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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
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ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Public Institution Residents. Unwinding FFCRA Continuous Enrollment Requirement FFCRA, Renewal Process and temporary Medicaid program.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 03/21/2023 5:00 PM

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

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.

The Families First Coronavirus Response and Recovery Act (FFCRA), 2020, set the requirement to maintain continuous enrollment of medical coverage for individuals who were eligible for and receiving benefits at any point during the COVID-19 public health emergency (PHE). Later, the Consolidated Appropriations Act, 2023, de-linked the continuous enrollment requirement from the PHE timeline effective March 31, 2023, mandating states begin the 'unwinding' of the continuous enrollment provisions by performing redeterminations of eligibility for all Medicaid/CHIP recipients. Oregon will begin this process on 4/1/2023 with the policy and procedural provisions outlined in OAR 410-200-0521. On April 1, 2023, the MAGI Expanded Adult program will be implemented to maintain eligibility for individuals who would otherwise be over-income for the MAGI Adult program up to 200% FPL.

Residents of Public Institutions; References To Newly-Created Programs.

These rules address the ways in which HSD Medical Program eligibility is handled for those who are residents of public institutions. Edits are being made to existing rules to allow for more flexibility in reinstating medical coverage without the need for a new application upon a person's release or discharge from a public institution. The changes also include texts edits to ensure respectful and inclusive language.

Additional edits are being made to add references for 3 new programs, rules for which are being separately filed – MAGI Expanded Adult Program, Compact of Free Association (COFA) Dental, and Veteran Dental – to ensure they are properly included in the medical program hierarchy and definition of Health Systems Division Medical Programs.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.
Consolidated Appropriations Act, 2023: https://www.congress.gov/bill/117th-congress/house-bill/2617/text
1115 Waiver approval: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf

Residents of Public Institutions; References To Newly-Created Programs.
None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.
These changes will be applied across all populations utilizing Oregon Health Plan services; timelines are being expanded and additional outreach efforts created to ensure the agency is able to process and inform members of needed activities and renewal results.

Residents of Public Institutions; References To Newly-Created Programs.
Applying greater flexibilities to the timeframes in which the Authority can reinstate medical coverage for individuals releasing or discharging from public institutions, as well as removing the requirement for the burden of reporting release or discharge from falling only on the individuals themselves, will help ensure more equitable and timely access to reinstated coverage for all, particularly for those who currently have difficulty meeting reporting requirements due to inherent systemic inequities. Historically, people of color have been incarcerated at a higher rate than others, and this change will have a positive impact for those communities.

FISCAL AND ECONOMIC IMPACT:

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.
The Authority anticipates a fiscal impact as follows:
-Administrative costs of performing outreach and renewal
-Program costs associated with the new MAGI Expanded Adult eligibility group

Residents of Public Institutions; References To Newly-Created Programs.
There may be a positive fiscal impact realized by stakeholders such as providers, community agencies who use local funds to assist in paying for services for this population, and OHP recipients themselves. Currently, many individuals release or discharge from public institutions without contacting the Agency to have medical benefits reinstated within the 10-day requirement. Thus, they are required to submit a new application which, if they follow-through, only allows for up to 3 months of retroactive coverage from the time of the application. Under the amended rule, the Agency may reinstate coverage up to 12 months in the past when it learns that a person with suspended Medicaid coverage is no longer a resident of a public institution which will allow for payment of covered Oregon Health Plan services for a longer retroactive period.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost

of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.
(1) No Impact
(2)
(a) Small business and industries are not impacted by this change.
(b) The Agency anticipates costs related to the administrative effort associated with performing the unwinding period renewal, and costs associated with the development, collection, and delivery of required reporting.
(c) The Agency anticipates increased administrative costs to perform a redetermination of eligibility for all OHP recipients during the unwinding period.
Additional OHA impact as follows:
-Administrative costs of performing outreach and renewal
-Program costs associated with the new MAGI Expanded Adult eligibility group

Residents of Public Institutions; References To Newly-Created Programs.
(1) There may be a fiscal impact to the Oregon Health Authority if reinstated coverage for extended retroactive months is utilized for payment of services at a higher frequency than what currently occurs. The extent of this potential impact cannot be accurately anticipated. There could also be some added workload for eligibility staff who may end up reinstating coverage for more individuals than who currently contact the agency for reinstatement, but this is not expected to be a significant impact.
(2)
(a) None
(b) No impact expected
(c) No impact expected

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Unwinding Continuous Enrollment Requirement of FFCRA; Unwinding Renewal Process And Temporary Medicaid Program.
None

Residents of Public Institutions; References To Newly-Created Programs.
None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-200-0015, 410-200-0110, 410-200-0120, 410-200-0140, 410-200-0235, 410-200-0315, 410-200-0436, 410-200-0520, 410-200-0521

AMEND: 410-200-0015

RULE SUMMARY: Adds reference to the new MAGI Expanded Adult program in the definition of Health Systems Division Medical Assistance. Updates text references of “inmate” and “incarceration” to “resident of a public institution” which also requires renumbering.

CHANGES TO RULE:

410-200-0015

~~General Definitions~~¶
(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.¶
(2) "Active renewal" means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.¶
(3) "Address Confidentiality Program (ACP)" means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.¶
(4) "AEN" means Assumed Eligible Newborn (OAR 410-200-0115).¶
(5) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).¶
(6) "Agency" means the Oregon Health Authority and Department of Human Services.¶
(7) "Applicant" means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.¶
(8) "Application" means:¶
(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or¶
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.¶
(9) "APTC" means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.¶
(10) "Assumed eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.¶
(11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).¶
(12) "Automated renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.¶
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disability medical program benefits, or APTC.¶
(14) "BRS" means Behavior Rehabilitation Services.¶
(15) "Budget month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.¶
(16) "Caretaker" means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child's care.¶
(17) "Caretaker relative" means an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:¶
(a) A relative of the dependent child, as follows:¶
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.¶
(B) Stepfather, stepmother, stepbrother, and stepsister.¶
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.¶
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;¶
(18) "CWM" means Citizenship Waived Medical, which is Medicaid coverage for emergency medical needs (OAR 410-134-0003(1)) 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) "CWM Plus" means medical services for pregnant CWM beneficiaries (OAR 410-200-0240) and includes:¶
(a) CWM Plus coverage (OAR 410-134-0003(3)) for the duration of the individual's pregnancy; and¶
(b) Reproductive Health Equity Act (RHEA) coverage (OAR 410-134-0003(4)) 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 (OAR 410-134-0003(5)) 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;¶
(F) MAGI Expanded Adult.¶
(48) "Healthier Oregon Program (HOP)" means an OHP Plus-equivalent benefit (OAR 410-134-0003(5) through (7)) for individuals described in OAR 410-200-0240.¶
(49) "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.¶
(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:¶~~
~~(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 their case has been adjudicated and while other living arrangements are being made for the individual¶~~
~~(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶~~
~~(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶~~
~~(i) Is under age 21;¶~~
~~(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶~~
~~(iii) Is age 65 or older.¶~~
(~~51~~) "Insurance affordability program" means a program that is one of the following:¶
(a) Medicaid;¶
(b) CHIP;¶
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;¶
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.¶
(5~~2~~1) "Legal argument" has the meaning given that term in OAR 137-003-0008(c).¶
(5~~3~~2) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.¶
(5~~4~~3) "MAGI" means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in OAR 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.¶
(5~~5~~4) "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 section; 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.¶
(5~~6~~5) "Minimum Essential Coverage" (MEC) means medical coverage under:¶
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), 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) Health insurance plans in place on or before March 23, 2010; 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.¶
(5~~7~~6) "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.¶
(5~~8~~7) "Non-citizen" means any individual who is not a citizen or national of the United States as defined at 8 U.S.C. 1101(a)(22).¶
(5~~9~~8) "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~~59) "Parent" means a natural or biological, adopted, or stepparent.¶
(6~~1~~0) "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.¶
(6~~2~~1) "Primary Contact" has the same meaning given "head of household" in this rule.¶
(6~~3~~2) "PRTF" means Psychiatric Residential Treatment Facility.¶
(6~~4~~3) "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.¶
(6~~5~~4) "Qualified hospital" means a hospital that:¶
(a) Participates as an enrolled Oregon Medicaid provider;¶
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;¶
(c) Agrees to make determinations consistent with Authority policies and procedures;¶
(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and¶
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).¶
(6~~6~~5) "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.¶
(6~~7~~6) "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.¶
(6~~8~~7) "Renewal" means a regularly scheduled periodic review of eligibility.¶
(6~~9~~8) "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.¶
(69) "Resident of a Public Institution" 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 a resident of a public institution 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 a resident. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:¶
(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 their case has been adjudicated and while other living arrangements are being made for the individual¶
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶
(i) Is under age 21;¶
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶
(iii) Is age 65 or older.¶
(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, 413.032, 414.231, 414.536, 414.706

AMEND: 410-200-0110

RULE SUMMARY: Updates text reference of “inmate” to “resident of a public institution”. Adds 3 new programs to the HSD Medical Program hierarchy – MAGI Expanded Adult, Compact of Free Association (COFA) Dental and Veteran Dental.

CHANGES TO RULE:

410-200-0110
Application and Renewal Processing and Timeliness Standards ¶

(1) General information as it relates to application processing is as follows:¶
(a) An individual may apply for one or more medical programs administered by the Authority, the Department, or the Federally Facilitated Marketplace (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 a~~n inmate~~ resident of a public institution and met the requirements of OAR 410-200-0140;¶
(e) An individual not receiving medical program benefits is added to an existing case where any members of the individual's EDG are receiving medical program benefits;¶
(f) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;¶
(g) During the ninety-day reconsideration period for eligibility following closure:¶
(A) The Authority shall redetermine in a timely manner (OAR 410-200-0110) the eligibility of an individual who:¶
(i) Lost HSD Medical Program eligibility because they did not return the pre-populated renewal form or respond to an RFI, and did not submit the information needed to renew eligibility; and¶
(ii) Within 90 days of the medical closure date, submits the pre-populated renewal form or provides the requested additional information.¶
(B) The date the pre-populated renewal form or RFI response is submitted within the ninety-day reconsideration period establishes a new date of request;¶
(C) In the event that the pre-populated renewal form is submitted within the ninety-day reconsideration period and an RFI is generated for which the due date lands outside of the ninety-day reconsideration period, a new application is not required.¶
(D) If the individual is found to meet HSD Medical Program eligibility based on the completed redetermination, the effective date of medical benefits is as described in 410-200-0115 (3) and (4).¶
(5) Signature requirements are as follows:¶
(a) Signatures accepted by the Agency may be:¶
(A) Handwritten;¶
(B) Electronic; or¶
(C) Telephonic.¶
(b) An application must be signed by one of the following:¶
(A) The head of household;¶
(B) An adult in the applicant's EDG;-¶
(C) An authorized representative; or¶
(D) If the applicant is a child or incapacitated, someone age 18 or older acting responsibly for the applicant.¶
(c) If the original signor of an application ceases to be a member of the case, the signature of an individual described in section (b) of this part is required.¶
(d) Hospital Presumptive Eligibility may be determined without a signature if no electronic data match with the FDSH will be performed;¶
(e) At renewal, if the Agency is unable to process an automated renewal, a signature is required on the pre-populated active renewal form sent to the beneficiary.¶
(6) Application and renewal processing timeliness standards are as follows:¶
(a) At initial eligibility determination, the Agency shall inform the individual of timeliness standards, make an eligibility determination, and send a decision notice by the 45th calendar day after the Date of Request if:¶
(A) All information necessary to determine eligibility is present;-¶
(B) An RFI has been issued, and the agency does not receive a response by the deadline provided; or¶
(C) A completed application is not received by the agency within 45 days after the Date of Request.¶
(b) At initial eligibility determination, the Agency may extend the 45-day period described in section (a) if:¶
(A) The Agency must request additional information or verification, and the due date of such request extends beyond the 45th day; or¶
(B) There is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;¶
(c) At periodic renewal of eligibility, if additional information or verification is required, the Authority shall provide the beneficiary at least 30 days from the date of the renewal form to respond and provide necessary information.¶
(7) Individuals may apply through the FFM. If the FFM determines the individual potentially eligible for Medicaid/CHIP, the FFM shall transfer the individual's electronic account to the Agency for HSD Medical Program eligibility determination or referral to the Department.¶
(8) HSD Medical Program eligibility is evaluated in the following order:¶
(a) For a child applicant:¶
(A) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (OAR 410-200-0405);¶
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);¶
(C) MAGI Pregnant Woman program (OAR 410-200-0425);¶
(D) MAGI Child (OAR 410-200-0415);¶

(E) EXT (OAR 410-200-0440);¶
(F) MAGI CHIP (OAR 410-200-0410);¶
(G) FFCYM (OAR 410-200-0407);¶
(H) BCCTP (OAR 410-200-0400)¶
(b) For an adult applicant:¶
(A) Substitute Care (OAR 410-200-0405);¶
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);¶
(C) MAGI Pregnant Woman (OAR 410-200-0425);¶
(D) FFCYM (OAR 410-200-0407);¶
(E) MAGI Adult (OAR 410-200-0435);¶
(F) EXT (OAR 410-200-0440);¶
(G) ~~BCCTP (OAR 410-200-040~~MAGI Expanded Adult (OAR 410-200-0436);¶
(H) BCCTP (OAR 410-200-0400);A¶
(I) Compact Of Free Association (COFA) Dental (OAR 410-200-0445);¶
(J) Veteran Dental (OAR 410-200-0450).
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 SUMMARY: Updates text reference of “inmate” to “resident of a public institution”.

CHANGES TO RULE:

410-200-0120
Notices ¶

(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) Exceptions to the requirement to provide timely continuing decision notice when HSD Medical Program benefits are reduced or closed:¶
(a) When a beneficiary becomes ~~an inmate~~ resident of a public institution or a correctional facility, the Agency shall send a basic decision notice to close, reduce, or suspend benefits;¶
(b) When a beneficiary has been placed in skilled nursing care, intermediate care, or long-term hospitalization, the Agency shall send a basic decision notice to close, suspend, or reduce benefits;¶
(c) 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.¶
(d) When a beneficiary ceases to be an Oregon Resident and the Agency is informed that they're eligible for medical benefits in another state, the Agency shall send a basic decision notice to end benefits;¶
(e) When a beneficiary, another adult member of the EDG, or the authorized representative requests benefits be closed, and the request includes a written or recorded verbal signature, the Agency shall send a basic decision notice to end benefits;¶
(f) When an individual who is not a recipient of any Medicaid/CHIP benefits makes a request to withdraw an application for benefits, the Agency shall send a basic decision notice.¶
(3) 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.¶
(4) Decision notices shall be written in plain language and be accessible to individuals who are limited English proficient and individuals with disabilities.¶
(5) 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.¶
(6) A decision notice approving HSD Medical Program benefits, including approvals for 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.¶
(7) A decision notice reducing, denying, or closing HSD Medical Program benefits shall include information about a beneficiary's right to continue receiving benefits.¶
(8) When electronic-only is the preferred communication method, and the Agency is unable to successfully deliver an electronic notification, the Agency shall send the notice by postal mail within three business days. The date on the notice shall be the date the notice is sent by postal mail.¶
(9) The Authority may amend:¶
(a) A decision notice with another decision notice; or¶
(b) A contested case notice.¶
(10) 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.¶
(11) 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, ORS 411.404, 413.042, 414.534, 42 CFR: 431.213, 435.110, 435.112, 435.115, 435.116, 435.118, 435.940, 435.1200, 458.350, 435.3, 435.4, 435.407, 435.952, 435.1008, 457.320, 435.406, 457.380, 435.117, 435.170, 435.190, 435.916, 435.917, 435.926, 435.1205, 447.56, 457.340, 457.350, 457.360, 457.805, 433.145, 433.147, 433.148, 433.146, 435.610, 435.403, 457.80, 435.119, 435.222, 435.602, 435.608, 435.956, 433.138
Statutes/Other Implemented: ORS 411.404, 414.534, ORS 411.400, 411.402, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.536, 414.706, 411.060, 411.095, 414.440

AMEND: 410-200-0140

RULE SUMMARY: Eliminates the 10-day reporting requirement for suspended medical coverage to be reinstated upon a person's release or discharge from a public institution without the need for a new application and, instead, allow the Authority to reinstate coverage upon learning of a person's release or discharge that occurred within the prior 12 months. Eliminates provision for good cause evaluations for reinstatement of medical coverage when the Authority learns of a person's release or discharge that is more than 12 months in the past. Updates text references of "inmate" and "incarceration" to "resident of a public institution" for more general and respectful references since this rule also applies to those residing in Oregon State Hospital.

CHANGES TO RULE:

410-200-0140
Eligibility for Inmates ¶

(1) A~~n inmate~~ resident of a public institution is not eligible for HSD Medical Program benefits, except for individuals residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital, who are:¶
(a) Under age 21;¶
(b) Age 21 if they were admitted to the IMD before their 21st birthday; or¶
(c) Age 65 or older.¶
(2) If an HSD Medical Program beneficiary becomes a~~n inmate~~ resident of a public institution, medical benefits shall be suspended for the duration of the ~~incarceration period.~~ period in which the individual is a resident of that institution.¶
(3) The effective date of the suspension of benefits is the day following the date on which the individual became ~~incarcerated.~~ a resident of a public institution.¶
(4) Suspended benefits shall be re~~stored to the release date~~instated effective the date on which an individual ceases to be a resident of a public institution 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~~ Agency learns that the individual is no longer a resident of a public institution wit~~h~~ai~~n~~ t~~en~~he 12 calendar ~~days from the release date, and there is good cause for the late reporting~~months following the date on which the change occurred; or¶
(~~c~~b) The in~~mate is released to a medical facility and begins receiving treatment~~dividual leaves the public institution to be admitted to a medical facility as an inpatient with an expected stay of at least 24 hours, providing the facility is not associated with the public institution where the individual ~~wa~~is a~~n inmate.~~ resident.¶
(5) Once benefits are re~~stor~~instated 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 aft~~, a redetermination of eligibility will be processed unless benefits are restored on a case where the e~~ligibility~~xisting renewal date ~~has passed, benefits shall be restored and a redetermination of eligibility processed~~is more than two (2) calendar months beyond the month in which the action is being taken.
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: 410-200-0235

RULE SUMMARY: Removes text requiring an individual to report their release or discharge from a public institution. Updates text reference of “inmate” to “resident of a public institution”.

CHANGES TO RULE:

410-200-0235
Changes That Must Be Reported ¶

(1) Reporting requirements described in this rule apply to any individual whose information is considered in determining eligibility for any case member.¶
(2) An individual or someone authorized to act on the individuals behalf shall report the following changes in circumstances within 10 calendar days of its occurrence:¶
(a) The receipt or loss of health care coverage;¶
(b) A change in mailing or residential address;¶
(c) A change in legal name;¶
(d) A change in pregnancy status;¶
(e) A change in tax-filing status;¶
(f) A change in citizenship or immigration status of an applicant or recipient;¶
(g) Someone joins or permanently leaves the household;¶
(h) Someone becomes ~~an inmate, or is released from the public institution in which they were an inmate,~~ resident of a public institution as described in OAR 410-200-0015(~~50~~69);¶
(i) For all HSD Medical Programs except MAGI CHIP, a change in availability of employer-sponsored health insurance;¶
(j) For the MAGI Parent or Caretaker Relative and EXT programs, when the beneficiary no longer has a dependent child living in the home, including:¶
(A) The only dependent child leaves the household; or¶
(B) The only dependent child is 18 years old and not a full-time student in a secondary school or equivalent vocational or technical training.¶
(k) An EDG member age 19 or older experiences a change in income, including:¶
(A) A change in source of income;¶
(B) A change in employment status:¶
(i) For a new job, the change occurs the first day of the new job;¶
(ii) For a job separation, the change occurs on the last day of employment.¶
(C) A change in earned income more than $100 per month. The change occurs upon the receipt by the beneficiary of the first paycheck from a new job or the first paycheck reflecting the updated income amount;¶
(D) A change in unearned income more than $50 per month. The change occurs the day the beneficiary receives the new or changed payment.¶
(3) Individuals shall report a claim for personal injury within 10 calendar days of its occurrence. The following information shall be reported:¶
(a) The names and addresses of all parties against whom the action is brought or claim is made;¶
(b) A copy of each claim demand; and¶
(c) If an action is brought, identification of the case number and the county where the action is filed.¶
(4) Changes may be reported via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.¶
(5) A change is considered reported on the date the information is received by the Agency.¶
(6) A change reported for one program is considered reported for all programs administered by the Agency in which the beneficiary participates.¶
(7) The following changes are not required to be reported:¶
(a) Periodic cost-of-living adjustments to the federal Black Lung Program, SSB, SSDI, SSI, and veterans assistance under Title 38 of the United States Code;¶
(b) Changes in eligibility criteria based on legislative or regulatory actions.
Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0315

RULE SUMMARY: Standards and Determining Income Eligibility – inclusion of the new eligibility category income threshold.

CHANGES TO RULE:

410-200-0315
Standards and Determining Income Eligibility ¶

(1) This rule outlines income thresholds for HSD Medical Programs. See OAR 410-200-0310 for eligibility and budgeting.¶
(2) The income standard for the MAGI Parent or Caretaker-Relative program is set as follows: See attached table.¶
(3) Effective March 1, 202~~2~~3, the income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the 202~~2~~3 FPL as follows: See attached table.¶
(4) Effective March 1, 202~~2~~3, the income standard for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under the age of one year is set at 185 percent of the 202~~2~~3 FPL as follows: See attached table.¶
(5) Effective March 1, 202~~2~~3, the income standard for the MAGI Expanded Adult Program is set at 200 percent of the 2023 FPL as follows: See attached table.¶
(6) Effective March 1, 2023, the income standard for MAGI CHIP is set at 300 percent of the 202~~2~~3 FPL as follows: See attached table.¶
(~~6~~7) Effective ~~January~~March 1, 2023, the income standard for the COFA Dental Program is set at 138 percent of the 202~~2~~3 FPL as follows: See attached table.¶
(~~7~~8) Effective ~~January~~March 1, 2023, the income standard for the Veteran Dental Program is set at 400 percent of the 202~~2~~3 FPL as follows: See attached table.¶
(~~8~~9) 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, 202~~2~~3, if the MAGI-based income of the EDG is below 163 percent of the 202~~2~~3 federal poverty level, 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 FPL through 300 percent FPL as described in section (4) of this rule, the Department 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, 435.117, 435.119, 435.1200, 435.1205, 435.170, 435.190, 435.222, 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

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

2023 Income Thresholds - Effective March 1, 2023
Oregon Health Plan, Health Systems Division Programs

Family Size	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) / MAGI Adult / COFA Dental		MAGI Expanded Adult	MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP		Vet Dental
	2023 Standard	Standard + 5% FPL Disregard	2023 Standard (133%)	Standard + 5% FPL Disregard (138%)	2023 Standard (200%)	2023 Standard (185%)	Standard + 5% FPL Disregard (190%)	2023 Standard (300%)	Standard + 5% FPL Disregard (305%)	2023 Standard (400%)
1	$ 399	$ 460	$ 1,616	$ 1,677	$ 2,430	$ 2,248	$ 2,309	$ 3,645	$ 3,706	$ 4,860
2	$ 515	$ 598	$ 2,186	$ 2,268	$ 3,287	$ 3,041	$ 3,123	$ 4,930	$ 5,013	$ 6,574
3	$ 611	$ 715	$ 2,756	$ 2,859	$ 4,144	$ 3,833	$ 3,937	$ 6,215	$ 6,319	$ 8,287
4	$ 747	$ 872	$ 3,325	$ 3,450	$ 5,000	$ 4,625	$ 4,750	$ 7,500	$ 7,625	$ 10,000
5	$ 872	$ 1,019	$ 3,895	$ 4,042	$ 5,857	$ 5,418	$ 5,564	$ 8,785	$ 8,932	$ 11,714
6	$ 998	$ 1,166	$ 4,465	$ 4,633	$ 6,714	$ 6,210	$ 6,378	$ 10,070	$ 10,238	$ 13,427
7	$ 1,114	$ 1,304	$ 5,035	$ 5,224	$ 7,570	$ 7,003	$ 7,192	$ 11,355	$ 11,545	$ 15,140
8	$ 1,230	$ 1,441	$ 5,604	$ 5,815	$ 8,427	$ 7,795	$ 8,006	$ 12,640	$ 12,851	$ 16,854
9	$ 1,321	$ 1,554	$ 6,174	$ 6,406	$ 9,284	$ 8,588	$ 8,820	$ 13,925	$ 14,158	$ 18,567
10	$ 1,456	$ 1,710	$ 6,744	$ 6,997	$ 10,140	$ 9,380	$ 9,633	$ 15,210	$ 15,464	$ 20,280
11	$ 1,592	$ 1,867	$ 7,313	$ 7,588	$ 10,997	$ 10,172	$ 10,447	$ 16,495	$ 16,770	$ 21,994
12	$ 1,728	$ 2,025	$ 7,883	$ 8,179	$ 11,854	$ 10,965	$ 11,261	$ 17,780	$ 18,077	$ 23,707
13	$ 1,864	$ 2,182	$ 8,453	$ 8,770	$ 12,710	$ 11,757	$ 12,075	$ 19,065	$ 19,383	$ 25,420
14	$ 2,000	$ 2,340	$ 9,022	$ 9,361	$ 13,567	$ 12,550	$ 12,889	$ 20,350	$ 20,690	$ 27,134
15	$ 2,136	$ 2,497	$ 9,592	$ 9,953	$ 14,424	$ 13,342	$ 13,703	$ 21,635	$ 21,996	$ 28,847
16	$ 2,272	$ 2,654	$ 10,162	$ 10,544	$ 15,280	$ 14,134	$ 14,516	$ 22,920	$ 23,302	$ 30,560
17	$ 2,408	$ 2,812	$ 10,731	$ 11,135	$ 16,137	$ 14,927	$ 15,330	$ 24,205	$ 24,609	$ 32,274
18	$ 2,544	$ 2,969	$ 11,301	$ 11,726	$ 16,994	$ 15,719	$ 16,144	$ 25,490	$ 25,915	$ 33,987
19	$ 2,680	$ 3,127	$ 11,871	$ 12,317	$ 17,850	$ 16,512	$ 16,958	$ 26,775	$ 27,222	$ 35,700
20	$ 2,816	$ 3,284	$ 12,440	$ 12,908	$ 18,707	$ 17,304	$ 17,772	$ 28,060	$ 28,528	$ 37,414
Each add'l add	$ 136	$ 158	$ 570	$ 592	$ 857	$ 793	$ 814	$ 1,285	$ 1,307	$ 1,714

Family Size	2023 100% Annual Income Threshold (2022 FPL used for 2023 determinations)	2024 100% Annual Income Threshold (2023 FPL used for 2024 determinations)
1	$ 13,590	$ 14,580
2	$ 18,310	$ 19,720
3	$ 23,030	$ 24,860
4	$ 27,750	$ 30,000
5	$ 32,470	$ 35,140
6	$ 37,190	$ 40,280
7	$ 41,910	$ 45,420
8	$ 46,630	$ 50,560
9	$ 51,350	$ 55,700
10	$ 56,070	$ 60,840
11	$ 60,790	$ 65,980
12	$ 65,510	$ 71,120
13	$ 70,230	$ 76,260
14	$ 74,950	$ 81,400
15	$ 79,670	$ 86,540
16	$ 84,390	$ 91,680
17	$ 89,110	$ 96,820
18	$ 93,830	$ 101,960
19	$ 98,550	$ 107,100
20	$ 103,270	$ 112,240
Each add'l add	$ 4,720	$ 5,140

2022 Income Thresholds - Effective March 1, 2022
Oregon Health Plan, Health Systems Division Medical Programs

Family Size	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) / MAGI Adult / COFA Dental		MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP		Vet Dental
	2022 Standard	Standard + 5% FPL Disregard	2022 Standard (133%)	Standard + 5% FPL Disregard (138%)	2022 Standard (185%)	Standard + 5% FPL Disregard (190%)	2022 Standard (300%)	Standard + 5% FPL Disregard (305%)	January 1, 2023 Standard
1	$ 399	$ 456	$ 1,507	$ 1,563	$ 2,096	$ 2,152	$ 3,398	$ 3,455	$ 4,530
2	$ 515	$ 592	$ 2,030	$ 2,106	$ 2,823	$ 2,900	$ 4,578	$ 4,654	$ 6,104
3	$ 611	$ 707	$ 2,553	$ 2,649	$ 3,551	$ 3,647	$ 5,758	$ 5,854	$ 7,677
4	$ 747	$ 863	$ 3,076	$ 3,192	$ 4,279	$ 4,394	$ 6,938	$ 7,054	$ 9,250
5	$ 872	$ 1,008	$ 3,599	$ 3,735	$ 5,006	$ 5,142	$ 8,118	$ 8,253	$ 10,824
6	$ 998	$ 1,153	$ 4,122	$ 4,277	$ 5,734	$ 5,889	$ 9,298	$ 9,453	$ 12,397
7	$ 1,114	$ 1,289	$ 4,646	$ 4,820	$ 6,462	$ 6,636	$ 10,478	$ 10,653	$ 13,970
8	$ 1,230	$ 1,425	$ 5,169	$ 5,363	$ 7,189	$ 7,384	$ 11,658	$ 11,852	$ 15,544
9	$ 1,321	$ 1,535	$ 5,692	$ 5,906	$ 7,917	$ 8,131	$ 12,838	$ 13,052	$ 17,117
10	$ 1,456	$ 1,690	$ 6,215	$ 6,449	$ 8,645	$ 8,878	$ 14,018	$ 14,252	$ 18,690
11	$ 1,592	$ 1,846	$ 6,738	$ 6,991	$ 9,372	$ 9,626	$ 15,198	$ 15,451	$ 20,264
12	$ 1,728	$ 2,001	$ 7,261	$ 7,534	$ 10,100	$ 10,373	$ 16,378	$ 16,651	$ 21,837
13	$ 1,864	$ 2,157	$ 7,784	$ 8,077	$ 10,828	$ 11,120	$ 17,558	$ 17,851	$ 23,410
14	$ 2,000	$ 2,313	$ 8,307	$ 8,620	$ 11,555	$ 11,868	$ 18,738	$ 19,050	$ 24,984
15	$ 2,136	$ 2,468	$ 8,831	$ 9,163	$ 12,283	$ 12,615	$ 19,918	$ 20,250	$ 26,557
16	$ 2,272	$ 2,624	$ 9,354	$ 9,705	$ 13,011	$ 13,362	$ 21,098	$ 21,450	$ 28,130
17	$ 2,408	$ 2,780	$ 9,877	$ 10,248	$ 13,738	$ 14,110	$ 22,278	$ 22,649	$ 29,704
18	$ 2,544	$ 2,935	$ 10,400	$ 10,791	$ 14,466	$ 14,857	$ 23,458	$ 23,849	$ 31,277
19	$ 2,680	$ 3,091	$ 10,923	$ 11,334	$ 15,194	$ 15,604	$ 24,638	$ 25,049	$ 32,850
20	$ 2,816	$ 3,247	$ 11,446	$ 11,877	$ 15,921	$ 16,352	$ 25,818	$ 26,248	$ 34,424
Each add'l add	$ 136	$ 156	$ 524	$ 543	$ 728	$ 748	$ 1,180	$ 1,200	$ 1,574

Family Size	2022 100% Annual Income Threshold (2021 FPL used for 2022 determinations)
1	$ 12,880
2	$ 17,420
3	$ 21,960
4	$ 26,500
5	$ 31,040
6	$ 35,580
7	$ 40,120
8	$ 44,660
9	$ 49,200
10	$ 53,740
11	$ 58,280
12	$ 62,820
13	$ 67,360
14	$ 71,900
15	$ 76,440
16	$ 80,980
17	$ 85,520
18	$ 90,060
19	$ 94,600
20	$ 99,140
Each add'l add	$ 4,540

ADOPT: 410-200-0436

RULE SUMMARY: Specific Requirements; MAGI Expanded Adult Program

CHANGES TO RULE:

410-200-0436
Specific Requirements: MAGI Expanded Adult Program
(1) The MAGI Expanded Adult program is effective April 1, 2023. ¶
(2) Individuals who lose eligibility for other HSD Medical Program benefits due to an increase of countable income may be eligible for the MAGI Expanded Adult program if they:¶
(a) Are 19 years of age or older and under age 65;¶
(b) Have household income greater than 138 percent federal poverty level through 200 percent federal poverty level (OAR 410-200-0315) for the applicable family size; ¶
(c) Meet citizenship or non-citizen status requirements outlined in OAR 410-200-0215;¶
(d) Are not entitled to or enrolled in Medicare benefits under part A or B of Title XVIII of the Act; and¶
(e) Are not receiving SSI benefits.¶
(3) The MAGI Expanded Adult program is not available to new applicants or individuals reapplying after a break in coverage.¶
(4) The MAGI Expanded Adult program is not subject to protected eligibility provisions related to pregnancy, described in OAR 410-200-0135 - Assumed, Continuous, and Protected Eligibility for Children and Pregnant Individuals section (3).¶
(5) The MAGI Expanded Adult program eligibility is not subject to the pursuit of assets requirements found in OAR 410-200-0220 - Requirement to Pursue Assets.
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, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.608, 433.138, 433.145, 433.146, 433.147, 433.148, 435.117, 435.119, 435.1205, 435.170, 435.190, 435.222, 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

AMEND: 410-200-0520

RULE SUMMARY: COVID-19 Emergency Policies – updates to align with recent federal guidance.

CHANGES TO RULE:

410-200-0520
COVID-19 Emergency Policies
The provisions in this rule apply to all HSD Medical Program eligibility determinations made as of March 18, 2020 through March 31, 2023.¶
(1) In accordance with the Families First Coronavirus Response Act (FFCRA) and OAR 410-120-0011, following the declaration of a national public health emergency (PHE), the Authority adopts temporary measures related to HSD Medical program eligibility.¶
(2) In accordance with the Consolidated Appropriations Act, 2023, the continuous enrollment provisions established as part of the FFCRA are no longer coupled with the national public health emergency effective March 31, 2023. See OAR 410-200-0521 for Agency policies effective April 1, 2023.¶
(3) Notwithstanding any other rule to the contrary in these Chapter 410, division 200 administrative rules, during the COVID-19 PHE, HSD Medical program eligibility shall be determined as set forth in this rule.¶
(~~3~~4) Except for individuals receiving coverage during a period of presumptive eligibility (see section 4 of this rule), individuals who were receiving HSD Medical Program benefits on March 18, 2020, or who begin receiving coverage following that date via full eligibility determination shall not have benefits terminated ~~during the national emergency period~~prior to April 1, 2023, with the following exceptions:¶
(a) Terminations of coverage shall be limited to the following reasons:¶
(A) Eligibility was approved for an HSD medical program at either initial application or during a redetermination, and it is later determined the decision was incorrect due to one of the following:¶
(i) Administrative error; or¶
(ii) When a court determines the individual made a false or misleading statement, or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining eligibility.¶
(B) The recipient dies;¶
(C) The recipient or someone authorized to act on their behalf requests voluntary termination of coverage; or¶
(D) The recipient is confirmed to no longer be a resident of Oregon.¶
(b) Coverage will be suspended for individuals who become incarcerated (see OAR 410-200-0140).¶
(~~4~~5) Individuals receiving coverage during a period of presumptive eligibility are not subject to the provisions described in section (3) of this rule, as a full eligibility determination has not been made.¶
(~~5~~6) Community Partners (see OAR 410-200-0015(27)) are granted authority to perform Presumptive Eligibility determinations pursuant to the policies outlined for Hospital Presumptive Eligibility in OAR 410-200-0105 for the duration of the PHE.¶
(~~6~~7) The agency shall accept self-attestation of all eligibility criteria necessary to determine eligibility with the following exception:¶
(a) In the event that an individual's attestation of US citizenship, US national, or non-citizen status cannot be verified via FDSH or electronic verification sources available to the agency, the individual shall be provided a reasonable opportunity period (see OAR 410-200-0015(66)) to provide verification of their attestation;¶
(b) ~~T~~For individuals who are provided a reasonable opportunity period through March 31, 2023, the reasonable opportunity period has been extended to 180 days ~~for the duration of the emergency period~~. Effective April 1, 2023, the reasonable opportunity period aligns with OAR 410-200-0015(65);¶
(c) If the beneficiary fails to submit verification as requested, and the reasonable opportunity period ends during the emergency period, coverage will not be terminated ~~for the duration of the emergency period~~prior to April 1, 2023; and¶
(d) Upon receipt of verification, the agency will determine ongoing eligibility in accordance with citizenship/non-citizen status requirements described in OAR 410-200-0215.¶
(~~7~~8) Federal Pandemic Unemployment Compensation (FPUC) is treated as follows:¶
(a) FPUC is excluded for all eligibility determinations based on monthly income, as described in 410-200-0310(4)(a).¶
(b) FPUC is counted for all eligibility determinations based on annual income, as described in 410-200-0310(4)(b).¶
(~~8~~9) Disaster relief payments as described in 26 U.S. Code §139 are excluded for all HSD Medical Program eligibility determinations, including determinations made based on both monthly (410-200-0310(4)(a)) and annual (410-200-0310(4)(b)) income.¶
(~~9~~10) Individuals receiving Reproductive Health Equity Fund benefits (see OAR 410-200-0240(2)(b)) on March 18, 2020, or who begin receiving RHEF benefits following that date, shall retain RHEF benefits ~~for the duration of~~

~~the emergency period~~until one of the following occur, whichever is earlier:¶
(a) The individual becomes eligible for other OHP Plus coverage; or¶
(b) The individual's eligibility is redetermined during the unwinding period (see OAR 410-200-0521).
Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.402, 411.404, 414.534, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.536, 414.706, ORS 411.060, 411.095, 411.400, 411.406, 411.439

ADOPT: 410-200-0521

RULE SUMMARY: Unwinding Period – HSD Medical Programs; updated policies and procedures for the unwinding period.

CHANGES TO RULE:

410-200-0521
Unwinding Period - HSD Medical Programs
(1) The provisions in this rule apply to all HSD Medical Program determinations performed as of April 1, 2023. Notwithstanding any other rule to the contrary in these chapter 410 division 200 rules, during the unwinding period, HSD Medical Program eligibility shall be determined as set forth in this rule.¶
(2) For the purposes of this rule, the term "unwinding period" refers to the period of 15 calendar months beginning April 1, 2023, in which the agency will initiate a full eligibility renewal for all HSD Medical Program beneficiaries.¶
(3) In accordance with the Consolidated Appropriations Act, 2023, the continuous enrollment conditions established via the Families First Coronavirus Response Act end effective March 31, 2023.¶
(4) Individuals who were receiving HSD Medical Program benefits prior to April 1, 2023, shall maintain coverage as described in OAR 410-200-0520 until their unwinding period renewal activity is initiated.¶
(5) The Agency shall determine eligibility based on self-attestation of financial eligibility information and will request necessary verification (see OAR 410-200-0230 - Verification) via post-eligibility Request for Information (RFI).¶
(6) Information about RFIs during the unwinding period:¶
(a) The Agency will provide 90-days to respond to RFIs;¶
(b) Failure to respond to a post-eligibility RFI will result in termination of benefits in accordance with section (7) of this rule, with the following exceptions:¶
(A) For individuals age 18 years and younger, failure to respond to a post-eligibility RFI for income verification will not result in termination of benefits; eligibility will be maintained through the 12-month Continuous Eligibility period (see OAR 410-200-0135) or the end of the month in which they turn 19 years of age, whichever is earlier;¶
(B) For pregnant individuals, failure to respond to a post-eligibility RFI for income verification will not result in termination of benefits; eligibility will be maintained through the duration of pregnancy and the postpartum eligibility period (see OAR 410-200-0135).¶
(7) Individuals who are determined ineligible for ongoing HSD Medical Benefits will be provided 60-day advance notice of termination or reduction of coverage and referred to the Federally Facilitated Marketplace as described in OAR 410-200-0100.
Statutory/Other Authority: ORS 411.402
Statutes/Other Implemented: ORS 411.402