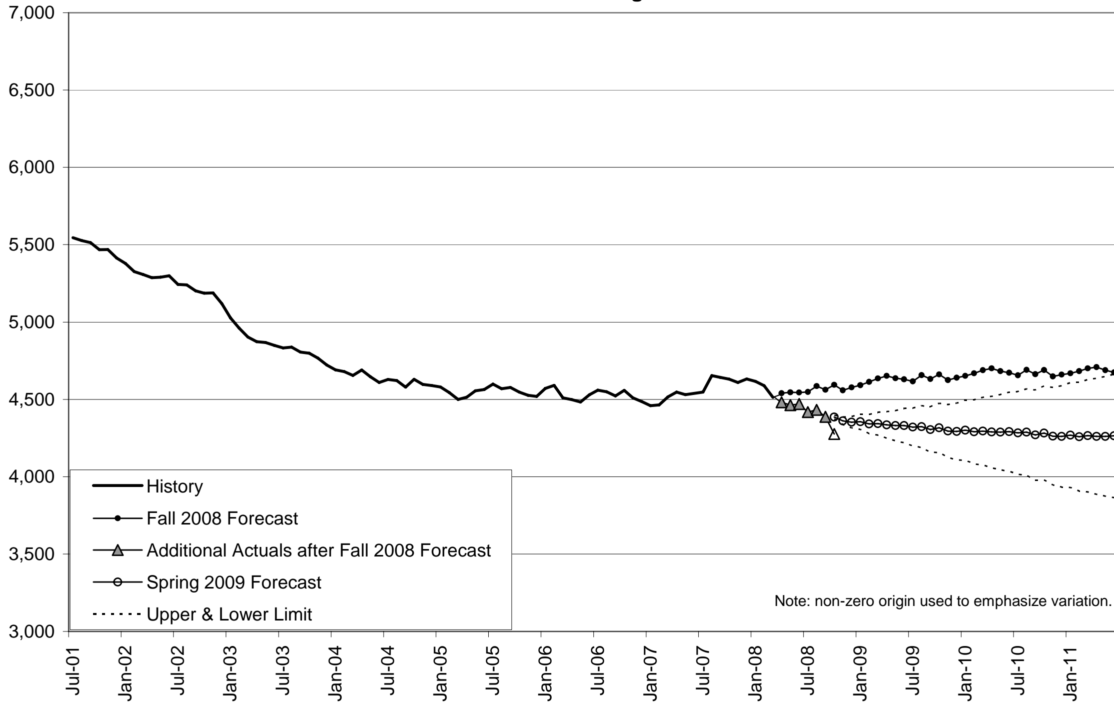


Exhibit E-16: Basic Nursing Facilities
7,000
6,500
6,000
5,500
5,000
4,500
4,000
3,500
3,000
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

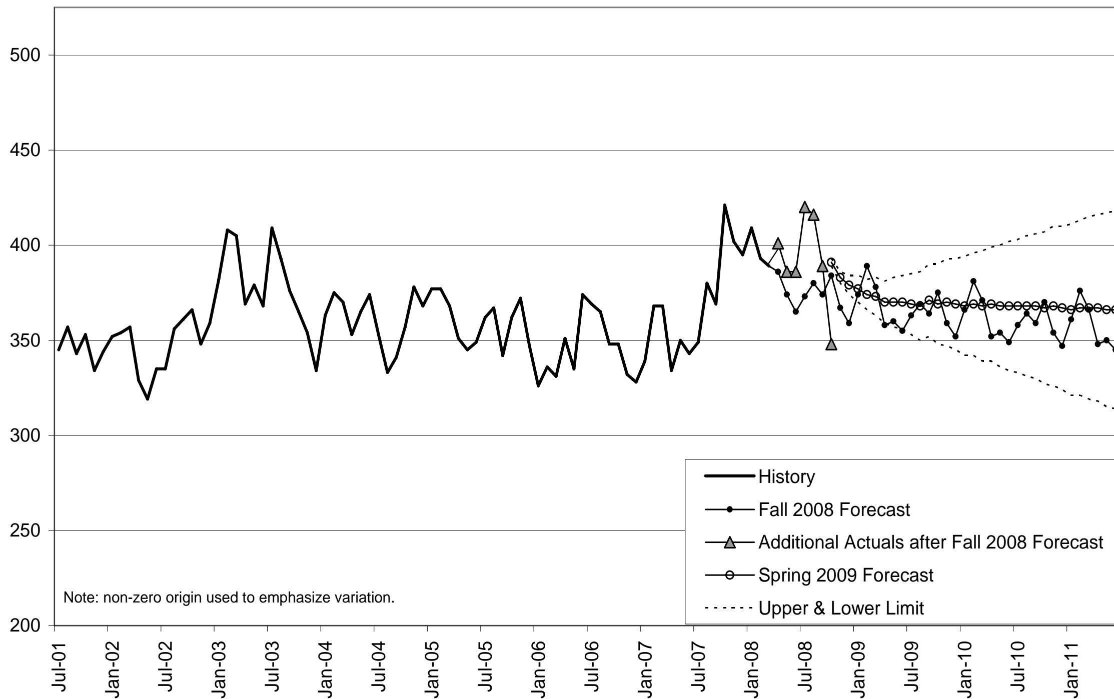


Exhibit E-17: Complex Medical Add-On Nursing Facilities
500
450
400
350
300
250
200
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

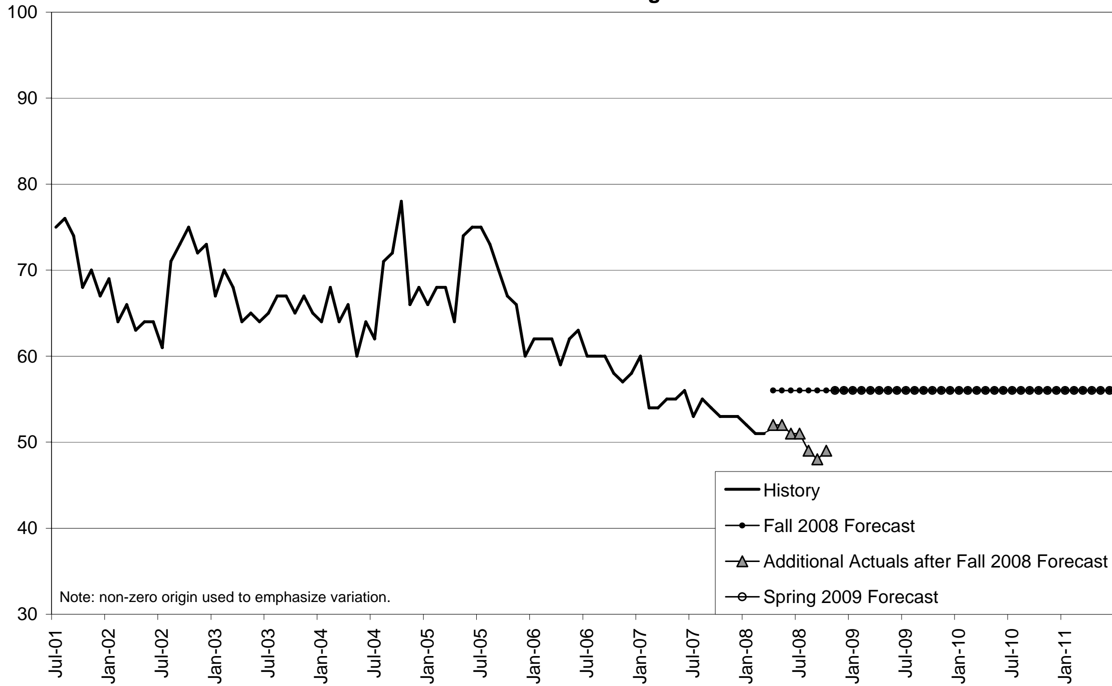


Exhibit E-18: Pediatric Nursing Facilities
100
90
80
70
60
50
40
30
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

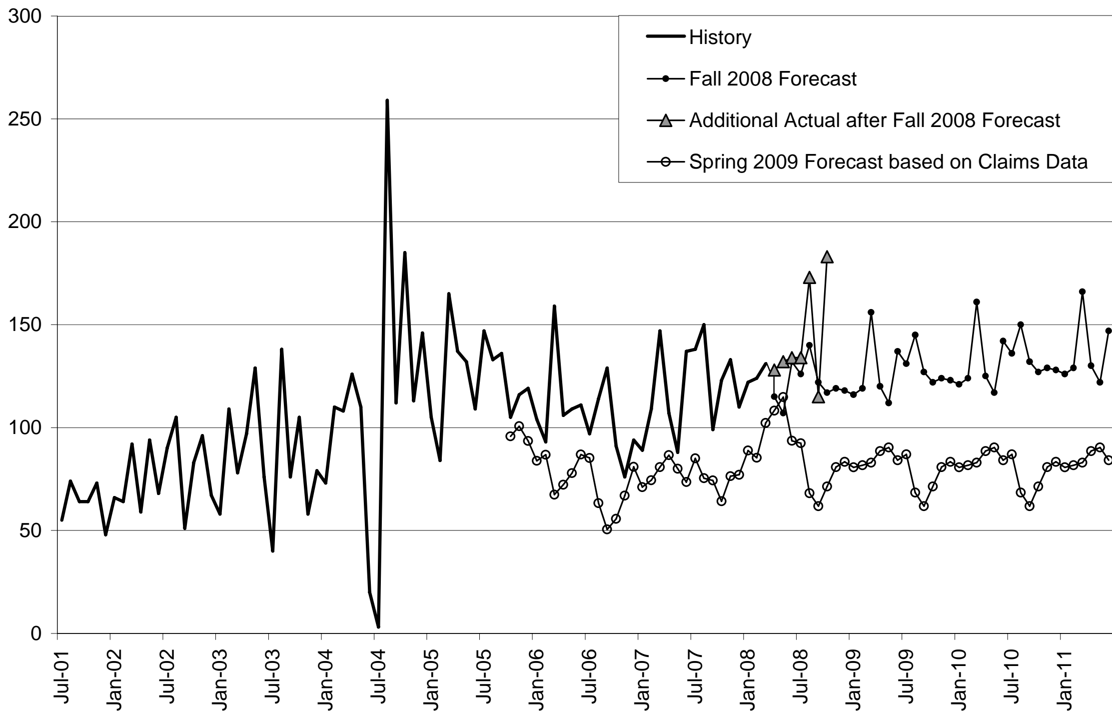


Exhibit E-19: Nursing Facilities: Extended Care
300
250
200
150
100
50
0
History
Fall 2008 Forecast
Additional Actual after Fall 2008 Forecast
Spring 2009 Forecast based on Claims Data
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

STAKEHOLDER SURVEY RESULTS FOR SENIORS AND PEOPLE WITH DISABILITIES

Community Demand for Stakeholder and DHS Services

- The majority of SPD stakeholders and field staff observed demand for stakeholder and DHS services increasing. Almost every respondent expected demand to increase by Fall 2009.
- Most SPD stakeholders and field staff noted the increase in demand among adults with disabilities, first-time clients, seniors, and low-income clients. Often, these clients need services that are more intensive.
- According to SPD field staff, the top three DHS programs in demand are Direct Financial Support, In-Home services, and Community-Based services.

Reasons for Increased Demand and Need

SPD stakeholders and field staff noted SPD clients' unique economic fragility. These clients often require assistance for extended periods of time, and already depend on limited resources to meet their needs. SPD clients live independently with fewer services when possible; however, when one of their supports – income, housing, access to adequate medical services – fails, they find themselves in need of stakeholder and DHS assistance to survive. These more intensive supports are more expensive for the client, for DHS and for stakeholders. SPD stakeholders and field staff expressed concern over proposed budget cuts and strains on DHS staff workload affecting client well-being.

Stakeholders and DHS staff frequently mentioned the following client issues when discussing increased demand:

- **Cost of Living – Necessities.** Financial assistance, Direct Financial Support, food and nutritional needs, housing, safety, utility assistance, clients going without food or medicine to make ends meet. Family supports that SPD clients rely on for their daily needs weaken because of the economy and family stress.
- **Unemployment and Income.** Vocational Rehabilitation policy changes; financial abuse; housing and stock market impacts on assets, income is not enough to meet the rising cost of basic client needs supportive family's income is not enough to help with care.

- **Health Care.** Medical benefits; medical, mental, behavioral, and cognitive health care needs; cost of health care (including prescription assistance), client dependence on safe, reliable, skilled health care to survive.

Public Health Division

CAREAssist Program

Introduction

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

Exhibit F-1: CAREAssist Biennial Average Comparisons

	2007-09 Biennium			2009-11 Biennium			Spring 2009 Forecast		
Comparison:	**Fall 08 to Spring 09**			**Fall 08 to Spring 09**			**2007-09 to 2009-11**		
Public Health **Biennial Averages by Forecast**	**Fall 08 Forecast 2007-09**	**Spring 09 Forecast 2007-09**	*%Diff. Fall 08 to Spring 09 2007-09*	**Fall 08 Forecast 2009-11**	**Spring 09 Forecast 2009-11**	*%Diff. Fall 08 to Spring 09 2009-11*	**Spring 09 Forecast 2007-09**	**Spring 09 Forecast 2009-11**	*% Diff. Spring 09 2007-09 to 2009-11*
CAREAssist	1,882	1,897	0.8%	2,063	2,362	14.5%	1,897	2,362	24.5%

CAREAssist Caseload

Overall, the CAREAssist forecast for Spring 2009 is 0.5 percent larger than the Fall 2008 forecast for the 2007-09 biennia (Exhibit F-1). This caseload is predicted to increase steadily through June 2011 (Exhibit F-2). The 2009-11 biennial average for the Spring 2009 forecast is estimated to increase by 24.5 percent over that for 2007-09.

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 percent 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 10.0 percent above or below the average monthly forecast for the 2007-09 biennium.

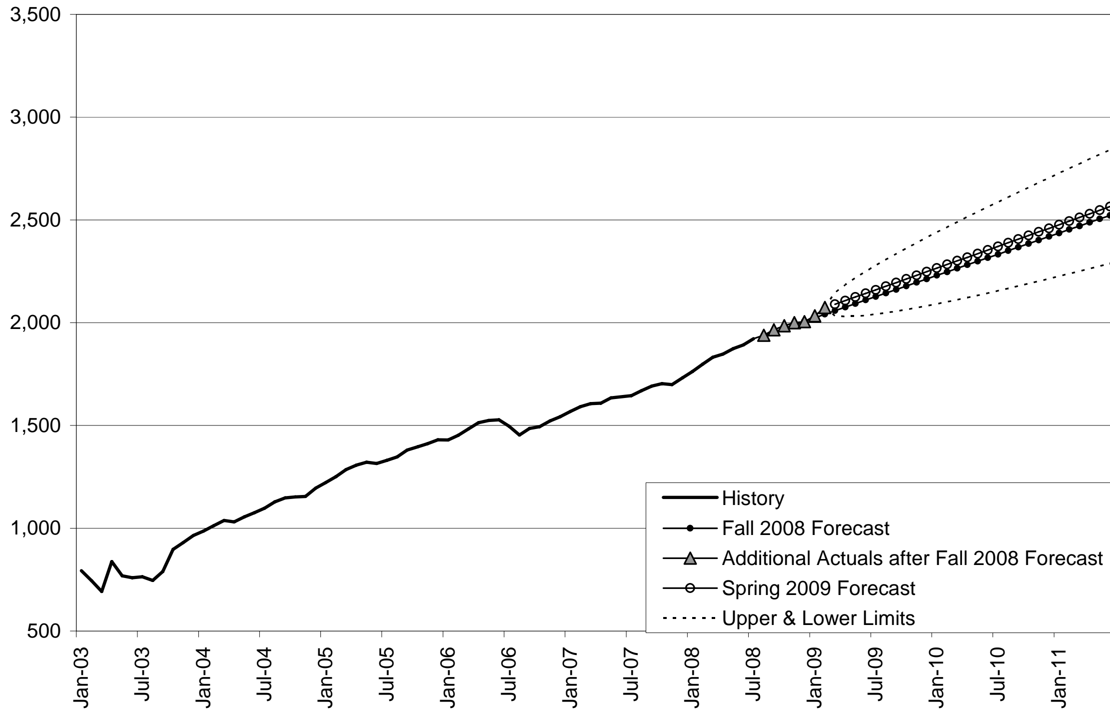


Exhibit F-2: CAREAssist
3,500
3,000
2,500
2,000
1,500
1,000
500
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limits

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-E[1] eligible children for whom returning home or adoption is not in their best interest.

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

Residential Treatment consists of three major types of service:
Regular Contract, which relates to a specific number of contracted beds for children with behavioral and emotional problems.

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[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 biennial average for 2007-09 is forecast to be 5,704, 1.9 percent lower than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 5,369, 7.6 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 5.9 percent lower than the currently forecast average for the 2007-09 biennium.

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 biennial average for 2007-09 is forecast to be 2,568, 5.5 percent lower than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 2,278, 15.5 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 11.3 percent lower than the currently forecast average for the 2007-09 biennium.

Paid Adoption Assistance

This service correlates strongly with the Adoption Assistance number-served caseload, so it presents a similar historical trend. The biennial average for 2007-09 is forecast to be 10,007, 0.2 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 11,083, 1.3 percent higher than was predicted in the previous forecast. The currently forecast average for 2009-11 is 10.8 percent higher than the currently forecast average for the 2007-09 biennium.

Paid Subsidized Guardianship

As with its number-served counterpart, Subsidized Guardianship ADP has been growing at a slower rate than in the past. The biennial average for 2007-09 is forecast to be 874, 1.4 percent lower than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 1,089, 7.0 percent lower than was predicted in the previous forecast. The currently forecast average for 2009-11 is 24.7 percent higher than the currently forecast average for the 2007-09 biennium.

Residential Care

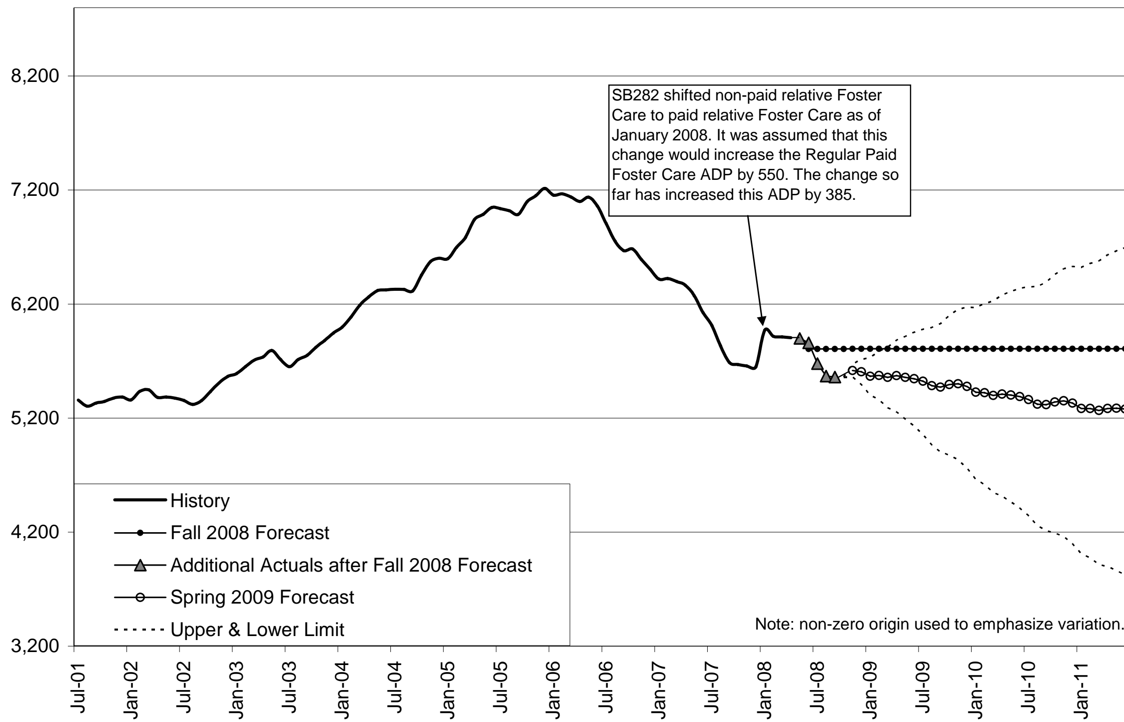
The biennial average for 2007-09 is forecast to be 471, 1.4 percent higher than was predicted in the previous forecast. The 2009-11 biennial average is forecast to be 460, about the same as was predicted in the previous forecast. The currently forecast average for 2009-11 is 2.2 percent lower than the currently forecast average for the 2007-09 biennium. 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 percent utilization is achieved.

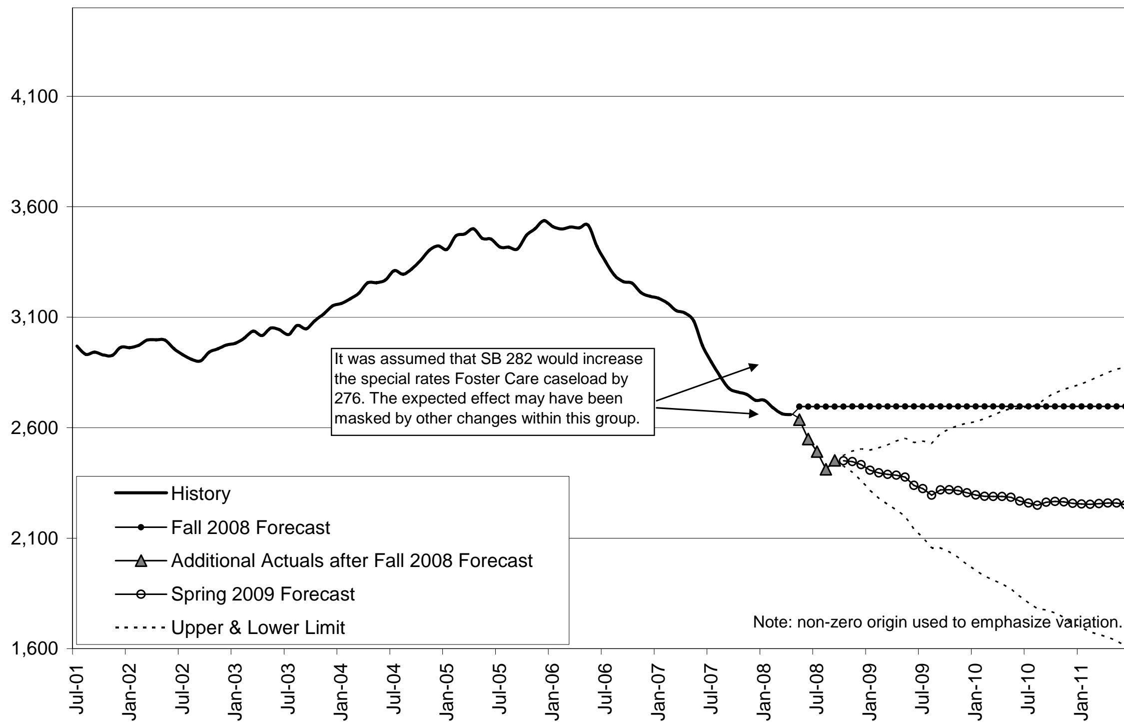
Risks and Assumptions

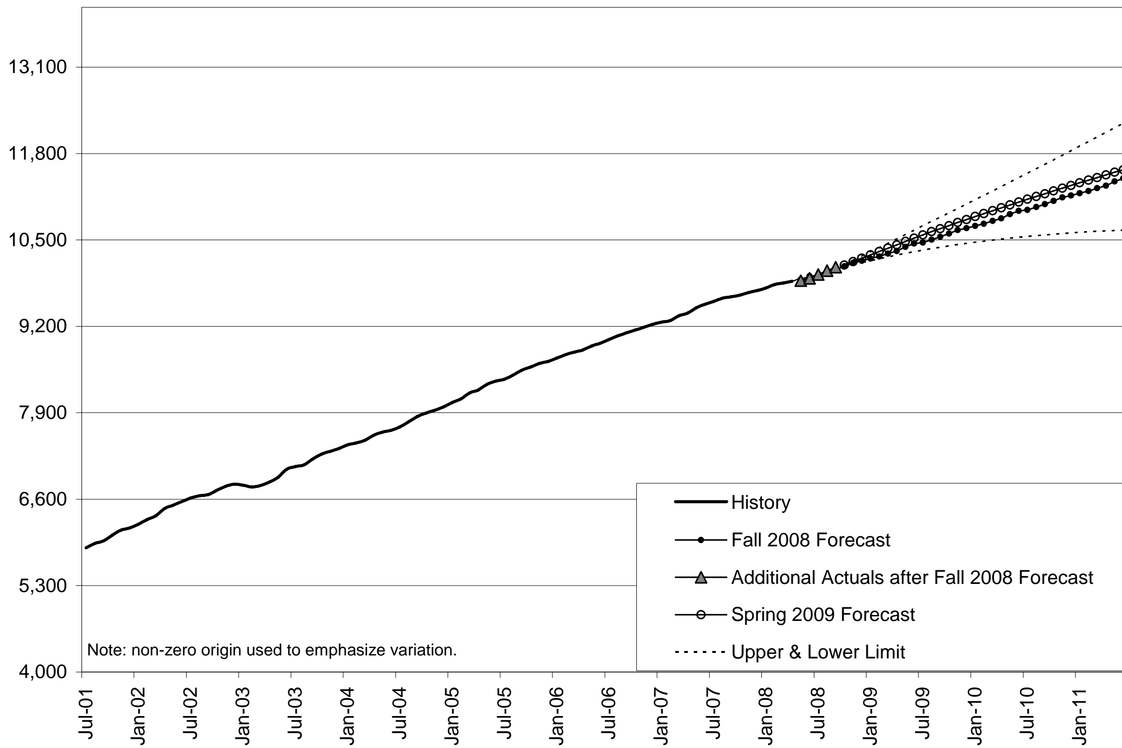
The Spring 2009 forecasts for Regular Paid and Special Rates Foster Care pose the greatest risk, since it is difficult to determine exactly why they have fallen over the past two years. As discussed in the section on number served, there are several factors that may have led to the decline in Foster Care. However, the data are not adequate to quantify the relative contribution of each factor. This uncertainty in turn leads to greater forecast risk.

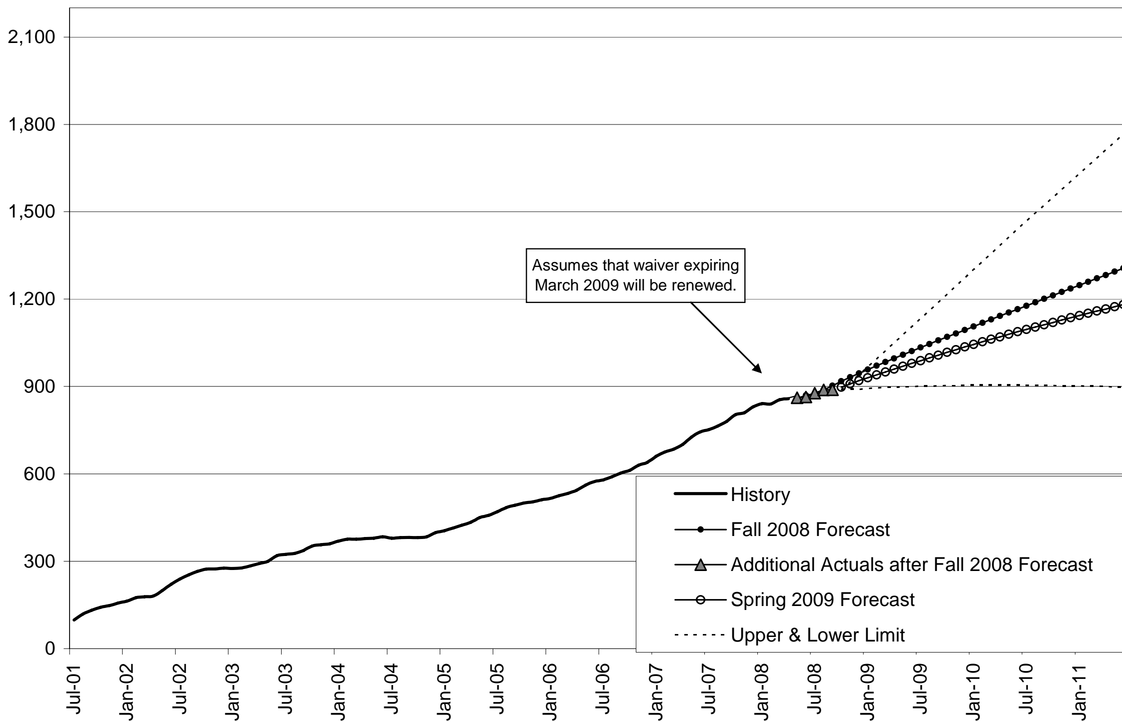
As with its corresponding number-served caseload, the Paid Adoption Assistance ADP and Subsidized Guardianship forecasts assume a continuation of the historical upward trend. Given the relative stability of this trend, the forecast presents little risk.

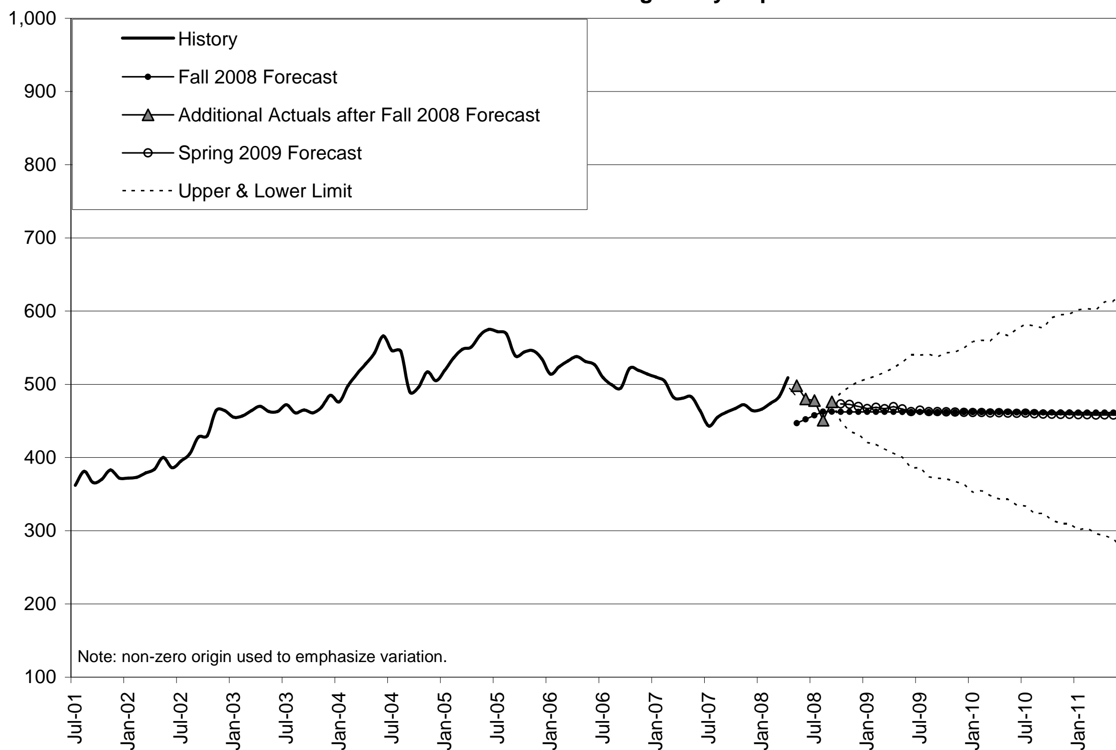
The forecast for Residential Care ADP poses a risk mostly in terms of the split between regular and special contract beds. This is due to the difficulty of estimating exactly how the reconfiguration of residential care contracts will impact the utilization of regular contract beds.

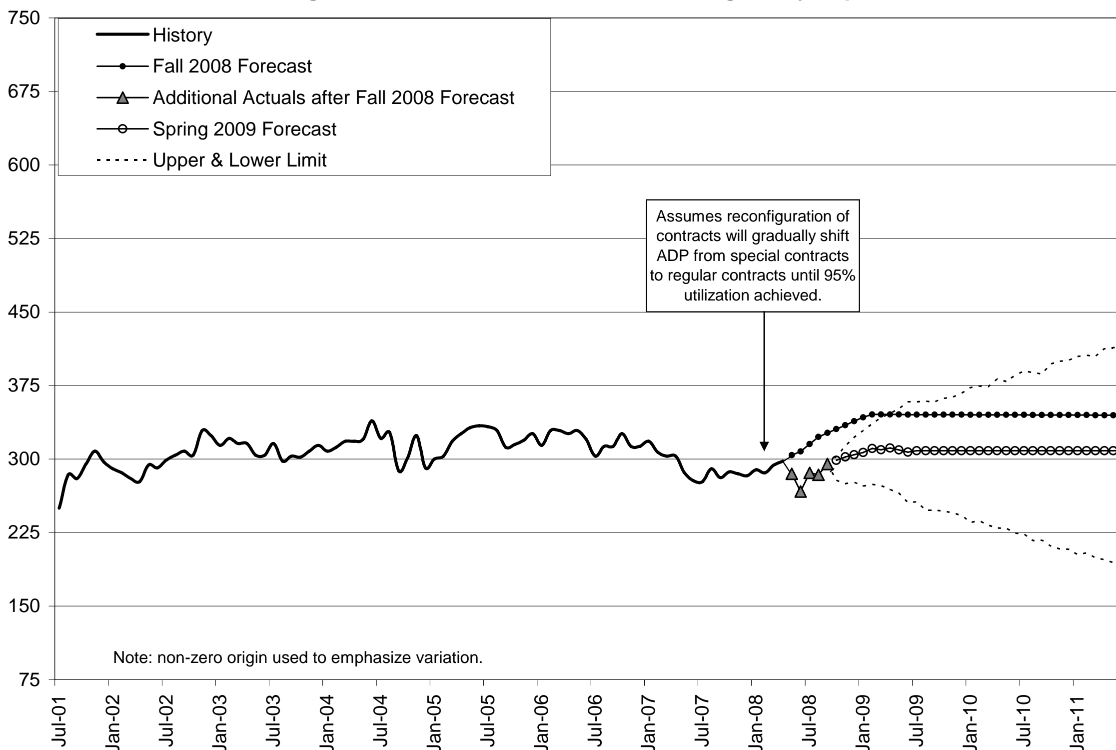

Regular Paid Foster Care - Average Daily Population
SB282 shifted non-paid relative Foster Care to paid relative Foster Care as of January 2008. It was assumed that this change would increase the Regular Paid Foster Care ADP by 550. The change so far has increased this ADP by 385.
8,200
7,200
6,200
5,200
4,200
3,200
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11


Special Rates Foster Care - Average Daily Population
4,100
3,600
3,100
2,600
2,100
1,600
It was assumed that SB 282 would increase the special rates Foster Care caseload by 276. The expected effect may have been masked by other changes within this group.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11


Paid Adoption Assistance - Average Daily Population
13,100
11,800
10,500
9,200
7,900
6,600
5,300
4,000
Note: non-zero origin used to emphasize variation.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11


Paid Subsidized Guardianship - Average Daily Population
2,100
1,800
1,500
1,200
900
600
300
0
Assumes that waiver expiring March 2009 will be renewed.
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11


Total Residential Care - Average Daily Population
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Note: non-zero origin used to emphasize variation.
1,000
900
800
700
600
500
400
300
200
100
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11


Regular Contract Residential Care - Average Daily Population
History
Fall 2008 Forecast
Additional Actuals after Fall 2008 Forecast
Spring 2009 Forecast
Upper & Lower Limit
Assumes reconfiguration of contracts will gradually shift ADP from special contracts to regular contracts until 95% utilization achieved.
Note: non-zero origin used to emphasize variation.
750
675
600
525
450
375
300
225
150
75
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
Jan-08
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11

Appendix II

Community Stakeholder Survey Methods

eSurvey Sample

To reflect the stakeholder field structure, analysts created a sampling frame to improve representation of the stakeholder population at the local, regional, and DHS division levels. Analysts selected stakeholders at the lowest level unit of analysis possible by collecting stakeholders from lists of DHS providers and partners and listing them each by type of program and by local branch programs within a main organization. Analysts selected stakeholders randomly by DHS division using proportionate random stratified sampling.

Of the 317 stakeholders invited to take the eSurvey, 127 (40 percent) completed a survey. In cases where one respondent represented several stakeholders, analysts identified the programs and branches selected for the survey and represented by the respondent and duplicated the responses for each represented program/branch. In cases where a respondent's programs or branches were in more than one sub-sample, we duplicated the responses to every applicable sample.

Analysts conducted the web-based survey through the Oregon State Library. The survey tool[10] covered demand for stakeholder and DHS services over the past three months and expected by June 2009, and client trends in local communities.

Interview Panel Sample

The interview panel consists of members of the Community Provider Advisory Group and selected participants from the previous biannual survey (Fall 2008). Of the 27 stakeholders invited to participate in the Spring 2009 panel (21 from Fall 2008 and 6 new), 16 completed interviews (59 percent). Ten stakeholders from the Fall 2008 interview panel continued in Spring 2009.

Analysts interviewed panel participants over the phone using a semi-scripted interview format similar to the we-based survey.

Seniors and People with Disabilities Field Staff Sample

Analysts selected field staff from AAAs and MSOs using a combination of proportionate sample by position and region (Case Managers, Human Service Specialists, and Adult Protective Service staff), and purposive judgement

[10] Copies of all survey tools are available upon request.

sampling through SPD program managers. Of the 503 represented for the sample, 242 (48 percent) completed web-based surveys.

Analysts conducted the web-based survey through the Oregon State Library. The survey tool[11] covered demand for SPD benefits over the past three months and expected by June 2009, top 3 programs in demand, and client trends in local communities. Analysts also asked SPD staff to indicate the demand for community partners' services and partners closing to referrals.

[11] Copies of all survey tools are available upon request.

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 survey 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, and 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 CAF, 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 MH and CareAssist caseload forecasts differ from the DMAP and SPD somewhat. They are created by applying statistical methods to historical caseload data, accounting for long-term trends, seasonality, and changes in policies and/or programs. Further details of the methodologies used are available in technical documents upon request.

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

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