SPRING 2024 ODHS/OHA CASELOAD FORECAST

BUDGET PLANNING AND ANALYSIS
OFFICE OF FORECASTING, RESEARCH AND ANALYSIS

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Executive Summary

The 2023-25 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 427,729 households, which is 2.2 percent lower than the Fall 2023 forecast. The 2025-27 biennial average forecast is 419,984 households, which is 1.8 percent lower than the 2023-25 forecast average.

The 2023-25 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 20,887 families, which is 5.2 percent higher than the Fall 2023 forecast. The 2025-27 biennial average forecast is 20,749 families, which is less than one percent lower than the 2023-25 forecast average.

The 2023-25 **Child Welfare (CW)** biennial monthly average forecast is 17,112 children, which is 1.5 percent lower than the Fall 2023 forecast. The 2025-27 biennial monthly average forecast is 16,622 children, which is 2.9 percent lower than the 2023–25 forecast average.

The 2023-25 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 35,441 clients, which is 4.9 percent higher than the Fall 2023 forecast. The 2025-27 biennial average forecast is 36,190 clients, which is 2.1 percent higher than the 2023-25 forecast average. These averages include the expansion of disability care through Healthier Oregon.

The 2023-25 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average is 35,927 clients, which is 1.0 percent higher than the Fall 2023 forecast. The 2025-27 biennial average forecast is 38,525 clients, which is 7.2 percent higher than the 2023-25 forecast average. These averages include the expansion of disability care through Healthier Oregon.

The 2023-25 **Vocational Rehabilitation (VR)** biennial average is 9,401 clients, which is 5.0 percent higher than the Fall 2023 forecast average. The 2025-27 Total VR biennial average forecast is 10,396 clients, which is 10.6 percent higher than the 2023-25 forecast average.

The 2023-25 **Health Systems Medicaid (HSM)** biennial average forecast for Total Medicaid (which includes the new Healthier Oregon coverage groups) is 1,397,848 clients, which is 6.7 percent higher than the Fall 2023 Forecast. The 2025-27 biennial average forecast is 1,313,999 clients, which is six percent lower than the 2023-25 forecast average.

The 2023-25 **Mental Health (MH)** biennial monthly average forecast is 88,673 adults. This includes 82,219 Never Committed clients, 4,146 Previously Committed clients, 773 Civilly Committed clients, and 1,535 Forensic clients. The forensic count includes 675 clients who are under the Psychiatric Security Review Board and 860 Aid and Assist clients. The 2025-27 biennial monthly average forecast is 94,325 adults, which is 6.4 percent higher than the 2023-25 forecast average.

Introduction

The End of the COVID-19 Public Health Emergency

The Public Health Emergency related to COVID-19 and the orders to limit physical distancing to mitigate its spread impacted every area we forecast, from major changes to caseload counts to indirect effects. The Public Health Emergency (PHE) related to COVID-19 were felt immediately upon the declaration of PHE in March of 2020. With the end of the official Public Health Emergency and a return to normal case processing, ODHS and OHA are entering a new phase of the COVID era – an "unwinding" of emergency conditions. Although the number of assumptions driving forecasting decisions is less than in the past, there still exists more uncertainty than usual in the environment for multiple program areas we forecast.

The largest and most obvious impact to the caseloads we forecast is in Medicaid and related health systems (see the *Health Systems/Medicaid* section of this document for more information). But the end of the PHE also had impacts on other areas we forecast. For many programs, the emergency conditions allowed for "contactless" interactions with applicants, including verbal attestations of income and assets, video calls in lieu of in-person assessments, and verbal consent rather than signatures. Some programs have increased capacity for alternatives to physical signatures – such as "e-sign" options. And these capacities are now part of the standard operating procedure of the agencies. But other requirements that were waived are being enforced again. We do not expect any of these shifts to have a measurable caseload impact, but they could create disturbances in normal case processing – especially for clients up for redeterminations that require more work than in the past three years. This may create more "churn" off and then back on the caseload than during the pandemic.

Integrated Eligibility

The Integrated Eligibility (IE) System completed its rollout in early 2021. What began as the Medicaid enrollment system for means-tested case types (the ONE system) now covers all OHA programs and multiple ODHS program areas. Although the rollover to IE included some system instability at the outset, it is now considered stable and includes enhanced functionality and an improved "rules engine" for determining eligibility compared to the old system.

The IE system was inaugurated during the PHE, and therefore has not operated in "normal" conditions. The initial rollout contained some unforeseen effects – such as cases being moved into or out of disability categories as determinations became more accurate. It is unknown if some new unforeseen effects will occur when the "unwinding" of emergency conditions is over, and the IE system reverts to "normal case processing" – a condition in which it has never operated.

Economics

The draw-down in employment due to pandemic-related restrictions was sharp, and the initial "bounce-back" was equally sharp. Today, total employment is higher in Oregon than it has ever been. However, supply chain constraints and a scramble by employers to fill vacancies has a downside – it is fueling inflation. The long era of modest inflation is over, but a "soft landing," – where jobs growth, wage growth and inflation all reduce without a recession – seems more likely than ever before.

The Spring 2024 Forecast

This document summarizes the Spring 2024 forecasts of client caseloads for ODHS and OHA. OFRA issues these forecasts in the spring and fall each year. The Spring 2024 caseload forecast is based on data (whether preliminary or final) available through February 2024.

Forecasts are developed using a combination of time-series techniques, input-output deterministic models, and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload, and through the annual forecast quality report which compares forecast accuracy across programs and over time.[1]

General Assumptions

Forecasts are based on specific assumptions about the future, and an important part of forecasting is identifying the major risks to those assumptions. Caseload dynamics are influenced by demographics, the economy, and policy choices. Demographic changes have a long-term and predictable influence on caseloads. Economic factors can have a dramatic effect on some caseloads, both during recessions and during recoveries. The most immediate and dramatic effects on caseloads, however, result from policy changes that alter the pool of eligible clients or the duration of their program eligibility. Sometimes economic factors influence policy changes. For example, a poor economy will cause tax receipts to decline, which can in turn force spending cuts that limit eligibility for some programs.

Specific risks and assumptions relevant to each program area were considered in the preparation of this forecast. They will be noted in the text for each section of the document.

[1] More information about the forecasting process and current monthly variance reports can be found on the OFRA web page: https://www.oregon.gov/odhs/data/Pages/forecasting.aspx

OREGON DEPARTMENT OF HUMAN SERVICES

Total Oregon Department of Human Services Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
Self Sufficiency								
Supplemental Nutrition Assistance Program (Households)	418,386	427,729	9,343	2.2%	427,729	419,984	-7,745	-1.8%
Temporary Assistance for Needy Families (Families: Cash/Grants)	19,850	20,887	1,037	5.2%	20,887	20,749	-138	-0.7%
Child Welfare (children served)								
Adoption Assistance	9,189	8,978	-211	-2.3%	8,978	8,768	-210	-2.3%
Guardianship Assistance	2,598	2,542	-56	-2.2%	2,542	2,588	46	1.8%
Out of Home Care[1]	4,438	4,366	-72	-1.6%	4,366	4,056	-310	-7.1%
Child In-Home	1,145	1,226	81	7.1%	1,226	1,210	-16	-1.3%
Aging & People with Disabilities[2]								
Long-Term Care: In Home	17,196	18,432	1,236	7.2%	18,432	18,768	336	1.8%
Long-Term Care: Community Based	12,892	13,156	264	2.0%	13,156	13,576	420	3.2%
Long-Term Care: Nursing Facilities	3,690	3,853	163	4.4%	3,853	3,846	-7	-0.2%
Intellectual and Developmental Disabilities[2]								
Total Case Management Enrollment[3]	35,555	35,927	372	1.0%	35,927	38,525	2,598	7.2%
Total I/DD Services	24,073	24,365	292	1.2%	24,365	25,827	1,462	6.0%
Vocational Rehabilitation	8,956	9,401	445	5.0%	9,401	10,396	995	10.6%

1. Includes residential and foster care.

2. APD Long-Term Care and Total IDD Services caseloads include Healthier Oregon clients.

3. Some clients enrolled in Case Management do not receive any additional I/DD services.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs (SSP) aid low-income families to become healthy, safe, and economically independent. For most SSP programs caseloads are defined as the number of families receiving program benefits within the month. For the SNAP program, caseloads are counted as the number of households receiving the benefit within the month.

The Public Health Emergency

Steps to limit the spread of COVID-19 had a significant impact on both economic activity and social behavior. Temporarily closing high-contact businesses had a severe economic fallout, leading to an increase in unemployment, especially in service-sector. This had a pronounced effect on SNAP and TANF, given that a substantial number of SSP clients enter or exit Self-Sufficiency from service sector jobs. Social distancing practices, designed to reduce the spread of the virus, led to an end to in-person schooling. This forced some people to have to choose between aiding their children with distance learning and going back to work, leading them to stay at home and remain voluntarily jobless.

These economic and social changes drove SNAP and TANF up, while the availability of Enhanced Unemployment Insurance (EUI) benefits drove the caseloads back down. When EUI ended in September 2021, entries in TANF and SNAP increased.

Economics

The current forecast was developed in concert with the first-quarter economic and revenue forecast released by the Oregon Office of Economic Analysis (OEA) in February 2024. In the past, the employment forecast has been used explicitly as an exogenous variable for SNAP and TANF, given that historically it has had a negative correlation to caseload volume – as employment went up, caseloads went down and vice versa. Since the start of the COVID-19 emergency, the relationship between Self-Sufficiency and employment has been effectively broken. Factors like the establishment and then expiration of Enhanced Unemployment Insurance has had more influence on Self-Sufficiency than the number of employed Oregonians. As a result, the economic forecast prepared by OEA has been used to inform the forecast, and guide assumptions, rather than be used explicitly as a variable in forecast equations.

The latest employment forecast states bluntly, “Oregon has fully recovered from the pandemic.” OEA assumes that the Oregon economy will continue to expand, despite inflation remaining higher than the Federal Reserve’s target. There are concerns about demographic trends – Oregon is not attracting migrants from other states the way it has in past economic good times. When demographics lead to a tight labor market in Oregon, people with little education or specialized training can get jobs and their foot in the door to expanded employment opportunities, often leaving SNAP and TANF behind. However, this has yet to be seen in our caseload patterns. OFRA will continue to look for signs of a “normalization” of our caseloads relative to employment.

Supplemental Nutrition Assistance Program (SNAP)

SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food. To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum gross income limit is 130 percent of the Federal Poverty (FPL) for most families and can be up to 200 percent of FPL for people with categorical eligibility, such as disability.

The Public Health Emergency and Federal Policy

The National Public Health Emergency (PHE) declared to combat COVID-19 expired on May 11, 2023. During the three-years of the PHE, the SNAP program experienced temporary policy changes that had not been seen in the history of the program. These policy changes have now all expired. These included:

- Waiving the requirement of an in-person interview. The in-person requirement has been reestablished for initial enrollment and recertifications.

- Rounds of suspending SNAP recertifications for up to six months and then reestablishing them has ended, and the effects of this on-again, off-again requirement has moved its way through the system. As the backlog of cases were reviewed, a temporary increase in exits occurred. All recertifications that were backlogged have been re-processed.

- The Families First Coronavirus Response Act (FFCRA) waived the Able-Bodied Adults Without Dependents (ABAWD) rule for the entire state starting in April 2020. The ABAWD rule is a three-month limit on SNAP benefits that applies to non-disabled adults without dependents who are aged 50 and under. Starting in July 2023, the eight most populous counties in Oregon re-applied the ABAWD time limit. Then the configuration of counties applying the time limit changed. As of January 2024, only Multnomah and Washington counties are true "time limit counties." Benton, Columbia, Hood River, Malheur, Polk, and Yamhill counties are also applying a time limit on ABAWD clients but can also defer some ABAWD closures monthly.

Other Policy Changes

Starting in January 2022, Oregon enacted Broad-Based Categorical Eligibility (BBCE) to families containing seniors and people with disabilities. BBCE families can have income up to 200 percent of the Federal Poverty Level (FPL) and do not have to meet the requirements of an asset test.

The Integrated Eligibility Program

The implementation of the Integrated Eligibility (I.E.) system expanded the Oregon Health Authority's ONE system to cover the Self-Sufficiency Program. The rollout began in November 2020 and was primarily completed by February 2021. Although there were data anomalies and modifications during the initial rollover, most caseloads appear to be accurately represented in the new system.

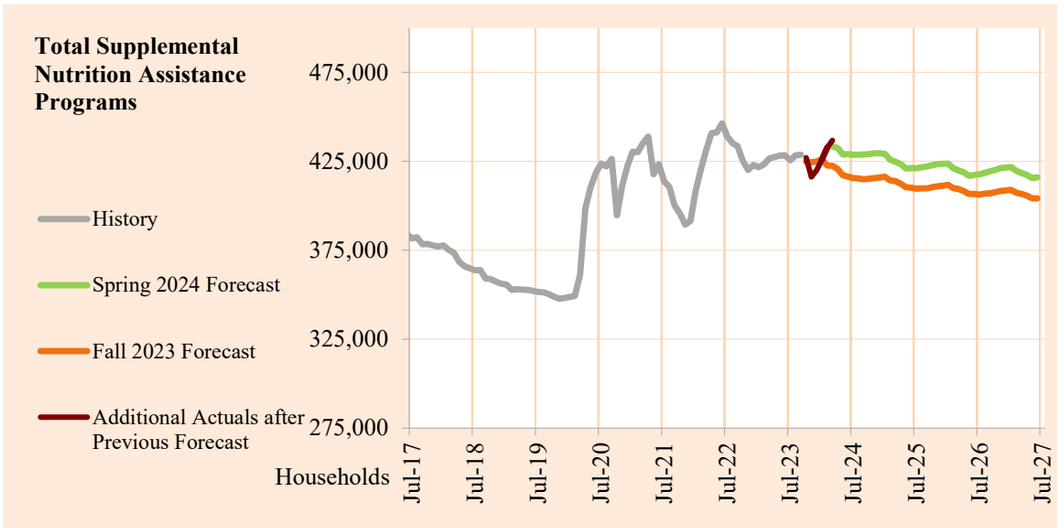
Integrated Eligibility (I.E.) temporarily changed the SNAP recertification period from 12 months to six months in 2020 and 2021. Regular recertification periods returned to their previous twelve-month cycle in March 2022. New cases entering the system and cases previously granted a six-month automatic recertification were assigned a twelve-month certification period.

Total Supplemental Nutrition Assistance Program (SNAP) – As of February 2024, 738,293 persons in 433,447 households were receiving SNAP benefits. This represents 17.44 percent of the population of Oregon.

Households receiving SNAP fell almost continuously from autumn 2012 through the start of 2019 and then hovered at about 350,000 households through most of the year. Due to the unemployment related to the COVID stay-at-home order, the number of new clients entering SNAP more than doubled in March and tripled in April compared to February 2020.

A hold on recertifications of SNAP eligibility occurred several times, pushing out the recertification date six months each time. Following the resumption of recertifications, the caseload fell precipitously. This occurred in episodes between July 2020 and April 2022. The current forecast assumes that all the cases influenced by the certification extensions have been resolved.

The Total SNAP monthly average forecast for the 2023-25 biennium is 427,729 households, which is 2.2 percent higher than the previous forecast. The prior forecast assumed that the growth of employment in the state would influence SNAP downward, however the caseload grew in the last months of 2023. The current forecast continues to assume that the caseload will be influenced downward due to a tight labor market, especially from 2025 onward. However, as already discussed, the fundamental relationship between the employment volume in Oregon and Self-Sufficiency caseloads has not emerged post-COVID, and this assumption may not hold up. The projected biennial monthly average for the 2025-27 biennium is 419,984 households, which is 1.8 percent lower than the 2023-25 biennial average forecast.



Temporary Assistance for Needy Families (TANF)

TANF provides case management and cash assistance to very poor families with minor children. The goal of the program is to reduce the number of families living in poverty through employment services and community resources.

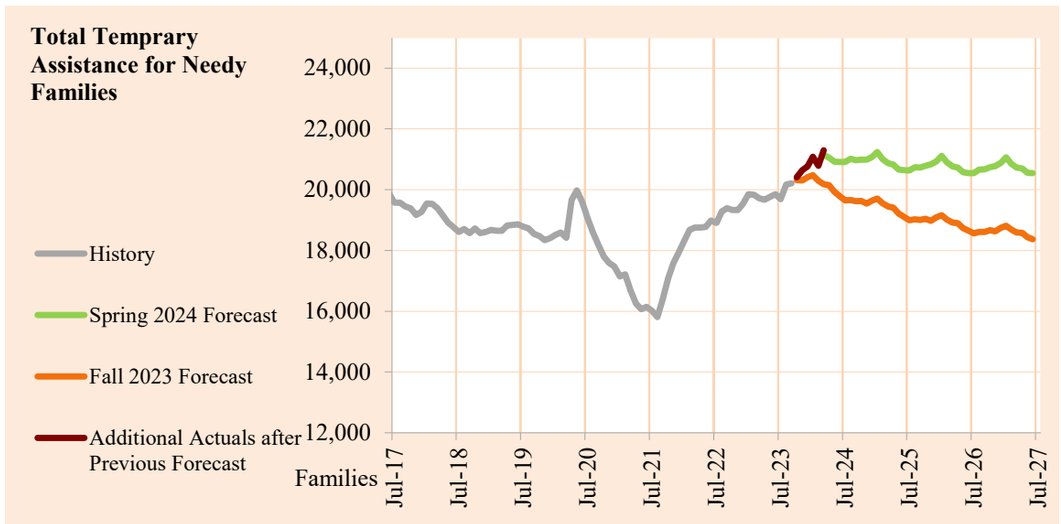
Recipients must meet basic TANF asset requirements to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for drug abuse or mental health as needed. Proof of deprivation (death, absence, incapacity, or unemployment of a parent) is no longer be a requirement of TANF enrollment.

The TANF caseload underwent nearly uninterrupted growth from January 2008 until February 2013 due to the Great Recession. The caseload then declined rapidly until July 2016, when it stabilized at around 18,500 cases (a 49 percent drop compared to its February 2013 peak). This trend continued until the COVID-19 pandemic hit, causing the caseload to increase from March to April 2020 by 6.8 percent to 19,662 families, primarily due to an influx of new clients. Subsequently, there were increased exits in June and July, leading to a slow reduction in the caseload. Cases entering in April accounted for 27.7 percent of exits in June and July and were likely related to eligibility for unemployment insurance, payroll protection payments, or re-employment after layoffs. Intakes increased by 60 percent in September and October 2021 compared to previous months due to the end of Enhanced Unemployment Insurance (EUI) benefits. The impact of the ending of EUI benefits on intakes began to fade in November 2021.

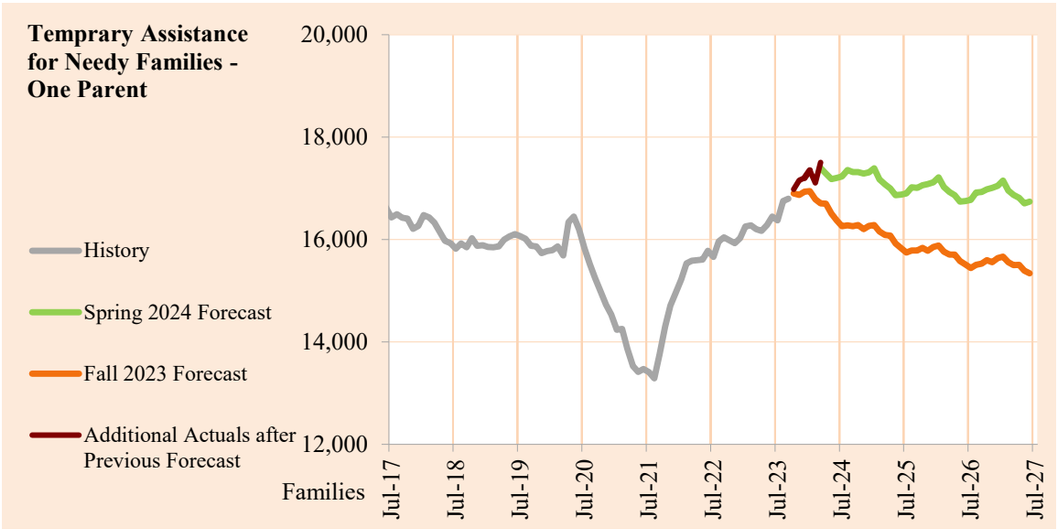
TANF exits tend to fluctuate seasonally, with reductions in the spring and summer and increases in the winter, often related to seasonal hiring patterns. However, since the beginning of the pandemic, seasonal patterns have been relatively weak. The TANF caseload is now higher than pre-pandemic levels, and the re-establishment of strong seasonal patterns in TANF must be considered a risk to forecast accuracy.

In February 2024, 21,340 families were receiving TANF benefits, representing 54,366 persons. TANF has been growing almost continuously since September 2021 when Enhanced Unemployment Insurance benefits ended. The caseload is currently 15.9 percent higher than it was in March 2020, before the COVID state of emergency began restricting employment.

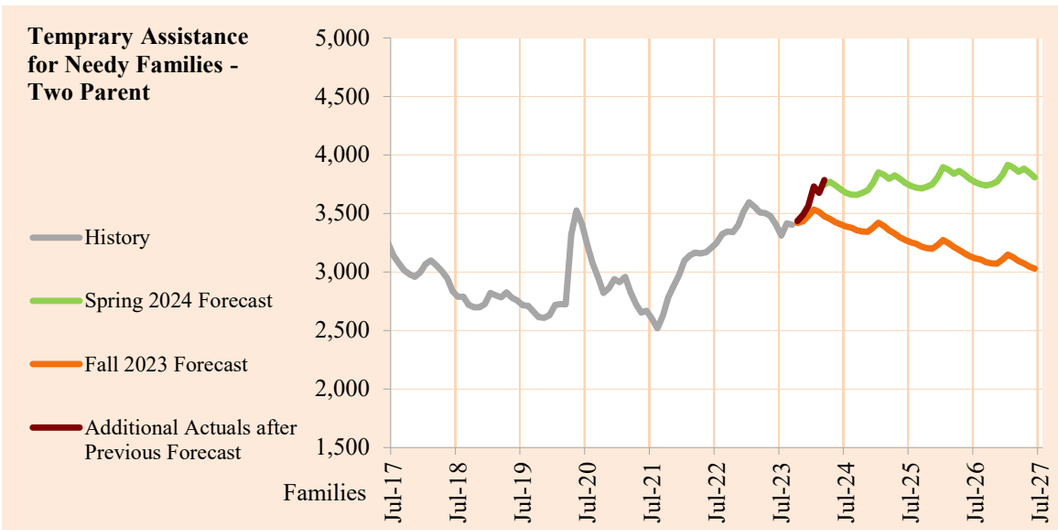
The total TANF monthly average forecast for the 2023-2025 biennium is 20,886 families, representing a 5.2 percent increase from the prior forecast. This is the second upward revision to the TANF forecast since the economy recovered, and the current forecast assumes that exits related to employment will remain modest. Therefore, the caseload is not expected to fall much through the forecast horizon in June 2027. For the 2025-27 biennium, the average monthly caseload is projected to be 20,749 families, which is a 0.7 percent reduction from the 2023-25 biennium.



The 2023-25 biennial average monthly caseload for the **TANF One-Parent Family** is projected to be 17,197 families, reflecting a 4.5 percent increase from the previous forecast. For the 2025-27 biennium, the average monthly caseload is expected to be 16,943 families, a 1.5 percent decrease from the 2023-25 biennium.



The 2023-25 biennial average caseload for **TANF Two-Parent Family** is expected to be 3,690 families, reflecting an 8.5 percent upward revision from the previous forecast. The TANF Two-Parent caseload has been growing consistently and vigorously since the end of Enhanced Unemployment Insurance. The average monthly caseload for 2025-27 is projected to be 3,806 cases, which is a 3.1 percent increase from the 2023-25 biennium.

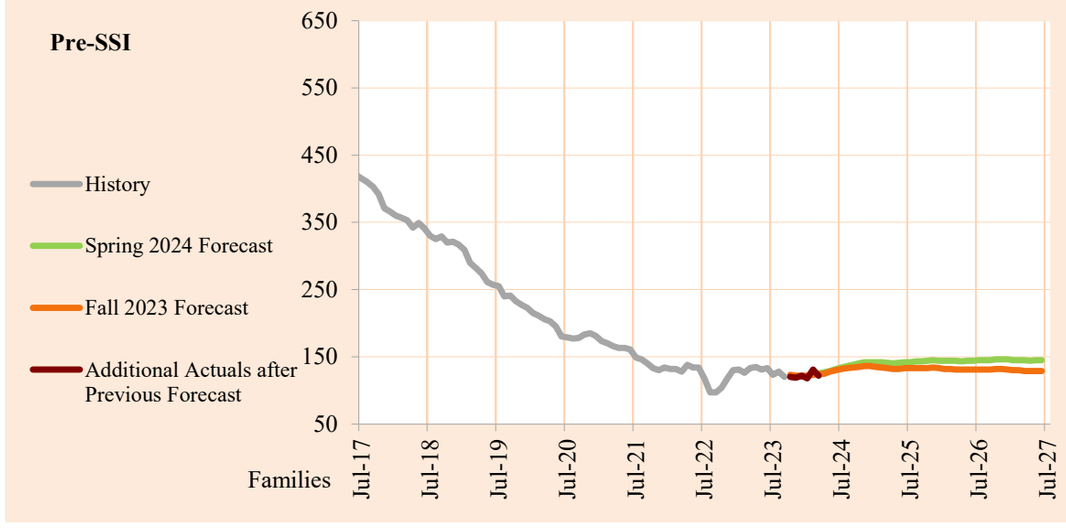


State Family Pre-Supplemental Security Income (Pre-SSI)

Pre-SSI provides temporary assistance for families while they apply for Supplemental Security Income, a benefit for the aged, blind, and disabled who have little or no income. Almost all Pre-SSI cases are transfers from TANF. Two factors primarily drive the Pre-SSI caseload: the percentage of TANF cases moving to Pre-SSI and the total volume of TANF exits. After the Great Recession, the percentage moving to Pre-SSI reduced from 4 percent in 2009 to less than one percent in 2019. One factor that may be playing into this pattern is that the Social Security Administration (SSA) has become more stringent in its interpretation of disability criteria, particularly in mental health criteria.

The Pre-SSI caseload remained stable at the beginning of the COVID-19 pandemic. However, starting in November 2020, the caseload fell faster than anticipated. Transfers from TANF decreased and exits of Pre-SSI increased. Although transfers increased in at the end of 2022, they fell again in the fall of 2023. The current forecast assumes that the Pre-SSI caseload will stabilize at a level like that experienced in mid-2023 and hold steady through the forecast horizon.

The 2023-25 biennial average forecast for Pre-SSI is 132 families, an increase of 2.2 percent from the previous forecast. The 2025-27 biennial average caseload is 144 families, an increase of 1.6 percent from the 2023-25 biennium.



Temporary Assistance for Domestic Violence Survivors (TA-DVS)

Temporary Assistance to Domestic Violence Survivors (TA-DVS) supports domestic violence survivors by providing temporary financial assistance. To be eligible, a survivor must demonstrate a current or future risk of domestic violence; be a pregnant woman or a parent or relative caring for a minor child; and must have income not exceeding TANF limits.

A change in TADVS Reporting

Since 2016, OFRA has been reporting TADVS in two groups: TADVS with-payment, and TADVS without-payment. This led to the inevitable assumption that these were two separate, stable groups – that some people authorized for TADVS accepted aid payments, and a separate group did not. However, this is not the case. The TADVS with-payment forecast represents a projection of those families who are authorized to receive a payment in a month and draw that payment down. The without-payment group represented those families who also were authorized to receive a payment in a month and did not draw a payment down. A family could be in the with-payment group in one month, and in the not-payment group in the next, and vice versa.

The original purpose of projecting the TADVS without-payment group was to illustrate that there were more TADVS clients than were represented in the with-payment category. The sum of TADVS with-payment and without-payment values yield the total number of people authorized for the service, which is a more representative count of the size of the program. Therefore, OFRA will be presenting a Total TADVS forecast, which shows the total size of the program. We will continue to present TADVS with-payment. TADVS without-payment will no longer be explicitly forecast.

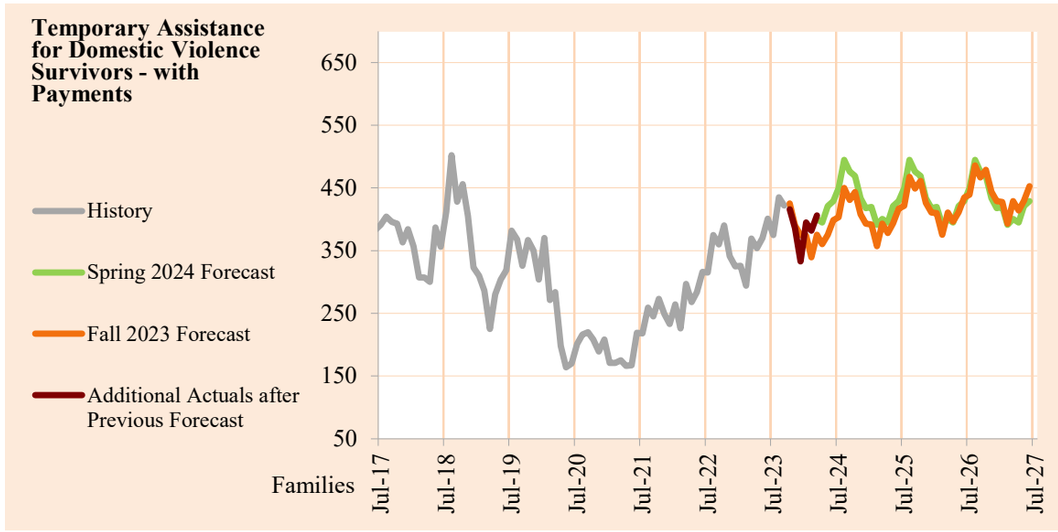
Both TA-DVS with- and without-payment experienced unprecedented drops in May and June 2020. This was likely due to people being willing to shelter in place during a pandemic, even with an abusive partner. TA-DVS tends to be highly seasonal, with cases increasing in the summer months when school is out, and relocation of children is easier, and decreasing in fall and winter. Seasonal patterns resumed in June 2021, with a typical summer increase.

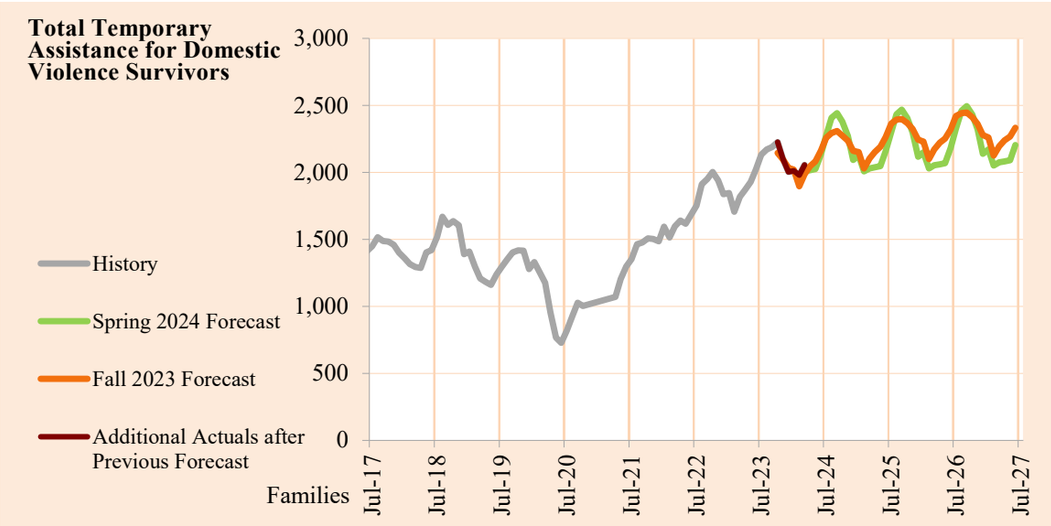
The rollout of the I.E. system caused unstable data processing for TA-DVS, including a gap in reporting of TADVS cases without a payment from November 2020 to March of 2021.

The current forecast is based on revised data, which employs a more accurate method of counting the caseload. As a result of this revision, Total TADVS, which averaged about 1,300 per month in calendar year 2019 averaged about 2,000 cases per month in calendar year 2023. This was not a natural increase in domestic violence cases in Oregon, but a result of an improved method of counting TADVS cases.

The average monthly caseload for Total TADVS for the 2023-25 biennium is 2,138 cases per month, which represents a 0.2 percent decrease compared to the previous forecast. The caseload is expected to continue to rise modestly, with a monthly average of 2,226 cases in the 2025-27 biennium, representing an increase of 4.1 percent.

The average monthly caseload for TA-DVS with-payment – a subset of Total TADVS – for the current biennium is forecasted to be 418 families per month, which is 5.4 percent higher than the previous forecast. The 2025-27 biennial average caseload is 433 families, an increase of 3.7 percent from the 2023-25 biennium.





Forecast Environment and Risks

The current forecast for SNAP was completed during a pivot of the number of counties applying the Able-bodied Adults without Dependents (ABAWD) exclusion. This is the second pivot in the number of counties applying the ABAWD exclusion we have seen since the end of the Public Health Emergency. It is unknown how ABAWD will be applied to counties in the future, or whether a phase in of true "ABAWD exclusion" will be applied, or an "ABAWD exclusion plus a deferred closure" of some percentage of cases will be applied.

The Farm Bill, which includes nutrition assistance programs, is reauthorized every five years. The last Farm Bill was enacted in December 2018 and expired 2023, and approval of a new bill appears to be stalled in the U.S. Congress. During reauthorization periods, changes in SNAP policy are possible, which represents a risk to forecast accuracy.

As previously stated, both SNAP and TANF seems unusually high when considering the Oregon employment picture. Although SNAP has extended enrollment to higher income levels for those families that are categorically eligible, the current enrollment picture is still higher than expected. When the creation of employment opportunities lifts people on Self-Sufficiency out of poverty and off services remains unknown, and a significant risk to forecast accuracy.

The budget approved in the 2024 Oregon State Legislature included an in increase to the payments that TADVS families will receive for family stability, moving the maximum 90-day benefit from $1,200 to $3,200. ODHS had not finalized a timing for the implementation of this increase at the time of the forecast, therefore an impact was not modeled. It is expected that the number of families enrolled in total TADVS is unlikely to change based on this increase, but the number of enrolled who receive payments is likely to grow, as the payments are primarily used for housing assistance and the dollar amount will increase the utility of the payments in the current housing market. This impact will be modeled for the Fall 2024 forecast, when an implementation date is likely to be known.

Economic changes in Oregon and the United States in general remains a risk to the accuracy of any forecast of means-tested caseloads. The likelihood of a recession because of higher inflation appears to be receding, but that likelihood is not zero. With interest rates high, there is a possibility that the Fed will miss the "turn," when the economy shows weakness and rate-cutting is necessary, tipping the economy into a recession.

Oregon may be in unfamiliar waters with demographic trends, as the usual and expected increase people moving to the state during economic good times has not appeared. This could lead to changes in the "boom cycle" of Oregon economics and create a tighter job market than has been seen previously. As with most novel developments, there is no pattern in our data to account for this in the Self-Sufficiency data and must be seen as a longer-term risk to accuracy.

Self-Sufficiency Programs Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
SELF-SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)	418,386	427,729	9,343	2.2%	427,729	419,984	-7,745	-1.8%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
One-Parent	16,450	17,197	747	4.5%	17,197	16,943	-254	-1.5%
Two-Parent	3,400	3,690	290	8.5%	3,690	3,806	116	3.1%
Total TANF	**19,850**	**20,887**	**1,037**	**5.2%**	**20,887**	**20,749**	**-138**	**-0.7%**
TANF Employment Payments	1,281	1,197	-84	-6.6%	1,197	1,273	76	6.3%
Pre-SSI	129	132	3	2.3%	132	144	12	9.1%
Temp. Assist. For Dom. Violence Survivors (Families)								
TA-DVS: with Payment	396	418	22	5.6%	418	433	15	3.6%
TA-DVS: Total (with or without payment)	2,141	2,138	-3	-0.1%	2,138	2,226	88	4.1%
Total TA-DVS	**2,537**	**2,556**	**19**	**0.7%**	**2,556**	**2,659**	**103**	**4.0%**

Child Welfare

Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups and typically first enter the Child Welfare system via an Assessment. There is an executive directive for branches to complete assessments in less than sixty days.

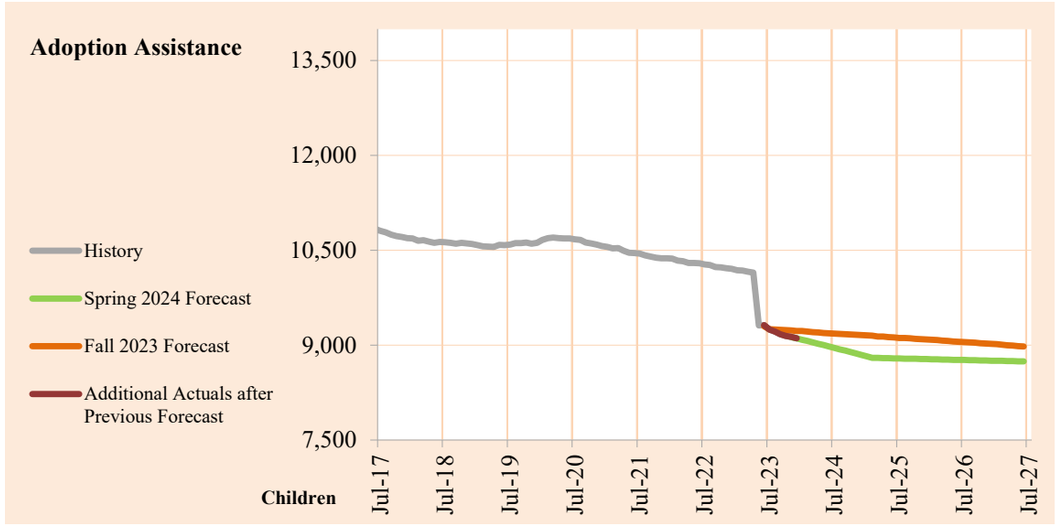
Adoption Assistance

The adoption assistance caseload has been gradually decreasing since 2016, except for a plateau between April 2019 and the start of the COVID-19 pandemic. There are several reasons for the decline:

1) There has been an increase in guardianship assistance as an alternative, with more relatives utilizing subsidized guardianship assistance.
2) Almost all new clients entering adoption assistance are from paid foster care, and the paid foster care caseload has been on a downward trajectory since late 2017; and
3) The pandemic effects on this caseload resulted in decreases throughout 2021 and 2022, due to the slow-down in cases moving through the court system. Court system delays affected finalizations of both Adoptions and Guardianships.

Between the Spring and Fall 2023 forecasts, forecasting data were migrated to a new server system, and it was discovered that the old server was retaining records that had been deleted in the ORKids database (the data source for Child Welfare case management). This primarily impacted Adoption Assistance data. The current data now reflect counts that align with ORKids, causing a level shift down in the adoption assistance caseload. This did not affect the overall trend.

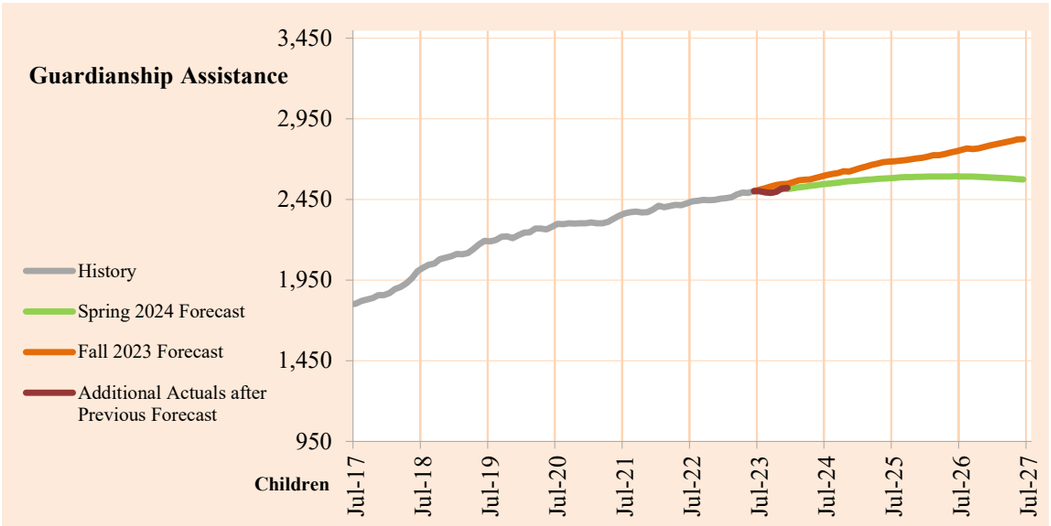
The forecasted Adoption Assistance caseload is expected to average 8,978 children per month through the end of the 2023-25 biennium. Over the 2025-27 biennium the caseload is expected to average 8,768 children per month, a decrease of 2.3 percent from the current biennium.



Guardianship Assistance

This caseload has exhibited steady growth for most of its history. The number one goal in child welfare is reunification, with policies in place to shorten the length of time to reach a permanent placement, so this caseload has grown as children move out of foster care. There was some slowdown in growth, beginning in April 2020, due to pandemic-related court closures. Growth picked up again in the second half of 2021 and continued throughout 2022 and into 2023. Between April 2023 and October 2023, however, the caseload remained flat, hovering right at 2,500 children per month.

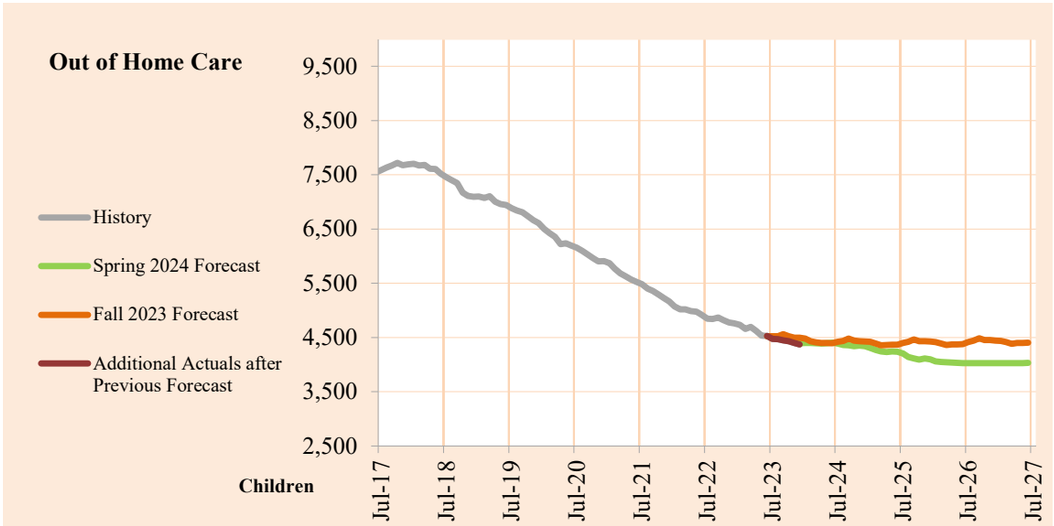
The forecast for Guardianship Assistance is expected to average 2,542 children per month through the end of the 2023-25 biennium. Over the 2025-27 biennium, the caseload is expected to average 2,588 children per month, which is 1.8 percent higher than the 2023-25 forecasted average.



Out of Home Care

This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and treatment services placements (formerly called residential care). Paid foster care is the largest portion of the group. Due to successful implementation of policies designed to achieve timely permanency and serve more children in home, this caseload fell from 6,223 in January 2018 to 3,475 in October 2023, a decrease of 44 percent.

The total Out of Home Care caseload forecast averages 4,366 children per month through the 2023-25 biennium. Over the 25-27 biennium, the caseload is expected to average 4,056 children per month, which is 7.1 percent lower than the 2023-25 forecasted average.

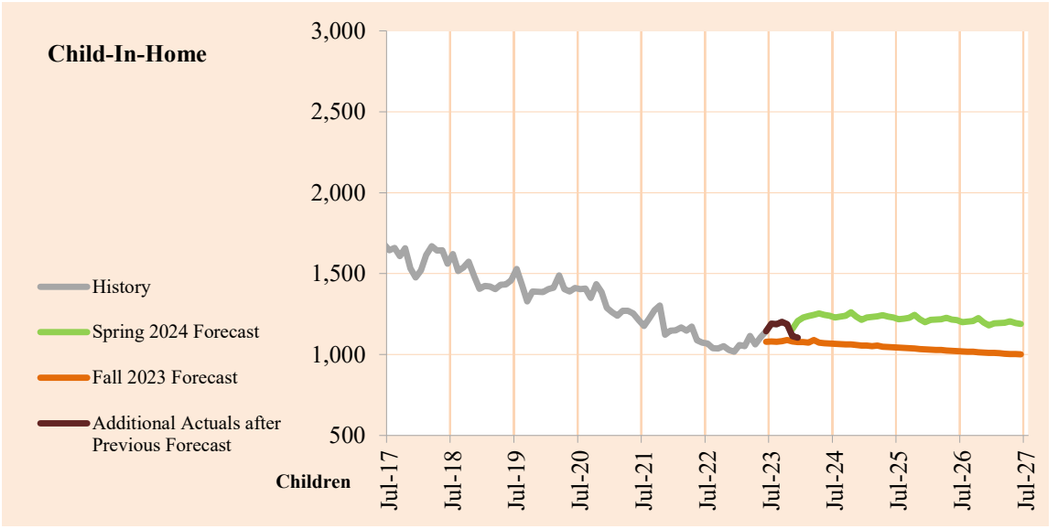


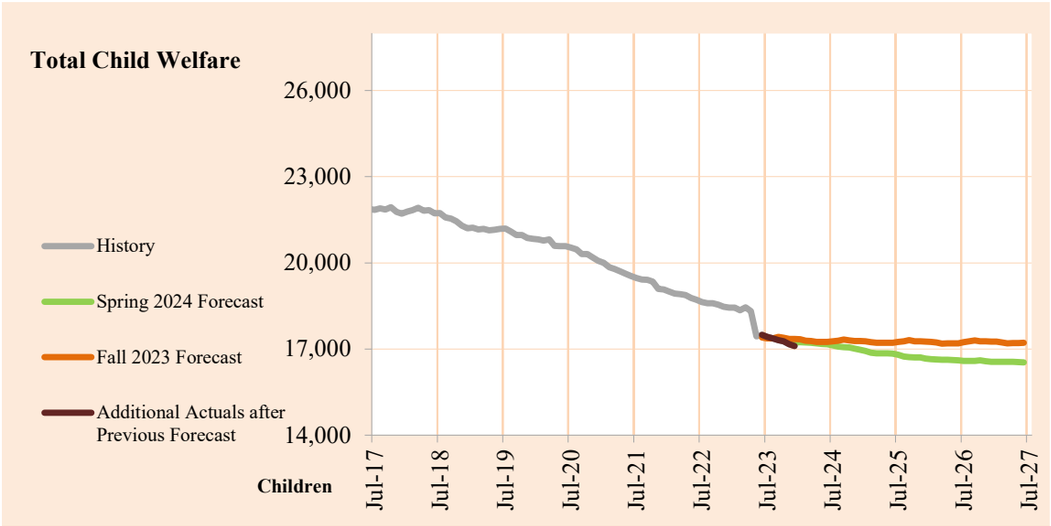
Child In-Home

In 2018 the Family First Prevention Services Act passed. With the passage of this Federal Act, Title IV-E funding to support States' efforts to prevent child abuse, neglect, and removal from families became available. Prevention activities include parenting programs, substance abuse prevention, and mental health services. Out of this, Oregon began a phased approach of a Family Preservation Service with the intent of better serving children and families at home. The Family Preservation demonstration began in March 2022 with three locations across the state. As of April 2024, seven districts are testing the Family Preservation approach, and data are being collected. These will continue to grow across the state, will help the program learn about who is getting served, and will create opportunities to serve families in-home instead of in foster care.

Prior to the Fall 2023 forecast cycle, the Child In-Home caseload was comprised of two groups: children with prior foster care and children without prior foster care. In the Fall 2023 Forecast the Family Preservation caseload category was included. This forecast cycle is the second one that forecasts the Family Preservation caseload. Currently, Family Preservation is less than 10 percent of total Child In-Home monthly caseload. The expectation is that this will grow as Family Preservation is implemented statewide.

The Child In-Home caseload is forecasted to average 1,226 children per month through the end of the 2023-25 biennium. Over the 2025-27 biennium, the caseload is expected to average 1,210 children per month, which is 1.3 percent lower than the 2023-25 forecasted average.





Forecast Environment and Risks

More than any demographic factor that can be counted or measured, the Child Welfare caseload is impacted by policy changes and program level interventions. In the recent past, the Child Welfare Program was highly scrutinized by the public and the governor. The Oregon Child Abuse Hotline, statewide centralized screening available 24 hours a day, 365 days a year, has been in effect statewide since April 2019, making it easier than before for concerned Oregonians to initiate an investigation. During the 2023 legislative session, Senate Bill 231 passed, allowing for online in addition to telephone reporting. There has also been an increase in conversations, workgroups, and trainings with communities across the state, with the focus on preventing children from entering foster care. The Family First Preservation service represents one of these efforts.

A risk to the Out of Home Care caseload is related to the capacity for psychiatric residential care. Providers may close suddenly or not accept referrals. As new programs start, it is unknown how quickly the beds will fill. It can be challenging to recruit foster parents as well as find people to provide services to high-needs children. These children are currently being served in Behavior Rehabilitation Services and family foster care. The pandemic led to less utilization of group care, and this trend has continued. Child Welfare's focus on service delivery to prevent placement changes and help stabilization is working. This work has resulted in a reduction of placement moves to Out of Home Care.

The main risk to the Child In-Home caseload is the complexity of tracking this population. These counts are based on the safety plan rather than the case plan, and a case cannot move forward until a caseworker enters an initial safety plan. A new business process is underway that includes a dashboard which will count children being served in the different Child In-Home service categories. This could change the count of children in Child In-Home, as data reporting improves.

Child Welfare Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
CHILD WELFARE (Children)								
Adoption Assistance	9,189	8,978	-211	-2.3%	8,978	8,768	-210	-2.3%
Guardianship Assistance	2,598	2,542	-56	-2.2%	2,542	2,588	46	1.8%
Out of Home Care[1]	4,438	4,366	-72	-1.6%	4,366	4,056	-310	-7.1%
Child In-Home	1,145	1,226	81	7.1%	1,226	1,210	-16	-1.3%
Total Child Welfare	**17,370**	**17,112**	**-258**	**-1.5%**	**17,112**	**16,622**	**-490**	**-2.9%**

1. Includes residential and foster care.

Aging and People with Disabilities (APD)

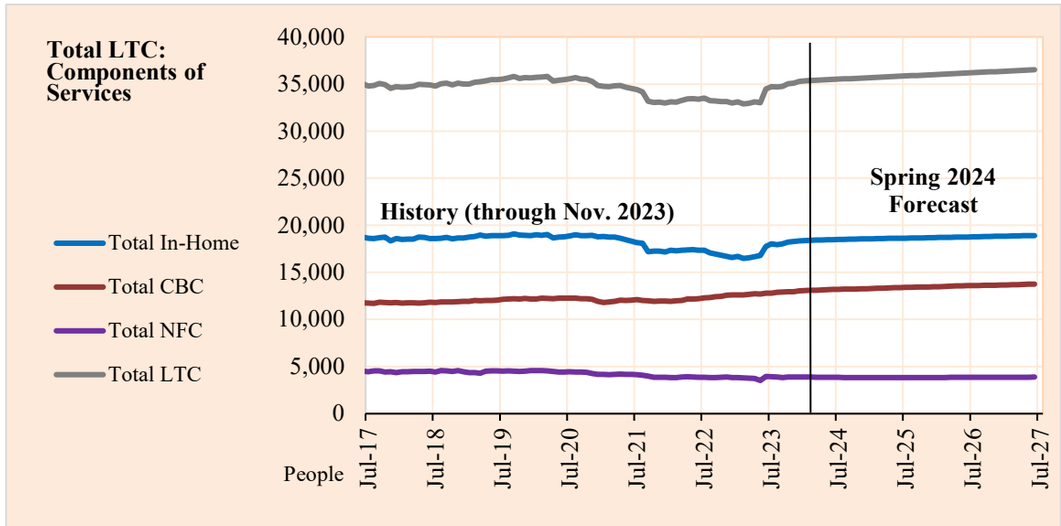
Historically, Oregon's Long-Term Care (LTC) services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as "K-Plan") under the Affordable Care Act (ACA); and now most services are provided through K-Plan rather than the HCBS Waiver. By shifting from operating under the HCBS Waiver to K-Plan in late 2013, the eligibility rules for long-term care were changed.

Under the ACA's K-Plan option, clients only need to meet two criteria: 1) be assessed as needing a requisite Level of Care; and 2) have income below 138 percent of FPL. The HCBS Waiver allowed clients with higher incomes than K-Plan; but K-Plan has no asset limits and no requirement that clients be over 65 or officially determined to have a disability. The volume of new clients entering long-term care between 2013 and 2016 indicated that the ACA (the combined effects of K-Plan and Medicaid expansion) contributed to long-term care caseload growth.

All LTC clients are assessed for need based on disability – a score referred to as Service Priority Level. Prior to 2008, there was a large decline in the caseload between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. Between 2008 and 2019, the total LTC caseload varied from a low of 25,900 clients in May 2008 to a high of 35,136 clients in December 2019. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, driven in part by significant growth in the number of Oregon seniors, and in part due to the Great Recession. Between 2013 and 2016, the average annual caseload grew by 5.3 percent due to factors such as the implementation of K-Plan, expansion of Medicaid, policy changes to make in-home care more attractive, and continued growth in the number of Oregon seniors. From 2016 to 2019, the caseload growth was stable, with an annual average growth rate of 0.9 percent.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. In-Home care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. As a result, In-Home services accounts for over 50 percent of the total LTC count.

CBC is forecasted to continue to grow due to the high demand for PACE and Contract Residential Care which includes Memory Care, although at a reduced rate to reflect the shift toward In-Home Care. CBC will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home, and because hospitals prefer discharging patients to higher service settings to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag private market rates, thus making Medicaid clients relatively less attractive to CBC providers.



General Assumptions for the Aging and People with Disabilities Long-Term Care Caseload

Public Health Emergency

The federal Department of Health and Human Services ended the Public Health Emergency (PHE) related to COVID-19 to lapse in the spring of 2023. This ended the Continuous Enrollment Condition for Medicaid. The Continuous Enrollment Condition led to the temporary suspension of Adverse Actions, including those associated with APD Medicaid Cases.

Adverse Actions are critical for closing Medicaid cases, but the suspension aimed to ensure that APD clients received uninterrupted services during the pandemic. This policy change may have reduced the number of clients leaving the program. With the end of the Continuous Enrollment Condition, individuals will undergo a redetermination of eligibility during an unwinding period that will continue through early 2025. This process may cause individuals over the income or asset limits for Medicaid to lose coverage for their Long-Term Care Services and Supports (LTSS). However, this forecast assumes that the impact of the PHE unwinding process will be minimal for APD clients, given that the Medicaid forecast assumes that most caseload reductions will occur in the means-tested groups, not the disability-specific ones. Additionally, this forecast assumes no new COVID-19 effects during the forecast period, even if there are surges in COVID cases in the future.

Healthier Oregon

In July 2021 the Oregon Legislature passed HB 3352, which expanded the Health Care for All Oregon Children program to include adults and renamed it Health Care for All Oregon. Now called Healthier Oregon (referred to here as Healthier Oregon Program, or HOP), it expands eligibility to adults who would qualify for Medicaid-funded medical assistance programs but for their immigration status. HOP began on July 1, 2022. The eligible population for year one was limited to children and adults aged 19-25 years or 55 years and older. Starting July 1, 2023, all remaining adults were eligible. Disability care is included in Healthier Oregon, therefore once individuals become eligible for Medicaid HOP, they may also become eligible for Long-Term Care.

Currently, demand for long-term care services among Healthier Oregon adults is low. Only 84 clients were receiving long-term care through HOP as of November 2023. Most of these clients choose In-Home care or Nursing Facility care. The new estimate predicts no growth in HOP through mid-2027, with an average of 84 clients per month for both the 2023-25 biennium and the 2025-27 biennium. The new estimate is approximately 21.7 percent higher than the Fall 2023 estimate.

Shortage of Healthcare Workers

The shortage of Long-Term Care workers is a concern for the availability and quality of care. Hospitals and Nursing/Residential Care Facilities continually lost employment during the pandemic. According to Oregon Office of Economic Analysis (OEA), employment in Oregon has fully recovered to its pre-COVID levels, including the job sector Healthcare and Social Assistance, which is forecasted to recover at a higher rate than the rate of total-nonfarm employment in the coming years. However, there may be parts of the state still experiencing a shortage of LTC workers, although in the long term this should resolve itself.

The supply of labor is affected by demographics. The most recent population estimate in 2023 shows stagnation in Oregon's population, which caused OEA to lower their population forecast. A lack of young adults moving to Oregon could have a negative effect on eldercare and increase the "greying" of the Oregon population in general. A mismatch between the number of young people being willing to work in social assistance and the number of elderlies needing it is a long-term concern.

Total Long-Term Care Case Management

For the first time, this document includes a forecast of Long-Term Care Case Management. This forecast was piloted in the fall of 2022 and was completed in 2023 for internal distribution. Case Management is a count of unique APD service clients who had direct or indirect case management done in a month. This count includes those clients who received Long-Term Care (LTC), along with clients who have not received LTC in the month. Clients not receiving LTC despite being authorized for it may be working to locate a provider or placement setting that works for them.

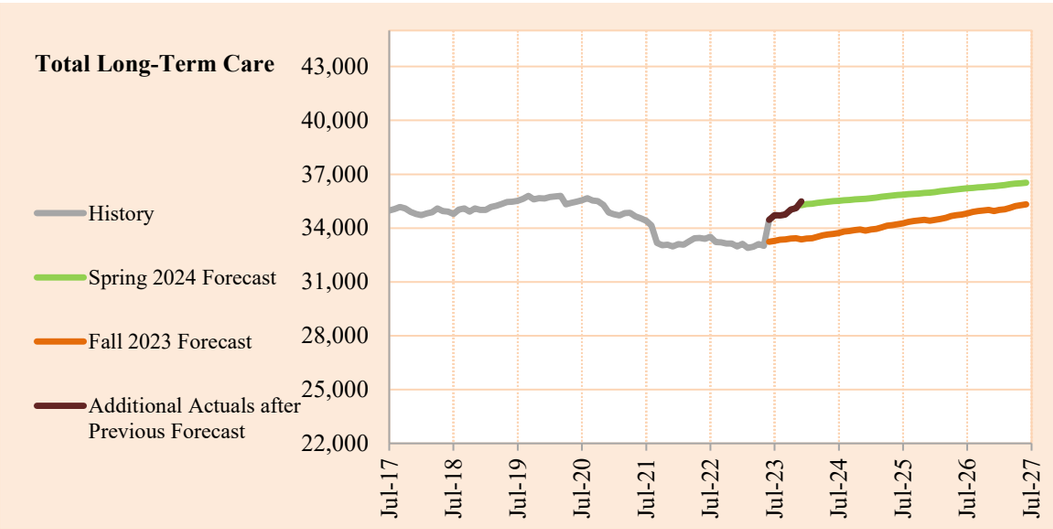
APD Case Managers are required to do case management work on all Long-Term Care clients each month, regardless of whether the client is actively in an LTC service setting or not. Therefore, this count represents the total number of clients authorized for services and that are receiving Case Management.

A total of 41,060 clients were enrolled in APD Case Management services in November 2023, and about 86 percent of these clients were receiving Long-Term Care services. The Case management Enrollment caseload is projected to average 41,259 cases per month over the 2023-25 biennium, a 0.7 percent increase from the Fall 2023 forecast. For the 2025-27 biennium, the caseload is expected to average 41,850 cases per month, approximately 0.8 percent higher than the Fall 2023 forecast.

Total Long-Term Care (LTC) – A total of 35,261 clients received long-term care services in November 2023, an increase of 2,090 clients compared to a year ago. While Nursing Facility Care services remained relatively

stable, Community Based Care and In-Home Care services saw a rise.

The LTC caseload, including HOP clients is projected to average 35,441 cases per month over the 2023-25 biennium, a 4.9 percent increase from the Fall 2023 forecast. For the 2025-27 biennium, the caseload is expected to average 36,190 cases per month, an increase of 2.1 percent compared to the 2023-25 average.



In-Home Care

From July 2013 to December 2015, the In-Home Care caseload grew by 29 percent. This caseload growth is attributed to several factors, including the expansion of Medicaid and the implementation of policy and program changes intended to promote the use of In-Home Care rather than more expensive forms of service. But the largest impact was likely the implementation of K-Plan. Clients are required to relinquish some of their monthly income to qualify for the program, and under K-Plan the amount clients were allowed to keep went up, making the program more attractive. In addition, the fact that options exist which allow family members, friends, or neighbors (known as natural supports) to be paid for providing services under certain circumstances led more individuals to request In-Home Care.

After the initial rapid growth related to K-Plan, increases in this caseload moderated considerably. In-Home Care grew by 7.0 percent between January 2016 and September 2017. Then the caseload began to decline – by 2.1 percent – between October and November 2017. This was due to the implementation of new guidelines regarding client assessment criteria and related services-per-benefit using the CA/PS system. The impact of these changes was felt in October and November 2017, after which the pattern of In-Home case exits and intakes returned to the pre-CA/PS levels, and the caseload increased by 3.3 percent between December 2017 to March 2020.

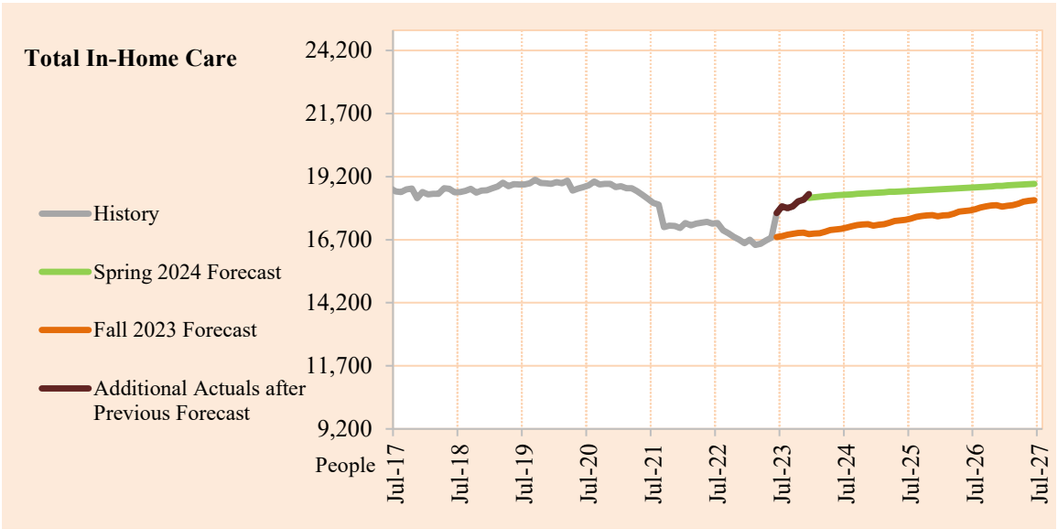
Prior to the impact of COVID-19 on clients in Long-Term Care, In-Home Care services were provided to 19,038 clients, which accounted for 53.2 percent of total LTC services as of March 2020. However, the caseload dropped suddenly by 2.1 percent in April, or 394 clients, which was approximately double the prior average number of exits in a month. Although the caseload slowly recovered starting in May 2020 due to low exits and a stable flow of new intakes, the patterns changed rapidly as exits exceeded intakes from November 2020 to November 2021 due to COVID-19 surges.

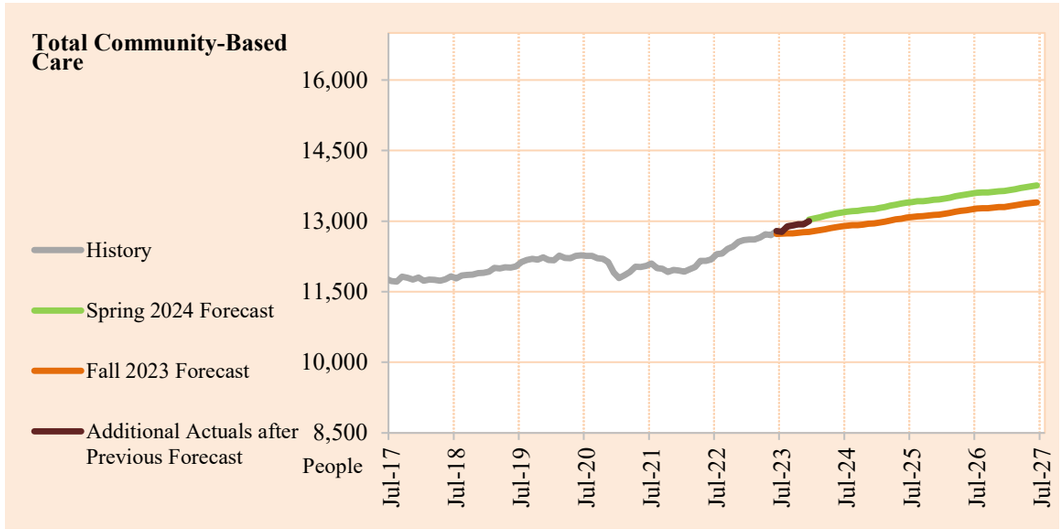
Moreover, the roll-out of a new provider time capture system, called OR PTC DCI, led to a dramatic drop in the caseload in September 2021, with the number of exits being more than double the usual amount. The caseload has not rebounded. Similarly, the In-Home caseload dropped significantly in the month following the implementation of new mandatory training for In-Home care workers in July 2022.

Starting in January 2022, the “pay-in” liability of In-Home clients was eliminated. Individuals were required to contribute a portion of service costs depending on their income and assets. By removing pay-in, consumers living in their family’s home will no longer pay for care.

In-Home Care caseloads started to show recovery in intake patterns in 2023, as the risks of COVID began to fade, and the number of healthcare workers began recovering. There has been an increase in the rate of returning clients – that is, those who exit long term care coverage and reestablish it in following months. This led to a 9 percent increase in the caseload since the Fall 2023 forecast, from 16,814 cases in May 2023 to 18,334 in November.

The In-Home Care caseload is expected to average 18,432 cases per month over the 2023-25 biennium, which is 7.2 percent higher than the prior forecast. For the 2025-27 biennium, the caseload is projected to average 18,768 clients per month, which is 1.8 percent higher than the current biennium.





Community-Based Care (CBC)

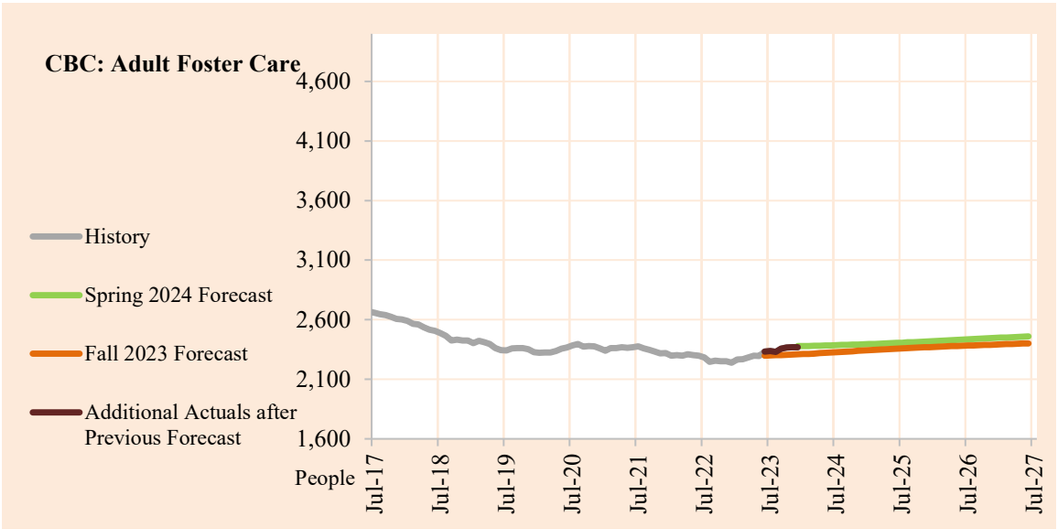
Community-Based Care includes several different types of services, and caseload counts are designed to accurately reflect a client's actual utilization of services. Consequently, the Program of All-Inclusive Care for the Elderly (PACE) and Residential Care has been revised to become a larger portion of the forecast, while Adult Foster Care (AFC) and Assisted Living Facility (ALF) have become smaller. A new provider of PACE began offering services in Southern Oregon in April 2021. High demand for the program is forecasted to lead to a rapid increase in clients until the facility reaches capacity.

In November 2023, total the number of clients receiving Community-Based Care was 13,020, which constituted 37 percent of total LTC services.

The Total Community Based Care caseload is forecasted to average 13,156 cases per month over the 2023-25 biennium, 2.0 percent higher than the Fall 2023 forecast. The caseload in the 2025-27 biennium to is expected to average 13,576 cases per month, 3.2 percent higher than the current biennium.

Several factors are contributing to the decline in the **Adult Foster Care** (AFC) caseload from August 2013 to July 2019: policy changes that made In-Home Care more attractive; providers' perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire. Since August 2019, the caseload has hovered at around 2,300 clients. Clients in AFC services are less likely to move out of the program, and some LTC clients preferred small-group services during the COVID-19 pandemic. This trend led to a slight increase in the caseload from 2,325 in March 2020 to 2,377 in July 2021. The caseload started to decrease after July 2021 due to a surge in COVID-19 cases. Clients receive financial incentives when they enter AFC after hospital discharge. The current forecast therefore assumes a rebound in this caseload with an increase in new clients.

The forecasted Adult Foster Care caseload is expected to average 2,383 clients in the 2023-25 biennium, a 2.3 percent increase over the prior forecast. The average monthly caseload is expected increase to 2,434 in the 2025-27 biennium, a 2.1 percent increase over the current biennium.



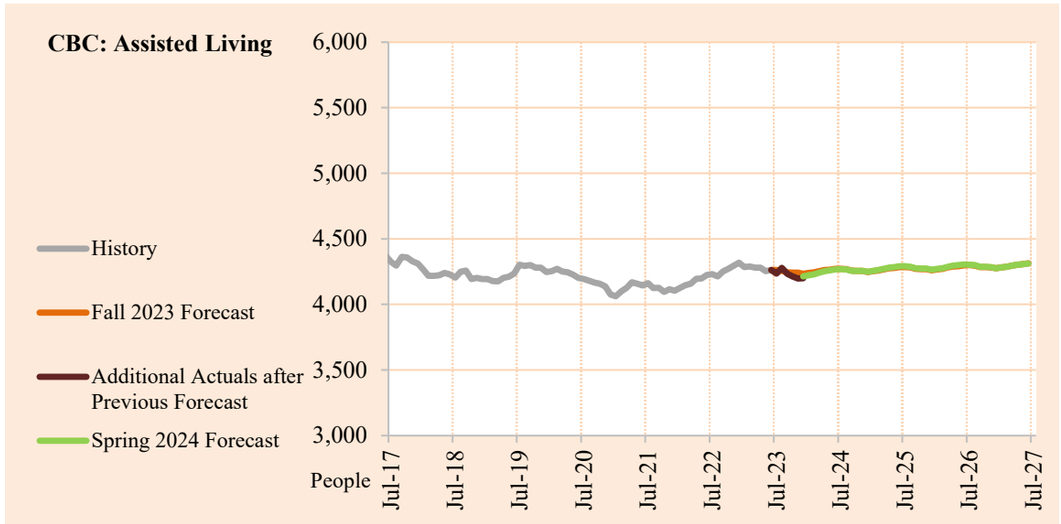
Assisted Living Facility (ALF) providers may prefer clients paying at market rates compared to Medicated reimbursement rates, limiting the number of beds available. This dynamic has led to volatility in the caseload and greater risk to forecast accuracy than with other areas of LTC. Overall, the caseload has had periods of increase and decrease through September 2019, when it began to continually decrease. This decrease was accelerated by large numbers of clients exiting ALF due to COVID-related concerns in 2020 and 2021. Since then, the caseload has been rising. This forecast assumed that clients are expected to gradually come back as the risk of COVID-19 fades.

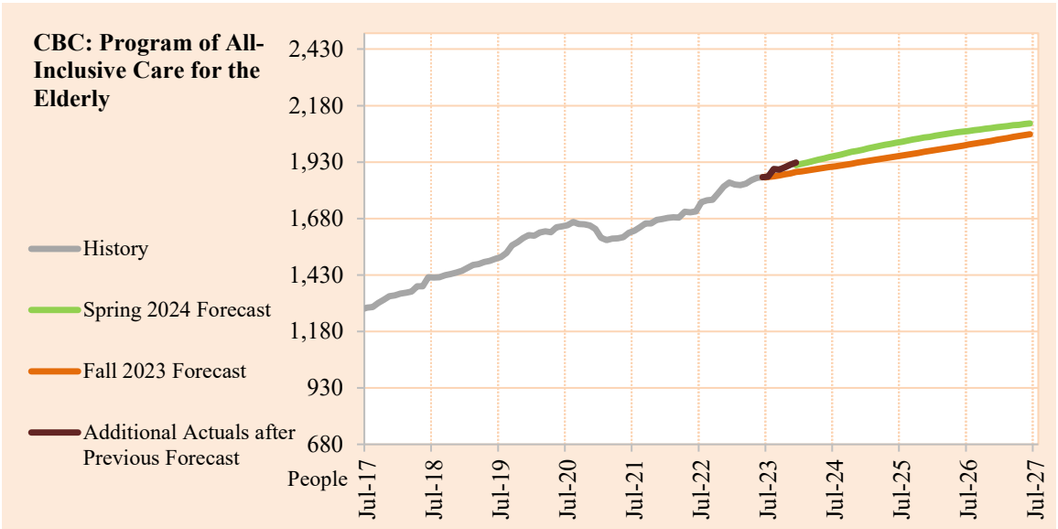
The forecasted Assisted Living Facilities caseload is expected to average 4,252 clients in the 2023-25 biennium, approximately the same as the previous forecast. The average monthly caseload is expected to slightly increase to 4,288 in the 2025-27 biennium, an increase of 5.7 percent from the current biennium.

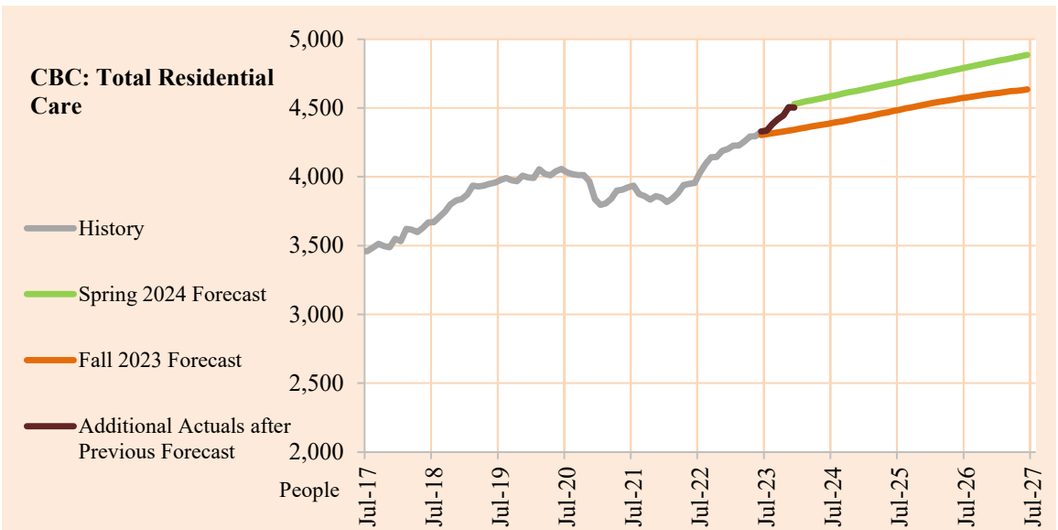
During the COVID-19 surge, exits from **Contract Residential Care** and **PACE** were significant. In December 2020 and January 2021, clients exited these programs at a rate one and a half times higher than in a regular month. This shifted the caseload down, especially in PACE. The caseload began to rebound in March and April 2021. Historically, these programs have been in demand, with new clients quickly filling vacancies when exits occur. The current forecast assumes that both caseloads gradually increase following the pre-Covid growth pattern.

The forecasted Contract Residential Care caseload is expected to average 3,795 in the 2023-25 biennium, 4.7 percent higher than the Fall 2023 forecast. The caseload is expected to increase to 4,011 in the 2025-27 biennium, 5.7 percent higher than the current biennium.

The forecasted PACE caseload is expected to average 1,953 cases in 2023-25, 2.3 percent higher than the Fall 2023 forecast. PACE is expected to increase to an average of 2,065 cases per month in the 2025-27 biennium, an increase of 5.7 percent from the current biennium.







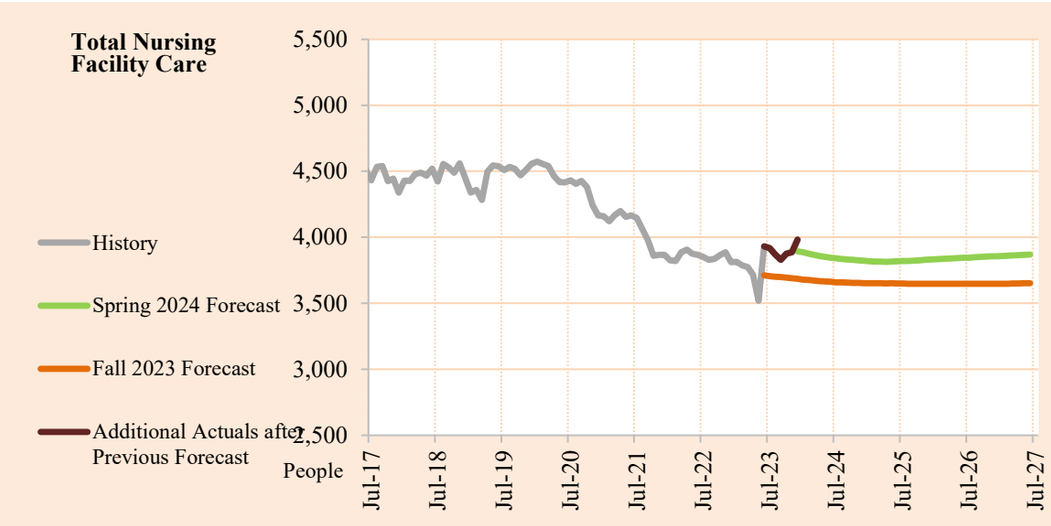
Nursing Facility Care (NFC)

Nursing Facility Care (NFC) includes four different types of service: Basic Care, Complex Medical Add-On, Enhanced Care, and Pediatric Care. Approximately 99 percent of NFC clients receive Basic Care or Complex Medical Add-On services.

NFC clients represented close to 20 percent of all LTC clients at the beginning of 2000. The NFC caseload reached a high of 5,800 in 2002, before dropping continuously through April 2013. The decreased NFC share of LTC is not only due to fewer clients receiving NFC services but also to increases in clients seeking In-Home Care and CBC. From May 2013-2019, the caseload ranged from 4,300 to 4,600 clients. After the pandemic began, both the number of new clients entering and the number of clients exiting the program decreased. This stabilized the case count until the fall 2020 COVID-19 surge. In November and December 2020, the number of existing clients increased while the number of new enters decreased. Before the delta-variant surge the following year, the caseload fluctuated at about 4,100. NFC lost approximately 10 percent of its clients from June to November 2021. Unlike the delta surge, the surge of cases related to the omicron variant did not influence the caseload. This has led to a stable caseload of around 3,840 per month or 11.5 percent of total LTC. In November 2023, 3,907 clients received NFC services, which constituted 11 percent of the total LTC services.

LTC caseload counts are derived from monthly expenditure data claimed by service providers. Providers can claim bills up to twelve months after the service is provided. Therefore, caseload counts provided each month may not reflect revised billing information. Although the forecasting model takes into consideration billing claim delays with a three-month delay before considering counts finalized, the billing claims from nursing facilities (mostly from Basic care and Complex Medial Add-On) take longer to reconcile than other LTC program providers. This leads to significant differences between caseloads calculated monthly (and published by OFRA in the monthly variance reports) and revised historical values which are more accurate. For this reason, Basic and Complex Medical Add-On services will be forecasted with revised values that accommodate this lag in reconciliation. This change will produce a more accurate forecast.

The Nursing Facility caseload is projected to average 3,853 cases per month over the 2023-25 biennium, about 4.4 percent higher than the Fall 2023 forecast. This caseload is expected to average 3,846 cases per month over the 2025-27 biennium, a slight reduction in caseload compared to the current biennium.



Forecast Environment and Risks

COVID-19

The COVID-19 pandemic has changed APD customers' sentiments toward LTC programs. Repeated surges of COVID-19 cases related to new variants have led to clients leaving the program and provoked hesitation in returning. There is still uncertainty regarding the extent to which consumer sentiment has been permanently or temporarily altered by the COVID-19 pandemic. The current forecast was conducted under the assumption that there would be no significant COVID-19 effects throughout the entire forecasting period, but it's important to acknowledge that this assumption is subject to change depending on how the situation evolves.

Healthier Oregon

The latest forecast has revised the estimated impact of Healthier Oregon on Long-Term Care based on APD HOP intakes between July 2022 and November 2023. The current forecast expects a stable number of HOP clients seeking LTC despite the increase in HOP adults covered by Medicaid. This is a conservative assumption based on the few people currently seeking LTC within the HOP population. However, as with any new service being offered, and especially services offered to immigrant groups, this may be incorrect – the actual caseload – especially in the 2025-27 biennium – could be higher or lower than forecast.

Other Risks

The American Rescue Plan Act of 2021 (ARP) provides an opportunity for states to change some Medicaid expenditures. OHA and ODHS have submitted a proposal to allow Deaf/Blind individuals who qualify for Medicaid to receive State Plan Personal Care (SPPC) services and eliminate In-Home consumers' "pay-in" contributions to services. The changes in SPPC eligibility criteria will likely increase the number of individuals on the caseload (initial estimates are around 680 new clients). The pay-in elimination was enacted in January 2022. Although In-Home services are more likely to be attractive to consumers, a limited number of clients can move from a Nursing Home or Community-Based Care provider to In-Home care, given the severity of their disability. New LTC clients are expected to be more likely to select In-Home Care if their needs can be met.

In addition to internal policy and program-related changes, external changes such as demographic shifts in Oregon's population and staffing shortages also pose a risk to the forecast's accuracy over the longer term. Oregon's population is aging, and elderly Oregonians are among the fastest-growing segments of the state population. In the past year, OEA has studied an alternative scenario for population change where in state migration does not rebound as expected and results in zero migration instead. A zero-migration scenario will result in a smaller labor force with a smaller number of health care workers. This scenario poses a risk for the availability and quality of health services.

Aging and People with Disabilities Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
AGING AND PEOPLE WITH DISABILITIES								
Case Management	**40,977**	**41,259**	**282**	**0.7%**	**41,259**	**41,850**	**591**	**1.4%**
In-Home Hourly without SPPC	12,013	12,383	370	3.1%	12,383	12,585	202	1.6%
In-Home Agency without SPPC	2,906	3,758	852	29.3%	3,758	3,854	96	2.6%
In-Home Spousal Pay	11	15	4	36.4%	15	15	0	0.0%
Independent Choices	525	530	5	1.0%	530	545	15	2.8%
Specialized Living	196	171	-25	-12.8%	171	169	-2	-1.2%
In-Home K Plan Subtotal	**15,651**	**16,857**	**1,206**	**7.7%**	**16,857**	**17,168**	**311**	**1.8%**
In-Home Hourly with State Plan Personal Care	1,052	1,010	-42	-4.0%	1,010	1,025	15	1.5%
In-Home Agency with State Plan Personal Care	493	565	72	14.6%	565	575	10	1.8%
In-Home non-K Plan Subtotal	**1,545**	**1,575**	**30**	**1.9%**	**1,575**	**1,600**	**25**	**1.6%**
Total In-Home	**17,196**	**18,432**	**1,236**	**7.2%**	**18,432**	**18,768**	**336**	**1.8%**
Adult Foster Care	2,330	2,383	53	2.3%	2,383	2,434	51	2.1%
Assisted Living	4,258	4,252	-6	-0.1%	4,252	4,288	36	0.8%
Contract Residential and Memory Care	3,625	3,795	170	4.7%	3,795	4,011	216	5.7%
Regular Residential Care	769	773	4	0.5%	773	778	5	0.6%
Program of All-Inclusive Care for the Elderly	1,910	1,953	43	2.3%	1,953	2,065	112	5.7%
Community-Based Care Subtotal	**12,892**	**13,156**	**264**	**2.0%**	**13,156**	**13,576**	**420**	**3.2%**
Basic Nursing Facility Care	2,956	2,894	-62	-2.1%	2,894	2,842	-52	-1.8%
Complex Medical Add-On	680	908	228	33.5%	908	953	45	5.0%
Enhanced Care	35	27	-8	-22.9%	27	27	0	0.0%
Pediatric Care	19	24	5	26.3%	24	24	0	0.0%
Nursing Facilities Subtotal	**3,690**	**3,853**	**163**	**4.4%**	**3,853**	**3,846**	**-7**	**-0.2%**
Total Long-Term Care*	**33,778**	**35,441**	**1,663**	**4.9%**	**35,441**	**36,190**	**749**	**2.1%**

* Total Long-Term Care Caseload includes Healthier Oregon clients.

Intellectual and Developmental Disabilities (I/DD)

Historically, Oregon provided I/DD services under a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. However, starting in July 2013 Oregon began offering services through the Community First Choice Option in 1915 (k) of the Social Security Act (referred to as K-Plan). Implementation of K-Plan required adjustments to program policies related to both eligibility and program delivery. As a result, more individuals with I/DD have chosen to enroll in Case Management and to request services.

General Assumptions for the Intellectual and Developmental Disabilities Forecast

The COVID-19 emergency in the spring of 2020 led to caseload decreases, specifically in In-Home Services (Adult and Children), but the caseload had rebounded by the fall of 2020. However, I/DD Employment and Day Support and Transportation services have experienced a significant disruption due to the COVID-19 pandemic and have had a slow recovery to pre-pandemic levels due to disruptions in employment and lack of qualified service providers. It is expected that these services will return to their normal, pre-COVID-19 patterns towards the middle of 23-25 biennium.

The Case Management Enrollment and In-Home Services (Adult In-Home Support, Children In-Home Services and Children In-Home Support) caseload forecasts began including Healthier Oregon Program (HOP) clients as of July 2022. Healthier Oregon was made possible by the passage of HB 3352, which expands healthcare coverage to adults who would be eligible for medical assistance except for their immigration status. Disability services are included in HOP eligibility. The initial rollout on July 1, 2022, included all children as well as adults between ages 19-25 and those 55 and older. On July 1, 2023, all remaining adults became eligible.

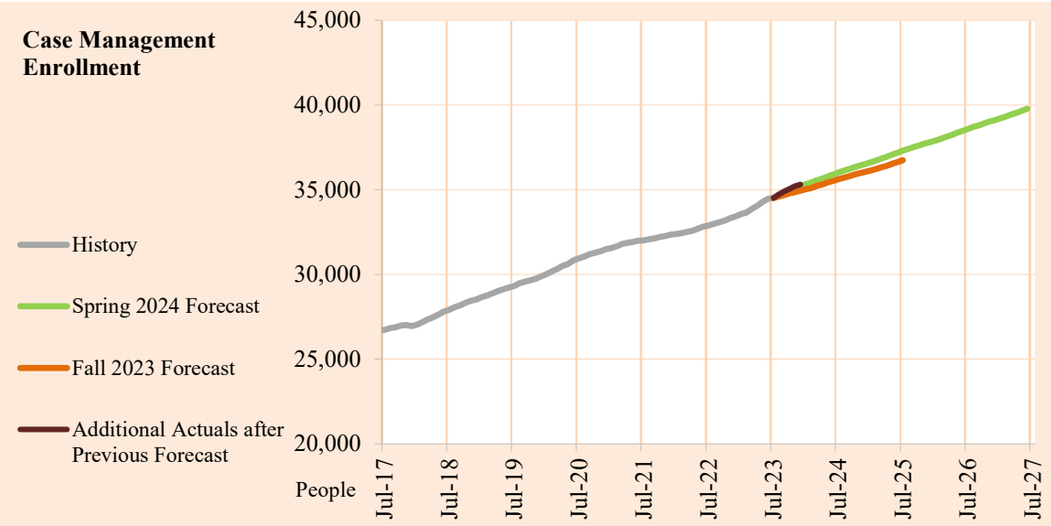
Because of the initial age restriction on enrollment, the Office of Developmental Disability Services (ODDS) narrowed the potential impact of Healthier Oregon to the Case Management Only population. It is expected that HOP clients would be enrolled in Case Management Only initially, and a very small number of enrollees would access I/DD services. Thus, the potential impact of HOP in ODDS service-related caseloads will be limited at first.

Case Management Enrollment

Case Management Enrollment is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. Since the Fall of 2018, Case Management Enrollment has included State Children (SE 248) who did not have I/DD Case Management enrollment. In addition, Oregon's Office of Developmental Disabilities Services (ODDS) initiated a review of I/DD enrollees in the Case Management category without a case management contact or without other I/DD services billed in a year. The review of I/DD enrollees with an open record, but without I/DD services, were closed back to the date they stopped receiving I/DD services. This cleanup process has reduced the Case Management Enrollment caseload slightly.

Case Management Enrollment is projected to grow until most I/DD individuals living in the state have enrolled. The Human Services Research Institute (HSRI), under a contract with ODDS, has estimated the "natural limit," where the caseload would plateau, by applying national prevalence estimates to Oregon's youth and adult populations through 2027.

The Case Management Enrollment forecast is expected to average 35,927 cases per month over the 2023-25 biennium, about 1.0 percent higher than the Fall 2023 forecast. This caseload is expected to grow to 38,525 in 2025-27. These totals include Healthier Oregon clients. The Healthier Oregon program is expected to contribute an average of 17 cases per month to Case Management Enrollment in 2023-25, and 43 cases per month in 2025-27. The remaining caseload categories are divided into adult services, children services, and other services.

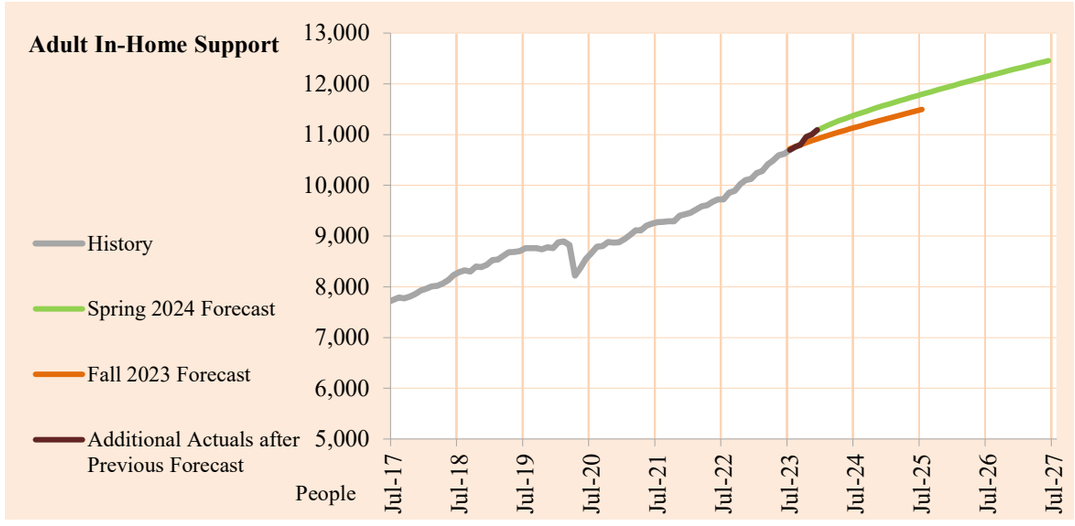


Adult Services

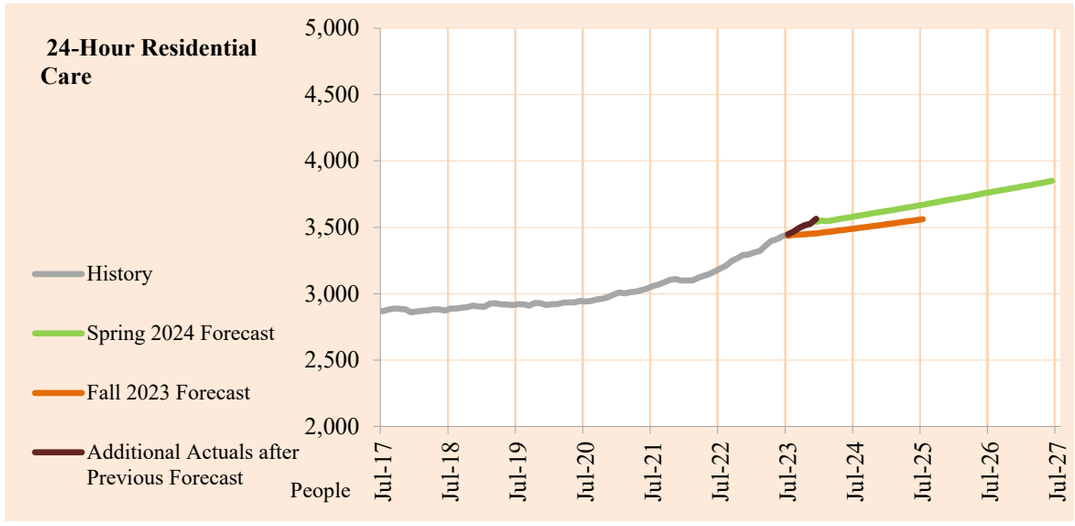
I/DD Adult Services were reorganized in the Fall of 2017 to combine Comprehensive In-Home Services and Brokerage Services as a new caseload category: Adult In-Home Support. Fifty-three percent of this caseload category is Brokerage Services and 47 percent is Community Developmental Disabilities Programs (CDDP) In-Home Services. OFRA does not report a separate forecast for Brokerage enrollment.

Adult In-Home Support – The Adult In-Home Support caseload category combines CDDP In-Home services and Brokerage services. This caseload category combines all In-Home services for adults and Brokerage Services, excluding employment and transportation services, and are grouped based on plan of care.

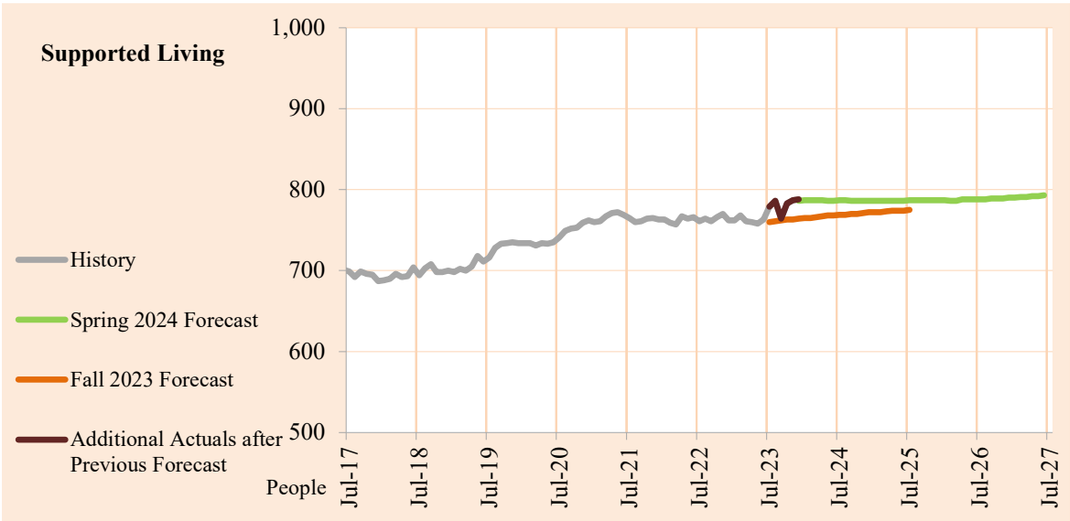
The Adult In-Home Support caseload forecast, including HOP cases, is expected to average 11,325 cases per month over the 2023-25 biennium, about nine percent higher than the previous forecast. The caseload experienced a sharp decline during the early days of the COVID-19 pandemic but has quickly rebounded and has been gradually but continually increasing ever since. This caseload is expected to average of 12,134 clients per month in 2025-27.



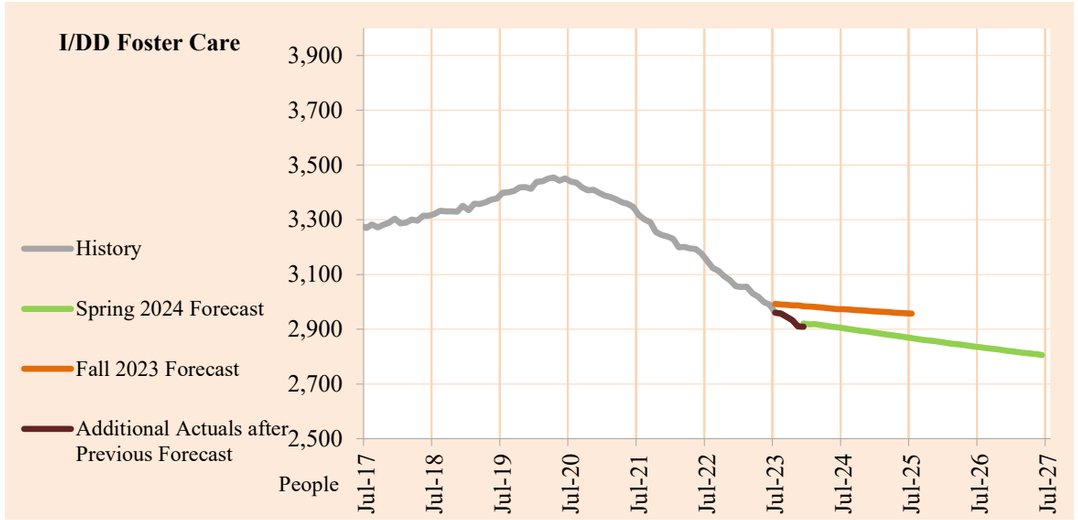
24-Hour Residential Care – The 24-Hour Residential Care caseload forecast, including HOP cases, averages 3,576 cases per month in the 2023-25 biennium, about 2.4 percent higher than the Fall 2023 forecast. The caseload is expected to average 3,760 cases over the 2025-27 biennium.



Supported Living – This caseload is expected to average 785 cases per month for the 2023-25 biennium. The caseload is expected to average 789 cases per month over the 2025-27 biennium.



I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately nine percent of the caseload. In 2023-25, this caseload is expected to average 2,974 cases, which is 3.5 percent lower than the Spring 2023 forecast. The caseload is expected to continue to decline over the 2025-27 biennium, averaging 2,941 cases per month.



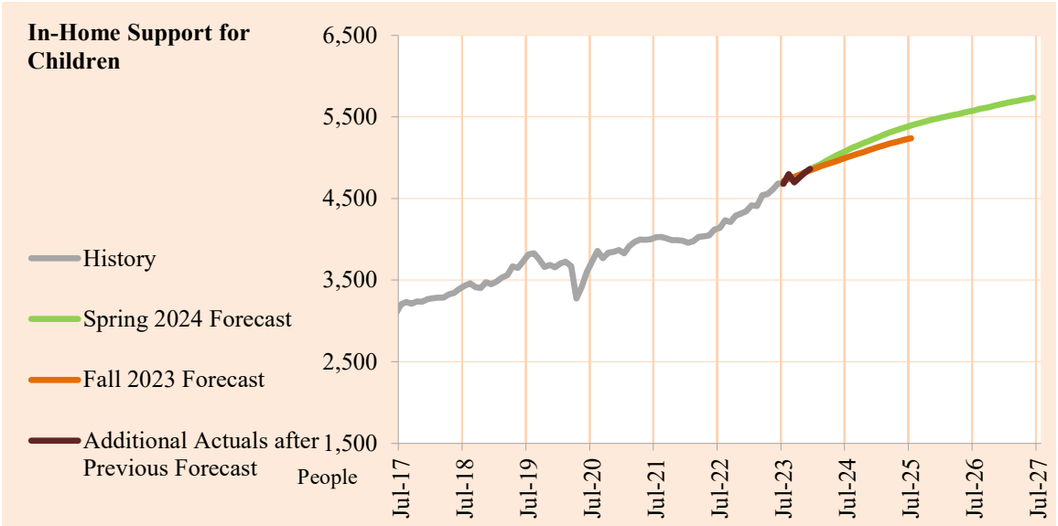
The Adult Foster Care caseload forecast averages 2,650 cases per month in 2023-25 and is expected to average 2,582 cases per month over the 2025-27 biennium.

The Child Foster Care caseload forecast averages 257 cases per month in 2023-25 and is expected to average 254 cases per month over the 2025-27 biennium.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 17 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 cases per month for both 2023-25 and 2025-27.

Children Services

In-Home Support for Children – This caseload significantly declined in early 2020 due to the COVID pandemic but rebounded to pre-COVID levels by the end of the year. In 2023-25, this caseload is expected to average 5,057 cases per month, which is 1.4 percent higher than the Fall 2023 forecast. The caseload is expected to average 5,573 cases per month over the 2025-27 biennium. These values include Healthier Oregon clients.



Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. This caseload is limited by capacity and is expected to grow gradually to 421 cases and remain at that level through the forecast horizon.

Children Residential Care – This caseload is expected to grow gradually to 205 cases per month and remain at that level through the forecast horizon.

Host Homes – Host Homes are private, single family community homes that provide a safe and structured environment for children with intellectual or developmental disabilities. These homes are managed by an agency and licensed by the state of Oregon. This caseload is in early stages of implementation and is going to take some time before it gets fully implemented. Therefore, it is expected to average about 10 clients per month in 2023-25 and 2025-27 biennia.

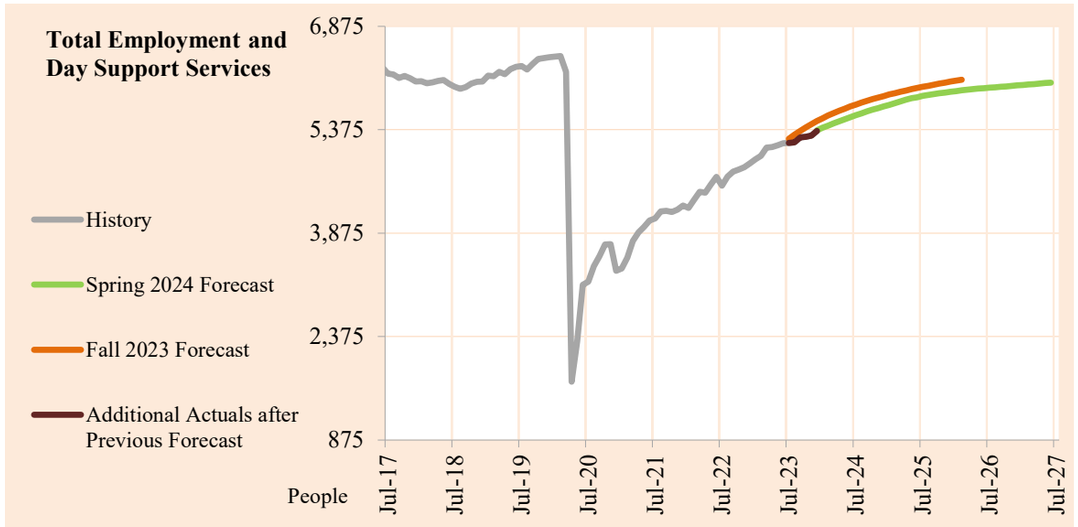
Other Services

Total Employment and Day Support Services

Employment and Daily Support Activities (DSA) are grouped together as 'Total Employment and Day Support Services' since the implementation of Employment First and the Plan of Care in Spring 2016. Employment claims data have a significantly longer lag time than the customary three months due to delayed billing and claims processing. Therefore, OFRA has based the current forecast on estimated preliminary actuals. The preliminary actuals account for the difference between the initially observed caseload and the caseload observed later, after claims have been fully processed.

Due to the COVID-19 pandemic, the demand for Employment and DSA services decreased by about 20 percent as clients reduced their employment and activities involving travel. This caseload is showing signs of recovery, but in a slower rate than expected in the Fall 2023 forecast.

The Total Employment and Day Support Services forecast is expected to average 5,547 cases per month, which is about 2.5 percent lower than the Fall 2023 forecast. The caseload is expected to average 5,975 cases per month over the 2025-27 biennium.



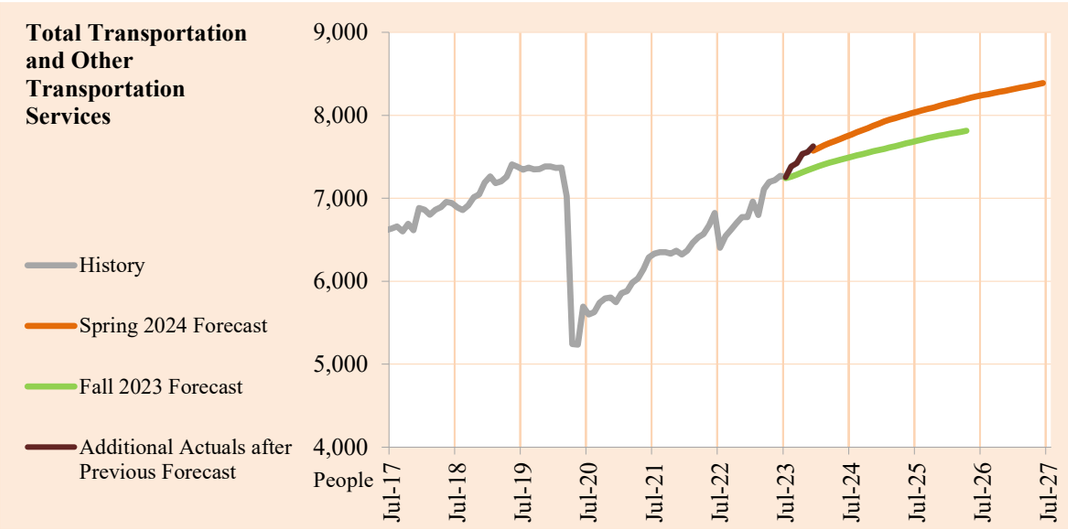
Total Transportation and Other Transportation Services

Historically, this caseload included only services paid with state funds, not those using local match funding. To provide a more complete picture, the definition of services counted in the

Transportation caseload has been expanded to include all services previously counted, plus transportation services provided under Plan of Care (e.g., transit passes and non-medical community transportation). This started in Fall 2022.

Since 2020 estimated preliminary actuals for Transportation services have been calculated in the same way as described under the Total Employment and Day Support Services.

The Total Transportation Services forecast is expected to average 7,736 cases in the 2023-25 biennium, about 3.4 percent higher than the Fall 2023 forecast. The caseload is expected to average 8,227 cases per month over the 2025-27 biennium.



Nursing Services – Direct Nursing Services are shift-type services provided to adults with medically complex needs. This is a new service and new caseload and does not have a long history. This caseload was created because of the unbundling of nursing services from other I/DD services. It is expected to average about 95 clients per month in 2023-25 and is expected to average 95 clients per month over the 2025-27 biennium.

Behavioral Services – the term "Behavior Services" refers to positive behavior support services provided to assist I/DD clients with challenging behaviors. This is a new service and new caseload and does not have a long history. This caseload created because of unbundling of behavioral services from other I/DD services. This caseload had a steep growth initially, but in recent months growth has slowed. It is expected to average about 1,636 clients per month in 2023-25 and 1,756 clients per month over the 2025-27 biennium.

Forecast Environment and Risks

Four I/DD services – In-Home Services (Adult and Children), Employment and DSA, and Transportation experienced a significant caseload decrease due to COVID-19. In-Home Support for Adults and Children has recovered quickly and is now following pre-pandemic patterns, but Employment and DSA services were more significantly disrupted. These services are gradually recovering from the impact of COVID-19, but at different recovery rates. The Transportation services caseload is recovering in the faster pace than the Employment and DSA Services and reached pre-pandemic levels in mid-2023. The Employment and DSA services caseload recovery may take longer due to a lack of service providers. Given that these sorts of disruptions to services have never occurred before, the pattern of recovery is speculative, and is a continuing risk to forecast accuracy.

Additional Risks and Assumptions

Adult In-Home Support – Adults can be served through two channels – Brokerages or Community Developmental Disabilities Programs (CDDPs). At present, most caseload growth is occurring in CDDP In-Home Services, while Brokerage Services remain flat. The Brokerage Services caseload is a little over three times larger than CDDP In-Home Services. Growth in adult caseloads generally comes from children who age into adult services, or previously unserved adults who are newly interested. Since the CDDP portion of the caseload is growing rapidly and without precedent, the forecast is highly sensitive to the assumptions used to produce it, and the risk of error is higher than usual. In addition, due to the factor of client choice playing a part choosing CDDP or Brokerage In-Home services, it is difficult to make reasonable assumptions without any established pattern of their service choices.

In-Home Support for Children – K-Plan implementation expanded the availability of services for many children. Prior to the implementation of K-Plan, children were only able to receive limited in-home services and could only access additional services if they met crisis criteria. A child may now access significant in-home support without meeting crisis criteria if they are eligible for I/DD services and Medicaid. As a result, a significantly larger number of children may now access In-Home Services.

Also, under Oregon's comprehensive waiver, additional children are now eligible for Medicaid services based solely on having a disability (meeting Supplemental Security Income standards), while not accounting for family financial resources. This may also increase the number of children who are able to access in-home services through K-Plan.

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
INTELLECTUAL AND DEVELOPMENTAL								
Total Case Management Enrollment [1]	**35,555**	**35,927**	**372**	**1.0%**	**35,927**	**38,525**	**2,598**	**7.2%**
Adult								
Adult In-Home Support	11,118	11,325	207	1.9%	11,325	12,134	809	7.1%
I/DD Foster Care	2,708	2,650	-58	-2.1%	2,650	2,582	-68	-2.6%
24 hr. Residential Care	3,491	3,576	85	2.4%	3,576	3,760	184	5.1%
Supported Living	768	785	17	2.2%	785	789	4	0.5%
Stabilization and Crisis Unit	99	97	-2	-2.0%	97	99	2	2.1%
Children								
I/DD Foster Care	267	257	-10	-3.7%	257	254	-3	-1.2%
In-Home Support for Children	4,986	5,057	71	1.4%	5,057	5,573	516	10.2%
Children Intensive In-Home Services	421	411	-10	-2.4%	411	421	10	2.4%
Children Residential Care	205	198	-7	-3.4%	198	205	7	3.5%
Host Homes	10	9	-1	-10.0%	9	10	1	11.1%
Total I/DD Services [2]	**24,073**	**24,365**	**292**	**1.2%**	**24,365**	**25,827**	**1,462**	**6.0%**
Other I/DD Services								
Employment & Day Support Activities [3]	5,687	5,547	-140	-2.5%	5,547	5,975	428	7.7%
Transportation [4]	7,479	7,736	257	3.4%	7,736	8,227	491	6.3%
Nursing Services	84	95	11	13.1%	95	95	0	0.0%
Behavioral Services	1,784	1,636	-148	-8.3%	1,636	1,756	120	7.3%

1. Some clients enrolled in Case Management do not receive any additional I/DD services.
2. Total I/DD services includes Healthier Oregon clients.
3. Employment and DSA actuals are estimated to account for under reporting of delayed claims.
4. Transportation actuals are estimated to account for under reporting of delayed claims.

Vocational Rehabilitation (VR)

Vocational Rehabilitation (VR) assists individuals with disabilities to get and keep a job that matches their skills, interests, and abilities. VR staff work in partnership with the community and businesses to develop employment opportunities for people with disabilities. VR services are individualized to help each eligible person receive services that are essential to their employment success.

The program has changed over its history with policy changes from:

1) The Workforce Innovation and Opportunity Act (WIOA). Among other things, WIOA mandates provision of services to school-age youth, with joint responsibility between Local Education Agencies and VR.
2) State Executive Order 15-01, which instituted an Employment First policy to increase competitive integrated employment of people living with Intellectual and Developmental Disabilities (I/DD); and
3) The Lane vs. Brown settlement, which set specific numeric targets for moving clients out of sheltered workshops and into competitive integrated employment, and for providing services to transition age clients.

These changes are all complex and interwoven, and when combined they have had a substantial impact on the VR caseload. Caseload increases started around January of 2015 and peaked in May 2018 before gradually reducing. This trend is expected to continue into the 2023-25 biennium.

The VR caseload was significantly impacted by COVID-19 starting in early 2020 and remained in decline until early 2022. The program is taking longer to recover to pre-COVID levels than other ODHS programs, however since early 2022 the caseload has stabilized and begun a gradual rebound. Starting the fall of 2023, the In-Plan portion of the VR caseload began growing more rapidly than the Application and Eligibility caseloads. This may be a result of the Inclusive Career Advancement Program (ICAP) which speeds up clients through the application and eligibility process into the In-Plan stage.

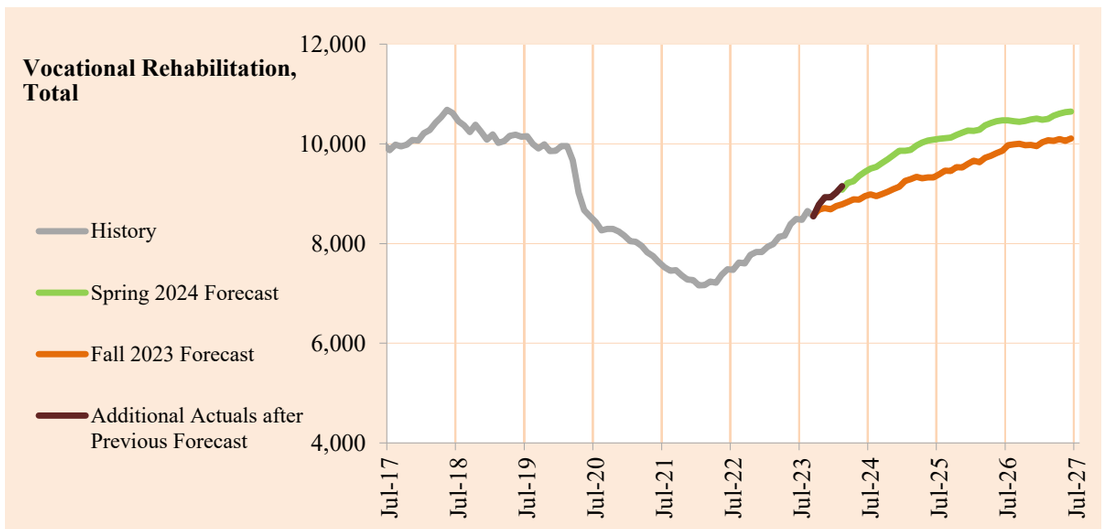
The changes in VR noted above impacted the composition of total VR caseload in terms of types of clients entering the program and how they move from the Application stage to eligibility determination and In-Plan stages. Some clients also receive post-employment services as part of the VR services.

General Assumptions for the Vocational Rehabilitation Forecast

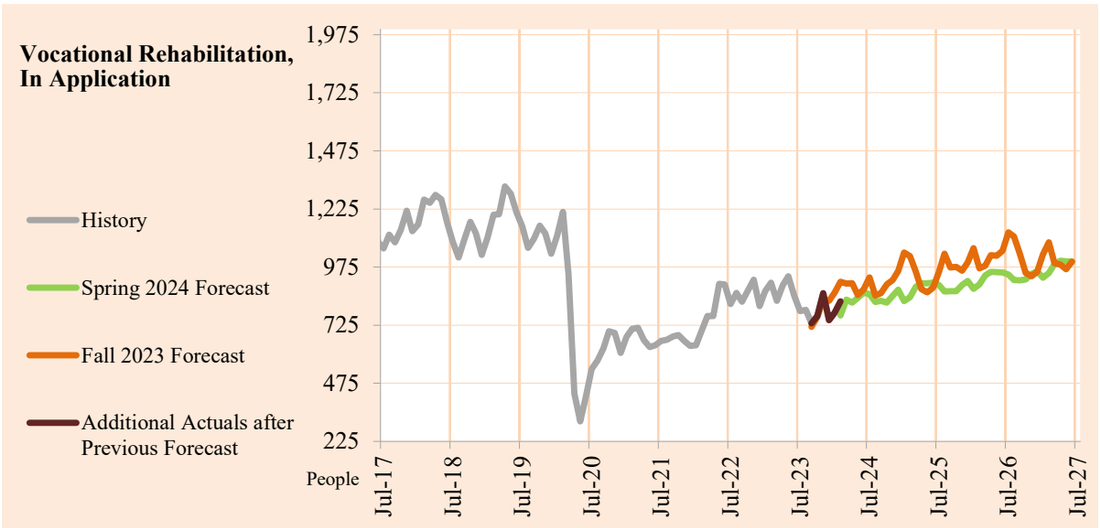
For all the services described below, a common pattern is expected – a caseload volume that dropped dramatically in the spring and summer of 2020 and remained stalled through 2021 and into 2023 is now recovering. Because it started later than previously expected, the caseload recovery pattern indicated in the prior forecast has been re-adjusted to run through the 2023-25 biennium.

Total Vocational Rehabilitation – The total caseload significantly declined after the COVID 19 state of emergency was declared in March of 2020 and continued to decline at a slower rate through the Fall 2021. Work with VR clients, which tends to be very contact-heavy, was suspended for a while as staff modified processes and changed the way they interacted with clients. VR has retooled, and the caseload has now stabilized and is growing. It is expected to gradually increase to the pre-pandemic levels through the middle of 2027.

The Total VR caseload forecast is the sum of In Application, In Eligibility, and In Plan. Post employment services were previously forecasted separately but are now contained within the count of regular VR services. The Total VR caseload forecast projects an average of 9,401 clients per month in 2023-25 biennium, which is 5.0 percent higher than the Fall 2023 forecast. The total VR caseload will average to 10,396 clients per month in 2025-27.



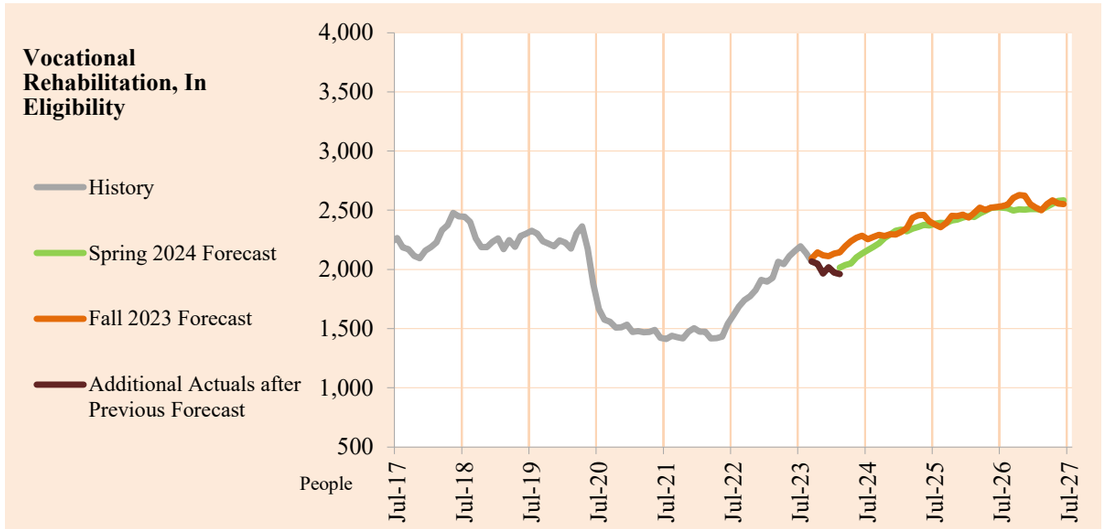
In Application – The current monthly average forecast for the 2023-25 biennium is 831 cases, lower than the 880 cases projected in Fall 2023, a decrease of 5.6 percent. Application volume is expected to recover more slowly than assumed in the prior forecast and is now expected to reach pre-COVID levels by the early months of 2024, reaching an average of 932 clients per month for the 2025-27 biennium.

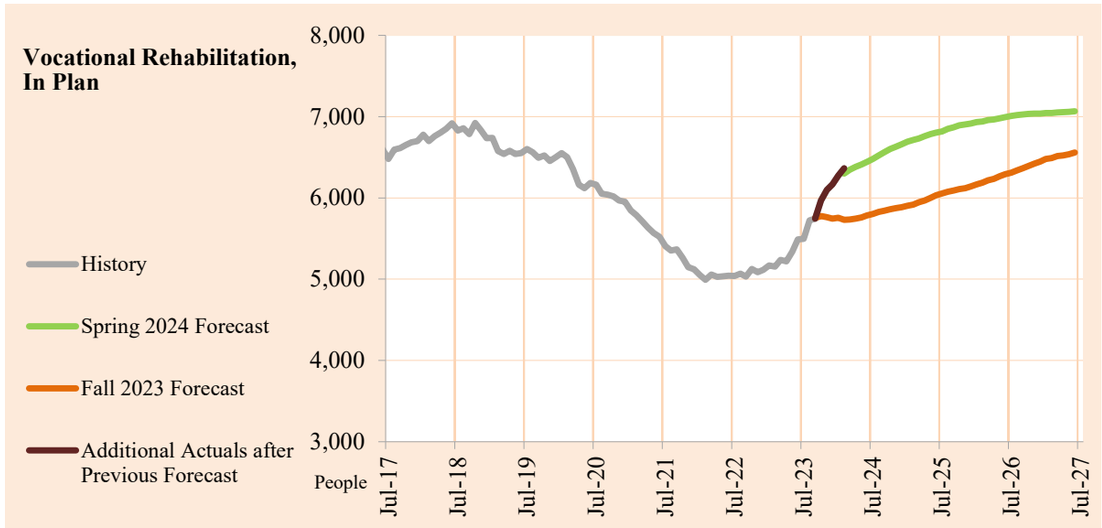


In Eligibility – The In Eligibility portion of the caseload is expected to recover slowly to pre-COVID levels in 2023-25 biennium. Therefore, the current monthly average forecast for the 2023-25 biennium is 2,180 cases, 3.5 percent lower than the previous forecast. The In Eligibility caseload is expected to grow to pre-COVID levels by the middle of 2025, and average 2,486 clients per month for the 2025-27 biennium, an increase of 14.0 percent.

In Plan – The post-pandemic normalization process and opening of employment opportunities is likely to encourage the medically vulnerable to re-join the workforce and therefore this portion of VR services will fully recover to a level anticipated prior to the pandemic. However, the transition from other stages of VR services into the In Plan stage has not been as smooth as in the pre-pandemic period, and therefore this caseload will see some monthly fluctuations.

The In-Plan current monthly average forecast for 2023-25 is 6,390, which is 9.8 percent higher than the Fall 2023. In-Plan caseload volume is expected to average 6,978 clients per month for the 2025-27 biennium, an increase of 9.2 percent.





Forecast Environment and Risks Related to COVID-19

Covid related disruptions in VR services and its service delivery practices are receding, and the caseload is being gradually restored to pre-Covid levels. Although the VR caseload decline has stabilized and rebounded, it may take a little longer to achieve a post-Covid normalcy for all VR services. For instance, while In-Eligibility service has returned to its normal pattern, In Application and In-Plan services are still fluctuating and not fully stabilized. This instability may be the result of changes that occurred in the VR Intake process during the retooling of the program to address COVID-19. Because VR has never been disrupted this way before, there is inherent risk in forecasting its recovery.

Some in-person services have been replaced with remote contact, depending on the preference of the VR client. This process has understandably caused issues related to adjusting to a virtual connection and working through initial technical difficulties and the adoption of new technology. Accommodations had to be made in the collection of the required signatures on paperwork from both clients and medical professionals. Although the VR program has implemented an 'eSign' or electronic signature capacity, it has encountered its own set of technical adjustment issues as well as reluctance to adopt the new technology, which has slowed down its seamless adoption. VR services may also be especially delayed in work placement due to a slow recovery of certain jobs in the Oregon economy.

Additional Risks and Assumptions

VR can provide services to any child with an Individualized Education Plan (IEP) in schools between ages 14 and 24. VR staff, when invited to IEP meetings, can then work with school districts to identify certain employment and pre-employment service needs of these students with disabilities. This process helps to identify the number of youths with disabilities that will need services with finding jobs in the future as they become adults. VR then provides pre-employment transition services to those students. This youth population’s potential entry into VR services may cause upward pressure on our current caseload forecast. VR is also actively working on to timely transition of clients through the service sequence process which was hindered due to limited access to students in face-to-face interaction at schools.

Additionally, VR is partnering with community Colleges to hire Career Coaches to support individuals identified as needing VR support to focus on an enhanced certification program which could lead to higher paying and more secure employment. VR is also exploring a collaboration with Self-Sufficiency’s SNAP Training and Employment Program (STEP).

These outreach programs may over time bring more new clients into the VR program than is currently projected.

Vocational Rehabilitation Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
VOCATIONAL REHABILITATION								
In Application	880	831	-49	-5.6%	831	932	101	12.2%
In Eligibility	2,258	2,180	-78	-3.5%	2,180	2,486	306	14.0%
In Plan	5,818	6,390	572	9.8%	6,390	6,978	588	9.2%
Total Vocational Rehabilitation	**8,956**	**9,401**	**445**	**5.0%**	**9,401**	**10,396**	**995**	**10.6%**

OREGON HEALTH AUTHORITY

Total Oregon Health Authority Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
Health Systems - Medicaid								
OHP								
Children's Medicaid	306,001	313,478	7,477	2.4%	313,478	301,982	-11,496	-3.7%
Children's Health Insurance Program	113,896	136,952	23,056	20.2%	136,952	124,150	-12,803	-9.3%
Foster, Substitute and Adoption Care	16,666	16,446	-221	-1.3%	16,446	16,098	-348	-2.1%
Aid to the Blind and Disabled	95,879	93,867	-2,012	-2.1%	93,867	93,407	-460	-0.5%
Old Age Assistance	71,757	80,327	8,570	11.9%	80,327	77,694	-2,633	-3.3%
Pregnant Women	15,576	16,172	596	3.8%	16,172	14,091	-2,080	-12.9%
Parent, Caretaker Relative	100,774	98,807	-1,967	-2.0%	98,807	94,910	-3,897	-3.9%
ACA Adults	492,023	529,045	37,022	7.5%	529,045	462,197	-66,848	-12.6%
Breast and Cervical Cancer Treatment Program	155	149	-6	-4.1%	149	171	23	15.2%
Healthier Oregon - Child	8,984	12,076	3,092	34.4%	12,076	16,229	4,153	34.4%
Healthier Oregon - Pregnant	3,453	3,703	250	7.2%	3,703	3,648	-55	-1.5%
Healthier Oregon - Adult	52,451	70,471	18,020	34.4%	70,471	79,666	9,195	13.0%
Total OHP	**1,277,615**	**1,371,491**	**93,876**	**7.3%**	**1,371,491**	**1,284,243**	**-87,248**	**-6.4%**
Total Medicaid	**1,310,283**	**1,397,848**	**87,565**	**6.7%**	**1,397,848**	**1,313,999**	**-83,848**	**-6.0%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	1,482	1,535	53	3.6%	1,535	1,542	7	0.5%
Civilly Committed	825	773	-52	-6.3%	773	763	-10	-1.3%
Previously Committed	3,120	4,146	1,026	32.9%	4,146	4,157	11	0.3%
Never Committed	84,396	82,219	-2,177	-2.6%	82,219	87,863	5,644	6.9%
Total Served	89,823	88,673	-1,150	-1.3%	88,673	94,325	5,652	6.4%

1. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

The End of the COVID-19 Public Health Emergency

The federal Department of Health and Human Services has allowed the Public Health Emergency (PHE) related to COVID-19 to lapse on May 11, 2023. However, this decision was superseded by the Consolidated Appropriations Act passed in December 2022 (CAA, 2023) which severed the Continuous Enrollment Condition of the Families First Coronavirus Response Act (FFCRA) from the PHE as of April 1, 2023.

During the PHE, anyone whose eligibility was based purely on income (as opposed to a categorical eligibility, such as a disability), women in the Breast and Cervical Cancer Treatment Program and those entering via Hospital Presumptive Eligibility (in which hospital staff engage in the application process on behalf of a patient) were not removed from the caseload due to the recording of an "adverse action." In other words, no client was removed from Medicaid for any reason except death, incarceration, requests to terminate coverage, error, fraud, or confirmation that they have left the state. In addition, their level of benefits was not reduced under the same rules. New intakes were processed as normal, and denials occurred if clients failed to provide appropriate information or if they were over the income limit; however, self-attestation was allowed for some elements of eligibility, including verification of income.

This policy led to a large reduction in the number of cases exiting the program, resulting in a large caseload increase. In addition, there have been changes in transfer patterns between certain non-OHP programs with lesser benefits, such as Qualified Medicare Beneficiary (QMB) and Citizenship Waived Medical (CWM).

The Centers for Medicare/Medicaid Services (CMS) provided guidance to the Oregon Health Authority on how case processing should change to address the backlog of cases with an adverse action. In addition, the passage of HB 4035 in the Oregon Legislature mandates that the Health Authority change case processing to minimize the loss of health insurance (there will be more discussion of HB 4035 below). CMS requirements and HB 4035 are dictating the timing of redeterminations and the closing of cases for those found ineligible.

The timing of the end of the Continuous Enrollment condition is as follows:

- The Continuous Enrollment Condition ended April 1, 2023. The "Unwinding" period began immediately.
- During the Unwinding, large numbers of cases are being processed each month, addressing the adverse action backlog. The most common reason for a notation of adverse action is simply being overdue for a redetermination.
- Most cases are either being passively renewed or have a Request for Information (RFI) sent. As per HB4035, clients will have 90 days to respond to RFIs. For those who do not satisfactorily respond, close notices will be sent after the 90-day period. Historically, the most common reason for non-response to an RFI is the inability to locate a client who has moved with no forwarding address. Clients will have 60 days to respond to the close notice. Mass case closures will occur 150 days after case processing begins.
- Renewals will be sequenced to balance workload and increase the likelihood of maintaining health insurance for clients. However, these sequencing criteria will have minimal impact on the forecast because many targeted characteristics that would lead certain kinds of cases to be considered early or late in the process will be distributed evenly across all case types forecasted.

Changes to the Unwinding Period Logic

The Center for Medicare/Medicaid Services has granted Oregon a "pause period" of three months during the Unwinding period. This pause was granted in February and was applied immediately. The Unwinding period logic and new batches of mass redeterminations will be paused for March, April, and May 2024.

This pause was enacted to retool the close notice to meet due process concerns and to address new guidance from CMS. Targeting certain types of cases for redetermination in the sequencing plan mentioned above led all members of a family to be redetermined along with the targeted case-person. This was logical, given that household income and composition are shared among all members of a household. But this led to closures in some states that may have been overly aggressive and reversed on appeal. To minimize this, individual household members who fit the sequencing pattern will be considered, and if that individual can be passively renewed other family members will be redetermined independently. These two modifications to the interim plan required time to implement, and therefore the three-month pause was enacted.

During the three-month pause, cases already in the process of redetermination will be addressed, but no new batches of mass-redeterminations will be processed. For cases in March, April and May, closes will occur because of past months of case processing, but no

new redeterminations, no passive renewals, and no Requests for Information will be sent. This will lead to a reduction of closures 150 days after the pause start, and last for three months. Therefore:

- The pause in February will impact case counts in September.
- The pause in March will impact case counts in October.
- The pause in April will impact case counts in November.

September, October, and November closes will be modest, and resemble the volume of closes experience during the Continuous Enrollment period.

Because of the three-month pause in case processing, the total number of months for the Public Health Emergency Unwinding (PHEU) has been extended to February 2025. The last set of mass closes related to the PHEU interim period will be effective on the last day of February and will influence the caseload down for March.

Revisions to Forecast Assumptions and Increased Risk to Accuracy

Due to the extensive change in timing entailed in the PHEU, the forecast has been retooled. It is assumed that the total caseload will likely rise in the months where the pause in the unwinding will be experienced, 150 days after the start of the pause, and run for three months – influencing case counts in September, October, and November of 2024.

We have several months of data showing the results of the PHEU. As expected, the patterns diverged from the initial assumptions built into the forecast. The initial forecasted reductions to case counts were based on past patterns in the data when redeterminations were paused and represented a "best guess." However, the conditions of the PHEU are unique and never experienced in the history of the program. Some caseloads were influenced downward due to mass closures, as expected. But other caseloads experienced much more shallow effects, and some no effect at all. This has required a major re-tooling of the forecast to accommodate the evidence at hand.

HB4035 requires increased outreach efforts to maintain contact with clients and help them avoid loss of health insurance. This appears to have worked to increase the likelihood of completed renewals. This both reduced exits for several caseload types, and inevitably reduced "caseload churn," where closed cases reopen as people who were disenrolled reenter the caseload. A reduction in churn leads to a reduction of new enters. This changes the overall pattern of the caseload and leads to greater divergence between different case types in how the Unwinding influences them.

The assumptions now built into the forecast for the effects of the pause in case processing were based on early information about the operational plan, and as with everything involved in the PHEU, subject to change based on limitations of systems and the people operating them. In addition, the new guidance from CMS on passively renewing individuals whenever possible may push cases requiring a full redetermination out to later months. This could lead to more closes at the end of the Unwinding.

Because the three-month pause in mass processing of cases will allow eligibility staff an opportunity to pivot to other work, the built-in "overhang period" where additional cases would be mass redetermined in a "cleanup phase" has been removed from the forecast. No trailing effect of the Unwinding is now assumed.

Other Risks to Forecast Accuracy

In addition to the risks inherent in the changes mentioned above, other known risks are still in effect:

- The number of cases processed each month will not be equal due to operational considerations like holiday time off, staff turnover and increased workload at the end of the year due to open enrollment in the federal marketplace.
- Operations staff reserves the right to change the plan to increase accuracy and productivity as the Unwinding occurs.
- The cleanup process for pending or missing cases at the end of the interim period could still occur, for an unspecified number of months.
- As part of the redetermination process, cases will be assigned a new redetermination month irrespective of when their case was touched during the Unwinding Period, to redistribute the cases more evenly. This will lead to new patterns of renewal, transfer, and closure after the end of the Unwinding.

Additional Elements of the Current Forecast

Temporary Medicaid Expansion and the Basic Health Plan

In addition to the elements already stated in this document, HB 4035 directed OHA to

provide a Temporary Expansion to Medicaid for those clients would lose OHP coverage during the Interim Period but are under 200% of the Federal Poverty Level (FPL). It has been approved by CMS under an 1115 Waiver and started on April 1, 2023.

Effective July 1, 2024, the Health Authority will put in place a long-term Basic Health Plan (BHP) and roll the Temporary Expansion clients into that new plan – for more information on the BHP, see the "Temporary Expansion of Medicaid and the Basic Health Plan" section of this document.

"Continuous Eligibility"

A new 1115 Demonstration Waiver has been negotiated between federal HHS and the Oregon Health Authority which provides continuous eligibility to children under six receiving Medicaid and CHIP and provides two-year eligibility to most eligibility groups over age six. These changes have been built into the current forecast. It is assumed that most of the effects will be felt in the 2025-27 biennium after the end of the Interim Period redetermination plan. However there have been some effects already, given that Continuous Eligibility stipulates that those cases covered by Continuous Eligibility not be transferred to a lower-benefit group during their two-year period of enrollment. The effects of this will be discussed more in the risks section at the end of this document.

Transfers In and Out of Disability Categories

Clients receiving disability care assistance through the Oregon Supplemental Income Program, Medical (OSIP-M) alleged that reductions to their coverage for being over-resourced violated due-process. As a result, cases that had been redetermined early in the Unwinding process and moved to lower-coverage dual-eligible and part-dual categories such as Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program were moved back into disability-related caseloads of Aid to Blind and Disabled or Old Age Assistance. These cases will be re-processed after the Unwinding pause.

General Summary of Health Systems Medicaid

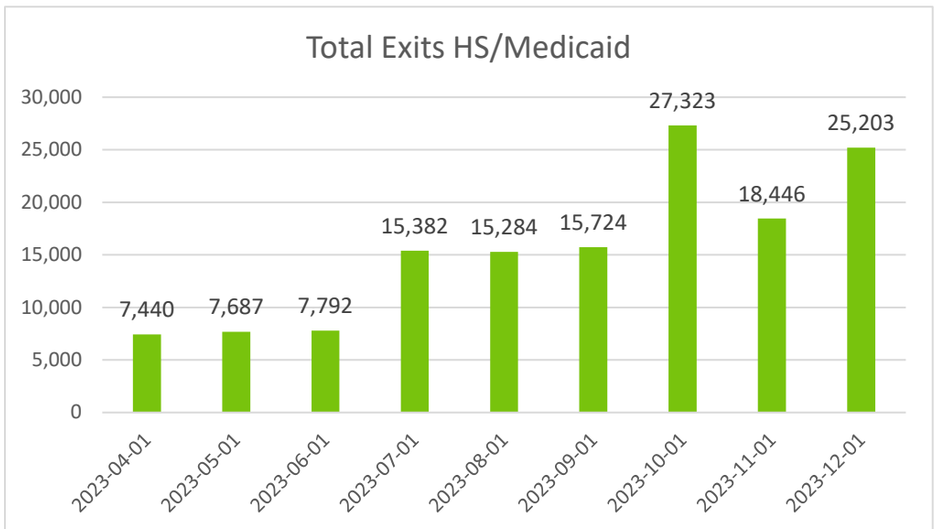
The expansion of Medicaid through the Affordable Care Act (ACA) beginning in January 2014 led the HSM caseload to grow in fits and starts related to two issues: open enrollment and delayed redeterminations. This led to a pattern of increases (due to a pause in processing redeterminations) and decreases (due to processing the backlog of redeterminations) from March 2016 through August 2017.

Additionally, since the ACA expansion, the number of new or returning entrants to Medicaid has shown yearly increases related to the Federal Marketplace open enrollment period. The exact timing of that bump has varied from year-to-year and seems loosely correlated with the exact start and stop dates of the open enrollment period.

Starting with the renewals scheduled for the end of February 2018, Oregon transitioned to a system of Automated Renewals (sometimes called passive or *ex parte* renewals). Automated Renewals is a system under which OHA automatically renews a client's Medicaid Eligibility if they have all the required information and the client is eligible. This system is in place in most states and is required by the federal CMS. If OHA cannot verify eligibility with the available data, the client will go through the normal, active renewal process that does require a response.

Recent Actuals and Trends

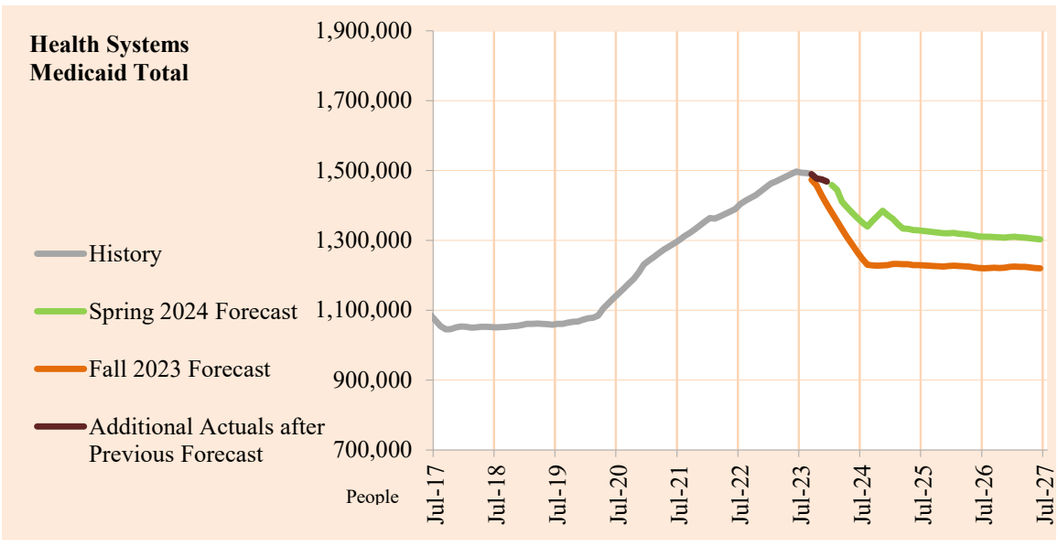
Many Oregonians lost their jobs either to furlough or to traditional layoffs due to restrictions put in place at the start of the Public Health Emergency (PHE). This resulted in a noticeable increase in the number of new enters into the Medicaid caseload in April and May of 2020. After that initial spike, new enters fell off and drifted lower during the PHE. Throughout the PHE, exits have been dramatically reduced, creating a long-sustained increase in the caseload starting in March 2020 and continuing through the summer of 2023, when the PHEU led to elevated case closes. Closes nearly doubled starting in July 2023 as cases slated for immediate close were processed, and increased again in October, 150 days after the initial cohort of mass redeterminations in April were processed.



As of November 2023, **the total number of people served by Health Systems/Medicaid** (including partial and dual-eligible Medicare/Medicaid clients) was 1,501,807 persons and the preliminary estimate for February 2024 is 1,470,533. The HS/Medicaid caseload reached a peak in June 2023 at 1,522,378 persons, and the last preliminary estimate shows a 3.4 percent reduction across seven months of case processing related to the Unwinding.

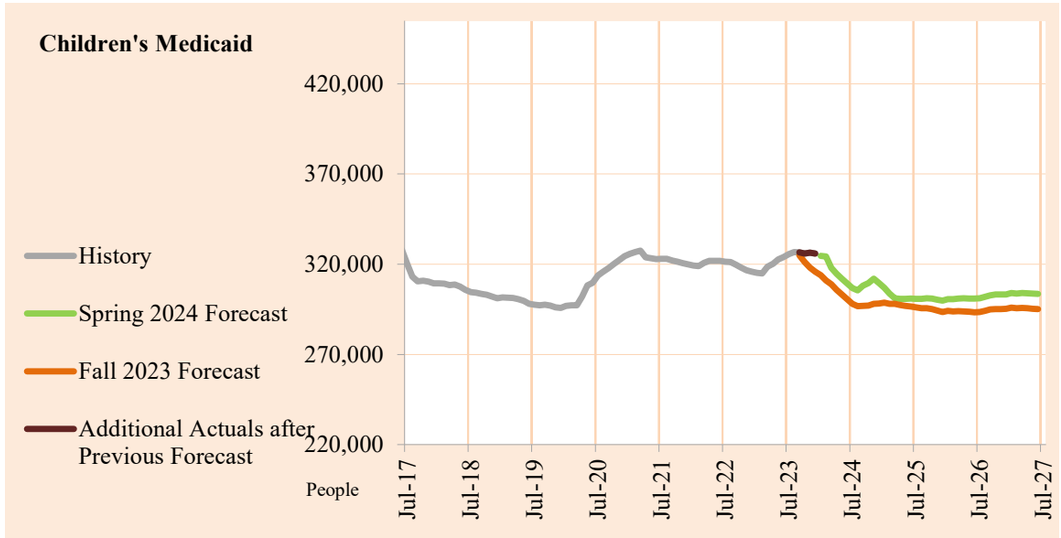
The final reductions experienced due to the Unwinding have been revised from previous forecasts. The caseload was initially estimated to reduce to about 1.25 million persons at the end of the Unwinding. The new total is likely to be in the range of 1.33 million. This total does not include those clients who will be served under the Basic Health Plan.

The 2023-25 **Total Health Systems/Medicaid (HSM) biennial average forecast** (which includes the Healthier Oregon population) is 1,397,848 clients, which is 6.7 percent higher than the Fall 2023 Forecast. The 2025-27 biennial average forecast is 1,313,999 clients, six percent lower than the current biennium.



Children's Medicaid – This caseload had shown a slow decline over the two years prior to the Public Health Emergency. After some growth in the first half of the PHE, it began to decline again, due to a high volume of transfers to the higher-income category CHIP. This pattern reversed in 2023, increasing the caseload as cases transferred in from CHIP. This began in February 2023, and was therefore independent of the Interim Period review process. The most recent finalized actual for November 2023 shows 326,358 clients on this caseload.

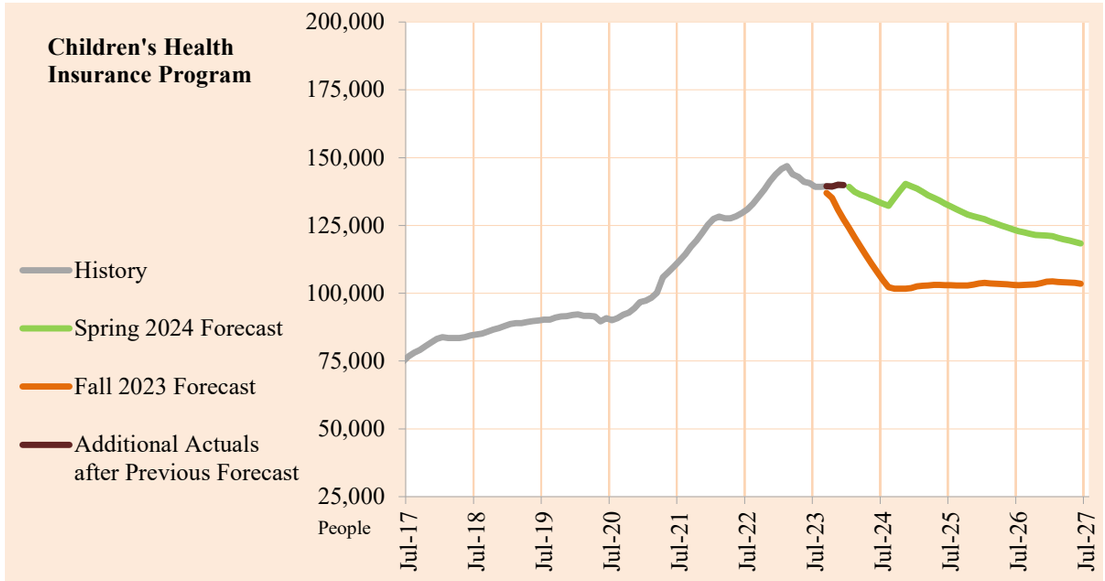
The Children's Medicaid average monthly caseload forecast for 2023-2025 is 313,478 cases, 2.4 percent higher than the previous forecast. The 2025-27 biennium is expected to be 301,982 cases, a 3.7 percent reduction from the current biennium.



Children's Health Insurance Program (CHIP) – The most recent finalized actual for November 2023 shows 139,959 children on this caseload. The Public Health Emergency has caused growth in this caseload, and that growth accelerated after the completion of the Integrated Eligibility system, which created a more robust client record, leading to transfers from Children's Medicaid. Additional growth was experienced in late 2022 due to an increase in referrals from the federal marketplace. The open enrollment period for the federal marketplace (aka "Obamacare") often leads to caseload increases, usually in the higher-income groups.

During the early months of the PHEU, the caseload stabilized at 139,000 as mass exits were balanced out by large numbers of transfers from Children's Medicaid. Recently, the caseload has begun to fall again, as exits have outstripped transfers in.

The CHIP forecasted average monthly caseload for the 2023-25 biennium is expected to be 136,952 cases, a 20.2 percent increase from the previous forecast. The high volume of transfers from Children's Medicaid necessitated this revision. The average monthly caseload forecast for the 2025-27 biennium is expected to be 124,150 cases, 9.3 percent lower than 2023-25.

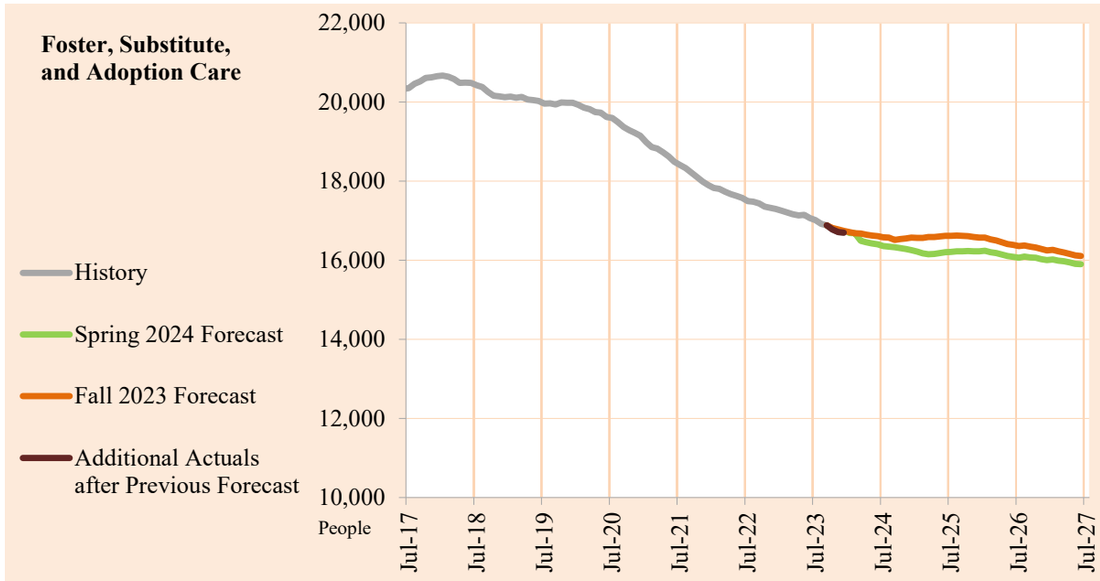


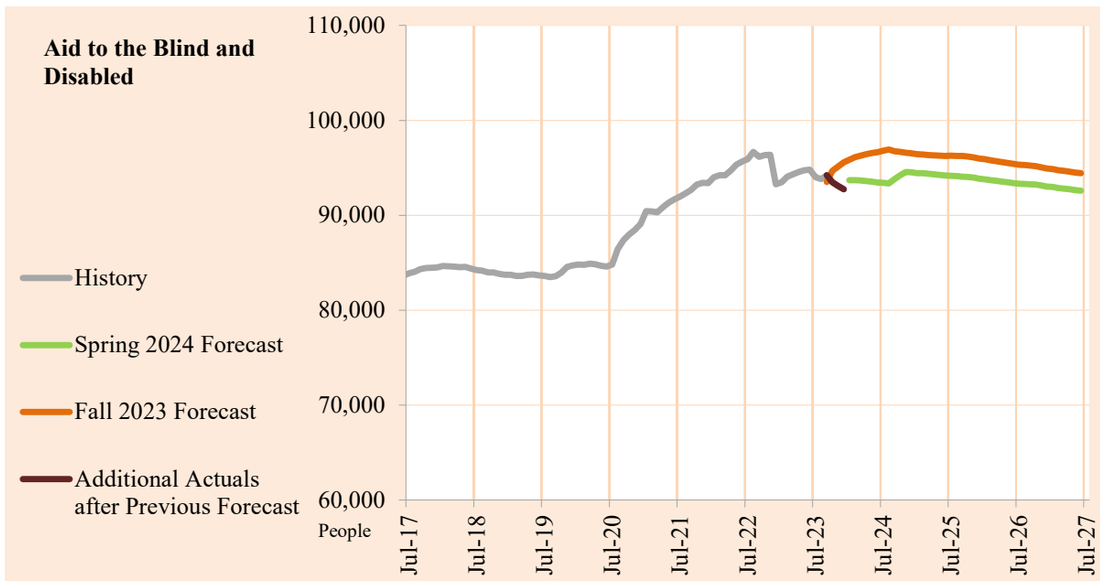
Foster, Substitute and Adoption Care – The most recent finalized actual for November 2023 shows 16,715 children on this caseload. This caseload has been declining for the last two years and has not been directly impacted by the Public Health Emergency. This decline is linked to the number of children placed in foster care and will be driven by current and future policy changes enacted by the Child Welfare program.

The Foster, Substitute and Adoption Care forecasted biennial average caseload for 2023-25 is projected to be 16,446 cases per month, 1.3 percent lower than the previous forecast. The average monthly caseload forecast for the 2025-27 biennium is expected to be 2.1 percent lower than 2023-25.

Aid to the Blind and Disabled (ABAD) – The most recent finalized actual for November 2023 shows 93,080 clients on this caseload. Prior to the Public Health Emergency, this caseload held steady at about 83,000 cases. Growth occurred since mid-2020, and there have been some level shifts up and down related to the switch to the Integrated Eligibility system, which has improved the accuracy of disability determinations across ODHS and OHA. This caseload has not been influenced by the mass-redeterminations of the PHEU and is expected to grow modestly through the forecast horizon.

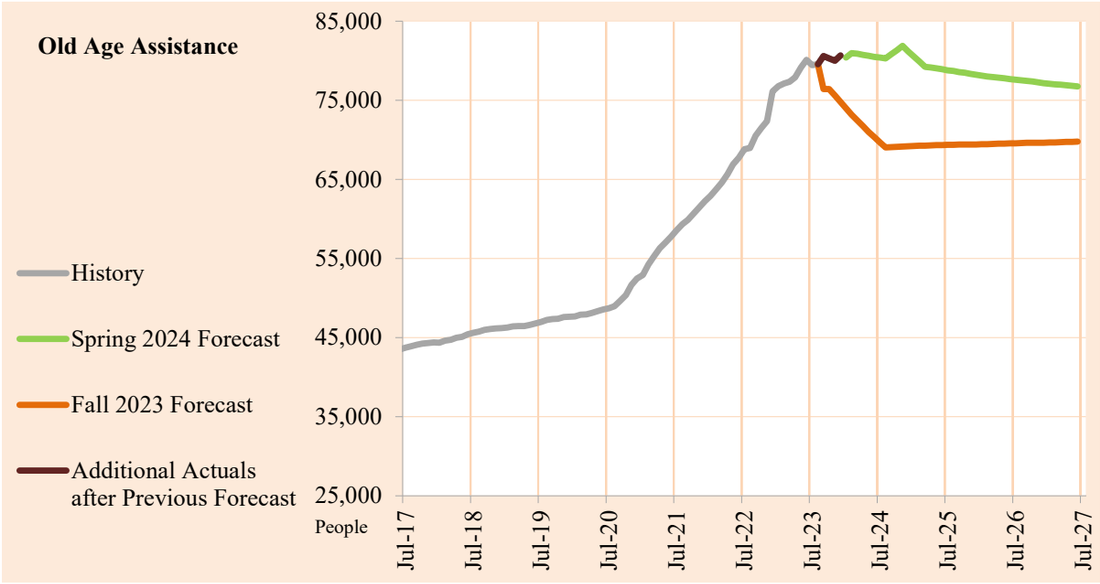
The average monthly caseload for ABAD is forecast to be 93,867 cases for 2023-2025, a 2.1 percent reduction from the previous forecast. It is expected to decline by one half of one percent in the 2025-27 biennium.





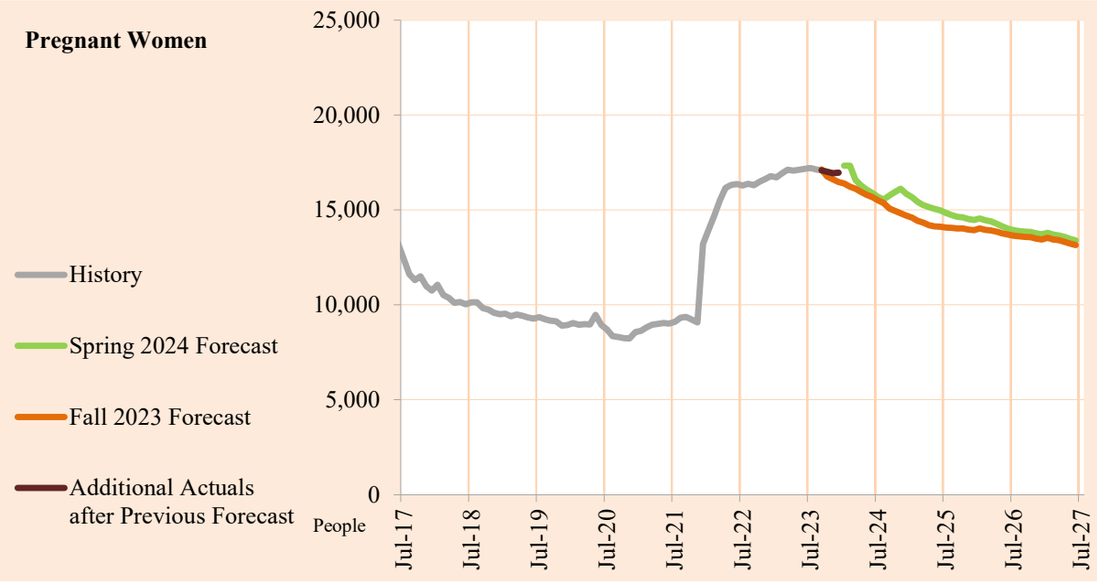
Old Age Assistance (OAA) – The most recent finalized actual for November 2023 shows 80,022 clients on this caseload. This caseload has shown increased growth and some upward shifts related to the switch to the Integrated Eligibility system. As cases were rolled into the new system, client eligibility was reexamined, improving the accuracy of the determination. There has also been some buildup during the Public Health Emergency as clients were not being transferred to lower-benefit partial or dual Medicare/Medicaid caseloads. The removal of clients from this caseload for being over-resourced, and then returned to OAA after complaints of due process violation has created some volatility in the caseload.

The forecasted average monthly caseload for OAA is expected to be 80,327 cases in 2023-25. This is a significant revision – 11.9 percent higher than the previous forecast. OAA has not been affected by the PHEU as expected, but instead has remained about 80,000 cases since July 2023. The 2025-27 average monthly caseload is expected to be 77,694, a 3.3 reduction from the current biennium. It is expected that cases returned to OAA from part and dual-eligible Medicare/Medicaid categories will be re-processed, and some reductions will occur near the end of the Unwinding.



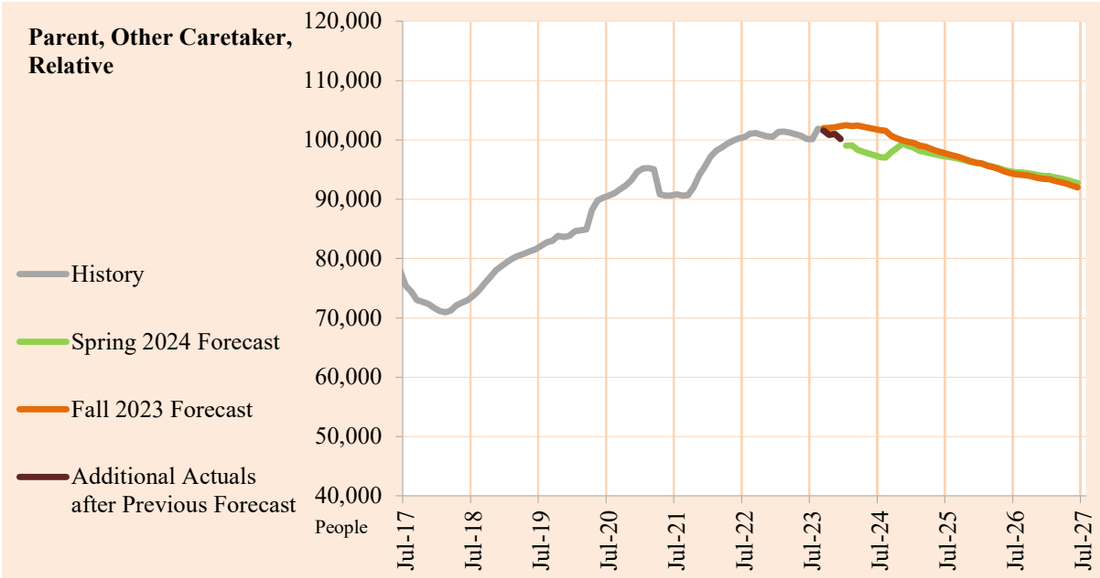
Pregnant Women – The most recent finalized actual for November 2023 shows 16,931 women on this caseload. The decline in the number of live births in the state of Oregon over the last several years has put downward pressure on this caseload, and the Public Health emergency caused a brief additional decrease in this caseload that then rebounded. More importantly, the extension from 2 months to 12 months of post-partum eligibility which was applied to cases going back to December of 2021 caused a large jump in the caseload even though the actual number of pregnancies did not change significantly. This caseload experienced a brief increase at the end of 2023; however, this increase appears to be winding down. The Pregnant Women caseload is expected to experience some reductions due to the mass redeterminations required in the Interim Period.

The average monthly caseload for the Pregnant Women caseload in 2023-25 is expected to be 16,172, 3.8 percent higher than the previous forecast. The average monthly caseload for 2025-27 is 14,091, about 13 percent lower than 2023-25.



Parent, Other Caretaker, Relative (PCR) – The most recent finalized actual for November 2023 shows 101,013 clients on this caseload. It has been growing sharply since 2018, with a pause in 2021. Recent increases have been driven by transfers from the ACA caseload into PCR. These transfers in plus new enters have been similar in volume to the transfers out and exits, stabilizing the caseload at about 100,000 cases. Recent preliminary values have shown a decline in the caseload, as clients who are Medicare-eligible have been transferred out during the Interim Period. This caseload is expected to continue to fall somewhat as closures exceed intakes and transfers in.

The average monthly caseload for PCR in 2023-25 is expected to be 98,807 cases, a two percent reduction from the previous forecast. The average monthly caseload for the 2025-27 biennium is expected to be 94,910, about four percent lower than the 2023-2025 caseload.

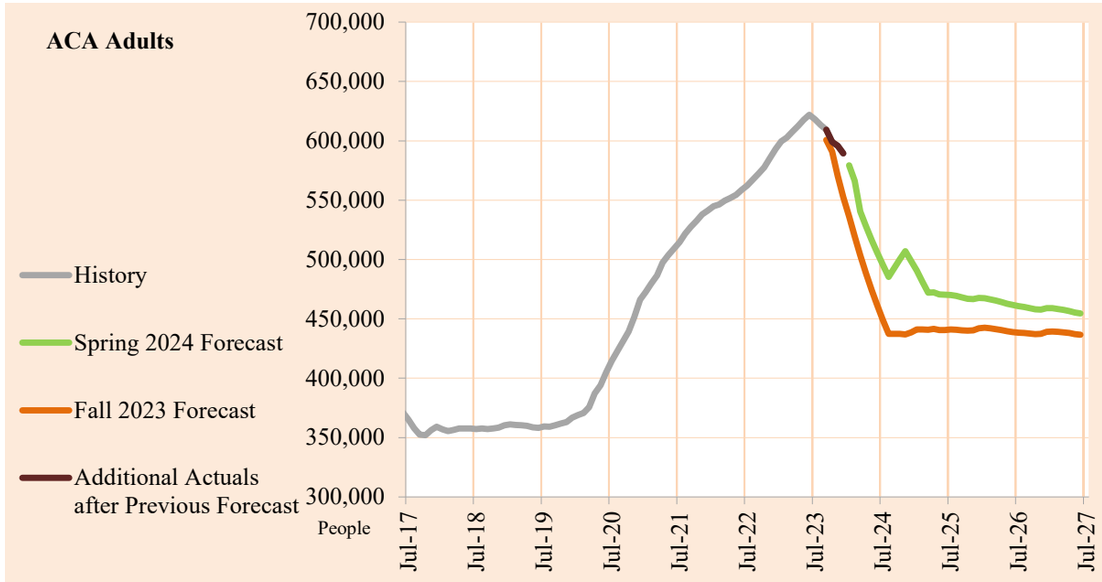


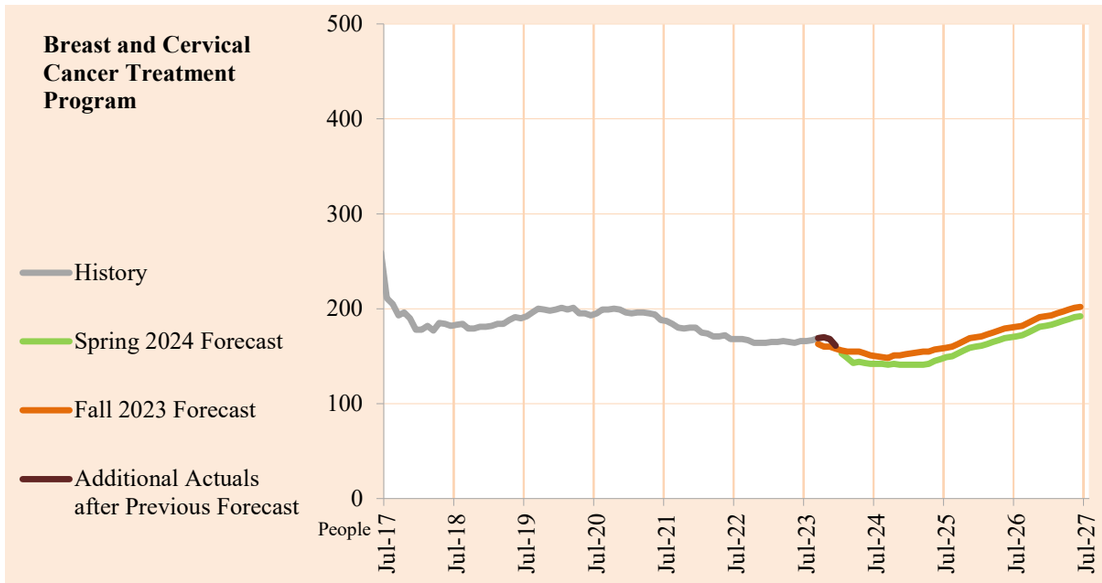
ACA Adults – The most recent finalized actual for November 2023 shows 595,774 clients on this caseload. This caseload grew very slightly from 2017 to the start of the Public Health Emergency. Since then, it has grown a great deal, driven in part by the increased transfers from PCR. Since the start of the Unwinding, this caseload has fallen due to a combination of closes and transfers to PCR. Transfer patterns between ACA Adults and PCR are a key element of both.

The average monthly caseload for ACA Adults for the 2023-25 biennium is 529,045 cases, 7.5 percent higher than the previous forecast. This caseload is not falling as aggressively as expected during the Unwinding. The average monthly caseload for the 2025-27 biennium is expected to be 462,197 cases, a decrease of 12.6 percent from the current biennium.

Breast and Cervical Cancer Treatment Program (BCCTP) – The most recent finalized actual for November 2023 shows 168 clients on this caseload.

BCCTP is forecasted to average 149 clients per month in the 2023-25 biennium and grow by 15.2 percent comparing the average monthly caseload for 2023-25 to 2025-27.





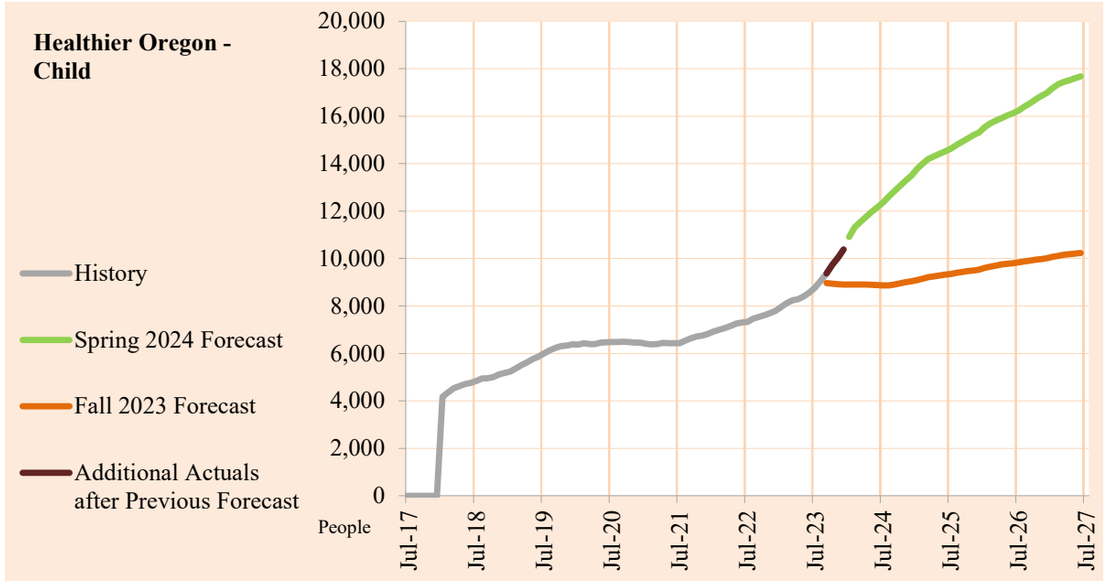
Healthier Oregon

Healthier Oregon, or the Healthier Oregon Program (HOP), expands healthcare eligibility to all Oregonians who would qualify for Medicaid-funded state medical assistance programs but for their immigration status. Healthier Oregon has replaced Cover All Kids for children and the emergency-only Citizenship Waived Medical (CWM) for adults, and CWM-plus for pregnant clients. Clients in this caseload are now counted in both Oregon Health Plan (OHP) and Medicaid. They will receive OHP level benefits, with emergency costs funded in part by Medicaid dollars and state dollars providing a wrap-around to cover the rest of the OHP benefits.

The program started accepting new enrollment on July 1, 2022. Existing Cover All Kids clients were rolled into HOP-Children on that date. The program also began accepting enrollment from adults under 26 and 55 or older. Adults in CWM (including CWM-plus) excluding 26–54-year-olds were rolled into HOP. Enrollment for all age groups began on July 1, 2023, and all adults in CWM not already in HOP were rolled into the program.

Healthier Oregon – Child (HOP-C) – This caseload was formerly known as Cover all Kids (CAK). The original program began January 1, 2018, when all children were transferred out of CWM-Child. It provides Oregon Health Plan benefits to all children in Oregon under the age of 19 who are under 300 percent of the Federal Poverty Level (FPL) who do not qualify for Medicaid due to citizenship status. This caseload started rising sharply in 2021 due to improved outreach efforts. This caseload is expected to continue to grow through the forecast horizon with minimal impact from the mass redetermination plan contained in the Interim Period logic. The most recent finalized actual for November 2023 shows 10,031 clients on this caseload.

The HOP-C average monthly caseload for 2023-25 is forecast to be 12,076 cases per month. This is 34.4 percent higher than the previous forecast. HOP-C experienced accelerated growth starting in the second half of 2023. Given that there is no impact of the PHEU expected, this caseload is forecast to continue to grow through the forecast horizon. It is expected to grow by another 34.4 percent in the 2025-27 biennium.

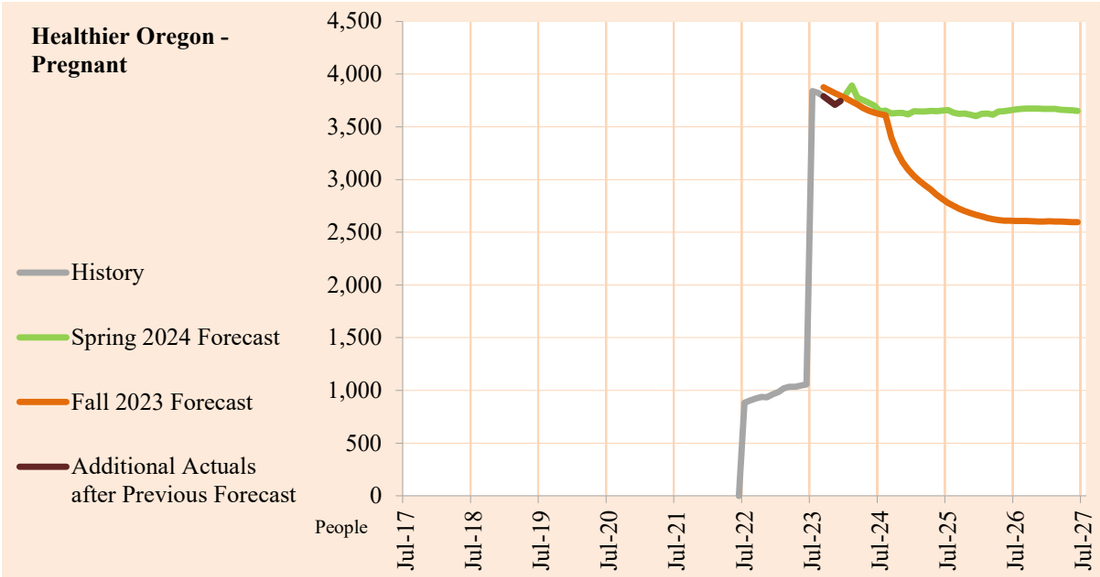


Healthier Oregon - Pregnant (HOP-P) – This caseload, formerly called CWM-pregnancy or CWM-plus has been rising sharply due to the case processing rules attached to the Public Health Emergency. No clients in CWM-plus were removed after the end of their postpartum period because transferring clients would be considered a reduction in services. Therefore, the caseload grew faster than any other forecasted area.

A small number of CWM-plus clients – those under age 26 – were moved to HOP-P in July 2022. The bulk of the caseload was transferred on July 1, 2023. During that transfer phase, eligibility was redetermined, and those CWM-plus clients who exceeded their postpartum coverage period were transferred out. This led to a one-time severe drop in the caseload. The prior forecast assumed another draw-down period would occur for those clients who are found to be over-income during the Unwinding, however early months of mass-redeterminations show no such effect. Therefore, this forecast has been significantly revised.

The most recent finalized actual for November 2023 shows a caseload of 3,709. Recent preliminaries have been moving upward, but this is expected to be a transitory effect (much like the pattern in the Pregnant Women category) and the caseload will stabilize.

The biennial average caseload for HOP-P for 2023-25 is expected to be 3,703 cases, a 7.2 percent increase from the previous forecast. The average monthly caseload is expected to drop modestly for 2025-27, to 3,648.



Healthier Oregon - Adult (HOP-A) – At the inauguration of this caseload on July 1, 2022, about 11,700 cases from CWM – Adult transferred in, representing the portion of CWMA under the age of 26 or over the age of 55. The remaining CWM-Adult caseload rolled into HOP-A on July 1, 2023. Both CWM-A and HOP-A were growing during the year between the first cohort rollover and the second.

The prior forecast assumed a relatively steep drop in caseload due to mass-redeterminations in the Unwinding period. However, HOP clients were passively redetermined during the rollover from CWM into HOP, and most resulting closures have already occurred. The current forecast accommodates this fact in a way the prior forecast failed to.

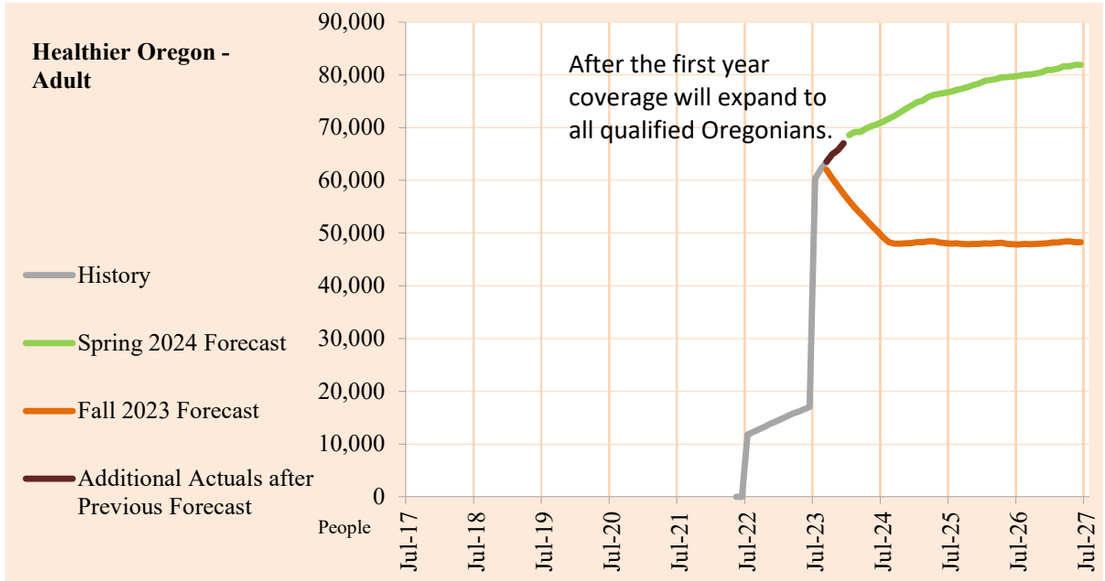
HOP-A clients numbered 65,737 in November 2023, the last month of finalized actuals. This caseload began experiencing accelerated growth starting in July 2023.

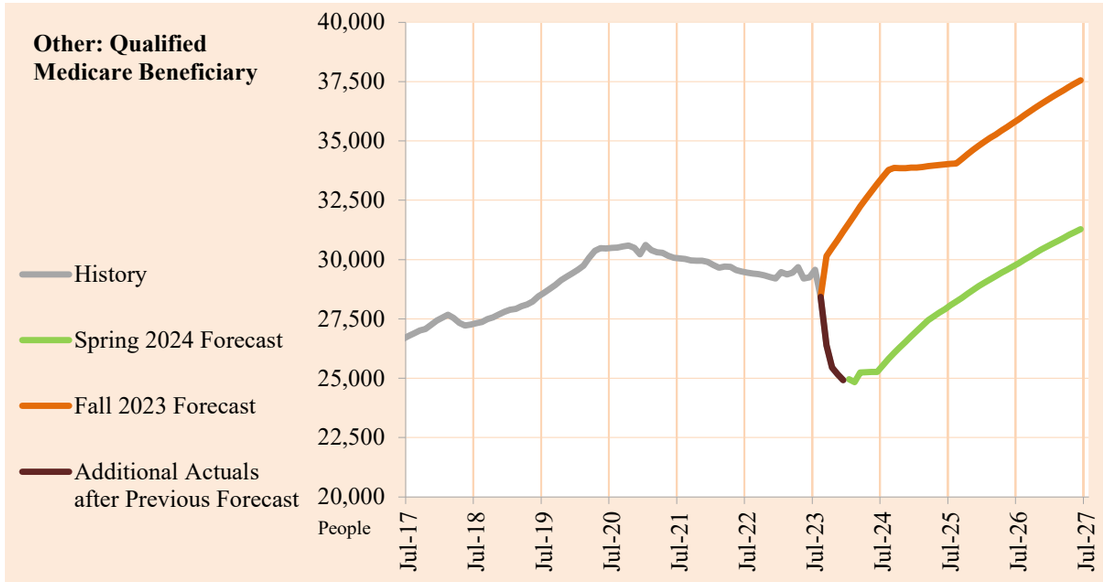
The forecasted HOP-A biennial average monthly caseload for 2023-25 is 70,471cases. This is an increase of 34.4 percent from the previous forecast, accommodating the lack of reductions expected during the Unwinding and the accelerated growth seen since July 2023. The average monthly caseload is expected to increase by 13 percent in the 2025-27 biennium, to 79,666. There is an open question as to whether this caseload will grow beyond 79 thousand, given that this is close to the estimated total number of adult immigrants without insurance in Oregon.

Other Medical Assistance Programs

Qualified Medicare Beneficiary (QMB) – The growth in this caseload ended at the start of the Public Health Emergency, as growth in QMB is largely determined by transfers in from full OHP coverage into this partial-benefit group. This caseload was influenced a great deal by the controversy concerning due process and transfers from OAA and ABAD. As a result, the caseload dropped from 29,573 in July 2023 to 25,164 in November as QMB cases that had been processed at the beginning of the Unwinding were returned to OHP coverage. It is expected that as these cases are re-processed, some percentage of them will again transfer to QMB, causing the caseload to rise.

The QMB average monthly caseload is forecast to be 26,356 in the 2023-25 biennium, a 19.3 percent reduction from the previous forecast. The recent reductions in the caseload are expected to reverse, therefore the biennial average caseload for 2025-27 is expected to be 29,756 cases, an increase of 12.9 percent.





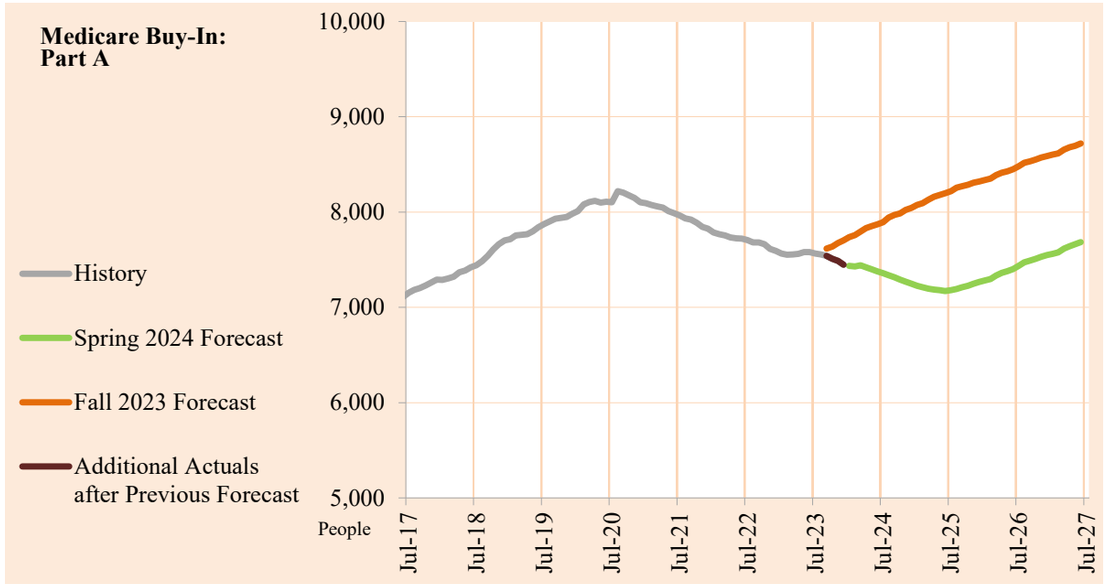
Medicare Part A/B Premium Assistance Programs

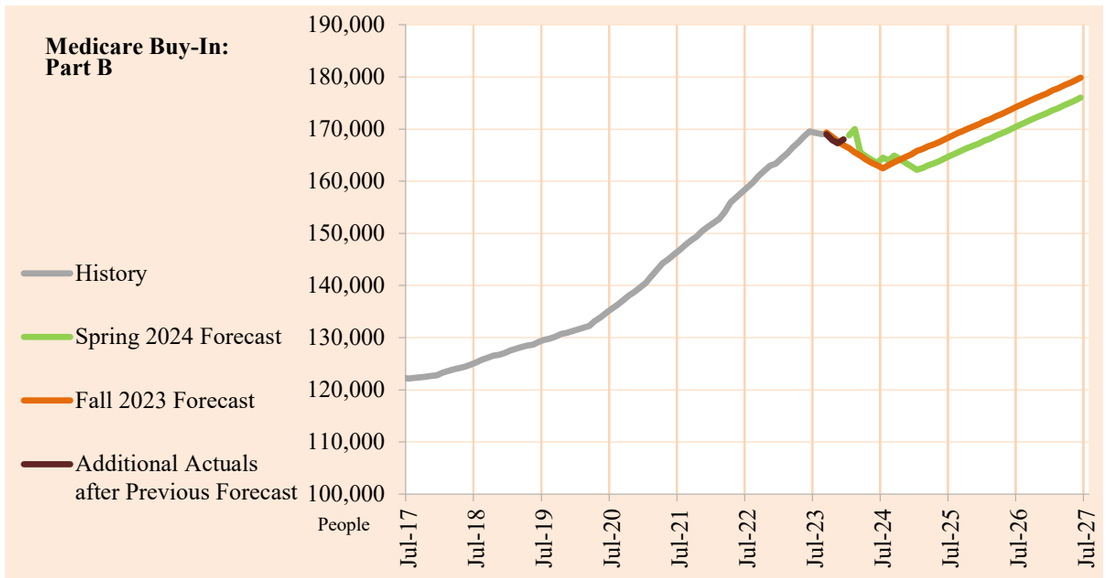
Medicare Part-A Premium Assistance – The most recent finalized actual for November 2023 shows 7,488 clients on this caseload. This caseload has been declining during the Public Health Emergency, since transfers in have been reduced. The prior forecast expected this caseload to begin to climb when transfer patterns return to normal during and after the Unwinding. That has not occurred, leading to a change in assumptions and a revision to the forecast.

The Medicare Part-A biennial average monthly caseload for 2023-25 is expected to be 7,360 cases, a 6.7 percent reduction from the previous forecast. It is expected to grow by less than one percent for the 2025-27 biennium.

Medicare Part B Premium Assistance – The most recent finalized actual for November 2023 shows 167,296 clients on this caseload. Unlike other dual-eligible Medicare/Medicaid caseloads, this caseload grew during the Public Health Emergency, due to a reduction in transfers out. As forecast, this caseload began to decline when transfers and exits resumed because of the Unwinding.

The forecasted average monthly caseload for Medicare Part B is 165,295 cases in the 2023-25 biennium, less than one percent lower than the prior forecast. It is expected that after the Unwinding ends, this caseload will begin to rise in a pattern like the one seen pre-COVID. The average monthly caseload for the 2025-27 biennium is 170,436 cases, a 3.1 percent increase from the current biennium.





The Temporary Expansion of Medicaid and the Basic Health Plan

To minimize the number of people who would lose health insurance during the Public Health Emergency Unwinding, the Oregon Health Authority applied for an 1115 SUD Waiver (different from the 1115 Demonstration Waiver, mentioned elsewhere in this document) to provide coverage to Oregonians who would qualify for Medicaid but for income up to 200 percent of the Federal Poverty Level. This Temporary Expansion of Medicaid would initially only be open to those who would lose Medicaid for being over-income during the PHEU.

On July 1, 2024, the state will inaugurate a Basic Health Program (BHP), also called Bridge Plan, a type of limited coverage available to persons up to 200 percent of the federal poverty level who are non-disabled and non-elderly. The Temporary Expansion group will be rolled into the BHP at startup. The Basic Health Program is allowable under Section 1331 of the Affordable Care Act, although only New York and Minnesota have provided it – Oregon would be the third state to do so. New York has announced that they will be suspending their Basic Health Plan in April 2024.

Our initial estimate was that as many as 59,300 clients – mostly in the Affordable Care Act Adult category – would qualify for the Temporary Expansion and the BHP at income between 138 and 200 percent of the Federal Poverty Level (FPL). Since then, we have worked with the Health Authority on an initial caseload forecast beyond the initial rollover population. The four groups estimated to join the BHP are:

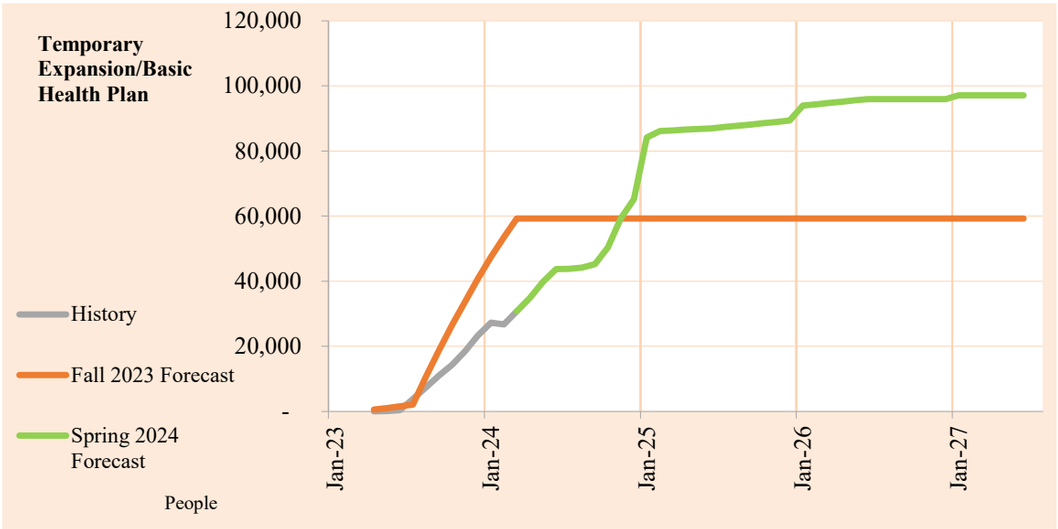
1) A rollover population who are in the Temporary Expansion group on July 1, 2024.
2) The additional transfers into BHP from Oregon Health Plan who are between 138 and 200 percent of FPL who will be redetermined during the PHEU between July 1, 2024, and February 2025.
3) Oregonians referred to the BHP from the federal marketplace who choose the BHP instead of marketplace coverage.
4) Uninsured Oregonians who apply for Oregon Health Plan who are over-income and eligible for BHP.

The initial estimate for Fall 2023 was confined to a modeling of the transfer rate into the Temporary Expansion group, which would cap at 59,300 persons. The new more comprehensive forecast includes the other groups that can join the BHP and accommodates the longer timeline for the PHEU which includes a three month pause in case processing in March, April, and May of 2024. Once the initial population – primarily from Oregon Health Plan transfers or referrals – have entered the Basic Health Plan, an additional "bump" in caseload will occur due to referrals from the federal marketplace, which will occur in the waning months of 2024 and 2025, with a more modest effect after 2025, as the eligible population become covered, and the BHP becomes a known commodity among Oregonians who may qualify. The forecast estimates that the BHP will top out at approximately 97,000 persons.

The Basic Health Plan biennial average monthly caseload for 2023-25 is expected to be 41,376 cases. The average monthly caseload for 2025-27 is projected to be 90,645.

There are unique risks to accuracy with this forecast. It is a new forecast area, representing a group who, because of income, were not covered before. The behavior of this group – the rate of exit for being over-income or the rate of transfer to OHP for having lower income – can only be guessed at. This forecast also assumes a relatively high uptake of the BHP for those Oregonians who qualify. Previous experience with the Affordable Care Act expansion does show that Oregonians by and large do respond to outreach programs and are quick to enroll in coverage when it is offered. However, we also know that new coverage doesn't attract everyone who qualifies. In addition to those who may not care to enroll for personal reasons, there are some who will turn down BHP and purchase insurance from the marketplace or private insurance through an employer, whether because these other insurance forms are more comprehensive in coverage or because they are simply more familiar.

Knowing that these factors exist, this forecast should be seen as something of an "upper bound" estimate – a projection of high enrollment based on an estimate of those in the community who qualify.



Risks to Forecast Accuracy

The 1115 Demonstration Waiver "Continuous Eligibility"

Section 1115 of the Social Security Act gives the states the right to petition the Secretary of Health and Human Services to modify Medicaid and related services to improve programs, expand eligibility or increase services. A new 1115 Demonstration Waiver has been negotiated between HHS and the Oregon Health Authority which will provide continuous eligibility to children under six receiving Medicaid and CHIP and provide two-year eligibility to most eligibility groups over age six. These changes have been built into the current forecast, and most effects will be felt in the 2025-27 biennium due to the overarching effects of the Interim Period redetermination plan. But any change of this type, involving the majority of those being covered by Medicaid, represents a significant risk to forecast accuracy.

Additional Risks

As throughout the Public Health Emergency, there are large risks associated with this forecast. Although we have some data on the nature of the Unwinding period and its effects on the caseload, the pause of three months and re-start of the mass-redetermination plan have heightened risk to accuracy. The assumptions of how the pause will influence the caseload was based on the best information available at the time, and the early experience of this Unwinding period is that things can and often do change between when plans are made and when they are executed.

As has already been stated elsewhere in the document, the outreach to clients and the extended period to return Requests for Information contained in HB 4035 have worked to keep people on the caseload. Patterns of exit and transfer that have been experienced early in the PHEU are being modeled in this forecast through to the end of the Unwinding period. However, those patterns could change if certain kinds of cases being processed at the end of the Unwinding are more or less likely to close than other types of cases processed earlier.

In past forecasts, an "overhang" period of additional cases redetermined in large quantities was specified after the last month of the Unwinding. This additional period would lead to closes and transfers because of large numbers of pended cases or those picked up in the system late as untargeted and in need of attention. Because the "pause" in redeterminations allows the system to reset, and workers to improve processes, no "overhang" period is modeled. But additional months of mass-redetermination after the last month in the plan is still possible.

"Churn" off and then back onto the caseload for those who inadvertently lose coverage was modest during the PHE, given how few closes there were. As people exit the caseload during the Unwinding, churn will increase the intake rate. Although this is accounted for in the current model, it could be greater or less than anticipated.

The "Continuous Eligibility" plan in the 1115 waiver will also influence exits and the "churn" of cases as people whose cases were closed re-enter. The longer period between redetermination (two years for most non-disabled people, longer for children under six) will obviously reduce exits but could be offset by a reduction in "churn," reducing enters. Continuous Eligibility also requires cases to remain in a higher-benefit group during their two years of continuous eligibility, even if a condition is detected that would move them into a lower-benefit group. That will reduce transfers. This will probably most influence the movement of cases from full OHP to dual and part-dual eligibility groups where benefit costs are shared between Medicare and Medicaid. The rate that this will be experienced remains unknown.

There are other potential risks that are known but are not related to the assumptions built into the forecast. These include:

- The possibility that OHA could change the mechanisms built into the Unwinding Period. These could include changes to the review order, changes in the number of cases that can be processed in a month, and the possibility that the state could complete the full mass-redetermination process early or later than specified.
- Changes to caseload dynamics related to the conversion to Integrated Eligibility (IE). The IE system has modified case processing and the way the "rules engine" calculates eligibility – most notably, around cases in disability categories. However, IE has not been used for routine redeterminations of means-tested cases before – it was rolled out during the Public Health Emergency, when those types of redeterminations were not being done.
- Changes to underlying household economics since the start of the pandemic. It has been noted that there has been a good deal of movement between higher income coverage and lower income coverage groups as mass-redeterminations commenced. This has been apparent in transfers to and from Children's Medicaid and CHIP and in movements between Parent Caretaker Relative and ACA Adults. Household income has not been systematically examined between March 2020 and April 2023. It is possible that more cases will transfer to higher or lower income categories than expected.

- The possibility of a recession. The State Economist is embracing the idea of a "soft landing" to the recent pattern of inflation and rate hikes undertaken by the Federal Reserve Open Market Committee. In that scenario, inflation is tamed without tipping the country into a recession. But a recession, with mass layoffs in the service sector, is still possible. This would, based on history, lead to increases in enrollment and movement of existing clients from higher-income groups to lower-income groups.
- After the end of the interim review period cases will be assigned a new eligibility determination month to spread out the workload of future redeterminations, which may change renewal, transfer, and exit patterns in the 2025-27 biennium.

Health Systems Medicaid Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
HEALTH SYSTEMS - MEDICAID								
OHP								
Children's Medicaid	306,001	313,478	7,477	2.4%	313,478	301,982	-11,496	-3.7%
Children's Health Insurance Program	113,896	136,952	23,056	20.2%	136,952	124,150	-12,803	-9.3%
Foster, Substitute and Adoption Care	16,666	16,446	-221	-1.3%	16,446	16,098	-348	-2.1%
Aid to the Blind and Disabled	95,879	93,867	-2,012	-2.1%	93,867	93,407	-460	-0.5%
Old Age Assistance	71,757	80,327	8,570	11.9%	80,327	77,694	-2,633	-3.3%
Pregnant Women	15,576	16,172	596	3.8%	16,172	14,091	-2,080	-12.9%
Parent, Caretaker Relative	100,774	98,807	-1,967	-2.0%	98,807	94,910	-3,897	-3.9%
ACA Adults	492,023	529,045	37,022	7.5%	529,045	462,197	-66,848	-12.6%
Breast and Cervical Cancer Treatment Program	155	149	-6	-4.1%	149	171	23	15.2%
Healthier Oregon - Child	8,984	12,076	3,092	34.4%	12,076	16,229	4,153	34.4%
Healthier Oregon - Pregnant	3,453	3,703	250	7.2%	3,703	3,648	-55	-1.5%
Healthier Oregon - Adult	52,451	70,471	18,020	34.4%	70,471	79,666	9,195	13.0%
Total OHP	**1,277,615**	**1,371,491**	**93,876**	**7.3%**	**1,371,491**	**1,284,243**	**-87,248**	**-6.4%**
Qualified Medicare Beneficiary	32,668	26,356	-6,312	-19.3%	26,356	29,756	3,400	12.9%
Total Medicaid	**1,310,283**	**1,397,848**	**87,565**	**6.7%**	**1,397,848**	**1,313,999**	**-83,848**	**-6.0%**
Temporary Medicaid Expansion/Basic Health Plan*		41,376			41,376	90,645	49,269	119.1%
Medicare Part A	7,885	7,360	-525	-6.7%	7,360	7,421	62	0.8%
Medicare Part B	165,763	165,295	-468	-0.3%	165,295	170,436	5,141	3.1%

*The temporary expansion of Medicaid will roll into the Basic Health Plan on July 1 2024.

Mental Health (MH)

This forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires that Mandated populations, including criminally and civilly committed patients, receive mental health services. There are three Mandated populations: (1) Aid and Assist; (2) Psychiatric Security Review Board (PSRB); and (3) Civilly Committed. The Non-Mandated populations include two groups: (1) Previously Committed individuals; and (2) Never Committed individuals.

Mandated mental health services are provided through community programs, including residential care and the Oregon State Hospital system. Non-Mandated services are primarily provided in community outpatient settings. Community programs provide outpatient services including intervention, therapy, case management, crisis, and pre-commitment services. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

Total Mandated Mental Health Services

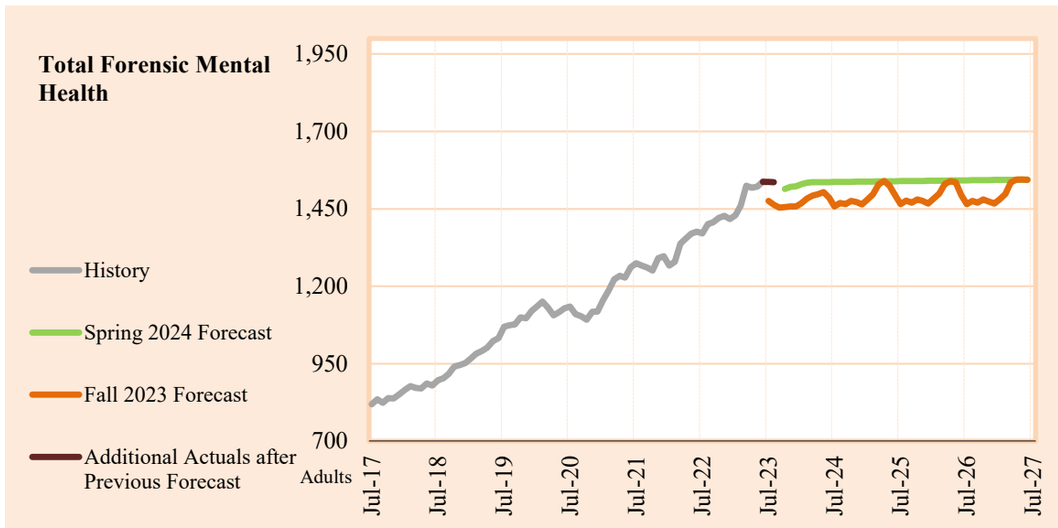
The mandated caseload encompasses the committed caseload (Aid and Assist, PSRB, and Civilly Committed clients). As with all MH categories forecasted in this report, the Mandated population includes only adults.

The Total Mandated Mental Health caseload for the 2023-25 biennium is expected to average 2,308 clients per month. The 2025-27 biennial monthly average is expected to be 2,305 clients, which is 0.1 percent lower than the 2023-25 biennial average.

Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and PSRB clients.

The Forensic Mental Health Services biennial average forecast for 2023-25 is 1,535 clients per month. The 2025-27 biennial monthly average is expected to be 1,542 clients, 0.5 percent higher than the 2023-25 biennial average.

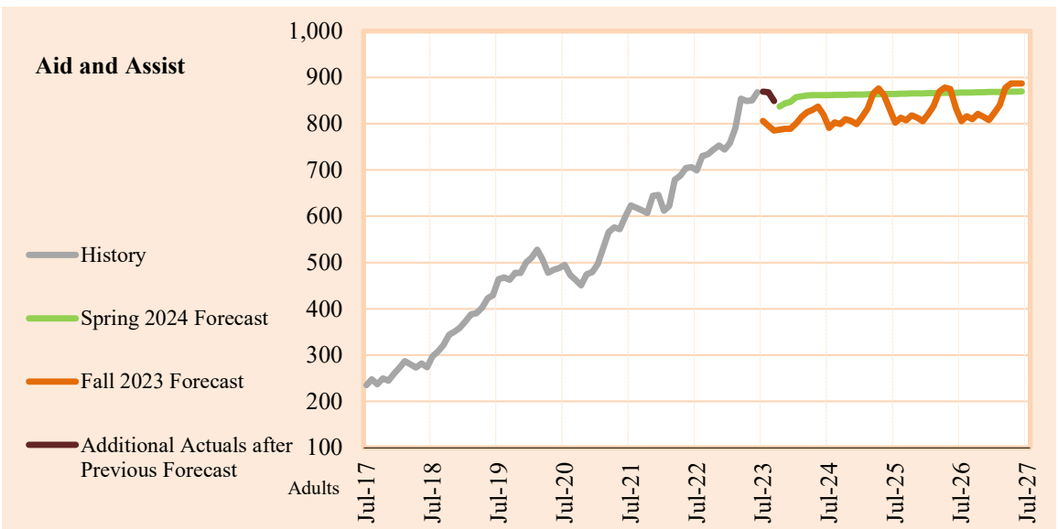


Aid and Assist – This caseload encompasses both Community Restoration Aid and Assist (CRAA) as well as State Hospital Aid and Assist. The Aid and Assist caseload have been growing steadily. Between November 2021 and November 2023, the total Aid and Assist caseload increased 31 percent.

Collection of CRAA data began in 2018, as self-report data from Community Mental Health Programs. Data are submitted quarterly and are due 45 days after the quarter ends. However, at the time of the Spring 2024 forecast, data were only complete through the end of 2022. The CRAA caseload averaged 184 clients per month in 2021 and 256 clients per month in 2022.

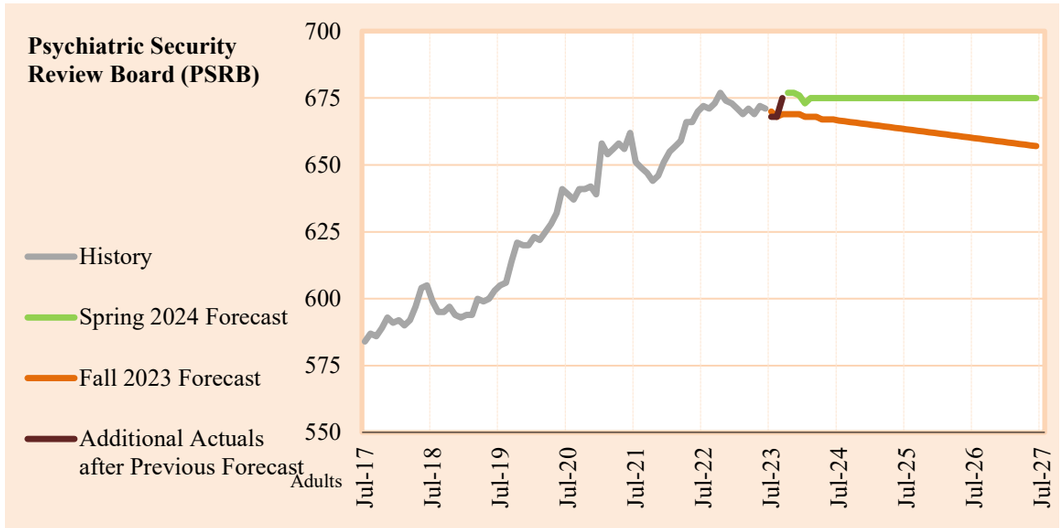
The Aid and Assist caseload at the State Hospital has been growing since 2013. Beginning in September 2022, a federal court order-imposed time limits for patients at the State Hospital which resulted in more patients cycling through each month. Increases in number served are due in part to this federal order. However, in 2023 orders for Aid and Assist fell. Whereas earlier in 2023 the Aid and Assist caseload at the State Hospital was around 500 clients, as of November 2023 the monthly count was 475.

The forecast for Aid and Assist for the 2023-25 biennium averages 860 clients per month. The 2025-27 biennial average is expected to be 867 clients per month, which is 0.8 percent higher than the 2023-25 biennial average.



Psychiatric Security Review Panel (PSRB) – These clients are under the jurisdiction of the Psychiatric Security Review Board, and caseloads are influenced by decisions made by members of the Board. Between mid-2019 and mid-2022, the PSRB caseload exhibited slow and steady growth. The caseload went from 614 in September 2019 to 673 in September 2022, an increase of 9.6 percent. For the last year, throughout 2023, the caseload remained flat, and in January 2024 the caseload was also 673.

The 2023-25 biennial average forecast for PSRB is 675 cases per month. The 2025-27 biennial average is expected to be unchanged from the 2023-25 biennial average.

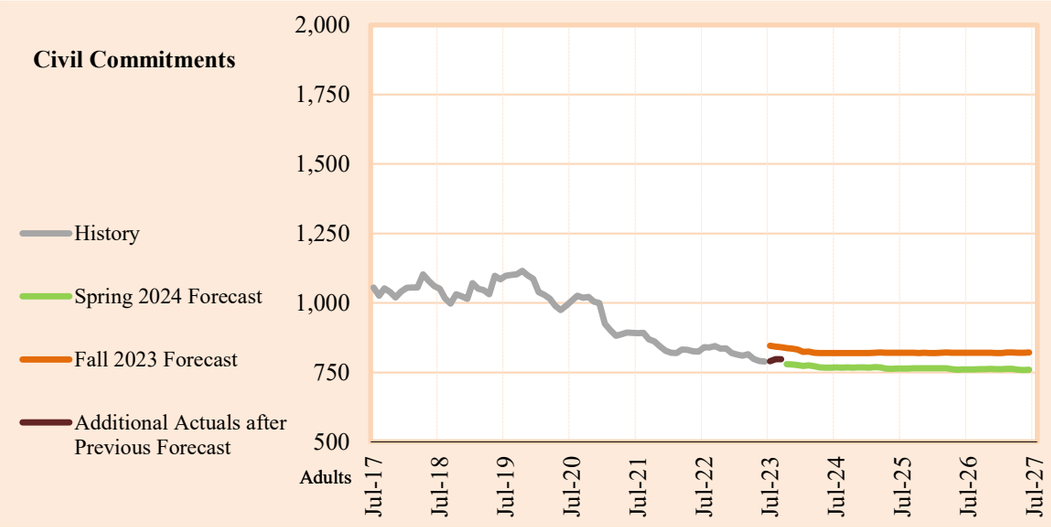


Civil Commitments

The data for this caseload are subject to the interaction of reporting practices, data system changes, and data warehouse activities. There has been ongoing work to improve data accuracy. Coincident with the expansion of Medicaid, such that more adults were eligible for health insurance, the caseload has been declining, almost continuously each month, from early 2014 up to the most recent month of finalized data.

The Civil Commitment forecast for the 2023-25 biennium shows an average of 773 clients per month. The 2025-27 biennial monthly

average is 763 clients, 1.3 percent lower than the 2023-25 biennial average.

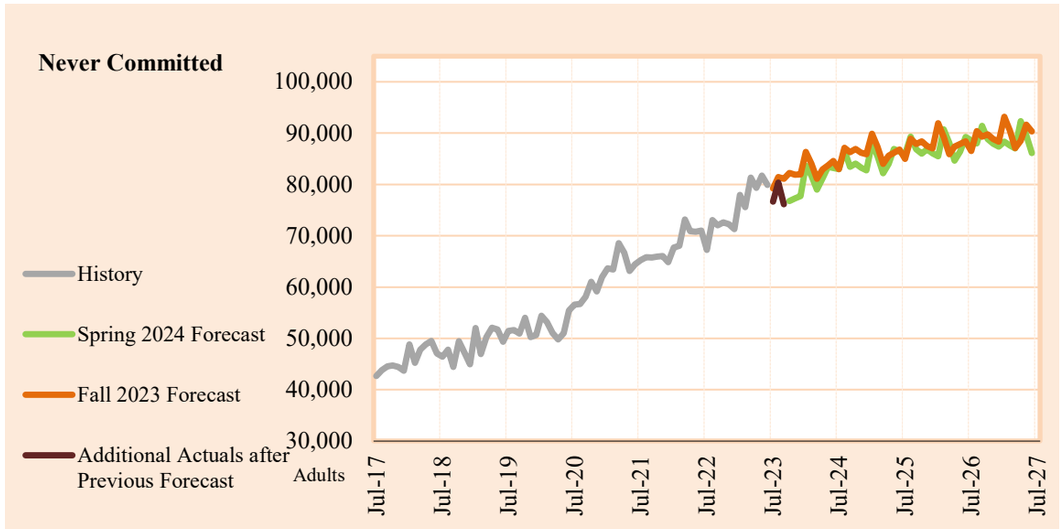


Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000. About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. With this Spring 2024 forecast cycle, the data are shifted up. This was not a natural increase in the caseload, but because of a data server change and a change in the way the business rules that generate the Previously Committed caseload were implemented.

The 2023-25 **Previously Committed biennial average caseload forecast** is 4,146 clients per month. The 2025-27 biennial monthly average is 4,157 clients, 0.3 percent higher than the 2023-25 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings.

The 2023-25 **Never Committed biennial average caseload forecast** is 82,219 clients per month. The 2025-27 biennial monthly average is 87,863 clients, 6.9 percent higher than the 2023-27 biennial average.



Forecast Environment and Risks

The Community Restoration Aid and Assist caseload is dependent upon complete data submission from the counties. Incomplete or revised data submissions are possible, adding to the amount of time necessary to finalize data and produce timely forecasts. The Aid and Assist caseload are also subject to variation at the county level. Recently, in Marion and Lane counties, crisis aversion groups have played a role in preventing people from being arrested. Differences in decision-making from one jurisdiction to another by law enforcement and the judiciary can affect who is referred to the Aid and Assist caseload.

The Psychiatric Security Review Board was created in 1978 as its own agency. It is a quasi-judicial entity that does not work with clients or provide clinical services but is an oversight body for everyone placed under its jurisdiction. The status of cases in the Psychiatric Security Review Board caseload are subject to review by the Board. In some cases, clients are released from jurisdiction early. Some clients on the PSRB have a charge that would be considered a violent felony, but they have not been found to be guilty except for insanity. A growing number of these PSRB clients started as Civilly Committed. Sometimes a person enters the State Hospital under one category and changes status during their time there.

A risk to the Civilly Committed caseload is related to the timeliness of reporting. Provider input delays, especially concerning civil commitment data, can lead to artificially low caseload numbers. The Civilly Committed population at the State Hospital was affected by the pandemic more than any other caseload. The Civilly Committed population at the State Hospital was also affected by laws requiring timely admission for criminally committed patients. However, in May 2023 Judge Mosman issued an amendment to his earlier order, resulting in more civilly committed patients being admitted to the State Hospital. Staffing shortages are a concern, and the Oregon State Hospital system is capacity constrained. Changes to court orders influencing the operation of the State Hospital are an ongoing risk to forecast accuracy.

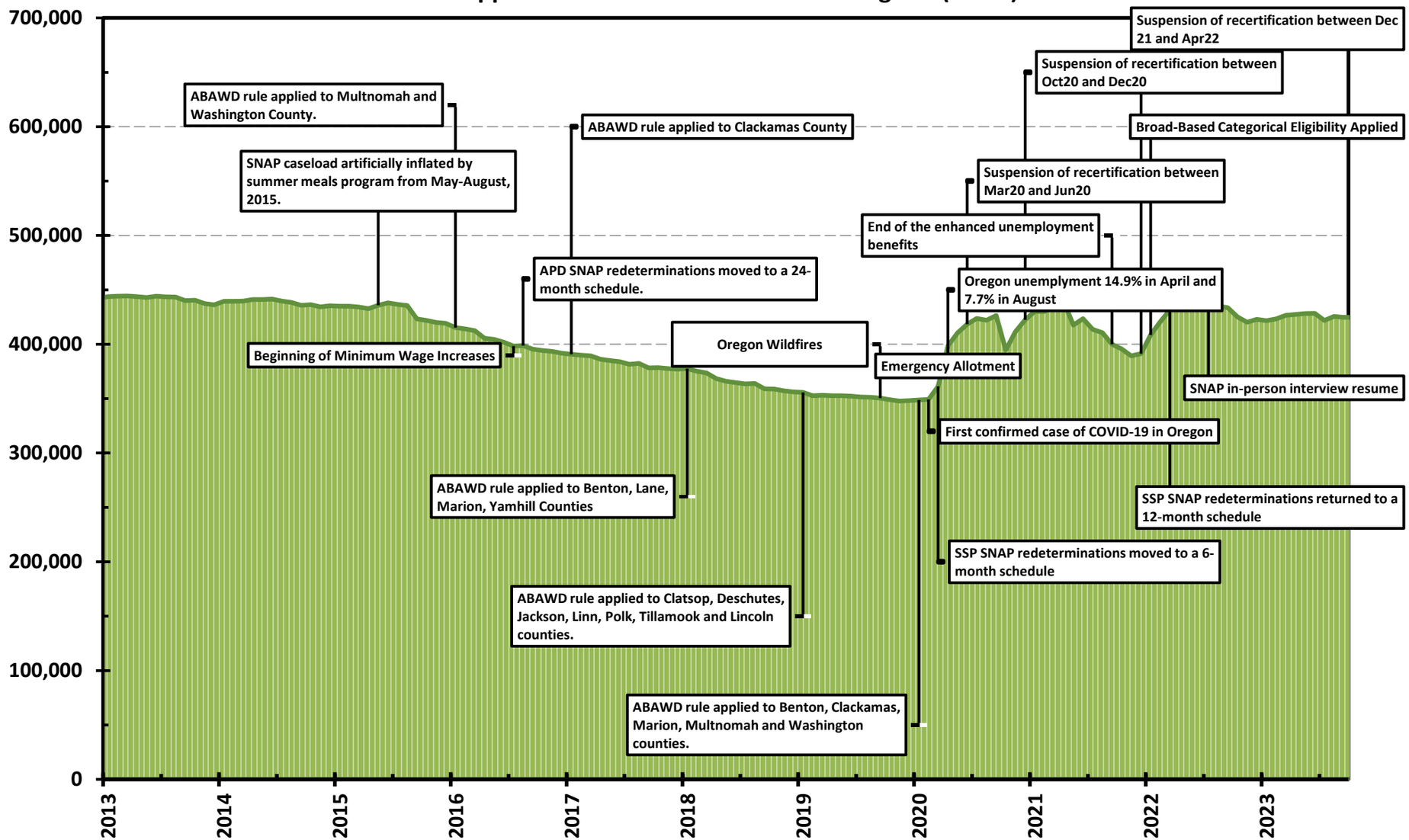
Mental Health Biennial Average Forecast Comparison

	2023-25 Biennium			*% Change Between Forecasts*	Spring 2024 Forecast			*% Change Between Biennia*
	Fall 23 Forecast	**Spring 24 Forecast**	**Change**		**2023-25**	**2025-27**	**Change**	
MENTAL HEALTH [1]								
Under Commitment								
Community Restoration Aid and Assist[2]	346	439	93	26.9%	439	448	9	2.1%
State Hospital Aid and Assist	511	478	-33	-6.5%	478	482	4	0.8%
Total Aid and Assist (State Hospital and Community Restoration)[3]	**815**	**860**	**45**	**5.5%**	**860**	**867**	**7**	**0.8%**
Psychiatric Security Review Board	667	675	8	1.2%	675	675	0	0.0%
Total Forensic Care	**1,482**	**1,535**	**53**	**3.6%**	**1,535**	**1,542**	**7**	**0.5%**
Civilly Committed	825	773	-52	-6.3%	773	763	-10	-1.3%
Total Mandated Mental Health Services	**2,307**	**2,308**	**1**	0.0%	**2,308**	**2,305**	**-3**	**-0.1%**
Previously Committed	3,120	4,146	1,026	32.9%	4,146	4,157	11	0.3%
Never Committed	84,396	82,219	-2,177	-2.6%	82,219	87,863	5,644	6.9%
Total Served	**89,823**	**88,673**	**-1,150**	**-1.3%**	**88,673**	**94,325**	**5,652**	**6.4%**

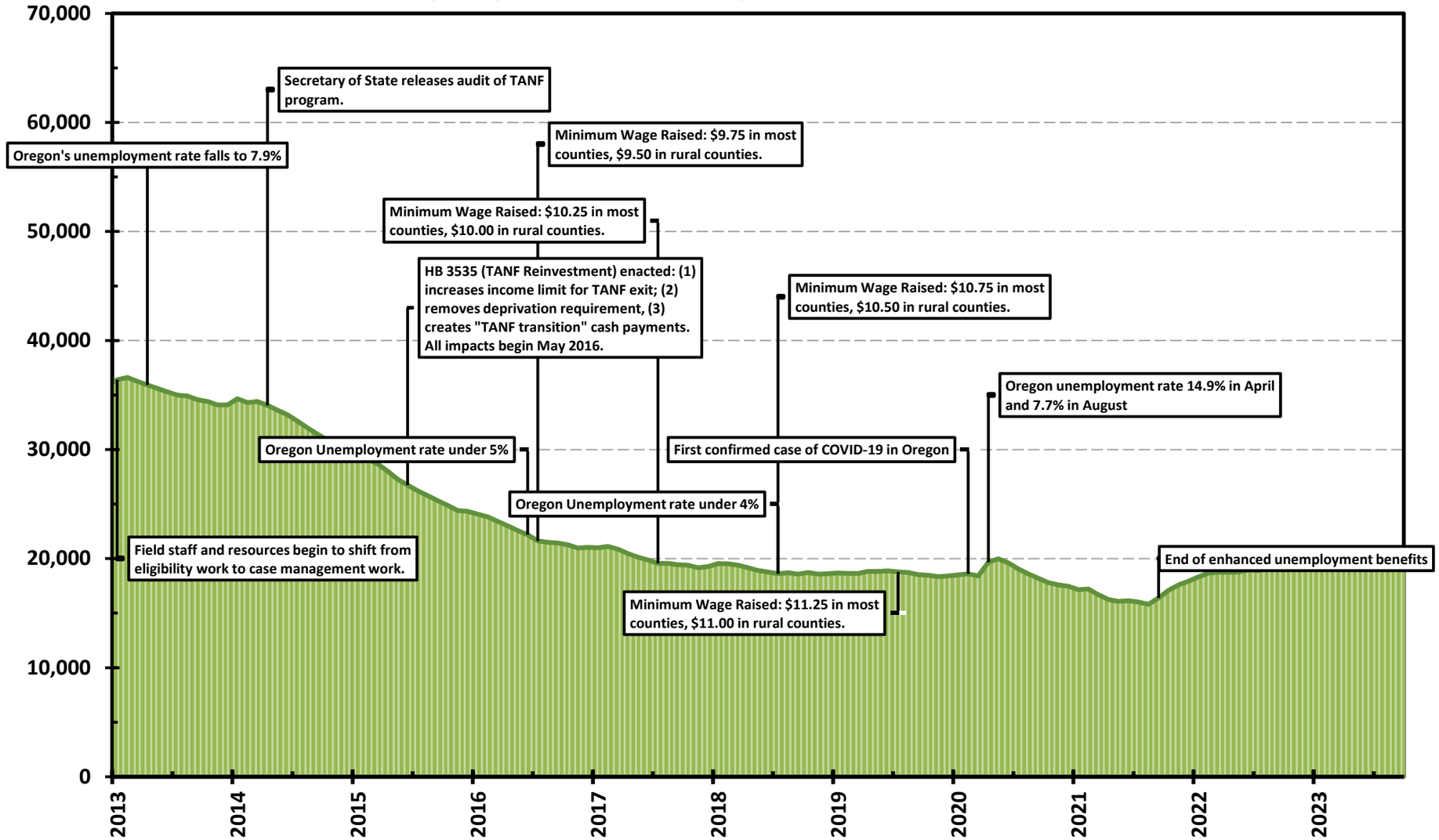
1. Numbers reported represent adults only.
2. These data are self report data from the County Mental Health Programs (CMHPs), and the data are submitted quarterly.
3. There is some overlap between Community Restoration and State Hospital Aid and Assist.

Appendix I
Oregon Department of Human Services – Caseload History and Definitions

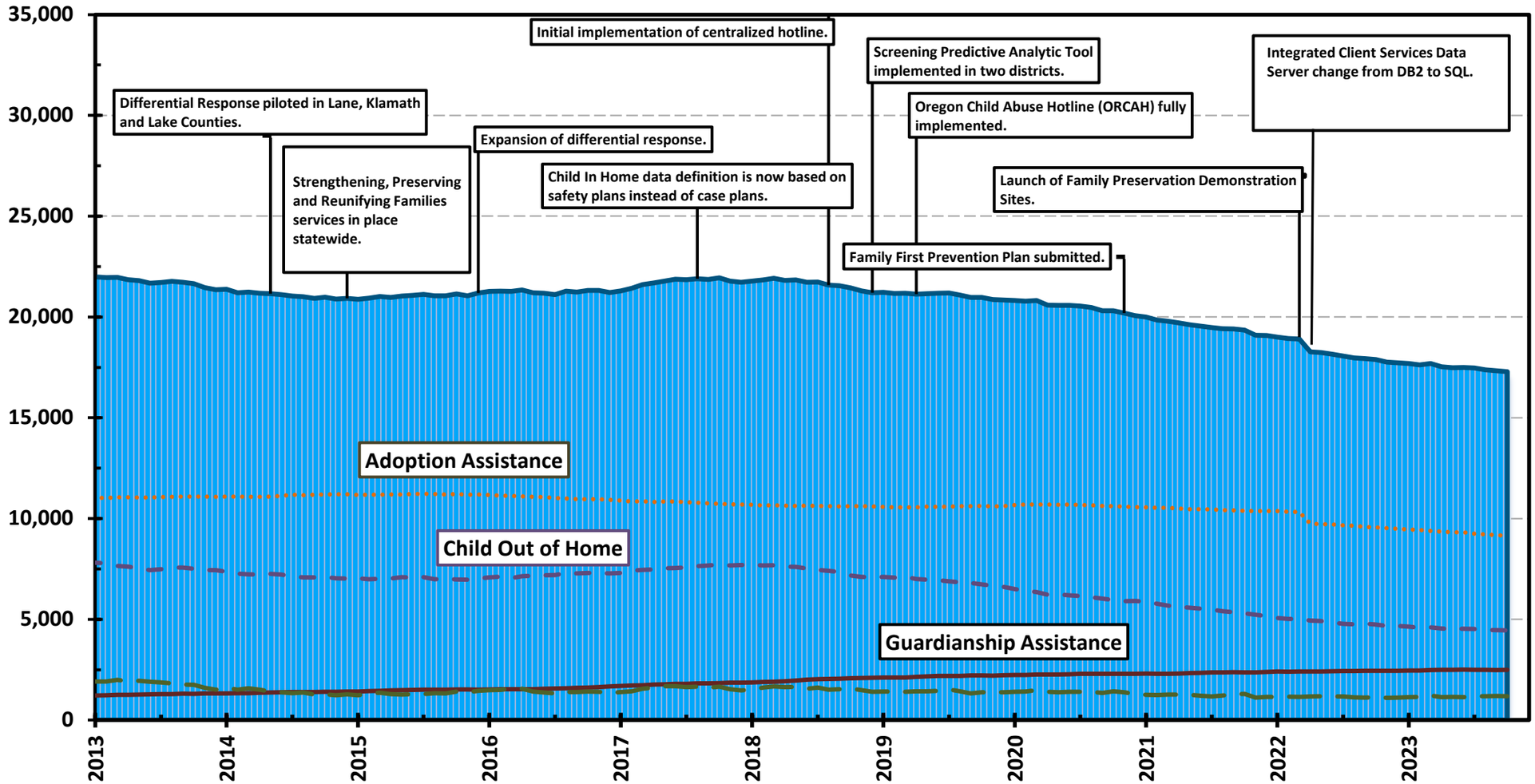
Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload



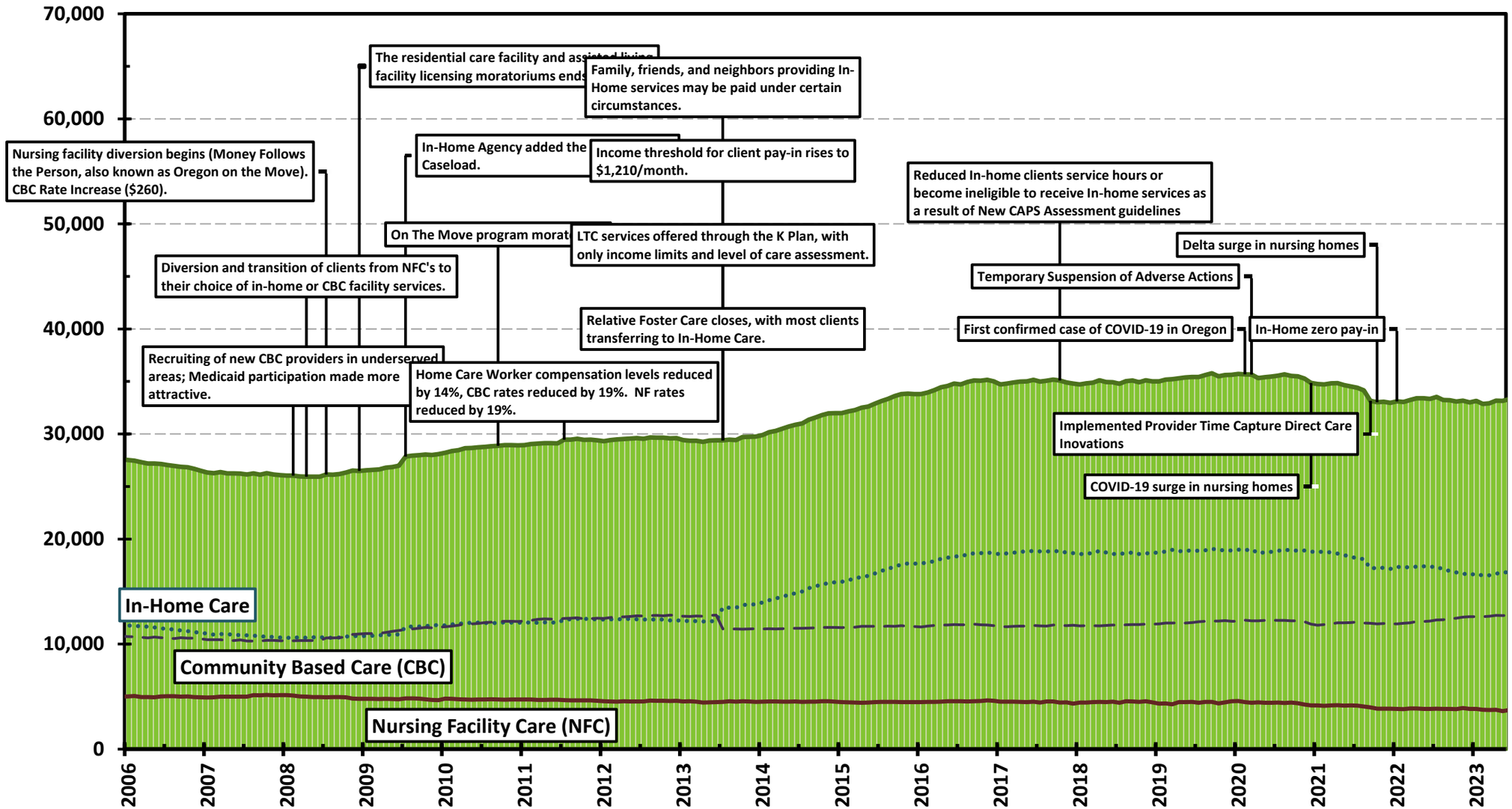
Self Sufficiency Programs:
Temporary Assistance for Needy Families (TANF) Caseload

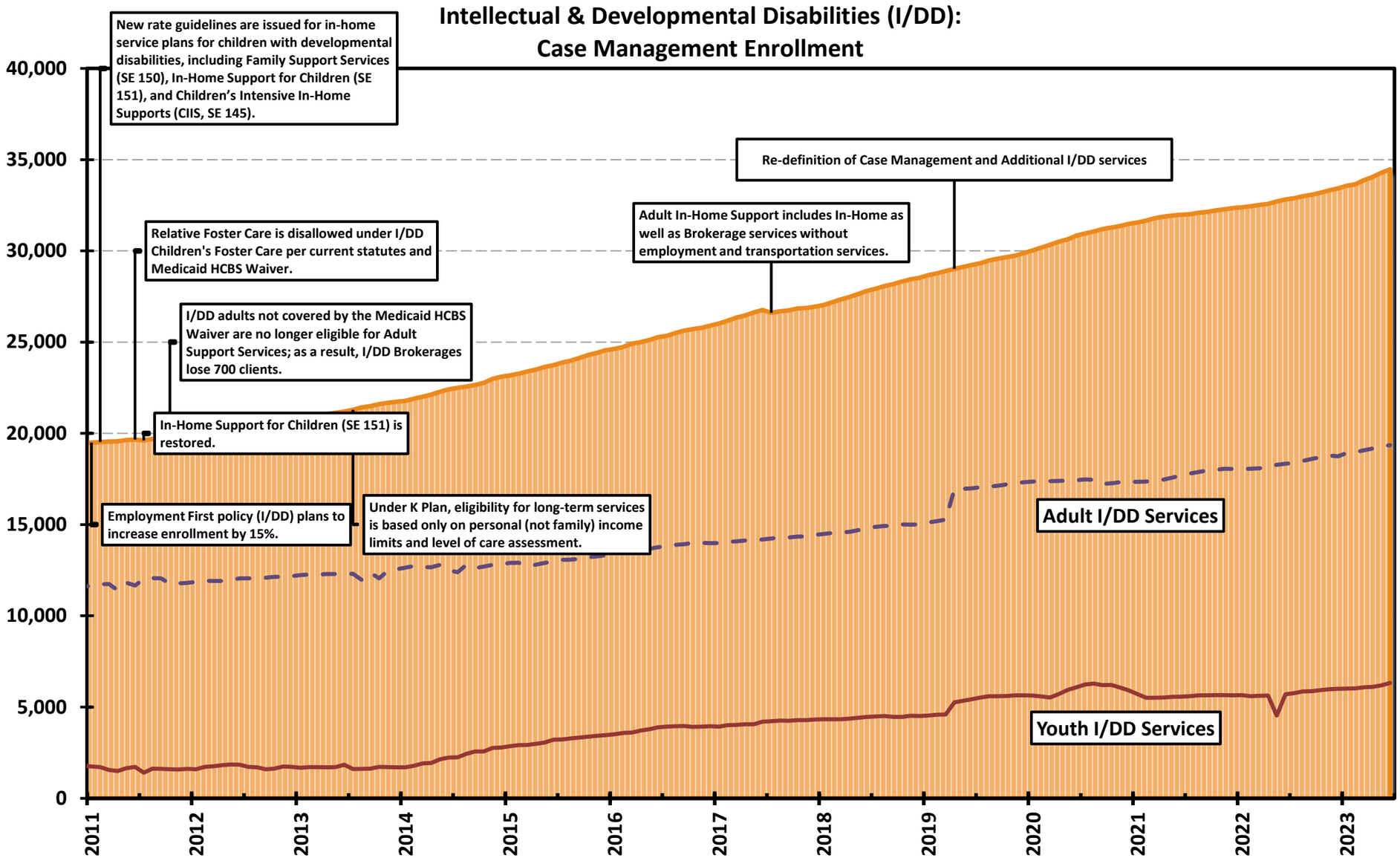


Child Welfare (CW) Caseload

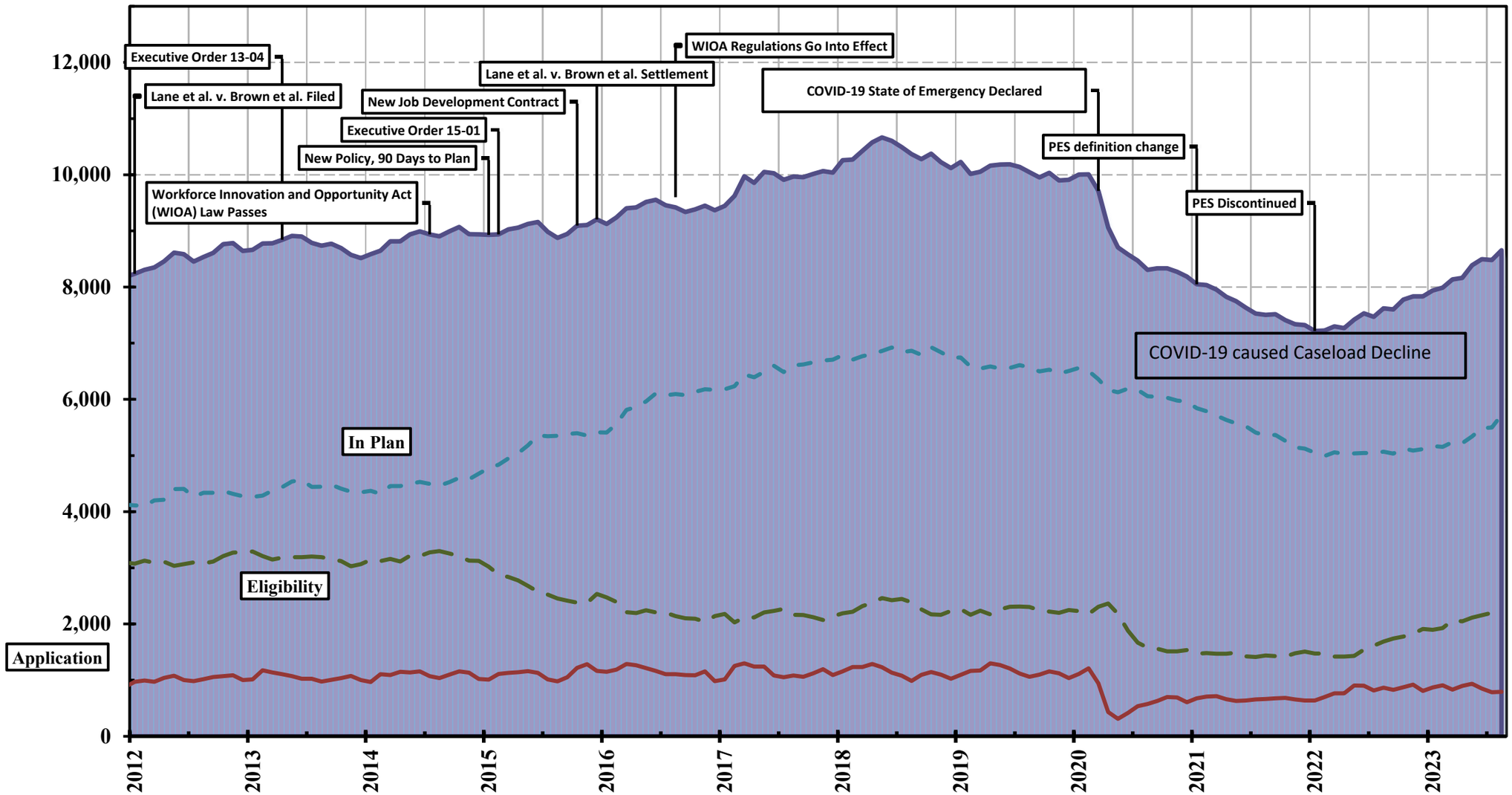


Aging and People with Disabilities (APD) Caseload




Intellectual & Developmental Disabilities (I/DD):
Case Management Enrollment
New rate guidelines are issued for in-home service plans for children with developmental disabilities, including Family Support Services (SE 150), In-Home Support for Children (SE 151), and Children's Intensive In-Home Supports (CIIS, SE 145).
Re-definition of Case Management and Additional I/DD services
Adult In-Home Support includes In-Home as well as Brokerage services without employment and transportation services.
Relative Foster Care is disallowed under I/DD Children's Foster Care per current statutes and Medicaid HCBS Waiver.
I/DD adults not covered by the Medicaid HCBS Waiver are no longer eligible for Adult Support Services; as a result, I/DD Brokerages lose 700 clients.
In-Home Support for Children (SE 151) is restored.
Employment First policy (I/DD) plans to increase enrollment by 15%.
Under K Plan, eligibility for long-term services is based only on personal (not family) income limits and level of care assessment.
Adult I/DD Services
Youth I/DD Services
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023

Vocational Rehabilitation



ODHS Caseload Definitions

Federal Poverty Level (FPL)

"The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL."[2]

2024 Poverty Guidelines: Annual Income (all states except Alaska and Hawaii)									
Household/ Family Size	**100%**	**125%**	**150%**	**175%**	**200%**	**225%**	**250%**	**275%**	**300%**
1	15,060.00	22,590.00	26,355.00	27,861.00	30,120.00	33,885.00	37,650.00	41,415.00	45,180.00
2	20,440.00	30,660.00	35,770.00	37,814.00	40,880.00	45,990.00	51,100.00	56,210.00	61,320.00
3	25,820.00	38,730.00	45,185.00	47,767.00	51,640.00	58,095.00	64,550.00	71,005.00	77,460.00
4	31,200.00	46,800.00	54,600.00	57,720.00	62,400.00	70,200.00	78,000.00	85,800.00	93,600.00
5	36,580.00	54,870.00	64,015.00	67,673.00	73,160.00	82,305.00	91,450.00	100,595.00	109,740.00
6	41,960.00	62,940.00	73,430.00	77,626.00	83,920.00	94,410.00	104,900.00	115,390.00	125,880.00
7	47,340.00	71,010.00	82,845.00	87,579.00	94,680.00	106,515.00	118,350.00	130,185.00	142,020.00
8	52,720.00	79,080.00	92,260.00	97,532.00	105,440.00	118,620.00	131,800.00	144,980.00	158,160.00

[2] For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs (SSP) aids with low-income families to help them become healthy, safe, and economically independent. Except for SNAP, SSP program caseloads count the number of families receiving program benefits within the month. In the SNAP program, caseloads count the number of households receiving the benefit within the month.

Supplemental Nutrition Assistance Program (SNAP)

SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food. To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum gross income limit is 130 percent of Federal Poverty (FPL).

Temporary Assistance for Needy Families (TANF) provides case management and cash assistance to very poor families with minor children. The goal of the program is to reduce the number of families living in poverty through employment services and community resources.

Recipients must meet basic TANF asset requirements (including a $2,500 - $10,000 resource limit and income less than 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for drug abuse or mental health as needed. Proof of deprivation (death, absence, incapacity, or unemployment of a parent) will no longer be a requirement of TANF enrollment.

TANF One-Parent used to be called TANF Basic, when it included one-parent families and two-parent families where at least one parent is disabled and unable to care for children. TANF One-Parent now contains only one-parent families.

TANF Two-Parent Used to be called TANF UN, when it included only two-parent families that did not have at least one parent who was disabled and unable to care for children. It now includes families where both parents can care for their children, or one parent is able to care for the children and the other is disabled.

State Family Pre-SSI (SFPSS) program provides cash assistance, case management, and professional level support to TANF eligible adults and their family in pursuing Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). To be eligible for Pre-SSI, the adult must be found eligible for a TANF grant and must have a severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

Broad-Based Categorical Eligibility (BBCE) enables states to raise income and asset limits to quality certain low-income households such as households/families receiving SNAP, TANF, SSI, or other general assistance. Also, BBCE permits states adopt less restrictive asset tests for households including elderly (60+) or disabled persons. Beginning of January 1st, 2022, households less below 200 percent of FPL qualify for SNAP based on BBCE, revised from 185 percent.

Temporary Assistance to Domestic Violence Survivors (TA-DVS) supports domestic violence survivors by providing temporary financial assistance to flee domestic violence. TA-DVS payments can be issued to meet the family's needs for shelter, food, medical care, relocation, stabilization, or to promote safety or independence from the abuser.

To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (40 percent of FPL; TA-DVS only considers income on hand that is available to meet emergency needs).

Child Welfare (CW)

Child Welfare programs oversee the safety of children who have been abused or neglected. The Child Protective Services (CPS) program investigates reports of child abuse or neglect. If abuse or neglect is founded, caseworkers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child can be counted only once during a month, and if there is participation in more than one of the programs listed below, they are counted in only one group. The groups are listed below in order of this counting priority.

Adoption Assistance coordinates and supervises adoption for children in foster care who cannot return safely to the care of their biological parents. Adoption Assistance services can include financial and/or medical help with the costs associated with the adoptive child's needs.

Guardianship Assistance helps remove financial barriers for individuals who provide a permanent home for children who would otherwise be in Foster Care. Guardianship allows an alternative plan to adoption. Guardianship Assistance services can include financial support for costs associated with the needs of the child (like a Foster Care payment).

Out of Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed with relatives, foster families, or in residential treatment care settings. The program aims to reunite children with their parents. Out of Home Care services can include financial support and/or medical help for costs associated with the child's needs.

Child In-Home Services provide support and safety monitoring services to prevent placement of children in Foster Care and to support reunification with parents after Foster Care. Caseworkers oversee services and monitor in-home safety plans for children. In-Home Services can include financial support for costs associated with the safety, permanence, and well-being of children. More families are now being served In Home due to the Family First Prevention Services Act. Prevention activities include mental health services, substance abuse prevention and treatment, and parenting programs.

Aging and People with Disabilities (APD)

Aging and People with Disabilities programs provide Long-Term Care (LTC) services to qualifying people who, due to their age or disabilities, need help with their activities of daily living (ADL), including eating, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder management, and cognition.

Area Agencies on Aging (AAA) and ODHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility. To qualify, clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under K-Plan or the HCBS Waiver.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver (under the Omnibus Budget Reconciliation Act of 1981), which allows the State to provide home and community-based care alternatives to institutional care such as nursing facilities.

Starting in July 2013, using a new option available under the Patient Protection and Affordable Care Act of 2010 (ACA), Oregon began offering services primarily through the Social Security Act's 1915 (k) Community First Choice Option (referred to as K-Plan).

The LTC caseloads are grouped into three major categories: In-Home, Community-Based Care, and Nursing Facilities.

In-Home Programs

In-Home programs provide personal services that help people stay in their homes when they need assistance with Activities of Daily Living (ADL).

In-Home Hourly caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks.

In-Home Agency is an alternative way to purchase in-home care. Under this program, client's contract with an agency for the services they need, and those services are delivered in the client's own home by an employee of the agency. Screening and scheduling are often simpler when working with an agency.

Live-In caseload includes clients who hire a live-in home care worker to provide 24-hour care. This service is closed as of October 2017.

Spousal Pay caseload includes clients who choose to have their paid care provided by their spouse. Spouses are paid for the services they provide.

Independent Choices allows clients more control in the way they receive their in-home services. Under this program, clients decide for themselves which services they will purchase, but are also required to keep financial records of the services they have purchased.

Specialized Living provides care in a home-like setting for clients with specialized needs (such as quadriplegics or clients with acquired brain injuries). These clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or be served in other Community-Based Care facilities.

State Plan Personal Care (Non-K-Plan Medicaid Services) are available to people who are eligible for Medicaid, but not eligible for waivered services. Services supplement the individual's own personal abilities and resources but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community-Based Care (CBC)

Community-Based Care caseload includes clients receiving services in licensed, community-based residential settings. Services include assistance with ADL, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

Assisted Living Facilities are licensed 24-hour care settings serving six or more residents that provide private apartments and focus on resident independence and choice.

Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people. These facilities are open to clients who are not related to the care provider.

Residential Care Facilities are licensed 24-hour care settings serving six or more residents. These facilities range in size from six beds to over 100. “Contract” facilities are licensed to provide specialized Alzheimer care.

Program of All-Inclusive Care for the Elderly (PACE) is a capitated Medicare/Medicaid program providing all-inclusive care. Seniors served in this program live in a variety of care settings. PACE is responsible for coordinating their clients’ acute health and long-term care needs.

Nursing Facilities (NFC)

Nursing Facilities provide institutional services for seniors and people with disabilities in facilities licensed and regulated by ODHS. Nursing facilities provide clients with skilled nursing services, housing, related services, and ongoing assistance with activities of daily living.

Basic Care clients need comprehensive, 24-hour care for assistance with ADL and ongoing nursing care due to either age or physical disability.

Complex Medical Add-On clients have medical conditions that require additional nursing services and staff assistance beyond Basic Care.

Enhanced Care clients have difficulty managing behavioral issues such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs that require special care in Nursing Facilities. Some of these clients are also served in community-based care facilities.

Pediatric Care clients are children under 21 who receive nursing care in pediatric nursing facility units.

Healthier Oregon Program (HOP), formerly known as Health Care for All Oregon began on July 1, 2022. It expands eligibility for disability services to Oregonians who would qualify for Medicaid-funded state medical assistance programs but for their immigration status. Initial enrollment was restricted to all children and adults between ages 19-25 and 55 and older in the first year of the program. Starting July 1, 2023, all remaining adults became eligible.

Intellectual and Developmental Disabilities (I/DD)

Intellectual and Developmental Disabilities programs provide support to qualified adults and children with intellectual and developmental disabilities through a combination of case management and services. Intellectual and Developmental Disabilities include intellectual disabilities, cerebral palsy, Down's syndrome, autism, and other impairments of the brain that occur during childhood. Some people with developmental disabilities also have significant medical or mental health needs.

Adults with developmental disabilities may be eligible for services ranging from supports to help individuals live in their own homes to 24-hour comprehensive services. Twenty-four-hour services are provided in a variety of settings, including group homes and foster homes. Children with developmental disabilities may be eligible for services ranging from family support to out-of-home placements. Placements include foster homes or residential group home settings.

The forecasts for Intellectual and Developmental Disabilities programs are counts of individual clients receiving a program's services within the month. Clients can receive services from more than one program in the same month (for example, from both a residential and a support program).

Case Management Enrollment

Case Management Enrollment provides entry-level eligibility evaluation and coordination services. The other caseloads are grouped into three broad categories: adult services, children services, and other services.

Adult Services Include:

Brokerage Enrollment provides planning and coordination of services that allow clients to live in their own home or in their family's home.

24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes.

Supported Living provides individualized support services to clients in their own home based on their Individual Support Plan.

Adult In-Home Services help individuals aged 18 years or older with intellectual and developmental disabilities to continue to live in their homes. In-Home services can be accessed through CDDP or Brokerages.

I/DD Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 89 percent and 11 percent respectively).

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable I/DD clients facing intensive medical or behavioral challenges when no other community-based option is available to them. The program serves both adults and children (approximately 83 percent and 17 percent respectively).

Children's Services Include:

In-Home Support for Children (also called Long-Term Support) provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own homes. This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program, and Medically Involved Programs.

Children Residential Care provides 24-hour care, supervision, training, and support services to individuals under the age of 18 in neighborhood homes other than the family home or foster care.

Host Homes Host Homes are private, single family community homes that provide a safe and structured environment for children with intellectual or developmental disabilities. These homes are managed by an agency and licensed by the State of Oregon.

Other I/DD Services Include:

Employment and Day Support Activities are out-of-home employment or community training services and related supports provided to individuals 14 or older, to improve the individual's productivity, independence, and integration in the community. Examples of services covered within this caseload include discovery, employment path services, initial and on-going job coaching, individual and small group employment support, and certain types of employment related day support activities.

Transportation services include all non-medical transportation services provided under Plan of Care (e.g., transit passes and non-medical community transportation).

Nursing Services – Direct Nursing Services are shift-type services provided to provide adults with intellectual or developmental disabilities and complex health management support needs to live (them) as independently as possible in their home and community. The services are delivered by Medicaid enrolled nursing services providers.

Behavioral Services – Professional Behavior Services are positive behavior support services provided to assist I/DD clients with challenging behaviors delivered by a behavior professional.

Healthier Oregon Program (HOP) – formerly known as Health Care for All Oregon began on July 1, 2022. It expands eligibility for IDD related services to Oregonians who would qualify for Medicaid-funded state medical assistance programs but for their immigration status. Initial enrollment was restricted to all children and adults between ages 19-25 and 55 and older in the first year of the program. Starting July 1, 2023, all remaining adults became eligible.

Vocational Rehabilitation (VR)

Vocational Rehabilitation assesses, plans, and coordinates services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. VR Services are provided through local VR offices across the state. VR partners with community resources and local providers to deliver a wide range of services: counseling, training, job placement, assistive technology, and extended services and supports.

Total Vocational Rehabilitation

This caseload counts all clients who had an active VR episode at any time in the given month. It is the sum of clients In Application, In Eligibility, and In Plan.

In Application is a count of clients who were in the application stage on the last day of the month or exited VR during the given month without advancing to the next stage. VR case is initiated by the client submitting their application to VR. In this stage, the application is reviewed, and eligibility is assessed.

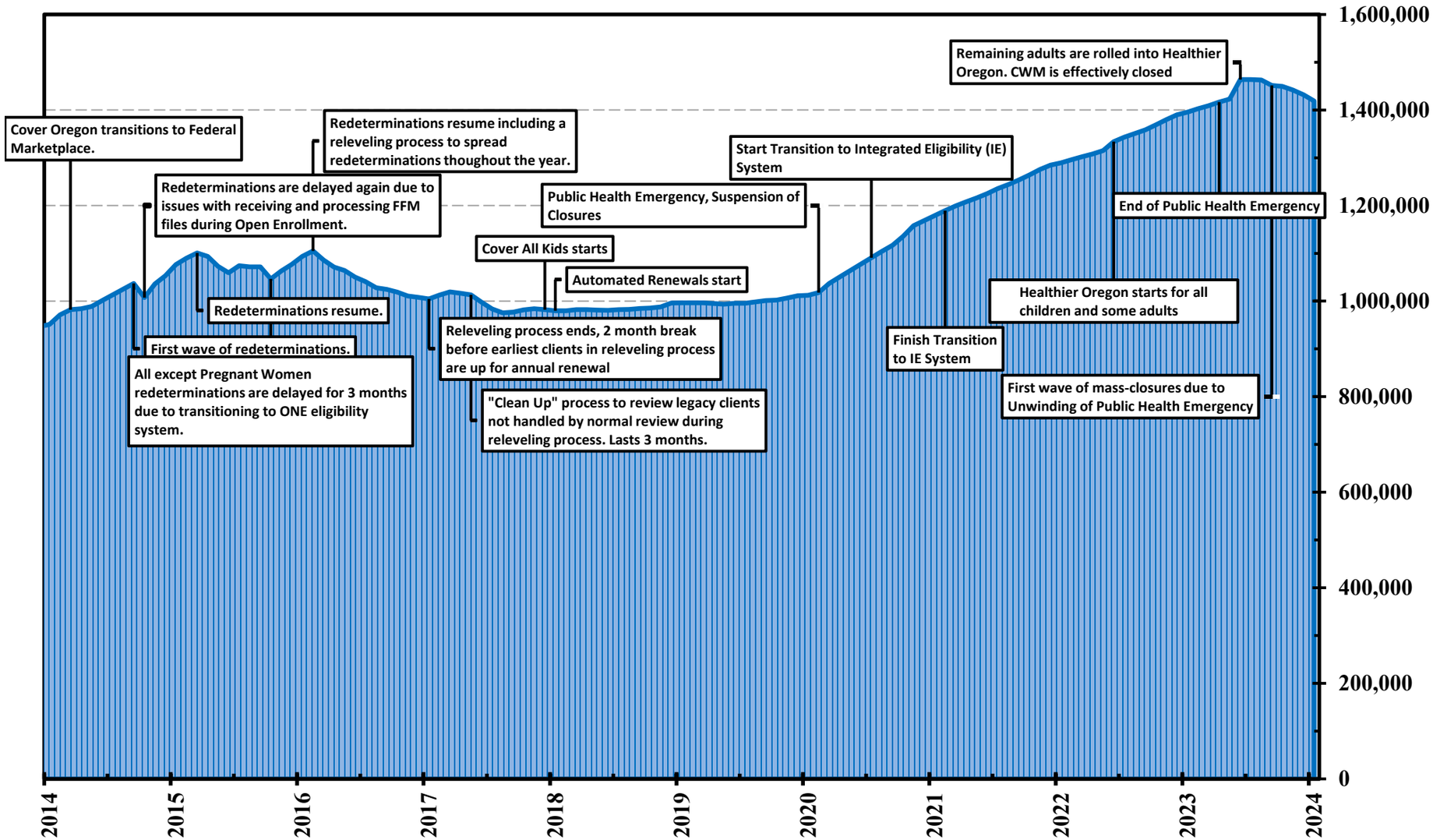
In Eligibility is a count of clients who were in the eligibility stage on the last day of the month or exited VR during the given month without advancing to the next stage. Typically, clients in this stage are either waiting for the final eligibility determination or are in the process of plan development.

In Plan is a count of clients who had an active plan at any time in each month. After employment, and if all is going well, a case is normally closed after 90 days.

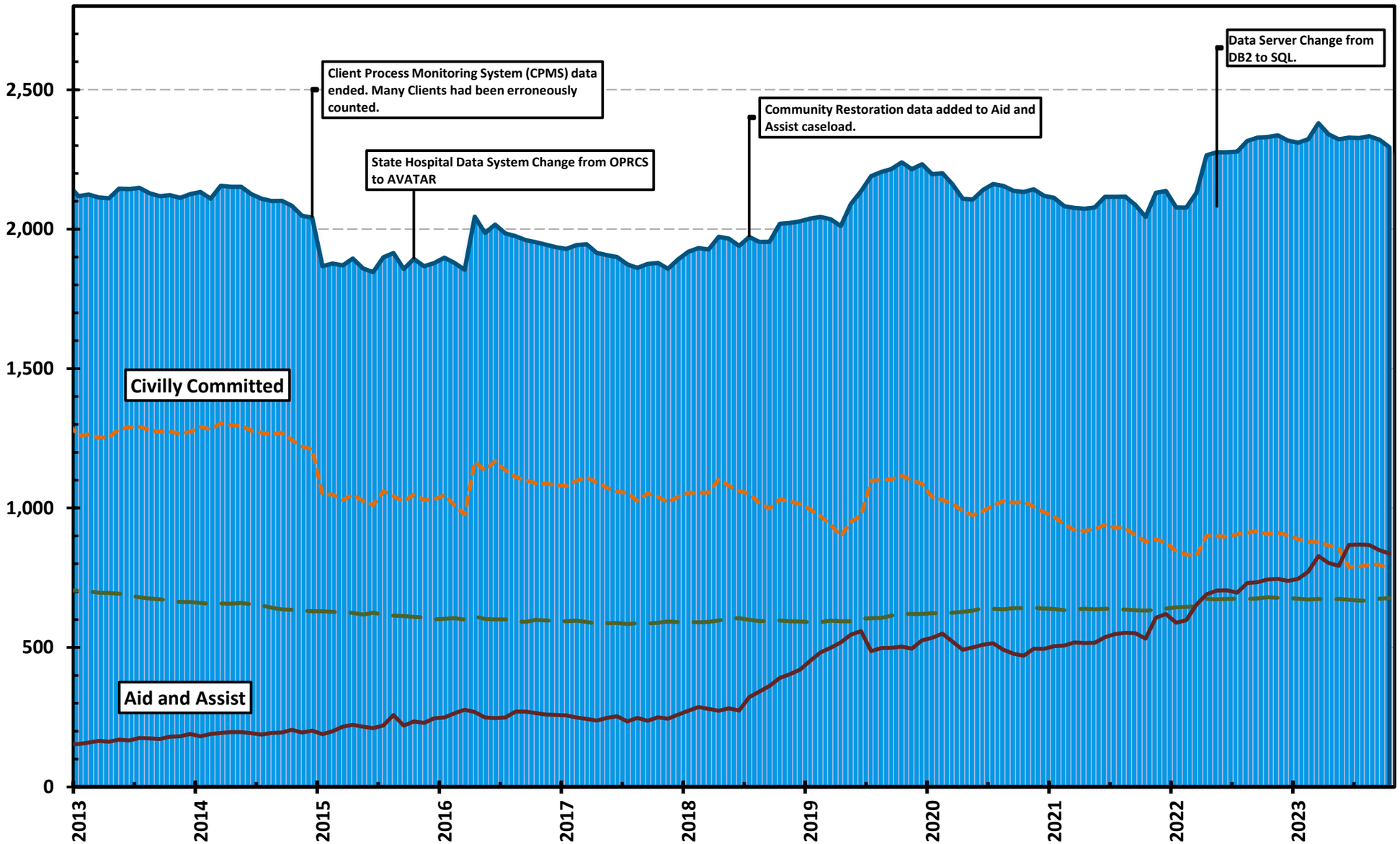
Healthier Oregon Program (HOP), formerly known as Health Care for All Oregon began on July 1, 2022. It expands eligibility for disability services to Oregonians who would qualify for Medicaid-funded state medical assistance programs but for their immigration status. Initial enrollment is restricted to all children and adults between ages 19-25 and 55 and older in the first year of the program. Starting July 1, 2023, all remaining adults will be eligible.

Appendix II
OHA Caseload History & Definitions

Health Systems - Medicaid, Total Oregon Health Plan



Mental Health (MH):
Total Mandated Mental Health Caseload (Adults)



OHA CASELOAD DEFINITIONS

Federal Poverty Level (FPL)

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3	25,820.00	38,730.00	45,185.00	47,767.00	51,640.00	58,095.00	64,550.00	71,005.00	77,460.00
4	31,200.00	46,800.00	54,600.00	57,720.00	62,400.00	70,200.00	78,000.00	85,800.00	93,600.00
5	36,580.00	54,870.00	64,015.00	67,673.00	73,160.00	82,305.00	91,450.00	100,595.00	109,740.00
6	41,960.00	62,940.00	73,430.00	77,626.00	83,920.00	94,410.00	104,900.00	115,390.00	125,880.00
7	47,340.00	71,010.00	82,845.00	87,579.00	94,680.00	106,515.00	118,350.00	130,185.00	142,020.00
8	52,720.00	79,080.00	92,260.00	97,532.00	105,440.00	118,620.00	131,800.00	144,980.00	158,160.00

[3] For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty

Health Systems Medicaid (HSM)

The Health Systems Division coordinates physical, oral, and behavioral health services funded by Medicaid.
Historically, pre-ACA, Medicaid programs were divided into three major categories based on benefit packages:

- Oregon Health Plan Plus (OHP Plus) – a basic benefit package.
- Oregon Health Plan Standard (OHP Standard) – a reduced set of benefits with additional premiums and co-payments for coverage.
- Other Medicaid – programs that provide medical benefits but are not considered part of OHP.

Since January 2014, there are only two major categories since OHP Standard was discontinued. At that time, all OHP Standard clients were moved to the new ACA Adults caseload group, where they became eligible for OHP benefits (what was previously called OHP Plus).

OHP Benefit Package

The OHP package offers comprehensive health care services to adults and children who are eligible under Medicaid and CHIP, or those otherwise eligible for Medicaid except for U.S. Citizenship/Residency requirements under the Healthier Oregon program. It was formerly known as OHP Plus to distinguish it from OHP standard.

Modified Adjusted Gross Income (MAGI) is an IRS based method for determining income eligibility for most Medicaid Caseloads, including Children's Medicaid, CHIP, Pregnant Women, PCR, and ACA Adult. It does not apply to those who are categorically eligible, such as due to age, disability, or placement in foster care. Oregon transitioned to MAGI eligibility determination a few months before the 2014 ACA expansion.

Children's Medicaid offers OHP medical coverage to children from birth through age 18 living in households with income from 0 to 133 percent of Federal Poverty Level (FPL). A potential five percent disregard makes the maximum upper limit 138% of FPL for qualifying children. This caseload is comprised of children who would previously have been included in three other older caseloads: children from the Poverty Level Medical Children caseload (PLMC), children from the TANF Medical caseloads (TANF-RM, TANF-EX), and children from lower income CHIP households. As a result of the 1115 Demonstration Waiver enacted by OHA in mid-2023 children under age 6 in this category will have "continuous eligibility," meaning that their cases will not be examined for redetermination on a regular basis. This will reduce the rate of exit from the program.

Children's Health Insurance Program (CHIP) covers uninsured children from birth through age 18 living in households with income from 134 to 300 percent of FPL. Previously, this caseload covered children from households with income from 100 to 200 percent of FPL. As a result of the 1115 Demonstration Waiver enacted by OHA in mid-2023 children under age 6 in this category will have "continuous eligibility," meaning that their cases will not be examined for redetermination on a regular basis. This will reduce the rate of exit from the program.

Foster, Substitute Care and Adoption Assistance provides medical coverage through Medicaid for children in foster or substitute care and children whose adoptive families are receiving adoption assistance services. Clients are served up to age 21, with the possibility of extending coverage to age 26 depending on client eligibility.

Aid to the Blind and Disabled Program (ABAD) provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). The income limit is 100 percent of the SSI level (roughly 75 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA) provides medical coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

Pregnant Women (formerly known as Poverty Level Medical Women (PLMW)) provides medical coverage to pregnant women with income levels up to 185 percent of the FPL. Effective April 2022, coverage is extended for 12 months after childbirth. Previously, it was 60 days.

Parent, Other Caretaker, Relative (PCR) is comprised of adults who would previously have been included in the Temporary Assistance for Needy Families caseloads (TANF Related Medical and TANF Extended). Parent/Caretaker Relative offers OHP medical coverage to adults with children who have incomes not to exceed approximately 42 percent of Federal Poverty Level (FPL).

ACA Adults represents the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled.

Breast and Cervical Cancer Treatment Program (BCCTP) historically provided medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Program administered by Public Health through county health departments and tribal health clinics. Since January 1, 2012, women have not needed to be enrolled for screening through the Breast and Cervical Cancer Program to access BCCTP. After determining eligibility, the client receives full OHP benefits. Clients are eligible until either reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens. Many women who would have been formerly enrolled in this program are not enrolled directly into ACA Adults.

Healthier Oregon Program (HOP), formerly known as Health Care for All Oregon, is a new state-funded program that supplements Citizen Waived Medical (CWM) to provide full OHP coverage. HOP began on July 1, 2022. It expands eligibility to adults who would qualify for Medicaid-funded state medical assistance programs but for their immigration status. All CWM clients were transferred into HOP in July 2022 save those aged 26-54. The remainder were transferred in July 2023.

> **Healthier Oregon - Child** (formerly Cover All Kids) is part of the new Healthier Oregon Program. It is a state funded wrap-around service that provides Oregon Health Plan benefits to all children in Oregon under the age of 19 who are under 300% of the Federal Poverty Level (FPL) and are otherwise eligible for Medicaid but for their immigration status.
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> **Healthier Oregon - Pregnant** (formerly CWM-Plus) covers all prenatal medical services (plus up to 12 months postpartum) for individuals who are otherwise eligible for Medicaid but for their immigration status.
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> **Healthier Oregon - Adult** is part of the new Healthier Oregon Program. It is a state funded wrap-around service that provides Oregon Health Plan benefits to all Adults in Oregon up to 133% of the Federal Poverty Level (FPL) and are otherwise eligible for Medicaid but for their immigration status.

Other Medicaid and Medical Assistance

Citizenship Waived Medical (CWM) was a program that covered emergent medical care for individuals who would qualify for Medicaid if they met the U.S. Citizenship/Residency requirements. This program was discontinued, and all CWM clients were transferred into Healthier Oregon in two waves, ending on July 1, 2023.

Qualified Medicare Beneficiary (QMB) clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 75 percent of FPL) to 100 percent of FPL, and do not meet the criteria for medical covered long-term care services. OHA pays for any Medicare
Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductibles not exceeding the Department’s fee schedule.

Medicare Part A/B Premium Assistance Programs[4]

Medicare Part-A Premium Assistance coverage is for Inpatient services. This coverage is free for most Medicare eligible individuals, except for those who don't have sufficient work history. Medicare Part-A Premium Assistance program is designed to help low-income individuals (under 100 percent of FPL) pay for the premiums when they do not have sufficient work history to qualify for free coverage.

Medicare Part B Premium Assistance coverage is for Outpatient services. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. Medicare Part B Premium Assistance program is designed to help low-income individuals (under 133 percent of FPL) pay the premium.

The Basic Health Program (BHP) coverage is for low-income adults with income is too high to qualify for Affordable Care Act coverage (above 138 percent of the federal poverty level) but below 200 percent of the federal poverty level. Coverage in the BHP may not be equivalent to OHP coverage in some respects but must include at least the ten essential health benefits specified in the Affordable Care Act for Minimum Essential Coverage.

[4] Part A and Part B caseloads are not mutually exclusive. For the most part, those who receive Part A premium assistance also receive Part B premium assistance. Likewise, Medicare Part A/Part B caseloads are not grouped under OHP or Other caseloads, because most of the individuals with Part A/Part B premium assistance have already been counted in one of our traditional Medicaid caseloads (OAA, ABAD, and QMB). There is a segment that is not in the traditional Medicaid caseloads. They are in Specified Low Income Medicare Beneficiary (SLMB) or Qualified Individual (QI) groups that we track but do not formally forecast. Lastly, there is a slight discrepancy in counts between people on the Medicaid caseload who have Medicare, and those who receive premium assistance.

Mental Health (MH)

The Mental Health program provides prevention and treatment options for clients with mental illnesses. The MH caseload forecast is the total number of adult clients receiving government paid mental health services per month. MH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population caseloads include both criminal commitment and civil commitment caseloads. Mandated populations are required to receive mental health services by Oregon law through community settings and State Hospitals. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

Aid and Assist – Community Restoration and State Hospital (or "Fitness to Proceed") serves clients who have been charged with a crime and are either served in the community or placed in the Oregon State Hospital for psychiatric assessment and treatment until they are fit to stand trial. “Fitness to Proceed” means that the client can understand and assist the attorney and stand trial.

Psychiatric Security Review Board (PSRB) includes clients who are under the jurisdiction of the Psychiatric Security Review Board. Most clients in PSRB caseloads have been found “guilty except for insanity” of a crime by a court. A growing number of clients in the PSRB have a charge that is considered a violent felony, and they were previously on an Aid and Assist or Civilly Committed caseload, but they have not been found to be guilty except for insanity. Due to rules around length of stay, they were transitioned to the PSRB. OHA is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training, and supports to assist their progress toward recovery.

Civil Commitment includes individuals currently under commitment (although a proxy rule is used to estimate the end date for clients’ mandated service). The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves because of mental illness, with the court mandating treatment for the individual. They may be served at the State Hospital or in the community.

Previously Committed includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings.

Never Committed includes people who have never been either civilly or criminally committed but who are receiving mental health services either in the community or in a residential setting. About 99 percent of these clients are served in non-residential settings. Clients in the State Hospital are of a voluntary or voluntary by guardian status.