Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Sandy Cafourek	500 Summer St Ne, Salem, OR 97301	503-945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Eligibility Requirements for the Authority's Office of Client and Community Services Medical Programs

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

February 18, 2014	10:30 a.m.	500 Summer St NE, Salem, OR 97301, Room 137B	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

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Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT : OAR 410-200-0010, 410-200-0015, 410-200-0100, 410-200-0105, 410-200-0110, 410-200-0111, 410-200-0115, 410-200-0120, 410-200-0125, 410-200-0130, 410-200-0135, 410-200-0140, 410-200-0145, 410-200-0146, 410-200-0200, 410-200-0205, 410-200-0210, 410-200-0215, 410-200-0220, 410-200-0225, 410-200-0230, 410-200-0235, 410-200-0240, 410-200-0305, 410-200-0310, 410-200-0315, 410-200-0400, 410-200-0405, 410-200-0410, 410-200-0415, 410-200-0420, 410-200-0425, 410-200-0435, 410-200-0440, 410-200-0500, 410-200-0505, 410-200-0510.

REPEAL: OAR 410-200-0515(T), 410-200-0406(T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth. : ORS 411.402, 411.404, 413.042, 414.534

Other Auth.: 42 CFR: 435.110, 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.940, 435.956, 435.406, 457.380, 435.117, 435.170, 435.190, 435.916, 435.917, 435.926, 435.952, 435.1200, 435.1205, 447.56, 457.340, 457.350, 457.360, 457.805, 433.145, 433.147, 433.148, 433.146, 435.610, 435.115, 435.403, 435.1200, 457.80, 457.340, 458.350, 435.119, 435.222, 435.118, 433.138, 433.147, 433.148,435.602 435.608

Stats. Implemented: ORS 411.060, 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

RULE SUMMARY

With passage of the Affordable Care Act (ACA), Medicaid and CHIP eligibility methodologies are mandated to be changed January 1, 2014 to use Modified Adjusted Gross Income (MAGI) methodologies. Oregon was approved for early implementation of the MAGI income and eligibility methodologies, an option provided by CMS to the states. These rules were adopted and effective on October 1, 2013 to explain the new household groups, whose income must be counted, and what income is considered in determining medical eligibility, time frames for determining medical eligibility, hearing processes, and processes for coordination when an individual must be referred to Cover Oregon.

Additional provisions of the ACA require that the above referenced rules be updated to reflect new policy effective January 1, 2014.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

February 20, 2014 by 5:00 p.m. E-mail: dmap.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Karen M. House Karen House 1-15-14

Signature Printed name Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division) — 410

Agency and Division — Administrative Rules Chapter Number

Eligibility Requirements for the Authority's Office of Client and Community Services Medical Programs

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The adoption of OAR 410-200-0010, 410-200-0015, 410-200-0100, 410-200-0105, 410-200-0110, 410-200-0111, 410-200-0115, 410-200-0120, 410-200-0125, 410-200-0130, 410-200-0135, 410-200-0140, 410-200-0145, 410-200-0146, 410-200-0200, 410-200-0205, 410-200-0210, 410-200-0215, 410-200-0220, 410-200-0225, 410-200-0230, 410-200-0235, 410-200-0240, 410-200-0305, 410-200-0310, 410-200-0315, 410-200-0400, 410-200-0405, 410-200-0410, 410-200-0415, 410-200-0420, 410-200-0425, 410-200-0435, 410-200-0440, 410-200-0500, 410-200-0505, 410-200-0510 and the repeal of 410-200-0515 (T) and 410-200-0406 (T).

Statutory Authority: ORS 411.402, 411.404, 413.042, 414.534

Other Authority: 42 CFR: 435.110, 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.940, 435.956, 435.406, 457.380, 435.117, 435.170, 435.190, 435.916, 435.917, 435.926, 435.952, 435.1200, 435.1205, 447.56, 457.340, 457.350, 457.360, 457.805, 433.145, 433.147, 433.148, 433.146, 435.610, 435.115, 435.403, 435.1200, 457.80, 457.340, 458.350, 435.119, 435.222, 435.118, 433.138, 433.147, 433.148,435.602 435.608

Stats. Implemented: ORS 411.060, 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

Need for the Rule(s): With passage of the Affordable Care Act (ACA), Medicaid and CHIP eligibility methodologies are mandated to be changed January 1, 2014 to use Modified Adjusted Gross Income (MAGI) methodologies. Oregon was approved for early implementation of the MAGI income and eligibility methodologies, an option provided by CMS to the states. The Authority needs to adopt these rules to explain the new household groups, whose income must be counted, and what income is considered in determining medical eligibility, time frames for determining medical eligibility, hearing processes, and processes for coordination when an individual must be referred to Cover Oregon.

Additional provisions of the ACA require that the above referenced rules be updated to reflect new policy effective January 1, 2014.

Documents Relied Upon, and where they are available: Affordable Care Act (ACA) available on the CMS website, Federal Register Final Rules from March 23, 2012, Federal Register Proposed Rules from January 22, 2013, and the Federal Register Final Rules from July 15, 2013.

Fiscal and Economic Impact:

Two changes to rules as a result of the ACA are anticipated to have a fiscal impact:
Medicaid Expansion:
Total Fund impact: $2,175,251,609
Federal Fund impact: $2,175,251,609
General Fund impact: $0
Note: Medicaid expansion expenses will be covered by 100 percent Federal match for the 2013-15 Biennium.
Hospital Presumptive Eligibility:
Total Fund impact: $19,006,141
Federal Fund impact: $11,968,167
General Fund impact: $7,037,974

Statement of Cost of Compliance:
1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Adopting these rules will have no fiscal impact on the other state agencies, local government, clients, the public, or businesses, including small businesses.
2. Cost of compliance effect on small business (ORS 183.336): None.

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: Medical providers/offices that are considered small businesses that are also Medicaid providers may experience an increase in volume of Medicaid patients.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None.

c. Equipment, supplies, labor and increased administration required for compliance: None.

How were small businesses involved in the development of this rule? None.
Administrative Rule Advisory Committee consulted? Yes. Membership included the Oregon Law Center.
If not, why?

Karen M. House	Karen House	1-15-14
Signature	Printed name	Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007

410-200-0010

Overview

(1) These rules, OAR 410-200-0010 through ~~0515~~-0510 describe eligibility requirements for *OCCS Medical Programs*.

(2) Rule text in italics indicates the term can be found in the definitions rule OAR 410-200-0015.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0015

General Definitions

(1) "*Action*" means a termination, suspension, or reduction of Medicaid or CHIP eligibility or covered services.

(2) "*Address Confidentiality Program (ACP)*" means a program of the Oregon Department of Justice, which provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.

(3) "*AEN*" means Assumed Eligible Newborn (see OAR 410-200-0115)

(4) "*Affordable Care Act*" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56).

(5) "*Agency*" means the Oregon Health Authority, Department of Human Services, and Cover Oregon.

(6) "*American Indian and Alaska Native exceptions*" means:

(a) Distributions from Alaska Native Corporations and Settlement Trusts;

(b) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(c) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(A) Rights of ownership or possession in any lands described in section (b) of this part; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.

(d) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

(e) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(f) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(7) "*Applicant*" means an individual who is seeking an *eligibility determination* themselves or someone for whom they are applying through an application submission or a transfer from another agency or *insurance affordability program*.

(8) "*Application*" means:

(a) The single streamlined application for all *insurance affordability programs* developed by Cover Oregon and the Authority; or

(b) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard, an application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual.

(9) "*APTC*" means Advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the *Affordable Care Act*) which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the *Affordable Care Act*.

(10) "*Assumed eligibility*" means an individual is deemed to be eligible for a period of time based on receipt of another program benefits or because of another individual's eligibility.

(11) "*Appeal Request* "means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority decision or action.

(12) "*Authorized Representative*" means an individual or organization that acts on behalf of an applicant or *beneficiary* in assisting with the individual's application and *renewal* of eligibility and other ongoing communications with the *Agency*. (See OAR 410-200-0111 Authorized Representatives).

(13) "*Beneficiary*" means an individual who has been determined eligible and is currently receiving OCCS Medical Program benefits.

(14) "*BRS*" means Behavioral Residential Services.

(15) "*Budget Month*" means the calendar month from which financial and nonfinancial information is used to determine eligibility.

(16) "*Caretaker*" means a *parent*, caretaker relative, or non-related caretaker who assumes primary responsibility for a *child*'s care.

(17) "*Caretaker Relative*" means a relative of a *dependent child* by blood, adoption, or marriage with whom the *child* is living, who assumes primary responsibility for the *child*'s care, which may, but is not required to, be indicated by claiming the *child* as a *tax dependent* for Federal income tax purposes, and who is one of the following:

(a) The *child*'s father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(b) The *spouse* of the *parent* or relative, even after the marriage is terminated by death or divorce.

(c) An individual described in this section who is a relative of the *child* based on blood, including those of half-blood, adoption, or marriage.

(18) "*CAWEM*" means Citizen/Alien-Waived Emergent Medical which is Medicaid coverage for emergent medical needs for clients who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements. See OAR 410-200-0240

(19) "*CAWEM Prenatal*" means medical services for pregnant *CAWEM* clients.

(20) "*Child*" means an individual, including minor *parent*, under the age of 19. *Child* does not include an unborn. *Child* includes a natural or biological, adopted or step *child*.

(21) "*Citizenship*" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and *non-citizen* nationals of the United States.

(22) "*Claim*" means a legal action or a demand by, or on behalf of, an applicant or *beneficiary* for damages for or arising out of a personal injury which is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.

(23) "*Claimant*" means an individual who has requested an appeal.

(24) "*Code*" means Internal Revenue Code of 1986, as amended.

(25) "*Combined eligibility notice*" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the *insurance affordability programs* and enrollment in a qualified health plan through Cover Oregon, for which a determination or denial was made by Cover Oregon or the Authority.

(26) "*Community partner*" means all external entities (non-agents) who partner with Cover Oregon and enter in formal agreement with the Authority to conduct outreach or enrollment assistance, whether or not they are funded or compensated by Cover Oregon.

(27) "*Coordinated content*" means information included in eligibility notice regarding the transfer of the individual's or households' electronic account to another *insurance affordability program* for a determination of eligibility.

(28) "*Cover Oregon*" means the Oregon Health Insurance Exchange Corporation.

(29) "*Custodial Parent*" means the *parent* with whom the *child* spends more than half of their nights.

(30) "*Date of Request*" means the earlier of:

(a) The date the request for medical benefits is received; or

(b) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.

(31) "*Decision notice*" means a written notice of a decision made regarding eligibility for an OCCS medical program benefit. A *decision notice* may be –

(a) "*Basic decision notice*"– Mailed no later than the date of action given in the notice.

(b) "*Combined Decision notice*"– Informs an individual, or multiple family members of a household when feasible, of the eligibility decision made for each of the MAGI *insurance affordability programs*.

(c) "*Timely continuing benefit decision notice*" – Informs the client of the right to continued benefits and is mailed no later than 15 calendar days prior to the effective date of the change for clients in the Address Confidentiality Program and 10 calendar days prior to the effective date of the change for all other clients.

(32) "*Department* "means the Department of Human Services.

(33) "*Dependent child*" means a *child* who is under the age of 18, or age 18 and a full-time student in a secondary school, or equivalent vocational or technical training, if before attaining age 19 the *child* may reasonably be expected to complete the school or training.

(34) "*ELA*" (Express Lane Agency) means the Department of Human Services making determinations regarding one or more eligibility requirements for the *OHP-OPC* or *OHP-CHP* programs.

(35) "*ELE*" (Express Lane Eligibility) means the Oregon Health Authority's~~Department of Human Services~~ option to rely on a determination, made within a reasonable period, by an *ELA* finding that a *child* satisfies the requirements for *OHP-CHP*, ~~or~~ *OHP-OPC*, MAGI Child, or MAGI CHIP program eligibility. *ELE* qualifies a *child* for medical assistance benefits based on a finding from another public agency, even when the other *Agency*'s eligibility methodology differs from that ordinarily used by the Department of Human Services to determine *OHP-CHP*, and *OHP-OPC* program eligibility.

(36) "*Electronic account*" means an electronic file that includes all information collected and generated by the *Agency* regarding each individual's Medicaid or CHIP eligibility and enrollment, including all required documentation and including any information collected or generated as part of a fair hearing process conducted by the Authority or through Cover Oregon appeals process.

(37) "*Electronic application*" means an application electronically signed and submitted through the internet

(38) "*Eligibility determination*" means an approval or denial of eligibility and a *renewal* or termination of eligibility.

(39) "*Expedited appeal* "means a hearing held within five working days of the Authority's receipt of an *appeal request*, unless the *claimant* requests more time.

(40) "*Family size*" means the number of individuals used to compare to the income standards chart for the applicable program. The *family size* consists of all members of the *Household group* and each unborn *child* of any pregnant members of the *Household group*.

(41) "*Federal data services hub*" means an electronic service established by the Secretary through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including SSA, the Department of Treasury, and the Department of Homeland Security.

(42~~1~~) "*Federal poverty level* (*FPL*) " means the *Federal poverty level* updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).

(43~~2~~) "*Household group*" consists of every individual whose income is considered for determining each medical applicant's eligibility, as defined in OAR 410-200-0310.

(44~~3~~) "*Inmate*" means :

(a) An individual living in a *public institution* that is:

(A) Confined involuntarily in a local, state or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;

(B) Residing involuntarily in a facility under a contract between the facility and a *public institution* where, under the terms of the contract, the facility is a *public institution*;

(C) Residing involuntarily in a facility that is under governmental control; or

(D) Receiving care as an outpatient while residing involuntarily in a *public institution*.

(b) An individual is not considered an *inmate* when:

(A) The individual is released on parole, probation, or post-prison supervision;

(B) The individual is on home or work-release, unless the individual is required to report to a *public institution* for an overnight stay;

(C) The individual is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and while other living arrangements are being made for the individual; or

(D) The individual is in a *public institution* pending other arrangements as defined in 42 CFR 435.1010.

(4~~5~~4) "*Insurance affordability program*" means a program that is one of the following:

(a) Medicaid

(b) CHIP

(c) A program that makes coverage available in a qualified health plan through Cover Oregon with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

(d) A program that makes coverage available in a qualified health plan through Cover Oregon with cost-sharing reductions established under section 1402 of the *Affordable Care Act*.

(4~~6~~5) "*Lawfully present*" means an individual:

(a) Is a *qualified non-citizen*, as defined in this section;

(b) Has valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

(c) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings; or

(d) Belongs to one of the following classes:

(A) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

(B) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(C) Granted employment authorization under 8 CFR 274a.12(c);

(D) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649, as amended;

(E) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(F) Granted Deferred Action status;

(G) Granted an administrative stay of removal under 8 CFR part 241; (viii) *Beneficiary* of approved visa petition that has a pending application for adjustment of status.

(e) Is an individual with a pending application for asylum under 8 U.S.C. 158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days.

(f) Has been granted withholding of removal under the Convention Against Torture;

(g) Is a *child* who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

(h) Is *lawfully present* in American Samoa under the immigration laws of American Samoa;

(i) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106–386, as amended (22 U.S.C. 7105(b)); or

(j) Exception. An individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be *lawfully present* with respect to any of the above categories in sections (a) through (i) of this rule.

(47~~6~~) "*Legal Argument*" has the meaning given that term in OAR 137-003-0008(c).

(48~~7~~) "*Medicaid* or *Oregon Health Plan (OHP)* " means Oregon's Medicaid program under title XIX of the Social Security Act.

(49~~8~~) *"MAGI"* means Modified Adjusted Gross Income and has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:

(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the *child* or *tax dependent* actually files a tax return:

(A) Children, regardless of age, who are included in the household of a *parent;*

(B) *Tax dependents.*

(b) In applying subsection (a) of this section, IRC § 6012(a)(1) is used to determine who is required to file a tax return.

(50~~49~~) *"MAGI-based income" means* income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code, with the following exceptions:

(a) *American Indian and Alaska Native exceptions;*

(b) Child support;

(c) Life insurance proceeds;

(d) Non-taxable Veterans' benefits;

(e) Non-taxable workers' compensation benefits;

(f) Scholarships, awards, or fellowship grants used for educational expenses;

(g) Supplemental Security Income (SSI);

(h) An amount received as a lump sum is counted as income only in the month received. Lump sum income includes but is not limited to:

(A) Winnings;

(B) Countable educational income;

(C) Capital gains;

(D) Dividends, interest, royalties.

(i) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses;

(j) Self-employment and business entity income is determined by adding gross receipts and other business income and subtracting deductions described in Internal Revenue Code (IRC) §§ 161 through 249. Items not deductible are described in IRC §§ 261 through 280 include, but are not limited to, most capital expenditures, such as business start-up costs, buildings, and furniture, and payments or deductions for personal, living, or family use. Business structures are determined by state statutes and are dependent on elections made by business owners. Each state may use different regulations for business structures. Salaries and wages paid to employees, including those who are owners or stockholders, are countable income to the employees. Business income is countable to owners and stockholders as described below:

(A) Sole proprietors, ~~and~~ independent contractors, and Limited Liability Companies (LLC) who choose to file Federal taxes as a sole proprietor: The necessary and ordinary costs of producing income are subtracted from gross receipts and other business income to determine countable income. Expenses related to costs for both business and personal use are prorated according to the proportions used for each purpose. Costs are limited to those described in IRC §§161 through 199 and Treasury Regulations §§ Sec. 1.162 through 1.263.

(B) Partnerships that are not publicly traded and LLCs who choose to file Federal taxes as a partnership~~limited liability companies (LLC)~~: Owners' income is determined as follows:

(i) The distributive share of income, gain and loss is determined proportionately according to the partnership agreement or the LLC agreement.

(ii) Income from other partnerships, estates and trusts is added to the amount in paragraph (A) of this subsection.

(iii) The costs of producing income described in subsection (4)(a), except for oil and gas depletion and costs listed below are proportionately subtracted from gross receipts to determine each partner's countable income:

(II) Bad debts;

(II) Guaranteed payments to partners;

(III) Losses from other partnerships, farms, estates and trusts;

(IV) Retirement plans.

(C) S Corporations and LLCs who choose to file Federal taxes as an S Corporation: Shareholders' income is determined as follows:

(i) The distributive share of profits, gain and loss are determined proportionately on the basis of the stockholders' shares of stock.

(ii) The costs of producing income described in subsection (a) are proportionately subtracted from gross receipts to determine each stockholder's countable income.

(iii) The distributive share of profits is countable income to the shareholders whether or not it is actually distributed to the shareholders.

(D) C Ceorporations and LLCs who choose to file taxes as C Corporations: Shareholders' income is countable when it is distributed to them through dividends.

(51~~0~~) "*MAGI income standard*" means the monthly income standard for the relevant program and *family size*, described in OAR 410-200-0315.

(52~~1~~) "*Minimum essential coverage*" means medical coverage under:

(a) A government-sponsored plan, including Medicare part A, Medicaid, CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;

(b) Employer-sponsored plans, with respect to an employee, including coverage offered by an employer, which is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;

(c) Plans in the individual market;

(d) Grandfathered health plans; and

(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.

(53~~2~~) "*Non-applicant*" means an individual not seeking an *eligibility determination* for him or herself and is included in an applicant's or *beneficiary*'s household to determine eligibility for the applicant or *beneficiary*.

(54~~3~~) *"Non-citizen"* has the meaning given the term "alien," as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

(55~~4~~) *"OCCS"* means the Office of Client and Community Services, part of the Medical Assistance Programs under the Oregon Health Authority.

(56~~5~~) *"OCCS Medical Programs"* means all programs under the Authority, OCCS including:

(a) *"CEC"* means Continuous Eligibility for *OHP-CHP* pregnant women. Title XXI medical assistance for a pregnant non-*CAWEM child* found eligible for the *OHP-CHP* program who, for a reason other than moving out of state or becoming a recipient of *private major medical health insurance*, otherwise would lose her eligibility.

(b) *"CEM"* means Continuous Eligibility for Medicaid. Title XIX medical assistance for a non-*CAWEM child* found eligible for Medicaid who loses his or her eligibility for a reason other than turning 19 years of age or moving out of state.

(c) *"MAA"* means Medical Assistance Assumed.

(d) *"MAF"* means Medical Assistance to Families. The Medical Assistance to Families program provides medical assistance to people who are ineligible for *MAA* but are eligible for Medicaid using ADC program standards and methodologies that were in effect as of July 16, 1996.

(e) *"EXT"* means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the *MAA*, *MAF*, or Pre-TANF program due to an increase in their *child* support or earned income.

(f) *"OHP"* means *Oregon Health Plan*. The *Oregon Health Plan* program provides medical assistance to many low-income individuals and families. The program includes five categories of individuals who may qualify for benefits. The acronyms for these categories are:

(A) *"OHP-CHP"*; Persons Under 19. *OHP* coverage for persons under 19 years of age who qualify at or below the 300 percent income standard.

(B) *"OHP-OPC"*; Children. *OHP* coverage for children who qualify under the 100 percent income standard.

(C) "*OHP-OPP*"; Pregnant Females and their newborn children. *OHP* coverage for pregnant females who qualify under the 185 percent income standard and their newborn children.

(D) "*OHP-OPU*"; Adults. *OHP* coverage for adults who qualify under the 100 percent income standard. A person eligible under *OHP-OPU* is referred to as a health plan new/non-categorical (HPN) client.

(E) "*OHP-OP6*"; Children under 6. *OHP* coverage for children under age 6 who qualify under the 133 percent income standard.

~~(g) "*HKC*"~~ *means* ~~Healthy KidsConnect. A program administered by the Office of Private Health Partnerships (OPHP) providing access to health care for children not eligible for any of the *Agency*'s other medical assistance programs.~~

(g~~h~~) "*SAC*" means Medical Coverage for Children in Substitute or Adoptive Care.

(h~~i~~) "*BCCTP*" means Breast and Cervical Cancer Treatment Program.

(i~~j~~) "*MAGI Medicaid/CHIP* "means *OCCS Medical Programs* for which eligibility is based on *MAGI*, including:

(A) MAGI Child;

(B) MAGI *Parent* or Other Caretaker Relative;

(C) MAGI Pregnant Woman;

(D) MAGI Children's Health Insurance Program (CHIP);

~~(E) MAGI Substitute or Adoptive Care (SAC);~~

(E~~F~~) MAGI Adult.

(57~~6~~) "*OCWP*" means Office of Child Welfare ~~Medical~~ Programs.

(58~~7~~) "*OSIPM*" means Oregon Supplemental Income Program Medical. *OSIPM* is a medical program administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities for:

(a) Individuals who receive Supplemental Security Income (SSI); or

(b) Individuals who receive home or community based services, or when the individual resides in a nursing facility or state institution.

(59~~8~~) "*Parent* "means a natural or biological, adopted or step *parent*.

(60~~59~~) "*Personal Injury*" means a physical or emotional injury to an individual including but not limited to assault, battery, or medical malpractice arising from the physical or emotional injury.

(61) "*Post-eligibility pend period*" means the period of time provided to a *beneficiary* or an individual of the *beneficiary*'s to ensure all verification and non-financial eligibility requirements are met.

(a) Begins on, and must extend 90 days from, the date on which notice is received by the individual.

(b) The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period.

(62~~0~~) "*Pregnant woman*" means a woman during pregnancy and the postpartum period, which begins on the date the pregnancy ends, extends 60 days, and ends on the last day of the month in which the 60-day period ends.

(63) "*Primary person*" means the primary person the *Agency* will communicate with, and:

(a) Is listed as the case name; or

(b) Is the individual named as the primary contact on the Cover Oregon/Oregon Health Authority medical application.

(64~~1~~) "*Private major medical health insurance*" means a comprehensive major medical insurance plan that, at a minimum, provides physician services; inpatient and outpatient hospitalization; outpatient lab, x-ray, immunizations; and prescription drug coverage. This term does not include coverage under the Kaiser Child Health Program or Kaiser Transition Program but does include policies that are purchased privately or are employer-sponsored.

(65~~2~~) "*PRTF*" means Psychiatric Residential Treatment Facility.

(66~~3~~) "*Public institution*" means any of the following:

(a) A state hospital (see ORS 162.135).

(b) A local correctional facility (see ORS 169.005) a jail or prison for the reception and confinement of prisoners that is provided, maintained and operated by a county or city and holds individuals for more than 36 hours.

(c) A Department of Corrections institution (see ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility.

(d) A youth correction facility (see ORS 162.135):

(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or

(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth, or youth offenders pursuant to a judicial commitment or order.

(e) As used in this rule, the term *public institution* does not include:

(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);

(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or

(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.

(67~~4~~) "*Qualified Hospital*" means a hospital that:

(a) Participates as an enrolled Oregon Medicaid provider;

(b) Notifies the Authority of their decision to make presumptive *eligibility determinations*;

(c) Agrees to make determinations consistent with Authority policies and procedures;

(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and

(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).

(68~~5~~) "*Qualified non-citizen*" means an individual that is any of the following:

(a) A *non-citizen* lawfully admitted for permanent residence under the INA (8 U.S.C. 1101 et seq);

(b) A refugee admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A *non-citizen* granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A *non-citizen* whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1253(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 1231(b)(3)) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A *non-citizen* paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A *non-citizen* granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980;

(g) A *non-citizen* who is a Cuban and Haitian entrant (as defined in section 501(3) of the Refugee Education Assistance Act of 1980);

(h) An Afghan or Iraqi alien granted Special Immigration Status (SIV) under section 101(a)(27) of the INA; or

(i) A battered *spouse* or *dependent child* who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the U.S. Citizenship and Immigration Services.

(6~~9~~6) *"Reasonable opportunity period"*:

(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status, or discrepancies between self-attested information and electronic data match.

(b) Begins on, and must extend 90 days from, the date on which notice is received by the individual. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period.

(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the *Agency* needs more time to complete the verification process.

(70~~67~~) "*Redetermination*" means a review of eligibility outside of regularly scheduled *renewals*. *Redeterminations* which result in the assignment of a new *renewal* date or a change in program are considered *renewals*.

(71~~68~~) "*Renewal*" means a regularly scheduled periodic review of eligibility resulting in a *renewal* or change of program benefits, including the assignment of a new *renewal* date, or a change in eligibility status.

(72~~69~~) "*Required documentation*" means :

(a) Facts to support the *Agency*'s decision on the application; and

(b) Either:

(A) A finding of eligibility or ineligibility; or

(B) An entry in the case record that the applicant voluntarily withdrew the application and the *Agency* sent a notice confirming the decision, that the applicant has died, or that the applicant cannot be located.

(73~~0~~) "*Secure electronic interface*" means an interface which allows for the exchange of data between Medicaid or CHIP and other *insurance affordability programs* and adheres to the requirements in 42 CFR part 433, subpart C.

(74~~1~~) "*Shared eligibility service" means* a common or shared eligibility system or service used by a State to determine individuals' eligibility for *insurance affordability programs*.

(75~~2~~) "*Sibling*" means natural or biological, adopted, or half or step *sibling*.

(76~~3~~) "*Spouse*" means an individual who is legally married to another individual under:

(a) The statutes of the state where the marriage occurred;

(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or

(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.

(77~~4~~) "*SSA*" means Social Security Administration.

(78~~5~~) "*Tax dependent*" has meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

~~(76) "*Timely*" means within 90 days of the date the notice of adverse action is received.~~

(79~~7~~) "*Title IV-E*" means *Title IV-E* of the Social Security Act (42 U.S.C. §§ 671-679b).

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0100

Coordinated Eligibility and Enrollment Process with the Department of Human Services and Cover Oregon

(1) This rule describes Oregon Health Authority's (Authority) coordination of eligibility and enrollment with the Department of Human Services (Department) and Cover Oregon (Exchange). The Authority shall:

(a) Minimize the burden on individuals seeking to obtain or renew eligibility, or to appeal a determination of eligibility for *insurance affordability programs*;

(b) Ensure determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards described in OAR 410-200-0110 based on the application date;

(c) Provide *coordinated content* for those household members whose eligibility status is not yet determined; and

(d) Screen every applicant or *beneficiary* who submits an application or *renewal* form, or whose eligibility is being renewed under a change in circumstance, for criteria that identify individuals for whom *MAGI-based income* methods do not apply.

(2) For individuals undergoing *eligibility determination* based on MAGI-based methodology and standards, the Authority, consistent with the timeliness standards described in OAR 410-200-0110, must:

(a) Determine eligibility for MAGI Medicaid/CHIP on the basis of having household income at or below the applicable MAGI-based standard, or

(b) If ineligible under section (a), screen for *APTC* and refer to Cover Oregon.

(3) If ineligible for MAGI Medicaid/CHIP, for individuals undergoing a Medicaid *eligibility determination* on a basis other than MAGI-based standards, the Authority must, consistent with the timeliness standards described in OAR 410-200-0110:

(a) Screen for eligibility for Medicaid on a basis other than MAGI-based standards, as indicated by information provided on the application or *renewal* form.

(b) Transfer via *secure electronic interface* the individual's *electronic account* information to the Department, as appropriate, and provide timely notice to the Department that the individual is not eligible for OCCS medical programs, but that a final determination of Medicaid eligibility on other bases is still pending.

(c) Provide notice to the individual that:

(A) The Authority has determined the individual ineligible for OCCS medical programs;

(B) The Department is continuing to evaluate Medicaid eligibility on one or more other bases, including a plain language explanation of the other bases being considered.

(C) The notice must include *coordinated content* relating to the transfer of the individual's *electronic account* to the Department, as appropriate; and

(D) There is a right to a hearing to challenge the eligibility decision.

(d) Provide, or assure that the Department has provided, the individual with notice of the final determination of eligibility on one or more other bases.

(4) For beneficiaries found ineligible for ongoing OCCS medical program benefits, the Authority shall maintain OCCS medical program benefits while eligibility is being determined by the Department or Cover Oregon, and may not take *action* to close benefits until determination of eligibility for other *insurance affordability programs* is complete.

(5) Coordination among agencies:

(a) The Authority shall maintain a *secure electronic interface* through which the Authority can receive an individual's *electronic account*, including any information provided by the individual as part of an appeal to any *Agency*, from the Department and Cover Oregon;

(b) The Authority may not request information or documentation from the individual included in the individual's *electronic account* or provided to the *Agency*; and

(c) If information is available through electronic data match, and is useful and related to eligibility for OCCS Medical Programs, the Authority must obtain the information through electronic data match.

(6) Cover Oregon may perform any obligation of the Authority under these rules pertaining to MAGI Medicaid/CHIP, except for hospital presumptive eligibility. Each *Agency* must either complete the processing of any application or *redetermination* for medical benefits or transfer the application to another *Agency* for completion.

Stat. Auth.: ORS , 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0105 ~~Effective 01/01/2014~~

~~Specific Requirements;~~ Hospital Presumptive Eligibility

This rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP based on the determination of a *qualified hospital* as of January 1, 2014.~~.~~

(1) The qualified hospital will determine eligibility for Hospital Presumptive Eligibility based on the following information declared by the individual:

(a) *Family size*;

(b) Household income;

(c) Receipt of other health coverage;

(d) US citizenship, US national, or non-citizen status.

(2) To be eligible for Hospital Presumptive Eligibility, ~~based on preliminary information,~~ an individual must be a US *citizen*, US National, or *qualified non-citizen*, and:

(a) A child under the age of 19 with income at or below 300 percent of the federal poverty level;

(b) A parent or caretaker relative of a dependent child with income at or below the MAGI Parent or Other Caretaker Relative income standard for the appropriate *family size* in OAR 410-200-0315;

(c) A pregnant woman age 19 and above with income at or below 185 percent of the federal poverty level; ~~or~~

(d) An adult between the ages of 19 through 64 with income at or below 138 percent of the federal poverty level; or~~.~~

(e) A woman under the age of 65 who has been determined eligible for the Breast and Cervical Cancer Treatment Program (OAR 410-200-0400).

(3~~2~~) To be eligible for the Hospital Presumptive Eligibility, ~~based on preliminary information,~~ an individual ~~may~~ must not:

(a) Be receiving SSI benefits;

(b) Be eligible for Medicare;

(c) Be receiving Medicaid through another program;

(d) Have *minimum essential coverage*, unless the coverage is provided through Indian Health Services;~~ or~~

(e) Be age 65 or above; or

(f) Have received Hospital Presumptive Eligibility for any portion of the full year (365 days) preceding a new Hospital Presumptive Eligibility period.~~.~~

(~~3~~4) The Hospital Presumptive Eligibility period begins on the date the qualified hospital determines the individual's eligibility based on the applicant's self-attestation that the household group's income does not exceed the applicable income level for the MAGI medical program on that date and the individual is otherwise eligible.

(4~~5~~) The Hospital Presumptive Eligibility period ends with and includes, the earlier of:

(a) In the case of an individual on whose behalf a Medicaid application has been filed, the day on which the state makes an eligibility determination~~determines the individual is not eligible~~ for MAGI Medicaid/CHIP and sends basic decision notice; or

(b) If subsection (a) is not completed, the last day of the month following the month during which the hospital makes the presumptive determination.

(~~5~~6) A Hospital Presumptive Eligibility decision does not qualify a beneficiary for 12-months of continuous eligibility, or for protected postpartum eligibility.

Stat. Auth.: ORS , 411.402, 411.404, 413.042, , 414.534
Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0110

Application and *Renewal* Processing and Timeliness Standards

(1) General information as it relates to application processing is as follows:

(a) An individual may apply for one or more medical programs administered by the Authority, the Department, or Cover Oregon, using a single streamlined application. An application may be submitted via the Internet, by telephone, via mail, in person, or through other commonly available electronic means. An application and any required verification may be submitted by the applicant, an adult who is in the applicant's household or family, the applicant's authorized representative or, if the applicant is a minor or incapacitated, someone acting on behalf of the applicant.

(b) The *Agency* must ensure that an application form is readily available to anyone requesting one, and that *community partners* are available to assist applicants who are unable to complete the application form or to gather information necessary to verify eligibility.

(c) If the *Agency* requires additional information to determine eligibility, the *Agency* must send the applicant or *beneficiary* written notice that includes a statement of the specific information needed to determine eligibility and the date by which the applicant or *beneficiary* must provide the required information in accordance with section (6) of this rule.

(d) If an application is filed containing the applicant or *beneficiary*'s name and address, the *Agency* must send the applicant or *beneficiary* a *decision notice* within the time frame established in section (6) of this rule.

(e) An application is complete if all of the following requirements are met:

(A) All information necessary to determine the individual's eligibility and benefit amount is provided on the application for each individual in the *household group*.

(B) The applicant, even if homeless, provides an address where they can receive postal mail.

(C) The application is signed in accordance with section (5) of this rule.

(D) The application is received by the *Agency*.

(f) To complete the application process, the applicant must:

(A) With the exception of sections (4) and (5) of this rule, complete and sign an application, and

(B) Provide necessary information to the *Agency* within the time frame established in section (6) of this rule.

(2) General information as it relates to *renewal* and *redetermination* processing is as follows:

(a) The Authority must redetermine eligibility at assigned intervals and whenever a *beneficiary*'s eligibility becomes questionable.

(b) When renewing or redetermining medical benefits, the *Agency* must, to the extent feasible, determine eligibility using information found in the *beneficiary*'s *electronic account* and electronic data accessible to the *Agency*.

(c) If the *Agency* is unable to determine a *beneficiary*'s eligibility using information found in the *beneficiary*'s *electronic account* and electronic data accessible to the *Agency*, then the *Agency* must provide a pre-populated *renewal* form to the *beneficiary* containing information known to the *Agency*, statement of the additional information needed to renew eligibility, and the date by which the *beneficiary* must provide the required information in accordance with section (6) of this rule.

(d) The *Agency* must assist applicants who are unable to complete the pre-populated *renewal* form or gather information necessary to renew eligibility.

(e) The pre-populated *renewal* form is complete if it meets the requirements identified in section (1)(e) of this rule.

(f) If the *Agency* provides the individual with a pre-populated *renewal* form, to complete the *renewal* process, the individual must:

(A) Complete and sign the form in accordance with section (5) of this rule.

(B) Submit the form via the Internet, by telephone, via mail, in person, and through other commonly available electronic means, and

(C) Provide necessary information to the *Agency* within the time frame established in section (6) of this rule.

(g) A *beneficiary* may withdraw a pre-populated *renewal* form at any time.

(3) A new application is required when:

(a) An individual requests medical benefits and no member of the *household group* currently receives medical benefits.

(b) A *child* turns age 19, is no longer claimed as a *tax dependent*, and wishes to retain medical benefits.

(4) A new application is not required when:

(a) The *Agency* determines an applicant is ineligible in the month of application and is determining if the applicant is eligible the following month.

(b) The *Agency* determines a new applicant is ineligible for medical in the months of October, November, or December 2013 for a reason other than failure to complete the application requirements as identified in sections (1) and (5) of this rule, and the *Agency* is redetermining the applicant's eligibility for the new medical programs effective January 1, 2014.

(c) Eligibility for OCCS medical programs is determined using the individual's Supplemental Nutrition Assistance Program (SNAP) eligibility pursuant to OAR 410-200-0505.

(d) Benefits are closed and reopened during the same calendar month.

(e) A *beneficiary*'s medical benefits are suspended because the *beneficiary* is an *inmate* who lives in a *public institution* and who meets the requirements of OAR 410-200-0140.

(f) An *assumed eligible newborn* (*AEN*) is added to a *household group* receiving medical program benefits.

(g) An individual not receiving medical program benefits is added to an ongoing *household group* receiving medical program benefits and eligibility can be determined using information found in the individual or *beneficiary*'s *electronic account* and electronic data available to the *Agency*.

(h) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program.

(i) At *renewal*, the *beneficiary* fails to submit additional information requested by the Agency within 30 days, but provides the requested information within 90 days after the date medical benefits were terminated.

(5) Signature requirements are as follows:

(a) The applicant must sign an application, except as follows:

(A) At least one caretaker relative or *parent* in the *household group*, or the *primary person* when there is no *parent* in the *household group*, or an authorized representative must sign the initial application for benefits.

(B) An individual required but unable to sign the application may sign with a mark, witnessed by an *Agency* employee, *community partner*, insurance broker, or insurance agent.

(C) When renewing eligibility, the *Agency* successfully determines eligibility using information found in the *beneficiary's electronic account* and electronic data accessible to the *Agency*.

(D) When the *Agency* successfully renews eligibility using information found in the *beneficiary's electronic account* and electronic data accessible to the *Agency*, sends an approval notice to the *beneficiary* on the basis of eligibility, and the *beneficiary* contacts the *Agency* providing information that differs from the information used to renew eligibility.

(E) When the application is one for presumptive eligibility only (see OAR 410-200-0105), as determined by a *qualified hospital*.

(b) When renewing eligibility, if the *Agency* is unable to determine eligibility using information found in the *beneficiary's electronic account* and electronic data accessible to the *Agency*, a signature is required on the pre-populated *renewal* form sent to the *beneficiary* for additional information.

(c) Signatures may be submitted and must be accepted by the *Agency* via internet, mail, telephone, in person, or other electronic means.

(d) An *electronic application* must be submitted to and received by the Authority with an electronic signature.

(6) Application and *renewal* processing timeliness standards are as follows:

(a) At initial *eligibility determination*, the *Agency* shall inform the individual of timeliness standards and determine eligibility and send a *decision notice* not later than the 45th calendar day after the *Date of Request* if:

(A) All information necessary to determine eligibility is present; or

(B) The application is not completed by the applicant within 45 days after the *Date of Request*.

(b) At initial *eligibility determination*, the *Agency* may extend the 45-day period described in section (a) if there is an administrative or other emergency beyond the control of the *Agency*. The *Agency* must document the emergency.

(c) Except for periodic *renewals* of eligibility described in section (d), the *Agency* provides the *reasonable opportunity period* to verify information after eligibility has been determined.

(d) At periodic *renewal* of eligibility, if additional information beyond data available to the *Agency* on the *beneficiary*'s *electronic account* or electronic data is required, the Authority must provide the *beneficiary* at least 45 days from the date of the *renewal* form to respond and provide necessary information.

(7) Medical program eligibility for October, November, and December 2013 budget months shall be determined in the following order:

(a) For a *child* applicant, the ~~hierarchy~~ order is as follows:

(A) *Assumed eligibility* for OCCS medical programs (see OAR 410-200-0135)

(B) *MAA*;

(C) *EXT*;

(D) *Oregon Health Plan* program categories in the following order:

(i) *OHP-OPP*;

(ii) *OHP-OPC*;

(iii) *OHP-OP6*;

(E) ~~MAGI SAC~~Substitute Care when the *child* is in Behavioral Rehabilitation Services (*BRS*) or in Psychiatric Residential Treatment Facility (*PRTF*) as identified in OAR 410-200-0405;

(F) BCCTP as identified in 410-200-0400;

(G) Continuous Eligibility as identified in OAR 410-200-0135;

(H) MAGI CHIP;

(b) For an adult applicant, the ~~hierarchy~~ order is as follows:

(A) *Assumed eligibility* for OCCS medical programs (see OAR 410-200-0135);

(B) *MAA*;

(C) *EXT*;

(D) *OHP-OPP*;

(E) ~~MAGI SAC~~Substitute Care;

(F) BCCTP

(G) *OHP-OPU*

(8) Medical program eligibility for January 2014 budget month and later is determined in the following order:

(a) For a *child* applicant, the order is as follows:

(A) *Assumed eligibility* for OCCS medical programs (see OAR 410-200-0135);

~~(B) Former Foster Care Youth Medical as identified in OAR 410-200-0406;MAGI~~

(B~~C~~) ~~MAGI SAC~~Substitute Care, when the *child* is in Behavioral Rehabilitation Services (*BRS*) or in Psychiatric Residential Treatment Facility (*PRTF*) as identified in OAR 410-200-0405;

(C~~D~~) MAGI Parent or Other Caretaker Relative Program as identified in OAR 410-200-0420;

(D~~E~~) Pregnant Woman program as identified in OAR 410-200-0425;

(E~~F~~) MAGI Child program as identified in OAR 410-200-0415;

(F~~G~~) EXT as identified in 410-200-0440;~~BCCTP as identified in 410-200-0400;~~

(G~~H~~) Continuous Eligibility as identified in OAR 410-200-0135;~~EXT as identified in 410-200-0440;~~

(H~~I~~) MAGI CHIP as identified in OAR 410-200-0410;~~Continuous Eligibility as identified in OAR 410-200-0135;~~

(I)~~J)~~ BCCTP as identified in 410-200-0400~~MAGI CHIP as identified in OAR 410-200-0410.~~

(b) For an adult applicant, the order is as follows:

(A) *Assumed eligibility* for OCCS medical programs (see OAR 410-200-0135);

~~(B) Former Foster Care Youth Medical as identified in OAR 410-200-0406;~~

(B~~C~~) ~~MAGI SAC~~Substitute Care as identified 410-200-0405;

(C~~D~~) MAGI Parent or Other Caretaker Relative Program as identified in OAR 410-200-0420; ~~*EXT;*~~

(D~~E~~) *EXT;*~~MAGI Parent or Other Caretaker Relative Program as identified in OAR 410-200-0420;~~

(E)~~F)~~ MAGI Pregnant Woman Program as identified in OAR 410-200-0425

(F~~G~~) MAGI Adult Program as identified in OAR 410-200-0435;

(G~~H~~) BCCTP as identified in OAR 410-200-0400.

[Ed. Note This rule replaces and amends information previously found in OAR 461-115-0010; 461-115-0020; 461-115-0050; 461-115-0071; 461-115-0090, 461-195-0305, 461-195-0310, 461-195-0321]

Stat. Auth.: ORS , 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0111

Authorized Representatives

(1) The following individuals may designate an *authorized representative*:

(a) A caretaker;

(b) The *primary person*, when there is no caretaker in the *household group*;

(c) An adult in the *household group*; or

(d) The *Agency*, if an authorized representative is needed but has not been designated by the individual.

~~(2) The *Agency* must allow an individual of the applicant's or *beneficiary's* choice to act as the authorized representative unless there is evidence that the individual may cause harm to the client or may be considered as having a conflict of interest.~~

(2~~3~~) The *Agency* may accept an *applicant* or *beneficiary*'s designation of an authorized representative via any of the following methods, and must include either a handwritten or electronic signature of both the *applicant* or *beneficiary* and designated *authorized representative*:

(a) The Internet;

(b) E-mail;

(c) Mail;

(d) Telephonic recording;

(e) In person; or

(f) Other electronic means.

(3~~4~~) Applicants and beneficiaries may authorize their authorized representative to:

(a) Sign an application on the applicant's behalf;

(b) Complete and submit a *renewal* form;

(c) Receive copies of the applicant or *beneficiary*'s notices and other communications from the *Agency*; or

(d) Act on behalf of the applicant or *beneficiary* in any or all other matters with the *Agency*.

(4~~5~~) The authorized representative must:

(a) Fulfill all responsibilities encompassed within the scope of the authorized representation as identified in section (4) to the same extent as the individual represented; and

(b) Maintain the confidentiality of any information regarding the applicant or *beneficiary* provided by the Authority.

(5~~6~~) In addition to authorized representatives as designated in sections (1) through (5) above, an individual is treated as an authorized representative if the individual has been given authority under state law. Such authority includes but is not limited to:

(a) A court order establishing legal guardianship;

(b) A health care representative, when the individual is unable to make their own decisions; or

(c) A court order establishing power of attorney.

(6~~7~~) As a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization with a service-providing relationship to the *beneficiary* must affirm that he or she will adhere to the regulations in 45 CFR 431, subpart F and at 45 CFR 155.260(f) and at 45 CFR 447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(7~~8~~) The power to act as an authorized representative is valid until the *Agency* is notified via any of the methods described in section (3) of any of the following:

(a) The applicant or *beneficiary* modifies the authorization or notifies the *Agency* that the representative is no longer authorized to act on his or her behalf;

(b) The authorized representative informs the *Agency* that he or she no longer is acting in such capacity; or

(c) There is a change in the legal authority upon which the individual or organization's authority was based.

[Ed. Note This rule replaces and amends information previously found in OAR 461-115-0090]

Stat. Auth.: ORS , 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0115

Effective Dates—OCCS Medical Programs

(1) *Date of Request.*

(a) For all OCCS medical programs the applicant or an individual authorized to act on behalf of the applicant must contact the Oregon Health Authority (Authority), the Department of Human Services (Department), or Cover Oregon (Exchange) to request medical benefits. The request may be via the internet, by telephone through a call

center, by an Authority contracted outreach worker or *community partner*, by regular mail, by electronic communication or in person.

(b) The *Date of Request* is the earlier of the following:

(A) The date the request for medical benefits is received; or

(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.

(c) For current beneficiaries of OCCS medical programs, the *Date of Request* is one of the following:

(A) The date the *beneficiary* reports a change requiring a *redetermination* of eligibility; or

(B) The date the *Agency* initiates a review, except that the automatic mailing of an application does not constitute a *Date of Request*.

(d) The *Date of Request* starts the application processing time frame.

(e) If the application is not received within 45 days after the *Date of Request*, or within the extended time that the Authority has allowed under OAR 410-200-0110 (Application Processing), the new *Date of Request* is the date the application is submitted to the *Agency*.

(2) For *EXT*, the effective date is determined according to OAR 410-200-0440.

(3~~2~~) Except for *CEM*, *CEC* and *EXT*, the effective date of medical benefits for new applicants for OCCS medical programs is whichever comes first:

(a) The *Date of Request*, if the applicant is found eligible as of that date; or

(b) If ineligible on the *Date of Request*, the first day following the *Date of Request* on which the client is determined to be eligible, within the month of the *Date of Request* or the following month.

(c) January 1, 2014, if not eligible based on budget month income from the months of October through December 2013, but the budget month income is below the income standard for January 1, 2014.

(4~~3~~) The effective date for retroactive medical benefits (see OAR 410-200-0130) for MAGI Medicaid/CHIP and BCCTP is the earliest date of eligibility during the three months preceding

the *Date of Request*. The Authority reviews each month individually for retroactive medical eligibility.

(54) Establishing a *renewal* date.

(a) Except for *CEM*, *CEC*, *EXT*, and as provided in subsection (b), for all OCCS Medical Programs, eligibility must be renewed every 12 months. The *renewal* date is the last day of the month, determined as follows:

(A) For initial eligibility, the *renewal* date is determined by counting 12 full months following the initial month of eligibility.

(B) For *renewals* that are regularly scheduled, the new *renewal* date is determined by counting 12 full months following the current *renewal* month.

(C) For ~~*renewals*~~ *redeterminations* that are the result of a reported change, the new *renewal* date is determined by counting 12 full months following the month the change occurred.

(b) Except for ~~*HKC,*~~ *OHP-OP6*, *OHP-OPP*, and individuals who are 18 turning 19 years of age, all OCCS Medical Program beneficiaries who have *renewal* dates between October 1, 2013 and March 31, 2014, the *renewal* date shall be extended by six calendar months, as follows:

(A) *Renewal* dates that fall in October 2013 shall be extended to April 2014.

(B) *Renewal* dates that fall in November 2013 shall be extended to May 2014.

(C) *Renewal* dates that fall in December 2013 shall be extended to June 2014.

(D) *Renewal* dates that fall in January 2014 shall be extended to July 2014.

(E) *Renewal* dates that fall in February 2014 shall l be extended to August 2014.

(F) *Renewal* dates that fall in March 2014 shall be extended to September 2014.

(65) Acting on Reported Changes (also see Changes That Must Be Reported OAR 410-200-0235)

(a) When the *beneficiary* reports a change in circumstances at any time other than the *renewal* month, eligibility must be redetermined for all *household group* members.

(b) Except for *OHP-OPP* and MAGI Pregnant Woman, based on the reported change, if the *beneficiary* is determined to be eligible for another OCCS Medical Program, the

effective date for the change is the first of the month following the month in which the determination was made.

(c) For *OHP-OPP* and MAGI Pregnant Woman, the effective date is the *Date of Request*.

(d) For beneficiaries whose eligibility was determined prior to January 1, 2014, who report changes that may affect eligibility in January, February or March, 2014 the following apply:

(A) Eligibility shall be redetermined using the budgeting policies outlined in OARs 410-200-0310 and 410-200-0315.

(B) If ineligible for OCCS medical programs using information gained during the January, February or March *redetermination*, the effective date of the change shall be April 1, 2014, or the end of the month following timely notice, whichever is later.

(C) OCCS medical program benefits shall be maintained during the period of time between the loss of eligibility and the *APTC* or closure effective date of April 1, 2014.

(7~~6~~) *Assumed eligibility*

(a) A pregnant woman eligible for and receiving Medicaid benefits the day the pregnancy ends or who was eligible for and receiving medical under any Medicaid program and becomes ineligible while pregnant is assumed eligible for continuous eligibility through the end of the calendar month in which the 60th following the last day of the pregnancy falls unless:

(A) She is no longer an Oregon resident; or

(B) She requests medical benefits to be closed.

(b) A *child* born to a mother eligible for and receiving Medicaid, *OHP-CHP* or MAGI CHIP benefits is an *assumed eligible newborn* (*AEN*) for medical benefits until the end of the month the *child* turns one year of age, unless:

(A) The *child* dies;

(B) The *child* is no longer an Oregon resident; or

(C) The *child*'s representative requests a voluntary termination of the *child*'s eligibility.

(8~~7~~) Twelve Month Continuous Eligibility

(a) A *child* determined eligible for MAGI Medicaid/CHIP or BCCTP at initial eligibility or at the *renewal* period shall have a 12 month continuous enrollment period. The 12 month continuous enrollment period begins on the *Date of Request* or date the *child* is initially found eligible, whichever is later, and continues for the following 12 full months.

(b) For a *child* transitioning from another Medicaid program, the 12 month continuous enrollment period begins the first month following the month in which the other Medicaid program ends.

(9~~8~~) Suspending or Closing Medical Benefits

(a) The effective date for closing all OCCS medical program benefits is the earliest of:

(A) The date of a *beneficiary*'s death;

(B) The last day of the month in which the *beneficiary* becomes ineligible and a *timely continuing benefit decision notice* is sent;

(C) The day prior to the start date for Office of *Child* Welfare Programs or *OSIPM* for beneficiaries transitioning from an OCCS medical program;

(D) The date the program ends; or

(E) The last day of the month in which a *timely continuing benefit decision notice* is sent if ongoing eligibility cannot be determined because the *beneficiary* does not provide required information within 30 days.

(b) Prior to closing medical benefits, the *Agency* must determine eligibility for all other *insurance affordability programs*.

(c) For suspension of OCCS Medical Program eligibility of beneficiaries who become incarcerated, see 461-200-0140.

(10~~9~~) Denial of Benefits. The effective date for denying OCCS Medical Program benefits is the earlier of the following:

(a) The date the decision is made that the applicant is not eligible; or

(b) The end of the application processing time frame, unless the time period has been extended to allow the applicant more time to provide required verification.

(11~~0~~) Eligibility Following Closure.

(a) The Authority must reconsider in a timely manner (see OAR 410-200-0110 Application Processing) the eligibility of an individual who:

(A) Lost OCCS Medical Program eligibility because they did not return necessary required information or pursue an available asset; and

(B) Within 90 days of the medical closure date, submits the information necessary for the *eligibility determination*.

(b) If the individual is found to meet medical eligibility based on the completed *redetermination*, eligibility shall be restored back to the day after medical benefits ended.

[Ed. Note This rule replaces and amends information previously found in OAR 461-180-0010, 461-180-0050, 461-180-0060, 461-180-0085, 461-180-0090, 461-180-0100, 461-180-0120, and 461-180-0140]

Stat. Auth.: ORS, 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0120

Notices

(1) Except as provided in this rule, the Authority shall send:

(a) A *basic decision notice* whenever an application for OCCS Medical Program benefits is approved or denied.

(b) A *timely continuing benefit decision notice* whenever OCCS Medical Program benefits are reduced or closed.

(2) For a *beneficiary* who is placed in a *public institution* or a correctional facility the Authority shall send a *basic decision notice* to close, reduce or suspend OCCS Medical Program benefits.

(3) For a *beneficiary* who has been placed in skilled nursing care, intermediate care, or long-term hospitalization, the Authority shall send a *basic decision notice* to close, suspend or reduce OCCS Medical Program benefits.

(4) The Authority shall send a *basic decision notice* to close OCCS Medical Program benefits for a *beneficiary* who has received them for less than 30 days and who is ineligible for any *insurance affordability program*.

(5) When returned mail is received without a forwarding address, and the *beneficiary's* whereabouts are unknown, the Authority shall send a *basic decision notice* to end benefits if the mail was sent by regular mail. If the returned mail was sent electronically, the Authority shall resend by regular mail within three business days. The date on the notice shall be the date the notice is sent by regular mail.

(6) The Authority shall send one of the following notices when a *beneficiary* ceases to be an Oregon Resident:

(a) A timely continuing benefit notice; or

(b) A *basic decision notice* if the *beneficiary* is eligible for benefits in the other state.

(7) Except as provided in section (9) of this rule, to close medical program benefits based on a request made by the *beneficiary*, another adult member of the *household group*, or the authorized representative, the Authority shall send the following decisions notices:

(a) A *timely continuing benefit decision notice* when an oral request is made to close benefits.

(b) A *basic decision notice* when a signed, written request to withdraw, end, or reduce benefits is made.

(c) A *basic decision notice* when an oral request to withdraw an application for benefits is made.

(8) No other notice is required when an individual completes a voluntary agreement if all of the following are met:

(a) The Authority provides the individual with a copy of the completed agreement; and

(b) The Authority acts on the request by the date indicated on the form.

(9) No *decision notice* is required in the following situations:

(a) The only individual in the *household group* dies.

(b) A hearing was requested after a notice was received and either the hearing request is dismissed or a final order is issued.

(10) *Decision notices* must be written in plain language and be accessible to individuals who are limited English proficient and individuals with disabilities. In addition,

(a) All *decision notices* must include:

(A) A statement of the *action* taken.

(B) A clear statement listing the specific reasons why the decision was made and the effective date of the decision;

(C) Rules supporting the *action*;

(D) Information about the individual's right to request a hearing and the method and deadline to request a hearing; and

(E) Details about medical programs for which eligibility is not MAGI-based and information regarding how to request a determination for such programs.

(F) A statement indicating under what circumstances a default order may be taken.

(G) Information about the right to counsel at a hearing and the availability of free legal services.

(b) A *decision notice* approving OCCS Medical Program benefits, including retroactive medical, must include:

(A) The level of benefits and services approved;

(B) If applicable, information relating to premiums, enrollment fees and cost sharing; and

(C) The changes that must be reported and the process for reporting changes.

(c) A *decision notice* reducing, denying, or closing OCCS Medical Program benefits must include information about a *beneficiary*'s right to continue receiving benefits.

(11) The Authority may amend:

(a) A *decision notice* with another *decision notice*; or

(b) A contested case notice.

(12) Except as the notice is amended, or when a delay results from the client's request for a hearing, a notice to reduce or close benefits becomes void if the reduction or closure is not made effective on the date stated on the notice.

(13) The Authority must provide individuals with a choice to receive *decision notices* and information referenced in this rule in an electronic format or by regular mail. If an individual

chooses to receive notices and information electronically, and has established and online account with Cover Oregon, the Authority must:

(a) Send confirmation of this decision by regular mail;

(b) Post notices to the individual's *electronic account* within one business day of the date on the notice;

(c) Send an email or other electronic communication alerting the individual that a notice has been posted to their *electronic account*;

(d) At the request of the individual, send by regular mail any notice or information delivered electronically;

(e) Inform the individual of the right to stop receiving electronic notices and information and begin receiving these through regular mail; and

(f) If any electronic communication referenced above is undeliverable, send the notice by regular mail within three business days of the failed communication.

[Ed. Note: This rule replaces and amends information previously found in OAR 461-175-0340, 461-175-0200, 461-175-0205, 461-175-0210, 461-175-0230, 461-175-0250]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0125

Acting on Reported Changes

(1) *Redeterminations*

(a) When an OCCS Medical Program *beneficiary* or *authorized representative* makes a timely report of a change in circumstances at any time between regular *renewals* of eligibility that may affect the *beneficiary*'s eligibility, the Authority must promptly redetermine eligibility before reducing or ending medical benefits.

(b) The Authority must limit requests for information from the individual to information related to the reported change.

(c) If the Authority has enough information to determine eligibility, a new 12-month *renewal* period must be given after a *redetermination*.

(d) If the Authority has information about anticipated changes in a *beneficiary's* circumstances that may affect eligibility, it must redetermine eligibility at the appropriate time based on the changes.

(2) For beneficiaries whose eligibility was determined prior to October, 2013, changes reported in October, November or December, 2013, may result in loss of eligibility for the OCCS Medical Program using the ~~budgeting~~ policies outlined in OAR 410-200-0310. For these beneficiaries:

(a) Information used for the October, November or December 2013 *redetermination* shall be used to determine eligibility for January 1, 2014 in the MAGI Child, MAGI Parent or Other Caretaker Relative, MAGI Pregnant Woman, or MAGI Adult programs. If eligible, the effective date of eligibility for the program is January 1, 2014.

(b) If ineligible for MAGI Child, MAGI Parent or Other Caretaker Relative, MAGI Pregnant Woman, or MAGI Adult programs using information from the October, November or December 2013 *redetermination*, the applicant shall be referred to the appropriate *Agency* in accordance with OAR 410-200-0100.

(c) OCCS Medical Program benefits may not be maintained during the period of time between the loss of eligibility and the January 1, 2014, effective date, or the effective date determined by another *Agency*.

(3) For beneficiaries who ~~were receiving~~were determined eligible for OCCS Medical Program benefits prior to January 1, 2014, without using MAGI-based methodology who report changes that may affect eligibility in January, February or March, 2014:

(a) Eligibility shall be redetermined using the budgeting policies outlined in OAR 410-200-0310.

(b) If eligible for MAGI Medicaid/CHIP, *CEC*, *CEM*, *EXT* or BCCTP, a new 12 month eligibility period shall be applied.

(c) If ineligible for MAGI Medicaid/CHIP, *CEC*, *CEM*, *EXT* or BCCTP, using information gained during the January, February or March 2014 *redetermination*:

(A) Eligibility shall be maintained until April 1, 2014, or the end of the timely continuing benefits notice period, whichever is later; and

(B) The *beneficiary* shall be referred to the appropriate *Agency* in accordance with OAR 410-200-0100.

Stat. Auth.: ORS , 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0130 ~~**Effective 10/01/13**~~

Retroactive Medical

(1) The Authority may evaluate the following for retroactive medical eligibility:

(a) Applicants requesting OCCS medical programs may be evaluated for retroactive medical benefits if they have unpaid medical bills or received donated medical services in Oregon in the ~~90 days~~three months preceding the *Date of Request* which would have been covered by Medicaid/CHIP benefits.

(b) Deceased individuals who would have been eligible for Medicaid covered services had they, or someone acting on their behalf, applied.

(2) If eligible for retroactive medical, the individual's eligibility may not start earlier than the date indicated by OAR 410-200-0115 Effective Dates.

(3) The Authority reviews each month individually for retroactive medical eligibility.

(4) The Authority shall evaluate requests for retroactive medical benefits submitted prior to Jan 1, 2014 using 2013 Medicaid/CHIP eligibility requirements as outlined in OAR 410-200-0510.

(5) Retroactive Medical eligibility shall not be determined on the basis of Hospital Presumptive Eligibility (OAR 410-200-0105).

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-0875]

Stat. Auth.: ORS 411.402, 411.404, , 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 413.032, , 414.025, 414.231, 414.534, 414.536, 414.706

410-200-0135 ~~**Effective 01/01/14**~~

Assumed Eligibility and Continuous Eligibility for Children and Pregnant Women

This rule sets out when an individual is eligible for *OCCS Medicaid/CHIP* based Continuous Eligibility or being *assumed eligible* as of January 1, 2014.

(1) Assumed Eligibility

(a) A child born to a mother eligible for and receiving Medicaid benefits *is assumed eligible* for the MAGI Child program until the end of the month in which the child turns one year of age, unless:

(A) The child dies;

(B) The child is no longer a resident of Oregon; or

(C) The child's representative requests a voluntary termination of the child's eligibility.

(b) An individual is assumed eligible for the Former Foster Care Youth if they meet the eligibility criteria outlined in OAR 410-200-0406.

(2) Continuous Eligibility

(a) Children under age 19 eligible for and receiving medical assistance under any Medicaid or CHIP program who lose eligibility for the medical program prior to the 12-month renewal date shall remain eligible until the end of the renewal month, regardless of any change in circumstances, except for the following:

(A) No longer an Oregon resident;

(B) Death;

(C) Turning age 19;

(D) For children in the CHIP program, receipt of *minimum essential coverage*; or

(E) When any adult in the household group requests the medical benefits are closed.

(b) Pregnant women eligible for and receiving medical assistance under any Medicaid program who lose eligibility for the medical program are eligible for continuous eligibility through the end of the calendar month in which the 60th day following the last day of the pregnancy falls, except in the following circumstances:

(A) She is no longer an Oregon resident;

(B) Death; or

(C) She requests medical benefits are closed.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0140 ~~Effective 10/01/13~~

Eligibility for *Inmates*

(1) An *inmate* of a *public institution* is not eligible for OCCS Medical Programs.

(2) If an OCCS Medical Program *beneficiary* becomes an *inmate* of a *public institution* with an expected stay of no more than 12 months, medical benefits shall be suspended for up to 12 full calendar months during the incarceration period.

(3) Suspended benefits shall be restored to the first day the individual is no longer an *inmate*, without the need for a new application, when:

(a) The individual reports their release to the *Agency* within 10 days of the release date; or

(b) The individual reports their release to the *Agency* more than 10 days from the release date, and there is good cause for the late reporting.

(4) Benefits may be restored pursuant to section (3) if:

(a) The individual is still within their 12 month eligibility period, then the eligibility *renewal* date shall be retained; or

(b) The individual is no longer within their 12 month eligibility period, then the date that the individual reports their release shall be treated as the *Date of Request* for *redetermination* of eligibility.

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-0950]

Stat. Auth.: ORS, 411.070, 411.404, 411.816, 412.014, 412.049 413.042

Stats. Implemented: ORS, 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049, 414.426,

410-200-0145

Contested Case Appeals

(1) For the purposes of this rule, *timely* means within 90 days of the date the notice of adverse action is received.

(2) This rule applies to contested case appeals for programs described in OAR chapter 410 division 200. Contested case appeals are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following, and ORS Ch. 183, except to the extent that Authority rules provide for different procedures

(3) The Authority's contested case appeals governed by this rule are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to the parties' consent and applicable confidentiality laws.

(4~~3~~) A *claimant* may request a contested case appeal upon the timely completion of an *appeal request* in medical assistance programs in the following situations:

(a) The Authority has not approved or denied an application within 45 days of the *Date of Request* for benefits, or the extended time the Authority has allowed for processing.

(b) The Authority acts to deny, reduce, close, or suspend medical assistance, including the denial of continued benefits pending the outcome of a contested case appeal.

(c) The Authority claims that an earlier medical assistance payment was an overpayment.

(d) A *claimant* claims that the Authority previously under issued medical assistance.

(e) A *claimant* disputes the current level of benefits.

(5~~4~~) The *claimant* has the burden of proof.

(6~~5~~) An officer or employee of the Authority or the Department of Human Services may appear on behalf of the Authority in medical assistance appeals described in this rule. The Authority's lay representative may not make *legal argument* on behalf of the Authority.

(7~~6~~) The Authority representative is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available on its website at http://www.doj.state.or.us. An Authority representative appearing under this rule must read and be familiar with it.

(8~~7~~) When an Authority representative is used, requests for admission and written interrogatories are not permitted.

(9~~8~~) The Authority representative and the *claimant* may have an informal conference in order to:

(a) Provide an opportunity to settle the matter;

(b) Review the basis for the *eligibility determination*, including reviewing the rules and facts that serve as the basis or the decision;

(c) Exchange additional information that may correct any misunderstandings of the facts relevant to the *eligibility determination*; or

(d) Consider any other matters that may expedite the orderly disposition of the appeal.

(10~~9~~) A client who is receiving medical assistance benefits and who is entitled to a continuing benefit *decision notice* may, at the option of the client, receive continuing benefits in the same manner and amount until a final order resolves the contested case. In order to receive continuing benefits, a client must request an appeal not later than the later of:

(a) The tenth day following the date the notice is received; and

(b) The effective date of the *action* proposed in the notice.

(~~10~~11) The continuing benefits are subject to modification based on additional changes affecting the client's eligibility or level of benefits.

(~~11~~12) When a *claimant* contests the denial of continuing benefits, the *claimant* shall receive an *expedited appeal*.

(~~12~~13) In computing timeliness under sections (4~~3~~) and (10~~9~~) of this rule:

(a) Delay caused by good cause circumstances beyond the reasonable control of the *claimant* is not counted; and

(b) The notice is considered to be received on the fifth day after the notice is sent unless the *claimant* shows the notice was received later or was not received.

[Ed. Note This rule replaces and amends information previously found in OAR 461-025-0300, 461-025-0301, 461-025-0305, 461-025-0310, 461-025-0311, 461-025-0315, and 461-025-0325, and 461-025-0350]

Stat. Auth.: ORS, , 411.404, 411.816, 412.014, 412.049, 413.042

Stats. Implemented: ORS 183.452, , 411.060, 411.404, 411.816, 412.014, 412.049

410-200-0146

Final Orders, Dismissals, and Withdrawals

(1) When the Authority refers a contested case under chapter 410 division 200 to the Office of Administrative Hearings (OAH), the Authority must indicate on the referral:

(a) Whether the Authority is authorizing a proposed order, a proposed and final order , or a final order; and

(b) If the Authority establishes an earlier deadline for written exceptions and argument because the contested case is being referred for an *expedited appeal.*

(2) When the Authority authorizes either a proposed order or a proposed and final order:

(a) The *claimant* may file written exceptions and written argument to be considered by the Authority. The exceptions and argument must be received at the location indicated in the OAH order not later than the 20th day after service of the proposed order or proposed and final order, unless subsection (1)(b) of this rule applies.

(b) Proposed Orders. After OAH issues a proposed order, the Authority shall issue the final order, unless the Authority requests that OAH issue the final order pursuant to OAR 137-003-0655.

(c) Proposed and Final Orders. If the *claimant* does not submit timely exceptions or argument following a proposed and final order, the proposed and final order becomes a final order on the 21st day after service of the proposed and final order unless:

(A) The Authority has issued a revised order; or

(B) Has notified the *claimant* and OAH that the Authority shall issue the final order.

(d) When the Authority receives timely exceptions or argument, the Authority shall issue the final order, unless the Authority requests that OAH issue the final order.

(3) In a contested case appeal if the OAH is authorized to issue a final order on behalf of the Authority, the Authority may issue the final order in the case of default.

(4) A petition by a *claimant* for reconsideration or rehearing must be filed with the individual who signed the final order, unless stated otherwise on the final order.

(5) A final order is effective immediately upon being signed or as otherwise provided in the order. Delay due to a postponement or continuance granted at the *claimant*'s request shall not

be counted in computing time limits for a final order. A final order shall be issued or the case otherwise resolved no later than:

(a) 90 days following the date of the appeal for the standard appeal time frame.

(b) 3 working days after the date the OAH hears an *expedited appeal.*

(6) In the event a request for appeal is not timely or the *claimant* has no right to a contested case appeal on an issue, and there are no factual disputes about whether this division of rules provides a right to an appeal, the Authority may issue an order accordingly. The Authority may refer an untimely request to the OAH for an appeal on timeliness or on the question of whether the *claimant* has the right to a contested case appeal.

(7) When the Authority receives an *appeal request* that is not filed within 90 days of the date of the *decision notice* but is filed within 75 days after a *decision notice* has become a final order:

(a) The Authority may refer the *appeal request* to the OAH for a contested case appeal on the merits of the Authority's *action* described in the notice:

(A) If the Authority finds that the *claimant* and *claimant*'s representative did not receive the *decision notice* and did not have actual knowledge of the notice; or

(B) If the Authority finds that the *claimant* did not meet the timeframe required by OAR 410-200-0145(5) due to excusable mistake or neglect, which may be due to significant cognitive or health issues, reasonable reliance on the statement of an Agency employee relating to procedural requirements, or due to misrepresentation or other misconduct of the Agency.

(b) The Authority may dismiss an *appeal request* if it finds it is untimely if the *claimant* does not qualify for an appeal under subsection (7)(a).

(8) When the Authority receives an *appeal request* more than 75 days after a *decision notice* became a final order:

(a) For an overpayment notice:

(A) The Authority shall verify whether its records indicate that the liable adult requesting the appeal was sent the overpayment notice to the address known to the Agency.

(B) If no overpayment notice was sent to the liable adult, the overpayment *appeal request* is timely. The Authority shall send the *claimant* a *decision notice* or a contested case notice.

(C) If the Authority determines that an overpayment notice was sent to the liable adult at the last address known to the Agency, there is no appeal right based on the issue of whether or not the *appeal request* was received timely.

(b) Any *appeal request* is treated as timely when required under the Servicemembers Civil Relief Act.

(c) The Authority may dismiss an *appeal request* as untimely if the *claimant* does not qualify for an appeal under subsections 8(a) and (b).

(9) A *claimant* may withdraw an *appeal request* at any time before a final order has been issued on the contested case. When a *claimant* withdraws an *appeal request*:

(a) The Authority shall send an order confirming the withdrawal to the *claimant*'s last known address.

(b) The *claimant* may cancel the withdrawal in writing. The withdrawal must be received by the Authority hearing representative no later than the tenth working day following the date the Authority sent the order confirming the withdrawal.

(10) An *appeal request* is dismissed by order by default when neither the *claimant* nor the *claimant*'s representative appears at the time and place specified for the appeal. The order is effective on the date scheduled for the appeal. The Authority shall cancel the dismissal order on request of the *claimant* on a showing that the *claimant* was unable to attend the appeal and unable to request a postponement for good cause reasons beyond his or her control.

[Ed. Note This rule replaces and amends information previously found in OAR 461-025-0310, 461-025-0350, 461-025-0356, 461-025-0371, 461-025-0375]

Stat. Auth.: ORS 183.341, 413.042, 411.060, 411.404, 411.408, 411.816, 412.014, 412.049

Stats. Implemented: ORS 183.341, 411.060, 411.404, 411.408, 411.816, 412.014, 412.049

410-200-0200

Residency Requirements

(1) To be eligible for OCCS Medical Programs, an individual must be a resident of Oregon.

(2) An individual is a resident of Oregon if the individual lives in Oregon, except:

(a) An individual 21 years of age or older who is placed in a medical facility in Oregon by another state is considered to be a resident of the state that makes the placement if:

(A) The individual is capable of indicating intent to reside; or

(B) The individual became incapable of indicating intent to reside after attaining 21 years of age (see section (6)).

(b) For an individual less than 21 years of age who is incapable of indicating intent to reside, or an individual of any age who became incapable of indicating that intent before attaining 21 years of age, the state of residence is one of the following:

(A) The state of residence of the individual's *parent* or legal guardian at the time of application.

(B) The state of residence of the party who applies for benefits on the individual's behalf if there is no living *parent* or the location of the *parent* is unknown, and there is no legal guardian.

(C) Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981, or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

(D) When a state agency of another state places the individual, the individual is considered to be a resident of the state that makes the placement.

(3) There is no minimum amount of time an individual must live in Oregon to be a resident. The individual is a resident of Oregon if:

(a) The individual intends to remain in Oregon; or

(b) The individual entered Oregon with a job commitment or is looking for work.

(4) An individual is not a resident if the individual is in Oregon solely for a vacation.

(5) An individual continues to be a resident of Oregon during a temporary period of absence if he or she intends to return when the purpose of the absence is completed.

(6) An individual is presumed to be incapable of indicating intent to reside if the individual falls under one or more of the following:

(a) The individual is assessed with an IQ of 49 or less, based on a test acceptable to the Authority.

(b) The individual has a mental age of seven years or less, based on tests acceptable to the Authority.

(c) The individual is judged legally incompetent by a court of competent jurisdiction.

(d) The individual is found incapable of indicating intent to reside based on documentation provided by a physician, psychologist, or other professional licensed by the state of Oregon in the field of intellectual disabilities.

[Ed. Note This rule replaces and amends information previously found in OAR 461-120-0010]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0205

Concurrent and Duplicate Program Benefits

(1) An individual receiving OCCS Medical Program benefits may not receive the following medical benefits at the same time:

(a) Any other OCCS Medical Program;

(b) Office of Child Welfare Medical;

(c) Oregon Youth Authority Medical;

(d) Oregon Supplemental Income Program-Medical (*OSIPM*); or

(e) Refugee Medical Assistance (REFM).

(f) A subsidy through the Family Health Insurance Assistance Program (FHIAP) established by ORS 735.720 to 735.740, or receiving a subsidy through the Office of Private Health Partnerships (OPHP) in accordance with ORS 414.826, 414.831, and 414.839.

(2) An individual may not receive OCCS Medical Program benefits and medical benefits from another state, unless the individual's provider refuses to submit a bill to the Medicaid/CHIP agency of the other state and the individual would not otherwise receive medical care.

[Ed. Note This rule replaces and amends information previously found in OAR 461-165-0030]

Stat. Auth.: ORS 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0210

Requirement to Provide Social Security Number

(1) The *Agency* may collect a Social Security Number (SSN) for the following purposes:

(a) The determination of eligibility for benefits. The SSN is used to verify income and other assets and to match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, child support, Social Security benefits, and unemployment benefits.

(b) The preparation of aggregate information and reports requested by funding sources for the program providing benefits.

(c) The operation of the program applied for or providing benefits.

(d) Conducting quality assessment and improvement activities.

(e) Verifying the correct amount of payments, recovering overpaid benefits, and identifying any individual receiving benefits in more than one household.

(2) As a condition of eligibility, except as provided in section (5) below, each applicant (including children) requesting medical benefits must:

(a) Provide a valid SSN; or

(b) Apply for an SSN if the individual does not have one and provide the SSN when it is received.

(3) Except as provided in section (5) below, if an applicant does not recall their SSN or has not been issued an SSN, and the SSN is not available to the *Agency*, the *Agency* must:

(a) Obtain required evidence under *SSA* regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and

(b) Either assist the applicant in completing an application for an SSN or, if there is evidence that the applicant has previously been issued an SSN, request *SSA* to furnish the number.

(4) The *Agency* may request that *non-applicants* or individuals determined eligible for *CAWEM* or *CAWEM Prenatal* provide an SSN on a voluntary basis. The *Agency* shall use the SSN for the purposes outlined in section (1).

(5) An applicant is not required to apply for or provide an SSN if the individual:

(a) Is determined eligible for *CAWEM* or *CAWEM Prenatal* medical; or

(b) Does not have an SSN and the SSN may be issued only for a valid-non-work reason; or

(c) Is a member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950 and the individual adheres to its tenets or teachings that prohibit applying for or using an SSN; or

(d) Is a newborn that is assumed eligible based on the eligibility of the mother of the newborn and who is under one year of age.

[Ed. Note This rule replaces and amends information previously found in OAR 461-120-0210]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.534, 414.536, 414.706

410-200-0215

Citizenship and Alien Status Requirements

(1) Except as provided in section (2) of this rule, to be a *beneficiary* of a medical program an individual must be:

(a) A citizen of the United States;

(b) A *qualified non-citizen* who meets the alien status requirements in section (3) of this rule;

(c) A citizen of Puerto Rico, Guam, the Virgin Islands or Saipan, Tinian, Rota or Pagan of the Northern Mariana Islands; or

(d) A national from American Samoa or Swains Islands

(2) To be eligible for *CAWEM* benefits, an individual must be ineligible for a Medicaid program solely because he or she does not meet citizenship or alien status requirements set forth in this rule.

(3) An individual is a *qualified non-citizen* if the individual is any of the following:

(a) A *non-citizen* lawfully admitted for permanent residence under the INA (8 U.S.C. 1101 et seq);

(b) A refugee admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A *non-citizen* granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A *non-citizen* whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1253(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 1231(b)(3)) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A *non-citizen* paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A *non-citizen* granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980;

(g) A *non-citizen* who is a Cuban and Haitian entrant (as defined in section 501(3) of the Refugee Education Assistance Act of 1980);

(h) An Afghan or Iraqi alien granted Special Immigration Status (SIV) under section 101(a)(27) of the INA; or

(i) A battered *spouse* or *dependent child* who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the U.S. Citizenship and Immigration Services.

(4) A *qualified non-citizen* meets the alien status requirements if the individual satisfies one of the following requirements:

(a) Effective October 1, 2009, is an individual under 19 years of age.

(b) Was a *qualified non-citizen* before August 22, 1996.

(c) Physically entered the United States before August 22, 1996, and was continuously present in the United States between August 22, 1996, and the date *qualified non-citizen* status was obtained. An individual is not continuously present in the United States if the individual is absent from the United States for more than 30 consecutive

days or a total of more than 90 days between August 22, 1996 and the date *qualified non-citizen* status was obtained.

(d) Has been granted any of the following alien statuses:

(A) Refugee under section 207 of the INA.

(B) Asylum under section 208 of the INA.

(C) Deportation being withheld under section 243(h) of the INA.

(D) Cubans and Haitians who are either public interest or humanitarian parolees.

(E) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988.

(F) A "victim of a severe form of trafficking in persons" certified under the Victims of Trafficking and Violence Protection Act of 2000 (22 U.S.C. 7101 to 7112.

(G) A family member of a victim of a severe form of trafficking in persons who holds a visa for family members authorized by the Trafficking Victims Protection Reauthorization Act of 2003 (22 U.S.C. 7101 to 7112).

(H) An Iraqi or Afghan alien granted special immigrant status (SIV) under section 101(a)(27) of the INA.

(e) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) (8 U.S.C. 1359) apply.

(f) A member of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).

(g) A veteran of the United States Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty service requirements described in 38 U.S.C. 5303A(d).

(h) A member of the United States Armed Forces on active duty (other than active duty for training).

(i) The *spouse* or a *dependent child* of an individual described in subsection (f) or (g) of this section.

(5) A *non-citizen* meets the alien status requirements if the individual is under the age of 19 and is one of the following:

(a) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.

(b) An individual described in 8 CFR section 103.12(a)(4) who belongs to one of the following classes of aliens permitted to remain in the United States because the Attorney General has decided for humanitarian or other public policy reasons not to initiate deportation or exclusion proceedings or enforce departure:

(A) An alien currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);

(B) An alien currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 USC 1229b);

(C) Cuban-Haitian entrants, as defined in section 202(b) Pub. L. 99–603 (8 USC 1255a), as amended;

(D) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649 (8 USC 1255a), as amended;

(E) An alien currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(F) An alien currently in deferred *action* status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a)(22); or

(G) An alien who is the *spouse* or child of a United States citizen whose visa petition has been approved and who has a pending application for adjustment of status.

(c) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including those individuals as specified in section 101(a)(15) of the INA (8 USC 1101).

(6) Except for individuals described in section (4) of this rule, a *non-citizen* who entered the United States or was given *qualified non-citizen* status on or after August 22, 1996:

(a) Is ineligible an OCCS Medical Program for five years beginning on the date the *non-citizen* received *qualified non-citizen* status.

(b) Meets the alien status requirement following the five-year period.

[Ed. Note This rule replaces and amends information previously found in OAR 461-120-0110, 461-120-0125]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536, 414.706

410-200-0220

Requirement to Pursue Assets

(1) As a condition of ongoing eligibility an applicant or *beneficiary* must make a good faith effort to obtain an asset to which they have a legal right or claim, except an applicant or *beneficiary* is not required to:

(a) Apply for Supplemental Security Income (SSI) from the Social Security Administration.

(b) Borrow money.

(c) Make a good faith effort to obtain such asset if the individual can show good cause for not doing so (see section (4).

(2) Pursuable assets include but are not limited to:

(a) Claims related to an injury;

(b) Disability benefits;

(c) Healthcare coverage;

(d) Retirement benefits;

(e) Survivorship benefits;

(f) Unemployment compensation; and

(g) Veteran's compensation and pensions.

(3) Except for beneficiaries in the *OHP-CHP* or MAGI CHIP programs, *caretakers* must obtain available health insurance coverage and cash medical support for *household group* members receiving medical assistance.

(a) Each *caretaker* in the *household group* must assist the *Agency* and the Division of Child Support (DCS) in establishing paternity for each child receiving medical assistance and in obtaining an order directing the non-custodial *parent* of a child receiving benefits to provide cash medical support and health care coverage for that child.

(b) A *parent* receiving medical assistance who fails to meet the requirements of section (3) (a) is applied the penalty identified in section (3) (e) or section (3) (f) after providing the *beneficiary* with notice and opportunity to show the provisions of section (4) of this rule apply.

(c) Each applicant, including a *parent* for their child, must make a good faith effort to obtain available coverage under Medicare. The Authority may not penalize children for non-cooperation.

(d) With the exception of *OHP-CHP*, MAGI CHIP, and *OHP-OPU*, *caretakers* who are OCCS Medical Program beneficiaries must apply for, accept, and maintain cost-effective employer-sponsored health insurance as set forth in OAR 461-155-0360, unless they have good cause.

(e) For *MAA*, *MAF*, *EXT*, *CEM*, and *SAC* medical programs, a *parent* who fails to meet the requirements of section (3) is excluded from the *family size*.

(f) With the exception of *OHP-CHP*, MAGI-CHIP, ~~*HKC*,~~ and *CEC*, a *parent* of a child receiving OCCS Medical Program benefits who fails to meet the requirements of section (3) is ineligible for assistance.

(4) Section (3) of this rule does not apply to individuals when:

(a) The individual's compliance would result in emotional or physical harm to the *dependent child* or to the *caretaker*. The statement of the *caretaker* serves as prima facie evidence that harm would result;

(b) The child was conceived as a result of incest or rape and efforts to obtain support would be detrimental to the *dependent child*. The statement of the *caretaker* serves as prima facie evidence on the issues of conception and detrimental effect to the *dependent child*;

(c) Legal proceedings are pending for adoption of the child;

(d) The *parent* is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption;

(e) The individual is pregnant; or

(f) Other good cause reasons exist for noncooperation.

(5) An individual involved in a personal injury must pursue a *claim* for the personal injury. If the *claim* or *action* to enforce such *claim* was initiated prior to the application for medical assistance, the individual must notify the *Agency* during the eligibility verification process (see OAR 410-200-0230 Verification). The following information is required:

(a) The names and addresses of all parties against whom the *action* is brought or *claim* is made;

(b) A copy of each *claim* demand; and

(c) If an *action* is brought, the case number and the county where the *action* is filed.

(6) Unless specified otherwise in this rule, an individual who fails to comply with the requirements of this rule is ineligible for benefits until the individual meets the requirements of this rule.

[Ed. Note This rule replaces and amends information previously found in OAR 461-120-0330, 461-120-0345, 461-120-0350, 461-155-0360 (reference), 461-195-0303, 461-195-0310]

Stat. Auth.: ORS 411.402, 411.404, 413.0042,

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 413.032, , 414.025, 414.231, 414.706

410-200-0225

Assignment of Rights

(1) The signature of the *applicant* or *authorized representative* on the application for assistance signifies the *applicant*'s agreement to assign the rights to reimbursement for medical care costs to the *Agency*.

(2) As a condition of eligibility, each *applicant* must:

(a) Assign to the *Agency* any rights of each *household group* member receiving benefits to reimbursement for medical care costs to the *Agency* including any third party

payments for medical care and any medical care support available under an order of a court or an administrative agency.

(b) Assign to the *Agency* any rights to payment for medical care from any third party and, once they receive assistance, to assist the *Agency* in pursuing any third party who may be liable for medical care or services paid by the *Agency*, including health services paid for pursuant to ORS 414.706 to 414.750 as set forth in OAR 410-200-0220, 461-195-0303 and 461-195-0310.

(c) Unless good cause exists as established in OAR 410-200-0220 (Requirement to Pursue Assets), failure to assign the right to reimbursement for medical care costs to the *Agency* shall result in ineligibility for the *household group* until the requirements of this rule are met.

(3) Except for the *OHP-OPU, OHP-CHP*, and MAGI CHIP programs:

(a) An *applicant* must assign to the state the right of any Medicaid-eligible individual in the *household group* to receive any cash medical support that accrues while the individual receives assistance, not to exceed the total amount of assistance paid; and

(b) Cash medical support received by the *Agency* shall be retained as necessary to reimburse the *Agency* for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed.

[Ed. Note This rule replaces and amends information previously found in OAR 461-120-0315, 461-120-0310, 461-195-0303, 461-195-0310]

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, , 414.025, 414.231, 414.706

410-200-0230

Verification

(1) Except as described in section (5) of this rule, *applicants*, beneficiaries, or individuals of *applicant* or *beneficiary*'s choosing ~~who apply in a way that allows for real-time eligibility determination, may~~must attest to the following information~~without further verification:~~:

(a) Age and date of birth;

(b) Application for other benefits;

(c) *Caretaker relative* status;

(d) Household composition;

(e) Legal name;

(f) Medicare;

(g) Pregnancy;

(h) Residency; ~~and~~

(i) Social Security number; and~~.~~

(j) American Indian/Alaska Native status.

~~(2) The *Authority* may verify information attested by the individual usingvailable electronic data~~

(2~~3~~) Except as provided in section (2~~3~~)(c), *applicants*, *beneficiaries*, or individuals of *applicant* or *beneficiary*'s choosing must make a declaration of citizenship, national status, or *non-citizen* status.

(a) Self-attestation shall be accepted upon receipt and verified post-eligibility *via the federal data services hub* or by ~~documentary evidence through a match with available~~ electronic data match available to the *Agency*; or

(b) In the event additional verification is needed, the Authority shall provide a *reasonable opportunity period* to verify citizenship and non-citizen status.

(c) The following are exempt from the requirement to verify citizenship ~~or *non-citizen*~~ status:

(A) Individuals who are assumed eligible (see OAR 410-200-0135);

(B) Individuals who are enrolled in Medicare;

(C) Individuals who are presumptively eligible for the BCCTP Program through the BCCTP screening program or through the Hospital Presumptive Medical process (see OAR 4~~61~~420-200-0400 and 410-200-0105);

(D) Individuals receiving Social Security Disability Income (SSDI); or

(E) Individuals whose citizen status was previously documented by the *Agency*. ~~have previously verified citizenship or *non-citizen* status with the *Agency*.~~ The

Agency may not re-verify or require an individual to re-verify citizenship at a *renewal* of eligibility or subsequent application following a break in coverage.

(~~4~~3) *Applicants*, *beneficiaries*, or individuals of the *applicant* or *beneficiary*'s choosing ~~must provide income information:~~

~~(a) Individuals who apply in a way that allows for real-time eligibility determination~~ must make a declaration of income:

(a) For individuals whose eligibility is able to be verified using the *federal data services hub*, self-attestation shall be ~~be accepted upon receipt~~used to approve MAGI-based Medicaid/CHIP, and:

(A) Verified ~~post-*eligibility determination*~~ by documentary evidence through a match with available electronic data; or

(B) In the event that additional verification is needed, the Authority shall provide a *post eligibility pend period* ~~reasonable opportunity period~~ to verify ~~their~~ income information.

(b) Individuals ~~who apply in a way that does not allow for~~whose eligibility is not able to be verified using the *federal data services hub* ~~real-time eligibility determination~~ must have their ~~eligibility~~ income information verified prior to eligibility determination:

(A) Using ~~available~~ electronic data match available to the *Agency*; or

(B) By providing verification of information to the *Agency*.

(c) In the event that verification is not available via the *federal data services hub*, electronic data match available to the *Agency*, or by any other method, the attested information will be accepted to determine eligibility.

(d) In the event that income verification via the *federal data services hub* or electronic data match available to the *Agency* is inconsistent with attested information:

(A) If the individual attests to income below the applicable standard, and the data source indicates income above the applicable standard, verification or reasonable explanation will be requested from the individual.

(B) If both the data source and attested information are below the applicable standard, the applicant is eligible for MAGI-based Medicaid/CHIP.

(C) If the individual's attested information is above the applicable standard, but the data source verification is below the standard, the *Agency* will accept the attestation, deny MAGI-based Medicaid/CHIP, and screen for potential APTC eligibility.

(4) Additional income verifications for MAGI-based Medicaid/CHIP program approvals will occur during a 90-day look-back process that will review income information used to determine eligibility using income data sources available to the *Agency*. After the 90-day look-back analysis, the results of a quarterly match against Employment Department wage data will be reviewed as it becomes available. If necessary, documentation may be required per section (5).

(5) The Authority may request that *applicants* and *beneficiaries* ~~for~~ of medical assistance provide additional information, including documentation, to verify most eligibility criteria if data obtained electronically is not reasonably compatible with attested information.

[Ed. Note This rule replaces and amends information previously found in OAR 461-115-0610 and 461-115-0705]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0235

Changes that must be reported

(1) Individuals must report the following changes in circumstances affecting eligibility for beneficiaries within 30 calendar days of its occurrence:

(a) The receipt or loss of health care coverage.

(b) A change in mailing address or residence.

(c) A change in legal name.

(d) A change in pregnancy status of a *household group* member.

(e) A *claim* for a personal injury. The following information must be reported :

(A) The names and addresses of all parties against whom the *action* is brought or *claim* is made;

(B) A copy of each *claim* demand; and

(C) If an *action* is brought, identification of the case number and the county where the *action* is filed.

(f) In addition to section (1) (a) – (e), in the *EXT* program, when a *household group* member receiving medical assistance is no longer a *dependent child*.

(g) In addition to section (1) (a) – (e), in the *OHP*, ~~*HKC*,~~ and MAGI CHIP programs, a change in availability of employer-sponsored health insurance.

(h) In addition to section (1) (a) – (e), adults in the *MAA*, *MAF*, *SAC*, *EXT*, BCCTP~~, MAGI SAC~~, MAGI Pregnant Woman, MAGI Parent or Other Caretaker Relative~~, MAGI Child~~, and MAGI Adult programs:

(A) A change in source of income.

(B) A change in employment status.

(i) For a new job, the change occurs the first day of the new job.

(ii) For a job separation, the change occurs on the last day of employment.

(C) A change in earned income more than $100. The change occurs upon the receipt by the *beneficiary* of the first paycheck from a new job or the first paycheck reflecting a new rate of pay.

(D) A change in unearned income more than $50. The change occurs the day the *beneficiary* receives the new or changed payment.

(E) A change in membership of the *household group*.

(F) A change in availability of employer-sponsored health insurance.

(i) In addition to section (1) (a) – (e), beneficiaries of the MAGI Child program:

(A) A change in membership of the *household group*.

(B) A change in availability of employer-sponsored health insurance.

(2) Beneficiaries, adult members of the *household group*, or *authorized representatives* may report changes via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.

(3) A change is considered reported on the date the *beneficiary*, adult member of the *household group*, or *authorized representative* reports the information to the *Agency*.

(4) A change reported by the *beneficiary*, adult member of the *household group*, or *authorized representative* for one program is considered reported for all programs administered by the *Agency* in which the *beneficiary* participates.

(5) Beneficiaries, adult members of the *household group*, or *authorized representatives* are not required to report any of the following changes:

(a) Periodic cost-of-living adjustments to the federal Black Lung Program, SSB, SSDI, SSI, and veterans assistance under Title 38 of the United States *Code*.

(b) Changes in eligibility criteria based on legislative or regulatory *actions*.

[Ed. Note This rule replaces and amends information previously found in OAR 461-105-0020; 461-170-0010; 461-170-0011; 461-170-0200; 461-195-0305; 461-195-0310; 461-195-0321]

Stat. Auth.: ORS 411.402, 411.404, 413.042, , 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

410-200-0240

Citizen/Alien Waived Emergent Medical

(1) To be eligible for *CAWEM* benefits, an individual must be ineligible for *OCCS Medical Programs*, solely because he or she does not meet the citizen or alien status requirements. A child who is ineligible for *OHP-CHP*, MAGI CHIP, *CEM*, or *CEC* solely because he or she does not meet the citizen or alien status requirements is not eligible for *CAWEM* benefits.

(2) To be eligible for the *CAWEM Prenatal* enhanced benefit package, a *CAWEM* recipient must be pregnant.

(3) The pregnant *CAWEM* client's enhanced medical benefits package ends when the pregnancy ends.

(4) The woman remains eligible for *CAWEM* emergent benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.025, 414.534,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706, 411.060

410-200-0305

Household Group - Modified Adjusted Gross Income (MAGI) based Medicaid and CHIP

When establishing eligibility for MAGI-based Medicaid or MAGI CHIP, each *applicant* or *beneficiary* must have their own countable *household group* determined individually, based on the following *household group* rules:

(1) Tax Payer's *Household group*:

(a) For tax-payers who are not claimed as a *tax dependent* by another individual, the *household group* consists of the taxpayer and all individuals whom the tax payer intends to claim as *tax dependents*.

(b) For tax-payers who are married and living with their *spouse*, each *spouse* shall be included in the *household group* of the other *spouse*, whether they file taxes together or separately.

(2) *Tax dependent's Household group*:

(a) In the case of an individual who expects to be claimed as a *tax dependent* by another individual, the *household group* is that of the individual claiming the *tax dependent*; or

(b) *Household group* is determined under section (3) of this rule, where the *tax dependent*:

(A) Is not the tax payer's *spouse* or *child*;

(B) Is a *child* living with both *parents* but the *parents* are not filing taxes jointly and one of the *parents* is claiming the *child* as a *tax dependent*; or

(C) Is a *child* claimed as a *tax dependent* by a non-custodial *parent*.

(3) The *household group* for a *tax dependent* who meets the criteria in section (2)(b) consists of the *tax dependent* and the following individuals, if living in the same household:

(a) The *tax dependent's spouse*;

(b) The *tax dependent's* children;

(c) If the *tax dependent* is a *child*, the *child's parents* and *siblings*.

(4) For individuals who do not file a tax return and are not claimed as a *tax dependent*, the individual's *household group* is determined in accordance with section (3).

(5) Notwithstanding the above sections, the *household group* for an inmate who becomes hospitalized as a patient consists of only the individual.

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.706

410-200-0310

Eligibility and Budgeting; MAGI Medicaid/CHIP; Not BCCTP or *EXT*

(1) The *budget month* means the calendar month from which nonfinancial and financial information is used to determine eligibility for *OCCS Medical Programs*.

(2) The *budget month* is determined as follows:

(a) For a new *applicant*, the *budget month* is:

(A) The month in which medical assistance is requested; or

(B) If ineligible in the month in which medical assistance is requested, the *budget month* is the following month.

(b) For a current Medicaid/CHIP *beneficiary*, the *budget month* is:

(A) The final month of the twelve-month enrollment period;

(B) The month a change that affects eligibility is reported, if reported timely; or

(C) The month the individual ages off a medical program or is no longer eligible for a medical assistance program.

(c) For retroactive medical, the *budget month* is the month in which the *applicant* received medical services for which they are requesting payment. Retroactive medical is determined on a month-by-month basis.

(3) Countable income anticipated or received in the *budget month* is determined as follows:

(a) Income is calculated by adding together the income of the *household group* already received in the *budget month*, and the income that is reasonably expected to be received in the remainder of the *budget month*.

(b) If ineligible in the *budget month*, countable income from the month following the *budget month* is considered.

(c) If ineligible under subsections (a) or (b) of this section because the countable income is over the income standard for *OCCS Medical Programs*, income shall be annualized using the requirements in 26 CFR §1.36 B-1(e) for the year in which medical has been requested, and applied to the *budget month*. If the annualized income is below 100% *FPL* as identified in 26 CFR §1.36 B-1(e), eligibility shall be determined for the appropriate program pursuant to OAR 410-200-0315.

(4) The *household group*'s *budget month* income is compared to the income standard for the appropriate *family size* to determine if an *applicant* may be eligible for an *OCCS Medical Program*.

[Ed. Note This rule replaces and amends information previously found in OAR 461-150-0055, 461-155-0060, 461-150-0070]

Stat. Auth.: ORS 411.402, 411.404, 413.042, ,

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, , 414.025, 414.231, 414.440, 414.706

410-200-0315

Standards and Determining Income Eligibility

(1) *MAGI-based income* not specifically excluded is countable, and its value is used in determining the eligibility and benefit level of an *applicant* or *beneficiary*.

(2) *MAGI-based income* is considered available on the date it is received or the date a member of the *household group* has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows:

(a) Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend.

(b) Income withheld or diverted at the request of an individual is considered available on the date the income would have been paid without the withholding or diversion.

(c) An advance or draw of earned income is considered available on the date it is received.

(3) In determining financial eligibility for each *applicant*, the sum of the *budget month MAGI-based income* of all *household group* members is combined and compared to the applicable income standard for the *family size*. If the income is at or below the *MAGI income standard*, the individual meets the financial eligibility requirements. Except as provided in section (4)(a), if income exceeds the *MAGI income standard*, the individual is ineligible.

(4) This section is effective January 1, 2014:

(a) If an individual is ineligible for MAGI Medicaid based solely on income, and would otherwise be eligible for MAGI CHIP or be referred to the Exchange for *APTC*, a disregard equivalent to 5 percentage points of the *federal poverty level* for the applicable *family size* shall be applied the *household group*'s income. If the resulting amount is below the income standard for the applicable program and *family size*, the individual meets the financial eligibility requirements in the following programs:

(A) The MAGI Parent or Other Caretaker Relative Program,

(B) The MAGI Child Program,

(C) The MAGI Adult Program, and

(D) The MAGI Pregnant Woman Program

(b) If an individual is ineligible for MAGI CHIP based solely on income, and would otherwise be referred to the Exchange for *APTC*, a disregard equivalent to 5 percentage points of the *federal poverty level* for the applicable *family size* shall be applied the *household group*'s income. If the resulting amount is below the income standard for the applicable program and *family size*, the individual meets the financial eligibility requirements in the MAGI CHIP.

(c) The *MAGI income standard* for the MAGI Parent or Other Caretaker-Relative program is set as follows:

Family size	Standard	If Income Exceeds Standard, for Individuals who are 65+ and Ineligible for Medicare	Income Prior to Applying Disregard
1	$399	$48	$447
2	515	65	580

3	611	82	693
4	747	99	846
5	872	115	987
6	998	132	1,130
7	1,114	149	1,263
8	1,230	166	1,396
9	1,321	182	1,503
10	1,456	199	1,655
+1	+136	+17	+153

(d) The *MAGI income standard* for the MAGI Child Program and the MAGI Adult Program is set at 133% of the *FPL* as follows. If an individual's *household group* income exceeds the income standard for their *family size*, the appropriate disregard for their *family size* described in section (4)(a) shall be applied:

Family size	Standard 133%	If income Exceeds 133%, Disregard	Income Prior to Applying Disregard
1	$1,274	$48	$1,322
2	1,720	65	1,785
3	2,165	82	2,247
4	2,611	99	2,710
5	3,056	115	3,171
6	3,502	132	3,634
7	3,947	149	4,096
8	4,393	166	4,559

9	4,838	182	5,020
10	5,284	199	5,483
+1	+446	17	+463

(e) The *MAGI income standard* for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under age one is set at 185% *FPL*. If an individual's *household group* income exceeds the income standard for their *family size*, the appropriate disregard for their *family size* described in section (4)(a) shall be applied:

Family size	Standard 185%	If income Exceeds 185%, Disregard	Income Prior to Applying Disregard
1	$1,772	$48	$1,820
2	2,392	65	2,457
3	3,011	82	3,093
4	3,631	99	3,730
5	4,251	115	4,366
6	4,871	132	5,003
7	5,490	149	5,639
8	6,110	166	6,276
9	6,730	182	6,912
10	7,350	199	7,549
+1	+620	17	637

(f) The *MAGI income standard* for the MAGI CHIP program is set through 300% of *FPL* as follows. If a *child's household group* income exceeds the income standard for their *family size*, and the *child* would be otherwise ineligible for MAGI CHIP, the appropriate disregard for their *family size* described in section (5)(a)(B) shall be applied:

Family size	Standard 300%	If Income Exceeds 300%, Disregard	Income Prior to Applying Disregard
1	$2,874	$48	$2,922
2	3,879	65	3,944
3	4,884	82	4,966
4	5,889	99	5,988
5	6,894	115	7,009
6	7,899	132	8,031
7	8,904	149	9,053
8	9,909	166	10,075
9	10,914	182	11,096
10	11,919	199	12,118
+1	1,005	17	1,022

(5) Effective October 1, 2013 through December 31, 2013, the *MAGI income standards* listed in this section are used.

(a) Individuals who apply from October 1, 2013 through December 31, 2013 shall first be considered for the programs described in OAR 410-200-0510. Individuals found ineligible based on information from all *budget months* of October, November, or December 2013 shall have their eligibility determined as follows:

(A) For individuals who would be eligible for programs based on eligibility and income standards found in section (4)(c) through (e) as of January 1, 2014, eligibility for the applicable program shall begin as of that date.

(B) For individuals who are ineligible for programs which begin on January 1, 2014 who would otherwise be eligible for MAGI CHIP or be referred to the Exchange for *APTC* as of January 1, 2014, a disregard equivalent to 5 percentage

points of the *federal poverty level* for the applicable *family size* will be applied the *household group*'s income. If the resulting amount is below the January 1, 2014 income standard found in section (4)(c) through (e) for the applicable program and *family size*, the individual meets the financial eligibility requirements for MAGI Medicaid/CHIP.

(b) The *MAGI-based income* standard for the *MAA* and ~~MAGI~~SAC programs is as follows. If a *child*'s *household group* income exceeds the income standard for their *family size*, and the *child* would be otherwise ineligible for Medicaid, the appropriate disregard for their *family size* described in section (5)(a)(B) shall be applied:

Family size	**Standard**	**If *child*'s *household group* is over the *MAA* income limit and *child* is otherwise ineligible for Medicaid, Disregard**	**Income Prior to Applying Disregard**
1	$399	$48	$447
2	515	65	580
3	611	82	693
4	747	99	846
5	872	115	987
6	998	132	1,130
7	1,114	149	1,263
8	1,230	166	1,396
9	1,321	182	1,503
10	1,456	199	1,655
+1	136	17	153

(c) The *MAGI-based income* standard for the *OHP-OPU* program is set at 100 percent of the *federal poverty level*:

Family size	Standard 100%
1	$958
2	1,293
3	1,628
4	1,963
5	2,298
6	2,633
7	2,968
8	3,303
9	3,638
10	3,973
+1	+335

(d) The *MAGI-based income* standard for the *OHP-OPC* program is set to 100 percent of the *federal poverty level*. If a *child's household group* income exceeds the income standard for their *family size*, and the *child* would be otherwise ineligible for Medicaid, the appropriate disregard for their *family size* described in section (5)(a)(B) shall be applied:

Family size	Standard 100%	If *child's household group* income exceeds 100% and *child* would otherwise be ineligible for Medicaid, Disregard	Income Prior to Applying Disregard
1	$958	$48	$1,006

2	1,293	65	1,358
3	1,628	82	1,710
4	1,963	99	2,062
5	2,298	115	2,413
6	2,633	132	2,765
7	2,968	149	3,117
8	3,303	166	3,469
9	3,638	182	3,820
10	3,973	199	4,172
+1	+335	17	352

(e) The *MAGI-based income* standard for the *OHP-OP6* program is set at 133 percent of the *federal poverty level*. If a *child's household group* income exceeds the income standard for their *family size*, and the *child* would be otherwise ineligible for Medicaid, the appropriate disregard for their *family size* described in section (5)(a)(B) shall be applied:

Family size	**Standard 133%**	**If a *child's household group* income exceeds 133%, Disregard**	**Income Prior to Applying Disregard**
1	$1,274	$48	$1,322
2	1,720	65	1,785
3	2,165	82	2,247
4	2,611	99	2,710
5	3,056	115	3,171
6	3,502	132	3,634

7	3,947	149	4,096
8	4,393	166	4,559
9	4,838	182	5,020
10	5,284	199	5,483
+1	+446	17	463

(f) The *MAGI-based income* standard for the *OHP-OPP* program is set at 185 percent of the *federal poverty level*. If a *child's household group* income exceeds the income standard for their *family size*, and the *child* would be otherwise ineligible for Medicaid, the appropriate disregard for their *family size* described in section (5)(a)(B) shall be applied:

Family size	**Standard 185%**	**If income Exceeds 185%, Disregard**	**Income Prior to Applying Disregard**
1	$1,772	$48	$1,820
2	2,392	65	2,457
3	3,011	82	3,093
4	3,631	99	3,730
5	4,251	115	4,366
6	4,871	132	5,003
7	5,490	149	5,639
8	6,110	166	6,276
9	6,730	182	6,912
10	7,350	199	7,549
+1	+620	17	637

(g) The *MAGI income standard* for the MAGI CHIP program is set through 300% of *FPL* as follows:

Family size	Standard 300%
1	$2,874
2	3,879
3	4,884
4	5,889
5	6,894
6	7,899
7	8,904
8	9,909
9	10,914
10	11,919
+1	1,005

(h) In the MAGI CHIP and MAGI Child Program, when the Department uses a finding made during an *ELE* determination and the *child* meets all other MAGI CHIP, or MAGI Child Program nonfinancial eligibility requirements, the standard for the number of eligibility group members determined by the is used to determine eligibility regardless of the *family size*. The countable income of the *household group* is the same as the income amount determined by the *ELA*. A *child* is deemed eligible for MAGI CHIP, or MAGI Child Program as follows:

(A) If the *MAGI-based income* of the *household group* is below 163 percent of the *federal poverty level* as listed below, the Department deems the *child* eligible for the MAGI Child Program.

Household	Standard

Size	
1	$1,561
2	2,107
3	2,653
4	3,199
5	3,745
6	4,291
7	4,838
8	5,384
9	5,930
10	6,476
+1	+547

(B) If the *MAGI-based income* of the *household group* is at or above 163 percent of the *FPL* through 300% percent of the *FPL* as listed in section (5)(b)(E) of this rule, the *Agency* deems the *child* eligible for MAGI CHIP.

[Ed. Note This rule replaces and amends information previously found in OAR 461-140-0010, 461-140-0040, 461-150-0055, 461-155-0180, and 461-155-0225.

Stat. Auth.: ORS , 411.402, 411.404, 413.042,,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.706

410-200-0400

Specific Requirements; Breast and Cervical Cancer Treatment Program (BCCTP)

This rule establishes eligibility criteria for medical assistance based on an individual's need of treatment for breast or cervical cancer, including pre-cancerous conditions (treatment). The Authority administers the Oregon Breast and Cervical Cancer Treatment Program (BCCTP) by entering into agreements with qualified entities as approved by the Authority to provide

screening services for BCCTP funded by the Centers for Disease Control in support of the National Breast and Cervical Cancer Early Detection Program.

(1) To be eligible for BCCTP, an individual must:

(a) Be found to need treatment following screening services provided by a qualified entity;

(b) Be under the age of 65;

(c) Not be covered for treatment by *minimum essential coverage*; and

(d) Not be eligible for Medicaid through a Medicaid program listed in 42 U.S.C. §1396a(a)(10)(A)(i) (mandatory Medicaid eligibility groups).

(2) An individual is presumptively eligible for BCCTP beginning the day a qualified entity determines, on the basis of preliminary information, that she is likely to meet the requirements of section (1). A qualified entity that determines an individual presumptively eligible for BCCTP must:

(a) Notify the Authority of the determination within five working days; and

(b) Explain to the individual at the time the determination is made the circumstances under which an application for medical assistance must be submitted to the Authority and the deadline for the application (see section (3)).

(3) To remain eligible for benefits, an individual determined by a qualified entity to be presumptively eligible for BCCTP must apply for medical assistance no later than the last day of the month following the month in which the determination of presumptive eligibility is made. Presumptive eligibility for BCCTP ends on:

(a) The last day of the month following the month in which presumptive eligibility begins, if the individual does not file an application by that date.

(b) The day on which a determination is made for other Medicaid/CHIP program benefits.

(4) An individual found eligible for the BCCTP by the Authority becomes ineligible upon the first of the following to occur:

(a) The treating health professional determines the course of treatment is complete.

(b) Upon reaching age 65.

(c) When the individual becomes covered for treatment by *minimum essential coverage*.

(d) Upon becoming a resident of another state.

(e) When the Authority determines she does not meet the requirements for eligibility.

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-1060]

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.540, 414.706

410-200-0405 ~~**Effective 10/01/13**~~

Specific Requirements; ~~MAGI Substitute and Adoptive Care (SAC)~~**Substitute Care**

In addition to eligibility requirements applicable to the ~~MAGI SAC~~Substitute Care program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the ~~MAGI SAC~~Substitute Care program as of January 1, 2014.

~~(1) Individuals may not be eligible for the MAGI SAC program with an effective date prior to October 1, 2013.~~

(1~~2~~) To be eligible for Substitute Care~~the MAGI SAC program~~, an individual must be~~:~~

~~(a)~~ ~~Be~~ under the age of 21 and live in an intermediate psychiatric care facility for which a public agency of Oregon is assuming at least partial financial responsibility, including those placed in an intermediate psychiatric care facility by the Oregon Youth Authority.~~;~~ ~~and~~

~~(b) Meet the hierarchy requirements in OAR 410-200-0110(7).~~

(3) While living in an intermediate psychiatric care facility, an individual's *household group* ~~is determined by the criteria described in OAR 410-200-0305(3).~~consists of the individual only.

(4) There is no income test for Substitute Care~~the MAGI SAC program~~.

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-0150]

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

~~410-200-0406 Effective 01/01/14~~ REPEAL

~~Specific Requirements; Former Foster Care Youth Medical~~

~~In addition to eligibility requirements applicable to the Former Foster Care Youth Medical program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the Former Foster Care Youth Medical program.~~

~~(1) Individuals may not be eligible for the Former Foster Care Youth Medical program with an effective date prior to January 1, 2014.~~

~~(2) There is no income test for the Former Foster Care Youth Medical program.~~

~~(3) An individual is assumed eligible for Former Foster Care Youth Medical if the criteria in section (1) is met and the individual:~~

~~(a) Is 18 years of age or older, but under 26 years of age;~~

~~(b) Was in foster care under the responsibility of the State or Tribe and enrolled in Medicaid under the State's Medicaid State plan or 1115 demonstration upon attaining:~~

~~(A) Age 18, or~~

~~(B) If over 18, the age at which Oregon Medicaid or Oregon Tribal foster care assistance ended under *Title IV-E* of the Act;~~

~~(c) Is not receiving SSI; and~~

~~(d) Is not receiving adoption assistance or foster care maintenance payments~~

~~Stat. Auth.: ORS 411.402, 411.404, 413.042~~

~~Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706~~

410-200-0410

Specific Requirements; MAGI CHIP

In addition to eligibility requirements applicable to the MAGI CHIP program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI CHIP program.

(1) Individuals may not be eligible for the MAGI CHIP program with an effective date prior to October 1, 2013.

(2) To be eligible for the MAGI CHIP program, an individual must be under 19 years of age and must:

(a) Not be eligible for MAGI Child, MAGI Pregnant Woman, MAGI Parent or Caretaker Relative or ~~MAGI SAC~~Substitute Care programs;

(b) Meet budgeting requirements of OAR 410-200-0315; and

(c) Not be covered by *minimum essential coverage*. For the purposes of this rule, a *child* is not considered to have *minimum essential coverage* if it is not accessible for one or more of the following reasons:

(A) The travel time or distance to available providers within the *minimum essential coverage* network exceeds:

(i) In urban areas: 30 miles, 30 minutes, or the community standard, whichever is greater; or

(ii) In rural areas: 60 miles, 60 minutes, or the community standard, whichever is greater.

(B) Accessing the *minimum essential coverage* would place a *household group* member at risk of harm.

(3) For the Authority to enroll a *child* in MAGI CHIP based on a determination made by an Express Lane Agency (*ELA*), the *child's parent* or guardian must give consent in writing, by telephone, orally, or through electronic signature.

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-1100 (7)]

Stat. Auth.: ORS 411.402, 411.404, 413.042, ,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

410-200-0415 **NEW RULE**

Specific Requirements; MAGI Child

In addition to eligibility requirements applicable to the MAGI Child program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Child Program.

(1) Individuals may not be eligible for the MAGI Child program with an effective date prior to January 1, 2014.

(2) To be eligible for the MAGI Child Program, the *child* must be under the age of 19 with household income at or below:

(a) 133 percent of the *federal poverty level* (see OAR 410-200-0315) for the applicable *family size* for a *child* over the age of one but less than age 19; or

(b) 185 percent of the *federal poverty level* for the applicable *family size* for an infant under the age of one.

(3) To be eligible for the MAGI Child Program, an individual may not:

(a) Be receiving, or deemed to be receiving, SSI benefits;

(b) Be receiving Medicaid through another program.

(4) A *child* born to a mother eligible for and receiving Medicaid benefits is assumed eligible for medical benefits under this rule until the end of the month the *child* turns one year of age, unless:

(a) The *child* dies;

(b) The *child* is no longer a resident of Oregon; or

(c) The *child*'s representative requests a termination of the *child*'s eligibility.

(5) To enroll a *child* in the MAGI Child Program based on a determination made by an Express Lane Agency (*ELA*), the *child*'s *parent* or guardian must give consent in writing, by telephone, orally, or through electronic signature.

(6) *ELE* qualifies a *child* for medical assistance benefits based on a finding from the Department, even when the Department's eligibility methodology differs from that used for *OCCS Medical Programs*.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.706

410-200-0420

Specific Requirements; MAGI Parent or Other Caretaker Relative

In addition to eligibility requirements applicable to the MAGI Parent and Other Caretaker Relative program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Parent ~~and~~ or Other Caretaker Relative Program.

(1) Individuals may not be eligible for the MAGI Parent and Other Caretaker Relative Program with an effective date prior to January 1, 2014.

(2) To be eligible for the MAGI Parent or Other Caretaker Relative program, an individual must ~~H~~have *household group* income at or below income standard for the applicable *family size* as identified in OAR 410-200-0315;

(3) To be eligible for the MAGI Parent or Other Caretaker Relative program, an individual must ~~H~~have a *dependent child* in the home. However, a *dependent child* for who foster care payments are made for more than 30 days is not eligible while the payments are being made for the *dependent child*.

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.706

410-200-0425

Specific Requirements; MAGI Pregnant Woman

In addition to eligibility requirements applicable to the MAGI Pregnant Woman program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Pregnant Woman program.

(1) Individuals may not be eligible for the MAGI Pregnant Woman program with an effective date prior to January 1, 2014.

(2) To be eligible for the MAGI Pregnant Woman program, an individual must be pregnant, and:

~~(a) Be pregnant; and~~

(a~~b~~) Have household income that is at or below 185 percent of the *federal poverty level* (see OAR 410-200-0315); or~~.~~

(b) Be eligible for Continuous Eligibility according to the policy described in OAR 410-200-0135(2).

(3) Once a *beneficiary* is eligible and receiving Medicaid through the MAGI Pregnant Woman program, they are eligible through the end of the calendar month in which the 60th following the last day of the pregnancy falls (see OAR 410-200-0135).

[Ed. Note This rule replaces and amends information previously found in OAR 461-135-1100]

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.440, 414.706

410-200-0435

Specific Requirements; MAGI Adult

In addition to eligibility requirements applicable to the MAGI Adult program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Adult program.

(1) An individual may not be eligible for the MAGI Adult program with an effective date prior to January 1, 2014.

(2) The *Agency* may not allow retroactive enrollment into the MAGI Adult program for effective dates prior to January 1, 2014.

(3) To be eligible for the MAGI Adult program an individual must:

(a) Be 19 years of age or older and under age 65; and

(b) Have household income at or below 133 percent *federal poverty level* (see OAR 410-200-0315) for the applicable *family size*.

(4) To be eligible for the MAGI Adult program, an individual may not be:

(a) Pregnant;

(b) Entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(c) Receiving SSI benefits; or

(d) A *parent* or other *caretaker relative* living with a *dependent child* who is not enrolled in *minimum essential coverage*.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.706

410-200-0440 ~~**Effective 01/01/14**~~

Specific Requirements; Extended Medical Assistance

This rule sets out when an individual is eligible for Extended Medical Assistance, as of January 1, 2014.

(1) Individuals who are eligible for and receiving Medical Assistance Assumed (MAA), Medical Assistance to Families (MAF), MAGI Child or MAGI Parent or Other Caretaker Relative benefits and lose eligibility:

(a) Due to the receipt or increase of earned income are eligible for 12 months of Extended Medical Assistance (EXT) benefits if eligibility is redetermined and the individual is not eligible for Medicaid/CHIP; or

(b) Due to the receipt or increase of spousal support are eligible for 4 months of EXT benefits if:

(A) Eligibility is redetermined and the individual is not eligible for Medicaid/CHIP; and

(B) They were eligible for and receiving benefits for three of six months preceding the receipt or increase of spousal support.

(2) Individuals who are eligible for and receiving MAGI Pregnant Woman benefits and lose eligibility due to the increase of earned income or spousal support are eligible for 4 months of EXT benefits if:

(a) Eligibility is redetermined and the individual is not eligible for Medicaid/CHIP; and

(b) They were eligible for and receiving MAGI Pregnant Women benefits for three of the six months preceding the receipt or increase of earned income or spousal support.

(3) To be eligible for EXT, the Household Group of individuals who lose eligibility for MAGI Parent or Other Caretaker Relative benefits must contain a dependent child who has minimum essential coverage.

(4) The EXT beneficiary must be a resident of Oregon.

(5) Individuals who lose EXT eligibility because they leave the household during the EXT eligibility period may regain eligibility if they return to the household.

(6) The effective date of EXT is the first of the month following the month in which MAA, MAF, MAGI Child, MAGI Parent or Other Caretaker Relative, or the MAGI Pregnant Women program eligibility ends.

(7) If an individual receives MAA, MAF, MAGI Child, MAGI Parent or Other Caretaker Relative, or MAGI Pregnant Women benefits during months when they were eligible for EXT:

(a) Such months are not an overpayment.

(b) Any month in which an individual receives MAA, MAF, MAGI Parent or Other Caretaker Relative, or MAGI Pregnant Women benefits when they were eligible for EXT is counted as a month of the EXT eligibility period.

(8) If a beneficiary of MAA, MAF, MAGI Child, MAGI Parent or Other Caretaker Relative, or MAGI Pregnant Women benefits experiences another change in conjunction with the receipt or increase of earned income or spousal support, and the other change, by itself, makes the Household Group ineligible for the current program, the beneficiary is not eligible for EXT.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025,

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.706

Replaces 461-135-0095; EXT and 461-135-0096 Eligibility Period; EXT

410-200-0500

Transitioning Benefits – 2013 Programs

(1) For individuals who apply for *OCCS Medical Programs* on or after October 1, 2013, eligibility and budgeting shall be determined according to this section of rules.

(2) Individuals who apply from October 1, 2013 through December 31, 2013 shall first be considered for the programs described in OAR 410-200-0510. If an individual is eligible for one of those programs, eligibility shall continue according to section (3) of this rule. Individuals found ineligible based on information from all *budget months* of October, November, or December 2013 shall have their eligibility determined as follows:

(a) Individuals who would be eligible for new programs based on eligibility and income standards which begin January 1, 2014, shall become eligible for applicable programs as of that date.

(b) Individuals who are ineligible for new programs which begin on January 1, 2014 shall be referred to the Exchange.

(3) Individuals who are eligible and receiving *OCCS Medical Program* benefits described in OAR 410-200-0510 on December 31, 2013, shall be treated as follows effective January 1, 2014:

(a) Individuals receiving *OHP-OPU* program benefits shall be converted to the MAGI Adult program.

(b) Individuals receiving *HKC* program benefits shall be converted to the MAGI CHIP program.

(c) Individuals receiving *OHP-CHP* whose household income is below 133 percent of *FPL* shall be converted to the MAGI Child program.

(d) All others shall maintain their current program benefits until:

(A) A change occurs that impacts their eligibility; or

(B) Their next scheduled *renewal* occurs according to OAR 410-200-0115.

Stat. Auth.: ORS , 411.402, 411.404, 413.042

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, , 414.025, 414.231, 414.440, 414.706

410-200-0505

Specific Requirements; SNAP-Based Eligibility for *MAA*, *OHP-OPP*, or MAGI Medicaid

In SNAP-based eligibility, the *Agency* relies on a determination made for SNAP program benefits. A SNAP recipient adult may be found eligible for these medical programs based on findings from the Department, even if the Department's eligibility methodology differs from that used by the *Agency* to determine eligibility for *OCCS Medical Programs*.

(1) For SNAP-based eligibility, the adult must have SNAP income that is at or below the applicable income standards for *MAA*, *OHP-OPP*, or MAGI Medicaid.

(2) A new application is not required for SNAP-based eligibility.

(3) For SNAP-based eligibility, the adult in the *household group* must:

(a) Not be eligible for or receiving Supplemental Security Income;

(b) Indicate they wish to pursue medical assistance;

(c) Agree to cooperate with the Division of Child Support; and

(d) Meet the specific program requirements for the applicable program.

(4) If the individual requests SNAP-based eligibility and is not eligible, the Authority must review the individual's eligibility for *OCCS Medical Programs* based on a full determination without requiring a new application. The *Date of Request* is the date the Authority received consent for SNAP-based eligibility.

Stat. Auth.: ORS , 411.402, 411.404, 413.042, 413.038,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

410-200-0510

Specific Program Requirements; BCCM, *CEC, CEM, EXT, MAA, MAF, OHP~~, HKC~~*, and *SAC*

(1) T~~Except for *HKC* as outlined in section (18),~~ this rule describes *OCCS Medical Programs* for which individuals may be determined eligible through December 31, 2013. See OAR 410-200-0500 for information regarding the treatment of those beneficiaries as of January 1, 2014.

(2) To be eligible for a program listed in this rule, an individual must meet the following:

(a) The eligibility factors set forth in OAR 410-200-0200 through 410-200-0240;

(b) The budgeting and income standard requirements set forth in OAR 410-200-0300 through 410-200-0315; and

(c) The individual must have established a *Date of Request* prior to January 1, 2014.

(3) For purposes of this rule, *private major medical health insurance* means a comprehensive major medical insurance plan that, at a minimum, provides physician services; inpatient and outpatient hospitalization; outpatient lab, x-ray, immunizations; and prescription drug coverage. This term does not include coverage under the Kaiser Child Health Program or Kaiser Transition Program but does include policies that are purchased privately or are employer-sponsored.

(4) For the purposes of this rule, the receipt of *private major medical health insurance* does not affect *OCCS Medical Program* eligibility if it is not accessible. *Private major medical health insurance* is not considered accessible if:

(a) The travel time or distance to available providers exceeds:

(A) In urban areas: 30 miles, 30 minutes, or the community standard, whichever is greater;

(B) In rural areas: 60 miles, 60 minutes, or the community standard, whichever is greater.

(b) Accessing the *private major medical health insurance* would place a filing group member at risk of harm.

(5) To be eligible for Chafee medical, the individual must be a *child* who was receiving foster care in Oregon, upon attaining:

(a) Age 18, or

(b) If over 18, the age at which Oregon Medicaid or Oregon Tribal foster care assistance ended under *Title IV-E* of the Act;

(6) *CEM* provides eligibility for the balance of the 12-month eligibility period for non-*CAWEM* children who were receiving Child Welfare (CW) medical, *EXT*, *MAA*, *MAF*, *OHP*, *OSIPM*, or *SAC* program benefits and lost eligibility for reasons other than moving out of state or turning 19 years old. *CEM* benefits end when:

(a) The *child* becomes eligible for CW medical, *EXT*, *MAA*, *MAF*, *OHP*, *OSIPM*, or *SAC* program benefits;

(b) The *child* turns 19 years of age;

(c) The *child* moves out of state; or

(d) Benefits are closed voluntarily.

(7) *CEC* provides eligibility for the *OHP-CHP* program for non-*CAWEM* pregnant children who were receiving *OHP-CHP* and would have otherwise lost eligibility for reasons other than moving out of state or becoming a recipient of *private major medical health insurance*. *CEC* eligibility for *OHP-CHP* ends the day following the end of the month in which the earliest of the following occur:

(a) The pregnancy ends;

(b) The individual moves out of state;

(c) The individual begins receiving *private major medical health insurance*;

(d) Benefits are closed voluntarily; or

(e) The individual becomes eligible for CW medical, *EXT*, *MAA*, *MAF*, *OHP*, *OSIPM*, or *SAC* program benefits.

(8) For the Authority to enroll a *child* in the program based on a determination made by an *ELA*, the *child*'s *parent* or guardian must give consent in writing, by telephone, orally, or through electronic signature.

(9) To be eligible for *EXT*, an individual must have been eligible for and receiving *MAA* or *MAF* and became ineligible due to a *caretaker relative*'s increased earned income or due to increased spousal support (see OAR 410-200-0440).

(10) To be eligible for *MAA* or *MAF*, an individual must be one of the following:

(a) A *dependent child* who lives with a *caretaker relative*. However, a *dependent child* for who foster care payments are made for more than 30 days is not eligible while the payments are being made.

(b) A *caretaker relative* of an eligible *dependent child*. However, a *caretaker relative* to who foster care payments are made for more than 30 days is not eligible while the payments are being made.

(c) A *caretaker relative* of a *dependent child*, when the *dependent child* is ineligible for *MAA* or *MAF* for one of the following reasons:

(A) The *child* is receiving SSI;

(B) The *child* is in foster care, but is expected to return home within 30 days; or

(C) The *child*'s citizenship has not been documented.

(d) An essential person. An essential person is a member of the *household group* who:

(A) Is not required to be in the filing group;

(B) Provides a service necessary to the health or protection of a member of the *household group* who has a mental or physical disability; and

(C) Is less expensive to include in the benefit group than the cost of purchasing this service from another source.

(e) A *parent* of an unborn as follows:

(A) For the *MAA* program:

(i) Any *parent* whose only *child* is an unborn *child*, once the mother's pregnancy has reached the calendar month preceding the month in which the due date falls.

(ii) The father of an unborn *child* who does not meet the criteria described in subsection (e)(A)(i) of this part may be eligible if there is another *dependent child* in the *household group*.

(B) For the *MAF* program, a mother whose only *child* is an unborn *child*, once the mother's pregnancy has reached the calendar month preceding the month in which the due date falls

(11) To be eligible for any *OHP* program in sections (12) through (15), an individual may not be:

(a) Receiving SSI benefits;

(b) Eligible for Medicare, except that this requirement does not apply to the *OHP-OPP* program:

(c) Receiving Medicaid through any other program concurrently.

(12) To be eligible for the *OHP-OPC* program, an individual must be less than 19 years of age.

(13) To be eligible for the *OHP-OP6* program, a *child* must be less than six years of age and not eligible for *OHP-OPC*.

(14) To be eligible for the *OHP-OPP* program, an individual must:

(a) Be pregnant;

(b) Be within the time period through the end of the calendar month in which the 60th following the last day of the pregnancy falls; or

(c) Be an infant under age one.

(15) To be eligible for the *OHP-CHP* program, an individual must be under 19 years of age and must:

(a) Not be eligible for the *OHP-OPC*, *OHP-OPP*, or *OHP-OP6* programs; and

(b) Not be covered by any *private major medical health insurance*. An individual may be eligible for *OHP-CHP* if the *private major medical health insurance* is not accessible as outlined in section (4).

(16) Effective July 1, 2004, the *OHP-OPU* program is closed to new *applicants*. Except as provided in subsections (a) and (b) of this section, a new *applicant* may not be found eligible for the *OHP-OPU* program.

(a) An individual is not a new *applicant* if the Department determines that the individual is continuously eligible for medical assistance as follows:

(A) The individual is eligible for and receiving benefits under the *OHP-OPU* program on June 30, 2004, and the Department determines that the individual continues after that date to meet the eligibility requirements for the *OHP-OPU* program.

(B) The individual is eligible for and receiving benefits under the *CAWEM* program on June 30, 2004, and is eligible for the *CAWEM* program based on the *OHP-OPU* program, and the Department determines that the individual continues to meet the eligibility requirements for the *OHP-OPU* program except for citizenship or alien status requirements.

(C) The eligibility of the individual ends under the BCCM, *CEC*, *CEM*, *EXT*, GAM, *HKC*, *MAA*, *MAF*, *OHP-CHP*, *OHP-OPC*, *OHP-OPP*, *OSIPM*, REFM, or *SAC* program, or the related *CAWEM* program; or because the individual has left the custody of the Oregon Youth Authority (OYA); and at that time the Department determines that the individual meets the eligibility requirements for the *OHP-OPU* program.

(D) The individual is a *child* in the custody of the Department whose eligibility for Medicaid ends because of the *child*'s age and at that time the Department determines that the individual meets the eligibility requirements for the *OHP-OPU* program.

(E) The Department determines that the individual was continuously eligible for the *OHP-OPU* program on or after June 30, 2004 under paragraphs (A) to (D) of this section.

(b) An individual who is not continuously eligible under subsection (a) is not a new *applicant* if the individual:

(A) Has eligibility end under the BCCM, *CEC*, *CEM*, *EXT*, *HKC*, *MAA*, *MAF*, *OHP-CHP*, *OHP-OPP*, *OHP-OPU*, *OSIPM*, REFM, or *SAC* program, or the related *CAWEM* program; because the individual has left the custody of the OYA; or is a *child* in the custody of the Department whose eligibility for Medicaid ends due to the *child*'s age;

(B) Established a *Date of Request* prior to the eligibility ending date in paragraph (A) of this section; and

(C) Meets the eligibility requirements for the *OHP-OPU* program or the related *CAWEM* program within either the month of the *Date of Request* or, if ineligible in the month of the *Date of Request*, the following month.

(17) To be eligible for the *OHP-OPU* program, an individual must meet the requirements listed in section (16), and be 19 years of age or older and may not be pregnant. Additionally, and individual must meet the following requirements:

(a) Must be currently receiving Medicaid or CHIP benefits when determined eligible for *OHP-OPU*.

(b) Must not be covered by any *private major medical health insurance*. An individual may be eligible for *OHP-CHP* if the *private major medical health insurance* is not accessible as outlined in section (4).

(c) May not have been covered by *private major medical health insurance* during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:

(A) Any of the criteria in section (4) are met;

(B) The individual has a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability;

(C) The individual's health insurance premium was reimbursed because the individual was receiving Medicaid, and the Department or the Authority found the premium was cost-effective;

(D) The individual's health insurance was subsidized through FHIAP or the Office of Private Health Partnerships in accordance with ORS 414.231, 414.826, 414.831, and 414.839; or

(E) A member of the individual's *household group* was a victim of domestic violence.

~~(18) The *HKC* program is closed to new enrollment effective October 1, 2013. To be eligible for the *HKC* program, an individual must be under 19 years of age and must:~~

~~(a) Not be eligible for the *OHP-OPC, OHP-CHP, OHP-OPP*, or *OHP-OP6* programs; and~~

~~(b) Not be covered by any *private major medical health insurance*. An individual may be eligible for *HKC* if the *private major medical health insurance* is not accessible as outlined in section (4).~~

(18~~9~~) To be eligible for the ~~SAC~~ Substitute Care program, an individual must meet the specific eligibility requirements for ~~MAGI SAC~~Substitute Care found in OAR 410-200-0405.

(19~~20~~) Except for *OHP-CHP* and *CEC*, a pregnant woman who is eligible for and receiving benefits through any program listed in this rule remains eligible through the end of the calendar month in which the 60th following the last day of the pregnancy falls.

(20~~21~~) A *child* who becomes ineligible for the *OHP* program because of age while receiving in-patient medical services remains eligible until the end of the month in which he or she no longer receives those services if he or she is receiving in-patient medical services on the last day of the month in which the age requirement is no longer met.

Stat. Auth.: ORS 411.402, 411.404, , 413.042, 414.534

Stats. Implemented: ORS , 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

~~410-200-0515 Effective 10/01/13 – 12/31/13~~ REPEAL

~~*OHP-OPU* Premiums~~

~~(1) *OHP-OPU* beneficiaries must pay a monthly premium unless the *beneficiary* is exempt as any of the following:~~

~~(a) A member of a federally recognized Indian tribe, band, or group.~~

~~(b) An Eskimo, Aleut, or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act.~~

~~(c) An individual eligible for benefits through an Indian Health Program.~~

~~(d) An individual eligible for *CAWEM* benefits (see OAR 410-200-0240).~~

~~(e) An individual whose *household group* income is 10 percent or less of the *federal poverty level* in at least one of the following situations:~~

~~(A) Using income assigned to the *budget month* at certification or *renewal*;~~

~~(B) Using income assigned to the *budget month* at most recent *eligibility determination*, when an *OHP-OPU beneficiary* leaves the *household group*.~~

~~(C) Using income assigned to the *budget month* at most recent *eligibility determination*, when multiple *OHP* program cases are combined into one case.~~

~~(2) Each non-exempt *beneficiary* is responsible for payment of premiums.~~

~~(3) Once the amount of the premium is established, the amount shall not change until a *redetermination* takes place, unless the conditions under at least one of the following apply:~~

~~(a) A *beneficiary* becomes pregnant.~~

~~(b) A *beneficiary* becomes eligible for another program.~~

~~(c) An *OHP-OPU beneficiary* leaves the *household group*, and the remaining *household group* income is 10 percent or less of the *federal poverty level*.~~

~~(d) *OHP* program cases are combined.~~

~~(e) A *beneficiary's* exemption status changes.~~

~~(4) A premium is considered paid on time when the payment is received by the *Oregon Health Plan* billing office on or before the due date which is the 20th of the month for which the premium was billed. The day the payment arrives in the billing office's post office box when sent via mail or the day it is submitted via telephone or electronically to the billing office is the date it is received. A premium not paid on time is in arrears. A premium is past due when it has not been paid within six months of the due date. A client will not lose eligibility due to premiums in arrears or past due premiums unless an *eligibility determination* takes place. All premiums in arrears and past due premiums for a filing group must be paid before a client can be redetermined for ongoing eligibility.~~

~~(5) For any billed premium, the *Agency* shall cancel the arrearage if the *applicant* is otherwise eligible for the *OHP-OPU* program and one of the following applies:~~

~~(a) The arrearage was incurred while the client was exempt from the requirement to pay a premium; or~~

~~(b) The *applicant* is exempt from the requirement to pay premiums under section (1)(e) of this rule.~~

~~(6) The *Agency* shall cancel any premium arrearage over three years old.~~

~~(7) The following steps are followed to determine the amount of the monthly premium for an individual:~~

~~(a) The number of persons in the *OHP household group* is determined in accordance with OAR 410-200-0305.~~

~~(b) The countable income of the *household group* is determined in accordance with OAR 410-200-0310.~~

~~(c) Based on the number in the *household group* and the countable income, the monthly premium for each non-exempt *OHP-OPU beneficiary* is determined using the following table:~~

~~*OHP* PREMIUM STANDARD~~

~~Number in *Household group*~~	~~Countable Income~~	~~Premium Amount Billed for Each Non-Exempt OPU Client~~
~~1~~	~~95.76 - 478.74~~ ~~478.75 - 622.37~~ ~~622.38 - 813.87~~ ~~813.88 - 957.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~2~~	~~129.26 - 646.24~~ ~~646.25 - 840.12~~ ~~840.13 - 1,098.62~~ ~~1,098.63 - 1,292.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~3~~	~~162.76 - 813.74~~ ~~813.75 - 1,057.87~~ ~~1,057.88 - 1,383.37~~ ~~1,383.38 - 1,627.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~4~~	~~196.26 - 981.24~~ ~~981.25 - 1,275.62~~ ~~1,275.63 - 1,668.12~~ ~~1,668.13 - 1,962.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~5~~	~~229.76 - 1,148.74~~ ~~1,148.75 - 1,493.37~~ ~~1,493.38 - 1,952.87~~ ~~1,952.88 - 2,297.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~6~~	~~263.26 - 1,316.24~~ ~~1,316.25 - 1,711.12~~ ~~1,711.13 - 2,237.62~~ ~~2,237.63 - 2,632.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~

~~7~~	~~296.76 – 1,483.74~~ ~~1,483.75 – 1,928.87~~ ~~1,928.88 – 2,522.37~~ ~~2,522.38 – 2,967.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~8~~	~~330.26 – 1,651.24~~ ~~1,651.25 – 2,146.62~~ ~~2,146.63 – 2,807.12~~ ~~2,807.13 – 3,302.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~9~~	~~363.76 – 1,818.74~~ ~~1,818.75 – 2,364.37~~ ~~2,364.38 – 3,091.87~~ ~~3,091.88 – 3,637.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~10~~	~~397.26 – 1,986.24~~ ~~1,986.25 – 2,582.12~~ ~~2,582.13 – 3,376.62~~ ~~3,376.63 – 3,972.99~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~
~~11 & Over~~	~~Each added 33.51 – 167.49~~ ~~Each added 167.50 – 217.74~~ ~~Each added 217.75 – 284.74~~ ~~Each added 284.75 – 335.00~~	~~9.00~~ ~~15.00~~ ~~18.00~~ ~~20.00~~

~~Stat. Auth.: ORS, 411.404, 411.431, 411.432413.042~~

~~Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.431, 411.432, 414.025~~