NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 04/17/2020 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.

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FILED
03/11/2020 3:17 PM
ARCHIVES DIVISION
SECRETARY OF STATE

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 04/15/2020
TIME: 10:00 AM
OFFICER: Brean Arnold
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500 Summer St. NE
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Salem, OR 97301

SPECIAL INSTRUCTIONS:
Submit written comments to
HSD.Rules@dhsoha.state.or.us

NEED FOR THE RULE(S):
HSD Medical Programs eligibility rules must be updated to incorporate corrections, updates communicated by CMS, and to bring policies into alignment among DHS and OHA programs in preparation for the Integrated Eligibility ONE system.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

FISCAL AND ECONOMIC IMPACT:
The Authority estimates that these rule amendments will result in little to no fiscal impact for applicants/beneficiaries of HSD medical programs. The authority estimates that these amendments will have no fiscal impact on other state agencies, local government, and business, including small business. There is no cost of compliance for small business. No
small businesses are subject to these rules.

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).

1) Amending these rules will have no fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses.
2) None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):
Small business was not involved as they are not affected by these rules.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

AMEND: 410-200-0010

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0010
Overview

These rules, OAR 410-200-0010 through 0510, describe eligibility requirements for the Office of Client and Community Services (OCCS) Health Systems Division (HSD) Medical Programs.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042
AMEND: 410-200-0100

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CHANGES TO RULE:

410-200-0100
Coordinated Eligibility and Enrollment Process with the Department of Human Services and the Federally Facilitated Marketplace ¶

(1) This rule describes Oregon Health Authority’s (Authority) the coordination of eligibility and enrollment with between the Oregon Health Authority (Authority), the Department of Human Services (Department), and the FFM. The Authority shall:
(a) Minimize the burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for insurance affordability programs;
(b) Ensure determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards described in OAR 410-200-0110 based on the application date;
(c) Provide coordinated content for those household members whose eligibility status is not yet determined; and
(d) Screen every applicant or beneficiary who submits an application or renewal form, or whose eligibility is being renewed under a change in circumstance, 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 OCCS HSD Medical Programs, the Authority, 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 OCCS HSD Medical Programs, the Authority shall, consistent with the timeliness standards described in OAR 410-200-0110:
(a) Screen for eligibility for non-MAGI programs as indicated by information provided on the application or renewal form;
(b) Transfer the individual's electronic account information to the Department via secure electronic interface, as appropriate;
(c) If transferred to the Department, the Authority shall provide notice to the individual that contains the following information:
(A) The Authority has determined the individual ineligible for OCCS Medical Programs;
(B) The Department is continuing to evaluate Medicaid eligibility on one or more other bases;
(C) The notice shall include coordinated content relating to the transfer of the individual's electronic account to the Department, as appropriate; and
(D) There is a right to a hearing to challenge the eligibility decision.
(d) Provide or assure that the Department has provided the individual with notice of the final determination of eligibility on one or more other bases.

(4) For beneficiaries found ineligible for ongoing OCCS 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 who are referred to the Department for a non-MAGI Medicaid eligibility review, the Authority shall maintain OCCS medical program benefits while eligibility for non-MAGI programs is being determined by the Department and may, and shall not take action to close benefits until determination of eligibility is complete.

(5) Coordination among agencies:

(a) The Authority shall maintain a secure electronic interface through which the Authority can send and receive an individual’s electronic account from the Department and the FFM;

(b) The Authority 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 OCCS HSD Medical Programs, the Authority shall obtain the information through electronic data match.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
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• 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.

CHANGES TO RULE:

410-200-0105
Hospital Presumptive Eligibility

This rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, BCCTP, and Former Foster Care Youth Medical (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 Former Foster Care Youth Medical (OAR 410-200-0407).

(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 Other Caretaker Relative income standard for the appropriate family size in OAR 410-200-0315;
(c) A pregnant woman 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) A woman 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.

(3a) 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.

(45) In addition to the requirements outlined in sections (23) and (34) 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.

(56) 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.

(67) 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.

(78) A Hospital Presumptive Eligibility decision does not qualify a beneficiary for continuous eligibility (OAR 410-200-0135). 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 Hospital Presumptive Eligibility period 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
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• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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)

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 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 written notice that 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 (7) 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 (7) of this rule;
(f) An application is complete if all of the following requirements are met:
   (A) All information necessary to determine the individual applicant’s eligibility and benefit level is provided on the application for each individual in the household group 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 (6) of this rule;
   (D) The application is received by the Agency;
   (g) To complete the application process, the applicant shall:
      (A) With the exception of sections (5) and (6) of this rule, complete and sign an application; and
      (B) Provide necessary information to the Agency within the time frame established in section (7) of this rule;

(2) General information as it relates to renewal and redetermination processing is as follows:
(a) The Authority shall re-determine 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 determine a beneficiary’s eligibility using information found in the
beneficiary’s electronic account and electronic data accessible to the Agency, then 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 (76) 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) The pre-populated renewal form is complete if it meets the requirements identified in section (1)(e) of this rule.

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

(A) Complete and sign the form in accordance with section (65) 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 (76) of this rule.

(g) An individual may withdraw their pre-populated renewal form at any time.

(new application is required when:

(3a) Except for individuals found eligible for MAGI Medicaid/CHIP through the Fast-Track enrollment process (OAR 410-200-0505), for renewals due between July 1, 2014 and December 31, 2014, the Authority shall:
(a) Utilize a pre-populated Expedited Renewal form to determine if the individual has experienced:
(A) A change in household members; or
(B) A change in income.
(b) Renew eligibility based on the individual’s attested information on the Expedited Renewal form if:
(A) There is no change in household members; and
(B) The attested income allows all beneficiaries to remain eligible for Medicaid/CHIP.
(c) If unable to renew eligibility based on the individual’s attested information on the Expedited Renewal form, the Authority shall send the beneficiary an application in order to complete a full eligibility review.

(4) A new application is required when:
(a) An individual requests medical benefits and no member of the household group currently receives OCCS medical programs 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.

(5) 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 OCCS 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 assumed eligible newborn (AEN) is added to a household group receiving medical program benefits.
(f) An individual not receiving medical program benefits is added to an on-going household group receiving medical program benefits, and eligibility can be determined using information found in the individual or beneficiary’s electronic account and electronic data available to the Agency.
Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;

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 OCCS-Medical program eligibility because they did not return the pre-populated renewal form or were requested to provide additional information, 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 requested additional information was provided within the ninety-day reconsideration period establishes a new date of request:

(i) A new application is not required when the requirements set forth in (a)(A) and (a)(B) of this section are met; and

(ii) 

(C) In the event that the pre-populated renewal form is submitted within the ninety-day reconsideration period and additional information is requested 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 OCCS-Medical program eligibility based on the completed redetermination, the effective date of medical benefits is as described in 410-200-0115 (3) and (4).

Signature requirements are as follows:

(a) For an application submitted via the Oregon Eligibility (ONE) system Applicant Portal, the individual identified as the primary applicant must electronically sign the application; Signatures accepted by the Agency may be:

(A) Handwritten;

(B) Electronic; or

(b) For an application submitted by means other than the Oregon Eligibility (ONE) system Applicant Portal, the Telephonic.

(b) An application must be signed by one of the following:

(A) The primary contact of household;

(B) At least one caretaker relative or parent in the household group, an adult in the applicant's EDG;

(C) An authorized representative.

(D) The primary contact when there is no parent in the household group; or

(E) If the applicant is a child or incapacitated, someone acting responsibly for the applicant.

Signature requirements may be:

(A) Handwritten;

(B) If the signer of an application ceases to be a member of the case, the signature of an individual described in section one; or

(C) Telephonic (b) of this part is required.

(d) Hospital Presumptive Eligibility may be determined without a signature described in (a) through (c) if an electronic match with the FDSH will be performed.

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

(f) Signatures may be submitted and shall be accepted by the Agency via Internet, mail, telephone, in person, or other electronic means.

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 not later than by the 45th calendar day after the Date of
Request if:

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

(B) An RFI has been issued, and the agency does not receive a response by the deadline provided; or

(C) The 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 beyond data available to the Agency on the beneficiary's electronic account or electronic data 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.

(87) 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 OCSS Medical Program eligibility determination or referral to the Department.

(9) HSD Medical Program eligibility is determined in the following order:

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

(A) Assumed eligibility for OCSS Medical Programs (OAR 410-200-0135);

(B) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (OAR 410-200-0405);

(C) MAGI Parent or Other Caretaker Relative (OAR 410-200-0420);

(D) MAGI Pregnant Woman program (OAR 410-200-0425);

(E) MAGI Child (OAR 410-200-0415);

(F) Continuous Eligibility (OAR 410-200-0435);

(G) MAGI CHIP (OAR 410-200-0440);

(H) Former Foster Care Youth Medical (OAR 410-200-0407);

(I) EXT BCCTP (OAR 410-200-0440).

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

(A) Assumed eligibility for OCSS Medical Programs (OAR 410-200-0135);

(B) Substitute Care (OAR 410-200-0405);

(C) MAGI Parent or Other Caretaker Relative (OAR 410-200-0420);

(D) MAGI Pregnant Woman program (OAR 410-200-0425);

(E) MAGI Pregnant Woman Former Foster Care Youth Medical (OAR 410-200-0425);

(F) MAGI Adult (OAR 410-200-0435);

(G) Former Foster Care Youth Medical EXT (OAR 410-200-0440);

(H) BCCTP (OAR 410-200-0440).

Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
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- 410-200-0111 – Authorized Representative
  o Removed language allowing the agency to establish an authorized representative on the applicant/beneficiary’s behalf

CHANGE TO RULE:

410-200-0111
Authorized Representatives ¶

(1) With the exception of individuals who are included in the household group 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 household group 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;
(d) If the Agency has determined that an authorized representative is needed based on the individual’s physical and mental ability to handle their own affairs, and an authorized representative has not been designated by the individual, the Agency may appoint one.

(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;
(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 OCCS HSD Medical Programs.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
AMEND: 410-200-0115

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• 410-200-0115 – HSD Medical Programs – Effective Dates
  o Updated effective dates for changes in eligibility to align with DHS programs and system functionality:
    Changes in eligibility at the same benefit-level are effective the 1st of the following month;
    Changes in eligibility at an increased benefit-level (i.e. CAW EM to OHP Plus, or reports of pregnancy) are effective the 1st of the month in which the qualifying change is reported.

CHANGES TO RULE:

410-200-0115
OCCS
HSD
Medical Programs-Effective Dates

(1) Date of Request:
(a) For all OCCS Medical Programs, the applicant or an individual authorized to act on behalf of the applicant must contact the Authority, the Department, or the FFM to request medical benefits. The request may be via the Internet, by telephone, community partner, by mail, by electronic communication, or in person;
(b) For new applicants, the Date of Request is the earlier of the following:
(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.
(c) For current beneficiaries of OCCS Medical Programs, the Date of Request is one of the following:
(A) The date the beneficiary reports a change requiring a redetermination of eligibility; or
(B) The date the Agency initiates a review, except that the automatic mailing of an application does not constitute a Date of Request.
(d) The Date of Request starts the application processing time frame;
(e) If the application is required under OAR 410-200-0110 and is not received within 45 days after the Date of Request or within the extended time that the Authority has allowed under OAR 410-200-0110, the new Date of Request is the date the application is submitted to the Agency.

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

(3) Except for EXT, the effective date of medical benefits for new applicants for OCCS Medical Programs 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.

(42) 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.

(54) Establishing a renewal date:

(a) Except for EXT and MAGI Pregnant Woman, as provided in subsection (b), for all OCCS 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 initial month of eligibility in which the DOR was established;

(B) For At renewal that are regularly scheduled, 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.

(65) Acting on 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 at any time other than the renewal month, eligibility shall be redetermined for all household group members;

(b) Except for reports of pregnancy, an EDG members;

(b) When a reported change results in a CAWEM recipient becoming eligible for Plus benefits, if the beneficiary is determined to be eligible for another OCCS medical program or loses eligibility as a result of the reported change, 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 beneficiaries who report a pregnancy, the effective date of MAGI Pregnant Woman, MAGI Parent or Other Caretaker Relative for pregnant women, or MAGI CHIP for pregnant individuals 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 of Request first of the month in which the pregnancy is reported; or

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

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

(76) Suspending or Closing Medical Benefits:

(a) The effective date for closing OCCS 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 OCCS 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 on-going eligibility cannot be determined because the beneficiary does not provide required information within 30 days.

(b) Exception 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 OCCS HSD Medical Programs; or

(B) Refer the beneficiary to the Department, if applicable, and confirm that the Department has made an eligibilityetermination.
decision.¶
(c) For beneficiaries of OCCS mHSD Medical pProgram benefits who become incarcerated (OAR 4610-200-0140), the effective date of suspension is the day following the date on which the individual became incarcerated.¶
(87) Denial of Benefits. The effective date for denying OCCS mHSD Medical pProgram 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
AMEND: 410-200-0120

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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 OCCS or HSD Medical Program benefits is approved or denied;
(b) A timely continuing benefit decision notice whenever OCCS or 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 OCCS or 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 OCCS or HSD Medical Program benefits.

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

(5) When returned 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.

(6) The Authority shall send one of the following notices when a beneficiary ceases to be an Oregon Resident:
(a) A timely continuing benefit notice; or
(b) A basic decision notice if the beneficiary is eligible for benefits in the other state.

(7) Except as provided in section (9) of this rule, to close medical program benefits based on a request made by the beneficiary, another adult member of the household group EDG, or the authorized representative, the Authority shall send the following decisions notices:
(a) A timely continuing benefit decision notice when an oral request is made to close benefits;
(b) A basic decision notice when a request to withdraw, end, or reduce or end benefits is made with written signature or recorded verbal signature waiving timely notice (see also section (8) of this rule);
(c) The Agency shall send a basic decision notice when an individual who is not a recipient of any Medicaid/CHIP benefits makes an oral request to withdraw an application for benefits.

(8) No other notice is required when an individual completes a voluntary agreement if all of the following are met:
(a) The Authority provides the individual with a copy of the completed agreement; and
(b) The Authority acts on the request by the date indicated on the form.

(9) No decision notice is required in the following situations:
(a) The only individual in the household group 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 OCCS mHSD 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 OCCS mHSD 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
AMEND: 410-200-0125

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0125
Acting on Reported Changes ¶

(1) When an OCCS mHSD Medical pProgram beneficiary or authorized representative makes a timely report of a change in circumstances at any time between regular renewals of eligibility that may affect the beneficiary's eligibility (any changes reported per OAR410-200-0235), the Authority 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 Authority shall limit requests for information from the individual to inform 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
AMEND: 410-200-0130

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

410-200-0130 – Retroactive Medical

Addition of text to address HPE as it relates to retroactive medical.

CHANGES TO RULE:

410-200-0130
Retroactive Medical

(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 OCCS HSD Medical Programs who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP in the months described in section (1); or, and
(b) Deceased individuals who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP in the months described in section (1), 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 only be determined on the basis of a medical service received be approved for months in which an individual received coverage during a Hospital Presumptive Eligibility period (OAR 410-200-0105), if the medical service received is not covered by, 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
AMEND: 410-200-0135

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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

CHANGES TO RULE:

410-200-0135
Assumed Eligibility and Continuous, Continuous, and Protected Eligibility for Children and Pregnant Women Individuals ¶

1) Assumed Eligibility - A child born to a mother who is eligible for and receiving Medicaid/CHIP benefits is assumed eligible for the MAGI Child program 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 - Children under age 19 who are eligible for and receiving medical assistance under any OCCS Medicaid or CHIP program who lose eligibility for a program who lose eligibility for a program prior to the 12-month renewal date will lose eligibility unless the loss of eligibility is due to any of the following:
   (a) The child is no longer an Oregon resident;
   (b) The child becomes incarcerated;
   (c) The child turns age 19;
   (d) For children in the CHIP program, receipt of minimum essential coverage;
   (e) When a child begins receiving Supplemental Security Income (SSI);
   (f) Eligibility for pregnancy or maternity;

3) Continuous 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, except in the following circumstances:
   (a) She is no longer an Oregon resident;
   (b) She becomes incarcerated;
(c) Death; or ¶
(d) An adult in the household group requests the medical benefits are closed; ¶
(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
AMEND: 410-200-0140

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0140
Eligibility for Inmates ¶

(1) An inmate of a public institution is not eligible for OCCS/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 OCCS/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) When released, once benefits shall be restored as described in section (4), and: ¶
(a) If the individual is released prior to their eligibility renewal date, the eligibility renewal date will not be changed; 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
RULE SUMMARY: Edits to all rules:

• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

410-200-0145 – Contested Case Hearing

o Addition of exception of HPE benefits and hearing rights.

CHANGE TO RULE:

410-200-0145
Contested Case Hearing ¶

(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; ¶

(5) An officer or employee of the Authority or the Department of Human Services may appear on behalf of the Authority. 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) Delay caused by circumstances meeting the good cause criteria described in OAR 137-003-0501(7) may not be counted; and
(b) The notice is considered to be received on the fifth day after the notice is sent unless the claimant shows the notice was received later or was not received.

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 SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0200
Residency Requirements ¶

(1) To be eligible for OCCS/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 (6)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.

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

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

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

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

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

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

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

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

(eC) The individual is judged legally incompetent by a court of competent jurisdiction;

(dD) 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
AMEND: 410-200-0205

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0205
Concurrent and Duplicate Program Benefits

(1) An individual receiving OCCS mHSD Medical Program benefits may not receive the following medical benefits at the same time:
(a) Any other OCCS mHSD 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 OCCS mHSD 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
AMEND: 410-200-0210

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0210
Requirement to Provide Social Security Number

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

(a) The determination of eligibility for benefits. The SSN is used to verify income and other assets and to match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, 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
AMEND: 410-200-0215

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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).

CHANGES TO RULE:

410-200-0215
Citizenship and Ali non-citizen Status Requirements

(1) To meet the citizen or non-citizen status requirements for an OCCS M 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 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;
   (F) 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) An alien non-citizen currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);
         (ii) An alien 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) An alien non-citizen currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
         (vi) An alien non-citizen currently in deferred action status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a) (22); or
         (vii) An alien 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) An alien 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) Aliens 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) An alien 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) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or ¶

(J) An alien 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 who 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 were lawfully present 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 Medical Programs.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534

AMEND: 410-200-0220

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0220
Requirement to Pursue Assets ¶

(1) As a condition of on-going 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) Make a good faith effort to obtain such asset if the individual can show good cause for not doing so (see section (46)).

(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;
(f) (including inheritance, devise or elective share);
(g) Discretionary or mandatory distribution from a trust;
(h) Unemployment compensation; and
(i) Veteran’s compensation and pensions.

(3) Except for beneficiaries in the OHP-CHP or MAGI CHIP programs, caretakers shall obtain available health insurance coverage and cash medical support for household group members receiving medical assistance. 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 household group 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) For a parent receiving medical assistance who fails to meet the requirements of section (3) (a), a penalty is applied.
(c) Each applicant, including a parent for their child, shall make a good faith effort to obtain available coverage under Medicare, if it is available;
(d) With the exception of OHP-CHP, MAGI CHIP, and OHP-OPU, caretakers who are OCCS medical program beneficiaries identified in this section (3) (e) or section (3) (f) after providing the beneficiary with notice and opportunity to show the provisions of 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 (46) of this rule apply);
beneficiaries shall apply for, accept, and maintain cost-effective employer-sponsored health insurance as set forth in OAR 461-155-0360 unless they have good cause; 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) For MAA, MAF, EXT, CEM, and Substitute Care medical programs, a parent who fails to meet the requirements of section (3) is excluded from the family size; 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) With the exception of OHP-CHP, MAGI-CHIP, and CEC, a parent of a child receiving OCCS medical program benefits who fails to meet the requirements of section (3) is ineligible for assistance.

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

(a) 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.

(5) 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.

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

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 SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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

CHANGES TO RULE:

410-200-0225
Assignment of Rights

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

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

(a) Assign to the Agency any rights of each household group 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 household group EDG until the requirements of this rule are met.

(3) Except for the OHP-OPU, OHP-CHIP, and MAGI CHIP programs 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 household group 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, ORS 411.402
Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.706, ORS 411.400
AMEND: 410-200-0230

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0230
Verification ¶

(1) Except as described in section (6) of this rule, applicants, beneficiaries, or an individual of the applicant or beneficiary's choosing 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 of the applicant or beneficiary's choosing 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 data match verification source available to the Agency; ¶
  (b) In the event that attested status cannot be verified via the federal data services hub or by electronic data match FDSH or by electronic verification sources available to the Agency, self-attested information shall be used to determine eligibility, and the Authority shall provide a reasonable opportunity period for the applicant or beneficiary to verify US citizen, US national, or non-citizen status; ¶
  (c) The following 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 citizen status 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); 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) Each redetermination of eligibility; or¶
(C) When a report of change of non-citizen status is received by the Agency.¶
(3) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing authorized to act on their
behalf shall make a declaration of income:¶
(a) If the individual's attested income is above the applicable standard attested income exceeds the threshold
that would produce eligibility for all EDG members, the Authority shall accept the attested information, deny
MAgi-based Medicaid/CHIPHSD Medical Programs, and refer to the Federally Facilitated Marketplace for
potential APTC eligibility;¶
(b) Self-attested income within the applicable standard is verified that would result in eligibility for one or more
EDG members is compared to documentary evidence through a match with the federal data services hub or
electronic data match FDSH or electronic verification sources available to the Agency;¶
(c) In the event that income information via the federal data services hub or electronic data match available to the
agency is inconsistent with self-attested inform. The attestation is considered reasonably compatible, and thus
does not require further verification if:¶
(A) If the individual attests to income below the applicable standard and the data source indicates income above
income information obtained via FDSH or other applicable standard, the Authority shall request verification or
reasonable explanation from the individual prior to determinable returnable electronic verification sources is not
discrepant by more than 10% when compared to the attest;¶
(B) If both the data source and attested information are below tested income and information obtained via FDSH
or other applicable standard, self-attested information is used to determine eligibility for QCOSavailable electronic
verification sources are within the income threshold for the same HSD Medical Programs.¶
(d) In the event that verification is not available via electronic data sources:¶
(A) The Authority shall request verification or reasonable explanation from the individual 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 self-attested income, self-attested information shall be accepted to determine eligibility, income, a reasonable explanation as to why.

(4) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing, 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 OCCC SHSD Medical Programs if:

(A) Information obtained through a match with available electronic data verification sources available to the agency does not conflict with self-attested information;

(B) Information obtained through a match with available electronic data conflicts with self-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 available electronic data the FDSH or electronic verification sources available to the agency conflicts with self-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 data obtained electronically is not reasonably compatible with attested information, attested information is questionable or a discrepancy is identified.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
AMEND: 410-200-0235

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 410-200-0235 – Changes that Must Be Reported
  o Reduced reporting timeline from 30 days to 10 days to align with DHS programs.

CHANGES TO RULE:

410-200-0235
Changes That Must Be Reported ¶

(1) Individuals shall report the following changes in circumstances affecting eligibility for beneficiaries: 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 310 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 of a household group member; ¶
(e) A change in tax-filing status; ¶
(e) A change in household group membership, citizenship or immigration status of an applicant or recipient; ¶
(f) In addition to section (1)(a)-(f), someone moves in or out of the household; ¶
(h) For all OCCS-HSD Medical Programs except OHP-CHP and MAGI CHIP, a change in availability of employer-sponsored health insurance; ¶
(g) In addition to section (1)(a)-(f), in the For the MAGI Parent or Caretaker Relative and EXT programs, when a household group member receiving medical assistance is the beneficiary no longer has a dependent child; ¶
(h) In addition to section (1)(a)-(f), adults in the MAA, MAF, EXT, MAGI Pregnant Woman, MAGI Parent or Other Caretaker Relative, and MAGI Adult programs 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 a new rate of pay 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.

(23) 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.

(34) Beneficiaries, adult members of the household group, or authorized representative. Changes may be reported via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.

(45) A change is considered reported on the date the beneficiary, adult member of the household group, or authorized representative reports the information to the Agency.

(56) A change reported by the beneficiary, adult member of the household group, or authorized representative for one program is considered reported for all programs administered by the Agency in which the beneficiary participates.

(67) Beneficiaries, adult members of the household group, or authorized representative. 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
AMEND: 410-200-0240

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0240
Eligibility for Individuals Who Do Not Meet the Citizen and Alien Status Requirements ¶

(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 OCCS HSD Medical Program benefits solely because he or she does not meet the Citizen and Ali 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 prenatalPlus benefits provide an enhanced benefit package (OAR 410-120-1210) for the duration of a recipient's pregnancy: ¶

(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 OCCS HSD Medical Programs solely because they do not meet the Citizen and Ali Non-Citizen Status Requirements (OAR 410-200-0215). ¶

(b) Children under age 19 are eligible for CAWEM prenatalPlus benefits through December 31, 2017, if the requirements outlined in (2)(a)(A) are met; ¶

(C) CAWEM prenatalPlus benefits end as follows: ¶

(i) CAWEM prenatalPlus 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 (42)(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 OCCS HSD Medical Program, except they do not meet the Citizen and Ali 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, 414.534, ORS
411.060
AMEND: 410-200-0305

RULE SUMMARY:

Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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

CHANGES TO RULE:

410-200-0305
Household Group - Modified Adjusted Gross Income (MAGI) based Eligibility Determination Group - MAGI Medicaid and CHIP ¶

When establishing eligibility for MAGI-based Medicaid or MAGI/CHIP, each applicant or beneficiary shall have their own household group Eligibility Determination Group (EDG) determined individually based on the following rules:

1. Tax filer’s household group:
   (a) For tax filers 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 household group EDG consists of:
         (A) The tax filer;
         (B) The individual to whom 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, is married and files jointly, and
                respective 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 are married and living with their spouse, each spouse shall be included in the household group of the other spouse, who expect to be claimed as a tax dependent by another individual, the EDG is determined under the spouse’s tax filing status; and

2. Tax dependent’s household group:
   (a) In the case when the individual is claimed as a tax dependent by someone other than the tax filer’s spouse or child;
   (b) Except as described in subsection (b) of this part, the EDG of an individual who expects to be claimed as a tax dependent by another individual, the household group is that of the individual claiming the tax dependent; or
   (b) Household group is determined under section (3) of this rule, where the tax dependent:
      (A) Is not the 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 the tax filer’s spouse or child.
(B) A parent or spouse: ¶

(B) The individual is a child living with both parents but the parents are not filing taxes jointly and one of the is claimed as a tax dependent by one parent; or ¶

(C) The individual is a child living with a parent's and is claiming the child as a tax dependent, or by a non-custodial parent. ¶

(C3) Is a child living with one parent and claimed as a tax dependent by a non-custodial parent. 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 who meets the criteria in section (2)(b) consists of the tax dependent and 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 tax dependent individual; ¶

(B) The individual's spouse; ¶

(C) The tax dependent individual's children; and ¶

(D) If the tax dependent individual is a child, the child's parents and child siblings. ¶

(4c) For individuals who do not file a tax return and are not claimed as a tax dependent, the individual's household group is determined in accordance with section (3) 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

AMEND: 410-200-0310

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0310
Eligibility and Budgeting; MAGI Medicaid/CHIP; Not BCCTP or EXT¶

(1) The budget month means the calendar month from which non-Eligibility is evaluated by reviewing the financial and non-financial information is used to determine eligibility for OCCS Medical Programs.¶
(2) for the applicable budget months. The budget month is determined as follows:¶
(a) For new applicants, the budget month is:¶
  (A) The initial budget month is the month in which medical assistance is requested as follows:¶
  (A) The month in which medical assistance is requested; or¶
  (B) If ineligible in the month in which medical assistance is requested, the budget month is the following month.
  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.¶
  (bc) For a current Medicaid/CHIP beneficiary, the budget month is:¶
  (A) The final month of the twelve-month enrollment period; at renewal, the month in which a renewal response is received by the agency;¶
  (B) The month a change that affects eligibility is reported, if reported timely; or¶
  (C) The month the individual ages off a medical program or is no longer eligible for a medical assistance program;¶
  (c) For retroactive medical, the budget month is the month in which the applicant received medical services for which they are requesting payment. Retroactive medical is determined on a month-by-month basis.¶
(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 basis date it is received.¶
(34) Countable income anticipated or received in the budget month 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) Income is calculated by adding the income of the household group already received in the initial budget month and the income that is reasonably expected to be received in the remaining 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 pay periods.

(b) If ineligible using the initial budget month, countable income from the month following 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 initial budget month is considered. If eligible, eligibility shall begin as described in OCCS Medical Programs – Effective Dates (OAR 410-200-0115). 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 subsections (a) and (b) of this section, because the countable MAGI-based income is over the income standard for all OCCS Medical Programs, 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:¶

(A) If the annualized 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.¶

(B) If ineligible for budget month eligibility pursuant to subsection (A), eligibility shall be determined for the appropriate program pursuant to subsection (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 410-200-03115 and begin as described in OCCS).¶

(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 – Effective Dates (OAR 410-200-0115).¶

(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

AMEND: 410-200-0315

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0315
Standards and Determining Income Eligibility ¶

(1) MAGI-based income not specifically excluded is countable, and its value is used in determining the eligibility and benefit level of an applicant or beneficiary.
(2) MAGI-based income is considered available on the date it is received or the date a member of the household group has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows: (a) Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend; (b) Income withheld or diverted at the request of an individual is considered available on the date the income would have been paid without the withholding or diversion; (c) An advance or draw of earned income is considered available on the date it is received.
(3) In determining financial eligibility for each applicant, the sum of the budget month MAGI-based income of all household group members is combined and compared to the applicable income standard for the family size. If the income is at or below the MAGI income standard, the individual meets the financial eligibility requirements. Except as provided in section (4) (a), if income exceeds the MAGI income standard, the individual is ineligible.
(4) This section applies to MAGI Medicaid/CHIP programs: (a) If an individual is ineligible for MAGI Medicaid based solely on income and would otherwise be eligible for MAGI CHIP or be referred to the Exchange for APTC, a disregard equivalent to five percentage points of the federal poverty level for the applicable family size shall be applied to the household group's income. If the resulting amount is below the income standard for the applicable program and family size, the individual meets the financial eligibility requirements in the following programs: (A) The MAGI Parent or Other Caretaker Relative Program; (B) The MAGI Child Program; (C) The MAGI Adult Program; and (D) The MAGI Pregnant Woman Program; (b) If an individual is ineligible for MAGI CHIP based solely on income and would otherwise be referred to the Exchange for APTC, a disregard equivalent to five percentage points of the federal poverty level for the applicable family size shall be applied to the household group’s income. If the resulting amount is below the income standard for the applicable program and family size, the individual meets the financial eligibility requirements in the MAGI CHIP.
(c) The MAGI 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 Other Caretaker-Relative program is set as follows: See attached table.

(d) Effective March 1, 2019, the MAGI income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the FPL as follows: If an individual’s household group income exceeds the income standard for their family size, the appropriate disregard for their family size described in section (4) (a) shall be applied: See attached table.

(e) Effective March 1, 2019, 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. If an individual’s household group income exceeds the income standard for their family size, the appropriate disregard for their family size described in section (4) (a) shall be applied as follows: See attached table.

(f) Effective March 1, 2019, the MAGI income standard for the MAGI CHIP program is set through 300 percent of FPL as follows: If a child’s household group income exceeds the income standard for their family size, the child would be otherwise ineligible for MAGI CHIP, the appropriate disregard for their family size described in section (5) (a) (B) shall be applied: See attached table.

(g) When the Department makes an ELE determination and the child meets all MAGI CHIP or MAGI Child Program nonfinancial eligibility requirements, the household 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, 2019, if the MAGI-based income of the household group EDG is below 163 percent of the 2019 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 household group 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.


Rule Attachments do not show changes. Please contact agency regarding changes.
**2020 Oregon Health Authority Medical Programs - effective March 1, 2020**

<table>
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<tr>
<th>Family Size</th>
<th>Parents &amp; Other Caretaker Relatives (PCR)</th>
<th>MAGI Child (age 1 - under 19) (CMO) / MAGI Adult (AMO)</th>
<th>MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)</th>
<th>MAGI CHIP (C21)</th>
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**Family Size**

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<th>Family Size</th>
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## 2019 Oregon Health Authority Medical Programs - effective March 1, 2019

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<th>Family Size</th>
<th>Parents &amp; Other Caretaker Relatives (PCR)</th>
<th>MAGI Child (age 1 - under 19) (CMO) / MAGI Adult (AMO)</th>
<th>MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)</th>
<th>MAGI CHIP (C21)</th>
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AMEND: 410-200-0400

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0400
Specific Requirements; Breast and Cervical Cancer Treatment Program (BCCTP)

This rule establishes eligibility criteria for medical assistance based on an individual’s need of treatment for breast or cervical cancer, including pre-cancerous conditions (treatment). The Authority administers the Oregon Breast and Cervical Cancer Treatment Program (BCCTP) by entering into agreements with qualified entities as approved by the Authority to provide screening services for BCCTP funded by the Centers for Disease Control in support of the National Breast and Cervical Cancer Early Detection Program.

(1) To be eligible for BCCTP, an individual must:
(a) Be found to need treatment following screening services provided by a qualified entity;
(b) Be under the age of 65;
(c) Not be covered for treatment by minimum essential coverage; and
(d) Not be eligible for 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 upon the first 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: ORS 411.402, 411.404, 413.042, 414.534
RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0405
Specific Requirements; Substitute Care ¶

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 household group 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
SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0407
Specific Requirements-Former Foster Care Youth Medical Program ¶

This rule describes specific eligibility requirements for the Former Foster Care Youth Program effective December 1, 2015.¶
(1) Individuals may not be eligible for the Former Foster Care Youth Medical Program with an effective date prior to January 1, 2014 (FFCYM).¶
(2) There is no income test for the Former Foster Care Youth Medical Program.¶
(3) An individual is eligible for the Former Foster Care Youth Medical 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 Other 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
AMEND: 410-200-0410

RULE SUMMARY: Edits to all rules:

- Removed references which speak specifically to the implementation/transitional period in 2014
- Removed references to pre-2014 OHP programs that are no longer in use
- Adjusted gender-specific terms to gender-neutral terms
- Replaced “OCCS” references with “HSD”
- Replaced terminology “alien” with “non-citizen”
- Replaced terminology “household group” with “eligibility determination group (EDG)”
- Non-substantive edits to terminology, wording, and format for better clarity and readability.

- 410-200-0410 - Specific Requirements; MAGI CHIP
  - 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).

CHANGES TO RULE:

410-200-0410
Specific Requirements; MAGI CHIP

In addition to eligibility requirements applicable to the MAGI CHIP program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI CHIP program.

(1) Individuals may not be eligible for the MAGI CHIP program with an effective date prior to October 1, 2013.

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

   (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) Not be eligible for MAGI Child, MAGI Pregnant Woman, MAGI Parent or Caretaker Relative, or Substitute Care programs;
   (b) Meet budgeting requirements of OAR 410-200-0315; and
   (c) Except as described in section (4), not 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 household group member, member of the household at risk of harm.

   (3) For the Authority to enroll a child in MAGI CHIP based on a determination made by an Express Lane Agency (ELA), the child’s parent or guardian shall give consent in writing, by telephone, orally, or through electronic signature.

   (4) For renewals in 2014, children with minimum essential coverage shall be enrolled in MAGI CHIP for a full 12-month eligibility period if:

      (a) At the time of renewal, the child is receiving Medicaid based on a 2013 non-MAGI based eligibility determination;
      (b) The child meets all other MAGI CHIP financial and non-financial eligibility requirements, except they are receiving minimum essential coverage; and
      (c) The child loses eligibility for Medicaid due to MAGI-based eligibility policy effective October 1, 2013, which eliminated the 50 percent self-employment income disregard.
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
Specific Requirements; MAGI Child

In addition to eligibility requirements applicable to the MAGI Child program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Child program.¶

1. Individuals may not be eligible for the MAGI Child program with an effective date prior to January 1, 2014, the child must:¶
   (a) Be under the age of 19; and¶
   (b) To be eligible for the MAGI Child program, the child must be under the age of 19 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. To be eligible for the MAGI Child Program, an individual may not:¶
   (a) Be receiving or deemed to be receiving SSI benefits;¶
   (b) Be receiving Medicaid through another program;¶
   (c) Be incarcerated.¶

3. A child born to a mother or an individual who is eligible for and receiving Medicaid/CHIP benefits is assumed eligible for medical benefits under this rule. Newborn (AEN) for the MAGI Child program until the end of the month in which the child turns one year of age unless:¶
   (a) The child dies (see OAR 410-200-0135). There is no income limit for an AEN.¶
   (b) The child is no longer a resident of Oregon; or be eligible for the MAGI Child Program, an individual may not:¶
      (a) Be receiving or deemed to be receiving SSI benefits;¶
      (b) The child's representative requests a termination of the child's eligibility.¶

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.¶

Statutory/Other Authority: ORS 411.402, 411.404, 413.042
AMEND: 410-200-0420

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

• 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.

CHANGES TO RULE:

410-200-0420
Specific Requirements; MAGI Parent or Other Caretaker Relative

In addition to eligibility requirements applicable to the MAGI Parent and Other Caretaker Relative program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Parent or Other Caretaker Relative program.

(1) Individuals may not be eligible for the MAGI Parent and Other Caretaker Relative program with an effective date prior to January 1, 2014, 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 Other Caretaker Relative program, an individual must have household group 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 Other 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
AMEND: 410-200-0425

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0425
Specific Requirements; MAGI Pregnant Woman

In addition to eligibility requirements applicable to the MAGI Pregnant Woman program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Pregnant Woman program.

(1) Individuals may not be eligible for the MAGI Pregnant Woman program with an effective date prior to January 1, 2014.

(2) To be eligible for the MAGI Pregnant Woman program, an individual must:
   (a) Be pregnant;
   (b) Be within the two calendar months following the month in which their pregnancy ended.

(3) 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 continuous protected eligibility according to the policy described in OAR 410-200-0135.

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

(5) 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 woman dies;
   (b) The woman moves out of state;
   (c) The woman becomes incarcerated;
   (d) An adult in the household group requests the medical benefits are closed.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042
AMEND: 410-200-0435

RULE SUMMARY: Edits to all rules:
• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

CHANGES TO RULE:

410-200-0435
Specific Requirements; MAGI Adult

In addition to eligibility requirements applicable to the MAGI Adult program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Adult program.

(1) An individual may not be eligible for the MAGI Adult program with an effective date prior to January 1, 2014.

(2) The Agency may not allow retroactive enrollment into the MAGI Adult program for effective dates prior to January 1, 2014.

(3) To be eligible for the MAGI Adult program an individual must:
   (a) Be 19 years of age or older and under age 65;
   (b) Have household income at or below 133 percent federal poverty level (OAR 410-200-0315) for the applicable family size.

(4) To be eligible for the MAGI Adult program, an individual may not be:
   (a) Pregnant;
   (b) Entitled to or enrolled for Medicare benefits under part A or B of Title XVIII of the Act;
   (c) Receiving SSI benefits; or
   (d) A parent or other caretaker relative living with a dependent child 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
AMEND: 410-200-0440

RULE SUMMARY: Edits to all rules:

• Removed references which speak specifically to the implementation/transitional period in 2014
• Removed references to pre-2014 OHP programs that are no longer in use
• Adjusted gender-specific terms to gender-neutral terms
• Replaced “OCCS” references with “HSD”
• Replaced terminology “alien” with “non-citizen”
• Replaced terminology “household group” with “eligibility determination group (EDG)”
• Non-substantive edits to terminology, wording, and format for better clarity and readability.

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

CHANGE TO RULE:

410-200-0440
Specific Requirements; Extended Medical Assistance

(1) The following individuals may lose eligibility for Extended Medical Assistance (EXT) if they lose eligibility for Medical Assistance Assumed (MAA), Medical Assistance to Families (MAF), or MAGI Parent or Other Caretaker Relative (PCR) due to the receipt or increase of earned income or spousal support for any one of the six months preceding the receipt or increase of earned income or spousal support that resulted in loss of MAGI PCR eligibility:

(a) Individuals who lose eligibility for MAA, MAF, or MAGI PCR due to the receipt or increase of earned income are eligible for 12 months of EXT if they were eligible for and receiving MAGI PCR benefits:

(b) Eligibility is redetermined and the individual is not found eligible for any other Medicaid/CHIP program except BCCTP or Substitute Care; and

(c) They are the parent or caretaker relative of a dependent child living in their home.

(b)2) Individuals who lose eligibility for MAA, MAF, or MAGI PCR due to the receipt or increase of spousal support are eligible for a period of up to four months of EXT benefits if:

(Aa) Individuals who were eligible for and receiving MAA, MAF, or 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, and

(Bb) Eligibility is redetermined and the individual is not found ineligible for any other Medicaid/CHIP program except BCCTP or Substitute Care; and

(2c) The EXT beneficiary must be a resident of Oregon.

(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 reasons may regain EXT eligibility for the remainder of the original eligibility period if the requirements outlined in sections (1) and (2) are met: 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 leaves 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 OCCS Medicaid program, and then a subsequent change in circumstance occurred that resulted in loss of eligibility for all OCCS Medicaid Programs, the i.¶
(6) Individual may regain EXT eligibility.¶
(4) The effective date of EXT is the first of the month following the month in which MAA, MAF, or MAGI PCR program eligibility ends.¶
(5) If an individual receives MAA, MAF, or MAGI PCR benefits during months when they were eligible for EXT:¶
(a) Such months are not an overpayment;¶
(b) Any month in which an individual receives MAA, MAF, or MAGI PCR benefits 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 when they were eligible for EXT is counted as a month of the EXT eligibility period.¶
(6) If a beneficiary of MAA, MAF, or MAGI PCR benefits experiences another change in conjunction with the receipt or increase of earned income or spousal support, and the other change, by itself, makes the beneficiary ineligible for the current program, the beneficiary is not eligible for EXT 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
REPEAL: 410-200-0505

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.

CHANGE TO RULE:

410-200-0505
Specific Requirements; Fast Track Eligibility and Enrollment for MAGI Medicaid.
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 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 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.

CHANGES TO RULE:

410-200-0510
Specific Program Requirements; BCCM, CEC, CEM, EXT, MAA, MAF, OHP, and Substitute Care
(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-
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, 414.231