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

FILING CAPTION: New Rules to Establish OHP Bridge Programs Launching in July.

EFFECTIVE DATE: 06/01/2024

AGENCY APPROVED DATE: 05/24/2024

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RULES:
410-115-0000, 410-115-0005, 410-115-0010, 410-115-0015, 410-115-0020, 410-115-0025, 410-115-0030, 410-115-0035, 410-115-0040, 410-115-0045, 410-115-0050, 410-200-0010, 410-200-0015, 410-200-0100, 410-200-0105, 410-200-0110, 410-200-0115, 410-200-0130, 410-200-0135, 410-200-0140, 410-200-0215, 410-200-0220, 410-200-0305, 410-200-0310, 410-200-0315, 410-200-0437, 410-200-0438

ADOPT: 410-115-0000

RULE TITLE: Purpose

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Clarifies the purpose of the newly established division within chapter 410 for OHP Bridge.

RULE TEXT:
The Purpose of this Chapter 410, Division 115, is to establish uniform standards for the Authority's administration of Oregon Health Plan (OHP) Bridge (as defined in OAR 410-115-0005 below). The rules set forth below in this Chapter 410, Division 115 apply exclusively to the administration and provision of OHP Bridge. Any rule set forth in this Chapter 410, Division 115 that contradicts or conflicts with any rules of general applicability found in other Divisions included in OAR Chapter 410 are superseded by the rules and provisions in this OAR Chapter 410, Division 115.

STATUTORY/OTHER AUTHORITY: ORS 414.241, 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.241, 413.042, 414.025, 414.65, 414.706

ADOPT: 410-115-0005

RULE TITLE: Acronyms and Definitions

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides acronyms and definitions that are unique to OHP Bridge.

RULE TEXT:

(1) The acronyms and definitions within this rule specifically pertain to OHP Bridge. This rule does not include an exhaustive list of acronyms and definitions that apply to OHP Bridge. Other acronyms and definitions that may apply to OHP Bridge are found in OAR 410-141-3500, OAR 410-120-0000, and OAR 410-200-0015.

(2) "Basic Health Program" means a joint federal and state funded program for medical assistance established under section 1331 of the federal Patient Protection and Affordable Care Act of 2010 and Title 42, Chapter IV, Subchapter 1 of the Code of Federal Regulations, which the state has elected to adopt and implement as OHP Bridge.

(3) "Oregon Health Plan (OHP) Bridge" means the health insurance programs established by the state under Oregon House Bill 4035 (2022 Regular Session) and in accordance with ORS 414.241 which is available to individuals who meet certain age, financial, and other eligibility requirements OAR Chapter 410, Division 200. OHP Bridge provides the same health insurance benefits (covered services) to all eligible individuals but due to federal law, OHP Bridge is delivered through two different medical assistance programs which are listed below in this rule:

(a) "OHP Bridge – Basic Medicaid" means the Medicaid eligibility category created by the state to provide OHP Bridge covered services to OHP Bridge – Basic Medicaid members described in OAR 410-200-0437.

(b) "OHP Bridge – Basic Health Program" means the Basic Health Program established by the state as a medical assistance program administered by the Authority, which provides OHP Bridge covered services to OHP Bridge – Basic Health Program members described in OAR 410-200-0438.

(4) "OHP Bridge Covered Services" means the services provided to OHP Bridge members.

(a) The OHP Bridge covered services for the OHP Bridge- Basic Health Program are described in OAR 410-115-0030 and in the OHP Bridge – Basic Health Program CCO Contract; and,

(b) The OHP Bridge covered services for recipients or members of OHP Bridge – Basic Medicaid are described in OAR 410-115-0030 and in the Medicaid CCO Contract.

(5). "OHP Bridge Members" means those individuals who are either:

(a) Enrolled in Coordinated Care Organizations after the Authority has processed their applications for medical assistance and determined they meet the financial and non-financial eligibility requirements for the OHP Bridge – Basic Health Program described in OAR 410-200-0438; or,

(b) Enrolled in OHP Bridge – Basic Medicaid after the Authority has processed their applications for medical assistance and determined they meet the financial and non-financial eligibility requirements described in OAR 410-200-0437.

(6) "OHP Bridge - BHP Trust Fund" means the Bridge Plan Fund established by ORS 414.245 to receive federal and non-federal funds that shall be used for the sole purpose of implementing and administering the OHP Bridge – Basic Health Program in compliance with Basic Health Program regulations found in 42 C.F.R. Part 600, Subpart H, and this OAR Chapter 410, Division 115.

(7) "OHP Bridge – Basic Health Program CCO Contract(s)" means an agreement between the State of Oregon acting by and through the Authority and a CCO to provide OHP Bridge – Basic Health Program covered services to OHP Bridge – Basic Health Program members.

(8) "Long-term Care" and "Long-term Services and Supports" has the same definition as in OAR 410-120-0000.

STATUTORY/OTHER AUTHORITY: ORS 413.071, 414.025, 414.241, 414.245, 42 CFR 600.5

STATUTES/OTHER IMPLEMENTED: 414.025, 414.241, 414.245, ORS 413.042, 414.65, 414.706

ADOPT: 410-115-0010

RULE TITLE: Application.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Outlines how the state will conduct its application process and the rights of applicants during the application process.

RULE TEXT:
(1) The Authority shall conduct the application process for OHP Bridge in accordance with the provisions outlined in OAR 410-200-0110.
(2) Consistent with 42 C.F.R. 435.905(b), the Authority must provide assistance to all individuals who apply or want to apply for OHP Bridge (applicants), including without limitation, those applicants who may be of Limited English Proficiency, as well as individuals living with disabilities.
(3) Applicants to OHP Bridge may utilize authorized representatives in accordance with OAR 410-200-0111.
(4) Applicants to OHP Bridge have the right to receive application and health care system navigation assistance from assisters, navigators, and other individuals certified by the Authority to provide application assistance, in accordance with OAR 410-120-0045.

STATUTORY/OTHER AUTHORITY: ORS 411.400, 411.402, 411.404, 413.042, 414.241, 414.534, 414.706

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 413.042, 414.241, 414.534, 414.706, 411.406, 411.439, 413.038, 414.025, 414.536

ADOPT: 410-115-0015

RULE TITLE: Eligibility and Enrollment.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Explains where unique eligibility and enrollment guidelines can be found for both OHP Bridge – Basic Health Program and OHP Bridge – Basic Medicaid and expands on the enrollment period, appeals and verification process.

RULE TEXT:
(1) Eligibility requirements for OHP Bridge – Basic Medicaid and OHP Bridge – Basic Health Program are described in OAR 410-200-0437 and in OAR 410-200-0438.
(2) Effective start dates for OHP Bridge – Basic Medicaid and OHP Bridge – Basic Health Program coverage are established in OAR 410-200-0115.
(3) In the event OHP Bridge coverage is incorrectly terminated or denied due to agency error, coverage shall commence or be reinstated as follows:
(a) If incorrectly denied due to agency error, the individual's enrollment in OHP Bridge and their benefit coverage shall begin on the first day of the month in which benefits may have been effective had the Authority not erred in its initial determination; or
(b) If incorrectly terminated due to agency error, the individual's OHP Bridge coverage shall be reinstated with no gap in coverage.
(4) OHP Bridge is not subject to any restricted application and enrollment period. Individuals have the right to apply to OHP Bridge at any time and, if determined eligible by the agency as set forth in this Division, be enrolled in OHP Bridge in accordance with this rule.
(5) Applicants who are determined to be ineligible for OHP Bridge have the right to appeal the determination in accordance with OAR Chapter 410, Division 141. If, on appeal, the applicant is determined to be eligible for OHP Bridge, eligibility shall be effective in accordance with section (3)(a) of this rule.
(6) Eligibility for OHP Bridge – Basic Health Program is evaluated for renewal every twelve (12) months.
(7) Eligibility for OHP Bridge – Basic Medicaid is evaluated for renewal as described in OAR 410-200-0115.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.241, 414.534, 42 CFR 433.138, 433.145-433.148, 435.3-435.4, 435.115-435.119, 435.170, 435.190, 435.222, 435.403, 435.940, 435.1200, 457.80, 457.340, 435.110, 458.350, 435.406-435.407, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.608, 435.610, 435.916-435.917, 435.1205, 447.56, 457.350, 457.360, 457.805 & 600, 45 CFR 155.420, 435.115

STATUTES/OTHER IMPLEMENTED: ORS 411.402, 411.404, 45 CFR 155.420, ORS 411.060, 411.095, 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.241, 414.440, 414.534, 414.536, 414.706

ADOPT: 410-115-0020

RULE TITLE: Continuity of Health Care

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Establishes OHA's role in maintaining continuity of care as it relates to OHP Bridge members.

RULE TEXT:

The agency shall coordinate eligibility and enrollment between the Oregon Health Authority (Authority), the Department of Human Services (Department), and the Federally Facilitated Marketplace as set forth in OAR 410-200-0110 – Coordinated Eligibility and Enrollment Process with the Department of Human Services and the Federally Facilitated Marketplace.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.241, 42 CFR 600

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.241

ADOPT: 410-115-0025

RULE TITLE: Grievances and Appeals: Managed Care Entities Obligations; OHP Bridge Program Member Rights.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Establishes that OHP Bridge will utilize the grievances, appeals and associated processes outlined in 410-141-3875 and 410-141-3915.

RULE TEXT:
(1) In administering OHP Bridge, Managed Care Entities must comply with the grievance, appeal, and contested case administrative rules set forth in OARs 410-141-3875 through 410-141-3915.
(2) OHP Bridge members have the right to file a grievance, appeal an adverse benefit determination, and request a contested case hearing as described in OARs 410-141-3875 through OAR 410-141-3915.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 414.241, 42 CFR 600.335

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.241, 414.727, 42 CFR 600

ADOPT: 410-115-0030

RULE TITLE: OHP Bridge Covered Services.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides a brief outline of the services covered by OHP Bridge and where to find more information in OARs.

RULE TEXT:

(1) OHP Bridge members shall be eligible for the Oregon Health Plan (OHP) Bridge benefit package.

(a) Benefit Package identifier: BRG

(b) Coverage for the OHP Bridge benefit package includes:

(A) Coverage of the ten (10) essential health benefits described in section 1302(b) of the Affordable Care Act as adopted under 42 CFR 600.405;

(B) Covered Services set forth for the Oregon Health Plan and defined in OAR 410-141-3820; and,

(C) All other services described in the applicable CCO Contracts.

(2) The OHP Bridge benefit package does not include:

(a) coverage for long-term care and long-term services and supports.

(b) coverage of Health Related Social Needs services defined in OAR 410-120-0000.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.241, 42 CFR 600

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.241, ORS 414.065

ADOPT: 410-115-0035

RULE TITLE: No Premiums or Copayments.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Establishes that OHP Bridge will not have premiums or copays.

RULE TEXT:
OHP Bridge members are not and shall not be required to pay any premiums, copayments and they do not and shall not have to pay any provider to receive covered services.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 414.241, 42 CFR 600.505, 600.510, 600.515, 600.520, 600.525

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.241

ADOPT: 410-115-0040

RULE TITLE: Service Authorization.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Establishes that OHP Bridge will follow the guidance outlined in OAR 410-141-3835.

RULE TEXT:
The service authorization provisions for OHP Bridge are described in OAR 410-141-3835.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 414.241, 414.615, 414.625, 414.635, 414.651, 42 CFR 600

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.241, ORS 414.610-414.685

ADOPT: 410-115-0045

RULE TITLE: CCO Administration of OHP Bridge – Basic Health Program; OHP Bridge Enrollment and Choice of CCO.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Establishes CCO administration of the OHP Bridge – Basic Health Program.

RULE TEXT:

(1) OHP Bridge – Basic Health Program shall be administered by Coordinated Care Organizations (CCOs) pursuant to an OHP Bridge – Basic Health Program CCO Contract entered into by each CCO and the state acting by and through the Authority.

(2) The terms and conditions included in the OHP Bridge – Basic Health Program CCO Contract shall comply with all applicable state and federal laws, including, without limitation 42 USC 18051, 42 CFR Part 660, ORS 414.241 and 414.245, and OAR Chapter 410, Division 141. The rules set forth in this Division 115, OAR Chapter 410, Division 141, and the federal regulations set forth in 42 CFR Part 600.

(3) Applicants determined by the Authority to be eligible for OHP Bridge – Basic Health Program shall be enrolled in a CCO. Enrollment and disenrollment from a CCO, including choice of CCO, shall be made in accordance with OAR 410-141-3805 and OAR 410-141-3810, except that:

(a) Exceptions to mandatory managed care enrollment described in OAR 410-141-3805 (4 – 16) do not apply to OHP Bridge - Basic Health Program; and

(b) OHP Bridge Basic Health Program members cannot be disenrolled from the OHP Bridge – Basic Health Program and be covered under the fee-for-service (FFS) delivery system under OAR 410-141-3810.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.241, 414.534, 42 CFR 600, 600.300

STATUTES/OTHER IMPLEMENTED: ORS 411.402, 411.404, 414.241, 414.534, ORS 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 411.447, 414.536, 414.706

ADOPT: 410-115-0050

RULE TITLE: OHP Bridge - BHP Trust Fund.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Proposes new rule providing an overview of the OHP Bridge – Basic Health Program Trust fund.

RULE TEXT:

The Authority shall maintain an OHP Bridge - BHP Trust Fund for the receipt of the federal funds and other non-federal funds the Authority is required to use to pay for the Basic Health Program. Pursuant to 42 CFR 600.705, the Authority does not have the right to use the funds maintained in the BHP Trust for any purpose other than the following:

(1) Paying contracted rates to the CCOs for providing OHP Bridge – Basic Health Program covered services to OHP Bridge – Basic Health Program members (including ancillary payments related to CCO or provider (or both) performance incentives, risk management, and similar purposes as set forth in the OHP Bridge – Basic Health Program CCO Contract);

(2) Paying the CCOs to provide additional covered services or benefits to OHP Bridge – Basic Health Program members, which may be delivered through a network managed by the Authority or its administrator;

(3) Paying health care providers directly for covered services that are not included in the OHP Bridge – Basic Health Program CCO contract(s), but are included in the BRG Benefit Package defined in OAR 410-115-0030; and,

(4) Paying health care providers directly to augment amounts paid by CCOs for services delivered to OHP Bridge – Basic Health Program members.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.241, 414.245, 42 CFR 600, 600.700, 600.705, 600.710, 600.715

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.241, 414.245, ORS 414.065

AMEND: 410-200-0010

RULE TITLE: Overview.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides overview of chapter 410 division 200.

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

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0015

RULE TITLE: General Definitions

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides general definitions related to Chapter 410 division 200.

RULE TEXT:

(1) “Action” means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.
(2) “Active renewal” means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.
(3) “Address Confidentiality Program (ACP)” means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.
(4) “AEN” means Assumed Eligible Newborn (OAR 410-200-0115).
(5) “Affordable Care Act” means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act of 2011 (Pub. L. 112–56).
(6) “Agency” means the Oregon Health Authority and Oregon Department of Human Services.
(7) “Applicant” means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.
(8) “Application” means:
(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.
(9) “APTC” means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.
(10) “Assumed eligibility” means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual’s eligibility.
(11) “Authorized Representative” means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual’s application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).
(12) “Automated renewal” means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary’s case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.
(13) “Beneficiary” means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disabilities medical program benefits, or APTC.
(14) “BRS” means Behavior Rehabilitation Services.
(15) “Budget month” means the calendar month from which financial and nonfinancial information is used to determine eligibility.
(16) “Caretaker” means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child’s care.
(17) “Caretaker relative” means an individual with whom the child is living who assumes primary responsibility for the child’s care, and who is one of the following:

(a) A relative of the dependent child, as follows:
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.
(B) Stepfather, stepmother, stepbrother, and stepsister.
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;
(18) "CWM" means Citizenship Waived Medical (CWM) and was a benefit package that ended on June 30, 2023. The CWM benefit package covered certain emergency services provided to individuals who met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship and non-citizen status requirements (OAR 410-200-0215). For information about CWM benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.
(19) "CWM Plus" means Citizenship Waived Medical Plus. CWM Plus was a benefit package that was previously referred to as "CWX" and ended on June 30, 2023. CWM Plus provided OHP Plus benefits to pregnant individuals and individuals who were sixty (60) days post-partum and who met the financial and non-financial status requirements for an HSD Medical Program, excluding MAGI Expanded Adult, except they did not meet the citizenship and non-citizen status requirements identified in OAR 410-200-0215. For more information about CWM Plus benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.
(21) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.
(22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.
(23) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.
(24) "Claimant" means an individual who has requested a hearing or appeal.
(25) "Code" means Internal Revenue Code.
(26) "Combined Eligibility Notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the HSD Medical Programs for which a determination or denial was made by the Authority.
(27) "Community Partner" has the same meaning as "Community Partner" as defined in OAR 410-120-0000.
(28) "Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.
(29) "Cover All Kids" refers to the OHP Plus-equivalent benefit (OAR 410-120-1210) provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP except for the Citizenship and Non-Citizen Status Requirements (OAR 410-200-0215). As of July 1, 2022, Cover All Kids is included under Healthier Oregon as defined in OAR 410-134-0001.
(30) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or
(b) If section (30) subsection (a) cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.
(31) "Date of Request (DOR)" means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.
(a) For new applicants, the DOR is established as follows:
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or

(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:
(A) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility;
(B) The month an individual ages off a medical program.
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.
(32) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a;
(a) "Basic decision notice" mailed no later than:
(A) The date of action given in the notice; or
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;
(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten (10) calendar days before the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than fifteen (15) calendar days before the effective date of the change.
(33) "Department" means the Oregon Department of Human Services.
(34) "Dependent child" means an individual who:
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before attaining age 19.
(b) Lives in the home of the parent or caretaker relative; and
(c) Is not absent from the home for more than thirty (30) days due to being in foster care while foster care payments are being made.
(35) "Express Lane Agency (ELA)" means the Oregon Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.
(36) "Express Lane Eligibility (ELE)" means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.
(37) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.
(38) "Electronic application" means an application electronically signed and submitted through the Internet.
(39) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.
(40) "Eligibility Determination Group" (EDG) means all persons whose financial and non-financial information is considered in determining each medical applicant's eligibility as defined in OAR 410-200-0305.
(41) "Expedited appeal" also called "expedited hearing" means a hearing held within five (5) working days of the Agency's receipt of a hearing request, unless the claimant requests more time.
(42) "Family Size" means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the EDG and each unborn child of any pregnant members of the EDG.

(43) “Federal Data Services Hub” means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.
(44) “Federal Poverty Level (FPL)” means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual’s eligibility in accordance with 42 CFR 435.603(h).
(45) “Federally Facilitated Marketplace (FFM)” means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.
(46) “Head of household (HOH)” means the primary person the Agency shall communicate with and:
(a) Is listed as the case name; or
(b) Is the individual named as the primary contact on the application.
(47) “Health Systems Division Medical Programs (HSD Medical Programs)" means all programs under the Health Systems Division including:
(a) “EXT” means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;
(b) “Substitute Care” means medical coverage for children in BRS or PRTF;
(c) “BCCTP” means Breast and Cervical Cancer Treatment Program;
(d) “FFCYM” means Former Foster Care Youth Medical;
(e) OHP Bridge - Basic Health Program
(f) “MAGI Medicaid/CHIP” means HSD Medical Programs for which eligibility is based on MAGI methodology, including:
(A) MAGI Child;
(B) MAGI Parent or Caretaker Relative;
(C) MAGI Pregnant Woman;
(D) MAGI Children’s Health Insurance Program (CHIP);
(E) MAGI Adult;
(F) MAGI Expanded Adult
(G) OHP Bridge -Basic Medicaid
(48) “Healthier Oregon” is defined in OAR 410-120-0000.
(49) “Hearing request” means a clear expression, oral or written, by an individual or the individual’s representative that the individual wishes to appeal an Authority or FFM decision or action.
(50) “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.
(51) “Legal argument” has the meaning given that term in OAR 137-003-0008(c).
(52) “Medicaid” means Oregon’s Medicaid program under Title XIX of the Social Security Act.
(53) “MAGI” means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in OAR 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for

the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:
(A) Children, regardless of age, who are included in the household of a parent;
(B) Tax dependents.
(b) In applying section (53)(a), IRC § 6012(a) (1) is used to determine who is required to file a tax return.
(54) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:
(a) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received;
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;
(c) Income from the following American Indian and Alaska Native sources is excluded:
(A) Distributions from Alaska Native Corporations and Settlement Trusts;
(B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;
(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this section; or
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.
(D) Distributions resulting from real property ownership interests related to natural resources and improvements:
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
(ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests.
(E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;
(F) Student financial assistance provided under the Bureau of Indian Affairs education programs.
(55) "Minimum Essential Coverage (MEC)" means medical coverage under:
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;
(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;
(c) Plans in the individual market;
(d) Health insurance plans in place on or before March 23, 2010; and
(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.
(56) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.
(57) "Non-citizen" means any individual who is not a citizen or national of the United States as defined at 8 U.S.C. 1101(a)(22).
(58) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for individuals who are 65 years of age or older, who are blind, or who have a disability. This program is administered by the Oregon Department of Human Services.
(59) "Parent" means a natural or biological, adopted, or stepparent.
(60) "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.
(61) "Primary Contact" has the same meaning given "head of household" in this rule.
(62) "PRTF" means Psychiatric Residential Treatment Facility.
(63) "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 sixteen (16) residents, as defined in 42 CFR 435.1009.
(64) “Qualified hospital” means a hospital that meets all of the following criteria:
(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 to complete a full application by the end of the presumptive eligibility period and offers applicants assistance with completing and submitting the full Medicaid application; 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).
(65) “Reasonable opportunity period”;
(a) May be used to obtain necessary verification or resolve discrepancies regarding an attestation of US citizenship or non-citizen status (OAR 410-200-0230 (2));
(b) Begins on and shall extend ninety (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 (5) days after the date on the notice, unless the individual shows they did not receive the notice within the five (5) day period;
(c) May be extended beyond ninety (90) days for individuals declaring a non-citizen status, 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.
(66) “Redetermination” means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.
(67) “Renewal” means a regularly scheduled periodic review of eligibility.
(68) “Request for information (RFI)” means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.
(69) “Resident of a Public Institution” means;
(a) An individual residing in a public institution that is:
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the

terms of the contract, the facility is a public institution;
(C) Residing involuntarily in a facility that is under governmental control; or
(D) Receiving care as an outpatient while residing involuntarily in a public institution.
(b) An individual is not considered a resident of a public institution when the individual is:
(A) Released on parole, probation, or post-prison supervision;
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is a resident. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or
(ii) Is expected to meet the criteria outlined in subsection (i) of this rule, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.
(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual.
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:
(i) Is under age 21;
(ii) Is age 21 but was admitted to the IMD before their 21st birthday; or
(iii) Is age 65 or older.
(70) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.
(71) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.
(72) "Sibling" means natural or biological, adopted, or half or step sibling.
(73) "Spouse" means an individual who is legally married to another individual under:
(a) The statutes of the state where the marriage occurred;
(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or
(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.
(74) "SSA" means Social Security Administration.
(75) "Tax dependent" has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.
(76) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).

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

STATUTES/OTHER IMPLEMENTED: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706, 414.241

AMEND: 410-200-0100

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

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Outlines the process for coordinated eligibility and enrollment with ODHS and FFM.

RULE TEXT:
(1) This rule describes the coordination of eligibility and enrollment between the Oregon Health Authority (Authority), the Oregon Department of Human Services (Department), and the FFM. The Agency shall:
(a) Minimize the burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for insurance affordability programs;
(b) Ensure determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards described in OAR 410-200-0110 based on the application date;
(c) Provide coordinated content for those household members whose eligibility status is not yet determined; and
(d) Screen every applicant or beneficiary who submits an application, renewal, or reports a change requiring redetermination of eligibility for criteria that identify individuals for whom MAGI and MAGI-based income methods do not apply.
(2) For individuals undergoing eligibility determinations for HSD Medical Programs, the Agency, consistent with the timeliness standards described in OAR 410-200-0110, shall:
(a) Determine eligibility for MAGI Medicaid/CHIP on the basis of having household income at or below the applicable MAGI-based standard; or
(b) If ineligible under section (2)(a), direct those individuals as appropriate to the FFM.
(3) The Agency shall, consistent with the timeliness standards described in OAR 410-200-0110, Screen for eligibility for non-MAGI programs as indicated by information provided on the application or renewal form.
(4) For HSD Medical Program beneficiaries who become ineligible for ongoing HSD Medical Program benefits, if an evaluation for non-MAGI programs is indicated by information provided in the case record, the Agency shall maintain HSD Medical Program benefits while eligibility for non-MAGI programs is being determined, and shall not take action to close benefits until determination of eligibility is complete.
(5) Coordination among agencies:
(a) The Agency shall maintain a secure electronic interface through which the Authority can send and receive an individual's electronic account from the FFM;
(b) The Agency may not request information or documentation from the individual included in the individual's electronic account or provided for the sake of other Agency benefits; and
(c) If information is available through electronic data match and is useful and related to eligibility for HSD Medical Programs, the Agency shall obtain the information through electronic data match.

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

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

AMEND: 410-200-0105

RULE TITLE: Hospital Presumptive Eligibility

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Explains hospital presumptive eligibility including what programs are exempt.

RULE TEXT:

With the exception of OHP Bridge - Basic Medicaid, this rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, BCCTP, and FFCYM (OAR 410-200-0407) based on the determination of a qualified hospital. In addition, presumptive eligibility for OHP Bridge Basic Health Program cannot be established based on the determination of a qualified hospital.

(1) A qualified hospital shall, with the consent of the individual or someone acting on the individual's behalf, determine Hospital Presumptive Eligibility (HPE) for MAGI Medicaid/CHIP, BCCTP, or FFCYM.

(2) The qualified hospital shall determine Hospital Presumptive Eligibility based on the following information attested by the individual:

(a) Family size;

(b) Household income;

(c) Receipt of other health coverage;

(d) Residency

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

(3) To be eligible via Hospital Presumptive Eligibility, an individual must be a US citizen, US National, or meet the citizenship and non-citizen status requirements found in OAR 410-200-0215 and one of the following:

(a) A child under the age of 19 with income at or below 300 percent of the federal poverty level;

(b) A parent or caretaker relative of a dependent child with income at or below the MAGI Parent or Caretaker Relative income standard for the appropriate family size in OAR 410-200-0315;

(c) A pregnant individual with income at or below 185 percent of the federal poverty level;

(d) A non-pregnant adult between the ages of 19 through 64 with income at or below 133 percent of the federal poverty level; or

(e) An individual under the age of 65 who has been screened by a licensed healthcare provider and determined to need treatment for breast or cervical cancer, or who has been determined eligible for the Breast and Cervical Cancer Treatment Program (OAR 410-200-0400);

(f) An individual under the age of 26 who was in Oregon foster care on their 18th birthday.

(4) To be eligible via Hospital Presumptive Eligibility, an individual may not:

(a) Be receiving Supplemental Security Income benefits;

(b) Be a Medicaid/CHIP beneficiary; or

(c) Have received a Hospital Presumptive Eligibility approval start date within the year (365 days) prior to a new Hospital Presumptive Eligibility period start date.

(5) In addition to the requirements outlined in sections (3) and (4) above, the following requirements also apply:

(a) To receive MAGI Adult benefits via Hospital Presumptive Eligibility, an individual may not be entitled to or enrolled in Medicare benefits under part A or B of Title XVIII of the Act;

(b) To receive MAGI CHIP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage that is accessible (OAR 410-200-0410(2)(c));

(c) To receive BCCTP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage.

(6) The Hospital Presumptive Eligibility period begins on the earlier of:

(a) The date the qualified hospital determines the individual is eligible; or

(b) The date that the individual received a covered medical service from the qualified hospital, if the hospital determines the individual is eligible and submits the decision to the Authority within five (5) calendar days following the date of

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

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

STATUTES/OTHER IMPLEMENTED: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706, 414.241

AMEND: 410-200-0110

RULE TITLE: Application and Renewal Processing and Timeliness Standards

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Sets standards for application and renewal processing timelines for individuals applying for programs administered by the Authority, the department or the FFM.

RULE TEXT:

(1) General information as it relates to application processing is as follows:

(a) An individual may apply for one or more medical programs administered by the Authority, the Department, or the Federally Facilitated Marketplace (FFM) using a single streamlined application;

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

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

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

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

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

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

(B) The applicant, even if homeless, provides an address where they can receive postal mail;

(C) The application is signed in accordance with section (5) of this rule;

(D) The application is received by the Agency.

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

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

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

(c) At renewal, if the Agency is unable to process an automated renewal, the Agency shall provide a pre-populated renewal form, referred to as an active renewal, to the beneficiary containing information known to the Agency, a statement of the additional information needed to renew eligibility, and the date by which the beneficiary must provide the required information in accordance with section (6) of this rule;

(d) The Agency shall assist applicants seeking assistance to complete the pre-populated renewal form or gather information necessary to renew eligibility;

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

(A) Complete and sign the form in accordance with section (5) of this rule;

(B) Submit the form via the Internet, by telephone, via mail, in person, and through other commonly available electronic means, and

(C) Provide necessary information to the Agency within the time frame established in section (6) of this rule.

(3) A new application is required when:

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

(b) A child turns age 19, is no longer claimed as a tax dependent, and wishes to retain medical benefits;

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

(C) A completed application is not received by the agency within 45 days after the Date of Request.
(b) At initial eligibility determination, the Agency may extend the 45-day period described in section (6)(a) if:
(A) The Agency must request additional information or verification, and the due date of such request extends beyond the 45th day; or
(B) There is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;
(c) At periodic renewal of eligibility, if additional information or verification is required, the Authority shall provide the beneficiary at least thirty (30) days from the date of the renewal form to respond and provide necessary information.
(7) Individuals may apply through the FFM. If the FFM determines the individual is potentially eligible for Medicaid/CHIP or OHP Bridge , the FFM shall transfer the individual's electronic account to the Oregon Department of Human Services for eligibility determination.
(8) HSD Medical Program eligibility is evaluated in the following order:
(a) For a child applicant:
(A) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (OAR 410-200-0405);
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);
(C) MAGI Pregnant Woman program (OAR 410-200-0425);
(D) MAGI Child (OAR 410-200-0415);
(E) Extended Medical Assistance (OAR 410-200-0440);
(F) MAGI CHIP (OAR 410-200-0410);
(G) FFCYM (OAR 410-200-0407);
(H) BCCTP (OAR 410-200-0400)
(b) For an adult applicant:
(A) Substitute Care (OAR 410-200-0405);
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);
(C) MAGI Pregnant Woman (OAR 410-200-0425);
(D) FFCYM (OAR 410-200-0407);
(E) MAGI Adult (OAR 410-200-0435);
(F) EXT (OAR 410-200-0440);
(G) MAGI Expanded Adult (OAR 410-200-0436);
(H) BCCTP (OAR 410-200-0400);
(I) OHP Bridge – Basic Medicaid (OAR 410-200-0437)
(J) OHP Bridge – Basic Health Program (OAR 410-200-0438)
(K) Compact of Free Association (COFA) Dental (OAR 410-200-0445);
(L) Veteran Dental (OAR 410-200-0450).

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

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

AMEND: 410-200-0115

RULE TITLE: HSD Medical Programs—Effective Dates

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides an overview of effective dates for HSD Medical Programs.

RULE TEXT:

(1) This section of the rule identifies the effective date of coverage for new applicants who are approved for HSD Medical Program benefits

(a) For all HSD Medical programs except OHP Bridge - Basic Health Program, the effective date is:

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

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

(b) For OHP Bridge - Basic Health Program:

(A) When the determination of eligibility is made on or before the 15th day of a month, the effective date of coverage is on the first day of the month following the month in which the determination was made; or

(B) When the determination of eligibility is made on or after the 16th day of a month, the effective date of coverage is the first day of the month following the next month.

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

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

(a) The first day of the earliest of the three (3) months preceding the month in which the Date of Request was established; or

(b) If ineligible pursuant to section (s)(a), the earliest date of eligibility within the three (3) months preceding the month in which the Date of Request was established.

(4) Establishing a renewal date:

(a) For all HSD Medical Programs except EXT (see OAR 410-200-0440), eligibility shall be renewed every twelve (12) months or upon the earliest Continuous Eligibility (CE) period end-date present on the case (see OAR 410-200-0135 Assumed, Continuous, and Protected Eligibility), whichever is later.

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

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

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

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

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

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

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

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

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

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

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

(6) Suspending or Closing Medical Benefits:

(a) The effective date for closing HSD Medical Program benefits is the earliest of:

(A) The date of a beneficiary's death;

(B) The last day of the month in which the beneficiary becomes ineligible and a timely continuing benefit decision notice is sent;
(C) The day prior to the start date for Office of Child Welfare Programs or OSIPM for beneficiaries transitioning from an HSD Medical Program;
(D) The date the program ends; or
(E) The last day of the month in which a timely continuing benefit decision notice is sent if ongoing eligibility cannot be determined because the beneficiary does not provide required information by the deadline provided.
(b) Except for benefits obtained via Hospital Presumptive Eligibility (see OAR 410-200-0105) or a presumptive eligibility period for BCCTP (see OAR 410-200-0400), prior to closing medical benefits, the Agency shall:
(A) Determine eligibility for all other HSD Medical Programs; or
(B) Refer the beneficiary to the Department, if applicable, and confirm that the Department has made an eligibility decision.
(c) For beneficiaries of HSD Medical Program benefits who become incarcerated (OAR 410-200-0140), the effective date of suspension is the day following the date on which the individual became incarcerated.
(7) Denial of Benefits. The effective date for denying HSD Medical Program benefits is the earlier of the following:
(a) The date the decision is made that the applicant is not eligible and notice is sent; or
(b) The end of the application processing time frame, unless the time period has been extended to allow the applicant more time to provide required verification.

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

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

AMEND: 410-200-0130

RULE TITLE: Retroactive Medical

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides descriptions on how retroactive eligibility applies to HAS Medical Programs.

RULE TEXT:

(1) The Authority may evaluate for retroactive medical eligibility for all HSD Medical Programs, except retroactive eligibility for OHP Bridge - Basic Health Program is not permitted.

(2) The Authority shall evaluate for retroactive medical eligibility for the three calendar months preceding the month in which the Date of Request was established for the following individuals:

(a) Applicants requesting HSD Medical Programs who have unpaid medical bills or received donated medical services that may have been covered by Oregon Medicaid/CHIP; and

(b) Deceased individuals who have unpaid medical bills or received donated medical services that may have been covered by Oregon Medicaid/CHIP, who may have been eligible for Medicaid covered services had they, or someone acting on their behalf, applied.

(3) If eligible for retroactive medical, the individual's eligibility shall not start earlier than the date indicated by OAR 410-200-0115 Effective Dates.

(4) The Authority reviews each month individually for retroactive medical eligibility.

(5) If an individual is determined to be eligible for retroactive medical eligibility, the period of retroactive eligibility shall be approved for months in which an individual received coverage during a Hospital Presumptive Eligibility period (OAR 410-200-0105), unless the retroactive benefits may be a reduction in benefit-level compared to the Hospital Presumptive Eligibility benefits.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 414.534

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

AMEND: 410-200-0135

RULE TITLE: Assumed, Continuous, and Protected Eligibility

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Provides information on how assumed, continuous, and protected eligibility.

RULE TEXT:

(1) Assumed Eligibility:

(a) A child born to an individual who is eligible for and receiving Medicaid/Children's Health Insurance Program (CHIP) benefits at the time of the birth is an assumed eligible newborn (AEN);

(b) An AEN is eligible for MAGI Child benefits (OAR 410-200-0415) effective the date of birth through 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.

(c) A new application or request for coverage is not required for an AEN.

(d) An AEN is entitled to assumed eligibility without providing a Social Security Number (SSN). An SSN is required to maintain coverage after the assumed eligibility period ends.

(2) Continuous Eligibility:

(a) The Continuous Eligibility (CE) period is the period of time an individual who is determined eligible for an HSD medical benefit shall maintain coverage despite changes in circumstance that may otherwise preclude eligibility, with consideration of exceptions described in section (2)(b);

(b) Coverage may be terminated during the CE period in the following circumstances:

(A) The individual is no longer an Oregon resident;

(B) The individual dies;

(C) The individual or someone authorized to act on their behalf requests voluntary termination of eligibility;

(D) The agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual or someone authorized to act on their behalf; or

(E) For recipients of the MAGI Expanded Adult Program (OAR 410-200-0436), the program ends.

(c) The CE period is established when an individual is determined eligible for HSD medical benefits with no outstanding requests for information, as follows:

(A) At initial approval of eligibility, the CE period begins on the first of the month in which the individual established a Date of Request (DOR);

(B) When approved for renewal of eligibility, the new CE period begins on the first of the month following the renewal due-date.

(d) The length of the CE period is based on age and program eligibility, as follows:

(A) Children under six (6) years of age are entitled to CE through the end of the month of their sixth (6) birthday or twenty-four (24) months, whichever is later;

(B) Except for individuals eligible for OHP Bridge - Basic Health Program, individuals age six (6) and above are entitled to twenty-four (24) months of CE.

(C) Individuals who are eligible for OHP Bridge - Basic Health Program are entitled to twelve (12) months of coverage in the program as long as they continue to meet non-financial eligibility criteria for the program described in OAR 410-200-0438 (2)(a) and (d) and (3) .

(e) An individual's benefits may be adjusted during the continuous eligibility as long as the adjustment does not result in the reduction or termination of coverage;

(f) If an individual's eligibility is redetermined during the continuous eligibility period and they no longer meet financial eligibility requirements for any HSD Medical Program of the same or better benefit, they shall retain coverage through

the program with the uppermost income eligibility threshold for which the individual meets non-financial eligibility requirements;
(g) If an individual's eligibility is redetermined during the continuous eligibility period and they no longer meet financial or non-financial eligibility requirements for any HSD Medical Program of the same or better benefit, they shall retain coverage through the Parent and Caretaker Relative program (OAR 410-200-0420).
(3) Protected Eligibility:
(a) Except for those individuals eligible for and receiving OHP Bridge – Basic Health Program benefits, individuals who are eligible for and receiving any HSD Medical Program benefits for any portion of their pregnancy are entitled to protected eligibility for the duration of the pregnancy and the postpartum eligibility period;
(b) The postpartum eligibility period is:
(A) Except as described in subsection (3)(b)(B), the postpartum eligibility period is twelve (12) calendar months following the month in which the pregnancy ends;
(B) For individuals who do not meet the citizen and non-citizen status requirements, who are eligible for and receiving Citizenship Waived Medical (CWM) Plus coverage for any portion of their pregnancy, the postpartum eligibility period is the two (2) calendar months following the month in which the pregnancy ends.
(c) Benefits may not be terminated or reduced during a period of protected eligibility unless:
(A) The individual is no longer an Oregon resident;
(B) The individual dies;
(C) The individual or someone authorized to act on their behalf requests a voluntary termination of eligibility; or
(D) The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual or someone authorized to act on their behalf.

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

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

AMEND: 410-200-0140

RULE TITLE: Eligibility for Residents of a Public Institution

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Explains how eligibility for HSD medical programs applies to residents of public institutions.

RULE TEXT:

(1) A resident of a public institution is not eligible for Health System Division (HSD) Medical Program benefits, except as follows:

(a) For individuals residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital, who are:

(A) Under age 21;

(B) Age 21 if they were admitted to the IMD before their 21st birthday; or

(C) Age 65 or older.

(b) Residents of a public institution may be eligible for OHP Bridge – Basic Health Program benefits if they are awaiting disposition of charges.

(2) For all individuals enrolled in HSD Medical Programs except for OHP Bridge – Basic Health Program who become a resident of a public institution, benefits shall be suspended for the duration of the period in which the individual is a resident of that institution.

(a) The effective date of the suspension of benefits is the day following the date on which an individual becomes a resident of a public institution.

(b) Suspended benefits shall be reinstated effective the date on which an individual ceases to be a resident of a public institution without the need for a new application when:

(A) The Agency learns the individual is no longer a resident of a public institution within the twelve (12) calendar months following the date on which the change occurred; or

(B) The individual leaves the public institution to be admitted to a medical facility as an inpatient with an expected stay of at least 24 hours, provided the medical facility is not associated with the public institution where the individual is a resident.

(c) Once benefits are reinstated as described in subsection (2)(b) of this rule, a redetermination of eligibility shall be processed unless benefits are restored on a case where the existing renewal date is more than two (2) calendar months beyond the month in which the action is being taken.

(3) For individuals enrolled in OHP Bridge – Basic Health Program who become a resident of a public institution, benefits shall be terminated effective the day following the day on which they became a resident of a public institution except that coverage shall be maintained while the individual's charges are pending disposition. In order to regain eligibility for OHP Bridge-Basic Health Program following release from the public institution, the individual must reapply.

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

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

AMEND: 410-200-0215

RULE TITLE: Citizenship and Non-Citizen Status Requirements

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Outlines citizenship and non-citizenship status requirements for HSD medical programs.

RULE TEXT:

(1) To meet the citizenship requirement for an HSD Medical Program, an individual must be:

(a) A citizen of the United States; or

(b) A citizen of Puerto Rico, Guam, the Virgin Islands or Saipan, Tinian, Rota or Pagan of the Northern Mariana Islands; or

(c) A national from American Samoa or Swains Islands.

(2) For the purposes of this rule, a Qualified Non-Citizen (QNC) is an individual who is:

(a) A non-citizen lawfully admitted for permanent residence under the INA (8 U.S.C. 1101 et seq);

(b) 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 (1) year;

(c) 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;

(d) A non-citizen granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as such statute was in effect prior to April 1, 1980;

(e) A refugee admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(f) A non-citizen granted asylum under section 208 of the INA (8 U.S.C. 1158);

(g) 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));

(h) A non-citizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(i) An Afghan or Iraqi non-citizen granted Special Immigration Status (SIV) as defined in section 101(a)(27) of the INA;

(j) Effective December 28, 2020, an individual lawfully residing in the United States in accordance with the Compacts of Free Association (i.e., the governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau);

(k) An individual granted immigration status under section 584(a) of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988;

(L) 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); or

(m) 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).

(3) For the purposes of this rule, an individual is Lawfully Present if they are:

(a) A QNC

(b) A non-citizen with a valid non-immigrant status, as defined in 8 USC 1101(a)(15) or as otherwise defined under other United States immigration laws (as defined in 8 USC 1101(a)(17));

(c) A non-citizen who has been paroled into the United States in accordance with 8 USC 1182(d)(5) for less than one (1) year, provided they have not been paroled for prosecution, for deferred inspection, or pending removal proceedings;

(d) A non-citizen who belongs to one of the following classes of non-citizens:

(A) Granted temporary resident status in accordance with 8 USC 1160 or 1255a;

(B) Granted temporary protected status (TPS) in accordance with 8 USC 1254a and individuals with a pending application for TPS who have been granted employment authorization;

(C) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649, as amended;

(D) Under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(E) Granted Deferred Action status; or
(F) Beneficiary of approved visa petition who has a pending application for adjustment of status.
(e) An individual with a pending applicant for asylum under 8 U.S.C. 1158, or for withholding of removal under section 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) A child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
(h) A non-citizen who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. 1806(e); or
(i) A non-citizen who is lawfully present in American Samoa under the immigration laws of American Samoa.
(4) To meet the non-citizen status requirements for MAGI Medicaid/CHIP programs, an individual must meet at least one of the following:
(a) Is a QNC as described in (2)(d) - (2)(m) of this rule; or,
(b) For the period of July 31, 2021 through March 31, 2023, or through the end of the individual's parole, whichever is later:
(A) Be a citizen or national of Afghanistan who is paroled into the US between July 31, 2021 through September 30, 2023;
(B) Be a spouse of an individual described in (4)(b)(A); or
(C) Be an unmarried child under the age of 21 of an individual described in (4)(b)(A).
(c) Effective February 24, 2022, the individual is a citizen or national of Ukraine, or if not a citizen or national of Ukraine but had been habitually residing in Ukraine when they:
(A) Were paroled into the United States between February 24, 2022 and September 30, 2023 and their parole has not been terminated; or
(B) Were paroled into the United States after September 30, 2023, their parole has not been terminated; and —
(i) they are the spouse or child of an individual described in subsection (4)(c)(A); or
(ii) they are the parent, legal guardian, or primary caregiver of an individual described in section (4)(c)(A) who is determined to be an unaccompanied child under section 462(g)(2) of the Homeland Security Act of 2002 (6 USC 279(g)(2)) or section 412(d)(2)(B) of the Immigration and Nationality Act (8 USC 1522(d)(2)(B)).
(d) An individual who is under the age of 19 and who is Lawfully Present as described in section (3) of this rule;
(e) An individual who is 19 or older, and is a QNC as described in (2)(a)-(c) of this rule and who meets at least one of the following:
(A) Was a QNC prior to August 22, 1996;
(B) Obtained the status described in section (2)(a)-(c) of this rule at least five (5) years before the request for benefits;
(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 thirty (30) consecutive days or a total of more than ninety (90) days between August 22, 1996, and the date qualified non-citizen status was obtained;
(D) Is a member of the United States Armed Forces on active duty (other than active duty for training);
(E) Is a veteran of the United States Armed Forces who was honorably discharged for reasons other than noncitizen status and who fulfilled the minimum active-duty service requirements described in 38 USC 5303A(d); or
(F) Is the child or spouse, including an un-remarried surviving spouse, of an individual described in section (4)(e)(D) or (4)(e)(E) of this subsection.
(5) To meet the non-citizen status requirements for OHP Bridge - Basic Health Program an individual must be:

(a) Lawfully Present as described in (3) of this rule; or

(b) An individual as described in (4)(b) or (4)(c) of this rule.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.534, 42 CFR: 435.110, 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.117, 435.170, 435.190, 435.916, 435.917, 435.926, 435.1205, 447.56, 457.350, 457.360, 457.805, 433.145, 433.148, 433.146, 435.610, 435.119, 435.222, 433.138, 433.147, 435.602, 435.608

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

AMEND: 410-200-0220

RULE TITLE: Requirement to Pursue Assets

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Outlines how pursuit of assets impacts eligibility for HSD medical program.

RULE TEXT:

(1) For all HSD Medical Programs except for OHP Bridge– Basic Health Program, as a condition of ongoing eligibility, an applicant or beneficiary shall make a good faith effort to obtain an asset to which they have a legal right or claim, except an applicant or beneficiary is not required to:

(a) Apply for Supplemental Security Income (SSI) from the Social Security Administration;

(b) Borrow money;

(c) Pursue an asset if the individual can show good cause for not doing so (see section (6) of this rule).

(2) For all HSD Medical Programs, pursuable assets include but are not limited to:

(a) Claims related to an injury;

(b) Disability benefits;

(c) Healthcare coverage;

(d) Retirement benefits;

(e) Survivorship benefits (including inheritance, devise or elective share);

(f) Discretionary or mandatory distribution from a trust;

(g) Unemployment compensation; and

(h) Veteran's compensation and pensions.

(3) For all HSD Medical Programs except MAGI CHIP and eligibility granted under Cover All Kids (OAR 410-200-0240) or during a period of Hospital Presumptive Eligibility (OAR 410-200-0105),Each caretaker in the EDG shall assist the Agency and the Division of Child Support (DCS) in establishing paternity for each child receiving medical assistance and in obtaining an order directing the non-custodial parent of a child receiving benefits to provide cash medical support and health care coverage for that child;

(4) An individual involved in a personal injury shall pursue a claim for the personal injury. If the claim or action to enforce such claim was initiated prior to the application for medical assistance, the individual shall notify the Agency during the eligibility verification process (OAR 410-200-0230). The following information is required:

(a) The names and addresses of all parties against whom the action is brought or claim is made;

(b) A copy of each claim demand; and

(c) If an action is brought, the case number and the county where the action is filed.

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

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

(a) Pursuing the asset may 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 may result;

(b) For individuals with the authority to pursue child support on behalf of a child who is applying for or receiving Medicaid benefits, the individual is considered to have good cause if:

(A) The child was conceived as a result of incest or rape and efforts to obtain support may be detrimental to the dependent child. The statement of the caretaker serves as prima facie evidence on the issues of conception and detrimental effect to the dependent child;

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

(C) The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption;

(D) The individual is pregnant; or

(E) Other good cause reasons exist for non-cooperation.

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

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0305

RULE TITLE: Eligibility Determination Group — Health System Division Medical Programs.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Explains eligibility determination groups for HSD medical program applicants.

RULE TEXT:

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

(a) Tax filer EDG:

(A) For individuals who intend to file a federal income tax return, who are not claimed as a tax dependent by another individual, the EDG consists of:

(i) The tax filer;

(ii) The tax filer's spouse, with the following considerations:

(I) If living together, the tax filer's spouse is included in the EDG of the tax filer, irrespective of the spouse's tax filing status; and

(II) If living separately, the tax filer's spouse is included in the EDG of tax filer if they intend to claim a tax filing status of Married Filing Jointly.

(iii) All individuals whom the tax filer intends to claim as tax dependents.

(B) For tax filers who expect to be claimed as a tax dependent by another individual, the EDG is determined in accordance with section (1)(b) of this rule.

(b) Tax dependent EDG:

(A) Except as described in subsection (B) of this part (1)(b)(B), the EDG of an individual who expects to be claimed as a tax dependent is the same as the EDG of the tax filer who intends to claim them, as outlined in section (1) of this rule.

(B) For tax dependents who meet any of the following exceptions, the EDG is determined in accordance with section (3) of this rule:

(i) The individual is claimed as a tax dependent by someone other than a parent or spouse;

(ii) The individual is a child living with both parents but is claimed as a tax dependent by one parent; or

(iii) The individual is a child living with a parent and is claimed as a tax dependent by a non-custodial parent.

(c) Non-filer EDG:

(A) An individual's EDG is determined in accordance with this section if:

(i) The individual does not expect to file a tax return and is not claimed as a tax dependent;

(ii) The individual does not expect to file a tax return and cannot substantiate whether or not they shall be included in the tax return of another individual; or

(iii) The individual expects to be claimed as a tax dependent and meets an exception described in section (1)(b) of this rule.

(B) The non-filer EDG consists of the following individuals, if living in the same household:

(i) The individual;

(ii) The individual's spouse;

(iii) The individual's children; and

(iv) If the individual is a child, their parents and child siblings;

(2) When establishing eligibility for OHP Bridge - Basic Health Program, each individual shall have their own Eligibility Determination Group (EDG) determined individually based on the following EDG rules:

(a) Tax filer EDG:

(A) For individuals who intend to file a federal income tax return, who are not claimed as a tax dependent by another individual, the EDG consists of:

(i) The tax filer;

(ii) The tax filer's spouse, if they intend to claim Married Filing Jointly; and

(iii) All individuals whom the tax filer intends to claim as tax dependents.
(B) For tax filers who expect to be claimed as a tax dependent by another individual, the EDG is determined in accordance with subsection (b) of this section (2)(b).
(b) Tax dependent EDG:
(A) The EDG of an individual who is claimed as a tax dependent by a tax-filer with whom they live consists of all individuals included in the tax-filer's EDG.
(B) The EDG of an individual who is claimed as a tax dependent by someone with whom they do not live is based on non-filer EDG criteria outlined in subsection (c) of this part.
(c) Non-filer EDG:
(A) An individual's EDG is determined in accordance with this section if:
(i) The individual does not expect to file a tax return and is not claimed as a tax dependent;
(ii) The individual does not expect to file a tax return and cannot substantiate whether or not they shall be included in the tax return of another individual;
(iii) The individual expects to be claimed as a tax dependent by someone outside of their home, as referenced in section (2)(b)(B) of this part; or
(iv) The Individual expects to file their tax return using a status of Married Filing Separately.
(B) The non-filer EDG consists of the following individuals, if living in the same household:
(i) The individual;
(ii) The individual's spouse;
(iii) The individual's children; and
(iv) If the individual is a child, their parents and child siblings;
(3) Individuals described in this rule are still considered EDG members if they are temporarily absent from the household with intent to return to the household when the purpose of their absence is complete. Reasons for temporary absence include but are not limited to:
(a) Education;
(b) Military;
(c) Work or training;
(d) Incarceration; or
(e) Hospitalization.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0310

RULE TITLE: Eligibility and Budgeting; Health Systems Division Medical Programs.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Explains eligibility and budgeting as it applies to HSD medical program members and new applicants.

RULE TEXT:

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

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

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

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

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

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

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

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

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

(2) MAGI and MAGI-based income not specifically excluded is countable, and its value is used in determining the eligibility and benefit level of an applicant or beneficiary.

(3) MAGI and MAGI-based income is considered available on the date it is received or the date a member of the EDG has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows:

(a) Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend;

(b) Income withheld or diverted at the request of an individual is considered available on the date the income may have been paid without the withholding or diversion;

(c) An advance or draw of earned income is considered available on the date it is received.

(4) For all HSD Medical Programs except OHP Bridge – Basic Health Program, financial eligibility is evaluated for the initial budget month by comparing the combined total of each EDG member's countable MAGI-based income to the income standards for the appropriate family size. Countable MAGI-based income is determined as follows:

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

(A) Average weekly income is multiplied by 4.3;

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

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

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

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

(A) For income expected to be received monthly or more frequently, the agency shall evaluate initial budget month eligibility by combining the actual income received and expected to be received in the budget month. Income is then converted to an ongoing amount using the methodology described in subsection (4)(a) of this part for ongoing eligibility.

(B) For income expected to be paid on a regular basis less often than monthly, income is converted as described in subsection (4)(a)(D) of this part for budget month and ongoing eligibility.

(5) If ineligible under section (4) because the MAGI-based income is over the applicable HSD Medical Program income standard based on family size, MAGI income shall be annualized using the requirements of 26 CFR §1.36 B-1(e) for the

calendar year in which medical has been requested.
(a) For all MAGI Medicaid/CHIP programs, if the annual income is at or below 100 percent FPL), income shall be divided by 12 to derive a monthly amount and applied to the budget month for initial and ongoing eligibility.
(b) For OHP Bridge – Basic Health Program , if the annual income is between 133 and 200 percent FPL, that amount shall be used in the eligibility determination.
(6) If ineligible under sections (4) or (5) of this rule, the agency shall evaluate eligibility for the subsequent month using the methodology described in section (4) of this rule. If eligible, the effective date of eligibility is established as described in HSD Medical Programs – Effective Dates (OAR 410-200-0115).
(7) Financial eligibility for retroactive months (see OAR 410-200-0130) is first evaluated in accordance with section (4) of this rule. If a conversion of ongoing income results in ineligibility, the agency shall consider the actual countable income received in the retroactive month. If eligible, the effective date of eligibility is established as described in HSD Medical Programs – Effective dates (OAR 410-200-0115).
(8) In the following scenarios, an individual's countable income may be reduced by an amount equivalent to five percentage points of the FPL based on the applicable family size:
(a) A child who is ineligible for MAGI Medicaid programs (MAGI Child (OAR 410-200-0415), MAGI Parent or Caretake Relative (OAR 410-200-0420), MAGI Pregnant Woman (OAR 410-200-0425)) and may otherwise be eligible for MAGI CHIP (OAR 410-200-0410); if the countable income reduced by five percentage points of the FPL is within the income standard for a MAGI Medicaid program, the individual meets the financial eligibility for that program.
(b) Allowable Reduction of Countable Income for all HSD Medical Programs, except OHP Bridge – Basic Health Program. If the countable income, when it is reduced by five percentage points of the FPL, is within the income standard for any HSD Medical Program, then the individual meets the financial eligibility requirements for that program. However, the five percentage point reduction is not used to determine financial eligibility for OHP Bridge – Basic Health Program.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042

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

AMEND: 410-200-0315

REPEAL: Temporary 410-200-0315 from DMAP 78-2024

RULE TITLE: Standards and Determining Income Eligibility

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Outlines income thresholds for HSD medical programs.

RULE TEXT:
(1) This rule outlines income thresholds for Health System Division (HSD) Medical Programs. See OAR 410-200-0310 for eligibility and budgeting.
(2) The income standard for the Modified Adjusted Gross Income (MAGI) Parent or Caretaker-Relative program is set as follows: See attached table.
(3) Effective March 1, 2024, the income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the 2024 Federal Poverty Level (FPL) as follows: See attached table.
(4) Effective March 1, 2024, the income standard for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under the age of one year is set at 185 percent of the 2024 FPL as follows: See attached table.
(5) Effective March 1, 2024, the income standard for the MAGI Expanded Adult Program is set at 200 percent of the 2024 FPL as follows: See attached table.
(6) Effective March 1, 2024, the income standard for MAGI Children's Health Insurance Program (CHIP) is set at 300 percent of the 2024 FPL as follows: See attached table.
(7) Effective July 1, 2024, the income standard for OHP Bridge - Basic Health Program and OHP Bridge – Basic Medicaid is set at 200 percent of the 2024 Federal Poverty Level (FPL) as follows: See attached table.
(8) Effective March 1, 2024, the income standard for the Compact of Free Association (COFA) Dental Program is set at 138 percent of the 2024 FPL as follows: See attached table.
(9) Effective March 1, 2024, the income standard for the Veteran Dental Program is set at 400 percent of the 2024 FPL as follows: See attached table.
[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]

STATUTORY/OTHER AUTHORITY: 42 CFR 435.110, ORS 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.608, 433.138, 433.145, 433.146, 433.147, 433.148, 435.117, 435.119, 435.1200, 435.1205, 435.170, 435.190, 435.222, 435.610, 435.916, 435.917, 447.56, 457.350, 457.360, 457.805, ORS 411.402, 411.404, 413.042, 414.534

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

ADOPT: 410-200-0437

RULE TITLE: Specific Requirements: OHP Bridge - Basic Medicaid.

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Proposes new rule outlining specific requirements for OHP Bridge – Basic Medicaid.

RULE TEXT:
In addition to the general eligibility requirements applicable to OHP Bridge - Basic Medicaid as set out in OAR Chapter 410, Division 200, this rule describes specific eligibility requirements for OHP Bridge - Basic Medicaid.
(1) OHP Bridge - Basic Medicaid is effective on July 1, 2024.
(2) To be eligible for OHP Bridge - Basic Medicaid an individual must:
(a) Be age 19 or older and under age 65;
(b) Have, as required under OAR 410-200-0315, monthly MAGI-based household income greater than 133 percent of the federal poverty level (FPL) up to and including 200 percent federal poverty level for the applicable family size;
(c) Meet citizenship requirements outlined in OAR 410-200-0215 (1) or non-citizen status requirements outlined in OAR 410-200-0215 (4);
(d) Be exempt from mandatory enrollment in a non-Indian Managed Care Entity based on American Indian or Alaska Native status as is specified in section 1932 (2)(C) of the Social Security Act and its implementing federal regulation, 42 CFR 438.50 (d)(2).
(3) Even if an individual meets the requirements in section (2) above of this rule, the individual shall not be eligible for OHP Bridge - Basic Medicaid if they:
(a) Are enrolled in Medicare benefits under part A or B of Title XVIII of the Act; or
(b) Are receiving other healthcare coverage that qualifies as Minimum Essential Coverage as defined in OAR 410-200-0015 (55), unless that coverage is an Insurance Affordability Program as defined in OAR 410-200-0015 (50); or
(c) Be able to access affordable coverage as described in section 36B(c)(2)(C)(i)(II) and §1.36B–2(c)(3)(v)(A)(1) of the IRS Code. The required contribution percentage is indexed annually under section 36B(c)(2)(C)(iv); or
(d) Are receiving Supplemental Security Income (SSI) benefits.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.241, 414.534, 42 CFR 433.138, 433.145-433.148, 435.3-435.4, 435.110, 435.115-435.119, 435.170, 435.190, 435.222, 435.403, 435.406-435.407, 435.608, 435.610, 435.916-435.917, 435.940, 435.952, 435.956, 435.1008, 435.1200, 435.1205, 447.56, 457.80, 457.320, 457.340, 457.350, 457.360, 457.380, 457.805, 458.350, 435.112

STATUTES/OTHER IMPLEMENTED: ORS 411.402, 411.404, 414.534, ORS 411.060, 411.095, 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.241, 414.440, 414.534, 414.536, 414.706

ADOPT: 410-200-0438

RULE TITLE: Specific Requirements: OHP Bridge – Basic Health Program

NOTICE FILED DATE: 03/01/2024

RULE SUMMARY: Proposes new rule outlining specific requirements for OHP Bridge – Basic Health Program.

RULE TEXT:

In addition to the general requirements applicable to OHP Bridge – Basic Health Program set forth in this Division 200, this rule describes specific eligibility requirements for OHP Bridge – Basic Health Program.

(1) OHP Bridge – Basic Health Program is effective on July 1, 2024.

(2) To be eligible for OHP Bridge – Basic Health Program an individual must:

(a) Be age 19 or older and under age 65;

(b) Have, as required under OAR 410-200-0315, monthly MAGI-based income which exceeds 133 percent of the federal poverty level (FPL) for the applicable family size; have annual household income for the applicable family size up to and including 200 percent FPL for the coverage year being requested; and

(c) Meet citizenship status requirements outlined in OAR 410-200-0215(1), or non-citizen status requirements outlined in OAR 410-200-0215(5).

(3) Even if an individual meets the requirements in section (2) of this rule, the individual shall not be eligible for OHP Bridge – Basic Health Program if they:

(a) Are enrolled in Medicare benefits under part A or B of Title XVIII of the Act; or

(b) Are receiving other healthcare coverage that qualifies as Minimum Essential Coverage as defined in OAR 410-200-0015(55), unless that coverage is an Insurance Affordability Program as defined in OAR 410-200-0015(50); or

(c) Are able to access affordable coverage as described in section 36B(c)(2)(C)(i)(II) of the IRS Code and 26 CFR section1.36B–2(c)(3)(v)(A)(1). The required contribution percentage is indexed annually under section 26 U.S.C. 36B(c)(2)(C)(iv); or

(d) Are receiving Supplemental Security Income (SSI) benefits.

(4) OHP Bridge – Basic Health Program eligibility is re-evaluated every twelve (12) months.

(5) An individual who is approved for OHP Bridge – Basic Health Program coverage is entitled to twelve (12) months of coverage provided they continue to meet non-financial eligibility criteria. Once approved, an individual's OHP Bridge – Basic Health Program coverage shall not be terminated during a twelve (12) month eligibility period due to an increase of countable income.

STATUTORY/OTHER AUTHORITY: ORS 411.402, 411.404, 413.042, 414.241, 414.534, 42 CFR 433.138, 433.145-433.148, 435.3-435.4, 435.110, 435.115-435.119, 435.190, 435.222, 435.403, 435.406-435.407, 435.608, 435.610, 435.916-435.917, 435.940, 435.952, 435.956, 435.1008, 435.1200, 435.1205, 447.56, 457.80, 457.320, 457.340, 457.350, 457.360, 457.380, 457.805, 458.350, 435.112, 435.170

STATUTES/OTHER IMPLEMENTED: ORS 411.402, 411.404, 414.241, ORS 411.060, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706, 411.095, 411.400