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

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

FILING CAPTION: Healthier Oregon Pathway to OHP Benefits Expansion to Include Members of All Ages.

EFFECTIVE DATE: 12/20/2023

AGENCY APPROVED DATE: 12/18/2023

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, 410-121-0147, 410-123-1540, 410-125-0230, 410-134-0000, 410-134-0001, 410-134-0002, 410-134-0003, 410-134-0004, 410-134-0005, 410-136-3020, 410-200-0015, 410-200-0100, 410-200-0240

AMEND: 410-120-0000

RULE TITLE: Acronyms and Definitions

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Changes to Citizenship Waived Medical to end date the program and Healthier Oregon program definitions, renumbering.

RULE TEXT:
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 program. 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 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 relates 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) “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.
(11) “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.
(12) “Adverse Event” means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.
(13) “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).”
(14) “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.
(15) “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).
(16) “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.
(17) “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.
(18) “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).
(19) “Ambulatory Surgical Center (ASC)” means a facility licensed as an ASC by the Authority.
(20) “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.
(21) “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).
(22) “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.
(23) “Anesthesia Services” means administration of anesthetic agents to cause loss of sensation to the body or body part.
(24) “Appeal” means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.
(25) “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.
(26) “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.
(27) “Audiologist” means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.
(28) “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.
(29) “Automated Voice Response (AVR)” means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.
(30) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.
(31) “Behavioral Health Assessment” means a qualified mental health professional’s determination of a member’s need for mental health services.
(32) “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.
(33) “Behavioral Health Evaluation” means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.
(34) “Benefit Package” means the package of covered health care services for which the client is eligible.
(35) “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.
(36) “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.
(37) “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.)
(38) “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.
(39) “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.
(40) "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.

(41) “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.
(42) “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.
(43) “Chiropractor” means an individual licensed to practice chiropractic by the relevant state licensing board.
(44) “Chiropractic Services” means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.
(45) “Citizenship Waived Medical (CWM) Benefit Package” means the coverage and limitations defined in 410-134-0005(2) for individuals who met the eligibility requirements in 410-200-0240(1). The CWM Benefit Package ended on June 30, 2023. See OARs 410-134-0005 and 410-200-0240.
(46) “Citizenship Waived Medical Plus (CWM Plus) Benefit Package” means coverage and limitations described in 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in 410-200-0240(2). The CWM Benefit Package which was previously referred to as “CWX”, ended on June 20, 2023. See OARs 410-134-0005 and 410-200-0240.
(47) “Claimant” means an individual who has requested a hearing.
(48) “Client” means an individual found eligible to receive OHP health services.
(49) “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.
(50) “Clinical Social Worker” means an individual licensed to practice clinical social work pursuant to state law.
(51) “Clinical Record” means the medical, dental, or mental health records of a client or member.
(52) “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.
(53) “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.
(54) “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 need;
(h) May give peer counseling and guidance on health behaviors; and
(i) May provide direct services such as first aid or blood pressure screening.
(55) “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.
(56) “Community Partner” means an organization that contracts with and who has been 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. The assistance provided by Community Partners includes, but is not limited to:
(a) Helping with Health coverage application;
(b) Helping with enrolling in health insurance plans;
(c) Assisting with Health coverage renewal assistance;

(d) Helping with Healthcare System Navigation defined in 410-120-0000; and
(e) Performing Outreach and engagement related to subsections (a) through (d) of this section.
(57) “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-V); 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.
(58) “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.
(59) “Contiguous Area” means the area up to 75 miles outside the border of the State of Oregon.
(60) “Contiguous Area Provider” means a provider practicing in a contiguous area.
(61) “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.
(62) “Coordinated Care Organization (CCO)” has the meaning given that term in OAR 410-141-3500(21).
(63) “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.)
(64) “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.
(65) “Cover All Kids (CAK)” meaning defined in 410-200-0015.
(66) “Covered Services” means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:
(a) Ancillary Services, as defined in OAR 410-120-0000;
(b) Diagnostic Services, as defined in OAR 410-120-0000;
(c) 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;
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Waiver.
(67) “Current Dental Terminology (CDT)” means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.
(68) “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.
(69) “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.
(70) “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.
(71) “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.
(72) “Dental Emergency Services” means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.
(73) “Dental Therapist” means a person licensed to practice dental therapy within the scope of practice as defined under state law.
(74) “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.
(75) “Denturist” means an individual licensed to practice denture technology pursuant to state law.
(76) “Denturist Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.
(77) “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.
(78) “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.
(79) “Dentally Appropriate” means health services, items, or dental supplies:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(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;
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply;
(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;
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.
(80) “Department of Human Services (Department or DHS)” means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.
(81) “Department Representative” means an individual who represents the Department and presents the Department’s position in a hearing.
(82) “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.
(83) “Diagnosis Related Group (DRG)” means a system of classification of diagnoses and procedures based on the ICD-10-CM.
(84) “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.
(85) “Division (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.
(86) “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.
(87) “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)” mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.
(88) “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.
(89) “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.
(90) “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.
(91) “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.
(92) “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 may not in fact have had the adverse results described in the previous sentence.
(93) “Emergency Health Benefit Funding” means funding for the health benefits defined in 410-134-0004(2)(a-j), included in the Healthier Oregon benefits package that are in part funded with state funding and matched with federal funds (42 CFR 440.255).
(94) “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.
(95) “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.
(96) “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.

(97) “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.
(98) “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.
(99) "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.
(100) “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.
(101) “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.
(102) “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.
(103) “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.
(104) “General Assistance (GA)” means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.
(105) “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.
(106) “Health Care Interpreter” Certified or Qualified have the meaning given those terms in ORS 413.550.
(107) “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.
(108) “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.
(109) “Healthcare System Navigation” means the process by which a Community Partner supports individuals who are in need of health care by:
(a) Assisting with applications for or renewals 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.
(110) “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.
(111) “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.
(112) “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.
(113) “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.
(114) “Healthier Oregon” means the medical assistance benefit package that is equal to the OHP Plus benefit package defined in OAR 410-120-1210. Healthier Oregon is for individuals;
a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and 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).
(115) “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.
(116) “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.
(117) “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.
(118) “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.
(119) “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.
(120) “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.
(121) “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.
(122) “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.
(123) "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.
(124) "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).
(125) "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.
(126) "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).
(127) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.
(128) "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.
(129) "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.
(130) "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).
(131) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.
(132) "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.)
(133) "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.
(134) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.
(135) "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.
(136) "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.
(137) “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).
(138) “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.
(139) “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.
(140) “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.
(141) “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.
(142) “Long-term Care or Long-term Services and Supports” 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” means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).
(143) “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.
(144) “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).
(145) “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.
(146) “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.
(147) “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.
(148) “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 accordinace with ORS 414.025(17).
(149) "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).
(150) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.
(151) "Medical Transportation" means transportation to or from covered medical services.
(152) "Medically Appropriate" means health services, items, or medical supplies that are:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(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;
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply;
(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;
(e) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.
(153) "Medically Necessary" means health services and items that are required by a client or member 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 results in health impairments or a disability;
(b) The ability for a client or member to achieve age-appropriate growth and development;
(c) The ability for a client or member 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 a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules 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;
(e) 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.
(154) "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.
(155) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.
(156) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under the age of 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use

them.
(157) “Member” means an OHP client enrolled with a pre-paid health plan or coordinated care organization.
(158) “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.
(159) “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.
(160) “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.
(161) “Naturopathic physician” means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.
(162) “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.
(163) “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 410-141-0520 Prioritized List of Health Services; and
(e) Any other applicable Division administrative rules.
(164) “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.
(165) “Non-Paid Provider” means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).
(166) “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.
(167) “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.
(168) “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.
(169) “Nursing Facility” means a facility licensed and certified by the Department and defined in OAR 411-070-0005.
(170) “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.
(171) “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.
(172) “Occupational Therapist” means an individual licensed by the State Board of Examiners for Occupational Therapy.
(173) “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.

(174) “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.
(175) “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.
(176) “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.
(177) “Optometric Services” means services provided within the scope of practice of optometrists as defined under state law.
(178) “Optometrist” means an individual licensed to practice optometry pursuant to state law.
(179) “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.
(180) “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.
(181) “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.
(182) “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.
(183) “Overdue Claim” means a valid claim that is not paid within 45 days of the date it was received.
(184) “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.
(185) “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.
(186) “Paid Provider” means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.
(187) “Payment Authorization” means authorization granted by the responsible agency, office, or organization for payment prior or after the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.
(188) “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.
(189) “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.
(190) “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.
(191) “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.
(192) “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.
(193) “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.
(194) “Pharmacist” means an individual licensed to practice pharmacy pursuant to state law.
(195) “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.
(196) “Physical Therapist” means an individual licensed by the relevant state licensing authority to practice physical therapy.
(197) “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.
(198) “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.
(199) “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.
(200) “Physician Services” means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.
(201) “Podiatric Services” means services provided within the scope of practice of podiatrists as defined under state law.
(202) “Podiatrist” means an individual licensed to practice podiatric medicine pursuant to state law.
(203) “Post-Payment Review” means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons after payment of the claim.
(204) “Practitioner” 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.
(205) “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)
(206) “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.
(207) “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.
(208) “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.
(209) “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.
(210) “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.
(211) “Provider” means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering 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.
(212) “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.)
(213) “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.
(214) “Public Health Clinic” means a clinic operated by a county government.
(215) “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.
(216) “Qualified Medicare Beneficiary (QMB)” means a Medicare beneficiary as defined by the Social Security Act and its amendments.
(217) “Qualified Medicare and Medicaid Beneficiary (QMM)” means a Medicare beneficiary who is also eligible for Division coverage.
(218) “Quality Improvement” means the efforts to improve the level of performance of a key process or processes in health services or health care.
(219) “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.
(220) “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.
(221) “Recipient” means an individual who is currently eligible for medical assistance (also known as a client).
(222) “Recreational Therapy” means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).
(223) “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.
(224) “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.
(225) “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.
(226) “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.
(227) “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.
(228) “Representative” means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.
(229) “Retroactive Medical Eligibility” means eligibility for medical assistance granted to a client retroactive to a date before the client's application for medical assistance.
(230) “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.
(231) “Rural” means a geographic area that is ten or more map miles from a population center of 30,000 people or less.
(232) “Sanction” means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.
(233) “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.
(234) “Self-Sufficiency” means the division in the Department of Human Services that administers programs for adults and families.
(235) “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.
(236) “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.
(237) “Social Worker” means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.
(238) “Speech-Language Pathologist” means an individual licensed by the Oregon Board of Examiners for Speech Pathology.
(239) “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.
(240) “State Facility” means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.
(241) “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), funded by the State.
(242) “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.
(243) “Subrogation” means right of the state to stand in place of the client in the collection of Third Party Resources

(TPR).
(244) “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).
(245) “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.
(246) “Surgical Assistant” means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.
(247) “Suspension” means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds shall be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.
(248) “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.
(249) “Termination” means a sanction prohibiting a provider's participation in the Division’s programs by canceling the provider's Authority-assigned billing number and agreement. 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 cited in 42 CFR 1001.221 are met; or
(b) Otherwise stated by the Authority at the time of termination.
(250) “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.
(251) “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.
(252) “Transportation” means medical transportation.
(253) “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.
(254) “Type A Hospital” means a hospital identified by the Office of Rural Health as a Type A hospital.
(255) “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.
(256) “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.
(257) “Type B Hospital” means a hospital identified by the Office of Rural Health as a Type B hospital.
(258) “Urban” means a geographic area that is less than ten map miles from a population center of 30,000 people or more.
(259) “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.
(260) “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.
(261) "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.
(262) "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 410 division 120).
(263) "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.
(264) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.
(265) "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.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.231, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 414.025

AMEND: 410-120-1210

RULE TITLE: Medical Assistance Benefit Packages and Delivery System

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Changes to end date the Citizenship Waived medical program.

RULE TEXT:

(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 the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);

(ii) Ancillary services, (OAR 410-141-3820);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) 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;

(v) Hospice;

(vi) Post-hospital extended care benefit up to a 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.

(D) Limitations: The following services have limited coverage for non-pregnant individuals 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 OAR 410-134-0005(2) and OAR 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.
(5) Division clients are enrolled for covered health 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 or dental care.
(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.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.312, 414.430, 414.690

AMEND: 410-121-0147

RULE TITLE: Exclusions and Limitations

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Changes to end date the Citizenship Waived medical program.

RULE TEXT:

(1) The following items are not covered for payment by the Division of Medical Assistance Programs (Division) Pharmaceutical Services Program:

(a) Drug products for diagnoses below the funded line on the Health Services Commission Prioritized List or an excluded service under Oregon Health Plan (OHP) coverage;

(b) Home pregnancy kits;

(c) Fluoride for individuals over 18 years of age or older;

(d) Expired drug products;

(e) Drug products from non rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines;

(f) Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS);

(g) Drug products that are not assigned a National Drug Code (NDC) number;

(h) Drug products that are not approved by the Food and Drug Administration (FDA);

(i) Drug products dispensed for Citizenship Waived Medical (CWM) client benefit type except when prescribed as an emergency medical service as defined by OAR 410-134-0005(2). The CWM Benefit Package ended on June 30, 2023.

(j) Drug Efficacy Study Implementation (DESI) drugs (see OAR 410-121-0420);

(k) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients (see OAR 410-121-0149, OAR 410-120-1200 & OAR 410-120-1210).

(2) Effective on or after April 1, 2008, Section 1903(i) of the Social Security Act requires that written (nonelectronic) prescriptions for covered outpatient drugs for Medicaid clients be executed on a tamper-resistant pad in order to be eligible for federal matching funds. To meet this requirement, the Division shall only reimburse for covered Medicaid outpatient drugs only when the written (nonelectronic) prescription is executed on a tamper-resistant pad, or the prescription is electronically submitted to the pharmacy.

(3) Drugs requiring a skilled medical professional for safe administration shall be billed by the medical professional's office; unless otherwise specified by the Division.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065, ORS 414.329

AMEND: 410-123-1540

RULE TITLE: Healthier Oregon Dental Benefits

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Changes to end date the Citizenship Waived medical program, renumbered

RULE TEXT:

(1) The CWM and CWM Plus benefit plan ended on June 30, 2023. See OAR 410-134-0005(2) for benefit coverage and limitations.

(2) CWM and CWM Plus services delivered on or before June 30, 2023 may be billed in accordance with OAR 410-120-1300. See OAR 410-134-0005(3) for CWM and CWM Plus billing guidance.

(3) As of July 1, 2022, Healthier Oregon members began receiving the same dental benefits that are included in the OHP Plus benefit package as defined in OAR 410-123-1220.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025, ORS 414.231, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.231, 414.065, 414.430

AMEND: 410-125-0230

RULE TITLE: Qualified Directed Payments

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Changes to end date the Citizenship Waived medical program.

RULE TEXT:

Qualified Directed Payments (QDP) are payments made by the Oregon Health Authority (Authority) to Coordinated Care Organizations (CCOs) from three Quality and Access pools for distinct provider classes as follows: (i) Rural Type A and Type B hospitals, (ii)Public Academic Health Centers and (iii) DRG hospitals. Each provider class is defined in §438.6(c) Preprint forms approved by the U.S. Department of health and Human Services Centers for Medicare and Medicaid Services. QDPs are tied to inpatient and outpatient encounters with Medicaid and Children's Health Insurance Program (CHIP) members enrolled in Coordinated Care Organizations. However, the Authority does not make Qualified Directed Payments for encounters with members who received Citizenship Waived Medical (CWM) or CWM Plus Benefit Packages.

(1) Type A and Type B hospitals:

(a) The Authority shall make a qualified directed payment only if the Type A or Type B hospital meets criteria established by the Authority for the Type A or Type B hospital Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;

(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each Type A and Type B hospital;

(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;

(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(2) Public Academic Health Centers:

(a) The Authority shall make a qualified directed payment only if the public academic medical center meets criteria established by the Authority for the Public Academic Medical Center Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates. One for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;

(e) The Authority shall combine the weekly encounters into a monthly report to assist CCOs in distributing the funds to the appropriate hospital. The report shall be distributed to each CCO and public academic health center;

(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by each public health center for the amount indicated on the report;

(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(3) Diagnosis Related Grouper (DRG) Hospitals:

(a) The Authority shall make a qualified directed payment only if the DRG Hospital meets criteria established by the Authority for the DRG Hospital Quality and Access Pool program in accordance with applicable federal requirements, which may be updated as needed.

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter

per member, per day, per facility;
(c) QDP amounts shall be at two separate rates. One for inpatient encounters and one for outpatient encounters;
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each DRG hospital;
(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.
(4) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.869

STATUTES/OTHER IMPLEMENTED: ORS 414.869

AMEND: 410-134-0000

RULE TITLE: Purpose

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Defines purpose of the Healthier Oregon program Emergency-Only Health Benefits and State Funded Supplemental Health Benefits. Renumbered.

RULE TEXT:

(1) The purpose of this OAR Chapter 410, division 134 is to set forth the rules that are specific to the Healthier Oregon program.

(2) The Healthier Oregon program is a medical assistance benefit package equal to OHP Plus defined and described in OAR 410-120-1210.

(3) The Healthier Oregon program is funded with state and federal dollars as described in OAR 410-134-0004.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.025, 414.065, 414.231, 414.706

AMEND: 410-134-0001

RULE TITLE: Acronyms and Definitions

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Updates to acronyms and definitions, renumbered.

RULE TEXT:

(1) The following acronyms and definitions within this rule specifically apply to the Healthier Oregon program in its entirety.

(a) The Authority incorporates acronyms and definitions in OAR 410-141-3500, OAR 410-120-0000 and OAR 410-200-0015;

(b) The acronyms and definitions adopted by the Department of Human Services (Department) in chapters 411, 413, and 461;

(c) Public Health Division chapter 333 division 4 definitions;

(d) Behavioral Health Division chapter 309 division 19 definitions.

(2) “Citizenship Waived Medical Benefit Package” (CWM) as defined in OAR 410-120-0000.

(3) “Citizenship Waived Medical Plus Benefit Package” (CWX or CWM Plus) as defined in OAR 410-120-0000.

(4) “Emergency Medical Condition” is defined in OAR 410-120-0000.

(6) “Emergency Health Benefit Funding: is defined in OAR 410-120-0000 and in OAR 410-134-0004 of this rule.

(7) “Healthier Oregon Cover All Kids (CAK)” means Cover All Kids as defined in OAR 410-200-0015:

(a) Before July 1, 2022, CAK recipients received state-funded coverage equal to OHP Plus as defined in OAR 410-120-1210.

(b) As of July 1, 2022, recipients are included in Healthier Oregon;

(i) Medical assistance benefit package and coverage is equal to OHP Plus as defined in OAR 410-120-1210; and

(ii) Funding is defined in OAR 410-134-0004.

(8) “Reproductive Health Equity Act (RHEA)” means Reproductive Health Equity Act (ORS 414.432) funding, which provides access to reproductive health and abortion services to Oregonians who are able to get pregnant and who would be eligible for federally funded medical assistance if not for 8 U.S.C. 1611 or 1612.

(9) “Supplemental Health Benefit State Funding” as defined in OAR 410-120-0000 and in OAR 410-134-0004 of this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, ORS 414.025, 414.231, 414.432, 414.706

REPEAL: 410-134-0002

RULE TITLE: Determining When A Client Has Medical Assistance

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: This section shall be repealed from rule.

RULE TEXT:

(1) The Medical Card has the client's name as listed with the OHP and their alpha-numeric prime number.
(2) Eligibility may change monthly. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided to assure that the client is eligible for date(s) of service (see OAR 410-120-1140).
(3) Providers must verify the client's eligibility on the date of service, regardless of if the client is anticipated to have PHP, CCO, FFS, or no Medicaid coverage. It is not required but recommended to print the client's eligibility verification to include within the client's chart.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042

AMEND: 410-134-0003

RULE TITLE: Healthier Oregon and Healthier Oregon Cover All Kids Coverage

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Healthier Oregon coverage is equal to the Oregon Health Plan.

RULE TEXT:

(1) The Healthier Oregon and Healthier Oregon Cover All Kids benefit package description, benefits package identifier, eligibility criteria, and coverage is described in this Rule.

(2) Healthier Oregon and Healthier Oregon Cover All Kids benefit package descriptions:

(A) Benefit Package identifiers:

(i) BMH: for non-pregnant adults 21 and over and Cover All Kids; or

(ii) BMP: for pregnant adults or individuals within their post-partum period, who are age 21 and over;

(B) Eligibility criteria: Eligible recipients are individuals who meet the financial and non-financial eligibility requirements for an Health Systems Division (HSD) or Oregon Supplemental Income Program Medical (OSIPM) Program, except they do not meet the citizenship or non-citizen status requirements pursuant to OAR 410-200-0215;

(C) Coverage and limitations:

(i) Oregon Health Plan services defined in OAR 410-120-1210;

(ii) Oregon Health Plan limitations defined in OAR 410-120-1210.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 414.231

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 414.231, ORS 414.025, 414.312, 414.430, 414.432, 414.706, 414.710

AMEND: 410-134-0004

RULE TITLE: Healthier Oregon Funding

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Defines Emergency Health Benefit Funding and State-Funded Health Benefit Funding.

RULE TEXT:

(1) The Healthier Oregon medical assistance benefit package is equal to the medical assistance benefits package defined and describe in OAR 410-120-1210 as OHP Plus but the funding for the benefits is different as set out in this rule.

(2) Emergency Health Benefit Funding includes services that are funded in part with state dollars and matched with federal dollars. Emergency Health Benefit Funding includes:

(a) Services to treat Emergency Medical Conditions as defined by 42 CFR 440.255 and OAR 410-120-0000. The Healthier Oregon Desk Reference, defines claims and limitations for services listed below, that the Oregon Health Authority determines an emergency located at: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-CWM.aspx ;

(b) Labor and Delivery;

(c) Behavioral Health Crisis as defined in OAR 309-019-0105;

(d) Outpatient dialysis to treat acute renal failure or End Stage Renal Disease (ESRD);

(e) Immunosuppressant medications post kidney transplant, including office visits and labs to prescribe and monitor such medications;

(f) Cancer treatment;

(g) Dental services provided in an emergency department or hospital setting;

(h) Covid 19 coverage shall be equal to the coverage available during the Federal Public Health Emergency (PHE) and shall end May 11, 2024;

(i) Pregnancy coverage equal to OHP Plus defined in OAR 410-120-1210; subparagraphs (1)(b)(B)(i-v) of this rule are funded by Supplemental Health Benefits State Funding. Pregnancy coverage is partially funded through Children Health Insurance Program (CHIP) as defined in 42 CFR §§ 457.10 and 457.618;

(j) Post-Partum coverage equal to OHP Plus defined in OAR 410-120-1210; subparagraphs (1)(b)(B)(i-v) of this rule set are funded by Supplemental Health Benefits State Funding, beginning the day after pregnancy ends and ending (12) twelve calendar months following the month in which the pregnancy ends. Post-partum coverage is partially funded through CHIP administrative funds as available and reverts to Supplemental Health Benefits State Funding, when CHIP administrative funds are not as available.

(3) Supplemental Health Benefit State Funding includes services that are funded with state funds only. State-Funded Supplemental Health Benefits include:

(a) Abortion services;

(b) Sterilization;

(c) Family Planning;

(d) Hospice;

(e) Death with dignity;

(f) Dental services equal to OHP coverage in OAR 410-123-1220;

(g) Post-Partum coverage beginning the day after pregnancy ends and ending (12) twelve calendar months following the month in which the pregnancy ends; if CHIP administrative funds are not available;

(h) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage and limitations defined in OAR 410-151-0000;

(i) Organ Transplants see OAR 410-124-0010;

(j) Pharmacy benefits equal to OHP Plus coverage;

(k) Long-Term Support Services (LTSS) defined in OAR 410-120-0000;

(L) Health Related Social Needs (HRSN) defined in OAR 410-120-0000

(m) OHP Plus coverage and limitations described in OAR 410-120-1210.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, ORS 414.231, 414.312, 414.430, 414.432, 414.706

ADOPT: 410-134-0005

RULE TITLE: Coverage and Billing for Citizenship Waived Medical and Citizenship Waived Medical Plus

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Citizenship Waived Medical benefits, limitations and billing for timely filing, CWM and CWM Plus benefit packages ended June 30, 2023.

RULE TEXT:
(1) The Citizenship Waived Medical (CWM) and Citizenship Waived Medical Plus (CWM Plus) benefit package ended on June 30, 2023. Prior to July 1, 2023, CWM Plus was referred to as “CWX”.
(2) Benefit and coverage limitations for members who were eligible for, or retroactively determined to be eligible for, the CWM and CWM Plus can be found under DMAP 65-2022, adopt filed 06/30/2022, effective 07/01/2022.
(3) Citizenship Waived Medical (CWM) and CWM Plus (previously referred to as “CWX”) services delivered on or before June 30, 2023, may be billed if claims are timely submitted in accordance with OAR 410-120-1300. CWM and CWM Plus billing guidance can be found under DMAP 13-2023, minor correction filed 03/30/2023, effective 03/30/2023.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, ORS 414.312, 414.430, 414.432, 414.706

AMEND: 410-136-3020

RULE TITLE: General Requirements for NEMT

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Citizenship Waived Medical (CWM) Benefit Package did not include Non- Emergency Medical Transport, the CWM Benefit Package ended June 30, 2023.

RULE TEXT:

(1) The Authority may enroll governmental transportation brokerages (local units of government) or other entities to arrange rides and pay subcontractors for NEMT services. The Authority may limit the enrollment with brokerages to units of local government;

(2) For purposes of the rules (OAR 410-136-3000 through 410-136-3360), "subcontractor" means the individual or entity with which the brokerage subcontracts or employs to drive the client to and from Oregon Health Plan (OHP) covered medical services;

(3) The brokerage shall:

(a) Prior authorize and pay subcontractors for the least costly but most appropriate mode of transport for the client's medical needs to and from an OHP covered medical service. The most appropriate and least costly ride may include requiring the client to share the ride with other clients;

(b) Verify that the client is obtaining OHP covered medical services in the client's local area. "Local area" means an area within the accepted community standard and includes the client's metropolitan area, city, or town of residence;

(c) Verify the client's OHP eligibility and that the client's benefit package includes NEMT services. The brokerage shall verify this through electronic eligibility information;

(d) Assess the client's access to other means of transportation, such as driving their own car or getting a ride from a family member or neighbor;

(e) Verify the client's attendance for continuing requests for rides if the medical provider could not affirm an appointment for a previous ride;

(f) Schedule a ride with an alternate subcontractor if the subcontractor originally assigned is unable to provide the ride; and

(g) Assign rides based on an evaluation of several factors including, but not limited to:

(A) Cost;

(B) The client's need for appropriate equipment and transportation;

(C) Any factors related to a subcontractor's capabilities, availability, and past performance; and

(D) Any factors related to the brokerage's need to maintain sufficient service capacity to meet client needs.

(4) Pursuant to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, clients receiving the following benefit packages are not eligible for NEMT:

(a) Citizenship Waived Medical (CWM) Benefits Package, which ended on June 30, 2023.

(b) Qualified Medicare Beneficiary (QMB) only.

(5) The brokerage shall maintain records of the reasons for authorizing a ride:

(a) That is not cost effective or not based on the factors specified in section (3) of this rule;

(b) With more than two attendants for an ambulance or stretcher car; or

(c) With more than one attendant for a wheelchair van.

(6) The brokerage shall provide a ride to a client to fill prescription medication only in the following situation:

(a) The client needs to stop on the way home to fill or pick up prescribed medication related to the medical service for which the brokerage provided the ride;

(b) It is medically necessary to fill or pick up the medication immediately; and

(c) The pharmacy is located on the return route or is the closest pharmacy to the return route.

(7) The brokerage may provide a ride to a client to fill prescribed medication under the following situations:

(a) The brokerage asks the client if the prescription service is available through the Authority's contracted postal

prescription service, and the client responds that it is not available through that source;
(b) The client has an urgent need to fill or pick up prescribed medication because the postal prescription service mailed the wrong medication, or the client has an unexpected problem caused by the medication; or
(c) The client is transient or without regular access to a mailbox. In this situation, the brokerage may evaluate the need on a case-by-case basis.
(8) The brokerage shall provide rides outside the brokerage's local service area as described in section 3(b) of this rule, under the following circumstances:
(a) The client is receiving an OHP covered medical service that is not available in the service or local area but is available in another area of the state;
(b) The client is receiving a covered service in California, Idaho, or Washington where the service location is no more than seventy-five (75) miles from the Oregon border; or
(c) No local medical provider or facility shall provide OHP covered medical services for the client.
(9) Brokerages may coordinate to provide a return ride to a client who receives medical services outside the client's local area.
(10) Brokerages shall retroactively authorize and pay for NEMT services that have already occurred only when the brokerage could not prior authorize the service because the brokerage was closed, and the request for authorization is within 30 days of the date of service. The brokerage also must confirm that one of the following circumstances supported the ride:
(a) The eligible client needed urgent medical care;
(b) The eligible client required secured transport pursuant to OAR 410-136-3120, Secured Transports; or
(c) The client was in a hospital, and the hospital discharged or transferred the client.
(11) Notwithstanding section (10) of this rule, a brokerage shall retroactively authorize NEMT services for ambulance transports when:
(a) An ambulance provider responds to an emergency call, but the client's medical condition does not warrant an emergency transport;
(b) The ambulance provider transports the client as a NEMT service; and
(c) The ambulance provider requests retroactive authorization within 30 days of the NEMT service.
(12) Brokerages shall not authorize or pay for rides outside their service areas based only on client preference or convenience.
(13) Brokerages shall provide toll-free call centers for clients to request rides. The following pertain to the brokerage's call center and scheduling of rides:
(a) The call center shall operate at a minimum Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage may close the call center on New Year's Day, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the brokerage requests the closure at least 30 days in advance.
(b) Brokerages shall make all reasonable efforts for clients to have access to available NEMT services 24 hours a day. When the call center is closed, the brokerages shall provide a recording or answering service to refer the client directly to a subcontractor. If no subcontractor is available, the brokerage must provide clients with recorded information about service hours and how to reach emergency services by calling 911;
(c) The brokerage shall allow a client to schedule rides at least 30 days in advance of the medical service; and
(d) The brokerage shall allow a client to request multiple ride requests at one time.
(e) The brokerage shall develop procedures and make reasonable efforts to arrange a ride requested on the day of the medical service when the medical service is:
(A) For an urgent medical condition; and
(B) Due to the urgency of the medical condition, the client scheduled an immediate medical appointment.
(14) The brokerage is not responsible for providing emergency medical transportation services. However, brokerages shall have procedures for referring clients requesting emergency medical transportation services to the appropriate

emergency transportation resources and procedures for subcontractors per OAR 410-136-3040, Vehicle Equipment and Subcontractor Standards.
(15) The Authority shall collaborate with brokerages and CCOs to develop and conduct a statewide client satisfaction survey at least once every two (2) years. The Authority may contract with one or more brokerages to conduct the survey. The Authority shall use the results of the survey to identify and address potential operational deficiencies and to identify and share successes in the NEMT program.
(16) Brokerages shall establish regional advisory groups consisting of representatives from the Authority, DHS, Area Agencies on Aging, consumers, representatives of client advocacy groups from within the service or local area, brokerage subcontractors, and providers of NEMT ambulance services. The role of the group includes, but is not limited to:
(a) Assisting in monitoring and evaluating the NEMT program; and
(b) Recommending potential policy or procedure changes and program improvements to brokerages and the Authority and assisting in prioritizing those changes and improvements.
(17) Brokerages shall have the discretion to use or not use DHS-approved volunteers. DHS shall provide brokerages with a list of approved and trained volunteers. DHS shall supervise the volunteers and assumes all liability for each volunteer as provided by law.
(18) Brokerages or their subcontractors shall not bill eligible clients for any transports to and from OHP covered medical services or any transports where the Authority denied reimbursement.
(19) On a minimum of five percent of the ride requests, brokerages shall contact medical providers to verify appointments and that the appointments are for OHP covered medical services.
(20) Brokerages may purchase tickets for common carrier transportation, such as inter- or intra-city bus, train, or commercial airline when deemed cost effective and safe for the client.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-200-0015

RULE TITLE: General Definitions

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Definitions updated to support the end of the Citizenship Waived Medical program and expansion of the Healthier Oregon program.

RULE TEXT:

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

child's care, and who is one of the following:
(a) A relative of the dependent child, as follows:
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.
(B) Stepfather, stepmother, stepbrother, and stepsister.
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;
(18) "CWM" means Citizenship Waived Medical (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, excluding MAGI Expanded Adult, except they did not meet citizenship and non-citizen status requirements (OAR 410-200-0215). For information about CWM benefits and eligibility prior to July 1, 2023, see OARs 410-134-0005 and 410-200-0240.
(19) "CWM Plus" means Citizenship Waived Medical Plus. CWM Plus was a benefit package that was previously referred to as "CWX" and ended on June 30, 2023. CWM Plus provided OHP Plus benefits to pregnant individuals and individuals who were 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 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.
"Community Partner" has the same meaning as "Community Partner" as defined in OAR 410-120-0000.
(27) "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.
(28) "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.
(29) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or
(b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.
(30) "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.
(31) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a:
(a) "Basic decision notice" mailed no later than:
(A) The date of action given in the notice; or
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;
(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten calendar days 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.
(32) "Department" means the Department of Human Services.
(33) "Dependent child" means an individual who:
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training if the individual may reasonably be expected to complete the school or training before attaining age 19.
(b) Lives in the home of the parent or caretaker relative; and
(c) Is not absent from the home for more than thirty (30) days due to being in foster care while foster care payments are being made.
(34) "ELA" (Express Lane Agency)" means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.
(35) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.
(36) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.
(37) "Electronic application" means an application electronically signed and submitted through the Internet.
(38) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.
(39) "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.
(40) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Agency's receipt of a hearing request unless the claimant requests more time.
(41) "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.
(42) “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.
(43) “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).
(44) “Federally Facilitated Marketplace” also called “FFM” means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.
(45) “Head of household” (HOH) means the primary person the Agency shall communicate with and:
(a) Is listed as the case name; or
(b) Is the individual named as the primary contact on the application.
(46) “Health Systems Division Medical Programs (HSD Medical Programs)” means all programs under the Health Systems Division including:
(a) “EXT” means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;
(b) “Substitute Care” means medical coverage for children in BRS or PRTF;
(c) “BCCTP” means Breast and Cervical Cancer Treatment Program;
(d) “FFCYM” means Former Foster Care Youth Medical;
(e) “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.
(47) “Healthier Oregon” is defined in OAR 410-120-0000.
(48) “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.
(49) “Insurance affordability program” means a program that is one of the following:
(a) Medicaid;
(b) CHIP;
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.
(50) “Legal argument” has the meaning given that term in OAR 137-003-0008(c).
(51) “Medicaid” means Oregon’s Medicaid program under Title XIX of the Social Security Act.
(52) “MAGI” means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in OAR 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for

the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:
(A) Children, regardless of age, who are included in the household of a parent;
(B) Tax dependents.
(b) In applying subsection (a) of this section, IRC § 6012(a) (1) is used to determine who is required to file a tax return.
(53) "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.
(54) "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.
(55) "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.
(56) "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).
(57) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.
(58) "Parent" means a natural or biological, adopted, or stepparent.
(59) "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.
(60) "Primary Contact" has the same meaning given "head of household" in this rule.
(61) "PRTF" means Psychiatric Residential Treatment Facility.
(62) "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.
(63) “Qualified hospital” means a hospital that:
(a) Participates as an enrolled Oregon Medicaid provider;
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;
(c) Agrees to make determinations consistent with Authority policies and procedures;
(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).
(64) “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 days after the date on the notice, unless the individual shows they did not receive the notice within the five-day period;
(c) May be extended beyond ninety (90) days for individuals who make an attestation of a non-citizen status if the individual is making a good faith effort to resolve any discrepancies or obtain any necessary documentation or the Agency needs more time to complete the verification process.
(65) “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.
(66) “Renewal” means a regularly scheduled periodic review of eligibility.
(67) “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.
(68) “Resident of a Public Institution” means:
(a) An individual residing in a public institution that is:
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;

(C) Residing involuntarily in a facility that is under governmental control; or
(D) Receiving care as an outpatient while residing involuntarily in a public institution.
(b) An individual is not considered a resident of a public institution when the individual is:
(A) Released on parole, probation, or post-prison supervision;
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is a resident. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or
(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.
(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:
(i) Is under age 21;
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or
(iii) Is age 65 or older.
(69) "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.
(70) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.
(71) "Sibling" means natural or biological, adopted, or half or step sibling.
(72) "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.
(73) "SSA" means Social Security Administration.
(74) "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.
(75) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).

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

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

AMEND: 410-200-0100

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

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Removing Citizenship Waived Medical (CWM) Benefit Package.

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

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

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

AMEND: 410-200-0240

RULE TITLE: Healthier Oregon and Citizenship Waived Medical and Citizenship Waived Medical Plus Benefits

NOTICE FILED DATE: 09/28/2023

RULE SUMMARY: Ending Citizenship Waived Medical Benefits Package and expansion of the Healthier Oregon pathway to Oregon Health Plan.

RULE TEXT:

(1) Healthier Oregon:

(a) Healthier Oregon benefits include Cover All Kids as of July 1, 2022 and are equal to OHP Plus benefits as defined in OAR 410-120-1210.

(b) Effective July 1, 2023, individuals are eligible for Healthier Oregon benefits if they:

(A) Meet all eligibility requirements for an HSD Medical Program, except the MAGI Expanded Adult program; and

(B) Do not meet the Citizenship and Non-Citizen Status Requirements set forth in OAR 410-200-0215;

(c) Through June 30, 2023, individuals were eligible for Healthier Oregon benefits if they were;

(A) Age 0 through 25 or age 55 and older;

(B) Met all eligibility requirements for an HSD Medical Program, other than the MAGI Expanded Adult program; and

(C) Did not meet the Citizenship and Non-Citizen Status Requirements set forth in OAR 410-200-0215;

(2) Citizenship Waived Medical (CWM) and Citizenship Waived Medical Plus (CWM Plus):

(a) Individuals eligible for CWM and CWM Plus through June 30, 2023 received benefits as defined in OAR 410-134-0005(2).

(b) To be eligible for CWM benefits, an individual must have:

(A) Been age 26 or older and under age 55;

(B) Met all eligibility requirements for an HSD Medical Program, other than the MAGI Expanded Adult program; and

(C) Did not meet the Citizenship and Non-Citizen Status Requirements set forth in OAR 410-200-0215.

(c) To be eligible for CWM Plus benefits, an individual must have met the CWM eligibility requirements described in section (b) of this rule and must have been pregnant or in their protected postpartum eligibility period as described in OAR 410-200-0135(3)(b)(B).

STATUTORY/OTHER AUTHORITY: ORS 411.060, 411.402, 411.404, 413.042, 414.025, 414.534

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