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DMAP 86-2025
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Update post-hospital extended care benefit maximum number of days stayed in a nursing facility.

EFFECTIVE DATE: 01/01/2026

AGENCY APPROVED DATE: 12/04/2025

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RULES:
410-120-1160, 410-120-1210

AMEND: 410-120-1160

RULE TITLE: Medical Assistance Benefits and Provider Rules

NOTICE FILED DATE: 09/26/2025

RULE SUMMARY: Updates post-hospital care benefit description Oregon Administrative Rule citation.

RULE TEXT:
(1) Providers enrolled with and seeking reimbursement for services through the Health Systems Division (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) website for the Division and its medical assistance programs. It is the provider's responsibility to become familiar with and abide by these rules.
(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Health Services:
(a) Acupuncture services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);
(b) Administrative examinations as described in the Administrative Examinations and Billing Services program provider rules (OAR chapter 410, division 150);
(c) Substance Use Disorder treatment services:
(A) The Division covers Substance Use Disorder (SUD) inpatient treatment services for medically managed intensive inpatient detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate. The Division covers medically monitored detoxification and clinically managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered medically appropriate;
(B) The Division covers non-hospital SUD treatment and recovery services on a residential or outpatient basis. For

information to access these services, contact the client's PHP or CCO if enrolled, the Community Mental Health Program (CMHP), an outpatient substance use disorder treatment provider, the residential treatment program, or the Addictions and Mental Health Division (AMH);
(C) The Division does not cover residential level of care provided in an inpatient hospital setting for substance use disorder treatment and recovery;
(d) Ambulatory surgical center services as described in the Medical-Surgical Services program provider rules (OAR 410, division 130);
(e) Anesthesia services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);
(f) Audiology services as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program provider rules (OAR chapter 410, division 129);
(g) Chiropractic services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);
(h) Clinical trials as described in these General Rules:
(A) Coverage includes routine patient costs for a beneficiary participating in a qualifying clinical trial or any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the items or services to the beneficiary are covered in the recipient's benefit package;
(B) "Qualifying clinical trial" is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition as described in section 1905(gg)(2)(A) of the Act;
(C) A qualifying clinical trial is a study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
(i) The National Institutes of Health (NIH);
(ii) The Centers for Disease Control and Prevention (CDC);
(iii) The Agency for Health Care Research and Quality (AHRQ);
(iv) The Centers for Medicare & Medicaid Services (CMS);
(v) A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs;
(vi) A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;
(vii) A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
(I) The Department of Energy;
(II) The Department of Veterans Affairs;
(III) The Department of Defense;
(viii) A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or
(ix) A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.
(D) Items and Services not included in clinical trial:
(i) Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial but is not included in the recipient's OHP benefit package;
(ii) Routine patient cost does not include any item or service that is provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the beneficiary

and is not otherwise in the recipients OHP benefit package.
(i) Dental services as described in the Dental Services program provider rules (OAR chapter 410, division 123);
(j) Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT) are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;
(k) Family planning services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130);
(l) Federally qualified health centers and rural health clinics as described in the Federally Qualified Health Centers and Rural Health Clinics program provider rules (OAR chapter 410, division 147);
(m) Home and community-based waiver services as described in the Authority and the Department's OARs of Child Welfare (CW), Self-Sufficiency Program (SSP), Addictions and Mental Health Division (AMH), and Aging and People with Disabilities Division (APD);
(n) Home enteral/parenteral nutrition and IV services as described in the Home Enteral/Parenteral Nutrition and IV Services program rules (OAR chapter 410, division 148) and related Durable Medical Equipment. Prosthetics, Orthotics and Supplies program rules (OAR chapter 410, division 122) and Pharmaceutical Services program rules (OAR chapter 410, division 121);
(o) Home health services as described in the Home Health Services program rules (OAR chapter 410, division 127);
(p) Hospice services as described in the Hospice Services program rules (OAR chapter 410, division 142);
(q) HRSN Services as described in the HRSN Services program rules (OAR 410-120-2000);
(r) Indian health services or tribal facility as described in The Indian Health Care Improvement Act and its amendments (Public Law 102-573), and the Division's American Indian/Alaska Native program rules (OAR chapter 410, division 146);
(s) Inpatient hospital services as described in the Hospital Services program rules (OAR chapter 410, division 125);
(t) Laboratory services as described in the Hospital Services program rules (OAR chapter 410, division 125) and the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(u) Licensed direct-entry midwife services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(v) Maternity case management as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(w) Medical equipment and supplies as described in the Hospital Services program, Medical-Surgical Services program, DMEPOS program, Home Health Services program, Home Enteral/Parenteral Nutrition and IV Services program, and other rules;
(x) When a client's benefit package includes mental health, the mental health services provided shall be based on the Health Evidence Review Commission (HERC) Prioritized List of Health Services;
(y) Naturopathic services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(z) Nutritional counseling as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(aa) Occupational therapy as described in the Physical and Occupational Therapy Services program rules (OAR chapter 410, division 131);
(bb) Organ transplant services as described in the Transplant Services program rules (OAR chapter 410, division 124);
(cc) Outpatient hospital services including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital as described in the Hospital Services program rules (OAR chapter 410, division 125);
(dd) Physician, podiatrist, nurse practitioner and licensed physician associate services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);
(ee) Physical therapy as described in the Physical and Occupational Therapy and the Hospital Services program rules (OAR chapter 410, division 131 and 125);
(ff) Post-hospital extended care benefit as described in OAR chapter 410, division 120, 141 and OAR chapter 411,

division 070, Aging and People with Disabilities (APD) program rules;
(gg) Prescription drugs including home enteral and parenteral nutritional services and home intravenous services as described in the Pharmaceutical Services program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services program (OAR chapter 410, division 148), and the Hospital Services program rules (OAR chapter 410, division 125);
(hh) Preventive services as described in the Medical-Surgical Services program (OAR chapter 410, division 130), the Dental Services program rules (OAR chapter 410, division 123), and prevention guidelines associated with the Health Evidence Review Commission's Prioritized List of Health Services (OAR 410-141-0520);
(ii) Private duty nursing as described in the Private Duty Nursing Services program rules (OAR chapter 410, division 132);
(jj) Radiology and imaging services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130), the Hospital Services program rules (OAR chapter 410, division 125), and Dental Services program rules (OAR chapter 410, division 123);
(kk) Rural health clinic services as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);
(ll) School-based health services as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);
(mm) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program rules (OAR chapter 410, division 129) and Hospital Services program rules (OAR chapter 410, division 125);
(nn) Transportation necessary to access a covered medical service or item as described in the Medical Transportation program rules (OAR chapter 410, division 136);
(oo) Vision services as described in the Visual Services program rules (OAR chapter 410, division 140).
(3) Other Authority or Department, divisions, units, or offices, including Vocational Rehabilitation, AMH, and APD may offer services to Medicaid eligible clients, that are not reimbursed by or available through the Division of Medical Assistance Programs.
[Publications: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.065, SB 269-b (2025)

AMEND: 410-120-1210

RULE TITLE: Medical Assistance Benefit Packages and Delivery System

NOTICE FILED DATE: 09/26/2025

RULE SUMMARY: Updates post-hospital care benefit nursing home stay from twenty (20) days to one hundred (100).

RULE TEXT:

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.

(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if they are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;

(C) Coverage includes:

(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage for individuals under age 21 and individuals who qualify for the Young Adults with Special Health Care Needs (YSHCN) program, as detailed in Chapter 410 Division 151.

(ii)Services consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);

(iii) Ancillary services, (OAR 410-141-3820);

(iv) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(v) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;

(vi) Hospice;

(vii) Post-hospital extended care benefit up to a one hundred (100) day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO; and

(viii) HRSN Services (OAR 410-120-2005).

(D) Limitations: Except for individuals who qualify for the Young Adults with Special Health Care Needs program (see OAR 410-200-0455), the following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123 and 200);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).

(b) OHP with Limited Drugs:

(A) Benefit package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes: services covered by Medicare and OHP Plus as described in this rule;

(D) Limitations:
(i) The same as OHP Plus as described in this rule;
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:
(I) Over-the-counter (OTC) drugs;
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall cover those indications).
(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.
(c) Qualified Medicare Beneficiary (QMB)-Only:
(A) Benefit Package identifier code MED;
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.
(d) Citizenship Waived Medical (CWM) Benefit Package defined in OAR 410-120-0000. Refer to OARs 410-134-0005(2) and 410-134-0005(3) for coverage and billing guidance.
(e) Compact of Free Association (COFA) Dental Program:
(A) Benefit Package identifier code DEN;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;
(C) Coverage is state funded and includes the types and extent of Dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123.
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.
(f) Veteran Dental Program:
(A) Benefit Package identifier code DEN and DNT;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;
(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123.
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.
(g) Young Adults with Special Health Care Needs (YSHCN) Program:
(A) Benefit package identifier codes BMH, BMM, or BMD;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0455;
(C) Coverage: Eligible individuals receive OHP Plus coverage with the following supplemental benefits:

(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage as described in chapter 410 Division 151;
(ii) All dental and vision services available to EPSDT beneficiaries, as detailed in chapter 410 Division 123 and chapter 410 Division 140; and
(iii) Health-Related Social Needs or "HRSN" services (as defined in OAR 140-120-0000 and detailed in OAR 410-120-2000) are available to those receiving YSHCN as an "HRSN Covered Population".
(D) Limitations: Individuals receiving OHP Plus benefits under the YSHCN program are not eligible for long-term care services and supports under Oregon's 1915(c) waiver, and HRSN services must be annually reassessed for eligibility for HRSN services as set out in OAR 410-120-2015.
(5) Division clients are enrolled for covered health services and HRSN Services to be delivered through one of the following means:
(a) Coordinated Care Organization (CCO):
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services, dental care, or HRSN Services.
(b) Fee-for-service (FFS):
(A) These clients are not enrolled in a CCO;
(B) Subject to limitations and restrictions in the Division's individual program rules, the client may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.
(C) Delivery of HRSN Services for members enrolled in FFS shall be provided as set forth in OAR 410-120-2000.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690, 414.572, 414.605, 414.665, 414.719, SB 269-b (2025)