Fall 2026 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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OREGON DEPARTMENT OF Human Services | OREGON HEALTH AUTHORITY

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Executive Summary

The 2025-**27 Supplemental Nutrition Assistance Program** (SNAP) biennial average forecast is 410,489 households, which is less than one percent lower than the Spring 2026 forecast. The 2027-29 biennial average forecast is 362,721 households, which is 11.6 percent lower than the 2025-27 forecast average.

The 2025-27 **Temporary Assistance to Needy Families** (TANF) biennial average forecast is 19,984 families, which is 2.2 percent higher than the Spring 2026 forecast. The 2027-29 biennial average forecast is 19,211 families, which is 3.9 percent lower the 2025-27 forecasted monthly average caseload.

The 2025-27 **Child Welfare** (CW) biennial monthly average forecast is 15,905 children, which is 1.1 percent lower than the Spring 2026 forecast. The 2027-29 biennial monthly average forecast is 15,568 children, which is 2.1 percent lower than the 2025–27 forecasted monthly average caseload.

The 2025-27 **Aging and People with Disabilities Long–Term Care** (LTC) biennial average forecast is 41,338 clients, which is almost identical to the Spring 2026 forecast. The 2027-29 biennial average forecast is 44,598 clients, which is 7.9 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 41,416 clients, which is almost identical to the Spring 2026 forecast. The 2027-29 biennial average forecast is 45,317 clients, which is 9.4 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 11,076 clients, which is 4.2 percent lower than the Spring 2026 forecast average. The 2027-29 Total VR biennial average forecast is 12,848 clients, which is sixteen percent higher

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** (HSM) biennial average forecast for Total Medicaid (which includes Healthier Oregon coverage groups) is 1,423,675 clients, which is less than one percent lower than the Spring 2026 Forecast. The 2027-29 biennial average forecast is 1,274,744 clients, which is 10.5 percent lower than the 2025-27 forecast average.

The **2025-27 Behavioral Health** (BH) biennial monthly average forecast for total served is 102,953 adults. The 2027-29 biennial monthly average forecast is 105,981 adults, which is 2.9 percent higher than the 2025-27 forecast average. The Mandated Behavioral Health Services forecast for 25-27 is 2,792 clients, 4.8 percent higher than the previous forecast. The 2027-29 biennial monthly average forecast is 3,003 clients, 7.6 percent higher than 2025-27 forecast average.

Introduction

HR1 (The "Big Beautiful Bill Act")

On July 4, 2025, House Referral 1 (HR1) was signed it into law, recorded as Public Law 119–21. 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 requires 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. All requirements are expected to be in place by January 1, 2028.

The final rules and operational requirements of HR1 have been completed by the Department of Agriculture Food and Nutrition Services for SNAP. This was a pressing requirement, as all SNAP changes were "effective upon passage." The Center for Medicare Medicaid Services has been working to finalize all HR1 related rules for Medicaid and have been communicating these rules piecemeal to the Health Authority. However as of this writing, not all rules are finalized. The Medicaid forecast presented here reflects what is known as of September 2026.

Economics

In general, Oregon's employment situation is "stalled." Economic growth has been mediocre since 2024. The total number of people employed in Oregon was lower in August 2026 than it was 12 months prior. Unemployment has been slowly dropping from a high point in November 2025 but remains above five percent – higher than the nation overall. The unemployment rate of 5.1 percent in August 2026 is ranked by the Bureau of Labor Statistics as one of the highest in the nation, tied with California and Connecticut. Only the District of Columbia, saddled with mass layoffs of the federal workforce, is higher. Some industrial sectors that typically pull people out of economic vulnerability and end their reliance on Human Services – like Leisure/Hospitality and Retail are in a post-COVID doldrum, not recovering to where they were in 2019.

The economic future is cloudy at best. Tariffs and a war in the economically important Persian Gulf region has driven up inflation. The general belief is that the economy will begin to grow in 2027, and there are signs of improvement in the Oregon Gross Domestic Product. But persistent inflation has required the Fed to raise interest rates, despite the weakness in hiring.

The Fall 2026 Forecast

This document summarizes the Fall 2026 forecasts of client caseloads for ODHS and OHA. OFRA issues these forecasts in the spring and fall each year. The Fall 2026 caseload forecast is based on data (whether preliminary or final) available through August 2026.

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

General Assumptions

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

[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

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

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Self Sufficiency				
Supplemental Nutrition Assistance Program (Households)	414,255	410,489	-3,766	-0.9%
Temporary Assistance for Needy Families (Families: Cash/Grants)	19,552	19,984	432	2.2%
Child Welfare (children served)				
Adoption Assistance	7,889	7,815	-74	-0.9%
Guardianship Assistance	2,649	2,654	5	0.2%
Out of Home Care	4,424	4,373	-51	-1.2%
Child In-Home	1,114	1,063	-51	-4.6%
Aging and People with Disabilities				
Long-Term Care: In Home	23,388	23,302	-86	-0.4%
Long-Term Care: Community Based	13,394	13,549	155	1.2%
Long-Term Care: Nursing Facilities	4,417	4,487	70	1.6%
Intellectual and Developmental Disabilities				
Total I/DD Case Management Enrollment	41,353	41,416	63	0.2%
Total I/DD Services	29,355	29,946	591	2.0%
Vocational Rehabilitation	11,565	11,076	-489	-4.2%

Total Department of Human Services Biennial Average Forecast Comparison

Fall 2026 Biennial comparison (2025–27 vs. 2027–29)

Program area	2025-27	2027-29	Change	% change between forecasts
Self Sufficiency				
Supplemental Nutrition Assistance Program (Households)	410,489	362,721	-47,768	-11.6%
Temporary Assistance for Needy Families (Families: Cash/Grants)	19,984	19,211	-773	-3.9%
Child Welfare (children served)				
Adoption Assistance	7,815	7,356	-459	-5.9%
Guardianship Assistance	2,654	2,738	84	3.2%
Out of Home Care	4,373	4,428	55	1.3%
Child In-Home	1,063	1,046	-17	-1.6%
Aging and People with Disabilities				
Long-Term Care: In Home	23,302	25,771	2,469	10.6%
Long-Term Care: Community Based	13,549	14,198	649	4.8%
Long-Term Care: Nursing Facilities	4,487	4,629	142	3.2%
Intellectual and Developmental Disabilities				
Total I/DD Case Management Enrollment	41,416	45,317	3,901	9.4%
Total I/DD Services	29,946	33,164	3,218	10.7%
Vocational Rehabilitation	11,076	12,848	1,772	16.0%

Notes:

- Out of Home Care includes treatment services placements and foster care.
- APD Long-Term Care and Total I/DD Services caseloads include Healthier Oregon clients.
- Some clients enrolled in Case Management do not receive any additional I/DD services.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs (SSP) aid low-income families to 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 *Second-Quarter Economic and Revenue Forecast* released by the Oregon Office of Economic Analysis (OEA) in June 2026. 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 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 as slow growth with low probability of a recession. The Oregon Gross Domestic Product (GDP) has now caught up to the national GDP, however there is a disconnect between economic growth and employment. The state's unemployment rate in June 2026 was 5.2 percent, which is tied for highest in the country with the exception of the District of Columbia (where layoffs of the federal workforce has created unique pressures on the job market).

Supplemental Nutrition Assistance Program (SNAP)

SNAP benefits improve the health and well-being of low-income individuals by providing them with 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, purchasing food and preparing 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 August 2026. 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.

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 Able-Bodied Adults without Dependents (ABAWD) work requirements to cover all counties, as opposed to the six Oregon metro areas previously covered. 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 were 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.

Since the completion of the Spring 2026 forecast, the SNAP program, working in conjunction with the US Department of Agriculture Food and Nutrition Service refined the implementation of HR 1 to include the following:

1) Starting Feb 1st, 2026, discretionary exemptions from ABAWD work requirements were applied automatically in seven rural counties: Crook, Gilliam, Jefferson, Morrow, Sherman, and Wheeler.
2) Starting June 1st, 2026, renewal interviews resumed for Non-Elderly Disabled (NED) households, which contain only adults age 60 and older or have disabled persons and have no earned income.
3) Starting June 2026 households had to verify their shelter and utility costs. Not doing so will not result in closure/denial but will result in a reduction of their monthly SNAP allotment in almost all cases.
4) From the 2,700 non-citizen cases that were initially dropped as ineligible under HR1, there were 300 cases that were incorrectly dropped off the caseload. A system update in September will correctly place these individuals back to the caseload.
5) Starting October 2026 Equifax data will be used to check individuals who are over-income.

While actual caseload contractions aligned closely with the primary projections established in the Spring 2026 forecast, the downstream effects of newly implemented Able-Bodied Adults Without Dependents (ABAWD) policy changes remain highly fluid. The long-term stabilization point of these caseloads remains difficult to isolate with absolute statistical certainty. The initial drop in caseload resulting from applying the policy changes to all cases at redetermination has concluded as of September 2026. However, the structural modifications to the system will continue to influence baseline

caseload trends. Future months are projected to exhibit altered enrollment patterns characterized by suppressed intake and elevated attrition relative to historical trends.

Oregon has received a waiver from HR1 requirements that allows individuals who do not meet work requirements to be eliminated from a household case without closing the case for the entire household. The case will be redetermined without the eliminated household member. This has blunted the impact of HR1 by reducing the caseload less than originally expected when HR1 was enacted but will effectively reduce the total food assistance received by the household by reducing the number of qualifying persons on the SNAP case.

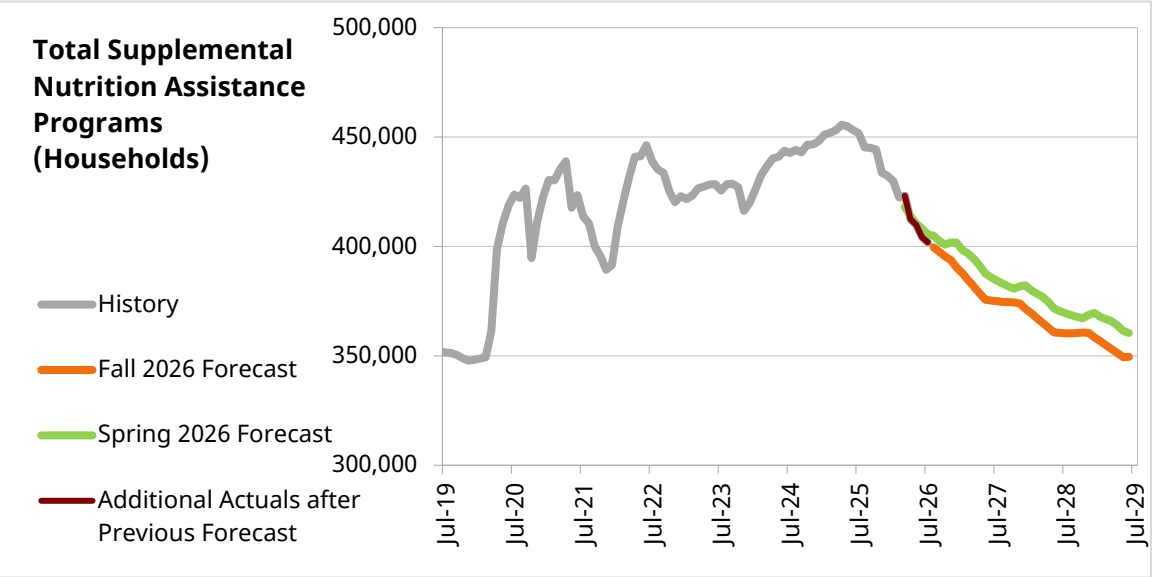
Based on these conditions, the spring 2026 forecast relied on preliminary information available since the implementation of HR1. Using the number of cases that qualify for an exemption, the volume of cases undergoing monthly redetermination, and the proportion of individuals able to meet ABAWD work requirements, a closure rate was developed to estimate the projected decline in caseload over time. The anticipated closure rate in Spring 2026 was 1.44 percent of total cases each month until all redeterminations are completed by July 2026. Since the previous forecast, the actual closure rate averaged 1.495 percent, which represents only a minor variance from what was forecasted.

OFRA will continue to collaborate with the Oregon Eligibility Partnership and the SNAP program to refine estimates of HR1's impact as additional information becomes available on affected clients.

Total Supplemental Nutrition Assistance Program (SNAP) – As of July 2026, 670,801 persons in 401,642 households were receiving SNAP benefits. This represents 15.70 percent of the population of Oregon.

The total SNAP monthly average forecast for the 2025-27 biennium is 410,489 households, which is 0.9 percent lower than the previous forecast. The prior forecast assumed that the impact of HR1 changes will put a downward pressure on caseload. Recent months have witnessed a decrease in the caseload that is slightly greater than what was anticipated in the Spring 2026 forecast. The current forecast continues to assume that the caseload will be influenced downward due to HR 1-related changes implemented in 2025 and additional changes that were effective between June and October of

2026. New program entries have been declining, and this forecast assumes a potential "chill effect" resulting from HR1 policy changes affecting non-citizens. Specifically, some individuals may be choosing not to apply, thereby reducing caseload entries, because they are reluctant to share personal information with government agencies.



The projected biennial monthly average for the 2027-29 biennium is 362,721 households, which is 11.6 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.

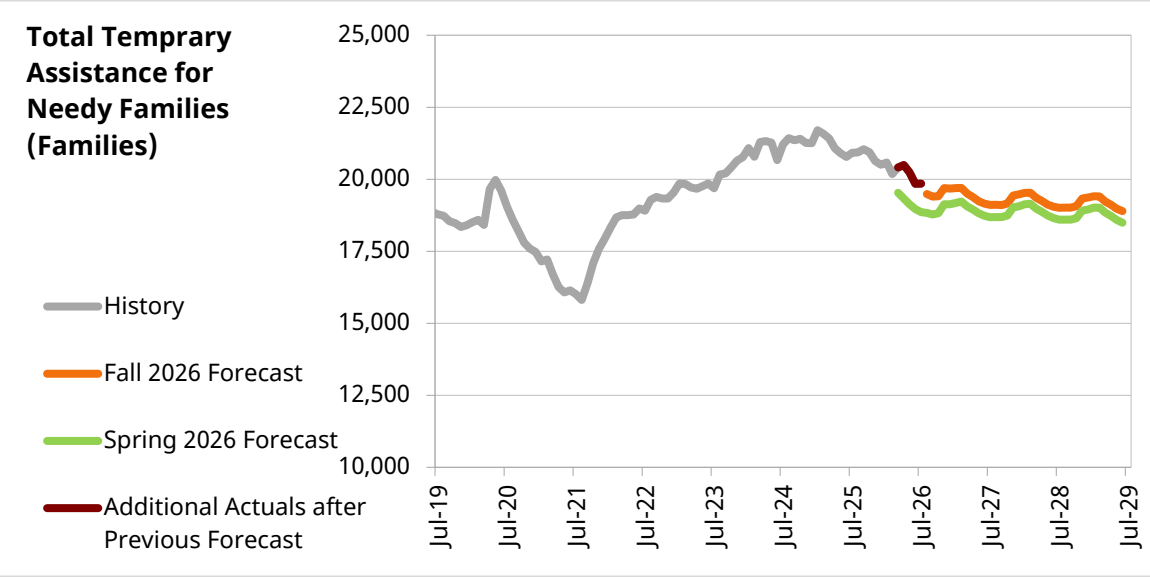
Recipients must meet basic TANF asset requirements to be eligible for the program. They must also meet non-financial eligibility requirements including having dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for 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 exists historically fluctuated with reductions in the spring and summer and increases in the winter related to seasonal hiring patterns. But during and after the pandemic, seasonal patterns were relatively weak. Since the Spring 2026 forecast, seasonal patterns started to reemerge, with caseload slightly dipping in June and July as summer hiring

picked up. Program exits experienced a moderate increase along with an increase in Employment Payments indicating that individuals were exiting the caseload into employment.

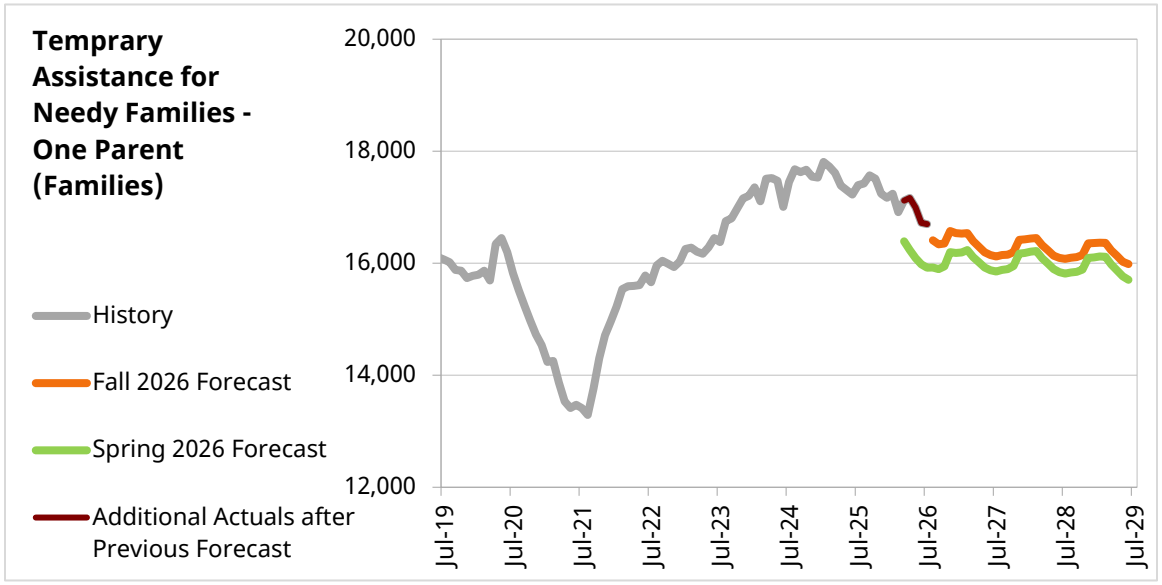
In Spring 2026, trends showed a growing disconnect between broader economic conditions and the TANF caseload. Despite elevated unemployment, the TANF caseload continued to decline, suggesting that individuals exiting the program were not doing so because they have secured employment.

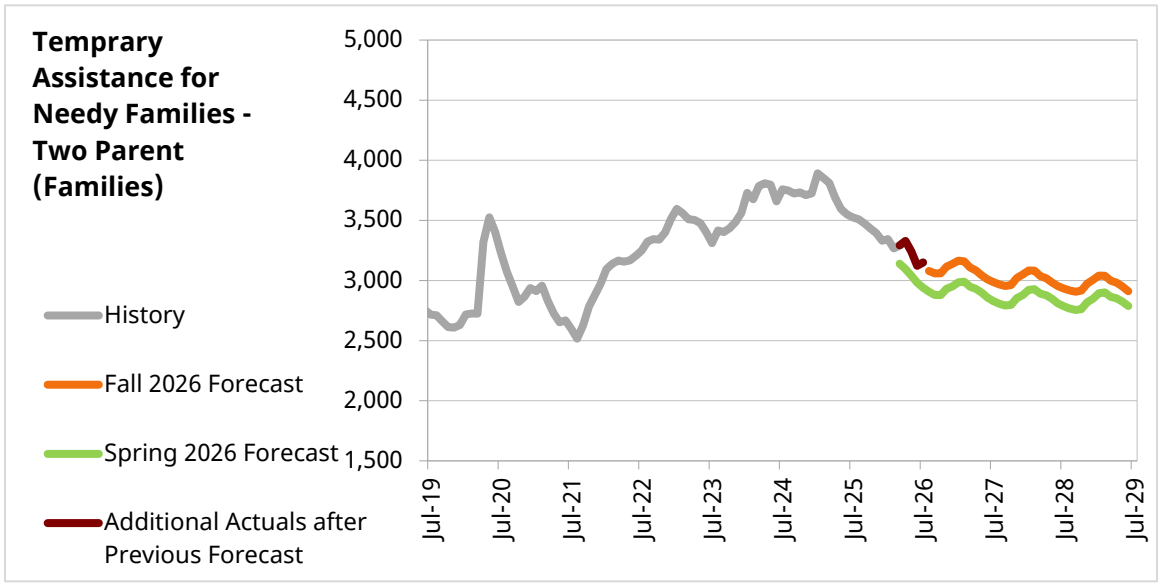
In July 2026, 19,538 families were receiving TANF benefits, representing 51,086 people. The caseload is currently 7.73 percent lower than it was a year ago.



The total TANF monthly average forecast for the 2025-2027 biennium is 19,984 families, representing a 2.2 percent decrease from the prior forecast. Recent patterns are following previous seasonality due to summer hiring. The current forecast assumes that the recent drop in caseload is due to individuals who entered during the COVID period has finally reached their 60-month time limit, leading to increased exits.

For the 2027-29 biennium, the average monthly caseload is projected to be 19,211 families, which is 3.9 percent lower than the forecasted average monthly caseload for 2025-27.





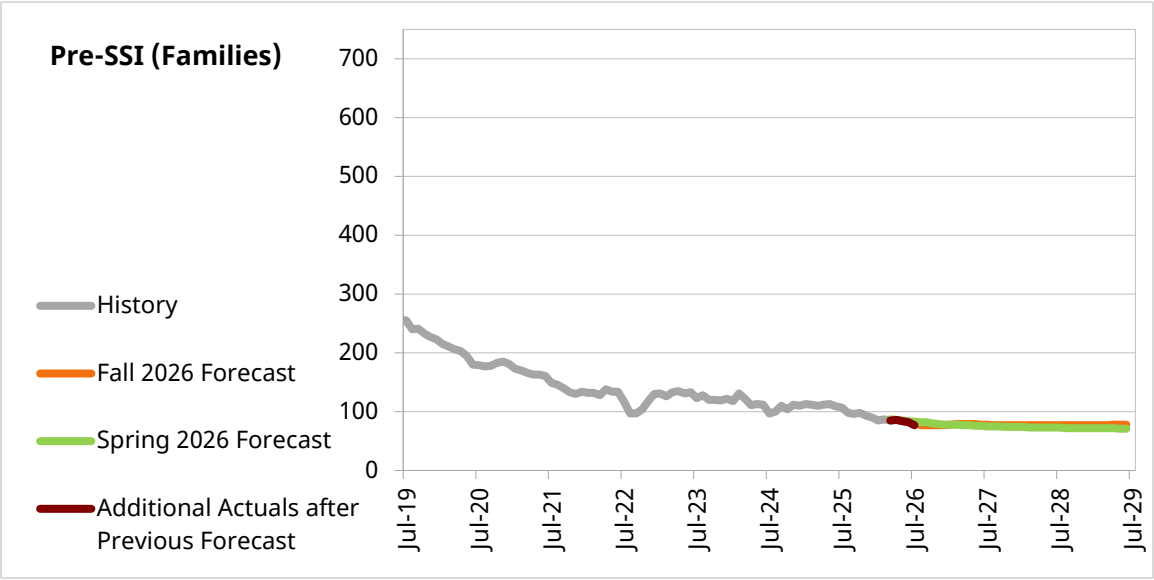
The 2025-27 biennial average monthly caseload for the TANF One-Parent Family is projected to be 16,759 families, reflecting a 1.9 percent decrease from the previous forecast. For the 2027-29 biennium, the average monthly caseload is expected to be 16,224 families, a 3.2 percent decrease from the 2025-27 biennium.

The 2025-27 biennial average caseload for TANF Two-Parent Family is expected to be 3,225 families, reflecting a 3.8 percent upward revision from the previous forecast. The TANF Two-Parent caseload had been growing consistently and vigorously since the end of pandemic-related Enhanced Unemployment Insurance, but the growth rate slowed down starting July 2024 and then started to decline due to higher exits and lower intakes. Caseloads stabilized after the Spring 2026 forecast and have returned to the historical pattern of seasonality due to summer hiring. The average monthly

caseload for 2027-29 is projected to be 2,987 cases, which is a 7.4 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 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. Even though the caseload has declined since the previous forecast, ODHS has instituted the goal of promoting the program and the process to access it more easily and efficiently. This might pose a risk to forecast accuracy as these efforts might cause caseload to pick up in the future.



The 2025-27 biennial average forecast for Pre-SSI is 84 families, a decrease of one percent from the previous forecast. The 2027-29 biennial average caseload is 77 families, a decrease of 8.3 percent from the 2025-27 biennium.

Temporary Assistance for Domestic Violence Survivors (TA-DVS)

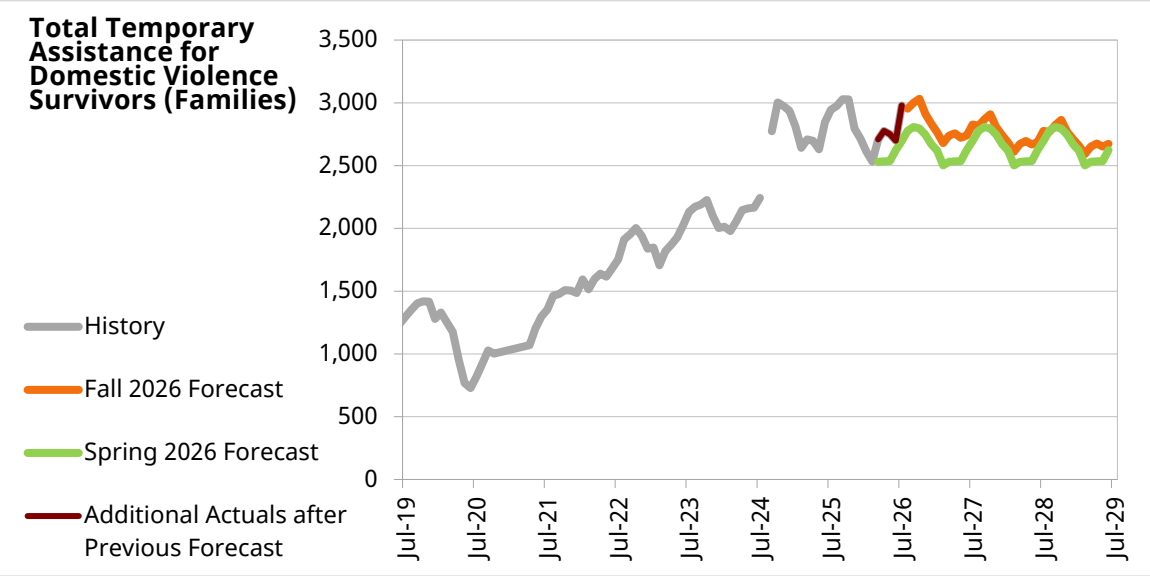
Temporary Assistance to Domestic Violence Survivors (TA-DVS) supports domestic violence survivors by providing temporary financial assistance to flee

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 the Federal Poverty Level; TA-DVS only considers income on hand that is available to meet emergency needs).

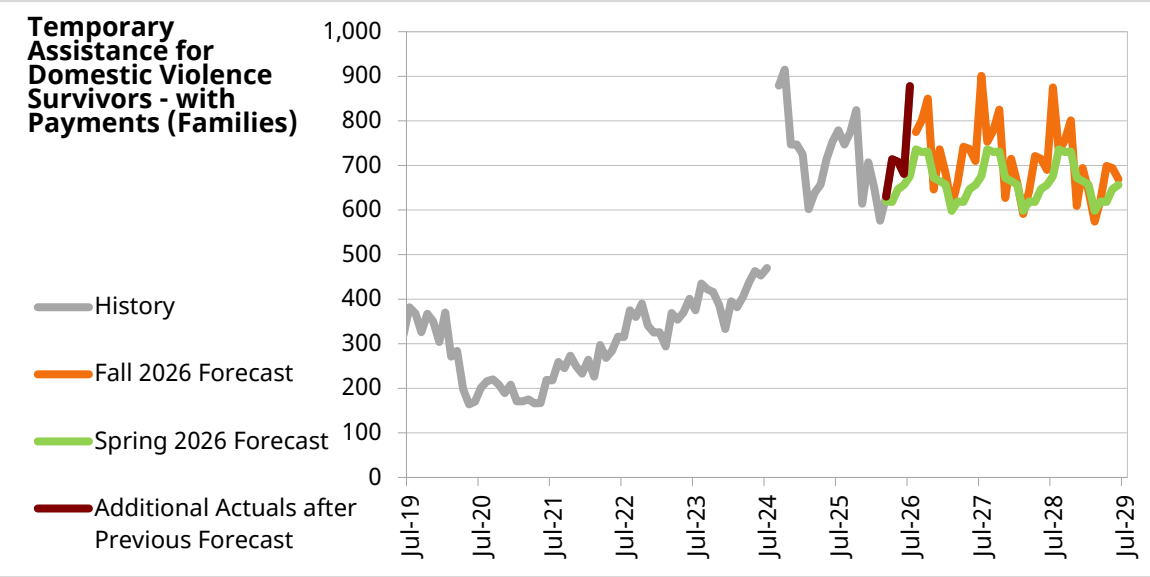
Policy Changes

The budget approved in the 2024 legislative session included an increase in 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. Since the new rate was introduced, Total TADVS increased 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 wanted to claim a higher rate. After this initial surge the caseload stabilized. In the months following stabilization, the caseload has exhibited heightened seasonal sensitivity, resulting in a significantly wider statistical variance between peak enrollment in the summer months and seasonal contractions in the winter.



The average monthly caseload for Total TA-DVS for the 2025-27 biennium is 2,820 per month, which represents a 4.9 percent increase compared to the previous forecast. The caseload is expected to continue to fluctuate seasonally, with a

monthly average of 2,734 cases in the 2027-29 biennium, representing a decrease of 3.1 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 718 families per month, which is 7.2 percent higher than the previous forecast. The 2027-29 biennial average caseload is 708 families, a decrease of 1.4 percent from the 2025-27 biennium.

Note: Data from November 2020 to May 2021 for this caseload is unavailable due to the rollout of the Intergrated Eligibility System.

Forecast Environment and Risks

This forecast assumes SNAP caseloads have already declined due to the application of the new ABAWD rules at redetermination. A significant risk to forecast accuracy is the uncertain long-term stabilization under HR1, which permanently depresses entries and increases exits, making future caseload levels fundamentally harder to anticipate.

Under HR1, states with payment error rates greater than or equal to six percent 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 to end 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 enhance 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. Oregon legislature has appropriated additional money to increase the eligibility workforce to cover the increased per-case workload in order to avoid long waiting times and increased eligibility errors that might occur. However, workforce issues could still have an impact on caseloads if 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 unemployment being high and tariffs creating inflation, the slow growth of the economy remains a risk to forecast accuracy.

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 changes, the more the potential impact, and this is an especially large change.

The Farm Bill is currently being debated in the US Congress. If the new Farm Bill results in changes to the Federal Poverty Level (FPL) used to determine eligibility and benefit amounts, as is being debated, some individuals may receive lower benefits. Should benefit levels fall too low, there is an increased likelihood that individuals may choose to exit the program rather than go through the redetermination process.

SNAP Federal funding is secured until September 30, 2026, but future funding depends on the federal budget, creating a significant risk to forecast accuracy.

A new version of the Public Charge Rule is being enacted in September. The Public Charge Rule requires that enrollment in social safety net services like SNAP and Medicaid be taken into account when seeking permanent legal residency (e.g. the “green card”). The rules will have implications for mixed-status households, as non-citizens may forgo enrollment in public benefits for their U.S. citizen children and other dependents out of fear of losing the ability to gain legal residency and a path to citizenship. Because Oregon and other states are currently suing to block implementation of the Public Charge Rule, no specific effect is modeled in this forecast.

Self-Sufficiency Programs Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Supplemental Nutrition Assistance Program (Households)	414,255	410,489	-3,766	-0.9%
Temporary Assistance for Needy Families (Families: Cash/Grants)- One Parent	16,444	16,759	315	1.9%
Temporary Assistance for Needy Families (Families: Cash/Grants) – Two Parent	3,108	3,225	117	3.8%
Total TANF	**19,552**	**19,984**	**432**	**2.2%**
TANF Employment Payments	923	953	30	3.3%
Pre-SSI	85	84	-1	-1.0%
TA-DVS: with Payment	670	718	48	7.2%
TA-DVS: Total (with or without payment)	2,689	2,820	131	4.9%

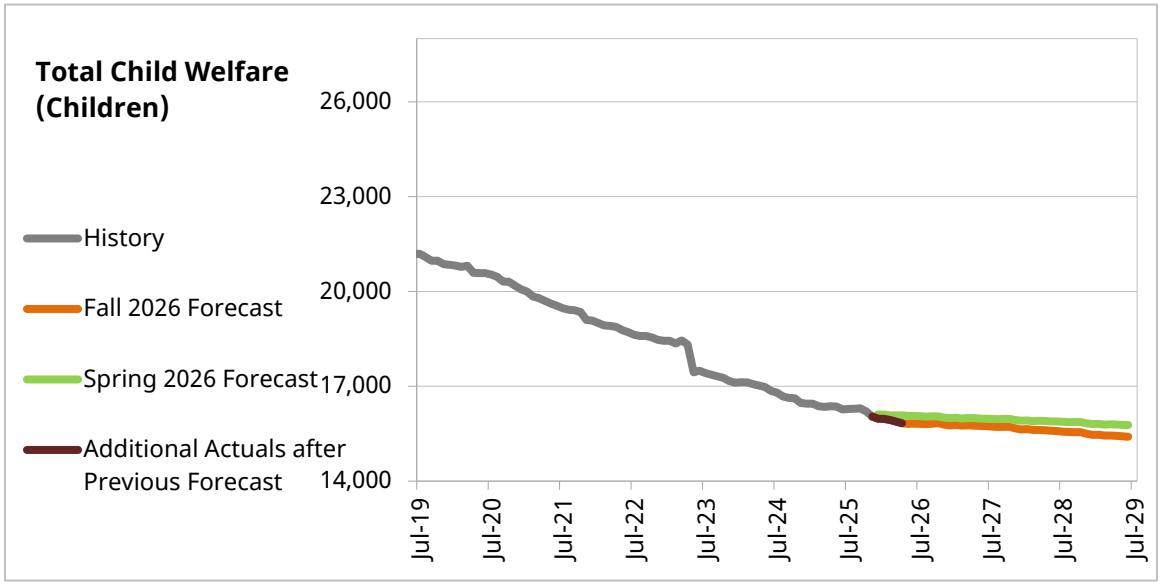
Self-Sufficiency Programs Biennial Average Forecast Comparison

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
Supplemental Nutrition Assistance Program (Households)	410,489	362,721	-47,768	-11.6%
Temporary Assistance for Needy Families (Families: Cash/Grants)- One Parent	16,759	16,224	-535	-3.2%
Temporary Assistance for Needy Families (Families: Cash/Grants) – Two Parent	3,225	2,987	-238	-7.4%
Total TANF	**19,984**	**19,211**	**-773**	**-3.9%**
TANF Employment Payments	953	917	-36	-3.8%
Pre-SSI	84	77	-7	-8.3%
TA-DVS: with Payment	718	708	-10	-1.4%
TA-DVS: Total (with or without payment)	2,820	2,734	-86	-3.1%

Child Welfare

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, case workers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

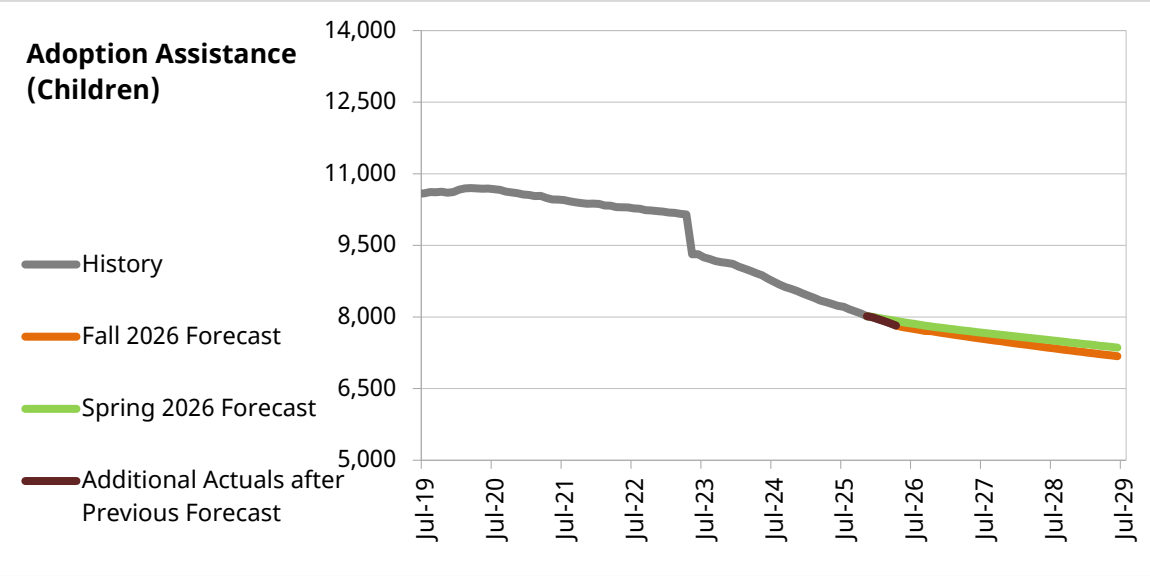


Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups and typically first enter the Child Welfare system via an Assessment. There is an executive directive for branches to complete assessments 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, with the exception of a plateau between April 2019 and March 2020. 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. However, the downward trend in paid foster care has recently reversed, and this will impact the adoption assistance caseload. Entries to adoption assistance lag 3 years behind entries to foster care, so after the foster care caseload has leveled out and increased for 3 years, we should start to see leveling out and increases to adoption assistance.

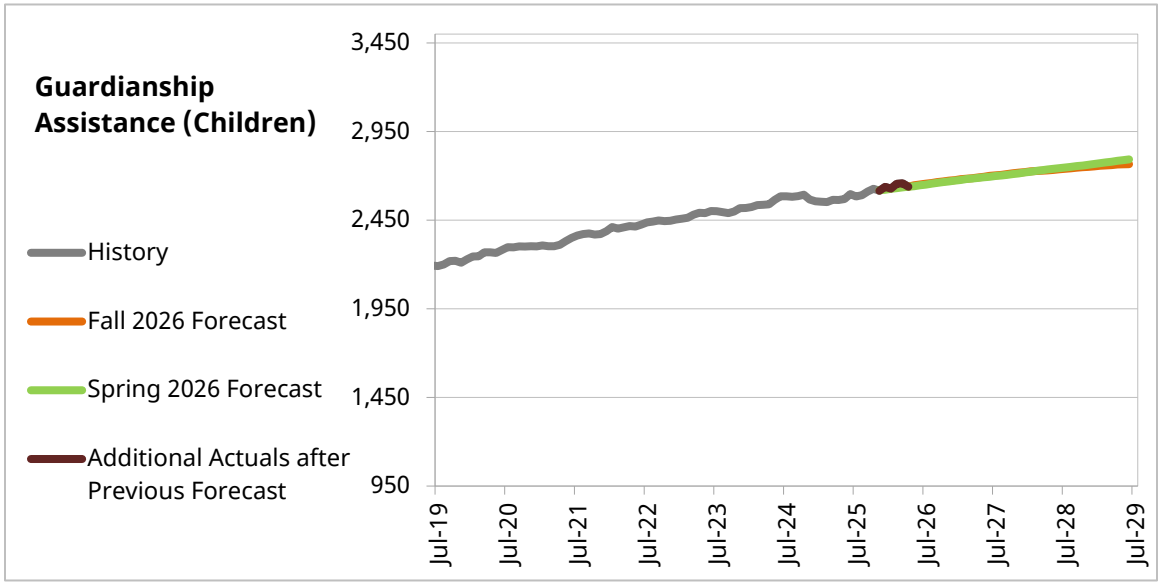
In 2023, data used for forecasting was revised to align with the ORKids database (the data source for Child Welfare case management), which had been deleting some records. This primarily impacted Adoption Assistance data. The Adoption Assistance caseload beginning in May 2023 reflects counts that align 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 7,815 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium the caseload is expected to average 7,356 children per month, a decrease of 5.9 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. Guardianship is considered a type of permanency that is an alternative to adoption when a child cannot return home, providing a legal, long-term care arrangement without terminating parental rights. The Guardianship Assistance caseload has grown as children move out of foster care and into permanency. Between April 2024 and April 2026, the caseload increased 4 percent.

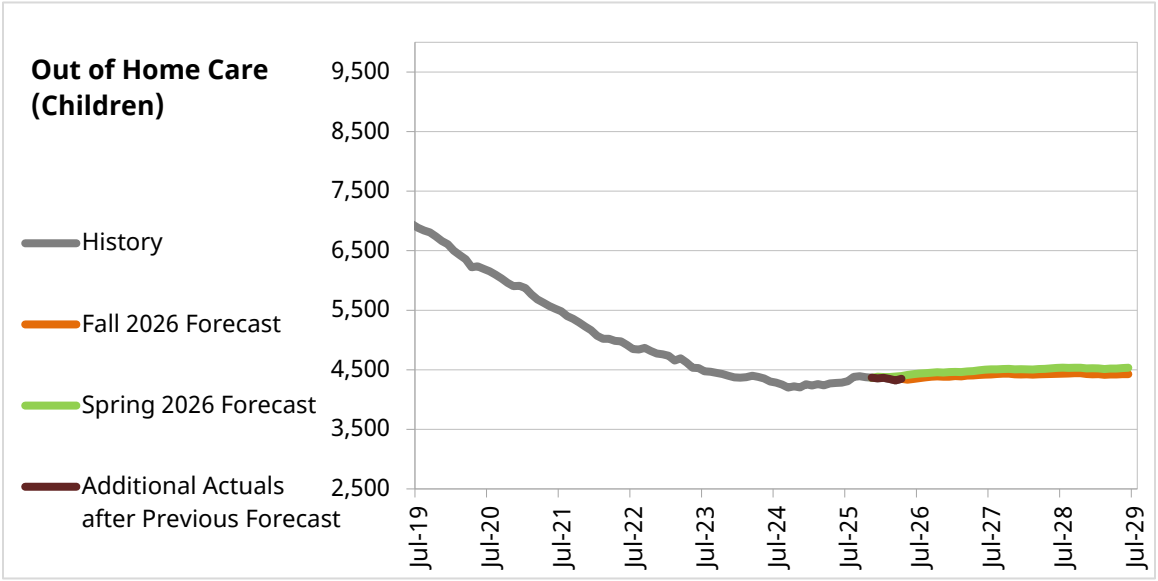


The forecasted Guardianship Assistance caseload is expected to average 2,654 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium, the caseload is expected to average 2,738 children per month, which is 3.2 percent higher than the 2025-27 forecasted average.

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 5,336 in October 2019 to 3,466 in October 2025, a decrease of 35 percent. However, it appears that this caseload reached a functional base at the end of 2024. Between November 2024 and April 2026, paid foster care increased 4 percent.



The total Out of Home Care caseload is forecasted to average 4,373 children per month through the 2025-27 biennium. Over the 27-29 biennium, the caseload is expected to average 4,428 children per month, which is 1.3 percent higher than the 2025-27 forecasted average.

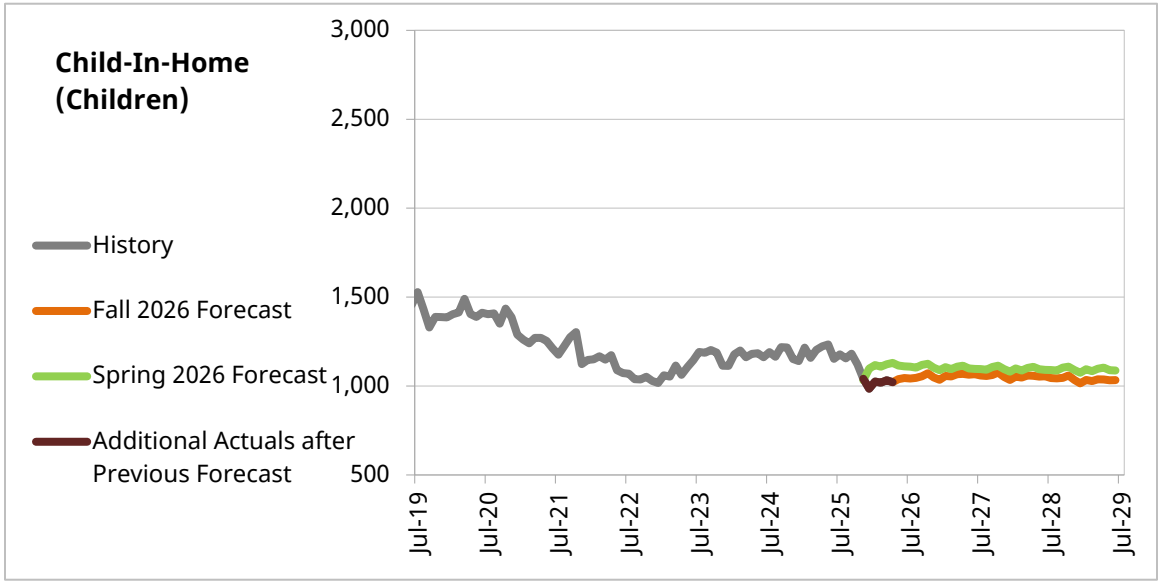
Child In-Home

The Federal Family First Prevention Services Act was enacted in 2018. The act authorizes Title IV-E funding to support States' efforts to prevent child abuse, neglect, and removal from the home. 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 County was added, and 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 6 percent of the total Child In-Home monthly caseload.



The Child In-Home caseload is forecasted to average 1,063 children per month through the end of the 2025-27 biennium. Over the 2027-29 biennium, the caseload is expected to average 1,046 children per month, which is 1.6 percent lower 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. The Oregon Child Abuse Hotline has been in effect statewide since April 2019, and online reporting was added in 2023. Over these years the call volume has fluctuated, but comparing 2021 with 2025 the call and contact volume is similar (148,864 calls in 2021 compared to 148,225 calls in 2025). There has been an increase in conversations, work groups, and training 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 accuracy of the Out of Home Care caseload forecast is related to the capacity for psychiatric residential care. Providers may close suddenly or not accept referrals. As new programs start, it is unknown how quickly the beds will fill. It can be challenging to recruit foster parents as well as find people to provide services to high-needs children. These children are currently being served in Behavior Rehabilitation Services and family foster care.

The 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 stressors 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. Given that the impact of HR1 will be felt over several years, this trend may 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 case worker enters an initial safety plan. A 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 number of children counted in Child In-Home, as data reporting improves.

Child Welfare Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Adoption Assistance	7,889	7,815	-74	-0.9%
Guardianship Assistance	2,649	2,654	5	0.2%
Out of Home Care	4,424	4,373	-51	-1.2%
Child In-Home	1,114	1,063	-51	-4.6%
Total Child Welfare	**16,076**	**15,905**	**-172**	**-1.1%**

Note: Out of Home Care includes treatment services placements and foster care.

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
Adoption Assistance	7,815	7,356	-459	-5.9%
Guardianship Assistance	2,654	2,738	84	3.2%
Out of Home Care	4,373	4,428	55	1.3%
Child In-Home	1,063	1,046	-17	-1.6%
Total Child Welfare	**15,905**	**15,568**	**-337**	**-2.1%**

Note: Out of Home Care 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 account for over 50 percent of the total LTC count.

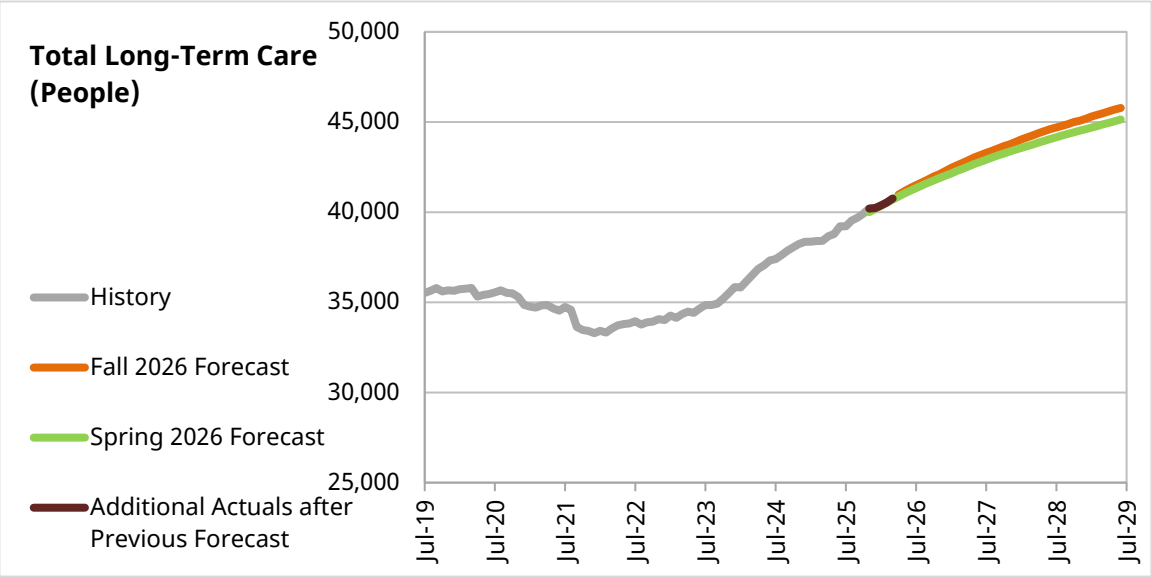
CBC is forecasted to continue to grow at a stable rate due to increase in the Adult Foster Care and Assisted Living Facilities. The decrease in regular residential care is flattening out now, and contract residential care is increasing at a slower rate compared to the previous forecast. CBC will continue 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. Recent increases in Medicaid reimbursement rates have improved client alignment and market appeal within CBC. A new rate of reimbursement for Adult Foster Care became effective January 1st, 2026, which started to attract more providers and increase capacity gradually. Residential care facilities received a 20 percent rate increase last year and they are expected to receive a similar rate increase again in 2026. That rate increase, along with a change in rate methodology, is expected to maintain the continuous upward growth trend for the Adult Foster Care (AFC) caseload.

Total Long-Term Care Case Management

Long-Term Care Case Management is a unique count of 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 that are receiving Case Management.

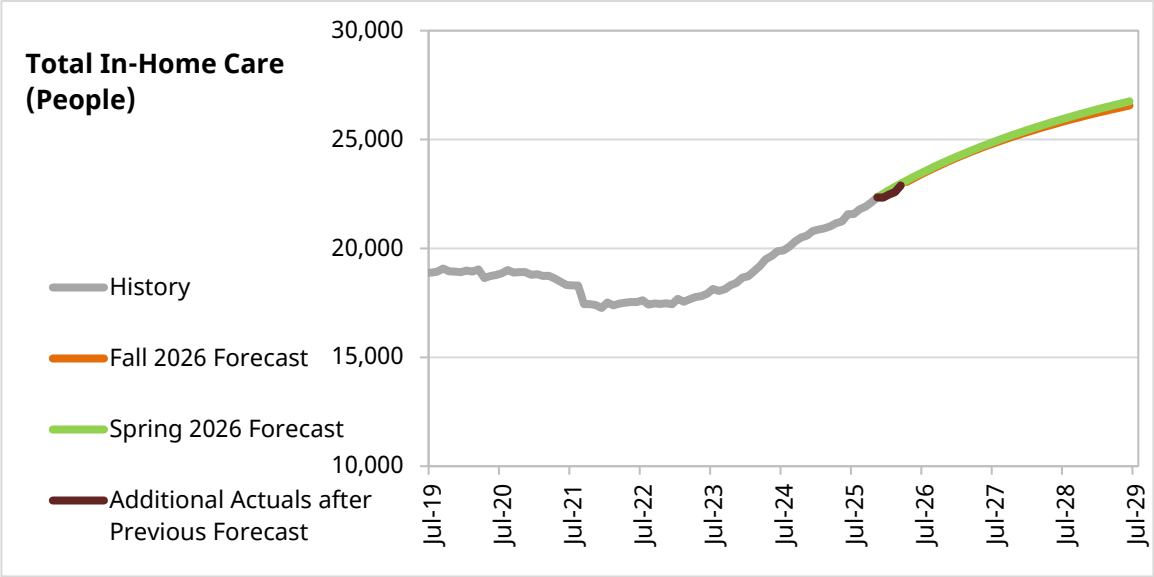
A total of 44,370 clients were enrolled in APD Case Management services in March 2026, and about 92 percent of these clients were receiving Long-Term Care services. The Case Management Enrollment caseload is projected to average 44,766 cases per month over the 2025-27 biennium, a 1.5 percent increase from the Spring 2026 forecast. For the 2027-29 biennium, the caseload is expected to average 46,988 cases per month, an increase of 3.3 percent compared to the Spring 2026 forecast and 5.0 percent compared to the 2025-27 biennium.



Total Long-Term Care (LTC) – A total of 40,756 clients received Long-Term Care services in March 2026, an increase of 6.1 percent compared to a year ago. Community Based Care services, Nursing Facility Care and In-Home Care services saw an increase. The LTC caseload, including Healthier Oregon Program (HOP) clients, is projected to average 41,336 cases per month over the 2025-27 biennium, a 0.9 percent increase from the Spring 2026 forecast. For the 2027-29 biennium, the caseload is expected to average 44,599 cases per month an increase of 1.7 percent compared to the previous forecast and 7.9 percent compared to the 2025-27 biennium.

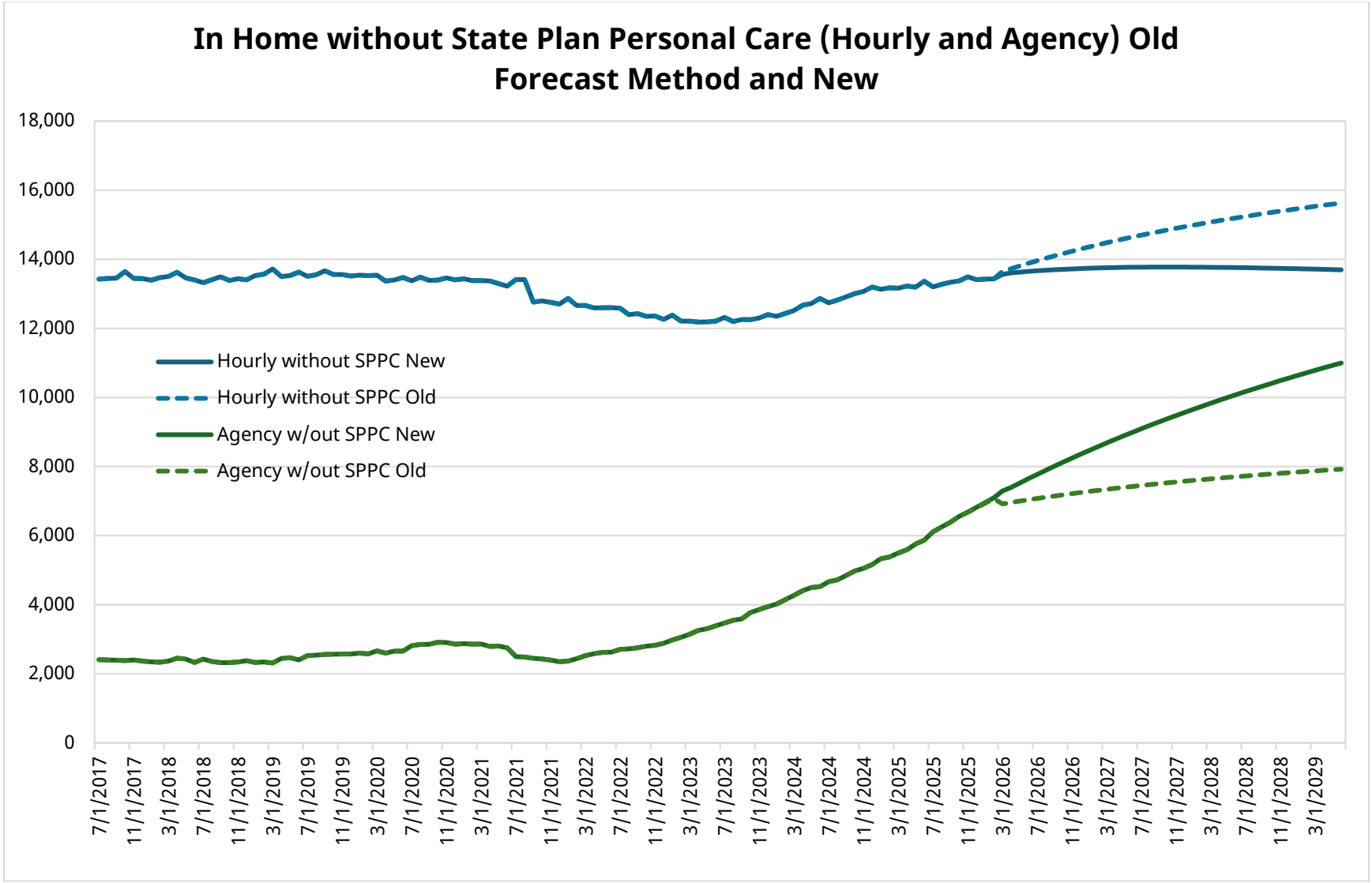
In-Home Care

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



The In-Home Care caseload is expected to average 23,302 cases per month over the 2025-27 biennium, which is 0.3 percent higher than the prior forecast. For the 2027-29 biennium, the caseload is projected to average 25,771 clients per month, which is 0.1 percent higher than the Spring 2026 forecast and 10.6 percent higher than the current biennium.

For the current forecast cycle, the methodology utilized to calculate the structural breakdown of In-Home care subcategories was revised to address a structural shift in historical data. Since the Spring 2026 forecast, the proportional distribution across these subcategories has shifted significantly. Previously, a moving average methodology was employed to project future distributions. Sharp shifts in the proportional distribution of cases within subcategories can be suppressed using this method, resulting in distorted and inaccurate subcategory projections. To accurately capture more rapid shifts in proportional distribution, each subcategory was modeled and forecasted independently. The dotted lines in the graph below represent the old methodology while the solid lines represent the new methodology.


In Home without State Plan Personal Care (Hourly and Agency) Old Forecast Method and New
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Hourly without SPPC New
Hourly without SPPC Old
Agency w/out SPPC New
Agency w/out SPPC Old
7/1/2017
11/1/2017
3/1/2018
7/1/2018
11/1/2018
3/1/2019
7/1/2019
11/1/2019
3/1/2020
7/1/2020
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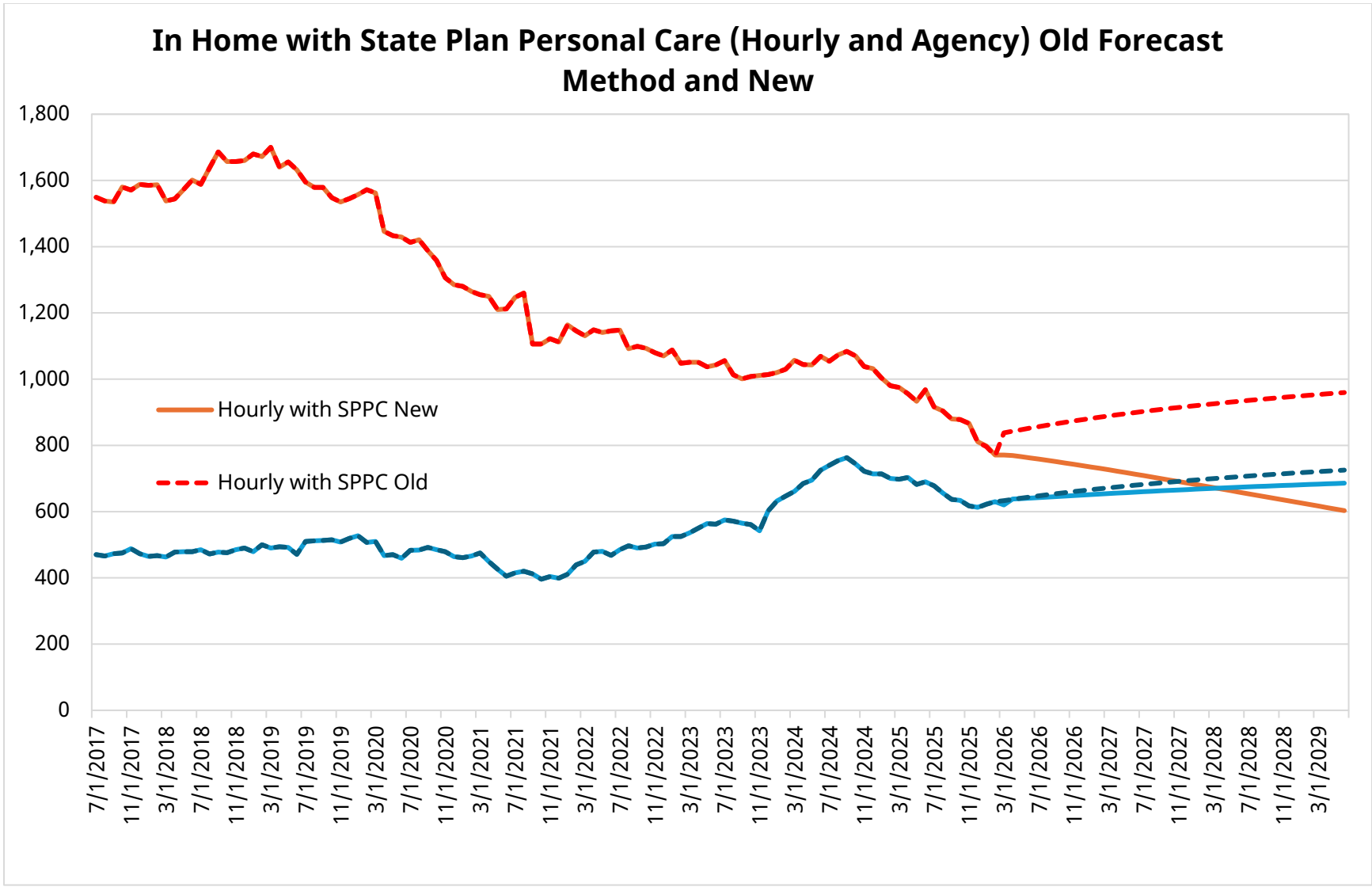
11/1/2028
3/1/2029


In Home with State Plan Personal Care (Hourly and Agency) Old Forecast Method and New
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Hourly with SPPC New
Hourly with SPPC Old
7/1/2017
11/1/2017
3/1/2018
7/1/2018
11/1/2018
3/1/2019
7/1/2019
11/1/2019
3/1/2020
7/1/2020
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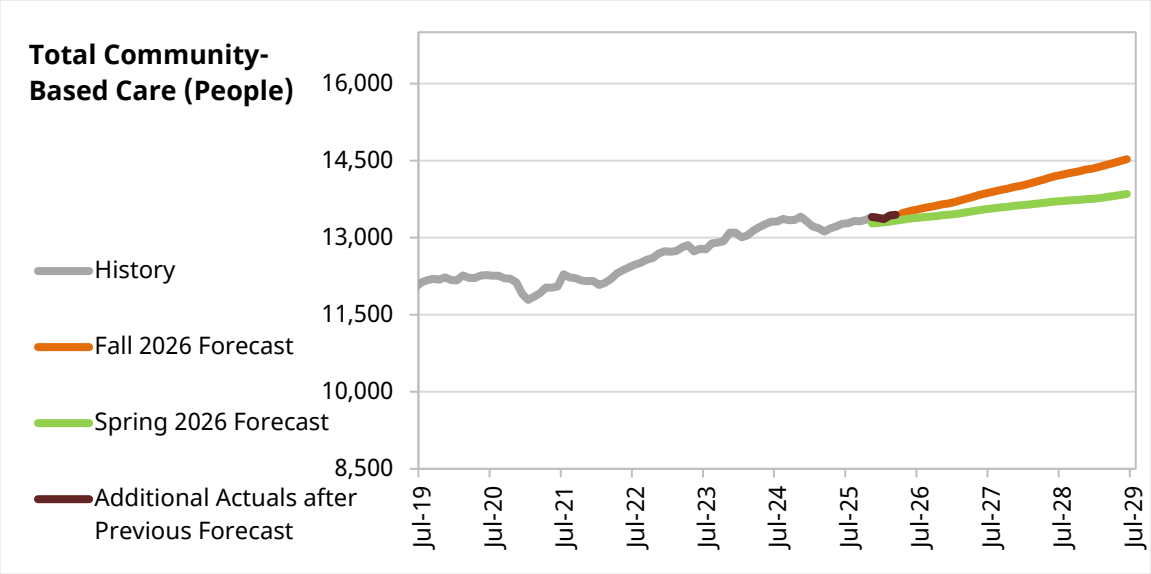
3/1/2028
7/1/2028
11/1/2028
3/1/2029

Community-Based Care (CBC)

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

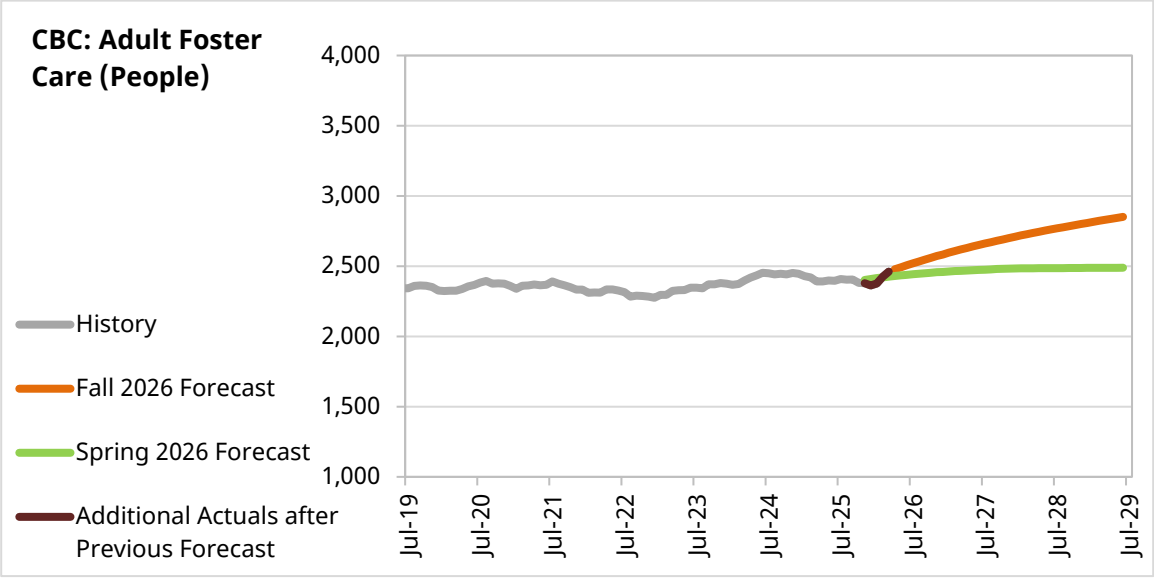
Community-Based Care includes several different types of services, including the Program of All-Inclusive Care for the Elderly (PACE), Residential Care, Adult Foster Care (AFC) and Assisted Living Facility (ALF).

Since Spring 2026 forecast, the total number of clients receiving Community-Based Care has increased due to an increase in Adult Foster Care, Regular Residential Care, and Assisted Living Facility caseloads. In March 2026 the total Community-Based Care caseload was 13,445, which constituted 33 percent of total LTC services.



The Total Community Based Care caseload is forecasted to average 13,548 cases per month over the 2025-27 biennium, this is 1.3 percent higher than the Spring 2026 forecast. The caseload in the 2027-29 biennium to is expected to average 14,199 cases per month, 3.8 percent higher than the Spring 2026 forecast and 4.8 percent higher than the current biennium.

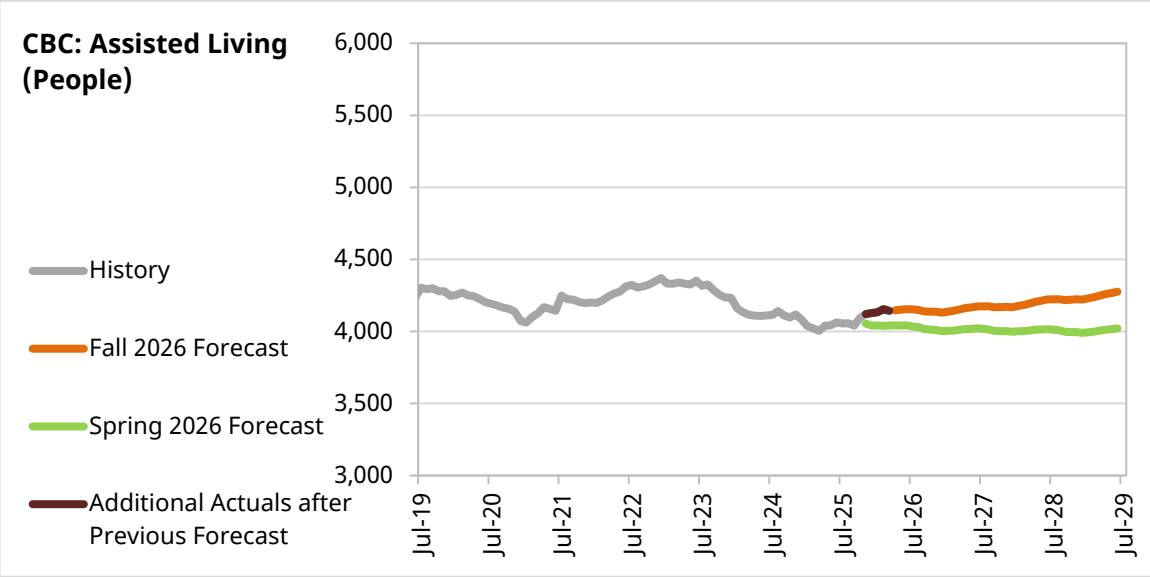
Adult Foster Care (AFC) declined from August 2013 to July 2019 due to a combination of policy changes and a reduction in providers. From August 2019 to the start of the pandemic in 2020 the caseload hovered at around 2,300 clients. Clients in AFC services are less likely to move out of the program, and 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 flat and slightly decreasing between July 2024 and January 2026, but that decline has stopped recently. Caseload started to pick up again due to an increased reimbursement rate that was enacted on January 1, 2026. Contrary to expectations that the revised rates would require an extended period to incentivize providers and build system capacity, recent data demonstrates an immediate upward trajectory in the AFC Caseload. AFC is expected to average 2,506 clients in the 2025-27 biennium; a 3.5 percent decrease compared to the prior forecast. The average monthly caseload is expected to increase to 2,762 in the 2027-29 biennium, a 12 percent increase compared to the Spring 2026 forecast and a 10.2 percent increase compared to 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.

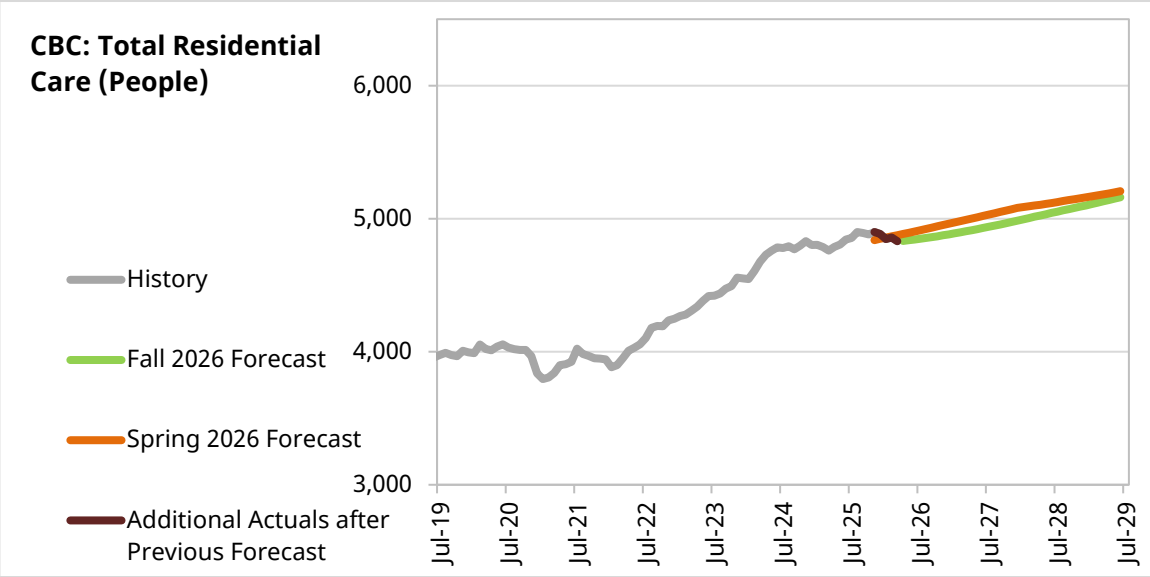
There was a consistent decrease in the ALF caseload since August 2023, with fewer clients entering and more clients exiting. It's possible that Assisted Living Facility operators chose not to serve high-acuity individuals. However, since March 2025 the caseload stopped declining, and then started increasing in the spring of 2026. This forecast assumes that the caseload will grow throughout the rest of the 2025-27 biennium and into the 2027-29 biennium.



The forecasted Assisted Living Facilities caseload is expected to average 4,132 clients in the 2025-27 biennium, approximately 2.5 percent higher than the previous forecast. The ALF caseload started to grow after the Spring 2026 forecast was completed. The average monthly caseload is expected to stabilize at 4,211 in the 2027-29 biennium, 5.1 percent higher than the Spring 2026 forecast and 1.9 percent higher 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.

The current forecast projects sustained growth through the current and subsequent biennium, albeit at a moderate pace relative to historical trends. This deceleration is primarily attributed to a marginal contraction in new entries paired with an increase in program exits.

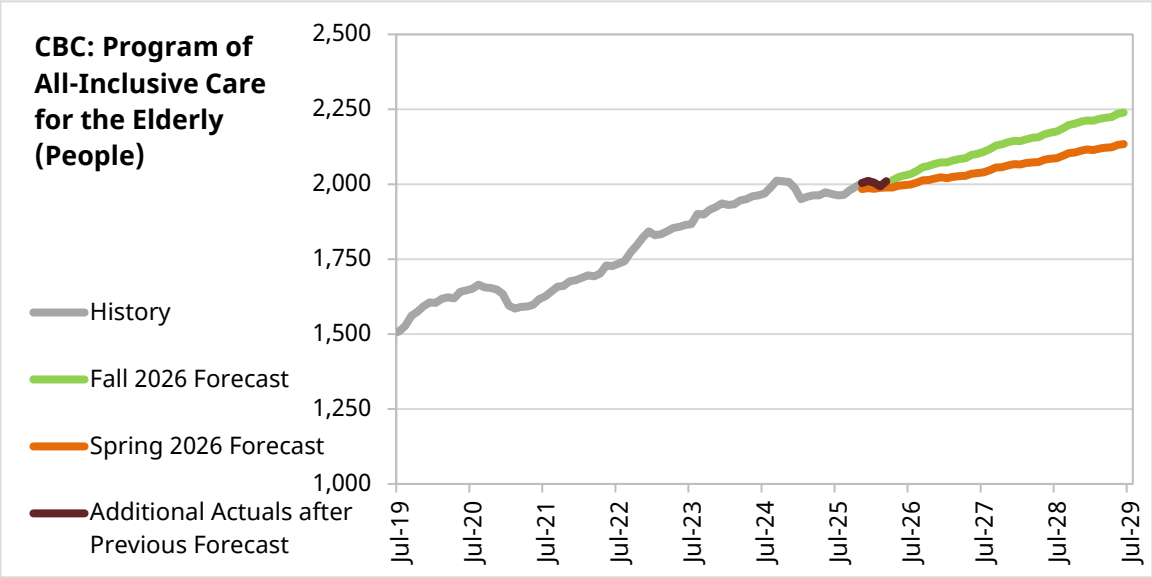


The forecasted Contract Residential Care caseload is expected to average 4,200 clients in the 2025-27 biennium, 1.7 percent lower than the Spring 2026 forecast. The average monthly caseload is expected to increase to 4,383 in the 2027-29 biennium, 3.0 percent lower than the Spring 2026 forecast and 4.4 percent higher than the current biennium.

The forecasted PACE caseload is expected to average 2,035 cases in 2025-27, 1.6 percent higher than the Spring 2026 forecast. PACE is expected to increase to an average of 2,177 cases per month in the 2027-29 biennium, an increase of 4.2 percent compared to the Spring 2026 forecast and an increase of 7 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. A new PACE facility started operating on July 1st, 2026. Another PACE facility is expected to begin services in Spring 2027. Although predicting the exact operational timeline for a new facility is difficult, this forecast assumes an expansion rate of 8 enrollments per month. Consequently, caseload volumes are projected to reach 28–46 enrollments in the first six months and 87–120 individuals by the second year, culminating in a final

projected census of 288 by June 2029. This is a very smooth expansion projection – the actual increase in PACE enrollments is likely to be greater or less than the forecast in any given month but will likely even out through the forecast horizon.

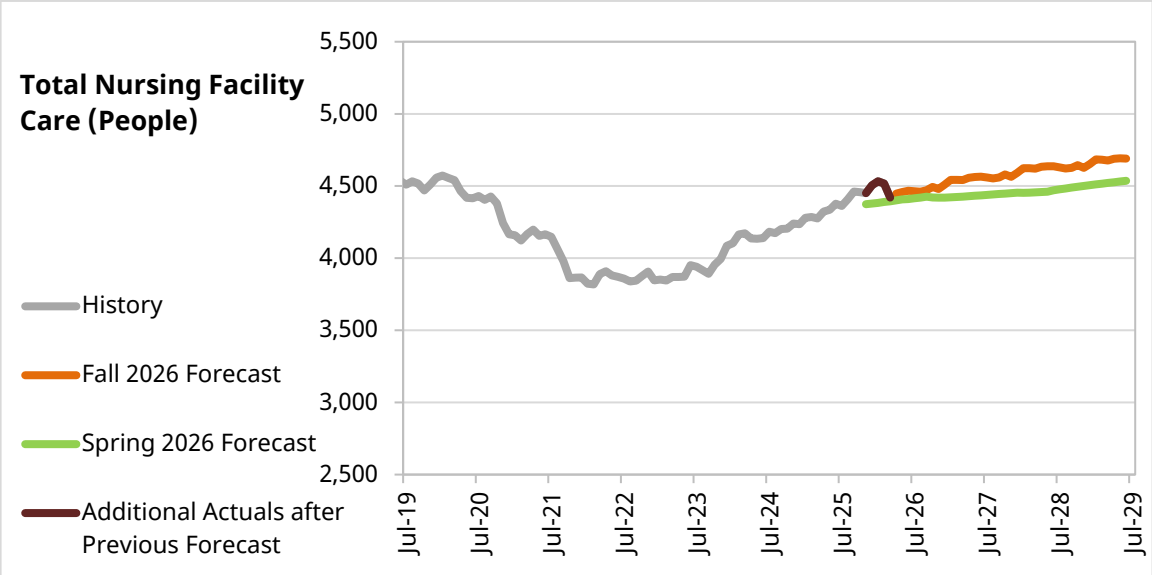


Nursing Facility Care

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 March 2026, 4,420 clients received NFC services, which constituted 10.8 percent of total LTC services.



The Nursing Facility caseload is projected to average 4,486 cases per month over the 2025-27 biennium, about 2.7 percent higher than the Spring 2026 forecast. This caseload is expected to average 4,629 cases per month over the 2027-29 biennium, a 4.5 percent increase compared to the Spring 20226 forecast and 3.2 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 for younger individuals with physical disability. OPIM also offers more services than the original OPI, including additional in-home service hours, home modifications, transportation, and support to unpaid caregivers. While OPI sometimes requires a fee, OPI-M services are fully covered without a fee and are exempt from state recovery.

The current forecast projects an average of 4,013 cases per month for the 2025-27 biennium, a 3.4 percent increase compared to the Spring 2026 forecast. The caseload is expected to average 6,051 cases per month over the 2027-29 biennium, a 4.1 percent increase compared to the Spring 2026 forecast and a 50.7 percent increase compared to the current biennium.

Healthier Oregon Program (HOP)

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 247 clients are receiving Long-Term Care through HOP as of March 2026. Most of these clients choose In-Home care or Nursing Facility Care.

HOP caseload is anticipated to increase as a direct result of statutory eligibility changes introduced by HR1 (the “Big Beautiful Bill Act”). This policy shift, which will be implemented in October 2026, will disqualify certain non-citizen populations from standard Medicaid coverage, resulting in an estimated rollover of 190 individuals into HOP. The current forecast projects an average of 312 clients per month for the 2025-27 biennium which is 38.1 percent higher than the Spring 2026 forecast and 430 clients per month for 2027-29 biennium, which is 90.3 percent higher than the Spring 2026 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 March 2026. The current forecast expects a growth in number of HOP clients seeking LTC due to the roll-over of non-citizens who will become ineligible for Medicaid under HR1 rules. However, as with any new service being offered, and especially services offered to immigrant groups, the exact impact is hard to pin down. 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 implemented a new reimbursement rate for adult foster Care effective January 1st, 2026. Contrary to an anticipated delay in provider enrollment and network capacity expansion, active caseloads have already demonstrated measurable increases. As more providers are approved to provide Adult Foster Care services, there will be an increase in the caseload. This increase in caseload and attraction of providers pose a significant risk to forecast accuracy, as the precise rate of capacity expansion and the eventual saturation point for new providers remain highly unpredictable. Because the timeline and scale of the capacity build are subject to variance, the resulting caseload metrics may ultimately track higher or lower than anticipated.

Residential Care Facilities

Residential care facilities received a 20 percent rate increase last year and they are expected to receive a similar rate increase again in 2026. That rate increase, along with a change in rate methodology, is expected to end the decline in the regular residential care caseload. The rate increase is a risk to forecast accuracy as it is hard to estimate the timing and magnitude of the impact on caseload.

PACE

A new PACE facility started operation as of July 1st, 2026. Another PACE facility is expected to begin services in Spring 2027. Even though this forecast modeled an uptake rate for enrollment into the new PACE facility; it is hard to predict when PACE Facility openings will impact caseload; hence this is a risk to forecast accuracy.

Agency with Choice (AwC)

Agency with Choice is a subcategory under In-Home care that started enrolling clients as of July 2026. Under the AwC model, duties are divided to maximize client autonomy while removing administrative burdens. Clients control day-to-day control over their care while a licensed AwC provider handles the legal, financial, and administrative overhead. This includes processing payroll, withholding taxes, managing worker's compensation, and verifying background checks. The operation of Agency with Choice as a distinct in-home care subcategory introduces substantial forecasting risk. Therefore, AwC will be forecasted when additional data becomes available, in the spring of 2027.

Other Risks

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 easily 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.

Aging and People with Disabilities Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Case Management	44,087	44,766	679	1.5%
In-Home Hourly without SPPC	14,338	13,588	-750	-5.2%
In-Home Agency without SPPC	6,692	7,646	954	14.3%
In-Home Spousal Pay	20	21	1	5.0%
Independent Choices	468	452	-16	-3.4%
Specialized Living	185	171	-14	-7.6%
In-Home K Plan Subtotal	**21,703**	**21,878**	**175**	**0.8%**
In-Home Hourly with State Plan Personal Care	977	781	-196	-20.1%
In-Home Agency with State Plan Personal Care	708	643	-65	-9.2%
In-Home non-K Plan Subtotal	**1,685**	**1,424**	**-261**	**-15.5%**
Total In-Home	**23,388**	**23,302**	**-86**	**-0.4%**
Adult Foster Care	2,440	2,506	66	2.7%
Assisted Living	4,031	4,132	101	2.5%
Contract Residential and Memory Care	4,277	4,200	-77	-1.8%
Regular Residential Care	643	676	33	5.1%
Program of All-Inclusive Care for the Elderly	2,003	2,035	32	1.6%
Community-Based Care Subtotal	**13,394**	**13,549**	**155**	**1.2%**

Aging and People with Disabilities Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Basic Nursing Facility Care	3,146	3,282	136	4.3%
Complex Medical Add-On	1,220	1,155	-65	-5.3%
Enhanced Care	38	39	1	2.6%
Pediatric Care	13	11	-2	-15.4%
Nursing Facilities Subtotal	**4,417**	**4,487**	**70**	**1.6%**

Aging and People with Disabilities Biennial Average Forecast Comparison

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
Total Long-Term Care	41,199	41,338	139	0.3%
Case Management	44,766	46,988	2222	5.0%
In-Home Hourly without SPPC	13,588	13,748	160	1.2%
In-Home Agency without SPPC	7,646	10,099	2,453	32.1%
In-Home Spousal Pay	21	25	4	19.0%
Independent Choices	452	415	-37	-8.2%
Specialized Living	171	154	-17	-9.9%
In-Home K Plan Subtotal	**21,878**	**24,441**	**2,563**	**11.7%**
In-Home Hourly with State Plan Personal Care	781	656	-125	-16.0%
In-Home Agency with State Plan Personal Care	643	674	31	4.8%
In-Home non-K Plan Subtotal	**1,424**	**1,330**	**-94**	**-6.6%**
Total In-Home	23,302	25,771	2,469	10.6%
Adult Foster Care	2,506	2,762	256	10.2%
Assisted Living	4,132	4,211	79	1.9%
Contract Residential and Memory Care	4,200	4,383	183	4.4%
Regular Residential Care	676	665	-11	-1.6%
Program of All-Inclusive Care for the Elderly	2,035	2,177	142	7.0%
Community-Based Care Subtotal	**13,549**	**14,198**	**649**	**4.8%**

Aging and People with Disabilities Biennial Average Forecast Comparison

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
Basic Nursing Facility Care	3,282	3,345	63	1.9%
Complex Medical Add-On	1,155	1,238	83	7.2%
Enhanced Care	39	37	-2	-5.1%
Pediatric Care	11	9	-2	-18.2%
Nursing Facilities Subtotal	**4,487**	**4,629**	**142**	**3.2%**
Total Long-Term Care	**41,338**	**44,598**	**3,260**	**7.9%**

Note: Total Long-Term Care Caseload includes Healthier Oregon clients.

Intellectual and Developmental Disabilities (I/DD)

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

Adults with developmental disabilities may be eligible for services ranging from support that help individuals live in their own homes to comprehensive 24-hour 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, including foster homes and residential group home settings.

I/DD forecasts represent the number of individual clients receiving services from a program during the month. Clients may receive services from more than one program in the same month; for example, a client may receive both a residential and a support services.

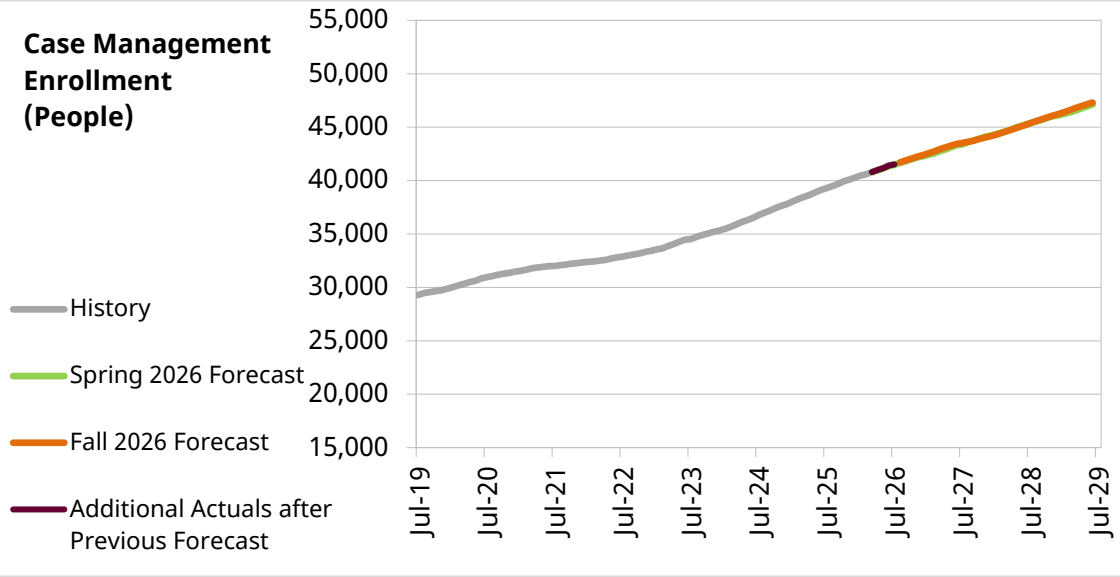
The Fall 2026 I/DD caseload forecast incorporates the estimated impact of federal H.R. 1 (the "One Big Beautiful Bill Act"), particularly changes to Medicaid eligibility for certain non-citizens. Under the new rules, some I/DD adults age 19 and older who are no longer eligible for Medicaid are expected to transition to Healthier Oregon Program (HOP) beginning October 1, 2026. The affected I/DD individuals were identified, and their projected enrollment was used to estimate the I/DD HOP caseload.

Case Management Enrollment

Case Management Enrollment (CME) is an entry-level eligibility, evaluation, and coordination service available to individuals determined to have intellectual and developmental disabilities, regardless of income level.

CME is expected to continue growing until most individuals with I/DD living in Oregon are enrolled. Conceptually, the "natural limit" of CME could be estimated by applying national prevalence rates to Oregon's youth and adult populations over the forecast horizon. However, prevalence rates vary across sources because of differences in the scopes of I/DD definitions and data collection methodologies. Prevalence estimates that include autism differ considerably from those that exclude autism. Administrative data may not contain certain populations, such as individuals who are undiagnosed, not receiving services, or no longer eligible. Survey data, in contrast, relies on self-reporting, which can be influenced by individuals' awareness of their condition and access to diagnosis. In addition, changes in service eligibility resulting from policy changes can affect the number of individuals eligible for CME over time.

Although incorporating prevalence rates into the caseload forecast is conceptually desirable, doing so could introduce additional forecast risk given the limitations described above. Therefore, the CME caseload forecast is based on observed intake, exit, and carry-forward patterns rather than an estimated prevalence-based natural limit.



The Case Management Enrollment forecast is expected to average 41,416 cases per month over the 2025-27 biennium, about 0.2 percent higher than the Spring 2026 forecast. This caseload is expected to grow to an average of 45,317 cases per month in 2027-29 biennium. These totals include Healthier Oregon clients.

Beginning in October 2026, approximately 19 clients are expected to become ineligible for Medicaid under the H.R.1 changes and transition to HOP. The HOP caseload is

expected to contribute an average of 141 cases per month to Case Management Enrollment in 2025-27 and 165 cases per month in 2027-29.

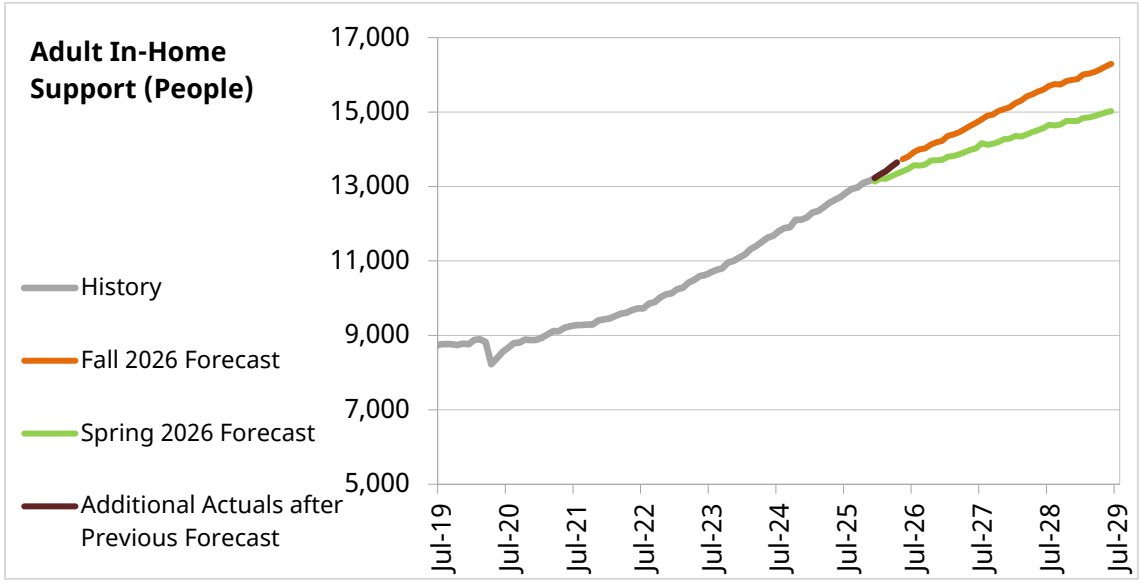
The Case Management Enrollment forecast is divided into adults and children based on independently forecasted proportions of children. The child Case Management Enrollment caseload, which accounted for 34.1 percent of the total caseload at the start of the Fall 2026 forecast, is expected to increase to 35.6 percent by June 2029.

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

Adult Services

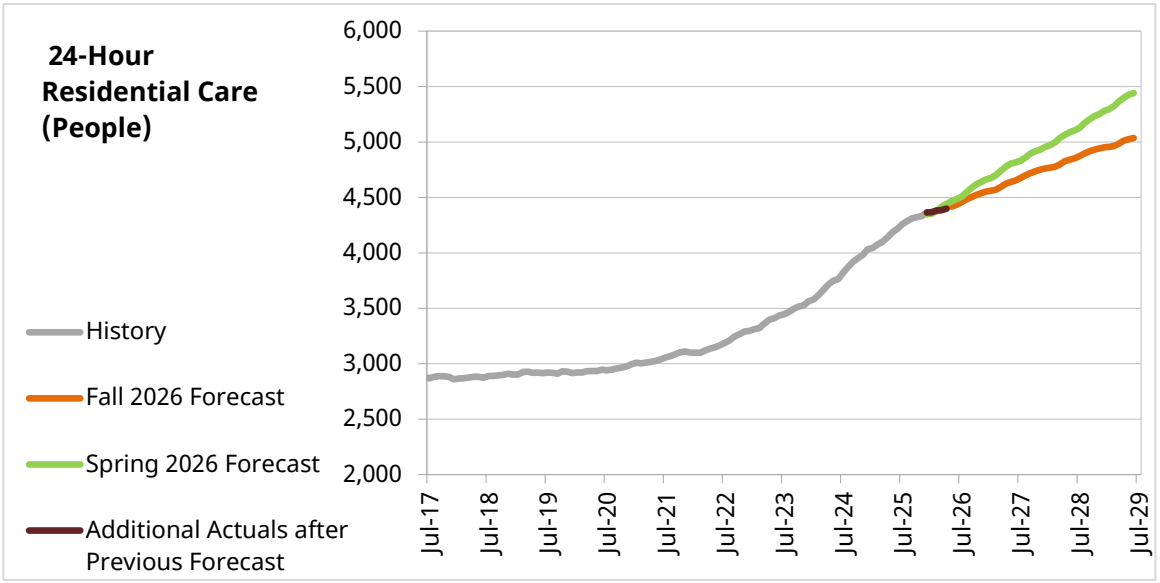
Adult In-Home Support consists of Comprehensive In-Home Services and Brokerage Services. Brokerage Services account for 44 percent of this caseload category, while Community Developmental Disabilities Program (CDDP) In-Home Services account for the remaining 56 percent. These proportional distributions are applied to the total Adult In-Home Support caseload forecast to generate separate forecasts for CDDP and Brokerage In-Home services forecasts.

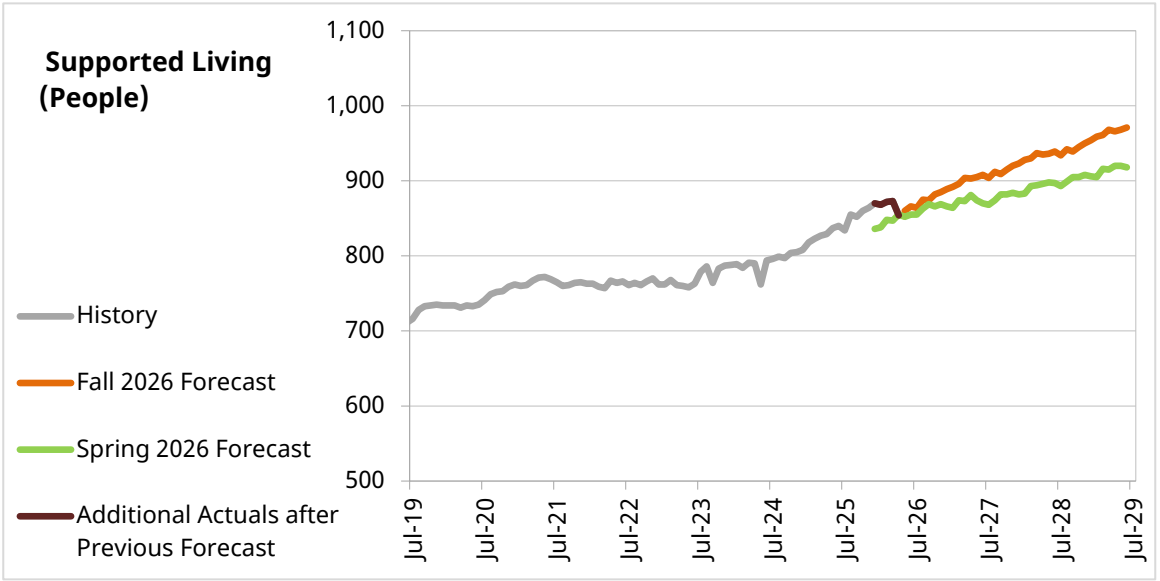
This category excludes employment and transportation services, which are forecasted separately.



The Adult In-Home Support caseload forecast, including HOP cases, is expected to average 13,801 cases per month over the 2025-27 biennium, 2.5 percent higher than the Spring 2026 forecast. The caseload experienced a sharp decline during the early stages of the COVID-19 pandemic but has since recovered and continued to grow gradually. The caseload is expected to average 15,584 clients per month in 2027-29 biennium.

As of April 2026, 46 Adult In-Home Support clients were enrolled through HOP. In addition, approximately 15 individuals are expected to become ineligible for Medicaid under the H.R.1 changes taking effect in October 2026 and transition to HOP. Incorporating these rule changes, HOP cases are expected to average 51 per month over the 2025–27 biennium and 67 per month over the 2027–29 biennium.

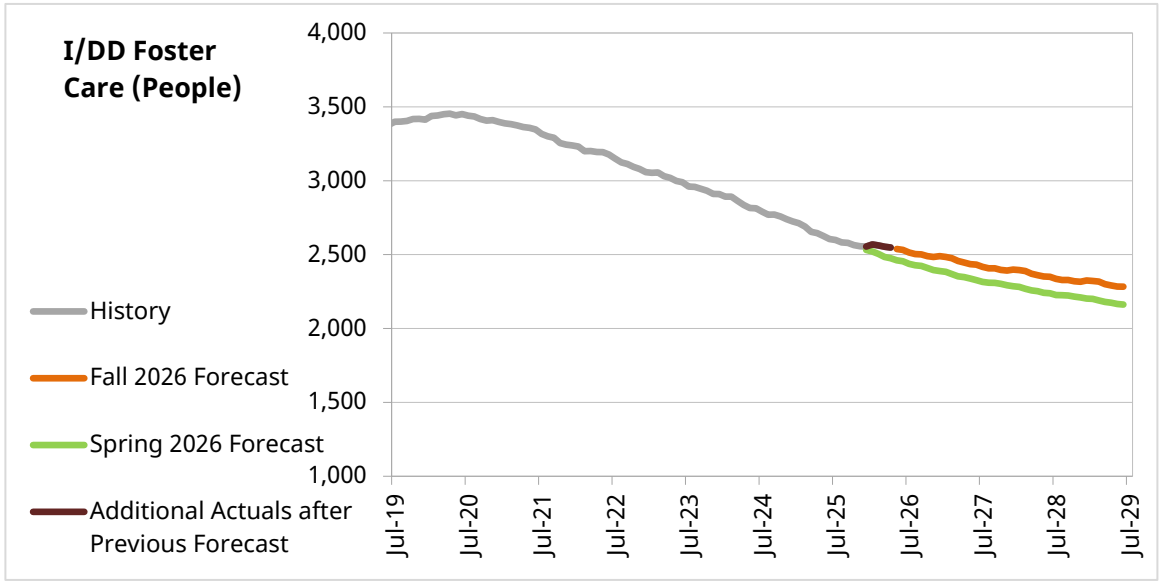




The 24-Hour Residential Care average monthly caseload forecast, including HOP cases, is 4,456 cases for the 2025-27 biennium, approximately 1.4 percent lower than the Spring 2026 forecast. The caseload is expected to average 4,862 cases over the 2027-29 biennium.

As of April 2026, three clients in 24-Hour Residential Care were enrolled through HOP. In addition, two clients were identified as ineligible for Medicaid and are expected to transition to HOP beginning in October 2026. As a result, HOP cases in 24-Hour Residential Care are expected to average four cases per month over the 2025–27 biennium and five cases per month over the 2027–29 biennium.

The Supported Living caseload is expected to average 875 cases per month over the 2025-27 biennium, about 2.6 percent higher than the Spring 2026 forecast. The caseload is expected to average 939 cases per month over the 2027-29 biennium.



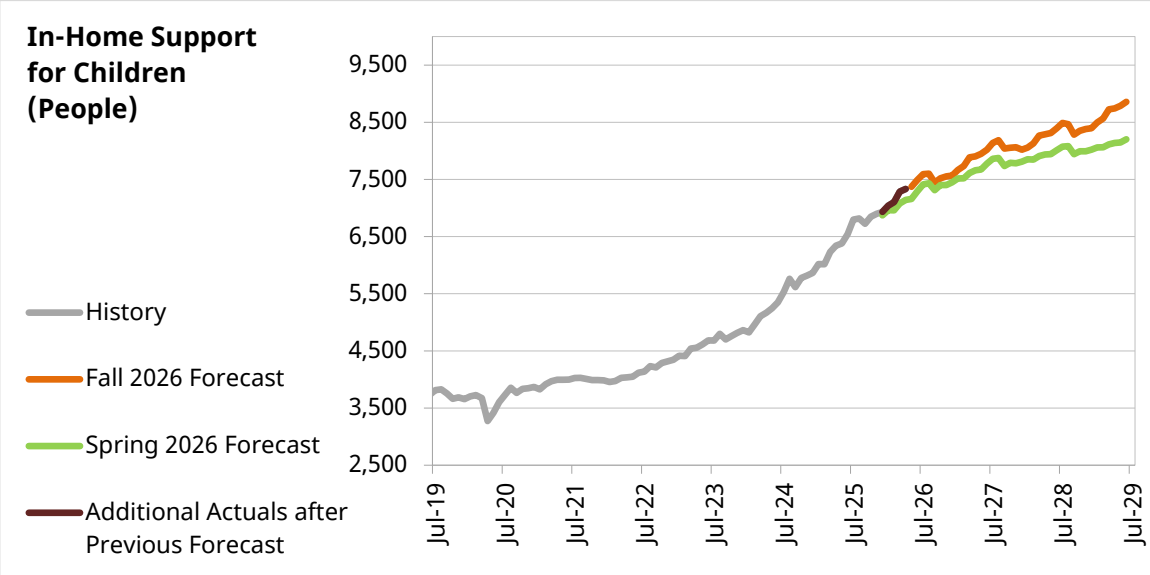
I/DD Foster Care serves both adults and children, with children representing approximately 9 percent of the caseload. The caseload is expected to average 2,519 cases per month over the 2025-27 biennium, 2.7 percent higher than the Spring 2026 forecast. The caseload is expected to continue to decline over the 2027-29 biennium, averaging 2,349 cases per month.

The Adult Foster Care caseload forecast is projected to average 2,288 cases per month over the 2025-27 biennium and is expected to average 2,133 cases per month over the 2027-29 biennium.

The Child Foster Care caseload forecast is projected to average 231 cases per month over the 2025-27 biennium and is expected to average 216 cases per month over the 2027-29 biennium.

Stabilization and Crisis Unit serves both adults and children, with children representing approximately 10 percent of the total caseload. This caseload is constrained by bed capacity, which decreased from 99 beds to 81 beds in April 2026. Incorporating the reduced bed capacity for the remainder of the forecast horizon, the caseload is projected to average 79 cases per month over the 2025-27 biennium and 81 cases per month for the 2027-29 biennium.

Children Services



The In-Home Support for Children caseload declined significantly in early 2020 due to the COVID-19 pandemic but rebounded to pre-COVID levels by the end of the year. The caseload is expected to average 7,378 cases per month over the 2025-27 biennium, 2.1 percent higher than the Spring 2026 forecast. The caseload is expected to average 8,354 cases per month over the 2027-29 biennium. These estimates include Healthier Oregon clients.

The Children Intensive In-Home Services (CIIS) caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and the Medically Involved Program. Each program operates under its own capped waiver, which is reflected in its caseload forecast. The combined waiver cap is 500 cases, and the caseload is expected to grow gradually toward this level and remain stable throughout the forecast horizon. As of April 2026, CIIS monthly actuals totaled 281 cases. For the 2025-27 biennium, the caseload is projected to average 411 cases per month, increasing to 500 cases per month at some point in the 2027-29 biennium.

Improvements in CIIS data reporting became available beginning in August 2026. Previously, CIIS monthly actuals were counted based on service eligibility rather than service received and paid. In addition, the historical actuals included cases receiving Children's Extraordinary Needs (CEN) waiver services. As the CEN program grows, accurately distinguishing CEN and CIIS cases is necessary to support accurate budget development and caseload forecasting for

both CEN and CIIS programs. The updated CIIS monthly actuals are now based on services received and paid and exclude CEN waiver cases.

Children's Extraordinary Needs (CEN) waiver services is an Oregon Medicaid waiver program that serves children under age 18 with significant medical or behavioral needs who require extraordinary care to remain in or return to their family home. The program allows eligible parents or guardians to provide paid attendant care for their child. Beginning with the Fall 2026 caseload forecasting cycle, the Office of Forecasting, Research and Analysis (OFRA) began presenting a separate CEN-PP caseload forecast.

The program launched in July 2024 and was initially capped at 155 children through June 2026, with the cap increased to 230 children effective July 1, 2026. To project future changes in CEN relative to the cap, the historical proportion of monthly actuals relative to the CEN cap will be used to develop the CEN caseload forecast.

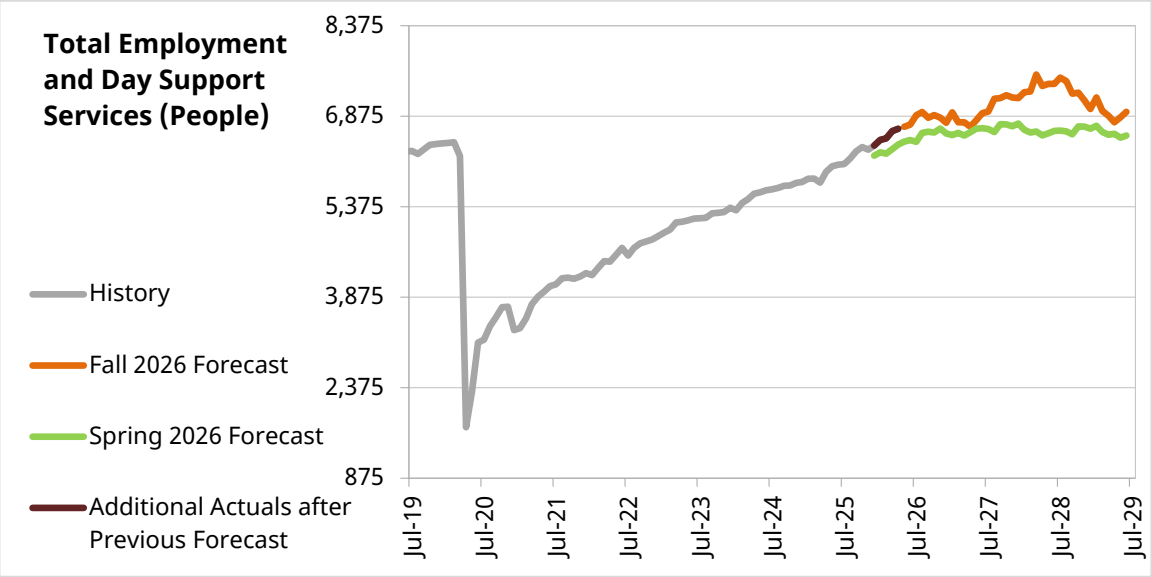
As of April 2026, CEN monthly actuals totaled 114 cases. For the 2025-27 biennium, the caseload is projected to average 134 cases per month, increasing to 161 cases per month in the 2027-29 biennium.

Children Residential Care provides 24-hour support, supervision, and training in community-based homes for children with I/DD who require intensive support. The service serves children under the age of 18, and demand for this service has continued to increase. As of April 2026, monthly actuals totaled 282 cases. The caseload is projected to average 286 cases per month over the 2025-27 biennium and gradually increases to 324 cases per month over the 2027-29 biennium.

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 remains very small, with an average of fewer than 7 cases per month in the 2025-27 biennium and is expected to average approximately 10 cases per month in the 2027-29 biennium.

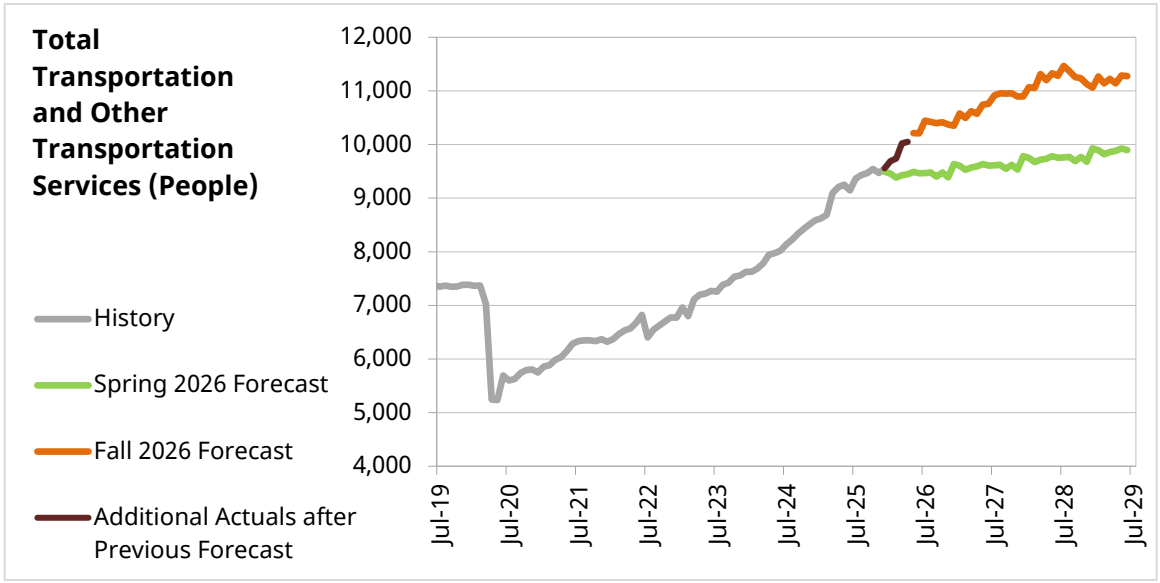
Other Services

Employment and Day Support Services 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. Preliminary actuals account for the difference between the caseload initially observed and the caseload observed later, after claims have been fully processed.



The caseload is projected to average 6,646 cases per month over the 2025-27 biennium, 3.0 percent higher than the Spring 2026 forecast. The caseload is projected to average 7,185 cases per month over the 2027-29 biennium.

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



The caseload is projected to average 10,126 cases per month over the 2025-27 biennium, 6.9 percent higher than the Spring 2026 forecast. The caseload is projected to average 11,153 cases per month over the 2027-29 biennium.

Nursing Services are shift-type services provided to adults and children with medically complex needs. This caseload was created following the unbundling of nursing services from other I/DD services, and as a result, does not have a long historical record.

The caseload is projected to average about 109 cases per month over the 2025-27 biennium, 2.8 percent higher than the Spring 2026 forecast. The caseload is projected to average 111 cases per month over the 2027-29 biennium.

Behavioral Services refer to positive behavior support services provided to assist I/DD clients with challenging behaviors. This caseload was created as a result of the unbundling of behavioral services from other I/DD services, and therefore, does not have a long historical record. The caseload experienced steep growth initially, followed by more stable growth during the COVID-19 pandemic. Growth accelerated again after the pandemic.

As part of the new Supported Living rate model effective July 1, 2026, professional behavior services are no longer bundled into the Supported Living budget. This change may result in an increase in the Behavioral Services caseload as behavioral services are authorized and tracked separately.

The caseload is projected to average approximately 2,877 cases per month over the 2025-27 biennium, 12 percent higher than the Spring 2026 forecast. The caseload is projected to average 3,532 cases per month over the 2027-29 biennium.

Forecast Environment and Risks

Healthier Oregon Program (HOP) - This forecast incorporates the estimated impact of federal H.R. 1, particularly the changes in Medicaid eligibility for certain non-citizens. I/DD individuals who become ineligible for Medicaid due to H.R. 1 are expected to transition to the HOP program in October 2026. However, the timing and volume of the transition remain key risks to the forecast. The timing of the transition may vary depending on individuals' other eligibility factors, including Medicaid-Medicare dual eligibility. In addition, the projected volume is based on April 2026 data. By the time the transition occurs, the number of individuals ultimately affected may differ from the current estimate due to changes in eligibility and caseload composition.

Case Management Enrollment (CME) - Individuals seeking I/DD services continue to increase. Annual growth in case management enrollment—the entry point into I/DD services—remained positive even during the COVID-19 pandemic. The average annual growth rate was 3.7 percent between March 2020 and April 2022, lower than the 4.5 percent average annual growth rate between February 2018 and February 2020. As public health risks subsided, enrollment growth accelerated, reaching an average annual growth rate of 5.6 percent between 2023 and 2025. Since the end of 2025, however, the growth rate has gradually declined.

For the Fall 2026 forecast, slower enrollment growth is projected, primarily due to fewer new entries into I/DD services. The caseload is projected to grow at an annual rate of 4.3 percent from August 2027 through June 2029. This slower growth does not imply reduced demand for I/DD services. The proportion of enrolled individuals who actively receive I/DD services has increased over time, providing additional evidence of continued demand. Before the COVID-19 pandemic, approximately 71.8 percent of enrolled I/DD participants, on average, received at least one I/DD service each month in 2018-2019. In more recent years, this share increased to approximately 76.4 percent in 2023-2025, suggesting that a larger proportion of enrolled participants are actively receiving I/DD services.

Adult In-Home Support – Adults can be served through two channels: Brokerages or CDDPs. At present, most caseload growth is occurring in CDDP In-Home Services, while Brokerage Services account for less than 50 percent of the total

caseload. Growth in adult caseloads generally comes from children who age into adult services or previously unserved adults who are newly seeking services.

Because the CDDP portion of the caseload is growing rapidly and without an established historical pattern, the forecast is highly sensitive to the assumptions used to project this caseload, resulting in a higher-than-usual risk of forecast error. In addition, because client choice plays a role in determining whether individuals receive CDDP or Brokerage In-Home services, it is difficult to develop reasonable assumptions about the future distribution between the two service channels without an established pattern of service choices.

In-Home Support for Children – The continued increase in children's enrollment in I/DD services is an important trend to consider. However, growth in enrollment should not necessarily be interpreted as an equivalent increase in the number of children with intellectual or developmental disabilities. Other factors, such as policy changes, expanded access, and broader identification of developmental disabilities, may also have contributed to the increase. A key question is when this growth will begin to stabilize.

Before the K Plan was implemented, families often had to reach a crisis or very high level of support needed before obtaining services because of limited access and service capacity. The implementation of the K Plan expanded access to home- and community-based services for eligible children, while the disregard of parental income increased access for children who met the eligibility requirements. Therefore, the increase in children's enrollment after 2013 does not simply imply that more children developed a need for I/DD services.

Children must meet Oregon's I/DD eligibility criteria to receive I/DD services. Although an autism diagnosis alone does not establish I/DD eligibility, increased identification of autism may contribute to the number of children who potentially qualify for I/DD services when they also meet the applicable functional and eligibility criteria.

Going forward, increased awareness of I/DD services, earlier identification and diagnosis of developmental disabilities, and greater coordination among schools, families, and community providers may continue to contribute to enrollment

growth. Therefore, children's I/DD enrollment is expected to continue increasing for some time, although the growth rate is likely to gradually moderate as the effects of expanded access and increased identification mature.

Clients who receive In-Home Support services as children are likely to continue receiving In-Home Support services as adults. As the number of children receiving In-Home Support services increases, growth in the adult In-Home Support caseload is likely to follow as these children transition to adulthood.

However, there is not yet a clear and established pattern for how children transition from children to adult I/DD services. In particular, the timing and proportion of children who continue receiving In-Home Support services after reaching adulthood are uncertain. Without reliable assumptions about the child-to-adult transition pattern, the projected increase in the adult caseload represents an additional source of forecast risk.

Foster Care and Residential Care – Provider reimbursement rates for residential care have increased and are now significantly higher on a per-case basis than rates for foster care services. This rate differential may create a financial motivation for foster care providers to convert their licenses to residential care. As providers transition their licensure, clients previously served in foster care settings may be reclassified and begin receiving services under residential care. Consistent with this shift, foster care caseloads have steadily declined since December 2020, while residential care caseloads have increased over the same period.

The forecast assumes a lower rate of conversion from foster homes to 24-hour residential homes. This assumption reflects recent ODDS actions to constrain the expansion of 24-hour residential capacity, including the 2025 moratorium on new 24-hour residential provider applications and the subsequent introduction of additional requirements for new provider agencies and endorsements, including a market study demonstrating service need. These changes suggest a more limited expansion of 24-hour residential capacity relative to historical trends.

Although ODDS actions may constrain license conversions to 24-hour residential care, the foster care caseload is still projected to decline. The extent and timing of caseload shift between these service settings are uncertain and represent a risk to forecast accuracy.

Stabilization and Crisis Unit – The Oregon Department of Human Services is in the process of redesigning the SACU operational plan pursuant to House Bill 5006 (2025). Under the revised model, SACU bed capacity may vary depending on the project design and implementation.

Children Intensive In-Home Services (CIIS) and **Children's Extraordinary Needs (CEN)** – Beginning with the Fall 2026 caseload forecast, OFRA presents the CEN caseload separately from the CIIS caseload. The CIIS forecast reflects the combined capacity of its three capped waivers, while the CEN forecast is estimated using historical caseload proportions relative to the applicable CEN waiver capacity. These forecasting methods are intended to reflect the maximum caseload based on program capacity and to estimate historical service utilization relative to program capacity. However, the methods themselves may introduce a new form of uncertainty and represent a risk to forecast accuracy.

In addition, uncertainty remains regarding the timing and extent to which the recent increase in CEN waiver capacity will translate into caseload growth. It may take several months for the increased waiver capacity to be reflected in the CEN caseload, creating an additional risk to forecast accuracy.

Agency with Choice – Effective January 1, 2026, ODDS implemented a new in-home support option, Agency with Choice (AWC), which was added to existing service models, including Personal Support Workers (PSW) and the Standard Model Agency, as authorized under SB 1521 and HB 4219 (2024). At the time of this publication, data for AWC are limited; therefore, OFRA will begin forecasting this caseload no earlier than Spring 2027.

VR Order of Selection – The Order of Selection (OOS) in the Vocational Rehabilitation program has been in operation 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 for more information). 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 an early stage of implementation and movement from the OOS waitlist to I/DD employment services has not yet been observed. The possibility of this type of movement has created a higher than usual risk to forecast accuracy for I/DD employment services.

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Total I/DD Case Management Enrollment	**41,353**	**41,416**	**63**	**0.2%**
Adult In-Home Support	13,465	13,801	336	2.5%
I/DD Foster Care	2,221	2,288	67	3.0%
24 hr. Residential Care	4,519	4,456	-63	-1.4%
Supported Living	853	875	22	2.6%
Stabilization and Crisis Unit	83	79	-4	-4.8%
I/DD Foster Care	232	231	-1	-0.4%
In-Home Support for Children	7,228	7,378	150	2.1%
Children Intensive In-Home Services	468	411	-57	-12.2%
Children's Extraordinary Needs - Parent Providers	-	134	-	-
Children Residential Care	277	286	9	3.2%
Host Homes	9	7	-2	-22.2%
Total I/DD Services	**29,355**	**29,946**	**591**	**2.0%**
Employment & Day Support Activities	6,450	6,646	196	3.0%
Transportation	9,475	10,126	651	6.9%
Nursing Services	106	109	3	2.8%
Behavioral Services	2,568	2,877	309	12.0%

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
Total I/DD Case Management Enrollment	**41,416**	**45,317**	**3,901**	**9.4%**
Adult In-Home Support	13,801	15,584	1,783	12.9%
I/DD Foster Care	2,288	2,133	-155	-6.8%
24 hr. Residential Care	4,456	4,862	406	9.1%
Supported Living	875	939	64	7.3%
Stabilization and Crisis Unit	79	81	2	2.5%
I/DD Foster Care	231	216	-15	-6.5%
In-Home Support for Children	7,378	8,354	976	13.2%
Children Intensive In-Home Services	411	500	89	21.7%
Children's Extraordinary Needs - Parent Providers	134	161	27	20.1%
Children Residential Care	286	324	38	13.3%
Host Homes	7	10	3	42.9%
Total I/DD Services	**29,946**	**33,164**	**3,218**	**10.7%**
Employment & Day Support Activities	6,646	7,185	539	8.1%
Transportation	10,126	11,153	1,027	10.1%
Nursing Services	109	111	2	1.8%
Behavioral Services	2,877	3,532	655	22.8%

Notes:

- Some Total Case Management clients do not receive any additional I/DD services.
- Total I/DD services include Healthier Oregon clients.
- Employment and DSA estimated actuals to account for under reporting of delayed claims.
- Transportation actuals are estimated to account for under reporting of delayed claim

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Vocational Rehabilitation (VR)

Vocational Rehabilitation (VR) assists individuals with disabilities in obtaining and maintaining employment that matches their skills, interests, and abilities. VR staff work in partnership with the communities and businesses to develop employment opportunities for people with disabilities. Services are individualized to meet the needs of each eligible person and are provided through local VR offices across the state. VR also partners with community organizations and local providers to deliver a wide range of services, including counseling, training, job placement, assistive technology, and extended services and supports.

Vocational Rehabilitation Order of Selection

Order of Selection (OOS) is required under federal vocational rehabilitation regulations and provides a framework for state VR programs to deliver services when resources are insufficient to serve all eligible individuals. Under OOS, a waitlist is established to manage service capacity and ensure that individuals with the most significant disabilities receive priority access to VR services. In Oregon, VR implemented OOS on June 14, 2025. Current clients enrolled in In-Plan services continue to receive uninterrupted services, while eligible applicants who do not yet have an Individualized Plan for Employment (IPE) are waitlisted. Applicants are prioritized using a disability scoring system with three priority categories, with lower numbers indicating more significant disabilities. Within each priority category, applicants are ranked by application date. Applicants with the most significant disabilities receive the highest priority, with application date determining the order of service within each priority category.

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

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

General Assumptions for the Vocational Rehabilitation Forecast

VR services are forecasted in three stages: In-Application, In-Eligibility, and In-Plan. The implementation of OOS has disrupted VR's normal operations and introduced greater uncertainty into the forecasting of all three stages.

Following the initial announcement of Order of Selection in February 2025, applications surged, consistent with the experiences of other states implementing OOS, where potential clients applied quickly, hoping to be placed at the top of the waitlist. Although applications increased, some individuals may have chosen to avoid the waitlist and instead seek alternative state services, such as those offered by ODDS or OED employment programs. The number of individuals authorized to receive job development services through ODDS has increased since OOS was implemented. As of June 2026, approximately 830 VR clients had opted to receive services through ODDS. Prior to OOS, very few VR clients opted for ODDS services.

As the need for accurate priority determinations increased, VR established a dedicated eligibility team to provide consistent and accurate eligibility determination when OOS was initiated. This initially caused delays in the transition from In-Application to In-Eligibility and contributed to continued growth in the In-Application caseload through November 2025. As the team became fully operational and the initial surge in applications subsided, the eligibility process gradually returned to normal.

The In-Eligibility caseload has increased in response to higher application volume and the pause in transfers to In-Plan. The In-Eligibility caseload began to increase in November 2025 as transfers from In-Application to In-Eligibility resumed while transfers from In-Eligibility to In-Plan remained paused. This trend is expected to continue until In-Plan reopens. Under current operations, transfers to In-Plan are expected to be primary mechanism for reducing the In-Eligibility

caseload once In-Plan reopening begins. Reopening In-Plan is also expected to result in additional exits from In-Eligibility as some individuals decline services or no longer need VR services when they are contacted.

The In-Plan caseload is gradually declining as clients complete their Individualized Plan for Employment and exit VR, with no new transfers into the In-Plan stage to take their place.

The Order of Selection-based Forecast:

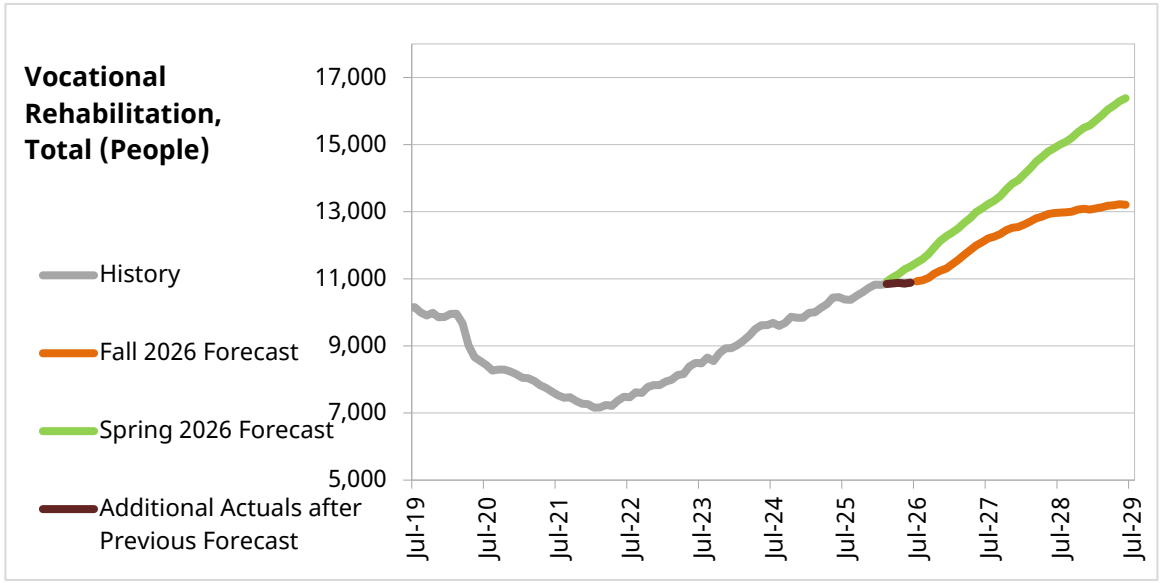
The current forecast is based on several operational assumptions under the OOS program. Due to the lack of sufficient historical data, there is limited empirical evidence to inform these assumptions. OFRA expected that progress on a financial model would be available for the Fall 2026 caseload cycle. Such a model would help manage available resources for the In-Plan caseload and provide guidelines for reopening the In-Plan caseload based on the available operating budget, cost per client and staff capacity. These factors would help determine the timing for opening or closing the In-Plan, as well as the number of clients who can be served within each priority category while remaining within financial constraints.

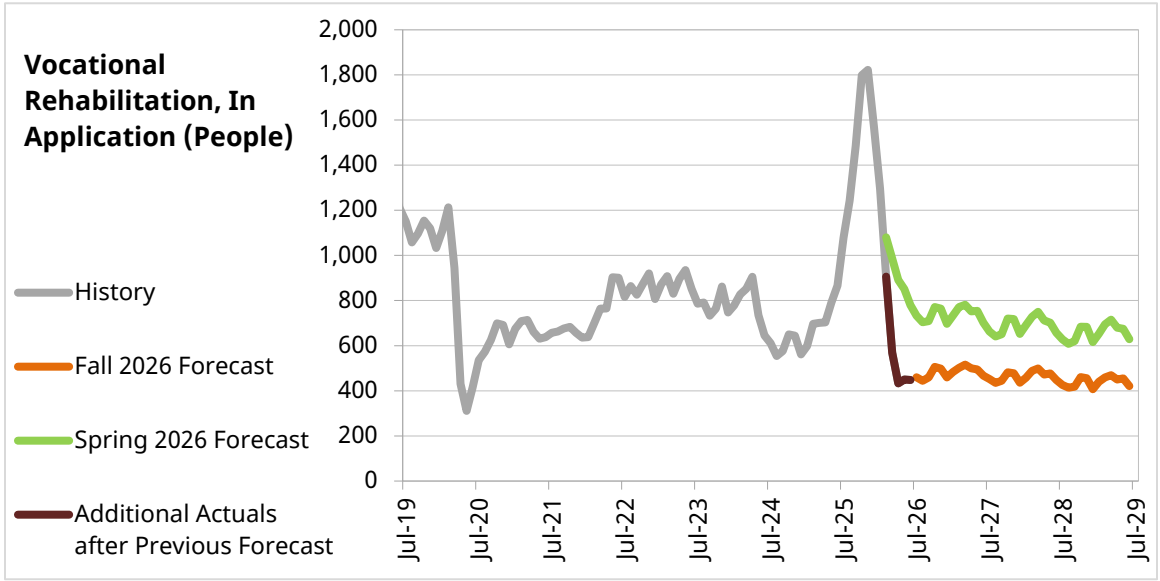
In the absence of a financial model, the Fall 2026 caseload forecast was developed based on assumptions that reflect the early-stage reopening plan developed by the VR leadership for the first three months of In-Plan reopening. Beginning in the fourth month, OFRA developed its own assumptions regarding the pace and volume of In-Plan reopening through the final month of the 2027-29 biennium.

The forecast is based on the following assumptions:

- **Priority of service**: Once In-Plan reopens, individuals in higher priority categories will be served first. Access for lower-priority groups will depend on further reductions in the In-Plan caseload, driven by ongoing exits and transfers under current patterns.

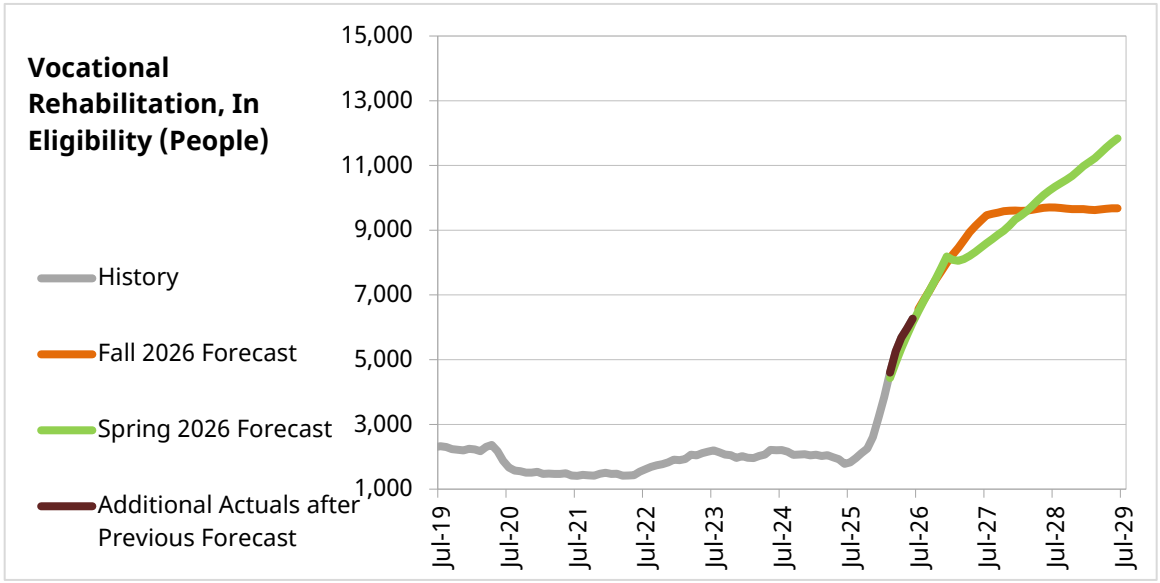
- **Initial Reopening**: Initial In-Plan reopening is expected to resume in November 2026, beginning with Priority One clients. During the first three months, the VR office is assumed to contact approximately 50 clients per month.
- **Gradual Increase in Contacts**: Beginning in the fourth month, the number of clients contacted is assumed to increase gradually by approximately 50 additional clients every three months.
- **Clients Declining Services**: Prior to OOS, approximately 30 percent of clients declined services after being contacted to develop their Individualized Plan for Employment (IPE). Given the extended waiting period, which has exceeded one year since the waitlist was introduced, OFRA expects the share of clients who decline services to be higher than the pre-OOS rate. Therefore, OFRA assumes a 40 percent service-decline rate for the forecast.
- **Staff Capacity**: VR staff who previously developed IPEs may currently be assigned to other duties and responsibilities. Managing workload across geographic areas is also an operational consideration. Given these workload constraints, the Fall 2026 forecast assumes that the maximum transfer capacity will be approximately 50 percent of the pre-OOS transfer volume. Prior to OOS, the monthly average transfer volume from Eligibility to In-Plan was approximately 320 individuals.
- **Transfer Timing**: It may take up to five months to complete transfer of clients from Eligibility to In-Plan after reopening begins. Once contacted by the VR office, clients have up to 60 days to respond regarding their need for VR services. For clients who request services, VR counselors and clients then develop an IPE, which may take up to 90 days. Therefore, the forecast assumes a potential lag of up to five months between the initial client contact and complete of the transfer to In-Plan.





The **Total Vocational Rehabilitation (Total VR) forecast** is the sum of In-Application, In-Eligibility, and In-Plan. Under OOS assumptions, the total VR caseload is projected to average 11,076 clients per month in 2025-27 biennium, which is 4.2 percent lower than the Spring 2026 forecast. The total VR caseload is further projected to average 12,848 clients per month in 2027-29 biennium, representing a 16 percent increase over the previous biennium.

In-Application –The current monthly average forecast for the 2025-27 biennium is projected to be 787 cases, which is 20 percent lower than the Spring 2026 forecast. Applications surged following the initial announcement of OOS in February 2025 but began to taper off in November 2025. New applications in recent months are at record-low levels. At the same time, transfers to In-Eligibility resumed after a delay. Assuming current application and transfers patterns continue throughout the forecast period, the In-Application

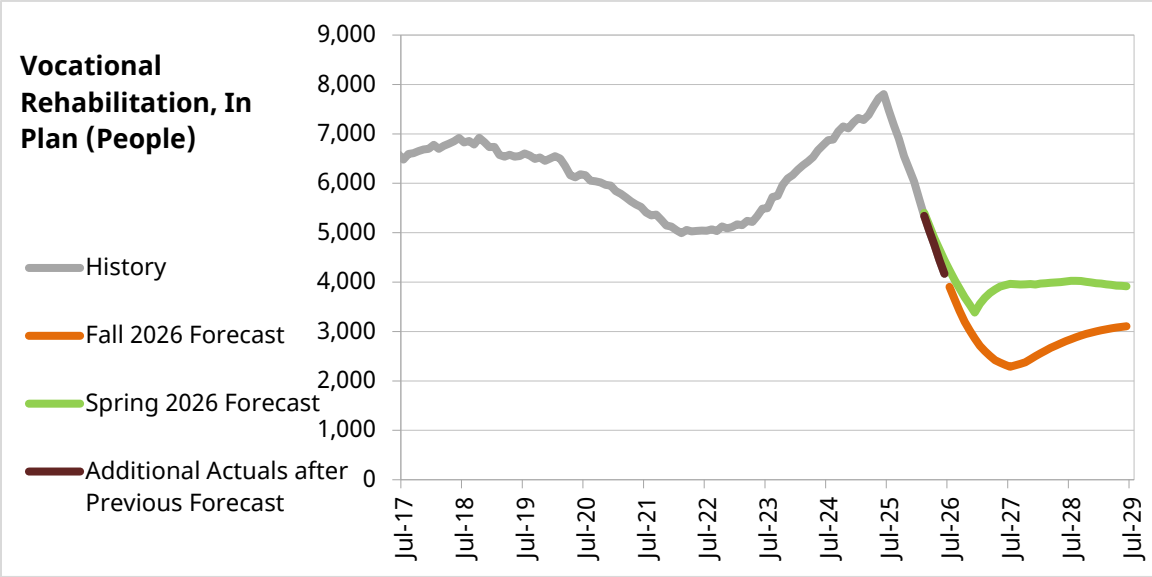


caseload is projected to average 452 cases per month in 2027-29 biennium, representing a 42.6 percent decrease from the 2025-27 forecast.

In-Eligibility – The In-Eligibility portion of the caseload is expected to remain elevated and continue increasing due to limited In-Plan capacity. The current monthly average forecast for the 2025-27 biennium is 5,921 cases, which is 3.1 percent higher than the Spring 2026 forecast. This increase is primarily driven by the pause in transfers to In-Plan, while clients continue to flow into In-Eligibility from In-Application. Exits from In-Eligibility occur mainly through transfers to In-Plan, although some individuals leave during the review process if they no longer wish to receive services. During the period when transfers to In-Plan are paused, the caseload continues to grow. The In-Eligibility caseload is projected to remain high, reaching an average of 9,630 cases in the 2027-29 biennium, which is 62.6 percent higher than the 2025-27 forecast.

In Plan – The average monthly In-Plan caseload forecast for 2025-27 biennium is forecasted at 4,368 clients, which is 9.7 percent lower than the Spring 2026 forecast. The caseload is expected to decline further to an average 2,766 clients in the 2027-29 biennium, representing a 36.7 percent decrease from the 2025-27 forecast.

As of June 2026, there were approximately 4,169 clients in the In-Plan caseload. With no new entries, the caseload is expected to decline to approximately 3,196 cases by October 2026. Although the forecast assumes that In-Plan will



gradually reopen to a small number of waitlisted clients beginning in November 2026, the In-Plan caseload is expected to continue declining through July 2027 because monthly exits are projected to exceed new entries during this period.

Beginning in August 2027, the In-Plan caseload is expected to gradually increase as new entries exceed exits under the current reopening assumptions. Individuals in the highest priority group will begin receiving services first. Under the current forecasting assumptions, the Priority Two group is expected to begin receiving services around September 2028, as the Priority One waitlist is sufficiently reduced.

Forecast Environment and Risks

The primary risk to the accuracy of this forecast is the implementation of the Order of Selection (OOS) budget and resource model. Specifically, limited information on current resource constraints requires OFRA to make critical assumptions regarding the timing of resumed transfers to In-Plan, the proportion of clients who will request VR services, staff workload and processing capacity, and the pace at which clients are contacted from the waitlist. These assumptions introduce significant uncertainty that may affect the accuracy of the Fall 2026 forecast.

As anticipated, the number of clients in the In-Plan stage began to decline in July 2025 following the pause in transfers from In-Eligibility and is expected to continue decreasing until sufficient resources are available to serve individuals on the waitlist. The timing of resumed transfers is highly uncertain, particularly given potential changes in resource availability. Although the current forecast follows VR program leadership's initial guidance that In-Plan reopening will begin in November 2026, actual conditions may result in earlier or later reopening than projected.

The forecast incorporates assumptions about the proportion of waitlisted clients who may require services and current staff workload capacity. Due to the long waiting periods, OFRA anticipates that fewer clients may request VR services when they are contacted. However, it is difficult to estimate the magnitude of this reduction because of the lack of empirical evidence and historical data. There is also uncertainty regarding the timing and extent of workload shifts for staff who previously processed IPEs but may currently be assigned to other duties, as well as the geographical distribution of demand when In-Plan reopening resumes. These factors may affect the timing and pace of caseload growth and pose a risk to forecast accuracy.

Consumer behavior is also a key driver of current caseload patterns. Anticipation of OOS created uncertainty, contributing to a significant increase in the In-Application caseload and subsequent growth in the In-Eligibility determination process. Awareness of the waitlist encouraged some individuals to apply quickly to secure a place. Now application levels are at historic lows, suggesting some people are delaying or forging applying altogether. Additionally,

some current In-Plan clients may remain in service longer than expected due to concerns about extended wait-times if they need to re-enter the caseload.

The implementation of OOS does not affect Pre-Employment Transition Services (Pre-ETS), as these services are supported by dedicated federal funding. Even under OOS, at least 15 percent of VR resources must be allocated to Pre-ETS.

Vocational Rehabilitation Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
In Application	984	787	-197	-20.0%
In Eligibility	5,742	5,921	179	3.1%
In Plan	4,839	4,368	-471	-9.7%
Total Vocational Rehabilitation	**11,565**	**11,076**	**-489**	**-4.2%**

Fall 2026 Biennial Comparison (2025-27 vs. 2027-29)

Program area	2025-2027	2027-2029	Change	% change between biennia
In Application	787	452	-335	-42.6%
In Eligibility	5,921	9,630	3,709	62.6%
In Plan	4,368	2,766	-1,602	-36.7%
Total Vocational Rehabilitation	**11,076**	**12,848**	**1,772**	**16.0%**

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Health Systems - Medicaid				
OHP				
Children's Medicaid	305,304	304,689	-615	-0.2%
Children's Health Insurance Program	138,920	137,835	-1,085	-0.8%
Foster, Substitute and Adoption Care	16,135	16,049	-86	-0.5%
Aid to the Blind and Disabled	82,596	82,029	-566	-0.7%
Old Age Assistance	61,013	61,986	973	1.6%
Pregnant Women	17,173	17,253	80	0.5%
Parent, Caretaker Relative	94,889	94,181	-708	-0.7%
ACA Adults	568,496	565,656	-2,840	-0.5%
Breast and Cervical Cancer Treatment Program	60	63	3	4.8%
Healthier Oregon - Child	14,536	14,322	-214	-1.5%
Healthier Oregon - Pregnant	4,493	4,296	-197	-4.4%
Healthier Oregon - Adult	81,958	79,304	-2,654	-3.2%
Youth with Special Healthcare Needs	2,576	2,591	16	0.6%
Permanent Medicaid Expansion	1,716	1,733	17	1.0%
Total OHP	**1,389,865**	**1,381,986**	**-7,879**	**-0.6%**
Total Medicaid	**1,431,779**	**1,423,675**	**-8,105**	**-0.6%**

Total Oregon Health Authority Biennial Average Forecast Comparison

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Behavioral Health				
Under Commitment				
Total Forensic Care	1,811	1,854	43	2.4%
Civilly Committed	854	938	84	9.8%
Previously Committed	4,019	4,056	37	0.9%
Never Committed	96,269	99,133	2,864	3.0%
Total Behavioral Health Served	**102,953**	**105,981**	**3,028**	**2.9%**

Note: Behavioral Health numbers reported represent adults only.

Total Oregon Health Authority Biennial Average Forecast Comparison

Fall 2026 Biennial comparison (2025–27 vs. 2027–29)

Program area	2025-27	2027-29	Change	% change between forecasts
Health Systems - Medicaid				
OHP				
Children's Medicaid	304,689	295,883	-8,806	-2.9%
Children's Health Insurance Program	137,835	134,810	-3,025	-2.2%
Foster, Substitute and Adoption Care	16,049	15,967	-82	-0.5%
Aid to the Blind and Disabled	82,029	81,777	-252	-0.3%
Old Age Assistance	61,986	63,789	1,803	2.9%
Pregnant Women	17,253	17,189	-64	-0.4%
Parent, Caretaker Relative	94,181	89,116	-5,065	-5.4%
ACA Adults	565,656	443,916	-121,740	-21.5%
Breast and Cervical Cancer Treatment Program	63	67	4	6.5%
Healthier Oregon - Child	14,322	13,611	-711	-5.0%
Healthier Oregon - Pregnant	4,296	4,358	63	1.5%
Healthier Oregon - Adult	79,304	58,969	-20,335	-25.6%
Youth with Special Healthcare Needs	2,591	5,745	3,153	121.7%
Permanent Medicaid Expansion	1,733	2,302	570	32.9%
Total OHP	**1,381,986**	**1,227,499**	**-154,487**	**-11.2%**
Total Medicaid	**1,423,675**	**1,274,744**	**-148,931**	**-10.5%**

Total Oregon Health Authority Biennial Average Forecast Comparison

Fall 2026 Biennial comparison (2025–27 vs. 2027–29)

Program area	2025-27	2027-29	Change	% change between forecasts
Behavioral Health				
Under Commitment				
Total Forensic Care	1,854	2,043	189	10.2%
Civilly Committed	938	960	22	2.3%
Previously Committed	4,056	4,040	-16	-0.4%
Never Committed	99,133	102,901	3,768	3.8%
Total Behavioral Health Served	**105,981**	**109,944**	**3,963**	**3.7%**

Note: Behavioral Health numbers 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. Mass case closures began in Spring 2023 and ended in February 2025. 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 1, 2023. It has effectually increased client retention, reducing exits and transfers to lower benefit groups.

HR1 – The "One Big Beautiful Bill Act"

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. Redeterminations will be scheduled every six months for ACA Adult clients, and one year for most other clients. Currently, most clients are on a two-year redetermination schedule.

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 August 2026, when the forecast was finalized. Details may change as additional guidance from the federal Center for Medicare/Medicaid Services (CMS) is received, however most specifics are known.

Different parts of the act will be enacted at different times. 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 (HOP), leading to an increase in transfers to HOP 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. Some changes, particularly work requirements, will undergo a staggered rollout due to complex interactions between the 1115 waiver and HR1 implementation timelines.

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 under 19 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.

Beginning in January 2027, new enrollees will be required to demonstrate evidence of meeting the work requirement or an exclusionary criterion in the months prior to enrollment. Based on more recent guidance from CMS, current enrollees will be required to demonstrate evidence of meeting these requirements at redeterminations beginning in January (therefore the first closures related to non-compliance with HR1 will be dated March 2027).

Clients who have not been redetermined between January and the end of the current 1115 waiver (by September 30, 2027) will have their redetermination date resequenced to fit a six-month schedule for ACA Adults or one year for most other clients and will have Continuous Eligibility protections removed. Pregnant women will have protected eligibility after this change, and children under six will still have a form of continuous eligibility.

This implementation plan is expected to increase exits throughout 2027, with the largest spike of increased exits occurring in Fall 2027 and remaining steady into Fall 2028.

When enacted, this policy will reduce enrollment in ACA Adults by decreasing new entries for people who don't meet the new work requirements. 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 losses.

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. As a result, changes to eligibility as enacted in HR1 apply to clients enrolled in HOP. Those adults who qualify for HOP Adults by meeting the criteria applied to Affordable Care Act Adults will be required to meet the HR1 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. Like all areas of Medicaid, HOP clients will be moved from a two-year eligibility determination to one year or six months as indicated in the above HR1 section.

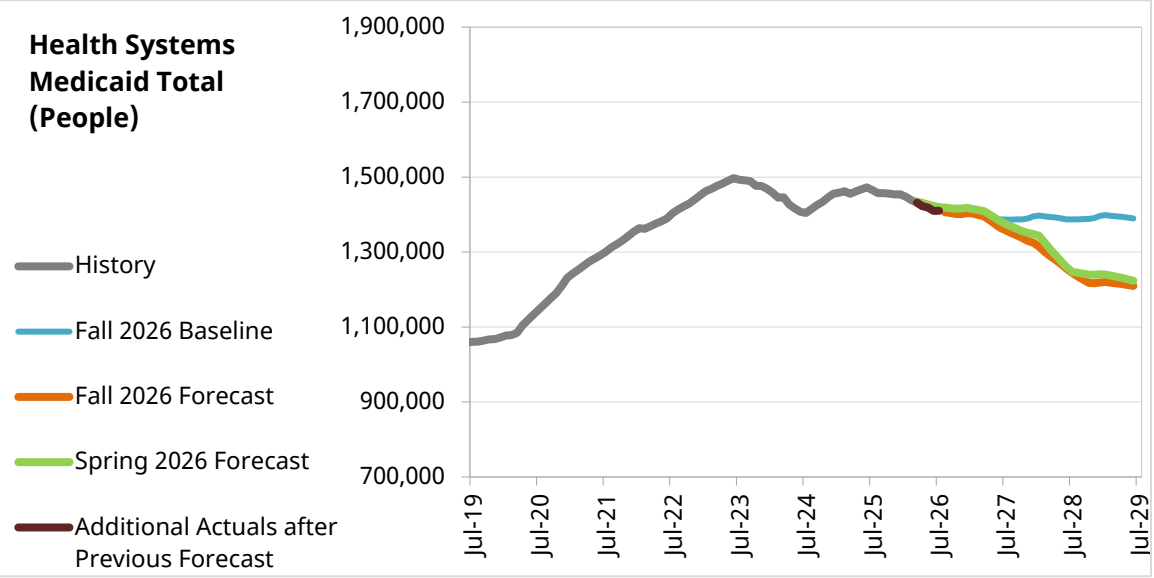
The Baseline forecast and the HR 1 forecast

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

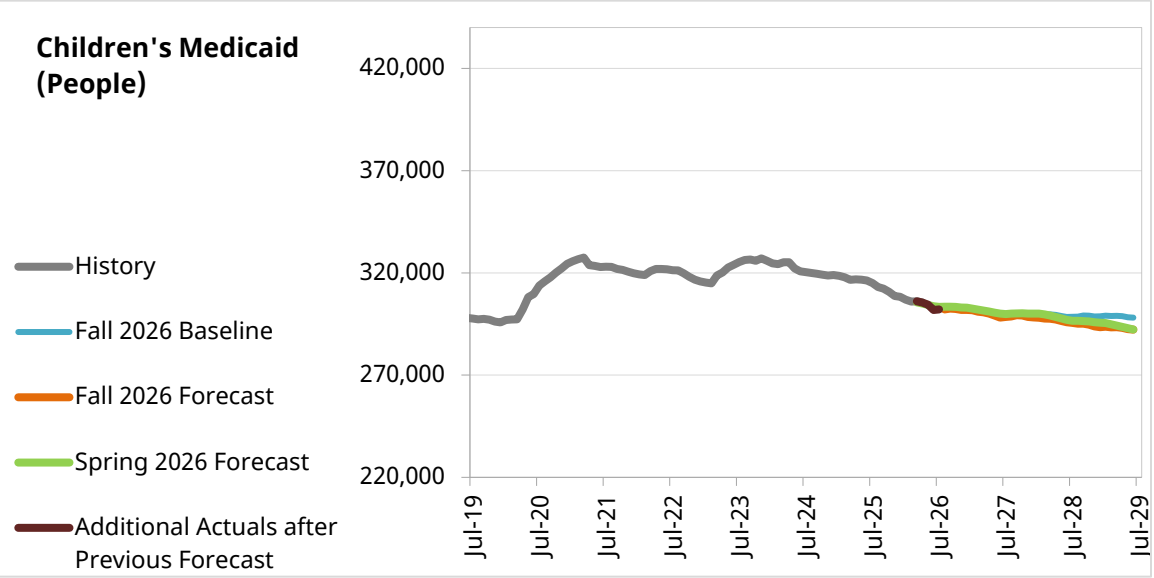
As of April 2026, **the total number of people served by Health Systems/Medicaid** (including all partial and dual-eligible Medicare/Medicaid clients and the Basic Health Plan) was 1,509,278 persons and the preliminary estimate for July 2026 is 1,499,088. Due to the Public Health Unwinding, the caseload fell by about 64,000 cases from a high point in September 2023 to a low point in July 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 data shows that the decline in the total number served is 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 slowly decline across the remainder of 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 2027-2028 as key provisions of HR1, especially work requirements, lead to a sustained reduction in enrollment among ACA Adults and HOP Adults.



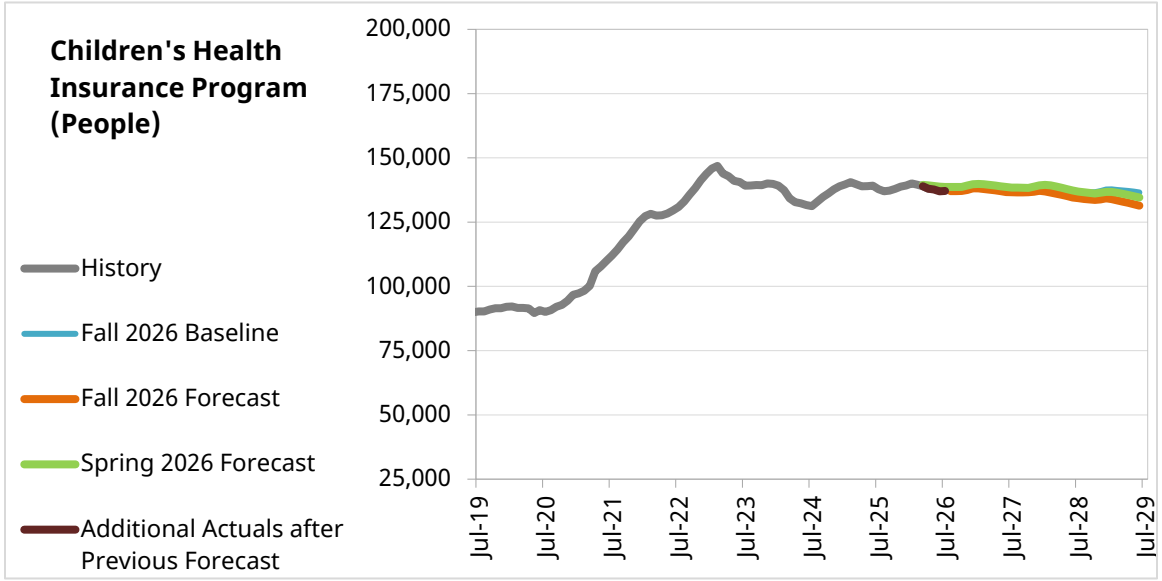
The 2025-27 **Total Health Systems/Medicaid (HSM) biennial average forecast** (which includes Healthier Oregon but excludes the Basic Health Plan and some dual and part-dual-eligible groups) is 1,423,675 clients, which is 0.6 percent lower than the Spring 2026 Forecast. The 2027-29 biennial average forecast is 1,274,744 clients, 10.5 percent lower than 25-27.

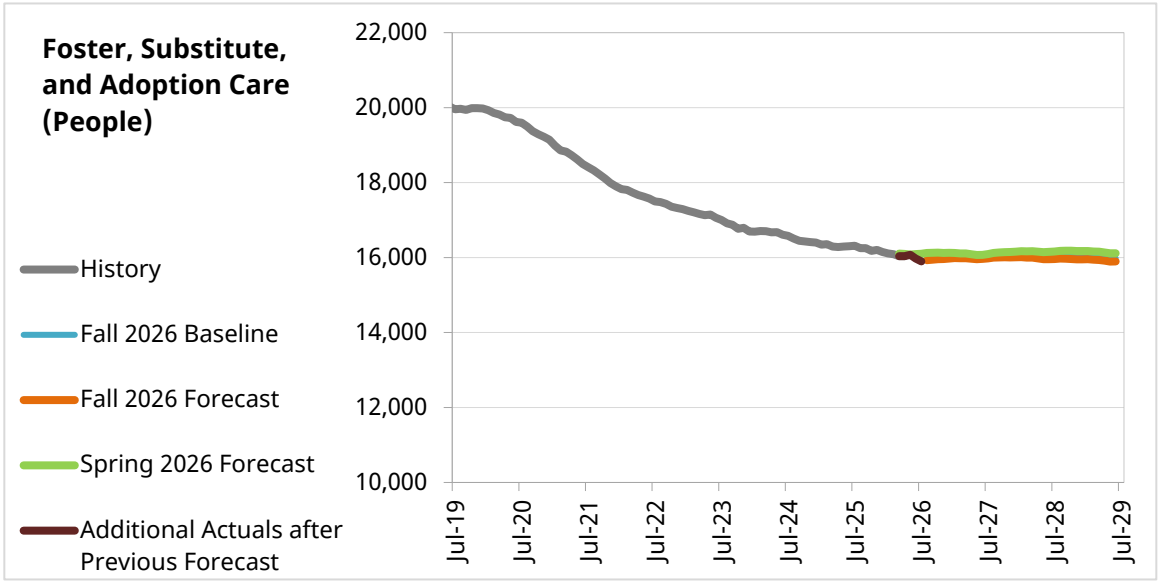
Children's Medicaid – This caseload is highly influenced by transfers to and from the higher-income Children's Health Insurance Program (CHIP). Recent data show an increase in exits and transfers to CHIP as previously re-sequenced cases undergo redetermination. The most recent finalized actual for April 2026 shows 305,500 clients on this caseload. The preliminary estimate for July 2026 is 302,122.



The Children's Medicaid average monthly caseload forecast for 2025-2027 is 304,689 cases, 0.2 percent lower than the previous forecast. It is expected that this caseload will continue to slowly fall as the transfers to CHIP continue and re-sequenced cases undergo redetermination. This would reestablish the pattern seen before the Public Health Emergency. The 2027-29 biennium is expected to average 295,883 cases a month, a 2.9 percent reduction from the current biennium.

Children's Health Insurance Program (CHIP) – The most recent finalized actual for April 2026 shows 137,966 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.





The CHIP forecasted average monthly caseload for the 2025-27 biennium is expected to be 137,835 cases, 0.8 percent lower than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 134,810 cases, 2.2 percent lower than 2025-27.

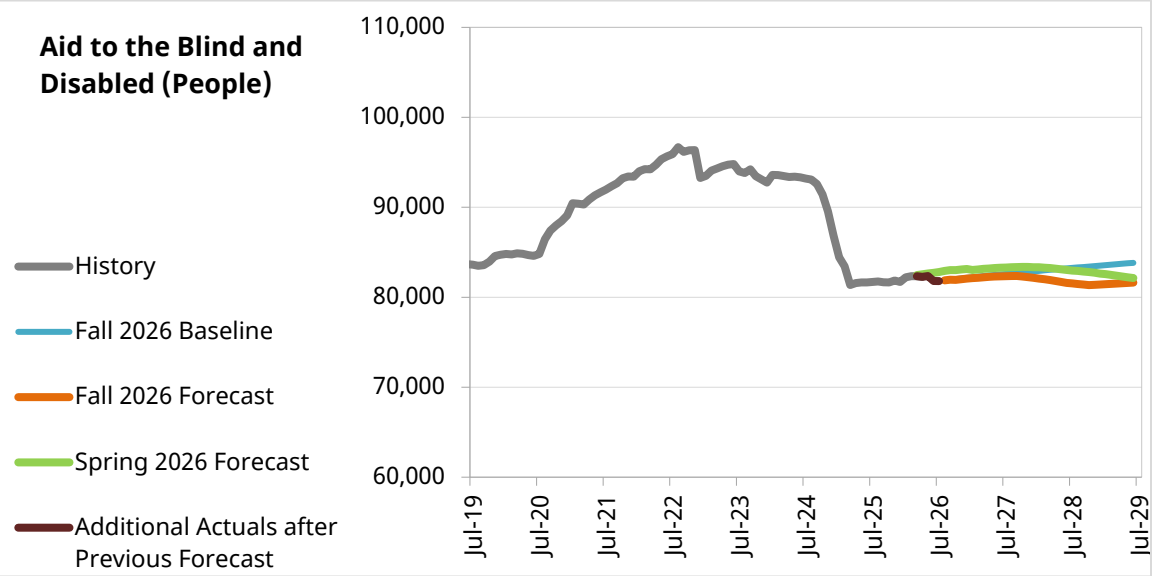
HR1 is expected to decrease children's caseloads (both Children's Medicaid and CHIP) when those over age five move from a two-year redetermination schedule to one-year schedule. Those ages five and under will go from a continuous eligibility status, with no scheduled redetermination, to a one-year eligibility schedule. The pattern of drawdown will depend largely on how children and households have their redetermination dates re-sequenced in the system.

Foster, Substitute and Adoption Care – The most recent finalized actual for April 2026 shows 16,036 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 16,049 cases per month, 0.5 percent lower than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 0.5 percent lower 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 an aging population.

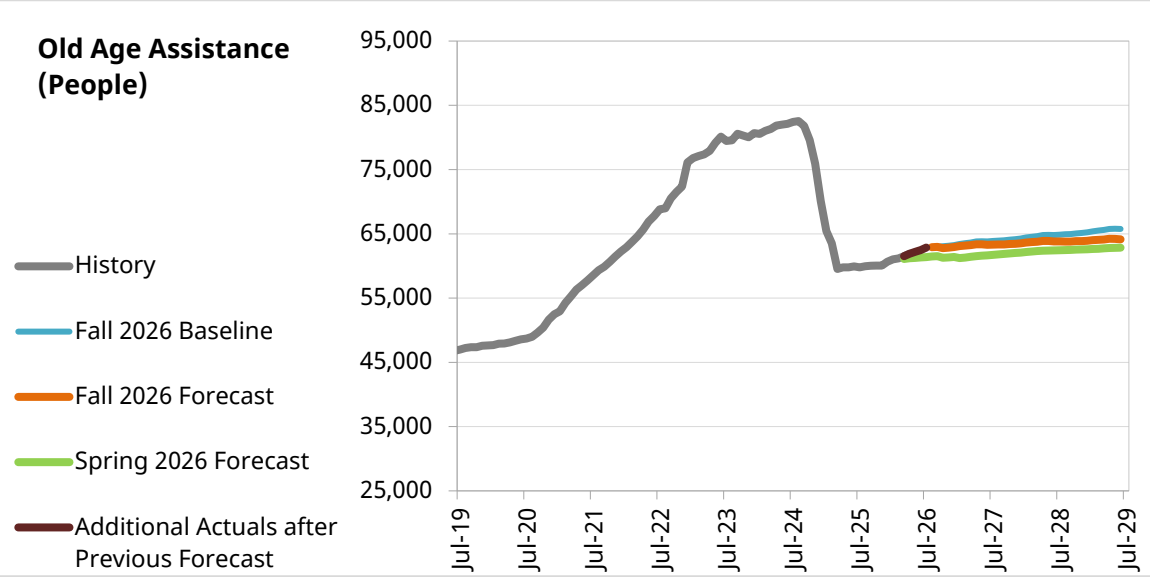


Aid to the Blind and Disabled (ABAD) – The most recent finalized actual for April 2026 shows 82,272 clients on this caseload. Because of the allegation of violation of due process mentioned above, these cases were held in place and mass-redetermined in large batches at the end of the Unwinding. As a 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 82,029 cases for 2025-2027, 0.7 percent lower than the previous forecast. The average monthly caseload forecast for the 2027-29 biennium is expected to be 0.3 percent lower 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 October 2026.

Old Age Assistance (OAA) – The most recent finalized actual for April 2026 shows 61,900 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.



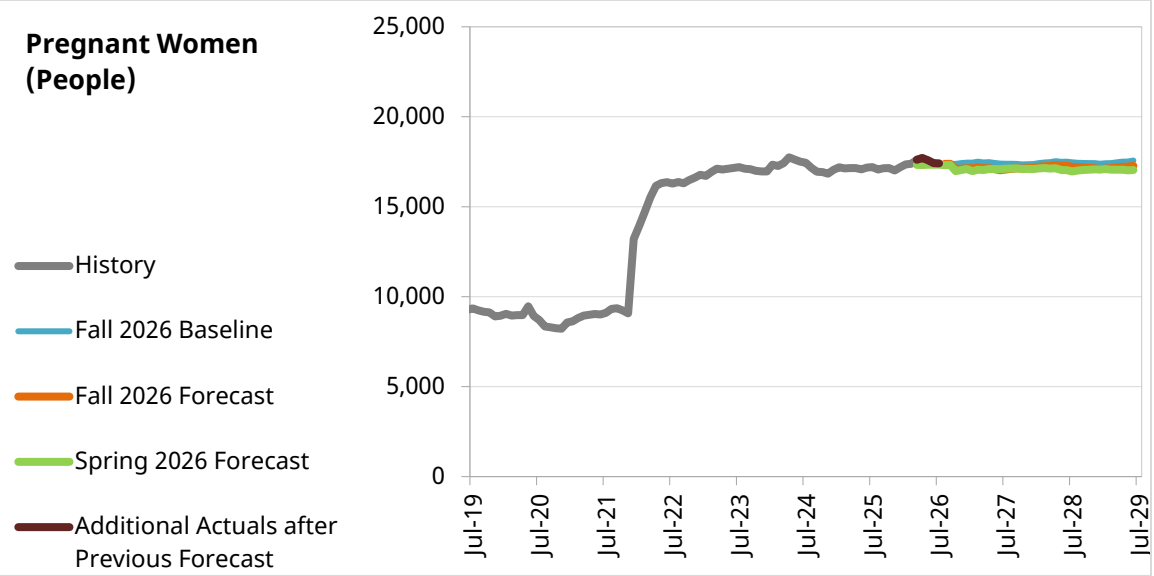
The forecasted average monthly caseload for OAA is expected to be 61,986 cases in 2025-27, 1.6 percent higher than the prior forecast. The 2027-29 average monthly caseload is expected to be 63,789 cases, a 2.9 percent increase from the current biennium.

Both ABAD and OAA will 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 these caseloads were expected to slowly increase due to the aging population in Oregon, HR1 will mute this growth through increased transfers and exits.

Pregnant Women – The most recent finalized actual for April 2026 shows 17,705 women on this caseload.

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 decrease as current members are transferred to HOP-Pregnant.

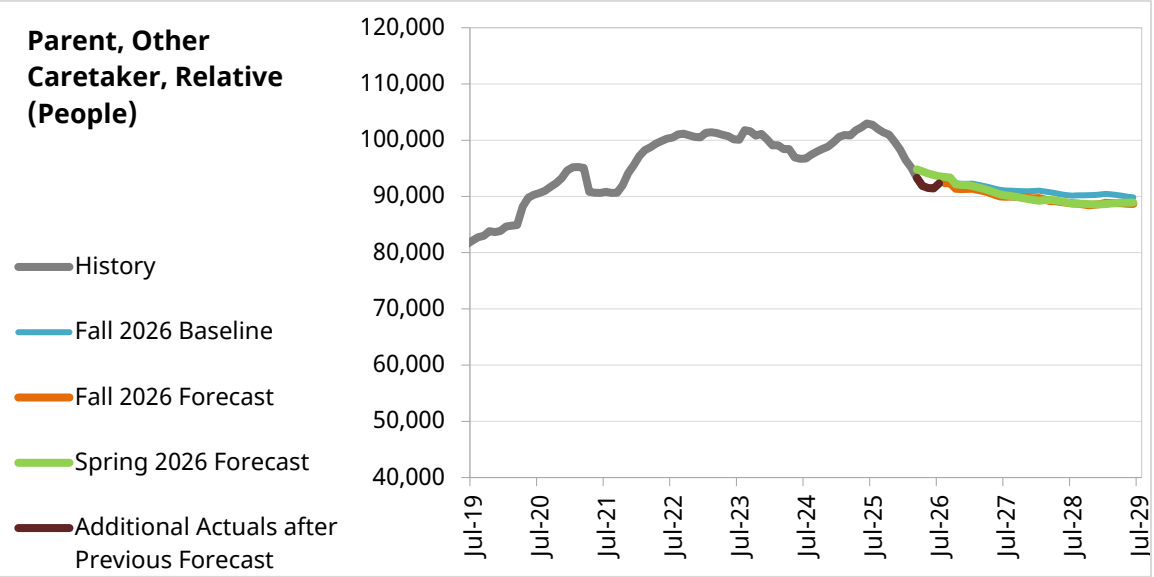


The average monthly caseload for the Pregnant Women caseload in 2025-27 is expected to be 17,253, 0.5 percent higher than the previous forecast. The average monthly caseload for 2027-29 is 17,189, about 0.4 percent lower than 2025-27.

Parent, Other Caretaker, Relative (PCR) – The most recent finalized actual for April 2026 shows 91,876 clients on this caseload. This caseload is driven in part by transfers to and from the higher-income Affordable Care Act (ACA) caseload. More recently, 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, but this trend has largely stabilized.

HR1 is expected to reduce the PCR caseload. First, there will be a one-time transfer of an estimated 900 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.



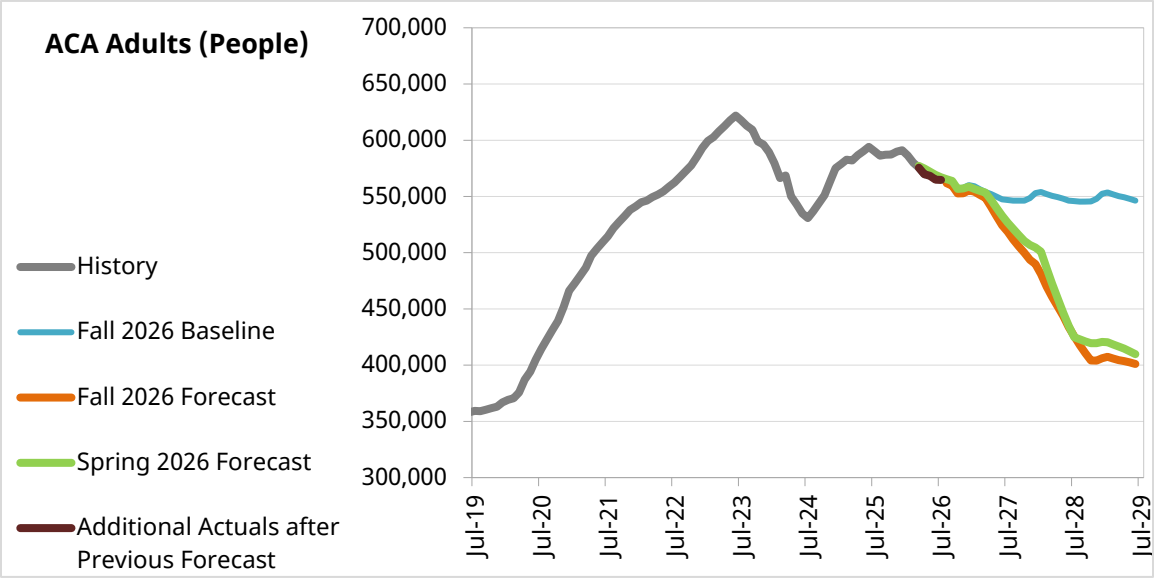
The average monthly caseload for PCR in 2025-27 is expected to be 94,181 cases, 0.7 percent lower than the previous forecast. The average monthly caseload for the 2027-29 biennium is expected to be 89,116 cases, 5.4 percent lower than 2025-2027.

ACA Adults – The most recent finalized actual for April 2026 shows 569,724 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 drop across the 25-27 biennium.

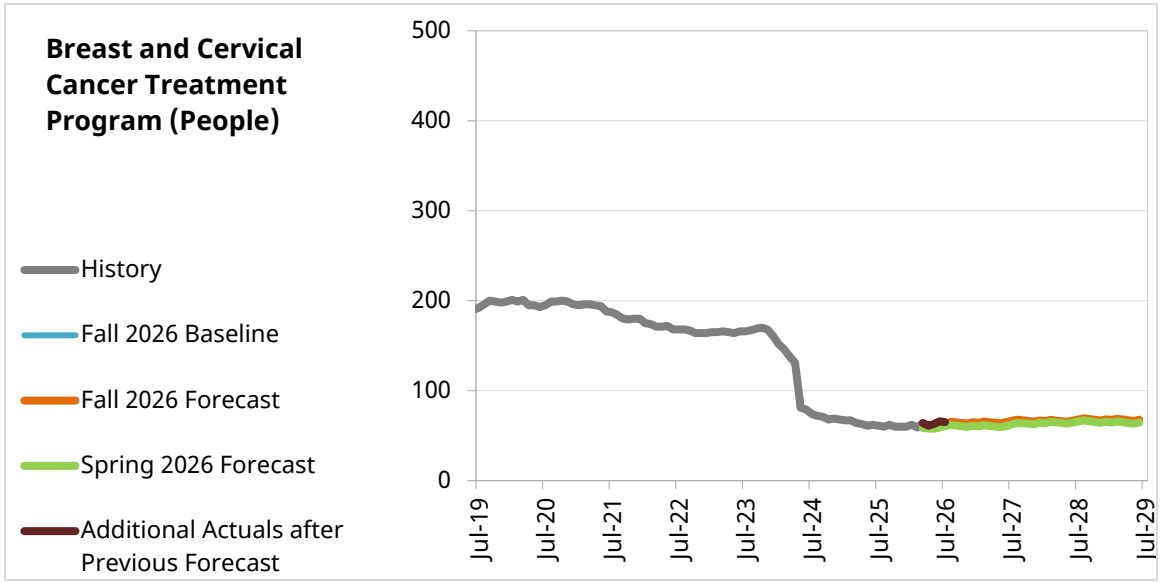
In October 2026, the change in the definition of ineligible non-citizens is expected to lead to the transfer of about 5,000 cases to HOP Adults.

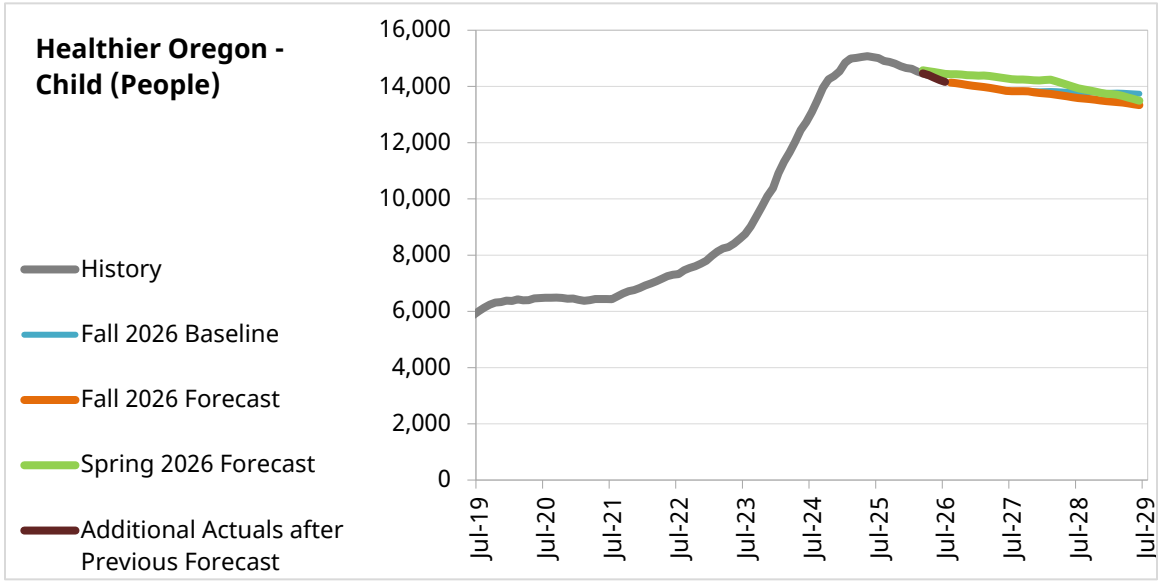
HR1 is expected to have a substantial impact to the ACA caseload – see the HR1 section above for details. The combined effects of policy changes related to HR1 are expected to lead to a sustained decline in ACA adults across late 2027 and into Fall 2028. Excess exits related to work requirements will be spread across 2027-28 biennium, peaking in late 2027 as all major HR1 policies are fully rolled out.



The average monthly caseload for ACA Adults for the 2025-27 biennium is 565,656 cases, 0.5 percent lower than the previous forecast. The average monthly caseload for the 2027-29 biennium is expected to be 443,916 cases, a decrease of 21.5 percent from the 2025-2027 biennium.

Breast and Cervical Cancer Treatment Program (BCCTP) – The most recent finalized actual for April 2026 shows 61 clients on this caseload. This caseload experienced a steep 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 63 clients per month in the 2025-27 biennium, a 4.8 percent downward revision to the prior forecast. This caseload is expected to remain relatively steady at its current historically low level, averaging 67 cases per month in the 2027-29 biennium.

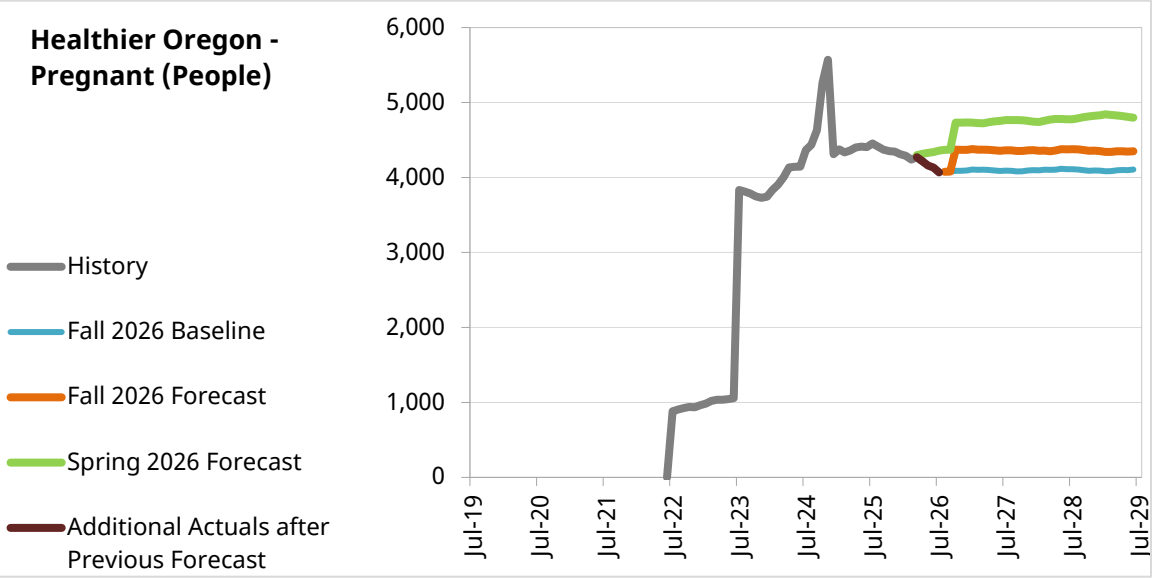
Healthier Oregon – Child (HOP-C) – This caseload was not impacted by the Unwinding. Instead, its growth was influenced by outreach efforts which improved after July 2021, leading to a sharp increase in cases, and again in July 2023. This caseload is expected to slowly decline through the forecast horizon, after appearing to have reached saturation as of Summer 2025. The most recent finalized actual for April 2026 shows 14,407 clients on this caseload.

The HOP-C average monthly caseload for 2025-27 is forecast to be 14,322 cases per month. This is a 1.5 percent decrease from the previous forecast. This caseload is

forecast to slowly decrease through the forecast horizon. It is expected to average 13,611 cases per month.

Healthier Oregon – Pregnant (HOP-P) – The most recent finalized actual for April 2026 shows a caseload of 4,217.

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

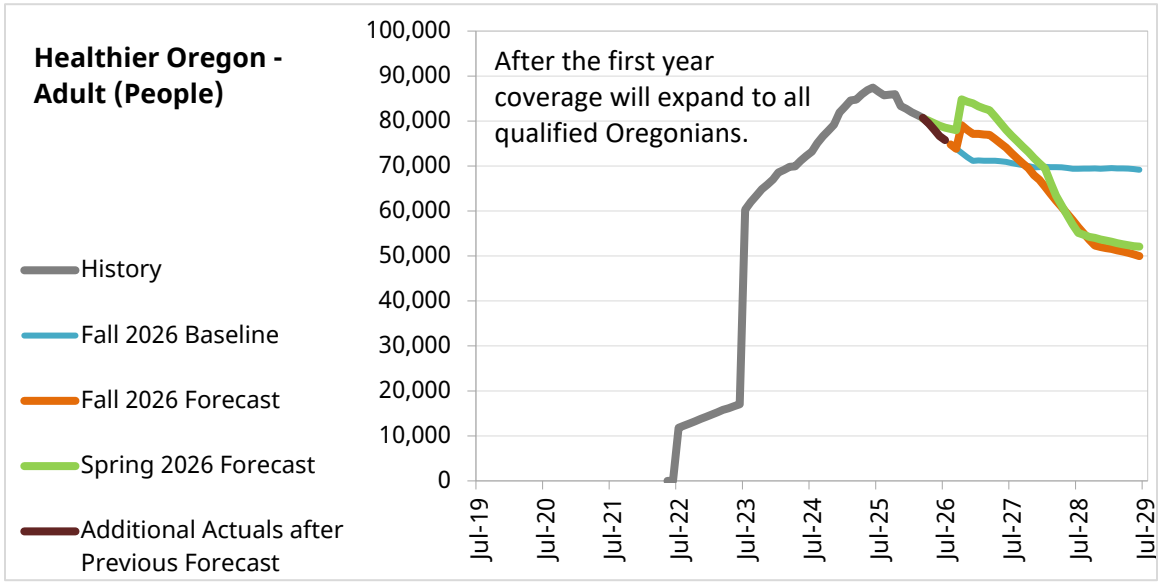


The biennial average caseload for HOP-P for 2025-27 is expected to be 4,296 cases, a 4.4 percent decrease from the previous forecast. The caseload is expected to increase in 2027-29, averaging 4,358 cases a month, a 1.5 percent increase compared to 2025-27.

Healthier Oregon – Adults (HOP-A) – The forecasted HOP-A biennial average monthly caseload for 2025-27 is 79,304 cases. This is a decrease of 3.2 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. Actual data from the early months of the 25-27 biennium show the caseload reached saturation in summer/fall of 2025. The most recent data shows the caseload to be decreasing. This change in caseload dynamics represents a combination of demographics, existing enrollees reaching their CE redetermination date, and

non-citizens being concerned about signing up for government healthcare at a time of increased scrutiny on their status from the federal government. Preliminary data suggests existing enrollees reaching their redetermination date and/or failing to respond to Request for Information documents is the major driver of this change.



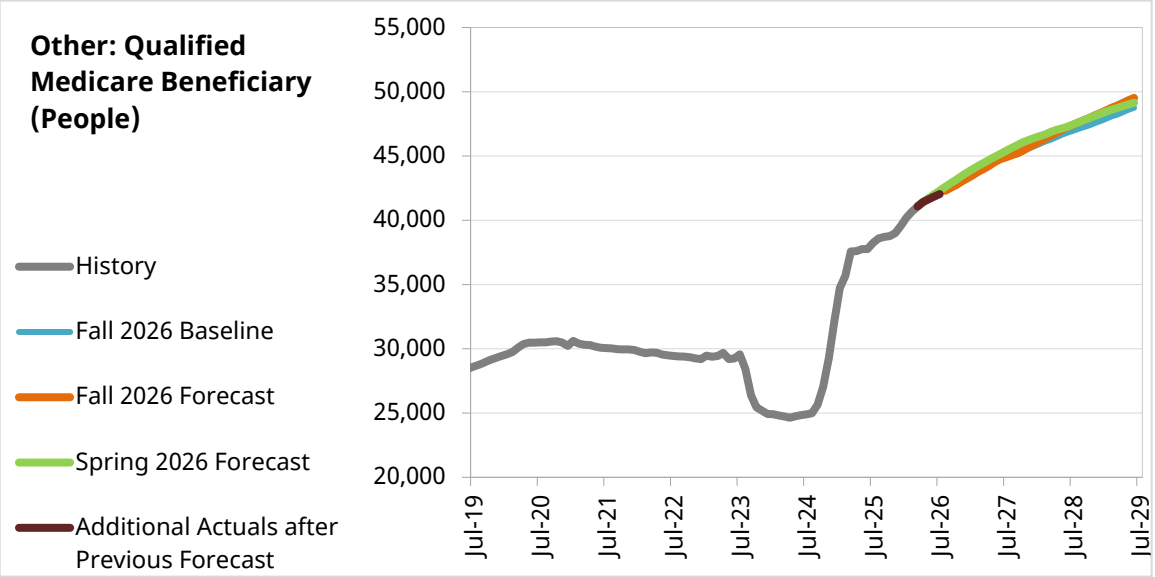
HR1 is expected to have complex impacts to the HOP-A caseload. First, changes to the definition of ineligible non-citizen will lead to a one-time substantial increase in HOP Adults in October 2026 as clients in ACA Adults, PCR, OAA, and ABAD transfer into HOP-A. In addition, the legislation that created Healthier Oregon stipulates that HOP clients be treated the same as traditional Medicaid clients but for citizenship. Therefore HOP-A clients who would qualify for ACA Adults but for citizenship are subject to the same HR1 requirements as ACA Adults (see the HR1 section above for details). This will lead to an increase in exits related to work requirements across 2027-28, with excess exits spiking across late 2027 and into Fall 2028. The average monthly caseload is expected to decrease by 25.6 percent in the 2027-29 biennium, to 58,969 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 at once, after due process concerns were resolved, driving down ABAD and OAA caseloads as cases transferred out to the dual-eligible groups. For more information about the due process issue, see the ABAD and OAA sections above.

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.

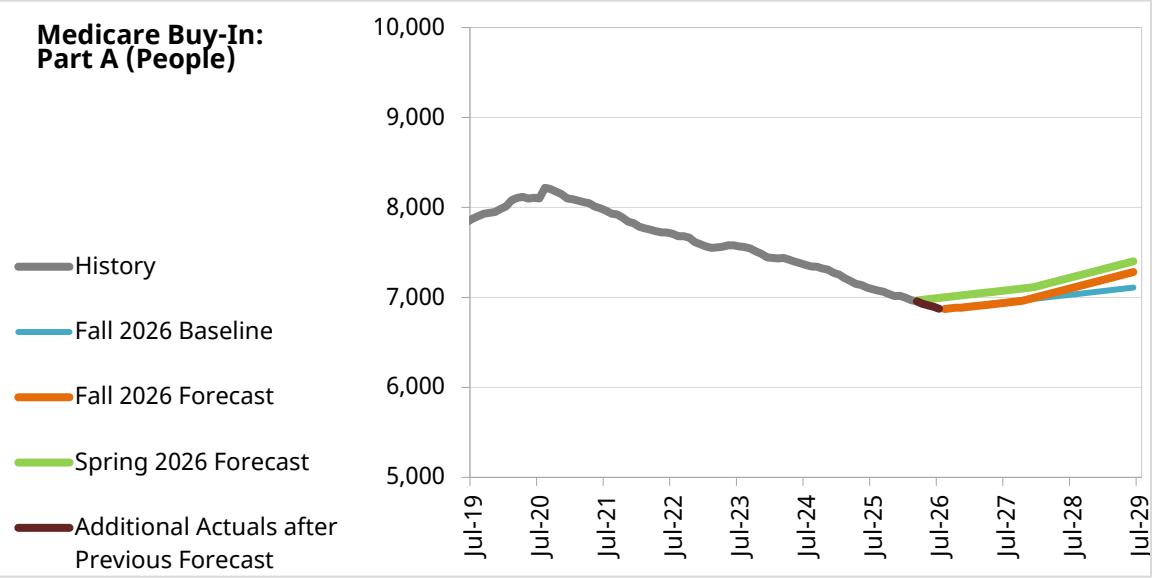
This caseload was influenced a great deal by the controversy concerning due process and transfers from OAA and ABAD. As a result, the caseload dropped from 29,573 in July 2023 to 24,641 in April 2024 as cases were transferred from QMB back into Oregon Health Plan categories. Starting in September 2024 this flow reversed, and cases began to transfer from OAA and ABAD into QMB and other dual-eligibility groups. The most recent actual, for April 2026, shows this caseload reaching about 41,414, nearly doubling compared to 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 July 2026 is over 42,038, with recent growth showing signs of more normal transfer patterns from OAA and PCR.



The QMB average monthly caseload is forecast to be 41,688 in the 2025-27 biennium, a 0.5 percent decrease from the previous forecast. The biennial average caseload for 2027-29 is expected to be 47,245 cases, a 13.3 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



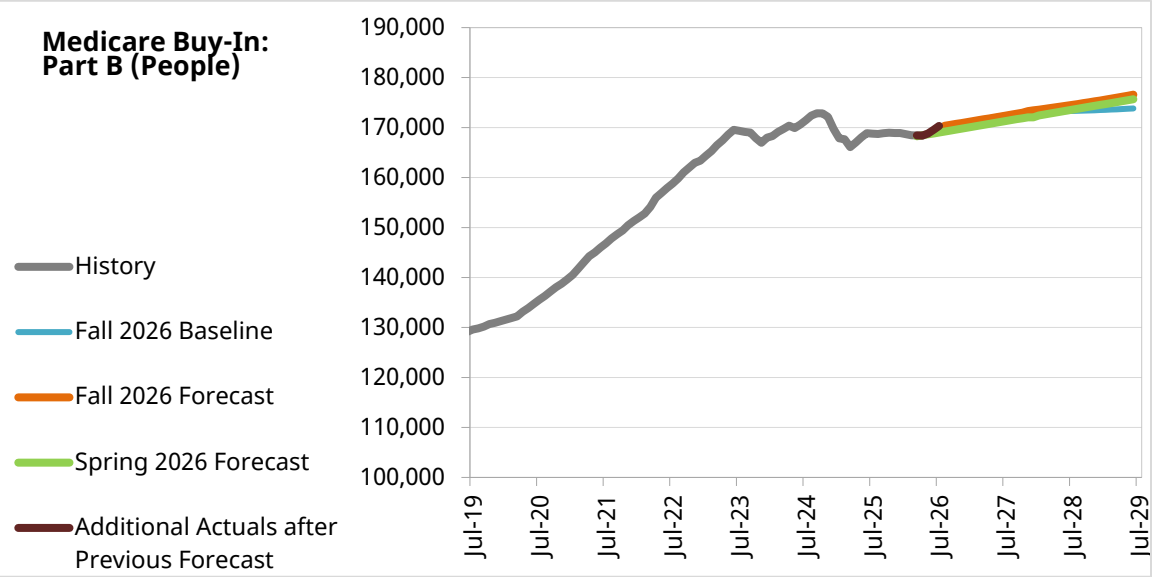
Medicare Part-A Premium Assistance coverage is for Inpatient services. This coverage is free for most Medicare eligible individuals, except for those who don't have sufficient work history. Medicare Part-A Premium Assistance program is designed to help low-income individuals (under 100 percent of FPL)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

The most recent finalized actual for April 2026 shows 6,930 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 6,948 cases, a 1.1 percent decrease compared to the previous forecast. It is expected to be about 2.2 percent higher in the 2027-29 biennium.

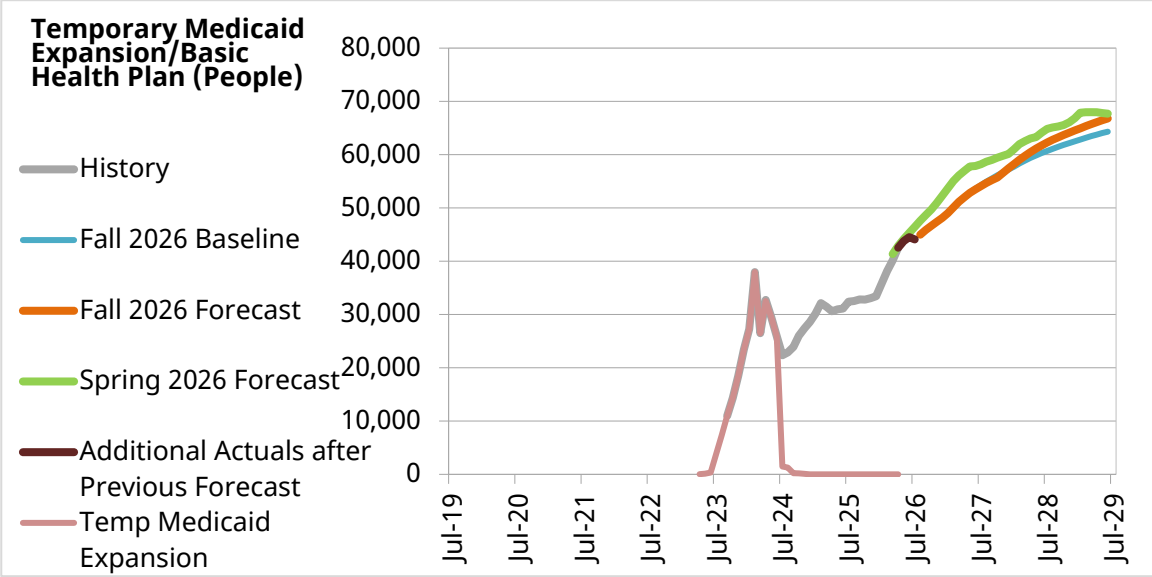
Medicare Part B Premium Assistance coverage is for Outpatient services. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. Medicare Part B Premium Assistance program is designed to help low-income individuals (under 133 percent of FPL) pay the premium.

The most recent finalized actual for April 2026 shows 168,394 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 Fall 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 169,993 cases in the 2025-27 biennium, slightly lower than the prior forecast. The average monthly caseload for the 2027-29 biennium is forecasted to be 174,489 cases.

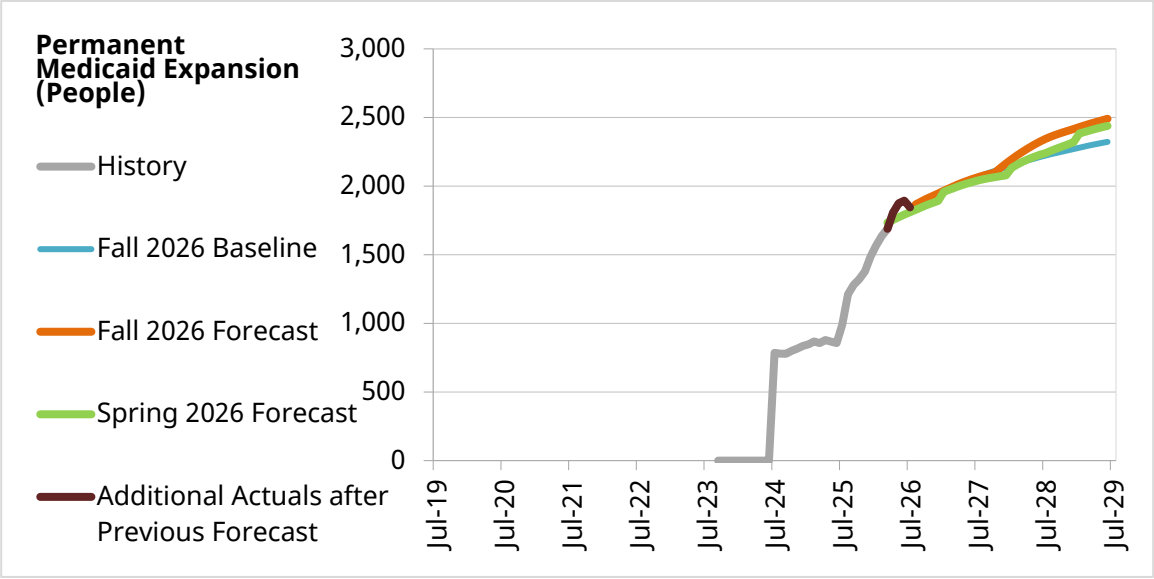
The Basic Health Plan or "OHP Bridge"



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. 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 42,823 cases. This is a 4.9 percent decrease from the previous forecast. The average monthly caseload for the Basic Health Plan for 2027-29 is projected to be 61,264.

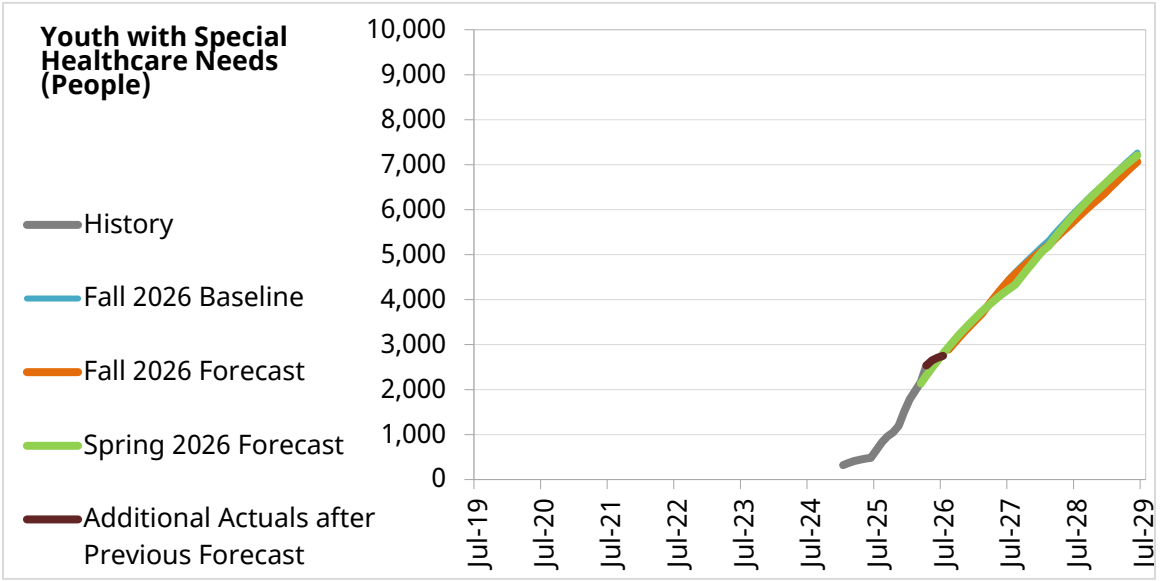


The Permanent Medicaid Expansion biennial average monthly caseload for 2025-27 is expected to be 1,733 cases. This is 1.0 percent higher than the previous forecast. The average monthly caseload for Permanent Medicaid Expansion for 2027-29 is projected to be 2,302.

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 Phase in of the program included 19- and 20-year-olds in 2025. It included 21-year-olds in 2026 and will include 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 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.

In most cases, EPSDT is an add-on service to existing OHP coverage, however EPSDT services are available for 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). Now these clients will remain covered due to their YSHCN status. This represents the “stand alone YSHCN population.”



The Young Adults with Special Healthcare Needs biennial average monthly caseload for 2025-27 is expected to be 2,591 cases. This is a 0.6 percent upward revision to the previous forecast. The average monthly caseload for 2027-29 is projected to be 5,745. We note that YSHCN has only been authorized through 2026 (not for the full 25-27 and 27-29 biennia), meaning 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 and the ability of the Health Authority to implement that guidance. Changes to the operational plan as outlined previously in this section would lead to different results and represent a significant risk to accuracy.

The estimation of the populations affected by HR1 represents 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 internal data derived from imperfect variables. Of particular note is the evolving operational definition of medical frailty and the now required link to an "inability to work." While our estimates align with some estimates of HR1– related Medicaid losses as provided by the congressional budget office and national think-tanks, these estimates are based on broad models. Oregon-specific effects may be larger or smaller than these decomposed 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 redetermination without Continuous Eligibility protections. 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.

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. It's believed that these increases in exit and transfer rates represent a system shifting to a transition phase, which may continue until sometime in late 2026. It is expected that by December 2026, all previously resequenced cases will have been processed. After this transition phase, it is expected that the caseload will reach a new equilibrium.

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 affordability of marketplace insurance has changed, and this has made the marketplace less attractive – influencing fewer people to apply for coverage, changing the transfer rates to Medicaid. We note that the most recent open enrollment period showed a relative decrease in new enters compared to previous years.

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.

A new version of the Public Charge Rule is being enacted in September 2026. The Public Charge Rule requires that enrollment in social safety net services like SNAP and Medicaid be considered when seeking permanent legal residency (e.g. the “green card”). As a result, non-citizens may forgo enrollment in public benefits for their U.S. citizen children and other dependents out of fear of losing the ability to gain legal residency and a path to citizenship. Because Oregon and other states are currently suing to block implementation of the Public Charge Rule, no specific effect is modeled in this forecast.

The forecast assumes that the current cohorts of YSHCN are generally reflective of future cohorts of YSHCN clients (with some exceptions), 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

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Children's Medicaid	305,304	304,689	-615	-0.2%
Children's Health Insurance Program	138,920	137,835	-1,085	-0.8%
Foster, Substitute and Adoption Care	16,135	16,049	-86	-0.5%
Aid to the Blind and Disabled	82,596	82,029	-566	-0.7%
Old Age Assistance	61,013	61,986	973	1.6%
Pregnant Women	17,173	17,253	80	0.5%
Parent, Caretaker Relative	94,889	94,181	-708	-0.7%
ACA Adults	568,496	565,656	-2,840	-0.5%
Breast and Cervical Cancer Treatment Program	60	63	3	4.8%
Healthier Oregon - Child	14,536	14,322	-214	-1.5%
Healthier Oregon - Pregnant	4,493	4,296	-197	-4.4%
Healthier Oregon - Adult	81,958	79,304	-2,654	-3.2%
Youth with Special Healthcare Needs	2,576	2,591	16	0.6%
Permanent Medicaid Expansion	1,716	1,733	17	1.0%
Total OHP	**1,389,865**	**1,381,986**	**-7,879**	**-0.6%**
Qualified Medicare Beneficiary	41,914	41,688	-226	-0.5%
Total Medicaid	**1,431,779**	**1,423,675**	**-8,105**	**-0.6%**
Temporary Medicaid Expansion/Basic Health Plan	45,023	42,823	-2,201	-4.9%
Medicare Part A	7,023	6,948	-76	-1.1%
Medicare Part B	169,366	169,993	626	0.4%

Health Systems/Medicaid Biennial Average Forecast Comparison

Fall 2026 Biennial comparison (2025–27 vs. 2027–29)

Program area	2025-27	2027-29	Change	% change between forecasts
Children's Medicaid	304,689	295,883	-8,806	-2.9%
Children's Health Insurance Program	137,835	134,810	-3,025	-2.2%
Foster, Substitute and Adoption Care	16,049	15,967	-82	-0.5%
Aid to the Blind and Disabled	82,029	81,777	-252	-0.3%
Old Age Assistance	61,986	63,789	1,803	2.9%
Pregnant Women	17,253	17,189	-64	-0.4%
Parent, Caretaker Relative	94,181	89,116	-5,065	-5.4%
ACA Adults	565,656	443,916	-121,740	-21.5%
Breast and Cervical Cancer Treatment Program	63	67	4	6.5%
Healthier Oregon - Child	14,322	13,611	-711	-5.0%
Healthier Oregon - Pregnant	4,296	4,358	63	1.5%
Healthier Oregon - Adult	79,304	58,969	-20,335	-25.6%
Youth with Special Healthcare Needs	2,591	5,745	3,153	121.7%
Permanent Medicaid Expansion	1,733	2,302	570	32.9%
Total OHP	**1,381,986**	**1,227,499**	**-154,487**	**-11.2%**
Qualified Medicare Beneficiary	41,688	47,245	5,557	13.3%
Total Medicaid	**1,423,675**	**1,274,744**	**-148,931**	**-10.5%**
Temporary Medicaid Expansion/Basic Health Plan	42,823	61,264	18,441	43.1%
Medicare Part A	6,948	7,100	153	2.2%
Medicare Part B	169,993	174,489	4,496	2.6%

Behavioral Health

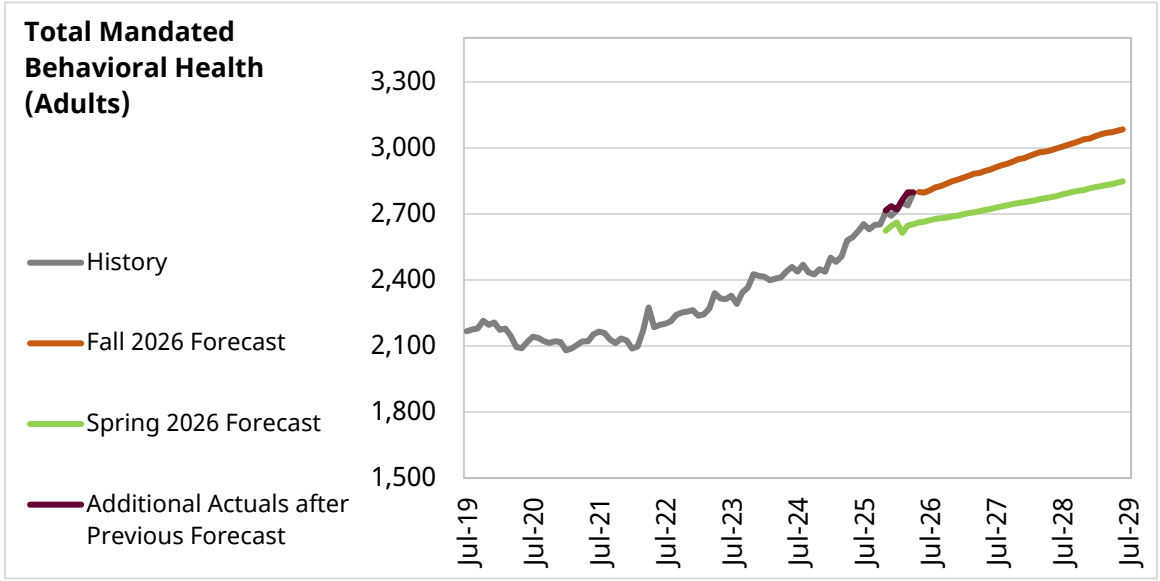
The Behavioral Health forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Behavioral Health caseload is divided between Mandated and Non-Mandated populations.

Oregon law requires that Mandated populations, including criminally and civilly committed patients, receive behavioral health services provided through community programs, including residential care and the Oregon State Hospital system. There are three Mandated populations: (1) Aid and Assist; (2) Psychiatric Security Review Board (PSRB); and (3) Civilly Committed. 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.

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 Non-Mandated populations include two groups: (1) Previously Committed individuals; and (2) Never Committed individuals.

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 2,792 clients per month. The 2027-29 biennial monthly average is expected to be 3,003 clients, which is 7.6 percent higher than the 2025-27 biennial average.

Total Forensic Behavioral Health Services

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

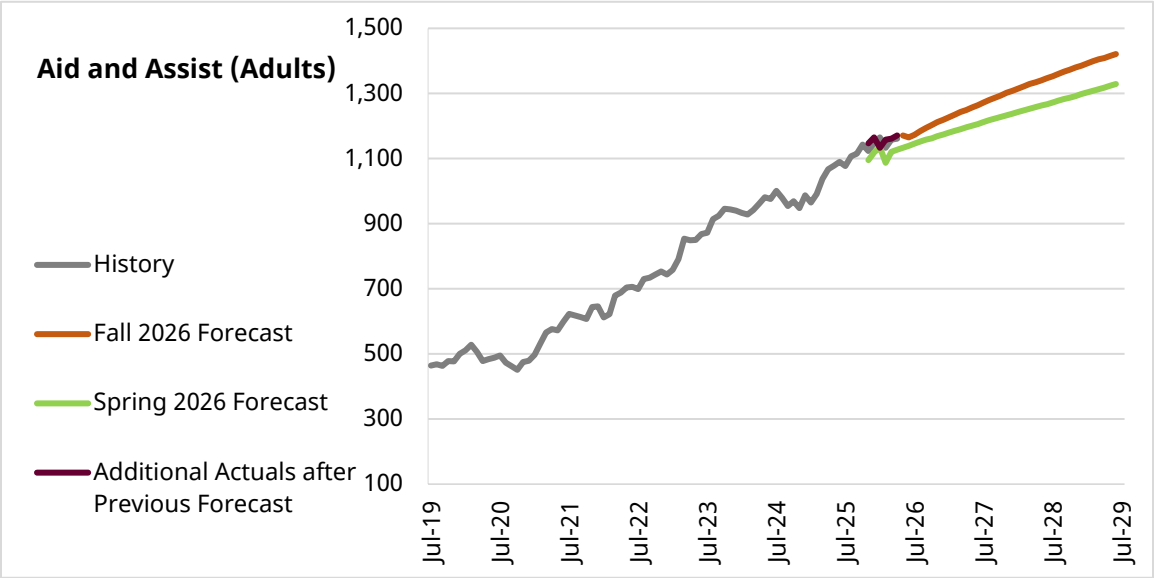
The Forensic Behavioral Health Services biennial average forecast for 2025-27 is 1,854 clients per month. The 2027-29 biennial monthly average is expected to be 2,043 clients, 10.2 percent higher than the 2025-27 biennial average.

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 2026, Community Restoration increased 42 percent, from 543 clients to 771. The total Aid and Assist caseload increased 18 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 late 2025, data was submitted quarterly. Now, counties are required to submit data each month. The new data collection process has enabled increased communication between the counties and the Behavioral Health division. Records that were erroneously open were closed, which led to a level shift down in the historical data in mid-2024.

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 fairly flat for the last four years. This caseload has a tendency 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. In June 2026 there was a modification to the federal court order, such that lower level charges no longer have to be admitted to the State Hospital within 7 days. The change led to a reduction in court orders from 100 per month down to an average of 77 per month over June, July, and August 2026. Because of this reduction, the State Hospital is now able to maintain a very small waitlist.

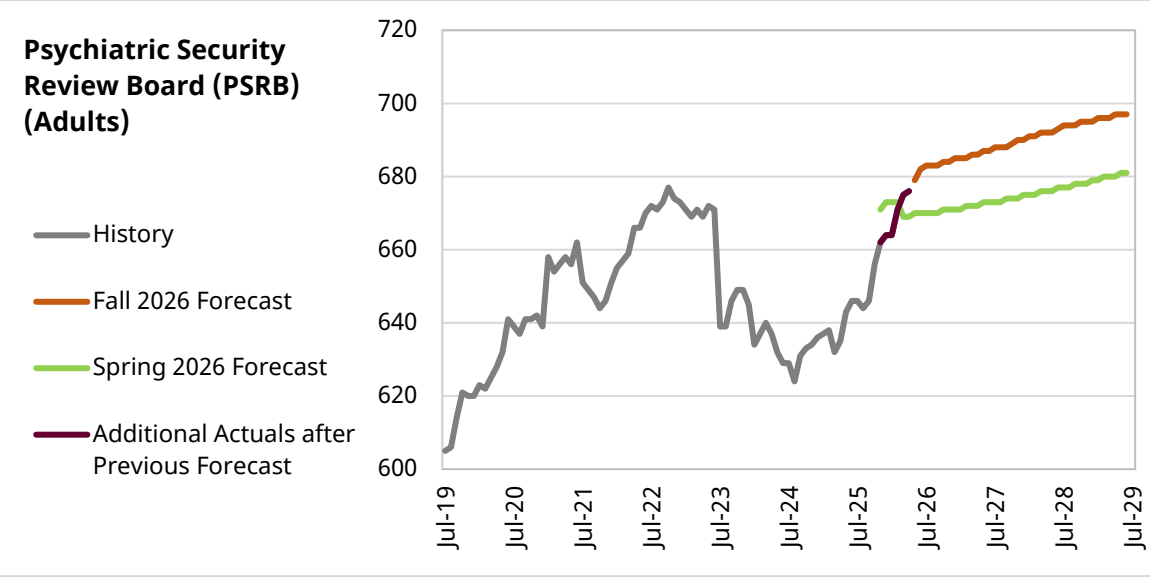


The forecast for Aid and Assist for the 2025-27 biennium is projected to average 1,180 clients per month. The 2027-29 biennial average is expected to be 1,350 clients per month, which is 14.4 percent higher than the 2025-27 biennial average.

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.

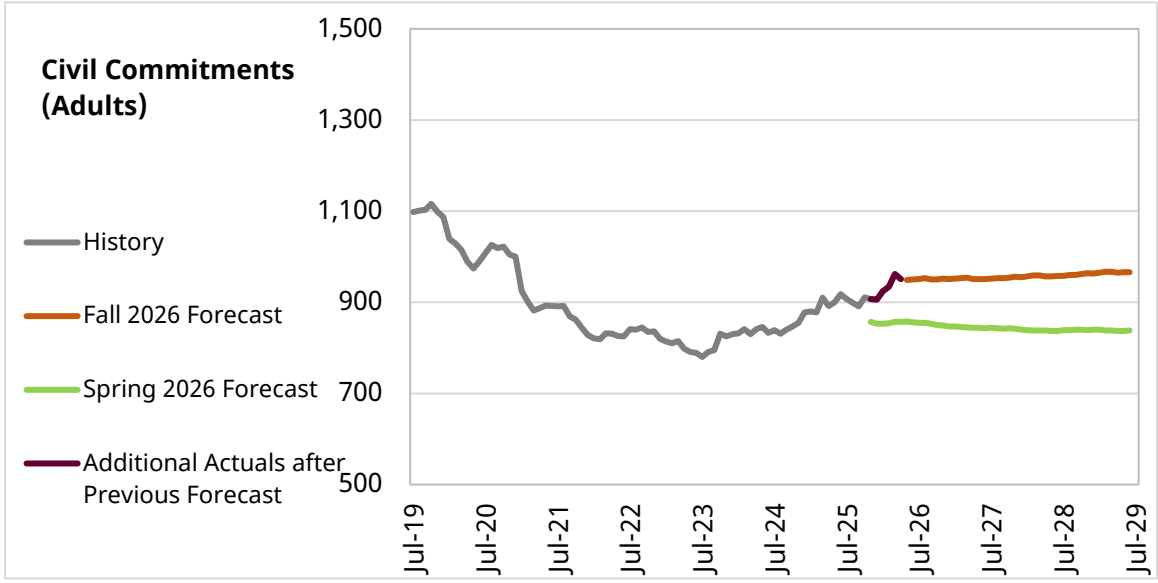
The PSRB caseload has been slowly growing since the middle of 2024. The growth that has occurred over the last few years is largely due to the addition of the extremely dangerous Civilly Committed clients. As of June 2026, the number of clients in this Civilly Committed PSRB population was 54. This is an increase of 29 percent since June 2024.

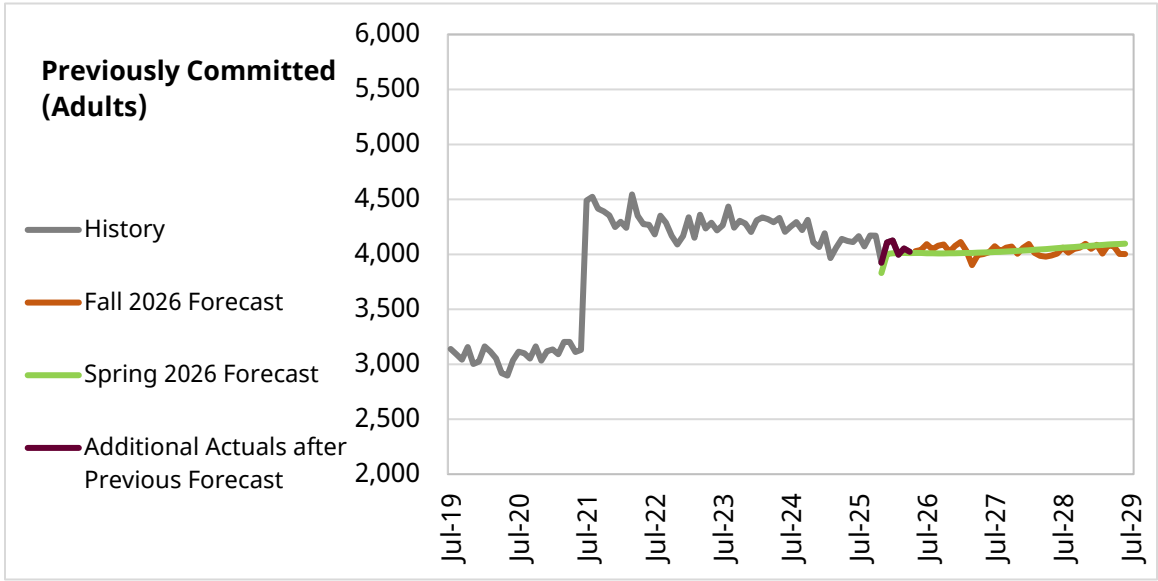


The 2025-27 biennial average forecast for PSRB is 674 cases per month. The 2027-29 biennial average is expected to be 693 clients per month, which is 2.8 percent higher than the 2025-27 biennial average.

Civil Commitments

Data for this caseload is 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. From 2024 to present, the caseload has been climbing. Between April 2024 and April 2026, the Civil Commit caseload increased 13 percent.





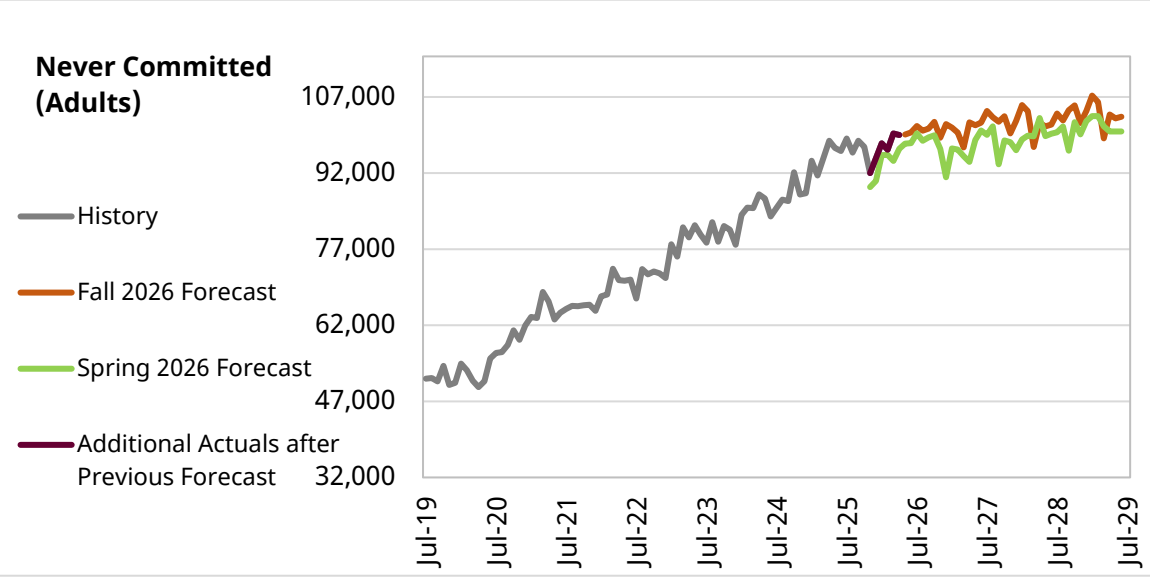
The Civil Commitment forecast for the 2025-27 biennium projects an average of 938 clients per month. The 2027-29 biennial monthly average is 960 clients, 2.3 percent higher than the 2025-27 biennial average.

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 4,056 clients per month. The 2027-29 biennial monthly average is 4,040 clients, 0.4 percent lower 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 99,133 clients per month. The 2027-29 biennial monthly average is 102,901 clients, 3.8 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 they are 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 criteria, 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 is 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 federal 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, 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

2025-2027 Biennium Forecast Comparison (Spring 2026 vs. Fall 2026)

Program area	Spring 2026 forecast	Fall 2026 forecast	Change	% change between forecasts
Community Restoration Aid and Assist	726	758	32	4.4%
State Hospital Aid and Assist	484	465	-19	-3.9%
Total Aid and Assist (State Hospital and Community Restoration)	**1,142**	**1,180**	**38**	**3.3%**
Psychiatric Security Review Board	669	674	5	0.7%
Total Forensic Care	**1,811**	**1,854**	**43**	**2.4%**
Civilly Committed	854	938	84	9.8%
Total Mandated Behavioral Health Services	**2,665**	**2,792**	**127**	**4.8%**
Previously Committed	4,019	4,056	37	0.9%
Never Committed	96,269	99,133	2,864	3.0%
Total Behavioral Health Served	**102,953**	**105,981**	**3,028**	**2.9%**

Notes:

- Behavioral Health numbers reported represent adults only.
- Community Restoration Aid and Assist data are self-report data from the County Mental Health Programs (CMHPs).
- Total Aid and Assist (State Hospital and Community Restoration) contains some overlap between Community Restoration and State Hospital Aid and Assist.

Behavioral Health Biennial Average Forecast Comparison

Fall 2026 Biennial comparison (2025–27 vs. 2027–29)

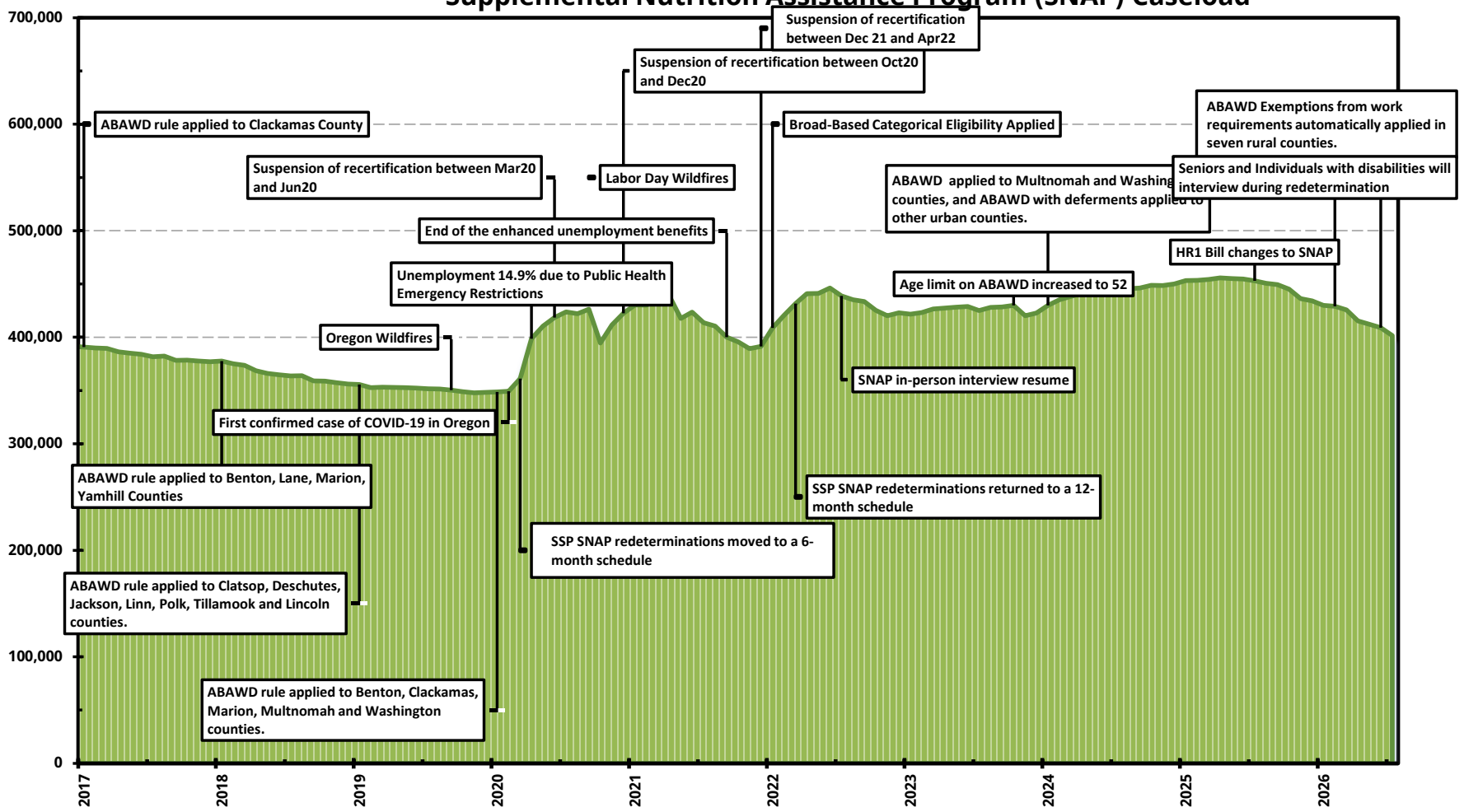
Program area	2025-27	2027-29	Change	% change between forecasts
Community Restoration Aid and Assist	758	945	187	24.7%
State Hospital Aid and Assist	465	445	-20	-4.3%
Total Aid and Assist (State Hospital and Community Restoration)	**1,180**	**1,350**	**170**	**14.4%**
Psychiatric Security Review Board	674	693	19	2.8%
Total Forensic Care	**1,854**	**2,043**	**189**	**10.2%**
Civilly Committed	938	960	22	2.3%
Total Mandated Behavioral Health Services	**2,792**	**3,003**	**211**	**7.6%**
Previously Committed	4,056	4,040	-16	-0.4%
Never Committed	99,133	102,901	3,768	3.8%
Total Behavioral Health Served	**105,981**	**109,944**	**3,963**	**3.7%**

Notes:

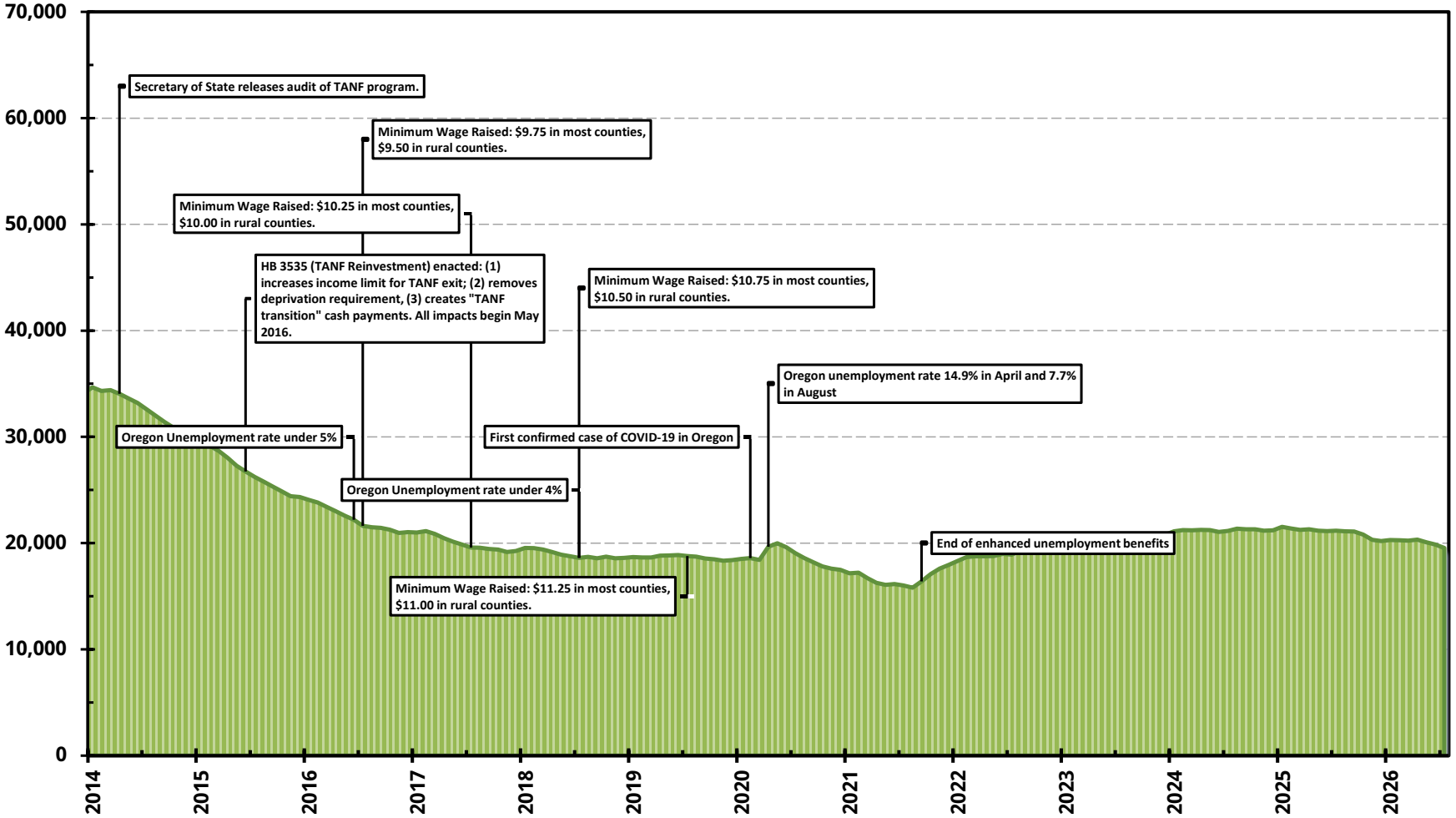
- Behavioral Health numbers reported represent adults only.
- Community Restoration Aid and Assist data are self-report data from the County Mental Health Programs (CMHPs).
- Total Aid and Assist (State Hospital and Community Restoration) contains some overlap between Community Restoration and State Hospital Aid and Assist.

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

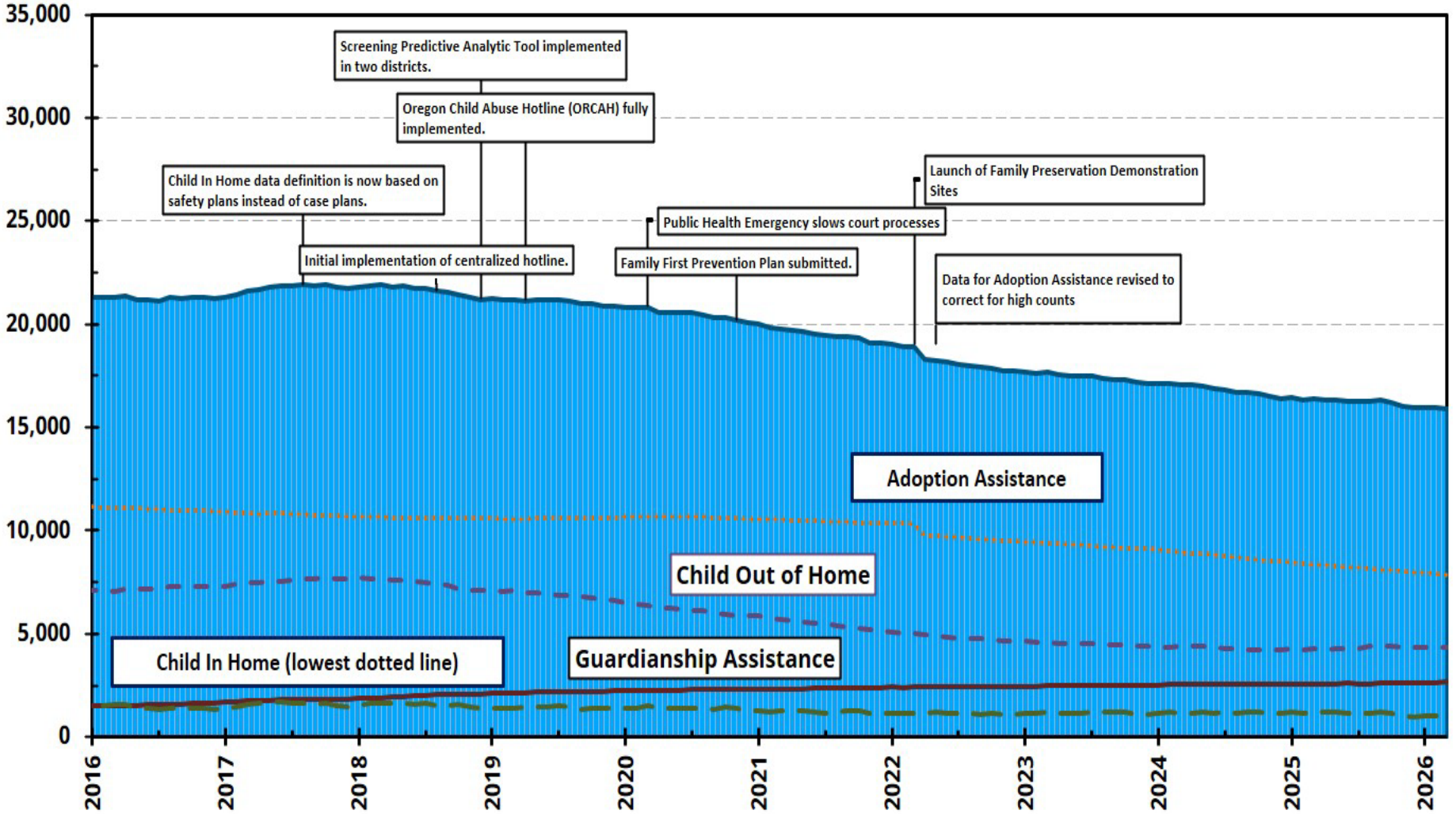
Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload



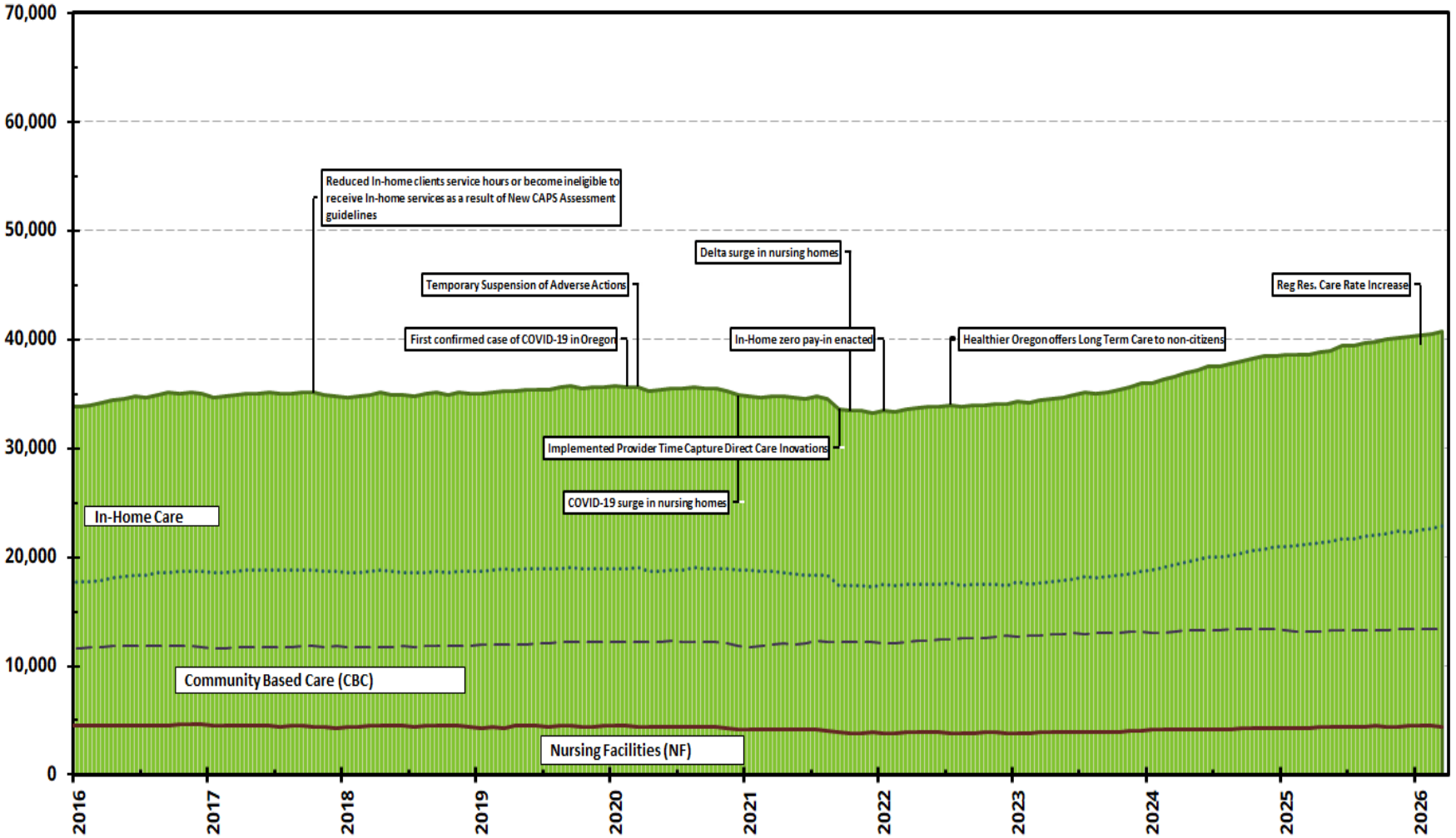
Self Sufficiency Programs:
Temporary Assistance for Needy Families (TANF) Caseload



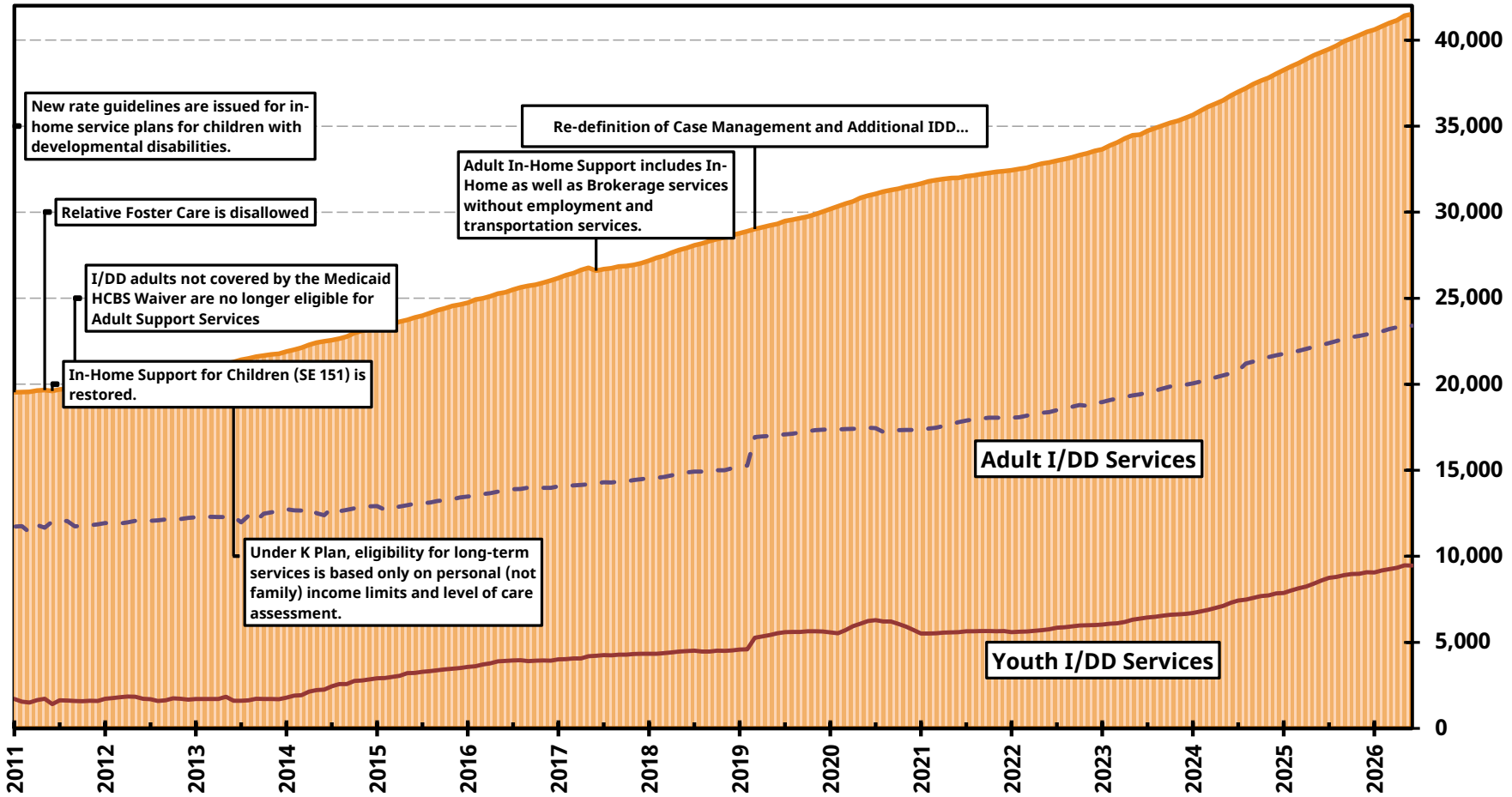
Child Welfare (CW) Caseload



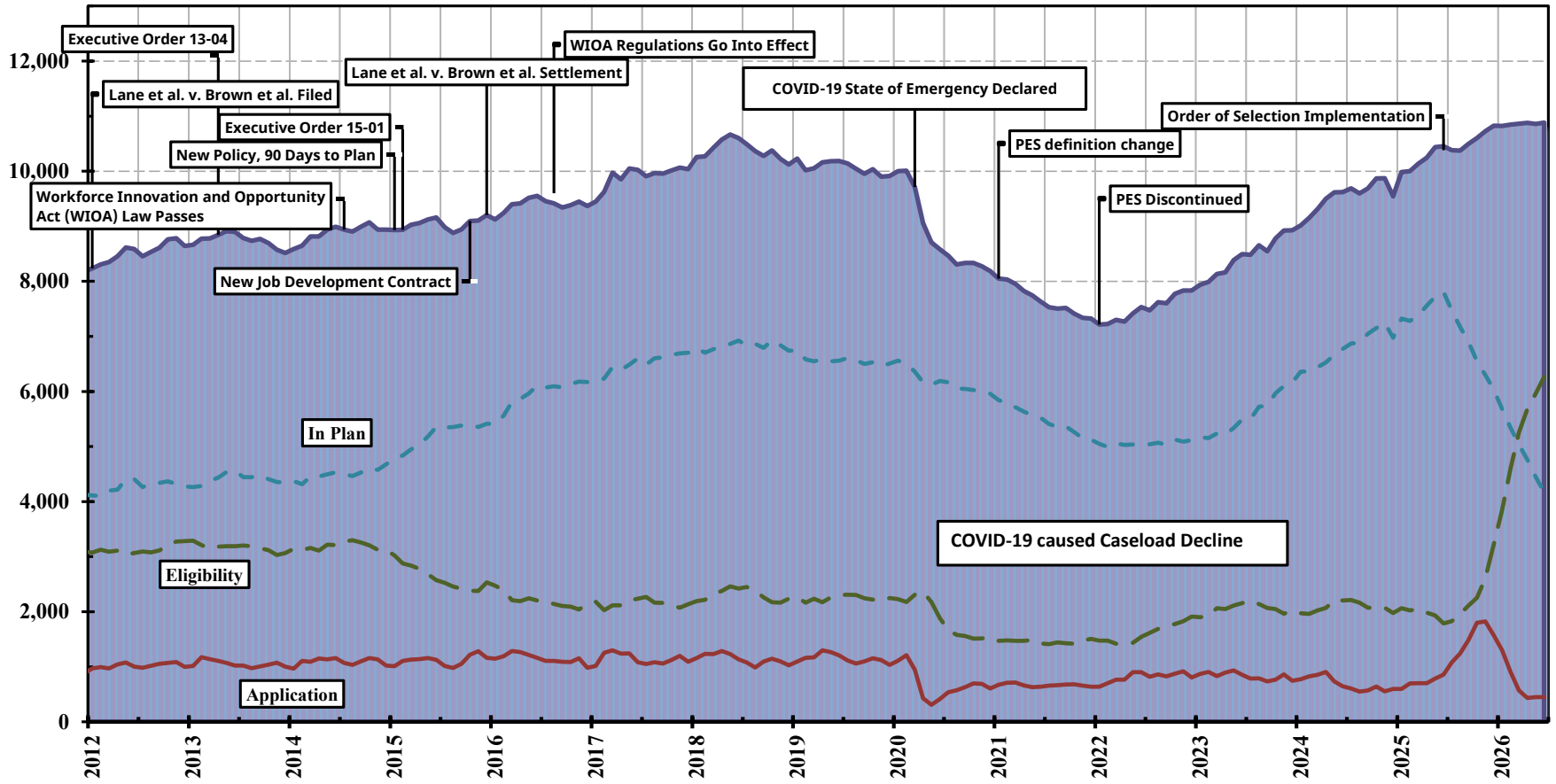
Aging and People with Disabilities (APD) Caseload



Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



Vocational Rehabilitation



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.

The table below shows the income requirements for FPL at 100 percent. For families/households with more than 8 persons, add $5,680 for each additional person.

2026 Poverty Guidelines for Oregon

Household/Family Size	Federal Poverty Level (100%)
1	15,960.00
2	21,640.00
3	27,320.00
4	33,000.00
5	38,680.00
6	44,360.00
7	50,040.00

Source: https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf

ODHS Caseload Definitions

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs (SSP) aid 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 with 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 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") required all counties adopt the ABAWD rule on January 1, 2026. 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.

Starting February 1st, 2026, discretionary exemptions from ABAWD work requirements were applied automatically in seven rural counties: Crook, Gilliam, Jefferson, Morrow, Sherman and Wheeler. These counties do not have WorkSource employment centers, which makes it difficult for residents to comply with the work requirements.

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

Temporary Assistance 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 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 non-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.

Both TA-DVS with- and without-payment experienced unprecedented drops in May and June 2020. This was likely due to people being unwilling to relocate 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, case workers 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 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 be adopted. 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. Case workers 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 waivered services. Services supplement the individual's own personal abilities and resources but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community-Based Care (CBC)

Community-Based Care caseload includes clients receiving services in licensed, community-based residential settings. Services include assistance with ADL, medication oversight, and social activities. Services can also include nursing and behavioral support 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 support 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. H.R. 1 (the "One Big Beautiful Bill Act") affects non-citizen I/DD adults who are no longer eligible for federally funded Medicaid. These individuals are expected to transition to Healthier Oregon (HOP), beginning on October 1, 2026.

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 month's most likely to change through claims reconciliation, the most recent three months will not be reported for any I/DD service-based caseloads.

Several adult service caseloads—including Employment and Day Support Services, Transportation Services, and Behavioral Services—have significantly longer lag periods than the customary three months due to delayed billing and claims processing. Therefore, OFRA reports preliminary actuals for the most recent six months. These preliminary actuals are estimated based on historical reconciliation rates and are used in caseload forecasting.

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.

A new caseload forecast series, **Children's Extraordinary Needs – Parent Providers (CEN-PP)**, is included beginning with the Fall 2026 Forecast. Previously, the CEN-PP caseload was embedded within either CIIS or In-Home Support for Children. With growing interest in CEN-PP and an increase in CEN waiver capacity, separate monitoring of the CEN-PP caseload is needed to improve the accuracy of budget development.

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's services, and other services. 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.

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. As part of the new Supported Living rate model effective July 1, 2026, Professional Behavior Services are no longer bundled into the Supported Living budget. Instead, these services are billed separately under the Behavior Services caseload.

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 Community Developmental Disabilities Programs (CDDPs) 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 90 percent and 10 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 89 percent and 11 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's Extraordinary Needs - Parent Providers (CEN-PP) is an Oregon Medicaid waiver that serves children under age 18 with significant medical or behavioral needs who require extraordinary care to remain in or return to their family home. It allows eligible parents or guardians to provide paid attendant care for their child.

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 and are delivered by a behavior professional. Professional Behavior Services that were previously bundled into the Supported Living budget are billed separately under the Behavior Services caseload beginning July 1, 2026.

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. H.R. 1 (the "One Big Beautiful Bill Act") affects non-citizen I/DD adults who are no longer eligible for federally funded Medicaid. These individuals are expected to transition to Healthier Oregon (HOP), beginning on October 1, 2026.

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). WIOA is a federal law passed in 2014 that connects job seekers with training and employment opportunities and helps employers find skilled workers. 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 (EO) 15-01. The order was issued in February 2015 and instituted an Employment First policy to increase competitive integrated employment of people living with Intellectual and Developmental Disabilities (I/DD); and
3) The Lane v. Brown settlement. The settlement agreement was approved by the court in December of 2015 and set specific numeric targets for moving clients out of sheltered workshops and into competitive integrated employment, and for providing services to transition age clients.

Pre-Employment Transition Services (Pre-ETS) provide early career supports to students with disabilities and were implemented nationwide under WIOA in 2015–2016. Historically, contracts between VR programs and school districts emphasized moving a targeted number of students through the full VR process, including application, eligibility determination, and individualized plan development. Beginning in July 2024, students were allowed to access Pre-ETS without applying for or being determined eligible for VR services. These services are short-term in nature; however,

students who require more comprehensive support must still complete the formal application and eligibility process. This policy change has reduced the expectation for students to apply for VR services, contributing to a decline in applications and reshaping the relationship between VR programs and school districts.

In 2016, the **Inclusive Career Advancement Program (ICAP)** was established to support implementation of EO 15-01 and the *Lane v. Brown* settlement. ICAP is a transitional program designed to assist adults with intellectual and developmental disabilities (I/DD) in moving from sheltered settings to competitive, integrated employment, with support from VR and ODDS.

VR Order of Selection (OOS) is mandated by the federal Rehabilitation Services Administration (RSA) and guides state VR programs in delivering services when resources are insufficient to serve all eligible individuals. Under OOS, VR programs prioritize individuals with the most significant disabilities and establish a waitlist to manage service capacity, ensuring that those in highest priority group receives first. In Oregon, VR established an OOS waitlist in June 2025.

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 in the fall of 2023, the In-Plan portion of the VR caseload began growing more rapidly than the Application and Eligibility caseloads until OOS was implemented in June 2025. The In-Plan caseload has continued to decline as of the Fall 2026 caseload forecast due to the pause in transfers from In-Eligibility to In-Plan.

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.

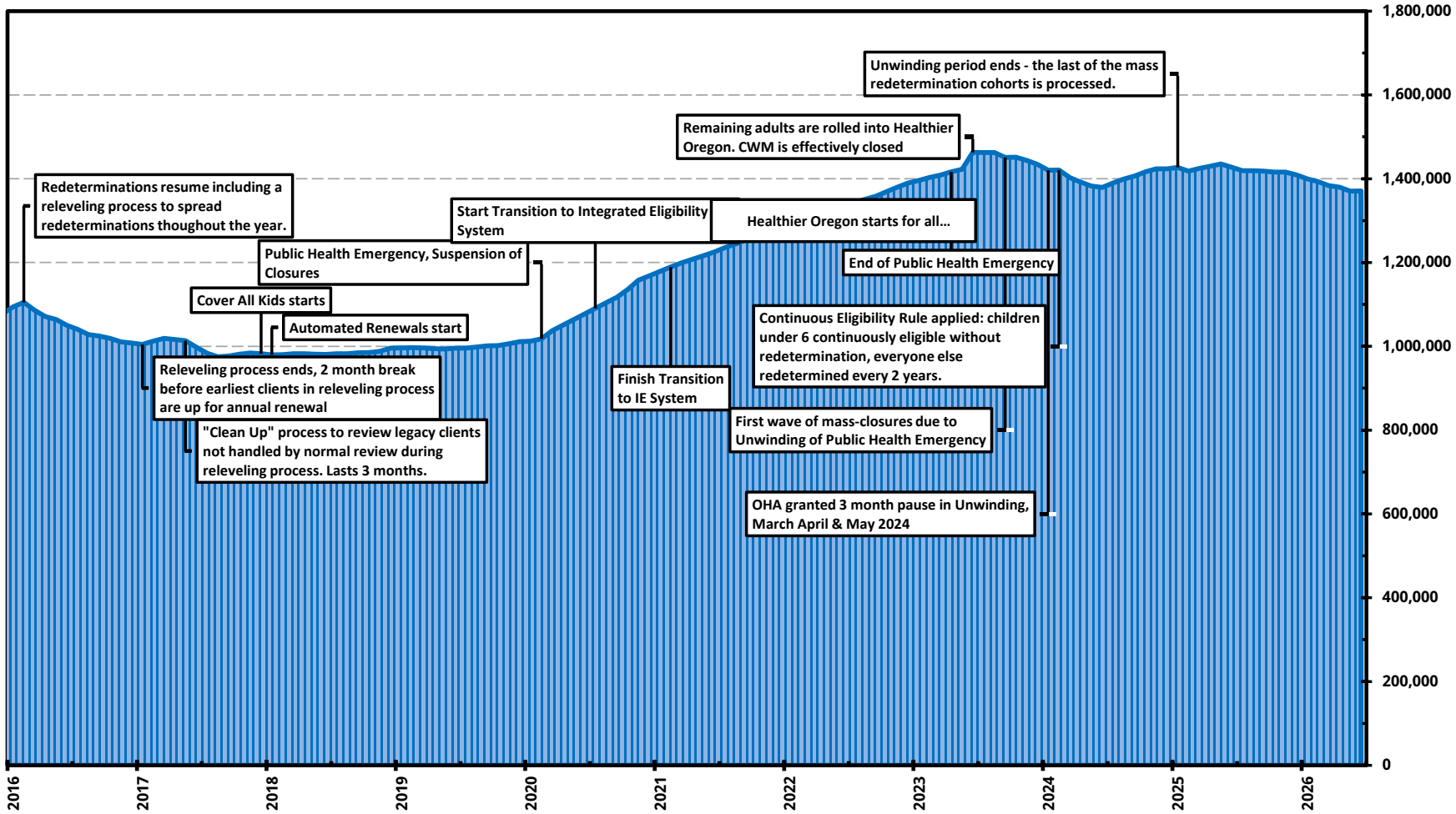
In Application is a count of clients who were in the application stage on the last day of the month or exited VR during the given month without advancing to the next stage. VR case is initiated by the client submitting their application to VR. In this stage, the application is reviewed, and eligibility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

Appendix II
Oregon Health Authority – Caseload History and Definitions

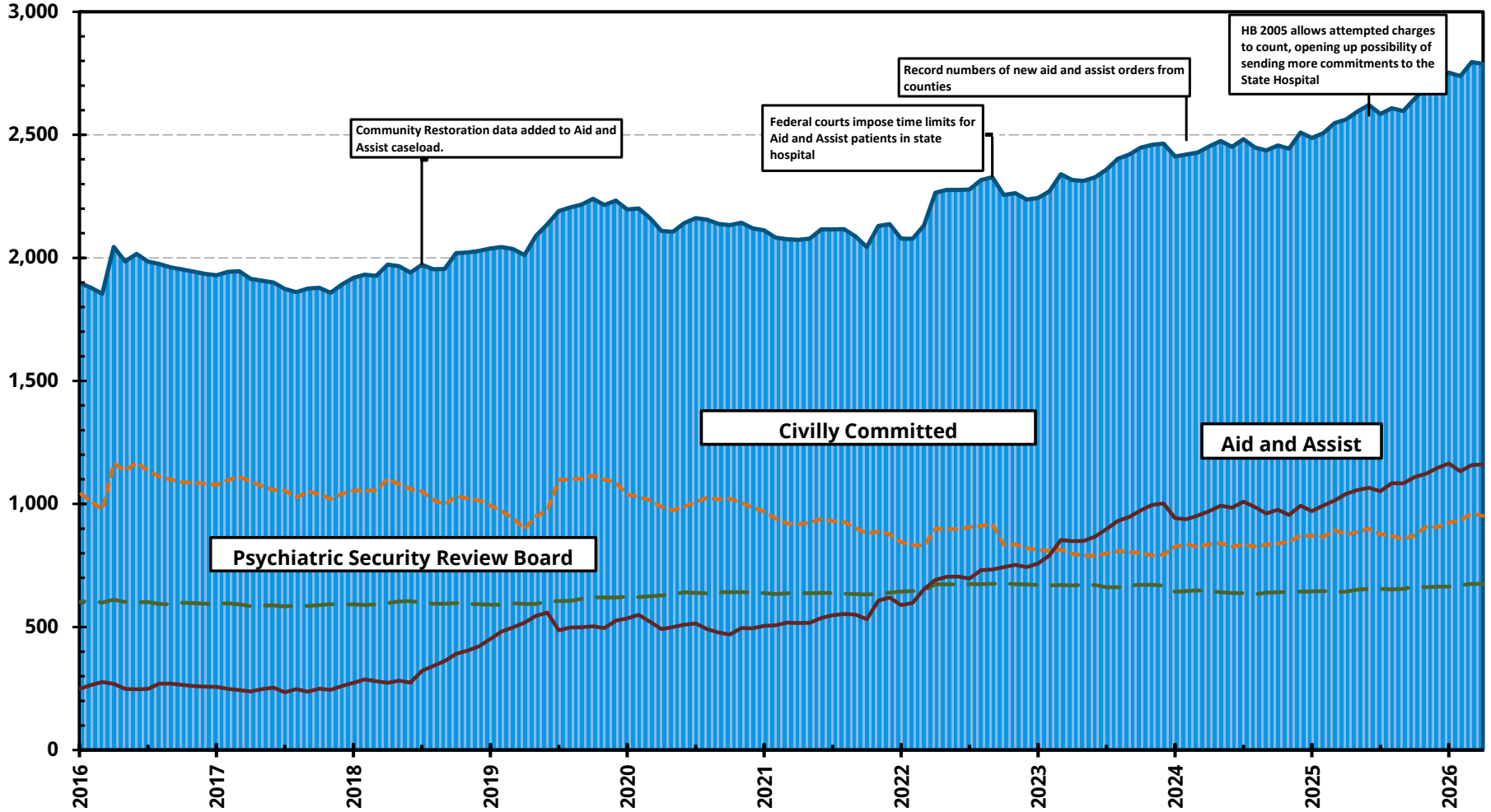
Health Systems - Medicaid,
Total Oregon Health Plan



OREGON DEPARTMENT OF Human Services

OREGON HEALTH AUTHORITY

Behavioral Health (BH):
Total Mandated Behavioral Health Caseload (Adults)



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.

The table below shows the income requirements for FPL at 100 percent. For families/households with more than 8 persons, add $5,680 for each additional person.

2026 Poverty Guidelines for Oregon

Household/Family Size	Federal Poverty Level (100%)
1	15,960.00
2	21,640.00
3	27,320.00
4	33,000.00
5	38,680.00
6	44,360.00
7	50,040.00

Source: https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf

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 HSM caseload to grow in fits and starts related to two issues: open enrollment and delayed redeterminations. This led to a pattern of increases (due to a pause in processing redeterminations) and decreases (due to processing the backlog of redeterminations) from March 2016 through August 2017.

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

Starting with the renewals scheduled for the end of February 2018, Oregon transitioned to a system of Automated Renewals (sometimes called passive or *ex parte* renewals). Automated Renewals is a system under which OHA

automatically renews a client's Medicaid Eligibility if they have all the required information and the client is eligible. This system is in place in most states and is required by the federal CMS. If OHA cannot verify eligibility with the available data, the client will go through the normal, active renewal process that does require a response.

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.
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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 receive outpatient care or travel 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/aliens. 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 forecast 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 Programs[2]

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.

[2] 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 included 19- and 20-year-olds in 2025, and 21-year-olds in 2026. Phase in of 22-year-olds, 23-year-olds, and 24-year-olds is expected in 2027,2028 and 2029, respectively. 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)

Behavioral Health (BH) 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 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 overseen by the PSRB have a charge that is considered a violent felony, but they have not been found to be guilty except for insanity. 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 support 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.