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PERMANENT ADMINISTRATIVE ORDER

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

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FILING CAPTION: Oregon's transition from using the Federally Facilitated Marketplace to a State-Based Marketplace

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RULES:
410-200-0015, 410-200-0100, 410-200-0110, 410-200-0230

AMEND: 410-200-0015

RULE TITLE: General Definitions

NOTICE FILED DATE: 08/11/2026

RULE SUMMARY: Specified coverage year differentiation between Federally Facilitated Marketplace (FFM) and State-Based Marketplace (SBM), added SBM, formatting corrections.

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) Assumed Eligible Newborn (AEN) "means (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, the Federally Facilitated Marketplace (FFM), or the State-Based Marketplace (SBM).
(8) "Application" means:
(a) The single streamlined application for all insurance affordability programs developed by the Authority, the FFM, or the SBM; 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) Advance payments of the premium tax credit (APTC), 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) Behavior Rehabilitation Services (BRS) means a program that provides services and placement-related activities to the BRS client to address their debilitating psychosocial, emotional, and behavioral disorders in a community placement utilizing either a residential care model or a proctor care model (OAR 410-170-0020).
(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 biological relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.
(B) Step-parent and step-siblings.
(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) Citizenship Waived Medical (CWM) 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) Citizenship Waived Medical Plus (CMW 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, 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 (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, the FFM, or the SBM 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, the SBM, 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. The following are types of decision notices:
(a) “Basic decision notice” which is mailed no later than the date of action given in the notice;
(b) “Combined decision notice” which informs an individual or multiple family members of a household of the eligibility decision made for each of the medical assistance programs;
(c) “Timely continuing benefit decision notice” which 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 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, CHIP, and OHP Bridge-Basic Health Program eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority, the FFM, or the SBM appeals process.
(38) “Electronic application” means an application electronically signed and submitted through the Internet.
(39) “Eligibility determination” means an approval, denial, 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 Oregon Department of Human Services 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, except when the eligibility decision is made through a Hospital Presumptive Eligibility determination (OAR 410-200-0105), including:
(a) Extended Medical Assistance (EXT);
(b) Substitute Care;
(c) Breast and Cervical Cancer Treatment Program (BCCTP);
(d) Former Foster Care Youth Medical (FFCYM);
(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) OHP Bridge -Basic Medicaid; and
(G) Young Adults with Special Health Care Needs (YSHCN).
(48) "Healthier Oregon" is defined in OAR 410-120-0000(131).
(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, FFM, or SBM decision or action.
(50) "Insurance affordability program" means one of the following programs:
(a) Medicaid;
(b) CHIP;
(c) A program that makes coverage available in a qualified health plan through the FFM or SBM 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 or SBM with cost-sharing reductions established under section 1402 of the Affordable Care Act.
(51) "Legal argument" has the meaning given in OAR 137-003-0008(c).
(52) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.
(53) Modified Adjusted Gross Income (MAGI) has the meaning defined in OAR 410-200-0310(4) and is used in determining eligibility based on annual income. 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) Oregon Supplemental Income Program Medical (OSIPM) means 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) "Psychiatric Residential Treatment Facility (PRTF) means a facility that is a structured residential treatment environment with daily 24-hour supervision and active psychiatric treatment including Psychiatric Residential Treatment Services (PRTS), Secure Children's Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute Psychiatric Treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.
(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, 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) "State-Based Marketplace (SBM)" means the online marketplace operated by the Oregon Health Authority's Oregon Health Insurance Marketplace which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The SBM also performs eligibility assessments for Oregon Medicaid, CHIP, and OHP Bridge-Basic Health Program and refers to the Oregon Department of Human Services electronic accounts of individuals who are found potentially eligible.
(76) "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.
(77) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).
(78) "Young Adults with Special Health Care Needs" or "YSHCN" means a program for young adults who meet pre-determined social and clinical criteria, which provides supplementary benefits, in addition to OHP Plus coverage, including EPSDT, HRSN services, and extended vision and dental services.

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, the Federally Facilitated Marketplace (FFM), and the State-Based Marketplace (SBM)

NOTICE FILED DATE: 08/11/2026

RULE SUMMARY: Update rule title, spell outed acronyms, grammar corrections, capitalize defined terms, addition of State-Based Marketplace and distinction between coverage years

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), the FFM, and the SBM. 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 Health Systems Division (HSD) Medical Programs, the Agency, consistent with the timeliness standards described in OAR 410-200-0110, shall:
(a) Determine eligibility for MAGI Medicaid/CHIP and OHP Bridge-Basic Health Program 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 for coverage year 2026 or to the SBM for coverage year 2027 or later.
(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 and the SBM;
(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: 410-200-0110

RULE TITLE: Application and Renewal Processing and Timeliness Standards

NOTICE FILED DATE: 08/11/2026

RULE SUMMARY: Specified coverage year differentiation between Federally Facilitated Marketplace (FFM) and State-Based Marketplace (SBM), added SBM, formatting corrections, capitalize defined terms, spell out acronyms

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, the Federally Facilitated Marketplace (FFM) through coverage year 2026, or the State-Based Marketplace (SBM) for coverage years 2027 and later using a single streamlined Application;
(b) An Application may be submitted via the Internet, the FFM, the SBM, 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; and
(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 Health Systems Division

(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 Eligibility Determination Group (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 Request For Information (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 Federal Data Services Hub (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 or the SBM. If the FFM or SBM determines the individual is potentially eligible for Medicaid/CHIP or OHP Bridge-Basic Health Program, the FFM or SBM shall transfer the individual's electronic account to the Oregon Department of Human Services for an eligibility determination.
(8) HSD Medical Program eligibility is evaluated in the following order:
(a) For a Child Applicant:
(A) Substitute Care (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) YSHCN (OAR 410-200-0455);
(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: 410-200-0230

RULE TITLE: Verification

NOTICE FILED DATE: 08/11/2026

RULE SUMMARY: Specified coverage year differentiation between Federally Facilitated Marketplace (FFM) and State-Based Marketplace (SBM), added SBM, formatting corrections

RULE TEXT:
(1) Applicants, beneficiaries, or an individual authorized to act on their behalf shall attest to the following information:
(a) Age and date of birth;
(b) Application for other benefits;
(c) Caretaker relative status;
(d) Household composition;
(e) Legal name;
(f) Medicare;
(g) Pregnancy;
(h) Receipt or availability of other healthcare coverage;
(i) Residency;
(j) Social Security number; and
(k) American Indian/Alaska Native status.
(2) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of US citizenship, US national, or non-citizen status;
(a) Self-attested information shall be verified via the federal data services hub (FDSH) or by electronic verification source available to the Agency;
(b) In the event that attested status cannot be verified via the FDSH or by electronic verification sources available to the Agency, self-attested information shall be used to determine eligibility, and the individual provided a reasonable opportunity period to provide verification of US citizen, US national, or non-citizen status as outlined in section (e) of this part. Exceptions to this verification requirement are described in sections (c) and (d) of this part
(c) Applicants or beneficiaries attesting to US citizenship are exempt from the requirement to verify their citizenship if they are one of the following:
(A) Individuals who are assumed eligible (OAR 410-200-0135);
(B) Individuals who are entitled to or enrolled in Medicare;
(C) Individuals who are presumptively eligible for the BCCTP program through the BCCTP screening program or through the Hospital Presumptive Eligibility process (OAR 420-200-0400 and 410-200-0105);
(D) Individuals receiving Social Security Disability Income (SSDI); or
(E) Individuals whose citizen status was previously documented by the Agency. The Agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility or subsequent application following a break in coverage.
(d) Applicants or beneficiaries age 19 and older who attest to having an immigration status that is not a qualified non-citizen status (see OAR 410-200-0215(2)) are exempt from the requirement to verify non-citizen status;
(e) US Citizen, US National, and Non-citizen status verification guidelines:
(A) Individuals attesting to US citizenship shall verify their status by submitting any of the documents permitted under section 1903(x) of the Social Security Act (42 U.S.C. 1396b);
(B) Individuals attesting to non-citizen status shall verify their status by:
(i) Submitting documentation or other proof from the Immigration and Naturalization Service which contains the individual's U.S. Citizenship and Immigrations Services (USCIS) number (or numbers if the individual has more than one number); or
(ii) Submitting other documents the State determines constitutes reasonable evidence indicating a satisfactory

immigration status.
(C) Non-citizens who attest to having no immigration status shall not be required to verify.
(f) For individuals with a qualified non-citizen status (see OAR 410-200-0215(2)), the Agency shall not require verification of the following unless questionable:
(A) Attestation to being continuously present in the U.S. since August 22, 1996;
(B) Attestation to being an honorably discharged veteran or in active military duty status; and
(C) Attestation to being the spouse or unmarried dependent child of an individual identified in subsection (B) of this part.
(g) Non-citizen status shall be reviewed and verified at the following times:
(A) Initial determination of eligibility;
(B) When a report of change of non-citizen status is received by the Agency.
(3) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of income:
(a) If the attested income exceeds the threshold that would produce eligibility for all EDG members, the Authority shall accept the attested information, deny HSD Medical Programs, and refer to the Federally Facilitated Marketplace (FFM) for coverage year 2026 or the State-Based Marketplace (SBM) for coverage years 2027 or later for potential APTC eligibility;
(b) Attested income that would result in eligibility for one or more EDG members is compared to documentary evidence through a match with the FDSH or electronic verification sources available to the Agency. The attestation is considered reasonably compatible, and thus does not require further verification if:
(A) Income information obtained via FDSH or other available electronic verification sources is not discrepant by more than 10% when compared to the attestation; or
(B) Both the attested income and information obtained via FDSH or other available electronic verification sources are within the income threshold for the same HSD Medical Program.
(c) In the event that attested income is not reasonably compatible with information obtained via the FDSH or electronic verification sources available to the agency, prior to the determination of eligibility the agency will:
(A) Request documentary verification of income from the individual; or
(B) If the individual cannot obtain verification of income, a reasonable explanation as to why.
(4) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of receipt of private health insurance:
(a) Self-attested information shall be used to determine eligibility for HSD Medical Programs if:
(A) Information obtained through a match with the FDSH or electronic verification sources available to the agency does not conflict with attested information;
(B) Information obtained through a match with available electronic data conflicts with attested information but does not affect eligibility; or
(C) Verification is not available via a match with available electronic data or by any other method at the time of application processing.
(b) In the event that information obtained through a match with the FDSH or electronic verification sources available to the agency conflicts with attested information and may affect eligibility, private health insurance information shall be verified prior to eligibility determination.
(5) The Authority may request that applicants and beneficiaries of medical assistance provide additional information, including documentation, to verify most eligibility criteria if attested information is questionable or a discrepancy is identified.

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

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