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

FILING CAPTION: HSD Medical Program Eligibility For Residents Of Public Institutions; References To Newly-Created Programs

EFFECTIVE DATE: 04/01/2023

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RULES:
410-200-0015, 410-200-0110, 410-200-0120, 410-200-0140, 410-200-0235

AMEND: 410-200-0015

NOTICE FILED DATE: 02/10/2023

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

CHANGES TO RULE:

410-200-0015
General Definitions ¶

~~General Definitions~~¶
(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.¶
(2) "Active renewal" means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.¶
(3) "Address Confidentiality Program (ACP)" means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.¶
(4) "AEN" means Assumed Eligible Newborn (OAR 410-200-0115).¶
(5) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).¶
(6) "Agency" means the Oregon Health Authority and Department of Human Services.¶
(7) "Applicant" means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.¶

(8) "Application" means:¶
(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or¶
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.¶
(9) "APTC" means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.¶
(10) "Assumed eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.¶
(11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).¶
(12) "Automated renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.¶
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disability medical program benefits, or APTC.¶
(14) "BRS" means Behavior Rehabilitation Services.¶
(15) "Budget month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.¶
(16) "Caretaker" means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child's care.¶
(17) "Caretaker relative" means an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:¶
(a) A relative of the dependent child, as follows:¶
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.¶
(B) Stepfather, stepmother, stepbrother, and stepsister.¶
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.¶
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;¶
(18) "CWM" means Citizenship Waived Medical, which is Medicaid coverage for emergency medical needs (OAR 410-134-0003(1)) for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do not meet citizenship and/or non-citizen status requirements (OAR 410-200-0240).¶
(19) "CWM Plus" means medical services for pregnant CWM beneficiaries (OAR 410-200-0240) and includes:¶
(a) CWM Plus coverage (OAR 410-134-0003(3)) for the duration of the individual's pregnancy; and¶
(b) Reproductive Health Equity Act (RHEA) coverage (OAR 410-134-0003(4)) through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.¶
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.¶
(21) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.¶
(22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.¶
(23) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.¶
(24) "Claimant" means an individual who has requested a hearing or appeal.¶
(25) "Code" means Internal Revenue Code.¶
(26) "Combined Eligibility Notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the HSD Medical Programs for which a determination or denial was made by the Authority.¶
(27) "Community partner" means an individual affiliated with a contracted organization who is trained and certified by the Community Partner Outreach Program to provide free assistance to Oregonians with health coverage application and enrollment.¶
(28) "Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of

eligibility.¶
(29) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:¶
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or¶
(b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.¶
(30) "Cover All Kids" refers to the OHP Plus-equivalent benefit (OAR 410-134-0003(5)) provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP, except they do not meet the citizen and non-citizen status requirements (OAR 410-200-0240).¶
(31) "Date of Request" (DOR) means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.¶
(a) For new applicants, the DOR is established as follows:¶
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or¶
(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.¶
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:¶
(A) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility;¶
(B) The month an individual ages off a medical program.¶
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or¶
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.¶
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.¶
(32) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a:¶
(a) "Basic decision notice" mailed no later than:¶
(A) The date of action given in the notice; or¶
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.¶
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;¶
(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.¶
(33) "Department" means the Department of Human Services.¶
(34) "Dependent child" means an individual who:¶
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before attaining age 19.¶
(b) Lives in the home of the parent or caretaker relative; and¶
(c) Is not absent from the home for more than 30 days due to being in foster care while foster care payments are being made.¶
(35) "ELA" (Express Lane Agency)" means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.¶
(36) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.¶
(37) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.¶
(38) "Electronic application" means an application electronically signed and submitted through the Internet.¶
(39) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.¶
(40) "Eligibility Determination Group" (EDG) means all persons whose financial and non-financial information is

considered in determining each medical applicant's eligibility as defined in OAR 410-200-0305.¶
(41) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Agency's receipt of a hearing request, unless the claimant requests more time.¶
(42) "Family Size" means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the EDG and each unborn child of any pregnant members of the EDG.¶
(43) "Federal Data Services Hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.¶
(44) "Federal Poverty Level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).¶
(45) "Federally Facilitated Marketplace" also called "FFM" means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.¶
(46) "Head of household" (HOH) means the primary person the Agency shall communicate with and:¶
(a) Is listed as the case name; or¶
(b) Is the individual named as the primary contact on the application.¶
(47) "Health Systems Division Medical Programs" means all programs under the Health Systems Division including:¶
(a) "EXT" means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;¶
(b) "Substitute Care" means medical coverage for children in BRS or PRTF;¶
(c) "BCCTP" means Breast and Cervical Cancer Treatment Program;¶
(d) "FFCYM" means Former Foster Care Youth Medical;¶
(e) "MAGI Medicaid/CHIP" means HSD Medical Programs for which eligibility is based on MAGI methodology, including:¶
(A) MAGI Child;¶
(B) MAGI Parent or Caretaker Relative;¶
(C) MAGI Pregnant Woman;¶
(D) MAGI Children's Health Insurance Program (CHIP);¶
(E) MAGI Adult;¶
(F) MAGI Expanded Adult.¶
(48) "Healthier Oregon Program (HOP)" means an OHP Plus-equivalent benefit (OAR 410-134-0003(5) through (7)) for individuals described in OAR 410-200-0240.¶
(49) "Hearing request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.¶
(50) ~~"Inmate" means:¶~~
~~(a) An individual residing in a public institution that is:¶~~
~~(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;¶~~
~~(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;¶~~
~~(C) Residing involuntarily in a facility that is under governmental control; or¶~~
~~(D) Receiving care as an outpatient while residing involuntarily in a public institution.¶~~
~~(b) An individual is not considered an inmate when the individual is:¶~~
~~(A) Released on parole, probation, or post-prison supervision;¶~~
~~(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;¶~~
~~(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:¶~~
~~(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or¶~~
~~(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to~~

~~another medical or extended care facility and does not actually stay in the medical institution for 24 hours.¶~~
~~(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual¶~~
~~(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶~~
~~(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶~~
~~(i) Is under age 21;¶~~
~~(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶~~
~~(iii) Is age 65 or older.¶~~
~~(51)~~ "Insurance affordability program" means a program that is one of the following:¶
(a) Medicaid;¶
(b) CHIP;¶
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;¶
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.¶
(5~~2~~1) "Legal argument" has the meaning given that term in OAR 137-003-0008(c).¶
(5~~3~~2) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.¶
(5~~4~~3) "MAGI" means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in OAR 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:¶
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:¶
(A) Children, regardless of age, who are included in the household of a parent;¶
(B) Tax dependents.¶
(b) In applying subsection (a) of this section, IRC 6012(a) (1) is used to determine who is required to file a tax return.¶
(5~~5~~4) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:¶
(a) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received;¶
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;¶
(c) Income from the following American Indian and Alaska Native sources is excluded:¶
(A) Distributions from Alaska Native Corporations and Settlement Trusts;¶
(B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;¶
(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:¶
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this section; or¶
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.¶
(D) Distributions resulting from real property ownership interests related to natural resources and improvements:¶
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or¶
(ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests.¶
(E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;¶
(F) Student financial assistance provided under the Bureau of Indian Affairs education programs.¶
(5~~6~~5) "Minimum Essential Coverage" (MEC) means medical coverage under:¶
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;¶
(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;¶
(c) Plans in the individual market;¶
(d) Health insurance plans in place on or before March 23, 2010; and¶
(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.¶

(5~~7~~6) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.¶
(5~~8~~7) "Non-citizen" means any individual who is not a citizen or national of the United States as defined at 8 U.S.C. 1101(a)(22).¶
(5~~9~~8) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.¶
(~~60~~59) "Parent" means a natural or biological, adopted, or stepparent.¶
(6~~1~~0) "Personal Injury" means a physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.¶
(6~~2~~1) "Primary Contact" has the same meaning given "head of household" in this rule.¶
(6~~3~~2) "PRTF" means Psychiatric Residential Treatment Facility.¶
(6~~4~~3) "Public institution" means any of the following:¶
(a) A state hospital (ORS 162.135);¶
(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;¶
(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;¶
(d) A youth correction facility (ORS 162.135):¶
(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or¶
(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order.¶
(e) As used in this rule, the term public institution does not include:¶
(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);¶
(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or¶
(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.¶
(6~~5~~4) "Qualified hospital" means a hospital that:¶
(a) Participates as an enrolled Oregon Medicaid provider;¶
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;¶
(c) Agrees to make determinations consistent with Authority policies and procedures;¶
(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and¶
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR 435.1110(d).¶
(6~~6~~5) "Reasonable opportunity period:"¶
(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;¶
(b) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows they did not receive the notice within the five-day period;¶
(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.¶
(6~~7~~6) "Redetermination" means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.¶
(6~~8~~7) "Renewal" means a regularly scheduled periodic review of eligibility.¶
(6~~9~~8) "Request for information (RFI)" means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.¶
(69) "Resident of a Public Institution" means:¶
(a) An individual residing in a public institution that is:¶
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;¶
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;¶

(C) Residing involuntarily in a facility that is under governmental control; or¶
(D) Receiving care as an outpatient while residing involuntarily in a public institution.¶
(b) An individual is not considered a resident of a public institution when the individual is:¶
(A) Released on parole, probation, or post-prison supervision;¶
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;¶
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is a resident. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:¶
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or¶
(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.¶
(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual¶
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶
(i) Is under age 21;¶
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶
(iii) Is age 65 or older.¶
(70) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.¶
(71) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.¶
(72) "Sibling" means natural or biological, adopted, or half or step sibling.¶
(73) "Spouse" means an individual who is legally married to another individual under:¶
(a) The statutes of the state where the marriage occurred;¶
(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or¶
(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.¶
(74) "SSA" means Social Security Administration.¶
(75) "Tax dependent" has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.¶
(76) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. □□ 671-679b).
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706

AMEND: 410-200-0110

NOTICE FILED DATE: 02/10/2023

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

CHANGES TO RULE:

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

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

(D) MAGI Child (OAR 410-200-0415);¶
(E) E~~XT~~xtended 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) BCCTP (OAR 410-200-040~~F) MAGI Expanded Adult (OAR 410-200-0436);¶
(G) BCCTP (OAR 410-200-0400);¶
(H) Compact of Free Association (COFA) Dental (OAR 410-200-0445);¶
(I) Veteran Dental (OAR 410-200-0450).
Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0120

NOTICE FILED DATE: 02/10/2023

RULE SUMMARY: Updates text reference of “inmate” to “resident of a public institution”.

CHANGES TO RULE:

410-200-0120
Notices ¶

(1) Except as provided in this rule, the Authority shall send:¶
(a) A basic decision notice whenever an application for HSD Medical Program benefits is approved or denied;¶
(b) A timely continuing benefit decision notice whenever HSD Medical Program benefits are reduced or closed.¶
(2) Exceptions to the requirement to provide timely continuing decision notice when HSD Medical Program benefits are reduced or closed:¶
(a) When a beneficiary becomes ~~an inmate~~ resident of a public institution or ~~a~~ correctional facility, the Agency shall send a basic decision notice to close, reduce, or suspend benefits;¶
(b) When a beneficiary has been placed in skilled nursing care, intermediate care, or long-term hospitalization, the Agency shall send a basic decision notice to close, suspend, or reduce benefits;¶
(c) When returned postal mail is received without a forwarding address and the beneficiary's whereabouts are unknown, the Authority shall send a basic decision notice to end benefits.¶
(d) When a beneficiary ceases to be an Oregon Resident and the Agency is informed that they're eligible for medical benefits in another state, the Agency shall send a basic decision notice to end benefits;¶
(e) When a beneficiary, another adult member of the EDG, or the authorized representative requests benefits be closed, and the request includes a written or recorded verbal signature, the Agency shall send a basic decision notice to end benefits;¶
(f) When an individual who is not a recipient of any Medicaid/CHIP benefits makes a request to withdraw an application for benefits, the Agency shall send a basic decision notice.¶
(3) No decision notice is required in the following situations:¶
(a) The only individual in the EDG dies;¶
(b) A hearing was requested after a notice was received and either the hearing request is dismissed, or a final order is issued.¶
(4) Decision notices shall be written in plain language and be accessible to individuals who are limited English proficient and individuals with disabilities.¶
(5) All decision notices shall include:¶
(a) A statement of the action taken;¶
(b) A clear statement listing the specific reasons why the decision was made and the effective date of the decision;¶
(c) Rules supporting the action;¶
(d) Information about the individual's right to request a hearing and the method and deadline to request a hearing;¶
(e) A statement indicating under what circumstances a default order may be taken;¶
(f) Information about the right to counsel at a hearing and the availability of free legal services.¶
(6) A decision notice approving HSD Medical Program benefits, including approvals for retroactive medical, shall include:¶
(a) The level of benefits and services approved;¶
(b) If applicable, information relating to premiums, enrollment fees, and cost sharing; and¶
(c) The changes that must be reported and the process for reporting changes.¶
(7) A decision notice reducing, denying, or closing HSD Medical Program benefits shall include information about a beneficiary's right to continue receiving benefits.¶
(8) When electronic-only is the preferred communication method, and the Agency is unable to successfully deliver an electronic notification, the Agency shall send the notice by postal mail within three business days. The date on the notice shall be the date the notice is sent by postal mail.¶
(9) The Authority may amend:¶
(a) A decision notice with another decision notice; or¶
(b) A contested case notice.¶
(10) Except as the notice is amended, or when a delay results from the client's request for a hearing, a notice to reduce or close benefits becomes void if the reduction or closure is not made effective on the date stated on the notice.¶

(11) The Authority shall provide individuals with a choice to receive decision notices and information referenced in this rule in an electronic format or by postal mail. If an individual chooses to receive notices and information electronically and has established an online account with the Applicant Portal of Oregon Eligibility (ONE), the Authority shall:¶
(a) Send confirmation of this decision by postal mail;¶
(b) Post notices to the individual's electronic account within one business day of the date on the notice;¶
(c) Send an email or SMS text message alerting the individual that a notice has been posted to their electronic account;¶
(d) At the request of the individual, send by postal mail any notice or information delivered electronically;¶
(e) Inform the individual of the right to stop receiving electronic notices and information and begin receiving these through postal mail; and¶
(f) If any electronic communication referenced above is undeliverable, send the notice by postal mail within three business days of the failed communication.
Statutory/Other Authority: ORS 411.402, ORS 411.404, 413.042, 414.534, 42 CFR: 431.213, 435.110, 435.112, 435.115, 435.116, 435.118, 435.940, 435.1200, 458.350, 435.3, 435.4, 435.407, 435.952, 435.1008, 457.320, 435.406, 457.380, 435.117, 435.170, 435.190, 435.916, 435.917, 435.926, 435.1205, 447.56, 457.340, 457.350, 457.360, 457.805, 433.145, 433.147, 433.148, 433.146, 435.610, 435.403, 457.80, 435.119, 435.222, 435.602, 435.608, 435.956, 433.138
Statutes/Other Implemented: ORS 411.404, 414.534, ORS 411.400, 411.402, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.536, 414.706, 411.060, 411.095, 414.440

AMEND: 410-200-0140

NOTICE FILED DATE: 02/10/2023

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

CHANGES TO RULE:

410-200-0140
Eligibility for ~~Inmates~~Residents of a Public Institution ¶

(1) A~~n inmate~~ resident of a public institution is not eligible for Health System Division (HSD) Medical Program benefits, except for individuals residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital, who are:¶
(a) Under age 21;¶
(b) Age 21 if they were admitted to the IMD before their 21st birthday; or¶
(c) Age 65 or older.¶
(2) If an HSD Medical Program beneficiary becomes a~~n inmate~~ resident of a public institution, medical benefits shall be suspended for the duration of the ~~incarceration period.~~ period in which the individual is a resident of that institution.¶
(3) The effective date of the suspension of benefits is the day following the date on which the individual bec~~a~~ome ~~incarcerated.~~ s a resident of a public institution.¶
(4) Suspended benefits shall be re~~stored to the release date~~instated effective the date on which an individual ceases to be a resident of a public institution without the need for a new application when:¶
(a) The ~~individual reports their release to the Agency within ten calendar days of the release date; ¶~~
~~(b) The individual reports their release to the Agency more~~ Agency learns that the individual is no longer a resident of a public institution wit~~h~~ai~~n~~ t~~en~~he 12 calendar ~~days from the release date, and there is good cause for the late reporting~~months following the date on which the change occurred; or¶
(~~c~~b) The in~~mate is released to a medical facility and begins receiving treatment~~dividual leaves the public institution to be admitted to a medical facility as an inpatient with an expected stay of at least 24 hours, providing the facility is not associated with the public institution where the individual ~~wa~~is a~~n inmate.~~ resident.¶
(5) Once benefits are re~~stor~~instated as described in section (4)~~:~~ ¶
~~(a) If the individual~~ of th~~is~~ re~~u~~l~~eased prior to their eligibility renewal date, the eligibility renewal date will be maintained; or ¶~~
~~(b) If the individual is released aft~~, a redetermination of eligibility will be processed unless benefits are restored on a case whe~~r~~e the e~~ligibility~~xisting renewal date ~~has passed, benefits shall be restored and a redetermination of eligibility processed~~is more than two (2) calendar months beyond the month in which the action is being taken.
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049, 414.426

AMEND: 410-200-0235

NOTICE FILED DATE: 02/10/2023

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

CHANGES TO RULE:

410-200-0235
Changes That Must Be Reported ¶

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