OFFICE OF THE SECRETARY OF STATE
BEV CLARNO
SECRETARY OF STATE

JEFF MORGAN
INTERIM DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
05/07/2020 11:48 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 23-2020
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Medicaid Eligibility Rules Updated for Clarity and Alignment with DHS Functionality and Integrated Eligibility System

EFFECTIVE DATE: 05/08/2020

AGENCY APPROVED DATE: 05/04/2020

CONTACT: Brean Arnold
503-569-0328
brean.n.arnold@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Brean Arnold
Rules Coordinator

RULES:
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, 410-200-0200, 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, 410-200-0407, 410-200-0410, 410-200-0415, 410-200-0420, 410-200-0425, 410-200-0435, 410-200-0440, 410-200-0505, 410-200-0510

AMEND: 410-200-0010

RULE TITLE: Overview

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
These rules, OAR 410-200-0010 through 0510, describe eligibility requirements for the Health Systems Division (HSD) Medical Programs.

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, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0015

RULE TITLE: General Definitions

NOTICE FILED DATE: 03/12/2020

RULE SUMMARY: • 410-200-0015 – General Definitions
o New definitions: “active renewal”, “automated renewal”, “eligibility determination group” (replaces ‘household group’), “head of household”, “Health Systems Division medical programs” and “HSD”;
o Removed definitions: “American Indian and Alaska Native income exceptions” (incorporated into MAGI-based income), “household group” (replaced by ‘eligibility determination group’);
o Updated definitions: “caretaker relative” (to align with DHS programs); “community partner”; “custodial parent”; “date of request” (moved text that existed in other rules to this definition); “Federally Facilitated Marketplace”; “inmate” (clarification re: inpatient, and updated IMD requirements to align with federal regulation).

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 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, including the Oregon State Hospital and:
(i) Is under age 21;
(ii) Is 21 but was admitted to the Oregon State Hospital 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: 410-200-0100

RULE TITLE: Coordinated Eligibility and Enrollment Process with the Department of Human Services and the Federally Facilitated Marketplace

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
(1) This rule describes the coordination of eligibility and enrollment between the Oregon Health Authority (Authority), the Department of Human Services (Department), and the FFM. The Agency 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, renewal, or reports a change requiring redetermination of eligibility for criteria that identify individuals for whom MAGI and MAGI-based income methods do not apply.
(2) For individuals undergoing eligibility determination for HSD Medical Programs, the Agency, consistent with the timeliness standards described in OAR 410-200-0110, shall:
(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) or if eligible for CAWEM-level benefits only, direct as appropriate to the FFM.
(3) If ineligible for HSD Medical Programs, the Agency shall, consistent with the timeliness standards described in OAR 410-200-0110, Screen for eligibility for non-MAGI programs as indicated by information provided on the application or renewal form.
(4) For HSD Medical Program beneficiaries who become ineligible for ongoing HSD Medical Program benefits, if an evaluation for non-MAGI programs is indicated by information provided in the case record, the Agency shall maintain HSD Medical Program benefits while eligibility for non-MAGI programs is being determined, and shall not take action to close benefits until determination of eligibility is complete.
(5) Coordination among agencies:
(a) The Agency shall maintain a secure electronic interface through which the Authority can send and receive an individual's electronic account from the FFM;
(b) The Agency may not request information or documentation from the individual included in the individual's electronic account or provided for the sake of other Agency benefits; and
(c) If information is available through electronic data match and is useful and related to eligibility for HSD Medical Programs, the Agency shall obtain the information through electronic data match.

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, 411.447, 414.534, 414.536, 414.706

AMEND: 410-200-0105

RULE TITLE: Hospital Presumptive Eligibility

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0105 – Hospital Presumptive Eligibility
o Addition of information about hearing rights, re: benefits produced during a period of HPE are not subject to hearing rights
o Addition of information about deemed, assumed, and extended eligibility, re: benefits produced during a period of HPE do not, on their own, entitle eligibility for deemed, assumed, or extended eligibility.

RULE TEXT:
This rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, BCCTP, and FFCYM (OAR 410-200-0407) based on the determination of a qualified hospital.
(1) A qualified hospital shall, with the consent of the individual or someone acting on the individual's behalf, determine Hospital Presumptive Eligibility (HPE) for MAGI Medicaid/CHIP, BCCTP, or FFCYM.
(2) The qualified hospital shall determine Hospital Presumptive Eligibility based on the following information attested by the individual:
(a) Family size;
(b) Household income;
(c) Receipt of other health coverage;
(d) Residency
(e) US citizenship, US national, or non-citizen status.
(3) To be eligible via Hospital Presumptive Eligibility, an individual must be a US citizen, US National, or meet the citizenship and non-citizen status requirements found in 410-200-0215 and one of the following:
(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 Caretaker Relative income standard for the appropriate family size in OAR 410-200-0315;
(c) A pregnant individual with income at or below 185 percent of the federal poverty level;
(d) A non-pregnant adult between the ages of 19 through 64 with income at or below 133 percent of the federal poverty level; or
(e) An individual under the age of 65 who has been screened by a licensed healthcare provider and determined to need treatment for breast or cervical cancer, or who has been determined eligible for the Breast and Cervical Cancer Treatment Program (OAR 410-200-0400);
(f) An individual under the age of 26 who was in Oregon foster care on their 18th birthday.
(4) To be eligible via Hospital Presumptive Eligibility, an individual may not:
(a) Be receiving Supplemental Security Income benefits;
(b) Be a Medicaid/CHIP beneficiary; or
(c) Have received a Hospital Presumptive Eligibility approval start date within the year (365 days) prior to a new Hospital Presumptive Eligibility period start date.
(5) In addition to the requirements outlined in sections (3) and (4) above, the following requirements also apply:
(a) To receive MAGI Adult benefits via Hospital Presumptive Eligibility, an individual may not be entitled to or enrolled in Medicare benefits under part A or B of Title XVIII of the Act;
(b) To receive MAGI CHIP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage that is accessible (OAR 410-200-0410(2)(c));
(c) To receive BCCTP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage.
(6) The Hospital Presumptive Eligibility period begins on the earlier of:
(a) The date the qualified hospital determines the individual is eligible; or

(b) The date that the individual received a covered medical service from the qualified hospital, if the hospital determines the individual is eligible and submits the decision to the Authority within five calendar days following the date of service.
(7) The Hospital Presumptive Eligibility period ends:
(a) For individuals on whose behalf a Medicaid/CHIP application has been filed by the last day of the month following the month in which the hospital presumptive eligibility period begins, the day on which the state makes an eligibility determination 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 in which the hospital presumptive eligibility period begins.
(8) A Hospital Presumptive Eligibility approval is not a full eligibility determination and does not entitle beneficiaries to the following:
(a) A child is not entitled to continuous eligibility (OAR 410-200-0135) based solely on the receipt of benefits during a period of Hospital Presumptive Eligibility;
(b) A baby born to an individual receiving benefits during a period of hospital presumptive eligibility is not assumed eligible (OAR 410-200-0135) based solely the Hospital Presumptive Eligibility determination of the parent;
(c) An individual is not entitled to EXT (OAR 410-200-0440) based solely on the receipt of MAGI PCR during a period of Hospital Presumptive Eligibility;
(d) An individual whose Hospital Presumptive Eligibility period is terminated due to incarceration is not entitled to automatic restoration of benefits upon release (OAR 410-200-0140);
(e) Individuals are not entitled to hearing rights (OAR 410-200-0145) for benefits received during a period of Hospital Presumptive Eligibility.

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: 410-200-0110

RULE TITLE: Application and Renewal Processing and Timeliness Standards

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0110 – Application and Renewal Processing and Timeliness Standards
o Updated signature requirements to align with DHS programs and system functionality
o Updated program hierarchy to align with regulation (correction)

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 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 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: 410-200-0111

RULE TITLE: Authorized Representatives

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0111 – Authorized Representatives
o Removed language allowing the agency to establish an authorized representative on the applicant/beneficiary's behalf

RULE TEXT:
(1) With the exception of individuals who are included in the EDG solely because they are part of a tax-filers tax group (see OAR 410-200-0305) and except as limited in sections (3), (4), and (5) of this rule, the following individuals may appoint an authorized representative on a form designated by the Agency:
(a) The primary contact;
(b) An individual age 18 or older who is included in the EDG with the primary contact, head of household (see OAR 461-001-0015), or primary person (see OAR 461-001-0000), for all programs with which the primary contact, head of household, or primary person participates;
(c) An individual given legal guardianship or power of attorney for an individual age 18 and older.
(2) The Agency shall accept an applicant or beneficiary's designation of an authorized representative via any of the following methods that 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) An authorized representative designated for one program is the authorized representative for all programs and benefits of the primary contact, head of household (see OAR 461-001-0015), or primary person (see OAR 461-001-0000), excluding Temporary Assistance for Domestic Violence Survivors (see OAR 461-135-1200) and long-term care services (see OAR 461-001-0000).
(4) Unless limited elsewhere in this rule, the authorized representative:
(a) May, with the exception of the Authorized Representative designation form and subject to the exception in subsection (b) of this section, complete, sign, and submit an application, renewal, or documents on the applicant's or beneficiary's behalf;
(b) May act on behalf of the applicant or recipient by reporting information and submitting requests to the Agency, except an individual's long-term care (see OAR 461-001-0000) services provider cannot serve as the individual's designated representative (see OAR 411-004-0010) or representative (see OAR 411-028-0010 and 411-030-0020) for long-term care services; and
(c) May receive copies of the applicant or beneficiary's notices and other communications from the Agency.
(5) The following may not serve as an authorized representative:
(a) An individual serving an Intentional Program Violation (see OAR 461-195-0601), unless the Agency determines no one else is available to serve as the authorized representative;
(b) Homeless meal providers for homeless SNAP recipients;
(c) An individual who presents a risk of harm to case individuals;
(d) An individual who presents a conflict of interest;
(e) An agency employee or an employee of a contractor who is involved in the certification or issuance processes for Agency program benefits may not act as an authorized representative without the specific written approval of a designated Agency official, and only if that official determines that no one else is available to serve as an authorized

representative;
(f) Retailers who are authorized to accept Department Electronic Benefit Transfer (EBT) cards may not act as an authorized representative without the specific written approval of a designated Agency official, and only if that official determines that no one else is available to serve as an authorized representative.
(6) The authorized representative must maintain the confidentiality of any information provided by the Agency regarding the represented individuals.
(7) An individual ceases to be an authorized representative when:
(a) The represented individual notifies the Agency that the designation is terminated;
(b) The represented individual appoints a different authorized representative;
(c) The authorized representative informs the Agency that the designation is terminated;
(d) The Agency determines the authorized representative is no longer permitted to be the authorized representative; or
(e) There is a change in the legal authority upon which the individual or organization's authority was based.
(8) An authorized representative may be subject to overpayments (see OAR 461-195-0501 and 461-195-0541) in addition to other penalties:
(a) In group living (see OAR 461-001-0015) arrangements or substance use disorder (SUD) treatment centers, the facility may be prosecuted under applicable federal or state law;
(b) For other authorized representatives not covered by subsection (a) of this part, the Agency may prohibit the person from serving as a representative for one year.
(9) Conditions and requirements related to the designation and administration of authorized representatives described in OAR 461-115-0090 also apply to HSD Medical Programs.

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

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

AMEND: 410-200-0115

RULE TITLE: HSD Medical Programs—Effective Dates

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0115 – HSD Medical Programs – Effective Dates
o Re-organization and phrasing for clarity and consistency.

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 date on 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 date on 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: 410-200-0120

RULE TITLE: Notices

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

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

(a) A basic decision notice whenever an application for HSD Medical Program benefits is approved or denied;

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

(2) For a beneficiary who becomes an inmate of a public institution or a correctional facility, the Authority shall send a basic decision notice to close, reduce, or suspend HSD 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 HSD Medical Program benefits.

(4) When returned postal 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 postal mail. If the returned mail was sent electronically only, the Authority shall resend by postal mail within three business days. The date on the notice shall be the date the notice is sent by postal mail.

(5) The Agency 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.

(6) To close medical program benefits based on a request made by the beneficiary, another adult member of the EDG, or the authorized representative, the Agency shall send the following decisions notices:

(a) A timely continuing benefit decision notice when a request is made to close benefits;

(b) A basic decision notice when a request to withdraw or end benefits is made with written signature or recorded verbal signature waiving timely notice (see also section (8) of this rule);

(7) The Agency shall send a basic decision notice when an individual who is not a recipient of any Medicaid/CHIP benefits makes a request to withdraw an application for benefits.

(8) No other notice is required when an individual completes a voluntary agreement if all 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 EDG 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 shall 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 shall 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;

(E) A statement indicating under what circumstances a default order may be taken;

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

(b) A decision notice approving HSD Medical Program benefits including retroactive medical shall 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 HSD Medical Program benefits shall 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 shall provide individuals with a choice to receive decision notices and information referenced in this rule in an electronic format or by postal mail. If an individual chooses to receive notices and information electronically and has established an online account with the Applicant Portal of Oregon Eligibility (ONE), the Authority shall:
(a) Send confirmation of this decision by postal 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 SMS text message alerting the individual that a notice has been posted to their electronic account;
(d) At the request of the individual, send by postal 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 postal mail; and
(f) If any electronic communication referenced above is undeliverable, send the notice by postal mail within three business days of the failed communication.

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: 410-200-0125

RULE TITLE: Acting on Reported Changes

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

(1) When an HSD Medical Program beneficiary or an individual authorized to act on the beneficiary's behalf reports a change that may affect eligibility, the Agency shall promptly redetermine eligibility before reducing or ending medical benefits.

(2) The Agency may send an RFI to request additional information or verification related to the reported change.

(3) If a beneficiary remains eligible as a result of a redetermination due to a reported change, a new 12-month eligibility period is not established; the original renewal date is maintained.

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

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: 410-200-0130

RULE TITLE: Retroactive Medical

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0130 – Retroactive Medical
o Addition of text to address HPE as it relates to retroactive medical.

RULE TEXT:
(1) The Authority may evaluate for retroactive medical eligibility for the three calendar months preceding the month in which the Date of Request was established for the following individuals:
(a) Applicants requesting HSD Medical Programs who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP; and
(b) Deceased individuals who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP, 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) Retroactive medical eligibility may be approved for months in which an individual received coverage during a Hospital Presumptive Eligibility period (OAR 410-200-0105), unless the retroactive benefits would be a reduction in benefit-level compared to the Hospital Presumptive Eligibility benefits.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 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: 410-200-0135

RULE TITLE: Assumed, Continuous, and Protected Eligibility for Children and Pregnant Individuals

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0135 – Assumed, Continuous, and Protected Eligibility for Children and Pregnant Individuals
o Separated terms 'assumed', 'continuous', and 'protected' eligibility for better clarity.

RULE TEXT:
(1) Assumed Eligibility – A child born to an individual who is eligible for and receiving Medicaid/CHIP benefits at the time of the birth is assumed eligible 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.
(2) Continuous Eligibility for children – When eligibility for a child under age 19 is redetermined and would result in a loss of eligibility for any Medicaid/CHIP program administered by the agency prior to the end of the renewal month, eligibility shall be maintained in the current program through the end of the renewal month, unless the loss of eligibility is due to any of the following:
(a) The child is no longer an Oregon resident;
(b) The child dies;
(c) The child becomes incarcerated;
(d) The child turns age 19;
(e) For children in the CHIP program, receipt of minimum essential coverage;
(f) An adult in the EDG requests the medical benefits are closed;
(g) The child begins receiving Supplemental Security Income (SSI); or
(h) Eligibility renewal or redetermination cannot be completed because requested information is not submitted by the deadline established by the agency.
(3) Protected Eligibility for pregnant individuals – Individuals who are eligible for and receiving Medicaid for any portion of their pregnancy shall remain eligible through the two calendar months following the month in which the pregnancy ends, unless the individual:
(a) Is no longer an Oregon resident;
(b) Becomes incarcerated;
(c) Dies;
(d) Begins receiving SSI; or
(e) Requests a voluntary termination of eligibility, including a request made by an individual authorized to act on the beneficiary's behalf.

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

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

AMEND: 410-200-0140

RULE TITLE: Eligibility for Inmates

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0140 – Eligibility for Inmates
o Addition of information about residents of the Oregon State hospital as it relates to incarceration. This is a regulatory requirement that was missing from OAR.

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, including the Oregon State Hospital, who are:
(a) Under age 22;
(b) Age 22 or older and admitted to the Oregon State Hospital before their 21st birthday; or
(c) Is 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: 410-200-0145

RULE TITLE: Contested Case Hearing

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0145 – Contested Case Hearing
o Addition of exception of HPE benefits and hearing rights;
o Correction of OAR reference pointing to “good cause” criteria.

RULE TEXT:
(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 hearings for programs described in OAR chapter 410 division 200, except for individuals receiving HSD Medical Program benefits during a period of Hospital Presumptive Eligibility (OAR 410-200-0105). Contested case hearings are conducted in accordance with the Attorney General's model rules OAR 137-003-0501 and following ORS Ch. 183 except to the extent that Authority rules provide for different procedures.
(3) The Authority’s contested case hearings 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) A claimant may request a contested case hearing upon the timely completion of a hearing 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 hearing;
(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) An officer or employee of the Authority or the Department of Human Services may appear on behalf of the Authority in medical assistance hearings described in this rule. The Authority’s lay representative may not make legal argument on behalf of the Authority.
(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 shall read and be familiar with it.
(7) When an Authority representative is used, requests for admission and written interrogatories are not permitted.
(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 for 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 hearing.
(9) A claimant who is receiving medical assistance benefits and who is entitled to a continuing benefit decision notice may, at the option of the claimant, receive continuing benefits in the same manner and amount until a final order resolves the contested case. In order to receive continuing benefits, a claimant must request a hearing not later than:
(a) The tenth day following the date the notice is received; and
(b) The effective date of the action proposed in the notice.
(10) The continuing benefits are subject to modification based on additional changes affecting the claimant’s eligibility or level of benefits.
(11) The claimant shall receive an expedited hearing in the following situations:
(a) When the claimant contests the denial of continuing benefits; or

(b) When following the final order timelines in OAR 410-200-0146 could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function.

(12) In computing timeliness under sections (1) and (9) of this rule:

(a) The agency follows criteria outlined in 461-125-0310(7); 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.

STATUTORY/OTHER AUTHORITY: ORS 411.404, 411.816, 412.014, 412.049, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 183.452, 411.060, 411.404, 411.816, 412.014, 412.049

AMEND: 410-200-0200

RULE TITLE: Residency Requirements

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
(1) To be eligible for HSD 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 (c) of this part).
(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.
(c) 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.
(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 they intend to return when the purpose of the absence is completed.

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: 410-200-0205

RULE TITLE: Concurrent and Duplicate Program Benefits

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

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

(a) Any other HSD 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);

(2) An individual may not receive HSD 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.

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: 410-200-0210

RULE TITLE: Requirement to Provide Social Security Number

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
(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, spousal 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 (6) below, each applicant (including children) requesting medical benefits shall:
(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) The agency may not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN or if the individual meets one of the exceptions identified in section (6).
(4) Except as provided in section (6) 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 shall:
(a) Obtain required evidence under SSA regulations to establish the age, the citizenship, or non-citizen 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.
(5) The Agency may request that non-applicants provide an SSN on a voluntary basis. The Agency shall use the SSN for the purposes outlined in section (1).
(6) An applicant is not required to apply for or provide an SSN if the individual:
(a) Does not have an SSN and the SSN may be issued only for a valid-non-work reason;
(b) Is not eligible to receive an SSN;
(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.

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, 413.038, 414.025, 414.231, 414.534, 414.536, 414.706

AMEND: 410-200-0215

RULE TITLE: Citizenship and Non-Citizen Status Requirements

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0215 – Citizenship and Non-citizen Status Requirements
o Addition of requirements related to military/veteran status (existing policy, added to this rule for clarity).

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 described in sections (2)(a) through (g), (2)(i), (3)(g)(B)(ii), (3)(g)(B)(iv), (3)(g)(B)(v), (3)(g)(B)(vii), and (3)(g)(D) through (J) with deferred action under 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: 410-200-0220

RULE TITLE: Requirement to Pursue Assets

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

(1) As a condition of ongoing eligibility, an applicant or beneficiary shall 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) Pursue an asset if the individual can show good cause for not doing so (see section (6)).

(2) For all HSD Medical Programs, 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 (including inheritance, devise or elective share);

(f) Discretionary or mandatory distribution from a trust;

(g) Unemployment compensation; and

(h) Veteran's compensation and pensions.

(3) For all HSD Medical Programs except MAGI CHIP and eligibility granted under Cover All Kids (410-200-0240) or during a period of Hospital Presumptive Eligibility (410-200-0105):

(a) Each caretaker in the EDG shall 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) Each applicant, including a parent for their child, shall make a good faith effort to obtain available coverage under Medicare, if it is available.

(c) HSD Medical Program beneficiaries described in this section, including a parent for their child, shall apply for, accept, and maintain cost-effective employer-sponsored health insurance unless they have good cause (see section (6) of this rule):

(A) The Health Insurance Group (HIG) determines if employer sponsored health insurance meets the criteria to be considered cost effective; and

(B) If the insurance is determined to be cost effective and the individual pursues the insurance, HIG will authorize reimbursement of the individual's portion of the premium per OAR 410-120-1960.

(4) An individual involved in a personal injury shall 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 shall notify the Agency during the eligibility verification process (OAR 410-200-0230). 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.

(5) Except as outlined in section (6) of this rule, a caretaker who has the authority to pursue an asset on behalf of a child applying for or receiving Medicaid/CHIP and fails to do so is ineligible for assistance. The child's eligibility is not impacted by the caretaker's failure to pursue an asset on their behalf.

(6) The requirement for an individual to pursue an asset does not apply when good cause exists. An individual is considered to have good cause if any of the following are true:

(a) Pursuing the asset 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) For individuals with the authority to pursue child support on behalf of a child who is applying for or receiving Medicaid/CHIP benefits, the individual is considered to have good cause if:
(A) 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;
(B) Legal proceedings are pending for adoption of the child;
(C) 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;
(D) The individual is pregnant; or
(E) Other good cause reasons exist for non-cooperation.
(7) 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.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0225

RULE TITLE: Assignment of Rights

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0225 – Assignment of Rights
o Addition of text re: exclusion of Cover All Kids.

RULE TEXT:
(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 shall:
(a) Assign to the Agency any rights of each EDG 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 EDG until the requirements of this rule are met.
(3) Except for the MAGI CHIP program, and eligibility granted under Cover All Kids (OAR 410-200-0240):
(a) An applicant shall assign to the state the right of any Medicaid-eligible individual in the EDG 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.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0230

RULE TITLE: Verification

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0230 – Verification
o Expanded explanation of the FDSH and how Oregon uses it;
o Clarified citizen/non-citizen verification requirements to align with clarification received from CMS;
o Addition of explanation of reasonable compatibility.

RULE TEXT:
(1) Applicants, beneficiaries, or an individual authorized to act on their behalf shall attest to the following information:
(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) Receipt or availability of other healthcare coverage;
(i) Residency;
(j) Social Security number; and
(k) American Indian/Alaska Native status.
(2) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of US citizenship, US national, or non-citizen status;
(a) Self-attested information shall be verified via the federal data services hub (FDSH) or by electronic verification source available to the Agency;
(b) In the event that attested status cannot be verified via the FDSH or by electronic verification sources available to the Agency, self-attested information shall be used to determine eligibility, and the individual provided a reasonable opportunity period to provide verification of US citizen, US national, or non-citizen status as outlined in section (e) of this part. Exceptions to this verification requirement are described in sections (c) and (d) of this part.
(c) Applicants or beneficiaries attesting to US citizenship are exempt from the requirement to verify their citizenship if they are one of the following:
(A) Individuals who are assumed eligible (OAR 410-200-0135);
(B) Individuals who are entitled to or enrolled in Medicare;
(C) Individuals who are presumptively eligible for the BCCTP program through the BCCTP screening program or through the Hospital Presumptive Eligibility process (OAR 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. 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.
(d) Applicants or beneficiaries age 19 and older who attest to having an immigration status that is not a qualified non-citizen status (see OAR 410-200-0215(2)) are exempt from the requirement to verify non-citizen status.
(e) US Citizen, US National, and Non-citizen status verification guidelines:
(A) Individuals attesting to US citizenship shall verify their status by submitting any of the documents permitted under section 1903(x) of the Social Security Act (42 U.S.C. 1396b).
(B) Individuals attesting to non-citizen status shall verify their status by:
(i) Submitting documentation or other proof from the Immigration and Naturalization Service which contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number); or
(ii) Submitting other documents the State determines constitutes reasonable evidence indicating a satisfactory

immigration status.
(C) Non-citizens who attest to having no immigration status shall not be required to verify.
(f) For individuals with a qualified non-citizen status (see OAR 410-200-0215(2)), the Agency shall not require verification of the following unless questionable:
(A) Attestation to being continuously present in the U.S. since August 22, 1996;
(B) Attestation to being an honorably discharged veteran or in active military duty status; and
(C) Attestation to being the spouse or unmarried dependent child of an individual identified in subsection (B) of this part.
(g) Non-citizen status shall be reviewed and verified at the following times:
(A) Initial determination of eligibility;
(B) When a report of change of non-citizen status is received by the Agency.
(3) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of income:
(a) If the attested income exceeds the threshold that would produce eligibility for all EDG members, the Authority shall accept the attested information, deny HSD Medical Programs, and refer to the Federally Facilitated Marketplace for potential APTC eligibility;
(b) Attested income that would result in eligibility for one or more EDG members is compared to documentary evidence through a match with the FDSH or electronic verification sources available to the Agency. The attestation is considered reasonably compatible, and thus does not require further verification if:
(A) Income information obtained via FDSH or other available electronic verification sources is not discrepant by more than 10% when compared to the attestation; or
(B) Both the attested income and information obtained via FDSH or other available electronic verification sources are within the income threshold for the same HSD Medical Program.
(c) In the event that attested income is not reasonably compatible with information obtained via the FDSH or electronic verification sources available to the agency, prior to the determination of eligibility the agency will:
(A) Request documentary verification of income from the individual; or
(B) If the individual cannot obtain verification of income, a reasonable explanation as to why.
(4) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of receipt of private health insurance:
(a) Self-attested information shall be used to determine eligibility for HSD Medical Programs if:
(A) Information obtained through a match with the FDSH or electronic verification sources available to the agency does not conflict with attested information;
(B) Information obtained through a match with available electronic data conflicts with attested information but does not affect eligibility; or
(C) Verification is not available via a match with available electronic data or by any other method at the time of application processing.
(b) In the event that information obtained through a match with the FDSH or electronic verification sources available to the agency conflicts with attested information and may affect eligibility, private health insurance information shall be verified prior to eligibility determination.
(5) The Authority may request that applicants and beneficiaries of medical assistance provide additional information, including documentation, to verify most eligibility criteria if attested information is questionable or a discrepancy is identified.

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: 410-200-0235

RULE TITLE: Changes That Must Be Reported

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0235 – Changes that Must Be Reported
o Re-write/reorganization for clarity and continuity.

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 30 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 moves in or out of the household;
(h) For all HSD Medical Programs except MAGI CHIP, a change in availability of employer-sponsored health insurance;
(i) 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.
(j) 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: 410-200-0240

RULE TITLE: Eligibility for Individuals Who Do Not Meet the Citizen and Non-Citizen Status Requirements

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
(1) Citizen/Alien Waived Emergency Medical (CAWEM) provides coverage for emergency services.
(a) With the exception of subsection (b) below, to be eligible for CAWEM benefits, an individual must:
(A) Be age 19 or older; and
(B) Be ineligible for Plus level HSD Medical Program benefits solely because he or she does not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).
(b) Children under age 19 are eligible for CAWEM benefits through December 31, 2017, if the requirement outlined in section (1)(a)(B) is met.
(2) Citizen/Alien Waived Emergency Medical Plus (CAWEM Plus) provides:
(a) CAWEM Plus benefits provide an enhanced benefit package (OAR 410-120-1210) for the duration of a recipient's pregnancy:
(A) To be eligible for the CAWEM Plus benefits, an individual must:
(i) With the exception of paragraph (B) of this part, be age 19 or older;
(ii) Be pregnant; and
(iii) Be ineligible for Plus level HSD Medical Programs solely because they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).
(B) Children under age 19 are eligible for CAWEM Plus benefits through December 31, 2017, if the requirements outlined in (2)(a)(A) are met;
(C) CAWEM Plus benefits end as follows:
(i) CAWEM Plus benefits continue through and end on the last day of the pregnancy; and
(ii) Through March 31, 2018, the individual remains eligible for CAWEM benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls (see OAR 410-200-0135).
(b) Reproductive Health Equity Fund (RHEF) benefits, effective April 1, 2018, provide an enhanced benefit package (OAR 410-120-1210) and begin on the day following the pregnancy end-date:
(A) An individual is eligible for RHEF benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls;
(B) An individual who is receiving CAWEM benefits under section (2)(a)(C)(ii) of this rule shall receive RHEF benefits effective April 1, 2018, through the end of the month in which the 60th day following the last day of the pregnancy falls.
(3) Effective January 1, 2018, Cover All Kids provides the OHP Plus-equivalent benefit package (OAR 410-120-1210). To be eligible for Cover All Kids benefits, an individual must:
(a) Be under the age of 19; and
(b) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).

STATUTORY/OTHER AUTHORITY: ORS 414.534, ORS 411.060, ORS 411.402, 411.404, 413.042, 414.025

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: 410-200-0305

RULE TITLE: Eligibility Determination Group — MAGI Medicaid/CHIP

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0305 - Eligibility Determination Group — MAGI Medicaid/CHIP
o Re-write/restructured explanation of EDG formation for readability and clarity.

RULE TEXT:
When establishing eligibility for MAGI Medicaid/CHIP, each applicant or beneficiary shall have their own Eligibility Determination Group (EDG) determined individually based on the following EDG rules:
(1) Tax filer EDG:
(a) For individuals who intend to file a federal income tax return, who are not claimed as a tax dependent by another individual, the EDG consists of:
(A) The tax filer;
(B) The tax filer's spouse, with the following considerations:
(i) If living together, the tax filer's spouse is included in the EDG of the tax filer, irrespective of the spouse's tax filing status; and
(ii) If living separately, the tax filer's spouse is included in the EDG of tax filer if they intend to claim a tax filing status of Married Filing Jointly.
(C) All individuals whom the tax filer intends to claim as tax dependents.
(b) For tax filers who expect to be claimed as a tax dependent by another individual, the EDG is determined in accordance with section (2).
(2) Tax dependent EDG:
(a) Except as described in subsection (b) of this part, the EDG of an individual who expects to be claimed as a tax dependent is the same as the EDG of the tax filer who intends to claim them, as outlined in section (1) of this rule.
(b) For tax dependents who meet any of the following exceptions, the EDG is determined in accordance with section (3) of this rule:
(A) The individual is claimed as a tax dependent by someone other than a parent or spouse;
(B) The individual is a child living with both parents but is claimed as a tax dependent by one parent; or
(C) The individual is a child living with a parent and is claimed as a tax dependent by a non-custodial parent.
(3) Non-filer EDG:
(a) An individual's EDG is determined in accordance with this section if:
(A) The individual does not expect to file a tax return and is not claimed as a tax dependent;
(B) The individual does not expect to file a tax return and cannot substantiate whether or not they will be included in the tax return of another individual; or
(C) The individual expects to be claimed as a tax dependent and meets an exception described in section (2)(b) of this rule.
(b) The non-filer EDG consists of the following individuals, if living in the same household:
(A) The individual;
(B) The individual's spouse;
(C) The individual's children; and
(D) If the individual is a child, their parents and child siblings;
(c) Individuals described in subsection (b) of this part are still considered EDG members if they are temporarily absent from the household with intent to return to the household when the purpose of their absence is complete. Reasons for temporary absence include but are not limited to:
(A) Education;
(B) Military;
(C) Work or training;

(D) Incarceration; or

(E) Hospitalization.

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

AMEND: 410-200-0310

RULE TITLE: Eligibility and Budgeting; MAGI Medicaid/CHIP

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0310 – Eligibility and Budgeting; MAGI Medicaid/CHIP
o Moved text related to "budget month" from General Definitions and Income Standards OARs into this rule;
o Updated with changes to budgeting methodology; ongoing/converted income, new/actual income;
o Clarified details about the annual income evaluation.

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 determined as follows:
(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 by comparing the combined total of each EDG member's MAGI-based income to the income standards for the appropriate family size to determine eligibility for the applicable budget month. Countable MAGI-based income is determined as follows:
(a) For EDG members with ongoing income (the income has not started 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 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:
(A) For EDG members who expect to be paid 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 EDG members who expect 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.
(c) If ineligible under subsection (a) and (b) of this part 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 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 initial budget month and ongoing.
(5) If ineligible under section (6) of this rule, the agency will evaluate eligibility for the subsequent month. If eligible, the effective date of eligibility is established as described in HSD Medical Programs – Effective Dates (OAR 410-200-0115).

(6) 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

AMEND: 410-200-0315

REPEAL: Temporary 410-200-0315 from DMAP 5-2020

RULE TITLE: Standards and Determining Income Eligibility

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0315 – Standards and Determining Income Eligibility
o The contents of this rule unrelated to program income thresholds were moved to other, more appropriate OARs (General Definitions, Budgeting). This rule now only contains income thresholds by program and family size.

RULE TEXT:
(1) This rule outlines income thresholds for HSD Medical Programs. See OAR 410-200-0310 for eligibility and budgeting.
(2) The MAGI-based income standard for the MAGI Parent or Caretaker-Relative program is set as follows: See attached table.
(3) Effective March 1, 2020, the MAGI income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the FPL as follows: See attached table.
(4) Effective March 1, 2020, the MAGI income standard for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under age one is set at 185 percent FPL as follows: See attached table.
(5) Effective March 1, 2020, the MAGI income standard for the MAGI CHIP program is set at 300 percent of FPL as follows: See attached table.
(6) When the Department makes an ELE determination and the child meets all MAGI CHIP or MAGI Child Program nonfinancial eligibility requirements, the EDG size determined by the Department is used to determine eligibility regardless of the family size. The countable income of the household is determined by the ELA. A child is deemed eligible for MAGI CHIP or MAGI Child Program as follows:
(a) Effective March 1, 2020, if the MAGI-based income of the EDG is below 163 percent of the 2020 federal poverty level as listed below, the Department deems the child eligible for the MAGI Child Program: See attached table.
(b) If the MAGI-based income of the EDG is at or above 163 percent of the FPL through 300 percent of the FPL as listed in section (4) (f) of this rule, the Agency deems the child eligible for MAGI CHIP.

STATUTORY/OTHER AUTHORITY: 42 CFR 435.110, ORS 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, 435.608, 433.138, 433.145, 433.146, 433.147, 433.148, 435.115, 435.117, 435.118, 435.119, 435.1200, 435.1205, 435.170, 435.190, 435.222, 435.403, 435.406, 435.610, 435.916, 435.917, 447.56, 457.350, 457.360, 457.805, ORS 411.402, 411.404, 413.042, 414.534

STATUTES/OTHER IMPLEMENTED: ORS 411.402, 411.404, ORS 411.060, 411.095, 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

2020 Oregon Health Authority Medical Programs - effective March 1, 2020

Family Size	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) (CMO) / MAGI Adult (AMO)		MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP (C21)	
	Standard	Standard + 5% FPL Disregard	Standard (133%)	Standard + 5% FPL Disregard (138%)	Standard (185%)	Standard + 5% FPL Disregard (190%)	Standard (300%)	Standard + 5% FPL Disregard (305%)
1	$ 399	$ 453	$ 1,415	$ 1,468	$ 1,968	$ 2,021	$ 3,190	$ 3,244
2	$ 515	$ 587	$ 1,911	$ 1,983	$ 2,658	$ 2,730	$ 4,310	$ 4,382
3	$ 611	$ 702	$ 2,408	$ 2,498	$ 3,349	$ 3,439	$ 5,430	$ 5,521
4	$ 747	$ 857	$ 2,904	$ 3,013	$ 4,040	$ 4,149	$ 6,550	$ 6,660
5	$ 872	$ 1,000	$ 3,401	$ 3,529	$ 4,730	$ 4,858	$ 7,670	$ 7,798
6	$ 998	$ 1,145	$ 3,897	$ 4,044	$ 5,421	$ 5,567	$ 8,790	$ 8,937
7	$ 1,114	$ 1,280	$ 4,394	$ 4,559	$ 6,112	$ 6,277	$ 9,910	$ 10,076
8	$ 1,230	$ 1,414	$ 4,890	$ 5,074	$ 6,802	$ 6,986	$ 11,030	$ 11,214
9	$ 1,321	$ 1,524	$ 5,387	$ 5,589	$ 7,493	$ 7,695	$ 12,150	$ 12,353
10	$ 1,456	$ 1,678	$ 5,884	$ 6,105	$ 8,184	$ 8,405	$ 13,270	$ 13,492
11	$ 1,592	$ 1,832	$ 6,380	$ 6,620	$ 8,874	$ 9,114	$ 14,390	$ 14,630
12	$ 1,728	$ 1,987	$ 6,877	$ 7,135	$ 9,565	$ 9,823	$ 15,510	$ 15,769
13	$ 1,864	$ 2,142	$ 7,373	$ 7,650	$ 10,256	$ 10,533	$ 16,630	$ 16,908
14	$ 2,000	$ 2,296	$ 7,870	$ 8,165	$ 10,946	$ 11,242	$ 17,750	$ 18,046
15	$ 2,136	$ 2,451	$ 8,366	$ 8,681	$ 11,637	$ 11,951	$ 18,870	$ 19,185
16	$ 2,272	$ 2,606	$ 8,863	$ 9,196	$ 12,328	$ 12,661	$ 19,990	$ 20,324
17	$ 2,408	$ 2,760	$ 9,359	$ 9,711	$ 13,018	$ 13,370	$ 21,110	$ 21,462
18	$ 2,544	$ 2,915	$ 9,856	$ 10,226	$ 13,709	$ 14,079	$ 22,230	$ 22,601
19	$ 2,680	$ 3,070	$ 10,352	$ 10,741	$ 14,400	$ 14,789	$ 23,350	$ 23,740
20	$ 2,816	$ 3,224	$ 10,849	$ 11,257	$ 15,090	$ 15,498	$ 24,470	$ 24,878
Each add'l add	$ 136	$ 155	$ 497	$ 516	$ 691	$ 710	$ 1,120	$ 1,139

Family Size	2019 100% Annual Income Test (2019 FPL used for 2020 determinations)	2020 100% Annual Income Test (2020 FPL used for 2021 determinations)
1	$ 12,490	$ 12,760
2	$ 16,910	$ 17,240
3	$ 21,330	$ 21,720
4	$ 25,750	$ 26,200
5	$ 30,170	$ 30,680
6	$ 34,590	$ 35,160
7	$ 39,010	$ 39,640
8	$ 43,430	$ 44,120
9	$ 47,850	$ 48,600
10	$ 52,270	$ 53,080
11	$ 56,690	$ 57,560
12	$ 61,110	$ 62,040
13	$ 65,530	$ 66,520
14	$ 69,950	$ 71,000
15	$ 74,370	$ 75,480
16	$ 78,790	$ 79,960
17	$ 83,210	$ 84,440
18	$ 87,630	$ 88,920
19	$ 92,050	$ 93,400
20	$ 96,470	$ 97,880
Each add'l add	$ 4,420	$ 4,480

2019 Oregon Health Authority Medical Programs - effective March 1, 2019

Family Size	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) (CMO) / MAGI Adult (AMO)		MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP (C21)		Family Size	Income Test (2018 FPL used for 2019 determinations)
	Standard	Standard + 5% FPL Disregard	Standard (133%)	Standard + 5% FPL Disregard (138%)	Standard (185%)	Standard + 5% FPL Disregard (190%)	Standard (300%)	Standard + 5% FPL Disregard (305%)		
1	$ 399	$ 451	$ 1,384	$ 1,436	$ 1,926	$ 1,978	$ 3,123	$ 3,175	1	$ 12,140
2	$ 515	$ 585	$ 1,874	$ 1,945	$ 2,607	$ 2,677	$ 4,228	$ 4,298	2	$ 16,460
3	$ 611	$ 700	$ 2,364	$ 2,453	$ 3,288	$ 3,377	$ 5,333	$ 5,421	3	$ 20,780
4	$ 747	$ 854	$ 2,854	$ 2,961	$ 3,970	$ 4,077	$ 6,438	$ 6,545	4	$ 25,100
5	$ 872	$ 998	$ 3,344	$ 3,470	$ 4,651	$ 4,777	$ 7,543	$ 7,668	5	$ 29,420
6	$ 998	$ 1,142	$ 3,834	$ 3,978	$ 5,333	$ 5,477	$ 8,648	$ 8,792	6	$ 33,740
7	$ 1,114	$ 1,277	$ 4,324	$ 4,486	$ 6,014	$ 6,177	$ 9,753	$ 9,915	7	$ 38,060
8	$ 1,230	$ 1,411	$ 4,813	$ 4,994	$ 6,695	$ 6,876	$ 10,858	$ 11,038	8	$ 42,380
9	$ 1,321	$ 1,520	$ 5,303	$ 5,503	$ 7,377	$ 7,576	$ 11,963	$ 12,162	9	$ 46,700
10	$ 1,456	$ 1,674	$ 5,793	$ 6,011	$ 8,058	$ 8,276	$ 13,068	$ 13,285	10	$ 51,020
11	$ 1,592	$ 1,828	$ 6,283	$ 6,519	$ 8,740	$ 8,976	$ 14,173	$ 14,409	11	$ 55,340
12	$ 1,728	$ 1,983	$ 6,773	$ 7,028	$ 9,421	$ 9,676	$ 15,278	$ 15,532	12	$ 59,660
13	$ 1,864	$ 2,137	$ 7,263	$ 7,536	$ 10,103	$ 10,376	$ 16,383	$ 16,656	13	$ 63,980
14	$ 2,000	$ 2,291	$ 7,753	$ 8,044	$ 10,784	$ 11,075	$ 17,488	$ 17,779	14	$ 68,300
15	$ 2,136	$ 2,446	$ 8,243	$ 8,553	$ 11,465	$ 11,775	$ 18,593	$ 18,902	15	$ 72,620
16	$ 2,272	$ 2,600	$ 8,733	$ 9,061	$ 12,147	$ 12,475	$ 19,698	$ 20,026	16	$ 76,940
17	$ 2,408	$ 2,755	$ 9,222	$ 9,569	$ 12,828	$ 13,175	$ 20,803	$ 21,149	17	$ 81,260
18	$ 2,544	$ 2,909	$ 9,712	$ 10,077	$ 13,510	$ 13,875	$ 21,908	$ 22,273	18	$ 85,580
19	$ 2,680	$ 3,064	$ 10,202	$ 10,586	$ 14,191	$ 14,575	$ 23,013	$ 23,396	19	$ 89,900
20	$ 2,816	$ 3,218	$ 10,692	$ 11,094	$ 14,872	$ 15,274	$ 24,118	$ 24,519	20	$ 94,220
Each add'l add	$ 136	$ 154	$ 490	$ 508	$ 681	$ 700	$ 1,105	$ 1,123	Each add'l add	$ 4,320

AMEND: 410-200-0400

RULE TITLE: Specific Requirements; Breast and Cervical Cancer Treatment Program (BCCTP)

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:
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 receiving 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 shall:
(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 shall 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 shall 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 at the point at which any of the following 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 they do not meet the requirements for eligibility.

STATUTORY/OTHER AUTHORITY: 411.404, 413.042, ORS 411.402, 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, 414.540, 414.706

AMEND: 410-200-0405

RULE TITLE: Specific Requirements; Substitute Care

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

In addition to eligibility requirements applicable to the Substitute Care program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the Substitute Care program, effective 10/01/13.

(1) To be eligible for Substitute Care, an individual shall 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.

(2) While living in an intermediate psychiatric care facility, an individual's EDG consists of the individual only.

(3) There is no income test for Substitute Care.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

AMEND: 410-200-0407

RULE TITLE: Specific Requirements—Former Foster Care Youth Medical Program

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0407 – Specific Requirements; Former Foster Care Youth Medical Program
o Addition of non-financial eligibility requirement for individuals to not be receiving adoption assistance or foster care maintenance payments as a condition of FFCYM eligibility.

RULE TEXT:
This rule describes specific eligibility requirements for the Former Foster Care Youth Program (FFCYM).
(1) There is no income test for the FFCYM Program.
(2) An individual is eligible for the FFCYM Program if the individual meets the requirements of all of the following:
(a) Is an adult at least age 18 and under age 26;
(b) Is not eligible for MAGI Child, MAGI CHIP, MAGI Pregnant Woman, or MAGI Parent or Caretaker Relative benefits;
(c) Was in foster care under the responsibility of the Oregon Department of Human Services or tribe and enrolled in Child Welfare Title XIX Medicaid 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.
(d) Is not receiving Supplemental Security Income (SSI);
(e) Is not receiving adoption assistance or foster care maintenance payments.

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

STATUTES/OTHER IMPLEMENTED: ORS 411.060, 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 411.447, 413.032, 413.038, 414.025, 414.231, 414.534, 414.536, 414.706

AMEND: 410-200-0410

RULE TITLE: Specific Requirements; MAGI CHIP

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0410 – Specific Requirements; MAGI CHIP
o Added requirement to not be "receiving or deemed to be receiving SSI benefits" (existing eligibility policy but was not called out specifically in this rule).

RULE TEXT:
In addition to eligibility requirements applicable to MAGI CHIP 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 MAGI CHIP with an effective date prior to October 1, 2013.
(2) To be eligible for MAGI CHIP, an individual must:
(a) Be under 19 years of age; and
(b) Meet the budgeting requirements of OAR 410-200-0315.
(3) To be eligible for MAGI CHIP, an individual may not:
(a) Be eligible for MAGI Child, MAGI Pregnant Woman, MAGI Parent or Caretaker Relative, or Substitute Care programs;
(b) Be receiving or deemed to be receiving SSI benefits; and
(c) 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 member of the household at risk of harm.
(4) 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 shall give consent in writing, by telephone, orally, or through electronic signature.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

AMEND: 410-200-0415

RULE TITLE: Specific Requirements; MAGI Child

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

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) To be eligible for the MAGI Child program, the child must:

(a) Be under the age of 19; and

(b) With the exception of section (3) below, have household income at or below:

(A) 133 percent of the federal poverty level (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.

(2) A child born to an individual who is eligible for and receiving Medicaid/CHIP benefits is an Assumed Eligible Newborn (AEN) for the MAGI Child program until the end of the month in which the child turns one year of age (see OAR 410-200-0135). There is no income limit for an AEN.

(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 eligible for Substitute Adoptive Care, MAGI Parent and Caretaker Relative, or MAGI Pregnant Woman programs.

(4) 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 shall give consent in writing, by telephone, orally, or through electronic signature.

(5) 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 HSD Medical Programs.

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, 413.038, 414.025, 414.231, 414.447, 414.706

AMEND: 410-200-0420

RULE TITLE: Specific Requirements; MAGI Parent or Caretaker Relative

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0420 – Specific Requirements; MAGI Parent or Caretaker Relative
o Updated program name from “MAGI Parent or Other Caretaker Relative” to “MAGI Parent or Caretaker Relative”;
o Added text clarification re: parents/caretakers and spouses of parents/caretakers.

RULE TEXT:
In addition to eligibility requirements applicable to the MAGI Parent or Caretaker Relative program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Parent or Caretaker Relative program.
(1) To be eligible for the MAGI Parent or Caretaker Relative program, an individual must be:
(a) A parent or caretaker relative who assumes primary responsibility for a dependent child; or
(b) The spouse of the individual described in subsection (a) of this part.
(2) To be eligible for the MAGI Parent or Caretaker Relative program, an individual must have EDG 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 Caretaker Relative program, an individual must 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.

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

AMEND: 410-200-0425

RULE TITLE: Specific Requirements; MAGI Pregnant Woman

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

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) To be eligible for the MAGI Pregnant Woman program, an individual must be pregnant, or be within the two calendar months following the month in which their pregnancy ended.

(2) To be eligible for the MAGI Pregnant Woman program, an individual must:

(a) Have household income that is at or below 185 percent of the federal poverty level (OAR 410-200-0315); or

(b) Be eligible for protected eligibility according to the policy described in OAR 410-200-0135.

(3) To be eligible for the MAGI Pregnant Woman program, an individual must not be receiving Supplemental Security Income (SSI).

(4) Once a beneficiary is eligible and receiving Medicaid through the MAGI Pregnant Woman program, they are continuously eligible through the two months following the month in which the pregnancy ends (OAR 410-200-0135) unless one or more of the following occur:

(a) The individual dies;

(b) The individual moves out of state;

(c) The individual becomes incarcerated; or

(d) An adult in the EDG requests the medical benefits are closed.

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

AMEND: 410-200-0435

RULE TITLE: Specific Requirements; MAGI Adult

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: These rule changes are necessary to update language and terminology to align with CMS and agency leadership guidance, system functionality, and operational needs.

RULE TEXT:

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) 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 (OAR 410-200-0315) for the applicable family size.

(2) 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 caretaker relative of a child living in the home who is not enrolled in minimum essential coverage.

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, 413.038, 414.025, 414.231, 414.447, 414.706

AMEND: 410-200-0440

RULE TITLE: Specific Requirements; Extended Medical Assistance

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0440 – Specific Requirements; Extended Medical Assistance
o Rewrite for clarity;
o Added details clarifying eligibility for EXT as communicated by CMS.

RULE TEXT:
(1) Individuals who lose eligibility for MAGI PCR due to the receipt or increase of earned income are eligible for a period of up to 12 months of Extended Medical Assistance if:
(a) They were eligible for and receiving MAGI PCR benefits for any one of the six months preceding the receipt or increase in earned income that resulted in loss of MAGI PCR eligibility;
(b) Eligibility is redetermined and the individual is found ineligible for any Medicaid program except BCCTP or Substitute Care; and
(c) They are the parent or caretaker relative of a dependent child living in their home.
(2) Individuals who lose eligibility for MAGI PCR due to the receipt or increase of spousal support are eligible for a period of up to four months of EXT if:
(a) They were eligible for and receiving MAGI PCR benefits for any three of the six months preceding the receipt or increase in spousal support that resulted in loss of MAGI PCR eligibility;
(b) Eligibility is redetermined and the individual is found ineligible for any Medicaid program except BCCTP or Substitute Care; and
(c) They are the parent or caretaker relative of a dependent child living in their home.
(3) The dependent children of individuals described in sections (1) and (2) are eligible for EXT for the same time period as their parent or caretaker relative if:
(a) They lost Medicaid eligibility due to the parent or caretaker relative's receipt or increase of earned income or spousal support; and
(b) Eligibility is redetermined and they are not eligible for any Medicaid program.
(4) The EXT eligibility period is established as described in sections (1) and (2) of this rule, beginning the first of the month following the month in which the beneficiary experienced the receipt or increase in earned income or spousal support resulting in loss of MAGI PCR eligibility. For individuals who receive other Medicaid/CHIP benefits during the EXT eligibility period:
(a) Such months are not an overpayment;
(b) Any month in which an individual receives other Medicaid/CHIP benefits when they were eligible for EXT is counted as a month of the EXT eligibility period.
(5) Individuals described in sections (1) through (3) of this rule who lose EXT eligibility for one of the following reasons may regain EXT eligibility for the remainder of the original EXT eligibility period if:
(a) EXT eligibility was lost because the individual left the household during the EXT eligibility period. The individual may regain EXT eligibility if they return to the household; or
(b) EXT eligibility was lost due to a change in circumstance that resulted in eligibility for another Medicaid program, and then a subsequent change in circumstance occurred that resulted in loss of eligibility for all Medicaid Programs.
(6) Individuals who lose eligibility for MAGI PCR and would be eligible to receive EXT except that they are determined eligible for another Medicaid program, and their dependent children, shall receive EXT benefits for the remainder of their original EXT eligibility period if:
(a) They subsequently lose eligibility for all Medicaid programs; and
(b) They continue to meet the non-financial eligibility requirements of MAGI PCR.

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

STATUTES/OTHER IMPLEMENTED: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.706

REPEAL: 410-200-0505

RULE TITLE: Specific Requirements; Fast Track Eligibility and Enrollment for MAGI Medicaid

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0505 and 410-200-0510 – These rules were put in place to maintain eligibility rules for pre-ACA OHP programs and to manage transition to MAGI-based programs, which is no longer needed.

RULE TEXT:

For Fast Track eligibility and enrollment, the Authority provides MAGI Medicaid benefits based on an individual's eligibility for SNAP program benefits, or for individuals who are parents of children determined eligible for OCCS Medicaid programs.

(1) A SNAP recipient adult may be found eligible for Fast Track eligibility and enrollment based on findings from the Department, even if the Department's eligibility methodology differs from that used by the Authority for OCCS Medical Programs if the adult:

(a) Has SNAP income is at or below the applicable income standards for MAGI Adult;

(b) Indicates they wish to pursue medical assistance;

(c) Is not eligible for or receiving Supplemental Security Income;

(d) Agrees to cooperate with the Division of Child Support; and

(e) Meets the specific program requirements for MAGI Adult (OAR 410-200-0435).

(2) The adult parent or parents of a MAGI Medicaid eligible child may be found eligible for Fast Track eligibility and enrollment if the adult:

(a) Indicates they wish to pursue medical assistance;

(b) Is not eligible for or receiving Supplemental Security Income;

(c) Agrees to cooperate with the Division of Child Support; and

(d) Meets the specific program requirements for the applicable program.

(3) A new application is not required for Fast Track eligibility and enrollment.

(4) If the individual requests Fast Track eligibility and enrollment and is not eligible due to eligibility for or receipt of Supplemental Security Income, the Authority shall refer the applicant to the Department for an eligibility determination. The Date of Request is the date the Authority received consent for Fast Track eligibility and enrollment.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 413.038

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

REPEAL: 410-200-0510

RULE TITLE: Specific Program Requirements; BCCM, CEC, CEM, EXT, MAA, MAF, OHP, and Substitute Care

NOTICE FILED DATE: 03/11/2020

RULE SUMMARY: • 410-200-0505 and 410-200-0510 – These rules were put in place to maintain eligibility rules for pre-ACA OHP programs and to manage transition to MAGI-based programs, which is no longer needed.

RULE TEXT:

(1) 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) 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 Substitute Care 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 Substitute Care program benefits;

(b) The child turns 19 years of age;

(c) The child moves out of state; or

(d) Benefits are closed voluntarily.

(6) 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 Substitute Care program benefits.

(7) For the Authority to enroll a child in the program based on a determination made by an ELA, the child's parent or guardian shall give consent in writing, by telephone, orally, or through electronic signature.

(8) 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 (OAR 410-200-0440).

(9) 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 whom 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 whom 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.
(10) 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.
(11) To be eligible for the OHP-OPC program, an individual must be less than 19 years of age.
(12) To be eligible for the OHP-OP6 program, a child must be less than six years of age and not eligible for OHP-OPC.
(13) 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 day following the last day of the pregnancy falls; or
(c) Be an infant under age one.
(14) 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).
(15) 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 Substitute Care 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 Substitute Care 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.
(16) 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.
(17) To be eligible for the Substitute Care program, an individual must meet the specific eligibility requirements for Substitute Care found in OAR 410-200-0405.
(18) 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 day following the last day of the pregnancy falls.
(19) 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.

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