Division of Medical Assistance Programs
Policy and Planning Section

Client and Community Services Medical Program Rulebook

Chapter 410, Division 200

Effective June 2, 2016

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410-200-0010 – Overview

These rules, OAR 410-200-0010 through 0510, describe eligibility requirements for the Office of Client and Community Services (OCCS) medical programs.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536, 414.706

410-200-0015 – General Definitions (T)

(1) “Action” means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.

(2) “Address Confidentiality Program (ACP)” means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.

(3) “AEN” means Assumed Eligible Newborn (OAR 410-200-0115).

(4) “Affordable Care Act” means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56).

(5) “Agency” means the Oregon Health Authority and Department of Human Services.

(6) “American Indian and Alaska Native income exceptions” means:

(a) Distributions from Alaska Native Corporations and Settlement Trusts;

(b) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;

(c) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:

(A) Rights of ownership or possession in any lands described in section (b) of this part; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(d) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(e) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

(f) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(7) “Applicant” means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.

(8) “Application” means:

(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or

(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.

(9) “APTC” means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

(10) “Assumed eligibility” means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual’s eligibility.

(11) “Authorized Representative” means an individual or organization that acts on behalf of an applicant or beneficiary in assisting with the individual’s application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).

(12) “Beneficiary” means an individual who has been determined eligible and is currently receiving OCCS medical program benefits, Aging and People with Disability medical program benefits, or APTC.

(13) “BRS” means Behavioral Rehabilitation Services .

(14) “Budget Month” means the calendar month from which financial and nonfinancial information is used to determine eligibility.

(15) “Caretaker” means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child’s care.

(16) “Caretaker Relative” means a relative of a dependent child by blood, adoption, or marriage with whom the child is living who assumes primary responsibility for the child’s care, which may but is not required to be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child’s father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;

(c) An individual described in this section who is a relative of the child based on blood, including those of half-blood, adoption, or marriage.

(17) “CAWEM” means Citizen/Alien-Waived Emergency Medical, which is Medicaid coverage for emergency medical needs for individuals who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements (OAR 410-200-0240).

(18) “CAWEM Prenatal” means medical services for pregnant CAWEM beneficiaries.

(19) “Child” means an individual including minor parent, under the age of 19. Child does not include an unborn. Child includes a natural or biological, adopted, or step child.

(20) “Children’s Health Insurance Program” also called “CHIP” means Oregon medical coverage under Title XXI of the Social Security Act.

(21) “Citizenship” includes status as a “national of the United States” defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.

(22) “Claim” means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker’s Compensation Board.

(23) “Claimant” means an individual who has requested a hearing or appeal.

(24) “Code” means Internal Revenue Code of 1986 as amended.

(25) “Combined eligibility notice” means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the OCCS Medical Programs for which a determination or denial was made by the Authority.

(26) “Community partner” means all external entities that partner with the Authority and enter into formal agreement with the Authority to conduct outreach or enrollment assistance, whether or not they are funded or compensated by the Authority. Insurance agents are not considered community partners.

(27) “Coordinated content” means information included in eligibility notice regarding the transfer of the individual’s or household’s electronic account to another insurance affordability program for a determination of eligibility.

(28) “Custodial Parent” means, for children whose parents are divorced, separated, or unmarried, the parent for whom:

(a) If living with one parent, a court order or binding separation, divorce, or custody agreement establishes physical custody controls; or

(b) If living with one parent and there is no such order or agreement described in section (a), or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights;

(c) If a child does not live with either parent, the parent who claims the child as a tax dependent is treated as the custodial parent for the purposes of OCCS medical program eligibility.

(29) “Date of Request” means the earlier of:

(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.

(30) “Decision notice” means a written notice of a decision made regarding eligibility for an OCCS medical program benefit. A decision notice may be a:

(a) “Basic decision notice” mailed no later than:

(A) The date of action given in the notice; or

(B) When suspending benefits due to incarceration (OAR 410-200-0140), the date on which the action is taken to suspend benefits effective the day following the date on which the individual became incarcerated.

(b) “Combined decision notice” informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;

(c) “Timely continuing benefit decision notice” informs the client of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.

(31) “Department” means the Department of Human Services.

(32) “Dependent child” means a child who is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if before attaining age 19 the child may reasonably be expected to complete the school or training.

(33) “ELA” (Express Lane Agency) means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.

(34) “ELE” (Express Lane Eligibility) means the Oregon Health Authority’s option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.

(35) “Electronic account” means an electronic file that includes all information collected and generated by the Agency regarding each individual’s Medicaid or CHIP eligibility and enrollment, including all required documentation and including any information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.

(36) “Electronic application” means an application electronically signed and submitted through the Internet.

(37) “Eligibility determination” means an approval or denial of eligibility and a renewal or termination of eligibility.

(38) “Expedited appeal” also called “expedited hearing” means a hearing held within five working days of the Authority’s receipt of a hearing request, unless the claimant requests more time.

(39) “Family size” means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the household group and each unborn child of any pregnant members of the household group.

(40) “Federal data services hub” means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies

needed to verify eligibility, including SSA, the Department of Treasury, and the Department of Homeland Security.

(41) “Federal poverty level (FPL)” means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual’s eligibility in accordance with 42 CFR 435.603(h).

(42) “Federally Facilitated Marketplace” also called “FFM” means a website used by consumers.

(43) “Hearing Request” means a clear expression, oral or written, by an individual or the individual’s representative that the individual wishes to appeal an Authority or FFM decision or action.

(44) “Household group” consists of every individual whose income is considered for determining each medical applicant’s eligibility as defined in OAR 410-200-0305.

(45) “Inmate” means:

(a) An individual living in a public institution that is:

(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;

(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;

(C) Residing involuntarily in a facility that is under governmental control; or

(D) Receiving care as an outpatient while residing involuntarily in a public institution;

(b) An individual is not considered an inmate when:

(A) The individual is released on parole, probation, or post-prison supervision;

(B) The individual is on home or work-release, unless the individual is required to report to a public institution for an overnight stay;

(C) The individual is receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate;

(D) The individual is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and while other living arrangements are being made for the individual; or

(E) The individual is in a public institution pending other arrangements as defined in 42 CFR 435.1010.

(46) “Insurance affordability program” means a program that is one of the following:

(a) Medicaid;

(b) CHIP;

(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;

(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.

(47) “Lawfully present” means an individual:

(a) Is a qualified non-citizen, as defined in this section;

(b) Has valid non-immigrant status, as defined in 8 U.S.C. 1101(a) (15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a) (17));

(c) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection, or pending removal proceedings; or

(d) Belongs to one of the following classes:

(A) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

(B) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a and individuals with pending applications for TPS who have been granted employment authorization;

(C) Granted employment authorization under 8 CFR 274a.12(c);

(D) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649, as amended;

(E) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(F) Granted Deferred Action status;

(G) Granted an administrative stay of removal under 8 CFR part 241; (viii) Beneficiary of approved visa petition that has a pending application for adjustment of status;

(e) Is an individual with a pending application for asylum under 8 U.S.C. 158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days;

(f) Has been granted withholding of removal under the Convention Against Torture;

(g) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a) (27) (J);

(h) Is lawfully present in American Samoa under the immigration laws of American Samoa;

(i) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106–386, as amended (22 U.S.C. 7105(b)); or

(j) Exception: An individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, may not be considered to be lawfully present with respect to any of the above categories in sections (a) through (i) of this rule.

(48) "Legal Argument" has the meaning given that term in OAR 137-003-0008(c).

(49) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.

(50) "MAGI" means Modified Adjusted Gross Income and has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:

(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:

(A) Children, regardless of age, who are included in the household of a parent;

(B) Tax dependents;

(b) In applying subsection (a) of this section, IRC § 6012(a) (1) is used to determine who is required to file a tax return.

(51) “MAGI-based income” means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:

(a) American Indian and Alaska Native income exceptions;

(b) Child support;

(c) Life insurance proceeds;

(d) Non-taxable Veterans’ benefits;

(e) Non-taxable workers’ compensation benefits;

(f) Scholarships, awards, or fellowship grants used for educational expenses;

(g) Supplemental Security Income (SSI);

(h) An amount received as a lump sum is counted as income only in the month received. Lump sum income includes but is not limited to:

(A) Winnings;

(B) Countable educational income;

(C) Capital gains;

(D) Dividends, interest, royalties;

(i) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses;

(j) Self-employment and business entity income is determined by adding gross receipts and other business income and subtracting deductions described in Internal

Revenue Code (IRC) §§ 161 through 249. Items not deductible are described in IRC §§ 261 through 280 include, but are not limited to, most capital expenditures, such as business start-up costs, buildings, and furniture and payments or deductions for personal, living, or family use. Business structures are determined by state statutes and are dependent on elections made by business owners. Each state may use different regulations for business structures. Salaries and wages paid to employees, including those who are owners or stockholders, are countable income to the employees. Business income is countable to owners and stockholders as described below:

(A) Sole proprietors, independent contractors, and Limited Liability Companies (LLC) who choose to file federal taxes as a sole proprietor: The necessary and ordinary costs of producing income are subtracted from gross receipts and other business income to determine countable income. Expenses related to costs for both business and personal use are prorated according to the proportions used for each purpose. Costs are limited to those described in IRC §§161 through 199 and Treasury Regulations §§ Sec. 1.162 through 1.263;

(B) Partnerships that are not publicly traded and LLCs who choose to file federal taxes as a partnership: Owners' income is determined as follows:

(i) The distributive share of income, gain, and loss is determined proportionately according to the partnership agreement or the LLC agreement;

(ii) Income from other partnerships, estates, and trusts is added to the amount in paragraph (A) of this subsection;

(iii) The costs of producing income described in subsection (4) (a) except for oil and gas depletion and costs listed below are proportionately subtracted from gross receipts to determine each partner's countable income:

(I) Bad debts;

(II) Guaranteed payments to partners;

(III) Losses from other partnerships, farms, estates, and trusts;

(IV) Retirement plans;

(C) S Corporations and LLCs who choose to file federal taxes as an S Corporation: Shareholders' income is determined as follows:

(i) The distributive share of profits, gain, and loss are determined proportionately on the basis of the stockholders' shares of stock;

(ii) The costs of producing income described in subsection (a) are proportionately subtracted from gross receipts to determine each stockholder's countable income;

(iii) The distributive share of profits is countable income to the shareholders whether or not it is actually distributed to the shareholders;

(D) C Corporations and LLCs who choose to file taxes as C Corporations: Shareholders' income is countable when it is distributed to them through dividends.

(52) "MAGI income standard" means the monthly income standard for the relevant program and family size described in OAR 410-200-0315.

(53) "Minimum essential coverage" means medical coverage under:

(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CAWEM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;

(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;

(c) Plans in the individual market;

(d) Grandfathered health plans; and

(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.

(54) "Non-applicant" means an individual not seeking an eligibility determination for him or herself and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.

(55) "Non-citizen" has the meaning given the term "alien" as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

(56) "OCCS" means the Office of Client and Community Services, part of the Division of Medical Assistance Programs under the Oregon Health Authority.

(57) "OCCS Medical Programs" means all programs under the Office of Client and Community Services including:

(a) “CEC” means Continuous Eligibility for OHP-CHP pregnant women. Title XXI medical assistance for a pregnant non-CAWEM child found eligible for the OHP-CHP program who, for a reason other than moving out of state or becoming a recipient of private major medical health insurance, otherwise would lose her eligibility;

(b) “CEM” means Continuous Eligibility for Medicaid: Title XIX medical assistance for a non-CAWEM child found eligible for Medicaid who loses his or her eligibility for a reason other than turning 19 years of age or moving out of state;

(c) “EXT” means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;

(d) “MAA” means Medical Assistance Assumed;

(e) “MAF” means Medical Assistance to Families. The Medical Assistance to Families program provides medical assistance to people who are ineligible for MAA but are eligible for Medicaid using ADC program standards and methodologies that were in effect as of July 16, 1996;

(f) “OHP” means Oregon Health Plan. The Oregon Health Plan program provides medical assistance to many low-income individuals and families. The program includes five categories of individuals who may qualify for benefits. The acronyms for these categories are:

(A) “OHP-CHP” Persons under 19. OHP coverage for persons under 19 years of age who qualify at or below the 300 percent income standard;

(B) “OHP-OPC” Children. OHP coverage for children who qualify under the 100 percent income standard;

(C) “OHP-OPP” Pregnant Females and their newborn children. OHP coverage for pregnant females who qualify under the 185 percent income standard and their newborn children;

(D) “OHP-OPU” Adults. OHP coverage for adults who qualify under the 100 percent income standard. A person eligible under OHP-OPU is referred to as a health plan new/non-categorical (HPN) client;

(E) “OHP-OP6” Children under 6. OHP coverage for children under age 6 who qualify under the 133 percent income standard;

(g) “Substitute Care” means medical coverage for children in BRS or PRTF;

(h) “BCCTP” means Breast and Cervical Cancer Treatment Program;

(i) “FFCYM” means Former Foster Care Youth Medical;

(j) “MAGI Medicaid/CHIP” means OCCS Medical Programs for which eligibility is based on MAGI, including:

(A) MAGI Child;

(B) MAGI Parent or Other Caretaker Relative;

(C) MAGI Pregnant Woman;

(D) MAGI Children’s Health Insurance Program (CHIP);

(E) MAGI Adult.

(58) “OCWP” means Office of Child Welfare Programs.

(59) “OSIPM” means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.

(60) “Parent” means a natural or biological, adopted, or step parent.

(61) “Personal Injury” means a physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.

(62) “Post-eligibility review” means a review period of 30 days following the eligibility determination during which the Authority shall verify information used to approve OCCS medical program benefits and ensure all non-financial eligibility requirements are met (OAR 410-200-0230).

(63) “Pregnant woman” means a woman during pregnancy and the postpartum period that begins on the date the pregnancy ends, extends 60 days and ends on the last day of the month in which the 60-day period ends.

(64) “Primary contact” means the primary person the Agency shall communicate with and:

(a) Is listed as the case name; or

(b) Is the individual named as the primary contact on the application.

(65) “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.

(66) “PRTF” means Psychiatric Residential Treatment Facility.

(67) “Public institution” means any of the following:

(a) A state hospital (ORS 162.135);

(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;

(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;

(d) A youth correction facility (ORS 162.135):

(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or

(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order;

(e) As used in this rule, the term public institution does not include:

(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);

(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or

(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.

(68) “Qualified Hospital” means a hospital that:

(a) Participates as an enrolled Oregon Medicaid provider;

(b) Notifies the Authority of their decision to make presumptive eligibility determinations;

(c) Agrees to make determinations consistent with Authority policies and procedures;

(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and

(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).

(69) “Reasonable opportunity period:”

(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;

(b) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that he or she did not receive the notice within the five-day period;

(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.

(70) “Redetermination” means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date are considered renewals.

(71) “Renewal” means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(72) “Required documentation” means:

(a) Facts to support the Agency's decision on the application; and

(b) Either:

(A) A finding of eligibility or ineligibility; or

(B) An entry in the case record that the applicant voluntarily withdrew the application, and the Agency sent a notice confirming the decision, that the applicant has died, or that the applicant cannot be located.

(73) “Secure electronic interface” means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.

(74) “Shared eligibility service” means a common or shared eligibility system or service used by a state to determine individuals’ eligibility for insurance affordability programs.

(75) “Sibling” means natural or biological, adopted, or half or step sibling.

(76) “Spouse” means an individual who is legally married to another individual under:

(a) The statutes of the state where the marriage occurred;

(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or

(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.

(77) “SSA” means Social Security Administration.

(78) “Tax dependent“ has meaning given the term “dependent” under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

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

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536, 414.706

410-200-0100 – Coordinated Eligibility and Enrollment Process with the Department of Human Services and the Federally Facilitated Marketplace (T)

(1) This rule describes Oregon Health Authority's (Authority) coordination of eligibility and enrollment with 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 for criteria that identify individuals for whom MAGI-based income methods do not apply.

(2) For individuals undergoing eligibility determination for OCCS 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 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 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 is being determined by the Department and may 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 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 to the Agency; and

(c) If information is available through electronic data match and is useful and related to eligibility for OCCS Medical Programs, the Authority shall obtain the information through electronic data match.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0105 – Hospital Presumptive Eligibility (T)

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) The qualified hospital shall determine Hospital Presumptive Eligibility for MAGI Medicaid/CHIP, BCCTP, or Former Foster Care Youth Medical based on the following information attested by the individual:

(a) Family size;

(b) Household income;

(c) Receipt of other health coverage;

(d) US citizenship, US national, or non-citizen status.

(2) To be eligible via Hospital Presumptive Eligibility, an individual must be a US citizen, US National, or meet the citizenship and alien 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 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.

(3) 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 Hospital Presumptive Eligibility for any portion of the full year (365 days) preceding a new Hospital Presumptive Eligibility period.

(4) In addition to the requirements outlined in sections (2) and (3) 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.

(5) 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.

(6) 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.

(7) A Hospital Presumptive Eligibility decision does not qualify a beneficiary for continuous eligibility (OAR 410-200-0135).

(8) A baby born to a woman receiving benefits during a Hospital Presumptive Eligibility period is not assumed eligible (OAR 410-200-0135).

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0110 – Application and Renewal Processing and Timeliness Standards (T)

(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 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's eligibility and benefit level is provided on the application for each individual in the household group;

(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 redetermine eligibility at assigned intervals 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) 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 the Agency shall provide a pre-populated renewal form 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 (7) 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 (6) 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 (7) of this rule;

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

(3) 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 program 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 ineligible 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 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;

(g) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;

(h) At renewal, the beneficiary fails to submit additional information requested by the Agency within 30 days but provides the requested information within 90 days after the date medical benefits were terminated.

(6) Signature requirements are as follows:

(a) For an application submitted via the Oregon Eligibility (ONE) system, the individual identified as the primary applicant must electronically sign the application;

(b) For an application submitted by means other than the Oregon Eligibility (ONE) system, the application must be signed by one of the following:

(A) The primary contact;

(B) At least one caretaker relative or parent in the household group;

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

(D) An authorized representative;

(c) Signatures accepted by the Agency may be:

(A) Handwritten;

(B) Electronic; or

(C) Telephonic

(d) Hospital Presumptive Eligibility may be determined without a signature described in section (a) through (c);

(e) When 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, a signature is required on the pre-populated 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;

(7) 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 the 45th calendar day after the Date of Request if:

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

(B) The application is not completed by the applicant 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 there is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;

(c) Except for periodic renewals of eligibility described in section (d), the Agency provides:

(A) The reasonable opportunity period to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status after eligibility has been determined; or

(B) The post-eligibility review period to verify information used to approve OCCS medical program benefits and ensure all non-financial eligibility requirements are met;

(d) At periodic renewal of eligibility, if additional information beyond data available to the Agency on the beneficiary's electronic account or electronic data 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.

(8) Individuals may apply through the FFM. If the FFM determines the individual potentially eligible for Medicaid, the FFM shall transfer the individual's electronic account to the Agency for OCCS medical program eligibility determination or referral to the Department.

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

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

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

(B) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (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 410-200-0135);

(G) MAGI CHIP (OAR 410-200-0410);

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

(H) EXT (OAR 410-200-0440);

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

(A) Assumed eligibility for OCCS 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) EXT (OAR 410-200-0440);

(E) MAGI Pregnant Woman (OAR 410-200-0425);

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

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

(H) BCCTP (OAR 410-200-0400).

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0111 – Authorized Representatives (T)

(1) The following individuals may designate an authorized representative:

(a) A caretaker;

(b) The primary contact when there is no caretaker in the household group;

(c) An adult in the household group; or

(d) The Agency, if an authorized representative is needed but has not been designated by the individual.

(2) The Agency shall accept an applicant or beneficiary's designation of an authorized representative via any of the following methods which must include either a handwritten or electronic signature of both the applicant or beneficiary and designated authorized representative:

(a) The Internet;

(b) E-mail;

(c) Mail;

(d) Telephonic recording;

(e) In person; or

(f) Other electronic means.

(3) Applicants and beneficiaries may authorize their authorized representative to:

(a) Sign an application on the applicant's behalf;

(b) Complete and submit a renewal form;

(c) Receive copies of the applicant or beneficiary's notices and other communications from the Agency; or

(d) Act on behalf of the applicant or beneficiary in any or all other matters with the Agency.

(4) The authorized representative must:

(a) Fulfill all responsibilities encompassed within the scope of the authorized representation as identified in section (3) to the same extent as the individual represented; and

(b) Maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Authority.

(5) In addition to authorized representatives as designated in sections (1) through (4) above, an individual is treated as an authorized representative if the individual has been given authority under state law. Such authority includes but is not limited to:

(a) A court order establishing legal guardianship;

(b) A health care representative, when the individual is unable to make their own decisions; or

(c) A court order establishing power of attorney.

(6) As a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization with a service-providing relationship to the beneficiary must affirm that he or she shall adhere to the regulations in 45 CFR 431, subpart F and at 45 CFR 155.260(f) and at 45 CFR 447.10 as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(7) The power to act as an authorized representative is valid until the Agency is notified via any of the methods described in section (2) of any of the following:

(a) The applicant or beneficiary modifies the authorization or notifies the Agency that the representative is no longer authorized to act on his or her behalf;

(b) The authorized representative informs the Agency that he or she no longer is acting in such capacity; or

(c) There is a change in the legal authority upon which the individual or organization's authority was based.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0115 – OCCS Medical Programs – Effective Dates (T)

(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 is whichever comes first:

(a) The first of the month in which the Date of Request is established, if the applicant is found eligible as of the Date of Request; or

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

(4) The effective date for retroactive medical benefits (OAR 410-200-0130) for MAGI Medicaid/CHIP and BCCTP is the first day of the earliest of the three months preceding the month in which the Date of Request was established. The Authority reviews each month individually for retroactive medical eligibility.

(5) Establishing a renewal date:

(a) Except for EXT and MAGI Pregnant Woman, as provided in subsection (b) for all OCCS Medical Programs, 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;

(B) For renewals 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.

(6) Acting on 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 OHP-OPP, MAGI Pregnant Woman, and MAGI Parent or Other Caretaker Relative for pregnant women, based on the reported change, if the beneficiary is determined to be eligible for another OCCS medical program, the effective date for the change is:

(A) If reported on or before the 15th of the month, the first of the month following the month in which the determination was made; or

(B) If reported on or after the 16th of the month, the first of the month after the month following the month in which the determination was made.

(c) For OHP-OPP, MAGI Pregnant Woman, and MAGI Parent or Other Caretaker Relative for pregnant women, the effective date is the Date of Request;

(7) Suspending or Closing Medical Benefits:

(a) The effective date for closing OCCS 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 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) Prior to closing medical benefits, the Agency shall:

(A) Determine eligibility for all other OCCS Medical Programs; or

(B) Refer the beneficiary to the Department, if applicable, and confirm that the Department has made an eligibility decision.

(c) For beneficiaries of OCCS medical program benefits who become incarcerated (OAR 461-200-0140), the effective date of suspension is the day following the date on which the individual became incarcerated.

(8) Denial of Benefits. The effective date for denying OCCS medical program benefits is the earlier of the following:

(a) The date the decision is made that the applicant is not eligible and notice is sent; or

(b) The end of the application processing time frame, unless the time period has been extended to allow the applicant more time to provide required verification.

(9) Ninety-day Reconsideration Period for eligibility following closure:

(a) The Authority shall redetermine in a timely manner (OAR 410-200-0110), without requiring a new application, the eligibility of an individual who:

(A) Lost OCCS medical program eligibility because they did not submit required information needed to renew eligibility; and

(B) Within 90 days of the medical closure date, submits the required information needed to renew eligibility.

(b) If the individual is found to meet OCCS medical program eligibility based on the completed redetermination using the original budget month, eligibility shall be restored effective the earliest date following the medical closure date on which the

individual requested benefits, as long as all necessary information is submitted within 90 days following the medical closure date.

(c) The date described in section (b) establishes a new date of request (see section (1)) and budget month (410-200-0310) if:

(A) The individual is ineligible based on the completed redetermination using the original budget month; or

(B) All necessary information is not submitted within 90 days following the medical closure date.

Stat. Auth.: ORS, 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0120 – Notices (T)

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

(a) A basic decision notice whenever an application for OCCS medical program benefits is approved or denied;

(b) A timely continuing benefit decision notice whenever OCCS medical program benefits are reduced or closed.

(2) For a beneficiary who is placed in a public institution or a correctional facility, the Authority shall send a basic decision notice to close, reduce, or suspend OCCS 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 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 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, 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 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 benefits is made with written signature or recorded verbal signature;

(c) 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 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 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 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0125 – Acting on Reported Changes (T)

(1) When an OCCS medical program 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 shall promptly redetermine eligibility before reducing or ending medical benefits.

(2) The Authority shall limit requests for information from the individual to information 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0130 – Retroactive Medical (T)

(1) The Authority may evaluate the following for retroactive medical eligibility:

(a) Applicants requesting OCCS Medical Programs who have unpaid medical bills or received donated medical services that would have been covered by Oregon Medicaid/CHIP in the three calendar months preceding the month in which the Date of Request was established.

(b) Deceased individuals 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 during a Hospital Presumptive Eligibility period (OAR 410-200-0105) if the medical service received is not covered by Hospital Presumptive Eligibility.

Stat. Auth.: ORS 411.402, 411.404 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536 & 414.706

410-200-0135 – Assumed Eligibility and Continuous Eligibility for Children and Pregnant Women (T)

(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 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 all Medicaid or CHIP programs prior to the 12-month renewal date shall remain eligible until the end of the renewal month, regardless of any change in circumstances, except for the following:

(a) No longer an Oregon resident;

(b) Death;

(c) Turning age 19;

(d) For children in the CHIP program, receipt of minimum essential coverage; or

(e) When any adult in the household group requests the medical benefits are closed;

(3) Continuous Eligibility for pregnant women – Pregnant women who are eligible for and receiving medical assistance under any Medicaid program who lose eligibility for the medical program shall receive continuous eligibility through the end of the calendar month in which the 60th day following the last day of the pregnancy falls, except in the following circumstances:

(A) She is no longer an Oregon resident;

(B) Death; or

(C) She requests medical benefits are closed.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025 & 414.534

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0140 – Eligibility for Inmates (T)

(1) An inmate of a public institution may not receive benefits with OCCS Medical Programs.

(2) If an OCCS medical program beneficiary becomes an inmate of a public institution with an expected stay of no more than 12 months, medical benefits shall be suspended for up to 12 full calendar months during 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 first day the individual is no longer an inmate without the need for a new application when:

(a) The individual reports their release to the Agency within ten days of the release date;

(b) The individual reports their release to the Agency more than ten 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, providing the facility is not associated with the institution where the individual was an inmate.

(5) When released, benefits shall be restored as described in section (3), and:

(a) If the individual is released prior to their eligibility renewal date, the eligibility renewal date may 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.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025 & 414.534

Stats. Implemented: ORS, 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049 & 414.426

420-200-0145 – 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. Contested case hearings are conducted in accordance with the Attorney General's model rules OAR 137-003-0501 and following ORS Ch. 183 except to the extent that Authority rules provide for different procedures.

(3) The Authority's contested case hearings governed by this rule are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to the parties' consent and applicable confidentiality laws.

(4) A claimant may request a contested case hearing upon the timely completion of a hearing request in medical assistance programs in the following situations:

(a) The Authority has not approved or denied an application within 45 days of the date of request for benefits or the extended time the Authority has allowed for processing;

(b) The Authority acts to deny, reduce, close, or suspend medical assistance, including the denial of continued benefits pending the outcome of a contested case hearing;

(c) The Authority claims that an earlier medical assistance payment was an overpayment;

(d) A claimant claims that the Authority previously under issued medical assistance;

(e) A claimant disputes the current level of benefits.

(5) An officer or employee of the Authority or the Department of Human Services may appear on behalf of the Authority in medical assistance hearings described in this rule. The Authority's lay representative may not make legal argument on behalf of the Authority.

(6) The Authority representative is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available on its website at http://www.doj.state.or.us. An Authority representative appearing under this rule shall read and be familiar with it.

(7) When an Authority representative is used, requests for admission and written interrogatories are not permitted.

(8) The Authority representative and the claimant may have an informal conference in order to:

(a) Provide an opportunity to settle the matter;

(b) Review the basis for the eligibility determination, including reviewing the rules and facts that serve as the basis for the decision;

(c) Exchange additional information that may correct any misunderstandings of the facts relevant to the eligibility determination; or

(d) Consider any other matters that may expedite the orderly disposition of the hearing.

(9) A claimant who is receiving medical assistance benefits and who is entitled to a continuing benefit decision notice may, at the option of the claimant, receive continuing benefits in the same manner and amount until a final order resolves the contested case. In order to receive continuing benefits, a claimant must request a hearing not later than:

(a) The tenth day following the date the notice is received; and

(b) The effective date of the action proposed in the notice.

(10) The continuing benefits are subject to modification based on additional changes affecting the claimant's eligibility or level of benefits.

(11) When a claimant contests the denial of continuing benefits, the claimant shall receive an expedited hearing.

(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.

Stat. Auth.: ORS 411.404, 411.816, 412.014, 412.049, 413.042

Stats. Implemented: ORS 183.452, 411.060, 411.404, 411.816, 412.014, 412.049

410-200-0146 – Final Orders, Dismissals and Withdrawals

(1) When the Authority refers a contested case under chapter 410 division 200 to the Office of Administrative Hearings (OAH), the Authority must indicate on the referral:

(a) Whether the Authority is authorizing a proposed order, a proposed and final order, or a final order; and

(b) If the Authority establishes an earlier deadline for written exceptions and argument because the contested case is being referred for an expedited hearing.

(2) When the Authority authorizes either a proposed order or a proposed and final order:

(a) The claimant may file written exceptions and written argument to be considered by the Authority. The exceptions and argument must be received at the location indicated in the OAH order not later than the 20th day after service of the proposed order or proposed and final order, unless section (1)(b) of this rule applies;

(b) The Authority shall issue the final order after OAH issues a proposed order unless the Authority requests that OAH issue the final order pursuant to OAR 137-003-0655.

(c) The proposed and final order becomes a final order on the 21st day after the service of the proposed and final order, if the claimant does not submit timely exceptions or arguments following a proposed and final order, unless:

(A) The Authority has issued a revised order; or

(B) The Authority has notified the claimant and OAH that the Authority shall issue the final order.

(d) The Authority shall issue the final order when the Authority receives timely exceptions or argument unless the Authority requests that OAH issue the final order.

(3) In a contested case hearing, if the OAH is authorized to issue a final order on behalf of the Authority, the Authority may issue the final order in the case of default.

(4) A petition by a claimant for reconsideration or rehearing must be filed with the individual who signed the final order unless stated otherwise on the final order.

(5) A final order is effective immediately upon being signed or as otherwise provided in the order. Delay due to a postponement or continuance granted at the claimant's request may not be counted in computing time limits for a final order. A final order shall be issued or the case otherwise shall be resolved no later than:

(a) Ninety days following the date of the hearing for the standard hearing time frame;

(b) Three working days after the date the OAH hears an expedited hearing.

(6) In the event a request for a hearing is not timely or the claimant has no right to a contested case hearing on an issue, and there are no factual disputes about whether this division of rules provides a right to a hearing, the Authority may issue an order accordingly. The Authority may refer an untimely request to the OAH for a hearing on timeliness or on the question of whether the claimant has the right to a contested case hearing.

(7) If the Authority serves a decision notice on the claimant by postal or electronic mail and the Authority receives an untimely hearing request from the claimant within 75 days from the date the decision notice became a final order, then one of the following shall occur:

(a) If the Authority finds that the claimant did not receive the decision notice and did not have actual knowledge of the notice, the Authority shall refer the hearing request to the OAH for a contested case hearing on the merits of the Authority's action described in the notice; or

(b) If there is a factual dispute regarding the claimant's receipt or knowledge of the notice, the Authority shall refer the hearing request to the OAH for a contested case hearing to determine whether the claimant received or had actual knowledge of the notice. The Authority has the burden to prove by a preponderance of the evidence that the claimant had actual knowledge of the notice or that the Authority mailed the notice to the claimant's correct mailing address or sent an electronic notice to the claimant's correct electronic mail address according to the information the claimant provided to the Authority.

(8) If the Authority receives an untimely hearing request from the claimant, regardless of the manner in which the Authority served the decision notice on the claimant, then:

(a) If the Authority finds that the claimant's hearing request was untimely for good cause as defined in OAR 137-003-0501(7), the Authority shall refer the hearing request to the OAH for a contested case hearing on the merits of the Authority's action described in the notice; or

(b) If there is a factual dispute regarding the existence of good cause, the Authority shall refer a hearing request to the OAH for a contested case hearing to determine whether there was good cause as defined in OAR 137-003-0501(7) for the claimant's delay in submitting the hearing request to the Authority.

(c) Any hearing request is treated as timely when required under the Servicemembers Civil Relief Act.

(d) The Authority may dismiss a hearing request as untimely if the claimant does not qualify for a hearing under sections 8(a), (b), or (c).

(9) A claimant may withdraw a hearing request at any time before a final order has been issued on the contested case. When a claimant withdraws a hearing request:

(a) The Authority shall send an order confirming the withdrawal to the claimant's last known address;

(b) The claimant may cancel the withdrawal in writing. The withdrawal must be received by the Authority hearing representative no later than the tenth working day following the date the Authority sent the order confirming the withdrawal.

(10) A hearing request is dismissed by order by default when neither the claimant nor the claimant's representative appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. The Authority shall cancel the dismissal order on request of the claimant on a showing that the claimant was unable to attend the hearing and unable to request a postponement due to circumstances meeting the good cause criteria described in OAR 137-003-0501(7).

Stat. Auth.: ORS 183.341, 413.042, 411.060, 411.404, 411.408, 411.816, 412.014 & 412.049

Stats. Implemented: ORS 183.341, 411.060, 411.404, 411.408, 411.816, 412.014 & 412.049

410-200-0200 – Residency Requirements (T)

(1) To be eligible for OCCS 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));

(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.

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

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

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

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

(d) The individual is found incapable of indicating intent to reside based on documentation provided by a physician, psychologist, or other professional licensed by the State of Oregon in the field of intellectual disabilities.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0205 – Concurrent and Duplicate Program Benefits

(1) An individual receiving OCCS medical program benefits may not receive the following medical benefits at the same time:

(a) Any other OCCS 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 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536, 414.706

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 alien 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.534, 414.536, 414.706

410-200-0215 – Citizenship and Alien Status Requirements (T)

(1) To meet the citizen or alien status requirements for an OCCS medical program, an individual must be:

(a) A citizen of the United States;

(b) A non-citizen who meets the alien status requirements in section (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 alien 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 alien 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 alien 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 been granted any of the following alien 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 alien granted special immigrant status (SIV) under section 101(a) (27) of the INA;

(g) Under the age of 19 and is one of the following:

(A) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S;

(B) An individual described in 8 CFR section 103.12(a)(4) who belongs to one of the following classes of aliens 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 currently in temporary resident status pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a);

(ii) An alien 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 currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) An alien currently in deferred action status pursuant to Department of Homeland Security Operating Instruction OI 242.1(a) (22); or

(vii) An alien 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 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 entered the United States or were given qualified non-citizen status on or after August 22, 1996 meet the alien status requirement five years following the date the non-citizen received the qualified non-citizen status.

(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 OCCS Medical Programs.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.534, 414.536 & 414.706

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 (4).

(2) 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) Unemployment compensation; and

(g) 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:

(a) Each caretaker in the household group 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 as identified in section (3) (e) or section (3) (f) after providing the beneficiary with notice and opportunity to show the provisions of section (4) of this rule apply;

(c) Each applicant, including a parent for their child, shall make a good faith effort to obtain available coverage under Medicare. The Authority may not penalize children for non-cooperation;

(d) With the exception of OHP-CHP, MAGI CHIP, and OHP-OPU, caretakers who are OCCS medical program 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;

(e) 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;

(f) 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) The individual's compliance 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) 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;

(c) Legal proceedings are pending for adoption of the child;

(d) 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;

(e) The individual is pregnant; or

(f) 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.

Stat. Auth.: ORS 411.402, 411.404 & 413.0042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231 & 414.706

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 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 until the requirements of this rule are met.

(3) Except for the OHP-OPU, OHP-CHP, and MAGI CHIP programs:

(a) An applicant shall assign to the state the right of any Medicaid-eligible individual in the household group 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 414.025, 414.231, 414.706

410-200-0230 – Verification (T)

(1) Except as described in section (6) of this rule, applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing 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 and beneficiaries who attest to US citizenship or US national status:

(a) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing shall make a declaration of US citizenship or US national status;

(b) Self-attested information shall be used to determine eligibility and verified post-eligibility via the federal data services hub or by electronic data match available to the Agency;

(c) In the event additional verification is needed, the Authority shall provide a reasonable opportunity period to verify US citizen or US national status.

(3) Applicants and beneficiaries who attest to being a non-citizen:

(a) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing shall make a declaration of non-citizen status:

(A) If an individual attests to being a non-citizen but does not provide information regarding their status, information shall be obtained by the Agency prior to making an eligibility determination;

(B) Self-attested information shall be used to approve OCCS Medicaid/CHIP as long as the information provided is considered satisfactory immigration status:

(i) The application is not considered incomplete even if the information provided does not include all the immigration information necessary to verify that the applicant meets Medicaid/CHIP non-citizen requirements; and

(ii) The information provided does not indicate that the applicant would be ineligible for full benefits;

(C) If information provided indicates the individual does not meet the Medicaid/CHIP non-citizen requirements, an otherwise eligible applicant shall be found eligible for CAWEM (OAR 410-200-0240);

(b) In the event additional verification is needed, the Authority shall provide a reasonable opportunity period to verify non-citizen status;

(c) The following are exempt from the requirement to verify citizen status:

(A) Individuals who are assumed eligible (OAR 410-200-0135);

(B) Individuals who are 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) 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.

(4) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing shall make a declaration of income:

(a) For individuals whose request for benefits is able to be processed using the federal data services hub, self-attested information shall be used to approve MAGI-based Medicaid/CHIP, and:

(A) Verified by documentary evidence through a match with available electronic data; or

(B) In the event that additional verification is needed, the Authority shall provide a post-eligibility pend period to verify income information;

(b) Individuals whose request for benefits is not able to be processed using the federal data services hub shall have their income information verified prior to eligibility determination:

(A) Using electronic data match available to the Agency; or

(B) By providing verification of information to the Agency;

(c) In the event that verification is not available via the federal data services hub, electronic data match available to the Agency, or by any other method, the attested information shall be accepted to determine eligibility;

(d) In the event that income verification via the federal data services hub or electronic data match available to the Agency is inconsistent with attested information:

(A) If the individual attests to income below the applicable standard and the data source indicates income above the applicable standard, verification or reasonable explanation shall be requested from the individual;

(B) If both the data source and attested information are below the applicable standard, the applicant is eligible for MAGI-based Medicaid/CHIP;

(C) If the individual's attested information is above the applicable standard but the data source verification is below the standard, the Agency shall accept the attested information, deny MAGI-based Medicaid/CHIP, and screen for potential APTC eligibility.

(5) Additional income verifications for MAGI-based Medicaid/CHIP program approvals shall occur during the post-eligibility review process, during which the results of a quarterly match against Employment Department wage data shall be reviewed as it becomes available. If necessary, documentation may be required per section (6).

(6) Applicants, beneficiaries, or individuals of the applicant or beneficiary's choosing shall make a declaration of receipt of private health insurance:

(a) For individuals whose request for benefits is able to be processed using the federal data services hub:

(A) Self-attested information shall be used to determine eligibility for MAGI-based Medicaid/CHIP if:

(i) Information obtained through a match with available electronic data does not conflict with self-attested information;

(ii) Information obtained through a match with available electronic data conflicts with self-attested information but does not affect eligibility; or

(iii) 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 conflicts with self-attested information and may affect eligibility, private health insurance information shall be verified prior to eligibility determination;

(b) Individuals whose request for benefits is not able to be processed using the federal data services hub who attest to private health insurance information that may affect eligibility shall have their private health insurance information verified prior to eligibility determination:

(A) Using electronic data match available to the Agency; or

(B) By providing verification of information to the Agency.

(7) 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0235 – Changes that must be reported (T)

(1) Individuals shall report the following changes in circumstances affecting eligibility for beneficiaries within 30 calendar days of its occurrence:

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

(b) A change in mailing address or residence;

(c) A change in legal name;

(d) A change in pregnancy status of a household group member;

(e) A change in household group membership;

(f) A claim for a personal injury. 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;

(g) In addition to section (1)(a)–(f), for all OCCS Medical Programs except OHP-CHP and MAGI CHIP, a change in availability of employer-sponsored health insurance;

(h) In addition to section (1)(a)–(f), in the EXT program, when a household group member receiving medical assistance is no longer a dependent child;

(i) 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:

(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. 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;

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

(2) Beneficiaries, adult members of the household group, or authorized representatives may report changes via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.

(3) 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.

(4) 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.

(5) Beneficiaries, adult members of the household group, or authorized representatives are not required to report any of the following changes:

(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.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706

410-200-0240 – Citizen/Alien Waived Emergency Medical (T)

(1) To be eligible for CAWEM benefits, an individual must be ineligible for OCCS Medical Programs solely because he or she does not meet the Citizen and Alien Status Requirements (OAR 410-200-0215). A child who is ineligible for OHP-CHP, MAGI CHIP, CEM, or CEC solely because he or she does not meet the citizen or alien status requirements is not eligible for CAWEM benefits.

(2) To be eligible for the CAWEM Prenatal enhanced benefit package, a CAWEM recipient must be pregnant.

(3) The pregnant CAWEM client's enhanced medical benefits package ends when the pregnancy ends.

(4) The woman remains eligible for CAWEM emergency benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.025 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447, 414.534, 414.536, 414.706 & 411.060

410-200-0305 – Household Group—Modified Adjusted Gross Income (MAGI)-Based Medicaid and CHIP

When establishing eligibility for MAGI-based Medicaid or MAGI CHIP, each applicant or beneficiary shall have their own household group determined individually based on the following household group rules:

(1) Tax filer's household group:

(a) For tax filers who are not claimed as a tax dependent by another individual, the household group consists of:

(A) The tax filer;

(B) The individual to whom the tax filer is married and files jointly; and

(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, whether they file taxes together or separately.

(2) Tax dependent's household group:

(a) In the case 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 tax filer's spouse or child;

(B) Is a child living with both parents but the parents are not filing taxes jointly and one of the parents is claiming the child as a tax dependent; or

(C) Is a child living with one parent and claimed as a tax dependent by a non-custodial parent.

(3) The household group for a tax dependent who meets the criteria in section (2) (b) consists of the tax dependent and the following individuals, if living in the same household:

(a) The tax dependent's spouse;

(b) The tax dependent's children;

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

(4) 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).

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447, 414.706

410-200-0310 – Eligibility and Budgeting; MAGI Medicaid/CHIP; Not BCCTP or EXT (T)

(1) The budget month means the calendar month from which nonfinancial and financial information is used to determine eligibility for OCCS Medical Programs.

(2) The budget month is determined as follows:

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

(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;

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

(A) The final month of the twelve-month enrollment period;

(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.

(3) Countable income anticipated or received in the budget month is determined as follows:

(a) Income is calculated by adding together 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 remainder of the initial budget month;

(b) If ineligible using the initial budget month, countable income from the month following the initial budget month is considered. If eligible, eligibility shall begin as described in OCCS Medical Programs – Effective Dates (OAR 410-200-0115).

(c) If ineligible under subsections (a) or (b) of this section because the countable income is over the income standard for all OCCS Medical Programs, 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 below 100 percent FPL as identified in 26 CFR §1.36 B-1(e), income shall be converted to a monthly amount and applied to the initial budget month;

(B) If eligible for budget month eligibility pursuant to subsection (A), eligibility shall be determined for the appropriate program pursuant to OAR 410-200-0315 and begin as described in OCCS Medical Programs – Effective Dates (OAR 410-200-0115).

(4) The household group's budget month income is compared to the income standard for the appropriate family size to determine if an applicant may be eligible for an OCCS medical program.

Stat. Auth.: ORS 411.402, 411.404 & 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447 & 414.706

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 income standard for the MAGI Parent or Other Caretaker-Relative program is set as follows:

Family size	Standard	Income Standard + 5% FPL Disregard
1	$399	$449
2	515	582
3	611	695
4	747	849
5	872	991
6	998	1134
7	1,114	1,268
8	1,230	1,401
9	1,321	1,509
10	1,456	1,662
11	1,592	1,815
12	1,728	1,968
13	1,864	2,122
14	2,000	2,275
15	2,136	2,428
16	2,272	2,582
17	2,408	2,735
18	2,544	2,888

19	2,680	3,042
20	2,816	3,195
+1	+136	+154

(d) Effective March 1, 2016, 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:

Family size	Standard 133% 2016 FPL	Income Standard + 5% FPL Disregard
1	$1,317	$1,367
2	1,776	1,843
3	2,235	2,319
4	2,694	2,795
5	3,153	3,271
6	3,611	3,747
7	4,071	4,224
8	4,532	4,703
9	4,994	5,181
10	5,455	5,660
11	5,916	6,138
12	6,377	6,616
13	6,838	7,095
14	7,299	7,573
15	7,760	8,052
16	8,221	8,530

17	8,682	9,008
18	9,143	9,487
19	9,604	9,965
20	10,065	10,444
+1	462	479

(e) Effective March 1, 2016, 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:

Family size	Standard 185% 2016 FPL	Income Standard + 5% FPL Disregard
1	$1,832	$1,881
2	2,470	2,537
3	3,108	3,192
4	3,747	3,848
5	4,385	4,503
6	5,023	5,159
7	5,663	5,816
8	6,304	6,475
9	6,946	7,133
10	7,587	7,792
11	8,228	8,451
12	8,870	9,109
13	9,511	9,768
14	10,152	10,427

15	10,794	11,085
16	11,435	11,744
17	12,076	12,403
18	12,718	13,061
19	13,359	13,720
20	14,000	14,379
+1	642	659

(f) Effective March 1, 2016, 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, and 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:

Family size	Standard 300% 2016 FPL	Income Standard + 5% FPL Disregard
1	$2,970	$3,020
2	4,005	4,072
3	5,040	5,124
4	6,075	6,177
5	7,110	7,229
6	8,145	8,281
7	9,183	9,336
8	10,223	10,393
9	11,263	11,451
10	12,303	12,508
11	13,343	13,565
12	14,383	14,623

13	15,423	15,680
14	16,463	16,737
15	17,503	17,795
16	18,543	18,852
17	19,583	19,909
18	20,623	20,967
19	21,663	22,024
20	22,703	23,081
+1	1,040	1,058

(g) When the Department makes an ELE determination and the child meets all MAGI CHIP or MAGI Child Program nonfinancial eligibility requirements, the household 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, 2016, if the MAGI-based income of the household group is below 163 percent of the 2016 federal poverty level as listed below, the Department deems the child eligible for the MAGI Child Program;

Household Size	Standard 163% 2016 FPL
1	$1,614
2	2,177
3	2,739
4	3,301
5	3,864
6	4,426
7	4,990
8	5,555

9 6,120

10 6,685

+1 566

(B) If the MAGI-based income of the household group 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447, 414.706

2016 Oregon OHA Medical Programs—Effective March 1, 2016

2016 Oregon Health Authority Medical Programs - effective March 1, 2016

Family Size	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) (CMO) / MAGI Adult (AMO)		MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP (C21)	
	Standard	Standard + 5% FPL Disregard	Standard (133%)	Income Standard + 5% FPL Disregard (138%)	Standard (185%)	Standard after adding Disregard (190%)	Standard (300%)	Standard after adding Disregard (305%)
1	$399	$449	$1,317	$1,367	$1,832	$1,881	$2,970	$3,020
2	$515	$582	$1,776	$1,843	$2,470	$2,537	$4,005	$4,072
3	$611	$695	$2,235	$2,319	$3,108	$3,192	$5,040	$5,124
4	$747	$849	$2,694	$2,795	$3,747	$3,848	$6,075	$6,177
5	$872	$991	$3,153	$3,271	$4,385	$4,503	$7,110	$7,229
6	$998	$1,134	$3,611	$3,747	$5,023	$5,159	$8,145	$8,281
7	$1,114	$1,268	$4,071	$4,224	$5,663	$5,816	$9,183	$9,336
8	$1,230	$1,401	$4,532	$4,703	$6,304	$6,475	$10,223	$10,393
9	$1,321	$1,509	$4,994	$5,181	$6,946	$7,133	$11,263	$11,451
10	$1,456	$1,662	$5,455	$5,660	$7,587	$7,792	$12,303	$12,508
11	$1,592	$1,815	$5,916	$6,138	$8,228	$8,451	$13,343	$13,565
12	$1,728	$1,968	$6,377	$6,616	$8,870	$9,109	$14,383	$14,623
13	$1,864	$2,122	$6,838	$7,095	$9,511	$9,768	$15,423	$15,680
14	$2,000	$2,275	$7,299	$7,573	$10,152	$10,427	$16,463	$16,737
15	$2,136	$2,428	$7,760	$8,052	$10,794	$11,085	$17,503	$17,795
16	$2,272	$2,582	$8,221	$8,530	$11,435	$11,744	$18,543	$18,852
17	$2,408	$2,735	$8,682	$9,008	$12,076	$12,403	$19,583	$19,909
18	$2,544	$2,888	$9,143	$9,487	$12,718	$13,061	$20,623	$20,967
19	$2,680	$3,042	$9,604	$9,965	$13,359	$13,720	$21,663	$22,024
20	$2,816	$3,195	$10,065	$10,444	$14,000	$14,379	$22,703	$23,081
Each additional person add	136	154	462	479	642	659	1,040	1,058

Family Size	Annual Standard (100%)
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890
9	$45,050
10	$49,210
11	$53,370
12	$57,530
13	$61,690
14	$65,850
15	$70,010
16	$74,170
17	$78,330
18	$82,490
19	$86,650
20	$90,810
Each additional person add	4,160

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 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 of the following to 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 she does not meet the requirements for eligibility.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536, 414.540, 414.706

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 consists of the individual only.

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

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

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.

(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.

Stat. Auth.: ORS 411.402, 411.404, 413.042, 414.534

Stats. Implemented: ORS 411.060, 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 411.447, 413.032, 413.038, 414.025, 414.231, 414.534, 414.536, 414.706

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 be under 19 years of age and must:

(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 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 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042,

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231, 414.706

410-200-0415 – Specific Requirements; MAGI Child (T)

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.

(2) To be eligible for the MAGI Child program, the child must be under the age of 19 with 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.

(3) To be eligible for the MAGI Child Program, an individual may not:

(a) Be receiving or deemed to be receiving SSI benefits;

(b) Be receiving Medicaid through another program.

(4) A child born to a mother eligible for and receiving Medicaid benefits is assumed eligible for medical benefits under this rule until the end of the month 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 termination of the child’s eligibility.

(5) 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.

(6) ELE qualifies a child for medical assistance benefits based on a finding from the Department, even when the Department’s eligibility methodology differs from that used for OCCS Medical Programs.

Stat. Auth.: ORS 411.402, 411.404 & 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447 & 414.706

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.

(2) To be eligible for the MAGI Parent or Other Caretaker Relative program, an individual must have household group 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.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447, 414.706

410-200-0425 – Specific Requirements; MAGI Pregnant Woman (T)

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 be pregnant and:

(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 Eligibility according to the policy described in OAR 410-200-0135(2).

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

(4) Once a beneficiary is eligible and receiving Medicaid through the MAGI Pregnant Woman program, they are eligible through the end of the calendar month in which the 60th day following the last day of the pregnancy falls (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; or

(d) The woman requests her benefits be closed.

Stat. Auth.: ORS 411.402, 411.404 & 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 411.447 & 414.706

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; and

(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 who is not enrolled in minimum essential coverage.

Stat. Auth.: ORS 411.402, 411.404, 413.042

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.706

410-200-0440 – Specific Requirements; Extended Medical Assistance (T)

(1) The following individuals may be eligible 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 (MAGI PCR) benefits:

(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 eligibility is redetermined and the individual is not eligible for any other Medicaid/CHIP program.

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

(A) Individuals 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 eligibility, and;

(B) Eligibility is redetermined and the individual is not eligible for any other Medicaid/CHIP program.

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

(3) Individuals who lose EXT eligibility for one of the 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:

(a) EXT eligibility is 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 is lost due to a change in circumstance that results in eligibility for another OCCS medical program, and then a subsequent change in circumstance occurs that results in ineligibility for all OCCS Medical Programs, the 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 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.

Stat. Auth.: ORS 411.095, 411.402, 411.404, 413.038, 414.025

Stats. Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.706

410-200-0505 – Specific Requirements; Fast Track Eligibility and Enrollment for MAGI Medicaid (T)

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

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

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

(b) Indicates they wish to pursue medical assistance;

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

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

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

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

(a) Indicates they wish to pursue medical assistance;

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

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

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

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

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

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 413.038

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 413.032, 413.038, 414.025, 414.231 & 414.706

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

(1) This rule describes OCCS Medical Programs for which individuals may be determined eligible through December 31, 2013. See OAR 410-200-0500 for information regarding the treatment of those beneficiaries as of January 1, 2014.

(2) To be eligible for a program listed in this rule, an individual must meet the following:

(a) The eligibility factors set forth in OAR 410-200-0200 through 410-200-0240;

(b) The budgeting and income standard requirements set forth in OAR 410-200-0300 through 410-200-0315; and

(c) The individual must have established a Date of Request prior to January 1, 2014.

(3) For purposes of this rule, private major medical health insurance means a comprehensive major medical insurance plan that, at a minimum, provides physician services; inpatient and outpatient hospitalization; outpatient lab, x-ray, immunizations; and prescription drug coverage. This term does not include coverage under the Kaiser Child Health Program or Kaiser Transition Program but does include policies that are purchased privately or are employer-sponsored.

(4) For the purposes of this rule, the receipt of private major medical health insurance does not affect OCCS medical program eligibility if it is not accessible. Private major medical health insurance is not considered accessible if:

(a) The travel time or distance to available providers exceeds:

(A) In urban areas: 30 miles, 30 minutes, or the community standard, whichever is greater;

(B) In rural areas: 60 miles, 60 minutes, or the community standard, whichever is greater;

(b) Accessing the private major medical health insurance would place a filing group member at risk of harm.

(5) CEM provides eligibility for the balance of the 12-month eligibility period for non-CAWEM children who were receiving Child Welfare (CW) medical, EXT, MAA, MAF, OHP, OSIPM, or Substitute Care program benefits and lost eligibility for reasons other than moving out of state or turning 19 years old. CEM benefits end when:

(a) The child becomes eligible for CW medical, EXT, MAA, MAF, OHP, OSIPM, or Substitute Care program benefits;

(b) The child turns 19 years of age;

(c) The child moves out of state; or

(d) Benefits are closed voluntarily.

(6) CEC provides eligibility for the OHP-CHP program for non-CAWEM pregnant children who were receiving OHP-CHP and would have otherwise lost eligibility for reasons other than moving out of state or becoming a recipient of private major medical health insurance. CEC eligibility for OHP-CHP ends the day following the end of the month in which the earliest of the following occur:

(a) The pregnancy ends;

(b) The individual moves out of state;

(c) The individual begins receiving private major medical health insurance;

(d) Benefits are closed voluntarily; or

(e) The individual becomes eligible for CW medical, EXT, MAA, MAF, OHP, OSIPM, or Substitute Care program benefits.

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

(8) To be eligible for EXT, an individual must have been eligible for and receiving MAA or MAF and became ineligible due to a caretaker relative’s increased earned income or due to increased spousal support (OAR 410-200-0440).

(9) To be eligible for MAA or MAF, an individual must be one of the following:

(a) A dependent child who lives with a caretaker relative. However, a dependent child for whom foster care payments are made for more than 30 days is not eligible while the payments are being made;

(b) A caretaker relative of an eligible dependent child. However, a caretaker relative to whom foster care payments are made for more than 30 days is not eligible while the payments are being made;

(c) A caretaker relative of a dependent child, when the dependent child is ineligible for MAA or MAF for one of the following reasons:

(A) The child is receiving SSI;

(B) The child is in foster care but is expected to return home within 30 days; or

(C) The child's citizenship has not been documented;

(d) An essential person. An essential person is a member of the household group who:

(A) Is not required to be in the filing group;

(B) Provides a service necessary to the health or protection of a member of the household group who has a mental or physical disability; and

(C) Is less expensive to include in the benefit group than the cost of purchasing this service from another source;

(e) A parent of an unborn as follows:

(A) For the MAA program:

(i) Any parent whose only child is an unborn child, once the mother's pregnancy has reached the calendar month preceding the month in which the due date falls;

(ii) The father of an unborn child who does not meet the criteria described in subsection (e)(A)(i) of this part may be eligible if there is another dependent child in the household group;

(B) For the MAF program, a mother whose only child is an unborn child, once the mother's pregnancy has reached the calendar month preceding the month in which the due date falls.

(10) To be eligible for any OHP program in sections (12) through (15), an individual may not be:

(a) Receiving SSI benefits;

(b) Eligible for Medicare, except that this requirement does not apply to the OHP-OPP program;

(c) Receiving Medicaid through any other program concurrently.

(11) To be eligible for the OHP-OPC program, an individual must be less than 19 years of age.

(12) To be eligible for the OHP-OP6 program, a child must be less than six years of age and not eligible for OHP-OPC.

(13) To be eligible for the OHP-OPP program, an individual must:

(a) Be pregnant;

(b) Be within the time period through the end of the calendar month in which the 60th day following the last day of the pregnancy falls; or

(c) Be an infant under age one.

(14) To be eligible for the OHP-CHP program, an individual must be under 19 years of age and must:

(a) Not be eligible for the OHP-OPC, OHP-OPP, or OHP-OP6 programs; and

(b) Not be covered by any private major medical health insurance. An individual may be eligible for OHP-CHP if the private major medical health insurance is not accessible as outlined in section (4).

(15) Effective July 1, 2004, the OHP-OPU program is closed to new applicants. Except as provided in subsections (a) and (b) of this section, a new applicant may not be found eligible for the OHP-OPU program:

(a) An individual is not a new applicant if the Department determines that the individual is continuously eligible for medical assistance as follows:

(A) The individual is eligible for and receiving benefits under the OHP-OPU program on June 30, 2004, and the Department determines that the individual continues after that date to meet the eligibility requirements for the OHP-OPU program;

(B) The individual is eligible for and receiving benefits under the CAWEM program on June 30, 2004 and is eligible for the CAWEM program based on the OHP-OPU program, and the Department determines that the individual continues to meet the eligibility requirements for the OHP-OPU program except for citizenship or alien status requirements;

(C) The eligibility of the individual ends under the BCCM, CEC, CEM, EXT, GAM, HKC, MAA, MAF, OHP-CHP, OHP-OPC, OHP-OPP, OSIPM, REFM, or Substitute Care program, or the related CAWEM program; or because the individual has left the custody of the Oregon Youth Authority (OYA); and at that time the Department determines that the individual meets the eligibility requirements for the OHP-OPU program;

(D) The individual is a child in the custody of the Department whose eligibility for Medicaid ends because of the child's age and at that time the Department

determines that the individual meets the eligibility requirements for the OHP-OPU program;

(E) The Department determines that the individual was continuously eligible for the OHP-OPU program on or after June 30, 2004 under paragraphs (A) to (D) of this section;

(b) An individual who is not continuously eligible under subsection (a) is not a new applicant if the individual:

(A) Has eligibility end under the BCCM, CEC, CEM, EXT, HKC, MAA, MAF, OHP-CHP, OHP-OPP, OHP-OPU, OSIPM, REFM, or Substitute Care program, or the related CAWEM program; because the individual has left the custody of the OYA; or is a child in the custody of the Department whose eligibility for Medicaid ends due to the child's age;

(B) Established a Date of Request prior to the eligibility ending date in paragraph (A) of this section; and

(C) Meets the eligibility requirements for the OHP-OPU program or the related CAWEM program within either the month of the Date of Request or, if ineligible in the month of the Date of Request, the following month.

(16) To be eligible for the OHP-OPU program, an individual must meet the requirements listed in section (16) and be 19 years of age or older and may not be pregnant. Additionally, and individual must meet the following requirements:

(a) Must be currently receiving Medicaid or CHIP benefits when determined eligible for OHP- OPU;

(b) Must not be covered by any private major medical health insurance. An individual may be eligible for OHP-CHP if the private major medical health insurance is not accessible as outlined in section (4);

(c) May not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:

(A) Any of the criteria in section (4) are met;

(B) The individual has a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability;

(C) The individual’s health insurance premium was reimbursed because the individual was receiving Medicaid, and the Department or the Authority found the premium was cost-effective;

(D) The individual's health insurance was subsidized through FHIAP or the Office of Private Health Partnerships in accordance with ORS 414.231, 414.826, 414.831, and 414.839; or

(E) A member of the individual's household group was a victim of domestic violence.

(17) To be eligible for the Substitute Care program, an individual must meet the specific eligibility requirements for Substitute Care found in OAR 410-200-0405.

(18) Except for OHP-CHP and CEC, a pregnant woman who is eligible for and receiving benefits through any program listed in this rule remains eligible through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.

(19) A child who becomes ineligible for the OHP program because of age while receiving in-patient medical services remains eligible until the end of the month in which he or she no longer receives those services if he or she is receiving in-patient medical services on the last day of the month in which the age requirement is no longer met.

Stat. Auth.: ORS 411.402, 411.404, 413.042 & 414.534

Stats. Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.534, 414.536 & 414.706