OFFICE OF THE SECRETARY OF STATE
LAVONNE GRIFFIN-VALADE
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE
AND TRIBAL LIAISON

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
11/26/2024 12:47 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 138-2024
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Young Adults with Special Health Care Needs.

EFFECTIVE DATE: 01/01/2025

AGENCY APPROVED DATE: 11/26/2024

CONTACT: Martha Martinez-Camacho
503-559-0830
hsd.rules@oha.oregon.gov

500 Summer Street NE
Salem,OR 97301

Filed By:
Martha Martinez-Camacho
Rules Coordinator

RULES:
410-120-0000, 410-120-1210, 410-122-0080, 410-141-3500, 410-151-0001, 410-200-0015, 410-200-0105, 410-200-0110, 410-200-0135, 410-200-0140, 410-200-0205, 410-200-0315, 410-200-0455

AMEND: 410-120-0000

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines Medicaid Terms, including YSHCN.

CHANGES TO RULE:

410-120-0000
Acronyms and Definitions ¶

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance programs. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program, (i) OAR 410-141-3500 Acronyms and Definitions, (ii) 410-200-0015 General Definitions, and (iii) any appropriate governing acronyms and definitions in the Oregon Department of Human Services (Department) administrative rules set found in chapters 411, 413, or 461 or contact the Division. ¶
(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority. ¶
(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500. ¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board. ¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law. ¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration. ¶

(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶
(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the Oregon Health Plan (OHP) 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶
(10) "Adults and Youths Discharged from an HRSN Eligible Behavioral Health Facility" means Members who have been discharged from one of the settings listed below within the last 365 calendar days. Eligibility for HRSN Services shall expire on the 366th calendar day after discharge.¶
(a) Acute Care Psychiatric Hospitals as defined in OAR 309-015-0005,¶
(b) Institution for Mental Diseases as defined in 42 CFR 435.1010,¶
(c) Integrated Psychiatric Residential Treatment Facilities and Residential Substance Use Disorders Treatment Programs as defined in OAR 309-022-0105,¶
(d) Residential Treatment Facilities (RTF) as defined in OAR 309-035-0105,¶
(e) Residential Treatment Homes (RTH) as defined in OAR 309-035-0105,¶
(f) Secure Residential Treatment Facilities (SRTF), as defined in OAR 309-035-0105,¶
(g) Psychiatric Residential Treatment Facilities (PRTF) as defined in OAR 309-022-0105, and¶
(h) Residential Substance Use Disorders Treatment Programs as defined in OAR 309-018-0105¶
(11) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections or tribal correctional facilities. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.¶
(12) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(13) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
(14) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(15) "Affiliation" means for provider requesting enrollment or revalidation as an Oregon Medicaid provider any of the following:¶
(a) Five (5) percent or greater direct or indirect ownership interest that an individual or entity has in another organization;¶
(b) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;¶
(c) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; includes sole proprietorships;¶
(d) An interest in which an individual is acting as an officer or director of a corporation; or¶
(e) Any payment assignment relationship under 42 CFR 447.10(g).¶
(16) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.¶
(17) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(18) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶
(19) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, Area Agencies on Aging (AAAs), and federally recognized American Indian tribes).¶
(20) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with a Managed Care Entity (MCE), including urgent care centers, hospice, birthing centers, out-placed

medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶
(21) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(22) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶
(23) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
(24) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶
(25) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶
(26) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(27) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(28) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
(29) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶
(30) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.¶
(31) "At Risk of Homelessness" means a Member who:¶
(a) Has an income that is 30 percent or less than the area median income where the individual resides according to the most recent available data from the U.S. Department of Housing and Urban Development; and,¶
(b) Lacks sufficient resources or support networks to prevent their homelessness; and,¶
(c) Meets any HRSN Housing and Nutrition Clinical Risk Factor as further defined in OAR 410-120-2005 in Table 2.¶
(32) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(33) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(34) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶
(35) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.¶
(36) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(37) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(38) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(39) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
(40) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(41) "Benefit Package" means the package of covered health care services for which the client is eligible.¶

(42) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶
(43) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
(44) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(45) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.¶
(46) "Care Coordination" means the act and responsibility of care coordination entities to deliberately organize culturally and linguistically appropriate member services, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health-Related Social Needs and Social Determinants of Health and Equity) of the member.¶
(47) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶
(48) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶
(49) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(50) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶
(51) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(52) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(53) "Citizenship Waived Medical (CWM) Benefit Package" means the coverage and limitations defined in OAR 410-134-0005(2) for individuals who met the eligibility requirements in OAR 410-200-0240(1).¶
(54) "Citizenship Waived Medical Plus (CWX) Benefit Package" means coverage and limitations described in OAR 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in OAR 410-200-0240(2).¶
(55) "Claimant" means an individual who has requested a hearing.¶
(56) "Client" means an individual found eligible to receive OHP health services.¶
(57) "Climate-Related Supports" means climate-related devices and services provided to HRSN- Authorized Members for whom such equipment and support are Clinically Appropriate as a component of health services treatment or prevention as detailed in OAR 410-120-2005.¶
(a) Clinically Appropriate climate-related devices include:¶
(A) Air conditioners for individuals at health risk due to significant heat;¶
(B) Heaters for individuals at increased health risk due to significant cold;¶
(C) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;¶
(D) Mini refrigeration units as needed for individuals for medication storage; and¶
(E) Portable power supplies (PPSs) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.¶
(b) Climate-Related Support services include, as may be needed by the Member, the provision and service delivery, and, as needed, installation of all the climate-related devices (identified (a)(A)- (E) above of this rule) and device maintenance.¶
(c) Ensuring safe utilization may also include an attestation from the Member that they can safely and legally install the device in their primary, non-institutional, non-congregate place of residence.¶
(d) Climate devices may stay with the Member in instances when a Member moves to a different housing setting, so long as the Member remains eligible. Members may also receive replacement devices as needed, so long as the Member remains eligible and total cost remains below the allowable max.¶

(58) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
(59) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(60) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(61) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor, each of which must be applicable to the HRSN Service for which the Member is authorized. For example, to determine if a Member shall be authorized to receive Climate-Related Supports, the member must, in addition to belonging to an HRSN Covered Population, have at least one HRSN Clinical Risk Factor and one HRSN Social Risk Factor. HRSN Services are not Clinically Appropriate if they are solely for the convenience or preference of the Member.¶
(62) "Closed Loop Referral" means the process of exchanging information between and among an MCE, the Oregon Health Authority (which may include its Fee For Service (FFS) Program), a Member, HRSN Service Providers, and other similar organizations, to make referrals and communicate about the status of referrals and services for a Member.¶
(63) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(64) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they require;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(65) "Community Information Exchange" and "CIE" each means a technology system used by a network of collaborative partners to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.¶
(66) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
(67) "Community Partner" means an individual affiliated with an organization contracted, trained, and certified by the Oregon Health Authority's Community Partner Outreach Program to provide free assistance to people applying for health coverage in Oregon that includes but is not limited to:¶
(a) Health coverage application;¶
(b) Help to enroll in health insurance plans;¶
(c) Health coverage renewal assistance;¶
(d) Healthcare System Navigation defined in OAR 410-120-0000; and¶
(e) Outreach and engagement related to subsections (a) through (d) of this section (6).¶
(68) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(69) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(70) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an

adverse benefit determination: ¶
(a) A client or member or their representative; ¶
(b) A member of an MCE after resolution of the MCE's appeal process; ¶
(c) An MCE member's provider; or ¶
(d) An MCE. ¶
(71) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon. ¶
(72) "Contiguous Area Provider" means a provider practicing in a contiguous area. ¶
(73) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment. ¶
(74) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21). ¶
(75) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.) ¶
(76) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client. ¶
(77) "Cover All Kids (CAK)" meaning defined in OAR 410-200-0015. ¶
(78) "Covered Services" means medically necessary and appropriate health services and items described in ORS chapter 414 and applicable administrative rules. Covered services include: ¶
(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature; ¶
(b) Ancillary Services OAR 410-120-0000 (22); ¶
(c) Diagnostic Services OAR 410-120-0000 (82); ¶
(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and ¶
(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 division 151. ¶
(79) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association. ¶
(80) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers. ¶
(81) "Credible Allegation of Fraud" means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis. ¶
(82) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN. ¶
(83) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped. ¶
(84) "Deactivation" means an action prohibiting a provider's participation where the Authority assigned provider number is terminated as the result of inactivity, as evidenced by failure to submit claims for eighteen (18) months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier. ¶
(85) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions. ¶
(86) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth. ¶
(87) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law. ¶
(88) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government. ¶
(89) "Denturist" means an individual licensed to practice denture technology pursuant to state law. ¶
(90) "Denturist Services" means services provided within the scope of practice as defined under state law by or

under the personal supervision of a denturist.¶
(91) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(92) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶
(93) "Dentally Appropriate"¶
(a) means dental services, items or dental supplies that are:¶
(A) Recommended by a licensed health provider practicing within the scope of their license; and¶
(B) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
(C) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶
(D) The most cost effective of the alternative levels or types of health services, items or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement.¶
(b) All covered services must be dentally appropriate for the member or client but not all medically appropriate services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410, division 151.¶
(94) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS chapter 409, including such divisions, programs and offices as may be established therein.¶
(95) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(96) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(97) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(98) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶
(99) "Dietitian" means an individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, chapter 834, division 60 (OAR 834-060-0000).¶
(100) "Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(101) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom-built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(102) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program requiring specific coverage for children and young adults, as described in chapter 410 division 151.¶
(103) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(104) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶
(105) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶
(106) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶
(107) "Emergency Health Benefit Funding" means funding for the health benefits defined in OAR 410-134-0004(2)(a-j), included in the Healthier Oregon benefits package that is in part funded with state funding and matched with federal funds (42 CFR 440.255).¶

(108) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. ¶
(109) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available. ¶
(110) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility. ¶
(111) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings. ¶
(112) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an overpayment. ¶
(113) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size. ¶
(114) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that: ¶
(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program; ¶
(b) Is qualified to participate in 340B discount purchasing as an HTC; ¶
(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website; ¶
(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and ¶
(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders. ¶
(115) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service. ¶
(116) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO. ¶
(117) "For Cause Termination" means a mandatory or discretionary termination by the Authority as is outlined in OAR 410-120-1400. ¶
(118) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. ¶
(119) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare

clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶
(120) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(121) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶
(122) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(123) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.¶
(124) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The Division uses HCPCS codes; however, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.¶
(125) "Healthcare System Navigation" means the process by which a Community Partner supports individuals who are in need of health care by:¶
(a) Assisting with application for or renewal of Oregon Health Plan (OHP);¶
(b) Assisting with the management of the application process for OHP;¶
(c) Assisting with accessing available benefits;¶
(d) Identifying and removing barriers to care;¶
(e) Providing the information needed to build the knowledge and confidence necessary for utilizing benefits; or¶
(f) Promoting the establishment of healthcare services and continuity of care.¶
(126) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶
(127) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶
(128) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶
(129) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶
(130) "Healthier Oregon" means the medical assistance benefit package that is equal to the OHP Plus benefit package defined in OAR 410-120-1210. The Healthier Oregon is for individuals;¶
(a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and OAR 461-120-0110; and¶
(b) Who do meet the financial and other non-financial eligibility requirements for a Health Systems Division (HSD) Medical Program (see OAR chapter 410 division 200) or an Oregon Supplemental Income Program Medical (OSIPM) Program (see OAR chapter 461).¶
(131) "Health-Related Social Needs" and "HRSN" each means the unmet climate, housing, nutrition, and outreach and engagement-related social needs, that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶
(132) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶
(133) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶
(134) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶
(135) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a

visiting basis in a place of residence used as the client's home. ¶
(136) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules. ¶
(137) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules. ¶
(138) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division. ¶
(139) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state. ¶
(140) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division. ¶
(141) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate). ¶
(142) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division. ¶
(143) "Housing-Related Supports" means housing services provided to eligible Members to help them maintain healthy and safe housing (as detailed in OAR 410-120-2005). Housing-Related Supports include: ¶
(a) Rent and Utility Costs ¶
(b) Hotel/Motel Stays ¶
(c) Utilities Arrears ¶
(d) Utilities Set Up ¶
(e) Storage Fees ¶
(f) Tenancy Services (paid via 15-minute increments) ¶
(g) Tenancy Services (paid per member per month) ¶
(h) Home Modifications ¶
(i) Home Remediations ¶
(144) "HRSN Authorized Member" means a Member who has participated in an HRSN Eligibility Screening and has been approved by the MCE or, as applicable, the Authority, to receive one or more HRSN Services. ¶
(145) "HRSN Clinical Risk Factor" is the generic term to describe the clinical risk a Member must have in order to be eligible for an HRSN service. All HRSN Clinical Risk Factors are identified in OAR 410-120-2005 in Tables 1 and 2. ¶
(146) "HRSN Connector" means any person or entity, including HRSN Service Providers and other similar social service organizations, that assists Members in documenting the information necessary to make an HRSN Request to an MCE for an HRSN Eligibility Screening and HRSN Service authorization. ¶
(147) "HRSN Covered Populations" means Members, excluding Members receiving the BRG service package defined in OAR 410-135-0030, who belong to one or more of the following populations, which are further defined in this OAR 410-120-0000: ¶
(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD); residential mental health and substance use disorder facility, or inpatient psychiatric unit ¶
(b) Adults and Youth Released from Incarceration ¶
(c) Individuals currently or previously involved in Oregon's Child Welfare system ¶
(d) Individuals Transitioning to Dual Medicaid and Medicare Status ¶
(e) Individuals who meet the definition of "HUD Homeless ¶
(f) Individuals who meet the definition of "At Risk of Homelessness" ¶

(g) Individuals identified as "Young Adults with Special Health Care Needs", beginning 2025.¶
(148) "HRSN Eligibility Screening" means the process set out in OAR 410-120-2015, followed by MCEs or, as applicable, the Authority to determine whether a Member meets the criteria necessary for authorizing an HRSN Service.¶
(149) "HRSN Eligible" means a Member, except for Members receiving the BRG service package defined in OAR 410-13~~3~~15-0030, who meets all of the following criteria:¶
(a) Belongs to at least one of the HRSN Covered Populations,¶
(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services,¶
(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services, and¶
(d) Meets any additional eligibility criteria and requirements that may apply to a specific HRSN Service all of which are identified in OAR 410-120-2005.¶
(150) "HRSN Fee Schedule" means the comprehensive list of rates that establishes the maximum allowable reimbursement amount for each HRSN Service. Each service is associated with a unique procedure code and a corresponding procedure code modifier, which are used to correctly identify each service for billing purposes.¶
(151) "HRSN Outreach and Engagement Services (HRSN O&E Services)" means the activities performed by HRSN Service Providers, the Authority, or MCEs as described in OAR 410-120-2005. HRSN Service Providers shall be compensated for providing HRSN O&E Services when provided to "Presumed HRSN Eligible" Members as described in OAR 410-120-2005.¶
(152) "HRSN Person-Centered Service Plan" and "HRSN PCSP" each means the HRSN-related component of the care plan that is developed in consultation with the Member upon authorization of HRSN Services. The HRSN PCSP must be reviewed and revised upon reassessment of need at least every six (6) months, when the Member's circumstances or needs change significantly, or at the request of the Member, while the Member is receiving one or more HRSN Services.¶
(153) "HRSN Self-Attestation" means an oral or written attestation made by the Member or Member Representative that they satisfy the applicable requirements necessary to establish the Member is HRSN Eligible to receive one or more HRSN Services.¶
(154) "HRSN Service Provider" means a private or public social service organization, community organization, or other similar individual or entity that provides HRSN Services.¶
(155) "HRSN Service Request(s)" and "HRSN Request" means a request from an HRSN Connector organization or individual made to an MCE or, as applicable, the Authority, for the purpose of requesting that the MCE, or as applicable, the Authority, perform an HRSN Eligibility Screening. HRSN Requests are comprised of, at minimum, the name and contact information of the individual being recommended and identification of the anticipated HRSN Service need. HRSN Requests may also include confirmation of OHP enrollment, including confirmation of MCE or FFS enrollment, as well as any other information regarding the individual's potential HRSN Eligibility. The MCE or, as applicable, the Authority, shall be required to document its attempts to collect the information needed to determine eligibility.¶
(156) "HRSN Service Vendor" means any individual or entity that is contracted or procured by an MCE or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been approved to receive HRSN Services. Examples of HRSN Service Vendors include, without limitation, entities or individuals that deliver or install air conditioners, heaters, air filtration devices, Portable Power Supply (PPSs) or mini refrigeration units , as well as home modification vendors, landlords, hotels/motels, chore service providers, utilities and moving companies, and pest eradication companies and storage facilities, and organizations that assess Members for, plan, prepare, or deliver Medically Tailored Meals.¶
(157) "HRSN Services" also called "HRSN benefits" means Climate-Related Supports, Housing-Related Supports, Nutrition-Related Supports, and HRSN Outreach and Engagement services that address a Member's Health-Related Social Needs. Additional information regarding the different components of HRSN Services are detailed in OAR 410-120-2005.¶
(158) "HRSN Social Risk Factor" means the need(s) of a Member related to a Health-Related Social Needs service. The HRSN Social Risk Factors are specific to each of the HRSN Services, which are Climate-Related Supports, Housing-Related Supports, Nutrition-Related Supports, and Outreach and Engagement Services. HRSN Social Risk Factors include:¶
(a) HRSN Climate Device Social Risk Factor: A Member who requires a climate device to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor.¶
(b) HRSN Housing-Related Social Risk Factor: A Member who (i) meets the HUD homeless definition as defined in OAR 410-120-0000, or (ii) is at risk of homelessness as defined in OAR 410-120-0000, or (iii) requires a home modification or remediation service to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor.¶
(c) HRSN Nutrition-Related Social Risk Factor: A Member who meets the USDA definition of low food security or very low food security as defined in OAR 410-120-0000.¶
(d) HRSN Outreach and Engagement Social Risk Factor: A Member who requires support to obtain or maintain

connection with benefit programs, services, or supports for basic needs. ¶
(159) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5. ¶
(160) "Eviction" means a tenant has received a Termination Notice, Notice to Evict, a court summons, or documentation of a similar nature, indicating that the tenant is at risk of being evicted from their home. ¶
(161) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). ¶
(162) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation. ¶
(163) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives. ¶
(164) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service. ¶
(165) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5). ¶
(166) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments. ¶
(167) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including Members who are currently or have previously been: ¶
(a) In foster/substitute care; ¶
(b) The recipient of adoption or guardianship assistance; ¶
(c) Served on an in-home plan; or ¶
(d) The subject of an open child welfare case. ¶
(168) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to Fully Dual Eligible as defined in this rule. Members who are Individuals Transitioning to Dual Status shall be included in HRSN Covered Population for the ninety (90) calendar days preceding the date Medicare coverage is to take effect and 270 calendar days after it takes effect. ¶
(169) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.) ¶
(170) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program. ¶
(171) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of thirty (30) days or more. ¶
(172) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases. ¶
(173) "Joint Fair Hearing Request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200. ¶
(174) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA). ¶
(175) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed

practitioner in an office or similar facility, hospital, or independent laboratory. ¶
(176) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division. ¶
(177) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages. ¶
(178) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time. ¶
(179) "Long-term Care or Long-term Services and Supports" ~~(LTSS)~~ means Medicaid funded Long-term care or long-term services and supports services that include: ¶
(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals; ¶
(b) "Long-term Services and Supports" ~~(LTSS)~~ means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization ~~and as~~s defined in OAR chapter 411, Division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined ~~(or defined)~~ in OAR ~~C~~chapter 410, ~~D~~division 172 (Medicaid Payment for Behavioral Health Services). ~~and outlined (or defined) in OAR Chapter 411, Division 4 (Home and Community-Based Services and Settings and Person-Centered Service Planning)~~¶
(180) "Low Food Security" means reduced quality, variety, or desirability of diet; little or no indication of reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here: https://www.ers.usda.gov/media/xxsjnqd1/short2024.pdf ¶
(181) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations. ¶
(182) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO). ¶
(183) "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the provider, whether the provider is an individual, institution, organization or agency. ¶
(184) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules. ¶
(185) "Meaningful access" means client or member-centered access reflecting the following statute and standards: ¶
(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), providers' telemedicine or telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92; ¶
(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and ¶
(c) As applicable to the client or member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx; ¶
(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring. ¶
(186) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority. ¶
(187) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System

(EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶
(188) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).¶
(189) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶
(190) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶
(191) "Medical Transportation" means transportation to or from covered medical services.¶
(192) "Medically Appropriate"¶
(a) Means health services, items, or medical supplies that are:¶
(A) Recommended by a licensed health provider practicing within the scope of their license; and¶
(B) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
(C) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and¶
(D) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.¶
(b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
(193) "Medically Necessary" means:¶
(a) Health services and items that are required to address one or more of the following:¶
(A) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or¶
(B) The client's or member's ability to achieve age-appropriate growth and development; or¶
(C) The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(D) The client's or member's ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice, when they are receiving Long Term Services or Supports (as defined in these rules);¶
(b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.¶
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
(194) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:¶
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and¶
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;¶
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.¶
(195) "Medical Nutrition Therapy means" an evidence-based application of the Nutrition Care Process provided by licensed dietitians; focused on prevention, delay or management of diseases and conditions; and involving an in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)¶
(196) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
(197) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
(198) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.¶
(199) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists

of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes. ¶
(200) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI. ¶
(201) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine. ¶
(202) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine. ¶
(203) "Non-Billing Provider" also referred to as non-payable, means a provider who is issued a provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters, or non-claims-use of the Provider Web Portal (e.g., eligibility verification). ¶
(204) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in: ¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and ¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System; ¶
(c) OAR 410-141-3820 OHP Benefit Package of Covered Services; ¶
(d) OAR 410-141-~~383~~0520 Prioritized List of Health Services;~~¶~~
~~(e) denied prior authorization request is a non covered service;~~ and ¶
(~~f~~e) Any other applicable ~~Oregon Health Authority~~Division administrative rules. ¶
(205) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available. ¶
(206) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists. ¶
(207) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law. ¶
(208) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing. ¶
(209) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005. ¶
(210) "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law. ¶
(211) "Nutrition-Related Supports" means nutrition services provided to Authorized Members starting in 2025 to improve their access to food and health (as detailed in OAR 410-120-2005). Nutrition-Related Supports include the following: ¶
(a) Assessment for Medically Tailored Meals, ¶
(b) Medically Tailored Meals, and ¶
(c) Nutrition Education. ¶
(212) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria. ¶
(213) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy. ¶
(214) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual. ¶
(215) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided. ¶
(216) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued. ¶
(217) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other

low-income populations and Medicaid and CHIP services under the State Plan. ¶
(218) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law. ¶
(219) "Optometrist" means an individual licensed to practice optometry pursuant to state law. ¶
(220) "Oregon Health Authority (Authority)" means the agency established in ORS chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital. ¶
(221) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections. ¶
(222) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon: ¶
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon; ¶
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon. ¶
(223) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125. ¶
(224) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received. ¶
(225) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority. ¶
(226) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful. ¶
(227) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that: ¶
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity; ¶
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; ¶
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; ¶
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; ¶
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or ¶
(f) Is a partner in a disclosing entity that is organized as a partnership. ¶
(228) "Participating provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider. ¶
(229) "Payable Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims directly to the Authority for payment. ¶
(230) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization. ¶
(231) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field. ¶
(232) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience such as (i) addiction to addiction, (ii) mental health condition to mental health condition, or (iii) family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be a self-identified individual: ¶
(a) Currently or formerly receiving addictions or mental health services; ¶
(b) In recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs; ¶
(c) In recovery from problem gambling. ¶
(233) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness. ¶

(234) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.¶
(235) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(236) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶
(237) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(238) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶
(239) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(240) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶
(241) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶
(242) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶
(243) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(244) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶
(245) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(246) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(247) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶
(248) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(249) "Presumed HRSN Eligible" means an OHP Member who, through self-attestation or other information available to the HRSN Service Provider or, as applicable, the Authority or the MCE, is believed to (i) belong to at least one HRSN Covered Population, (ii) have an HRSN Clinical Risk Factor, and (iii) have an HRSN Social Risk Factor. If the Member provides the HRSN Service Provider with self-attestation, the self-attestation does not need to identify the Member's specific HRSN Covered Population or their specific HRSN Clinical Risk Factors. For purposes of making a Presumption of HRSN Eligibility, it is sufficient that the Member attest that they belong to one of the HRSN Covered Populations and have at least one Clinical Risk Factor. However, the Member must attest to the specific HRSN Service need.¶
(250) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(251) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶
(252) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶
(253) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶
(254) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not

in a health care facility. ¶
(255) "Provider" means an individual, facility, institution, corporate entity, or other organization enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified. ¶
(256) "Provider Organization" means a group practice, facility, or organization that is: ¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or ¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or ¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and ¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization; ¶
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.) ¶
(257) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others. ¶
(258) "Public Health Clinic" means a clinic operated by a county government. ¶
(259) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients. ¶
(260) "Public Safety Power Shutoff" and "PSPS" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events, which could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area. ¶
(261) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments. ¶
(262) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage. ¶
(263) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care. ¶
(264) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization. ¶
(265) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility. ¶
(266) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client). ¶
(267) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets). ¶
(268) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments. ¶
(269) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested twenty (20) physical therapy visits and the Division denies the individual's coverage of twenty (20) visits, covering instead only ten (10) visits-this is considered a denial of a service and could be appealed. ¶
(270) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority. ¶
(271) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions. ¶
(272) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf

of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶
(273) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶
(274) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(275) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶
(276) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶
(277) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(278) "Sanction" means an action against providers taken by the Authority in cases of misuse or abuse of Oregon Health Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.¶
(279) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶
(280) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(281) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶
(282) "Service location" means the location of a provider when services are rendered.¶
(283) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶
(284) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(285) "Special Health Care Needs" (SCHCN)" means individuals of any age who experience or exhibit signs of developing;¶
(a) Physical, functional, intellectual or developmental disabilities; or¶
(b) Long-standing or chronic medical condition(s); or¶
(c) Complex behavioral health conditions, including "Substance Use Disorders" or "Serious and Persistent Mental Illness;" or¶
(d) Live with other health or social conditions placing them at risk, that without intervention will likely cause negative impact to an individual's health or wellbeing.¶
(286) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(287) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.¶
(288) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(289) "Supplemental Health Benefit State Funding" means funding for the health benefits included in the Healthier Oregon benefits package described in OAR 410-134-0004(3)(a-m).¶
(290) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶
(291) "Subrogation" means right of the state to stand in place of the client in the collection of Third Party Resources (TPR).¶
(292) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an

interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶
(293) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶
(294) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(295) "Suspension" means a temporary sanction prohibiting a provider's participation in the medical assistance programs by suspending the provider's Authority-assigned provider number for a specified period of time for one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or State Funds shall be made for services provided while the provider is suspended.¶
(296) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶
(297) "Telecommunication technologies" means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.¶
(298) "Telehealth" includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.¶
(299) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare.¶
(300) "Termination" means a sanction prohibiting a provider's participation in the Authority's programs by canceling the provider's Authority-assigned provider number and provider agreement for one or more of the reasons in OAR 410-120-1400 and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. No payments, Title XIX, or state funds shall be made for services provided after the date of termination. Termination is permanent unless:¶
(a) The exceptions to mandatory exclusion are met; or¶
(b) Otherwise stated by the Authority at the time of termination.¶
(301) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶
(302) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, birth doula, or other similar health workers not regulated or certified by the State of Oregon.¶
(303) "Transportation" means medical transportation.¶
(304) "Trauma informed approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.¶
(305) "Trauma Informed Services" means those services provided using a trauma informed approach.¶
(306) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶
(307) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(308) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶
(309) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶
(310) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(311) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(312) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶
(313) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or

regulation:¶
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.¶
(314) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶
(315) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in these General Rules (OAR chapter 410 division 120).¶
(316) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(317) "Very Low Food Security" means reports of multiple indications of disrupted eating patterns and reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here: https://www.ers.usda.gov/media/xxsjnqd1/short2024.pdf¶
(318) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(319) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360. ¶
(320) "Young Adults with Special Health Care Needs~~" or "~~ (YSHCN)" means a program ~~for~~that provides young adults who meet pre-determined social and clinical criteria w~~hich may qualify for~~ith supplementary ~~Medicaid~~ benefits, in addition to OHP Plus ~~coverage,~~or Healthier Oregon coverage. The supplementary benefits includ~~inge~~ EPSDT services, HRSN ~~S~~services, and e~~nhanc~~xtended vision and dental ~~benefit~~service~~s~~. The YSHCN~~s shall be implemented during the 2025 calendar year~~ program is more fully described in OAR 410-200-0455.
Statutory/Other Authority: ORS 413.042, 414.231, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.025

AMEND: 410-120-1210

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines Medicaid benefit packages, including YSHCN.

CHANGES TO RULE:

410-120-1210
Medical Assistance Benefit Packages and Delivery System ¶

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.¶
(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules.¶
(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.¶
(4) Benefit package descriptions:¶
(a) Oregon Health Plan (OHP) Plus:¶
(A) Benefit package identifier: BMH;¶
(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if they are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;¶
(C) Coverage includes:¶
(i) ~~Services above the funding line on~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage for individuals under age 21 and individuals who qualify for the Young Adults with Special Health Care Needs (YSHCN) program, as detailed in Chapter 410 Division 151. ¶
(ii)Services consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);¶
(iii) Ancillary services, (OAR 410-141-3820);¶
(~~ii~~iv) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;¶
(~~i~~v) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;¶
(vi) Hospice;¶
(vii) Post-hospital extended care benefit up to a twenty (20) day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO; and¶
(viii) HRSN Services (OAR 410-120-2005).¶
(D) Limitations: Except for ~~YSHCN Members~~individuals who qualify for the Young Adults with Special Health Care Needs program (see OAR 410-200-0455), the following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):¶
(i) Selected dental (OAR chapter 410, division 123 and 200);¶
(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).¶
(b) OHP with Limited Drugs:¶
(A) Benefit package identifier: BMM, BMD;¶
(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;¶
(C) Coverage includes: services covered by Medicare and OHP Plus as described in this rule;¶
(D) Limitations:¶
(i) The same as OHP Plus as described in this rule;¶
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:¶
(I) Over-the-counter (OTC) drugs;¶
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall cover those indications).¶

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;¶
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;¶
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.¶
(c) Qualified Medicare Beneficiary (QMB)-Only:¶
(A) Benefit Package identifier code MED;¶
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;¶
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;¶
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;¶
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.¶
(d) Citizenship Waived Medical (CWM) Benefit Package defined in OAR 410-120-0000. Refer to OARs 410-134-0005(2) and 410-134-0005(3) for coverage and billing guidance.¶
(e) Compact of Free Association (COFA) Dental Program:¶
(A) Benefit Package identifier code DEN;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of Dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(f) Veteran Dental Program:¶
(A) Benefit Package identifier code DEN and DNT;¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;¶
(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123.¶
(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.¶
(E) No copayments, deductibles or cost sharing shall be required for eligible clients.¶
(g) Young Adults with Special Health Care Needs (YSHCN) Program: ¶
(A) Benefit package identifier codes BMH, BMM, or BMD; ¶
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0455;¶
(C) Coverage: Eligible individuals receive OHP Plus coverage with the following supplemental benefits: ¶
(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage as described in chapter 410 Division 151; ¶
(ii) All dental and vision services available to EPSDT beneficiaries, as detailed in chapter 410 Division 123 and chapter 410 Division 140; and ¶
(iii) Health-Related Social Needs or "HRSN" services (as defined in OAR 140-120-0000 and detailed in OAR 410-120-2000) are available to those receiving YSHCN as an "HRSN Covered Population".¶
(D) Limitations: Individuals receiving OHP Plus benefits under the YSHCN program are not eligible for long-term care services and supports under Oregon's 1915(c) waiver, and HRSN services must be annually reassessed for eligibility for HRSN services as set out in OAR 410-120-2015.¶
(5) Division clients are enrolled for covered health services and HRSN Services to be delivered through one of the following means:¶
(a) Coordinated Care Organization (CCO):¶
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;¶
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services, dental care, or HRSN Services.¶
(b) Fee-for-service (FFS):¶
(A) These clients are not enrolled in a CCO;¶
(B) Subject to limitations and restrictions in the Division's individual program rules, the client may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for

any covered service and shall receive a fee for the service provided.¶
(C) Delivery of HRSN Services for members enrolled in FFS shall be provided as set forth in OAR 410-120-2000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690, 414.572, 414.605, 414.665, 414.719

AMEND: 410-122-0080

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describes DMEPOS, and adds YSHCN to the list of covered programs.

CHANGES TO RULE:

410-122-0080
Conditions of Coverage, Limitations, and Restrictions ¶

(1) For clients under the age of 21: and clients in the Young Adults with Special Health Care Needs or "YSHCN" program (as defined in OAR 410-200-0455): The EPSDT program covers all medically necessary and medically appropriate services needed to correct or ameliorate health conditions, or to improve the client's ability to grow, develop, or participate in school, regardless of placement on or inclusion in the Prioritized List of Health Services. Coverage for medical equipment and supplies shall not be denied without an individual review for medical necessity and medical appropriateness, as defined in OAR 410-151-0001. ¶
(2) For clients age 21 and older: The Division may pay for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) when the item meets all criteria in these rules, including all of the following conditions. The item:¶
(a) Is approved for marketing and registered or listed as a medical device by the Food and Drug Administration (FDA), when FDA approval is required for the item, and is otherwise generally considered to be safe and effective for the intended purpose. In the event of delay in FDA approval and registration, the Division shall review purchase options on a case-by-case basis;¶
(b) Is medically appropriate and medically necessary for the client, as defined in OAR 410-120-0000;¶
(c) Is primarily and customarily used to serve a medical purpose;¶
(d) Is generally not useful to an individual in the absence of medical disability, illness, or injury;¶
(e) Is suitable for use in a client's home or any non-institutional setting in which normal life activities take place;¶
(f) Specifically for durable medical equipment, the item can withstand repeated use and can be reusable or removable;¶
(g) Meets the coverage criteria as specified in this division and subject to service limitations of the Division rules;¶
(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) or qualify for coverage under OAR 410-141-3820(11); ¶
(i) Is included in the Oregon Health Plan (OHP) client's benefit package of covered services;¶
(j) Is the least costly, medically appropriate item that meets the medical needs of the client;¶
(k) Coverage is not restricted to items covered by the Medicare program.¶
(3) Conditions for Medicare-Medicaid Services:¶
(a) If Medicare is the primary payer and Medicare denies payment, an appeal to Medicare must be filed timely prior to submitting the claim to the Division for payment. If Medicare denies payment based on failure to submit a timely appeal, the Division may reduce any amount the Division determines could have been paid by Medicare;¶
(b) If Medicare denies payment on appeal, the Division shall apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the OHP;¶
(c) Providers are not required to bill Medicare for items that are statutorily excluded and therefore not recognized as part of a covered Medicare benefit (e.g., incontinence supplies, bath equipment, adaptive car seats, standing frames). Prior authorization criteria for these services/items must still be met.¶
(4) The Division may not cover DMEPOS items when the item or the use of the item is:¶
(a) Not primarily medical in nature (e.g., personal hygiene items, sporting and fitness equipment, equipment used with the primary intent to physically restrain an individual);¶
(b) For personal comfort or convenience of the client or caregiver;¶
(c) A self-help device;¶
(d) Not therapeutic or diagnostic in nature;¶
(e) Used for precautionary reasons (e.g., pressure-reducing support surface for prevention of decubitus ulcers);¶
(f) Inappropriate for client use in the home or non-institutional setting (e.g., institutional equipment like an oscillating bed);¶
(g) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or¶
(h) Reimbursed as part of the bundled rate in a nursing facility as described in OAR 411-070-0085 or as part of a home and community-based care waiver service or by any other public, community, or third-party resource.¶
(5) Codes that are identified in these rules or in fee schedules are provided as a mechanism to facilitate payment

for covered items and supplies consistent with OAR 410-122-0186, but codes do not determine coverage. If prior authorization is required, the request for reimbursement shall document that prior authorization was obtained in compliance with the rules in this division.¶
(~~5~~6) DMEPOS providers shall have documentation on file that supports coverage criteria are met.¶
(~~6~~7) Billing records shall demonstrate that the provider has not exceeded any limitations and restrictions in the DMEPOS rules. The Division may require additional claim information from the provider consistent with program integrity review processes.¶
(~~7~~8) Documentation described in sections (4~~5~~), (~~5~~6), and (~~6~~7) above shall be made available to the Division upon request.¶
(~~8~~)9) The Division fee schedule provides a list of HCPCS codes that may be covered when criteria are met. Coverage may be provided for HCPCS codes that do not appear on the fee schedule with an individual medical appropriateness review as outlined in this rule.¶
(~~9~~10) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System).¶
(1~~0~~1) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and is prohibited. Refer to the Division General Rules (chapter 410, division 120) for specific rules on buying up.¶
(1~~1~~2) Equipment purchased by the Division for a client becomes the property of the client.¶
(1~~2~~3) Rental charges starting with the initial date of service, regardless of payer, apply to the purchase price.¶
(1~~3~~4) A provider who supplies rented equipment shall continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances.¶
(14~~5~~) Before renting, providers must consider purchase for long-term requirements.¶
(1~~5~~6) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a home health plan of care and covered home health care services.¶
(1~~6~~7) The Division may not pay DMEPOS providers for medical supplies separately while a client is under a hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, the Division, or other carrier.¶
(1~~7~~8) Separate payment may not be made to DMEPOS providers for equipment and medical supplies provided to a client when the cost of the items is already included in the capitated (per diem) rate paid to a facility or organization.¶
(1~~8~~9) Certain specified medical equipment and supplies require a face-to-face examination as described in these rules consistent with federal regulations at 42 CFR 440.70. See OAR 410-122-0090 for the face-to-face requirements.¶
(~~19~~20) Non-contiguous out-of-state DMEPOS providers may seek Medicaid payment only under the following circumstances:¶
(a) Medicare/Medicaid clients:¶
(A) For Medicare covered services and then only Medicaid payment of a client's Medicare cost-sharing expenses for DMEPOS services when all of the following criteria are met:¶
(i) Client is a qualified Medicare beneficiary (QMB);¶
(ii) Service is covered by Medicare;¶
(iii) Medicare has paid on the specific code. Prior authorization is not required.¶
(B) Services not covered by Medicare:¶
(i) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records;¶
(ii) Some examples of services not reimbursable to a non-contiguous out-of-state provider include but are not limited to incontinence supplies, grab bars;¶
(iii) Services billed must be covered under the OHP;¶
(iv) Services provided and billed to the Division shall be in accordance with all applicable Division rules.¶
(b) Medicaid-only clients:¶
(A) For a specific Oregon Medicaid client who is temporarily outside Oregon and only when the prescribing practitioner has documented that a delay in service may cause client harm;¶
(B) For foster care or subsidized adoption children placed out of state;¶
(C) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing practitioner and maintained in the DMEPOS provider's records;¶
(D) Services billed must be covered under the OHP;¶
(E) Services provided and billed to the Division shall be in accordance with all applicable Division rules.¶
(2~~0~~1) An individual medical appropriateness review shall be conducted by the Division or CCO on requests for any DMEPOS item, related supplies, or services that are not already identified as covered by the Division in these rules or the Division fee schedule:¶
(a) The DME supplier must submit clinical documentation from the prescribing practitioner that is client-specific

and demonstrates there is no equally effective, less costly covered item or service that meets the client's medical needs;¶
(b) The client's prescribing practitioner must certify that the less costly alternatives have been tried and failed or could be reasonably expected to fail or is inappropriate for the client;-¶
(c) Documentation must support that the requested item or service is medically appropriate and medically necessary as defined in OAR 410-120-0000 for clients age 21 and older and OAR 410-151-0001 for clients under the age of 21; and clients in the YSHCN program as defined in OAR 410-200-0455; ¶
(d) Requests under this section for clients enrolled in CCOs shall be directed to the CCO in which the client is enrolled, in accordance with OAR 410-122-0040(2).¶
(21~~1~~2) See General Rules OAR 410-120-1200 Excluded Services and Limitations for more information on general scope of coverage and limitations.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: 414.065

AMEND: 410-141-3500

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines Oregon Health Plan terms, including YSHCN.

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR ~~c~~Chapter 410, ~~d~~Division 141. The Oregon Health Authority (Authority) also incorporates the definitions in OAR 410-120-0000, OAR 309-032-0860 for any terms not defined in this rule.¶
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final Managed Care Entity (MCE) claims decision or the Authority issuing a final hearings decision. For a final Managed Care Entity (MCE) claims decision, the date of "Adjudication" is the date on which an MCE has both (a) processed and (b) either paid or denied a Member's claim for services.¶
(3) "Aging and People with Disabilities (APD)" means the division in the Oregon Department of Human Services (ODHS) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.¶
(4) "Area Agency on Aging (AAA)" means the designated entity with which the ODHS contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.¶
(5) "~~T~~The Authority" means the Oregon Health Authority (OHA).¶
(6) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; Centers for Medicare and Medicaid Services (CMS) Section 1557 of the Affordable Care Act (ACA) outlines requirements for health plans and providers on alternative formats.¶
(7) "Auxiliary Aids and Services" means services available to members as defined in 45 Code of Federal Regulations (CFR) Part 92.¶
(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and The Authority are in effect.¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.¶
(11) "Capitated Services" means those covered services that a~~n~~ Managed Care Entity (MCE) agrees to provide for a capitation payment under contract with the Authority.¶
(12) "Capitation Payment" means monthly prepayment to a~~n~~ Managed Care Entity (MCE) for capitated services to Managed Care Entity (MCE) members.¶
(13) "Care Coordination" means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member. Care Coordination requirements are described in OARs 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with CFR 438.208.¶
(14) "Care Plan" means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the member's providers, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs. Care Plan requirements are described in OAR 410-141-3865 and OAR 410-141-3870.¶
(15) "Care Profile" means the electronic record a CCO develops and maintains for all members. The Care Profile is the platform that receives feeds from different data sources used to identify, track and manage a member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the member. Care Profile requirements are further described in OAR 410-141-3865 and OAR 410-141-3870.¶
(16) "Care Setting Transitions" means a transition between different locations, settings or levels of care. ¶
(17) "Coordinated Care Organization Payment or CCO Payment" means the monthly payment to a Coordinated Care Organization (CCO) for services the CCO provides to members in accordance with the global budget.¶
(18) "Certificate of Authority" means the certificate issued by Department of Consumer and Business Services (DCBS) to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.¶
(19) "Client" means an individual found eligible to receive Oregon Health Plan (OHP) health services, whether or

not the individual is enrolled as an CCO member.¶
(20) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.572 and in accordance with criteria specified in ORS 414.575. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:¶
(a) In a Service Area where only one (1) federally recognized tribe exists, the CCO shall seek one (1) tribal representative to serve on the CAC;¶
(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one (1) tribal representative from each tribe to serve on the CAC; and¶
(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.¶
(21) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.¶
(22) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:¶
(a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to;¶
(A) Alcohol;¶
(B) Illicit Drugs; and¶
(C) Gambling.¶
(b) Physical Health conditions, including but not limited to:¶
(A) Cancer;¶
(B) Diabetes; ¶
(C) Bariatric ~~I~~Care.¶
(c) Developmental Disabilities.¶
(23) "Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.¶
(24) "Contract" means an agreement between the State of Oregon acting by and through The Authority and a Managed Care Entity (MCE) to provide health services to eligible members.¶
(25) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.572 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.¶
(26) "Coordinated Care Services" mean a Managed Care Entity's (MCE) fully integrated physical, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) services.¶
(27) "Corrective Action" or "Corrective Action Plan (CAP)" means an Authority-initiated request for a Managed Care Entity (MCE) or a Managed Care Entity (MCE)-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.¶
(28) "Culturally and Linguistically Responsive and Appropriate Services" means the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and Linguistically appropriate services are further defined in 42 CFR □ 59.2.¶
(29) "Delivery System Network (DSN)" means the entirety of those Participating Providers who:¶
(a) Contracts with; or-¶
(b) Are employed by, a CCO for purposes of providing services to the Members of such CCO. "Provider Network" has the same meaning.¶
(30) "Dental Care Organization (DCO)" has the meaning as provided for in ORS 414.025 (24).¶
(31) "Dental Health" means conditions of the mouth, teeth, and gums.¶
(32) "Department" means the Oregon Department of Human Services (ODHS).¶
(33) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.¶
(34) "Disenrollment" means the act of removing a member from enrollment with an MCE.¶
(35) "Diversity of the workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and

empathy of a mix of providers that can be brought to the delivery of health care.¶
(36) "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818 and under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided:-¶
(a) Were covered services, non-covered services, or other Health-Related Social Needs services; or¶
(b) Were not paid; or¶
(c) Paid for on a Fee- For-Service or capitated basis; or¶
(d) Were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and-¶
(e) Were performed pursuant to Subcontractor agreement, special arrangement with a facility or program, or other arrangement.¶
(37) "Enrollment" means the assignment of a member to a Managed Care Entity (MCE) for management and coordination of health services.¶
(38) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health Plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:¶
(a) Annual exams;¶
(b) Contraceptive education and counseling to address reproductive health issues;¶
(c) Prescription contraceptives (such as birth control pills, patches or rings);¶
(d) IUDs and implantable contraceptives and the procedures requires to inserted remove them;¶
(e) Injectable hormonal contraceptives (such as Depo-Provera);¶
(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);¶
(g) Laboratory tests including appropriate infectious disease and cancer screening;¶
(h) Radiology services;¶
(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.¶
(39) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits.¶
(40) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.¶
(41) "Grievance System" means the overall system that includes:¶
(a) Grievances to a Managed Care Entity (MCE) on matters other than adverse benefit determinations;¶
(b) Appeals to a Managed Care Entity (MCE) on adverse benefit terminations; and¶
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.¶
(42) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.¶
(43) "Health-Related Services (HRS)" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.¶
(44) "Health Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a member, their representative or guardian about key areas of their health, including their physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health). The HRA is intended to inform the coordination of services and supports that meet the members individualized needs as described in OAR 410-141-3860, 410-141-3865 and 410-141-3870.¶
(45) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of Oregon Health Plan (OHP).¶
(46) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through Oregon Health Plan (OHP) fee-for-service, based on permanent residency.¶
(47) "Indian" and/or "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).¶
(48) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶
(49) "In Lieu of Service" (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-

3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).¶
(50) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.¶
(51) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.¶
(52) "Legal Holiday" means the days described in ORS 187.010 and 187.020.¶
(53) "Licensed Health Entity" means a Managed Care Entity (MCE) that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.¶
(54) "Managed Care Entity (MCE)" is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
(55) "Managed Care Organization (MCO)" is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.¶
(56) "Material Change to Delivery System" means:¶
(a) Any change to the CCO's Delivery System Network (DSN) that may result in more than five (5) percent of its members changing the physical location(s) of where services are received; or¶
(b) Any change to CCO's DSN that may likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sol provider specialty type; or¶
(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or¶
(d) Any combination of the above changes.¶
(57) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:¶
(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;¶
(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.¶
(58) "Member" means an Oregon Health Plan (OHP) client enrolled with a CCO.¶
(59) "Member Representative" means an individual who can make Oregon Health Plan (OHP)-related decisions for a member who is not able to make such decisions themselves.¶
(60) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.¶
(61) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.¶
(62) "Ombudsperson Services" means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.¶
(63) "Oregon Health Plan (OHP)" means Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both.¶
(64) "Oregon Integrated and Coordinated Health Care Delivery System" means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.570.¶
(65) "Participating Provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(66) "Patient-Centered Primary Care Home (PCPCH)" means a recognized clinic that takes a patient and family-

centered approach to all aspects of care. PCPCHs work with the member and their health care team to improve and coordinate care and help to eliminate repetitive procedures. As defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040 and means the definition as set forth in OAR 409-055-0010.¶
(67) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.¶
(68) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶
(a) CCOA: Physical, dental, and behavioral health services are paid by the client's CCO;¶
(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Dental services are paid the fee-for-service program;¶
(c) CCOE: Behavioral health services are paid by the client's CCO. Physical health and dental services are paid by the fee-for-service program;¶
(d) CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120. Any reference to CCOF means the benefit package covers dental services only; and¶
(e) CCOG: Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.¶
(69) "Post Hospital Extended Care Services" (PHECS). Consistent with 42 USC 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than three (3) consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility:¶
(a) Within thirty (30) days after discharge from such hospital; or¶
(b) Within such time as it may be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care may not be medically appropriate within thirty (30) days after discharge from a hospital; and¶
(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within thirty (30) days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.¶
(70) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.¶
(71) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:¶
(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;¶
(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-055-0010 and OAR 410-120-0000.¶
(72) "Provider" means an individual, facility, institution, corporate entity, or other organization that:¶
(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or¶
(b) Bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a Provider, (and also termed a "Billing Provider"); and¶
(c) Supplies health services or items (also termed a "Rendering Provider").¶
(73) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.¶
(74) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.¶
(75) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:¶
(a) An infant, child or youth, between the ages of birth to 21 years of age; and¶
(b) Must meet criteria for diagnosis, functional impairment and duration:¶

(A) Diagnosis: The infant, child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):¶
(i) For children three (3) years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);¶
(ii) For children four (4) years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).¶
(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;¶
(C) Duration: The identified disorder and functional impairment must have been present for at least one (1) year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than one (1) year.¶
(76) Social Determinants of Health and Equity (SDOH-E) each has the meaning provided for in OAR 410-141-3735.¶
(77) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders and either:¶
(a) Have functional disabilities;¶
(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or¶
(c) Are a Prioritized Population member. This includes members who:¶
(A) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;¶
(B) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);¶
(C) Are children ages 0-5:¶
(i) Showing early signs of social/emotional or behavioral problems; or¶
(ii) Have a Serious Emotional Disorder (SED) diagnosis.¶
(D) Are in medication assisted treatment for SUD;¶
(E) Are women who have been diagnosed with a high-risk pregnancy;¶
(F) Are children with neonatal abstinence syndrome;¶
(G) Children in Child Welfare;¶
(H) Are IV drug users;¶
(I) People with SUD in need of withdrawal management;¶
(J) Have HIV/AIDS or have tuberculosis;¶
(K) Are veterans and their families;¶
(L) Are at risk of first episode psychosis;¶
(M) Individuals within the Intellectual and developmental disability (IDD) populations; or ¶
(N) Are in the Young Adults with Special Health Care Needs (or "YSHCN") program as defined in OAR 410-200-0455.¶
(78) "Subcontract" means either:¶
(a) A contract between a CCO and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the CCO under its contract with the State; or¶
(b) Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.¶
(79) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.¶
(80) "Transition of Care" applies to Medicaid members who are enrolled in a CCO ("the receiving CCO") immediately after disenrollment from a "predecessor plan" which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS).-Transition of Care does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan. Meets the standards pursuant to OAR 410-141-3850."¶
(81) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services

programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.¶
(82) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.¶
(83) "Trauma-informed services" means those services provided using a Trauma Informed Approach.¶
(84) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that shall be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.¶
(85) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.¶
(86) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-151-0001

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describes EPSDT, and includes YSHCN.

CHANGES TO RULE:

410-151-0001
Definitions.
The definitions in this rule apply to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program only.¶
(1) "EPSDT Dentally Appropriate"¶
(a) Means dental services, items, or dental supplies that are:¶
(A) Recommended by a licensed health practitioner practicing within the scope of their license; and¶
(B) Safe, effective, and appropriate for an EPSDT Beneficiary based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and¶
(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities; and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or dental supply; and¶
(D) The most cost-effective level or type of health services, items, or supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.¶
(b) All covered services must be EPSDT Dentally Appropriate for the EPSDT Beneficiary but not all EPSDT Dentally Appropriate services are covered services.¶
(2) "EPSDT Beneficiary" means an individual under the age of 21 who is covered by the Oregon Health Plan (OHP). or an individual in the Young Adults with Special Health Care Needs (YSHCN) program as defined in OAR 410-200-0455¶
(3) "EPSDT Medically Appropriate:"¶
(a) Means health services, items, or medical supplies that are:¶
(A) Recommended by a licensed health practitioner practicing within the scope of their license; and¶
(B) Safe, effective, and appropriate for the EPSDT Beneficiary and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and¶
(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or medical supply; and¶
(D) The most cost-effective level or type of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.¶
(b) All covered services must be EPSDT Medically Appropriate for the EPSDT Beneficiary, but not all EPSDT Medically Appropriate services are covered services.¶
(4) "EPSDT Medically Necessary:"¶
(a) Means health services, items and medical supplies that are required to address one or more of the following for an EPSDT Beneficiary:¶
(A) The prevention, diagnosis, treatment or amelioration of an EPSDT Beneficiary's disease, condition, or disorder that results in health impairments or a disability;¶
(B) The ability for an EPSDT Beneficiary to achieve age-appropriate growth and development. Services that may be EPSDT Medically Necessary to achieve age-appropriate growth and development include but may not be limited to services that are reasonably calculated to improve the EPSDT Beneficiary's ability to participate in work or school, or the prevention, diagnosis, detection, treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability, regardless of whether they are ~~included on the~~consistent with the condition and treatment pairs identified in Prioritized List of Health Services (defined in OAR 410-120-0000) or are below the funding line on the Prioritized List of Health Services;¶
(C) The ability for an EPSDT Beneficiary to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(D) The opportunity for an EPSDT Beneficiary receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, to participate in their own care planning, and to live and work in the setting of their choice.¶

(b) An EPSDT Medically Necessary service must also be EPSDT Medically Appropriate. All covered services must be EPSDT Medically Necessary for the EPSDT Beneficiary.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

AMEND: 410-200-0015

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines Medicaid program terms, including YSHCN.

CHANGES TO RULE:

410-200-0015
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 a~~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, 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 a~~Advance ~~p~~Payments of the ~~p~~Premium ~~t~~Tax ~~c~~Credit~~, which~~ (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 ~~e~~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 ~~r~~Renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.¶
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disabilities medical program benefits, or APTC.¶
(14)~~"BRS" means~~ Behavior Rehabilitation Services. (BRS) has the meaning as defined in OAR 410-170-0020. ¶
(15) "Budget ~~m~~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 ~~r~~Relative" means an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:¶
(a) A relative of the dependent child, as follows:¶
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.¶
(B) Stepfather, stepmother, stepbrother, and stepsister.¶
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.¶
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;¶

(18) "~~CWM" means~~ Citizenship Waived Medical (CWM)" ~~and~~ was a benefit package that ended on June 30, 2023. The CWM benefit package covered certain emergency services provided to individuals who met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship and non-citizen status requirements (OAR 410-200-0215). For information about CWM benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.¶
(19) "~~CWM Plus" means~~ Citizenship Waived Medical Plus~~. CWM~~ (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, excluding MAGI Expanded Adult, except they did not meet the citizenship and non-citizen status requirements identified in OAR 410-200-0215. For more information about CWM Plus benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.¶
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.¶
(21) "Children's Health Insurance Program~~" also called "~~ (CHIP)" means Oregon medical coverage under Title XXI of the Social Security Act.¶
(22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.¶
(23) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.¶
(24) "Claimant" means an individual who has requested a hearing or appeal.¶
(25) "Code" means Internal Revenue Code.¶
(26) "Combined Eligibility Notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the HSD Medical Programs for which a determination or denial was made by the Authority.¶
(27) "Community Partner" has the same meaning as "Community Partner" as defined in OAR 410-120-0000.¶
(28) "Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.¶
(29) "Cover All Kids" refers to the OHP Plus-equivalent benefit (OAR 410-120-1210) provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP except for the Citizenship and Non-Citizen Status Requirements (OAR 410-200-0215). As of July 1, 2022, Cover All Kids is included under Healthier Oregon as defined in OAR 410-134-0001.¶
(30) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:¶
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or¶
(b) If section (30) subsection (a) cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.¶
(31) "Date of Request (DOR)" means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.¶
(a) For new applicants, the DOR is established as follows:¶
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or¶
(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.¶
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:¶
(A) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility;¶
(B) The month an individual ages off a medical program.¶
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or¶
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.¶
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.¶
(32) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a;¶
(a) "Basic decision notice" mailed no later than:¶
(A) The date of action given in the notice; or¶
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following

the date on which the individual became incarcerated.¶
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;¶
(c) "Timely ~~c~~Continuing ~~b~~Benefit ~~d~~Decision ~~n~~Notice" informs the client of the right to continued benefits and is mailed no later than ten (10) calendar days before the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than fifteen (15) calendar days before the effective date of the change.¶
(33) "Department" means the Oregon Department of Human Services.¶
(34) "Dependent ~~c~~Child" means an individual who:¶
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before attaining age 19.¶
(b) Lives in the home of the parent or caretaker relative; and¶
(c) Is not absent from the home for more than thirty (30) days due to being in foster care while foster care payments are being made.¶
(35) "Express Lane Agency (ELA)" means the Oregon Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.¶
(36) "Express Lane Eligibility (ELE)" means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.¶
(37) "Electronic ~~a~~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 ~~a~~Application" means an application electronically signed and submitted through the Internet.¶
(39) "Eligibility ~~d~~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 ~~a~~Appeal" also called "expedited hearing" means a hearing held within five (5) working days of the Agency's receipt of a hearing request, unless the claimant requests more time.¶
(42) "Family Size" means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the EDG and each unborn child of any pregnant members of the EDG.¶
(43) "Federal Data Services Hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.¶
(44) "Federal Poverty Level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).¶
(45) "Federally Facilitated Marketplace (FFM)" means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.¶
(46) "Head of ~~h~~Household (HOH)" means the primary person the Agency shall communicate with and:¶
(a) Is listed as the case name; or¶
(b) Is the individual named as the primary contact on the application.¶
(47) "Health Systems Division Medical Programs (HSD Medical Programs)" means all programs under the Health Systems Division including:¶
(a) "~~EXT" means~~ Extended Medical Assistance~~. T~~ (EXT)" means the Extended Medical Assistance program that 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~~ (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) MAGI Expanded Adult;¶
(G)-OHP Bridge -Basic Medicaid; and¶
(H) Young Adults with Special Health Care Needs (YSHCN). ¶
(48) "Healthier Oregon" is defined in OAR 410-120-0000.¶
(49) "Hearing request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.¶
(50) "Insurance affordability program" means ~~a program that is~~ one of the following programs:¶
(a) Medicaid;¶
(b) CHIP;¶
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;¶
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.¶
(51) "Legal ~~a~~Argument" has the meaning given ~~that term~~ in OAR 137-003-0008(c).¶
(52) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.¶
(53) ~~"MAGI" means~~ Modified Adjusted Gross Income (MAGI) has the meaning defined in OAR 410-200-0310(4) and is used in determining eligibility based on annual income ~~as described in OAR 410-200-0310(4)~~. MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:¶
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:¶
(A) Children, regardless of age, who are included in the household of a parent;¶
(B) Tax dependents.¶
(b) In applying section (53)(a), IRC 6012(a) (1) is used to determine who is required to file a tax return.¶
(54) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:¶
(a) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received;¶
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;¶
(c) Income from the following American Indian and Alaska Native sources is excluded:¶
(A) Distributions from Alaska Native Corporations and Settlement Trusts;¶
(B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;¶
(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:¶
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this section; or¶
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.¶
(D) Distributions resulting from real property ownership interests related to natural resources and improvements:¶
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or¶
(ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests.¶
(E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;¶
(F) Student financial assistance provided under the Bureau of Indian Affairs education programs.¶
(55) "Minimum Essential Coverage (MEC)" means medical coverage under:¶
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;¶
(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any

plan established by an Indian tribal government;¶
(c) Plans in the individual market;¶
(d) Health insurance plans in place on or before March 23, 2010; and¶
(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.¶
(56) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.¶
(57) "Non-citizen" means any individual who is not a citizen or national of the United States as defined at 8 U.S.C. 1101(a)(22).¶
(58) ~~"OSIPM" means~~ Oregon Supplemental Income Program Medical~~. M~~ (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) "~~PRTF" means~~ Psychiatric Residential Treatment Facility (PRTF) has the meaning as defined in OAR 309-022-0105.¶
(63) "Public institution" means any of the following:¶
(a) A state hospital (ORS 162.135);¶
(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;¶
(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;¶
(d) A youth correction facility (ORS 162.135):¶
(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or¶
(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order.¶
(e) As used in this rule, the term public institution does not include:¶
(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);¶
(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or¶
(C) A publicly operated community residence that serves no more than sixteen (16) residents, as defined in 42 CFR 435.1009.¶
(64) "Qualified hospital" means a hospital that meets all of the following criteria:¶
(a) Participates as an enrolled Oregon Medicaid provider;¶
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;¶
(c) Agrees to make determinations consistent with Authority policies and procedures;¶
(d) Informs applicants for presumptive eligibility of their responsibility to complete a full application by the end of the presumptive eligibility period and offers applicants assistance with completing and submitting the full Medicaid application; and¶
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).¶
(65) "Reasonable opportunity period";¶
(a) May be used to obtain necessary verification or resolve discrepancies regarding an attestation of US citizenship or non-citizen status (OAR 410-200-0230 (2));¶
(b) Begins on and shall extend ninety (90) days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five (5) days after the date on the notice, unless the individual shows they did not receive the notice within the five (5) day period;¶
(c) May be extended beyond ninety (90) days for individuals declaring a non-citizen status, if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.¶
(66) "Redetermination" means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.¶
(67) "Renewal" means a regularly scheduled periodic review of eligibility.¶
(68) "Request for information (RFI)" means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with

information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.¶
(69) "Resident of a Public Institution" means;¶
(a) An individual residing in a public institution that is:¶
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;¶
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;¶
(C) Residing involuntarily in a facility that is under governmental control; or¶
(D) Receiving care as an outpatient while residing involuntarily in a public institution.¶
(b) An individual is not considered a resident of a public institution when the individual is:¶
(A) Released on parole, probation, or post-prison supervision;¶
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;¶
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is a resident. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:¶
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or¶
(ii) Is expected to meet the criteria outlined in subsection (i) of this rule, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.¶
(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual.¶
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶
(i) Is under age 21;¶
(ii) Is age 21 but was admitted to the IMD before their 21st birthday; or¶
(iii) Is age 65 or older.¶
(70) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.¶
(71) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.¶
(72) "Sibling" means natural or biological, adopted, ~~or~~ half or step sibling.¶
(73) "Spouse" means an individual who is legally married to another individual under:¶
(a) The statutes of the state where the marriage occurred;¶
(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or¶
(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.¶
(74) "SSA" means Social Security Administration.¶
(75) "Tax dependent" has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.¶
(76) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. 671-679b).¶
(77) "Young Adults with Special Health Care Needs" or "YSHCN" means a program that provides young adults who meet pre-determined social and clinical criteria with supplementary benefits, in addition to OHP Plus or Healthier Oregon coverage. The supplementary benefits include EPSDT, HRSN services, and extended vision and dental services, as defined in OAR 410-200-0455.
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: 410-200-0105

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Establishes criteria for hospital presumptive eligibility, which includes specifications for YSHCN.

CHANGES TO RULE:

410-200-0105
Hospital Presumptive Eligibility ¶

With the exception of OHP Bridge - Basic Medicaid and YSHCN, this rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, BCCTP, and FFCYM (OAR 410-200-0407) based on the determination of a qualified hospital. In addition, presumptive eligibility for OHP Bridge Basic Health Program cannot be established based on the determination of a qualified hospital.¶
(1) A qualified hospital shall, with the consent of the individual or someone acting on the individual's behalf, determine Hospital Presumptive Eligibility (HPE) for MAGI Medicaid/CHIP, BCCTP, or FFCYM.¶
(2) The qualified hospital shall determine Hospital Presumptive Eligibility based on the following information attested by the individual:¶
(a) Family size;¶
(b) Household income;¶
(c) Receipt of other health coverage;¶
(d) Residency¶
(e) US citizenship, US national, or non-citizen status.¶
(3) To be eligible via Hospital Presumptive Eligibility, an individual must be a US citizen, US National, or meet the citizenship and non-citizen status requirements found in OAR 410-200-0215 and one of the following:¶
(a) A child under the age of 19 with income at or below 300 percent of the federal poverty level;¶
(b) A parent or caretaker relative of a dependent child with income at or below the MAGI Parent or Caretaker Relative income standard for the appropriate family size in OAR 410-200-0315;¶
(c) A pregnant individual with income at or below 185 percent of the federal poverty level;¶
(d) A non-pregnant adult between the ages of 19 through 64 with income at or below 133 percent of the federal poverty level; or¶
(e) An individual under the age of 65 who has been screened by a licensed healthcare provider and determined to need treatment for breast or cervical cancer, or who has been determined eligible for the Breast and Cervical Cancer Treatment Program (OAR 410-200-0400);¶
(f) An individual under the age of 26 who was in Oregon foster care on their 18th birthday.¶
(4) To be eligible via Hospital Presumptive Eligibility, an individual may not:¶
(a) Be receiving Supplemental Security Income benefits;¶
(b) Be a Medicaid/CHIP beneficiary; or¶
(c) Have received a Hospital Presumptive Eligibility approval start date within the year (365 days) prior to a new Hospital Presumptive Eligibility period start date.¶
(5) In addition to the requirements outlined in sections (3) and (4) above, the following requirements also apply:¶
(a) To receive MAGI Adult benefits via Hospital Presumptive Eligibility, an individual may not be entitled to or enrolled in Medicare benefits under part A or B of Title XVIII of the Act;¶
(b) To receive MAGI CHIP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage that is accessible (OAR 410-200-0410(2)(c));¶
(c) To receive BCCTP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any minimum essential coverage.¶
(6) The Hospital Presumptive Eligibility period begins on the earlier of:¶
(a) The date the qualified hospital determines the individual is eligible; or¶
(b) The date that the individual received a covered medical service from the qualified hospital, if the hospital determines the individual is eligible and submits the decision to the Authority within five (5) calendar days following the date of service.¶
(7) The Hospital Presumptive Eligibility period ends:¶
(a) For individuals on whose behalf a Medicaid/CHIP application has been filed by the last day of the month following the month in which the hospital presumptive eligibility period begins, the day on which the state makes an eligibility determination for MAGI Medicaid/CHIP and sends basic decision notice; or¶
(b) If subsection (7)(a) is not completed, the last day of the month following the month in which the hospital presumptive eligibility period begins.¶
(8) A Hospital Presumptive Eligibility approval is not a full eligibility determination and does not entitle

beneficiaries to the following:¶
(a) A child is not entitled to continuous eligibility (OAR 410-200-0135) based solely on the receipt of benefits during a period of Hospital Presumptive Eligibility;¶
(b) A baby born to an individual receiving benefits during a period of hospital presumptive eligibility is not assumed eligible (OAR 410-200-0135) based solely the Hospital Presumptive Eligibility determination of the parent;¶
(c) An individual is not entitled to EXT (OAR 410-200-0440) based solely on the receipt of MAGI PCR during a period of Hospital Presumptive Eligibility;¶
(d) An individual is not entitled to receive YSHCN benefits as described in OAR 410-200-0455; ¶
(e) An individual whose Hospital Presumptive Eligibility period is terminated due to incarceration is not entitled to automatic restoration of benefits upon release (OAR 410-200-0140); ¶
(ef) Individuals are not entitled to hearing rights (OAR 410-200-0145) for benefits received during a period of Hospital Presumptive Eligibility.
Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706, 414.241

AMEND: 410-200-0110

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines general eligibility criteria for Medicaid programs, including YSHCN.

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 resident of a public institution and met the requirements of OAR 410-200-0140;¶
(e) An individual not receiving medical program benefits is added to an existing case where any members of the individual's EDG are receiving medical program benefits;¶
(f) Redetermining or renewing eligibility for beneficiaries and the Agency has sufficient evidence to redetermine or renew eligibility for the same or new program;¶
(g) During the ninety (90) day reconsideration period for eligibility following closure:¶
(A) The Authority shall redetermine in a timely manner (OAR 410-200-0110) the eligibility of an individual who:¶
(i) Lost HSD Medical Program eligibility because they did not return the pre-populated renewal form or respond to an RFI, and did not submit the information needed to renew eligibility; and¶
(ii) Within ninety (90) days of the medical closure date, submits the pre-populated renewal form or provides the requested additional information.¶
(B) The date the pre-populated renewal form or RFI response is submitted within the ninety (90) day reconsideration period establishes a new date of request;¶
(C) In the event that the pre-populated renewal form is submitted within the ninety (90) day reconsideration period and an RFI is generated for which the due date lands outside of the ninety (90) day reconsideration period, a new application is not required.¶
(D) If the individual is found to meet HSD Medical Program eligibility based on the completed redetermination, the effective date of medical benefits is as described in OAR 410-200-0115(3) and (4).¶
(5) Signature requirements are as follows:¶
(a) Signatures accepted by the Agency may be:¶
(A) Handwritten;¶
(B) Electronic; or¶
(C) Telephonic.¶
(b) An application must be signed by one of the following:¶
(A) The head of household;¶
(B) An adult in the applicant's EDG;¶
(C) An authorized representative; or¶
(D) If the applicant is a child or incapacitated, someone age 18 or older acting responsibly for the applicant.¶
(c) If the original signor of an application ceases to be a member of the case, the signature of an individual described in (5(b)) of this rule is required.¶
(d) Hospital Presumptive Eligibility may be determined without a signature if no electronic data match with the FDSH shall be performed;¶
(e) At renewal, if the Agency is unable to process an automated renewal, a signature is required on the pre-populated active renewal form sent to the beneficiary.¶
(6) Application and renewal processing timeliness standards are as follows:¶
(a) At initial eligibility determination, the Agency shall inform the individual of timeliness standards, make an eligibility determination, and send a decision notice by the 45th calendar day after the Date of Request if:¶
(A) All information necessary to determine eligibility is present;¶
(B) An RFI has been issued, and the agency does not receive a response by the deadline provided; or¶
(C) A completed application is not received by the agency within 45 days after the Date of Request.¶
(b) At initial eligibility determination, the Agency may extend the 45-day period described in section (6)(a) if:¶
(A) The Agency must request additional information or verification, and the due date of such request extends beyond the 45th day; or¶
(B) There is an administrative or other emergency beyond the control of the Agency. The Agency must document the emergency;¶
(c) At periodic renewal of eligibility, if additional information or verification is required, the Authority shall provide the beneficiary at least thirty (30) days from the date of the renewal form to respond and provide necessary information.¶
(7) Individuals may apply through the FFM. If the FFM determines the individual is potentially eligible for Medicaid/CHIP or OHP Bridge-, the FFM shall transfer the individual's electronic account to the Oregon Department of Human Services for eligibility determination.¶
(8) HSD Medical Program eligibility is evaluated in the following order:¶
(a) For a child applicant:¶
(A) Substitute Care, when the child is in Behavioral Rehabilitation Services (BRS) or in Psychiatric Residential Treatment Facility (PRTF) (OAR 410-200-0405);¶
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);¶
(C) MAGI Pregnant Woman program (OAR 410-200-0425);¶
(D) MAGI Child (OAR 410-200-0415);¶

(E) Extended Medical Assistance (OAR 410-200-0440);¶
(F) MAGI CHIP (OAR 410-200-0410);¶
(G) FFCYM (OAR 410-200-0407);¶
(H) BCCTP (OAR 410-200-0400)¶
(b) For an adult applicant:¶
(A) Substitute Care (OAR 410-200-0405);¶
(B) MAGI Parent or Caretaker Relative (OAR 410-200-0420);¶
(C) MAGI Pregnant Woman (OAR 410-200-0425);¶
(D) FFCYM (OAR 410-200-0407);¶
(E) MAGI Adult (OAR 410-200-0435);¶
(F) EXT (OAR 410-200-0440);¶
(G) MAGI Expanded Adult (OAR 410-200-0436);¶
(H) YSHCN (OAR 410-200-0455);¶
(I) BCCTP (OAR 410-200-0400);¶
(~~I~~J) OHP Bridge - Basic Medicaid (OAR 410-200-0437)¶
(~~J~~K) OHP Bridge - Basic Health Program (OAR 410-200-0438)¶
(~~K~~L) Compact of Free Association (COFA) Dental (OAR 410-200-0445);¶
(~~L~~M) 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: 410-200-0135

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Defines and describes Medicaid program continuous eligibility and includes YSHCN.

CHANGES TO RULE:

410-200-0135
Assumed, Continuous, and Protected Eligibility ¶

(1) Assumed Eligibility:¶
(a) A child born to an individual who is eligible for and receiving Medicaid/Children's Health Insurance Program (CHIP) benefits at the time of the birth is an assumed eligible newborn (AEN);¶
(b) An AEN is eligible for MAGI Child benefits (OAR 410-200-0415) effective the date of birth through the end of the month in which the child turns one year of age, unless:¶
(A) The child dies;¶
(B) The child is no longer a resident of Oregon; or¶
(C) The child's representative requests a voluntary termination of the child's eligibility.¶
(c) A new application or request for coverage is not required for an AEN.¶
(d) An AEN is entitled to assumed eligibility without providing a Social Security Number (SSN). An SSN is required to maintain coverage after the assumed eligibility period ends.¶
(2) Continuous Eligibility:¶
(a) The Continuous Eligibility (CE) period is the period of time an individual who is determined eligible for an HSD medical benefit shall maintain coverage despite changes in circumstance that may otherwise preclude eligibility, with consideration of exceptions described in section (2)(b)~~;~~.¶
(b) Coverage may be terminated during the CE period in the following circumstances:¶
(A) The individual is no longer an Oregon resident;¶
(B) The individual dies;¶
(C) The individual or someone authorized to act on their behalf requests voluntary termination of eligibility;¶
(D) The agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual or someone authorized to act on their behalf; or¶
(E) For recipients of the MAGI Expanded Adult Program (OAR 410-200-0436), the program ends.¶
(c) The CE period is established when an individual is determined eligible for HSD medical benefits with no outstanding requests for information, as follows:¶
(A) At initial approval of eligibility, the CE period begins on the first of the month in which the individual established a Date of Request (DOR)~~;~~, or¶
(B) When approved for renewal of eligibility, the new CE period begins on the first of the month following the renewal due~~-~~ date.¶
(d) The length of the CE period is based on age and program eligibility, as follows:¶
(A) Children under six (6) years of age are entitled to CE through the end of the month of their sixth (6) birthday or twenty-four (24) months, whichever is later~~;~~.¶
(B) Except for individuals eligible for OHP Bridge - Basic Health Program, individuals age six (6) and above are entitled to twenty-four (24) months of CE.¶
(C) Individuals who are eligible for OHP Bridge - Basic Health Program are entitled to twelve (12) months of coverage in the program as long as they continue to meet non-financial eligibility criteria for the program described in OAR 410-200-0438 (2)(a) and (d) and (3)-.¶
(e) An individual's benefits may be adjusted during the ~~continuous eligibility~~CE period as long as the adjustment does not result in the reduction or termination of coverage~~;~~, except that individuals in the YSHCN program when they turn age 26 shall lose the supplemental benefits described in OAR 410-200-0455 (2)(a) and (b) but shall maintain OHP Plus coverage for the remainder of their CE period as described in (2)(f) and (g) of this rule.¶
(f) If an individual's eligibility is redetermined during the continuous eligibility period and they no longer meet financial eligibility requirements for any HSD Medical Program of the same or better benefit, they shall retain coverage through the program with the uppermost income eligibility threshold for which the individual meets non-financial eligibility requirements~~;~~.¶
(g) If an individual's eligibility is redetermined during the continuous eligibility period and they no longer meet financial or non-financial eligibility requirements for any HSD Medical Program of the same or better benefit, they shall retain coverage through the Parent and Caretaker Relative program (OAR 410-200-0420).¶
(3) Protected Eligibility:¶

(a) Except for those individuals eligible for and receiving OHP Bridge - Basic Health Program benefits, individuals who are eligible for and receiving any HSD Medical Program benefits for any portion of their pregnancy are entitled to protected eligibility for the duration of the pregnancy and the postpartum eligibility period;¶
(b) The postpartum eligibility period is:¶
(A) Except as described in subsection (3)(b)(B), the postpartum eligibility period is twelve (12) calendar months following the month in which the pregnancy ends;¶
(B) For individuals who do not meet the citizen and non-citizen status requirements, who are eligible for and receiving Citizenship Waived Medical (CWM) Plus coverage for any portion of their pregnancy, the postpartum eligibility period is the two (2) calendar months following the month in which the pregnancy ends.¶
(c) Benefits may not be terminated or reduced during a period of protected eligibility unless:¶
(A) The individual is no longer an Oregon resident;¶
(B) The individual dies;¶
(C) The individual or someone authorized to act on their behalf requests a voluntary termination of eligibility; or¶
(D) The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual or someone authorized to act on their behalf.
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.095, 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706

AMEND: 410-200-0140

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describe Medicaid program eligibility for residents of public institutions.

CHANGES TO RULE:

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

(1) A resident of a public institution is not eligible for Health System Division (HSD) Medical Program benefits, except as follows:¶
(a) For individuals residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital, who are:¶
(A) Under age 21;¶
(B) Age 21 if they were admitted to the IMD before their 21st birthday; or¶
(C) Age 65 or older.¶
(b) Residents of a public institution may be eligible for OHP Bridge - Basic Health Program benefits if they are awaiting disposition of charges.¶
(2) For all individuals enrolled in HSD Medical Programs except for OHP Bridge - Basic Health Program who become a resident of a public institution, benefits shall be suspended for the duration of the period in which the individual is a resident of that institution.¶
(a) The effective date of the suspension of benefits is the day following the date on which an individual becomes a resident of a public institution.¶
(b) ~~Suspended benefits shall be reinstated~~Except as described in section (2)(c) of this rule, suspended benefits shall be reinstated to the same level of coverage the individual was receiving when they became a resident of a public institution effective the date on which an individual ceases to be a resident of a public institution without the need for a new application when:¶
(A) The Agency learns the individual is no longer a resident of a public institution within the twelve (12) calendar months following the date on which the change occurred; or¶
(B) The individual leaves the public institution to be admitted to a medical facility as an inpatient with an expected stay of at least 24 hours, provided the medical facility is not associated with the public institution where the individual is a resident.¶
(c) Individuals who were in the YSHCN program when they became a resident of a public institution and who have turned age 26 on or prior to their release date shall not have the supplemental YSHCN benefits described in OAR 410-200-0455(2)(a) and (b) reinstated upon their release. ¶
(d) Once benefits are reinstated as described in subsection (2)(b) of this rule, a redetermination of eligibility shall be processed unless benefits are restored on a case where the existing renewal date is more than two (2) calendar months beyond the month in which the action is being taken.¶
(3) For individuals enrolled in OHP Bridge - Basic Health Program who become a resident of a public institution, benefits shall be terminated effective the day following the day on which they became a resident of a public institution except that coverage shall be maintained while the individual's charges are pending disposition. In order to regain eligibility for OHP Bridge-Basic Health Program following release from the public institution, the individual must reapply.
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.070, 411.404, 411.439, 411.443, 411.445, 411.816, 412.014, 412.049, 414.426

AMEND: 410-200-0205

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describes concurrent program eligibility.

CHANGES TO RULE:

410-200-0205
Concurrent and Duplicate Program Benefits ¶

(1) An individual receiving HSD Medical Program benefits may not receive the following medical benefits at the same time except as described in section (3) of this rule:¶
(a) Any other HSD Medical Program;¶
(b) Office of Child Welfare Medical;¶
(c) Oregon Youth Authority Medical;¶
(d) Oregon Supplemental Income Program-Medical (OSIPM); or¶
(e) Refugee Medical Assistance (REFM);.¶
(2) An individual may not receive HSD Medical Program benefits and medical benefits from another state unless the individual's provider refuses to submit a bill to the Medicaid/CHIP agency of the other state and the individual would not otherwise receive medical care.¶
(3) Individuals may receive the supplemental YSHCN program benefits as described in OAR 410-200-0455(2)(a) and (b) concurrent with the MAGI Medicaid/CHIP programs defined in OAR 410-200-0015(d) and 410-200-0015(f)(A)-(E), and OSIPM programs as defined in OAR 461-101-0010(18).
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: 410-200-0315

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describes Medicaid program income eligibility, including YSHCN.

CHANGES TO RULE:

410-200-0315
Standards and Determining Income Eligibility ¶

(1) This rule outlines income thresholds for Health System Division (HSD) Medical Programs. See OAR 410-200-0310 for eligibility and budgeting.¶
(2) The income standard for the Modified Adjusted Gross Income (MAGI) Parent or Caretaker-Relative program is set as follows: See attached table.¶
(3) Effective March 1, 2024, the income standard for the MAGI Child Program and the MAGI Adult Program is set at 133 percent of the 2024 Federal Poverty Level (FPL) as follows: See attached table.¶
(4) Effective March 1, 2024, the income standard for the MAGI Pregnant Woman Program and for MAGI Child Program recipients under the age of one year is set at 185 percent of the 2024 FPL as follows: See attached table.¶
(5) Effective March 1, 2024, the income standard for the MAGI Expanded Adult Program is set at 200 percent of the 2024 FPL as follows: See attached table.¶
(6) Effective March 1, 2024, the income standard for MAGI Children's Health Insurance Program (CHIP) is set at 300 percent of the 2024 FPL as follows: See attached table.¶
(7) Effective July 1, 2024, the income standard for OHP Bridge - Basic Health Program and OHP Bridge - Basic Medicaid is set at 200 percent of the 2024 Federal Poverty Level (FPL) as follows: See attached table.¶
(8) Effective March 1, 2024, the income standard for the Compact of Free Association (COFA) Dental Program is set at 13~~8~~3 percent of the 2024 FPL as follows: See attached table.¶
(9) Effective March 1, 2024, the income standard for the Veteran Dental Program is set at 400 percent of the 2024 FPL as follows: See attached table.¶
(10) Effective January 1, 2025, the income standard for the Young Adults with Special Health Care Needs Program is set at 200 percent of the 2024 FPL as follows: See attached table.¶
[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]
Statutory/Other Authority: 42 CFR 435.110, ORS 435.112, 435.115, 435.116, 435.118, 435.403, 435.940, 435.1200, 457.80, 457.340, 458.350, 435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, 457.380, 435.608, 433.138, 433.145, 433.146, 433.147, 433.148, 435.117, 435.119, 435.1200, 435.1205, 435.170, 435.190, 435.222, 435.610, 435.916, 435.917, 447.56, 457.350, 457.360, 457.805, ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.402, 411.404, ORS 411.060, 411.095, 411.400, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.440, 414.534, 414.536, 414.706

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

2024 Income Thresholds - Effective March 1, 2024
Oregon Health Plan, Health Systems Division Programs

Family Size	Parents & Other Caretaker Relatives		MAGI Child (age 1 - under 19) / MAGI Adult / COFA Dental		MAGI Child (under age 1) / MAGI Pregnant Woman		Young Adults with Special Health Care Needs / OHP Bridge - Basic Medicaid (PME)		MAGI CHIP		Vet Dental
	2024 Standard	Standard + 5% FPL Disregard	2024 Standard (133%)	Standard + 5% FPL Disregard (138%)	2024 Standard (185%)	Standard + 5% FPL Disregard (190%)	2024 Standard (200%)	2024 Standard (205%)	2024 Standard (300%)	Standard + 5% FPL Disregard (305%)	2024 Standard (400%)
1	$ 399	$ 462	$ 1,670	$ 1,732	$ 2,322	$ 2,385	$ 2,510	$ 2,573	$ 3,765	$ 3,828	$ 5,020
2	$ 515	$ 601	$ 2,266	$ 2,351	$ 3,152	$ 3,237	$ 3,407	$ 3,492	$ 5,110	$ 5,196	$ 6,814
3	$ 611	$ 719	$ 2,862	$ 2,970	$ 3,981	$ 4,089	$ 4,304	$ 4,411	$ 6,455	$ 6,563	$ 8,607
4	$ 747	$ 877	$ 3,458	$ 3,588	$ 4,810	$ 4,940	$ 5,200	$ 5,330	$ 7,800	$ 7,930	$ 10,400
5	$ 872	$ 1,025	$ 4,055	$ 4,207	$ 5,640	$ 5,792	$ 6,097	$ 6,250	$ 9,145	$ 9,298	$ 12,194
6	$ 998	$ 1,173	$ 4,651	$ 4,826	$ 6,469	$ 6,644	$ 6,994	$ 7,169	$ 10,490	$ 10,665	$ 13,987
7	$ 1,114	$ 1,312	$ 5,247	$ 5,445	$ 7,299	$ 7,496	$ 7,890	$ 8,088	$ 11,835	$ 12,033	$ 15,780
8	$ 1,230	$ 1,450	$ 5,844	$ 6,063	$ 8,128	$ 8,348	$ 8,787	$ 9,007	$ 13,180	$ 13,400	$ 17,574
9	$ 1,321	$ 1,564	$ 6,440	$ 6,682	$ 8,958	$ 9,200	$ 9,684	$ 9,926	$ 14,525	$ 14,768	$ 19,367
10	$ 1,456	$ 1,721	$ 7,036	$ 7,301	$ 9,787	$ 10,051	$ 10,580	$ 10,845	$ 15,870	$ 16,135	$ 21,160
Add'l add	$ 136	$ 159	$ 597	$ 619	$ 830	$ 852	$ 897	$ 920	$ 1,345	$ 1,368	$ 1,794

Family Size	2024 100% Annual Income Threshold (2023 FPL used for 2024 determinations)	2025 100% Annual Income Threshold (2024 FPL used for 2025 determinations)	2024 200% Annual Income Threshold for OHP Bridge - Basic Health Program (BHP) ONLY
1	$ 14,580	$ 15,060	$ 30,120
2	$ 19,720	$ 20,440	$ 40,880
3	$ 24,860	$ 25,820	$ 51,640
4	$ 30,000	$ 31,200	$ 62,400
5	$ 35,140	$ 36,580	$ 73,160
6	$ 40,280	$ 41,960	$ 83,920
7	$ 45,420	$ 47,340	$ 94,680
8	$ 50,560	$ 52,720	$ 105,440
9	$ 55,700	$ 58,100	$ 116,200
10	$ 60,840	$ 63,480	$ 126,960
Add'l add	$ 5,140	$ 5,380	$ 10,760

2023 Income Thresholds - Effective March 1, 2023
Oregon Health Plan, Health Systems Division Medical Programs

	Parents & Other Caretaker Relatives (PCR)		MAGI Child (age 1 - under 19) / MAGI Adult / COFA Dental		MAGI Child (under age 1) (CMO) / MAGI Pregnant Woman (PWO)		MAGI CHIP		Vet Dental	MAGI Expanded Adult
Family Size	2023 Standard	Standard + 5% FPL Disregard	2023 Standard (133%)	Standard + 5% FPL Disregard (138%)	2023 Standard (185%)	Standard + 5% FPL Disregard (190%)	2023 Standard (300%)	Standard + 5% FPL Disregard (305%)	2023 Standard (400%)	2023 Standard (200%)
1	$ 399	$ 456	$ 1,616	$ 1,677	$ 2,248	$ 2,309	$ 3,645	$ 3,706	$ 4,860	$ 2,430
2	$ 515	$ 592	$ 2,186	$ 2,268	$ 3,041	$ 3,123	$ 4,930	$ 5,013	$ 6,574	$ 3,287
3	$ 611	$ 707	$ 2,756	$ 2,859	$ 3,833	$ 3,937	$ 6,215	$ 6,319	$ 8,287	$ 4,144
4	$ 747	$ 863	$ 3,325	$ 3,450	$ 4,625	$ 4,750	$ 7,500	$ 7,625	$ 10,000	$ 5,000
5	$ 872	$ 1,008	$ 3,895	$ 4,042	$ 5,418	$ 5,564	$ 8,785	$ 8,932	$ 11,714	$ 5,857
6	$ 998	$ 1,153	$ 4,465	$ 4,633	$ 6,210	$ 6,378	$ 10,070	$ 10,238	$ 13,427	$ 6,714
7	$ 1,114	$ 1,289	$ 5,035	$ 5,224	$ 7,003	$ 7,192	$ 11,355	$ 11,545	$ 15,140	$ 7,570
8	$ 1,230	$ 1,425	$ 5,604	$ 5,815	$ 7,795	$ 8,006	$ 12,640	$ 12,851	$ 16,854	$ 8,427
9	$ 1,321	$ 1,535	$ 6,174	$ 6,406	$ 8,588	$ 8,820	$ 13,925	$ 14,158	$ 18,567	$ 9,284
10	$ 1,456	$ 1,690	$ 6,744	$ 6,997	$ 9,380	$ 9,633	$ 15,210	$ 15,464	$ 20,280	$ 10,140
11	$ 1,592	$ 1,846	$ 7,313	$ 7,588	$ 10,172	$ 10,447	$ 16,495	$ 16,770	$ 21,994	$ 10,997
12	$ 1,728	$ 2,001	$ 7,883	$ 8,179	$ 10,965	$ 11,261	$ 17,780	$ 18,077	$ 23,707	$ 11,854
13	$ 1,864	$ 2,157	$ 8,453	$ 8,770	$ 11,757	$ 12,075	$ 19,065	$ 19,383	$ 25,420	$ 12,710
14	$ 2,000	$ 2,313	$ 9,022	$ 9,361	$ 12,550	$ 12,889	$ 20,350	$ 20,690	$ 27,134	$ 13,567
15	$ 2,136	$ 2,468	$ 9,592	$ 9,953	$ 13,342	$ 13,703	$ 21,635	$ 21,996	$ 28,847	$ 14,424
16	$ 2,272	$ 2,624	$ 10,162	$ 10,544	$ 14,134	$ 14,516	$ 22,920	$ 23,302	$ 30,560	$ 15,280
17	$ 2,408	$ 2,780	$ 10,731	$ 11,135	$ 14,927	$ 15,330	$ 24,205	$ 24,609	$ 32,274	$ 16,137
18	$ 2,544	$ 2,935	$ 11,301	$ 11,726	$ 15,719	$ 16,144	$ 25,490	$ 25,915	$ 33,987	$ 16,994
19	$ 2,680	$ 3,091	$ 11,871	$ 12,317	$ 16,512	$ 16,958	$ 26,775	$ 27,222	$ 35,700	$ 17,850
20	$ 2,816	$ 3,247	$ 12,440	$ 12,908	$ 17,304	$ 17,772	$ 28,060	$ 28,528	$ 37,414	$ 18,707
Each add'l add	$ 136	$ 156	$ 570	$ 592	$ 793	$ 814	$ 1,285	$ 1,307	$ 1,714	$ 857

Family Size	2023 100% Annual Income Threshold (2022 FPL used for 2023 determinations)
1	$ 13,590
2	$ 18,310
3	$ 23,030
4	$ 27,750
5	$ 32,470
6	$ 37,190
7	$ 41,910
8	$ 46,630
9	$ 51,350
10	$ 56,070
11	$ 60,790
12	$ 65,510
13	$ 70,230
14	$ 74,950
15	$ 79,670
16	$ 84,390
17	$ 89,110
18	$ 93,830
19	$ 98,550
20	$ 103,270
Each add'l add	$ 4,720

ADOPT: 410-200-0455

NOTICE FILED DATE: 09/30/2024

RULE SUMMARY: Describes specific requirements for YSHCN eligibility.

CHANGES TO RULE:

410-200-0455
Specific Requirements - Young Adults with Special Health Care Needs.
In addition to the other eligibility requirements applicable to the Young Adults with Special Health Care Needs (YSHCN) program as set forth elsewhere within Chapter 410, including Division 200, this rule describes the specific eligibility requirements for the YSHCN program.¶
(1) The YSHCN program is effective January 1, 2025. ¶
(2) The YSHCN program provides OHP Plus coverage and supplementary benefits for individuals who meet the eligibility criteria, as follows:¶
(a) For individuals who are not eligible for an OHP Plus-level HSD Medical program under OAR 410-200-0015(47)(d) or 410-200-0015(47)(f)(A)-(E) or OSIPM program under OAR 461-101-0010(18), YSHCN provides full OHP Plus coverage as described in OAR 410-120-1210(4)(g)(A) as well as supplemental benefits described in OAR 410-120-1210(4)(g)(A)-(C).¶
(b) For individuals who are eligible for an OHP Plus-level HSD Medical program under OAR 410-200-0015(47)(d) or 410-200-0015(47)(f)(A)-(E) or OSIPM program under OAR 461-101-0010(18), YSHCN provides supplemental benefits described in OAR 410-120-1210(4)(g)(A)-(C).¶
(3) To be eligible for the YSHCN program, an individual must:¶
(a) Meet one of the two age criteria:¶
(A) Be 19 or 20 years of age; or¶
(B) Be eligible for and receiving YSHCN coverage at the time they turn 21 years of age. ¶
(b) Meet one of the two financial criteria:¶
(A) Be eligible for a MAGI Medicaid/CHIP program defined in OAR 410-200-0015(47)(d) or 410-200-0015(47)(f)(A)-(E) or OSIPM program as defined in OAR 461-101-0010(18); or¶
(B) Have MAGI-based household income under 200 percent of the federal poverty level (OAR 410-200-0315) for the applicable family size. ¶
(c) Meet at least one (1) of the following non-financial health-related criteria:¶
(A) Be identified as having a "complex chronic" condition or conditions based on the Pediatric Medical Complexity Algorithm (PMCA) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035595/); ¶
(B) Have a serious emotional disturbance or serious mental health issue as defined by an OHA-approved list of behavioral health diagnoses;¶
(C) Be eligible for services due to an intellectual or developmental disability, as described in OAR 411-320-0080, on or after turning age 16; or¶
(D) Meet at least two of the six categories represented in the YSHCN eligibility screening questions as follows:¶
(i) Receives or requires prescription medication for a physical, behavioral, developmental, emotional, or mental health condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19;¶
(ii) Often uses or often needs medical care, mental health, or other health services for a physical, behavioral, developmental, emotional, or mental health condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19;¶
(iii) Needs assistance to perform everyday activities due to a physical, behavioral, developmental, emotional, or mental health condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19;¶
(iv) Receives or needs treatment or counseling for a mental health, substance use, or emotional condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19;¶
(v) Often uses or often needs medical therapies, excluding counseling or talk therapy, for a physical, behavioral, developmental, emotional, or mental health condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19; or¶
(vi) Often uses or often needs medical equipment or assistive devices due to a physical, behavioral, developmental, emotional, or mental health condition which has lasted, or is expected to last, at least one (1) year and began before the individual was aged 19.¶
(4) The health-related qualifications for YSHCN non-financial eligibility described in section (3)(c) of this rule shall be reassessed as described below based on the method by which eligibility was initially determined as follows:¶
(a) For YSHCN beneficiaries who were determined eligible based on the Pediatric Medical Complexity Algorithm

(PMCA) described in section (3)(c)(A) of this rule, at each renewal, the Agency shall review submitted claims to confirm whether the individual has continued to receive care for the qualifying condition within the prior three (3) years. The Agency will:¶
(A) Continue YSHCN eligibility for the individual after confirming that the individual has sought care or services for their qualifying condition within the prior three (3) years, and as long as all other eligibility conditions are met; or¶
(B) Disenroll the individual from YSHCN after confirming that the individual has not sought care or services for their qualifying condition within the prior three (3) years.¶
(b) For YSHCN beneficiaries who were determined eligible based on a qualifying behavioral health diagnosis as described in sections (3)(c)(B) of this rule, at renewal, the Agency shall review submitted claims to confirm whether the individual has continued to receive care for the qualifying condition within the prior two (2) years. The Agency shall:¶
(A) Continue YSHCN eligibility for the individual after confirming that the individual has sought care or services for their qualifying condition within the prior two (2) years, and as long as all other eligibility conditions are met; or¶
(B) Disenroll the individual from YSHCN after confirming that the individual has not sought care or services for their qualifying condition within the prior two (2) years.¶
(c) For YSHCN beneficiaries who were determined eligible based on the YSHCN eligibility screening questions described in section (3)(c)(D), the screening must be performed at least every two (2) years at renewal. If the individual meets at least two (2) of the six (6) categories represented in the screening, this requirement is considered met when eligibility is evaluated.¶
[ED. NOTE: To view the list of behavioral health diagnoses referenced in rule text, click here for PDF copy.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.572, 414.605, 414.665, 414.719, 414.632, 411.402, 411.404, 411.095, 411.400, 411.406, 413.032, 413.038, 414.706

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Appendix A – List of Qualifying Behavioral Health Conditions

ICD-10 Diagnosis Code *The condition is challenging, chronic and complicated, regardless of individual characteristics and circumstances. A young adult with the condition should automatically be eligible for the Medicaid benefits.*	**ICD-10 Diagnosis Code Description**
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F78	Other intellectual disabilities
F78.A1	SYNGAP1-related intellectual disability
F78.A9	Other genetic related intellectual disability
F79	Unspecified intellectual disabilities
F80.1	Expressive language disorder
F80.2	Mixed receptive-expressive language disorder
F80.4	Speech and language development delay due to hearing loss
F80.81	Childhood onset fluency disorder (stuttering)
F81	Specific developmental disorders of scholastic skills
F81.0	Specific reading disorder
F81.2	Mathematics disorder
F81.8	Other developmental disorders of scholastic skills
F81.81	Disorder of written expression
F81.89	Other developmental disorders of scholastic skills
F81.9	Developmental disorder of scholastic skills, unspecified
F82	Specific developmental disorder of motor function
F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F88	Global developmental delay
F90	Attention-deficit hyperactivity disorders
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type
F95.1	Chronic motor or vocal tic disorder
F95.2	Tourette's disorder

F06.0	Psychotic disorder due to another medical condition (Psychotic disorder with hallucinations due to known physiological condition)
F06.2	Psychotic disorder due to another medical condition (Psychotic disorder with delusions due to known physiological condition)
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.8	Other schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia
F21	Schizotypal disorder
F25	Schizoaffective disorders
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other specified schizophrenia spectrum disorder
F29	Unspecified schizophrenia spectrum disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F31	Bipolar disorder
F31.0	Bipolar disorder, current episode hypomanic
F31.1	Bipolar disorder, current episode manic without psychotic features
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.3	Bipolar disorder, current episode depressed, mild or moderate severity

F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.6	Bipolar disorder, current episode mixed
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.7	Bipolar disorder, currently in remission
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.8	Other bipolar disorders
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F34.0	Cyclothymic disorder
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.4	Major depressive disorder, recurrent, in remission
F33.41	Major depressive disorder, recurrent, in partial remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

F34.8	Disruptive mood dysregulation disorder
F06.4	Anxiety disorder due to another medical condition
F40.0	Agoraphobia
F41.0	Panic disorder
F41.1	Generalized anxiety disorder
F41.9	Unspecified anxiety disorder
F93	Separation anxiety disorder
F94	Selective mutism
F06.8	Obsessive-compulsive and related disorder or other specified mental disorder due to another medical condition
F42	Obsessive compulsive disorder, hoarding, and related disorders
F42.2	(Mixed obsessional thoughts and acts)
F42.3	(Hoarding disorder)
F42.4	(Excoriation [skin-picking] disorder)
F42.8	(Other obsessive-compulsive disorder)
F42.9	Obsessive-compulsive disorder, unspecified
F45.22	Body dysmorphic disorder
F63.3	Trichotillomania (hair pulling disorder)
F43	Acute stress disorder
F43.1	PTSD
F43.12	(PTSD, chronic)
F94.1	Reactive attachment disorder
F44.0	Dissociative amnesia
F44.81	Dissociative identity disorder
F44.89	(Other specified dissociative disorder)
F45.22	Body dysmorphic disorder
F45.8	(Other specified somatic symptom and related disorder)
F48.1	(Dissociative disorders. Depersonalization/Derealization disorder)
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F45.21	Hypochondriasis / (Somatic symptom and related disorders. Illness anxiety disorder)
F50	Eating disorders
F50.0	Anorexia nervosa
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	(Feeding and eating disorders. In adults) / Other eating disorders
F50.81	Binge eating disorder

F50.89	(Other specified feeding or eating disorder)
F98.3	(Feeding and eating disorders. In children) [Pica]
F98.1	Encopresis not due to a substance or known physiological condition
F64	Gender dysphoria
F63	Impulse disorders
F63.1	Pyromania / (Disruptive, impulse control, and conduct disorders. Pyromania)
F63.2	Kleptomania
F63.81	Intermittent explosive disorder
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other conduct disorders
F91.9	Conduct disorder, unspecified
F10.2*	F10.22-.288 Now alcohol use disorder moderate, severe, alcohol intoxication with severe Sx, alcohol withdrawal with severe Sx, alcohol-induced disorders
F10.21	Alcohol dependence, in remission
F10.9*	Alcohol induced disorders; F10.96 Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F11.1*	Opioid use disorder and intoxication, mild
F11.2*	Opioid use disorder and intoxication, severe
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.9*	Opioid induced disorders
F12.2*	Cannabis dependence
F12.20	(Substance-related and addictive disorders. Moderate, severe)
F13.1*	Sedative, hypnotic, or anxiolytic-related abuse
F13.2*	Sedative, hypnotic, or anxiolytic-related dependence
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F14.2*	Cocaine dependence
F14.20	Cocaine dependence, uncomplicated
F15.2*	Other stimulant dependence
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F16.2*	Hallucinogen dependence
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F18.2*	Inhalant dependence

F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F19.2*	Other psychoactive substance dependence
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F63.0	Pathological gambling
F02.811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
F02.818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
F02.82	Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance
F02.83	Dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance
F02.84	Dementia in other diseases classified elsewhere, unspecified severity, with anxiety
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety
F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety

F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
F03.911	Unspecified dementia, unspecified severity, with agitation
F03.918	Unspecified dementia, unspecified severity, with other behavioral disturbance
F03.92	Unspecified dementia, unspecified severity, with psychotic disturbance
F03.93	Unspecified dementia, unspecified severity, with mood disturbance
F03.94	Unspecified dementia, unspecified severity, with anxiety
F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.A11	Unspecified dementia, mild, with agitation
F03.A18	Unspecified dementia, mild, with other behavioral disturbance
F03.A2	Unspecified dementia, mild, with psychotic disturbance
F03.A3	Unspecified dementia, mild, with mood disturbance
F03.A4	Unspecified dementia, mild, with anxiety
F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.B11	Unspecified dementia, moderate, with agitation
F03.B18	Unspecified dementia, moderate, with other behavioral disturbance
F03.B2	Unspecified dementia, moderate, with psychotic disturbance
F03.B3	Unspecified dementia, moderate, with mood disturbance
F03.B4	Unspecified dementia, moderate, with anxiety
F03.C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.C11	Unspecified dementia, severe, with agitation
F03.C18	Unspecified dementia, severe, with other behavioral disturbance
F03.C2	Unspecified dementia, severe, with psychotic disturbance
F03.C3	Unspecified dementia, severe, with mood disturbance
F03.C4	Unspecified dementia, severe, with anxiety
G10	Huntington's disease
F60	Specific personality disorders
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder

F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.8	Other specific personality disorders
F60.81	Narcissistic personality disorder
F60.89	Other specific personality disorders
F60.9	Personality disorder, unspecified
F65*	Paraphilic disorder
G04	Encephalitis, myelitis and encephalomyelitis
G04.0	Acute disseminated encephalitis and encephalomyelitis (ADEM)
G04.3	Acute necrotizing hemorrhagic encephalopathy
G04.31	Postinfectious acute necrotizing hemorrhagic encephalopathy
G04.32	Postimmunization acute necrotizing hemorrhagic encephalopathy
G04.8	Other encephalitis, myelitis and encephalomyelitis
G04.81	Other encephalitis and encephalomyelitis
G04.9	Encephalitis, myelitis and encephalomyelitis, unspecified
G04.90	Encephalitis and encephalomyelitis, unspecified
G05	Encephalitis, myelitis and encephalomyelitis in disease classified elsewhere
G05.3	Encephalitis and encephalomyelitis in disease classified elsewhere
G09	Sequelae of inflammatory diseases of central nervous system
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia
G11.10	Early-onset cerebellar ataxia, unspecified
G11.3	Cerebellar ataxia with defective DNA repair
G11.8	Other hereditary ataxias
G12	Spinal muscular atrophy and related syndromes
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.2	Motor neuron disease
G12.21	Amyotrophic lateral sclerosis
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G23	Other degenerative diseases of basal ganglia
G23.0	Hallervorden-Spatz disease

G23.1	Progressive supranuclear ophthalmoplegia [Steele-Richardson-Olszewski]
G23.2	Striatonigral degeneration
G23.8	Other specified degenerative diseases of basal ganglia
G25.82	Stiff-man syndrome
G31.81	Alpers disease
G31.82	Leigh's disease
G31.9	Degenerative disease of nervous system, unspecified
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere
G35	Multiple sclerosis
G37.2	Central pontine myelinolysis
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G40.0	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset
G40.00	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable
G40.001	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus
G40.009	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus
G40.011	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
G40.101	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus

G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
G40.11	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable
G40.2	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40.21	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40.3	Generalized idiopathic epilepsy and epileptic syndromes
G40.30	Generalized idiopathic epilepsy and epileptic syndromes, not intractable
G40.301	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.31	Generalized idiopathic epilepsy and epileptic syndromes, intractable
G40.311	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.4	Other generalized epilepsy and epileptic syndromes
G40.40	Other generalized epilepsy and epileptic syndromes, not intractable

G40.401	Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.409	Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.41	Other generalized epilepsy and epileptic syndromes, intractable
G40.411	Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419	Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.42	Cyclin-Dependent Kinase-Like 5 Deficiency Disorder
G40.5	Epileptic seizures related to external causes
G40.50	Epileptic seizures related to external causes, not intractable
G40.501	Epileptic seizures related to external causes, not intractable, with status epilepticus
G40.509	Epileptic seizures related to external causes, not intractable, without status epilepticus
G40.511	Special epileptic syndromes, intractable, with status epilepticus
G40.80	Other epilepsy
G40.801	Other epilepsy, not intractable, with status epilepticus
G40.809	Other epilepsy, not intractable, without status epilepticus
G40.811	Lennox-Gastaut syndrome, not intractable, with status epilepticus
G40.812	Lennox-Gastaut syndrome, not intractable, without status epilepticus
G40.813	Lennox-Gastaut syndrome, intractable, with status epilepticus
G40.814	Lennox-Gastaut syndrome, intractable, without status epilepticus
G40.819	Other epilepsy, intractable, without status epilepticus
G40.82	Epileptic spasms
G40.821	Epileptic spasms, not intractable, with status epilepticus
G40.822	Epileptic spasms, not intractable, without status epilepticus
G40.823	Epileptic spasms, intractable, with status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus
G40.833	Dravet syndrome, intractable, with status epilepticus
G40.834	Dravet syndrome, intractable, without status epilepticus
G40.9	Epilepsy, unspecified
G40.90	Epilepsy, unspecified, not intractable
G40.901	Epilepsy, unspecified, not intractable, with status epilepticus
G40.909	Epilepsy, unspecified, not intractable, without status epilepticus

G40.91	Epilepsy, unspecified, intractable
I69.920	Aphasia following unspecified cerebrovascular disease
I69.921	Dysphasia following unspecified cerebrovascular disease
I69.922	Dysarthria following unspecified cerebrovascular disease
I69.923	Fluency disorder following unspecified cerebrovascular disease
B25.9	Cytomegaloviral disease, unspecified
Q90.2	Trisomy 21
Q90.9	Down syndrome, unspecified
Q99.2	Fragile X chromosome
I169.31	Cognitive deficits following cerebral infarction
*** Indicates that all subcodes are included.**	

Appendix B – Final YSHCN Screener for OHP Application

The next questions will be used to screen for a program for young adults with ongoing health conditions. This program covers more services than other OHP programs for adults like extra dental and vision services and more types of specialty care. If you choose to answer these questions, [individual name/s] will be screened for this medical program.

1. **Currently, do you take <u>prescription medicine</u>? (This <u>excludes</u> vitamins and birth control.)**
   - ○ Yes → Go to Question 1b
   - ○ No → Go to Question 1a

1a. Do you <u>need</u> prescription medicine that you do <u>not</u> get? (This <u>excludes</u> vitamins and birth control.)
- ○ Yes → Go to Question 1b
- ○ No → Go to Question 2

1b. Is this because of <u>any</u> health condition? A health condition is a physical, behavioral, developmental, emotional, or mental health condition.
- ○ Yes → Go to Question 1c
- ○ No → Go to Question 2

1c. Has this condition lasted for at least one year, or is it expected to last for at least one year?
- ○ Yes → Go to Question 1d
- ○ No → Go to Question 2

1d. Did this condition begin <u>before</u> you turned 19 years old?
- ○ Yes → Go to Question 2

- No → Go to Question 2
- I am younger than 19 years old. → Go to Question 2

2. **Do you often use <u>medical care, mental health, or other health services</u>?**
   - Yes → Go to Question 2b
   - Yes, when your condition is worse or exacerbated → Go to Question 2b
   - No → Go to Question 2a

2a. Do you <u>need</u> medical care, mental health, or other health services that you do <u>not</u> get?
- Yes → Go to Question 2b
- No → Go to Question 3

2b. Is this because of <u>any</u> health condition? A health condition is a physical, behavioral, developmental, emotional, or mental health condition.
- Yes → Go to Question 2c
- No → Go to Question 3

2c. Has this condition lasted for at least one year, or is it expected to last for at least one year?
- Yes → Go to Question 2d
- No → Go to Question 3

2d. Did this condition begin <u>before</u> you turned 19 years old?
- Yes → Go to Question 3
- No → Go to Question 3
- I am younger than 19 years old → Go to Question 3

3. **Do you need assistance to do your <u>everyday activities</u>? Examples of everyday activities include cooking, doing housework, completing paper work or school work, going to school or work or appointments, spending time with friends, and other activities. Assistance can include someone helping you or using a device or equipment to help you.**
   - Yes, all of the time → Go to Question 3a
   - Yes, some of the time → Go to Question 3a
   - No → Go to Question 4

3a. Is this because of <u>any</u> health condition? A health condition is a physical, behavioral, developmental, emotional, or mental health condition.
- Yes → Go to Question 3b
- No → Go to Question 4

3b. Has this condition lasted for at least one year, or is it expected to last for at least one year?

- Yes → Go to Question 3c
- No → Go to Question 4

3c. Did this condition begin <u>before</u> you turned 19 years old?

- Yes → Go to Question 4
- No → Go to Question 4
- I am younger than 19 years old → Go to Question 4

4. **Do you get <u>treatment or counseling</u> for a mental health, substance use, or emotional condition? Treatment or counseling can include talk therapy, group therapy, hospitalization, inpatient or outpatient care, exposure therapy, Applied Behavior Analysis, and other treatments.**
   - Yes → Go to Question 4b
   - Sometimes → Go to Question 4b
   - No → Go to Question 4a

4a. Do you <u>need</u> treatment or counseling for a mental health, substance use, or emotional condition that you do <u>not</u> get?

- Yes → Go to Question 4b
- No → Go to Question 5

4b. Has this condition lasted for at least one year, or is it expected to last for at least one year?

□ Yes → Go to Question 4c
□ No → Go to Question 5

4c. Did this condition begin <u>before</u> you turned 19 years old?

- Yes → Go to Question 5
- No → Go to Question 5
- I am younger than 19 years old → Go to Question 5

5. **Do you often use <u>medical</u> therapies? Medical therapies can include acupuncture, dialysis, infusions, physical therapy, occupational therapy, speech therapy, respiratory therapy, therapy to manage or reduce pain, and others. Medical therapies <u>do not include</u> counseling or talk therapy.**
   - Yes → Go to Question 5b
   - No → Go to Question 5a

5a. Do you often need medical therapies that you do <u>not</u> get?

- Yes → Go to Question 5b
- No → Go to Question 6

5b. Is this because of <u>any</u> health condition? A health condition is a physical, behavioral, developmental, emotional, or mental health condition.

- Yes → Go to Question 5c
- No → Go to Question 6

5c. Has this condition lasted for at least one year, or is it expected to last for at least one year?

- Yes → Go to Question 5d
- No → Go to Question 6

5d. Did this condition begin <u>before</u> you turned 19 years old?

- Yes → Go to Question 6
- No → Go to Question 6
- I am younger than 19 years old → Go to Question 6

6. **Do you often use medical equipment or assistive devices? Medical equipment and assistive devices include canes, communication devices, crutches, diabetes pumps, gastrointestinal tubes, hearing aids, nebulizers, note-taking systems, reminder systems, ventilators, vision aids, wheelchairs, and other equipment and devices.**
   - Yes → Go to Question 6b
   - No → Go to Question 6a

6a. Do you need medical equipment or assistive devices that you do <u>not</u> have?

- Yes → Go to Question 6b
- No → End YSHCN Questions

6b. Is this because of <u>any</u> health condition? A health condition is a physical, behavioral, developmental, emotional, or mental health condition.

- Yes → Go to Question 6c
- No → End YSHCN Questions

6c. Has this condition <u>lasted</u> for at least one year, or is it <u>expected to last</u> for at least one year?

- Yes → Go to Question 6d
- No → End YSHCN Questions

6d. Did this condition begin <u>before</u> you turned 19 years old?

- Yes → End YSHCN Questions
- No → End YSHCN Questions
- I am younger than 19 years old → End YSHCN Questions