



Fall 2025 Oregon Department of Human Services and Oregon Health Authority Caseload Forecast

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

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Table of Contents

Executive Summary	3
Introduction.....	4
OREGON DEPARTMENT OF HUMAN SERVICES	
Biennial Average Overview Table	7
Self-Sufficiency Programs.....	8
Child Welfare	17
Aging and People with Disabilities	22
Intellectual and Developmental Disabilities	31
Vocational Rehabilitation.....	38
OREGON HEALTH AUTHORITY	
Biennial Average Overview Table	44
Health Systems/Medicaid.....	45
Mental Health	62
Appendix I: Oregon Department of Human Services – Caseload History and Definitions	
History	70
Definitions	71
Appendix II: Oregon Health Authority – Caseload History and Definitions	
History	87
Definitions	88

Executive Summary

The 2025-27 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 429,087 households, which is 3.1 percent higher than the Spring 2025 forecast. The 2027-29 biennial average forecast is 416,503 households, which is 2.9 percent lower than the 2025-27 forecast average.

The 2025-27 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 20,862 families, which is less than one percent lower than the Spring 2025 forecast. The 2027-29 biennial average forecast is 20,774 families, also less than one percent lower the 2025-27 forecasted monthly average caseload.

The 2025-27 **Child Welfare (CW)** biennial monthly average forecast is 16,275 children, which is almost identical to the Spring 2025 forecast. The 2027-29 biennial monthly average forecast is 16,334 children, which is less than one percent higher than the 2025-27 forecasted monthly average caseload.

The 2025-27 **Aging and People with Disabilities Long-Term Care (LTC)** biennial average forecast is 40,341 clients, which is less than one percent higher than the Spring 2025 forecast. The 2027-29 biennial average forecast is 42,860 clients, which is 6.2 percent higher than the 2025-27 forecast average. These averages include the expansion of disability care through Healthier Oregon.

The 2025-27 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average is 41,098 clients, which is one percent higher than the Spring 2025 forecast. The 2027-29 biennial average forecast is 44,818 clients, which is 9.1 percent higher than the 2025-27 forecast average. These averages include the expansion of disability care through Healthier Oregon.

The 2025-27 **Vocational Rehabilitation (VR)** biennial average is 7,788 clients, which is 21 percent lower than the Spring 2025 forecast average. The 2027-29 Total VR biennial average forecast is 7,372 clients, which is 5.3 percent lower than the 2025-27 forecast average. The VR caseload is now subject to Order of Selection rules, which creates a waitlist for In-Plan services. Order of Selection is designed to reduce the caseload to a manageable level to conform to a reduced budget.

The 2025-27 **Health Systems Medicaid (HS/M)** biennial average forecast for Total Medicaid (which includes Healthier Oregon coverage groups) is 1,454,208 clients, which is 2.4 percent lower than the Spring 2025 Forecast. The 2027-29 biennial average forecast is 1,406,739 clients, which is 3.3 percent lower than the 2025-27 forecast average.

The 2025-27 **Behavioral Health (BH)** biennial monthly average forecast is 100,247 adults. This includes 93,445 Never Committed clients, 4,110 Previously Committed clients, 850 Civilly Committed clients, and 1,842 Forensic clients. The forensic count includes 665 clients who are under the Psychiatric Security Review Board and 1,177 Aid and Assist clients. The 2027-29 biennial monthly average forecast is 103,142 adults, which is 2.9 percent higher than the 2025-27 forecast average.

Introduction

HR1 (The “Big Beautiful Bill Act”)

On July 3, 2025, the US House of Representatives passed the final version of House Referral 1, and President Trump signed it into law on July 4, 2025. HR1 was a budget reconciliation bill, designed to require only a simple majority of both the House and Senate to pass, thereby avoiding the filibuster in the Senate. Reconciliation bills are designed to address only tax and spending, not policy changes. However, by financing tax cuts by changing the rules governing SNAP and Medicaid, HR1 did in fact create new policy.

For the first time in history, the United States has significantly reduced entitlement programs for the poor. The forecasts contained here and the descriptions of HR1 in this document will be limited to the caseload impacts, both direct and indirect, although some of the changes contained in HR1 involve other issues related to the operation of Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) including funding transfers to states, calculation of benefits, and taxes.

For SNAP, HR1 modifies the rules governing Able Bodied Adults without Dependent (ABAWD) exclusions. ABAWD requires able bodied adults under a certain age to have a job or engage in work-readiness activities. ABAWD was suspended during the Public Health Emergency and re-enacted in Oregon’s six most populous counties in 2025. HR1 will require all counties to apply ABAWD, and in a more restrictive way. See the Self-Sufficiency section for details.

HR1 also limits Medicaid, specifically applying work rules to the ACA Adults Medicaid Expansion group. This is an extraordinary change to Medicaid – work requirements have never been applied to Medicaid before. The specific rules on what would satisfy work requirements or “community engagement” can be found in the Health Systems/Medicaid section of this document, and the appendix on Medicaid Background and Definitions.

HR1 also eliminates eligibility for entitlements for refugees and asylees. This requirement will be initiated first, followed by the other requirements in 2026 and 2027. All requirements are expected to be in place by January 1, 2028.

As of this writing, final rules and operational requirements of HR1 have not been spelled out by the Department of Agriculture Food and Nutrition Services for SNAP nor the Center for Medicare Medicaid Services in the case of Medicaid. The forecasts presented here are an estimate based on what was known at the time that the forecasts were completed, in October 2025.

The End of the COVID-19 Public Health Emergency “Unwinding”

The Public Health Emergency (PHE) related to COVID-19 ended in April 2023. Since then, exit and transfer patterns have changed, which is to be expected. The system is now operating “normally” in an era of Continuous Eligibility (CE), which provides two years between eligibility determinations for most case types. CE was initiated during the PHE but not acted on in-full until the end of the unwinding.

Economics

In general, Oregon’s employment situation is “stalled.” Economic growth has been mediocre in 2024 and 2025, and the total number of persons employed in Oregon was lower as of September 2025 compared to the year before. Unemployment has been inching up since mid-2023. Some industrial sectors like Manufacturing and Leisure/Hospitality are in a post-COVID doldrum, not recovering to where they were in 2019.

The economic future is cloudy at best. The government shutdown starved the state Office of Economic Analysis of the data used to forecast employment and revenue. Alternative methods of gauging the national and local economy were employed for the 4th Quarter 2025 Economic and Revenue Forecast. The general belief is that the economy will begin to grow in 2026 and 2027, as tariffs are reduced via negotiations, and the Fed reduces interest rates to deal with employment weakness.

The Fall 2025 Forecast

This document summarizes the Fall 2025 forecasts of client caseloads for ODHS and OHA. OFRA issues these forecasts in the spring and fall each year. The Fall 2025 caseload forecast is based on data (whether preliminary or final) available through September 2025. 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

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>



—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.



Oregon Department of Human Services

Total Department of Human Services Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
Self Sufficiency								
Supplemental Nutrition Assistance Program (Households)	442,953	429,087	-13,866	-3.1%	429,087	416,503	-12,583	-2.9%
Temporary Assistance for Needy Families (Families: Cash/Grants)	21,026	20,862	-164	-0.8%	20,862	20,774	-88	-0.4%
Child Welfare (children served)								
Adoption Assistance	8,331	8,036	-295	-3.5%	8,036	7,910	-126	-1.6%
Guardianship Assistance	2,634	2,613	-21	-0.8%	2,613	2,645	32	1.2%
Out of Home Care ¹	4,130	4,384	254	6.2%	4,384	4,517	133	3.0%
Child In-Home	1,176	1,242	66	5.6%	1,242	1,262	20	1.6%
Aging & People with Disabilities²								
Long-Term Care: In Home	22,179	22,789	610	2.7%	22,789	24,985	2,197	9.6%
Long-Term Care: Community Based	13,590	13,202	-388	-2.9%	13,202	13,455	253	1.9%
Long-Term Care: Nursing Facilities	4,240	4,351	111	2.6%	4,351	4,419	69	1.6%
Intellectual and Developmental Disabilities²								
Total Case Management Enrollment ³	40,679	41,098	419	1.0%	41,098	44,818	3,720	9.1%
Total I/DD Services	28,050	28,779	729	2.6%	28,779	30,684	1,905	6.6%
Vocational Rehabilitation	9,854	7,788	-2,066	-21.0%	7,788	7,372	-416	-5.3%

1. Includes treatment services placements 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) 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.

Economics

The current forecast was developed in concert with the Third-quarter economic and revenue forecast released by the Oregon Office of Economic Analysis (OEA) in September 2025. 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 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 Office of Economic Analysis (OEA) considers the current state of the economy challenging to diagnose. The Oregon economy is currently facing slower economic growth with a rising concern about a potential recession. The Oregon labor market is weaker than the national average with unemployment rate rising by one percent in the past year and forecasted to reach a high of 5.2 percent in 2027. Oregon lost 19,000 jobs in the second quarter of 2025: with most jobs being lost from the manufacturing,

construction, financial activities, private education, and information sectors.

OEA presented three forecast scenarios, a baseline scenario, a downside scenario and a severe downside scenario. This forecast assumed a mix of the baseline scenario and the downside scenario, suggesting that the economy will face a mild recession in early 2026 due to persistent inflation and delayed federal rate cuts. The recession is not expected to last long, but there will continue to be some job losses due to tight labor markets that will ease slowly; nonetheless, unemployment may rise to 6 percent towards the end of the 2025-27 biennium.

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.

Policy Changes

This forecast was completed in October 2025. It contains the best available information about the rollout of changes to SNAP specified in HR1, the “Big Beautiful Bill Act”, or Public Law 119-21. Since the finalization of this forecast, Oregon’s Attorney General joined with other attorneys general in suing the US Department of Agriculture over interpretation of “ineligible non-citizen” contained in a guidance letter dated October 31, 2025. The outcome of this suit could render one or

more assumptions built into this forecast moot. Other changes to the operational plan to conform to HR1 requirements could also be developed which will invalidate aspects of this forecast.

HR1 was signed into law on July 4, 2025. The bill sets forth Federal changes that will impact SNAP recipients. Under HR1, there will be an expansion of the Able-Bodied Adults without Dependents (ABAWD) work requirements to cover all counties, as opposed to the six Oregon metro areas previously indicated. For all Oregon counties, The ABAWD rules will change as follows:

- 1) Raising the age limit from 54 to 64,
- 2) Changing the definition of dependent children from under 18 to under 14 and,
- 3) Eliminating exemptions for veterans, people experiencing homelessness, and former foster youth (ages 18-24). Exemptions for American Indian, Urban Indian and California Indian groups will be added.

Individuals who apply for SNAP can receive as many as three months of ABAWD-waived SNAP within a three-year period. Applicants who have used up their three waived months during a previous SNAP service spell will have to meet ABAWD requirements immediately at application until the three year “clock” is up.

The bill also introduces the following waiver restrictions:

- 1) States can only waive ABAWD rules in counties that have an unemployment rate above 10 percent.
- 2) Discretionary exemptions to ABAWD are reduced from eight percent of a county’s total SNAP caseload to one percent of the caseload, and
- 3) Asylum seekers and refugees are barred from receiving SNAP benefits.

This forecast models the impact of the bill to enacted in four stages:

- 1) **September 2025:** discretionary exemptions were removed in the 6 counties that already apply the ABAWD rules. As a result, the caseload saw a drop in enters and an increase in exits.
- 2) **October 2025:** HR1 policies will be implemented in the 6 metro counties that are currently applying the ABWD rule.
- 3) **October 2025:** Refugees and Asylees who were redetermined and allowed to remain on the caseload between the bill effective date (July 4, 2025) and September 2025 will be removed from the caseload. This is expected to be about 1,000 households. An additional approximately 2,000 refugee/asylee households will also be removed from SNAP by the end of the month.
- 4) **December 2026:** HR1 changes are applied statewide. This is modeled to be a gradual impact over the span of 18 months. The new ABAWD exclusionary rules will be applied as cases get redetermined on their customary recertification date.

The effects of HR1 are difficult to quantify since system changes to meet HR1 are still being implemented by Oregon Eligibility Partnership. All rules contained in HR1 related to SNAP were “effective upon passage” of the bill, but implementation of a sweeping change in case processing rules requires time to implement. In order to meet statutory changes, states routinely work with the US Department of Agriculture Food and Nutrition Service (USDA FNS) to determine what is allowable under the law that would also fit operational realities. However, communication with USDA FNS has been intermittent since the bill’s passage. It’s believed that all critical decisions and rules have been ironed out between Oregon and the USDA, but there is a risk that guidance could change subsequent to this forecast.

Oregon has received a waiver from HR1 requirements that allows individuals who do not meet work requirements to be eliminated from a household case, and the case be redetermined. This will likely blunt the impact of HR1 in reducing the caseload somewhat but will effectively reduce the total food assistance received by the household by reducing the number of qualifying persons on the SNAP case.

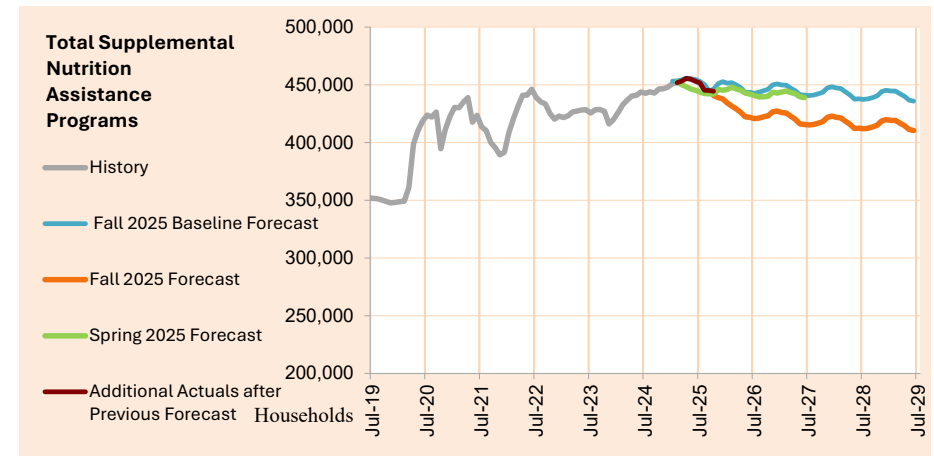
Based on these conditions, coming up with a solid numerical target for SNAP reductions was deemed impossible. Instead, general effects were modeled based on the timeline for implementation of HR1 in Oregon and national estimates of the HR1 effect. OFRA will continue to work with the Oregon Eligibility Partnership and the SNAP program to estimate effects of HR1 as more information on affected clients becomes available.

Based on this generalized model, Oregon is expected to lose 28,780 cases to the changes contained in HR1.

Total Supplemental Nutrition Assistance Program (SNAP) – As of September 2025, 738,671 persons in 444,740 households were receiving SNAP benefits. This represents 17.3 percent of the population of Oregon.

The total SNAP monthly average forecast for the 2025-27 biennium is 429,087 households, which is 3.1 percent lower than the previous forecast. The prior forecast assumed that the upward pressure on caseload will drive growth into the 2027 forecast horizon; however, the last couple of months have witnessed a decrease in caseload that is due to higher exits and lower enters. The current forecast continues to assume that the caseload will be influenced downward due to the changes that are contained in HR1.

The projected biennial monthly average for the 2027-29 biennium is 416,503 households, which is 2.9 percent lower than the 2025-27 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 a requirement of TANF enrollment. In general, families can receive no more than 60 total months of TANF – although there are exceptions.

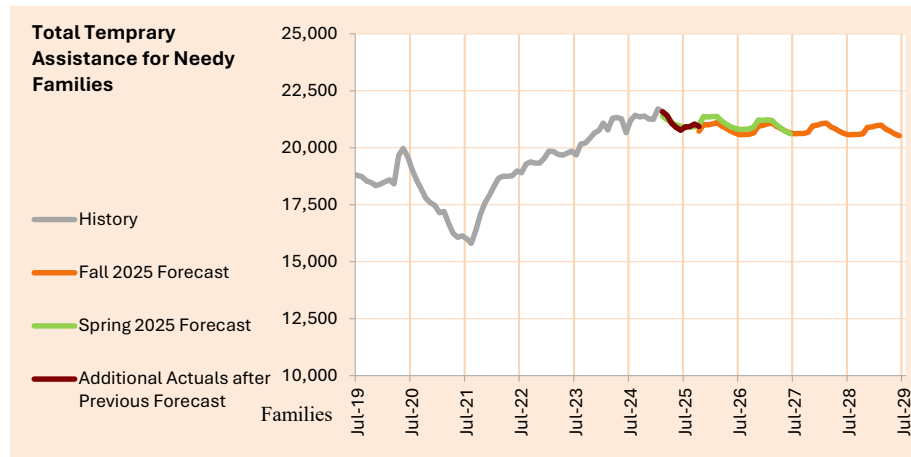
TANF exits tend to fluctuate, with reductions in the spring and summer and increases in the winter, often related to seasonal

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.

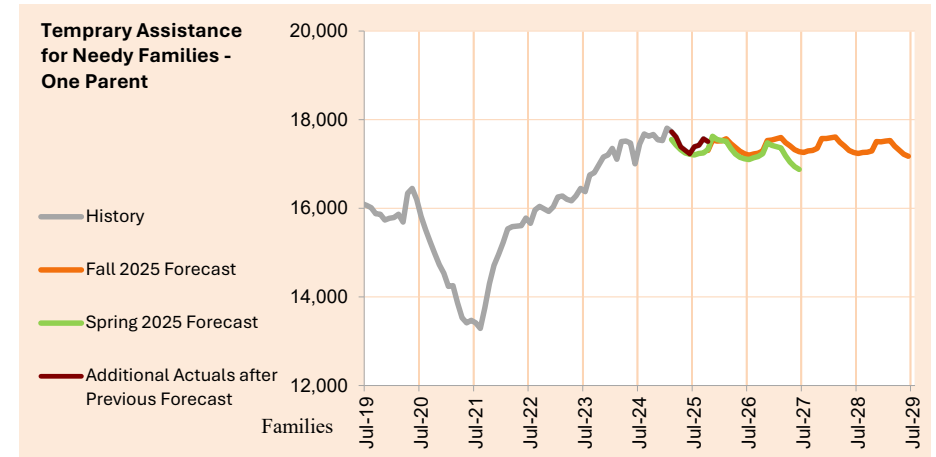
In September 2025, 20,721 families were receiving TANF benefits, representing 54,167 persons. The caseload is currently 2.67 percent lower than it was a year ago.

The total TANF monthly average forecast for the 2025-2027 biennium is 20,862 families, representing a 0.8 percent decrease from the prior forecast. Recent patterns are in line with what was anticipated in the previous forecast. The current forecast assumes that exits related to employment will remain modest due to rising unemployment. Therefore, the caseload is not expected to fall much through the forecast horizon in June 2029.

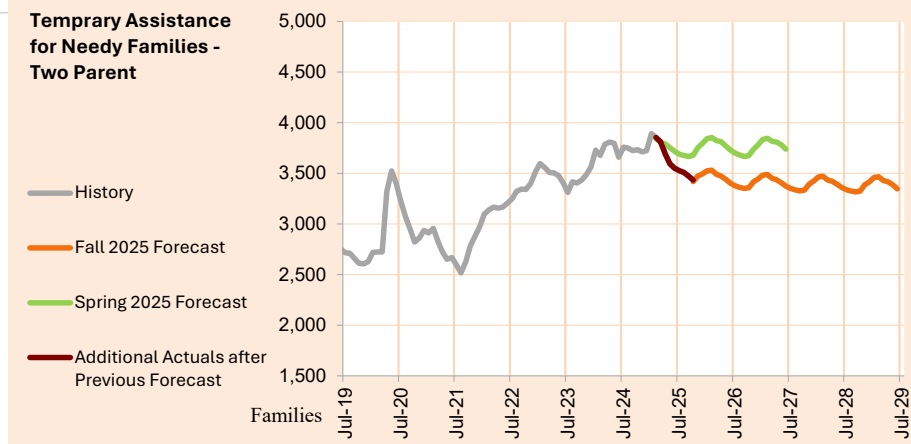
For the 2027-29 biennium, the average monthly caseload is projected to be 20,774 families, which is 0.4 percent lower than the forecasted average monthly caseload for 2025-27.



The 2025-27 biennial average monthly caseload for the TANF One-Parent Family is projected to be 17,413 families, reflecting a 0.8 percent increase from the previous forecast. For the 2027-29 biennium, the average monthly caseload is expected to be 17,386 families, a 0.2 percent decrease from the 2025-27 biennium.



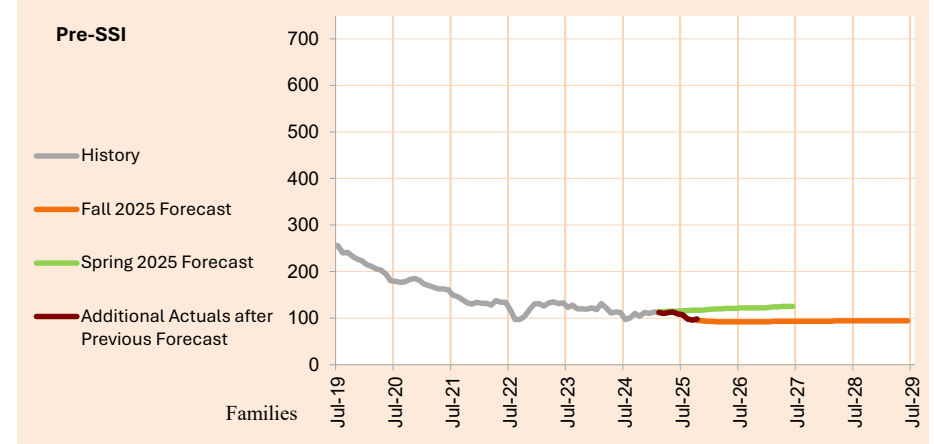
The 2025-27 biennial average caseload for TANF Two-Parent Family is expected to be 3,449 families, reflecting a 8.2 percent downward revision from the previous forecast. The TANF Two-Parent caseload has been growing consistently and vigorously since the end of Enhanced Unemployment Insurance, but the growth rate slowed down since July 2024. The average monthly caseload for 2027-29 is projected to be 3,389 cases, which is a 1.8 percent decrease from the 2025-27 biennium.



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

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. Almost all Pre-SSI cases are transfers from TANF.

The 2025-27 biennial average forecast for Pre-SSI is 93 families, a decrease of 22.8 percent from the previous forecast. The 2027-29 biennial average caseload is 94 families, an increase of 0.4 percent from the 2025-27 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 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).

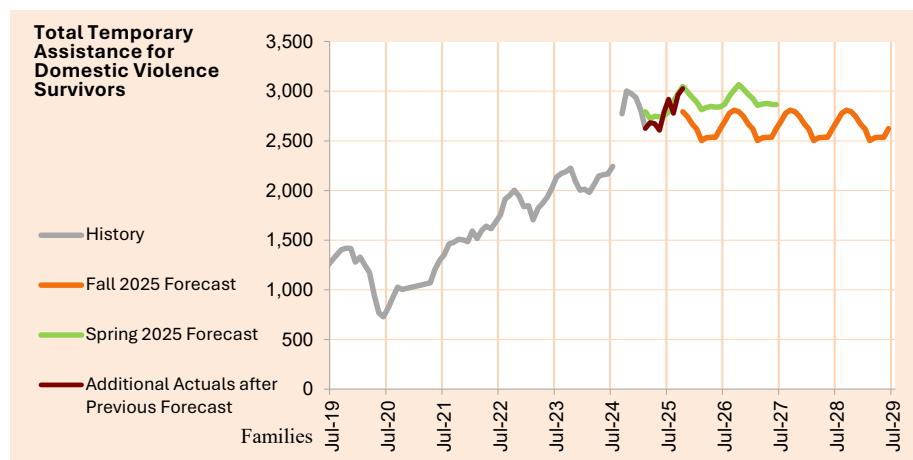
Policy Changes

The budget approved in the 2024 legislative session included an increase to the payments that TA-DVS families receive, moving the maximum 90-day benefit from \$1,200 to \$3,200 for new and existing clients beginning in August 2024. It was expected that the number of families enrolled in Total TA-DVS is unlikely to change based on this increase, but the number of enrolled who request

payments is likely to grow, as the dollar amount will increase the utility of the program.

Since the new rate was introduced, the Total TADVS caseload increased unexpectedly due to outreach efforts highlighting the improved utility of the program. The TADVS with Payment group also increased as more people from the existing pool and the new clients wanted to claim the higher rate. The caseload faced an initial surge however this level shift is stabilizing with the usual seasonal fluctuations.

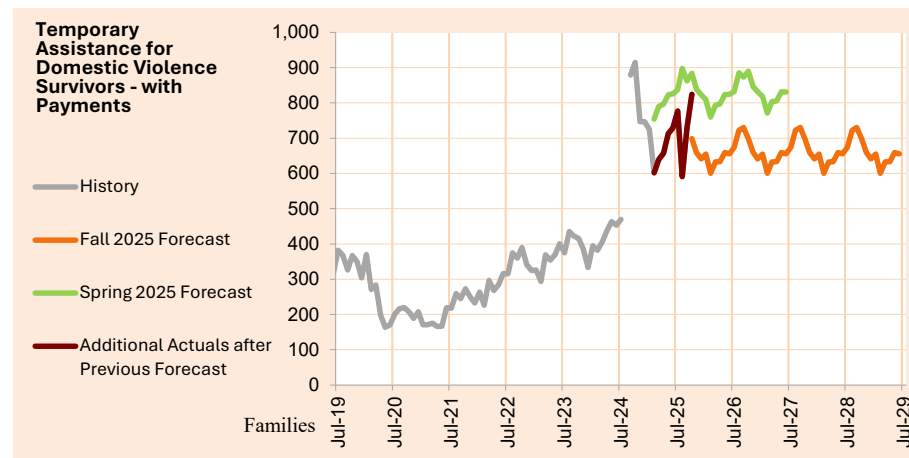
The average monthly caseload for Total TA-DVS for the 2025-27 biennium is 2,669 per month, which represents an 8.3 percent decrease compared to the previous forecast. The caseload is expected to continue to stabilize, fluctuating seasonally, with a monthly average of 2,653 cases in the 2027-29 biennium, representing a decrease of 0.6 percent compared to the current biennium.



The average monthly caseload for TA-DVS with-payment – a subset of Total TA-DVS – for the current biennium is forecasted to be 662 families per month, which is 20.4 percent lower than the

previous forecast. The 2027-29 biennial average caseload is 663 families, an increase of 0.2 percent from the 2025-27 biennium.

The percent increase from the current biennium to the next for both Total TA-DVS and TA-DVS with-payment is due to caseload growth which occurred quickly after the rate change in August 2024.



Forecast Environment and Risks

The current forecast for SNAP was completed during a pivot of operations to implement HR1. There might be rule changes from the USDA Food and Nutrition Services that will change Oregon's implementation of the act. This represents a significant risk to forecast accuracy.

Under HR1, states with payment error rates greater than or equal to 6% must pay between 5 to 15 percent of SNAP benefit cost. Because of a previous high error rate, Oregon would pay 15 percent. Although this does not have a direct caseload impact, it could influence Oregon to change case processing rules to make certain that the state does not pay this enhanced administrative penalty. The most likely change would be ending Broad Based Categorical Eligibility, a set of rules that makes families more likely to qualify for SNAP.

Because there is currently no plan to implement any changes to eligibility rules to avoid the enhanced penalties, no related impact to caseloads was modeled.

HR 1 increases the administrative burden on states to enroll and redetermine SNAP. It also reduces the amount of federal overhead funds available to cover case processing costs starting in 2027. The Oregon legislature will need to appropriate additional monies

to keep the current eligibility workforce intact and would likely need to increase eligibility worker numbers to cover the increased per-case workload if long wait-times and increased eligibility errors are to be avoided.

Workforce issues could have an impact on caseloads by reducing intakes as the eligibility system becomes difficult to manage. Exit rates could be influenced up or down based on errors and error types.

Economic changes in Oregon and the United States in general remain a risk to the accuracy of any forecast of means-tested caseloads. With interest rates high and tariffs potentially creating inflation, the possibility of a recession has increased significantly.

The passage of HR1 put SNAP and other Human Services programs in the spotlight, and not in a positive way. Any major disruptions to a human services program could have ripple effects among people who might qualify. Talk of work requirements may lead people not to apply, whether they would qualify or not. Behavioral shifts in response to policy changes are always a risk to forecast accuracy. The bigger the policy change, the more the potential impact – and this is an especially large change.

Self-Sufficiency Programs Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
SELF-SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)	442,953	429,087	-13,866	-3.1%	429,087	416,503	-12,583	-2.9%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
One-Parent	17,269	17,413	144	0.8%	17,413	17,386	-27	-0.2%
Two-Parent	3,757	3,449	-308	-8.2%	3,449	3,389	-61	-1.8%
Total TANF	21,026	20,862	-164	-0.8%	20,862	20,774	-88	-0.4%
TANF Employment Payments	1,114	1,100	-14	-1.3%	1,100	1,102	2	0.2%
Pre-SSI	121	93	-28	-23.1%	93	94	1	1.1%
Temp. Assist. For Dom. Violence Survivors (Families)								
TA-DVS: with Payment	832	662	-170	-20.4%	662	663	1	0.2%
TA-DVS: Total (with or without payment)	2,911	2,669	-242	-8.3%	2,669	2,653	-16	-0.6%

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.

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. The goal is to manage children safely in their homes.

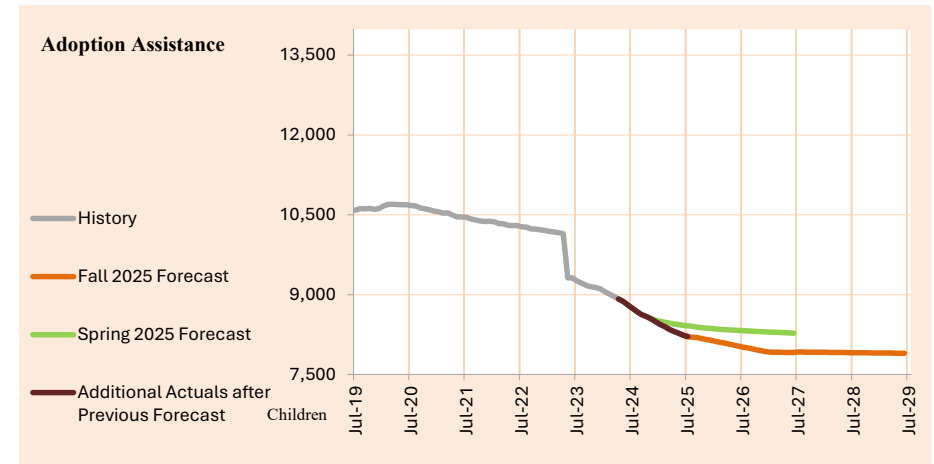
Adoption Assistance

The adoption assistance caseload has been decreasing since 2016, except for a plateau between April 2019 and March 2020. Between June 2023 and June 2025, the caseload fell 12 percent. The main reason for this decline is the emphasis on guardianship assistance as an alternative, with more relatives utilizing subsidized guardianship assistance. The second reason is that 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. The downward trend in paid foster care has recently reversed which may have downstream and future impacts on adoption assistance.

In 2023, data used for forecasting was revised to align with the ORKids database (the data source for Child Welfare case management), which had been deleting some records. This primarily impacted Adoption Assistance data. The Adoption

Assistance caseload beginning in May 2023 reflects counts that align with ORKids, causing a level shift down in the adoption assistance caseload. The overall trend was not affected.

The forecasted Adoption Assistance caseload is expected to average 8,036 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium the caseload is expected to average 7,910 children per month, a decrease of 1.6 percent from the current biennium.

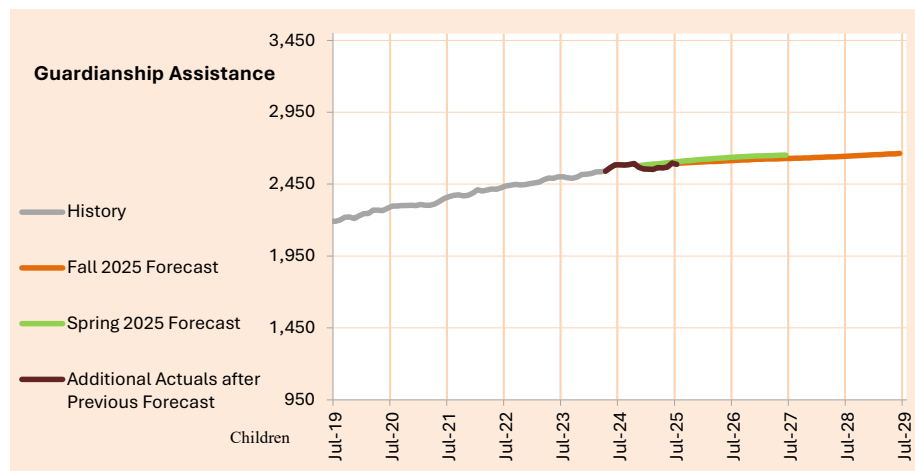


Guardianship Assistance

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. The Guardianship Assistance 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 June 2023 and June 2025, the caseload increased 4 percent.

The forecast for Guardianship Assistance is expected to average 2,613 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium, the caseload is expected to average 2,645 children per month, which is 1.2 percent higher than the 2025-27 forecasted average.



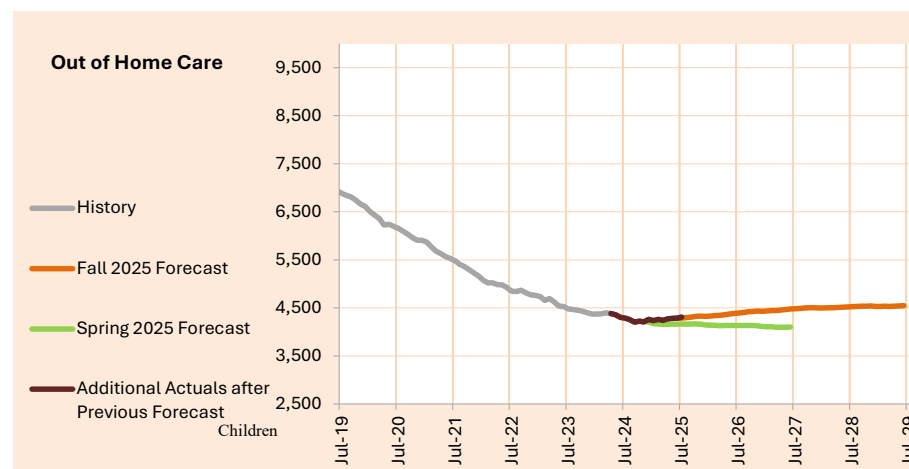
Out of Home Care

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, contributing about 80 percent of the caseload.

Due to successful implementation of policies designed to achieve timely permanency and serve more children in-home, the paid foster care caseload fell from 5,573 in June 2019 to 3,373 in June 2025, a decrease of 39 percent. It's possible that this caseload has reached a functional base. Following the Spring 2025 forecasts, paid foster care increased 3 percent, from 3,298 in

November 2024 to 3,401 in June 2025. Treatment services placements also increased since the end of 2024, from 181 in November 2024 to 214 in June 2025, an increase of 18 percent. These gains are mostly in family-based proctor foster care with small increases in congregate care.

The total Out of Home Care caseload forecast averages 4,384 children per month through the 2025-27 biennium. Over the 27-29 biennium, the caseload is expected to average 4,517 children per month, which is three percent higher than the 2025-27 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.

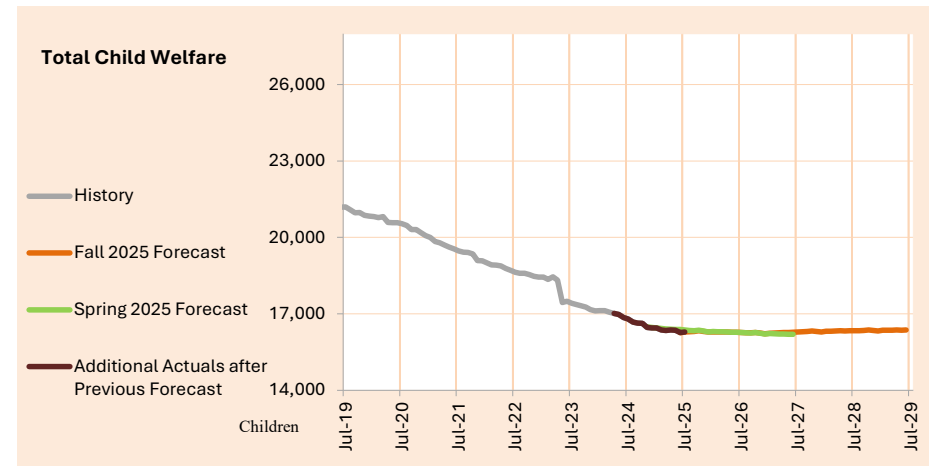
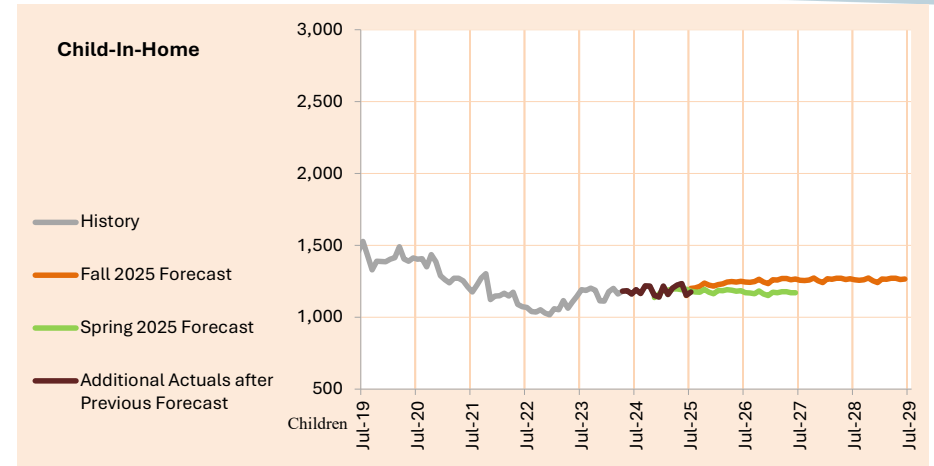
Oregon began phasing in Family Preservation Services with the intent of better serving children and families at home in March

2022 with three locations across the state. Data are being collected from ten counties now, with the goal of determining the best model to successfully keep children at home. In April 2025 Marion, Clatsop, Columbia and Tillamook counties were added, and the data will start being counted at the end of December 2025. The family preservation team expects that by the end of 2026 the whole state will be utilizing this approach.

A complicating and important factor in the development of Family Preservation is that it involves not only the Child Welfare Program but also the Self-Sufficiency Program, Tribes, and other community partners to assess and serve the needs of the whole family. The phased approach provides the opportunity to evaluate in situ what is working and what needs to be improved.

Currently, Family Preservation makes up about 7 percent of the total Child In-Home monthly caseload. The other two Child In-Home groups that are forecasted are children with prior foster care and children without prior foster care. When Family Preservation is implemented statewide, its proportional contribution to total Child In-Home caseload will be greater.

The Child In-Home caseload is forecasted to average 1,242 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium, the caseload is expected to average 1,262 children per month, which is 1.6 percent higher than the 2025-27 forecasted average.



Forecast Environment and Risks

More than any demographic or economic factor that can be counted or measured, the Child Welfare caseload is impacted by policy changes and program level interventions. Over the years, the Child Welfare Program has been highly scrutinized by the public. The Oregon Child Abuse Hotline has been in effect statewide since April 2019, and online reporting was added in 2023. Since July 2024 there has been an increase in the number of calls to the hotline, but the number of children served in assessments has remained flat. Child Welfare leadership is investigating whether people are using the hotline to serve non-Child Welfare related problems. 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. Child Welfare's focus on service delivery to prevent placement changes and help stabilization has been effective, resulting in a reduction of transfers to Out of Home Care.

The federal bill HR 1 that became Public Law 119-21 in July 2025 may impact Child Welfare caseloads. Widespread loss of food stamps and medical assistance will increase stresses on families, and it is expected that there will be more calls to the Child Abuse Hotline. More children may end up in Child In-Home and Out of Home caseloads. In August 2025 more foster care entries were seen than in the past several years. It's possible that this trend will continue.

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

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
CHILD WELFARE (Children)								
Adoption Assistance	8,331	8,036	-295	-3.5%	8,036	7,910	-126	-1.6%
Guardianship Assistance	2,634	2,613	-21	-0.8%	2,613	2,645	32	1.2%
Out of Home Care ¹	4,130	4,384	254	6.2%	4,384	4,517	133	3.0%
Child In-Home	1,176	1,242	66	5.6%	1,242	1,262	20	1.6%
Total Child Welfare	16,271	16,275	4	0.0%	16,275	16,334	59	0.4%

1. Includes treatment services placements and foster care.

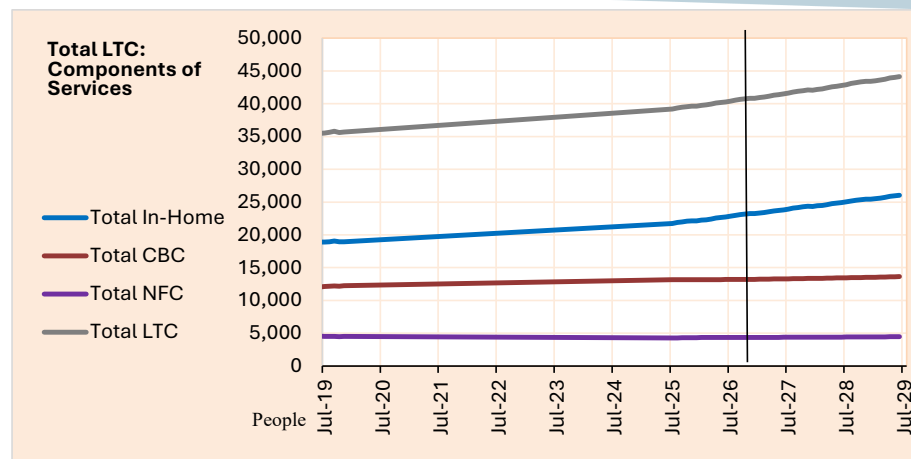
Aging and People with Disabilities (APD)

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.

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 at a lower rate due to a decrease in the Adult Foster Care, Living Facility and Contract Residential Care caseloads. CBC will continue to be a stable placement choice for many LTC clients because hospitals prefer discharging patients to higher service settings to reduce the risk of repeat emergency visits or readmission.

Medicaid reimbursement rates continue to lag private market rates, thus making Medicaid clients relatively less attractive to CBC providers; a new rate of reimbursement for Adult Foster Care effective January 1st, 2026. The new rate is expected to attract more providers and increase capacity gradually.



Total Long-Term Care Case Management

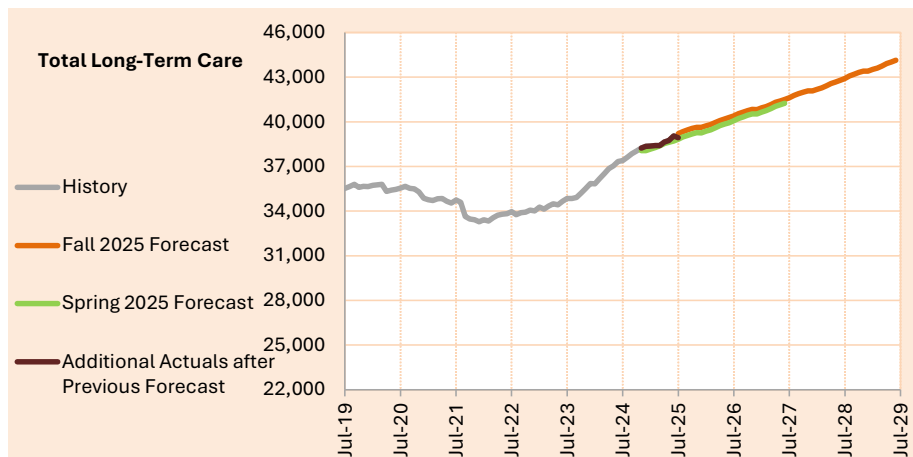
Long-Term Care Case Management is a count of unique APD clients who had direct or indirect case management services done in a month. This count includes those clients who received LTC, along with clients who did not receive Long-Term Care services in the month. Clients not receiving LTC despite being 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 43,292 clients were enrolled in APD Case Management services in June 2025, and about 90 percent of these clients were receiving Long-Term Care services. The Case Management Enrollment caseload is projected to average 43,796 cases per month over the 2025-27 biennium, a 0.4 percent decrease from the Spring 2025 forecast. For the 2027-29 biennium, the caseload

is expected to average 44,758 cases per month, an increase of 2.2 percent compared to the 2025-27 biennium.

Total Long-Term Care (LTC) – A total of 39,079 clients received long-term care services in June 2025, an increase of 4.3 percent compared to a year ago. Community Based Care services slightly decreased, while Nursing Facility Care and In-Home Care services saw an increase. The LTC caseload, including Healthier Oregon Program (HOP) clients is projected to average 40,341 cases per month over the 2025-27 biennium, a 0.8 percent increase from the Spring 2025 forecast. For the 2027-29 biennium, the caseload is expected to average 42,860 cases per month an increase of 5.9 percent compared to the 2025-27 biennium.

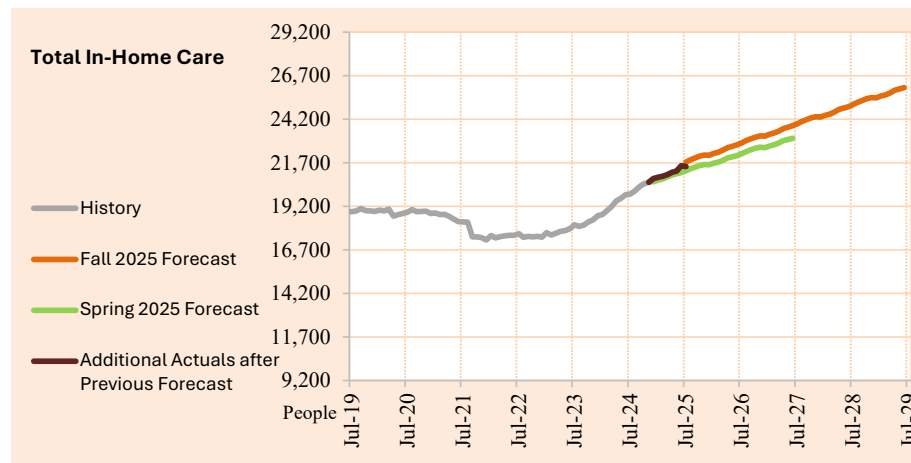


In-Home Care

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

The In-Home Care caseload is expected to average 22,788 cases per month over the 2025-27 biennium, which is 2.7 percent higher than the prior forecast. For the 2027-29 biennium, the caseload is

projected to average 24,986 clients per month, which is 8.8 percent higher than the current biennium.



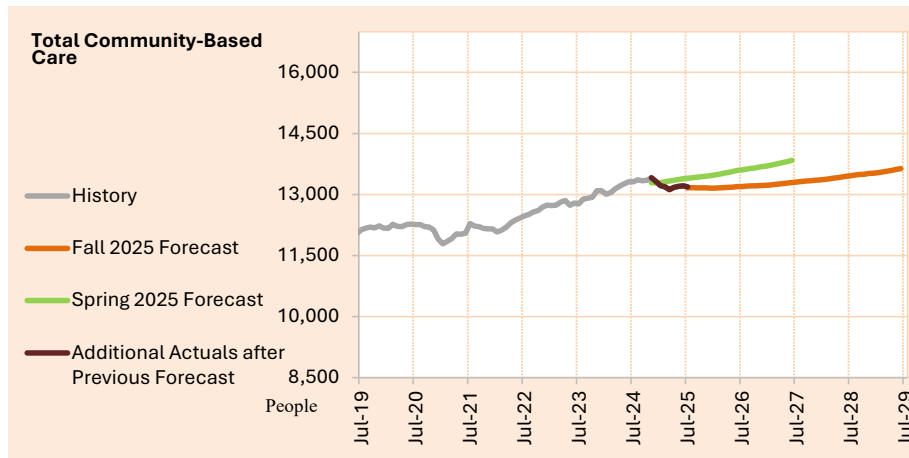
Community-Based Care (CBC)

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.

Community-Based Care includes several different types of services, including the Program of All-Inclusive Care for the Elderly (PACE), Residential Care, Adult Foster Care (AFC) and Assisted Living Facility (ALF).

Since October 2024, total the number of clients receiving Community-Based Care has decreased due to a decrease in the Adult Foster Care, Regular Residential Care, PACE and Living Facility caseloads. In June 2025 the total Community-Based Care caseload was 13,164, which constituted 34 percent of total LTC services.

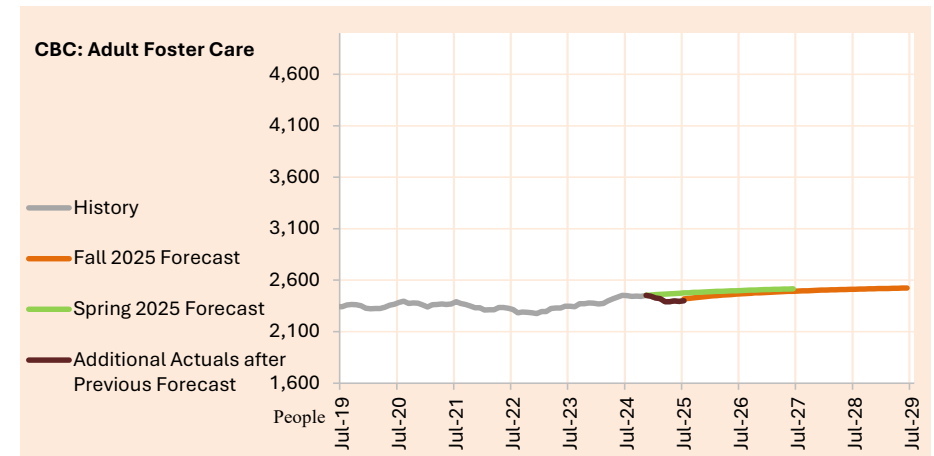
— **The Total Community Based Care caseload** is forecasted to average 13,202 cases per month over the 2025-27 biennium, this is 3 percent lower than the Spring 2025 forecast. The caseload in the 2027-29 biennium is expected to average 13,455 cases per month, 1.9 percent higher than the current biennium.



Adult Foster Care (AFC) declined from August 2013 to July 2019 due to a combination of policy changes and a reduction in providers. From August 2019 to the start of the pandemic in 2020 the caseload 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 pandemic, which 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 new surge in COVID-19 cases.

The forecasted Adult Foster Care caseload has been growing, but that growth has stopped recently. It may pick up again as a new reimbursement rate has been approved effective January 1, 2026. It will take time for this rate to attract providers and add to capacity. AFC is expected to average 2,462 clients in the 2025-27 biennium, a 1.4 percent decrease compared to the prior forecast. The average monthly caseload is expected increase to 2,511 in the

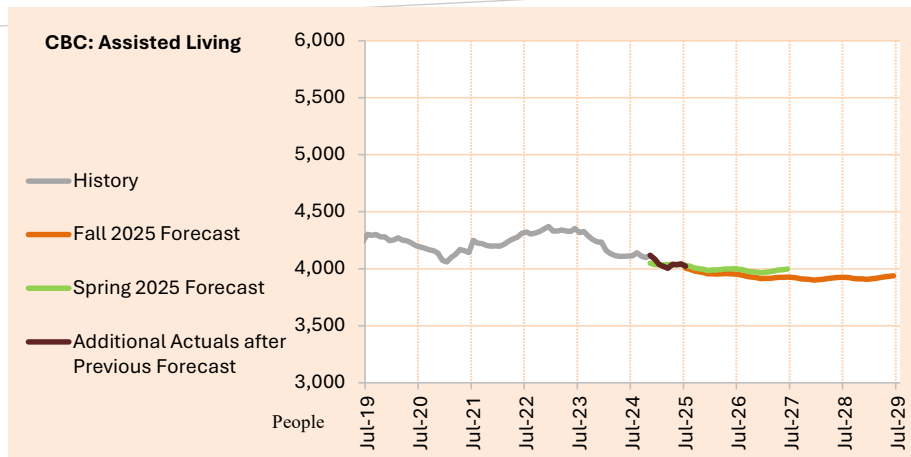
2027-29 biennium, a 2.0 percent increase over the current biennium.



Assisted Living Facility (ALF) providers may prefer clients paying at market rates compared to Medicaid 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.

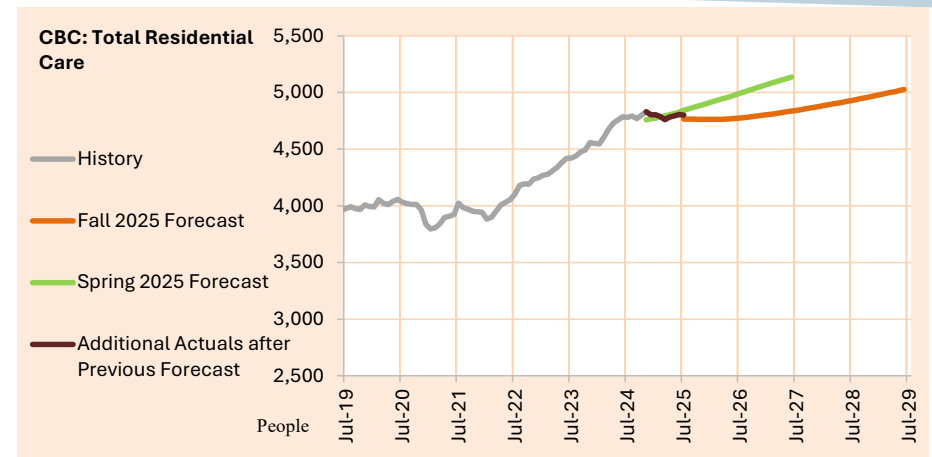
There has been a consistent decrease in ALF since August 2023, with fewer clients entering and more clients exiting. One possible reason behind the decline in caseload is that Assisted Living Facility operators have chosen not to serve high-acuity individuals who would need to be transferred to a Contract Residential Care facility instead. This forecast assumes that the caseload will continue to decrease through the 2025-27 biennium and flatten out through the 2027-29 biennium.

The forecasted Assisted Living Facilities caseload is expected to average 3,947 clients in the 2025-27 biennium, approximately one percent lower than the previous forecast. The average monthly caseload is expected to slightly decrease to 3,917 in the 2027-29 biennium, 0.75 percent lower than the current biennium.



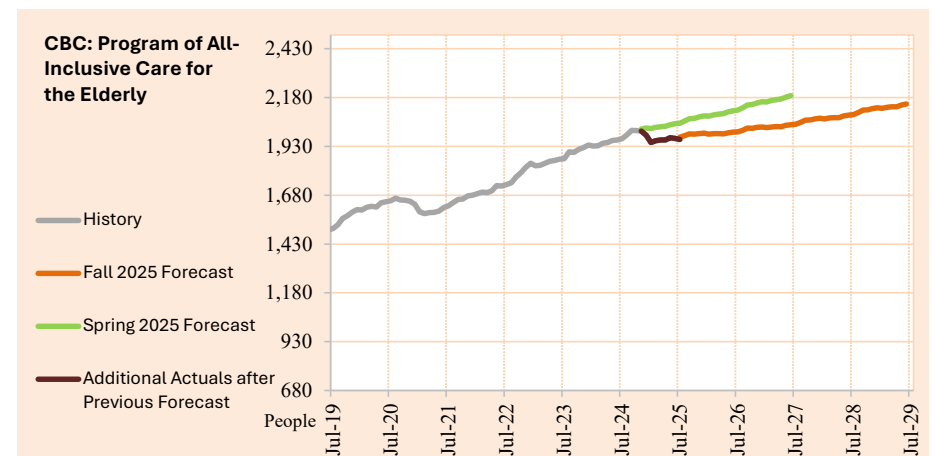
Historically, **Contract Residential Care** and **PACE** have been in demand, with new clients quickly filling vacancies when exits occur. The Contract Residential Care caseload has been increasing steadily since April 2023 due to an increase in the needs of the clients who are being served in Long-Term Care, including an increased need for memory care. This forecast assumes that it will continue growing through this biennium and the next biennium, although at a slightly lower rate than previously observed.

The forecasted Contract Residential Care caseload is expected to average 4,950 clients in the 2025-27 biennium, 3.0 percent lower than the Spring 2025 forecast. The average monthly caseload is expected to increase to 4,333 in the 2027-29 biennium, 4.4 percent higher than the current biennium. The current forecast assumes a slower rate of growth than the prior forecast.



The forecasted PACE caseload is expected to average 2,009 cases in 2025-27, 5.2 percent lower than the Spring 2025 forecast. PACE is expected to increase to an average of 2,097 cases per month in the 2027-29 biennium, an increase of 4.4 percent from the current biennium.

One of the PACE providers closed in 2024 and the clients transferred to other CBC facilities. This led to a one-time drop of approximately 60 cases in January 2025. Despite this temporary decline, the caseload continues to grow at a consistent rate in the current and next biennia.



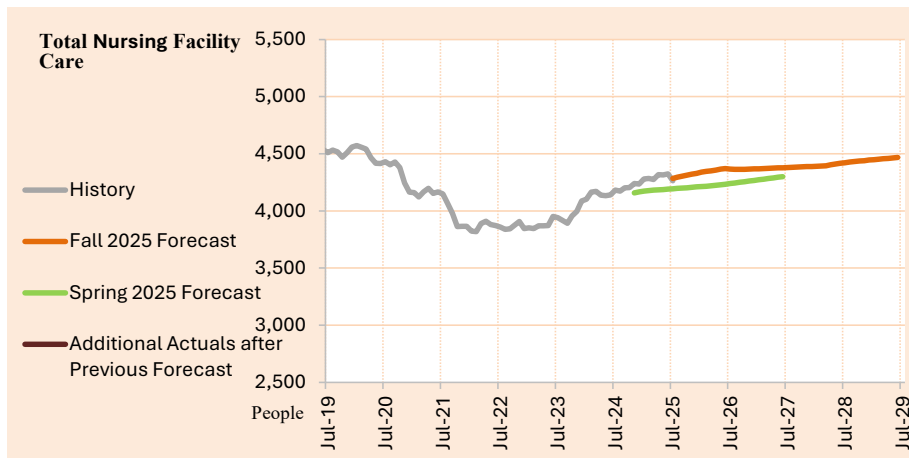
Nursing Facility Care

Nursing Facilities provide institutional services for older adults 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.

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.

Since May 2023, the caseload has been gradually increasing with mild fluctuation, and this forecast assumes that the caseload will continue to increase through June 2029. In June 2025, 4,282 clients received NFC services, which constituted 11.0 percent of total LTC services.

The Nursing Facility caseload is projected to average 4,350 cases per month over the 2025-27 biennium, about 2.6 percent higher than the Spring 2025 forecast. This caseload is expected to average 4,419 cases per month over the 2027-29 biennium, a 1.6 percent increase compared to the current biennium.



Oregon Project Independence Medicaid (OPI-M)

Oregon Project Independence-Medicaid (OPI-M) which launched publicly in March 2024 is an extension of Oregon Project Independence (OPI). The key difference between OPI and OPI-M is that OPI-M uses Medicaid funds to expand access to care.

OPI only accepted younger adults with dementia, while OPI-M includes care to younger individuals with a physical disability. OPI-M also offers more services than the original OPI, including additional in-home service hours, home modifications, transportation, and supports to unpaid caregivers. While OPI sometimes requires a fee, OPI-M services are fully covered without a fee, and are exempt from state recovery.

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.

Currently, demand for long-term care services among Healthier Oregon adults is low. Only 224 clients are receiving long-term care through HOP as of June 2025. Most of these clients choose In-Home care or Nursing Facility Care. The new estimate predicts no growth in HOP through mid-2029. The current forecast projects an average of 214 clients per month for the 2025-27 and 2027-29 biennia, which is 30 percent higher than the Spring 2025 estimate.

Forecast Environment and Risks

Healthier Oregon

The latest forecast has revised the estimated impact of Healthier Oregon on Long-Term Care based on APD HOP intakes through June 2025. 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 2027-29 biennium, could be higher or lower than forecast.

The current environment of promised and actualized mass deportations could influence enrollment in Healthier Oregon, both in terms of those currently covered and the likelihood of future enrollments. Immigrants may feel especially vulnerable to government action and may not want to risk becoming “known” to the authorities, even though Oregon’s status as a sanctuary state forbids it to cooperate with federal deportation efforts. These issues could stifle interest in Long Term Care among disabled immigrants reducing new enters, or lead to large numbers of exits.

Adult Foster Care

APD program has approved a new reimbursement rate for adult foster Care effective January 1st, 2026. It will take some time for this new rate to attract providers and add capacity. As more providers are approved to provide Adult Foster Care services, there will be an increase in the caseload. This poses a risk to forecast accuracy as it is hard to predict how many providers will be approved or when will they be ready to accept clients and provide them services. It is always hard to measure the impact of

new providers on capacity and on the number of new clients. The current environment for AFC increases risk to forecast accuracy beyond the usual level.

Other Risks

The American Rescue Plan Act of 2021 (ARPA) 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 for In-Home care 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 potential 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. The Office of Economic Analysis 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.



—Caseloads are measured for APD through expenditure data – that is, billing. There are lags in finalized data between billing and the processing of payments for Long Term Care services representing a technical misalignment between two systems used to finalize authorizations. This affects In-Home Care and Nursing Facility Care caseloads the most. The delay in finalizing expenditure data poses a risk to accuracy as historical numbers may be revised.

Federal Policy Changes

The current environment is one of maximal disruption from the federal government. Funding for many programs have been cut or are being questioned. Long Term Care is funded by Medicaid, which may or may not be on the chopping block. Any major revision would require congressional action to be implemented. When and how this might occur is impossible to predict but must be acknowledged as a risk to accuracy.

Aging and People with Disabilities Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
AGING AND PEOPLE WITH DISABILITIES								
Case Management	43,981	43,796	-185	-0.4%	43,796	44,758	962	2.2%
In-Home Hourly without SPPC	14,381	14,410	29	0.2%	14,410	15,843	1,433	9.9%
In-Home Agency without SPPC	5,075	5,834	759	14.9%	5,834	6,415	582	10.0%
In-Home Spousal Pay	17	15	-2	-11.8%	15	16	1	6.7%
Independent Choices	506	472	-34	-6.7%	472	463	-9	-1.8%
Specialized Living	194	187	-7	-3.8%	187	191	4	2.2%
In-Home K Plan Subtotal	20,173	20,917	744	3.7%	20,917	22,928	2,011	9.6%
In-Home Hourly with State Plan Personal Care	1,201	1,096	-105	-8.8%	1,096	1,204	109	9.9%
In-Home Agency with State Plan Personal Care	805	776	-29	-3.6%	776	853	77	9.9%
In-Home non-K Plan Subtotal	2,006	1,871	-135	-6.7%	1,871	2,057	186	9.9%
Total In-Home	22,179	22,789	610	2.7%	22,789	24,985	2,197	9.6%
Adult Foster Care	2,498	2,462	-36	-1.4%	2,462	2,511	49	2.0%
Assisted Living	3,991	3,947	-44	-1.1%	3,947	3,917	-30	-0.7%
Contract Residential and Memory Care	4,272	4,150	-122	-2.9%	4,150	4,333	183	4.4%
Regular Residential Care	709	635	-74	-10.4%	635	597	-38	-6.0%
Program of All-Inclusive Care for the Elderly	2,120	2,009	-111	-5.2%	2,009	2,097	88	4.4%
Community-Based Care Subtotal	13,590	13,202	-388	-2.9%	13,202	13,455	253	1.9%
Basic Nursing Facility Care	3,289	3,210	-79	-2.4%	3,210	3,219	10	0.3%
Complex Medical Add-On	906	1,092	186	20.5%	1,092	1,152	60	5.5%
Enhanced Care	33	37	4	12.1%	37	36	-1	-2.7%
Pediatric Care	12	12	0	0.0%	12	12	0	0.0%
Nursing Facilities Subtotal	4,240	4,351	111	2.6%	4,351	4,419	69	1.6%
Total Long-Term Care*	40,009	40,341	332	0.8%	40,341	42,860	2,518	6.2%

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

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).

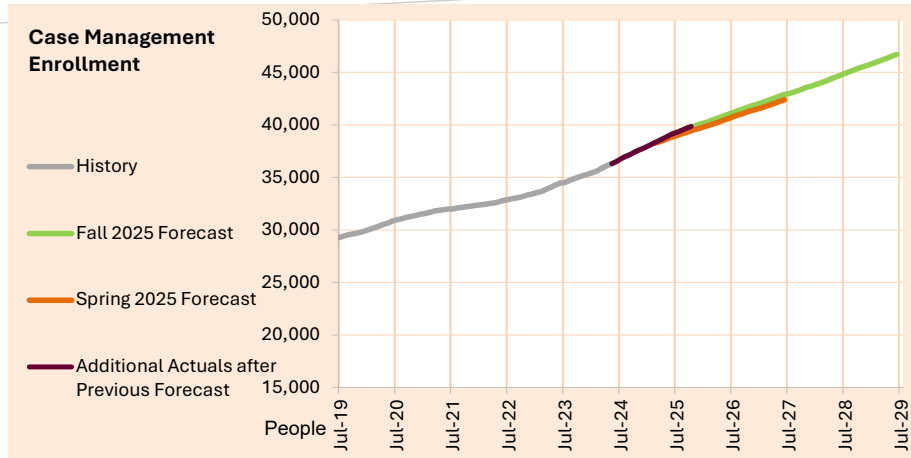
Case Management Enrollment

Case Management Enrollment 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 and Brokerage Enrollment.

Case Management Enrollment (CME) is projected to continue growing until most individuals with intellectual or developmental disabilities (I/DD) living in Oregon are enrolled. The "natural limit" of Case Management Enrollment—where the caseload is expected to plateau—was estimated by applying national prevalence rates to Oregon's youth and adult populations through the forecast horizon. The national prevalence rates were sourced from the In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends study, published by the Residential Information Systems Project (RISP) at the University of Minnesota.

The Case Management Enrollment forecast is expected to average 41,098 cases per month over the 2025-27 biennium, about 1.0 percent higher than the Spring 2025 forecast. This caseload is expected to grow to 44,818 in 2027-29. These totals include Healthier Oregon clients. The Healthier Oregon program is expected to contribute an average of 140 cases per month to Case Management Enrollment in 2025-27, and 177 cases per month in 2027-29. The Case Management Enrollment forecast is divided into adults and children categories based on independently forecasted proportions of children. The children Case Management Enrollment caseload, which averaged 34 percent at the start of the Fall 2025 forecast, is expected to increase to 39 percent by June 2029.



The remaining caseload categories are divided into adult services, children services, and other services.

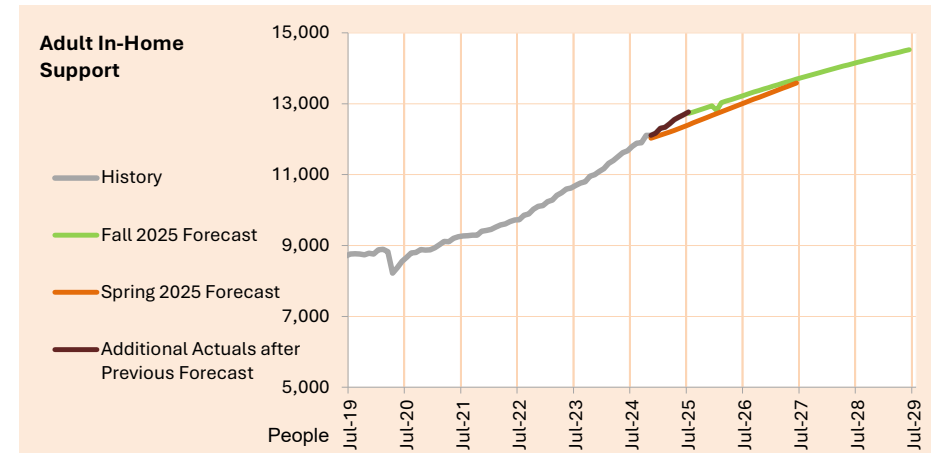
Adult Services

Adult In-Home Support is made up of Comprehensive In-Home Services and Brokerage Services. Forty-nine percent of this caseload category is Brokerage Services and 51 percent is non-brokerage Community Developmental Disabilities Programs (CDDP) In-Home Services. The proportional distributions of Brokerage Services and non-brokerage CDDP In-Home services are applied to Adult In-Home Support caseload forecast to generate non-brokerage CDDP vs. Brokerage In-Home services forecasts.

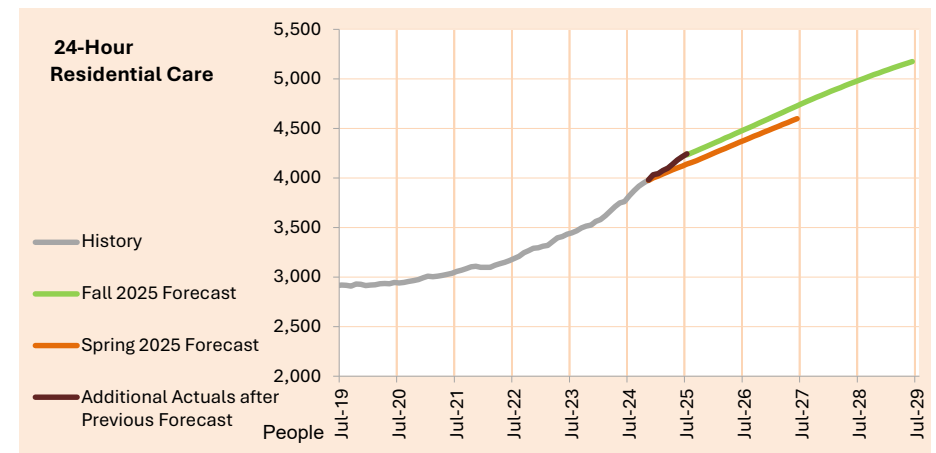
This category excludes employment and transportation services, which is forecasted separately.

The Adult In-Home Support caseload forecast, including HOP cases, is expected to average 13,218 cases per month over the 2025-27 biennium, 1.7 percent higher than the Spring 2025 forecast. The caseload experienced a sharp decline during the early days of the COVID-19 pandemic but has quickly rebounded

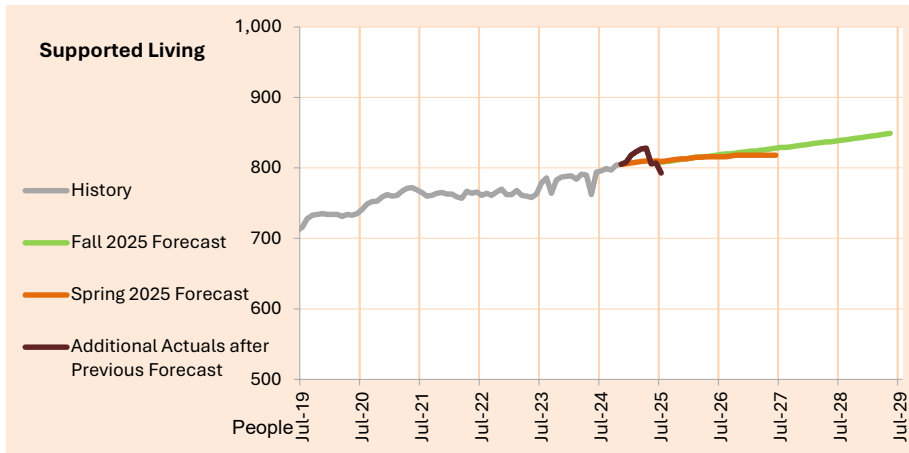
and has been gradually but continually increasing ever since. This caseload is expected to average of 14,142 clients per month in 2027-29.



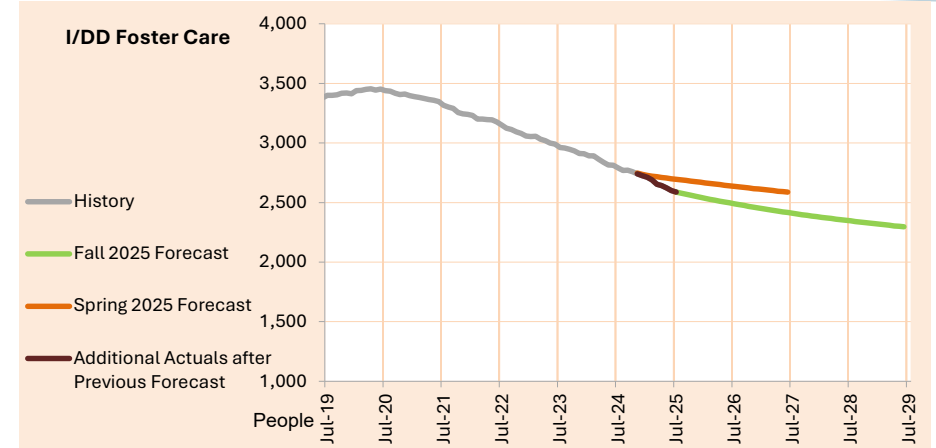
24-Hour Residential Care – The 24-Hour Residential Care average monthly caseload forecast, including HOP cases, is 4,479 cases for the 2025-27 biennium, about 2.5 percent higher than the Spring 2025 forecast. The caseload is expected to average 4,974 cases over the 2027-29 biennium.



Supported Living – This caseload is expected to average 818 cases per month for the 2025-27 biennium. The caseload is expected to average 839 cases per month over the 2027-29 biennium.



I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately nine percent of the caseload. In 2025-27, this caseload is expected to average 2,496 cases, which is 5.4 percent lower than the Spring 2025 forecast. The caseload is expected to continue to decline over the 2027-29 biennium, averaging 2,350 cases per month.



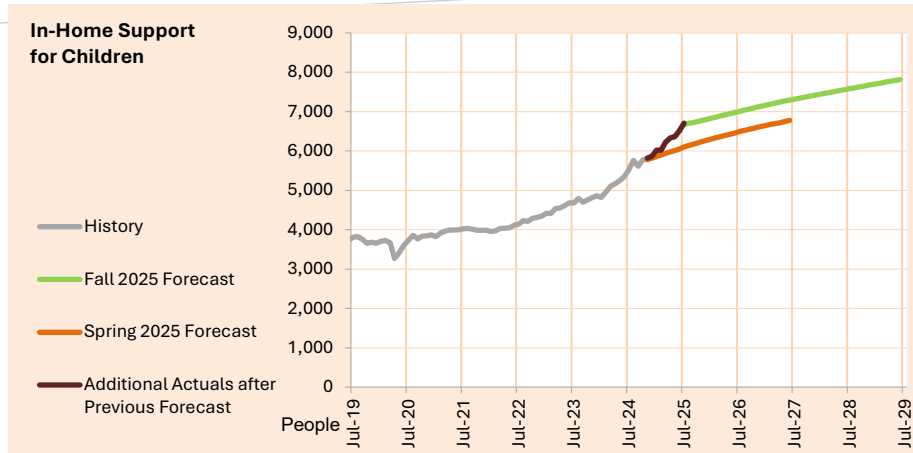
The Adult Foster Care caseload forecast is projected to average 2,263 cases per month in 2025-27 and is expected to average 2,139 cases per month over the 2027-29 biennium.

The Child Foster Care caseload forecast is projected to average 233 cases per month in 2025-27 and is expected to average 220 cases per month over the 2027-29 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 forecast to average 86 cases per month in 2025-27, and 99 cases per month for the 2027-29 biennium.

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 2025-27, this caseload is expected to average 6,988 cases per month, which is 8.1 percent higher than the Spring 2025 forecast. The caseload is expected to average 7,569 cases per month over the 2027-29 biennium. These values include Healthier Oregon clients.



Children Intensive In-Home Services (CIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. In 2025-27, this caseload is expected to average 421 cases per month. 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 – In the 2025-27 biennium, this caseload is expected to average 263 cases per month and is expected to grow gradually to 280 cases per month over the 2027-29 biennium.

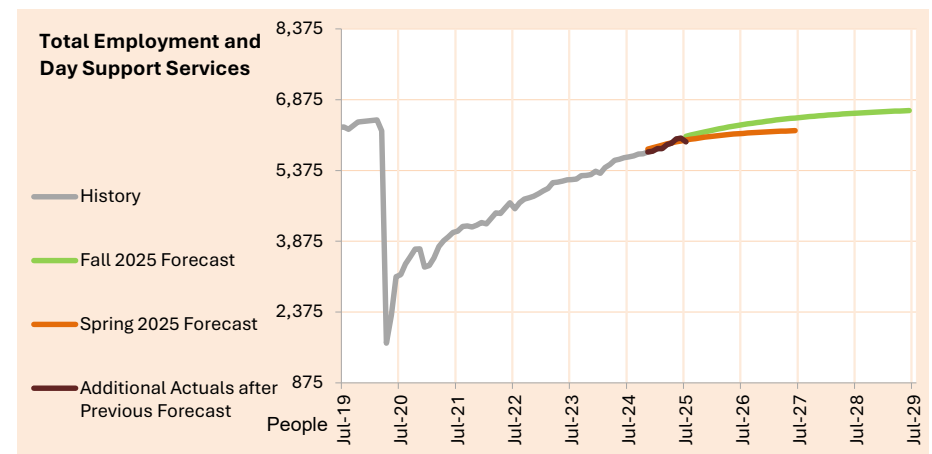
Host Homes – Host Homes are private, single family community homes that provide a safe and structured environment for children with intellectual or developmental disabilities. These homes are managed by an agency and licensed by the state of Oregon. This caseload is still very small with under 6 cases in 2025-27 and is expected to average about 10 cases per month in 2027-29.

Other Services

Total Employment and Day Support Services

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.

The Total Employment and Day Support Services forecast is expected to average 6,322 cases per month, which is 2.9 percent higher than the Spring 2025 forecast. The caseload is expected to average 6,582 cases per month over the 2027-29 biennium.

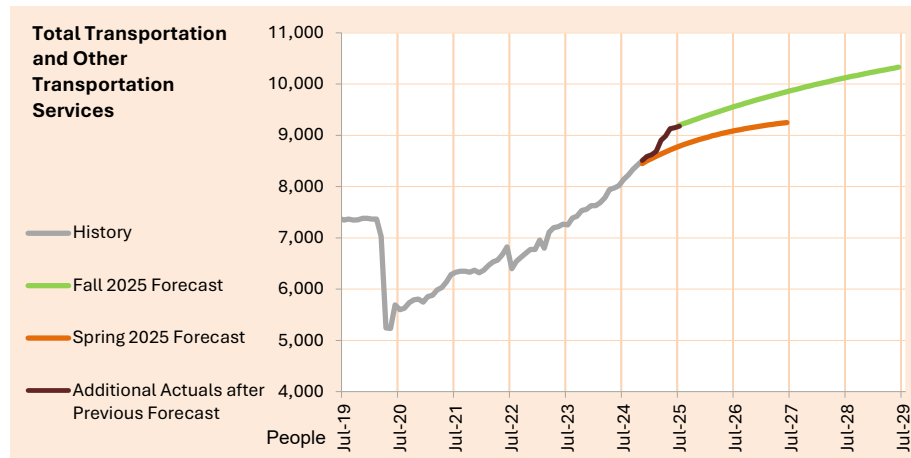


Transportation Services

Transportation Services have been calculated in the same way as described under the Total Employment and Day Support Services to account for the difference between the initially observed caseload and the caseload observed later, after claims have been fully processed.

The Total Transportation Services forecast is expected to average 9,544 cases in the 2025-27 biennium, about 5.3 percent

— higher than the Spring 2025 forecast. The caseload is expected to average 10,115 cases per month over the 2027-29 biennium.



Nursing Services – Direct Nursing Services are shift-type services provided to adults with medically complex needs. This caseload was created because of the unbundling of nursing services from other I/DD services, and as a result, does not have a long history. It is expected to average about 110 clients per month in 2025-27 and is expected to average 117 clients per month over the 2027-29 biennium.

Behavioral Services – the term “Behavior Services” refers to positive behavior support services provided to assist I/DD clients with challenging behaviors. This caseload created because of unbundling of behavioral services from other I/DD services, and as a result, does not have a long history. This caseload had a steep growth initially, but in recent months growth has slowed. It is expected to average about 2,547 clients per month in 2025-27 and 2,706 clients per month over the 2027-29 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, but Employment and DSA services were more significantly disrupted. These services are recovering at different rates. The Transportation services caseload 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 under fifty percent. 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, and clients receiving In-Home Support services as children are likely to continue In-Home services as an adult. As more children enroll in In-Home support services, increases in adult services caseloads are likely. There is not a clear and established pattern of children transferring to adult I/DD services. Without the reasonable assumptions about the transfer pattern, our forecast is exposed to additional risk to accuracy.

VR Order of Selection – The Order of Selection (OOS) in the VR program is operational since June 2025 which has created a waitlist of eligible applicants for VR services based on their disability priority (see the Vocational Rehabilitation section of this document). This may lead to an influx of VR clients who choose to opt out of the VR program and enroll in ODDS employment services, such as job discovery, job development and job coaching. Some of these clients may also enroll in employment path programs. ODDS employment services may also be more attractive due to a higher reimbursement rate. However, the OOS is in the early stage of implementation but gradually the movement from OOS led waitlist in VR to I/DD employment services may pose a higher risk to I/DD employment services caseload forecast.

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment¹	40,679	41,098	419	1.0%	41,098	44,818	3,720	9.1%
Adult								
Adult In-Home Support	13,001	13,218	217	1.7%	13,218	14,142	924	7.0%
I/DD Foster Care	2,390	2,263	-127	-5.3%	2,263	2,130	-133	-5.9%
24 hr. Residential Care	4,370	4,479	109	2.5%	4,479	4,974	495	11.1%
Supported Living	815	818	3	0.4%	818	839	21	2.6%
Stabilization and Crisis Unit	99	86	-13	-13.1%	86	99	13	15.1%
Children								
I/DD Foster Care	249	233	-16	-6.4%	233	220	-13	-5.6%
In-Home Support for Children	6,462	6,988	526	8.1%	6,988	7,569	581	8.3%
Children Intensive In-Home Services	421	421	0	0.0%	421	421	0	0.0%
Children Residential Care	233	263	30	12.9%	263	280	17	6.5%
Host Homes	10	10	0	0.0%	10	10	0	0.0%
Total I/DD Services²	28,050	28,779	729	2.6%	28,779	30,684	1,905	6.6%
Other I/DD Services								
Employment & Day Support Activities ³	6,144	6,322	178	2.9%	6,322	6,582	260	4.1%
Transportation ⁴	9,062	9,544	482	5.3%	9,544	10,115	571	6.0%
Nursing Services	107	110	3	2.8%	110	117	7	6.4%
Behavioral Services	2,250	2,547	297	13.2%	2,547	2,706	159	6.2%

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. 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.

General Assumptions for the Vocational Rehabilitation Forecast

Order of Selection:

VR has implemented an Order of Selection (OOS) service delivery model, which creates a waitlist for applicants determined eligible for VR services. Current clients enrolled in VR In-Plan services will continue to receive uninterrupted services. OOS goes into effect when the full range of VR services cannot be provided to all eligible applicants of VR services. The OOS started on June 14, 2025.

The OOS is mandated by the federal Rehabilitation Services Administration (RSA) and directs state VR programs on how to deliver services when resources are insufficient to serve all eligible individuals. Under OOS, a waitlist is established to manage service costs, ensuring that individuals with the most significant disabilities receive priority access to VR services.

Since the implementation of OOS, VR is maintaining a waitlist of eligible applicants who do not yet have an Individualized Plan for

Employment (IPE), ranking them based on their new disability score (priority 1, priority 2 and priority 3) and application date. Applicants with the most significant disabilities will be given priority according to their application date. Applicants with a disability score from the previous system will be maintained as legacy categories.

Clients will remain on the waitlist until resources become available. In the meantime, VR will collaborate with other state employment programs, including ODDS and the Oregon Employment Department (OED), to help waitlisted clients access alternative employment services.

An exception to the OOS rule is that some clients at the eligibility determination stage who are at immediate risk of losing their job due to disability-related reasons can initiate services without being placed on the waitlist, regardless of their disability level. This group of clients is expected to be very small.

The implementation of OOS disrupts VR's normal operations and has introduced greater uncertainty into caseload forecasting. It has led to a surge in applications since the initial announcement of OOS in February 2025. This fits with the experiences of other States that have participated in OOS, where potential clients rushed to apply and get cued into the wait list. Although applications are up, it is expected that some applicants may choose to avoid the waitlist and seek alternative state services such as ODDS or OED employment programs.

The In-Eligibility caseload is growing on pace with the application process. This will lead to an increase in the In-Eligibility group as clients currently in the eligibility determination process will be assigned to the waitlist based on their disability priority

determination. Those who are not initially placed on the waitlist will have to wait until all existing waitlisted clients are served, which depends on the availability of resources.

The In-Plan caseload is gradually declining as no new transfers into the In-Plan stage have occurred since the implementation of the OOS.

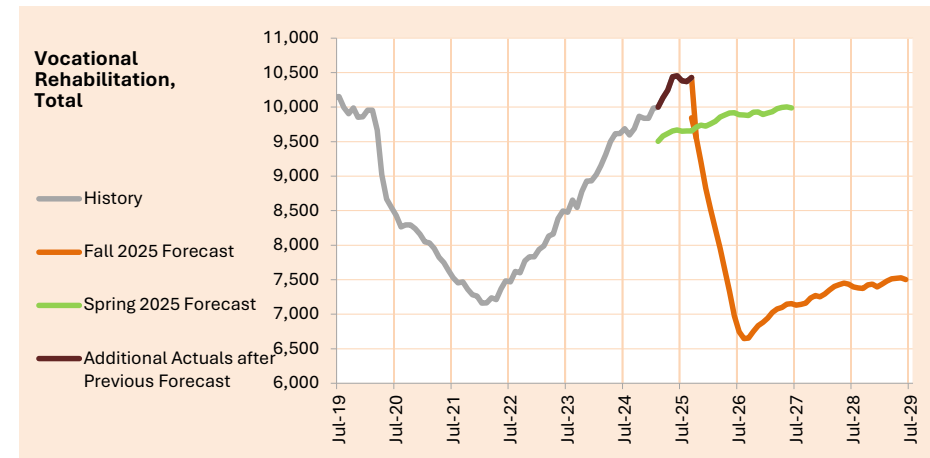
The Order of Selection-based Forecast:

The current forecast is based on OOS assumptions. We do not have reasonable historical evidence upon which to base this forecast. However, we are making some reasonable assumptions based on the consensus of the Caseload Forecast Advisory Committee:

- The current distribution of disability priority scale (based on the old scoring system) will be applied to the In-Eligibility group, creating a projected waitlist based on eligible applicants' disability into Priority 1, 2 and 3.
- The In-Eligibility caseload in the OOS waitlist will be small at first due to the small number of eligible applicants that fall into priority groups 1, 2 or 3.
- There will be no new transfers from In Eligibility group to In-Plan until July 2027. In-Plan will be gradually opened to eligible applicants on the waitlist after the existing In-Plan caseload declines to a sustainable level.

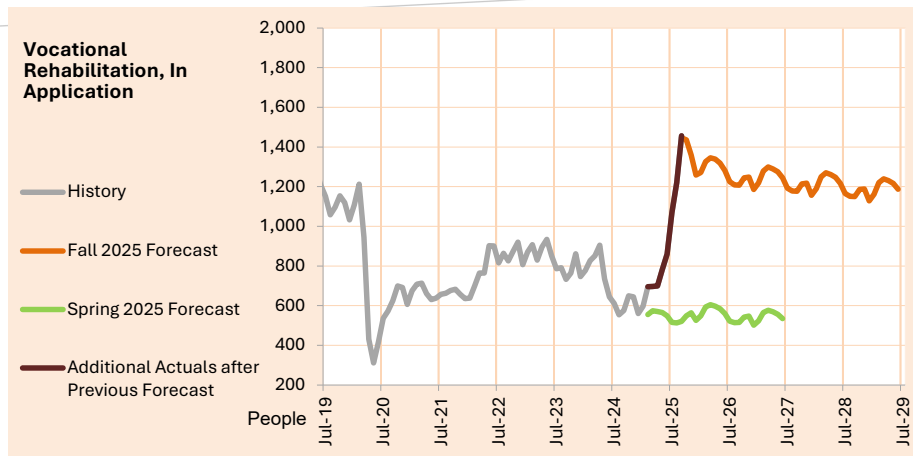
The **Total Vocational Rehabilitation (Total VR) forecast** is the sum of In Application, In Eligibility, and In Plan. The Total OOS based VR caseload forecast projects to average of 7,788 clients per month in 2025-27 biennium, which is 21 percent lower than the Spring 2025 forecast. The total VR caseload will average to

7,372 clients per month in 2027-29 biennium, a decrease of 5.3 percent from the previous biennium.



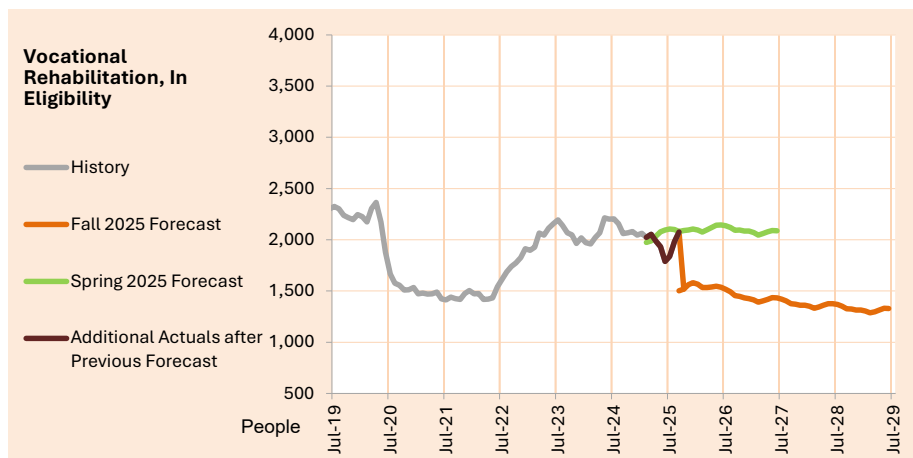
In Application –The current monthly average forecast for the 2025-27 biennium is expected to be 1,275 cases, which is more than double the Spring 2025 forecast. There has been a surge in applications since the initial announcement of OOS in February 2025.

In-Application caseload is expected to average 1,275 cases in the 2025-27 biennium. The initial surge in applications due to the OOS is expected to taper off, therefore the In-Application caseload volume is expected to average 1,200 in 2027-29 biennium, which is 5.9 percent lower than the 2025-27 forecast.

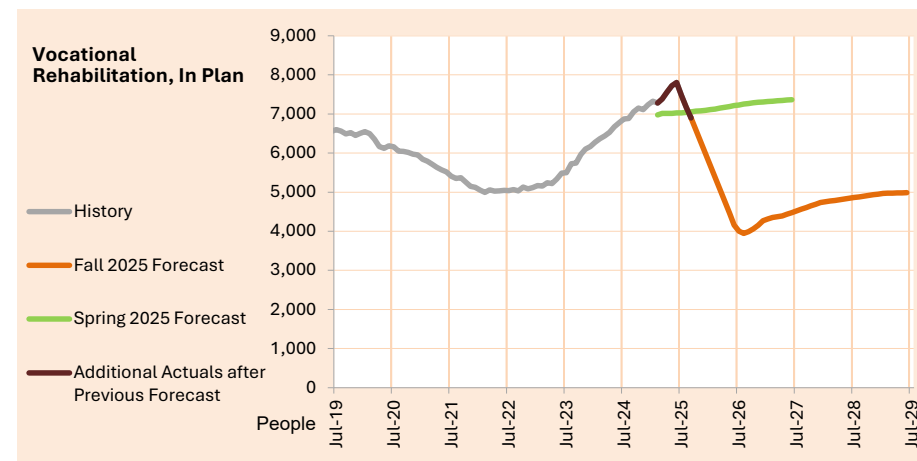


In Eligibility – The In-Eligibility portion of the caseload is also expected to remain volatile due to OOS. The current monthly average forecast for the 2025-27 biennium is 1,484 cases, 29.2 percent lower than the Spring 2025 forecast. This is mainly due to In-Eligibility caseload group includes only eligible clients who meet the OOS criteria and are in the waitlist group with disability conditions in priority 1, 2 and 3.

The In-Eligibility caseload is expected to remain lower – at 1,345 in 2027-29, which is 9.3 percent lower than the 2025-27 forecast.



In Plan – The In-Plan average monthly caseload forecast for 2025-27 is 5,029 clients, which is 30.2 percent lower than the Spring 2025 forecast. The In-Plan caseload volume is expected to average 4,827 in 2027-29 biennium – four percent lower than the 2025-27 forecast.



Note: the timing for the release of names from the wait list to initiate In-Plan development is dependent upon funds/resources. The forecast assumes that resources will be available July 2026.

This is a situation of extreme volatility, and this assumption was based on program consensus. This qualitative forecast decision is appropriate in situations of extreme uncertainty, where no caseload history is available to fall back on.

Forecast Environment and Risks

The overwhelming risk to this forecast's accuracy is implementation of Order of Selection (OOS). Waitlisting applicants has violated core assumptions contained in the prior forecast.

Consumer behavior is playing a large part in the current patterns seen in the caseload. The expectations related to OOS created an environment of uncertainty which led to a significant jump in the In-Application caseload that also led to increase in In-Eligibility determination process.

As planned, the number of clients in the In-Plan stage started to decline in July 2025. This decline will continue until resources are available to address the waitlisted clients in the In-Eligibility stage. Exactly when that point will be reached is extremely difficult to forecast. The current forecast is based on the VR State Plan, which included a projected maintenance caseload size. The actual point at which resources are available to open In-Plan may be larger or smaller than indicated in the plan.

There are currently about 7,000 clients in the In-Plan group. It is expected to drop, with no new entries, until mid-2026 when the total In-Plan will be around 4,000 cases. The total caseload will be

managed from that point to be between 4,700 and 4,800 cases per month. If current exits from In-Plan continue as they have historically, about 300 openings per month will occur in In-Plan, allowing new entries from the In-Eligibility group to move to an enacted treatment plan.

The Order of Selection implementation has introduced a great deal of variability that could render the fall 2025 forecast incorrect. More or fewer clients could enter the Application stage because of hearing about the waiting list for services. Clients could be motivated to get the application process finished quickly to move to the wait list stage as soon as possible, or clients could stop the application process or not apply at all after hearing about the wait list. Currently, applications have reached an all-time high, suggesting people are moving quickly to start the VR approval process.

A new dedicated eligibility review unit in VR is being stood up to move clients more rapidly into the In-Eligibility stage, but the total numbers in the Eligibility stage will be dependent on the volume of applications. If the transition from Application to In-Plan is expedited, it will create a larger waitlist group.

The OOS implementation does not impact Pre-Employment Transition Services as it is supported with dedicated federal resources. Even under OOS, fifteen percent of all resources must be dedicated to Pre-Employment Transition Services.

Vocational Rehabilitation Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
VOCATIONAL REHABILITATION								
In Application	548	1,275	727	132.7%	1,275	1,200	-75	-5.9%
In Eligibility	2,096	1,484	-612	-29.2%	1,484	1,345	-139	-9.4%
In Plan	7,210	5,029	-2,181	-30.2%	5,029	4,827	-202	-4.0%
Total Vocational Rehabilitation	9,854	7,788	-2,066	-21.0%	7,788	7,372	-416	-5.3%



Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast		
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change
Health Systems - Medicaid							
OHP							
Children's Medicaid	315,776	311,042	-4,734	-1.5%	311,042	308,089	-2,953
Children's Health Insurance Program	139,097	136,644	-2,453	-1.8%	136,644	134,695	-1,949
Foster, Substitute and Adoption Care	16,357	16,231	-126	-0.8%	16,231	16,268	37
Aid to the Blind and Disabled	82,045	82,247	202	0.2%	82,247	82,306	59
Old Age Assistance	62,444	60,529	-1,916	-3.1%	60,529	60,727	199
Pregnant Women	18,003	16,856	-1,147	-6.4%	16,856	16,612	-244
Parent, Caretaker Relative	106,992	100,335	-6,657	-6.2%	100,335	97,946	-2,388
ACA Adults	590,138	578,416	-11,721	-2.0%	578,416	531,999	-46,417
Breast and Cervical Cancer Treatment Program	78	67	-11	-14.5%	67	73	7
Healthier Oregon - Child	17,459	14,993	-2,466	-14.1%	14,993	14,962	-31
Healthier Oregon - Pregnant	5,828	4,490	-1,339	-23.0%	4,490	4,641	151
Healthier Oregon - Adult	90,326	88,180	-2,146	-2.4%	88,180	88,382	202
Youth with Special Healthcare Needs ¹	3,591	2,876	-715	-19.9%	2,876	6,692	3,816
Permanent Medicaid Expansion ²	2,444	1,422	-1,022	-41.8%	1,422	1,693	271
Total OHP	1,450,578	1,414,327	-36,252	-2.5%	1,414,327	1,365,084	-49,243
Total Medicaid	1,489,350	1,454,208	-35,143	-2.4%	1,454,208	1,406,739	-47,469
Behavioral Health³							
Under Commitment							
Total Forensic Care	1,972	1,842	-130	-6.6%	1,842	1,975	133
Civilly Committed	742	850	108	14.6%	850	838	-12
Previously Committed	4,259	4,110	-149	-3.5%	4,110	4,129	19
Never Committed	87,542	93,445	5,903	6.7%	93,445	96,200	2,755
Total Served	94,515	100,247	5,732	6.1%	100,247	103,142	2,895

¹Program begin date 1/1/2025 - biennial average for 2023-25 does not include averaged zeroes for months before implementation.

²Rollover from Temporary Medicaid Expansion: 7/1/2024 - biennial average for 2023-25 does not include averaged zeroes for months before implementation.

³Numbers reported represent adults only.

Health Systems/Medicaid (HS/M)

The Medicaid Division oversees the Oregon Health Plan (OHP), Oregon's medical assistance program. It coordinates physical, oral, and behavioral health services funded by Medicaid and CHIP.

Programs are divided into four major categories based on benefit packages:

- Oregon Health Plan (OHP) – a basic benefit package funded by Medicaid and CHIP.
- Healthier Oregon Program (HOP) which provides Medicaid-like coverage for Oregonians who would qualify for Medicaid or CHIP but for their citizenship status.
- “Other Medicaid” – programs that provide medical benefits but are not considered part of OHP.
- OHP Bridge – also called the Basic Health Plan, which covers adults between 138 percent and 200 percent of the federal poverty level.

General Summary of Recent Medicaid and Related Services Caseload Dynamics

The COVID 19 Public Health Emergency and Unwinding

During the COVID 19 Public Health Emergency (PHE), clients were not removed from the caseload due to the recording of an “adverse action.” New intakes were processed as normal, and denials occurred if clients failed to provide appropriate information or if they were over the income limit. This policy led to

a large reduction in the number of cases exiting the program, resulting in a large caseload increase.

The PHE ended April 1, 2023. An “Unwinding” period began immediately. Large numbers of cases were processed each month, addressing the adverse action backlog. The most common reason for a notation of adverse action was being overdue for a redetermination. This led to a period of mass case closures that began in Spring 2023 and ended in February 2025, with the last set of mass closes related to the unwinding being recorded in March. At the end of the unwinding period, cases were assigned a new redetermination month irrespective of when their case was touched during the unwinding, to redistribute the cases more evenly. This led to new patterns of renewal, transfer, and closure after the end of the unwinding.

Continuous Eligibility

During the Public Health Emergency, a new 1115 Demonstration waiver was initiated. The new waiver provides “continuous eligibility” to children under age six receiving Medicaid and CHIP, and two-year eligibility to most eligibility groups over age six. Cases covered by Continuous Eligibility are not transferred to a lower-benefit group during their two-year period of enrollment, even if a status change related to the client is detected.

This policy began July 1st, 2023. It has effectually increased client retention on caseloads, reducing exits and transfers to lower benefit groups. The preliminary data used in the Fall 2025 forecast coincides with the beginning of redeterminations for those clients who received the earliest two-year continuous eligibility protections.

HR1 – The “One Big Beautiful Bill Act”

This forecast was completed in October 2025. It contained the best available information about the rollout of changes to Medicaid specified in HR1, the “Big Beautiful Bill Act”, or Public Law 119-21. Since the finalization of this forecast, it was determined that aspects of this forecast were made invalid by guidance from the Center for Medicare Medicaid Services (CMS) related to the implementation of work requirements for Affordable Care Act (ACA) Adults. Other changes to the operational plan to conform to HR1 requirements could also be developed which will invalidate other aspects of this forecast. It may be necessary for the Office of Forecasting Research and Analysis to revise this forecast prior to the 2026 legislative session. If so, results of this revision will be made available as soon as is practical.

HR1, now recorded as Public Law 119–21, represents a significant shift in Medicaid policy which will have a large impact on caseload dynamics. The Act:

- Changes in the legal definition of non-citizen eligibility for Medicaid services,
- Sets new limits on the number of months clients can claim retroactive coverage,
- Establishes work or “community engagement” requirements for ACA expansion clients, and
- Establishes a more frequent redetermination schedule for Medicaid and CHIP clients.

The forecast contained in this document is based on a timeline and set of case processing rules as they were known at the end of October 2025, when the forecast was finalized. At that time, a general outline was known. However, details may change as CMS technical assistance sessions take place. At the time of this

forecast, there has not been finalized CMS technical assistance provided to the state.

Different parts of the act will be enacted at different times, based on guidance from the federal Center for Medicare/Medicaid Services (CMS). The first major change from HR1 will be the **changes to non-citizen eligibility**. Beginning October 1, 2026, federal Medicaid funding must be limited to U.S. citizens, nationals, lawful permanent residents, Cuban and Haitian entrants, and individuals under Compacts of Free Association. Refugees and Asylees will become ineligible for Medicaid. Once reclassified as “ineligible non-citizens,” these clients will be eligible for the Healthier Oregon Program, leading to an increase in transfers rather than an increase in closures.

Other changes to Medicaid and CHIP are specified by HR1 to start on January 1, 2027. However, since Oregon’s current 1115 waiver runs through September 30, 2027, CMS has allowed some changes contained in the Act to be frozen until the waiver expires. In addition, CMS gave Oregon additional time to implement changes to the eligibility system, allowing for a final implementation date of January 1, 2028.

A second major change from HR1 is **retroactive coverage reduction**. Currently, new enrollees across Medicaid programs are eligible for retroactive coverage for three months prior to their begin-eligibility date. This backdated coverage allows members to have medical bills accrued in past months paid for by Medicaid if they can prove they would have qualified for Medicaid during the retroactive months. HR1 implements a reduction in the retroactive coverage window to one month for ACA Adults and two months for all others. This will reduce the number of months a client will be enrolled in a Medicaid program for those clients claiming retroactive eligibility.

A third change from HR1 is the enactment of **work requirements** for clients in the ACA Adult eligibility group. For the first time in Medicaid’s history, clients will only be eligible in a coverage group

—if they engage in work, community service, work/training programs, and/or enrollment in educational programs. The work requirements will be waived for parents of dependent children, but defines a dependent child as under age 14, not 18 and under as previously defined. There is a large list of exemptions to the work requirements, including client-based exclusions like participation in a drug or alcohol treatment program and environmental exclusions, like living in a federal disaster area. For a complete list of exclusions, see the *Background and Definitions* section.

New enrollees will be required to demonstrate evidence of meeting the work requirement or an exclusion criterion in the months prior to enrollment. Current enrollees will be required to demonstrate evidence of meeting these requirements at redetermination.

When enacted, this policy will reduce enrollment in ACA Adults by decreasing new entries when people who don't meet the new work requirements are found ineligible at application. It will also increase exits for those who fail to meet requirements at redetermination. Federal estimates show that work requirements will have the largest impact on reducing Medicaid caseloads, accounting for nearly 70% of total projected loss.

The fourth change from HR1 is the creation of a new **redetermination schedule**. As stated in the *Continuous Eligibility* section of this document, the current 1115 Demonstration Waiver allows Oregon to engage in a full redetermination every two years for children and adults over age five and waives redeterminations for children five and under. HR1 requires states to redetermine clients in the ACA Adults group every 6 months and requires all other groups to be redetermined every 12 months.

HR 1 also removes the condition of continuous eligibility that protects clients from being moved to a lesser coverage group until their official redetermination date, with the exception of children.

HR 1 and Healthier Oregon

In 2021, the Oregon State Legislature passed HB 3352, or Health Care for All Oregon. This legislation created the Healthier Oregon Program (HOP) to be parallel in construction to Medicaid for those who would qualify for Medicaid but for citizenship. This forecast assumes that changes to eligibility as enacted in HR1 apply to clients enrolled in HOP. Although likely to be true, this interpretation of the law has not been settled as of this writing. Those adults who qualify for HOP Adults by meeting the criteria applied to Affordable Care Act Adults will be required to meet the HR1 the work requirement or demonstrate criteria for exclusion. Those adults who qualify for HOP Adults under the same criteria as Parent Caretaker Relative Medicaid clients will not be affected.

The Baseline forecast and the HR 1 forecast

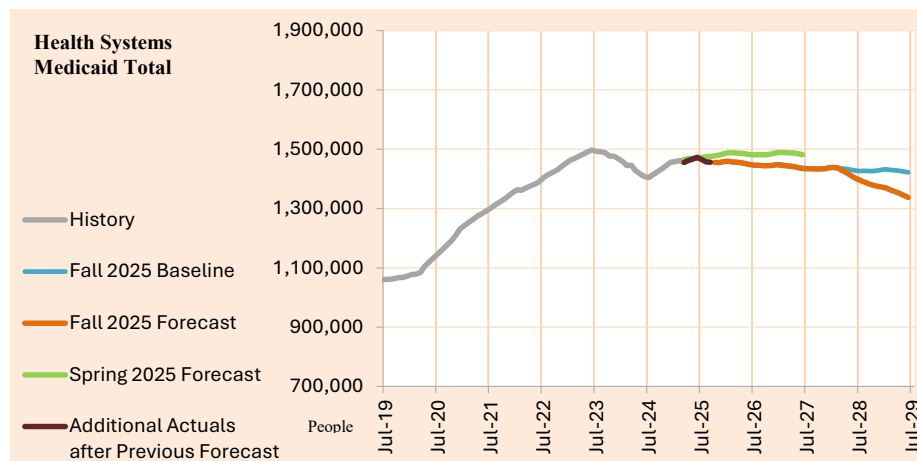
To demonstrate the effects of HR1, this forecast includes a “baseline” or “no HR1” forecast. This baseline forecast is meant to serve as a counterfactual illustration of what the forecast would look like without the effects of HR1. The counterfactual baseline is not the official forecast – the official forecast includes the effects of HR1.

Recent Actuals and Trends

As of June 2025, **the total number of people served by Health Systems/Medicaid** (including all partial and dual-eligible Medicare/Medicaid clients and the Basic Health Plan) was 1,472,364 persons and the preliminary estimate for September 2025 is 1,456,579. Due to the Public Health Unwinding, the caseload fell by about 64,000 cases from a high point in September 2023 to a low point in June 2024. The total number of people served increased due to a pause in case processing in early 2024, the creation of the Basic Health Plan and other new coverage groups related to the 1115 waiver, the rules of Continuous Eligibility (CE) and by increases in Healthier Oregon.

More recent preliminary data shows a slight decline in the total number served, driven by increased exits as cases previously re-sequenced during the Unwinding are now being redetermined. The forecasted enrollment in total HS/M is expected to slightly decline across 25-27 as more persons reach their first redeterminations since the enactment of Continuous Eligibility. The forecasted total HS/M enrollment is expected to drop steadily in 2028 as key provisions of HR1, especially work requirements, lead to a sustained reduction in enrollment among ACA Adults and HOP Adults.

The 2025-27 **Total Health Systems/Medicaid (HS/M) biennial average forecast** (which includes Healthier Oregon but excludes the Basic Health Plan and some dual and part-dual-eligible groups) is 1,414,327 clients, which is 2.5 percent lower than the Spring 2025 Forecast. The 2027-29 biennial average forecast is 1,365,084 clients, 3.3 percent lower than 25-27.

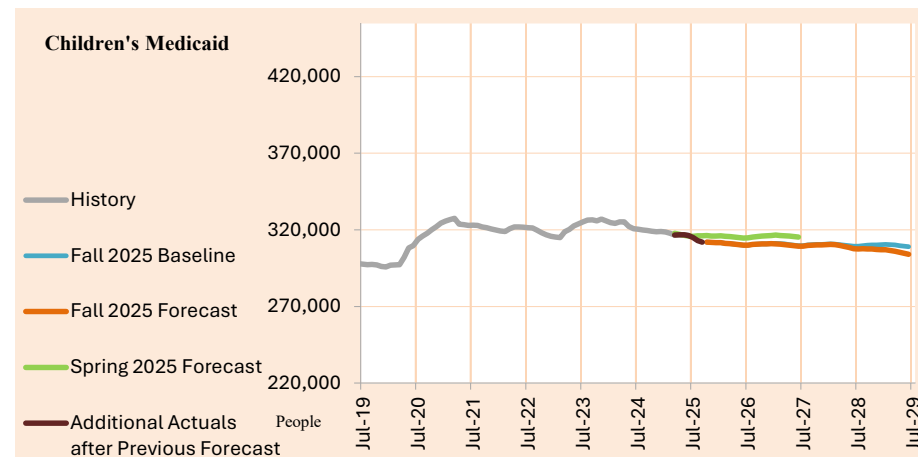


Children's Medicaid – This caseload is highly influenced by transfers to and from the higher-income Children's Health Insurance Program (CHIP). Preliminary data shows a slight increase in exits and transfers to CHIP as previously re-sequenced cases undergo redetermination. The most recent finalized actual

for June 2025 shows 316,265 clients on this caseload. The preliminary estimate for September 2025 is 312,020.

The Children's Medicaid average monthly caseload forecast for 2025-2027 is 311,042 cases, 1.5 percent lower than the previous forecast. It is expected that this caseload will continue to fall slowly as the transfers to CHIP continue. This would reestablish the pattern seen before the Public Health Emergency. The 2027-29 biennium is expected to average 308,089 cases a month, a 0.9 percent reduction from the current biennium.

HR1 is expected to decrease the caseload as those over age five will move from a two-year redetermination schedule to one-year schedule. Those age five and under will go from a continuous eligibility status, with no scheduled redetermination, to a one-year eligibility schedule. The pattern of caseload drawdown will depend largely on how children and households have their redetermination dates re-sequenced in the system.

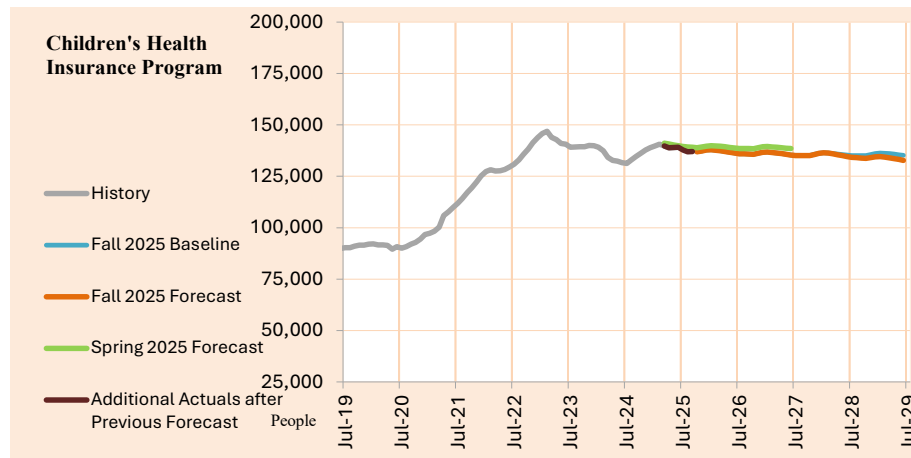


Children's Health Insurance Program (CHIP) – The most recent finalized actual for June 2025 shows 139,191 children on this caseload. This caseload hit a peak during the Public Health Emergency of 146,864 in February of 2023 before it began to drop due to the Unwinding. This caseload is expected to hold relatively steady through the current biennia, as exits remain relatively high

but are counteracted by large numbers of transfers from Children's Medicaid.

As with Children's Medicaid, HR1 is expected to decrease this caseload through the change in redetermination rescheduling – from two years to one year for children over age five, and from a continuous eligibility status to redeterminations once a year for children five and under. The magnitude of the decline will depend on how cases have their redetermination dates re-sequenced in the system.

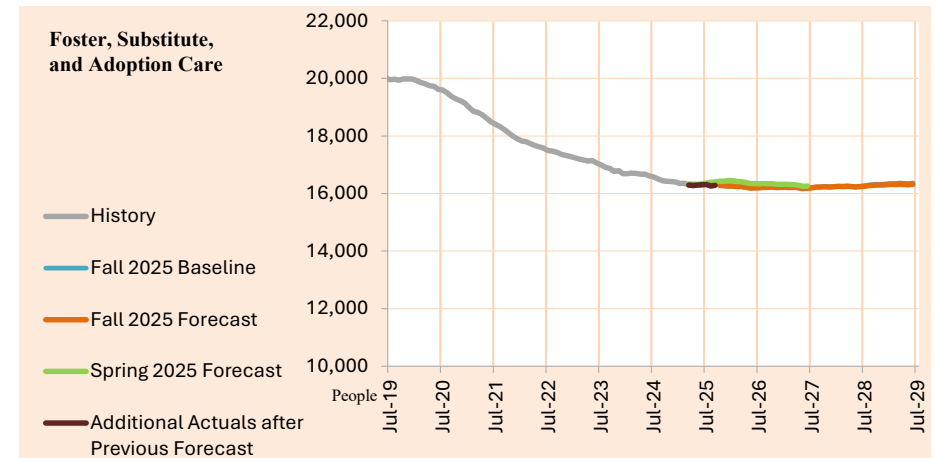
The CHIP forecasted average monthly caseload for the 2025-27 biennium is expected to be 136,644 cases, 1.8 percent lower than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 134,695 cases, 1.4 percent lower than 2025-27.



Foster, Substitute and Adoption Care – The most recent finalized actual for June 2025 shows 16,302 children on this caseload. This caseload is driven by policy changes enacted by the Child Welfare program. It has been declining for the last two years due to a decline in the number of children placed in foster care in Oregon.

The Foster, Substitute and Adoption Care forecasted biennial average caseload for 2025-27 is projected to be 16,231 cases per

month, slightly lower than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 0.2 percent higher than 2025-27.



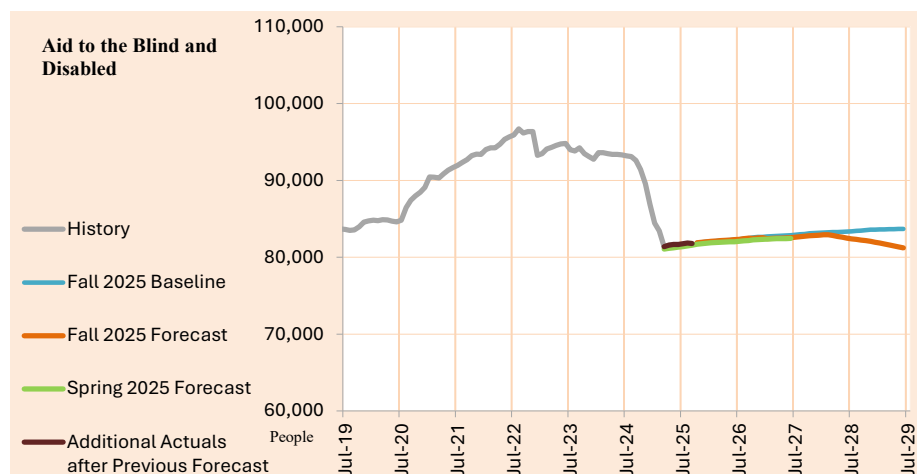
Aid to the Blind and Disabled and Old Age Assistance are two caseload areas that have been influenced down strongly by mass redeterminations at the end of the Public Health Unwinding. These caseloads were impacted by the allegation of violation of due process in the close notices sent to aged and disabled people who were determined to be over-resourced at the end of the PHE. Case processing on these cases was halted until new language was developed for close notices and were then redetermined in large numbers at the end of the Unwinding starting in late 2024. These mass redeterminations led to large numbers of transfers and closes beginning in September 2024 and continued through March 2025. Following these mass transfers, the caseloads have stabilized and now show signs of slow but sustained growth attributed to population aging.

Aid to the Blind and Disabled (ABAD) – The most recent finalized actual for June 2025 shows 81,652 clients on this caseload. Because of the allegation of violation of due process mentioned above, these cases were held in place and mass-redetermined in large batches at the end of the Unwinding. As a result, this

caseload fell from some 93,000 cases in August 2024 to around 81,000 cases in spring 2025.

The average monthly caseload for ABAD is forecast to be 82,247 cases for 2025-2027, 0.2 percent higher than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 0.1 percent higher than the current biennium.

HR1 is expected to reduce the ABAD caseload due to the redefinition of “ineligible non-citizens.” This will lead to non-citizen cases being transferred to Healthier Oregon in 2026. The caseload will also be affected by the loss of Continuous Eligibility, which will increase transfers to dual Medicare/Medicaid case types and increase exits. Under the rules of CE, transfers to dual Medicare/Medicaid case types are frozen until redetermination, since this would be considered a movement to a lesser benefit group. With CE ended, cases will transfer more freely. While this caseload was expected to slowly increase due to the aging population in Oregon, HR1 will mute this growth through increased transfers and exits.

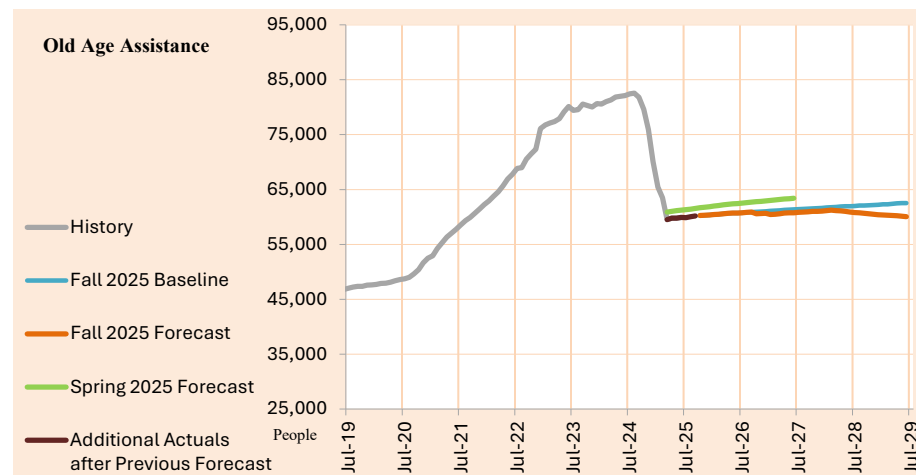


Old Age Assistance (OAA) – The most recent finalized actual for June 2025 shows 59,933 clients on this caseload. Because of the

allegation of violation of due process mentioned above, these cases were held in place and mass-redetermined in large batches at the end of the Unwinding. As a result, this caseload began to fall from some 82,500 cases in August to around 59,000 cases in spring 2025. This is a steep drop and represents a reduction of over 25 percent of the total caseload.

The forecasted average monthly caseload for OAA is expected to be 60,529 cases in 2025-27. OAA was significantly affected by the last months of the Unwinding; therefore, the current forecast is 3.1 percent lower than the prior forecast. The 2027-29 average monthly caseload is expected to be 60,727 cases, a 0.3 percent increase from the current biennium.

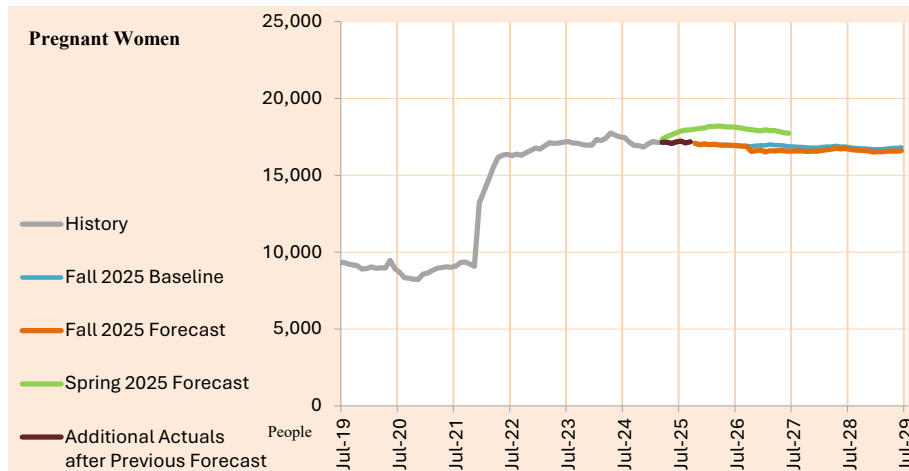
The expected growth in this caseload due to the aging population in Oregon is expected to be muted because of HR1, due to a loss of Continuous Eligibility, which will increase transfers to dual Medicare/Medicaid case types, and increased exits. Under the rules of CE, transfers to dual Medicare/Medicaid case types are frozen until redetermination, since this would be considered a movement to a lesser benefit group. With CE ended, cases will transfer more freely.



Pregnant Women – The most recent finalized actual for June 2025 shows 17,174 women on this caseload. There was a substantial difference between the Spring 2025 forecast and the Fall 2025 forecast. This deviation comes as the result of an unrelated Integrated Eligibility system error that artificially inflated the preliminary data used in the Spring 2025 forecast. This error was corrected and resulted in a retroactive reduction in cases. This reduction is built into the Fall forecast.

This caseload is expected to generally be stable through the forecast horizon apart from transfers due to the redefinition of “ineligible non-citizen” contained in HR1. This will lead to a one-time step decrease as current members are transferred to HOP-Pregnant.

The average monthly caseload for the Pregnant Women caseload in 2025-27 is expected to be 16,856, 6.4 percent lower than the previous forecast. The average monthly caseload for 2027-29 is 16,612, 1.4 percent lower than 2025-27.

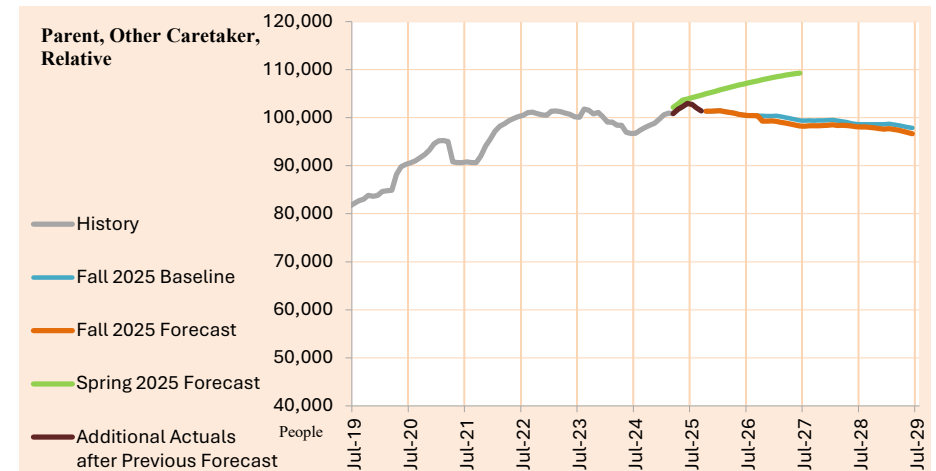


Parent, Other Caretaker, Relative (PCR) – The most recent finalized actual for June 2025 shows 102,968 clients on this caseload. This caseload is driven in part by transfers to and from the higher-income Affordable Care Act (ACA) caseload. This

caseload has shown a decline driven by an increase in exits related to the processing of cases that had their redetermination dates re-sequenced during the Unwinding.

HR1 is expected to reduce the PCR caseload. First, there will be a one-time transfer of an estimated 1,000 clients from PCR to HOP Adults due to the change in the definition of “ineligible non-citizen.” This caseload will also be influenced by the reduction in retroactive coverage and the change in the redetermination schedule to once a year, increasing exits. It is assumed that the HR1 – related increases in ACA Adult redeterminations will increase transfers into PCR, limiting the downward pressure of HR1.

The average monthly caseload for PCR in 2025-27 is expected to be 100,335 cases, 6.2 percent lower than the previous forecast. The average monthly caseload for the 2027-29 biennium is expected to be 97,946 cases, 2.4 percent lower than the 2025-2027.



ACA Adults – The most recent finalized actual for June 2025 shows 594,1699 clients on this caseload. This caseload was highly sensitive to the Public Health Emergency case processing rules. It was generally stable from 2017-2019, essentially hovering around

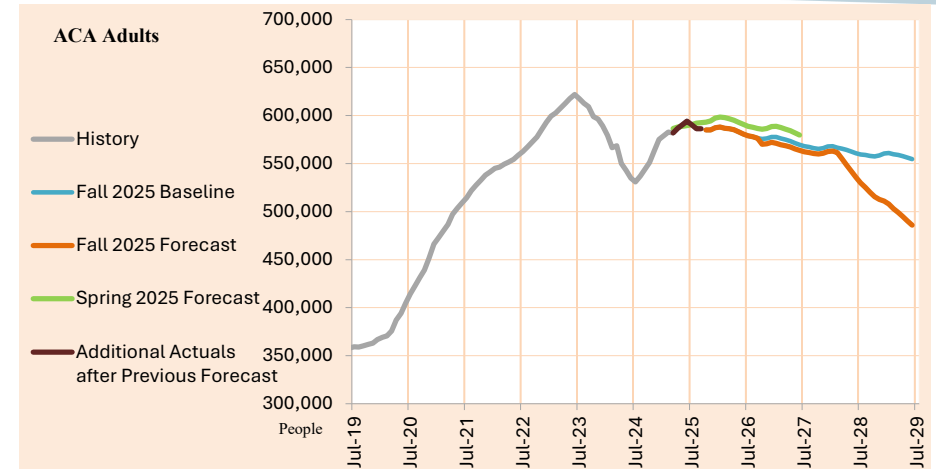
360,000 cases, but grew a great deal during the Public Health Emergency, reaching a high of about 618,000 cases – before falling due to the Unwinding. The mass redetermination of ACA Adult cases led to large numbers of closes and transfers to PCR. Transfer patterns between ACA Adults and PCR are a key element of both.

Since the end of the Unwinding, exits have returned to a pre-pandemic level. This caseload, driven by a relative increase in exits, is expected to slowly drop across the 25-27 biennium, with some periods of increase due to referrals from the federal marketplace.

HR1 is expected to have a substantial impact to the ACA caseload. In October 2026, the change in the definition of ineligible non-citizen is expected to lead to the transfer of about 5,500 cases to HOP Adults. The reduction in retroactive coverage is expected to reduce the caseload beginning January 2027. The end of the 1115 waiver coupled with the implementation of work requirements and redetermination rescheduling from two years to every six months is expected to lead to a sustained decline in ACA adults. This effect will be spread across 2027-29 biennium and will likely to influence the caseload until sometime in 2030.

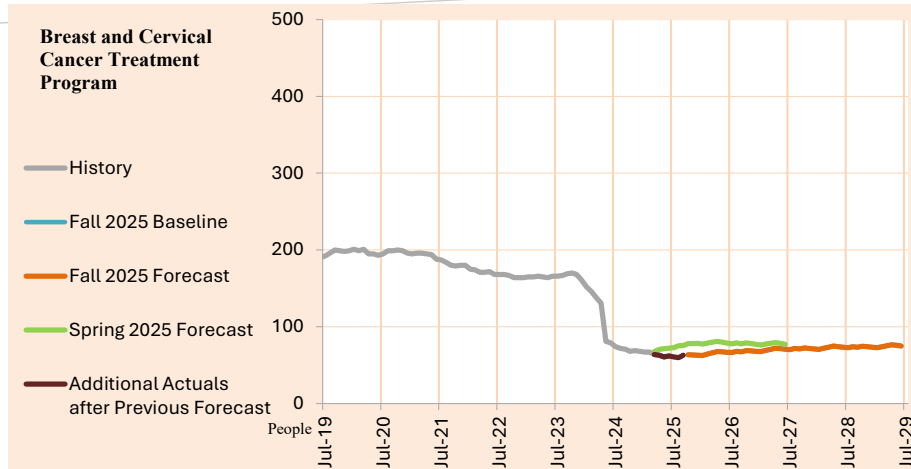
The accuracy of this forecast is highly dependent on the implementation timeline for work requirements and redetermination rescheduling.

The average monthly caseload for ACA Adults for the 2025-27 biennium is 578,416 cases, 2.0 percent lower than the previous forecast. The average monthly caseload for the 2027-29 biennium is expected to be 531,999 cases, a decrease of 8 percent from the 2025-2027 biennium.



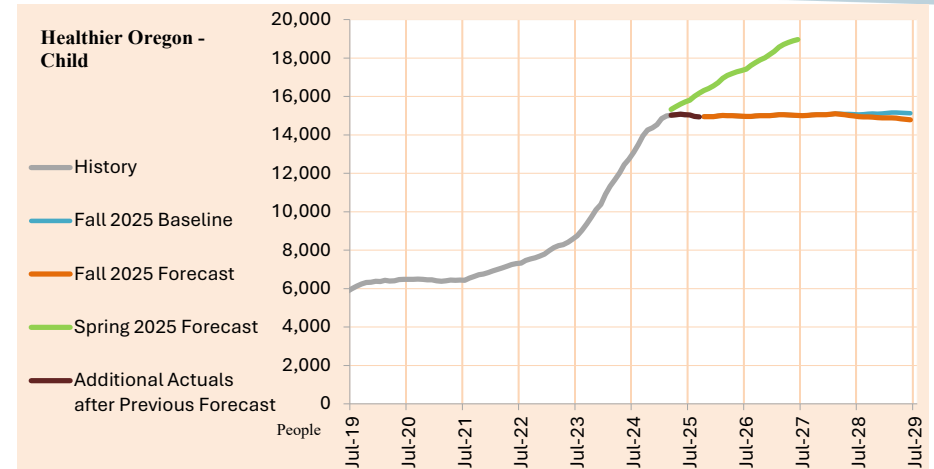
Breast and Cervical Cancer Treatment Program (BCCTP) – The most recent finalized actual for June 2025 shows 62 clients on this caseload. This caseload experienced a steep caseload drop after November 2023 due to the Public Health Emergency Unwinding, going from 168 cases in December 2023 to 81 cases by mid-2024.

BCCTP is forecasted to average 67 clients per month in the 2025-27 biennium, a 14.5 percent downward revision to the prior forecast. This caseload was expected to grow to pre-PHE levels after the Unwinding, however that pattern has not developed. Instead, this caseload is expected to remain relatively steady at its current historically low level, averaging 73 cases per month in the 2027-29 biennium.



Healthier Oregon – Child (HOP-C) This caseload was not impacted by the Unwinding. Instead, it's growth was influenced by outreach efforts which improved after July 2021, leading to a sharp increase in cases, and again in July 2023. This caseload is expected to hold steady through the forecast horizon, as it appears to have reached saturation as of Summer 2025. The most recent finalized actual for June 2025 shows 15,046 clients on this caseload.

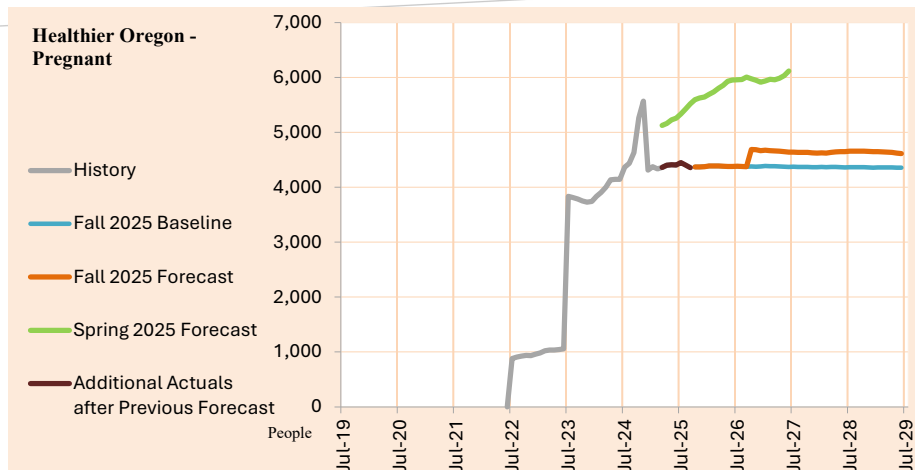
The HOP-C average monthly caseload for 2025-27 is forecast to be 14,993 cases per month. This is a 14.1 percent decrease from the previous forecast. This caseload is forecast to remain stable through the forecast horizon. It is expected to average 14,962 cases per month.



Healthier Oregon – Pregnant - The most recent finalized actual for June 2025 shows a caseload of 4,405. This caseload rose sharply in the fall of 2024 in a manner like the Pregnant Women category and then dropped almost as sharply by December 2024. Like the Pregnant Women caseload, there was a substantial difference between the Spring 2025 forecast and the Fall 2025 forecast due to a system error in Integrated Eligibility that artificially inflated the preliminary data leading up to the Spring 2025 forecast. The error was corrected and resulted in a retroactive reduction in this category.

HR1 will result in a steep increase in the HOPP caseload, as changes to the definition of ineligible non-citizen leads to a transfer several hundred members from the Pregnant Women category to HOPP. Except for that one-time increase, this caseload is expected to be generally stable.

The biennial average caseload for HOP-P for 2025-27 is expected to be 4,490 cases, a 23.1 percent decrease from the previous forecast. The caseload is expected to increase in 2027-29, averaging 4,641 cases a month, a 3.4 percent increase compared to 2025-27.



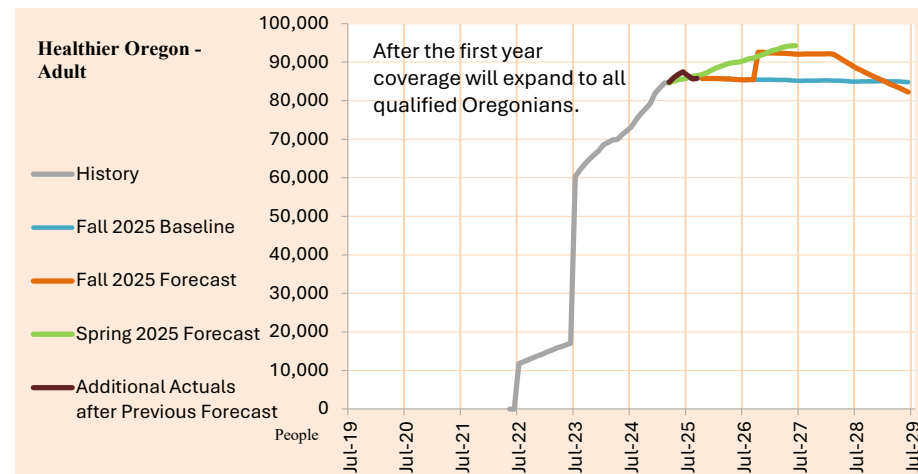
The forecasted HOP-A biennial average monthly caseload for 2025-27 is 88,180 cases. This is a decrease of 2.4 percent from the previous forecast.

Previous forecasts did not assume a ceiling on this caseload based on estimates of the uninsured adult immigrants in Oregon. Estimates of immigrants and their socioeconomic status in Oregon (and anywhere in the country) have been known to be somewhat inaccurate. The most recent months of preliminary data show the caseload no longer growing quickly, but stabilizing. It is unclear if demographics are at work in ending this growth, or if non-citizens have become concerned about signing up for government healthcare at a time of increased scrutiny on their status from the federal government.

HR1 is expected to have complex impacts to the HOPA caseload. First, changes to the definition of ineligible non-citizen will lead to a one-time substantial increase in HOP Adults in October 2026 as clients in ACA Adults, PCR, OAA, and ABAD transfer into HOPA.

Like ACA Adults, it is expected that the end of the 1115 waiver coupled with the implementation of work requirements and changes in the redetermination schedule will lead to a substantial and sustained decline in HOP Adults who would qualify for ACA

Adults but for citizenship. These clients will be subject to work requirements and a 6-month redetermination schedule after the expiration of the current 1115 waiver. Like ACA Adults, this will spread losses related to work requirements across 2027-29 biennium and continue until 2030. The average monthly caseload is expected to increase by 0.2 percent in the 2027-29 biennium, to 88,382 cases per month.



Other Medical Assistance Programs

Dual and part-dual eligibility groups were influenced a great deal at the end of the Public Health Emergency Unwinding, as large numbers of aged and disabled cases were processed, driving down ABAD and OAA caseloads as cases transferred out to the dual-eligible groups.

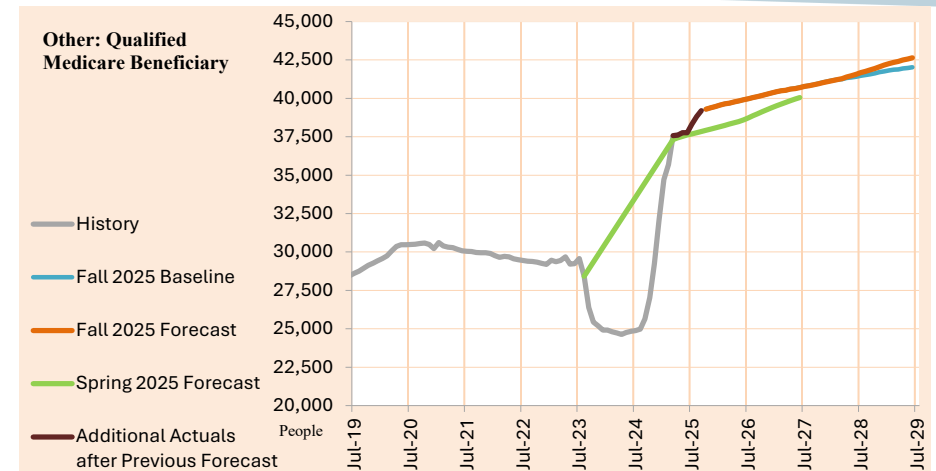
Qualified Medicare Beneficiary (QMB) – The growth in this caseload ended at the start of the Public Health Emergency, as this caseload is dependent upon transfers in from full OHP coverage into this partial-benefit group.

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 24,641 in

April 2024 as cases were transferred from QMB back into Oregon Health Plan categories. Starting in September 2024 this flow reversed, and cases began to transfer from OAA and ABAD into QMB and other dual-eligibility groups. The most recent actual, for June 2025, shows this caseload reaching about 37,755, an increase of nearly 52 percent from June 2024. It was expected that these extraordinary increases would end in March 2025, when the last cohort of the Unwinding was finished processing. This was not the case. The most recent preliminary value for September 2025 is over 39,198, with recent growth driven by a delayed uptick in transfers from OAA and ABAD.

The QMB average monthly caseload is forecast to be 39,881 in the 2025-27 biennium, a 2.9 percent increase from the previous forecast. The biennial average caseload for 2027-29 is expected to be 41,655 cases, a 4.4 percent increase compared to 2025-27.

The expected growth in this caseload is due to the aging population in Oregon and the effect of HR1. Due to the loss of Continuous Eligibility, transfers to QMB and other dual Medicare/Medicaid case types from ABAD and OAA will increase. Under the rules of CE, transfers from ABAD and OAA to dual Medicare/Medicaid case types are frozen until redetermination, since this would be considered a movement to a lesser benefit group. When CE ends, cases will transfer more freely.



Medicare Part A/B Premium Assistance Programs

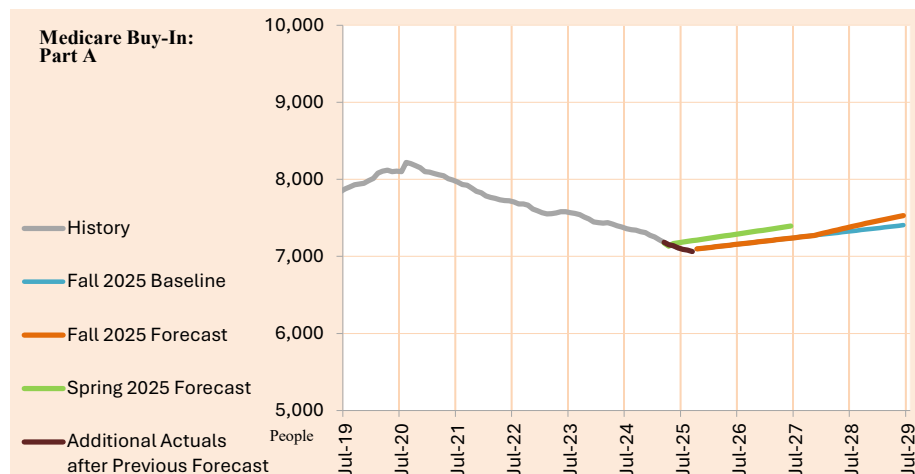
Medicare Part-A Premium Assistance coverage is for Inpatient services. This coverage is free for most Medicare eligible individuals, except for those who don't have sufficient work history. Medicare Part-A Premium Assistance program is designed to help low-income individuals (under 100 percent of FPL)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

Medicare Part-A Premium Assistance – The most recent finalized actual for June 2025 shows 7,109 clients on this caseload. This caseload declined during the Public Health Emergency, since transfers in were reduced. This transfer in reductions will continue, given that the rules of Continuous Eligibility state that cases cannot be transferred to a lower-benefit group until their redetermination date. As a result, movement to premium assistance caseloads will be slower than in the past. This will

change following the end of CE, where this caseload is expected to grow.

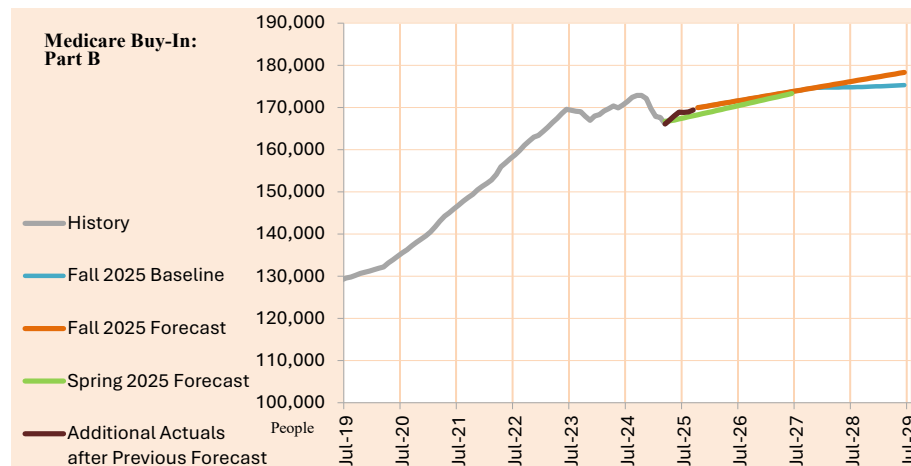
The Medicare Part-A biennial average monthly caseload for 2025-27 is expected to be 7,156 cases, a 2.8 percent decrease compared to the previous forecast. It is expected to be about 3.1 percent higher in the 2027-29 biennium.



Medicare Part B Premium Assistance – The most recent finalized actual for June 2025 shows 168,889 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. This caseload experienced increases and decreases due to the re-processing of cases in and out of Oregon Health Plan categories and dual-eligible categories. The last set of mass redeterminations, focusing on the aged and disabled, has led this caseload to decrease starting in autumn 2024. This caseload began increasing in line with the pre-COVID history of the program until the last Unwinding cohort was processed, in March 2025.

The forecasted average monthly caseload for Medicare Part B is 171,500 cases in the 2025-27 biennium, slightly higher than the

prior forecast. The average monthly caseload for the 2027-29 biennium is forecasted to be 176,124 cases.



The Basic Health Plan or “OHP Bridge”

On July 1, 2024, the state inaugurated a Basic Health Program (BHP), also called Bridge Plan. The Basic Health Program, allowable under Section 1331 of the Affordable Care Act, is a type of limited coverage available to persons up to 200 percent of the federal poverty level who are non-disabled and non-elderly. A Temporary Expansion of Medicaid group was created during the Unwinding to preserve coverage for those who would qualify for OHP Bridge. That group was rolled into the BHP at startup.

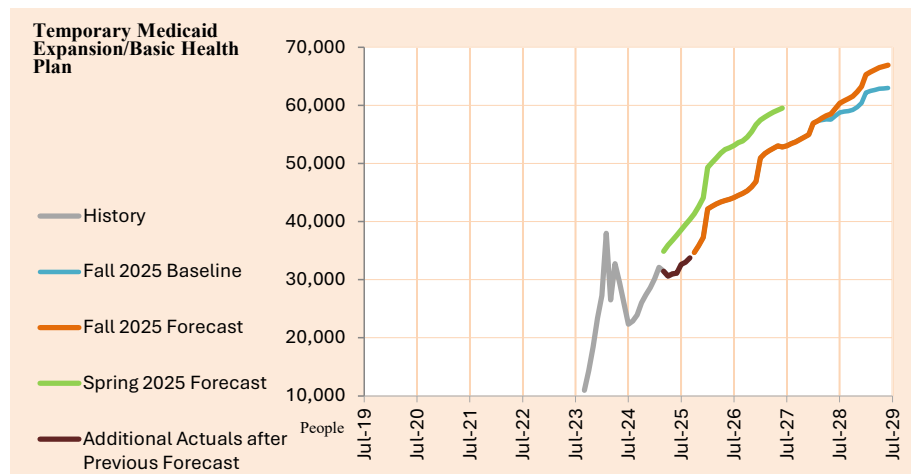
Permanent Expansion of Medicaid is designed for American Indians and Alaska Natives who would qualify for Basic Health Plan. Because American Indians and Alaska Natives cannot be required to join a Coordinated Care Organization (CCO), and BHP members must be enrolled in a CCO, this separate group was created.

Previous forecasts used estimates derived from the Health Authority and their consultants of the number of OHP members who would transfer to the Basic Health Plan and the number of clients who would be referred from the federal marketplace. These

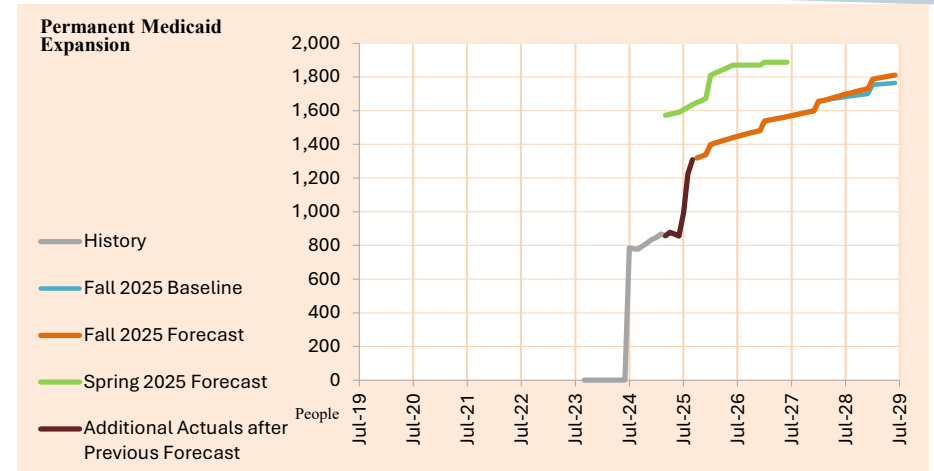
estimates proved to be high and were reduced in the current forecast based on available information. Both of these caseloads assume relatively stable growth over the forecast horizon, with the largest increases occurring during open enrollment periods.

The loss of Continuous Eligibility and the scheduling redeterminations every six months for ACA Adults and higher income HOP clients due to HR1 is expected to increase BHP and PME enrollment, as higher income adults have their cases redetermined at a more frequent rate.

The Basic Health Plan biennial average monthly caseload for 2025-27 is expected to be 43,776 cases. This is a 14.8 percent reduction from the previous forecast. The average monthly caseload for the Basic Health Plan for 2027-29 is projected to be 59,933.



The Permanent Medicaid Expansion biennial average monthly caseload for 2025-27 is expected to be 1,422 cases. This is 41.8 percent lower than the previous forecast. The average monthly caseload for Permanent Medicaid Expansion for 2027-29 is projected to be 1,693.

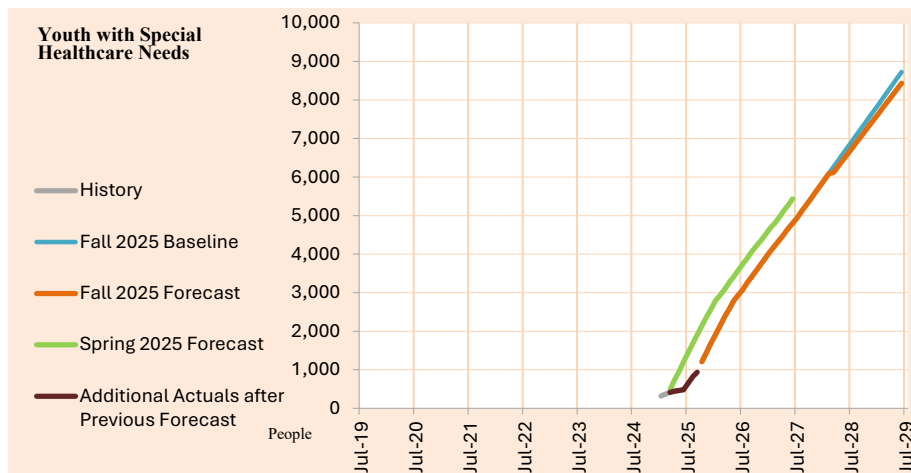


Young Adults with Special Health-Care Needs (YSHCN)

Starting January 1, 2025, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services were offered to youth with special needs or at risk for negative physical, developmental, behavioral or emotional conditions. In most cases, EPSDT is an add-on service to existing OHP coverage. Phase in of the program included 19- and 20-year-olds in 2025. It will include 21-year-olds in 2026, and 22-year-olds in 2027. It is expected that the legislature will approve of funding to add this service incrementally until all youth from ages 19 to 26 will be covered. However, only 2025 and 2026 coverage is currently approved. The forecast assumes 23-year-olds will be eligible in 2028 and 24-year-olds will be eligible in 2029.

Currently, EPSDT services for Young Adults with Special Health Care Needs will cover clients up to 205 percent of the federal poverty level (FPL). Normally, young people above 138 percent of the federal poverty level would lose OHP coverage on their 19th birthday (aging out of CHIP). However, these clients would remain covered due to their YSHCN status. This represents the “stand alone YSHCN population.”

The Young Adults with Special Health-Care Needs biennial average monthly caseload for 2025-27 is expected to be 2,876 cases. This is a significant revision to the previous forecast (a reduction of 19.9 percent). The average monthly caseload for 2027-29 is projected to be 6,692. Given that there is relatively limited actual (6 months) and preliminary data available at the time of this forecast, and YSHCN has only been authorized through 2026 (not for the full 25-27 and 27-29 biennia) this forecast should be considered subject to significant revision.



Forecast Environment and Risks

HR 1 Effects

There are large substantial risks to forecast accuracy related to the implementation of HR1.

HR1 represents the most significant change to Medicaid policy in the program's history and will result in substantial declines in enrollment. This forecast makes major assumptions around the timing and magnitude of such declines, guided by continued conversations with OHA about the implementation timeline of specific HR1 changes and a combination of national estimate decomposition and analysis of client data from IE/ONE.

HR1 will certainly decrease enrollment – that was its intent, being that it is a budget reconciliation bill designed to offset tax cuts with savings from reduced Medicaid enrollment. However, the timing and magnitude of these declines will depend on how and when Oregon implements specific HR1 requirements. These timings will be dependent on guidance from CMS. As was stated early in this section, no technical assistance sessions have occurred between the Health Authority and CMS at the time of this writing. Based on the current environment, all assumptions contained in this forecast concerning how Oregon implements HR1 should be considered subject to change, and a risk to accuracy.

The estimation of the populations affected by HR1 represent a risk to accuracy. This includes the numbers of people who will be reclassified as ineligible non-citizens. An initial count of these clients was produced for this forecast; however, this policy will not be enacted until October 2026, and the numbers involved may be larger or smaller than the counts identified in a recent data pull.

The estimate of the number of persons who cannot meet the work or “community engagement” requirements in the ACA Adults and HOP-Adults groups relies heavily on national estimates of HR1–related Medicaid losses as provided by the congressional budget office and refined by national think-tanks. These estimates are based on broad models that consider caseload decline through 2034. Oregon-specific effects may be larger or smaller than national estimates.

The forecast assumes that increased redetermination rates mandated by HR1 will increase enrollment in Bridge (BHP) and Permanent Expansion as ACA Adult clients experience more frequent redeterminations without Continuous Eligibility protections against moving to a lower benefit group. This rate of transfer is highly speculative.

The change in retroactive Medicaid coverage from three months to one month for ACA Adult and some HOP-Adult clients and two months for others will change the number of months clients are on the caseload, reducing caseload size. But this kind of change has never happened before. Changes without established patterns to fall back on make the estimates more speculative than we would like.

Indirect HR 1 Effects

The change in retroactive Medicaid coverage from three months to one month for some clients and two months for others represents a unique issue for forecast accuracy. Clients receive retroactive coverage after enrollment, moving the caseload up after initial, preliminary counts are obtained. For example, a count of cases in March will be revised upward in April, May, and June as the number of clients retroactive eligible for March is verified. In order to account for this, OFRA has estimated the effects of retroactive enrollment on the preliminary months and used these modified values for forecasting. The change to retroactive enrollment will require re-calculation of the effect of retroactive eligibility that

—could lead to some instability in the estimate until enough months pass in the new system to create a good estimate of effect.

This is a risk based on a change in estimation methodology, which is unusual. The impact of this won't be seen until after the implementation of HR1 and does not represent a known risk to this forecast.

Compliance with HR1 represents a unique challenge to all states' eligibility systems. New work requirements and changes to case processing rules will increase the workload of eligibility workers who will also be dealing with new rules and restrictions for SNAP clients. Increases in the time it takes to process each case would naturally suggest increased staffing for the Oregon Eligibility Partnership. However, HR1 also reduces the amount of money provided by the federal government for administrative functions. It is possible that the Oregon Legislature may create a remedy, but a projected budget shortfall in 2025-2027 makes it unlikely that the eligibility system will be fully staffed when workloads increase. As a result, long wait times and incorrect determinations of eligibility seem likely. This could reduce new enters and increase exits through human error and a negative client experience with the eligibility system. This is both likely and difficult to quantify.

Non-HR1 Risks

The Public Health Unwinding impacts on the caseload were expected to come to an end in March 2025. However, there has been an unexpected rise in exits and transfers since March, showing cases are being closed or moved into lower benefit groups as they are being redetermined post-Unwinding. It's believed that these increases in exit and transfer rates represent a system shifting to a transition phase, which may continue until all

cases redetermined during the Unwinding have a subsequent redetermination, which will be sometime in late 2026. After this transition phase, it is expected that the caseload will reach a new equilibrium.

This transition phase is hypothetical, but reasonable – the result of a unique situation created by the pandemic. If it is not, the new pattern may have greater or lesser duration than expected, representing a risk to accuracy.

Each year, open enrollment in the federal marketplace (i.e. “Obamacare”) leads to large referrals into adult caseloads – ACA Adults and Parent Caretaker Relatives. The future affordability of marketplace insurance is currently being debated at the federal level, and those debates may make the marketplace more or less attractive – influencing more or fewer people to apply for coverage, changing the transfer rates to Medicaid.

It is assumed that some people who apply for marketplace insurance will instead enroll in the Bridge Plan (BHP) or Permanent Medicaid Expansion. The instability in marketplace insurance affordability will also influence the open enrollment referrals to these groups.

The forecast assumes that the current cohorts of YSHCN are reflective of future cohorts of YSHCN clients, and that YSHCN will continue to grow at a similar pace to the initial rollout. This is a unique program where it is expected to add additional age groups through 2029. This could effectively allow the initial cohort of 19-year-olds to stay on YSHCN until age 26. Funding mechanisms however are only approved into 2026. Changes to YSHCN rollout related to eligibility will impact the accuracy of the forecast.

Health Systems/Medicaid Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
HEALTH SYSTEMS - MEDICAID								
OHP								
Children's Medicaid	315,776	311,042	-4,734	-1.5%	311,042	308,089	-2,953	-0.9%
Children's Health Insurance Program	139,097	136,644	-2,453	-1.8%	136,644	134,695	-1,949	-1.4%
Foster, Substitute and Adoption Care	16,357	16,231	-126	-0.8%	16,231	16,268	37	0.2%
Aid to the Blind and Disabled	82,045	82,247	202	0.2%	82,247	82,306	59	0.1%
Old Age Assistance	62,444	60,529	-1,916	-3.1%	60,529	60,727	199	0.3%
Pregnant Women	18,003	16,856	-1,147	-6.4%	16,856	16,612	-244	-1.4%
Parent, Caretaker Relative	106,992	100,335	-6,657	-6.2%	100,335	97,946	-2,388	-2.4%
ACA Adults	590,138	578,416	-11,721	-2.0%	578,416	531,999	-46,417	-8.0%
Breast and Cervical Cancer Treatment Program	78	67	-11	-14.5%	67	73	7	10.1%
Healthier Oregon - Child	17,459	14,993	-2,466	-14.1%	14,993	14,962	-31	-0.2%
Healthier Oregon - Pregnant	5,828	4,490	-1,339	-23.0%	4,490	4,641	151	3.4%
Healthier Oregon - Adult	90,326	88,180	-2,146	-2.4%	88,180	88,382	202	0.2%
Youth with Special Healthcare Needs ¹	3,591	2,876	-715	-19.9%	2,876	6,692	3,816	132.7%
Permanent Medicaid Expansion ²	2,444	1,422	-1,022	-41.8%	1,422	1,693	271	19.0%
Total OHP	1,450,578	1,414,327	-36,252	-2.5%	1,414,327	1,365,084	-49,243	-3.5%
Qualified Medicare Beneficiary	38,772	39,881	1,109	2.9%	39,881	41,655	1,774	4.4%
Total Medicaid	1,489,350	1,454,208	-35,143	-2.4%	1,454,208	1,406,739	-47,469	-3.3%
Temporary Medicaid Expansion/Basic Health Plan ³	51,366	43,776	-7,590	-14.8%	43,776	59,933	16,157	36.9%
Medicare Part A	7,289	7,156	-133	-1.8%	7,156	7,380	224	3.1%
Medicare Part B	170,405	171,500	1,095	0.6%	171,500	176,124	4,624	2.7%

1. Program begin date 1/1/2025 - biennial average for 2023-25 does not include averaged zeroes for months before implementation.

2. Rollover from Temporary Medicaid Expansion: 7/1/2024 - biennial average for 2023-25 does not include averaged zeroes for months before implementation.

3. Biennial average is the combination of Temporary Medicaid Expansion and Basic Health Plan. Temporary Medicaid Expansion ended Dec 31 2024.

Behavioral Health (BH)

The Mental Health program is being renamed “Behavioral Health” (BH) to reflect an increased emphasis on the Behavioral Health program in both its mission and administration within the Oregon Health Authority.

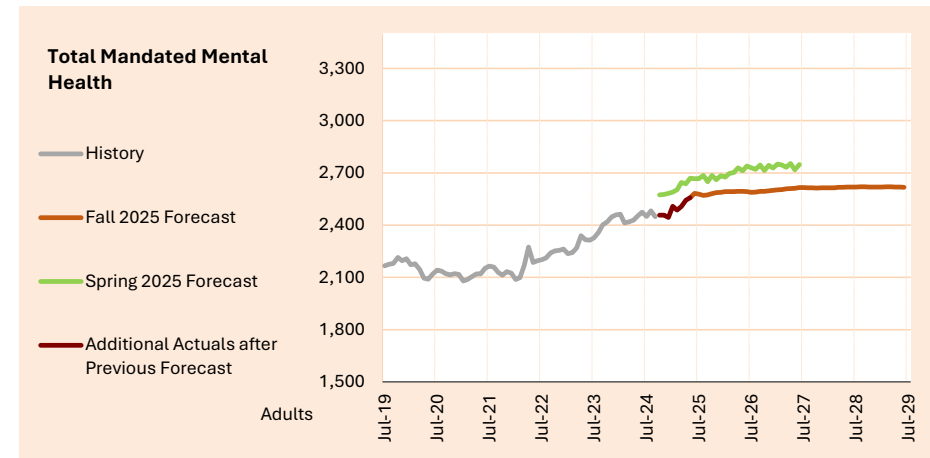
The Behavioral Health forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Behavioral Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires that Mandated populations, including criminally and civilly committed patients, receive behavioral 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 behavioral 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 Behavioral Health Services

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

The Total Mandated Behavioral Health caseload for the 2025-27 biennium is expected to average 2,692 clients per month. The 2027-29 biennial monthly average is expected to be 2,813 clients, which is 4.5 percent higher than the 2025-27 biennial average.



Total Forensic Behavioral Health Services

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

The Forensic Behavioral Health Services biennial average forecast for 2025-27 is 1,842 clients per month. The 2027-29 biennial monthly average is expected to be 1,975 clients, 7.2 percent higher than the 2025-27 biennial average.

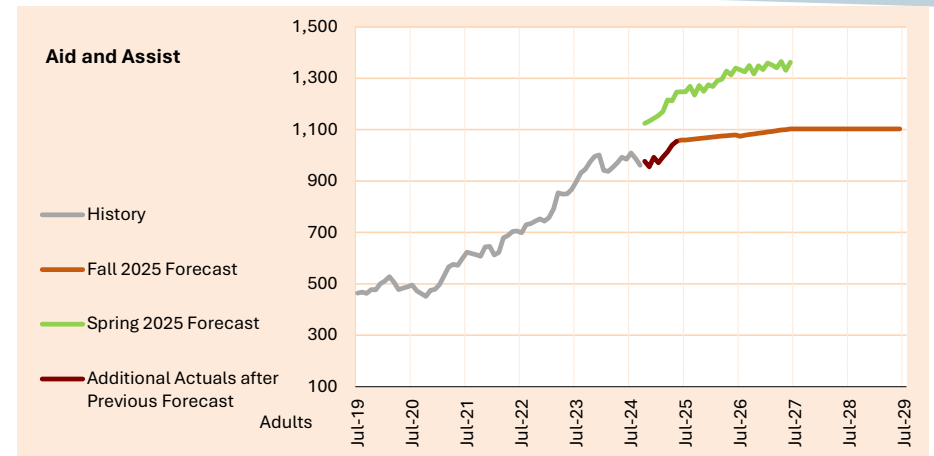
Aid and Assist – This caseload encompasses both Community Restoration Aid and Assist (CRAA) and State Hospital Aid and Assist. Because the State Hospital is capacity constrained, growth in Aid and Assist is, for the most part, due to growth in Community Restoration. Between July 2024 and July 2025, Community Restoration increased 12 percent, from 546 clients to 610. The total Aid and Assist caseload increased 4 percent in that same time frame.

Collection of CRAA data began in 2018, as self-report data from Community Mental Health Programs. From 2018 until this Fall 2025 forecast, data were submitted quarterly. As of July 2025, a new data collection process is in effect, and counties are required to submit data each month. This process has enabled increased communication between the counties and the Behavioral Health division. Records that were erroneously open have been closed, which led to a level shift down in the historical data. As a result, the caseload went from about 700 clients for the Spring 2025 forecast, to 530 clients for the Fall 2025 forecast – a reduction of 24 percent.

Despite the one-time drop in caseload mentioned above, the overall trend in the CRAA caseload is steady upward growth. For the last seven years there has been an emphasis on diverting clients from the State Hospital by local jurisdictions. This has been a coordinated effort by local judges, district attorneys and public defenders, along with law enforcement.

The Aid and Assist caseload at the State Hospital has been flat for the last four years. This caseload tends to fluctuate depending on rules determining time limits and shifting priorities for admitting PSRB or Civil patients. 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. Then in 2023, court orders for Aid and Assist fell and the State Hospital Aid and Assist caseload plateaued. As of November 1, 2025, there were fifty-four patients waiting to get in to the State Hospital on Aid and Assist orders from counties around the state.

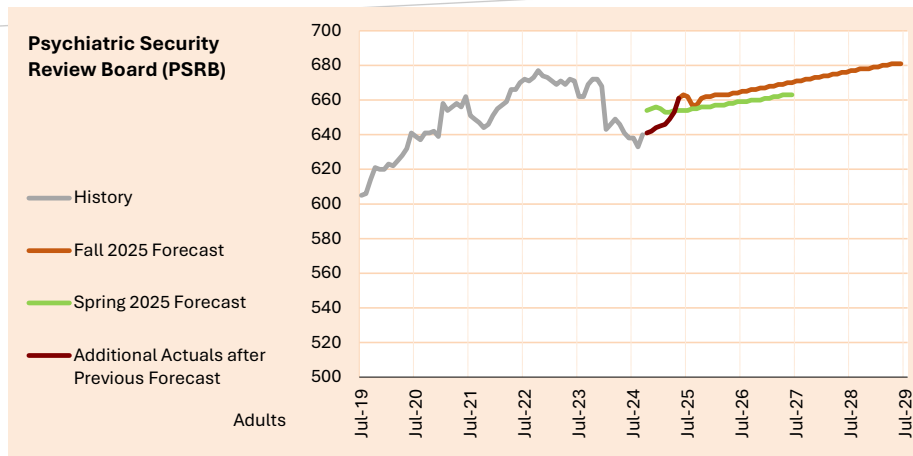
The forecast for Aid and Assist for the 2025-27 biennium is projected to average 1,177 clients per month. The 2027-29 biennial average is expected to be 1,299 clients per month, which is 10.4 percent higher than the 2025-27 biennial average.



Psychiatric Security Review Board (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. Most clients in PSRB caseloads have been found “guilty except for insanity” of a crime by a court; a small but growing number of these patients were Civilly Committed, but due to the high risk of potential harm, they are being monitored by the PSRB and are counted in the PSRB caseload. All of these Civilly Committed PSRB patients are at the State Hospital.

The PSRB caseload has been relatively flat since 2020, fluctuating between 640 and 660 clients each month. The growth that has occurred over the last few years is largely due to the addition of the extremely dangerous Civilly Committed clients. As of October 3, 2025, the number of clients in this Civilly Committed PSRB population was 51. This is an increase of 50 percent since 2023.

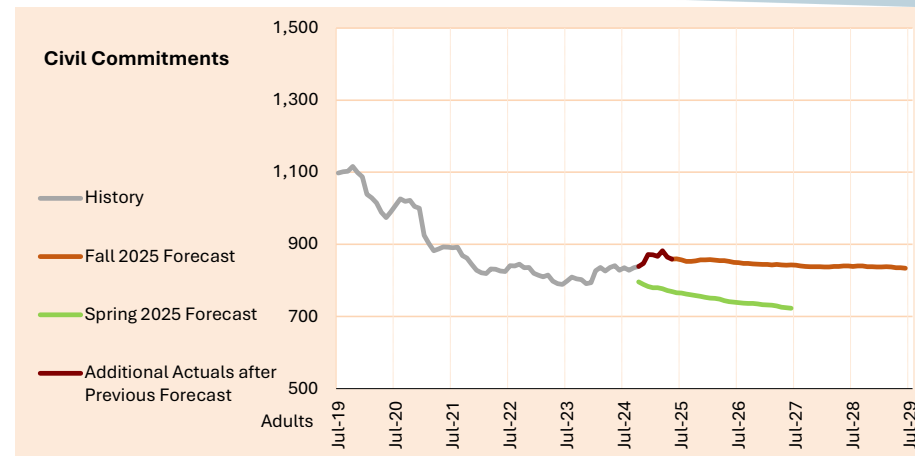
The 2025-27 biennial average forecast for PSRB is 665 cases per month. The 2027-29 biennial average is expected to be 676 clients per month, which is 1.8 percent higher than the 2025-27 biennial average.



Civil Commitments

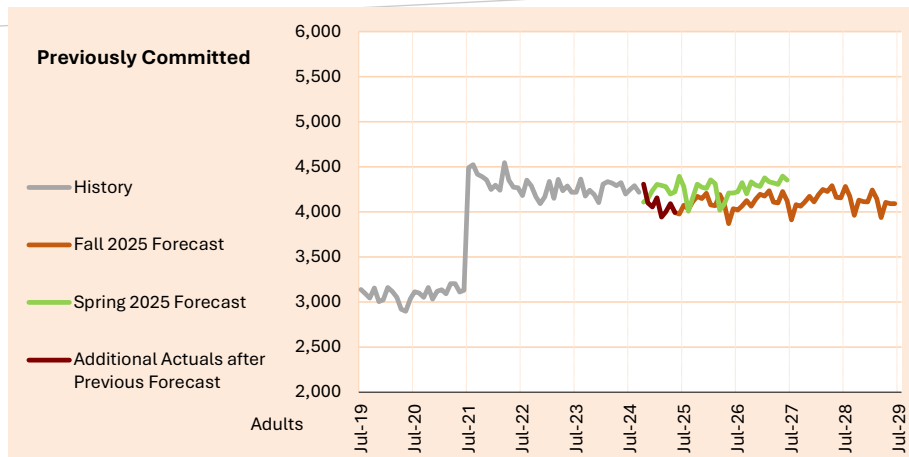
The data for this caseload are subject to the interaction of reporting practices, data system changes, and data warehouse activities. There has been ongoing work to improve data accuracy. With the passage of the Affordable Care Act, more adults became eligible for Medicaid. As a result, the caseload steadily declined almost continuously each month, from 2014 to 2024. For the past year, the caseload has been relatively flat.

The Civil Commitment forecast for the 2025-27 biennium shows an average of 850 clients per month. The 2027-29 biennial monthly average is 838 clients, 1.4 percent lower than the 2025-27 biennial average.



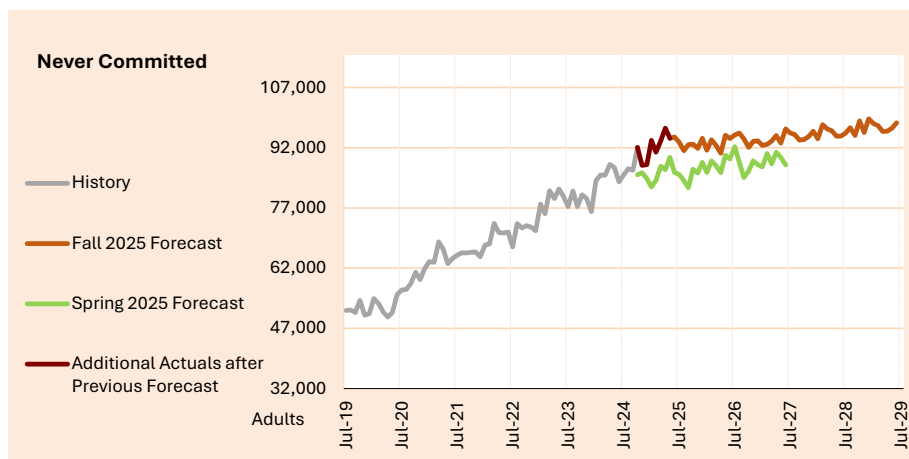
Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000. About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings.

The 2025-27 **Previously Committed biennial average caseload forecast** is 4,110 clients per month. The 2027-29 biennial monthly average is 4,129 clients, 0.5 percent higher than the 2025-27 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 2025-27 **Never Committed biennial average caseload forecast** is 93,445 clients per month. The 2027-29 biennial monthly average is 96,200 clients, 2.9 percent higher than the 2025-27 biennial average.



Forecast Environment and Risks

During the 2025 Legislative Session, two House Bills (HB) passed that have the potential to affect Behavioral Health caseloads in multiple ways. HB2005:

1. States that an extremely dangerous person may stay in the State Hospital until no longer extremely dangerous. This clause allows the courts to pause time limits if a person isn't participating in their treatment, which could make time limits moot.
2. Gives the judges (instead of the State Hospital) responsibility for determining if and when an Aid and Assist patient gets placed out of the State Hospital and into the community.
3. Impacts the caseload overseen by the PSRB by expanding the definition of PSRB cases to include people who have *attempted* serious and dangerous acts. As a result, the PSRB caseload at the State Hospital may grow more quickly than in the past. However, the Oregon State Hospital system is capacity constrained and is currently operating at full capacity.
4. Lessens the criteria for courts to civilly commit a person, so we may see an increase in Civilly Committed patients over the next few years. These clients will likely be served in the community, because priority for entrance to the State Hospital goes to Aid and Assist and PSRB patients first. Civilly Committed patients may be admitted to the State Hospital if they meet an exception criterion, and because the length of stay is longer for exception criteria patients, this will cause the caseload to grow faster.

The second House Bill that may influence the Behavioral Health caseload is HB 2059 which appropriates \$65 million General Fund to expand residential treatment capacity for Behavioral Health.

Rather than affecting caseload totals directly, this bill could change the service setting for some patients. It could help the State Hospital stay in compliance with rules around how quickly patients are admitted, because there will be more community beds for patients to move to once they are ready to place out of the State Hospital.

The federal bill HR 1 that became Public Law 119-21 in July 2025 changes the rules for eligibility in the Affordable Care Act expansion of Medicaid. As stated in the Civil Commitment section of this document, the Affordable Care Act (ACA) increased the number of adults eligible for Medicaid, leading to a steady decline in Civil Commit from 2014 to 2024. Changes to the eligibility rules that reduce the ACA Adult caseload could reverse this trend, sending Civil Commit upwards.

The Community Restoration Aid and Assist caseload is dependent upon complete and correct 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 is also subject to variation at the county level. 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. These movements – both the timing of releases and the numbers changing status – are difficult to anticipate and add to the risk to forecast accuracy.

Another 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 has also been 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. Even with this amendment, Civilly Committed patients are third in the priority list for entrance to the State Hospital, after PSRB and Aid and Assist.

More than any other area we forecast, court mandated requirements can influence this forecast by requiring changes in the operation of the State Hospital. In August 2022, federal Judge Mosman made changes to the patient discharge process with the intended effect of assisting the Oregon State Hospital to be in compliance with the Mink-Bowman order. Mink-Bowman requires that (1) PSRB and Aid and Assist patients are both admitted to the State Hospital with the same criteria and (2) patients are admitted to the State Hospital within 7 days. Oversight by a federal judge for compliance is still ongoing, and a Neutral Expert is constantly monitoring the State Hospital. Court actions are a significant ongoing risk to forecast accuracy.

Behavioral Health Biennial Average Forecast Comparison

	2025-27 Biennium			% Change Between Forecasts	Fall 2025 Forecast			% Change Between Biennia
	Spring 25 Forecast	Fall 25 Forecast	Change		2025-27	2027-29	Change	
BEHAVIORAL HEALTH ¹								
Under Commitment								
Community Restoration Aid and Assist ²	872	700	-172	-19.7%	700	818	118	16.9%
State Hospital Aid and Assist	471	504	33	7.0%	504	505	1	0.2%
Total Aid and Assist (State Hospital and Community Restoration) ³	1,313	1,177	-136	-10.4%	1,177	1,299	122	10.4%
Psychiatric Security Review Board	659	665	6	0.9%	665	676	11	1.7%
Total Forensic Care	1,972	1,842	-130	-6.6%	1,842	1,975	133	7.2%
Civilly Committed	742	850	108	14.6%	850	838	-12	-1.4%
Total Mandated Behavioral Health Services	2,714	2,692	-22	-0.8%	2,692	2,813	121	4.5%
Previously Committed	4,259	4,110	-149	-3.5%	4,110	4,129	19	0.5%
Never Committed	87,542	93,445	5,903	6.7%	93,445	96,200	2,755	2.9%
Total Served	94,515	100,247	5,732	6.1%	100,247	103,142	2,895	2.9%

1. Numbers reported represent adults only.

2. These data are self report data from the County Mental Health Programs (CMHPs).

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

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 SNAP and TANF. define eligibility income limits as some percentage of FPL.²

2025 Poverty Guidelines for Oregon

Persons in family/ household	Poverty guideline (100% FPL)
1	\$15,650
2	\$21,150
3	\$26,650
4	\$32,150
5	\$37,650
6	\$43,150
7	\$48,650
8	\$54,150

For families/households with more than 8 persons, add \$5,500 for each additional person.

² Source: Annual Update of the HHS Poverty Guidelines; Federal Register January 17, 2024, 89 FR 2961. See: <https://www.federalregister.gov/documents/2024/01/17/2024-00796/annual-update-of-the-hhs-poverty-guidelines>

Self-Sufficiency Programs (SSP)

Program Background and History

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).

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 Integrated Eligibility Program and SNAP

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. 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.

The **Able Bodied Adults without Dependents Rule (ABAWD)** limits SNAP benefits to three months for non-disabled adults without dependents. The age limit for individuals with Able Bodied Adults without Dependents Status changed from 50 to 52 during the pandemic. On October 1st, 2024, it changed again to include adults up to age 54. Also starting October 1st, the ability to defer some clients from closure was applied to all counties where the ABAWD rule is in place. In addition, in January 2025 all clients had their ABAWD months reset back to zero, making it possible for clients to go three months before losing coverage regardless of the months previously counted toward exclusion.

During the pandemic, the ABAWD rule was waived for all counties. It has now been re-applied in a limited way. As of January 2024, only Multnomah and Washington counties are true “time limit counties,” while 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 on a monthly basis. All other counties still have the ABAWD rule waived.

HR 1 (the “One Big Beautiful Bill Act”) will require all counties adopt the ABAWD rule by January 1 2027. In addition, HR1:

- Changes the Able-Bodied Adults Without Dependents (ABAWD) work requirement age range to those 18-64.
- Changes the exception for those with dependent children to only apply to children under 14.
- Removes the exceptions for people who are experiencing homelessness, are aged 24 or under and were in foster care when they turned 18, or a veteran.
- Includes a new exemption for individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Services.
- Limits ABAWD waivers to only be permissible if an area has an unemployment rate above 10% and removes the ability for waivers to be based on lack of sufficient jobs.

Broad-Based Categorical Eligibility (BBCE) enables states to raise income and asset limits to qualify 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 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.

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. This trend continued until the COVID-19 pandemic hit, causing the caseload to increase in March to April 2020 by 6.8 percent. There were increased subsequent exits in June and July, 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 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.

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.

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).

Changes in TA-DVS Reporting

Since 2016, OFRA has been reporting TA-DVS in two groups: TA-DVS with-payment, and TA-DVS without-payment. This led to the inevitable assumption that these were two separate, stable groups – that some people authorized for TA-DVS accepted aid payments, and a separate group did not. However, this is not the case. The TA-DVS 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 TA-DVS without-payment group was to illustrate that there were more TA-DVS clients than were represented in the with-payment category. The sum of TA-DVS 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 TA-DVS



—forecast, which shows the total size of the program. We will continue to present TA-DVS with-payment. TA-DVS 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 unwilling to relocated during a pandemic, despite experiencing domestic violence. 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 TA-DVS 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 TA-DVS, 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 TA-DVS cases.



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 (similar to a Foster Care payment).

Out of Home Care provides safe, temporary homes for abused/neglected children who cannot remain safely in their homes of origin. Children in the program are placed with relatives or foster families or in residential treatment care settings. The goal is 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 include support and safety monitoring services to prevent placement of children in Foster Care and 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 behavioral health services, substance abuse prevention and treatment, and parenting programs.

Aging and People with Disabilities (APD)

Program Background and History

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. Between 2013 and 2016, the average annual caseload grew by 5.3 percent due to the implementation of K-Plan along with Medicaid expansion and the 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.

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).

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.

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.

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

In-Home Programs

From July 2013 to December 2015, the In-Home Care caseload grew by 29 percent. This caseload growth has been attributed to several factors, but the largest impact was likely the implementation of K-Plan (see above for more information on K-Plan).

After the initial rapid growth related to K-Plan, increases in this caseload moderated considerably. In-Home Care grew by seven percent between January 2016 and September 2017, then began to decline 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.

Starting in January 2022, the “pay-in” liability of In-Home clients was eliminated. Individuals had been required to contribute a portion of service costs depending on their income and assets. By removing this pay-in, In-Home Care becomes more affordable.

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 waived 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.

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 PACE caseload began to rebound in March and April 2021.

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.

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 Community Based Care.

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.



— **Oregon Project Independence Medicaid (OPI-M)** is an expansion of Oregon Project Independence (OPI) with federal funding and offers assistance for adults with physical disabilities aged 18 and older and individuals who are aged 60 and older who need support with personal care tasks. OPI-M has higher income and asset eligibility limits than regular OPI.

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).

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.

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.

I/DD Data Reporting Changes

OFRA has been reporting static historical actual data for both I/DD Case Management Enrollment and I/DD services, based on claims records. Client claims records reflect true service utilization, but these records can take up to a year to reconcile. The updated historical actuals allow for capturing the most accurate and reconciled information, whereas static historical data did not include reconciled updates. Case Management Enrollment is not based on claims and is not influenced in this way.



In order to deal with the limitations of claims data, the history of the program was revised with updated data, rather than using static data which did not include reconciled information. This methodological change began with the Spring 2025 Forecast. In addition, the most recent three months of actuals will be considered preliminary. Since preliminary months represent the months most likely to change through claims reconciliation, the most recent three months will not be reported for any I/DD service-based caseloads.

I/DD Case Management records, on the other hand, are based on enrollment and are not subject to data reconciliation constraints. Therefore, starting with the Spring 2025 Forecast, I/DD Case Management Enrollment actuals will be reported without a three-month lag period.

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.

Employment and Daily Support Services (DSA) have been grouped together as 'Total Employment and Day Support Services' since 2016.

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

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.

Nursing Services – Direct Nursing Services are shift-type services provided to adults with intellectual or developmental disabilities and complex health management support needs in order 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 I/DD 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)

Program Background

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.

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.

The VR caseload was significantly impacted by COVID-19 starting in early 2020 and remained in decline until early 2022 when the caseload stabilized and began 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.

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 a given month. After employment, and if all is going well, a case is normally closed after 90 days.

Pre-Employment Transition Services

Starting in July 2024, the VR program allowed students to use Pre-Employment Transition Services (Pre-ETS) before being determined eligible for VR services without needing to go through the application process. The Pre-ETS services are short-term in nature. However, if students require more comprehensive services beyond Pre-ETS, they must go through the formal application process to be determined eligible. This change in the law reduced the expectation for students to apply for VR services, leading to a decline in applications. Additionally, this change disrupted the existing relationship between the VR program and school districts.

Under the previous contracts, the focus was on getting a mutually agreed-upon number of students through the VR process, which included substantial service delivery such as applications and plan development. The new contracts, however, emphasize providing earlier services like Pre-Employment Transition Services. These services are short-term and do not require an application.

VR Order of Selection (OOS) is mandated by the federal Rehabilitation Services Administration (RSA) and directs state VR programs on how to deliver services when resources are insufficient to serve all eligible individuals. Under OOS, a waitlist is established to manage service costs, ensuring that individuals with the most significant disabilities receive priority access to VR services. VR OOS was developed in 2025.



Appendix II

Oregon Health Authority – Caseload History and Definitions

OHA 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.³

2025 Poverty Guidelines for Oregon

Persons in family/ household	Poverty guideline (100% FPL)
1	\$15,650
2	\$21,150
3	\$26,650
4	\$32,150
5	\$37,650
6	\$43,150
7	\$48,650
8	\$54,150

For families/households with more than 8 persons, add \$5,500 for each additional person.

³<https://www.federalregister.gov/documents/2025/01/17/2025-01377/annual-update-of-the-hhs-poverty-guidelines>

Health Systems/Medicaid (HS/M)

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).

General Summary of Health Systems/Medicaid

The expansion of Medicaid through the Affordable Care Act (ACA) beginning in January 2014 led the HS/M 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.

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.

Work Requirements have been enacted for ACA Adults clients to be implemented January 1 2027. Medicaid clients covered under ACA Adults expansion are required to complete 80 hours per month of work or engage in a ‘community engagement’ activity including education, community service, or can attest to being able to have non-work income equivalent to 80 hours of work in a month at minimum wage.

Exemptions to the work or community engagement requirements include:

- Pregnant women,
- People under 19 or over 64,
- Former foster youth under 26,
- Tribal members and Alaska Natives,
- Veterans with rated disabilities,
- Medically frail individuals,
- People participating in a substance use or alcohol use disorder treatment program,
- People who are compliant with TANF/SNAP work requirements,
- People who are parents or caregivers of a dependent child 13 years of age and under or someone with a disability,
- People who are currently incarcerated or have been released within the past 90 days, and
- Family caregiver as defined in RAISE Family Caregivers Act.

Short-term hardship waivers can be applied for:

- People who are receiving in-person hospital services, skilled nursing, inpatient psychiatric treatment, or other medical services of similar acuity including outpatient care as determined by federal CMS
- Natural disasters,
- Counties in which there is an unemployment rate of over 8% or 1.5 times the national rate, and

- Individuals receiving outpatient care or traveling long distances to receive specialized care.

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/alien. Many women who would have been formerly enrolled in this program are not enrolled directly into ACA Adults.

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 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 – This program was originally called Cover all Kids (CAK), and 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.

Healthier Oregon - Pregnant (HOP-P) – This caseload, formerly called CWM-pregnancy or CWM-plus rose sharply from 2020 through 2023 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.

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. 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.

Other Medicaid and Medical Assistance

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 Programs⁴

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.

Temporary Medicaid Expansion was offered during the unwinding of COVID-19 public health emergency In order to minimize the number of people who would lose health insurance. This temporary expansion was allowed under an 1115 SUD Waiver, and was offered to Oregonians who would qualify for Medicaid but for income up to 200 percent of the Federal Poverty Level. On July 1 2024 the Temporary Expansion group were rolled into the Basic Health Program, also called "OHP Bridge."

The Basic Health Program (BHP) or "OHP Bridge" coverage is for low-income adults who would qualify for Medicaid but for income, exceeding 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.



Permanent Expansion of Medicaid is designed for American Indians and Alaska Natives who would qualify for Basic Health Plan. Because American Indians and Alaska Natives cannot be required to join a Coordinated Care Organization (CCO), and BHP members must be enrolled in a CCO, this separate group was created.

Young Adults with Special Health-Care Needs (YSHCN) describes young adults who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Phase in of the program will include 19- and 20-year-olds in 2025, and 21 year-olds in 2026. For most clients, this will be an add-on service to existing OHP coverage. But for clients who are 19 or older and have a household income between 138 and 205 percent of the federal poverty level, YSHCN status requires a new forecasted caseload group.

Behavioral Health (BH)

The Mental Health program is being renamed “Behavioral Health” (BH) to reflect the emphasis of the Oregon Health Authority. Behavioral Health provides prevention and treatment options for clients with mental illnesses. The BH caseload forecast is the total number of adult clients receiving government paid mental health services per month. BH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population caseload includes both criminal commitment and civil commitment caseloads. Mandated populations are required to receive behavioral 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, most 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 is able to 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 as a result 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 90 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 behavioral health services either in the community or in a residential setting. More than 99 percent of these clients are served in non-residential settings.