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DMAP 67-2020

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Updating OARs To Align With Policy Changes Effective Upon Implementation Of The IE One System

EFFECTIVE DATE: 01/01/2021

AGENCY APPROVED DATE: 12/21/2020

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RULES:
410-200-0015, 410-200-0110, 410-200-0115, 410-200-0140, 410-200-0215, 410-200-0235, 410-200-0310

AMEND: 410-200-0015

REPEAL: Temporary 410-200-0015 from DMAP 33-2020

RULE TITLE: General Definitions

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0015:

- (11) Added age requirement for an Authorized Representative
- (50) Corrected acronym “IMD” in definition of “inmate”

RULE TEXT:

(1) “Action” means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.
(2) “Active renewal” means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.
(3) “Address Confidentiality Program (ACP)” means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.
(4) “AEN” means Assumed Eligible Newborn (OAR 410-200-0115).
(5) “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).
(6) “Agency” means the Oregon Health Authority and Department of Human Services.
(7) “Applicant” means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.
(8) “Application” means:

(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.
(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) that 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 benefit or because of another individual's eligibility.
(11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).
(12) "Automated renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disability medical program benefits, or APTC.
(14) "BRS" means Behavior Rehabilitation 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 an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:
(a) A relative of the dependent child, as follows:
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.
(B) Stepfather, stepmother, stepbrother, and stepsister.
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;
(18) "CAWEM" means Citizen/Alien-Waived Emergency Medical, which is Medicaid coverage for emergency medical needs for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do not meet citizenship and/or non-citizen status requirements (OAR 410-200-0240).
(19) "CAWEM Plus" means medical services for pregnant CAWEM beneficiaries (OAR 410-200-0240) and includes:
(a) CAWEM Plus coverage for the duration of the individual's pregnancy; and
(b) Reproductive Health Equity Fund (RHEF) coverage through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.
(21) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.
(22) "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.
(23) "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 that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.
(24) "Claimant" means an individual who has requested a hearing or appeal.

(25) “Code” means Internal Revenue Code.
(26) “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 HSD Medical Programs for which a determination or denial was made by the Authority.
(27) “Community partner” means an individual affiliated with a contracted organization who is trained and certified by the Community Partner Outreach Program to provide free assistance to Oregonians with health coverage application and enrollment.
(28) “Coordinated content” means information included in an eligibility notice regarding the transfer of the individual’s or household’s electronic account to another insurance affordability program for a determination of eligibility.
(29) “Custodial Parent” means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or
(b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.
(30) “Cover All Kids” refers to the OHP Plus-equivalent benefit provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP, except they do not meet the citizen and non-citizen status requirements (OAR 410-200-0240).
(31) “Date of Request” (DOR) means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.
(a) For new applicants, the DOR is established as follows:
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; 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.
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:
(A) The date the beneficiary or someone authorized to act on the beneficiary’s behalf reports a change requiring a redetermination of eligibility;
(B) The month an individual ages off a medical program.
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.
(32) “Decision notice” means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a:
(a) “Basic decision notice” mailed no later than:
(A) The date of action given in the notice; or
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.
(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 ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.
(33) “Department” means the Department of Human Services.
(34) “Dependent child” means an individual who:

(a) 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 the individual may reasonably be expected to complete the school or training before attaining age 19.
(b) Lives in the home of the parent or caretaker relative; and
(c) Is not absent from the home for more than 30 days due to being in foster care while foster care payments are being made.
(35) "ELA" (Express Lane Agency)" means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.
(36) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.
(37) "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 documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.
(38) "Electronic application" means an application electronically signed and submitted through the Internet.
(39) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.
(40) "Eligibility Determination Group" (EDG) means all persons whose financial and non-financial information is considered in determining each medical applicant's eligibility as defined in OAR 410-200-0305.
(41) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Agency's receipt of a hearing request, unless the claimant requests more time.
(42) "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 EDG and each unborn child of any pregnant members of the EDG.
(43) "Federal Data Services Hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.
(44) "Federal Poverty Level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department 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).
(45) "Federally Facilitated Marketplace" also called "FFM" means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.
(46) "Head of household" (HOH) means the primary person the Agency shall communicate with and:
(a) Is listed as the case name; or
(b) Is the individual named as the primary contact on the application.
(47) "Health Systems Division Medical Programs" means all programs under the Health Systems Division including:
(a) "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 PCR program due to an increase in their spousal support or earned income;
(b) "Substitute Care" means medical coverage for children in BRS or PRTF;
(c) "BCCTP" means Breast and Cervical Cancer Treatment Program;
(d) "FFCYM" means Former Foster Care Youth Medical;
(e) "MAGI Medicaid/CHIP" means HSD Medical Programs for which eligibility is based on MAGI methodology, including:
(A) MAGI Child;
(B) MAGI Parent or Caretaker Relative;

(C) MAGI Pregnant Woman;
(D) MAGI Children's Health Insurance Program (CHIP);
(E) MAGI Adult.
(48) "Hearing request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.
(49) "HSD" means Health Systems Division, Medical Assistance Programs (Division) under the Oregon Health Authority.
(50) "Inmate" means:
(a) An individual residing 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 the individual is:
(A) Released on parole, probation, or post-prison supervision;
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician, and:
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or
(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.
(D) Residing 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;
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:
(i) Is under age 21;
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or
(iii) Is age 65 or older.
(51) "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 the FFM 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 the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.
(52) "Legal argument" has the meaning given that term in OAR 137-003-0008(c).
(53) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.
(54) "MAGI" means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in 410-200-0310(4). MAGI 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.
(55) "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) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received.
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;
(c) Income from the following American Indian and Alaska Native sources is excluded:
(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, including farming, from:
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this part; or
(ii) 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:
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
(ii) 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.
(56) "Minimum Essential Coverage" (MEC) means medical coverage under:
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CAWEM), 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 that 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.
(57) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.
(58) "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).
(59) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.
(60) "Parent" means a natural or biological, adopted, or stepparent.
(61) "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.
(62) "Primary Contact" has the same meaning given "head of household" in this rule.
(63) "PRTF" means Psychiatric Residential Treatment Facility.
(64) "Public institution" means any of the following:
(a) A state hospital (ORS 162.135);
(b) A local correctional facility (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 (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 (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.
(65) “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).
(66) “Reasonable opportunity period:”
(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;
(b) Begins on and shall 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 five days after the date on the notice, unless the individual shows they did not receive the notice within the five-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.
(67) “Redetermination” means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.
(68) “Renewal” means a regularly scheduled periodic review of eligibility.
(69) “Request for information (RFI)” means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.
(70) “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.
(71) “Shared eligibility service” means a common or shared eligibility system or service used by a state to determine individuals’ eligibility for insurance affordability programs.
(72) “Sibling” means natural or biological, adopted, or half or step sibling.
(73) “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.
(74) “SSA” means Social Security Administration.

(75) “Tax dependent” has the 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) “Title IV-E” means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).

STATUTORY/OTHER AUTHORITY: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 411.443, 413.032, 414.231, 414.447, 414.536, 414.706

AMEND: 410-200-0110

REPEAL: Temporary 410-200-0110 from DMAP 33-2020

RULE TITLE: Application and Renewal Processing and Timeliness Standards

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0110:

• (5) Added age requirement for an individual signing an application on behalf of an individual who is a child or incapacitated.

RULE TEXT:

(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 the FFM using a single streamlined application;

(b) An application may be submitted via the Internet, the FFM, by telephone, by mail, in person, or through other commonly available electronic means;

(c) The Agency shall ensure that an application form is readily available to anyone requesting one and that community partners or Agency staff are available to assist applicants to complete the application process;

(d) If the Agency requires additional information to determine eligibility, the Agency shall send the applicant or beneficiary an RFI which includes a statement of the specific information needed to determine eligibility and the date by which the applicant or beneficiary shall provide the required information in accordance with section (6) of this rule.

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

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

(A) All information necessary to determine all applicant's eligibility and benefit level is provided on the application for each individual in the EDG;

(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.

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

(a) The Authority shall review eligibility at assigned intervals, when changes are reported, and whenever a beneficiary's eligibility becomes questionable;

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

(c) At renewal, if the Agency is unable to process an automated renewal, the Agency shall provide a pre-populated renewal form, referred to as an active renewal, to the beneficiary containing information known to the Agency, a 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 shall assist applicants seeking assistance to complete the pre-populated renewal form or gather information necessary to renew eligibility;

(e) 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.

(3) A new application is required when:

(a) Except as described in section (4) of this rule, an individual who is not currently receiving HSD Medical Program benefits, and is not being added to an active HSD Medical Program benefits case, requests medical benefits;

(b) A child turns age 19, is no longer claimed as a tax dependent, and wishes to retain medical benefits;
(c) The Authority determines that an application is necessary to complete an eligibility determination.
(4) A new application is not required when:
(a) The Agency determines an applicant is not eligible in the month of application and:
(A) Is determining if the applicant is eligible the following month; or
(B) Is determining if the applicant is eligible retroactively (OAR 410-200-0130).
(b) Determining initial eligibility for HSD Medical Programs via Fast-Track enrollment pursuant to OAR 410-200-0505;
(c) Benefits are closed and reopened during the same calendar month;
(d) An individual's medical benefits were suspended because they became an inmate and met the requirements of OAR 410-200-0140;
(e) An individual not receiving medical program benefits is added to an existing case where any members of the individual's EDG are receiving medical program benefits;
(f) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;
(g) During the ninety-day reconsideration period for eligibility following closure:
(A) The Authority shall redetermine in a timely manner (OAR 410-200-0110) the eligibility of an individual who:
(i) Lost HSD Medical Program eligibility because they did not return the pre-populated renewal form or respond to an RFI, and did not submit the information needed to renew eligibility; and
(ii) Within 90 days of the medical closure date, submits the pre-populated renewal form or provides the requested additional information.
(B) The date the pre-populated renewal form or RFI response is submitted within the ninety-day reconsideration period establishes a new date of request;
(C) In the event that the pre-populated renewal form is submitted within the ninety-day reconsideration period and an RFI is generated for which the due date lands outside of the ninety-day reconsideration period, a new application is not required.
(D) If the individual is found to meet HSD Medical Program eligibility based on the completed redetermination, the effective date of medical benefits is as described in 410-200-0115 (3) and (4).
(5) Signature requirements are as follows:
(a) Signatures accepted by the Agency may be:
(A) Handwritten;
(B) Electronic; or
(C) Telephonic.
(b) An application must be signed by one of the following:
(A) The head of household;
(B) An adult in the applicant's EDG;
(C) An authorized representative; or
(D) If the applicant is a child or incapacitated, someone age 18 or older acting responsibly for the applicant.
(c) If the original signor of an application ceases to be a member of the case, the signature of an individual described in section (b) of this part is required.
(d) Hospital Presumptive Eligibility may be determined without a signature if no electronic data match with the FDSH will be performed;
(e) At renewal, if the Agency is unable to process an automated renewal, a signature is required on the pre-populated active renewal form sent to the beneficiary.
(6) Application and renewal processing timeliness standards are as follows:
(a) At initial eligibility determination, the Agency shall inform the individual of timeliness standards, make an eligibility determination, and send a decision notice by the 45th calendar day after the Date of Request if:
(A) All information necessary to determine eligibility is present;

(B) An RFI has been issued, and the agency does not receive a response by the deadline provided; or
(C) A completed application is not received by the agency 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:
(A) The Agency must request additional information or verification, and the due date of such request extends beyond the 45th day; or
(B) There is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;
(c) At periodic renewal of eligibility, if additional information or verification is required, the Authority shall provide the beneficiary at least 30 days from the date of the renewal form to respond and provide necessary information.
(7) Individuals may apply through the FFM. If the FFM determines the individual potentially eligible for Medicaid/CHIP, the FFM shall transfer the individual's electronic account to the Agency for HSD Medical Program eligibility determination or referral to the Department.
(8) HSD Medical Program eligibility is evaluated in the following order:
(a) For a child applicant:
(A) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (OAR 410-200-0405);
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);
(C) MAGI Pregnant Woman program (OAR 410-200-0425);
(D) MAGI Child (OAR 410-200-0415);
(E) EXT (OAR 410-200-0440);
(F) MAGI CHIP (OAR 410-200-0410);
(G) FFCYM (OAR 410-200-0407);
(H) BCCTP (OAR 410-200-0400)
(b) For an adult applicant:
(A) Substitute Care (OAR 410-200-0405);
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);
(C) MAGI Pregnant Woman (OAR 410-200-0425);
(D) FFCYM (OAR 410-200-0407);
(E) MAGI Adult (OAR 410-200-0435);
(F) EXT (OAR 410-200-0440);
(G) BCCTP (OAR 410-200-0400).

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0115

REPEAL: Temporary 410-200-0115 from DMAP 33-2020

RULE TITLE: HSD Medical Programs—Effective Dates

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0115:

• (5) Updated effective date text to align with changes effective upon implementation of the IE ONE system; changes in eligibility that result in a higher-level benefit shall be effective on the first of the month in which the change was reported.

RULE TEXT:

(1) For new applicants, the effective date of HSD Medical Program benefits is whichever comes first:

(a) The earliest date of eligibility within the month in which the Date of Request is established; or

(b) If ineligible within the month in which the Date of Request was established, the first day within the following month in which the client is determined to be eligible.

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

(3) The effective date for retroactive medical benefits (OAR 410-200-0130) for MAGI Medicaid/CHIP and BCCTP is the earlier of:

(a) The first day of the earliest of the three months preceding the month in which the Date of Request was established; or

(b) If ineligible pursuant to section (a), the earliest date of eligibility within the three months preceding the month in which the Date of Request was established.

(4) Establishing a renewal date:

(a) For all HSD Medical Programs except EXT (see OAR 410-200-0440), eligibility shall 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 established by counting 12 full months, including the month in which the DOR was established;

(B) At renewal, the new renewal date is established by counting 12 full months following the current renewal month.

(b) For redeterminations that are initiated by a reported change, outside of the established renewal date, the renewal date is not adjusted.

(5) Effective dates of eligibility changes resulting from Reported Changes (also see Changes That Must Be Reported OAR 410-200-0235):

(a) When the beneficiary reports a change in circumstances, eligibility shall be redetermined for all EDG members;

(b) When a reported change results in a reduction or loss of eligibility, the effective date for the change is:

(A) If the determination is made on or before the 15th of the month, the first of the next month; or

(B) If the determination is made on or after the 16th of the month, the first of the month following the next month.

(c) For reported changes which result in a determination of ongoing eligibility for an HSD Medical Program at the same benefit level, the effective date of the change is the 1st of the month following the date of processing.

(d) For beneficiaries who report a pregnancy, the effective date of the pregnancy-related HSD Medical Program benefit is the earlier of:

(A) The first of the month in which the pregnancy is reported; or

(B) The date that a prenatal service related to the pregnancy was received.

(e) For beneficiaries of CAWEM-level benefits who report a change that results in eligibility for Plus level benefits, the effective date of the Plus-level benefit is the first of the month which it's reported.

(6) Suspending or Closing Medical Benefits:

(a) The effective date for closing HSD 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 HSD 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 by the deadline provided.
(b) Except for benefits obtained via Hospital Presumptive Eligibility (see OAR 410-200-0105) or a presumptive eligibility period for BCCTP (see OAR 410-200-0400), prior to closing medical benefits, the Agency shall:
(A) Determine eligibility for all other HSD Medical Programs; or
(B) Refer the beneficiary to the Department, if applicable, and confirm that the Department has made an eligibility decision.
(c) For beneficiaries of HSD Medical Program benefits who become incarcerated (OAR 410-200-0140), the effective date of suspension is the day following the date on which the individual became incarcerated.
(7) Denial of Benefits. The effective date for denying HSD Medical Program benefits is the earlier of the following:
(a) The date the decision is made that the applicant is not eligible and notice is sent; 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.

STATUTORY/OTHER AUTHORITY: ORS, 411.402, 411.404, 413.042, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0140

REPEAL: Temporary 410-200-0140 from DMAP 33-2020

RULE TITLE: Eligibility for Inmates

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0140:

- Added acronym "(IMD)"
- Corrected age requirements for an individual in an IMD (this was updated in the 'General Definitions' rule previously, and is now being corrected in this rule to align)

RULE TEXT:

(1) An inmate of a public institution is not eligible for HSD Medical Program benefits, except for individuals residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital, who are:
(a) Under age 21;
(b) Age 21 if they were admitted to the IMD before their 21st birthday; or
(c) Age 65 or older.
(2) If an HSD Medical Program beneficiary becomes an inmate of a public institution, medical benefits shall be suspended for the duration of the incarceration period.
(3) The effective date of the suspension of benefits is the day following the date on which the individual became incarcerated.
(4) Suspended benefits shall be restored to the release date without the need for a new application when:
(a) The individual reports their release to the Agency within ten calendar days of the release date;
(b) The individual reports their release to the Agency more than ten calendar days from the release date, and there is good cause for the late reporting; or
(c) The inmate is released to a medical facility and begins receiving treatment as an inpatient with an expected stay of at least 24 hours, providing the facility is not associated with the institution where the individual was an inmate.
(5) Once benefits are restored as described in section (4):
(a) If the individual is released prior to their eligibility renewal date, the eligibility renewal date will be maintained; or
(b) If the individual is released after the eligibility renewal date has passed, benefits shall be restored and a redetermination of eligibility processed.

STATUTORY/OTHER AUTHORITY: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049, 414.426

AMEND: 410-200-0215

REPEAL: Temporary 410-200-0215 from DMAP 33-2020

RULE TITLE: Citizenship and Non-Citizen Status Requirements

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0215:

- (5) Removed erroneous inter-rule reference.

RULE TEXT:

(1) To meet the citizen or non-citizen status requirements for an HSD Medical Program, an individual must be:
(a) A citizen of the United States;
(b) A non-citizen who meets the non-citizen status requirements in section (3) or (4) 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) 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(e) of the Refugee Education Assistance Act of 1980);
(h) An Afghan or Iraqi non-citizen granted Special Immigration Status (SIV) under Section 8120 of the December 19, 2009 Defense Appropriations Bill (Public Law 111-118); or
(i) A battered spouse or child who meets the requirements of 8 U.S.C. 1641(c) as determined by the U.S. Citizenship and Immigration Services.
(3) A non-citizen meets the non-citizen status requirements if the individual is:
(a) 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;
(b) 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));
(c) A veteran of the United States Armed Forces who was honorably discharged for reasons other than non-citizen status and who fulfilled the minimum active-duty service requirements described in 38 U.S.C. 5303A(d);
(d) A member of the United States Armed Forces on active duty (other than active duty for training);
(e) The spouse or a child of an individual described in subsection (c) or (d) of this section.
(f) A qualified non-citizen and meets one of the following criteria:
(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 active-duty military status or is an honorably discharged veteran, and the spouse or unmarried dependent child

of such person,
(E) Has been granted any of the following non-citizen statuses:
(i) Refugee under section 207 of the INA;
(ii) Asylum under section 208 of the INA;
(iii) Deportation being withheld under section 243(h) of the INA;
(iv) Cubans and Haitians who are either public interest or humanitarian parolees;
(v) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988;
(vi) 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;
(vii) 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);
(viii) An Iraqi or Afghan non-citizen granted special immigrant status (SIV) under section 101(a) (27) of the INA.
(g) 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 non-citizens 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:
(i) A non-citizen currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);
(ii) A non-citizen currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 USC 1229b);
(iii) Cuban-Haitian entrants, as defined in section 202(b) Pub. L. 99–603 (8 USC 1255a), as amended;
(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649 (8 USC 1255a), as amended;
(v) A non-citizen currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) A non-citizen currently in deferred action status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a) (22); or
(vii) A non-citizen 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);
(D) A non-citizen in non-immigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(E) Non-citizens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
(F) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
(G) A non-citizen who has been granted withholding of removal under the Convention Against Torture;
(H) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(I) A non-citizen who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(J) A non-citizen who is lawfully present in American Samoa under the immigration laws of American Samoa.
(4) Individuals 19 and older who are described in sections (2)(a), (2)(e), (2)(f), and (2)(i) of this rule meet the non-citizen

status requirement five years following the date on which they obtained the qualified non-citizen status, if the following are true:
(a) The individual entered the United States or was given qualified non-citizen status on or after August 22, 1996; and
(b) The individual does not otherwise meet the non-citizen status requirements described in section (3)(f) of this rule.
(5) Individuals with deferred action under the Deferred Action for Childhood Arrivals (DACA) process do not meet the non-citizen requirement for HSD Medical Programs.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536, 414.706

AMEND: 410-200-0235

REPEAL: Temporary 410-200-0235 from DMAP 33-2020

RULE TITLE: Changes That Must Be Reported

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0235:

- Updated reporting requirements from 30 days to 10 days, to align with changes effective upon implementation of the IE ONE system
- (1)(g-h) Added clarifying text to reporting requirements, requirement to report incarceration status

RULE TEXT:

(1) Reporting requirements described in this rule apply to any individual whose information is considered in determining eligibility for any case member.

(2) An individual or someone authorized to act on the individuals behalf shall report the following changes in circumstances within 10 calendar days of its occurrence:

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

(b) A change in mailing or residential address;

(c) A change in legal name;

(d) A change in pregnancy status;

(e) A change in tax-filing status;

(f) A change in citizenship or immigration status of an applicant or recipient;

(g) Someone joins or permanently leaves the household;

(h) Someone becomes an inmate, or is released from the public institution in which they were an inmate, as described in OAR 410-200-0015(50);

(i) For all HSD Medical Programs except MAGI CHIP, a change in availability of employer-sponsored health insurance;

(j) For the MAGI Parent or Caretaker Relative and EXT programs, when the beneficiary no longer has a dependent child living in the home, including:

(A) The only dependent child leaves the household; or

(B) The only dependent child is 18 years old and not a full-time student in a secondary school or equivalent vocational or technical training.

(k) An EDG member age 19 or older experiences a change in income, including:

(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 per month. The change occurs upon the receipt by the beneficiary of the first paycheck from a new job or the first paycheck reflecting the updated income amount;

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

(3) Individuals shall report a claim for personal injury within 10 calendar days of its occurrence. The following information shall 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.

(4) Changes may be reported via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.

(5) A change is considered reported on the date the information is received by the Agency.

(6) A change reported for one program is considered reported for all programs administered by the Agency in which the

beneficiary participates.

(7) The following changes are not required to be reported:

(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.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0310

REPEAL: Temporary 410-200-0310 from DMAP 33-2020

RULE TITLE: Eligibility and Budgeting; MAGI Medicaid/CHIP

NOTICE FILED DATE: 11/02/2020

RULE SUMMARY: 410-200-0310

• (4) Adjusted policy information to align with changes effective upon implementation of the IE ONE system. Changes to the methodology used to establish budget-month countable income. Addition of conversion standards used to establish ongoing countable income.

RULE TEXT:

(1) Eligibility is evaluated by reviewing the financial and non-financial information for the applicable budget months. The budget month is established as follows.

(a) For new applicants, the budget month is:

(A) The initial budget month is the month in which the Date of Request (DOR) is established; or

(B) If ineligible in the initial budget month, the agency will evaluate eligibility for the subsequent month.

(b) For retroactive medical, the budget month is the month in which the applicant received medical services for which they are requesting payment.

(c) For a current Medicaid/CHIP beneficiary, the budget month is:

(A) At renewal, the month in which a renewal response is received by the agency;

(B) The month a change that affects eligibility is reported; or

(C) The month the individual ages off a medical program.

(2) 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.

(3) MAGI-based income is considered available on the date it is received or the date a member of the EDG 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.

(4) Financial eligibility is evaluated for the initial budget month by comparing the combined total of each EDG member's countable MAGI-based income to the income standards for the appropriate family size. Countable MAGI-based income is determined as follows:

(a) For EDG members with ongoing income (the income has not started, changed, or ended in the month being evaluated), the agency will evaluate eligibility based on converted income. Converted income is calculated by considering the average amount of representative income received per pay period, then converting to a monthly amount using the following conversion standards:

(A) Average weekly income is multiplied by 4.3;

(B) Average bi-weekly income is multiplied by 2.15;

(C) Average twice-monthly income is multiplied by 2;

(D) For ongoing income received less frequently than monthly (i.e. quarterly), the payment amount will be divided by the appropriate number of months to arrive at a monthly average.

(b) For EDG members whose income started or ended in a month being evaluated for eligibility, or changed such that income prior to the month being evaluated is not representative of current or future months:

(A) For income expected to be received monthly or more frequently, the agency will evaluate initial budget month eligibility by combining the actual income received and expected to be received in the budget month. Income is then converted to an ongoing amount using the methodology described in subsection (a) of this part for ongoing eligibility.

(B) For income expected to be paid on a regular basis less often than monthly, income is converted as described in subsection (a)(D) of this part for budget month and ongoing eligibility.
(5) If ineligible under section (4) because the MAGI-based income is over the applicable HSD Medical Program income standard based on family size, MAGI income shall be annualized using the requirements of 25 CFR §1.36 B-1(e) for the calendar year in which medical has been requested. If the annual income is at or below 100 percent FPL as identified in 26 CFR §1.36 B-1(e), income shall be divided by 12 to derive a monthly amount and applied to the budget month and ongoing.
(6) If ineligible under sections (4) or (5) of this rule, the agency will evaluate eligibility for the subsequent month using the methodology described in section (4). If eligible, the effective date of eligibility is established as described in HSD Medical Programs – Effective Dates (OAR 410-200-0115).
(7) Financial eligibility for retroactive months (see OAR 410-200-0130) is first evaluated in accordance with section (4). If a conversion of ongoing income results in ineligibility, the agency will consider the actual countable income received in the retroactive month. If eligible, the effective date of eligibility is established as described in HSD Medical Programs – Effective dates (410-200-0115).
(8) In the following scenarios, an individual's countable income may be reduced by an amount equivalent to five percentage points of the FPL based on the applicable family size:
(a) A child who is ineligible for MAGI Medicaid programs (MAGI Child (OAR 410-200-0415), MAGI Parent or Caretake Relative (OAR 410-200-0420), MAGI Pregnant Woman (OAR 410-200-0425)) and would otherwise be eligible for MAGI CHIP (OAR 410-200-0410); if the countable income reduced by five percentage points of the FPL is within the income standard for a MAGI Medicaid program, the individual meets the financial eligibility for that program.
(b) An individual who is ineligible for any HSD Medical Program. If the countable income reduced by five percentage points of the FPL is within the income standard for any HSD Medical Program, the individual meets the financial eligibility requirements for that program.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.447, 414.706