DEPARTMENT OF HUMAN SERVICES

SPRING 2006 FORECAST

DHS
oregon department
of human services

FINANCE & POLICY ANALYSIS
CLIENT CASELOAD FORECASTING
MARCH 2006

EXECUTIVE SUMMARY

The Department of Human Services (DHS) is Oregon's largest agency serving approximately one million Oregonians every year. The department predicts the number of clients, or the caseload, it will serve. The caseload forecast is one element of the agency's budgeting process. The department's programs also use the forecast to plan policy.

These are three major groups of programs for which DHS forecasts caseloads. They are Children, Adults and Families (CAF) program, Medical Assistance Programs (OMAP), and Seniors and People with Disabilities programs (SPD). This document summarizes all of the caseloads that DHS currently forecasts.

Children, Adults and Families (CAF)

Children, Adults and Families administer programs that help people become safe and independent. DHS centrally forecasts the caseloads of Self-Sufficiency, Child Welfare, and Vocational Rehabilitation.

Self-Sufficiency

- **Food Stamps:** There are around a quarter of a million households that receive Food Stamps in Oregon, which translates to over 400,000 individuals who receive benefits through this program. Individuals and households receive food stamps either through the Children, Adults and Families (CAF) program (around 70 percent of the total Food Stamp caseload) or the Seniors and People with Disabilities (SPD) program. Both groups of recipients have undergone steady growth since 2001. However, recently the CAF Food Stamp population has been leveling off, while the SPD program has grown slowly but steadily. The Total Food Stamp Spring 2006 forecast indicates that the average number of households receiving food stamps in the 2005-07 biennium is about 3 percent lower than that shown in the Fall 2005 forecast, but only about 1 percent lower than the Spring 2005 forecast.

    - The **CAF Food Stamp** Spring 2006 biennial average for households at 158,586 is around 3 percent lower than the Fall 2005 forecast, and slightly lower, by 1.6 percent, than the Spring 2005 forecast. The biennial averages for individuals for Spring 2006 compared with the Fall 2005 and Spring 2005 forecasts are also slightly lower (about 3.9 percent, and 2.6 percent lower respectively).

- The Spring 2006 forecast predicts slower growth for the **SPD Food Stamp** population. The biennial average of 65,149 households is slightly lower (around 1.4 percent) than the Fall 2005 forecast; while slightly higher, also by around 1.2 percent, than the Spring 2005 forecast. The biennial average number of individuals is virtually the same over the three forecasts, varying by less than one percentage point.

- **Temporary Assistance for Needy Families (TANF):** The Spring 2006 biennial average number of families (18,322) is significantly lower (around 7 percent) than the Spring 2005 and the Fall 2005 forecasts. The lower estimate is about the same for the estimated number of individuals (who make up the families) on TANF. Proportionately, the drop is larger in the TANF-UN (unemployed or underemployed parent) population, although this population is relatively small, making up only about 6 percent of the total TANF families.

- **Employment Related Daycare (ERDC):** The Spring 2006 forecast for families for 2005-07 is somewhat lower than the Fall 2005 estimate (3.5 percent), but only slightly lower than the Spring 2005 estimate (1.3 percent). Due to an estimated increase in the number of children per case, however, the Spring 2006 forecast for the average number of children in the 2005-07 biennium is virtually the same across the forecasts.

- **Temporary Assistance for Domestic Violence Survivors (TA-DVS):** This relatively small program (averaging around 600 to 650 families, or 1,500 to 1,600 individuals) is estimated for the Spring 2006 forecast to be somewhat lower than what was forecast in Fall of 2005 (about 4 percent lower for both cases and individuals). This is about 8 percent lower than the Spring 2005 estimate.

Child Welfare

Each month CAF serves over 24,000 children who have suffered from neglect or abuse[1]. Overall, Child Welfare caseloads have been on an upward trend for several years, increasing approximately 5 or 6 percent each year since July 2001. The Spring 2006 Child Welfare forecast is not directly comparable to prior forecasts because of a change in methodology.

[1] Not including children being assessed by Child Protective Services

- **Adoption Assistance:** The Spring 2006 forecast for number served is predicted to increase 17.2 percent from the 2003-05 biennial average of 8,222 clients to 9,635 clients in the 2005-07 biennium.

- **Subsidized Guardianship:** The number served forecast for this relatively small caseload is predicted to grow 48.5 percent from a 392 biennial average for 2003-05 to a biennial average of 582 for 2005-07.

- **Foster Care:** The Spring 2006 forecast predicts growth of 18.5 percent from 9,132 children served for the 2003-05 biennium to 10,820 children for the 2005-07 biennium.

- **Child in Home:** The Spring 2006 forecast for number served is down 9.7 percent from a 4,990 biennial average for 2003-05 to a 4,507 biennial average for 2005-07. The fact that the overall Child Welfare caseload maintained a steady upward trend even while the Child in Home caseload fell suggests a possible shift from in-home care to Foster Care. This may be an indication that fewer children were in situations where they could remain in their homes, which would be consistent with the rising impact of methamphetamine use by parents.

Vocational Rehabilitation:

This is the second time the Vocational Rehabilitation caseload has been centrally forecast, and it is still undergoing some methodological adjustments. Adjusting the Fall 2005 forecast to compensate for the change in methodology, the Spring 2006 estimate of 9,895 clients is about 3 percent lower than the Fall 2005 forecast.

Medical Assistance Programs

The historical data utilized in the completion of the forecast include client-level Oregon Medical Assistance Programs (OMAP) eligibility and participation data beginning with January of 2000 and extending through September of 2005, the last month of available valid and reliable client data.

Overall, the Spring 2006 forecast predicts a leveling off of the Medical Assistance Programs that is 1.2 percent lower than the Fall 2005 forecast, but higher than the Spring 2005 forecast by almost 6 percent. The forecasts for the individual programs that make up OMAP are described below:

OHP Plus populations:

Spring 2006 projections for 2005-07 are slightly lower overall than what was projected in the Fall 2005 forecast, but still higher than the Spring 2005 forecast. There is a similar trend for the individual programs, except those for children.

- **Temporary Assistance of Needy Families (TANF):** The program has experienced rapid growth for the past few years. However, recent evidence suggests this program is leveling off. As a result, the Spring 2006 forecast is 8 percent lower than projected in Fall 2005, but 6.5 percent higher than projected in Spring 2005.

- **Poverty Level Medical - Women (PLMW):** This program grew moderately during the last year, which was in keeping with the trend predicted by the Fall 2005 forecast. Thus, the Spring 2006 forecast is substantively equivalent to the Fall 2005 forecast, which was about 8 percent higher than what was projected for Spring 2005.

- **Aid to the Blind and Disabled (ABAD):** This population has experienced slow but steady growth in the last year, which is similar to trends prior to major program changes that occurred in early 2003. The Spring 2006 estimates continue to predict steady growth, but at a somewhat lower rate than projected for Fall 2005. The Spring 2006 estimates are 3.1 percent lower than projected for Fall 2005, but higher (around 6 percent) than what was projected in the Spring 2005 forecast.

- Estimates for all child-related eligibility groups in the Oregon Health Plan, such as the **Poverty-Level Medical Children** (PLM-Children) and **Children's Health Insurance Program** (CHIP) programs are substantially higher than what was projected in Fall 2005, except for a slight decrease in the estimate for Foster Children. For the 2005-07 biennium, the Spring 2006 forecast is 8.4 percent higher than the Fall 2005 forecast for PLM-Children and 13.0 percent for CHIP. The Foster/Substitute Care program is expected to decline by 3.2 percent over the same period.

OHP Standard

The OHP Standard program continues to be closed to new enrollment and has continued to decline gradually. The biennial target caseload of 24,000 clients is the number used for the biennial averages for the Spring and Fall 2005 forecasts, as well as the Spring 2006 forecast. The "Families" group is held at a constant 7000 clients. The "Adults & Couples" group is held at a constant 17,000 clients.

Other Medical Assistance Programs

- **Citizen-Alien Waived Emergency Medical Program (CAWEM):** The Spring 2006 projections for the CAWEM program are lower than what had been projected in the Fall 2005 forecast by around 8 percent, and substantially lower than what had been projected in Spring 2005. There has been a steady decline in the population since the closure of the OHP Standard program.

- **Qualified Medicare Beneficiary (QMB):** The Spring 2006 forecast predicts a steady increase in the QMB population. This is somewhat higher than the Fall 2005 forecast, and significantly higher than the Spring 2005 forecast.

- **Breast and Cervical Cancer (BCC):** This relatively new program has experienced rapid growth since its inception in 2002, although its total size is quite small. The Spring 2006 projections are higher than what was projected for the Fall 2005 forecast, and significantly higher than what was forecast for Spring 2006.

Seniors and People with Disabilities: Long Term Care for Aged and Physically Disabled

Seniors and People with Disabilities (SPD) administer programs that assist seniors and people with physical and developmental disabilities and increase their independence. This forecast applies only to long-term care (LTC) programs for the aged and physically disabled. It does not include long-term care services for the developmentally disabled.

There are a range of long-term care services for people with chronic illnesses and physical disabilities, including Nursing Facilities, Community Based Care Facilities and In-Home Care programs.

Most of the LTC caseloads experienced steady increases until cuts to service priority levels occurred in early 2003. One exception is the Nursing Facilities caseload, which experienced a steady decline largely due to the promotion of in-home and community-based care facilities as an alternative to institutional care, as well as a gradual decrease in the average length of time people stay in a nursing facility. In general, since the cuts, there have been gradual declines in the LTC caseloads, most dramatically in the In-Home Care caseload.

The Spring 2006 forecast predicts a gradual decline to a nearly flat caseload overall. The Spring 2006 forecast is negligibly higher than the Fall 2005 projections, and negligibly lower than the Spring 2005 forecasts. This trend is evidenced in most of the categories of LTC services, except for Nursing Facilities, for which the estimates are higher in comparison to the Spring and Fall 2005 forecasts.

In-Home Care

The total In-Home Care services caseload, which makes up just over 40 percent of the LTC caseload, is forecasted to average 11,624 clients in the 2005-07 biennium and 11,517 clients in the 2007-09 biennium. This estimate is nearly the same as the Fall 2005 forecast; and slightly lower than the Spring 2005 forecast by about 1 percent.

Community-Based Care

The total Community-Based Care (CBC) caseload makes up about 40 percent of the total LTC caseload. The Spring 2006 forecast biennial average estimate for the 2005-07 biennium is 11,098 clients, and 11,145 clients for the 2007-09 biennium. The Spring 2006 total CBC caseload forecast is about the same as the Fall 2005 forecast, and slightly lower than the Spring 2005 forecast (about 1 percent).

- **Relative and Commercial Adult Foster Care:** These programs account for 14 and 22 percent respectively of the CBC caseload. In the 2005-07 biennium, the relative adult foster care caseload is forecasted to continue its downward trend. Due to a more rapid decrease in the program in recent history, the Spring 2006 forecast estimate is 6 percent lower compared to the Spring and Fall 2005 forecasts. However, given recent leveling off of the commercial adult foster care caseload, the Spring 2006 forecast for the 2005-07 biennium is slightly higher, by about 3 percent, compared with the Fall 2005 forecast. This is 7.4 percent higher than the Spring 2005 forecast.

- **Regular and Contract Residential Care:** These programs account for about 10 percent each of the total community-based care caseload. The Regular Residential Care caseload in recent history has been relatively flat with very slight growth. The forecast is slightly lower than the Fall 2005 forecast, while 12.4 percent lower than the Spring 2005 forecast, which was based on the assumption of a continuation of a rapid increase that had happened close to the time of that forecast. The Contract Residential Care caseload has shown relatively steady growth. The Spring 2006 forecast indicates continued growth but at a slightly increased pace over what was predicted for the Fall 2005 forecast. The Spring 2006 forecast is about 8 percent lower than the Spring 2005 forecast.

- **Assisted Living Facility (ALF):** This caseload accounts for 36 percent of the total CBC caseload. Overall, it increased gradually in the past couple of years; this trend is expected to continue. The ALF caseload in the Spring 2006 forecast is relatively unchanged from the Spring 2005 and Fall 2005 forecasts.

- **Providence ElderPlace:** This caseload accounts for 6 percent of the total CBC caseload, and while a relatively small caseload, has experienced steady growth since July of 2003. This growth is anticipated to continue until their capacity is reached. The Providence ElderPlace Spring 2006 forecast is slightly higher, by about 3 percent, than the Fall 2005 forecast, but nearly 10 percent higher than the Spring 2005 forecast.

Nursing Facilities

The total Nursing Facilities Spring 2006 forecast biennial average is 4,917 clients for the 2005-07 biennium. This is approximately 3 percent higher than the Spring and Fall 2005 forecasts.

- **Nursing Facility Basic Care:** This caseload, which accounts for 88 percent of the total Nursing Facilities caseload, also is responsible for the major portion of the increase. The Spring 2006 forecast for NF basic care is about 3 percent higher than the Spring 2005 and Fall 2005 forecasts.

- **Nursing Facilities-Complex Medical Add-On:** The Spring 2006 forecast for this much smaller program segment is 6 percent higher than the Fall 2005 forecast, and over 10 percent higher than the Spring 2005 forecast.

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ABOUT THE FORECAST

The Department of Human Services (DHS) is Oregon's largest agency serving approximately one million Oregonians every year. The department predicts the number of clients, or the caseload, it will serve. The caseload forecast is one element of the agency's budgeting process. The department's programs also use the forecast to plan policy.

There are three groups of programs for which DHS forecasts caseloads. These groups are Children, Adults and Families (CAF), Office of Medical Assistance Programs (OMAP), and Seniors and People with Disabilities (SPD). DHS does not centrally forecast all of its caseloads. This document summarizes all the caseloads that DHS centrally forecasts.

Forecast Process

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

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

A list of the members of the steering committees is listed in Appendix III.

Once the forecast agreement is final, the forecaster uses mathematical models to produce preliminary forecasts. Then, the forecaster discusses the preliminary forecasts with the program's steering committee. The steering committee provides information about past and future policy changes and their effects. The forecaster incorporates these events into the forecast, and the steering committee agrees on a final forecast.

A new addition to the forecasting process for this forecast is a review of the forecast and methods by the DAS Forecast Review Team, which consists of representatives from LFO, BAM, and the Office of Economic Analysis. This review occurs after the steering committee review and provides another review of the forecast. A list of the group members is listed in Appendix III.

Another part of the forecasting process is a twice-yearly meeting of the Peer Review Group. This group of experts from other Oregon state agencies, the Oregon universities, and private industry provides advice on the forecasting methodology and how to improve it. A list of the members of the Peer Review Group is listed in Appendix III.

Forecast Methodology

To create the forecast, DHS determines how many clients it *has* served in the past and applies mathematical models to project how many it *will* serve in the future. There are counts of clients for each month and the forecast predicts a number of clients for each future month of the forecast. The OMAP and SPD forecasts use the number of people entering those programs' services, how long they receive services, and the patterns of people transferring between programs to forecast. The Children, Adults and Families caseload forecasts differ from the OMAP 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.

Structure of This Document

Each group of programs begins with a description of that group, along with the programs that it contains and the services that are forecast within each of those programs. The OMAP and SPD group sections include combined forecasts for their group of programs. The program sections include a summary table that shows the Spring 05, Fall 05, and Spring 06 biennial averages and compares them for the 2005-07 and 2007-09 biennia, as well as a graph that shows the past caseload, the available past forecasts, and the Spring 06 forecast.

Within the programs, each forecast includes a description of the service followed by a graph that shows the past caseload, the available past forecasts, and the Spring 06 forecast. The history of the caseload, a description and comparison of the forecasts can also be found in this section. Finally, risks and assumptions that are relevant to that caseload forecast are at the end of the section.

CHILDREN, ADULTS AND FAMILIES

INTRODUCTION

Children, Adults and Families (CAF) administer programs to protect abused and neglected children and to help Oregon families achieve self-sufficiency. These two areas of service are identified as Child Welfare and Self-Sufficiency, respectively. In addition, CAF operations include the Office of Vocational Rehabilitation Services (OVRS), which assists individuals with disabilities in getting and keeping a job. The program caseloads included in the CAF Spring 2006 forecast appear in Exhibit 1. Further details regarding each group will be detailed in each section.

Exhibit 1: Children, Adults and Families program caseloads

Self-Sufficiency	Child Welfare	Vocational Rehabilitation
Food Stamps Temporary Assistance for Needy Families Employment Related Daycare Temporary Assistance for Domestic Violence Survivors	Adoption Assistance Subsidized Guardianship Foster Care Child in Home	Vocational Rehabilitation

Self-Sufficiency

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

Exhibit 2: Self-Sufficiency programs.

Food Stamps
Temporary Assistance for Needy Families (TANF)
Employment Related Daycare (ERDC)
Temporary Assistance for Domestic Violence Survivors (TA-DVS)

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

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

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

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

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

Exhibit 3: Total Self-Sufficiency Caseload Biennial Average Comparison by Forecasts (Cases)

	2005-07 Biennium					
Comparison:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) - Cases **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
SELF-SUFFICIENCY (Cases)						
Food Stamps						
Children, Adults and Families	161,083	163,914	1.8%	161,083	158,586	-1.6%
Seniors and People with Disabilities	64,362	66,105	2.7%	64,362	65,149	1.2%
Total Food Stamps	**225,445**	**230,019**	2.0%	**225,445**	**223,735**	-0.8%
Temporary Assistance for Needy Families						
Basic	18,333	18,506	0.9%	18,333	17,284	-5.7%
UN	1,299	1,204	-7.3%	1,299	1,048	-19.3%
Total TANF	**19,632**	**19,710**	0.4%	**19,632**	**18,332**	-6.6%
Employment Related Daycare	**9,836**	**10,060**	2.3%	**9,836**	**9,707**	-1.3%
Temp. Assist. for Dom. Violence Survivors	**653**	**628**	-3.8%	**653**	**601**	-8.0%

	2005-07 Biennium			2007-09 Biennium		
Comparison:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) - Cases **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
SELF-SUFFICIENCY (Cases)						
Food Stamps						
Children, Adults and Families	163,914	158,586	-3.3%	169,412	163,384	-3.6%
Seniors and People with Disabilities	66,105	65,149	-1.4%	73,237	71,242	-2.7%
Total Food Stamps	**230,019**	**223,735**	-2.7%	**242,649**	**234,626**	-3.3%
Temporary Assistance for Needy Families						
Basic	18,506	17,284	-6.6%	19,574	17,734	-9.4%
UN	1,204	1,048	-13.0%	1,256	1,168	-7.0%
Total TANF	**19,710**	**18,332**	-7.0%	**20,830**	**18,902**	-9.3%
Employment Related Daycare	**10,060**	**9,707**	-3.5%	**10,241**	**9,772**	-4.6%
Temp. Assist. for Dom. Violence Survivors	**628**	**601**	-4.3%	**632**	**642**	1.6%

Food Stamps

The Food Stamp program supplements food budgets for low-income families and individuals, people receiving public assistance, and seniors and people with disabilities. Households entering the program through Children, Adults and Families are classified as CAF households, while those entering the program through Seniors and People with Disabilities are classified as SPD households.

Forecast

Exhibit 4 shows that the Spring 2006 forecast of 223,735 households for the total Food Stamp caseload is approximately 3 percent lower than the 230,019 figure from the Fall 2005 forecast. The Spring 2006 figure of 437,252 clients is approximately 3 percent below the 452,212 clients forecasted in Fall 2005.

Exhibit 4: Total Food Stamp Caseload Biennial Average Comparison by Forecasts (Cases & Clients)

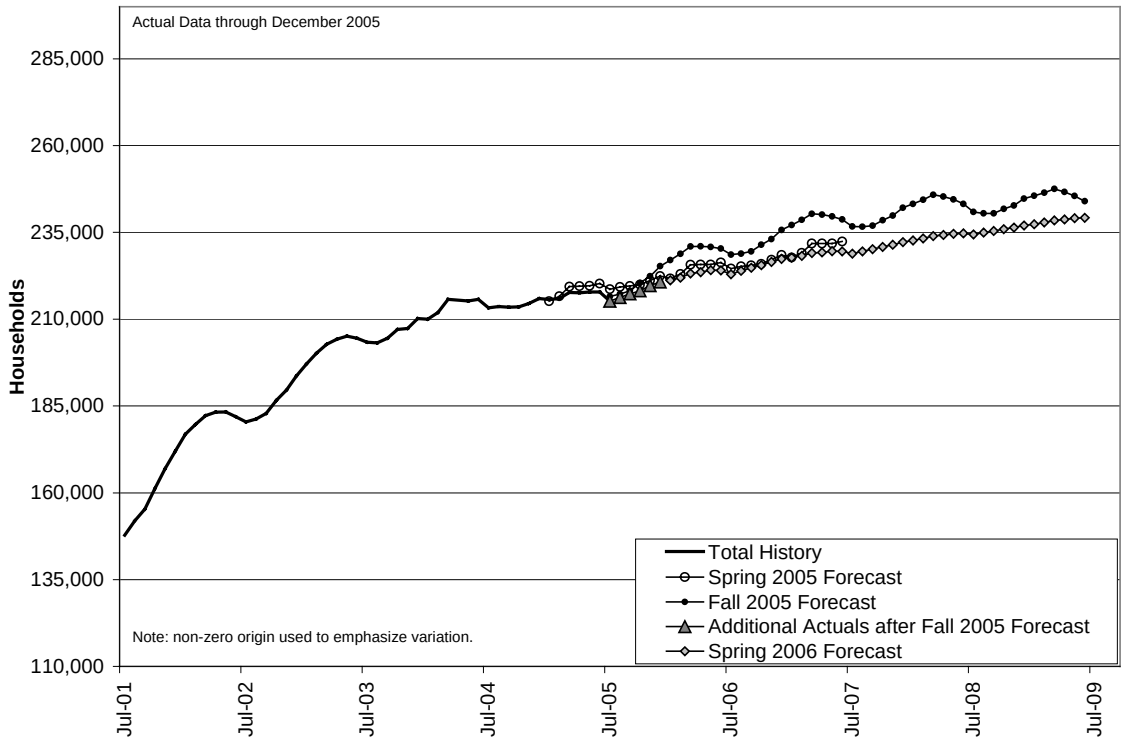
	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
SELF-SUFFICIENCY (Households)						
Food Stamps						
Children, Adults and Families	161,083	163,914	1.8%	161,083	158,586	-1.6%
Seniors and People with Disabilities	64,362	66,105	2.7%	64,362	65,149	1.2%
Total Food Stamps (Households)	**225,445**	**230,019**	2.0%	**225,445**	**223,735**	-0.8%
SELF-SUFFICIENCY (Clients)						
Food Stamps						
Children, Adults and Families	371,783	376,847	1.4%	371,783	362,300	-2.6%
Seniors and People with Disabilities	75,175	75,365	0.3%	75,175	74,952	-0.3%
Total Food Stamps (Clients)	**446,958**	**452,212**	1.2%	**446,958**	**437,252**	-2.2%

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
SELF-SUFFICIENCY (Households)						
Food Stamps						
Children, Adults and Families	163,914	158,586	-3.3%	169,412	163,384	-3.6%
Seniors and People with Disabilities	66,105	65,149	-1.4%	73,237	71,242	-2.7%
Total Food Stamps (Households)	**230,019**	**223,735**	-2.7%	**242,649**	**234,626**	-3.3%
SELF-SUFFICIENCY (Clients)						
Food Stamps						
Children, Adults and Families	376,847	362,300	-3.9%	386,543	374,353	-3.2%
Seniors and People with Disabilities	75,365	74,952	-0.5%	84,007	82,284	-2.1%
Total Food Stamps (Clients)	**452,212**	**437,252**	-3.3%	**470,550**	**456,637**	-3.0%

The Fall 2005 forecast book cited a risk that the forecast for Food Stamp households may have been too high for the 2005-07 biennium due to improvements in the economy. However, due to concern that hurricane relief efforts could increase caseloads, the Fall 2005 forecast was not adjusted. With the economy continuing to improve, and substantially increased caseloads from hurricane relief failing to materialize, the additional actuals for the number of

households have been slightly lower than the Fall 2005 forecast, as shown in Exhibit 5. The Spring 2006 forecast reflects this recent trend.

Exhibit 5: Total Food Stamp Households



Neither the Spring 2006 nor the Fall 2005 forecasts predict a continuation of the rapid growth exhibited in 2001. The reason for this is that the growth in 2001 was largely due to earlier outreach efforts and changes in eligibility. The first eligibility change came in December 1999, with eligibility automatically granted to those participating in certain Self-Sufficiency programs. A second change came in December 2000, when the income limit was raised to 185 percent of the federal poverty level. The Spring 2006 forecast also exhibits less of a seasonal pattern, which is more in line with that exhibited for the 2003-05 biennium.

Although the Spring 2006 forecast for Food Stamps is below the Fall 2005 forecast, it still displays an upward trend. Most of the growth is in the SPD portion, which accounts for just under a third of the total Food Stamp caseload. The Spring 2006 forecast of 158,586 households for CAF Food Stamps is 3.3 percent lower than the Fall 2005 forecast of 163,914 households. The Spring 2006 forecast for SPD Food Stamp households shows a decrease of only 1.4 percent from 66,105 households for fall 2005 to 65,149 households for Spring 2006. This is consistent with the actual caseload trends shown in Exhibit 6 and Exhibit 7. The pattern of the CAF Food Stamps trend leveling off and the SPD Food Stamps trend remaining relatively steady most likely stems from an improving economy, which tends to slow growth in the CAF-related caseload, and a continuously increasing elderly and disabled population, which keeps the SPD-related caseload on its existing growth trend.

Exhibit 6: Self-Sufficiency Children, Adults and Families Food Stamps (Households).

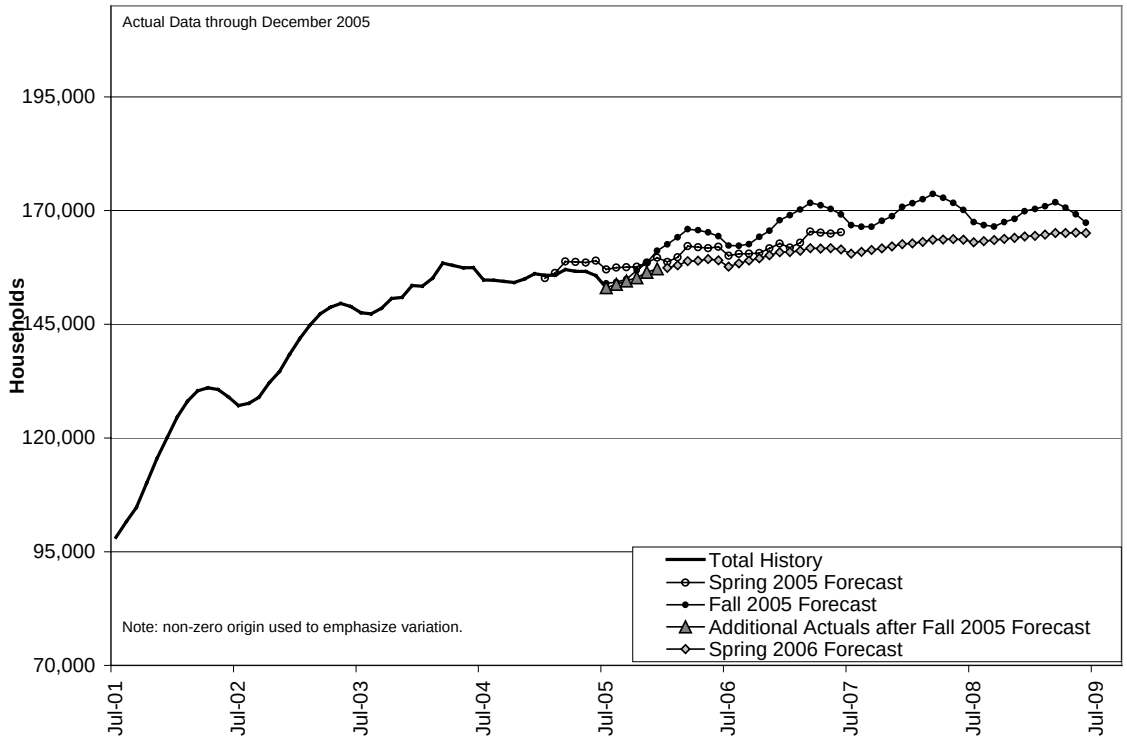
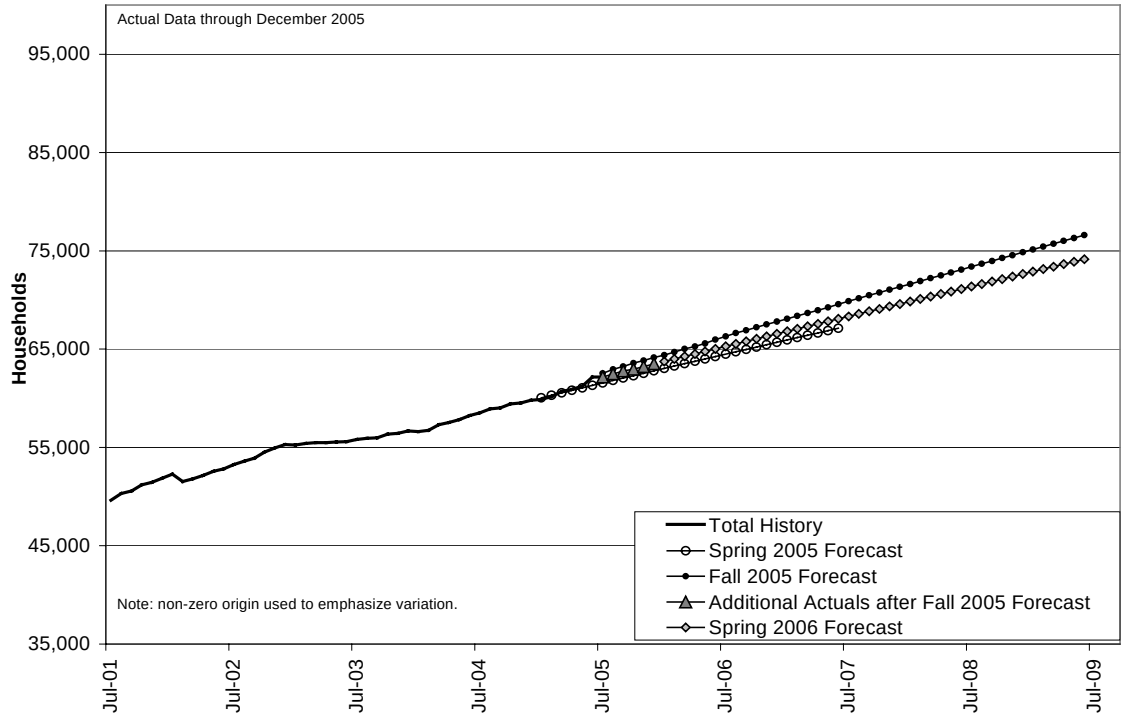


Exhibit 7: Self-Sufficiency Seniors and People with Disabilities Food Stamp (Households).



Risks and Assumptions

The forecast assumes that the Food Stamp Program will continue in its present form with no substantial changes in policy or legislation. Despite concern that the Fall 2005 forecast may have been too low given the potential for increased caseload due to the Medicare Modernization Act (MMA—see SPD section), the additional actuals do not appear to show any substantial impact from MMA. However, this may be due to setbacks in implementation. There may still be a risk of caseloads increasing beyond the Spring 2006 forecast.

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. Families with TANF medical only are not in this caseload. TANF families may be divided into two main categories:

TANF Basic includes one-parent families and 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 Basic makes up approximately 94 percent of TANF.

TANF UN includes families where both parents are able to care for their children, but both are unemployed or underemployed. TANF UN makes up approximately 6 percent of TANF.

Forecast

The Spring 2006 forecast for TANF is lower the 2005-07 biennial average by approximately 7 percent compared to the Fall 2005 forecast, as shown in Exhibit 8. As evident from Exhibit 9, caseloads have fallen off sharply since the Fall 2005 forecast. This is particularly evident in Exhibit 10, with TANF Basic caseloads falling in October, November and December when the seasonal pattern would usually be increasing. Although TANF UN exhibited the natural upward seasonal swing in October, November and December, it was more muted than usual (Exhibit 11). The improving economy is a logical explanation. The Spring 2006 forecast has adjusted for the recent downward trend. For TANF Basic families the Spring 2006 forecast is 6.6 percent lower compared to the Fall 2005 forecast, while TANF UN families for the Spring 2006 forecast are lower by 13 percent.

Exhibit 8: Self-Sufficiency Temporary Assistance for Needy Families Biennial Average Comparison Forecasts (Families & Clients)

	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
Temporary Assistance for Needy Families (Families)						
Basic	18,333	18,506	0.9%	18,333	17,284	-5.7%
UN	1,299	1,204	-7.3%	1,299	1,048	-19.3%
Total TANF (Families)	**19,632**	**19,710**	0.4%	**19,632**	**18,332**	-6.6%
Temporary Assistance for Needy Families (Clients)						
Basic	42,683	43,556	2.0%	42,683	40,714	-4.6%
UN	4,150	4,066	-2.0%	4,150	3,515	-15.3%
Total TANF (Clients)	**46,833**	**47,622**	1.7%	**46,833**	**44,229**	-5.6%

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
Temporary Assistance for Needy Families (Families)						
Basic	18,506	17,284	-6.6%	19,574	17,734	-9.4%
UN	1,204	1,048	-13.0%	1,256	1,168	-7.0%
Total TANF (Families)	**19,710**	**18,332**	-7.0%	**20,830**	**18,902**	-9.3%
Temporary Assistance for Needy Families (Clients)						
Basic	43,556	40,714	-6.5%	46,888	41,883	-10.7%
UN	4,066	3,515	-13.6%	4,817	3,905	-18.9%
Total TANF (Clients)	**47,622**	**44,229**	-7.1%	**51,705**	**45,788**	-11.4%

Exhibit 9: Self-Sufficiency Temporary Assistance for Needy Families Total (Families).

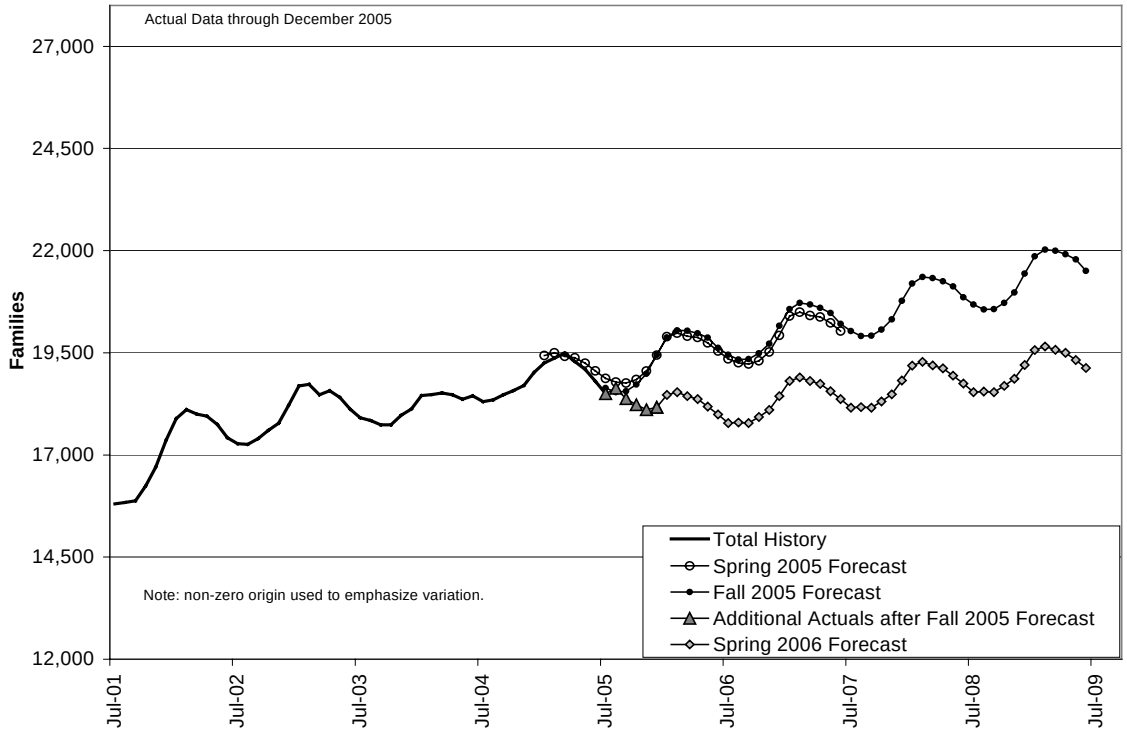


Exhibit 10: Self-Sufficiency Temporary Assistance for Needy Families Basic (Families).

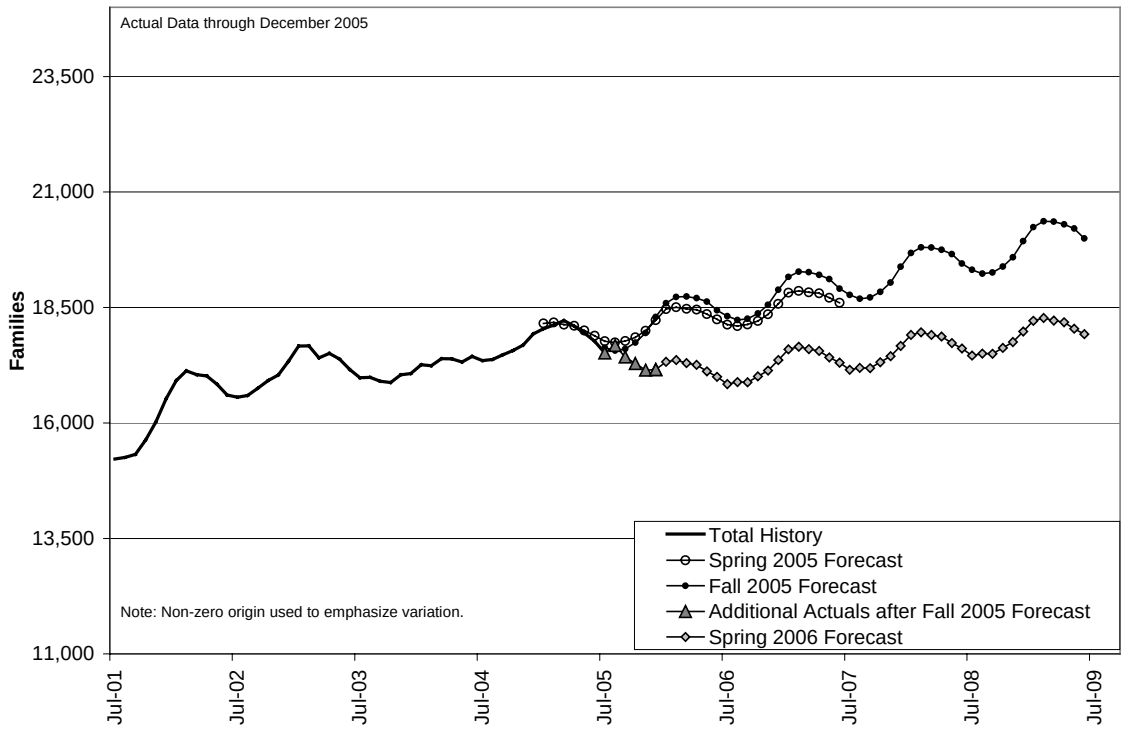
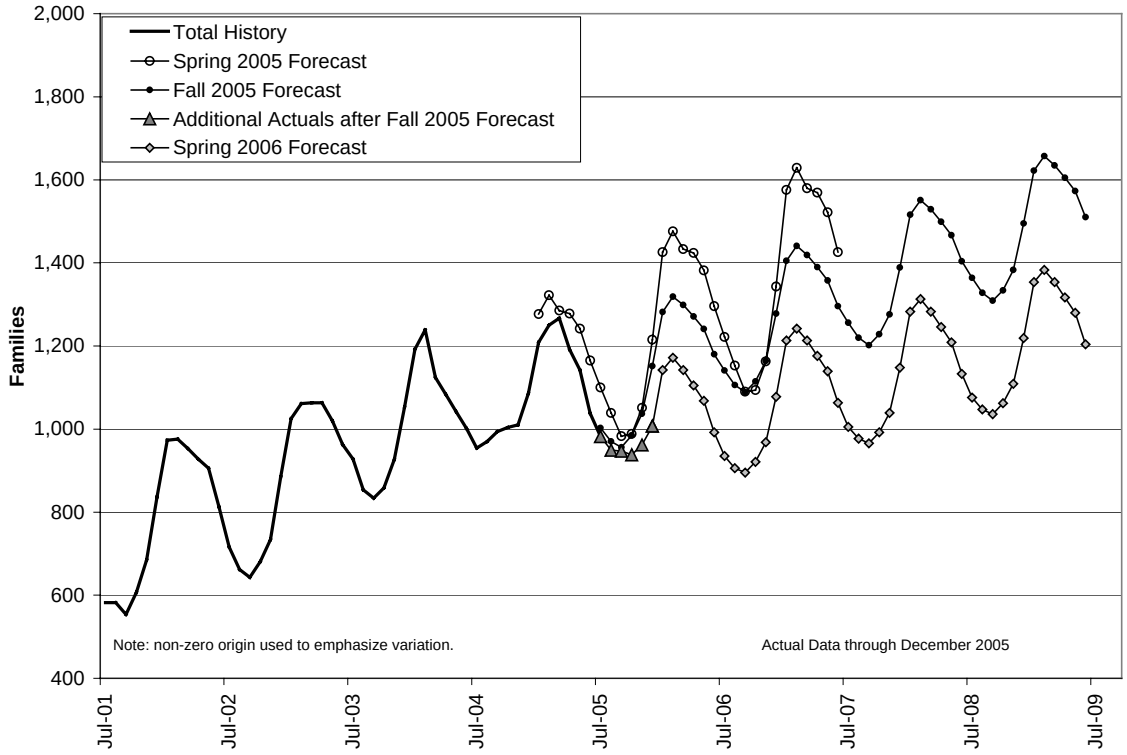


Exhibit 11: Self-Sufficiency Temporary Assistance for Needy Families UN (Families).



Risks and Assumptions

The Spring 2006 forecast assumes continued gradual improvement in the economy. However, major changes in the economy could affect the TANF population, in particular TANF UN, where the employment status of the parents can impact eligibility.

Upcoming policy changes affecting eligibility related to TANF transitional benefits known as TANF Extended Medical (see section on Medical Assistance Programs) could create a situation where families who left TANF may end up back on the TANF caseload. For example, if former TANF clients find themselves without health insurance, un-addressed health problems could make it difficult for them to maintain employment, causing them to return to the TANF caseload. In addition, the Deficit Reduction Act (DRA) poses a significant but uncertain risk to the TANF caseload forecast.

Employment Related Daycare

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

Forecast

The Spring 2006 forecast for ERDC families is 3.5 percent lower than the Fall 2005 forecast, as shown in Exhibit 12. The Spring forecast for ERDC children, on the other hand, is only 0.2 percent lower. A change in methodology created a difference in children per family between the Spring 2006 and Fall 2005 forecasts, resulting in the forecast for number of children remaining essentially unchanged while the forecast for number of families was adjusted downward.

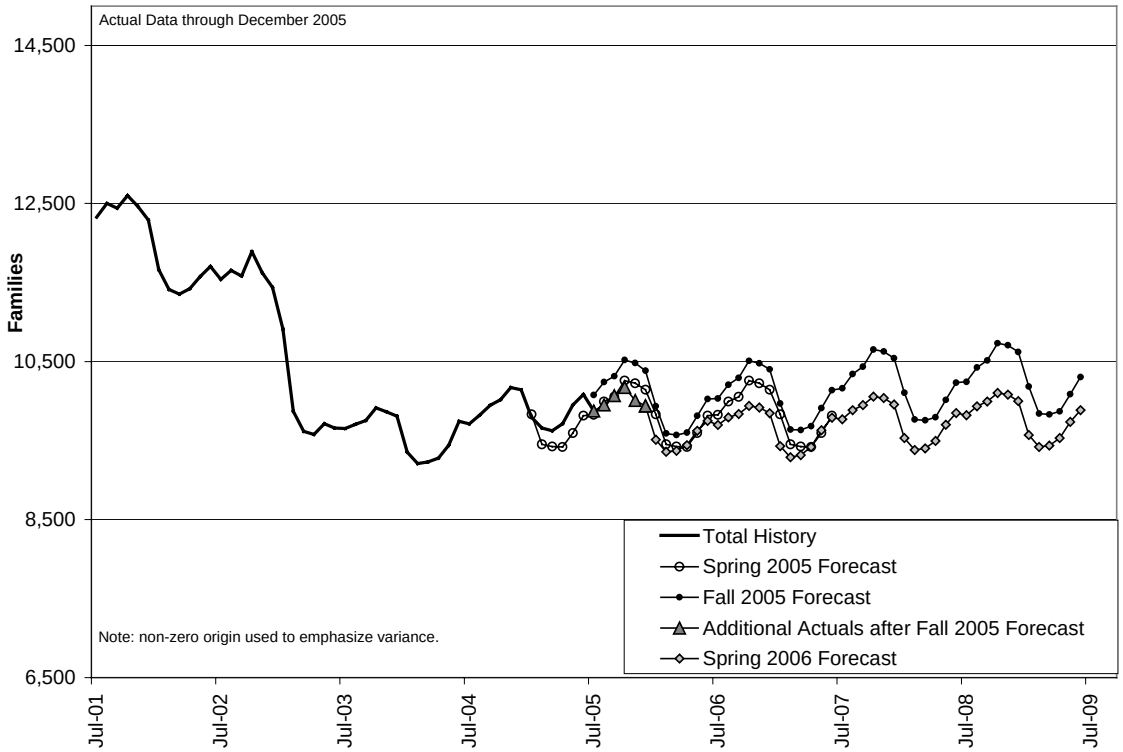
Exhibit 12: Self-Sufficiency Employment Related Daycare Biennial Average Comparison by Forecasts (Families & Clients)

	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
Employment Related Daycare (Families)	**9,836**	**10,060**	2.3%	**9,836**	**9,707**	-1.3%
Temp. Assist. for Dom. Violence Survivors (Families)	**653**	**628**	-3.8%	**653**	**601**	-8.0%
Employment Related Daycare (Children)	**18,377**	**18,207**	-0.9%	**18,377**	**18,174**	-1.1%
Temp. Assist. for Dom. Violence Survivors (Clients)	**1,672**	**1,592**	-4.8%	**1,672**	**1,537**	-8.1%

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
Employment Related Daycare (Families)	**10,060**	**9,707**	-3.5%	**10,241**	**9,772**	-4.6%
Temp. Assist. for Dom. Violence Survivors (Families)	**628**	**601**	-4.3%	**632**	**642**	1.6%
Employment Related Daycare (Children)	**18,207**	**18,174**	-0.2%	**18,302**	**18,251**	-0.3%
Temp. Assist. for Dom. Violence Survivors (Clients)	**1,592**	**1,537**	-3.5%	**1,619**	**1,632**	0.8%

Exhibit 13 shows the additional actuals for ERDC families dipping below the Fall 2005 forecast. This downward shift is reflected in the Spring 2006 forecast. Also apparent in the graph is a significant drop in caseload around February 2003. This is the result of a one-time change in the eligibility requirements that lowered the income limit from 185 percent of the federal poverty level (FPL) to 150 percent of FPL.

Exhibit 13: Self-Sufficiency Employment Related Daycare Caseload



Risks and Assumptions

One assumption made for the Spring 2006 forecast is that citizenship requirement changes to be implemented could cause a decrease in the ERDC caseload. The Spring 2006 forecast assumes the ERDC caseload will fall slightly from April 2006 through September 2006 due to this change.

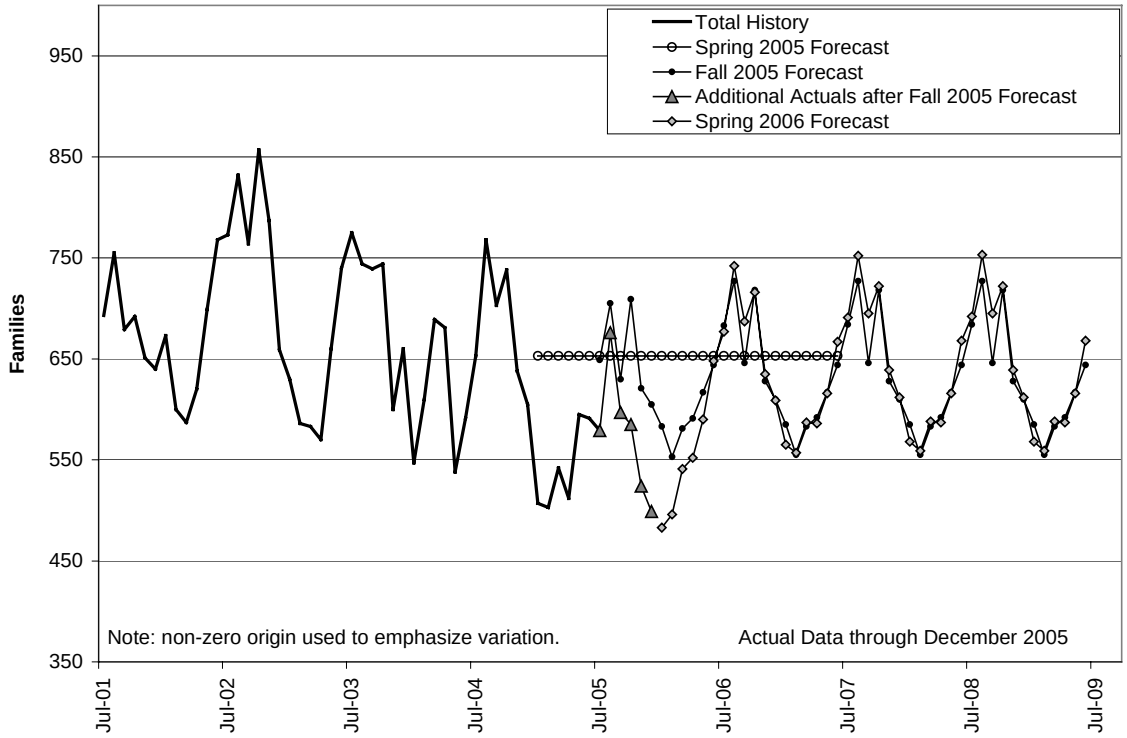
Temporary Assistance for Domestic Violence Survivors

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

Forecast

The Spring 2006 forecast for TA-DVS families is about 4 percent lower than the Fall 2005 forecast, as shown Exhibit 12. Exhibit 14 shows the additional actuals dropping substantially below the Fall 2005 forecast. However, this drop is within the normal range of variation that this caseload has exhibited historically, thus, the Spring 2006 forecast has the TA-DVS caseload gradually returning to the pattern originally projected in the Fall 2005 forecast.

Exhibit 14: Self-Sufficiency Temporary Assistance for Domestic Violence Survivors Caseload.



Risks and Assumptions

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

CHILD WELFARE

The Child Welfare system provides services to protect abused and neglected children. The forecast projects the number of children who are served in a given month, divided into the following categories[2]:

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

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

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

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

The Spring 2006 Child Welfare forecast is significantly different methodologically from prior forecasts. The changes were made in response to an evaluation of the methods and categorizations, and deemed to be more appropriate and relevant. In prior forecasts, caseloads were measured in number of children receiving services on the last day of the month. The Spring 2006 forecast measures caseloads as the total number of children who were served in the month. Also, some caseloads that used to be forecasted separately are combined in the Spring 2006 forecast. As a result, direct comparisons are not possible, and prior forecasts are not compared here. However, to facilitate budget development, the new methodology also includes forecasts for services provided to children on the caseload referred to as Average Daily Populations. This does allow comparisons to prior forecasts for some of the prior forecasts. For a comprehensive write-up, see the Child Welfare Average Daily Population Appendix I.

[2] The Child Welfare caseload excludes assessments done by Child Protective Services; Psychiatric Residential Treatment, which is part of the Office of Mental Health and Addiction Services (OMHAS); and Developmentally Disabled Foster Care, which is part of Seniors and People with Disabilities (SPD).

Forecast

The total Child Welfare caseload appears in Exhibit 15, detailed by program. Since this is the first time these caseloads have been forecasted in this fashion, the comparisons made will be between biennia, and not between forecasts.

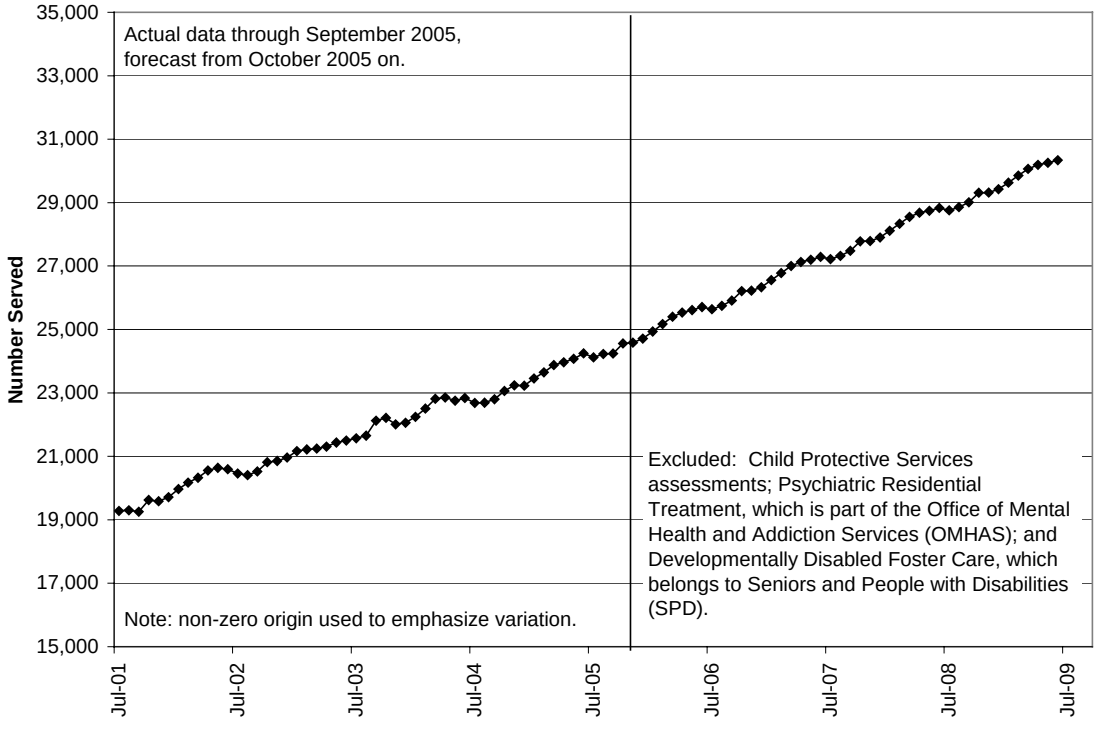
Overall, the Child Welfare caseload is expected to increase 12.4 percent from the actual 2003-05 biennial average of 22,736 children to the forecast 2005-07 biennial average of 25,544 children. This is consistent with the historical trend, which can be seen in Exhibit 16.

Exhibit 15: Total Child Welfare Biennial Average Comparison by Forecasts

	Actuals 2003-2005	Forecast 2005-2007	03-05 to 05-07 Change	% Change	Forecast 2007-2009	05-07 to 07-09 Change	% Change
Total Child Welfare	22,736	25,544	2,808	12.4%	28,642	3,098	12.1%
Adoption Assistance	8,222	9,635	1,413	17.2%	11,049	1,414	14.7%
Subsidized Guardianship	392	582	190	48.5%	762	180	30.9%
Foster Care	9,132	10,820	1,688	18.5%	12,130	1,310	12.1%
Child in Home	4,990	4,507	(483)	-9.7%	4,701	194	4.3%

Note: excludes Child Protective Services assessments; Psychiatric Residential Treatment, which is part of the Office of Mental Health and Addiction Services (OMHAS); and Developmentally Disabled Foster Care, which which is part of Seniors and People with Disabilities (SPD).

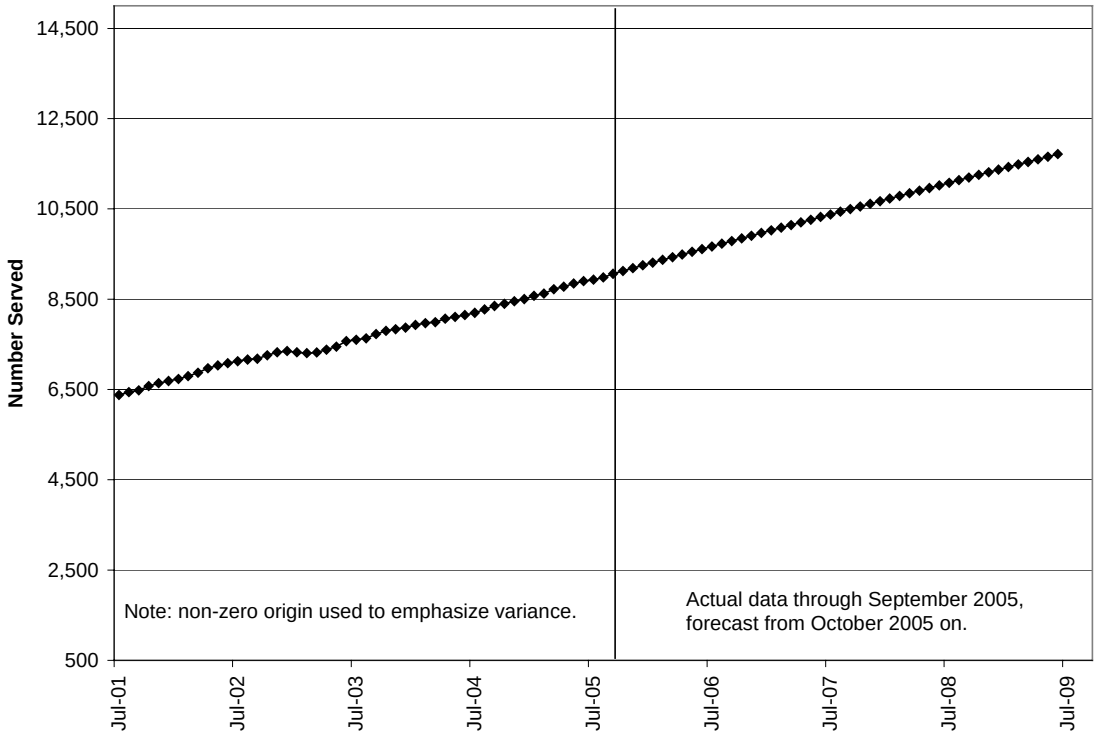
Exhibit 16: Total Child Welfare Number Served



Adoption Assistance

The Spring 2006 forecast for number served in **Adoption Assistance** is predicted to increase 17.2 percent from the actual 2003-05 biennial average of 8,222 children to 9,635 children in the 2005-07 biennium. As shown in Exhibit 17, this is consistent with the historical trend.

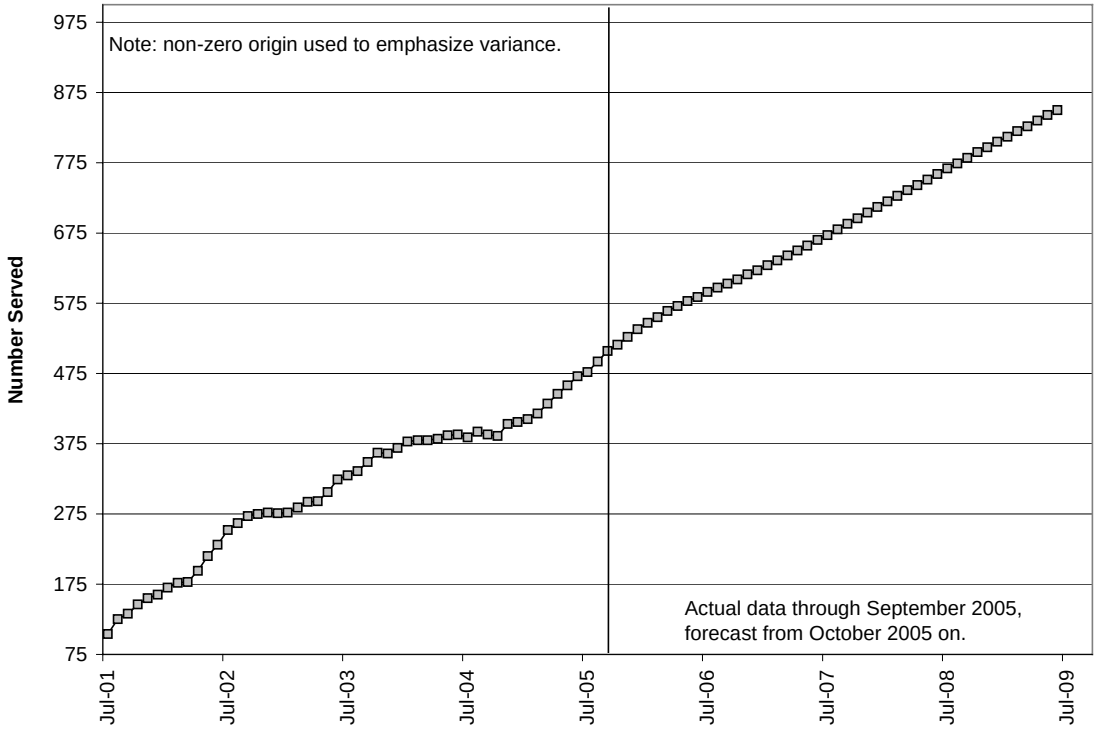
Exhibit 17: Child Welfare Adoption Assistance Number Served



Subsidized Guardianship

The number served forecast for the relatively small caseload of **Subsidized Guardianship** is predicted to grow 48.5 percent from an actual 392 biennial average for 2003-05 to a forecast biennial average of 582 for 2005-07. In Exhibit 18, one can see a leveling off of the caseload during 2004. This was due primarily to concerns that the waiver authorizing the program might be terminated. Once these concerns subsided, the caseload resumed its historical growth pattern, which is reflected in the Spring 2006 forecast.

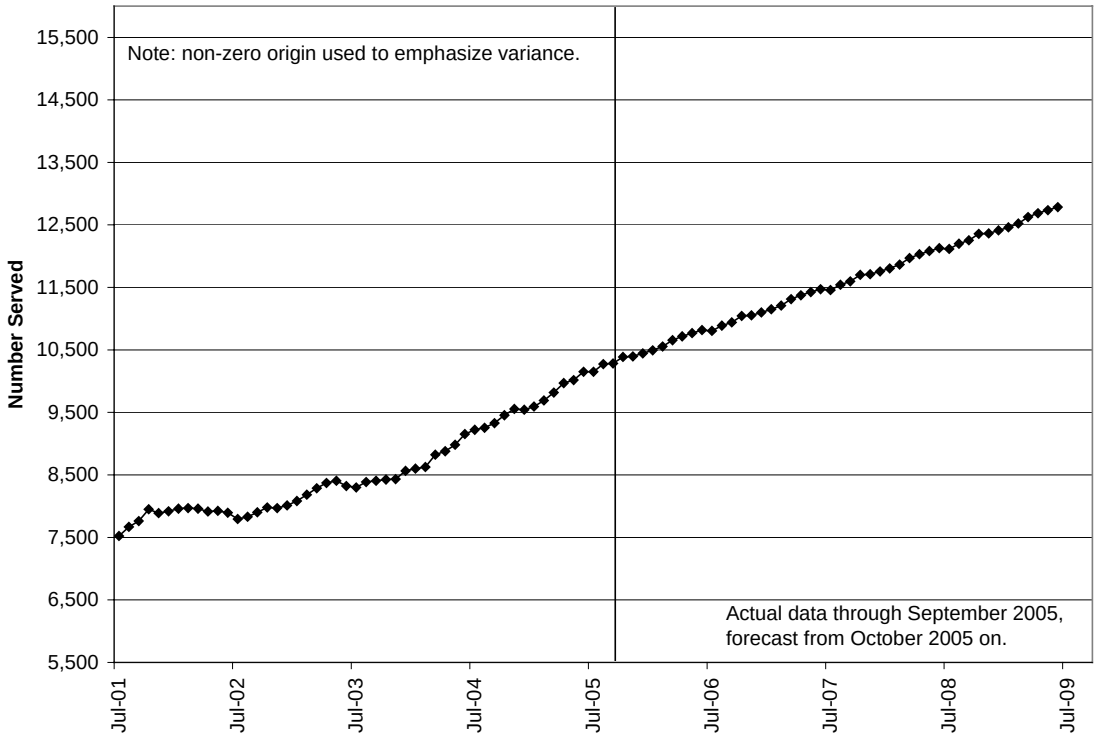
Exhibit 18: Child Welfare Subsidized Guardianship Number Served



Foster Care

For **Foster Care**, the Spring 2006 forecast predicts growth of 18.5 percent from 9,132 children for the 2003-05 biennium to 10,820 children for the 2005-07 biennium. As shown in Exhibit 19, this caseload increased more rapidly from 2003 through 2005 than 2001 and 2002. While no quantitative data are available, anecdotal information suggests that this recent increase may be due to the burgeoning number of parents addicted to methamphetamines and methamphetamines labs in homes. The rate of increase in the Foster Care caseload seems to have tapered off slightly in recent months, so the Spring 2006 forecast projects steady but somewhat dampened growth.

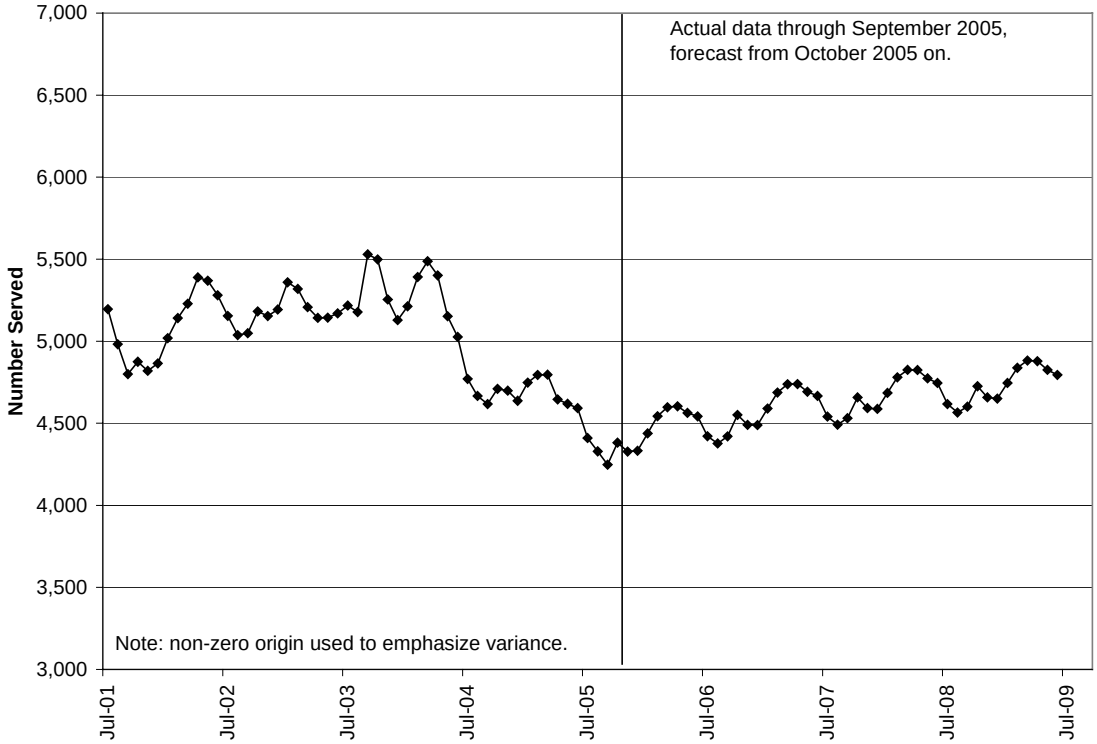
Exhibit 19: Child Welfare Foster Care Number Served



Child In-Home

The Spring 2006 forecast projection for **Child in Home** caseload is down 9.7 percent from the 4,990 actual biennial average for 2003-05 to a forecast 4,507 biennial average for 2005-07. As shown in Exhibit 20, this caseload has fallen since the middle of 2004. This may be an indication that fewer children were in situations where they could remain in their homes. This would be consistent with the impact of methamphetamine, which creates an environment where children must be removed. The fact that the overall Child Welfare caseload maintained a steady upward trend even while the Child in Home caseload fell, suggests a possible shift from in-home care to foster care, which further reinforces the notion that fewer of these children can be safely left at home.

Exhibit 20: Child Welfare Child In-Home Number Served



VOCATIONAL REHABILITATION

The Office of Vocational Rehabilitation Services (OVRS) helps individuals with disabilities get and keep a job. It does this by partnering with community resources and purchasing training and services from a range of local providers. Funding comes from a combination of state and federal sources.

Forecast

For the Fall 2005 forecast, which was the first time the Vocational Rehabilitation (VR) client caseload was forecasted, the client caseload represented a count of clients at the end of the month in each of four categories: application processing, plan development, plan implementation, and post-employment. However, this approach did not adequately model the VR caseload. In its place, the Spring 2006 forecast used the overall caseload, defined as the number of unique clients served during a month.

In order to provide comparable data, the Fall 2005 forecast was adjusted using this new definition and methodology. This produced a 2005-07 biennial average of 10,229 clients for the Fall 2005 forecast. The Spring 2006 forecast of 9,895 clients is 3.3 percent lower, as shown in Exhibit 21.

Exhibit 21: Vocational Rehabilitation Biennial Average Comparisons by Forecast

	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
VOCATIONAL REHABILITATION (Clients Served[1])		10,229			9,895	

1. Fall 2005 end-of-month counts translated to clients served using average ratio from January 2003 through June 2005.

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
VOCATIONAL REHABILITATION (Clients Served[1])	10,229	9,895	-3.3%	10,562	9,869	-6.6%

1. Fall 2005 end-of-month counts translated to clients served using average ratio from January 2003 through June 2005.

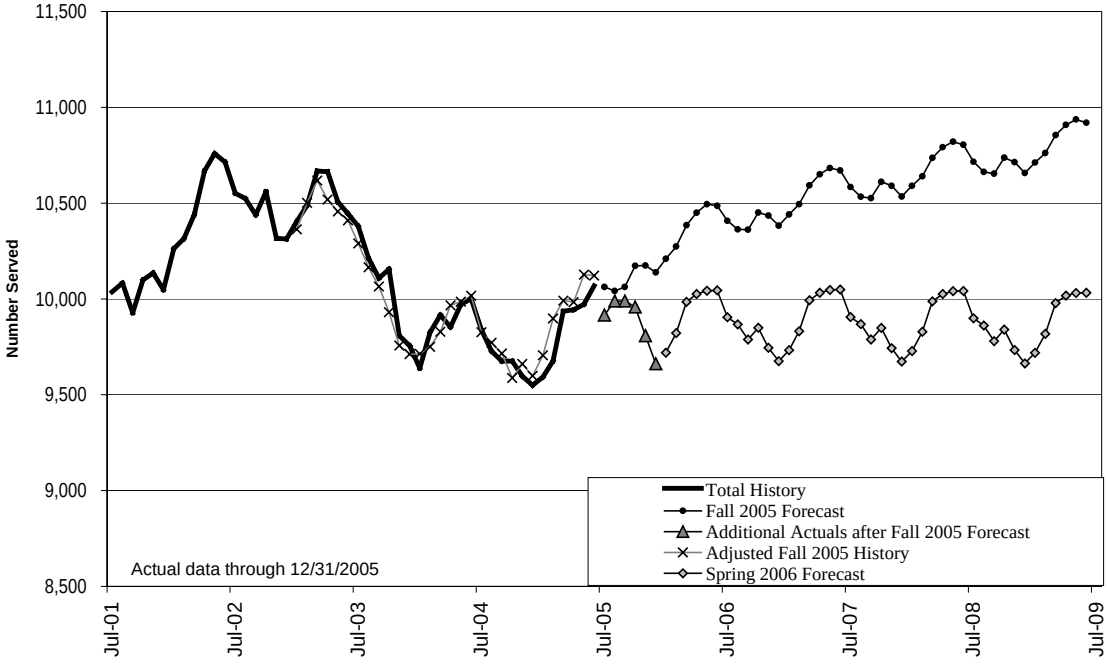
Forecast

The Fall 2005 forecast projected the VR caseload to gradually return to the levels experienced back in 2002 and 2003 (see Exhibit 22). However, the additional actuals show caseloads remaining at the levels experienced during 2004 and 2005. The Spring 2006 forecast projects a continuation of this flattened trend.

Risks and Assumptions

A key assumption of the Spring 2006 forecast is that VR caseloads will follow the flattened trend exhibited during 2004 and 2005. However, there is a risk that they could return to their 2003-2004 levels, in which case the Fall 2005 forecast would be a more appropriate projection.

Exhibit 22: Vocational Rehabilitation Number Served



Note: Caseload based on number of unique clients served during the month. Previous forecast based on end-of-month count, so factor based on average ratio of number served to end-of-month for January 2003 through June 2005 used to translate end-of-month counts to equivalent number served.

MEDICAL ASSISTANCE PROGRAMS

INTRODUCTION

The Office of Medical Assistance Programs (OMAP) provides health insurance coverage for low-income Oregonians. OMAP programs are divided into three major categories: Oregon Health Plan Plus (OHP Plus), Oregon Health Plan Standard (OHP Standard), and Other Medical Assistance Programs that are administered by the Office of Medical Assistance Programs. These three groups are shown in Exhibit 1 along with the names of the individual programs within each group. The specific services covered through the various OMAP programs are established by administrative rule. 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. Forecasts for each of the thirteen programs listed in Exhibit 1 are discussed below.

Exhibit 1: Office of Medical Assistance Programs benefit groups within program categories.

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

Comparisons of Forecasts Over Time

Exhibit 2 provides comparisons of the previous three semi-annual forecasts including the current forecast, for each of the thirteen OMAP programs. These are summary tables and the appropriate portion of each of these tables is reprinted under the OHP Plus, OHP Standard and Other Medical Assistance Programs sections. These tables provide an overview of how the forecasts have changed over time as the historical activity in the individual programs has changed.

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

	2005-07 Biennium					
Comparision:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
OHP Plus						
TANF-Related Medical		108,523			96,056	
TANF-Extended		40,477			41,507	
Subtotal - TANF*	**129,208**	**149,000**	15.3%	**129,208**	**137,564**	6.5%
Poverty Level Medical - Women	9,185	9,973	8.6%	9,185	9,926	8.1%
Poverty Level Medical - Children	79,402	76,012	-4.3%	79,402	82,380	3.8%
Aid to the Blind & Disabled	58,639	63,871	8.9%	58,639	61,912	5.6%
Old Age Assistance	31,574	30,691	-2.8%	31,574	30,872	-2.2%
Foster Care	16,390	19,065	16.3%	16,390	18,446	12.5%
Children's Health Insurance Program	21,702	27,633	27.3%	21,702	31,235	43.9%
OHP Plus subtotal	**346,100**	**376,245**	8.7%	**346,100**	**372,335**	7.6%
OHP Standard						
Families	7,000	7,000	0.0%	7000	7,000	0.0%
Adults/couples	17,000	17,000	0.0%	17000	17,000	0.0%
OHP Standard	**24,000**	**24,000**	0.0%	**24,000**	**24,000**	0.0%
Other Medical Assistance Programs						
Citizen-Alien Waived Emergency Medical	21,962	19,742	-10.1%	21,962	18,118	-17.5%
Qualified Medicare Beneficiary	9,835	10,678	8.6%	9,835	11,193	13.8%
Breast & Cervical Cancer program	219	297	35.6%	219	320	46.0%
Other Subtotal	**32,016**	**30,717**	-4.1%	**32,016**	**29,630**	-7.5%
Total Medical Assistance Programs	**402,116**	**430,962**	7.2%	**402,116**	**425,965**	5.9%

Exhibit 2 (continued)

	2005-07 Biennium			2007-09 Biennium		
Comparision:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 2005 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
OHP Plus						
TANF-Related Medical	108,523	96,056	-11.5%	134,870	96,881	-28.2%
TANF-Extended	40,477	41,507	2.5%	48,435	42,508	-12.2%
Subtotal - TANF*	**149,000**	**137,564**	-7.7%	**183,305**	**139,389**	-24.0%
Poverty Level Medical - Women	9,973	9,926	-0.5%	10,685	10,698	0.1%
Poverty Level Medical - Children	76,012	82,380	8.4%	71,978	82,894	15.2%
Aid to the Blind & Disabled	63,871	61,912	-3.1%	71,615	64,811	-9.5%
Old Age Assistance	30,691	30,872	0.6%	30,957	32,805	6.0%
Foster Care	19,065	18,446	-3.2%	22,483	20,334	-9.6%
Children's Health Insurance Program	27,633	31,235	13.0%	28,093	35,990	28.1%
OHP Plus subtotal	**376,245**	**372,335**	-1.0%	**419,115**	**386,921**	-7.7%
OHP Standard						
Families	7,000	7,000	0.0%	7,000	7,000	0.0%
Adults/couples	17,000	17,000	0.0%	17,000	17,000	0.0%
OHP Standard	**24,000**	**24,000**	0.0%	**24,000**	**24,000**	0.0%
Other Medical Assistance Programs						
Citizen-Alien Waived Emergency Medical	19,742	18,118	-8.2%	22,436	17,118	-23.7%
Qualified Medicare Beneficiary	10,678	11,193	4.8%	11,371	12,012	5.6%
Breast & Cervical Cancer program	297	320	7.7%	419	468	11.8%
Other Subtotal	**30,717**	**29,630**	-3.5%	**34,226**	**29,598**	-13.5%
Total Medical Assistance Programs	**430,962**	**425,965**	-1.2%	**477,341**	**440,519**	-7.7%

* TANF not broken out into TANF Related Medical and TANF Extended for Spring '05

TOTAL MEDICAL ASSISTANCE PROGRAMS FORECAST

The total OMAP caseload was 421,644 clients in September 2005, the last month of available data. During the historical period shown in Exhibit 3, caseload growth began to accelerate beginning in January 2001, reaching a historical high of 468,533 clients in April 2002. Over the following ten months, until February 2003, the total caseload remained stable with an average of about 464,000 clients. Beginning in March 2003, the total caseload began to decline relatively rapidly until it reached a low of 415,260 clients in December 2003. It was during this period that management actions designed to address budgetary issues were implemented, such as the closure of some small medical assistance programs and the reduction of certain benefits in the OHP Standard program. The effect of these management actions and associated policy changes was to decrease the OHP Standard caseload by approximately 50,000 clients.

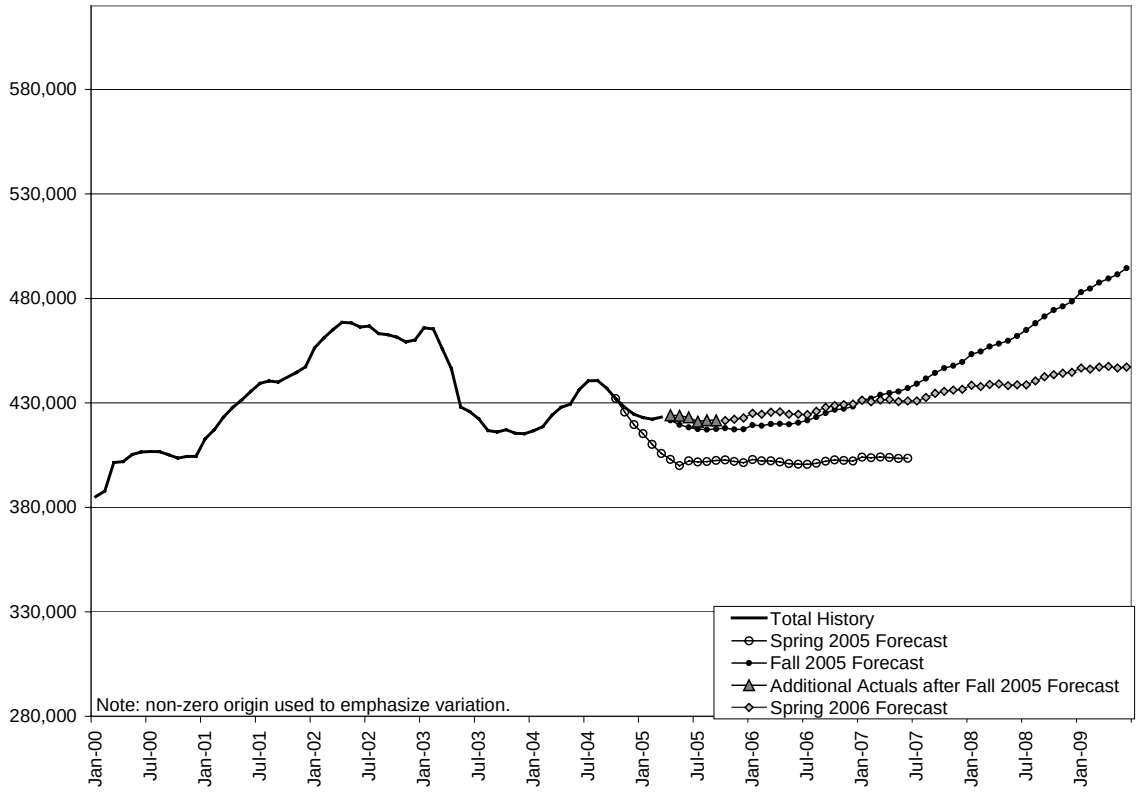
Beginning in early 2004, increased outreach by advocates in response to news of the planned closure of OHP Standard contributed to a brief period of accelerated growth in OMAP programs. The total OMAP client population was about 440,000 clients in the summer of 2004 with the OHP Standard groups (OHP Standard Families, and OHP Adults and Couples) accounting for nearly 57,000 of those clients. In July 2004, the OHP Standard program was closed to all new clients. This closure to new applicants had the effect of reducing the OHP Standard population, and thus the total OMAP caseload.

Forecast

The Spring 2006 forecast for all OMAP programs (see Exhibit 3) predicts slow growth through June 2009. By June 2007, the total client population is expected to reach 430,482 clients. By June 2009 the population is expected to climb to 446,574 clients.

The Spring 2006 forecast predicts a 2005-07 biennial average 1.2 percent lower than the Fall 2005 forecast, and a 2007-09 biennial average approximately 7.7 percent lower than the Fall 2005 forecast. Exhibit 3 displays the history and comparative forecasts for the total OMAP caseload.

Exhibit 3: Total Medical Assistance Programs Caseload



OREGON HEALTH PLAN PLUS

As noted in the introduction, the Oregon Health Plan Plus program represents one of three program categories administered by the DHS Office of Medical Assistance Programs (OMAP). In February 2003, the Department replaced the original OHP Basic benefit package with the OHP Plus package. The OHP Plus package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules. The total OHP Plus population is broken into eight categories that will be described in greater detail in each section below.

The OHP Plus population constitutes the largest proportion of total OMAP clients with 86.7 percent of the total in September of 2005. During the full historical period (see Exhibit 6), increased growth began in January of 2001, reaching 330,169 by April of 2002. Over the following 20 months, until December of 2003, the total caseload remained relatively stable. Beginning in January of 2003, the total Plus caseload grew once again until reaching an historical high of 365,659 in September of 2005, the last month of historical data available for the Spring 2006 forecast.

Forecast

The combined total forecast for all the eight benefit groups within the OHP Plus program anticipates a growth of approximately 613 clients per month over the next two biennia. By June of 2007, the total Plus client population is expected to reach 377,120. By June of 2009, the population is expected to climb to 392,654.

The Spring 2006 total OHP Plus forecast is approximately 1 percent lower than the Fall 2005 forecast for the 2005-07 biennium and 7.7 percent lower for the 2007-09 biennium. Exhibit 5 displays the history and comparative forecasts for the combined caseloads comprising the OHP Plus program.

Exhibit 4: Oregon Health Plan Plus benefit groups within the Office of Medical Assistance Programs program categories.

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

Exhibit 5: Oregon Health Plan Plus Biennial Average Comparison by Forecasts.

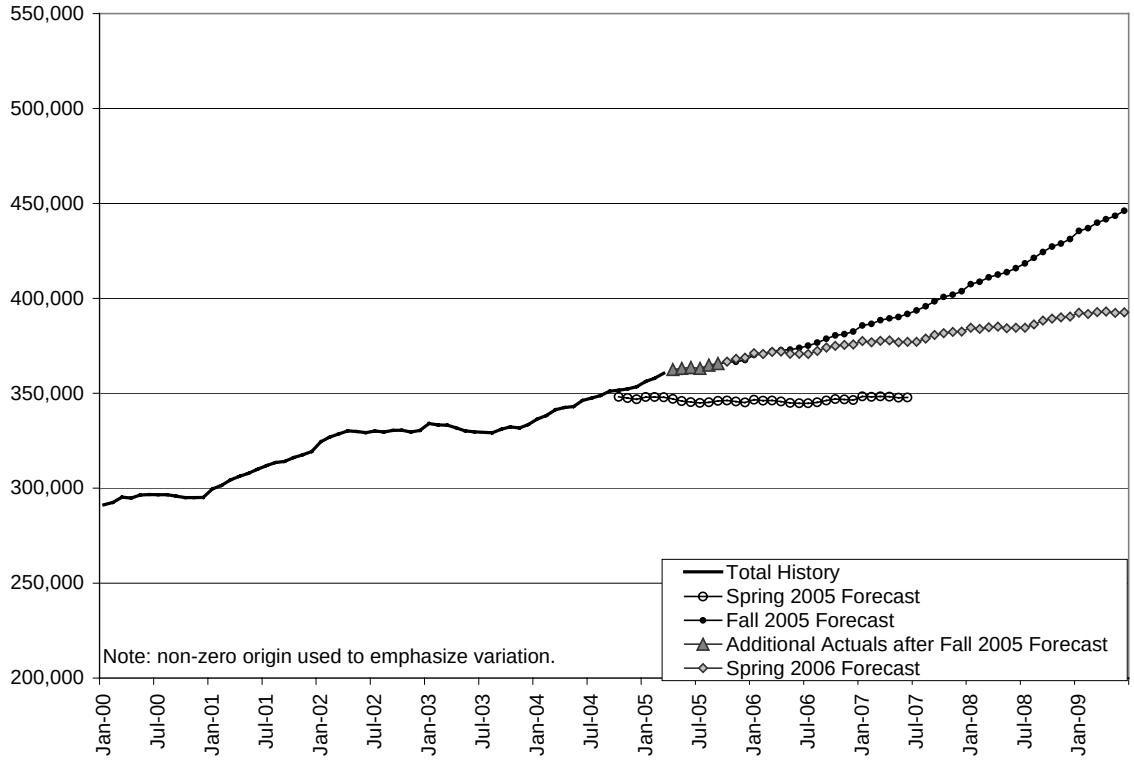
	2005-07 Biennium					
Comparision:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
OHP Plus						
TANF-Related Medical		108,523			96,056	
TANF-Extended		40,477			41,507	
Subtotal - TANF	**129,208**	**149,000**	15.3%	**129,208**	137,564	6.5%
Poverty Level Medical - Women	9,185	9,973	8.6%	9,185	9,926	8.1%
Poverty Level Medical - Children	79,402	76,012	-4.3%	79,402	82,380	3.8%
Aid to the Blind & Disabled	58,639	63,871	8.9%	58,639	61,912	5.6%
Old Age Assistance	31,574	30,691	-2.8%	31,574	30,872	-2.2%
Foster Care	16,390	19,065	16.3%	16,390	18,446	12.5%
Children's Health Insurance Program	21,702	27,633	27.3%	21,702	31,235	43.9%
OHP Plus Total	**346,100**	**376,245**	8.7%	**346,100**	**372,335**	8%

* TANF not broken out into TANF Related Medical and TANF Extended for Spring '05

Exhibit 5 (continued)

	2005-07 Biennium			2007-09 Biennium		
Comparision:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 2005 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
OHP Plus						
TANF-Related Medical	108,523	96,056	-11.5%	134,870	96,881	-28.2%
TANF-Extended	40,477	41,507	2.5%	48,435	42,508	-12.2%
Subtotal - TANF*	**149,000**	137,564	-7.7%	**183,305**	**139,389**	-24.0%
Poverty Level Medical - Women	9,973	9,926	-0.5%	10,685	10,698	0.1%
Poverty Level Medical - Children	76,012	82,380	8.4%	71,978	82,894	15.2%
Aid to the Blind & Disabled	63,871	61,912	-3.1%	71,615	64,811	-9.5%
Old Age Assistance	30,691	30,872	0.6%	30,957	32,805	6.0%
Foster Care	19,065	18,446	-3.2%	22,483	20,334	-9.6%
Children's Health Insurance Program	27,633	31,235	13.0%	28,093	35,990	28.1%
OHP Plus Total	**376,245**	**372,335**	-1.0%	**419,115**	**386,921**	-7.7%

Exhibit 6: Total Medical Assistance Program OHP Plus Caseload

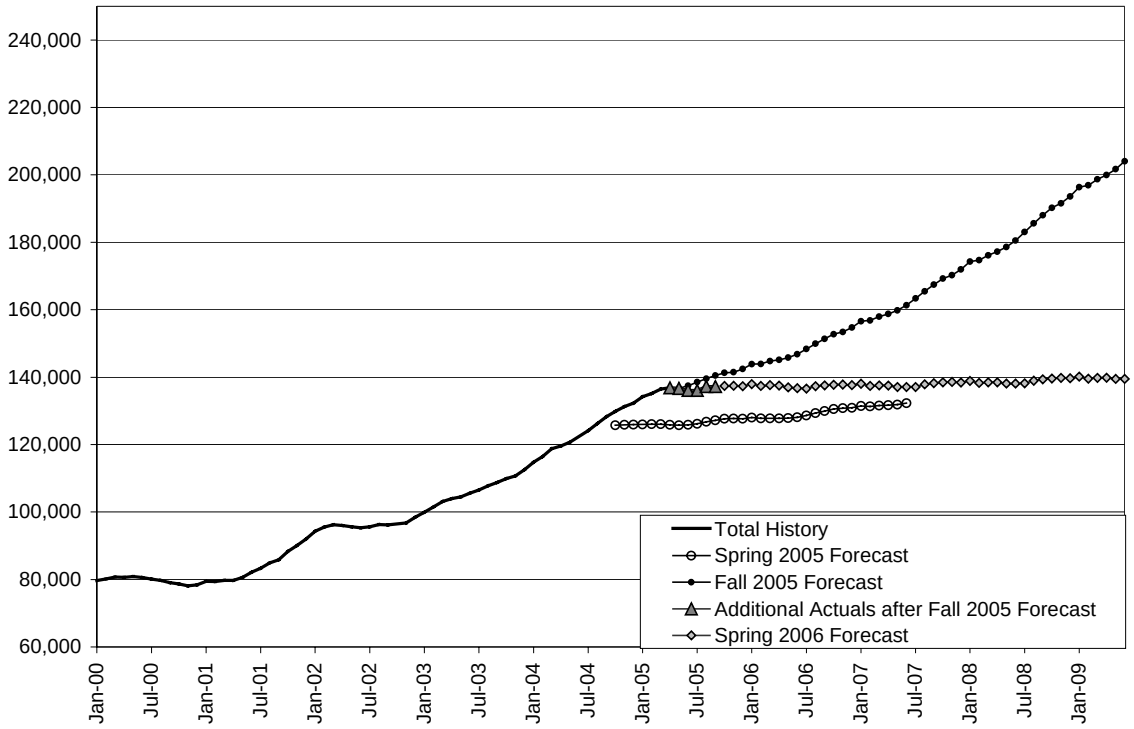


Oregon Health Plan Plus Total Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program is made up of two groups, TANF Related Medical and TANF Extended. These caseloads are closely tied programmatically but differ in their characteristics. Clients in the TANF Related Medical program are those who meet the criteria to receive TANF cash grants. However, they may choose to receive both cash and medical benefits, or medical benefits only. Clients in the TANF Extended caseload are individuals who have left TANF Related Medical due to changes in their financial circumstances related to increased employment income or child support payments. These clients may receive up to 12 months of transitional benefits if the increase in income is due to employment, or four months if the increase is due to child support payments.

The total TANF medical assistance caseload experienced steady growth from late 2002 through April 2005 and then saw a leveling off over the summer of 2005. The growth has largely occurred in the TANF Related Medical caseload, and more specifically among families who have chosen to receive medical assistance only, but not the cash assistance or other services offered by the Self Sufficiency Program. The growth in TANF programs responds to economic downturns, outreach by related human services programs such as food stamps, and changes in DHS business practices due to implementation of budget-cutting measures in the Oregon Health Plan Exhibit 7 displays the history and comparative forecasts for these group.

Exhibit 7: Total Temporary Assistance for Needy Families Caseload



Temporary Assistance for Needy Families Related Medical

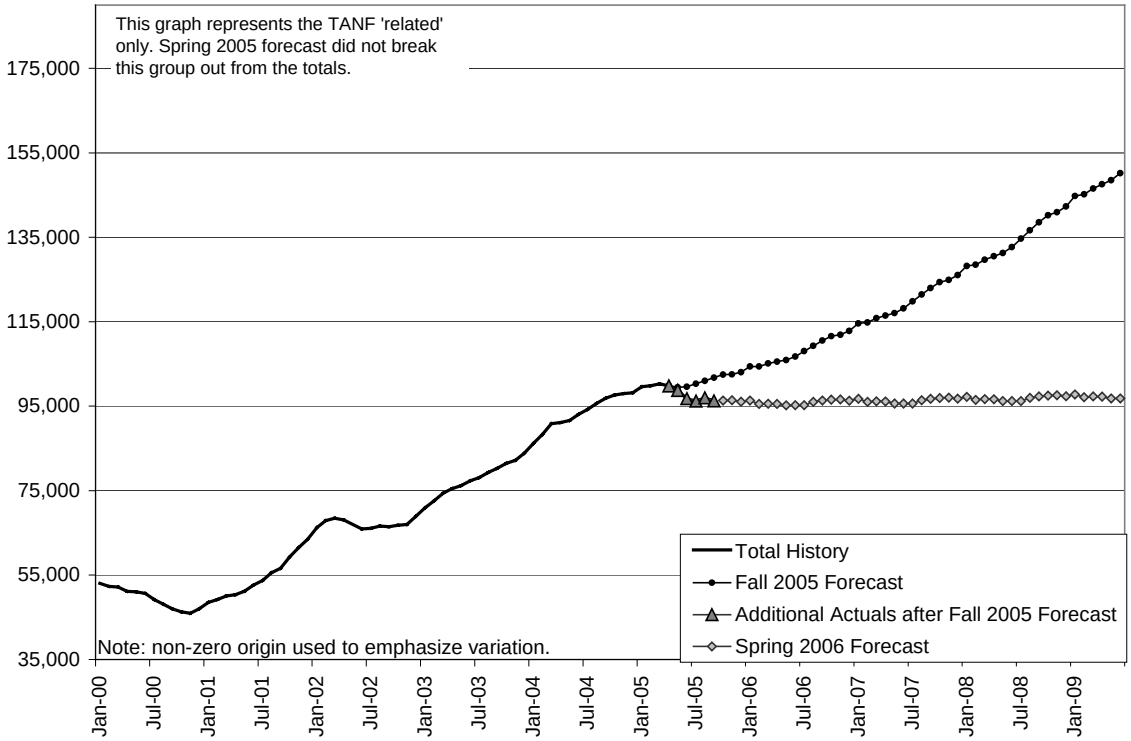
The TANF Related Medical caseload experienced its largest and most sustained period of growth between November 2002 and March 2005. During this period, the caseload grew to a historic high of 100,309 clients. A similar, but shorter, period of substantial growth occurred between November 2000 and March 2002. Since March 2005, the caseload has declined slightly and leveled off.

Forecast

The Spring 2006 forecast for the 2005-07 biennium predicts that the TANF Related Medical caseload will flatten out in the future due to the leveling off of the number of new clients in the TANF Related Medical program over the summer of 2005 and the decline in overall caseload seen during that period.

The Spring 2006 forecast biennial average is 11.5 percent lower than the Fall 2005 forecast in the 2005-07 biennium. In the 2007-09 biennium, the Spring 2006 forecast biennial average is 28.2 percent lower than the Fall 2005 forecast. Exhibit 8 displays the history and comparative forecasts for this group.

Exhibit 8: Temporary Assistance for Needy Families Related Medical Caseload



Temporary Assistance for Needy Families Extended

The TANF Extended caseload is made up of clients who have left the TANF Related Medical caseload due to increased income, as explained above. This caseload may increase for a period of time after the TANF Related Medical caseload begins to decrease. The TANF Extended caseload remained relatively stable between January 2001 and March 2004. Since then the caseload has increased from 28,400 clients in April 2004 to 41,000 clients in September 2005. Beginning in March 2004, the number of clients moving from TANF Related Medical to TANF Extended increased substantially. The number of clients making this transfer from TANF Related Medical increased from approximately 3,000 clients in March 2004 to a high of approximately 5,000 clients in September 2005.

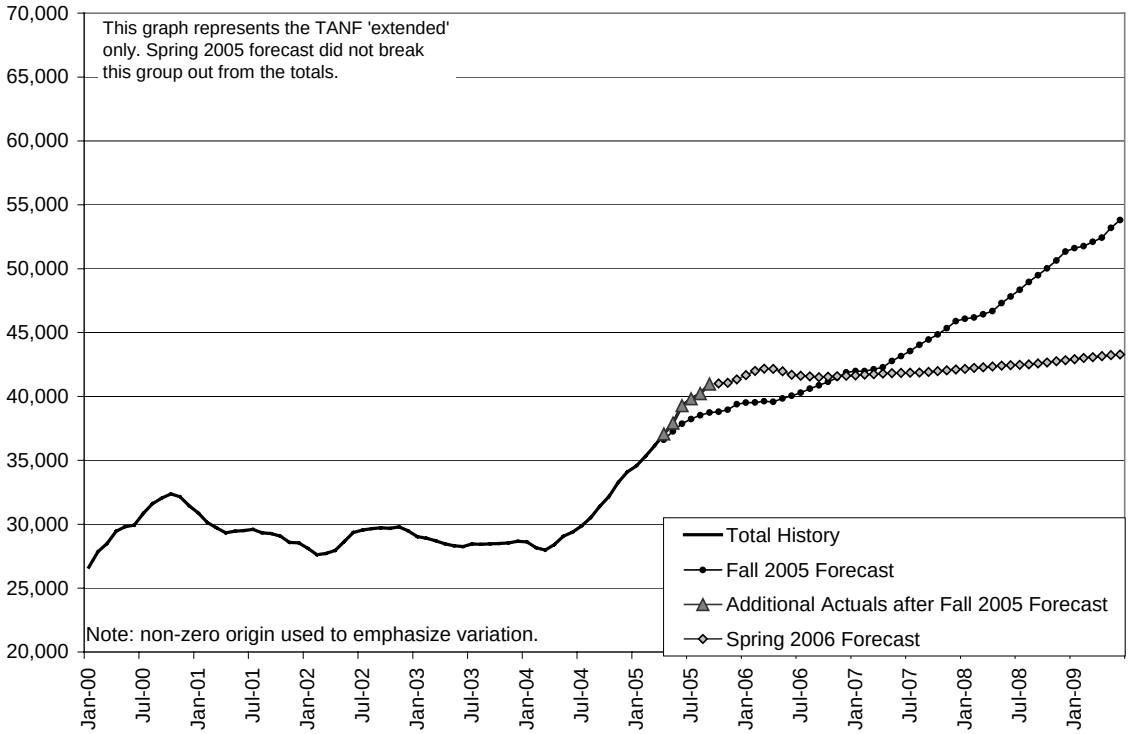
Forecast

For the 2005-07 biennium, the Spring 2006 TANF Extended forecast predicts a continued, but moderating, rise through early 2006 and then a leveling off as the effects of the declining TANF Related Medical caseload roll up into TANF Extended.

The Spring 2006 forecast biennial average is 2.5 percent higher than the Fall 2005 forecast in the 2005-07 biennium. In the 2007-09 biennium, the Spring

2006 forecast biennial average is 12.2 percent lower than the Fall 2005 forecast. Exhibit 9 displays the history and comparative forecasts for this group.

Exhibit 9: Temporary Assistance for Needy Families Extended Caseload



Oregon Health Plan Plus Poverty Level Medical Women

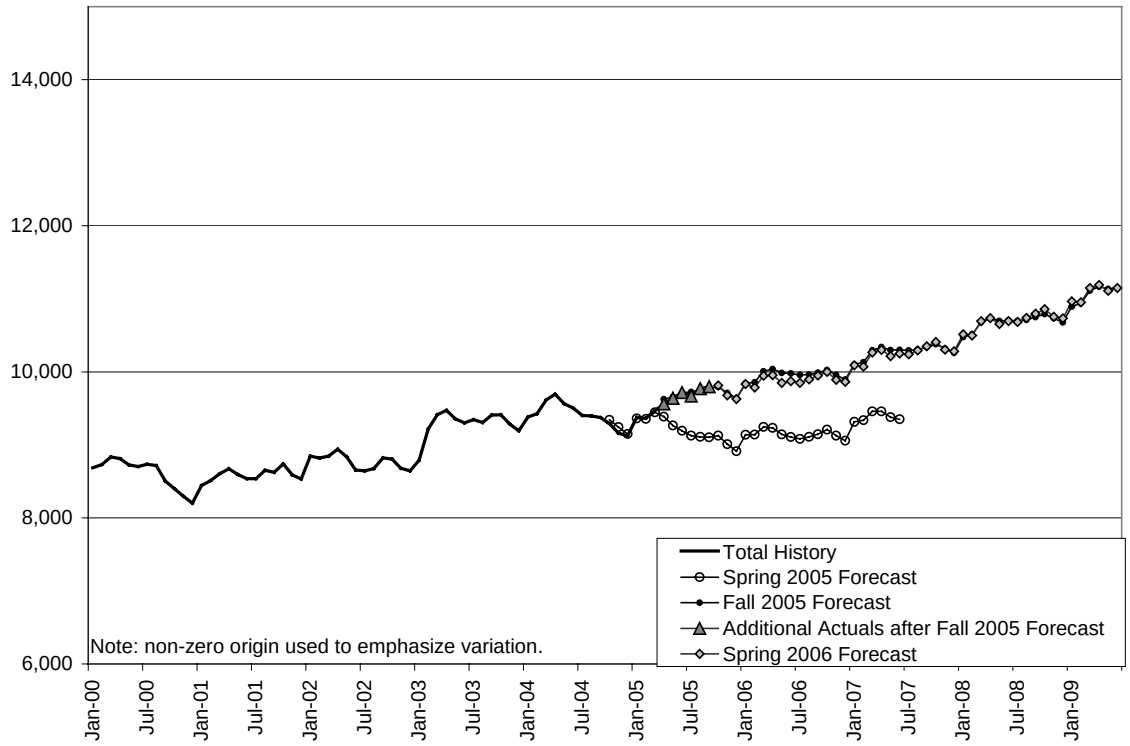
The Poverty Level Medical Women (PLMW) program provides medical insurance coverage to pregnant women with income levels up to 185 percent of the federal poverty level (FPL). Coverage is extended for 60 days after childbirth. The income eligibility limit was increased from 170 percent to 185 percent of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

The Poverty Level Medical Women program group has grown consistently, though moderately, since November 2000. In early 2003, this caseload experienced a large one time increase followed by a return to its prior rate of growth. In April 2004, a downtrend appeared and persisted through December of that year (losing approximately 71 cases per month) that led to a Spring 2005 forecast that predicted a downward trend. However, the most recent available data has indicated that the caseload rebounded over the spring and summer of 2005, returning to a typical overall growth pattern for this caseload.

Forecast

The Spring 2006 forecast of the 2005-07 biennial average for Poverty Level Medical Women is 9,926 and the Fall 2005 forecast was 9,973. The Spring 2006 forecast for this group projects a continuing increase in the caseload through the 2007-09 biennium. The caseload is expected to grow from 9,798 clients in September 2005 to 10,252 clients by June 2007, and 11,149 clients by the end of the 2007-09 biennium. Exhibit 10 displays the history and comparative forecasts for this group.

Exhibit 10: Poverty Level Medical Women Caseload



Oregon Health Plan 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.

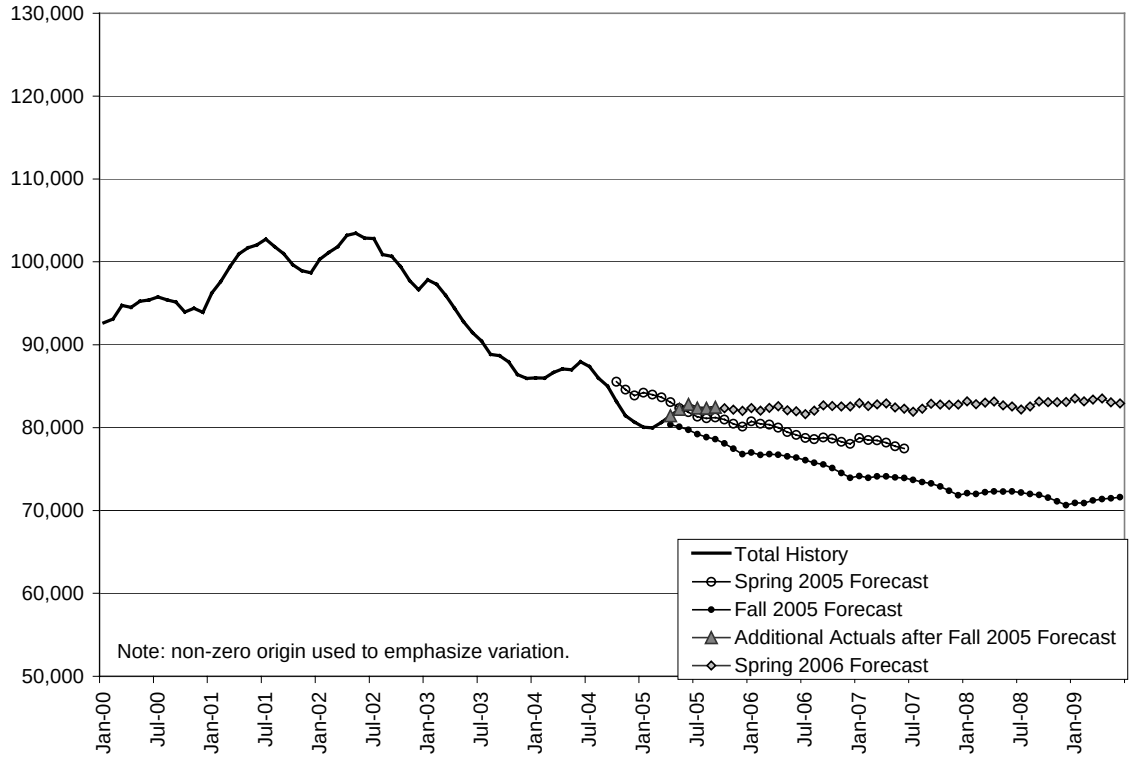
The Poverty Level Medical Children caseload increased intermittently from December 1999 through May 2002 at which time the caseload reached a historical high of 103,440 clients. Since that time the program has experienced a steep decline interspersed with brief periods of growth until it reached a historical low of 79,958 clients in February 2005. Although there was a slight caseload

increase from February 2005 to June 2005, the most recent preliminary data available indicates this caseload has leveled off at approximately 82,000 clients.

Forecast

The Spring 2006 forecast for PLM Children projects this group will continue to stabilize over the 2005-07 and 2007-09 biennia. The caseload is predicted to decline very slightly from the actual caseload count of 82,449 in September 2005 to 82,288 in June 2007 and then increase slightly to 82,925 by the end of the 2007-09 biennium. This predictive trend is based on the stabilization pattern that emerged between January and September of 2005. The prediction of caseload leveling is in contrast to the declines predicted by the Fall 2005 forecast. The Spring 2006 forecast is 8.4 percent higher for the 2005-07 biennium than the Fall 2005 forecast due to this leveling trend that is apparent in the most recently available data. Exhibit 11 displays the history and comparative forecasts for this group.

Exhibit 11: Poverty Level Medical Children Caseload



Oregon Health Plan 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.

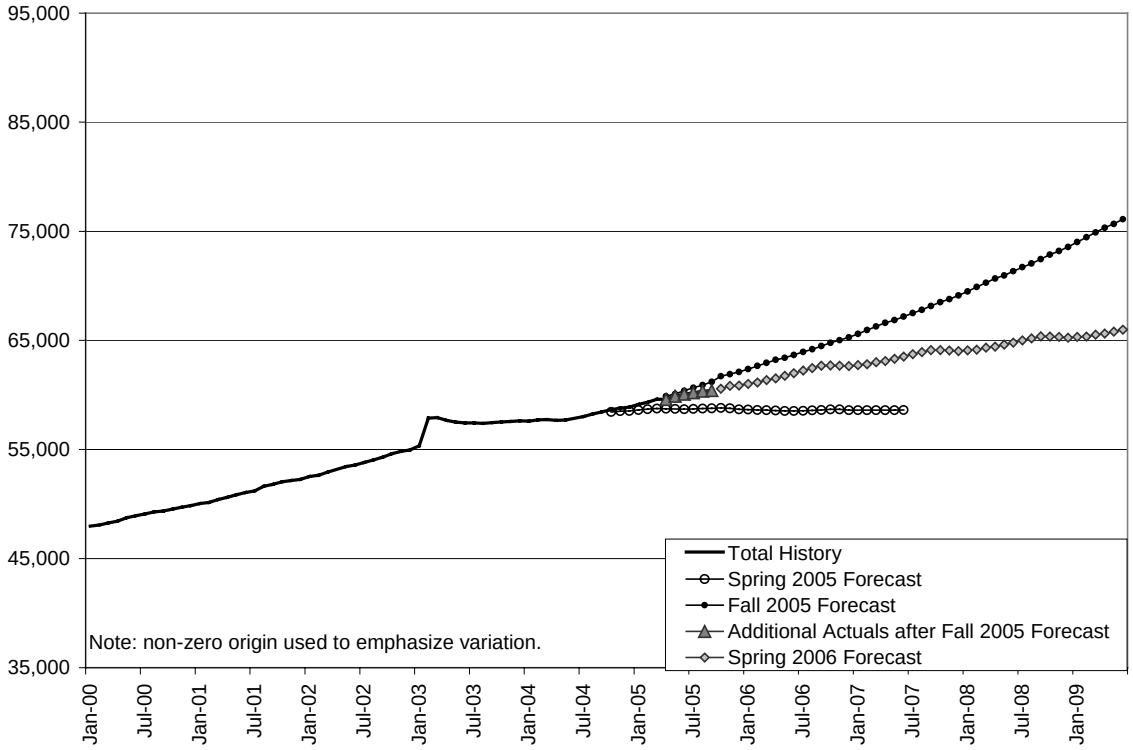
The Aid to the Blind and Disabled caseload increased substantially from July of 1999 through January 2003. During that period the caseload grew from 46,585 clients to 55,332 clients. In February 2003, approximately 2,500 clients entered this caseload after the closure of the General Assistance (GA) program. At the time of the closure, clients were evaluated to determine if they were eligible for other programs. Many had disabilities and qualified for the AB/AD program, causing a one-time increase in AB/AD. The GA program reopened in November 2003 with only a few hundred clients and then closed permanently in October 2005.

After the entrance of the GA clients, the AB/AD caseload remained stable until it began increasing in July 2004. Since that time, the caseload has continued to increase at a rate of approximately 170 clients per month.

Forecast

The Spring 2006 caseload forecast for this group projects an increase through the 2005-07 and 2007-09 biennia similar to that seen since July 2004. The caseload is expected to grow from 60,408 clients in September 2005 to 63,520 clients by June 2007 and 65,989 clients by the end of the 2007-09 biennium. The Spring 2006 biennial average forecast is 3.1 percent lower for the 2005-07 biennium than the Fall 2005 forecast, but about 6 percent higher than the Spring 2005 forecast for the same biennium. The Spring 2006 biennial average forecast is 9.5 percent lower for the 2007-09 biennium than the Fall 2005 forecast. Exhibit 12 displays the history and comparative forecasts for this group.

Exhibit 12: Aid to the Blind and Disabled Caseload



Oregon Health Plan Plus Old Age Assistance

The Old Age Assistance Program provides medical insurance coverage through Medicaid for individuals who are age 65 or over and eligible for federal Supplemental Security Income (SSI). Aged, blind and disabled populations meeting long-term care criteria are eligible up to 300 percent of the SSI level (which is equivalent to approximately 225 percent of the FPL); otherwise, these populations are eligible up to 100 percent of the SSI level.

The Old Age Assistance caseload experienced a fundamental change beginning in February 2003. Prior to February 2003, the caseload increased at a steady pace. In February 2003, the caseload 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 resulted in a stable caseload of approximately 30,000 clients.

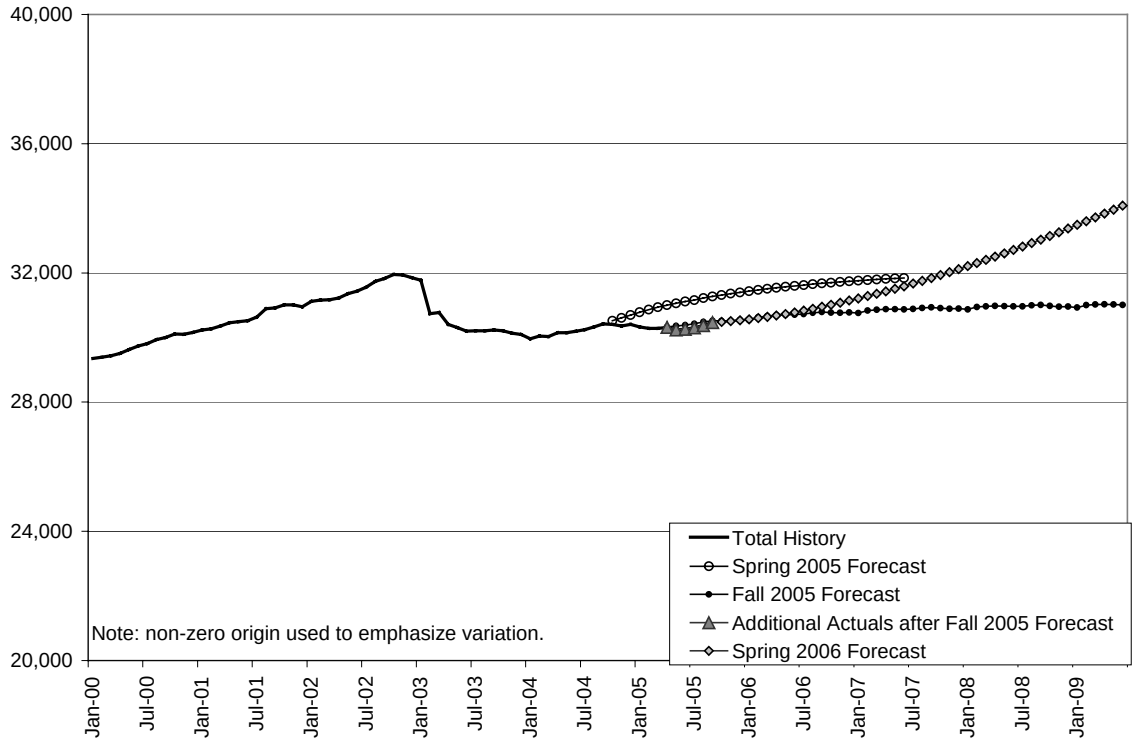
Forecast

The Spring 2006 forecast for this group projects a slow growth through the 2005-07 biennium and then accelerating growth through the 2007-09 biennium. The major contributor to this increase will be disabled clients in the Aid to the Blind and Disabled benefit group. As these disabled clients' turn age 65, they are automatically moved into the OAA group. As the AB/AD caseload grows (see the AB/AD section above for growth predictions), the number of clients reaching age 65 increases and, as a result, the OAA caseload will continue to increase in size.

For the 2005-07 biennium, the Spring 2006 OAA forecast predicts a slight rise to 31,587 by June 2007. By June 2009, the caseload is expected to increase to 34,083.

The Spring 2006 forecast biennial average is 0.6 percent higher than the Fall 2005 forecast for the 2005-07 biennium. For the 2007-09 biennium, the Spring 2006 forecast biennial average is 6.0 percent higher than the Fall 2005 forecast. Exhibit 13 displays the history and comparative forecasts for this group.

Exhibit 13: Old Age Assistance Caseload



Oregon Health Plan Plus Foster/Substitute Care

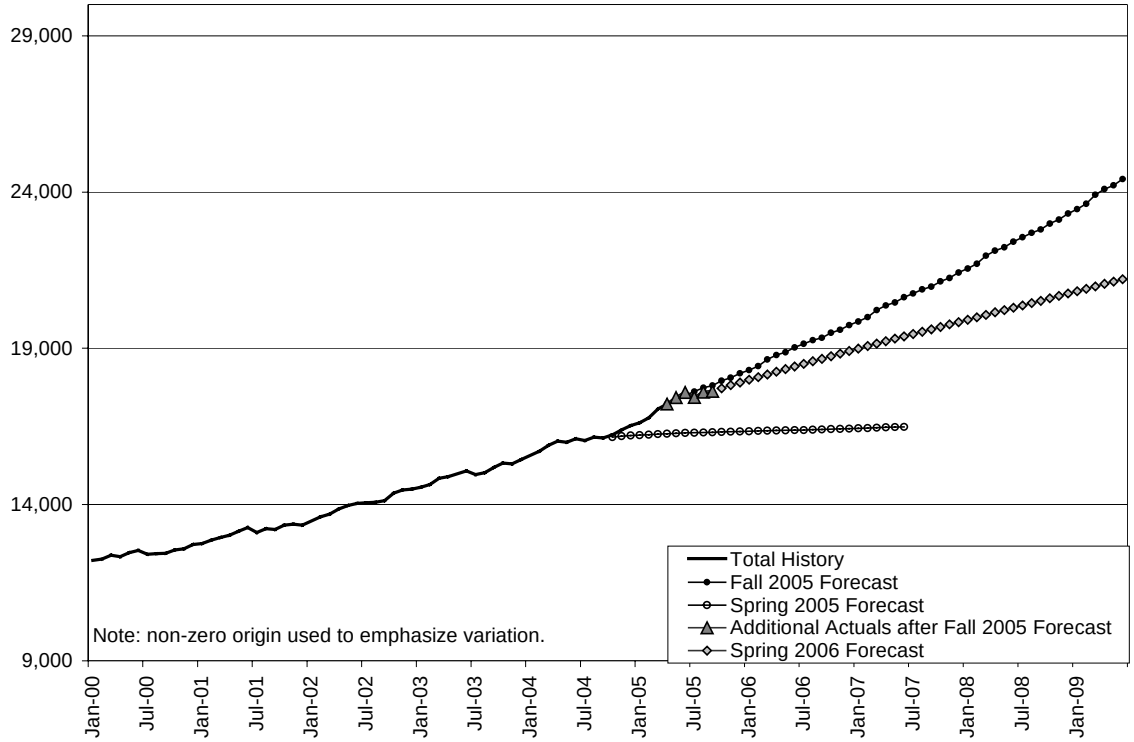
The Foster/Substitute Care benefit group provides medical insurance coverage through Medicaid for children in foster care and children whose adoptive families are receiving adoption assistance payments.

The Foster/Substitute Care caseload has increased consistently since July of 1999 with brief, intermittent periods of flat growth. An analysis of new clients entering this group reveals a pattern of slow growth from August 2004 through September 2005. The effects of the long-running methamphetamine epidemic on foster care are widely considered to be a major contributor to the increase in this caseload.

Forecast

The Spring 2006 forecast for this group projects a continued increase, but not at the same rapid pace predicted in the Fall 2005 forecast due to a slight leveling off apparent in recent months. The Spring 2006 forecast for the 2005-07 biennial average is 3.2 percent lower than that of the Fall 2005 forecast. For 2007-09, the biennial average prediction from the Spring 2006 forecast is 9.6 percent lower than the Fall 2005 forecast. This slower pattern of growth is consistent with the Children, Adults and Families Child Welfare caseload forecast. Exhibit 14 displays the history and comparative forecasts for this group.

Exhibit 14: Foster/Substitute Care Caseload



Oregon Health Plan Plus Children's Health Insurance Program

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

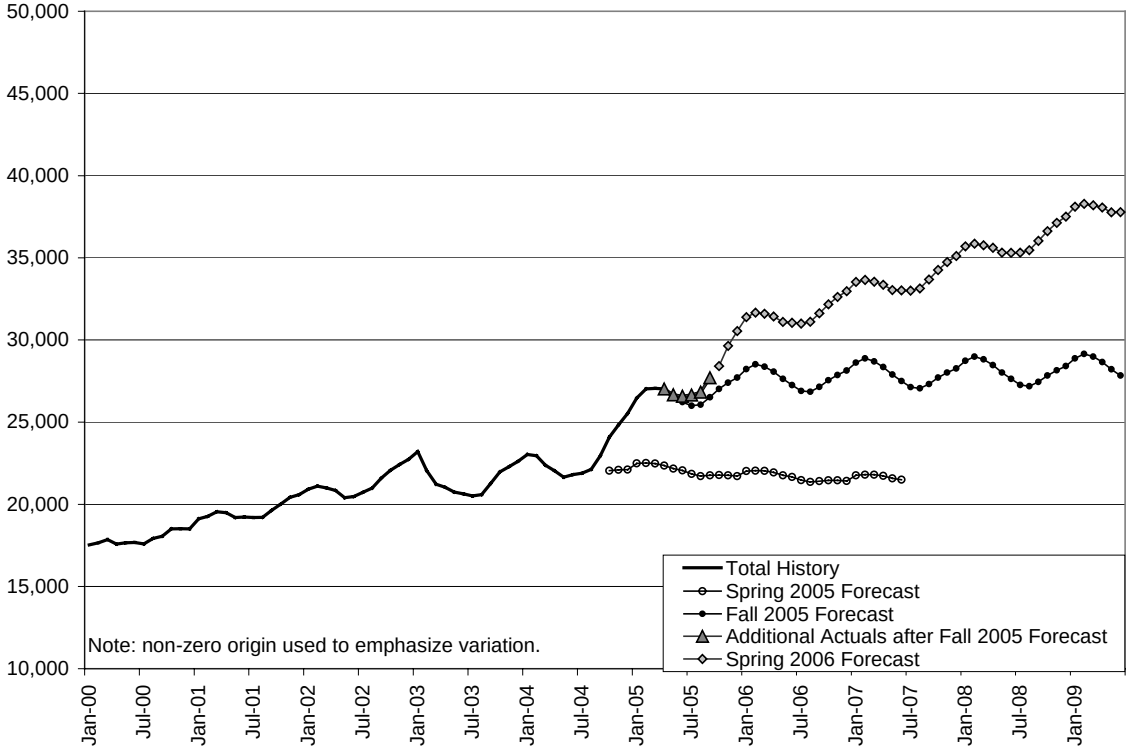
The total CHIP caseload has grown in different patterns over the years. From July of 1999 through November 2001, the CHIP caseload increased slowly but steadily to a total of 20,426. From November 2001 through August 2002, the caseload growth slowed. Beginning around September 2002 and continuing through September 2004, a seasonal pattern of caseload growth and decline with high points occurring near January of each year emerged. In keeping with seasonal patterns, a short period of stabilization appeared in the summer months of 2005 before a return to a steady increase.

Forecast

For the total CHIP caseload, the Spring 2006 forecast estimates an increase from 27,695 clients in September 2005 to 33,014 clients in June 2007 and 37,777 clients by June 2009. As noted above, a pattern of seasonality emerged in the historic data in late 2002 and this pattern continues to appear in the forecast.

Comparing the current Spring 2006 forecast with that of Fall 2005 reveals an estimated increase of 13 percent in the average caseload for the 2005-07 biennium. The Spring 2006 biennial average is 31,235 clients compared to the Fall 2005 biennial average of 27,633 clients. For the 2007-09 biennium, the average caseload predicted by the Spring 2006 forecast is 35,990 clients while the Fall 2005 forecast predicted an average of 28,093, an increase of 28.1 percent. Exhibit 15 displays the history and comparative forecasts for this group.

Exhibit 15: Total Children's Health Insurance Program Caseload



OREGON HEALTH PLAN STANDARD

The OHP Standard program was created in February 2003 with a somewhat reduced package of covered medical services compared to the OHP Plus program that retained the original set of OHP benefits. 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 OHP Standard program consists of two benefit groups: 1) Families, and 2) Adults and Couples. The clients in these two groups are not eligible for traditional Medicaid programs and represent an expansion under the Oregon Health Plan.

Later in 2003, OHP Standard program clients were subject to a variety of benefit cuts and restorations. As of July 2004, this program was closed to new clients. However, individuals already participating in other DHS programs were, and continue to be, allowed to transfer into either the Families or Adults and Couples programs if they are eligible.

In January 2003, the combined population for these two groups was just over 100,000. In February 2004, after 13 months of rapidly decreasing caseloads associated with benefit reductions, increased co-payments and strict enforcement of premium payment requirements, the combined population was fewer than 48,000 clients. During the period immediately prior to closure of the program in July 2004, the caseload increased as a direct result of outreach by advocacy groups. The subsequent closure initiated a caseload decline that has continued through the end of the available historical data. As of September 2005, the combined populations of these two groups stood at 25,798.

All state General Fund support for the Standard program was eliminated during the 2003 legislative session. However, a tax package was proposed by the legislature that would have funded the program. In February 2004 a referendum, Measure 30, was put before voters and defeated, overturning the Legislature's proposed tax package and leaving the Standard program without funding. Subsequently, the program was funded through provider taxes assessed on health care organizations that provide services for OHP clients. In early 2005, an analysis of available revenue indicated that the Standard program could provide benefits for only 24,000 clients. The Spring 2006 forecast presumes that the caseload is maintained at 24,000 clients through the end of the forecast.

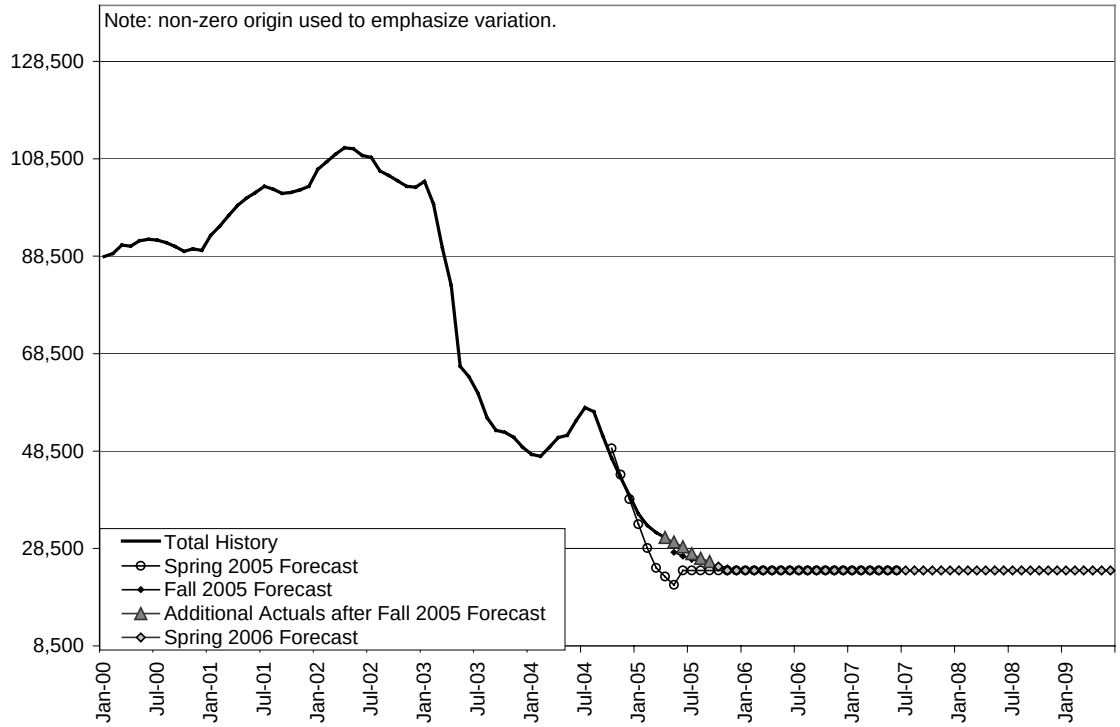
Exhibit 16: Oregon Health Plan Standard within the Office of Medical Assistance Programs program categories.		
OHP Plus	**OHP Standard**	**Other Medical Assistance Programs**
TANF Related Medical	**Adults & Couples**	Qualified Medicare Beneficiary
TANF Extended	**Families**	Citizen-Alien Waived Emergency Medical
Poverty Level Medical Women		Breast & Cervical Cancer Program
Poverty Level Medical Children		
Aid to the Blind & Disabled		
Old Age Assistance		
Foster/Substitute Care		
Children's Health Insurance Program		

Exhibit 17: Total Medical Assistance Programs Standard Biennial Comparison by Forecasts

	2005-07 Biennium					
Comparision:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
OHP Standard						
Families	7,000	7,000	0.0%	7,000	7,000	0.0%
Adults/couples	17,000	17,000	0.0%	17,000	17,000	0.0%
OHP Standard Total	**24,000**	**24,000**	0.0%	**24,000**	**24,000**	0.0%

	2005-07 Biennium			2007-09 Biennium		
Comparision:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Medical Assistance Programs **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 2005 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
OHP Standard						
Families	7,000	7,000	0.0%	7,000	7,000	0.0%
Adults/couples	17,000	17,000	0.0%	17,000	17,000	0.0%
OHP Standard Total	**24,000**	**24,000**	0.0%	**24,000**	**24,000**	0.0%

Exhibit 18: Total Medical Assistance Programs: OHP Standard Program Caseload



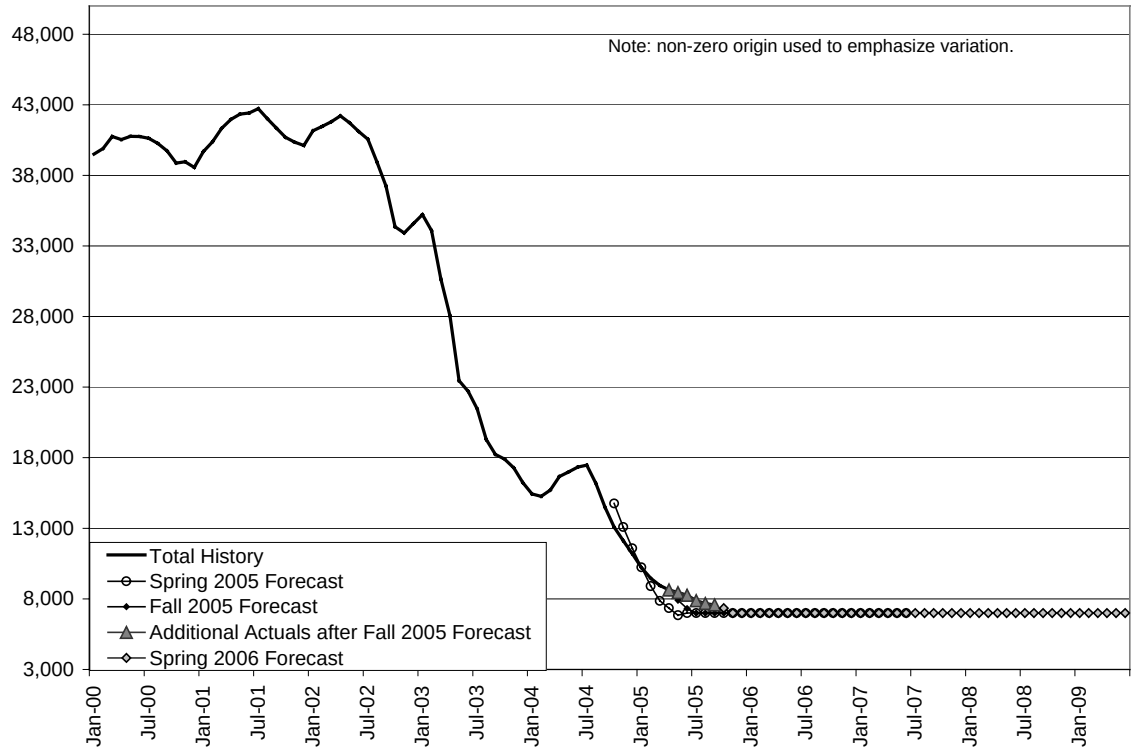
Oregon Health Plan Standard Families

The OHP Standard Families benefit group provides a reduced package of medical benefits for adults whose income is up to 100 percent of the federal poverty level, who have children, but don't qualify for traditional Medicaid programs.

Forecast

The Spring 2006 forecast for this group holds the client population at a constant 7,000. Exhibit 19 displays the history and comparative forecasts for this group.

Exhibit 19: Medical Assistance Programs: OHP Standard Families Caseload



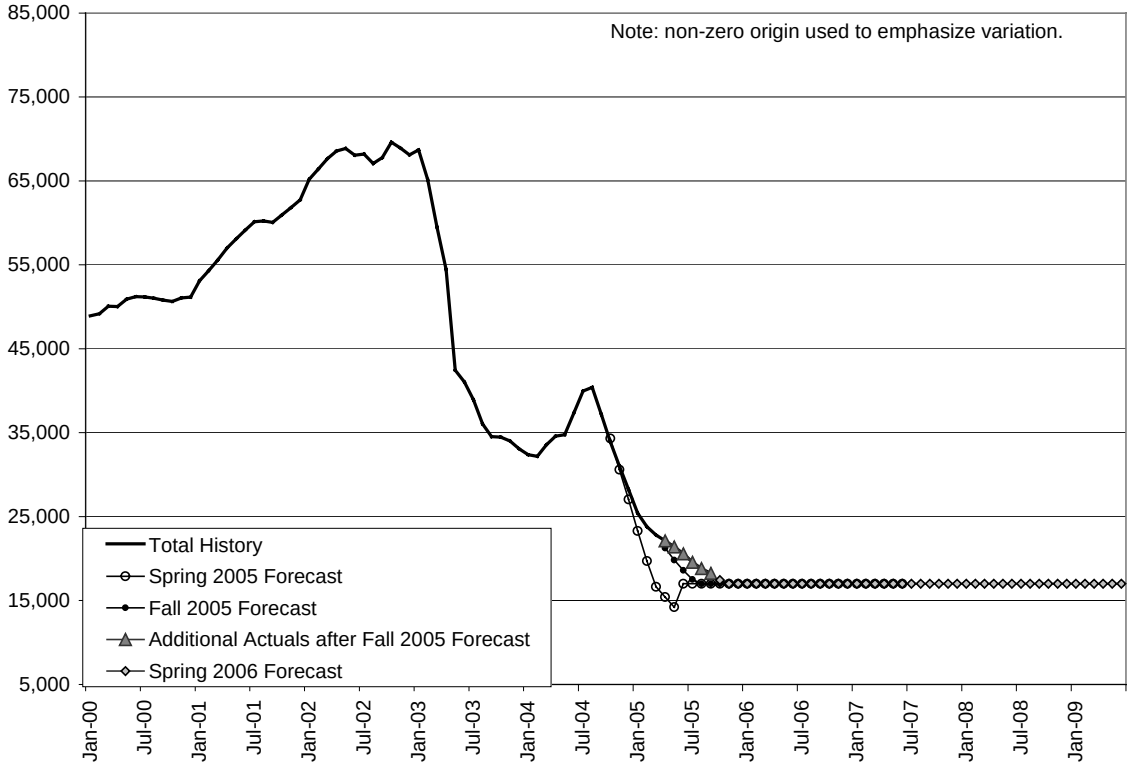
Oregon Health Plan Standard Adults and Couples

The OHP Standard Adults and Couples benefit group provides a reduced package of medical benefits for adults with income up to 100 percent of the federal poverty level, who don't have children, and do not qualify for traditional Medicaid programs.

Forecast

The Spring 2006 forecast for this group projects holds the client population at a constant 17,000. Exhibit 20 displays the history and comparative forecasts for this group.

Exhibit 20: Oregon Health Plan Standard Adults and Couples Caseload



OTHER MEDICAL ASSISTANCE PROGRAMS

Three OMAP benefit groups comprise the remaining portion of the forecast. The total number of clients in these groups has historically represented between 5 and 7 percent of the total OMAP client caseload. The Breast and Cervical Cancer program has by far the smallest caseload, representing less than 1 percent of the total of the three groups in September 2005. Each of these programs is discussed separately below.

Exhibit 20: Other Medical Assistance Programs with the Office of Medical Assistance Programs program categories

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

Other Medical Assistance Program Qualified Medicare Beneficiary

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. The Department of Human Services pays for Medicare Part A and Part B premiums as well as any applicable coinsurance and/or deductibles not exceeding the Department's fee schedule.

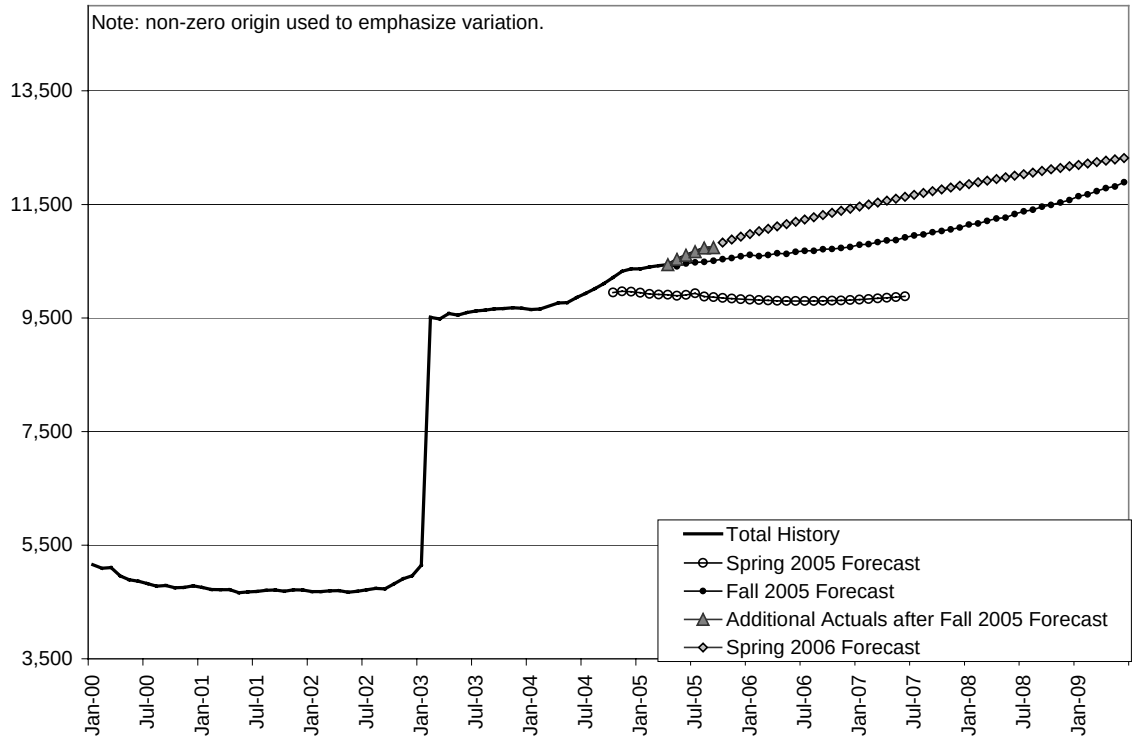
Forecast

The QMB caseload has undergone a significant shift. The closure of the Medically Needy program in February 2003 resulted in a shift of clients from that program into the QMB group. This shift increased the caseload by approximately

4,400 clients. Since February 2003, the caseload has increased slowly with the majority of growth beginning in the Spring of 2004 and continuing to the present.

The Spring 2006 forecast for the QMB benefit group projects a continued increase in caseload. The Spring 2006 forecast predicts a 2005-07 biennial average 4.8 percent higher than the Fall 2005 forecast with 11,636 clients by June 2007. In the 2007-09 biennium the Spring 2006 forecast biennial average is also higher than the Fall 2005 forecast by 5.6 percent predicting 12,319 clients by June 2009. Exhibit 21 displays the history and comparative forecasts for this group.

Exhibit 21: Other Medical Assistance Programs Qualified Medicare Beneficiary Caseload



Other Medical Assistance Programs: Citizen-Alien Waived Emergency Medical

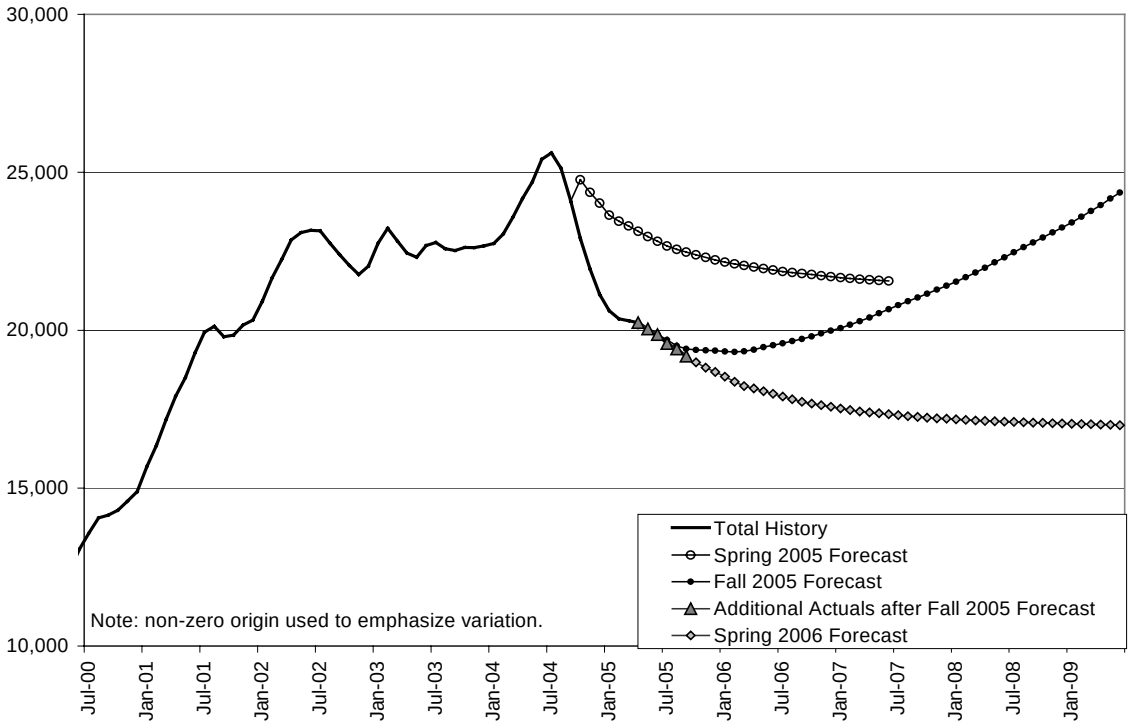
The Citizen-Alien Waived Emergency Medical (CAWEM) program is a federal mandated program that covers emergency care and childbirth services for non-citizens who are otherwise eligible for Medicaid services. CAWEM beneficiaries became identifiable as a group in January 2000 when separate computer codes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

The CAWEM caseload increased rapidly from January 2000, through June 2002. Between July 2002 and January 2004, the caseload remained relatively stable. From January through July 2004, the caseload once again began to increase to a historical high of 25,614 clients. From July 2004 through September 2005 the caseload decreased rapidly to 19,178 clients. This caseload decline closely tracked that of the OHP Standard population after that program was closed to new clients. Applicants who would have met OHP Standard eligibility requirements except for citizenship were now required to meet the more restrictive eligibility requirements of OHP Plus, thus reducing the number of new clients entering this program.

Forecast

The Spring 2006 forecast for this group projects a continued decrease. Although the Fall 2005 forecast predicted a shorter period of decline followed by an increase to historic highs, more recent data suggest that this pattern will not continue. The Spring 2006 forecast predicts the caseload will decline slowly as the effects of the closure of OHP Standard subside. The Spring 2006 forecast of the 2005-07 biennial average is 8.2 percent lower than the Fall 2005 prediction, declining to 17,339 by June 2007. For the 2007-09 biennium, the Spring 2006 forecast predicts a biennial average that is 23.7 percent below the Fall 2005 forecast with 16,995 clients by June 2009. Exhibit 22 displays the history and comparative forecasts for this group.

Exhibit 22: Citizen/Alien Waived Medical Emergency Medical Caseload



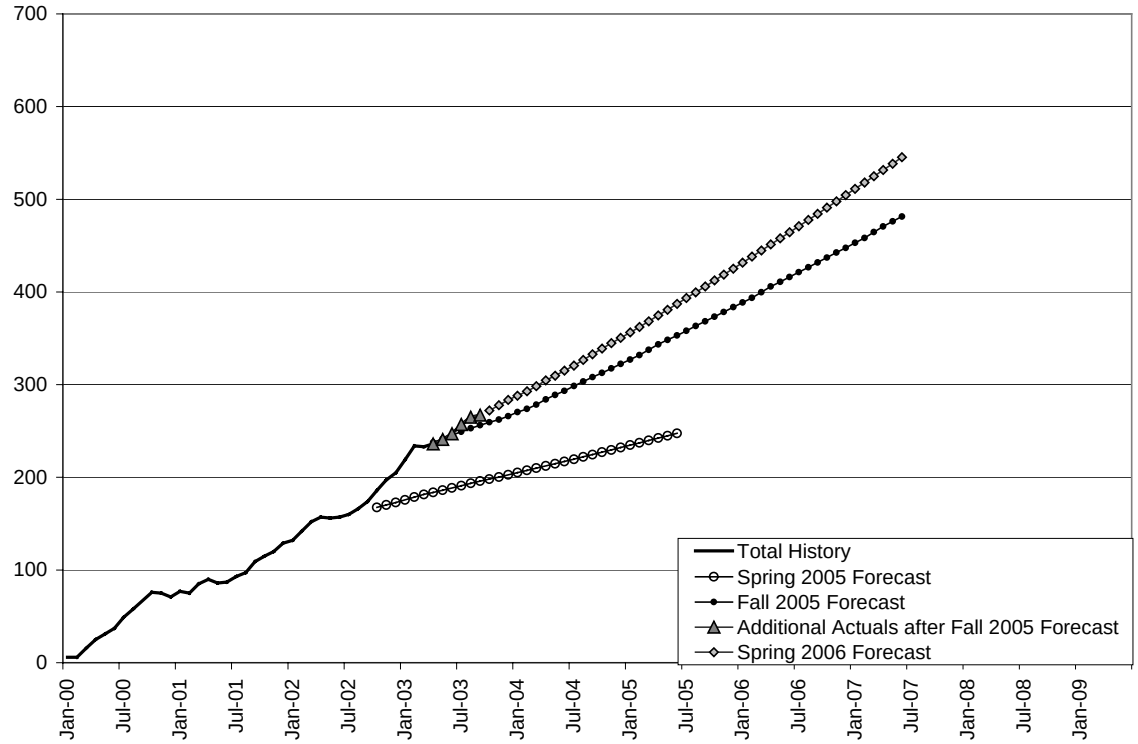
Other Medical Assistance Program: Breast and Cervical Cancer Program

The Breast and Cervical Cancer program (BCCP) began in January 2002 to provide medical benefits for women who are diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection program administered by Health Services through county health departments and tribal health clinics. After determining the eligibility, the client receives all Medicaid services, including mental and dental health. A client is eligible until she reaches the age of 65, obtains creditable coverage or ends treatment. As of September 2005, the caseload had grown to 267 clients. While this group is quite small, the caseload increase has been consistent and rapid.

Forecast

The Spring 2006 forecast anticipates a continuing increase in the caseload for this group. From the September 2005 actual count of 267, the June 2007 caseload is predicted to be 387 and the June 2009 count is predicted to be 545. The Spring 2006 forecast for the 2005-07 biennial average is 7.7 percent higher than that of the Fall 2005 forecast. In 2007-09, the biennial average from the Spring 2006 forecast is 11.7 percent higher than predicted by the Fall 2005 forecast. Exhibit 23 displays the history and comparative forecasts for this group.

Exhibit 23: Breast and Cervical Cancer Program Caseload



Risks to the Forecast

Risks to the current Spring 2006 forecast take a variety of forms. These risks may be grouped into two broad categories: systemic/behavioral, and policy related.

Certain risks below are specific to one or more benefit groups within the OMAP program structure. Other risks are more sweeping in scope and could have generalized effects across broad categories of social service delivery systems. In some cases, there may be interaction effects of identifiable risks that either mitigate or exacerbate otherwise expected outcomes.

OMAP caseloads are sensitive to both available economic resources and access to health care systems. Systemic changes in economic conditions, especially the availability of jobs, can exert upward or downward pressure on these caseloads. As job availability improves, especially jobs that carry with them affordable health care coverage, it would be expected that OMAP caseloads might decline. Oregon is currently experiencing a recovery from a recent deep recession of relatively long duration. The pace of this recovery has been partially credited with contributing to the recent downturn in TANF Related Medical caseloads.

While this relationship is not one-to-one, continued recovery is expected to put downward pressure on this particular caseload. It should be noted here that "all economic recoveries are not equal". The simple availability of new jobs does not guarantee either income adequate to escape federal poverty level ceilings or access to health care. There is some evidence to indicate that current job availability in Oregon, while increasing, is focused in the low-wage sectors such as the service industry. Typically these jobs do not carry health benefits. To the extent that this is true, the downward pressure on OMAP caseloads may be both less than anticipated and slower to materialize.

Demographic changes specific to the aging of the population also represent a systemic risk to DHS caseloads, especially those that focus services and benefits on the elderly. The caseloads most likely to be affected within the OMAP forecast groups are Aid to the Blind and Disabled and Old Age Assistance. The post-war generation is just now beginning to reach the point of retirement. As this large segment of the Oregon population ages, health issues also arise. The combination of improved medical technology leading to longer lives combined with the possible lack of resources to address inevitable health issues is ultimately expected to contribute to increasing caseloads in the future. (See Risks and Assumptions in Seniors and People with Disabilities).

A final systemic risk to the current forecast lies in the methamphetamine epidemic that has been both pervasive and growing. By some accounts, the continually increasing foster/substitute care population is predominantly due to the social and personal ravages of this epidemic. Children of individuals who are involved in methamphetamine use and/or manufacturing are routinely removed from the home and placed in foster care. Should this epidemic continue unabated, the caseloads for foster/substitute care would be expected to continue to increase at a rapid rate.

The OMAP caseloads may gain new clients as a result of the policy related risk of January 2006 implementation of the Medicare Modernization Act (MMA) of 2003. Some people may learn about DHS services as a result of the information provided in MMA materials, and subsequently apply for services.

The MMA provides prescription drug coverage to elderly and disabled people who are enrolled in the Medicare programs. Approximately 264,000 Oregonians were informed about their potential eligibility for low-income subsidies that would pay for this coverage. A subset of these individuals may be eligible for other State-funded benefits like the Oregon Health Plan. Another group may have the functional needs to qualify for long-term care services.

Outreach efforts to identify individuals eligible for program services that are carried out by advocate groups, providers, DHS programs or DHS representatives contain a direct risk to DHS client caseloads. Currently there are two specific such efforts underway in two areas of Oregon targeting uninsured children. The combined effects of these efforts have the potential of increasing

the CHIP and Poverty Level Medical Children caseloads. This could also affect caseloads associated with the parents of these children. The most significant effect, however, would be expected in the groups focusing on benefits for children.

Two program integrity efforts by DHS are scheduled to begin within the next few months. Each of these efforts is expected to place a downward pressure on a variety of client populations. The first includes the review of approximately 8,000 cases across the Children Adults, and Families cluster and the Seniors and People with Disabilities cluster that have been identified as possibly overdue for re-certification reviews. Downward pressure on client caseloads would occur to the extent that these clients are found ineligible through the review process.

The second program integrity effort is a policy of more rigorous and routine reviews of individuals transitioning to and within the TANF Extended population. The effect of this tightening of enforcement is expected to place downward pressure on this caseload. An additional risk, however, is that some of these clients may be found eligible for participation in other OMAP programs. This would, in effect, shift clients to other eligibility groups. Groups most likely affected would be TANF Related Medical, CHIP, Poverty Level Medical Children, and the OHP Standard Families group. Increases in these caseloads could occur.

A final risk to the current Spring 2006 forecast lies with the recently adopted Federal Deficit Reduction Act. While federal rules for implementation have yet to be formulated, there is a high risk that these rules will result in substantially reduced caseloads as a result of federal changes.

SENIORS AND PEOPLE WITH DISABILITIES

INTRODUCTION

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

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

Exhibit 1: Long-Term Care Program Categories.

In-Home Care	**Community-Based Care Facilities**	**Nursing Facilities**
In-Home Hourly	Adult Foster Care: Relative	Basic Care
In-Home Live-In	Adult Foster Care: Commercial	Complex Medical Add-On
In-Home Spousal-Pay	Residential Care Facilities: Regular	Pediatric Care
Not Included in Forecast:	Residential Care Facilities: Contract	New Forecast:
Independent Choices	Assisted Living Facilities	Medicare Extended Care
	Specialized Living Facilities	OHP Post-Hospital Benefit
	Providence ElderPlace	Enhanced Care

It should be noted that there is a program that is not part of the long-term care caseload forecast listed below called Oregon Project Independence (OPI).

Oregon Project Independence: 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, meet the requirement of long-term care service priority rules, and are not receiving Medicaid long-term care services. OPI served about 3,129 clients in 2005.

The long-term care services mentioned above in Exhibit 1 will be described at appropriate sections in the forecast book.

Total Spring 2006 Caseload Forecast

The total long-term care caseload forecast for Spring 2006 includes in-home care, community-based care and nursing facilities. In the Spring 2006 forecast, the other nursing facilities services such as Medicare Extended Care, Enhanced Care and the OHP Post-Hospital Benefit caseloads are forecasted for the first time. These other nursing facilities caseloads are not rolled-up in the total long-term care caseload so that the Spring 2006 caseloads can be compared to the previous forecasts (the Spring 2005 and the Fall 2005).

Nursing facilities make up about 18 percent of the total long-term care caseload, while the in-home and community-based care facilities account for 42 and 40 percent respectively (see Exhibit 2). Overall, this caseload distribution pattern has not changed significantly. The biennial average long-term care caseload population was 28,021 clients in the 2003-05 biennium. The average long-term care caseload, measured as a biennial average, is forecasted to decrease to 27,639 clients in the 2005-07 biennium. The decline in the total LTC caseload forecast represents slightly more than one percent drop in the 2005-07 biennium. The total LTC caseload is anticipated to average 27,402 in the 2007-09 biennium.

Exhibit 2: Total Long-Term Care Caseload Distribution by Service Categories

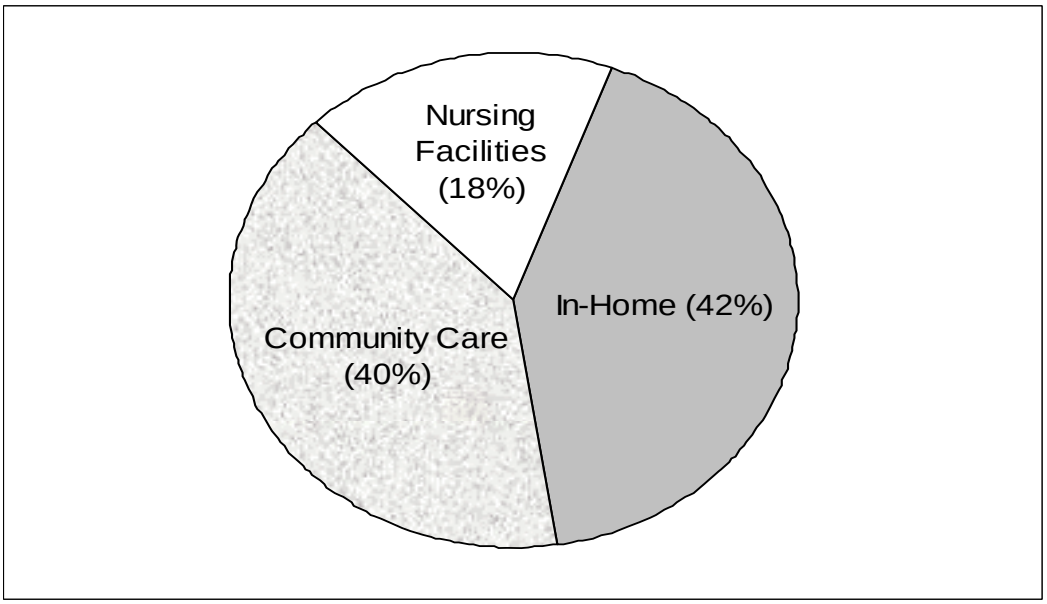
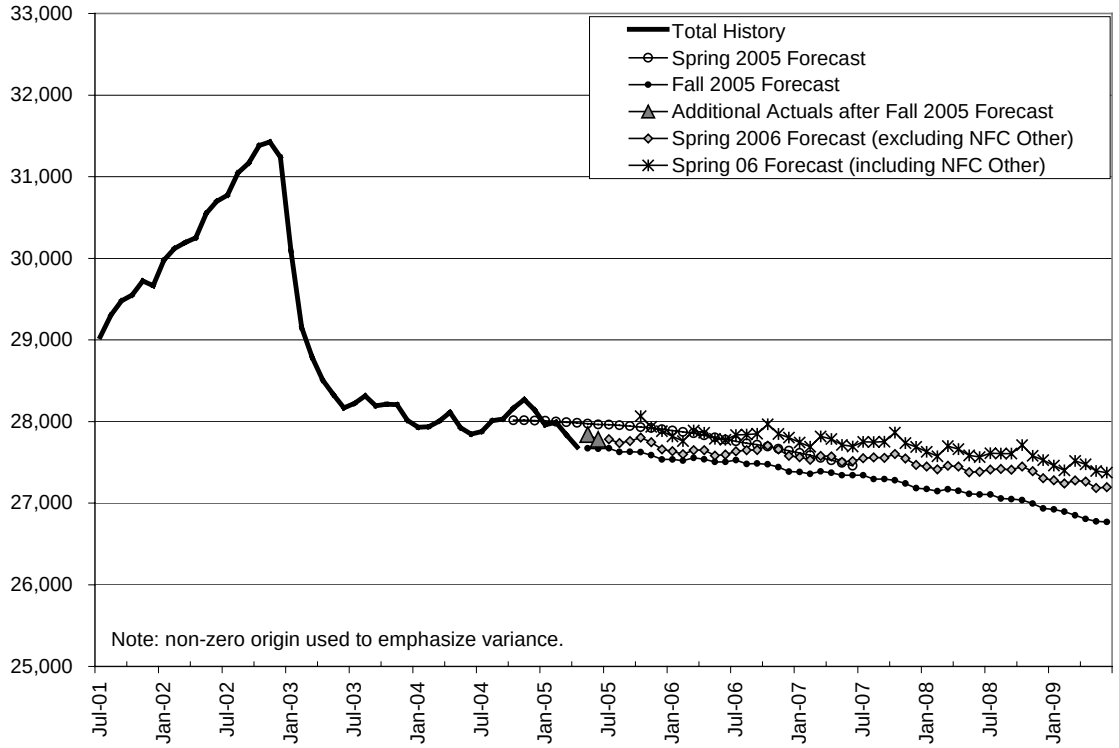


Exhibit 3: Total Long Term Care Caseload (with & without Nursing Care Facilities Other)



As illustrated in Exhibit 3, the overall long-term care caseload in the first eight months of 2003 (November 2002-June 2003) declines about 10 percent, or more than 3,000 cases. This was primarily due to the elimination of long-term care service priority levels 12 through 17 implemented in February and April 2003[3].

Exhibit 3 also shows two forecast lines for Spring 2006 one line does not include the other nursing facilities caseload (Medicare Extended Care, OHP Post-Hospital Benefit, and Enhanced Care) while the other forecast line does. This enables comparison of the Spring 2006 forecast with prior forecasts.

For the 2005-07 biennium, the Spring 2006 forecast projects a slightly higher number of clients in the total LTC caseload over the Fall 2005 forecast, or less than 1 percent. The Spring 2006 forecast also projects higher numbers of clients in the 2007-09 biennium over the Fall 2005 forecast. The higher caseload forecasts for both the 2005-07 and 2007-09 biennia are due to growth in the nursing facility caseload. These forecast comparisons are illustrated in Exhibit 4.

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

Exhibit 4: Total Long-Term Care Caseload Biennial Average Comparison by forecasts

Forecasts compared:	2005-07 Biennium					
	Spring 2005 to Fall 2005			Spring 2005 to Spring 2006		
Aged and Physically Disabled **Biennial averages by forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
In-Home Hourly	10,384	10,281	-1.0%	10,384	10,260	-1.2%
In-Home Live-In	1,245	1,232	-1.0%	1,245	1,230	-1.2%
In-Home Spousal pay	136	135	-1.0%	136	135	-1.1%
Subtotal - In-Home	**11,765**	**11,648**	-1.0%	**11,765**	**11,624**	-1.2%
Relative Adult Foster Care	1,631	1,616	-0.9%	1,631	1,524	-7%
Commercial Adult Foster Care	2,325	2,424	4.2%	2,325	2,496	7.4%
Regular Residential Care	1,215	1,069	-12.0%	1,215	1,065	-12.4%
Contract Residential Care	1,293	1,177	-9.0%	1,293	1,195	-7.6%
Assisted Living	3,973	3,976	0.1%	3,973	3,986	0.3%
Specialized Living	172	172	0.0%	172	165	-4.2%
Providence ElderPlace	609	649	6.5%	609	668	9.6%
ubtotal - Community-Based Care	**11,219**	**11,083**	-1.2%	**11,219**	**11,098**	-1.1%
Basic Nursing Facility Care	4,391	4,367	-0.5%	4,391	4,503	2.5%
Complex Medical Add-On	309	324	4.9%	309	344	11.3%
Pediatric Care	70	70	0.0%	70	70	0.5%
Subtotal - Nursing Facilities	**4,770**	**4,761**	-0.2%	**4,770**	**4,917**	**3.1%**
Total Long-Term Care	**27,754**	**27,492**	**-0.9%**	**27,754**	**27,639**	**-0.4%**
Extended Care NFC					142	
Enhanced Care					56	
Post-Hospital Benefit					6	
Other Nursing Facility Services					**204**	

Exhibit 4 (continued)

Forecasts compared:	2005-07 Biennium Fall 2005 to Spring 2006			2007-09 Biennium Fall 2005 to Spring 2006		
Aged and Physically Disabled biennial averages by forecast	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
In-Home Hourly	10,281	10,260	-0.2%	10,056	10,165	1.1%
In-Home Live-In	1,232	1,230	-0.2%	1,206	1,218	1.1%
In-Home Spousal pay	135	135	-0.1%	132	134	1.1%
Subtotal - In-Home	**11,648**	**11,624**	-0.2%	**11,394**	**11,517**	1.1%
Relative Adult Foster Care	1,616	1,524	-5.7%	1,389	1,330	-4.2%
Commercial Adult Foster Care	2,424	2,496	3.0%	2,306	2,425	5.2%
Regular Residential Care	1,069	1,065	-0.4%	1,090	1,087	-0.3%
Contract Residential Care	1,177	1,195	1.5%	1,328	1,340	0.9%
Assisted Living	3,976	3,986	0.2%	4,115	4,098	-0.4%
Specialized Living	172	165	-4.2%	172	165	-4.1%
Providence ElderPlace	649	668	2.9%	696	700	0.6%
Subtotal - Community-Based Care	**11,083**	**11,098**	0.1%	**11,095**	**11,145**	0.4%
Basic Nursing Facility Care	4,367	4,503	3.1%	4,207	4,342	3.2%
Complex Medical Add-On	324	344	6.1%	307	328	6.8%
Pediatric Care	70	70	0.5%	70	70	0.0%
Subtotal - Nursing Facilities	**4,761**	**4,917**	3.3%	**4,582**	**4,740**	**3.4%**
Total Long-Term Care	**27,492**	**27,639**	**0.5%**	**27,071**	**27,402**	**1.2%**
Extended Care NFC		142			142	
Enhanced Care		56			56	
Post-Hospital Benefit		6			6	
Other Nursing Facility Services		**204**			**204**	

Notes:

** Spring 06 Forecast: Actual through September 2005.*

** Fall 05 Forecast: Actual through April 2005.*

** Other Nursing Facilities Services are new caseload forecast for the Spring 06 Forecast and are not rolled up in the Total NFC and Total LTC caseloads.*

When comparing the Fall 2005 and the Spring 2006 Forecasts, we note the following:

1. The in-home caseload is slightly lower in the 2005-2007 biennium. However, it is higher by 1 percent in the 2007-09 biennium.

2. The community-based care caseload remains nearly identical in the 2005-07 biennium and is slightly higher in the 2007-09 biennium.

3. The nursing facilities caseload is higher by 3 percent in the 2005-07 and the 2007-2009 biennia.

The following sections examine each LTC caseload forecast in greater detail.

IN-HOME

The in-home program provides personal assistance services that help people stay in their homes when they need assistance in Activities of Daily Living[4] (ADLs). Home care workers are hired directly by clients to provide the in-home services. Historically, the average in-home services caseload represented approximately two-fifths of the total long-term care caseload.

The total in-home care population includes the three major service categories shown in Exhibit 5.

Exhibit 5: In-Home Care services within the Long-Term Care program categories.

In-Home Care	**Community-Based Care Facilities**	Nursing Facilities
In-Home Hourly	Adult Foster Care: Relative	Basic Care
In-Home Live-In	Adult Foster Care: Commercial	**Complex Medical Add-On**
In-Home Spousal-Pay	Residential Care Facilities: Regular	Pediatric Care
Not in Forecast:	Residential Care Facilities: Contract	New Forecast:
Independent Choices	Assisted Living Facilities	Medicare Extended Care
	Specialized Living Facilities	OHP Post-Hospital Benefit
	Providence ElderPlace	Enhanced Care

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

A small percentage of the in-home hourly caseload includes Personal Care services. These are essential supportive services, which enable clients to move into and/or remain in their own homes. SPD manages entry into Personal Care for people who are aged, physically or developmentally disabled, or who qualify to 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.

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

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

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

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

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

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

The total in-home caseload was growing rapidly in 2001-03 with a biennial average of more than 13,000. This caseload averaged just over 11,800 in the 2003-05 biennium. In the first eight months of 2003-05 (November 2002 to June 2003), the in-home services caseload declined by about 16 percent, or more than 2,200 cases as illustrated in Exhibit 6. This caseload decline is primarily due to the elimination of the long-term care service priority levels 12 through 17 that were implemented in February and April 2003.

In the 2005-07 biennium, the total in-home services caseload is forecasted to be 11,624 clients, slightly lower than the Fall 2005 forecast of 11,648 (see Exhibit 7). The Spring 2006 forecast for the 2005-07 biennium is lower by about 1 percent, compared to the Spring 2005 forecast. The total in-home caseload is projected to average 11,517 in the 2007-09 biennium.

Exhibit 6: Total In-Home Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts

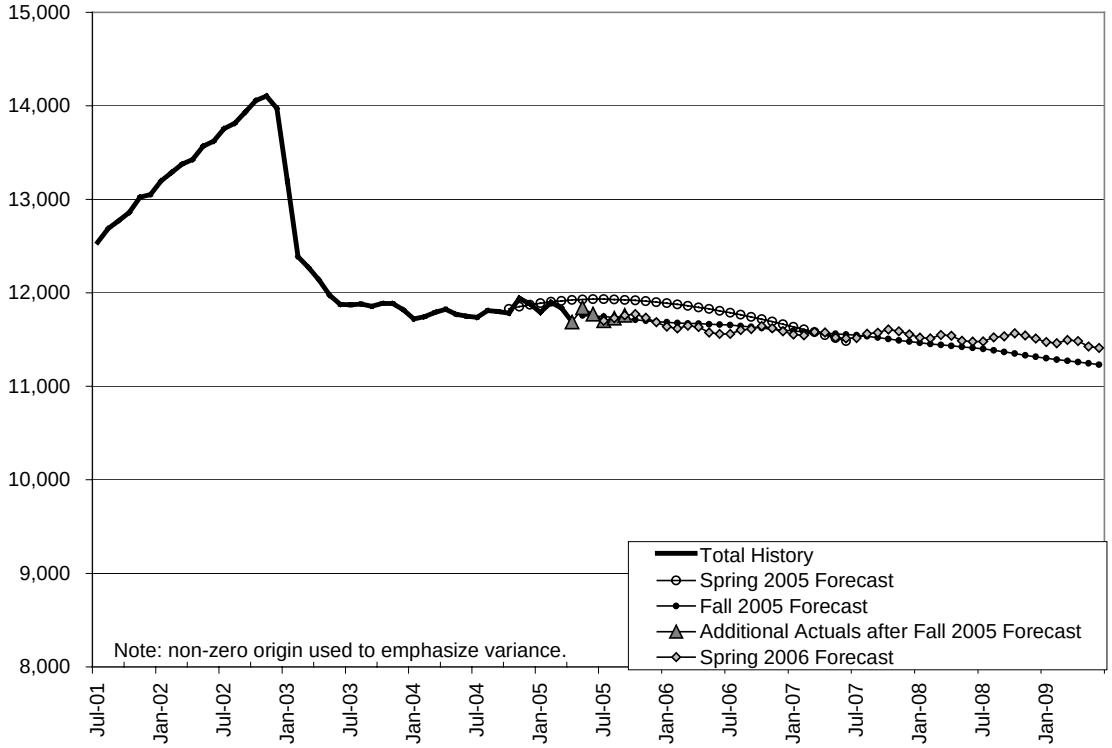


Exhibit 7: Total In-Home Caseload Biennial Average Comparison by Forecasts

Forecasts compared:	2005-07 Biennium					
	Spring 2005 to Fall 2005			Spring 2005 to Spring 2006		
Aged and Physically Disabled **Biennial averages by forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
In-Home Hourly	10,384	10,281	-1.0%	10,384	10,260	-1.2%
In-Home Live-In	1,245	1,232	-1.0%	1,245	1,230	-1.2%
In-Home Spousal pay	136	135	-1.0%	136	135	-1.1%
Subtotal - In-Home	**11,765**	**11,648**	**-1.0%**	**11,765**	**11,624**	**-1.2%**

Forecasts compared:	2005-07 Biennium			2007-09 Biennium		
	Fall 2005 to Spring 2006			Fall 2005 to Spring 2006		
Aged and Physically Disabled **biennial averages by forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
In-Home Hourly	10,281	10,260	-0.2%	10,056	10,165	1.1%
In-Home Live-In	1,232	1,230	-0.2%	1,206	1,218	1.1%
In-Home Spousal pay	135	135	-0.1%	132	134	1.1%
Subtotal - In-Home	**11,648**	**11,624**	**-0.2%**	**11,394**	**11,517**	**1.1%**

COMMUNITY-BASED CARE FACILITIES

The community-based care caseload (also referred to as licensed community facilities) includes clients receiving long-term care services in licensed community-based care setting. Such community-based care (CBC) facilities are located throughout Oregon and serve both Medicaid and non-Medicaid clients. The community-based care facilities, even though they are licensed differently from one another or other types of facilities, can provide care for all long-term care clients, except when a client needs specialized services. Thus, some LTC clients can and do change their care settings over time. Exhibit 8 outlines the various types of community-based care settings.

The average community-based care caseload represents about two-fifths of the total long-term care caseload. This total caseload is comprised of adult foster care (36 percent), assisted living facilities (36 percent) and residential care facilities (20 percent). Specialized Living Facilities and Providence ElderPlace account for about 2 percent and 6 percent of the total community-based care caseload.

Exhibit 8: Community-Based Care Facilities services within the Long-Term Care program categories

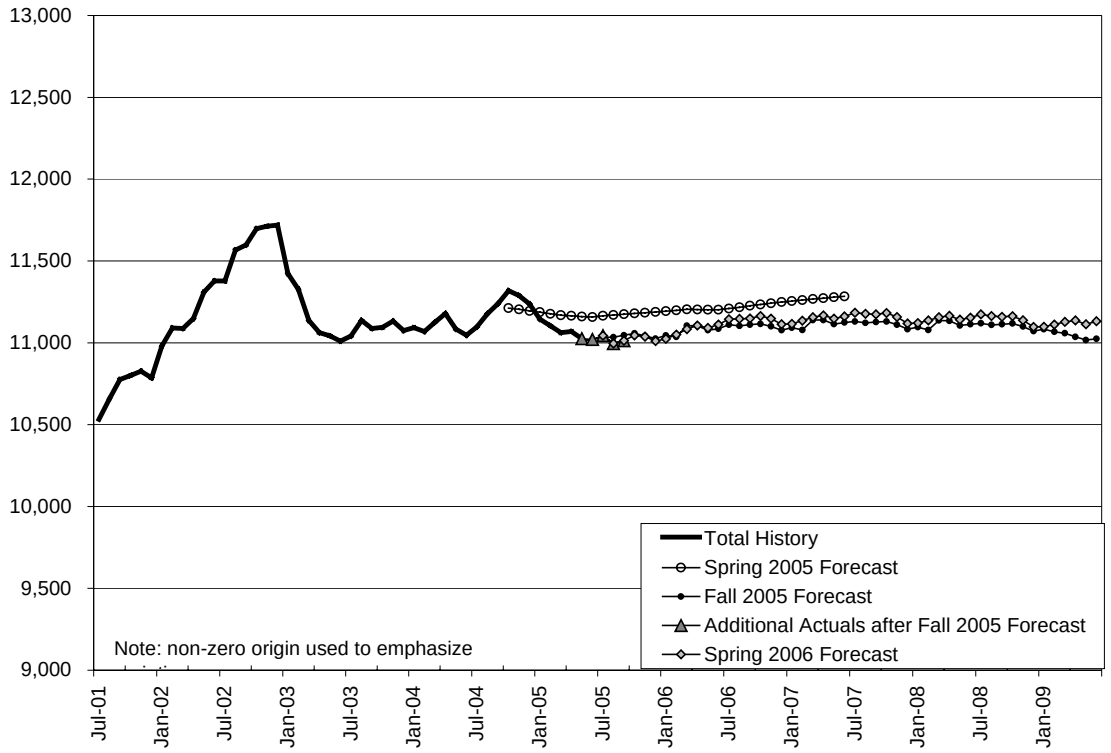
In-Home Care	**Community-Based Care Facilities**	**Nursing Facilities**
In-Home Hourly	**Adult Foster Care: Relative**	Basic Care
In-Home Live-In	**Adult Foster Care: Commercial**	Complex Medical Add-On
In-Home Spousal-Pay	**Residential Care Facilities: Regular**	Pediatric Care
Not in Forecast:	**Residential Care Facilities: Contract**	New Forecast:
Independent Choices	**Assisted Living Facilities**	Medicare Extended Care
	Specialized Living Facilities	OHP Post-Hospital Benefit
	Providence ElderPlace	Enhanced Care

It should be noted that **Special Need Contract** is a special group of clients that receive services in community-based care facilities, and are included in the appropriate CBC caseloads. Special need contract clients have targeted needs. In September 2005, approximately 148 clients were being served under special need contracts in residential care, adult foster care and assisted living facilities.

Forecast

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

Exhibit 9: Total Community-Based Care Caseload with the Spring 2005, Fall 2005 and Spring 2006



The Spring 2006 total community-based care caseload forecast for the 2005-07 biennium is nearly identical to the Fall 2005 forecast (see Exhibit 9). The Spring 2006 forecast is only about 1 percent lower than the Spring 2005 forecast (biennial average of 11,098 versus 11,219). In the 2007-09 biennium, the total community-based care caseload is slightly higher than the Fall 2005 estimate. This is shown in Exhibit 10.

Exhibit 10: Total Community-Based Care Caseload Biennial Average Comparison by Forecasts

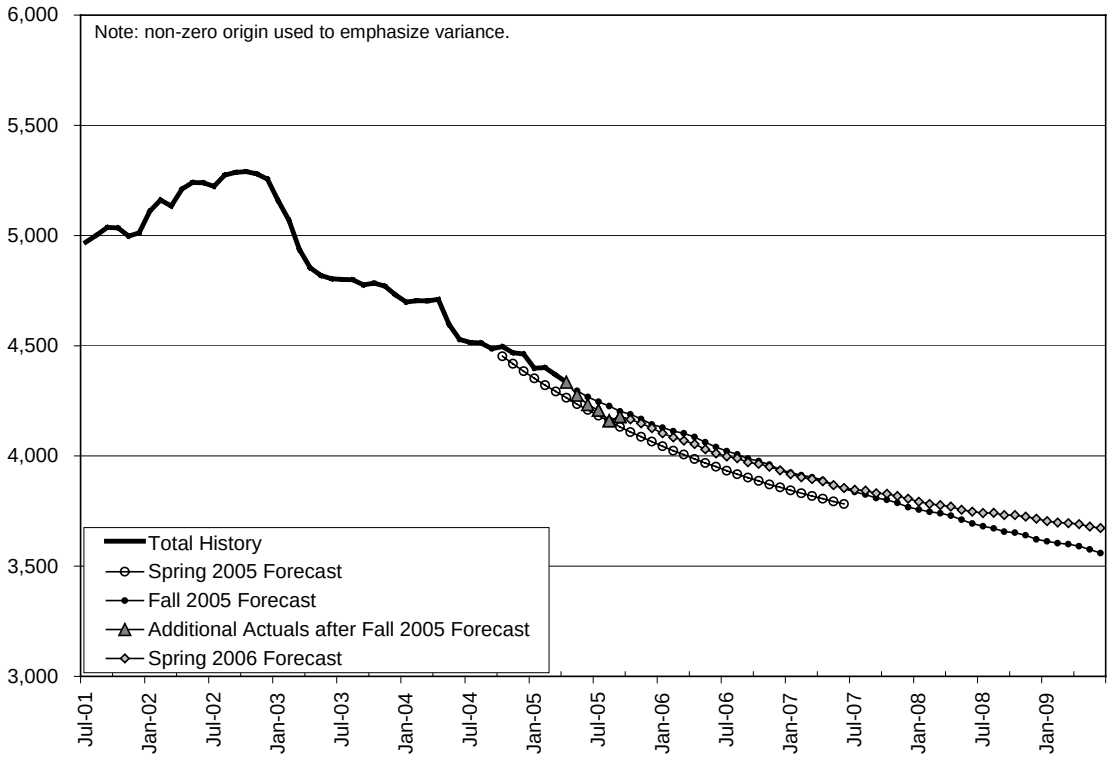
	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Aged and Physically Disabled **Biennial averages by forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
Relative Adult Foster Care	1,631	1,616	-0.9%	1,631	1,524	-7%
Commercial Adult Foster Care	2,325	2,424	4.2%	2,325	2,496	7.4%
Regular Residential Care	1,215	1,069	-12.0%	1,215	1,065	-12.4%
Contract Residential Care	1,293	1,177	-9.0%	1,293	1,195	-7.6%
Assisted Living	3,973	3,976	0.1%	**3,973**	3,986	0.3%
Specialized Living	172	172	0.0%	172	165	-4.2%
Providence ElderPlace	609	649	6.5%	609	668	9.6%
Subtotal - Community-Based Care	**11,219**	**11,083**	-1.2%	**11,219**	**11,098**	-1.1%

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Aged and Physically Disabled **Biennial averages by forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
Relative Adult Foster Care	**1,616**	1,524	-5.7%	1,389	1,330	-4.2%
Commercial Adult Foster Care	2,424	2,496	3.0%	2,306	2,425	5.2%
Regular Residential Care	1,069	1,065	-0.4%	1,090	1,087	-0.3%
Contract Residential Care	1177	1,195	1.5%	1,328	1,340	0.9%
Assisted Living	3,976	3,986	0.2%	4,115	4,098	-0.4%
Specialized Living	172	165	-4.2%	172	165	-4.1%
Providence ElderPlace	649	668	2.9%	696	700	0.6%
Subtotal - Community-Based Care	**11083**	**11,098**	0.1%	**11,095**	**11,145**	0.4%

Total Adult Foster Care

Adult Foster Care (AFC) provided by Adult Foster Homes, offers long-term care in home-like settings licensed for five or fewer unrelated people. Adult foster homes represent 36 percent of the total CBC caseload in the Spring 2006 forecast. It accounted for 41 percent of the CBC caseload in 2003-05. 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.

Exhibit 11: Adult Foster Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.



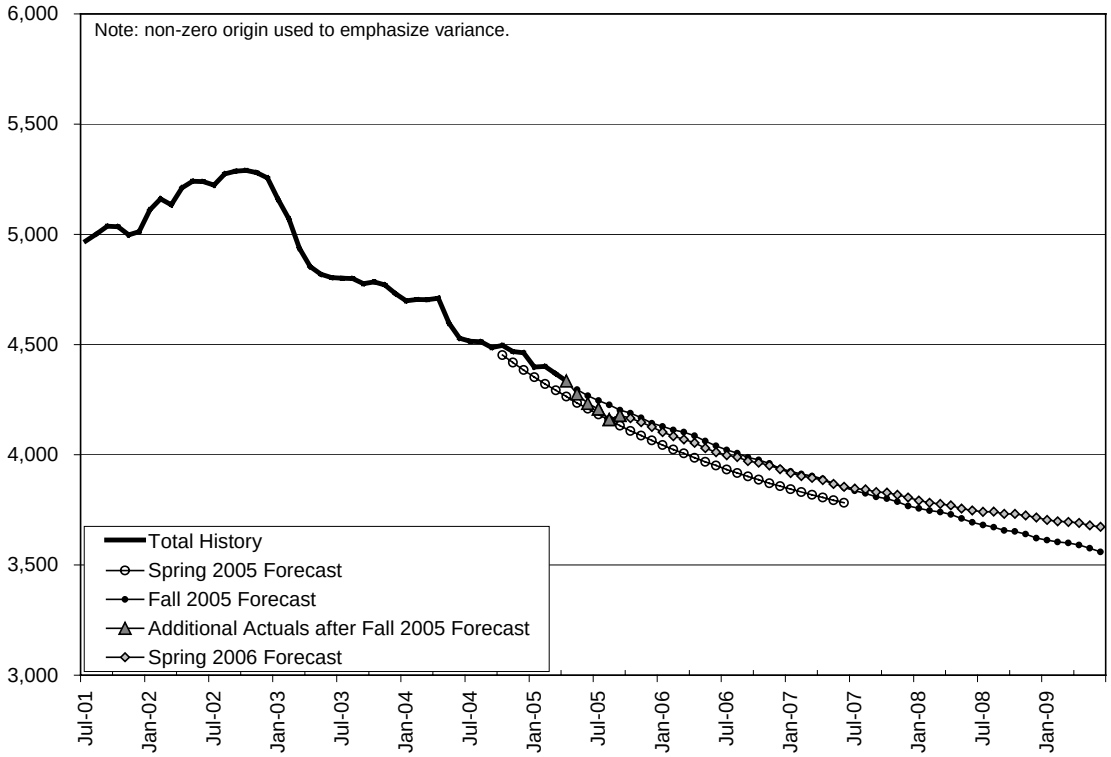
Relative Adult Foster Care

The relative adult foster care caseload constitutes 14 percent of the total community-based care caseload and 38 percent of the total AFC caseload (total equals 4,020) in the Spring 2006 forecast. As Exhibit 12 shows, the relative AFC caseload has been declining at a rapid rate since January 2004.

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

The relative adult foster care caseload in the Spring 2006 forecast is lower than the Fall 2005 by 6 percent for the 2005-07 biennium. This is 7 percent lower than the Spring 2005 forecast, as illustrated in Exhibits 10 and 12. It reflects continued decline in this caseload and, therefore, the Spring 2006 forecast is revised downward. This caseload is projected to average 1,330 in the 2007-09 biennium.

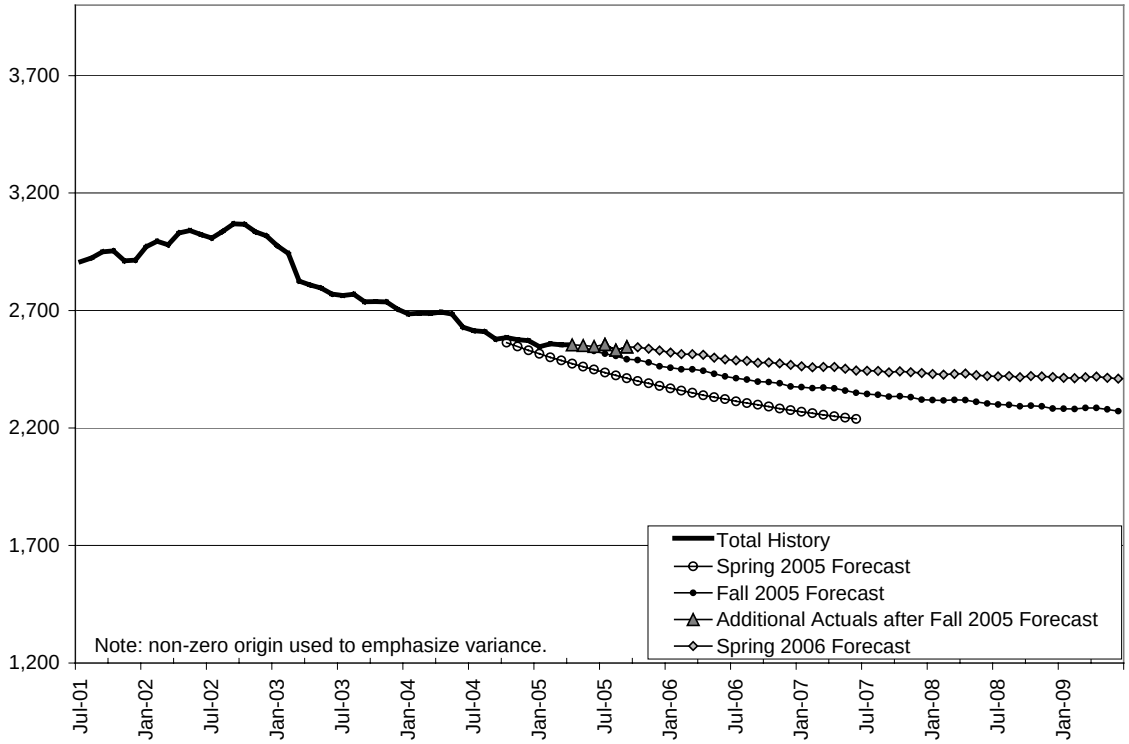
Exhibit 12: Relative Adult Foster Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 forecasts.



Commercial Adult Foster Care

The commercial adult foster care caseload is 22 percent of the total community-based care caseload, and it accounts for 62 percent of the total AFC caseload (total equals 4,020) in the Spring 2006 forecast. The commercial adult foster care caseload was increasing prior to 2003 but it began to decline rapidly in the early part of the 2003. However, it has shown a stabilizing trend in recent months leading up to the Spring 2006 forecast.

Exhibit 13: Commercial Adult Foster Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.

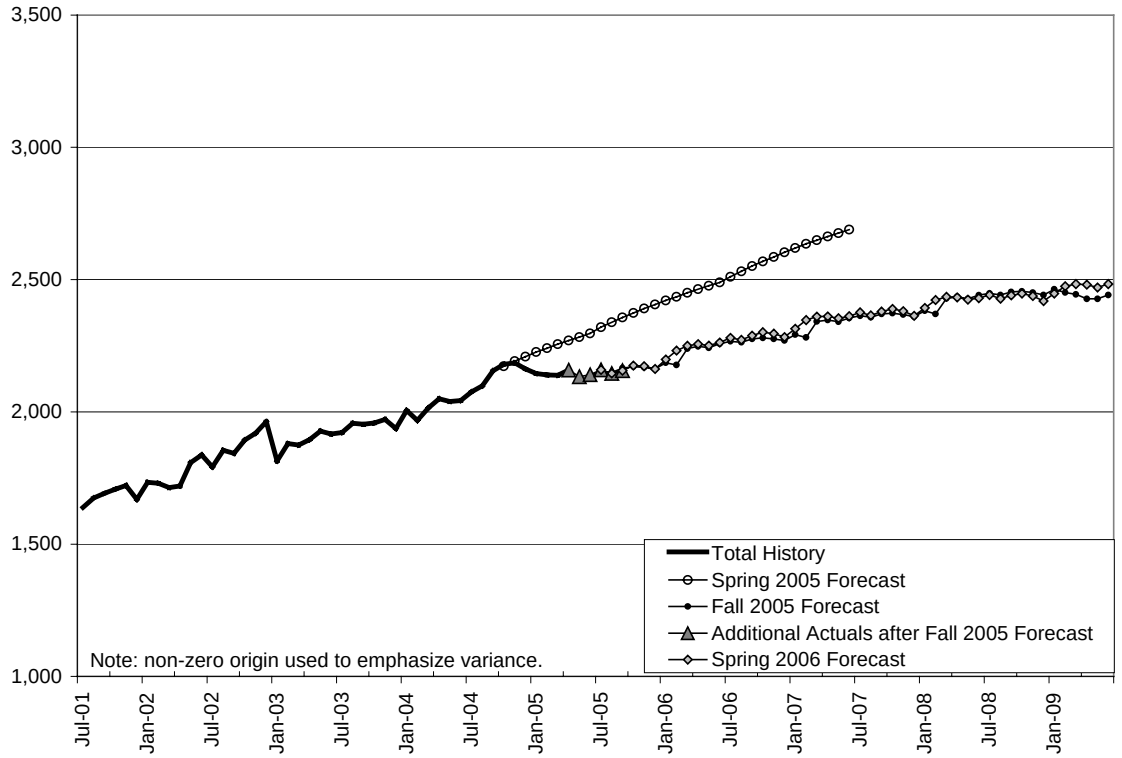


The Spring 2006 commercial adult foster care caseload forecast (2,496) is 3 percent higher than in the Fall 2005 forecast. As illustrated in the Exhibit 13, this is about 7 percent higher than the Spring 2005 forecast. This caseload is projected to average 2,425 in the 2007-09 biennium.

Total Residential Care Facilities

Residential Care Facilities (RCF) are licensed 24-hour care settings serving six or more residents. Facilities range in size from six beds to over 100. Different types of residential care include 24-hour residential care for adults as well as specialty Alzheimer care facilities. Overall, the total residential care caseload accounts for 20 percent of all CBC caseloads in the Spring 2006 forecast. It accounted for 19 percent of the CBC caseload in 2003-05 biennium.

Exhibit 14: Total Residential Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.

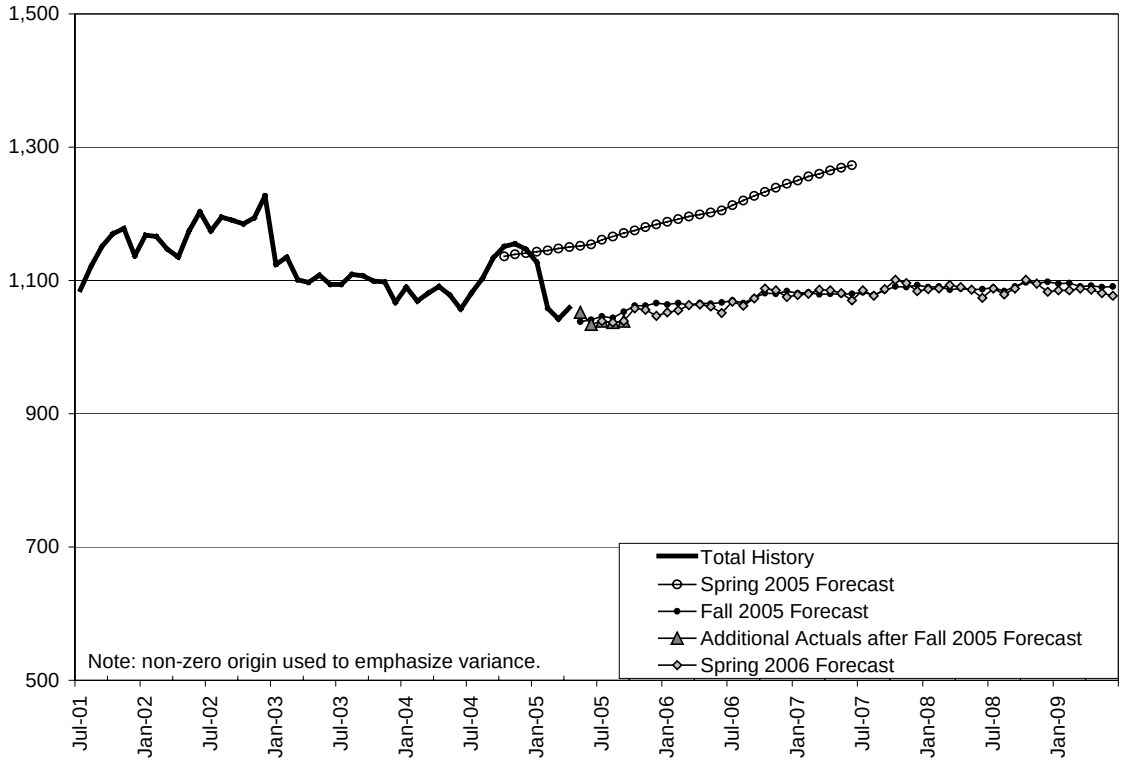


The total RCF caseload is projected to grow in the 2005-07 and 2007-09 forecast periods. Over the next three to four years, the contract rate RCF caseload is expected to continue to gain a larger share of the total RCF caseload. One of the reasons for this trend is due to the fact that the Medicaid contract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

Regular Residential Care Facilities

The regular residential care facilities accounts for 10 percent of the total CBC caseload. It accounts for 47 percent of the total RCF caseload (total equals 2,260). As with most other long-term care caseloads, the regular RCF caseload was also growing prior to 2003. However, since that time it has been in gradual decline (see Exhibit 15). One of the reasons for this decline has to do with the gradual increase of the contract RCF caseload (see Exhibit 16). The regular RCF caseload bump between July 2004 and February 2005 indicates the increased RCF enrollment followed by the subsequent move of some RCF regular clients to contract residential facilities (Exhibit 15).

Exhibit 15: Regular Residential Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.

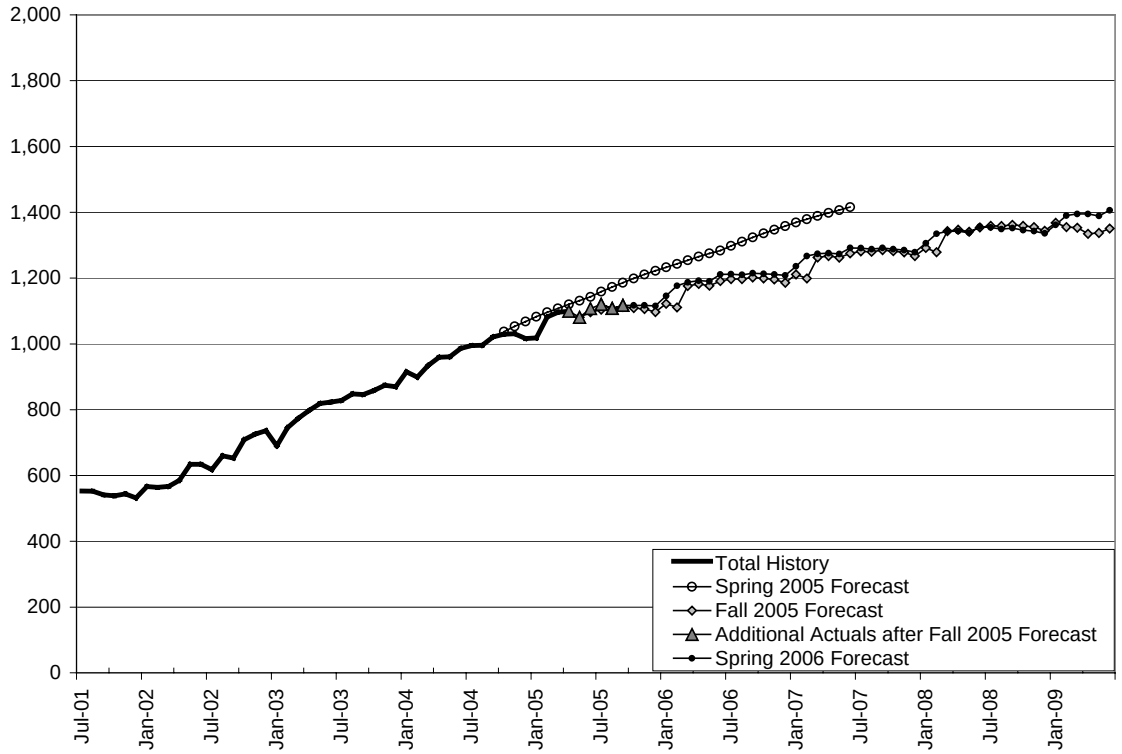


In the Spring 2006 forecast, the regular RCF caseload of 1,065 remains virtually unchanged compared to the Fall 2005 forecast of 1,069 in the 2005-07 biennium. The 1,065 is 12.4 percent lower than in the Spring 2005 forecast, when it was anticipated to grow at a higher level. The Spring 2006 forecast estimates an average of 1,087 clients in the 2007-09 biennium.

Contract Residential Care

The Contract Residential Care caseload is 11 percent of the total CBC caseload in the Spring 2006 forecast accounts for 53 percent of the total RCF caseload (total equals 2,260). As noted earlier, this caseload has been growing steadily through early 2005, at which point it leveled off. It is expected to continue to grow, although at a slower pace than occurred in 2003 through 2004. The contract rate residential caseload is forecasted to increase to 53 percent of the total RCF caseload in 2005-07 biennium.

Exhibit 16: Contract Residential Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.



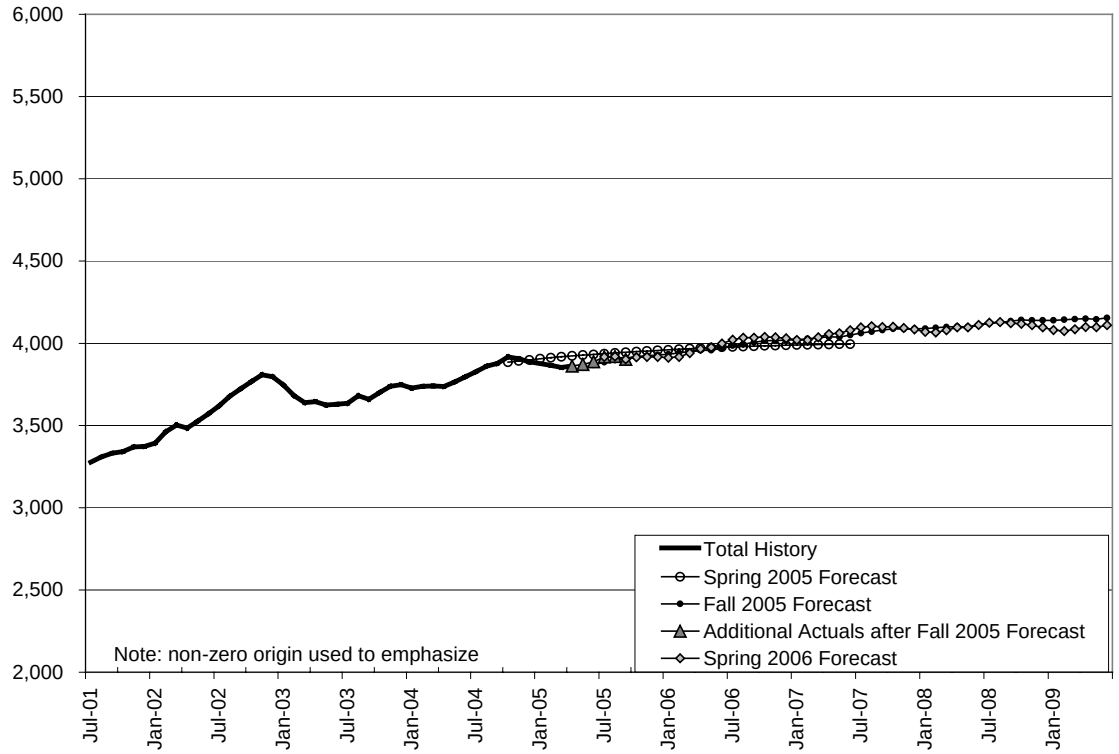
The contract RCF caseload is higher in the Spring 2006 forecast for the 2005-07 biennium than in the Fall 2005 forecast (Exhibit 16). It is forecasted to be slightly higher by about 1.5 percent, growing to 1,195 clients, over the Fall 2005 forecast of 1,177 clients. However, this caseload is lower by 7.6 percent from the Spring 2005 forecast. The contract RCF caseload is anticipated to average 1,340 per month in the next biennium (2007-09).

Assisted Living Facilities

The Assisted Living Facilities (ALF) are licensed 24-hour care settings for six or more residents that include private apartments. Services are comparable to residential care facilities but have special focus on resident independence and choice. Also, registered nurse consultation services are required by regulation. ALF constitutes 36 percent of the total CBC caseload.

The ALF caseload was growing rapidly prior to the elimination of long-term care service priority levels 12-17 in 2003 at which point there was a one-time drop in the caseload. Since that time, the ALF caseload has experienced gradual growth.

Exhibit 17: Assisted Living Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.



The Spring 2006 ALF caseload forecast for 2005-07 is 3,986, which is slightly higher than the Fall 2005 forecasts, as shown in Exhibits 10 and 17. This caseload is projected to average 4,098 in the 2007-09 biennium, which is nearly the same as the Fall 2005 estimate.

Specialized Living Facilities

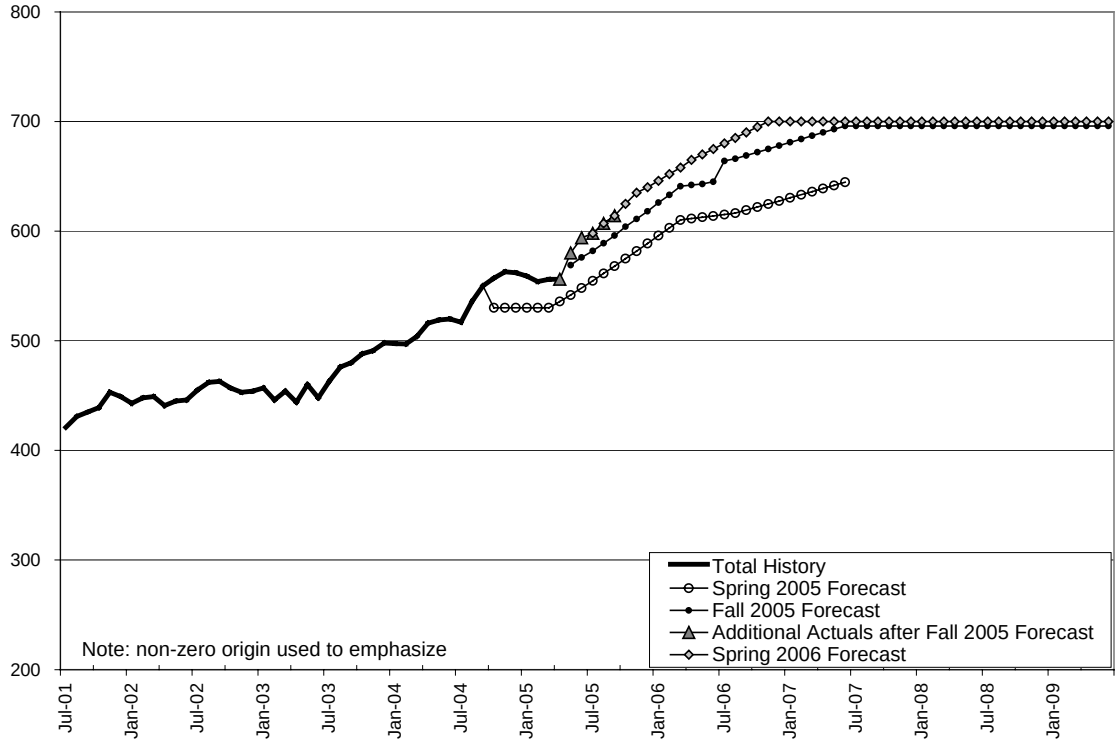
Specialized Living Facilities (SLF) provide care in a home-like environment for clients with specialized needs such as quadriplegics or clients with acquired brain injuries. The clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or are served in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

The SLF caseload forecast is lowered and maintained at a monthly average of 165 instead of 172 in the 2005-07 and the 2007-09 biennia. (No graph included because of the small number and relatively flat caseload).

Providence ElderPlace

Providence ElderPlace (PEP) is a capitated Medicare/Medicaid program that provides all-inclusive care for the elderly (also known as PACE), which provides an integrated program for acute health care and long-term care services. Seniors served in this program generally attend adult day care services and live in a variety of care settings. The ElderPlace program is responsible for providing and coordinating their clients' full health and long-term care needs in all of these settings. Most clients served through ElderPlace are dually eligible for both Medicare and Medicaid. The ElderPlace services are only available in Multnomah County, and account for 6 percent of the total CBC caseload.

Exhibit 18: Providence ElderPlace Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts



Forecast

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

In the Spring 2006 forecast, the 2005-07 PEP caseload is estimated to be 668, which is a 2.9 percent increase over the Fall 2005 forecast of 649. This caseload averages about 10 percent higher in the current forecast than in the Spring 2005, as indicated in Exhibit 10. In the 2007-09 biennium, this caseload is projected to average 700 clients per month.

NURSING FACILITIES

The Nursing Facilities (NF) clients comprise approximately one-fifth of the total long-term care caseload. The nursing facility client population falls into six service categories. These services are shown in Exhibit 19.

Exhibit 19: Nursing Facility services within the Long-Term Care program categories.

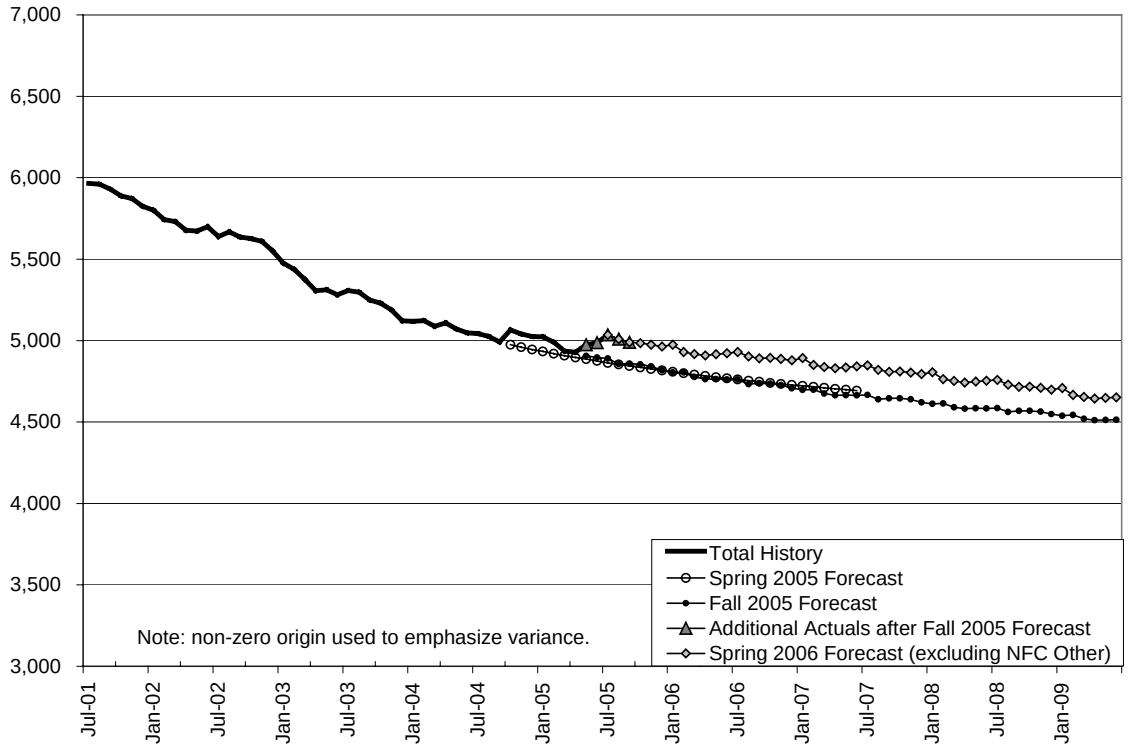
In-Home Care	Community-Based Care Facilities	**Nursing Facilities**
In-Home Hourly	Adult Foster Care: Relative	**Basic Care**
In-Home Live-In	Adult Foster Care: Commercial	**Complex Medical Add-On**
In-Home Spousal-Pay	Residential Care Facilities: Regular	**Pediatric Care**
Not in Forecast:	Residential Care Facilities: Contract	**New Forecast:**
Independent Choices	Assisted Living Facilities	**Medicare Extended Care**
	Specialized Living Facilities	**OHP Post-Hospital Benefit**
	Providence ElderPlace	**Enhanced Care**

Historically, the nursing facilities caseload has experienced a steady decline. 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[5].

In the Spring 2006 forecast, the total nursing facility caseload (excluding the three groups listed under "New Forecast" in Exhibit 19 which were not previously projected) of 4,917 is about 3 percent higher than the Fall 2005 and the Spring 2005 forecasts. This caseload is projected to average 4,740 in the 2007-09 biennium (see Exhibits 20 and 22).

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

Exhibit 20: Nursing Facility Caseload Excluding "Other": the Spring 2005, Fall 2005 and Spring 2006 Forecasts.



Other Nursing Facilities Services:

In the Spring 2006 forecast, the other nursing facility services are included in the NF caseload forecast for the first time. The other NF services include the Medicare Extended Care, Enhanced Care and OHP Post-Hospital Benefit. These three NF services have relatively small caseloads. Exhibits 21 and 22 shows total NF caseload including the new forecast caseloads.

Exhibit 21: Total Nursing Facility Caseload including Extended care, Post-Hospital and Enhanced Care Caseload

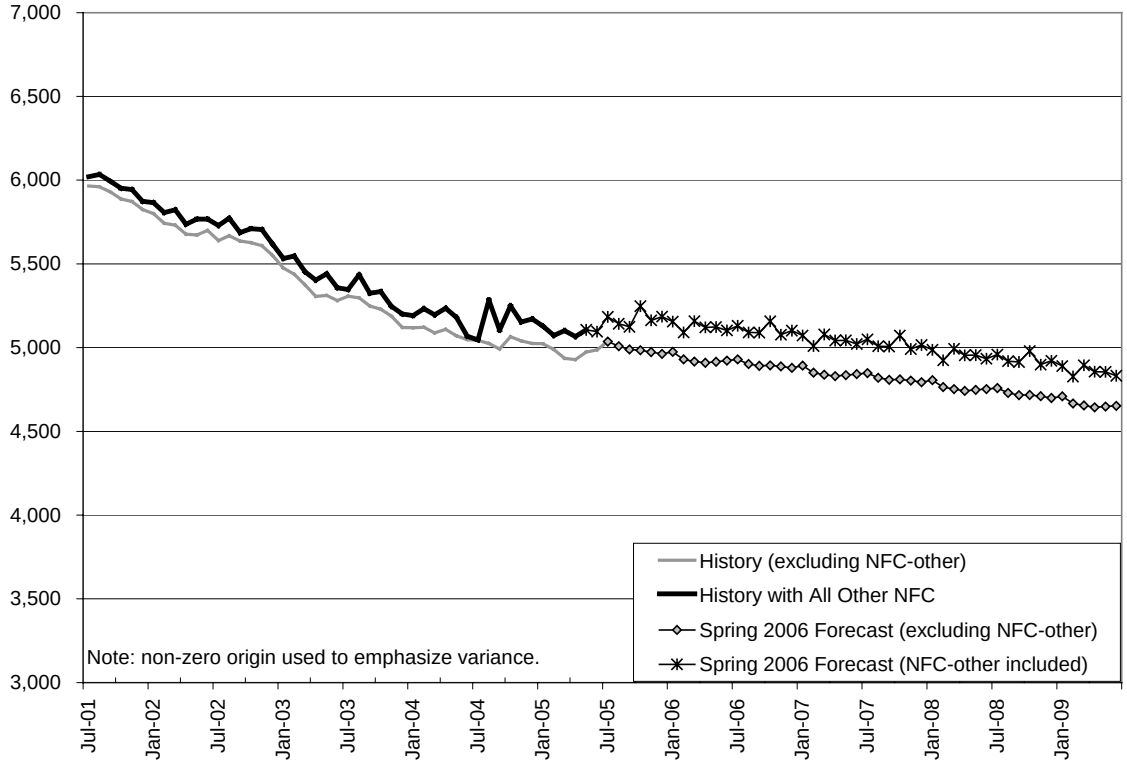


Exhibit 22: Total Nursing Facility Caseload Biennial Average Comparison by forecasts

	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Aged and Physically Disabled **Biennial averages by forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
Basic Nursing Facility Care	4,391	4,367	-0.5%	4,391	4,503	2.5%
Complex Medical Add-On	309	324	4.9%	309	344	11.3%
Pediatric Care	70	70	0.0%	70	70	0.5%
Subtotal - NFC	4,770	4,761	-0.2%	4,770	4,917	3.1%
Extended Care NFC					142	
Enhanced Care					56	
Post-Hospital Benefit					6	
Other NFC Services Total					204	

Exhibit 22 (continued)

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Aged and Physically Disabled **Biennial averages by forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
Basic Nursing Facility Care	4367	4,503	3.1%	4,207	4,342	3.2%
Complex Medical Add-On	324	344	6.1%	307	328	6.8%
Pediatric Care	70	70	0.5%	70	70	0.0%
Subtotal - NFC	**4761**	**4,917**	**3.3%**	**4,582**	**4,740**	**3.4%**
Extended Care NFC		142			142	
Enhanced Care		56			56	
Post-Hospital Benefit		6			6	
Other NFC Services Total		**204**			**204**	

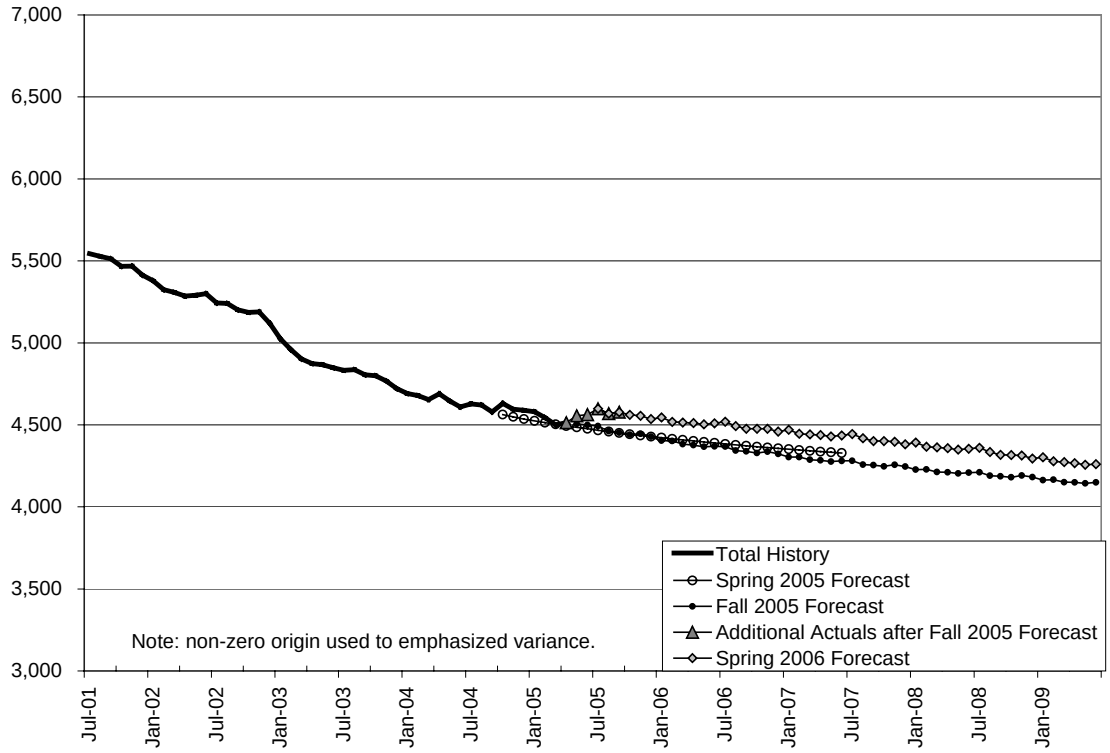
Basic Nursing Facility Care

The basic nursing facility care caseload includes about 88 percent of total nursing facility clients[6]. The clients in this caseload need 24-hour comprehensive care in nursing facilities for assistance with activities of daily living and ongoing nursing care either due to age or physical disability.

As noted earlier, this caseload has been decreasing gradually over time. However, the Spring 2006 NF basic care caseload forecast of 4,503 is 3 percent higher than the Fall and the Spring 2005 forecasts. This caseload is projected to average 4,342 in the 2007-09 biennium as seen in Exhibits 22 and 23.

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

Exhibit 23: Basic Nursing Care Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.

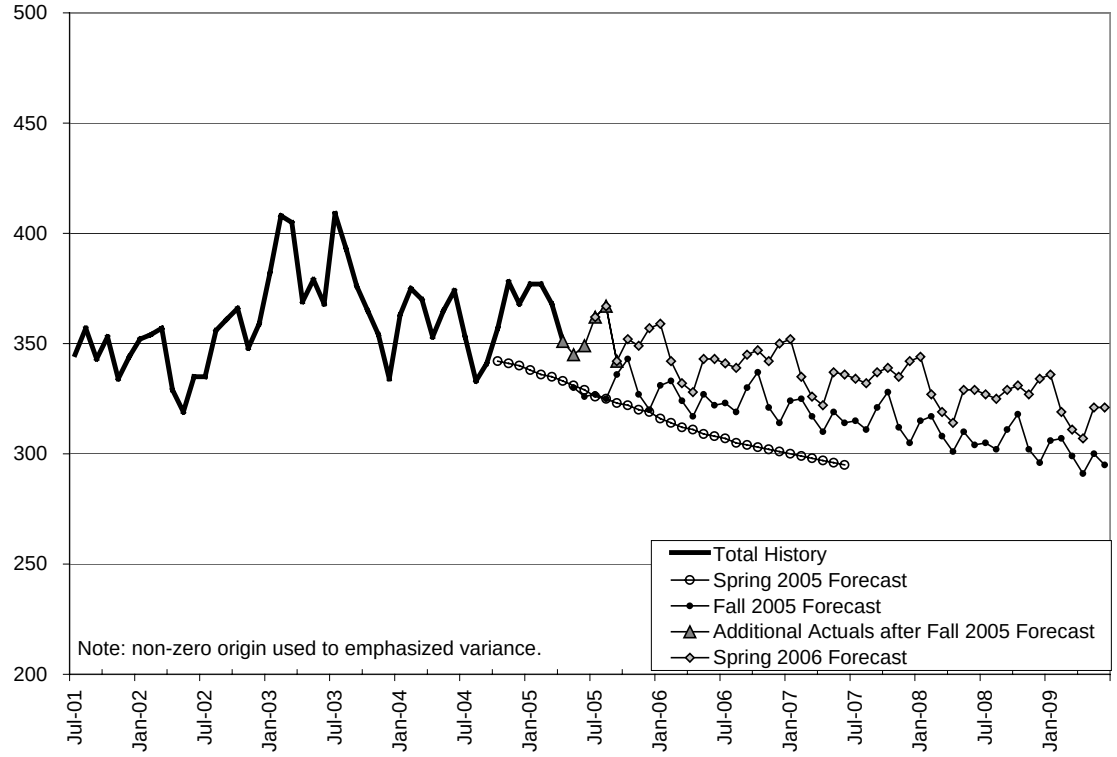


Complex Medical Add-On

The NF complex medical add-on caseload includes about 7 percent of total nursing facility clients. Clients in this caseload have medical conditions and needs that require additional nursing services and staff assistance beyond the basic care.

The complex medical add-on caseload is projected to average 344 in the 2005-07 biennium and 328 in the 2007-09 biennium (see Exhibit 22 and 24). Comparing the previous forecasts, the Spring 2006 complex medical add-on forecast is 6 percent higher than the Fall 2005 forecast for the 2005-07 biennium. This is an 11 percent increase over the Spring 2005 forecast.

Exhibit 24: Complex Medical Add-On Caseload with the Spring 2005, Fall 2005 and Spring 2006 Forecasts.



Other Nursing Facilities Services

Pediatric Care

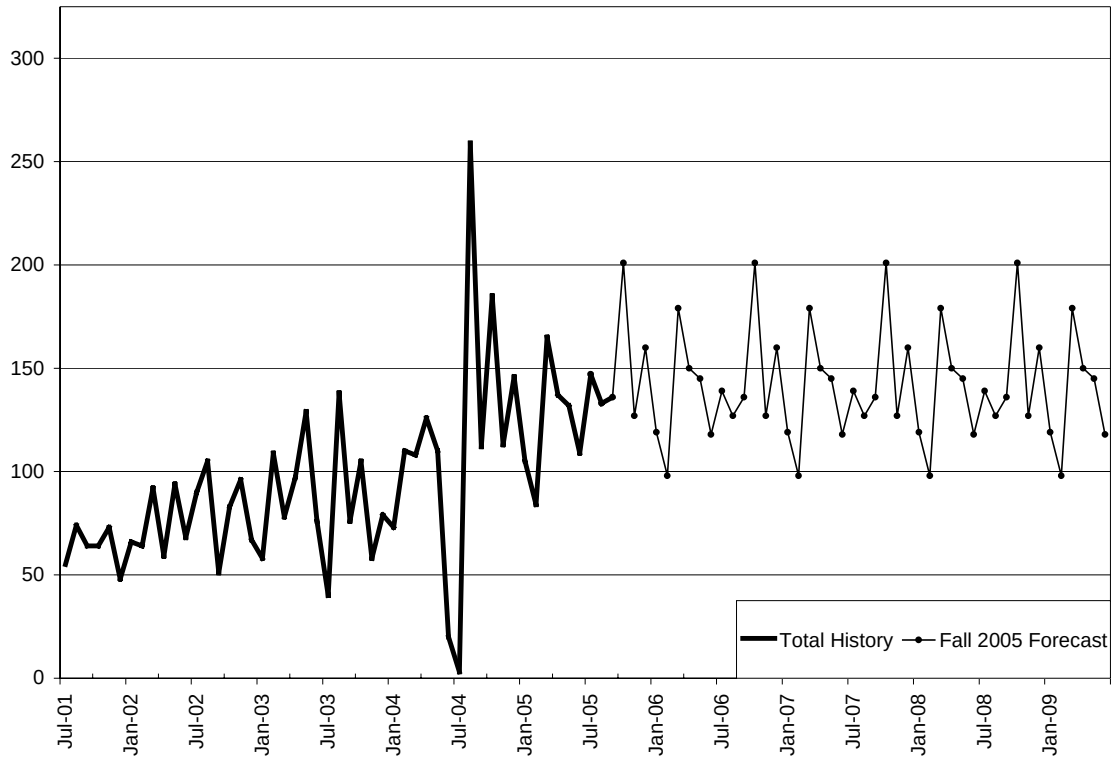
Children under 21 who receive care in the state's pediatric nursing facility units are included in the pediatric care caseload. There are 70 pediatric facility placements available in Oregon.

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

Medicare Extended Care

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

Exhibit 25: Nursing Facilities Extended Care Caseload with the Fall 2005 and Spring 2005 Forecasts.



The extended care caseload is forecasted to remain at an average of 142 clients in the current (2005-07 biennium) and the next biennia (2007-09) as shown in Exhibits 22 and 25.

Post-Hospital Benefit

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

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

Nursing Facilities: Enhanced Care

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

There are fixed placements available (206 in 2005) for Enhanced Care services in the various community care setting and nursing facilities. The caseloads in the various community care settings already count these Enhanced Care clients. The Enhanced Care caseload served in nursing facilities is reported in this Nursing Facility Enhanced Care section.

Approximately 56 clients are being served under Enhanced Care services in nursing facilities. Additionally, 115 clients are being served in various community-based care settings.

In the 2005-07 and the 2007-09 biennia, the Nursing Facility Enhanced Care caseload is forecasted to remain at the biennial average of 56 clients.

Risks and Assumptions

The implementation of the Medicare Modernization Act, the interaction of Medicaid market dynamics in community-based care facilities, the increased reimbursements in the nursing facility market and the ever-increasing elderly population in Oregon generates a real risks to the long-term care caseload forecast.

- **MMA Impact on In-Home Caseload:**

The in-home hourly caseload may gain new clients as a result of the January 2006 implementation of the Medicare Modernization Act (MMA) of 2003. Some people may learn about DHS services as a result of the information provided in MMA materials and subsequently apply for services.

The MMA provides prescription drug coverage to elderly and disabled people who are enrolled in the Medicare programs. Approximately 264,000 Oregonians were informed about their potential eligibility for low-income subsidies that would pay for this coverage. A subset of these individuals may be eligible for other State-funded benefits like the Oregon Health Plan. Another group may have the functional needs to qualify for long-term care services.

About one-third of the Medicaid LTC clients will be required by the MMA to participate in premium payment and cost sharing. If these people live in nursing facilities, they will be exempted from the required cost sharing under current

regulations. However, if they live in community-based care, they will be subject to cost sharing. This co-payment requirement may provide an incentive to move out of community-based care and into a nursing facility.

- **Community-Based Care Market Forces:**

In the community-based care setting, the total adult foster care caseload is in decline; this is especially true for the relative adult foster care caseload. In the 2001-03 biennium, this caseload was increasing before the elimination of service priority level 12-17. Since then, this caseload has experienced the service priority level related caseload reduction, the risk of program elimination and the uncertainty of possible budget reduction for the 2005-07 biennium. However, this program was restored for 2005-07, and as result, this caseload may level off or begin to increase.

The commercial adult foster care caseload has also declined. However, in recent months this caseload has stabilized. The residential care and assisted living markets have a licensing moratorium through 2009. As a result, we may observe capacity constraints in RCF and ALF markets in the forecast periods of 2005-07 and 2007-09 biennium. Furthermore, RCF is serving a larger share of the special need contract caseload. And, at the same time, RCF and ALF may also make their facility beds available to the more lucrative private-pay market. This may cause some increase in the Medicaid adult foster care caseload especially in the commercial adult foster care market.

The all-inclusive Providence ElderPlace caseload has also seen a rapid increase in the caseload in recent months, which may pose some risk to the LTC caseload.

- **Nursing Facilities Reimbursement:**

One risk to the NF caseload forecast is the change in the nursing facility rate methodology implemented in 2004. It increased the Medicaid daily reimbursement by more than 50 percent, from about $113 during the first six months of 2003 to an average daily rate of about $170 in the last six months of 2005. The NF rate increase was a direct result of implementation of the long-term care provider tax. During the same 24-month period, most Medicaid rates paid to alternative, lower cost service providers such as adult foster homes, residential and assisted living facilities were frozen or received small cost-of-living increases. The higher Medicaid reimbursement rate may allow nursing facilities to serve more Medicaid clients.

- **Growing Elderly Population:**

Elderly Oregonians are among the fastest growing segments of the state population. While the total Oregon population is expected to increase 6 percent by 2010, the 65 and older group will grow by 10.5 percent. The 85 and older

group will increase by 8 percent. Both of these groups will grow through 2040. As the elderly live longer, they also risk depleting their resources. If they do, they will likely become eligible for the DHS Medicaid and long-term care programs.

The following explores the possible effect of the growing elderly population in Oregon on its long-term care service delivery system, if one were to assume no other changes in the LTC programs, client characteristics, LTC market and economy[7].

Exhibit 26 explores the relationship of increasing elderly Oregonian and the Medicaid long-term care population. The long-term care client population is the combination of all three types of LTC services described earlier.

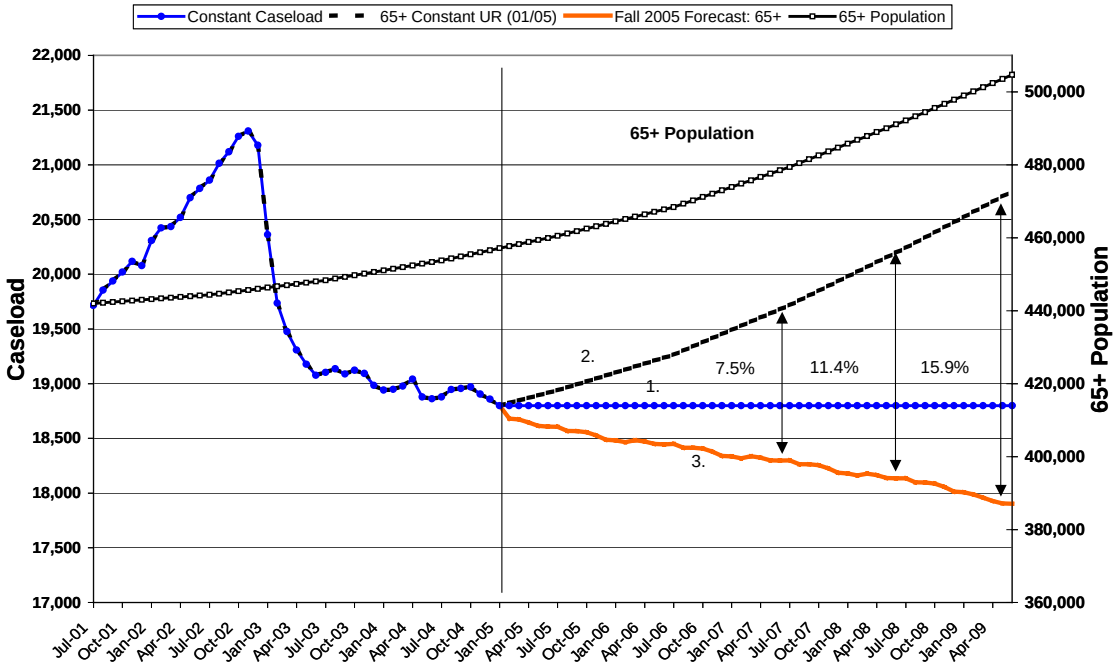
The vertical line on Exhibit 26 separates the historical period from the forecasted period at the time this analysis was completed. The exhibit shows two different types of numbers and three alternative projections. First, the historical and projected[8] population numbers are given for all individuals who are 65 years and older. These are assigned to the axis on the right side (vertical line) of the exhibit. Second, the 65 years and older LTC caseload is shown as history and as projections through June 2009. These are assigned to the axis on the left side of the exhibit. The three projections are as follows:

1. **Constant Caseload**. This assumes that the LTC caseload is maintained at the January 2005 number (18,799) through June 2009. This is simply a line for reference and assumes that SPD staff implement management actions that allow this consistency.

2. **65+ Constant Utilization Rate**[9]. This projection assumes that the LTC caseload matches population growth at a constant proportion based on January 2005. The January 2005 Utilization Rate is 4.1 percent of the total 65+ population. This rate was applied to project the population-based caseload forecast. However, it should be noted that the utilization rate does change with time.

3. **Fall 2005 Forecast.** This line is estimated number of 65+ clients in the Fall 2005 Forecast[10].

[7] This preliminary study is the result of joint work done by staff from the Seniors and People with Disabilities and Client Caseload Forecast Team.
[8] All population numbers are based on the September 2005 population estimates produced by the Office of Economic Analysis, Department of Administrative Services, State of Oregon.
[9] Utilization Rate = (65+ Monthly caseload) / (65+ Population). This is the proportion of a particular population subgroup that receives services and benefits from Oregon's Long-term Care program.
[10] Since this preliminary study was done prior to the Spring 2006 caseload forecast and the two LTC forecasts (the Fall 2005 and the Spring 2006) are very similar, the Fall 2005 forecast was used for demonstration purposes.



Percentages next to the arrows are the percent differences between the constant Utilization Rate projection and the Fall 2005 Forecast. The effects of an increasing elderly population, if there were no other changes, are clear. It should be noted, however, that historically the long-term care caseload has not changed directly in response to population changes. For example, growth in the LTC caseload for the 65 + population was much greater than the 65+ population change from July 2001 through July 2002. Since 2003, however, the LTC caseload has been declining while the population has grown slowly.

It is unknown if the population characteristics that affect the elderly demand for LTC service will change as these numbers increase. For example, if people delay needing LTC due to improved health or they do not need LTC because they have more resources (including a social-support system), their demand for services may be different than the current demand structure of the LTC clients. Potentially, this population could delay entry into the LTC caseload (at more advanced age) and may require more costly institutional services. Nonetheless, given the relatively large demographic changes in the near to long-term future, particularly in the 85+ age group, there is an increased likelihood of demand for DHS LTC services. Therefore, program policies, service priorities, and the future availability of adequate resources will have to be evaluated relative to the growth in demand for long-term care services in upcoming years.

APPENDIX I

CHILD WELFARE AVERAGE DAILY POPULATION BY SERVICE CATEGORY

Service Categories

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

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

Subsidized Guardianship: The ADP for Subsidized Guardianship includes payments made to remove financial barriers in achieving permanency for Title IV-E[11] eligible children for whom returning home or adoption is not in their best interest.

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

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

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

[11] 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 Issues

As noted in the main body of the report, the Spring 2006 forecast for Child Welfare possesses a number of methodological differences compared to the forecast done in Fall 2005. For Fall 2005, caseloads were measured in terms of end-of-month counts. In contrast, the Spring 2006 forecast is now measured in terms of number served during a month and has consolidated some of the caseloads. The Spring 2006 forecast incorporates an additional level of detail, forecasting ADP by service category, which is outlined here. This provides information appropriate for the budgeting process.

For the most part, the ADP figures calculated here for the Spring 2006 forecast roughly match the end-of-month counts used for the Spring 2005 and Fall 2005 forecasts. A major exception is Adoption Assistance, where the end-of-month count used for prior forecasts included non-cash cases, whereas ADP used for Spring 2006 only includes cases receiving cash assistance. Another exception is Residential Treatment.

Forecast

Biennial averages for the Spring 2005, Fall 2005, and Spring 2006 forecasts by service category appear in Exhibit 1. As previously noted, methodological differences mean comparisons of the Spring 2006 forecast to previous forecasts for Adoption Assistance and Residential Treatment are not possible. Also, it should be noted that since the service categories listed are not mutually exclusive (i.e., a child may receive multiple kinds of service within a month), the numbers cannot be added to arrive at a total figure.

Exhibit 1: Total Child Welfare Average Daily Population Comparison by Forecast

	2005-07 Biennium					
Forecasts compared:	**Spring 2005 to Fall 2005**			**Spring 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Spring 05 Forecast 2005-07**	**Fall 05 Forecast 2005-07**	*%Diff. Spring 05 to Fall 05 2005-07*	**Spring 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Spring 05 to Spring 06 2005-07*
CHILD WELFARE (Average Daily Population)						
Adoption Assistance[1]	9,322	9,540	2.3%	9,322	9,039	N/A
Subsidized Guardianship[2]	535	558	4.3%	535	573	7.1%
Regular Paid Foster Care[2]	6,747	7,916	17.3%	6,747	7,304	8.3%
Special Rates Foster Care[2]	3,274	3,604	10.1%	3,274	3,591	9.7%
Residential Treatment[1]	560	588	5.0%	560	563	N/A

1. Spring 2005 and Fall 2005 figures are not comparable to the Spring 2006 figures.
2. Spring 2005 and Fall 2005 figures represent end-of-month counts, but in this case they are roughly equivalent to ADP, and therefore reasonably comparable.

Exhibit 1 (continued)

	2005-07 Biennium			2007-09 Biennium		
Forecasts compared:	**Fall 2005 to Spring 2006**			**Fall 2005 to Spring 2006**		
Children, Adults and Families (CAF) **Biennial Averages by Forecast**	**Fall 05 Forecast 2005-07**	**Spring 06 Forecast 2005-07**	*% Diff. Fall 05 to Spring 06 2005-07*	**Fall 05 Forecast 2007-09**	**Spring 06 Forecast 2007-09**	*% Diff. Fall 05 to Spring 06 2007-09*
CHILD WELFARE (Average Daily Population)						
Adoption Assistance[1]	9,540	9,039	N/A	10,868	10,461	N/A
Subsidized Guardianship[2]	558	573	2.7%	743	751	1.1%
Regular Paid Foster Care[2]	7,916	7,304	-7.7%	8,913	8,396	-5.8%
Special Rates Foster Care[2]	3,604	3,591	-0.4%	3,770	3,872	2.7%
Residential Treatment[1]	588	563	N/A	646	631	N/A

The trend lines for Adoption Assistance appear in Exhibit 2. Although the Spring 2006 forecast is lower due to the difference in methodology, the trend parallels the Fall 2005 forecast. In other words, both forecasts project a similar growth pattern.

Exhibit 2: Adoption Assistance Average Daily Population

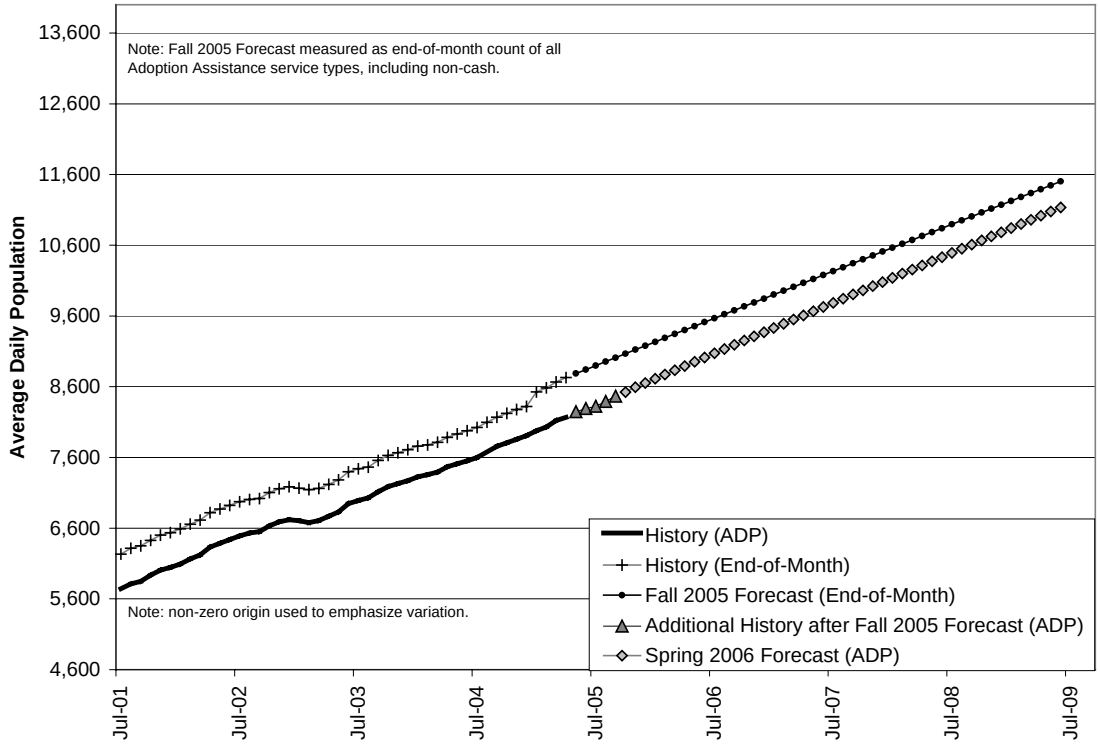
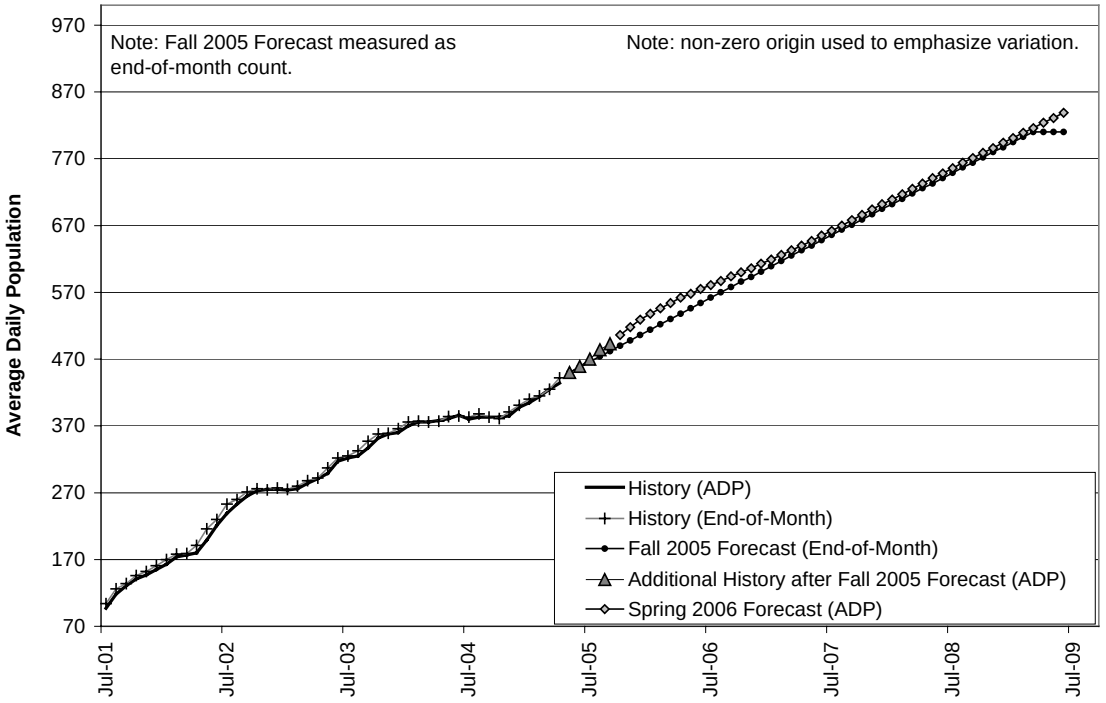


Exhibit 3 shows that the **Subsidized Guardianship ADP** history used for the Spring 2006 forecast closely matches the end-of-month history used for the Fall 2005 forecast. Therefore, the ADP used for the Spring 2006 forecast seems to

be roughly comparable to the end-of-month counts used for the Fall 2005 and Spring 2005 forecasts. The triangles, which mark the additional data acquired since the Fall 2005 forecast, show slightly faster growth than was evident when the Fall 2005 forecast was done. The Spring 2006 forecast continues this trend, but gradually turns to the longer-term trend.

Exhibit 3: Subsidized Guardianship Average Daily Population



For **Regular Paid Foster Care**, the ADP history used for the Spring 2006 forecast appears to match the end-of-month history used for the Fall 2005 forecast reasonably well, as shown in Exhibit 4. This makes the ADP used for the Spring 2006 forecast somewhat comparable to the end-of-month counts used for the Fall 2005 and Spring 2005 forecasts.

The trend line for the Spring 2006 forecast shows a downward shift compared to the Fall 2005 forecast. The reason for this is that when the Fall 2005 forecast was being prepared, the data indicated that Regular Paid Foster Care was experiencing rapid growth that began around 2003 that was at least anecdotally linked to the worsening methamphetamine epidemic. Both the Fall 2004 and Spring 2005 forecasts had underestimated the growth, so the Fall 2005 forecast assumed that the recent rate of growth would continue throughout much of the 2005-07 biennium and then gradually return to the longer-term trend. However, data obtained since the Fall 2005 forecast indicate a slackening of the recent trend with it flattening out and even dipping a bit over the summer months.

This led to the conclusion that the Spring 2006 forecast should incorporate a lower growth rate tempered by a seasonal pattern.

Exhibit 4: Regular Paid Foster Care Average Daily Population (excluding Native American)

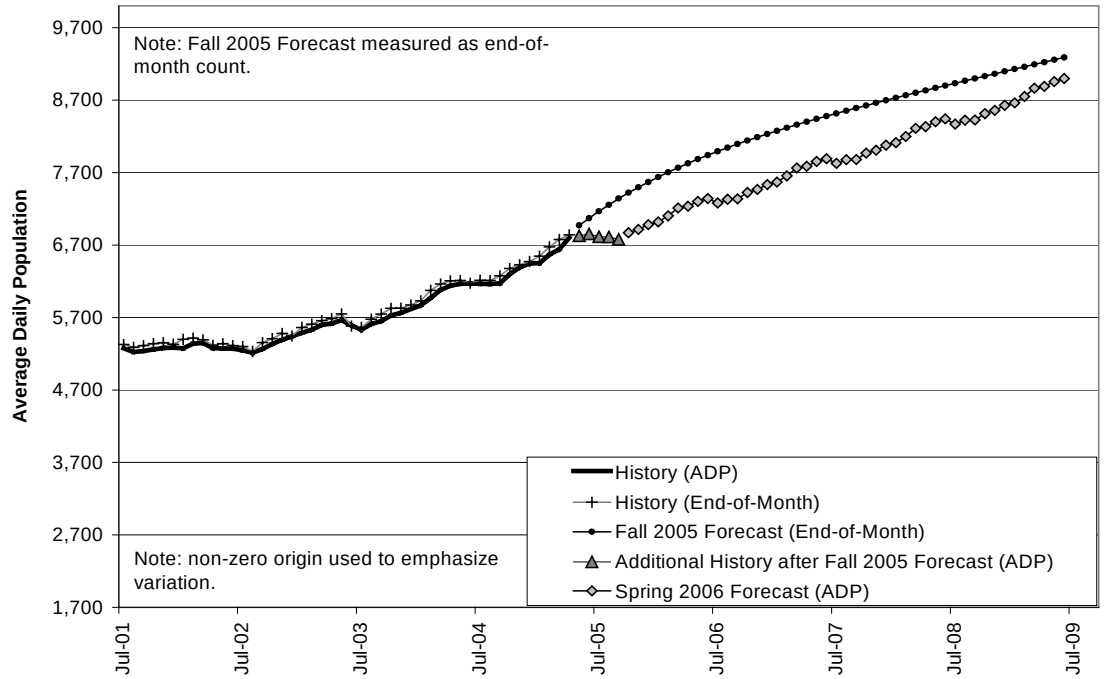
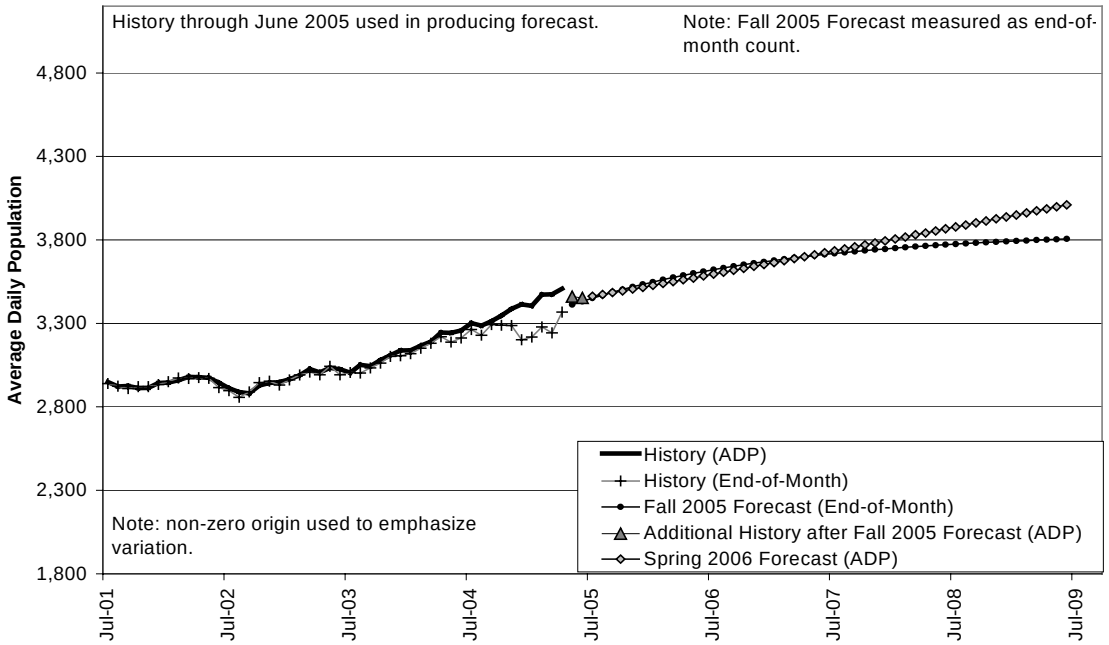


Exhibit 5: Special Rates Foster Care Average Daily Population

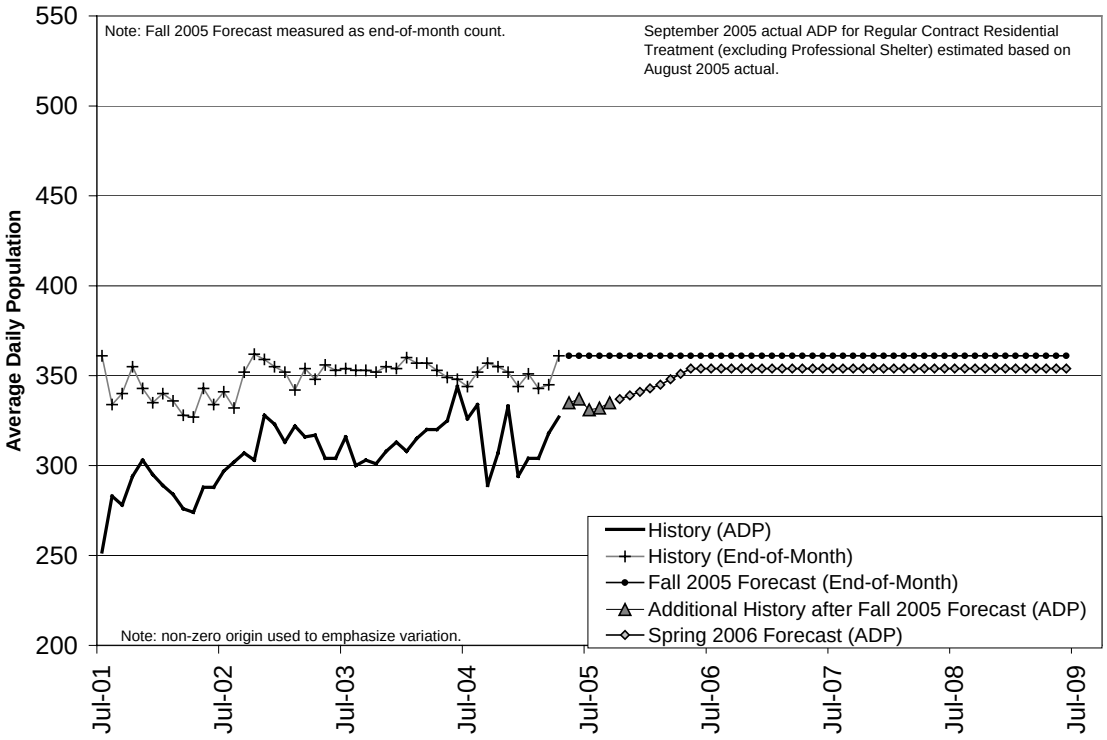


Despite methodological changes between forecasts, the ADP history through September 2005 for **Special Rates Foster Care** closely coincides with the end-of-month counts used to produce the Fall 2005 forecast, as seen in Exhibit 5.

However, the ADP and end-of-month lines diverge after September 2005, which appears to be due to data settling issues. As a precaution, the Spring 2006 forecast only used actual data through June 2005 for Special Rates Foster Care instead of through September 2005 as with the other Child Welfare caseloads and services, allowing six months for the data to settle. With this accommodation, the Special Rates Foster Care ADP figures for Spring 2006 seem to be comparable to the end-of-month counts given for the Fall 2005 and Spring 2005 forecasts. A comparison of the Spring 2006 and Fall 2005 forecast trend lines shows them being closely aligned for most of the 2005-07 biennium, with the Spring 2006 forecast continuing its pattern of steady growth into the 2007-09 biennium instead of leveling off as in the Fall 2005 forecast.

Unlike Subsidized Guardianship and Foster Care, the end-of-month counts for **Residential Treatment** used in the Fall 2005 and Spring 2005 forecasts do not appear to be comparable to the ADP figures used in the Spring 2006 forecast. Therefore, caution must be used when comparing these forecasts. The graph for Residential Treatment appears in Exhibit 6. Although the Spring 2006 forecast is lower than the Fall 2005 forecast, the two trend lines do parallel one another from July 2006 on, with similar patterns of seasonality.

Exhibit 6: Total Residential Treatment Average Daily Population Caseload



Risks and Assumptions

A major component of the Residential Treatment caseload is **Regular Contract**, which relates to a specific number of contracted beds for children with behavioral and emotional problems. Another component is **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. The capacity for Regular Contract beds is 361.25, so the Fall 2005 forecast projected the end-of-month count to be a constant 361. However, a recent internal review indicates that there may have been some underutilization in the regular contract residential treatment program, and management actions are expected to increase utilization to where it should reach 98 percent (which equates to 354 beds) by June 2006. This underutilization simply creates a shift in ADP from Regular Contract to Special Contract, so there is no impact on total number of beds filled. The Spring 2006 forecast assumes that ADP for Regular Contract Residential Treatment will increase until it levels off at 354 in June 2006.

APPENDIX II

MEDICAL ASSISTANCE PROGRAM TIMELINES

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

The four graphs included here illustrate the following caseloads:

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

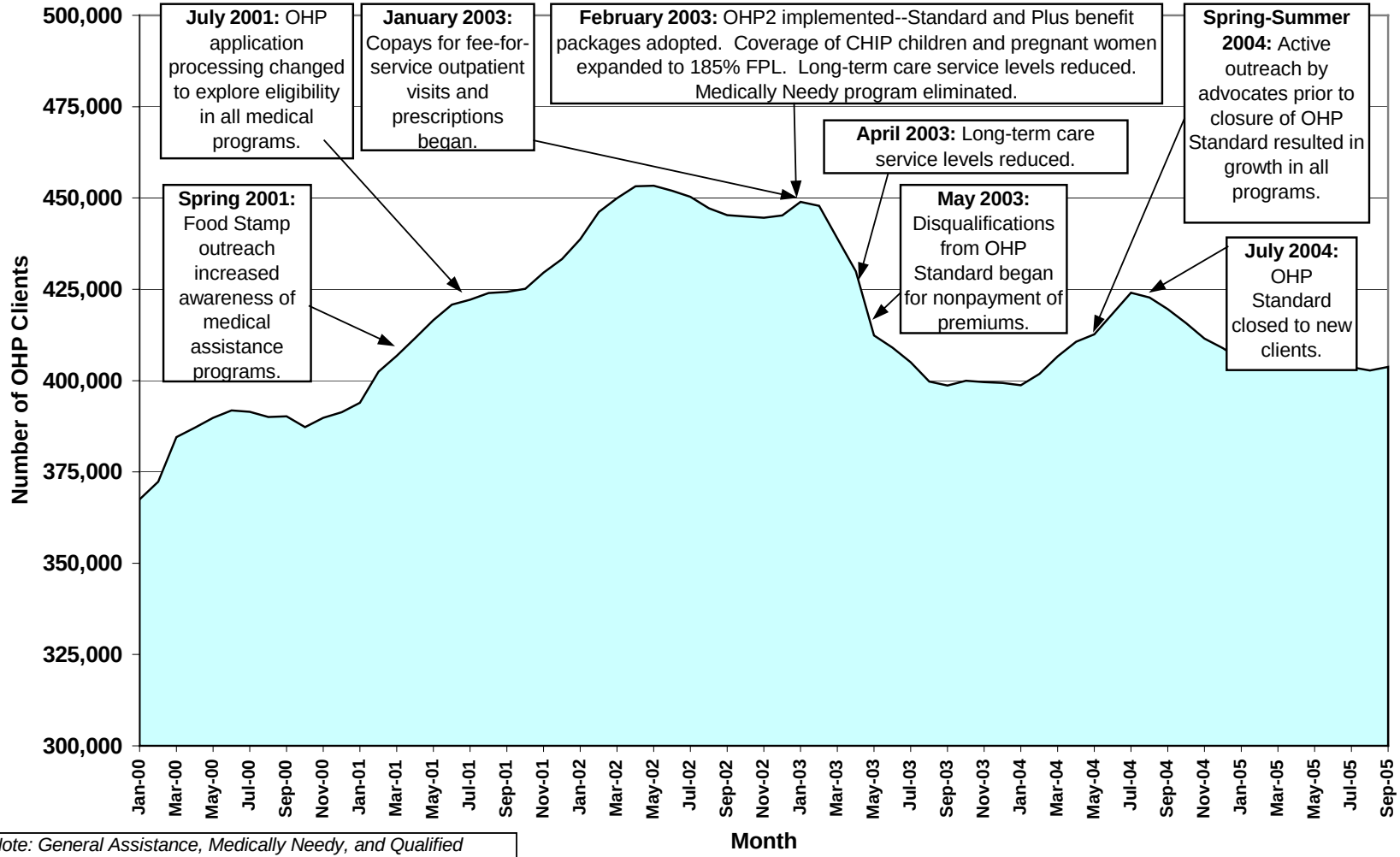
- **Oregon Health Plan Plus Population**
    - TANF Related Medical
    - TANF Extended
    - Poverty Level Medical Women
    - Poverty Level Medical Children
    - Aid to the Blind and Disabled
    - Old Age Assistance
    - Foster/Substitute Care
    - Children's Health Insurance Program

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

- **Oregon Health Plan CHIP Population**

Total Oregon Health Plan Population

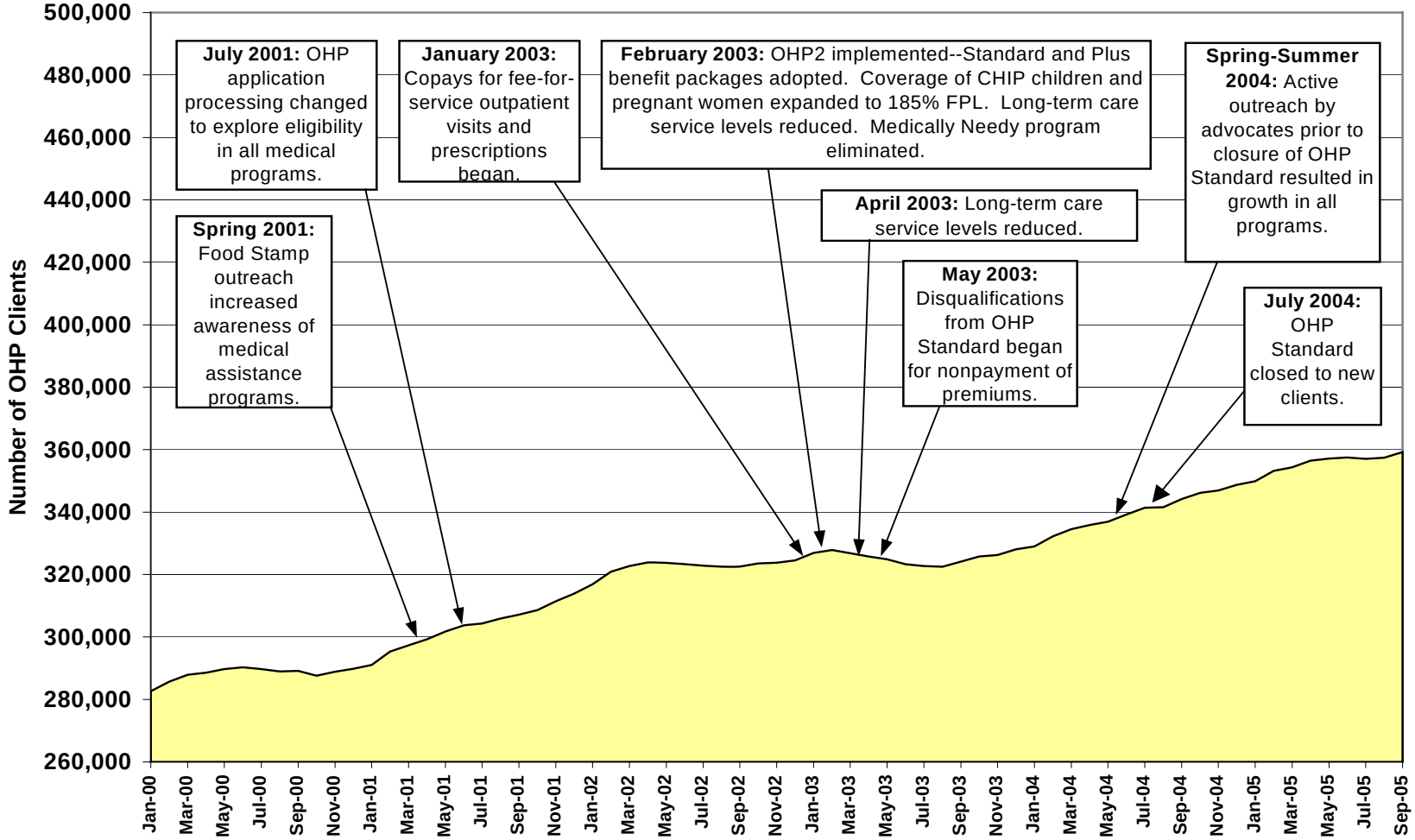
January 2000 through September 2005



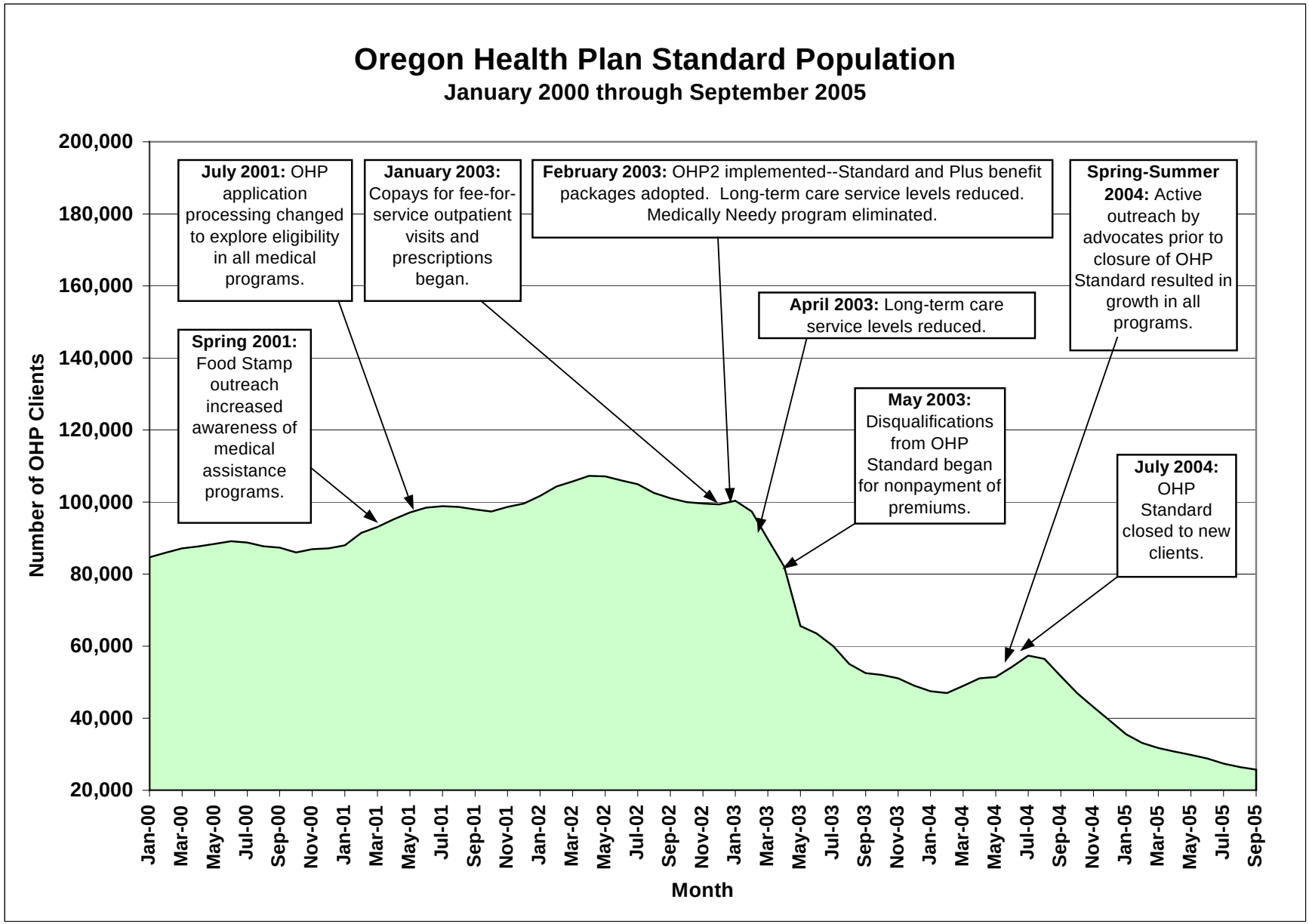
Note: General Assistance, Medically Needy, and Qualified Medicare Beneficiary programs not included in graph.

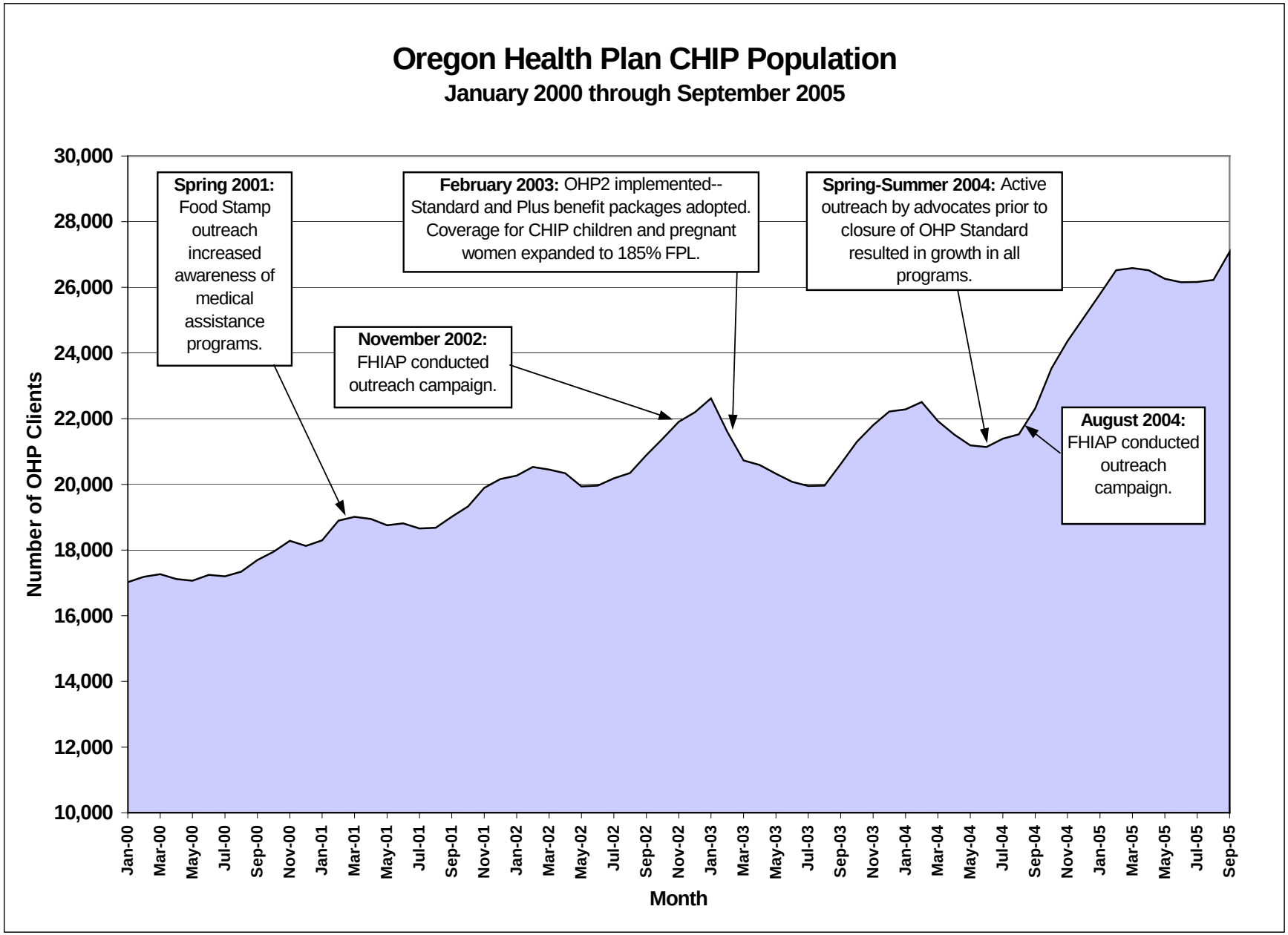
Oregon Health Plan Plus Population

January 2000 through September 2005



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


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


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

APPENDIX III

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