



NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410

OREGON HEALTH AUTHORITY

HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/28/2026 11:31 AM

ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Work or Activity Rules for Medicaid Expansion and 1115 waiver program population.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:

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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/19/2026

TIME: 11:00 AM - 11:45 AM

OFFICER: Brenna Bird

REMOTE HEARING DETAILS

MEETING URL: [Click here to join the meeting](#)

PHONE NUMBER: 669-254-5252

CONFERENCE ID: 1657600792

SPECIAL INSTRUCTIONS:

Meeting ID: 165 760 0792

Passcode: 545785

NEED FOR THE RULE(S):

Section 71119 of the One Big Beautiful Bill Act requires the implementation of community engagement requirements for Medicaid applicants and recipients (known as Medicaid Work or Activity Rules in Oregon). These work rules

specifically impact individuals applying for or receiving benefits as part of the ACA Medicaid Expansion Group (Adult Program), the Healthier Oregon Adult Group, and the waiver program-Young Adults with Special Health Care Needs group (YSHCN). Individuals evaluated for these programs, or receiving benefits in these programs are required to demonstrate work or other activity or to meet and exemption as a condition of eligibility. The change takes effect with new applications with DOR on or after January 1, 2027 and for existing members with renewal dates of 3/31/2027.

410-200-0015-General Definitions-Amending: This rule is amended to add new definitions relating to new Medicaid Work or Activity Rules.

410-200-0105-Hospital Presumptive Eligibility-Amending: This rule is amended to implement the changes in eligibility requirements related to new work or activity rules to receive benefits in the MAGI Adult group as part of a Hospital Presumptive determination.

410-200-0221 Specific Requirements; Medicaid Work or Activity Rules: This is a new rule created to define a new condition of eligibility to receive benefits in the MAGI Adult Program including under Healthier Oregon, and the Young Adults with Special Health Care Needs, including under Healthier Oregon. This rule defines the specific requirements of the work or activity rules as required by federal legislation.

410-200-0230 Verification – Amending: This rule is amended to include new verification requirements for new data elements collected as part of the new Medicaid Work or Activity Rules and to align with the State’s Verification Plan on how income is verified.

410-200-0235 Changes That Must Be Reported – Amending: This rule is amended for minor grammar and simple word changes to improve clarity and the addition of Medicaid work or activity rules related reporting requirements.

410-200-0435 Specific Requirements; MAGI Adult Group – Amending: This rule is amended to include the requirement to be excluded from, or to demonstrate compliance with Medicaid Work or Activity Rules as a condition of eligibility for this group.

410-200-0455 Specific Requirements; Youth with Special Health Care Needs – Amending: This rule is amended to include the requirement to be excluded from, or to demonstrate compliance with Medicaid Work or Activity Rules as a condition of eligibility for this group, and to make digitally accessible tables.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Section 71119 Reducing State Medicaid Costs in "Text - H.R.1 - 119th Congress (2025-2026): An act to provide for reconciliation pursuant to title II of H. Con. Res. 14." Congress.gov, Library of Congress, 4 July 2025, <https://www.congress.gov/bill/119th-congress/house-bill/1/text>.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

We anticipate the Work or Activity rule changes will impede our state’s work to achieve health equity for all people in Oregon by 2030, but we do not have data yet to confirm the consequences of these rules. The Work or Activity rules create additional administrative requirements for OHP members and community members applying for OHP, which puts eligible community members at risk of losing health care coverage. These rules may impact communities of color disproportionately, as Hispanic, Black, American Indian or Alaska Native, and Native Hawaiian or Pacific Islander communities are more likely than White communities to be enrolled in Medicaid. OHP members and community members applying for OHP who experience structural racism due to their race/ethnicity and additional barriers to

accessing public systems due to other parts of their identity (such as due to ability, sexual orientation, gender identity, gender, geography, and socio-economic status) may find it difficult to learn about the new rules and to report their activities to meet the rules or their qualifying exemptions. These community members may be especially at risk of losing or being denied OHP coverage. During other periods of large administrative changes to Medicaid, such as when continuous enrollment ended in some states after the COVID-19 pandemic, many members lost coverage due to “procedural reasons” – essentially, applications with missing information or missing contact information. In a national survey, Black and Hispanic community members were twice as likely as White community members to share they lost Medicaid due to challenges with the renewal process.² In addition, we anticipate any process to secure paperwork from a health care provider – for example, to demonstrate a health condition impairs someone’s ability to work at least part-time – may burden communities of color disproportionately due to systemic barriers these communities face in accessing trusted, culturally responsive health care.

Oregon is implementing several strategies to limit the reporting burden on OHP members and community members applying for OHP and to mitigate the possible loss of OHP coverage by:

- Increasing automatic verification and using technology so people can automatically upload payroll documents
- Increasing ease of access
 - o ONE Online accounts and the Oregon ONE Mobile app user access have been enhanced and member access made easier
 - o OHP members can text wage stubs for automated processing into the ONE Eligibility System
- Leveraging SNAP and TANF work registration compliance information
 - o Case Managers have prioritized supporting people getting enrolled in SNAP and TANF work requirement programs; if a person meets the SNAP or TANF work requirements, they will be automatically exempt from Medicaid

Oregon remains committed to advancing health equity by ensuring OHP members, community members applying for OHP, community organization partners, and health care providers remain informed about the new rules, how to comply with them, and where to seek support. These rule changes will be communicated to individuals through notices, websites describing HR1 changes, and media, and will also be communicated to community partners to assist in getting the message to OHP members and community members applying for OHP in their preferred languages and communication venues.

INPUT SUMMARIES FROM RAC MEMBERS:

Communities experiencing systemic barriers, especially Black, Indigenous, undocumented, houseless individuals, and people living in rural or frontier Oregon, are likely to be disproportionately affected by work and activity requirements. Higher unemployment rates among Black and Indigenous communities, combined with existing health inequities, mean these groups may struggle more to keep their coverage. Many people already face language barriers, limited access to technology, fear of engaging with government systems, or the added challenges of living in rural and frontier areas where natural disasters and infrastructure gaps make meeting requirements even harder. Losing coverage would significantly disrupt people’s ability to stay healthy. Anything the state can do to create exemptions wherever possible will help the most vulnerable community members maintain their coverage.

Engaging HRSN service providers could be a valuable way to strengthen outreach and support members in meeting Medical Work Requirements. Service providers working with houseless communities have also raised concerns about their capacity to hire, train, and dedicate OHP assisters, and will need support to ramp up that work.

1) Kaiser Family Foundation: <https://www.kff.org/medicaid/medicaid-efforts-to-address-racial-health-disparities/>

FISCAL AND ECONOMIC IMPACT:

Comments from RAC members highlight significant concerns that increased administrative requirements or loss of OHP coverage will disproportionately affect priority populations, including people with language barriers, limited literacy, unstable house or lack of access to technology. These barriers could make it difficult for individuals to renew coverage, provide required documentation, leading to loss of coverage that could result in disruptions to medication access and essential care.

From a financial perspective, safety net provider anticipate major financial impacts due to gaps in insurance that would result in reduced reimbursement, and increased reliance on emergency care vs preventative care, which will cause an increase reliance on emergency care, raising costs for the health system across the state.

The increase in administrative burden for both clients and health systems is challenging and resource-intensive for vulnerable populations and providers.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).

Oregon Health Authority, local public health agencies, community-based organizations, Federally Qualified Health Centers, community health centers, public health partners, and Medicaid recipients may be economically affected by the rule change.

(2) Effect on Small Businesses:

The Centers for Medicare and Medicaid Services (CMS) and the Oregon Health Authority (OHA) do not currently track the rate of Medicaid enrolled providers that are also small businesses.

(a) Estimate the number and type of small businesses subject to the rule(s);

While small businesses themselves aren't directly subject to the rules, they could realize impacts of the rules on their patients if those patients begin to lose medical insurance due to the new Medicaid eligibility requirements. Examples of small businesses likely impacted could include rural health providers, clinicians with private practices, and privately-owned medical clinics. Oregon Health Authority does not have data to identify the number of small businesses potentially impacted by this change.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);

These rule changes are not expected to affect small business reporting, recordkeeping or administrative activities except to the degree that they might voluntarily wish to help patients comply with the rules.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

The Oregon Health Authority anticipates increased costs and administration to ensure compliance with these rules to the degree small businesses might voluntarily wish to assist patients with compliance. However, the exact fiscal impact and timeline for data are unknown.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited to and participated in the Rules Advisory Committees to help identify the racial equity and fiscal impact of these rules.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-200-0015, 410-200-0105, 410-200-0221, 410-200-0230, 410-200-0235, 410-200-0435, 410-200-0455

AMEND: 410-200-0015

RULE SUMMARY: Capitalize defined terms, spell out acronyms and grammar corrections. Addition of defined terms "Legal Guardian" and "Family Caregiver"

CHANGES TO RULE:

410-200-0015

General Definitions ¶¶

The following definitions apply to Oregon Administrative Rules (OAR) Chapter 410, Division 200. The definitions in OAR 410-120-0000 are incorporated and apply to any terms not defined in this division of OAR. If the same term appears in both OAR 410-120-0000 and this rule, and the defined meanings are different, the definition for the term as it appears in this rule shall take precedence.¶¶

(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or ~~€~~Covered ~~€~~Services.¶¶

(2) "Active ~~€~~Renewal" means the ~~€~~Renewal process for cases that are not processed via ~~€~~Automated ~~€~~Renewal wherein a prepopulated ~~€~~Renewal notice is sent to the ~~€~~Head of ~~€~~Household and ~~€~~Authorized ~~€~~Representative, if applicable. The ~~€~~Active ~~€~~Renewal notice is populated with the most current case information relevant to renewal.¶¶

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

(4) ~~"Assumed Eligible Newborn (AEN) means (" has the meaning provided in OAR 410-200-0145)35.¶¶~~

(5) "Affordable Care Act (ACA)" 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 ~~€~~FFMthe Federally Facilitated Marketplace (FFM), or the State-Based Marketplace (SBM).¶¶

(8) "Application" means:¶¶

(a) The single streamlined ~~€~~Application for all ~~€~~Insurance ~~€~~Affordability ~~€~~Programs developed by the Authority, the ~~€~~FFM, or the ~~€~~FFSBM; or¶¶

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

(9) ~~"Advance ~~€~~Payments of the ~~€~~Premium ~~€~~Tax ~~€~~Credit (APTC)," means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.¶¶~~

(10) "Assumed ~~€~~Eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.¶¶

- (11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an ~~a~~Applicant or ~~b~~Beneficiary in assisting with the individual's ~~a~~Application and renewal of eligibility and other on-going communications with the Agency (see OAR 410-200-0111).¶
- (12) "Automated ~~r~~Renewal" means a ~~r~~Renewal of eligibility, initiated by the Agency, based on reliable information contained in the ~~b~~Beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the ~~a~~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 Health Systems Division (HSD) Medical Programs benefits, Aging and People with Disabilities medical program benefits, or ~~APT~~CAdvance payments of the Premium Tax Credit (APTC).¶
- (14) "Behavior Rehabilitation Services (BRS)" means a program that provides services and placement-related activities to the BRS ~~client~~beneficiary to address their debilitating psychosocial, emotional, and behavioral disorders in a community placement utilizing either a residential care model or a proctor care model (OAR 410-170-0020).-¶
- (15) "Budget ~~m~~Month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.¶
- (16) "Caretaker" means a ~~p~~Parent, ~~e~~Caretaker ~~r~~Relative, or non-related ~~e~~Caretaker who assumes primary responsibility for a ~~e~~Child's care.¶
- (17) "Caretaker ~~r~~Relative" means an individual with whom the ~~e~~Child is living who assumes primary responsibility for the ~~e~~Child's care, and who is one of the following:¶
- (a) A relative of the dependent ~~e~~Child, as follows:¶
 - (A) A biological relative, including ~~p~~Parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great;¶
 - (B) Step-parent and step-siblings; ~~or~~¶
 - (C) An individual who legally adopts the ~~e~~Child and any individual related to the individual adopting the child.¶
 - (b) The ~~s~~Spouse of the ~~p~~Parent or relative even after the marriage is terminated by death or divorce.¶
- (18) "Citizenship Waived Medical (CWM)" was a benefit package that ended on June 30, 2023. The CWM benefit package covered certain emergency services provided to individuals who met the financial and non-financial eligibility requirements for an HSD Medical Program, except they did not meet citizenship and ~~a~~Non-~~e~~Citizen status requirements (OAR 410-200-0215). For information about CWM benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.¶
- (19) "Citizenship Waived Medical Plus (CMW Plus)" was a benefit package that was previously referred to as "CWX" and ended on June 30, 2023. CWM Plus provided OHP Plus benefits to pregnant individuals and individuals who were sixty (60) days post-partum and who met the financial and non-financial status requirements for an HSD Medical Program, except they did not meet the citizenship and ~~a~~Non-~~e~~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 ~~p~~Parent, under the age of 19. Child does not include an unborn.¶
- (21) "Children's Health Insurance Program (CHIP)" means Oregon medical coverage under Title XXI of the Social Security Act.¶
- (22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and ~~a~~Non-~~e~~Citizen nationals of the United States.¶
- (23) "Claim" means a legal action or a demand by, or on behalf of, an ~~a~~Applicant or ~~b~~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 Division 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 ~~e~~Content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another ~~i~~Insurance ~~a~~Affordability ~~p~~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 ~~p~~Parents are divorced, separated, or unmarried, the ~~p~~Parent with whom the ~~e~~Child lives, with the following considerations:¶

(a) If the ~~e~~C~~h~~i~~l~~d lives part-time with both ~~p~~P~~a~~r~~e~~n~~t~~s, the ~~p~~P~~a~~r~~e~~n~~t~~ with whom the ~~e~~C~~h~~i~~l~~d spends most nights is the ~~e~~C~~u~~s~~t~~o~~d~~i~~a~~l ~~p~~P~~a~~r~~e~~n~~t~~; or

(b) If section (30) subsection (a) cannot be determined due to the ~~e~~C~~h~~i~~l~~d spending equal nights with both ~~p~~P~~a~~r~~e~~n~~t~~s, a court order or binding custody agreement establishing physical custody is used to identify the ~~e~~C~~u~~s~~t~~o~~d~~i~~a~~l ~~p~~P~~a~~r~~e~~n~~t~~.

(31) "Date of Request (DOR)" means the date on which the ~~a~~A~~p~~p~~l~~i~~c~~a~~n~~t or an individual authorized to act on behalf of the ~~a~~A~~p~~p~~l~~i~~c~~a~~n~~t contacts the ~~A~~u~~t~~h~~o~~r~~i~~t~~y~~, ~~t~~h~~e~~ ~~D~~e~~p~~a~~r~~t~~m~~e~~n~~t~~a~~g~~e~~n~~c~~y, ~~t~~h~~e~~ ~~F~~F~~M~~, or the ~~F~~F~~S~~B~~M~~ to request medical benefits.

(a) For new ~~a~~A~~p~~p~~l~~i~~c~~a~~n~~ts, the DOR is established as follows:

(A) The ~~d~~D~~a~~t~~e~~ the ~~r~~R~~e~~q~~u~~e~~s~~t for medical benefits is received by the Agency, the FFM, ~~t~~h~~e~~ ~~S~~B~~M~~, or a ~~e~~C~~o~~m~~m~~u~~n~~i~~t~~y ~~p~~P~~a~~r~~t~~n~~e~~r; or

(B) The date the ~~a~~A~~p~~p~~l~~i~~c~~a~~n~~t received a ~~m~~M~~e~~d~~i~~c~~a~~l ~~s~~S~~e~~r~~v~~i~~c~~e, if the request for medical benefits is received by midnight of the following business day.

(b) For current ~~b~~B~~e~~n~~e~~f~~i~~c~~i~~a~~r~~i~~e~~s of HSD Medical Programs, the Date of Request is:

(A) The date the ~~b~~B~~e~~n~~e~~f~~i~~c~~i~~a~~r~~y or someone authorized to act on the ~~b~~B~~e~~n~~e~~f~~i~~c~~i~~a~~r~~y's behalf reports a change requiring a ~~r~~R~~e~~d~~e~~t~~e~~r~~m~~i~~n~~a~~t~~i~~o~~n 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;

(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 ~~r~~R~~e~~n~~e~~w~~a~~l or RFI.

(c) The request may be submitted via the Internet, by telephone, ~~e~~C~~o~~m~~m~~u~~n~~i~~t~~y ~~p~~P~~a~~r~~t~~n~~e~~r, by mail, by electronic communication, or in person.

(32) "Decision ~~n~~N~~o~~t~~i~~c~~e~~" means a written notice of a decision made regarding eligibility for an ~~H~~S~~D~~ ~~D~~i~~v~~i~~s~~i~~o~~n Medical Program benefit. The following are types of ~~d~~D~~e~~c~~i~~s~~i~~o~~n~~ ~~n~~N~~o~~t~~i~~c~~e~~s:

(a) "Basic ~~d~~D~~e~~c~~i~~s~~i~~o~~n~~ ~~n~~N~~o~~t~~i~~c~~e~~" which is mailed no later than the date of action given in the notice;

(b) "Combined ~~d~~D~~e~~c~~i~~s~~i~~o~~n~~ ~~n~~N~~o~~t~~i~~c~~e~~" which informs an individual or multiple family members of a household of the eligibility decision made for each of the ~~m~~M~~e~~d~~i~~c~~a~~l ~~a~~A~~s~~s~~i~~s~~tance ~~p~~P~~r~~o~~g~~r~~a~~m~~s~~;~~

(c) "Timely ~~e~~C~~o~~n~~t~~i~~n~~u~~i~~n~~g~~ ~~b~~B~~e~~n~~e~~f~~i~~t ~~d~~D~~e~~c~~i~~s~~io~~n~~ ~~n~~N~~o~~t~~i~~c~~e~~" which informs the ~~c~~l~~i~~e~~n~~t~~M~~e~~m~~b~~e~~r 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 ~~e~~l~~i~~e~~n~~t~~M~~e~~m~~b~~e~~r~~s~~ 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 ~~e~~C~~h~~i~~l~~d" means an individual who:

(a) Is under the age of 18, or is 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 ~~e~~C~~a~~r~~e~~t~~a~~k~~e~~r ~~r~~R~~e~~l~~a~~t~~i~~v~~e~~; 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 ~~e~~C~~h~~i~~l~~d satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.

(37) "Electronic ~~a~~A~~c~~c~~o~~u~~n~~t" 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 ~~A~~u~~t~~h~~o~~r~~i~~t~~y~~, ~~t~~h~~e~~ ~~F~~F~~M~~, or the ~~F~~F~~S~~B~~M~~ appeals process.

(38) "Electronic ~~a~~A~~p~~p~~l~~i~~c~~a~~t~~i^on" means an ~~a~~A~~p~~p~~l~~i~~c~~a~~t~~i^on electronically signed and submitted through the Internet.

(39) "Eligibility ~~d~~D~~e~~t^er~~m~~iⁿa^ti^on" means an approval, denial, renewal, or termination of eligibility.

(40) "Eligibility Determination Group" (EDG)" means all persons whose financial and non-financial information is considered in determining each medical ~~a~~A~~p~~p~~li^caⁿt's eligibility as defined in OAR 410-200-0305.~~

(41) "Expedited ~~a~~A~~p~~p~~e~~a^l" ~~also called or~~ "eExpedited ~~h~~H~~e~~a^riⁿg" means a hearing held within five (5) working days of the Agency's receipt of a hearing request, unless the ~~e~~C~~l~~aⁱm^an^t requests more time.

(42) "Family Caregiver" means an adult family member or other individual who has a significant relationship with, and who provides care within a broad range of assistance to, a Child under the age of 14 or to a disabled individual of any age who meets the Americans with Disabilities Act definition of disability at 28 CFR 35.108. A significant relationship includes a relative, someone in the same tax filing group, or someone who resides in the same

household.

(43) "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.

(44) "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.

(45) "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).

(46) "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~~ ~~Oregon Department of Human Services~~ ~~Electronic~~ ~~Accounts~~ of individuals who are found potentially eligible.

(47) "Head of ~~h~~ Household (HOH)" means the primary ~~person~~ individual 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 ~~a~~ Application.

(48) "Health Systems Division Medical Programs (HSD Medical Programs)" means all programs under the Health Systems Division, except when the eligibility decision is made through a Hospital Presumptive Eligibility determination (OAR 410-200-0105), including:

(a) Extended Medical Assistance (EXT);

(b) Substitute Care;

(c) Breast and Cervical Cancer Treatment Program (BCCTP);

(d) Former Foster Care Youth Medical (FFCYM);

(e) OHP Bridge - Basic Health Program;

(f) "MAGI Medicaid/CHIP" means HSD Medical Programs for which eligibility is based on MAGI methodology, including:

(A) MAGI Child;

(B) MAGI Parent or Caretaker Relative;

(C) MAGI Pregnant Woman;

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

(E) MAGI Adult;

(F) OHP Bridge -Basic Medicaid; and

(G) Young Adults with Special Health Care Needs (YSHCN).

(49) "Healthier Oregon" is defined in OAR 410-120-0000(134).

(50) "Hearing ~~r~~ Request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to ~~a~~ Appeal an ~~Authority~~ ~~agency~~, ~~FFM~~, or ~~FFSBM~~ decision or ~~a~~ Action.

(51) "Insurance ~~a~~ Affordability ~~p~~ Program" means one of the following programs:

(a) Medicaid;

(b) CHIP;

(c) A program that makes coverage available in a qualified health plan through the FFM or SBM with ~~a~~ Advance ~~p~~ Payments of the ~~p~~ Premium ~~t~~ Tax ~~e~~ Credit established under section 36B of the Internal Revenue Code available to qualified individuals; or

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

(52) "Legal ~~a~~ Argument" has the meaning given in OAR 137-003-0008(c).

(53) "Legal Guardian" means an individual who is appointed by a court in accordance with ORS 125.305, and acting within the scope of the order or letters of guardianship issued by the court.

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

(55) "Modified Adjusted Gross Income (MAGI)" has the meaning defined in OAR 410-200-0310(4) and is used in determining eligibility based on annual income. MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:

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

(A) Children, regardless of age, who are included in the household of a ~~p~~ Parent; or

(B) Tax ~~d~~Dependents.¶

(b) In applying ~~subsection (535)~~(a) of this rule, IRC § 6012(a) (1) is used to determine who is required to file a tax return.¶

(546) "MAGI ~~b~~Based ~~i~~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; and¶

(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 paragraph (56)~~(c)(B) of this ~~section~~rule; 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; and¶

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

(557) "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.¶

(568) "Non-~~a~~Applicant" means an individual not seeking an eligibility determination for themselves and is included in an ~~a~~Applicant's or ~~b~~Beneficiary's household to determine eligibility for the ~~a~~Applicant or ~~b~~Beneficiary.¶

(579) "Non-~~e~~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).¶

(5860) "Oregon Supplemental Income Program Medical (OSIPM)" means medical coverage for individuals who are 65 years of age or older, who are blind, or who have a disability. This program is administered by the Oregon Department of Human Services.¶

(5961) "Parent" means a natural or biological, adopted, or stepparent.¶

(602) "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.¶

(613) "Primary Contact" has the same meaning given "~~H~~Head of ~~H~~Household" in this rule.¶

(624) "Psychiatric Residential Treatment Facility (PRTF)" means a facility that is a structured residential treatment environment with daily 24-hour supervision and active psychiatric treatment including Psychiatric Residential Treatment Services (PRTS), Secure Children's Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute Psychiatric Treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.¶

(635) "Public ~~i~~nstitution" 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; or¶

(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 OARs for chapter 410, division 200, 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.

~~(646)~~ "Qualified ~~H~~Hospital" means a hospital that meets all of the following criteria:

(a) Participates as an enrolled Oregon Medicaid ~~P~~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 ~~a~~Applicants for presumptive eligibility of their responsibility to complete a full ~~a~~Application by the end of the presumptive eligibility period and offers ~~a~~Applicants assistance with completing and submitting the full Medicaid ~~a~~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).

~~(657)~~ "Reasonable ~~o~~Opportunity ~~p~~Period";

(a) May be used to obtain necessary verification or resolve discrepancies regarding an attestation of US citizenship or ~~n~~Non-~~c~~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 ~~n~~Non-~~c~~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.

~~(668)~~ "Redetermination" means a review of eligibility outside of regularly scheduled ~~r~~Renewal. Redeterminations that result in the assignment of a new ~~r~~Renewal date are considered ~~r~~Renewals.

~~(679)~~ "Renewal" means a regularly scheduled periodic review of eligibility.

~~(6870)~~ "Request for ~~i~~Information (RFI)" means a notice sent by the ~~a~~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.

~~(6971)~~ "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 ~~p~~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~~ paragraph (i) above, 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.¶

(702) "Secure eElectronic 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.¶

(743) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.¶

(724) "Sibling" means natural or biological, adopted, half or step sibling.¶

(735) "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.¶

(746) "SSA" means Social Security Administration.¶

(77) "State-Based Marketplace (SBM)" means the online marketplace operated by the Oregon Health Authority's Oregon Health Insurance Marketplace which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The SBM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Oregon Department of Human Services electronic accounts of individuals who are found potentially eligible.¶

(758) "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.¶

(769) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).¶

(7780) "Young Adults with Special Health Care Needs" ~~or~~ "(YSHCN)" means a program for young adults who meet pre-determined social and clinical criteria, which provides supplementary benefits, in addition to OHP Plus coverage, including EPSDT, HRSN services, and extended vision and dental services.

Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534

Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706, 414.241, 42 USC §1396a (xx)

RULE SUMMARY: Capitalize defined terms, spell out acronyms and addition of Medicaid work or activity condition

CHANGES TO RULE:

410-200-0105

Hospital Presumptive Eligibility ¶

With the exception of OHP Bridge - Basic Medicaid and Young Adults with Special Health Care Needs (YSHCN), this rule sets out when an individual is presumptively eligible for MAGI Medicaid/CHIP, ~~BCCTP, and FFCYM, Breast and Cervical Cancer Treatment Program (BCCTP), and Former Foster Care Youth Medical (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 applicant's attestation of the following information:~~¶

(a) Family ~~Size~~;¶

(b) Household income;¶

(c) Receipt of other health coverage;¶

(d) Residency; ~~and~~¶

(e) US citizenship, US national, or ~~Non-Citizen~~ status.¶

(f) For individuals described in section (3)(d), attestation of either being in compliance with or meeting an exemption from Work or Activity Rules (OAR 410-200-0221).¶

(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 Adult~~ benefits via Hospital Presumptive Eligibility, an individual ~~may not be covered by any~~ must meet or be exempt from Work or Activity Rules (OAR 410-200-0221).¶

(c) To receive MAGI CHIP benefits via Hospital Presumptive Eligibility, an individual must not be receiving Minimum eEssential eCoverage that is accessible (OAR 410-200-0410(2)(c));¶

~~(d) To receive BCCTP benefits via Hospital Presumptive Eligibility, an individual may not be covered by any receiving Minimum eEssential eCoverage.~~¶

(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 ~~a~~Application has been filed by the last day of the month following the month in which the ~~Hospital Presumptive eEligibility~~ period begins, the day on which the state

makes an ~~e~~Eligibility ~~d~~Determination for MAGI Medicaid/CHIP and sends ~~b~~Basic ~~d~~Decision ~~n~~Notice; or¶

(b) If subsection (7)(a) is not completed, the last day of the month following the month in which the ~~h~~Hospital ~~p~~Presumptive ~~e~~Eligibility period begins.¶

(8) A Hospital Presumptive Eligibility approval is not a full ~~e~~Eligibility ~~d~~Determination and does not entitle ~~b~~Beneficiaries to the following:¶

(a) A ~~e~~Child is not entitled to ~~e~~Continuous ~~e~~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 ~~h~~Hospital ~~p~~Presumptive ~~e~~Eligibility is not assumed eligible (OAR 410-200-0135) based solely on the Hospital Presumptive Eligibility determination of the ~~p~~Parent;¶

(c) An individual is not entitled to Extended Medical Assistance (EXT) (OAR 410-200-0440) based solely on the receipt of MAGI ~~P~~arent or ~~C~~aretaker Relative program 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~~becoming a Resident of a Public Institution is not entitled to automatic restoration of benefits upon release (OAR 410-200-0140);-¶

(f) 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, 42 USC §1396a (xx)

ADOPT: 410-200-0221

RULE SUMMARY: New rule to support Medicaid work or activity rules.

CHANGES TO RULE:

410-200-0221

Specific Requirements: Work or Activity Rules

(1) The requirements outlined in this rule apply to individuals being evaluated for the following medical programs:

(a) MAGI Adult Program (OAR 410-200-0435), including under Healthier Oregon (OAR 410-200-0240(1)); and

(b) Young Adults with Special Health Care Needs (YSHCN) Program (OAR 410-200-0455(1)(a)), including under Healthier Oregon (OAR 410-200-0240(1)).

(2) For the purposes of this rule, the evaluation month means:

(a) At initial application, the budget month as described in 410-200-0310(1)(a);

(b) At Renewal, the first month of the eligibility period being Renewed; and

(c) At Redetermination;

(A) The first month following the month that a person becomes ineligible for coverage in a Medicaid, CHIP, or OHP Bridge - Basic Health Program that is not subject to work or activity rules according to section (1); or

(B) The first month after an individual's continuous eligibility period ends.

(3) For the purposes of this rule, lookback period means:

(a) At initial application, the one calendar month immediately preceding the Application month;

(b) At Renewal, the six (6) calendar months leading up to the Renewal due date; and

(c) At Redetermination according to section (4)(c), the six (6) calendar months immediately prior to the evaluation month as defined in section (2).

(4) Individuals who are applying, Renewing, or for whose eligibility is being Redetermined for any of the programs identified in section (1) must meet the following criteria:

(a) At initial application, an Applicant must:

(A) Meet a specified exclusion according to section (5) of this rule;

(B) Meet a mandatory exception or short-term hardship exception as described in sections (6) and (7) of this rule in the lookback period as defined in section (3); or

(C) Meet qualifying activity requirements described in section (8) of this rule in the lookback period as defined in section (3).

(b) At Renewal, a Beneficiary must:

(A) Meet a specified exclusion according to section (5) of this rule; or

(B) Meet a mandatory exception or short-term hardship exception as described in sections (6) and (7) of this rule in any one of the months in the lookback period as defined in section (3); or

(C) Meet qualifying activity requirements described in section (8) of this rule in any one of the months in the lookback period as defined in section (3).

(c) Work or activity rules apply in the following Redetermination scenarios:

(A) A Beneficiary of a Medicaid, CHIP, or OHP Bridge - Basic Health Program eligibility category that is not described in section (1) of this rule has a change in circumstance that makes them no longer eligible for that eligibility category; or

(B) A Beneficiary's continuous eligibility period (OAR 410-200-0135) ends.

(C) At Redetermination according to subsections (A) and (B), a Beneficiary must:

(i) Meet a specified exclusion according to section (5) of this rule; or

(ii) Meet a mandatory exception or short-term hardship exception as described in sections (6) and (7) of this rule in any one of the months in the lookback period as defined in section (3); or

(iii) Meet qualifying activity requirements described in section (8) of this rule in any one of the months in the lookback period as defined in section (3).

(5) Work or activity rules do not apply to an individual if they meet a specified exclusion. An individual meets a specified exclusion as described in 42 CFR 435.554 if they meet any one of the following for at least one day in the evaluation month as defined in section (2).

(a) A former foster care youth as outlined in OAR 410-200-0407(2)(a) and (b);

(b) An American Indian or Alaska Native as defined in 42 CFR 447.51;

(c) A Parent, Legal Guardian, or Caretaker Relative, as defined in OAR 410-200-0015, who provides care on a regular, non-incident, basis to a child under the age of 14 or to a person of any age who meets the Americans with Disabilities Act definition of disability at 28 CFR §35.108 and who needs help performing daily activities;

(d) A Family Caregiver as defined in 410-200-0015, who provides care on a regular, non-incident, basis to a child under the age of 14 or to a person of any age who meets the Americans with Disabilities Act definition of disability

at 28 CFR §35.108 and needs help performing daily activities; and:¶

(A) Resides with the person they care for; or¶

(B) Is a relative (as specified in the Caretaker Relative definition at OAR 410-200-0015, without regard to the requirements to live with and to assume primary responsibility) of the person receiving care and with whom the Family Caregiver does not reside; or¶

(C) Does not reside with and is not a relative (as specified in the Caretaker Relative definition at OAR 410-200-0015, without regard to the requirements to live with and to assume primary responsibility) of the person they care for, and provides not less than 80 hours of care in a calendar month.¶

(e) A veteran with a temporary or permanent disability from the Department of Veterans Affairs rated as 100% (total) under 38 U.S.C. 1155;¶

(f) An individual who:¶

(A) Is pregnant in the evaluation month as defined in section (2); or¶

(B) Is eligible for post-partum coverage in the evaluation month, as defined in section (2), because they were pregnant and received coverage in any Medicaid or CHIP program while pregnant in at least one of the 12 calendar months prior to the evaluation month;¶

(g) An individual participating in a drug addiction or alcohol treatment and rehabilitation program;¶

(h) Is or was a Resident of a Public Institution (OAR 410-200-0015) for at least one day in the evaluation month as defined in section (2);¶

(i) Receives Temporary Assistance for Needy Families (TANF) benefits, is required to participate in the Job Opportunity and Basic Skills (JOBS) program to be eligible for TANF (OAR 461-130-0310(2), and is in compliance with JOBS program requirements (OAR 461-130-0315(1));¶

(j) Is a member of a household that receives Supplemental Nutrition Assistance Program (SNAP) benefits and is not exempt from the:¶

(A) SNAP employment registration (OAR 461-130-0310); or¶

(B) SNAP time limit (OAR 461-135-0520);¶

(k) Has a health condition that significantly impairs their ability to comply with the qualifying activities described in section (8) of this rule based on one or more of the following:¶

(A) Is blind or disabled (as defined in section 1614 of the Social Security Act);¶

(B) Has a Substance Use Disorder (OAR 309-019-0105) that is not in sustained recovery. For the purposes of this rule, "sustained recovery" means a period of time for which an individual with a Substance Use Disorder has maintained recovery, without relapse or other drug or alcohol use, that equals at least five (5) years;¶

(C) Has a disabling mental disorder;¶

(D) Has a physical, intellectual or developmental disability that significantly impairs the individual's ability to perform one or more Activities of Daily Living as defined in OAR 410-172-0600; or¶

(E) Has a serious or complex health condition, which means the health condition meets one or more of the following:¶

(i) Life threatening;¶

(ii) Seriously disabling without being life threatening;¶

(iii) Causes significant pain or discomfort that can cause serious interruptions to life activities;¶

(iv) Requires a major time or effort commitment from caregivers for a substantial period;¶

(v) Requires frequent monitoring;¶

(vi) Associated with severe or negative consequences for someone else;¶

(vii) Affects multiple organ systems;¶

(viii) Requires management to tight physiological parameters;¶

(ix) Requires coordination of multiple specialties;¶

(x) Requires treatment that carries a risk of serious complications; or¶

(xi) Requires adjustments in non-medical environments.¶

(6) Individuals who are subject to work or activity rules are deemed to be compliant if they have any of the mandatory exceptions described below for at least one day of any month within a lookback period as defined in section (3):¶

(a) Was under the age of 19;¶

(b) Was entitled to or enrolled in Medicare Part A; or was enrolled in Medicare Part B;¶

(c) Was enrolled for benefits in a mandatory categorically needy eligibility group as defined in 42 CFR 435 Subpart B;¶

(d) Was released from a Public Institution (OAR 410-200-0015) in a lookback period, as defined in section (3), or within the three (3) calendar months preceding a month within a lookback period; or¶

(e) Met a specified exclusion as described in Section (5) of this rule.¶

(7) Individuals who are subject to work or activity rules are deemed to be compliant with the rules if they have any of the short-term hardship exceptions described below for at least one day of any month within a lookback period

as defined in section (3):¶

(a) Was residing in an Oregon county with an unemployment rate that is at or above the lesser of eight percent or 1.5 times the national unemployment rate:¶

(b) Traveled outside of their community to seek health care for themselves or their dependent for at least seven (7) consecutive days in a calendar month; or concurrently missed regular work or other qualifying activities described in section (8) of this rule to stay home and coordinate care, appointments, travel logistics, or other care supports for a dependent during the same month that the dependent traveled and stayed outside of their community for at least seven (7) consecutive days in a calendar month to seek health care services. For the purposes of this rule, dependent includes:¶

(A) Child, stepchild, or adopted Child; and¶

(B) Tax Dependent:¶

(c) Was residing in an Oregon county for which there was a federally-declared emergency or disaster, and that emergency or disaster prevented the individual from being able to perform any of the qualifying activities described in section (8) of this rule; or¶

(d) Received care in one of the following settings:¶

(A) Inpatient services (42 CFR 440.2) including:¶

(i) Hospital services (42 CFR 440.10):¶

(ii) Nursing facility services (42 CFR 440.155):¶

(iii) Services in an intermediate care facility for individuals with intellectual disabilities (42 CFR 440.150); or¶

(iv) Inpatient psychiatric hospital services (42 CFR 440.160) including the services for individuals under the age of 21 without regard to whether such services are in an institution for mental diseases; or¶

(B) Other services of similar acuity including:¶

(i) Inpatient services furnished in a critical access hospital (42 CFR 440.170(g)):¶

(ii) Inpatient services furnished in an emergency hospital (42 CFR 440.170(e)):¶

(iii) Inpatient services furnished in an institution for mental diseases; or¶

(iv) Non-institutional services that an individual receives which, without the receipt of such services, would likely result in the individual receiving services specified in paragraphs (d)(A)(i) - (d)(B)(iii), regardless of whether they are received in an institutional setting.¶

(8) Individuals who are subject to work or activity rules who are not deemed to be compliant due to meeting an exception described in sections (6) or (7) must demonstrate compliance with one or more of the following qualifying activities in one month of the lookback period:¶

(a) Work at least 80 hours. Under this rule, Work includes:¶

(A) Work in exchange for money:¶

(B) Work in exchange for goods or services; or¶

(C) Unpaid work (other than Community Service as defined in Subsection (b) of this Section).¶

(b) Complete at least 80 hours of Community Service. Under this rule, Community Service means unpaid work, completed voluntarily or required by court order, with a structured program that is completed for the direct benefit of the community under the oversight of a public or nonprofit organizations (including embedded activities of the program that allow an individual to develop skills necessary to complete Community Service).¶

(A) The public or nonprofit organizations must provide oversight of the activity and have a process in place to track the Community Service completed by individuals including the:¶

(i) Type of Community Service activity:¶

(ii) Dates and hours the Community Service were completed; and¶

(iii) A point of contact who can confirm the hours completed.¶

(B) The type of Community Service activities performed must not serve a partisan purpose.¶

(c) Participate in a Work Program for at least 80 hours. Under this rule, Work Programs include any of the following:¶

(A) A program under Title I of the Workforce Innovation and Opportunity Act (WIOA) (29 U.S.C. 3111 et seq.):¶

(B) A program under section 236 of the Trade Act of 1974 (19 U.S.C. 2296):¶

(C) A program of employment and training operated or supervised by a State or political subdivision of a State, including a program under subsection (d)(4) of section 6 of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(d)(4)), other than a supervised job search program or job search training program. However, a program under this subsection may include supervised job search or job search training as subsidiary activities provided such activity is less than half the required hours of the program:¶

(D) A program of employment and training for veterans operated by the Department of Labor or the Department of Veterans Affairs; and ¶

(E) A workforce partnership under subsection (d)(4)(N) of section 6 of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(d)(4)(N)).¶

(d) Be enrolled in an educational program that is one of the following:¶

(A) A high school as defined in title VIII of the Elementary and Secondary Education Act (20 U.S.C. 7801 et seq.);¶
(B) A State-approved program of study leading to a certificate of high school equivalence for an individual who has not received a high school diploma;¶
(C) An institution of higher education as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001) (not including recreational or personal enrichment classes) for at least half-time as defined by the institution in which the student is enrolled; or¶
(D) A program of career and technical education as defined in Section 3(5) of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2302(5)) for at least half-time as defined by the institution in which the student is enrolled.¶
(e) Engage in any one or more of the activities described in subsections (a) - (d) for a total of at least 80 hours;¶
(f) Be in an Eligibility Determination Group (EDG) with monthly countable gross income that is not less than the federal minimum wage multiplied by 80 hours;¶
(g) Be a seasonal worker as described in 26 U.S.C. 45(R)(d)(5) and have an average monthly income over the six (6) calendar months preceding the evaluation month, as defined in section (2), that is not less than the federal minimum wage multiplied by 80 hours.
Statutory/Other Authority: ORS 411.042, 411.404, 413.042, 414.025, 414.534
Statutes/Other Implemented: ORS 411.042, 411.404, 414.025, 414.534, 42 USC §1396a (xx), ORS 411.400, 411.406, 411.439, 411.443, 413.032, 413.046, 414.440, 414.536, 414.706

RULE SUMMARY: Capitalize defined terms, spell out acronyms, addition of Medicaid work or activity related verification requirements and revise language to align with the State's Verification Plan on how income is verified.

CHANGES TO RULE:

410-200-0230

Verification ¶

(1) Applicants, ~~b~~Beneficiaries, or an individual authorized to act on their behalf shall attest to the following information:¶

- (a) Age and date of birth;¶
- (b) Application for other benefits;¶
- (c) Caretaker relative status;¶
- (d) Household composition;¶
- (e) Legal name;¶
- (f) Medicare;¶
- (g) Pregnancy;¶
- (h) Receipt or availability of other healthcare coverage;¶
- (i) Residency;¶
- (j) Social Security number; and¶
- (k) American Indian/Alaska Native status.¶

(2) Applicants, ~~b~~Beneficiaries, or individuals authorized to act on their behalf shall make a declaration of US citizenship, US national, or ~~a~~Non-~~e~~Citizen status;¶

(a) Self-attested information shall be verified via the ~~f~~Federal ~~d~~Data ~~s~~Services ~~h~~Hub (FDSH) or by electronic verification source available to the Agency;¶

(b) In the event that attested status cannot be verified via the FDSH or by electronic verification sources available to the Agency, self-attested information shall be used to determine eligibility, and the individual provided a reasonable opportunity period to provide verification of US citizen, US national, or ~~a~~Non-~~e~~Citizen status as outlined in section (e) of this part. Exceptions to this verification requirement are described in sections (c) and (d) of this part.¶

(c) Applicants or ~~b~~Beneficiaries attesting to US citizenship are exempt from the requirement to verify their citizenship if they are one of the following:¶

- (A) Individuals who are assumed eligible (OAR 410-200-0135);¶
- (B) Individuals who are entitled to or enrolled in Medicare;¶
- (C) Individuals who are presumptively eligible for the ~~BCCTP program~~ Breast and Cervical Cancer Treatment Program (BCCTP) through the BCCTP screening program or through the Hospital Presumptive Eligibility process (OAR 420-200-0400 and 410-200-0105);¶
- (D) Individuals receiving Social Security Disability Income (SSDI); or¶
- (E) Individuals whose citizen status was previously documented by the Agency. The Agency may not re-verify or require an individual to re-verify citizenship at a ~~r~~Renewal of eligibility or subsequent ~~a~~Application following a break in coverage.¶

(d) Applicants or ~~b~~Beneficiaries age 19 and older who attest to having an immigration status that is not a ~~a~~Qualified ~~a~~Non-~~e~~Citizen status (see OAR 410-200-0215(2)) are exempt from the requirement to verify ~~a~~Non-~~e~~Citizen status;¶

(e) US Citizen, US National, and Non-~~e~~Citizen status verification guidelines:¶

(A) Individuals attesting to US citizenship shall verify their status by submitting any of the documents permitted under section 1903(x) of the Social Security Act (42 U.S.C. 1396b);¶

(B) Individuals attesting to ~~a~~Non-~~e~~Citizen status shall verify their status by:¶

(i) Submitting documentation or other proof from the Immigration and Naturalization Service which contains the individual's U.S. Citizenship and Immigrations Services (USCIS) number (or numbers if the individual has more than one number); or¶

(ii) Submitting other documents the State determines constitutes reasonable evidence indicating a satisfactory immigration status.¶

(C) Non-citizens who attest to having no immigration status shall not be required to verify.¶

(f) For individuals with a ~~a~~Qualified ~~a~~Non-~~e~~Citizen status (see OAR 410-200-0215(2)), the Agency shall not require verification of the following unless questionable:¶

(A) Attestation to being continuously present in the U.S. since August 22, 1996;¶

(B) Attestation to being an honorably discharged veteran or in active military duty status; and¶

(C) Attestation to being the ~~s~~Spouse or unmarried ~~e~~Dependent ~~e~~Child of an individual identified in subsection (B) of this part.¶

(g) Non-~~e~~Citizen status shall be reviewed and verified at the following times:¶

(A) Initial determination of eligibility;¶

(B) When a report of change of a~~n~~Non-~~e~~Citizen status is received by the Agency.¶

(3) Applicants, ~~b~~Beneficiaries, or individuals authorized to act on their behalf shall make a declaration of income:¶

(a) If the attested income exceeds the threshold that would produce eligibility for all EDGeligibility Determination Group (EDG) members, the ~~Authority~~Agency shall accept the attested information, deny Health Systems Division (HSD) Medical Programs, and refer to the Federally Facilitated Marketplace for ~~potential APTC~~coverage year 2026 or the State-Based Marketplace for coverage years 2027 or later for potential Advanced Premium Tax Credit eligibility;¶

(b) Attested income that would result in eligibility for one or more EDG members is compared to documentary evidence through a match with the FDSH, ~~or electronic verification sources available to the Agency.~~ The attestation is considered reasonably compatible, and thus does not require further verification if:¶

(A) Income information obtained via FDSH ~~or other available electronic verification sources,~~ is not discrepant by more than 10% when compared to the attestation; or¶

(B) Both the attested income and information obtained via FDSH ~~or other available electronic verification sources,~~ are within the income threshold for the same HSD Medical Program.¶

(c) In the event that attested income is not reasonably compatible with information obtained via the FDSH ~~or electronic verification sources available to the agency, prior to the determination of eligibility,~~ self-attested information shall be used to determine eligibility. After the eligibility determination, the aAgency will:¶

(A) Request documentary verification of income from the individual; or¶

(B) If the individual cannot obtain verification of income, a reasonable explanation may be accepted as to why.¶

(4) Applicants, ~~b~~Beneficiaries, or individuals authorized to act on their behalf shall make a declaration of receipt of private health insurance:¶

(a) Self-attested information shall be used to determine eligibility for HSD Medical Programs if:¶

(A) Information obtained through a match with the FDSH or electronic verification sources available to the agency does not conflict with attested information;¶

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

(C) Verification is not available via a match with available electronic data or by any other method at the time of ~~a~~Application processing.¶

(b) In the event that information obtained through a match with the FDSH or electronic verification sources available to the ~~a~~Agency conflicts with attested information and may affect eligibility, private health insurance information shall be verified prior to eligibility determination.¶

(5) ~~The Authority may request that applicants and beneficiaries of medical assistance provide additional information, including documentation, to verify most eligibility criteria if attested information is questionable or a discrepancy is identified.~~Applicants, Beneficiaries, or individuals authorized to act on their behalf shall attest to meeting, being deemed to meet, or qualifying for a specified exclusion from work or activity rules as described in 410-200-0221.¶

(a) Meets, is deemed to meet, or has a specified exclusion from work or activity rules:¶

(A) To determine if an individual meets or is deemed to meet work or activity rules, or qualifies for a specified exclusion, with the exception of section (b) below, Applicants, Beneficiaries, or individuals authorized to act on their behalf shall make an attestation of:¶

(i) The number of hours an Applicant or Beneficiary provides caregiving activities outside of their home to an unrelated child under age 14 or unrelated disabled individual;¶

(ii) The number of hours an Applicant or Beneficiary participates in a job training program, unpaid work, or volunteering;¶

(iii) Participation in a Substance Use Disorder (SUD) rehabilitation or treatment program;¶

(iv) Being a Resident of a Public Institution (410-200-0015);¶

(v) Being a veteran with a disability rated as total;¶

(vi) Receiving care as an inpatient in a hospital, nursing facility, intermediate care facility, or psychiatric hospital, or receiving other services of similar acuity in an outpatient setting;¶

(vii) Having traveled outside community to seek health care for themselves or their dependent for at least seven (7) consecutive days in a month, or was unable to engage in qualifying activities due to coordinating care and other supports for a dependent traveling outside their community for at least seven (7) consecutive days in a month;¶

(viii) Education enrollment status as verified through a match with the National Student Clearinghouse (NSC).¶

(B) Attestation described in subsection (a)(A) of this part shall be verified as follows:¶

(i) For the period of January 1, 2027, through December 31, 2027: The Agency will attempt to verify attested information using data available to the State including from electronic data sources. If unable to verify via information available to the State, then self-attestation will be accepted.¶

(ii) Effective January 1, 2028: The Agency will attempt to verify attested information using data available to the State including from electronic data sources. If unable to verify via information available to the State, or if available information is discrepant with the attestation, the Agency must request other documentation to be submitted by or on behalf of the beneficiary.¶

(b) To determine if an individual meets a specified exclusion due to having a physical, mental, or other behavioral health condition that significantly impairs their ability to comply with work or other activity as described in 410-200-0221, attestation of such shall be verified as follows:¶

(A) For the period of January 1, 2027, through December 31, 2027: Attestation of meeting this specified exclusion may be verified using claims and encounter data within the preceding 12 months via an electronic data source available to the Agency. If unable to verify via encounter data, self-attestation will be accepted.¶

(B) Effective January 1, 2028:¶

(i) At intake: Attestation of meeting this specified exclusion may be verified using claims and encounter data within the preceding 12 months via an electronic data source available to the Agency. If there is no reliable information available to the Agency, or if the information available is discrepant, the Agency will accept the attestation.¶

(ii) At renewal: Attestation of meeting this specified exclusion may be verified using claims and encounter data within the preceding 12 months via an electronic data source available to the Agency. If there is no reliable information available to the Agency, or if the information available is discrepant with the attestation provided, the Agency must request other documentation submitted by or on behalf of the beneficiary.¶

(6) For all eligibility criteria, the Agency may request that Applicants and Beneficiaries of medical assistance provide additional information, including documentation, to verify attested information, resolve a discrepancy, or to provide missing information.

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, 42 USC §1396a (xx)

RULE SUMMARY: Capitalize defined terms, spell out acronyms, and addition of Medicaid work or activity related reporting requirements

CHANGES TO RULE:

410-200-0235

Changes That Must Be Reported ¶¶

- (1) Reporting requirements described in this rule apply to any individual whose information is considered in determining eligibility for any ~~case~~ Eligibility Determination Group (EDG) member.¶¶
- (2) An individual or someone authorized to act on the ~~individual's~~ behalf shall report the following changes in circumstances within 10 calendar days of its occurrence:¶¶
- (a) The receipt or loss of health care coverage;¶¶
 - (b) A change in mailing or residential address;¶¶
 - (c) A change in legal name;¶¶
 - (d) A change in pregnancy status;¶¶
 - (e) A change in tax-filing status;¶¶
 - (f) A change in citizenship or immigration status of an applicant or recipient;¶¶
 - (g) Someone joins or permanently leaves the ~~household~~ EDG;¶¶
 - (h) Someone in the EDG becomes a ~~Resident~~ of a ~~Public Institution~~;¶¶
 - (i) For all ~~HSD~~ Health Systems Division (HSD) Medical Programs except MAGI CHIP, a change in availability of employer-sponsored health insurance;¶¶
 - (j) For the MAGI Parent or Caretaker Relative and Extended Medical Assistance (EXT) programs, when the ~~Beneficiary~~ no longer has a dependent ~~Child~~ living in the home, including:¶¶
 - (A) The only ~~dependent~~ child leaves the household; or¶¶
 - (B) The only ~~dependent~~ child turns 18 years old and is not a full-time student in a secondary school or equivalent vocational or technical training.¶¶
 - (k) An EDG member age 19 or older experiences a change in income, including:¶¶
 - (A) A change in source of income;¶¶
 - (B) A change in employment status:¶¶
 - (i) For a ~~new job~~ employment, the change occurs the first day of ~~the new job~~ employment;¶¶
 - (ii) For a ~~job~~ employment separation, the change occurs on the last day of employment.¶¶
 - (C) A change in earned income of more than \$100 per calendar month. The change occurs upon the ~~receipt by the beneficiary~~ EDG member's receipt of their first paycheck from a new job or the first paycheck reflecting the updated income amount;¶¶
 - (D) A change in unearned income of more than \$50 per calendar month. The change occurs the day the ~~beneficiary~~ EDG member receives the new or changed ~~payment~~.¶¶
- ~~(3) Individuals shall report a claim.~~ unearned income.¶¶
- (3) Applicants and Beneficiaries must report a claim, accident with the potential of a claim, or action for personal injury to OHA within 10 calendar days of its occurrence in accordance with OAR 461-195-0303 and 461-195-0310. ¶¶
- (4) Changes may be reported via the Internet, by telephone, via mail, in person, and through other commonly available electronic means.¶¶
- (5) A change is considered reported on the date the information is received by the Agency.¶¶
- (6) A change reported for one program is considered reported for all programs administered by the Agency in which the ~~Beneficiary~~ participates.¶¶
- (7) The following changes are not required to be reported:¶¶
- (a) Periodic cost-of-living adjustments to the federal Black Lung Program, SSB, SSDI, SSI, and Veterans' assistance under Title 38 of the United States Code;¶¶
 - (b) Changes in eligibility criteria based on legislative or regulatory actions.
- Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
- Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706, 42 USC §1396a (xx)

AMEND: 410-200-0435

RULE SUMMARY: Capitalize defined terms, spell out acronyms and addition of Medicaid work or activity eligibility requirements

CHANGES TO RULE:

410-200-0435

Specific Requirements; MAGI Adult ¶

In addition to eligibility requirements applicable to the MAGI Adult program in other rules in chapter 410 division 200, this rule describes specific eligibility requirements for the MAGI Adult program.¶

(1) To be eligible for the MAGI Adult program an individual must:¶

(a) Be 19 years of age or older and under age 65; ~~and~~¶

(b) Have household income at or below 133 percent ~~f~~Federal ~~p~~Poverty ~~L~~Level (OAR 410-200-0315) for the applicable family size; ~~and~~¶

(c) Effective as of January 1, 2027, meet the qualifying activities requirements, or one of the exceptions or exclusions, for work or activity rules as described in OAR 410-200-0221.¶

(2) To be eligible for the MAGI Adult program, an individual may not be:¶

(a) Pregnant;¶

(b) Entitled to or enrolled for Medicare benefits under part A or B of Title XVIII of the Act;¶

(c) Receiving SSI benefits; or¶

(d) A ~~p~~Parent or ~~e~~Caretaker ~~r~~Relative of a child living in the home who is not enrolled in ~~m~~Minimum ~~e~~Essential ~~e~~Coverage.

Statutory/Other Authority: ORS 411.402, 411.404, 413.042

Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.706, 42 USC §1396a (xx)

RULE SUMMARY: Capitalize defined terms, spell out acronyms, and addition of Medicaid work or activity eligibility requirements. Updates eligibility criteria for 2027 and creates digitally accessible tables.

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 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 Oregon Supplemental Income Program Medical (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).

(2) To be eligible for the YSHCN program, an individual must meet the following criteria:

(a) Meet the age requirement:

(A) For dates of request or ~~Redeterminations~~ during the 2025 calendar year:

(i) Be 19 or 20 years of age in the month of their ~~date of request or Redetermination~~; or

(ii) Be eligible for and receiving YSHCN coverage at the time they turn 21 years of age.

(B) For ~~dates of request or Redeterminations~~ during the 2026 calendar year:

(i) Be 19, 20 or 21 years of age in the month of their ~~date of request or Redetermination~~; or

(ii) Be eligible for and receiving YSHCN coverage at the time they turn 22 years of age.

(C) For Dates of Request or Redeterminations during the 2027 calendar year:

(i) Be 19, 20, 21 or 22 years of age in the month of their Date of Request or Redetermination; or

(ii) Be eligible for and receiving YSHCN coverage at the time they turn 22 years of age.

(b) Meet the financial requirement:

(A) Be eligible for a MAGI Medicaid/CHIP program as defined in OAR 410-200-0015(47)(d) or 410-200-0015(47)(f)(A)-(E) or an OSIPM program as defined in OAR 461-101-0010(18); or

(B) Have MAGI-based household income under 200 percent (200%) 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), which is found at the following URL:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035595/>; or

(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 16 years of age; or

(D) Meet at least two (2) of the six (6) 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.-¶

(d) As of January 1, 2027, comply with Work or Activity Rules as outlined in OAR 410-200-0221 if YSHCN eligibility is evaluated based on Subsections (1)(a) and (2)(b)(B) of this rule.-¶

(3) The health-related qualifications for YSHCN non-financial eligibility described in section (2)(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 (2)(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 ~~b~~Beneficiaries who were determined eligible based on a qualifying behavioral health diagnosis as described in sections (2)(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 ~~b~~Beneficiaries who were determined eligible based on the YSHCN eligibility screening questions described in section (2)(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.

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, 42 USC §1396a (xx)