Advanced Elder Law 2022—“Thinking Out Loud” (Ed Sheeran)

Cosponsored by the Elder Law Section

Friday, October 7, 2022
9 a.m.–3:45 p.m.

5.5 General CLE credits (ID 92560)
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Planning Chair: Rebecca Kueny, Kueny Law LLC, Salem
Megan Fuhrer, Attorney at Law, Fairview
Kathryn Gapinski, Gapinski Law LLC, Portland
S. Jane Patterson, Patterson Smith PC, Gresham
Kay Hyde-Patton, Leahy Cox LLP, Springfield
Julie Meyer Rowett, Yazzolino & Rowett LLP, Portland
John Shickich, Fisher Investments, Camas, Washington
Mark Williams, Jordan & Williams, Junction City,

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OREGON STATE BAR
16037 SW Upper Boones Ferry Road
P.O. Box 231935
Tigard 97281-1935
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SCHEDULE

8:00  Continental Breakfast and Registration

9:00  “ABC” Advanced Planning Strategies (Jackson 5)
      ♦ Advanced Medicaid eligibility
      ♦ Redetermination
      ♦ Estate recovery analysis
      ♦ Other advanced planning strategies
      Meredith Williamson, NW Estate Law LLC, Beaverton

9:45  Transition

9:50  “Take Me Home, Country Roads” Asset Protection Trusts (John Denver)
      ♦ Medicaid asset protection trusts
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      ♦ Tax planning issues
      Alana Hawkins, Kueny Law LLC, Salem
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10:35 Transition

10:40  “Don’t Stop Believing” Maintaining Eligibility After a Triggering Event (Journey)
      ♦ Maintaining eligibility after a triggering event
      ♦ House sales post-eligibility
      ♦ Death of a spouse
      ♦ Inheritance
      Darin Dooley, Draneas Huglin Dooley LLC, Lake Oswego

11:25  Break

11:35  “Bridge Over Troubled Water” Dept. of Human Services v. Hobart (Simon and Garfunkel)
      ♦ Breadth of Hobart: what we know and what we don’t know
      ♦ Estate planning with estate recovery in mind
      Garvin Reiter, Law Offices of Nay & Friedenberg LLC, Portland

12:35  Lunch

1:15  “Never Ending Math Equation” Elective Share (Modest Mouse)
      ♦ How to calculate the elective share
      ♦ Who receives notice when it’s in the will (not a petition)
      ♦ Best practice—help!
      ♦ Post-Hobart
      Joel Smith, Jordan & Williams, LLC, Junction City

2:00  Transition
SCHEDULE (Continued)

2:05  “Changes” (Tupac)
   ♦ Updates in Oregon Administrative Rules
   ♦ The Oregon Eligibility (ONE) system and applying for benefits
     Alejandra Klein, Attorney at Law, Portland
     Rebecca Kueny, Kueny Law LLC, Salem

2:50  Break

3:00  “Whenever I Call You Friend” Medicaid Eligibility for Unmarried Partners (Kenny Loggins)
     Monica Pacheco, Douglas Conroyd Gibb & Pacheco PC, Salem

3:45  Adjourn
FACULTY

Darin Dooley, *Draneas Huglin Dooley LLC, Lake Oswego*. Mr. Dooley practices in the areas of estate planning, elder law, Medicaid, special needs planning, probate, guardianship/conservatorship, wrongful death probate, and trust administration. He is a member of the Oregon State Bar Elder Law Section Executive Committee and Estate Planning and Administration Section.

Alana Hawkins, *Kueny Law LLC, Salem*. Ms. Hawkins’s primary practice areas include long-term care planning with Medicaid and VA benefits, estate planning and administration, probates, protective proceedings, and special needs trust planning.

Alejandra Klein, *Attorney at Law, Portland*. Ms. Klein focuses her practice on estate planning and transactional law. She provides legal services in both Spanish and English. Ms. Klein is admitted to practice in California and Oregon.

Rebecca Kueny, *Kueny Law LLC, Salem*. Ms. Kueny has been working in estate planning and elder law industry since 2008. She is accredited with the Department of Veterans Affairs. She is very active with the Salem charitable community, assisting vulnerable populations receive legal protections and educating the community on the legal principles surrounding life and mental incapacity.

Mark Munson, *Ruder Ware LLSC, Wausau, Wisconsin*. Mr. Munson focuses his practice in the areas of elder law, public benefits (including special needs trusts), estate and trust planning, and taxation. He regularly advises clients in the areas of asset protection and medical assistance eligibility, as well as probate and estate administration, trust administration, and guardianship. He is a Certified Elder Law Attorney (CELA) by the National Elder Law Foundation and an accredited attorney by the Veterans Administration. Mr. Munson is a member of the National Academy of Elder Law Attorneys Executive Committee, Tax Section Steering Committee, and Special Needs Trusts Section, the State Bar of Wisconsin Elder Law Section and Real Property, Probate and Trust Section, and the American Bar Association Section on Real Property, Probate and Trust and Senior Lawyers Division.

Monica Pacheco, *Douglas Conroyd Gibb & Pacheco PC, Salem*. Ms. Pacheco’s practice concentrates on estate planning and elder law, particularly as it relates to Medicaid, VA, and disability planning. She speaks regularly on the matters related to Medicaid planning, VA Aid and Attendance pension, elder law issues, and asset protection for disabled individuals to various forums in the community. She is a member of the National Academy of Elder Law Attorneys and the Academy of Special Needs Planners, and she is accredited by the Veterans Administration.

Garvin Reiter, *Law Offices of Nay & Friedenberg LLC, Portland*. Mr. Reiter is a member of the Oregon State Bar Elder Law Section Executive Committee and is a Certified Elder Law Attorney through the National Elder Law Foundation. His practice emphasizes estate planning, special needs planning and long-term care planning.

Joel Smith, *Jordan & Williams, LLC, Junction City*.

Meredith Williamson, *NW Estate Law LLC, Beaverton*. Ms. Williamson specializes in estate planning, Medicaid, protective proceedings, and estate administration. She was the legal editor of the Oregon State Bar’s 2012 publication, Legal Issues for Older Adults, a guest speaker on the Oregon State Bar’s legal podcast (OSBtv), a contributor to LegalLinks, and legal editor for The Senior List. She is admitted to practice in Oregon, Washington, and California (inactive).
Chapter 1
Advanced Planning Strategies

MEREDITH WILLIAMSON
NW Estate Law LLC
Beaverton, Oregon

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PART I
INTRODUCTION

These materials provide an overview of some advanced Medicaid planning techniques. If you are new to Elder Law, I recommend the CLE Elder Law Boot Camp as a starting point. For a list of definitions, see OAR 461-001-0000. A list of frequently used acronyms can be found here: www.dhs.state.or.us/spd/tools/glossary.htm.

A. Program Overview

The Oregon Department of Human Services (DHS) administers the Medicaid program on behalf of the State. Each state’s program must comply with applicable federal statutes and regulations to receive federal reimbursement. These materials focus on Oregon rules and federal laws. Unless specified the materials only cover the Oregon Supplemental Income Program - Medical (OSIPM).

OSIPM pays for, among other things, portions of long-term care costs for qualifying Oregonians. This includes Nursing Home Care (NFC) as well as an expanded program of Community Based Care (CBC) which includes Adult Foster Homes (AFH), Assisted Living Facilities (ALF), Residential Care Facilities (RCF), Specialized Living Facilities (SNF) for people in specific target groups which exist as the result of a problem, condition, or dysfunction resulting from a physical disability or a behavioral disorder, and In-Home Care Services (IHC) (OAR 461-001-0000(17) and OAR 411-030-0020). To receive payment from Medicaid, the long-term care facility must be contracted with the State for this program.

B. OSIPM Coverage

OSIPM pays the long-term care facility directly for a portion of the monthly cost of care for the Medicaid Recipient. Depending on the Medicaid Recipient’s income and any possible diversion to their Community Spouse, the Medicaid Recipient will also pay toward their cost of care. The Medicaid Recipient is also responsible for their room and board if living in a Community Based Care Facility, which is currently $654.00 per month. Medicaid pays the difference between the Medicaid contract rate and the contribution from the Medicaid Recipient. See the attached schedule for current rates.

The Medicaid Recipient can keep a Personal Needs Allowance as follows:

- $68.77 if residing in an NCF.
- $90.00 if receiving Aid and Attendance and residing in an NCF.
- $187.00 if living in Community Based Care.
- $841.00 for IHC if SSI is sole income source.
- $841.00 plus $500.00 for IHC with other income sources.
Note: Most Community Based Care Providers do not accept Medicaid as a payor source. Make sure the client understands their options and locates a care facility that meets their needs and accepts Medicaid.

C. Eligibility

The following Oregonians are eligible for OSIPM:

1) People meeting eligibility for Medicaid based on Supplemental Security Income (SSI) or through 1619(b) status as provided under Section XVI of the Social Security Act.
2) A Disabled Adult Child or through the Pickle Amendment.
3) People with income below the SSI standard.
4) People receiving behavioral health services with income below 150% of the SSI standard.
5) People receiving Title XIX Long-Term Services and Supports through Aging and People with Disabilities (APD) or through the Office of Developmental Disabilities Services (ODDS) Intellectual/Developmental Disability (I/DD) services program in a home or community-based setting, nursing facility, or state institution, and have income below 300% of the SSI standard.
6) People who meet the requirements of the Employed Persons with Disabilities (EPD) program with income below 250% of the federal poverty level.

Note. As of July 1, 2022, people ages 19 through 25 or 55 and older who meet financial and non-financial eligibility requirements (except immigration status) are eligible for a program called Healthier Oregon Medical Program (OAR 461-135-1080). In addition, Long-Term Services and Supports may be provided to this group with a few excepted programs.

Oregonians seeking OSIPM to pay for long-term care must also:

1) Need assistance with certain Activities of Daily Living (ADL),
2) Meet the income threshold, and
3) Meet the resource threshold.

Financial Criteria

Resources

A Medicaid Applicant, whether single or married, may have no more than $2,000.00 in countable resources in their name. Countable resources generally include all resources except:

1) Personal property, such as clothing, furniture, and jewelry (OAR 461-145-0390);
2) One vehicle used for transportation of the Medicaid Applicant or the Community Spouse (OAR 461-145-0360(4));
3) Burial/Cremation property such as a casket, urn, gravestone, plot, and burial funds of $1,500, or an irrevocable burial plan (OAR 461-145-0050, 461-145-0040(5));
4) Certain life insurance policies or policies with minimum values (OAR 461-145-0320);
5) Income Producing Property for self-employment (not rental property or rental in one’s home) (OAR 461-145-0089, 461-145-0600);

6) Resources that are considered inaccessible (OAR 461-140-0020(2)) where the Medicaid Applicant:
   a. Does not know they have ownership of the interest;
   b. Does not have the ability to access the resource;
   c. Owns the resource with other people who are unwilling to sell their interest and the portion owned by the Medicaid Applicant is not reasonable saleable; or
   d. Is at risk of domestic violence by accessing the resource.

7) The residential home so long as meets OAR 461-145-0220:
   a. The Medicaid Applicant lives in the home and the home’s equity is less than $636,000.00;
   b. The Medicaid Applicant or their Community Spouse is absent so they may receive care or has an illness and intends to return home;
   c. The home is listed for sale and does not exceed the equity value listed above (OAR 461-145-0420);
   d. The Community Spouse resides in the home at any value;
   e. The Medicaid Applicant’s disabled child lives in the home; or
   f. The Medicaid Applicant’s child, under the age of twenty-one, lives in the home.

Income

A Medicaid Applicant’s countable income must be equal to or less than 300% of SSI - currently $2,523.00 (OAR 461-155-0250). This amount is generally adjusted each year. If the Medicaid Applicant’s income is over this amount, they need to establish an Income Cap Trust to qualify for Medicaid (OAR 461-145-0540 (10)(c)).

Note: An eligibility worker may tell the Medicaid Applicant that an Income Cap Trust should not be opened until a Service Priority Level is established. However, it is best to establish it in the month the Medicaid Applicant wants the State to start paying for long-term care.

Certain income, such as Veteran’s Administration Aid and Attendance and Housebound Benefits are not considered income for OSIPM purposes of determining if an Income Cap Trust is required. However, the Medicaid Recipient will still have to use these funds toward their cost of care each month (OAR 461-145-0580(2)(a)(A)).

Income generated from countable resources is not also considered income – for example, the equity value of IRAs are considered a resource so the distributions do not count as income. Rather, the distributions are considered a conversion of one resource (IRA) to another resource (checking account).
The State only considers the Medicaid Applicant’s income, and not the income of the Community Spouse, for purposes of an Income Cap Trust. Review OAR 461-140-0040 to see how the State determines the availability of income.

**Note.** The State looks at the Medicaid Applicant’s gross income, so gather income verification letters rather than relying on the amounts deposited into bank accounts to determine if an Income Cap Trust is needed. Also review the bank statement for additional income sources the Medicaid Applicant may have forgotten about.

**Note.** Have clients bring all their financial documents to your initial meeting. Applicants may not understand what counts as income or resources. For example, the difference between net and gross income, IRAs with RMDs, complexities of annuities, and cash value of a whole life insurance policy.

### Non-Financial Criteria

#### Activities of Daily Living

A Case Manager will determine what level of care a Medicaid Applicant has through a series of questions known as CA/PS. When determining if a Medicaid Applicant meets the Activities of Daily Living prong, the Case Manager will consider four main categories: Mobility, Eating, Elimination, and Cognition (OAR 411-015-0006). Assistance must usually be hands-on and must always be from another person out of necessity and not because it is more convenient or easier for the Medicaid Applicant.

- **Mobility** has two subcategories: Ambulation and Transfers. A person must require hands-on assistance in the act of moving in the care setting; rising or sitting from a couch, chair, bed, or toilet; or getting up after a fall. To meet the assistance requirements, the care must happen at a specific frequency.

- **Eating** is the act of direct feeding, cueing, or setting up feeding tubes or feeding devices. Choking and aspiration hazards must require physical intervention or assistance. Meal preparation, supervision, and monitoring are not enough to qualify a person for assistance in Eating.

- **Elimination** has three subcategories: Bladder, Bowel, and Toileting.
  - **Bladder** and **Bowel** refer to procedures or devices needed to void the bladder or bowel.
  - **Toileting** refers to assistance from another person to cleanse after bladder or bowel movements, hands-on assistance to change incontinence supplies, or cueing to prevent incontinence.
**Cognition** relates to a person’s ability to understand and therefore use information. It requires daily assistance from another person beyond medication management and forgetfulness to preserve one’s health and safety.

**Note.** When interviewing a client, ask them to provide examples of times they need assistance. Discuss how often they need assistance with each activity. The frequency of events is important; if assistance is required only once every few months, this will not be enough to meet a category.

The assistance timeframe may be extended in evaluating cognition (OAR 411-015-0006(3)(b)).

**Note.** While other Activities of Daily Living may qualify a Medicaid Applicant for payment under a long-term care policy or meet care needs to qualify them for assisted living, these may not meet the criteria for Medicaid which can be confusing to clients. When discussing ADLs, focus on Mobility, Eating, Elimination, and Cognition.

**Note:** Focusing on financial criteria, DHS may tell the Medicaid Applicant to spend down before they will assess their Activities of Daily Living. However, DHS should be working on both pieces concurrently and it is appropriate to ask for a care assessment if the Medicaid Applicant is close to SPL.

A Medicaid Applicant must be rated as service priority level 1 through 13 to qualify for OSIPM. There are other programs, such as State Plan Personal Care, Oregon Project Independence, and Extended Waiver Eligibility, which may apply in some cases (OARs Chapter 411 Division 015).

**Continuous Period of Care**

Defined under OAR 461-001-0030, a Continuous Period of Care is established when the Medicaid Applicant:

“Resides for a period of at least thirty consecutive days or until death in a long-term care facility, home and community-based care setting, or an acute care hospital. There must be sufficient evidence to show there is a reasonable expectation that the client will remain in care for at least thirty consecutive days. For the purposes of this policy, an interruption in care (for example, leaving and then returning to a nursing home, or switching from one type of care to another) that lasts less than 30 days is not considered a break in the thirty consecutive days of care. A new period of care begins if care is interrupted for 30 or more days.”

**Note.** To establish the Continuous Period of Care for a client in home and community-based care settings, have a conversation with the client about when qualifying needs started. If the caseworker requests proof, you may need to support the CPC with evidence, such as care notes. Establishing this date can be difficult when a person is qualifying based on a cognitive deficit, but a specific date is not required. So long as there
has not been a break in aid for 30 days or more consecutively, the closest estimate should suffice. Consider a CPC date as the earliest time a person would have met the SPL requirements for Title XIX.

D. Spousal Impoverishment Protections

The Medicare Catastrophic Coverage Act of 1988 was enacted, in part, to protect a Community Spouse from complete impoverishment when a married couple is faced with long-term care costs. The Community Spouse is now allowed to keep their own income and may be able to have some of the Medicaid Applicant’s income diverted to them. The Community Spouse is also allowed to keep a certain amount of Resources in their name.

Resources

Each state sets the Community Spouse resource cap so long as it meets the minimum federal threshold. This is known as the Community Spouse Resource Allowance (CSRA). The CSRA limit is adjusted each year. The current minimum CRSA is $27,480.00, and the maximum is $137,400.00 (OAR 461-160-0580). A Community Spouse can keep the lesser of the maximum or half the total countable resources the couple has at the time of Continuous Period of Care (OAR 461-001-0030(2)). If a married couple’s total countable resources are less than $54,960.00, the Community Spouse may keep the minimum.

Example. A couple owns $90,000.00 in countable resources on the date the Medicaid Applicant enters a hospital with qualifying and continuing needs, the Medicaid Applicant will be eligible for Medicaid once their combined resources have been reduced to $47,000.00 ($2,000 for the Medicaid Applicant and $45,000.00 (one-half of $90,000.00) for the Community Spouse).

Example. A couple owns $250,000.00 in countable resources on the date the Medicaid Applicant enters the hospital with qualifying and continuing needs. The Medicaid Applicant will be eligible for Medicaid once their combined resources are $127,000.00 ($2,000.00 for the Medicaid Applicant plus a maximum of $125,000.00 for the Community Spouse).

The Community Spouse can keep the highest of the following resource options (OAR 461-160-0580(2)(c) as their Community Spouse Resource Allowance (CSRA):

1) Half the couple’s combined countable resources at the beginning of the Continuous Period of Care, but not more than $137,400.00 (current 2022 number).

2) The Minimum CSRA – currently $27,480.00.

3) A court ordered CSRA.

4) A shortfall in income to meet the Community Spouse’s Monthly Maintenance Needs Allowance. If the combined incomes a married couple does not meet the monthly needs allowance, look at using an annuity based CRSA. After considering
the income of the Community Spouse (see OAR 461-001-0030) and the income available from the Medicaid Applicant, the Community Spouse can keep the amount which, if invested, would raise the Community Spouse’s income to the monthly needs allowance equal to an amount required to purchase a single premium immediate annuity to make up the shortfall. This is outlined in detail later in these materials.

### Income

In all circumstances, once Medicaid begins, the income of the Community Spouse will continue to the Community Spouse undisturbed - the Community Spouse will not have to pay toward the Medicaid recipient’s cost of care (liability) or their room and board. In some cases, part of the Medicaid recipient’s income will divert to the Community Spouse.

DHS has determined an income floor for the Community Spouse, known as the Minimum Monthly Maintenance Needs Allowance. The amount will increase based on the shelter costs. (Where the Community Spouse can show hardship, DHS may award a larger monthly needs allowance, but only after requesting an exception (OAR 461-160-0620(3)(d)(C)). The monthly needs allowance may range from a low of $2,288.75 to a high of $3,435.00 a month.

**Step 1—Determine the maintenance needs allowance.** Add $2,288.75 to the amount over $686.63 needed to pay monthly shelter expenses for the couple’s principal residence. This sum, or $3,435.00, whichever is less, is the monthly maintenance needs allowance. For the purpose of this calculation, shelter expenses include the rent or mortgage (principal and interest), taxes, insurance, required maintenance charges for a condominium or cooperative, and the full standard utility allowance for the SNAP program (OAR 461-160-0420). If an all-inclusive rate covers items that are not allowable shelter expenses such as meals or housekeeping in an assisted living facility, or utilities to the extent they can be distinguished, these must be deducted from the all-inclusive rate to determine the allowable shelter expenses.

**Step 2—Compare the maintenance needs allowance with the Community Spouse’s countable income.** Deduct the countable income (see OAR 461-001-0000) of the Community Spouse from the maintenance needs allowance determined in Step 1.

**Step 3—Consider exceptional circumstances.** If a spousal support order or exceptional circumstances results in significant financial distress require a greater income allowance than that calculated in step 2, the higher amount is the allowance.

**Note.** Where the Community Spouse can show hardship, DHS may award a larger monthly needs allowance but only after a request for exceptional circumstance.
If the Community Spouse’s income is more than the established monthly needs allowance, none of the Medicaid Spouse’s income will be available to the Community Spouse.

If the combined income available to the Community Spouse and Medicaid Spouse is not sufficient to cover the monthly needs allowance, consider using excess resources, if any, as a way to qualify under OAR 461-160-0580(2)(f)(D).

**PART II**

**PLANNING**

An Elder Law Attorney can counsel a client on several planning techniques. Understanding your client’s goals, situation, and outlook is essential to providing a clear path. Each strategy may not be suitable for every client. Due to the complexity of Medicaid, it is important to determine which, if any, strategy is appropriate for an individual client. An attorney can assist the client with a general understanding of a budget, proper spend-down techniques, and transfer penalties.

Often, a simple spend down is the most cost-effective plan. Despite the costs of long-term care, there are advantages to paying privately for long-term care. By paying privately, an individual is more likely to gain entrance to a higher-quality facility.

The obvious disadvantage of paying privately for long-term care is the expense; in Oregon, basic long-term care can range between $5,500.00 and $10,000.00 per month. As a result, long-term care residents can lose the bulk of their savings without proper planning. For most individuals, long-term care planning aims to protect savings (by avoiding paying them to a long-term care community) while simultaneously qualifying for nursing home Medicaid benefits. This is especially important for married couples.

**A. Pre-Planning Options**

**Transfers**

One of the most common questions an Elder Law attorney receives is, “can I gift my money?” Transfers to certain people may be allowed, but generally, a transfer (including gifting, selling for less than fair market value, or transferring into an irrevocable trust) will result in a penalty where a Medicaid Applicant is disqualified for Medicaid for a certain period.

Asset transfers will be disqualifying unless the transfer meets the criteria under OAR 461-140-0220:

1. It was an excluded personal belonging.
2. It was sold or traded for equal or greater fair market value.
3. It was transferred between members of the same financial group.
4. It was to settle a legally enforceable debt.
5. The amount was equal to or less than the amount excluded in the initial month of eligibility because of a Qualified Partnership Policy.
6. The court ordered the transfer and
   a. The transfer occurred more than 60 months before the Date of Request and
   b. The amount of resources allocated does not exceed the largest of the CSRA amounts to the Community Spouse.
7. The individual was a victim of fraud and has taken legal steps to recover it.
8. It was to purchase a Medicaid Compliant Annuity.

**Transfer Penalty**

DHS has a right to look back at resources sixty (60) months from the Date of Request. If a Medicaid Applicant or the Community Spouse transfers resources, he or she will be ineligible for Medicaid for a period based on the amount of the transfer (OAR 461-140-0210(5)). Transfers for less than fair market value must be disclosed and may result in a penalty where the Medicaid Applicant is not eligible to receive Medicaid OSIPM for up to five (5) years from the date of application.

The penalty length is determined by transferred amount by the divisor (currently $9,551.00) - this amount increases and is intended to reflect the cost of one month of care in a nursing facility.

Another way to look at this is that for every $9,551.00 transferred, a Medicaid Applicant will be ineligible for Medicaid long-term care benefits for one month.

**Example.** John moved into assisted living in January 2021. John is applying for Medicaid in June 2022. He made gifts totaling $100,000.00 to his daughter in September of 2021. This transfer occurred within the five-year look back, and because he was in care at the time of the gift, Medicaid could be anticipated. He is disqualified from Medicaid for 10.47 months ($100,000.00 ÷ $ 9,551.00 = 10.47), rounding down to the nearest full day.

It is important to remember that the penalty period does not begin until the person making the transfer spends down their countable resources to the Medicaid resource limit (and the CSRA for a married couple) meets Medicaid qualifying Service Priority Level for Activities of Daily Living.

**Example.** A Medicaid Applicant transfers enough resources causing a 12-month penalty period on June 1, 2018 and spends down to $2,000.00 by June 1, 2020 and applies on that day. He will be ineligible for Medicaid coverage until June 1, 2021 because the 12-month penalty period for the transfer did not begin until the Date of Request.

**Exceptions to the Transfer Penalty**

If a transfer was not made in anticipation of applying for or continuing Medicaid, then it is not disqualifying. Consider a person’s age, time from the transfer to application, health at the time of transfer, and what occurred to necessitate a Medicaid application after the transfer. Further, a transfer made exclusively for purposes other than establishing or maintaining benefits is not disqualifying (OAR 461-140-0242(2)(a)).
Transferring resources to certain groups will not initiate a period of ineligibility. These exempt transfers are found in OAR 461-140-0242:

1. The spouse;
2. A blind or disabled child;
3. A child under age 21.
4. A third party for the sole benefit of the spouse or a blind or disabled child. To be considered for the sole benefit, so long as the transfer instrument provides for the spending of the funds involved for the benefit of the individual based on the life expectancy of the person receiving the benefit;
5. A sibling of the Medicaid Applicant—limited to a home the sibling has an equity interest in and who was residing in the house for at least one year immediately before the Medicaid Applicant requires care;
6. A transfer to a pooled trust for a child or spouse under the age of sixty-five, which is defined under OAR 461-145-0540(11) as:
   a. Established and managed by a non-profit association;
   b. Holds a separate account for each person;
   c. Is established by the individual, the individual’s parent, grandparent, legal guardian, or court for individuals with disabilities;
   d. Upon the death of the beneficiary or termination of the trust, the trust pays to the state an amount equal to the total medical assistance paid on behalf of the beneficiary under the state plan for Medicaid. The amount paid to the state may be reduced by administrative costs related to administering the sub-trust account of the beneficiary; and
   e. The trust holds the resources or income of an individual who has a disability that meets the SSI criteria.
7. A natural or adoptive child that meets OAR 461-140-0242(3)(c) to be a Caregiver Child. To qualify as a Caregiver Child, the person must meet the following criteria:
   a. Is the child of the Medicaid Applicant;
   b. Lived in the house with the Medicaid Applicant for at least two years immediately prior to the Medicaid Applicant moving into a long-term care community;
   c. Assisted the Medicaid Applicant with ADLs and IADLs on a daily basis, totaling at least 20 hours per week, and to such a degree that the Medicaid Applicant did not need to move to a long-term care community; and
   d. Did not receive payment from the state for providing the care described above.
   e. This provision cannot be applied retroactively unless sufficient proof of caregiving exists. While not required, provide your clients with forms 3306, 3307, and 3308, so they are informed of what might be required. Clients should save communication about this provision from their attorney to establish intent to meet this rule.
Hardship Waiver
In some instances, the Medicaid Applicant may apply for a hardship waiver to the transfer penalty (OAR 461-140-0300, APD Form 544). The Medicaid Applicant must show:

1. There are no other means for meeting his or her needs. The client has the burden of proving that no other means exist by:
   a. Exploring and pursuing all reasonable means to recover the asset(s) to DHS’s satisfaction, including legal remedies and consultation with an attorney; and 
   b. Cooperating with the DHS to take action to recover the asset(s).
2. The disqualification would deprive the client of:
   a. Medical care such that the client’s health or life would be endangered; or
   b. Food, clothing, shelter, or other necessities of life without which the health or life of the client would be endangered.

Cure
The return of the asset to the Medicaid Applicant can cure a transfer in whole or part resulting in a complete elimination or partial reduction of the penalty period.

Intentional Transfers
In some cases, transfers with a penalty may be advisable. Transfers generally fall into one of two categories: 1) those outlasting 60 months or 2) those requiring a two-step application process. Before deciding on a transfer, evaluate a person’s Activities of Daily Living, the tax implications, available asset types, and how the client will cover expenses during the penalty period.

Transfers can be made to another person, but this is risky and generally not recommended - look at an Irrevocable Trust instead.

The Five-Year Plan. Under this plan, a Medicaid Applicant may transfer all or a part of their resources. They will wait to file the Medicaid application until 60 months (five years) have elapsed from the date of transfer. Usually, the Medicaid Applicant retains resources outside the trust/transfer to pay for expenses during the 60 months. The Medicaid Applicant does not need to have met the three-prong test at the time of the transfer. However, this transfer may be a risky approach if care needs are already high.

The Two-Application Plan. Under this plan, a Medicaid Applicant should already meet the income and Activities of Daily Living requirements at the time of the transfer. Due to increases in the cost of care, which is averaging $8,000.00 per month, this is a riskier approach than in years past. After a careful evaluation of a Medicaid Applicant’s needs, income, and ability to follow the plan if it is still a viable option, they would complete the following steps:

1. The Medicaid Applicant transfers all remaining resources (except $2,000.00 for the Medicaid Applicant and CSRA for Community Spouse).
2. Apply for Medicaid and have DHS issue a Notice of Disqualification which provides the Medicaid Applicant with the term of the penalty.
3. The Medicaid Applicant serves the disqualification period. This period may be the entire term or reduced with a partial cure, as described above.
4. Reapply for Medicaid long-term care at the end of the disqualification period.

Example. John and Jane are married and in their early seventies. Jane was recently diagnosed with dementia but is independent in her Activities of Daily Living. They have an adult child who lives near them and is willing to help. They have $250,000.00 in IRAs, $200,000.00 in other countable resources, and a residential home.

Step 1 – Evaluate CSRA = $137,400.00.
Step 2 – Evaluate expenses and needs—currently, no care needs, and the son is willing to help. They should be able to outlast the 60-month timeframe.
Step 3 – Evaluate what resources they may want to transfer— they will want to avoid cashing out all the IRA due to taxes and will need to leave some cash on hand to pay for care. Therefore, they must budget enough resources outside the transfer to pay for care.

Example. Jack and Susie are a married couple in their eighties. Jack was diagnosed with frontal lobe dementia a year ago. He has behaviors which have progressed to the point that he is no longer safe at home. They have $250,000.00 in IRAs, $200,000.00 in other countable cash resources, and a residential home. Susie found a facility for Jack with a cost of $8,000.00 per month.

Step 1 – Evaluate CSRA = $137,400.00
Step 2 – Evaluate expenses and needs— currently, Jack has qualifying care needs, so it is likely too late for the 60-month transfer, depending on their incomes. The cost of care is close to the penalty divisor of $9,551.00, half their resources are in taxable accounts, and Jack has a progressive disease. All these factors should be discussed before transfer as it may be risky since the majority of the resources need to be transferred under the two-application plan.

Step 3 – If the client wants to move forward with a full understanding of the costs and risks, they need to transfer $310,600.00.
Step 4 – Apply for Medicaid and receive a Notice of Disqualification.
Step 5 – Apply again when the penalty period has elapsed.

Qualified Long-Term Care Partnership Policy (QPP)
Starting in January 2008, Oregon implemented a program in connection with long-term care policies that meet current federal and state rules, known as Qualified Partnership Policies (QPP). If a long-term care policy provides written verification of its partnership status at the time the individual purchased the policy and that person later applies for Medicaid, the amount the policy paid for care is treated as an excluded resource (OAR 461-160-0855(1)) and is not subject to estate recovery (OAR 461-160-0855(3)). The DHS worker guide states this amount may also be gifted without penalty. It cannot be used to reduce the value of a residential home (currently $636,000.00), and it does not apply to other countable resources.
Example. Mike has been using his QPP policy supplement to pay for care. The policy pays $5,000.00 per month, and he has received $75,000.00 in payments to date. He has an income of $3,000.00 per month and expenses of $10,000.00 per month. He has $100,000.00 in resources remaining. He would need to spend privately for four more months and will keep up to $96,000.00 in resources assuming the QPP paid all four months ($75,000.00 plus $20,000.00 (four months of policy payments) plus the $2,000.

Example. Matt and Lyda are married. Lyda moved into care a year ago. At that time, they had countable resources of $200,000.00, and she has been in a continuous period of care from that date. She has received $50,000.00 from a QPP, and they have spent $50,000.00 from existing resources. She is now eligible for Medicaid. Matt’s CSRA is $100,000.00, and the $50,000 of QPP payments is an excluded resource for Lyda.

Note. If you have clients come in before eligibility and they have a long-term care policy, make sure they obtain the letter indicating it is a QPP, as it is easier to collect these documents before applying for Medicaid.

B. Spousal Protection Immediate Planning

Increase in Monthly Maintenance Needs Allowance
As discussed above, the current Minimum Monthly Maintenance Needs Allowance for the Community Spouse is $2,288.75, and the maximum is $3,435.00. Many clients do not feel this is adequate to cover their monthly needs but for most, a budget or reduction of expenses may be sufficient. However, OAR 461-160-0580(4) allows DHS to waive the requirement for income to be considered first if they determine the CSRA would create an undue hardship on the Community Spouse. Undue hardship is not defined but things considered include the Community Spouse’s age and health, if income currently available from the Medicaid Applicant ends on that person’s death (for example, a pension with no death benefit), and high monthly household expenses.

Promissory Notes/Loans
Federal law has given some leeway for Promissory Notes. However, Oregon rules have made the use of Promissory Notes a high-risk, low-reward strategy.

If the loan is both a negotiable loan agreement and a bona fide agreement, for financial groups in a non-standard (receiving services) living arrangement:

1. Only the interest portion of payments made by the borrower to the lender is counted as unearned income.
2. The principal portion of any payments is excluded.
3. The outstanding principal balance is counted as a resource. If the loan is not both negotiable and bona fide, for financial groups in a standard living arrangement:
   a. Both the principal and interest payments are treated as unearned income.
b. The balance of the loan is excluded as a resource.

Requirements for a loan to be treated in accordance with a standard living arrangement in one of the above scenarios - For a loan beginning after July 1, 2006, the total value of the transaction being repaid to the Medicaid Applicant or Community Spouse within three months of the life expectancy of the person (individual or spouse) according to the Life Estate and Remainder Interest Table, payments are made in equal amounts. If jointly owned, the requirements are met if the transaction is repaid according to the life expectancy of either the individual or the individual’s spouse, payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments, the contract is not canceled upon the death of the individual receiving the payments, no one other than the estate of the lender is the designated remainder beneficiary. Failure to meet these requirements in the lender/applicant/recipient experiences a disqualification period. After serving that period, the principal is excluded, and payments (principal and interest) are treated as unearned income.

**Medicaid Compliant Annuity**

The purpose of the Medicaid Compliant Annuity is to transform excess resources into an income stream for the Community Spouse while decreasing the excess resources. The result is that a married couple can access Medicaid in the month the annuity is purchased so long as they meet the resource, income, and Activities of Daily Living requirements.

OAR 461-145-0022(11) outlines the conditions the annuity must meet to be treated as a disqualifying transfer of assets. These conditions are as follows:

1. Irrevocable;
2. Non-assignable;
3. Actuarially sound – payments in equal installments of the life expectancy of the annuitant with no deferral or balloon payments, concluding within 12 months on either side of the life expectancy established by the SSA table;
4. The annuity is issued by a licensed business approved to issue a commercial annuity by the state in which the annuity was purchased.
5. The annuity must comply with one of the following paragraphs:
   A. The first remainder beneficiary is the spouse of the individual; DHS is named as the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual; and if the spouse transfers any of the remainder of the annuity for less than fair market value (see OAR 461-001-0000), the Department is the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual.
   B. The first remainder beneficiary is the annuitant's child; the Department is named as the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual; and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than fair market value, the Department
is the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual.

C. The first remainder beneficiary is the Department for up to the total amount of medical assistance paid on behalf of the individual.

If all the criteria above are met, and the annuity was purchased on or after July 1, 2006, the resources used to purchase the annuity are no longer available, and the purchase is not a disqualifying transfer. The distributions will be counted as unearned income to the payee in the month received.

If the annuity does not meet the criteria listed above, it may be treated as a disqualifying transfer of assets by DHS.

If a Medicaid Applicant purchased an annuity before July 1, 2006, it might be treated as a disqualifying transfer under OAR 461-140-0210.

**Note.** The Medicaid Compliant Annuity may be discussed in the pre-planning stages before care is needed, but the client should refrain from purchasing until the month of application, so they do not unnecessarily restrict access to the principal.

Remember to calculate an annuity based CSRA before suggesting the client purchase a Medicaid Compliant Annuity (461-160-0580(2)(d)). If there is a shortfall in the income available to meet the minimum monthly needs allowance, and resources are available to make up the shortfall, then the purchase of the annuity may not be needed. Further, the Medicaid Compliant Annuity restricts the Community Spouse's access to the principal of the funds used to purchase the annuity, but the annuity-based CSRA allows the Community Spouse complete access to the funds and may use them to make a higher-yield investment.

**How to Calculate the Annuity-Based CSRA Calculation**

Use [https://digital.fidelity.com/prgw/digital/gie/](https://digital.fidelity.com/prgw/digital/gie/) to enter the shortfall. When on the site follow these instructions:

1. Select Just Me
2. Enter the Date of Birth of the Community Spouse
3. Enter the Gender of the Community Spouse
4. Enter the state of residence of the Community Spouse
5. Select "how much I want to invest"
6. Enter the monthly income needed (round up to the nearest whole dollar)
7. Select the first of the following month as the start date
8. Select non-qualified
9. Do not opt to increase by two percent
10. The top result, "cash refund," is the new CSRA
11. This amount is not added to any other part of the CSRA rules
*This tool will not work if the Community Spouse is 85 years of age or older. When this occurs, retrieve the life expectancy from the SSA table, convert it to months, and multiply it by the shortfall calculated in accordance with the provisions above.

**Note.** If the Medicaid Applicant uses an annuity-based CSRA and still has excess resources, have them wait to purchase an annuity until DHS has confirmed the annuity-based CRSA. The amount of income the Medicaid Applicant can divert to the Community Spouse will ultimately decrease. This diversion to the Community Spouse is known as LDS.

If a married couple's resources do not exceed the CSRA, they do not need to purchase an annuity.

**Note.** Before a client purchases an annuity, refer them to a financial advisor, if needed, and a tax advisor to learn about the benefits and detriments of purchasing an annuity.

**Example.** Krystal and Aaron, a married couple, come to you for Medicaid planning due to Aaron's need for long-term care. The Community Spouse, Krystal, receives a combined gross income of social security and a pension of $2,025.00 per month. Aaron receives gross monthly social security of $1,300.00. Krystal lives in an apartment and pays $600.00 per month. They have combined resources of $200,000.00 on the Continuous Period of Care (CPC) date when Aaron moved.

To calculate Krystal's CSRA and need for a Medicaid Compliant Annuity, start with the CRSA calculation, determine if there is a shortfall, how much would be required to make up the shortfall, and what would give them the highest resources.

**Step 1**—Find the Community Spouse’s Monthly Maintenance Needs Allowance

Add

- Rent or mortgage $600.00
- SNAP Full Utility Allowance $450.00
- HOA or community dues $0
- Property taxes $0
- Property insurance $0

**Total** $1,050.00

Subtract

- Shelter allowance $686.63

**Total** $363.37

Add the total to MMMNA $2,288.75

**Total Monthly Needs** $2,652.12

**Step 2**—Calculate Community Spouse’s Available Income to divert

Subtract

- Applicant Income $1,300.00
- OSIP standard $841.00

**Total Available** $459.00
Chapter 1—Advanced Planning Strategies

**Step 3**—Add Total Community Spouse Gross Income with OSIP Standard

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Spouse Income</td>
<td>$2,025.00</td>
</tr>
<tr>
<td>Potential diversion</td>
<td>$459.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,484.00</strong></td>
</tr>
</tbody>
</table>

**Step 4**—Determine how much will be diverted to Community Spouse and shortfall, if any.

Subtract

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Income</td>
<td>$2,484.00</td>
</tr>
<tr>
<td>Monthly Needs Allowance</td>
<td>$2,652.12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>($168.12)</strong></td>
</tr>
</tbody>
</table>

**Step 5**—Compare with Standard CSRA

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Based CSRA</td>
<td>$29,518.00</td>
</tr>
<tr>
<td>Combined Resources on Snapshot Date</td>
<td>$200,000.00</td>
</tr>
<tr>
<td><strong>CSRA</strong></td>
<td><strong>$100,000.00</strong></td>
</tr>
</tbody>
</table>

If Krystal was born in July 1954, her CSRA using the annuity-based calculation is $29,518.00. Because this amount is lower than half of what their combined resources were at the beginning of continuous care, she can keep the $100,000.00.

**Step 6**—Determine Spend Down

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Spouse Resource Allowance</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>CSRA</td>
<td>$100,000.00</td>
</tr>
<tr>
<td><strong>Spend down</strong></td>
<td><strong>$97,000.00</strong></td>
</tr>
</tbody>
</table>

The clients can spend down privately or purchase a Medicaid Compliant Annuity.

**Example.** The calculation is as follows using the same information above for Krystal and Aaron but with increased expenses.

**Step 1**—Find Minimum Monthly Maintenance Needs Allowance

Add

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent or mortgage</td>
<td>$1,700.00</td>
</tr>
<tr>
<td>SNAP Full Utility Allowance</td>
<td>$450.00</td>
</tr>
<tr>
<td>HOA or community dues</td>
<td>$40.00</td>
</tr>
<tr>
<td>Property taxes</td>
<td>included in mortgage</td>
</tr>
<tr>
<td>Property insurance</td>
<td>included in mortgage</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,190</strong></td>
</tr>
</tbody>
</table>

Subtract

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter allowance</td>
<td>$686.63</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,503.37</strong></td>
</tr>
</tbody>
</table>
Add to needs allowance $2,288.75

**Total Monthly Needs**

$3,792.07

$3,435.00 (Max)

---

**Step 2**—Calculate Community Spouse's available income

Subtract

<table>
<thead>
<tr>
<th>Applicant’s Income</th>
<th>$1,300.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSIP standard</td>
<td>$841.00</td>
</tr>
</tbody>
</table>

**Total Available** $459.00

---

**Step 3**—Add Total Community Spouse Gross Income with OSIP Standard

<table>
<thead>
<tr>
<th>Community Spouse Income</th>
<th>$2,025.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential CSIA</td>
<td>$459.00</td>
</tr>
</tbody>
</table>

**Total** $2,484.00

---

**Step 4**—Determine how much will be diverted to Community Spouse and shortfall, if any.

Subtract

<table>
<thead>
<tr>
<th>Combined Income</th>
<th>$2,484.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Needs Allowance</td>
<td>$3,435.00</td>
</tr>
</tbody>
</table>

**Total** ($951.00)

---

**Step 5**—Compare with Spend Down CSRA with Annuity Based CRSA

<table>
<thead>
<tr>
<th>Annuity-based CSRA</th>
<th>$166,103.00*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Resources on Snapshot Date</td>
<td>$200,000.00</td>
</tr>
<tr>
<td>Standard CSRA</td>
<td>$100,000.00</td>
</tr>
</tbody>
</table>

*Because this amount is more than $100,000.00, it is used as the CSRA.

---

**Step 6**—Determine Spend Down

<table>
<thead>
<tr>
<th>Annuity Based CSRA</th>
<th>$166,103.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Spouse Allowance</td>
<td>$2,000.00</td>
</tr>
</tbody>
</table>

**Total to keep** $168,103.00

**Spend down** $29,897.00

Add Aaron’s OSIP resource limit of $2,000.00; they need to spend down $29,897.00 to $168,103.00.

Krystal can keep this in any form of countable resource and does not need to convert the resources unless they are in Aaron’s name. They can still use the difference to purchase an annuity and qualify immediately, or they can use the excess to pay privately and secure a more desirable long-term facility, pay for property repairs, or other items Krystal may need.
Example. If all the information above was the same, but Krystal was born in 1984 instead of 1954 - Krystal's annuity-based CSRA would increase to $233,772.00 resulting in no required spend down because their combined countable resources are less than $233,772.00.

PART III
REDETERMINATION, REAPPLICATION, RESTORATION, AND REASSESSMENT

DHS uses the terms Redetermination, Reapplication, Restoration, Reassessment, and Recertification, all of which an Elder Law Attorney should have a general understanding.

Recertification is TANF and SNAP specific and will not be covered here.

Reassessment
Reassessments are related to Services and completed at least annually. The Medicaid case manager can copy the previous assessment and ask the recipient if there have been any changes. Reassessments can also be done during short-certified cases (such as when a person is in an NFC and improvement was expected to occur beyond one month following the assessment date but before one year). Sometimes reassessments are conducted before the annual review is due, even without a short certification in situations such as a person having an unexpected improvement in condition, questionable circumstances, and other observations from a case manager. These instances require the worker to provide a Notice of Service Eligibility Review 70B.

Redetermination
Redetermination aims to ensure that the Medicaid Recipient is still eligible for services. A redetermination occurs at least annually. Sometimes, a redetermination may happen more than once a year, such as if an asset is acquired or disposed of, resulting in a change of circumstances. In this instance, a Medicaid Recipient should alert an eligibility worker about a change in circumstance so the worker can address it in the ONE Eligibility Program used by Oregon for Medicaid applications.

The annual redetermination is prompted a couple of months before the determination (year) lapses. The authorized representative will receive a packet to report potential changes (see addendum). Part 1 of the redetermination packet asks if there has been a change of circumstances. If the authorized representative indicates no change in circumstances, they only sign part one and return the form to DHS. However, if there has been a change in circumstances, the authorized representative or client must fill out Part 2 of the packet and return it to their local DHS office. They may also mail it to Salem or call VEC, but these options are heavily discouraged. Once the packet is received, DHS will verify assets. If there is a discrepancy, DHS should request the client or their Authorized Representative to verify the information to resolve the discrepancy.
DHS should only inquire about the Medicaid recipient’s resources in the annual redetermination. However, DHS may inquire about the Community Spouse’s resources, for example if the Community Spouse is receiving LDS.

If a redetermination is received requesting more information on the Community Spouse, it may be that the ONE system has erroneously applied for benefits on behalf of the Community Spouse or that something was sent in error. Contact the eligibility workers at the local branch to determine the reason for the request.

If there are excess resources, determine if they are excluded or if they should be converted to an excluded resource such as a burial plan, and personal property. If the client receives a federal tax refund, it should be excluded for twelve months following receipt but will need to be spent or converted before the twelve months has elapsed.

**Restoration**
A Restoration is used primarily when a determination was made erroneously or when the previously submitted application can be used rather than the Medicaid Applicant submitting a new application. An example is when a case is processed based on an Asset Verification System (AVS) result in a specific month. If the client timely shows that the AVS result was incorrect, the eligibility worker can restore the application, input the data, and run EDBC. Other situations are when a client requests continuing benefits while pending a hearing.

**Reapplication**
Reapplications occur when there is a break in aid, such as a lapsed program that was not renewed or restored, or when there is a period of ineligibility, such as a disqualification or spend-down. They are used to establish a new date of request (DOR) and report the change in financial circumstances. Usually, a new assessment will be conducted in association with the new DOR but not always. For example, suppose less than two months have elapsed since the previous assessment was conducted, and the Medicaid Applicant has not had a change in functionality. In that case, the case manager can create or restart a service plan with the existing assessment, presuming the eligibility determination is also made timely.

**PART IV**
**ESTATE RECOVERY**

The State of Oregon is entitled under federal law to recover benefits paid for Medical and other Medicaid programs on behalf of a Medicaid recipient. The Estate Administration Unit handles recovery on behalf of the Department of Human Services.

Two biggest misconceptions are that the State holds a lien against a person's property and that the State will "take the house."
Not a Lien. The State does not have a lien but rather a claim against the estate similar to other creditors. The Department's claim has priority over most, but not all, different types of claims (ORS 115.125).

Not a Taking. The State does not take the house or other property. Claims are limited to reimbursement of the amount paid on a Medicaid recipient's behalf. Interest does not start to accrue during the person's lifetime, the Community Spouse's lifetime, or the lifetime of a disabled or minor child. Therefore, there may be sufficient funds to settle a claim outside the sale of the real property.

Oregon takes a broad approach to Estate Recovery through the definition of ESTATE, which includes probate and non-probate property, defined under OAR 461-135-0832(12) as:

"...All real property, personal property, or other assets, wherever located, in which a recipient had any legal title or ownership or beneficial interest at the time of death, including real property, personal property, or other assets conveyed by the recipient to, subsequently acquired by, or traceable to, a person, including the recipient's spouse and any successor-in-interest to the recipient's spouse, through: tenancy by the entirety; joint tenancy; tenancy in common; right of survivorship; life estate; transfer on death deed; living trust; an annuity purchased on or after April 1, 2001; or other similar arrangement."

Claims

There are limits to when the State may recover from the estate. These limitations generally act as a protection to the Community Spouse and certain children of the decedent. These rules can be found in OAR 461-135-0835 and below. Notwithstanding these limitations, the Medicaid recipients' estates pay back money paid by the State for the recipient during the person's lifetime. This includes overpayments and conventional payments.

Overpayments

Overpayments may occur when the Medicaid recipient was ineligible to receive some or all benefits paid on their behalf (ORS 461-195-0501, 411.635, 411.640, 416.350(1)). Overpayments generally happen in one of three ways:

1) An error in calculation by DHS.
2) An error by the Medicaid recipient or filing group.
3) Fraud.

Retroactively effective April 21, 2021, for medical assistance, the Department will only establish a client error overpayment when an individual received unreduced liability or unreduced benefits pending a contested case hearing decision or other final order favorable to the Department or in a fraud overpayment when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact to establish or maintain eligibility (ORS 461-195-0501(3)). In the event of an overpayment, the Department will seek recovery on the estate on the death of the Medicaid recipient and may not wait until the death of the Community Spouse.
Conventional Payments
For proper payments, the Department will seek recovery from the estate of the decedent if unmarried or upon the surviving spouse's death if married.

Limitations on Claims
There are certain limits to estate recovery as follows:

1) If the claim is for correctly paid payments, the State will wait for recovery until the surviving spouse's death.
2) If there is a child under twenty-one (21), so long as they survive probate.
3) If there is a blind or disabled child, so long as they survive probate.
4) Claims are limited to resources the Medicaid recipient had an ownership interest in at the recipient's death.
5) For services paid before July 18, 1995, only property subject to probate would be available to satisfy the claim.
6) No recovery when the person needed services because of a crime committed against them (ORS 416.350(3)).
7) Funds can be used for a plain and decent burial, up to $3,500 (OAR 461-135-0833).

*We will not fully address the current status of Nay and Hobart here as they are being discussed in another presentation today.

Claims on Certain Assets
Some assets have unique recovery:

1) ABLE Accounts – no recovery until proceeds become part of the estate (ORS 178.380).
2) Qualified Long-Term Care Insurance – no recovery, is not a countable resource, must be assigned to the State (OAR 461-120-0315(3)).
3) Income Cap Trust – payback provision included in the trust.
4) First Party Special Needs Trusts - payback provision included in the trust.
5) Annuities – The State is a required death beneficiary if used to qualify a person for Medicaid.
6) Personal Injury Claims – the State has a right to seek a lien on the award (ORS 416.540).

Hardship Waiver
A hardship waiver may also be applied for by the decedent's beneficiaries, heirs, or family members. If allowed, DHS may waive enforcement of the recovery claim (OAR 461-135-0841). The request for the hardship waiver must show recovery will result in an undue hardship to the person who would otherwise be entitled to the property:

A hardship may exist if it would make the Medicaid Applicant eligible for public or medical assistance or cause that person to become homeless (OAR 461-135-0841(2)).
If DHS determines there is a hardship, they can use a waiver to forgive all or part of the claim or have the heir take a mortgage or trust deed in lieu of enforcement (OAR 461-135-0841(3)).

There is a limit to the allowance of a waiver where the waiver applicant or deceased client divested, transferred, or otherwise encumbered assets, in whole or in part, to avoid estate recovery (OAR 461-135-0841(3)).

**During Lifetime**
The State is limited to recovery at the Medicaid recipient's death (or Community Spouse's death if married). There are instances where property excluded at application or redetermination is later sold or disposed of during the Medicaid Recipient's lifetime. There is no obligation to use the proceeds to pay back the State. However, the sale or transfer may constitute a countable resource once converted, thus rendering the owner ineligible for Medicaid until the funds are spent down or otherwise excluded per rule. If other options are not available to avoid the resource being countable, such as purchasing another excluded resource, the Medicaid recipient can use the proceeds to pay down the claim and, if enough resources are used, remain on Medicaid.

**Transfers**
Certain interspousal transfers upon Medicaid eligibility are required to keep the Medicaid recipient under the $2,000.00 limit. Other interspousal transfers may avoid recovery. However, if the Department determines a transfer was made for the purpose of avoiding estate recovery, the State may enforce its claim against the person who benefited from the transfer.

**The Elder Law Attorney's Role in Estate Recovery**
Estate recovery should be discussed as part of the initial consultation with clients. A client may opt to remain off Medicaid so as not to be subject to estate recovery.

After a Medicaid recipient dies, their estate will receive a recovery claim. The notice they receive will depend on the type of claim and what assets are available for the claim. An attorney should review the claim to see when services were rendered, as the time of service has different rules - ask for a written summary to determine dates to ensure the claimed amount is congruent with the rules.

Make sure there are no limitations that should be enforced, such as in the case of a disabled child.
Notice of Service Eligibility Review

Your review of Medicaid service eligibility is due by ___________. Your Case Manager will contact you soon to schedule a time to meet with you to review your care needs.

At the meeting, you and your case manager will talk about your care needs and on-going services. You are encouraged to invite people in your life who assist you, including family members, to the meeting.

Your honesty in reporting your care needs is important for an accurate assessment. Please be prepared to discuss what kind of care is needed, including how long and how often assistance occurs. It may be helpful to document your care needs prior to meeting with the case manager.

You may request a time and date, before ___________, that is convenient for you to meet. Assessments are done at your home during business days and hours, except in special circumstances.

If you do not agree with your review or service plan, please speak with your case manager. You may also appeal the decision by asking for a hearing.
Here are some things to expect during assessment:

- The case manager will ask you different questions about what kind of help you need from others. Some of these questions are very personal topics with you that may be uncomfortable. However, this information helps the case manager determine if you are eligible for any Medicaid services. The case manager will ask these questions with dignity and respect.

- The questions asked by the case manager will also include how often you need help from others.

- It may be helpful to show the case manager around your home. This will help the case manager better understand your care needs.

- With your permission, the case manager may need to ask others to help provide additional information about what you need help with. The case manager may also ask for medical documentation.

Here are some things to expect after the assessment is completed:

- If there are any changes to the services that you receive, you will receive information that will let you know why the decision was made. Please talk to your case manager with any questions that you may have.

- If you are still eligible to receive services, you will receive some paperwork that you will need to review, sign, and return to the case manager as soon as possible.

- You and your case manager will work together on the best way to get the help you need. This includes discussing all the options that are available to you.

- If you are eligible and decide to receive paid care in your own home, the case manager will determine how many hours you are eligible for. However, if you need more hours, you may request an "exception", which, if approved, allows for additional hours to meet your needs. Your case manager will work with you on this request by looking at how long and how often you need help with specific tasks. The case manager will work with their manager and other staff to determine if you are eligible for the additional hours.
Your Hearing Rights

What you can do when you do not agree with this decision:

- You have the right to challenge this decision by requesting a hearing. Hearings are held by the Office of Administrative Hearings, which is independent from the Department of Human Services (DHS) or Oregon Health Authority (OHA).

If you want a hearing, you must request it on time.
- You can also talk with a manager. You can call a local office phone number listed at https://www.oregon.gov/DHS/Offices/Pages/index.aspx. Your deadline date to request a hearing (part 1 below) does not change even if you are in contact with a manager or are trying to reach one. If you still need further assistance, you may contact the Governor's Advocacy Office at 1-800-442-5238.

Part 1 — Ask for a hearing.

What must I do to get a hearing? For food benefits and medical eligibility, you can ask for a hearing on form MSC 0443, by phone, in writing, or by asking a DHS employee in person. For other benefits, you must fill out an Administrative Hearing Request form (MSC 0443) and return it to a DHS or OHA office. You can get this form at a DHS or OHA office or on the web at https://apps.state.or.us/Forms/Served/me0443.pdf. Your local office can help you with a hearing request. You may request a hearing at any time if you disagree with the current amount of your food benefits. You have 90 days to request a hearing for food benefits, medical eligibility, and for TANF reductions for not cooperating with your case plan. For medical service denials: if you are a fee-for-service member you have 60 days from the date of notice to request a hearing; if you are enrolled in a Coordinated Care Organization (CCO), once the appeal is completed through your CCO you have 120 days from the date on the Notice of Appeal Resolution letter to request a hearing. In other situations, DHS must receive your request within 45 days from the date on the notice.

Note to military personnel: Active duty service members have a right to stay (delay) these proceedings under the federal Servicemembers Civil Relief Act (SCRA). For more information, you may contact the Oregon State Bar (1-800-452-8260), the Oregon Military Department (503-584-3571) or the nearest legal assistance office, legalassistance.law.af.mil.

Who can help with my hearing? For food benefits and for medical programs, anyone may represent you. In all other programs, you must represent yourself or have a lawyer or a legal assistant (supervised by a Legal Aid attorney) represent you. You may call the Public Benefits Hotline (a program of Legal Aid Services of Oregon and the Oregon Law Center) at 1-800-520-5292 for advice and possible representation.

What are my other hearing rights? At the hearing, you can tell why you do not agree with the decision. You can have people testify for you. The laws about your hearing rights and the hearing process are at OAR 137-003-0501 to 0700, 410-120-1860, 410-141-0264, 461-025-0300 to 0375, ORS 183.411 to 183.470 and ORS 411.095.

What happens if there is no hearing? If you do not ask for a hearing on time, or if you withdraw the hearing request or miss your hearing, you may lose your right to a hearing. This notice will be the final DHS or OHA decision (called a “final order by default”). You will not get a separate final order by default. The case file, along with any materials you submitted in this matter, is the record. The record is used to support the DHS decision upon default. You may appeal the final order by default by filing a petition in the Oregon Court of Appeals (ORS 183.482). If you do not ask for a hearing, this appeal must be filed within 60 days of the date this notice becomes a final order, by default. If you withdraw a hearing request or miss your hearing, the appeal deadline is set out in the dismissal order.
Part 2 — How can I keep getting benefits until my hearing?

- You can ask for your benefits to stay the same until the hearing decision ("continuing benefits"). For food and medical benefits, use form MSC 0443, phone, write or ask a DHS employee in person. In other programs, you must ask on the Administrative Hearing Request form (MSC 0443).
- You must ask your branch for continuing benefits by either the “effective date” on the notice, 10 days after the date of the notice, or (for medical only) 10 days after receipt of the notice. You must ask by whichever date is later.
- If you keep getting benefits but lose the hearing, you must pay back the benefits you should not have received.
- If you don’t keep getting benefits and win the hearing, DHS or OHA will give you the benefits you should have received.

Part 3 — Can I have an expedited hearing?

You may have the right to an “expedited hearing” for any of the following types of benefits or situations:
- Expedited or emergency food benefits
- JOBS and Pre-TANF payments
- Temporary Assistance for Domestic Violence Survivors (TA-DVS) eligibility and payments
- In a medical case, you have an immediate need for health services and standard timeline for the appeal process could jeopardize your life or health or ability to attain, maintain, or regain maximum function
- DHS or OHA denied your request to keep getting benefits until your hearing.

DHS and OHA do not discriminate against anyone. This means that DHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs, disability or sexual orientation. You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons.

MSC 0447 (10/19)
Activities of Daily Living (ADLs)

Mobility = Ambulation / Transfers

- **Ambulation OAR 411-015-0006(7)(d):** Ambulation means the tasks of moving around inside and outside the home or care setting. This includes assessing the individual’s needs after taking into consideration their level of independence while using assistive devices such as walkers, canes, crutches, manual and electric wheelchairs, and motorized scooters. Ambulation does not include exercise or physical therapy.
  - Even with assistive devices, the individual requires assistance from another person to ambulate.

Select the most appropriate response:

- B. Required HANDS-ON assistance from another person to ambulate:
  - OUTSIDE the home or case setting at least one day each week totaling four days per month; or
  - INSIDE their home or care setting less than one day each week.
- C. Requires HANDS-ON assistance to get around INSIDE their home or care setting periodically at least one day each week totaling four days per month.
- D. ALWAYS needs HANDS-ON assistance inside the home or care setting every time the individual is required to ambulate. An individual who is confined to bed is a Full Assist in Ambulation.

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Ambulation Notes:

- **Transfers OAR 411-015-0006(7)(e):** Transfer means the tasks of moving to or from a chair, bed, toileting area, or wheelchair using assistive devices, if needed. This includes...
assessing one’s ability to transfer from areas used on a daily or regular basis, such as sofas, chairs, recliners, beds, and other areas inside the home or care setting based on their reasonable personal preferences. When individuals are confined to their bed or wheelchair, repositioning is also considered as a transfer task. This assistance must be required because of the individual’s physical limitations, not their physical location or personal preference.

- The individual requires assistance from another person to transfer to and from a chair, bed, toileting area, or wheelchair inside their home or care setting, with or without assistive devices.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Needs HANDS-ON assistance to transfer at least one day each week totaling four days per month.
C. ALWAYS needs HANDS-ON assistance to transfer every time the activity is attempted.

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Transfer Notes:

• **Eating OAR 411-015-0006(5):** Eating means the tasks of eating, feeding, nutritional IV set-up, or feeding tube set-up by another person and may include using assistive devices.
- When eating, the individual requires assistance of another person with or without the use of assistive devices (Cutting food or bringing food to the table is considered in Meal Preparation).

Select the most appropriate response:

A. Independent – Does not meet criteria for an assist.
B. The individual requires assistance from another person and to be within sight and immediately available at least one day each week totaling four days per month for:
   - HANDS-ON assistance with feeding, special utensils, or to address choking; or
   - SET-UP assistance for nutritional IV or feeding tube set-up; or
   - CUEING during the act of eating.

C. ALWAYS needs one-on-one assistance for:
   - SET-UP assistance for nutritional IV or feeding tube set-up; or
   - CUEING during the act of eating.

D. ALWAYS needs one-on-one assistance for:
   - HANDS-ON assistance with feeding or to address choking.

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Eating Notes:

**Elimination = Bladder / Bowel / Toileting**

- **Bladder OAR 411-015-0006(6)(a):** Bladder means the tasks of catheter care and ostomy care. The tasks of catheter or ostomy care are specific to the individual.
  - Needs assistance from another person to accomplish the individual’s specific tasks of bladder care listed below, with or without assistive devices:
    - Catheter care; or
    - Ostomy care.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.

B. Requires HANDS-ON assistance to complete a task of bladder care at least one day each week totaling four days per month.

C. ALWAYS requires HANDS-ON assistance to manage all assessed tasks of bladder care every time the activity is attempted.
### AGING & PEOPLE WITH DISABILITIES CA/PS ASSESSMENT – UPDATED 5/20/19

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Requires:
- □ Catheter care
- □ Ostomy care

Bladder Notes:

- **Bowel OAR 411-015-0006(6)(b):** Bowel means the tasks of digital stimulation, suppository insertion, ostomy care, and enemas.
  - Needs assistance from another person to accomplish the individual’s specific tasks of bowel care, with or without assistive devices, including tasks such as:
    - Digital stimulation;
    - Suppository insertion;
    - Enemas; or
    - Ostomy care.

Select the most appropriate response:
- A. Independent – Does not meet the criteria for assist.
- B. Requires HANDS-ON assistance to accomplish some tasks of bowel care at least one day each week totaling four days per month.
- C. ALWAYS requires HANDS-ON assistance to manage any tasks of bowel care every time the activity is attempted.
Toileting OAR 411-015-0006(6)(c): Toileting means the assessed tasks of cleansing after elimination, changing soiled incontinence supplies or soiled clothing, adjusting clothing to enable elimination, or cueing to prevent incontinence.

- Needs CUEING to prevent incontinence or HANDS-ON assistance to cleanse after elimination, change soiled incontinence supplies or soiled clothing, or to remove and replace clothing to enable elimination.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Requires HANDS-ON assistance with a task of toileting care or CUEING to prevent incontinence at least one day each week totaling four days per month.
C. ALWAYS needs HANDS-ON assistance with each assessed task of toileting every time all tasks of toileting are attempted.

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Toileting Notes:

Cognition = Self-Preservation / Decision Making / Make Self Understood / Challenging Behaviors

- Self-Preservation OAR 411-015-0006(3)(f)(A): Self-Preservation means an individual’s actions or behaviors reflecting the individual’s understanding of their health and safety needs and how to meet those needs. Self-preservation refers to an individual’s cognitive ability to recognize and act in a changing environment or a potentially harmful situation.
o Even with assistive devices, the individual requires assistance from another person to assist them in understanding and managing their health and safety needs.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Requires assistance at least one day each month to ensure that they are able to meet their basic health and safety needs. The need may be event specific.
C. Requires assistance because they cannot act on nor understand the need for self-preservation at least daily.
D. Requires assistance to ensure that they meet their basic health and safety needs throughout each day. The individual cannot be left alone without risk of harm to themselves or others or the individual would experience significant negative health outcomes. This does not include the assistance types of support or monitoring.

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Self-Preservation Notes:

- Decision Making OAR 411-015-0006(3)[f](B): Decision-making means an individual’s ability to make everyday decisions about ADLs, IADLs, and the tasks that comprise those activities. An individual needs assistance if that individual demonstrates they are unable to make decisions, needs help understanding how to accomplish the tasks necessary to complete a decision, or does not understand the risks or consequences of their decisions.
  o Even with assistive devices, the individual requires the assistance of another person to make everyday decisions about ADLs, IADLs and the tasks that comprise those activities.
Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Requires assistance at least one day each month with decision making. The need may be even specific.
C. Requires assistance in decision making and completion of ADL and IADL tasks at least daily.
D. Requires assistance through each day in order to make decisions and to understand the tasks necessary to complete ADLs and IADLs critical to one’s health and safety. The individual cannot be left alone without risk of harm to themselves or others or the individual would experience significant negative health outcomes. This does not include the assistance types of support or monitoring.

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**Decision Making Notes:**

- **Ability to Make Self Understood OAR 411-015-0006(3)(f)(C):** Ability to make self-understood means an individual’s cognitive ability to communicate or express needs, opinions, or urgent problems, whether in speech, writing, sign language, body language, symbols, pictures, or a combination of these including use of assistive technology. An individual with a cognitive impairment in this component demonstrates an inability to express themselves clearly to the point their needs cannot be met independently. Ability to make self-understood does not include the need for assistance due to language barriers or physical limitations to communicate.
  - Even with assistive devices, the individual requires the assistance of another person communicate or express needs, opinions or urgent problems.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Requires assistance at least one day each month in finding the right words or finishing thoughts to ensure their health and safety needs. The need may be event specific.
C. Requires assistance to communicate their health and safety needs at least daily.
D. The individual needs constant assistance to communicate their health and safety needs to the level that the individual cannot be left alone for any extended period of time during the day. This does not include the assistance types of support or monitoring.

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Ability to Make Self Understood Notes:

- **Challenging Behaviors OAR 411-015-0006(3)(f)(D):** Challenging behaviors means an individual exhibits behavior(s) that negatively impact their own, or others’, health or safety. An individual who requires assistance with challenging behaviors does not understand the impact or outcome of their decisions or actions.
  - Even with assistive devices, the individual requires the assistance of another person to address or manage challenging behaviors because it negatively impacts their own or others’ health or safety.

Select the most appropriate response:
A. Independent – Does not meet criteria for assist.
B. Requires assistance at least one day each month dealing with a behavior that may negatively impact their own or others’ health or safety. The individual sometimes displays behaviors but can be distracted or is able to self-regulate behaviors with assistance. This does include the assistance type of reassurance.
C. Requires assistance in managing or mitigating their behaviors at least daily. The individual displays challenging behaviors and assistance is needed because the individual cannot self-regulate the behavior and does not understand the consequences of their behaviors.
D. Requires assistance throughout each day to manage or mitigate behaviors. The individual displays behaviors that require additional support to prevent significant harm to themselves or others. The individual needs constant assistance to the level that the individual cannot be left alone for any extended period of time during the day. The individual cannot self-regulate their behaviors and does not understand the consequences of their behaviors. This does not include the assistance type of monitoring.

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<td>□ Monitoring</td>
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Challenging Behaviors Notes:

**Bathing & Personal Hygiene**

- **Bathing OAR 411-015-0006(2)(a):** Bathing means the tasks of getting in and out of a bathtub or shower, washing hair, and washing the body, while using assistive devices, if needed. This includes, but is not limited to, sponge baths, bed baths, bathing in a tub, or showering, as chosen by an individual. For individuals who are confined to a bed, bathing is assessed without considering the need to get in or out of the bathtub or shower.
  - The individual requires assistance washing the body, hair, or assistance getting in and out of the bathtub or shower.

Select the most appropriate response:

A. Independent – Does not meet the criteria for assist.
B. Requires another person to provide HANDS-ON, CUEING or STAND-BY assistance for at least one task of bathing at least one day each week totaling four days per month.
C. Always needs HANDS-ON assistance to complete the assessed tasks of bathing each time the activity is attempted.

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Page 9 of 19
### Assist Types:
- [ ] Hands-on
- [ ] Cueing
- [ ] Stand-by

### Frequency:
- [ ] None
- ___ x’s per day
- ___ x’s per week
- ___ x’s per month
- [ ] Always

### Duration:
___ Minutes each time

### Bathing Notes:

- **Personal Hygiene OAR 411-015-0006(2)(b):** Personal hygiene means the tasks of shaving, caring for the mouth, or assistance with tasks of menstruation care. This includes, but is not limited to shaving the face, legs, or other desired areas, brushing teeth, maintaining dentures, caring for gums, and using feminine hygiene products to address menstrual needs.
  - The individual needs, with or without assistive devices, assistance from another person to complete tasks of shaving, caring for the mouth, or menstruation care.

Select the most appropriate response:

A. Independent – Does not meet criteria for assist.
B. Requires another person to provide:
  - HANDS-ON assistance for only one task at least one day each week totaling four days each month; or
  - CUEING or STAND-BY assistance for one or more tasks of the activity at least one day each week totaling four days each month.
C. Always needs HANDS-ON assistance for at least two tasks for personal hygiene each time the activity is attempted.

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### Personal Hygiene Notes:
Dressing & Grooming

- **Dressing OAR 411-015-0006(4)(a):** Dressing is comprised of three tasks; putting on clothing, taking off clothing, and putting on or taking off shoes and socks. This includes, but is not limited to, the consideration of an individual’s ability to use clothing with buttons, zippers, and snaps, and reflects the individual’s choice and reasonable preferences.
  - The individual needs, with or without assistive devices, assistance from another person to dress and undress.

Select the most appropriate response:

A. Independent – Does not meet the criteria for assist.
B. Requires another person to provide:
  - HANDS-ON assistance for only one task at least one day each week totaling four days each month; or
  - CUEING or STAND-BY assistance needed for one or both tasks at least one day each week totaling four days each month.
C. Always needs HANDS-ON assistance with each assessed task of dressing each time the activity is attempted.

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Dressing Notes:

- **Grooming OAR 411-015-0006(4)(b):** Grooming means the tasks of nail and hair care based on the individual’s reasonable personal preferences. This includes, but is not
limited to, tasks of clipping and filing both toe nails and finger nails, and brushing, combing, braiding, or otherwise maintaining one’s hair or scalp.
  o The individual needs, with or without assistive devices, assistance from another person for nail and hair care.

Select the most appropriate response:

A. Independent – Does not meet the criteria for assist.
B. Requires another person to provide:
  o HANDS-ON assistance for nail or hair care at least one day each week totaling four days each month; or
  o CUEING or STAND-BY assistance during the activity of nail and/or hair care at least one day each week totaling four days each month.
C. Always needs HANDS-ON assistance for nail care and hair care.

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Grooming Notes:

Instrumental Activities of Daily Living (IADLs)

- **Housekeeping OAR 411-015-0007(4):** Housekeeping means the ability to maintain the interior of the individual’s residence for the purpose of health and safety. Housekeeping includes activities such as wiping surfaces, cleaning floors, making the individual’s bed, cleaning dishes, taking out the garbage and dusting.
  o The individual needs assistance from another person in order to accomplish housekeeping tasks which maintain their health and safety within their residence (Does not include pet care, home repair or housekeeping activities related to other household members).

Select the most appropriate response:
Chapter 1—Advanced Planning Strategies

### AGING & PEOPLE WITH DISABILITIES CA/PS ASSESSMENT – UPDATED 5/20/19

A. Independent
B. Unable to accomplish some housekeeping tasks without assistance.
C. Always needs assistance for all tasks.

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Housekeeping Notes:

- **Laundry OAR 411-015-0007(5):** Laundry means the ability to gather and wash soiled clothing and linens, use washing machines and dryers, hang clothes, fold and put away clean clothing and linens.
  - The individual needs assistance from another person in order to complete laundry tasks.

Select the most appropriate response:
A. Independent
B. Unable to accomplish some laundry tasks without assistance.
C. Always needs assistance for all tasks and phases.

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Laundry Notes:
• **Breakfast Meal Preparation OAR 411-015-0007(6):** Meal preparation means the ability to safely prepare food to meet the basic nutritional requirements of the individual. It includes cutting food and placing food, dishes and utensils within reach for eating.
  - The individual needs assistance from another person to safely prepare food meeting basic nutritional requirements.

Select the most appropriate response:

A. Independent  
B. Is able to accomplish a majority of the meal preparation tasks, but not all the tasks.  
C. Is able to accomplish only a small portion of the meal preparation tasks without assistance.  
D. Always needs assistance for all tasks of meal preparation.

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Breakfast Meal Preparation Notes:

• **Lunch Meal Preparation OAR 411-015-0007(6):** Meal preparation means the ability to safely prepare food to meet the basic nutritional requirements of the individual. It includes cutting food and placing food, dishes and utensils within reach for eating.
  - The individual needs assistance from another person to safely prepare food meeting basic nutritional requirements.

Select the most appropriate response:

A. Independent  
B. Is able to accomplish a majority of the meal preparation tasks, but not all the tasks.  
C. Is able to accomplish only a small portion of the meal preparation tasks without assistance.  
D. Always needs assistance for all tasks of meal preparation.

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Breakfast Meal Preparation Notes:
**AGING & PEOPLE WITH DISABILITIES CA/PS ASSESSMENT – UPDATED 5/20/19**

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**Lunch Meal Preparation Notes:**

- **Dinner / Supper Meal Preparation OAR 411-015-0007(6):** Meal preparation means the ability to safely prepare food to meet the basic nutritional requirements of the individual. It includes cutting food and placing food, dishes and utensils within reach for eating.
  - The individual needs assistance from another person to safely prepare food meeting basic nutritional requirements.

Select the most appropriate response:

A. Independent
B. Is able to accomplish a majority of the meal preparation tasks, but not all the tasks.
C. Is able to accomplish only a small portion of the meal preparation tasks without assistance.
D. Always needs assistance for all tasks of meal preparation.

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**Dinner / Supper Meal Preparation Notes:**
**Medication Management OAR 411-015-0007(7):** Medication management means the ability to order, organize and administer prescribed medications. Administering prescribed medications includes pills, drops, ointments, creams, injections, inhalers, and suppositories unrelated to bowel care. Administering as a paid service means set-up, reminding, cueing checking for effect and monitoring for choking while taking medications. Oxygen management is included in medication management. Oxygen management means assistance with the administration of oxygen, monitoring the equipment and assuring adequate oxygen supply.

- The individual needs assistance from another person to order, organize or administer prescribed medications and/or oxygen. The assistance may include: set-up, reminding, cueing, checking for effect and monitoring for choking or administering O2 or monitoring equipment to assure adequate O2 supply.

Select the most appropriate response:

- **A. Independent**
- **B. Is able to accomplish a majority of the medication/O2 management tasks, but not all the tasks.**
- **C. Is able to accomplish only a small portion of the medication/O2 management tasks without assistance.**
- **D. Always needs assistance for all tasks of medication/O2 management.**

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Medication / O2 Management Notes:

**Shopping OAR 411-015-0007(8):** Shopping means the ability to purchase goods that are necessary for the health and safety of the individual being assessed and are related to the individual’s service plan. Goods that are related to the service plan include items...
such as food, (meal preparation), clothing (dressing), and medicine (medication management).
  
  o The individual needs assistance from another person to purchase goods that are necessary for the health and safety of the individual and are related to the individual’s service plan, such as:
  
  ▪ Food (meal preparation);
  ▪ Clothing (dressing); or
  ▪ Medicine (medication management).

Select the most appropriate response:

A. Independent
B. Is able to accomplish a majority of the shopping tasks, but not all the tasks.
C. Is able to accomplish only a small portion of the shopping tasks without assistance.
D. Always needs assistance for all tasks of shopping.

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- **Transportation OAR 411-015-0007(9):** Transportation means, assuming transportation is available, the ability to arrange rides, the ability to get in or out of a vehicle, and the need for assistance during a ride. The need for assistance during a ride means assistance for a physical or cognitive need such as spasticity, memory impairment, aspiration, choking or seizure. Transportation as a paid service means in accordance with a plan of care, assisting an individual during a ride, assisting an individual to get in or out of a vehicle, or arranging a ride for an individual. Transportation does not include mileage reimbursement.
  
  o The individual needs assistance from another person to:
    ▪ Arrange rides; and/or
**AGING & PEOPLE WITH DISABILITIES CA/PS ASSESSMENT – UPDATED 5/20/19**

- Get in or out of a vehicle; and/or
- Physical or cognitive assistance during a ride, such as for spasticity, memory, aspiration, choking or seizure.

Select the most appropriate response:

A. Independent
B. Is able to accomplish a majority of the transportation tasks, but not all the tasks.
C. Is able to accomplish only a small portion of the transportation tasks without assistance.
D. Always needs assistance for all tasks of transportation.

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Transportation Notes:

- **Shift Services OAR 411-030-0068:** The individual requires the assistance of another person, including assistance types and tasks per the definition in the ADLs/IADLs, at least once each hour the individual is awake in order to ensure their safety and well-being, and the person meets either 1 or 2 below:
  
1. The individual is assessed as full assist in cognition and cannot be left alone for any part of the day; or
2. The individual is assessed as full assist in mobility or elimination, and has at least one of the following debilitating medical conditions:
   - Cachexia;
   - Severe neuropathy;
   - Coma;
   - Persistent or re-occurring stage 3 or 4 wounds;
   - Late stage cancer;
   - Frequent and unpredictable seizures;
   - Debilitating muscle spasms;
If the answer below is A (Yes), submit to Central Office for final approval.
Select the most appropriate response:

A. Yes
B. No

Shift Services Notes:

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Misc. Notes:
“ABC” Advanced Planning Strategies

Oregon State Bar Elder Law CLE

Agenda

• Brief Overview
  • Financial Eligibility
  • Service Eligibility
  • Spousal Impoverishment Protections
• Advanced Planning Techniques
  • Pre-Planning
  • Emergency Planning
• Redetermination, et al.
• Estate Recovery Primer
What does OSIPM Cover?

- Long-Term Care Costs at CONTRACTED long-term care:
  - Nursing Home
  - Waiver for Community-Based Care
    - Adult Foster Homes
    - Assisted Living Facilities
    - Residential Care Facilities
    - Specialized Nursing Facilities
    - In-Home Care

What are the Medicaid Recipient’s Responsibilities?

- Room and Board in a community-based care setting
- Liability based on the Medicaid Recipient’s income and allowable deductions
- The Medicaid Recipient can keep a Personal Needs Allowance as follows:
  - $68.77 if residing in an NCF
  - $90.00 if receiving Aid and Attendance and residing in an NCF
  - $187.00 if living in Community-Based Care
  - $841.00 plus $500.00 for IHC with other income sources*
- For certain married people, the Medicaid Recipient may redirect some income to the Community Spouse, called Community Spouse Income Allowance (referred to as CSIA or LDS)
- *Effective January 1, 2022, APD eliminated liability for recipients of in-home services, Independent Choices Program, Spousal Pay, and PACE Services (policy transmittal APD-PT-21-042)
What does OSIPM Not Cover?

- Room and Board for most Community Based Care
- Care in a non-contracted long-term care facility
- Care for non-eligible persons

*The state may pay for Room and Board for those whose income is lower than the SSI standard

The 1, 2, 3 of eligibility

1) Needs certain assistance with Activities of Daily Living (ADL),
2) Meets the income threshold, and
3) Meets the resource threshold.
Chapter 1—Advanced Planning Strategies

1. **Resources**

   • $2,000.00 in countable resources
     • Excluded:
       • Personal property
       • One vehicle used for transportation
       • Burial/Cremation property, irrevocable contract, or certain accounts
       • Certain life insurance policies
       • Certain business property
       • Inaccessible property
       • The residential home ($636,000.00 limit or spouse’s/child’s primary residence)

2. **Income**

   For the Medicaid Recipient
   • $2,523.00 or less
   or
   • Establishes an Income Cap Trust

   *Medicaid does not look at the Community Spouse’s income
3. Activities of Daily Living

- **Mobility** Ambulation and Transfers. A person must require hands-on assistance in the act of moving in the care setting; rising or sitting from a couch, chair, bed, or toilet; or getting up after a fall. To meet the assistance requirements, the care must happen at a specific frequency.

- **Eating** is the act of direct feeding, cueing, or setting up feeding tubes or feeding devices. Choking and aspiration hazards must require physical intervention or assistance. Meal preparation, supervision, and monitoring are not enough to qualify a person for assistance in Eating.

- **Elimination** has three subcategories: Bladder, Bowel, and Toileting.
  - **Bladder and Bowel** refer to procedures or devices needed to void the bladder or bowel.
  - **Toileting** refers to assistance from another person to cleanse after bladder or bowel movements, hands-on assistance to change incontinence supplies, or cueing to prevent incontinence.

- **Cognition** relates to a person’s ability to understand and therefore use information. It requires daily assistance from another person beyond medication management and forgetfulness to preserve one’s health and safety.

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**Spousal Impoverishment Protections**
Resources

• The Community Spouse can keep:
  • Half the couple’s combined countable resources at the beginning of the Continuous Period of Care
    • Maximum of $137,400.00 if their total countable resources are more than $274,800.00
    • $27,480.00 if countable resources are $54,960.00 or under
  • Court ordered CSRA.
  • An allowance based on shortfall of income to meet the Community Spouse’s Monthly Maintenance Needs Allowance, across the life expectancy of the Community Spouse

Continuous Period of Care

In care setting for thirty consecutive days and will continue to need care for an additional thirty days

OAR 461-001-0030 (2)

Snap-Shot Date
Examples – On Snap-Shot Day

- A couple owns $90,000 in countable resources
  - Medicaid Applicant will be eligible for Medicaid once their combined resources have been reduced to $47,000
    - $2,000 for the Medicaid Applicant
    - $45,000 for Community Spouse
    - Spend Down is at least $43,000
- A couple owns $350,000 in countable resources
  - Medicaid Applicant will be eligible for Medicaid once their combined resources are $139,400
    - $2,000 for the Medicaid Applicant
    - $137,400 for Community Spouse
    - Spend Down is at least $210,600
- A couple owns $50,000 in countable resources
  - Medicaid Applicant will be eligible for Medicaid once their combined resources are $29,480
    - $2,000 for the Medicaid Applicant
    - $27,480 for Community Spouse
    - Spend Down is at least $20,520

*Tip: It’s good practice to explain the spend down will be more than the difference in resources on CPC because the couple, or individual, receives income, thus increasing the net spend.

Income

- Community Spouse keeps all his or her income
- May receive CSIA/LDS from the Medicaid recipient if CS’ income does not meet monthly needs allowance
  - $2,288.75 - $3,435.00 based on needs, may be increased if an extreme need exists
Calculating LDS

• **Step 1—Determine the maintenance needs allowance.** Add $2,288.75 to the amount over $686.63 needed to pay monthly shelter expenses for the CS' principal residence. This sum or $3,435.00, whichever is less, is the monthly maintenance needs allowance.

• **Step 2—Compare the maintenance needs allowance with the Community Spouse's countable income.** Deduct the countable income (see OAR 461-001-0000) of the Community Spouse from the maintenance needs allowance determined in Step 1.

• **Step 3—Consider exceptional circumstances.** If a spousal support order or exceptional circumstances results in significant financial distress require a greater income allowance than that calculated in Step 2, the higher amount is the allowance.

Example – Krystal and Aaron

• Aaron is in long-term care
• Aaron’s gross income is $1,300 per month
• Krystal is the Community Spouse
• Krystal’s gross income is $2,025 per month
• Krystal lives in an apartment and pays $600 per month
Calculate LDS

Step One  *Find Minimum Monthly Needs Allowance*

*Add*
- Rent or mortgage: $600
- SNAP Full Utility Allowance: $452
- HOA or community dues: $0
- Property taxes: $0
- Property insurance: $0

**Total**: $1,050

*Subtract* Shelter allowance: $686.63

**Total**: $365.37

*Add* above total to minimum: $2,288.75

**Krystal’s Total Monthly Needs**: $2,654.12

Calculate LDS

Step Two – Calculate Community Spouse’s Available Income to divert

*Subtract*
- Medicaid Applicant’s Income: $1,300
- OSIP standard: $841

**Total Available for LDS**: $459

Step Three — Add Total Community Spouse Gross Income with OSIP Standard

- Community Spouse Income: $2,025
- Available for LDS: $459

**Total**: $2,484

Step Four — Determine how much will be diverted to Community Spouse and shortfall

*Subtract*
- Combined Income: $2,484.00
- Monthly Needs Allowance: $2,652.12

**Total**: ($168.12) shortfall
Planning Beyond
Spend Down

Planning Ahead

- Qualified Long-Term Care Partnership Policy
- Transfers
- Increasing Countable Resources (short-term planning)
**Qualified Long-Term Care Partnership Policy (QPP)**

- Funds paid on the policy will be an excluded resource
- Not subject to estate recovery
- Need to utilize the policy to get the benefit
- Should be a conversation in early planning while able to qualify for LTC insurance
  - No pre-existing conditions
  - Age restrictions
  - Written Verification the policy meets QPP at time of purchase

**Example 1 – QPP usage**

Client A (single person) has QPP paying $5,000 per month.

He has received $75,000 in payments to date.

Income of $3,000 and expenses of $10,000 per month.

$100,000 in remaining countable resources.

$100,000 - $77,000 ($75,000 payment and $2,000 resource limit)  
- $23,000 excess resources at time of application

Client needs to spend privately for four more months and will keep up to $97,000.00 in resources assuming the QPP paid all four months ($75,000.00 plus $20,000.00 (four months of policy payments)) plus the $2,000 resource limit.
Example – QPP Usage

Married Couple with $200,000 in countable resources at CPC date. Medicaid Spouse has received $50,000 from a QPP. They have spent $50,000 from countable resources and have $150,000 remaining.

| CSRA    | $100,000 |
| QPP     | $ 50,000 |
| Medicaid Spouse’s resource limit | $ 2,000 |
| Total to keep | $152,000 |

Medicaid applicant is eligible for Medicaid.

Transfers

Types of Transfers

5-year look back

2-step plan

Transfer penalty – If Applicant or CS transfers property for less than FMV within 60 months prior to application, Medicaid Applicant is not eligible to receive LTC Services for up to five (5) years from the date of application.

Divisor – $9,551 = one month of penalty
Transfer Penalty Exceptions

- The spouse
- A blind or disabled child
- A child under age 21
- A third-party for the sole benefit of the spouse or a blind or disabled child
- A home owned with a sibling of the Medicaid applicant who was residing in the house for at least one year immediately before the Medicaid applicant requires care
- A transfer to a pooled trust for a child or spouse under the age of sixty-five, defined under OAR 461-145-0540(11) as:
  - Established and managed by a non-profit association;
  - Holds a separate account for each person;
  - Is established by the individual, the individual’s parent, grandparent, legal guardian, or court for individuals with disabilities;
  - Upon the death of the beneficiary or termination of the trust, the trust pays to the state an amount equal to the total medical assistance paid on behalf of the beneficiary under the state plan for Medicaid. The amount paid to the state may be reduced by administrative costs related to administering the sub-trust account of the beneficiary; and
  - The trust holds the resources or income of an individual who has a disability that meets the SSI criteria.

Transfer Penalty Exceptions Continued

The Caregiver Child Exception

A natural or adoptive child that meets OAR 461-140-0242(3)(c) may qualify as a caregiver child; the person must meet the following criteria:

a. Is the child of the Medicaid applicant;
b. Has lived in the house with the Medicaid applicant for at least two years immediately prior to the Medicaid applicant admitting to long-term care;
c. Assisted the Medicaid Applicant with ADLs and IADLs on a daily basis, totaling at least 20 hours per week, and to such a degree that the Medicaid applicant did not need to move to a long-term care community; and
d. Did not receive payment from the state for providing the care.

This provision cannot be applied retroactively unless sufficient proof of intent exists.

Provide client with forms 3306, 3307, and 3308 so they are informed of what might be required and requested.

Keep good records of all care provided. Hard to prove intent.
Transfer Hardship Waiver

The Medicaid applicant must show:

1. There are no other means for meeting his or her needs. The client has the burden of proving that no other means exist by:
   a. Exploring and pursuing all reasonable means to recover the asset(s) to DHS' satisfaction, including legal remedies and consultation with an attorney; and
   b. Cooperating with the DHS to take action to recover the asset(s).

2. The disqualification would deprive the client of:
   a. Medical care such that the client’s health or life would be endangered; or
   b. Food, clothing, shelter, or other necessities of life without which the health or life of the client would be endangered.

Used if there has been a transfer prior to meeting with attorney.

Transfer Cure

The return of the asset to the Medicaid applicant can cure a transfer in whole or in part, reducing the penalty period.
The 5-Year Plan

Medicaid applicant transfers a portion of their resources.

Wait to file the Medicaid application until 60 months (five years) from date of transfer elapse.

Pay for living expenses from retained funds.

The Medicaid applicant does not need to have met all eligibility criteria at the time of the transfer.

This may be too risky if funds are low or already has care needs.

The Two-Application Plan

**Step One.** Create an Irrevocable Trust

**Trustee and Beneficiary must be someone other than Medicaid applicant or Community Spouse**

**Step Two.** Transfer all countable resources (except $2,000.00 for the Medicaid Applicant and CSRA for Community Spouse) to the trust.

**Step Three.** Apply for Medicaid and have DHS issue a Notice of Disqualification to start the disqualification period.

**Step Four.** The Medicaid Applicant serves the disqualification period. This period may be the entire term or reduced with a partial cure.

**Step Five.** Reapply for Medicaid long-term care services at the end of the disqualification period.

**Funds remaining in trust will be available to lifetime beneficiaries.**
Example

John and Jane are married and in their early seventies. Jane was recently diagnosed with dementia but is independent in her Activities of Daily Living. They have an adult child who lives near them and is willing to help. They have $250,000.00 in IRAs, $200,000.00 in other countable resources, and a residential home.

**Step One** – Evaluate CSRA = $137,400.00.
**Step Two** – Evaluate expenses and needs – currently, no care needs, and the son is willing to help. They should be able to outlast the 60-month timeframe.
**Step Three** – Evaluate what resources they want to transfer – they will want to avoid cashing out all the IRA due to taxes and will need to leave some cash on-hand to pay for care. They must budget enough resources outside the transfer to pay for care.

Example

Jack and Susie are a married couple in their eighties. Jack was diagnosed with frontal lobe dementia a year ago. He has behaviors which have progressed to the point that he is no longer safe at home. They have $250,000.00 in IRAs, $200,000.00 in other countable cash resources, and a residential home. Susie found a facility for Jack with a cost of $8,000.00 per month.

**Step One** – Evaluate CSRA = $137,400.00
**Step Two** – Evaluate expenses and needs – currently, Jack has qualifying care needs, so it is likely too late for the 60-month transfer, depending on their incomes. The cost of care is close to the penalty divisor of $9,551.00, half their resources are in taxable accounts, and Jack has a progressive disease. All these factors should be discussed before transfer as it may be risky since the majority of the resources need to be transferred under the two-application plan.
**Step Three** – If the client wants to move forward with a full understanding of the costs and risks, they need to transfer $310,600.00.
**Step Four** – Apply for Medicaid and receive a Notice of Disqualification.
**Step Five** – Apply again when the penalty period has elapsed.
Increase Countable Resources

Timeline for a move can be important if a married couple has less than the maximum CSRA in countable resources.

• Primary residence is an excluded resource if living there or listed for sale at time of move.
• Primary Residence is potentially countable if they have already moved increasing CSRA to maximum.
• Important step if they were going to sell anyway and have low resources.
• Also, good for burial plans – do not have them spend on supplies before setting CSRA.

Urgency Planning

Medicaid Compliant Annuity
Promissory Notes/Loans
Increase in Monthly Maintenance Needs Allowance
Increase in Monthly Maintenance Needs Allowance if Hardship

DHS to waive the requirement for income to be considered first if they determine the CSRA would create an undue hardship on the Community Spouse. Undue hardship is not defined but things considered include the CS’ age, health, if income currently available from the Medicaid applicant ends on that person’s death (for example, a pension with no death benefit), and high allowable monthly expenses.

Promissory Note

- Federal law has given some leeway for promissory notes.
- Oregon rules have made the use of promissory notes a high-risk, low-reward strategy.

If the loan is a negotiable agreement and a bona fide agreement, for financial groups in a non-standard living arrangement:
  1. Only the interest portion of payments made by the borrower to the lender is counted as unearned income.
  2. The principal portion of any payments is excluded.
  3. The outstanding principal balance is counted as a resource.

If the loan is not both negotiable and bona fide, for financial groups in a standard living arrangement:
  1. Both the principal and interest payments are treated as unearned income.
  2. The balance of the loan is excluded as a resource.

Standard living arrangement means not applying for long-term care services.
Medicaid Compliant Annuity

Goal:
Transform excess resources into an income stream for the Community Spouse while decreasing the excess resources.

Medicaid Compliant Annuity

Must meet all the following (or be considered a transfer):
- **Irrevocable**
- **Non-assignable**
- **Actuarially sound**
  - Payments in equal installments of the life expectancy of the annuitant with no deferral or balloon payments, concluding within 12 months on either side of the life expectancy established by the SSA table
- **Issued by a licensed business approved** to issue a commercial annuity by the state in which the annuity was purchased
- **Death beneficiary**
  - The spouse of the Medicaid recipient, or
  - The annuitant’s child, and
  - The first remainder beneficiary is the Department for up to the total amount of medical assistance paid on behalf of the individual (applicant/recipient)
Medicaid Compliant Annuity

The Medicaid Compliant Annuity may be discussed in the pre-planning stages before care is needed, but the client should refrain from purchasing until the month of application, so they do not unnecessarily restrict access to the principal or decrease CSRA if CPC has not been established.

Annuity-Based CSRA

- Use if there is a shortfall in income to meet Minimum Monthly Maintenance Needs Allowance
- May not need to spend down resources
Chapter 1—Advanced Planning Strategies

Annuity Based CSRA Calculation

https://digital.fidelity.com/prgw/digital/gie/

1. Select Just Me
2. Enter the Date of Birth of the Community Spouse
3. Enter the Gender of the Community Spouse
4. Enter the state of residence of the Community Spouse
5. Select “how much I want to invest”
6. Enter the monthly income needed (round up to the nearest whole dollar)
7. Select the first of the following month as the start date
8. Select non-qualified
9. Do not opt to increase by two percent
10. The “cash refund” is the new CSRA
11. This amount is not added to any other part of the CSRA rules

*This tool will not work if the Community Spouse is 85 years of age or older. When this occurs, retrieve the life expectancy from the SSA table, convert it to months, and multiply it by the shortfall calculated in accordance with the provisions above.

Example – Krystal and Aaron

If they had $100,000 at CPC
• Standard CSRA = $50,000

Krystal had a short fall of $168.12.

We can look at resources to determine if annuity or annuity-based or CSRA is best.

If Krystal was born in July 1954, her CSRA using the annuity-based calculation is $29,518.

Standard CSRA is higher, purchase a Medicaid Compliant Annuity to spend down.
Example 2 – Increased Expenses

Step 1—Find Minimum Monthly Maintenance Needs Allowance

Add
- Rent or mortgage $1,700.00
- SNAP Full Utility Allowance $452.00
- HOA or community dues $40.00
- Property taxes included in mortgage
- Property insurance included in mortgage
  Total $2,192

Subtract
- Shelter allowance $686.63
  Total $1,505.37

Add $1,505.37 to minimum needs allowance $2,288.75
  Total Monthly Needs $3,794.12

Step 2—Calculate Community Spouse's available income

Subtract
- Applicant's income $1,300.00
- OSIP standard $841.00
  Total Available $459.00

Step 3—Add Total Community Spouse Gross Income with LDS

- Community Spouse income $2,025.00
- Potential CSIA/LDS $459.00
  Total $2,484.00

Example 2 – Increased Expenses Continued

Step 4—Determine how much will be diverted to Community Spouse and shortfall, if any.

Subtract
- Combined income $2,484
- Monthly Needs Allowance $3,435
  Total ($951)

Step 5—Compare with Spend Down CSRA with Annuity Based CSRA

- Annuity-based CSRA $166,103*
- Combined Resources on Snapshot Date $200,000
- Standard CSRA $100,000

*Because this amount is more than $100,000, it is used as the CSRA.

Step 6—Determine Spend Down

- Annuity Based CSRA $166,103
- Medicaid Spouse Allowance $2,000
  Total to keep $168,103

- Excess $29,897
  • Add Aaron's OSIP resource limit of $2,000. Remember, they will likely have to spend more to qualify.
Example 2 – Increased Expenses Continued

Krystal can keep $166,103 in any form of countable resource and does not need to convert the resources unless they are in Aaron’s name.

Look at a qualified domestic relations order if it’s an IRA they do not want to annuitize.

Excess of $29,897

Can purchase a Medicaid Compliant Annuity and qualify immediately, or

Use the excess to pay privately and secure a more desirable long-term facility (spending more money overall), or

Pay for property repairs, or other items they may need.

Example Three – Higher Expenses, Younger Spouse

If all the information above was the same, but Krystal was born in 1984 instead of 1954.

• Krystal’s annuity-based CSRA would increase to $233,772.00.
• No required spend down because their combined countable resources are less than $233,772.00.
REDETERMINATION, REAPPLICATION, RESTORATION, AND REASSESSMENT (oh my)

Reassessments

Services (ADL) related:

Completed:
- At least annually
- If there are changes in circumstances
- In short-certified cases (such as when a person is in an NFC and improvement was expected to occur after one month following the assessment date but before one year)
- After unexpected improvement in condition
- If the department receives or observes information contrary to the active assessment

ONE/Worker will provide a Notice of Service Eligibility Review 70B.
Redetermination

Resource related:

Occurs annually or if an asset is acquired or disposed of, resulting in a change of circumstances.

Medicaid Recipient should alert an eligibility worker about a change in circumstance so the worker can address it in the ONE system.

Redetermination (Annual Review)

Sent to Authorized Representative before one year.

Part One – Change in Circumstance?

If no changes – send
If yes – complete Part Two

Part Two – List Change

Return to local office (or send to Salem or VEC, but this will result in incorrect information or delays)

DHS may verify resources

If there is a discrepancy, DHS should request the client or their Authorized Representative to verify the information to resolve the discrepancy. If you're aware of a discrepancy, do not wait for DHS to request you to address it.
Redetermination
(Change in Circumstances)

Medicaid recipient should alert an eligibility worker about a change.

Redetermination

DHS should only inquire about the Medicaid recipient’s resources, unless the recipient/spouse/authorized representative did not separate resources if necessary.

DHS may inquire about the Community Spouse’s income or expenses, for example if the Community Spouse is receiving LDS.

• If a redetermination is received requesting more information on the Community Spouse, it may be that the ONE system has erroneously applied for benefits on behalf of the Community Spouse or that something was sent in error.

• Contact the eligibility workers at the local branch to determine the reason for the request.
Redetermination – Excess Resources

• Are they excluded?

• Are they temporarily excluded? – A federal tax refund should be excluded for twelve months following receipt but will need to be spent or converted before the period elapses.

• Can they be converted to an excluded resource such as a burial plan, and personal property?

Restoration

Used when a determination was made erroneously or when the previously submitted application can be used rather than the applicant submitting a new application. An example is when a case is processed based on an Asset Verification System (AVS) result in a specific month. If the client timely shows that the AVS result was incorrect, the eligibility worker can restore the application, input the data, and reprocess. Other situations are when a client requests continuing benefits while pending a hearing.
Reapplication

Reapplications occur when there is a break in aid, such as a lapsed program that was not renewed or restored, or when there is a period of ineligibility, such as a disqualification or spend down. They are used to establish a new date of request (DOR) and report the change in financial circumstances. Usually, a new assessment will be conducted in association with the new DOR but not always. For example, suppose less than two months have elapsed since the previous assessment was conducted, and the applicant has not had a change in functionality. In that case, the case manager can create or restart a service plan with the existing assessment, presuming the eligibility determination is also made timely.
Estate Recovery

**Required Under Federal Law**

**Not a Lien.** The state does not have a lien but rather a claim against the estate similar to other creditors. The Department's claim has priority over most, but not all, types of claims (ORS 115.125).

**Limited to Reimbursement.** Limited to amount paid on a Medicaid recipient’s behalf.

**Interest.** Interest does not start to accrue during the person’s lifetime, the Community Spouse's lifetime, or the lifetime of a disabled or minor child.

Conventional Payments

For proper payments DHS will seek recovery from the estate of the decedent or at surviving spouse’s death.
Overpayments

Overpayments may occur when the Medicaid recipient was ineligible to receive some or all benefits paid on their behalf.

Overpayments generally happen in one of three ways:
1) An error in calculation by DHS.
2) An error by the Medicaid recipient or filing group.
3) Fraud.

In the event of an overpayment, the Department will seek recovery on the estate on the death of the Medicaid recipient and may not wait until the death of the Community Spouse.

Overpayment – changes 2021

Currently DHS will only establish a client error overpayment when:
1. an individual received unreduced liability or unreduced benefits pending a contested case hearing decision or other final order favorable to DHS, or
2. when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact to establish or maintain eligibility (fraud).
Limitations on Claims

• If the claim is for correctly paid payments, the State will wait for recovery until the surviving spouse’s death.

• If there is a child under twenty-one (21), so long as this child survives probate.

• If there is a blind or disabled child, so long as he or she survives probate.

• Claims are limited to resources the Medicaid recipient had an ownership interest in at the recipient’s death.*

• For services paid before July 18, 1995, only property subject to probate would be available to satisfy the claim.

• No recovery when the person needed services because of a crime committed against them (ORS 416.350(3)).

• Funds can be used for a plain and decent burial, up to $3,500 (OAR 461-135-0833).

Hardship Waivers

A hardship may exist if it would make the heir or beneficiary eligible for public or medical assistance or cause that person to become homeless.

If DHS finds hardship, they can forgive all or part of the claim or have the heir take a mortgage or trust deed in lieu of enforcement.
Questions
Chapter 2

Medicaid Planning with Irrevocable Trusts

ALANA HAWKINS
Kueny Law LLC
Salem, Oregon

MARK MUNSON
Ruder Ware LLSC
Wausau, Wisconsin

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MEDICAID LAW.

1) 42 U.S.C. § 1396p


i) Look-back period is 60 months prior to the date of application or 60 months prior to the date of transfer of assets, whichever is later.


i) The number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all of the assets transferred by the individual (or individual’s spouse) on or after the look-back date, divided by the average monthly cost to a private patient of nursing facility services in the State at the time of application.


i) If there are circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income –

(1) To or for the benefit of the individual, shall be considered income of the individual, and

(2) For any other purpose, shall be considered a transfer of assets by the individual subject to subsection 42 U.S.C. § 1396p(c) discussed above; and

ii) Any portion of the (irrevocable) trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection 42 U.S.C. 1396p(c) discussed above, and the value of the trust shall be determined for purposes of 42 U.S.C. 1396(c) by including the amounts of any payments made from such portion of the trust after such date.

2) OAR 461-140-0210(5)(b)(B): Look-back period. 5 years (60 months).

a) OAR 461-140-0210(6): Calculating the duration of the penalty if assets are transferred within 5 years.
Chapter 2—Medicaid Planning with Irrevocable Trusts

i) OAR 461-140-0296: Length of Disqualification (OSIPM).

   (1) Total value of non-exempt asset transfers divided by the Average monthly cost of private pay at a nursing facility in Oregon, which is currently $9,551, however it is due to be updated annually on October 1 of each year.

ii) OAR 461-140-0296(4)(c)(e)(iv): Disqualification period begins on the Medicaid application date or the date at which the applicant is otherwise eligible for Medicaid, whichever is later.

iii) OAR 461-140-0300: Adjustments to the Disqualification for Asset Transfer [“Curing Transfers”]

   (1) OAR 461-140-0300(2):

   (a) If ALL funds are returned, the disqualification ends if the transfer that caused the disqualification is rescinded.

   (b) If there is a partial return of the transfer that caused the disqualification, then there will be a recalculation of the penalty period to account for the modified transfer.

3) Social Security Administration Programs Operations Manual System (“POMS”).

   a) SI 01120.200. Information on Trusts.

      i) This section of the POMs provides an overview regarding how SSA defines and treats different types of trusts.

   b) SI 01120.201. Trusts established with the Assets of an Individual on or after 01/01/00, which includes the definition of “legal instrument, device or arrangement similar to a trust.”

4) Oregon Programs Eligibility Notebook (available online – see resources for link)

   a) Section 5: Financial Eligibility: Availability of assets: Treatment of specific assets: Trusts other than special needs trust, income cap trusts, and pooled trusts.

      i) For OSIPM generally See Page 356.

      ii) For Irrevocable Trusts See Page 357.
(1) If the trust is irrevocable, treat as follows: for OSIPM in a non-standard living situation, if, under any circumstances, the funds transferred into the trust are unavailable and the trustee has no discretion in which to distribute funds to or for the benefit of the individual, the individual is subject to a transfer of resources penalty as outlined in the 140 Section of the OARS (beginning with 461-140-0210).

(2) If under any circumstances, payments could be made to or on behalf of the individual, the share of the trust from which the payment could be made shall be considered a resource. For OSIPM individuals in a non-standard living situation, payments made for any reason other than to or for the benefit of the individual shall be considered a transfer or assets subject to disqualification per the 140 Section of the OARS (beginning with 461-140-0210).

(3) If, under any circumstances, income is generated by the trust and could be paid to the individual such income will be considered unearned income. For OSIPM individuals in a non-standard living situation, payments made for any reason other than to or for the benefit of the individual shall be considered a transfer of assets subject to disqualification per the 140 Section of the OARS (beginning with 461-140-0210).

(4) If any change in circumstance, make assets (income or resources) from the trust unavailable to the individual, a disqualifying transfer will be assessed as of the date of the change (again, for OSIPM individuals in a non-standard living situation).

(5) The provisions of this rule may be waived for an irrevocable trust if ODHS OHA determines denial of benefits would create an undue hardship on the individual...


   a) Wisconsin case, the Court determines whether assets in an irrevocable trust are available resources for the purposes of determining financial eligibility for medical assistance. The Court held, if there are circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to or for the benefit of the individual could be made is considered a resource available to the individual.

6) CMS Letter

7) HCFA “Transmittal” 64.
TRUST PLANNING CONSIDERATIONS.

1) Types Of Trusts.

   a) Irrevocable Income-Only Trust.

      i) **Income**: Mandatory distribution standard to or on behalf of settlor(s).

      ii) **Principal**: Discretionary distribution standard to or on behalf of non-settlor beneficiary or beneficiaries.

   iii) Definition of Trust Income.

      (1) Trust accounting income.

      (2) Income subject to income tax.

      (3) Combination.

      (4) Real estate considerations.

      (5) Oregon Uniform Principal and Income Act (ORS Chapter 129 (UPIA))

   b) Irrevocable (No Income, No Principal) Trust – discretionary distributions to non-settlor(s) beneficiaries during lifetime of settlor(s).

   c) Testamentary special needs trust created pursuant to deceased spouse’s will for the primary benefit of the surviving spouse and secondary benefit of the couple’s children and more remote descendants.

   d) Trust-like instruments, devices, or arrangements, which require: (see POMS: SI 01120.201.B.5 and 001120.201.G.).

      i) A grantor or individual who provides assets to fund the legal instrument, device or arrangement.

      ii) who transfers property (or whose property is transferred to another); and

      iii) to an individual or entity with fiduciary obligations.

      iv) Examples include, but are not limited to, escrow accounts, investment accounts, guardianship and conservatorship accounts, pension funds, annuities, and Uniform Transfers to Minors Act account.
2) Income Taxation.

a) Grantor Trust (where trust income, deductions and credits are attributable to the grantor (i.e., settlor or trust creator) and must be reported on that individual’s income tax returns (see Internal Revenue Code (“IRC”) §§ 671 – 679)).

b) Non-Grantor Trust (where trust is recognized and subject to income tax as a separate legal entity and the trustee must prepare and file fiduciary income tax returns for the trust (generally, see IRC §§ 641 – 668)).

c) Stepped-Up Basis. See IRC § 1014(b)(6) (for double-stepped-up basis of community property martial property) and (9) (for stepped-up basis for any property included in a decedent’s gross estate for estate tax purposes).

i) As to an irrevocable trust, one way to ensure a stepped-up basis is to have the settlor(s) retain a testamentary limited (or special) power of appointment over the trust assets.

(1) A retained testamentary limited power of appointment to change remainder beneficiaries of the trust by the settlor will cause the property to be included in his/her gross estate for estate tax purposes pursuant to IRC § 2036(a)(2), which triggers IRC § 1014(b)(9).

(2) Community Property (Oregon is not a community property state). In the case of married couples, a marital property agreement should be entered into stating that assets of the irrevocable trust are classified as marital property in order to realize a double-stepped-up basis upon the death of the first spouse.

3) Gift And Estate Taxation.

a) Completed gift – removed from gross estate for estate tax purposes, but no stepped-up basis at death. Need to file IRS Form 709 by April 15 in the year after the gift(s) were made.

b) Incomplete gift – included in gross estate for estate tax purposes, but entitled to receive stepped-up basis at death.
4) Trustee Selection.

a) Grantor as trustee.

i) Concern: Trust assets will be deemed available resources for purposes of Medical Assistance eligibility.

ii) No law or case has made a determination either way.

iii) If settlor is the trustee, it is advisable to state in the trust document that the settlor is not entitled to receive compensation for services rendered as trustee and reimbursement for expenses incurred as trustee (i.e., settlor must be willing to serve as trustee for free).

b) Individual or entity other than settlor as trustee – if the settlor is not going to serve as trustee due to concerns of trust assets being deemed available resources, it may be advisable to expressly state in the trust document that the settlor(s) is/are prohibited from being able to serve as trustee or in any other fiduciary capacity. Another question to be answered is whether the settlor(s) can retain a power to remove and replace the trustee with or without cause and whether the type of replacement trustee should be limited, such as to an independent trustee.

c) Grantor as a directing party.

i) Can the grantor serve as a directing party as to investments?

ii) Can the grantor serve as a directing party as to distributions?

iii) Concern. Same as cited above at (5)(i) - Trust assets will be deemed available resources for purposes of Medical Assistance eligibility.

d) Grantor holding the power to veto distributions if not the trustee. If the grantor holds an inter vivos veto power, does raise the same concerns as being the trustee and/or serving as a directed party?

5) Retained Testamentary Limited (or Special) Power of Appointment.


i) New York, case involving a claim by the State Medicaid Agency that the assets of the applicant’s spouse’s irrevocable trust were countable for purposes of Medicaid. Terms of the applicant’s spouse’s irrevocable trust – reserved the right to change the
beneficiary. The right was limited, in that settlor was specifically prohibited from naming himself, his spouse, and/or their creditors. The Court held:

(1) Although it was conceivable that settlor could put pressure of beneficiaries to make payments for spouse applicant’s benefit, the relevant law stated that the availability of assets, for Medicaid eligibility purposes, depends on the “trustee’s authority, under the specific terms of the trust agreement.”

(2) Although the trustees and beneficiaries are currently the same people, that is not necessarily so under the terms of the trust... their roles as trustees and beneficiaries must be considered as legally separate.

(3) The speculative possibility of a revocation pursuant to NY law did not render the corpus of the trust “potentially available” to the petitioner, as there was no evidence presented that the beneficiaries would consent to such revocation.


i) New York class action for six elderly nursing home residents who created irrevocable self-settled income only trusts, that were denied Medicaid benefits because the trust contained provisions reserving a limited power of appointment. County and State Medicaid officials determined that a limited power of appointment makes the assets of a trust an available resource for purposes of determining Medicaid eligibility on the basis that the settlors could utilize the retained power to change beneficiaries to individuals amenable to revoking an otherwise irrevocable trust. The US District Court held:

(1) The denial of Medicaid benefits because the settlors are allegedly potential beneficiaries of self-settled trusts containing limited powers of appointment exceeds the limits of federal law.

(2) Absent evidence of bad faith or fraud, the decision of whether or not to provide Medicaid benefits should not be based upon the remote possibility of collusion.

c) Estate and gift tax impact. See IRC § 2511 and more importantly see 26 Code of Federal Regulations § 25.2511-2 entitled “Cessation of donor’s dominion and control.”
6) Trustee Powers and Authorities.

   a) Power to sell and purchase – sales and purchases between settlor(s) and trust must be for fair market value.

   b) Power to borrow and lend – should the trustee be able to borrow money from the settlor(s) or lend money to the settlor(s)?

   c) Life insurance – if life insurance is owned by the trust, the trustee should be required to update beneficiary designations if the beneficiary is the settlor(s), creditors of the settlor(s), the estate of the settlor(s), or creditors of the estate of the settlor(s) AND the trustee should be expressly prohibited from being able to designate any of the above as a beneficiary of the policy.

   d) Non-qualified tax-deferred annuities – same advice as for life insurance.

   e) General trustee limitation – the trust should contain a general clause that prohibits the trustee from possessing any power or taking any action that causes or would cause the assets to be deemed available resources as to the settlor(s) for medical assistance purposes; this should also be made to apply to a “special trustee” if the trust document has language authorizing the appointment of a special trustee.
Helpful Links and Resources

42 US Code Section 1396p:
https://www.law.cornell.edu/uscode/text/42/1396p

SSA POMS Generally:
https://search.ssa.gov/search/docs?affiliate=ssa&dc=1585&query=

SSA POMS: Introductions to Trusts.
https://secure.ssa.gov/poms.nsf/lnx/0501120200

SSA POMS: Trust established with the Assets of an Individual on or after 01/01/00
https://secure.ssa.gov/poms.nsf/lnx/0501120201

Oregon SOS Department of Human Services Self-Sufficiency Programs – Chapter 461
https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=90

Oregon Programs Eligibility Notebook:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served//de2818.pdf

OSB CLE Materials.


Hedlund v. Wisconsin Department, 807 N.W.2d 672, 337 Wis. 2d 634, 2011 WI App. 153 (Wis. Ct. App. 2011)


December 23, 1993

Ms. Ellice Fatoullah  
Alzheimer’s Disease and Related Disorders Association, Inc.  
420 Lexington Avenue  
Suite 610  
New York, New York 10170

Dear Ms. Fatoullah:

I am responding to your letter asking us to confirm your understanding of the meaning of Section 13611(b) of OBRA 93, as codified in section 1917(d)(3)(B)(i) of the Social Security Act (the Act). This section discusses treatment of irrevocable trusts for purposes of determining eligibility for Medicaid.

Briefly, the cited section provides that if there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, actual payments made are considered to be income to the individual. Payments that could be made, but are not, are considered resources to the individual. Payments made for any purpose other than to or for the benefit of the individual are treated as a transfer of assets under section 1917(c) of the Act.

You interpret this part of the statute as meaning that, if a person establishes an irrevocable trust guaranteeing the income of the trust to him or herself for life, but excluding distribution of the trust corpus to him or herself, the corpus of the trust will not be considered an available resource to the individual after the applicable transfer of assets waiting period (which you believe to be 60 months). You have asked us to confirm your interpretation.

Your understanding of the statutory requirements is essentially correct. However, as a technical point, we would note that the appropriate statutory reference dealing with the situation you describe is section 1917(d)(3)(B)(ii), rather than subsection (i). Subsection (ii) deals specifically with trusts where there is some portion of the trust from which distributions cannot, for any reason, be made to or for the benefit of the grantor. In this situation, the 60 month transfer of assets waiting period to which you refer applies. The section you referenced in your letter actually deals with trusts where some distribution can be made to or for the benefit of the grantor. In such situations, the portion that could be distributed is counted as a resource to the individual. Where distributions can be made, the waiting period for treatment as transfers of assets of distributions made to or for someone other than the grantor is 36 months.
Also, you should understand that where a portion of a trust cannot, under any circumstances, be distributed to or for the benefit of the grantor, that portion is never considered an available resource to the grantor. Rather, the value of that portion of the trust is treated as a transfer of assets for less than fair market value. An individual who transfers assets for less than fair market value can still be eligible for Medicaid. However, the Medicaid program will not pay for the cost of various long term care services, including nursing facility care. The length of time for which payment for services would be denied would depend on the value of the transferred asset (or, in the situation you describe, the value of that portion of the trust which cannot be paid to or for the benefit of the grantor).

I hope this information is useful to you.

Sincerely,

Sally K. Richardson
Director
Medicaid Bureau
Chapter 2—Medicaid Planning with Irrevocable Trusts

MEDICAID PLANNING WITH IRREVOCABLE TRUSTS

Presented By:
Mark D. Munson, JD
Ruder Ware, LLSC
Alana J. Hawkins, JD
Kueny Law, LLC

MEDICAID LAW

FEDERAL

OREGON

SOCIAL SECURITY ADMINISTRATION PROGRAMS OPERATION MANUAL SYSTEM (POMS)

Other Sources
MEDICAID LAW – 42 U.S.C. § 1396P

  - Payment from the Trust to or for the benefit of Medicaid applicant?
  - Available Resource verses Transfer of Assets?

MEDICAID LAW – OREGON ADMINISTRATIVE RULES

- OAR 461-140-0210(5)(b)(B): Look-back period. 5 years.
- OAR 461-140-0210(6): Calculating the duration of the penalty if assets are transferred within 5 years:
  - OAR 461-140-0296: Length of Disqualification (OSIPM)
  - OAR 461-140-0300: Adjustments to the Disqualification for Asset Transfer
MEDICAID LAW – SOCIAL SECURITY ADMINISTRATION PROGRAMS OPERATIONS MANUAL SYSTEM ("POMS").

- SI 01120.200. Information on Trusts.
- SI 01120.201. Trusts established with the Assets of an Individual on or after 01/01/00, which includes the definition of "legal instrument, device or arrangement similar to a trust."

MEDICAID LAW – OREGON PROGRAMS ELIGIBILITY NOTEBOOK

Oregon Programs Eligibility Notebook
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de2818.pdf

- Section 5: Financial Eligibility: Availability of assets: Treatment of specific assets: Trusts:
  - For OSIPM generally See Page 356.
  - For Irrevocable Trusts See Page 357.
MEDICAID LAW – OTHER SOURCES

- Case Law (Hedlund)
- CMS Letter
- HCFA “Transmittal”64

TRUST PLANNING CONSIDERATIONS

- TYPES OF TRUSTS
- INCOME TAXATION
- GIFT AND ESTATE TAXATION
- TRUSTEE SELECTION
  - RETAINED TESTAMENTARY LIMITED (OR SPECIAL)POWER OF APPOINTMENT
  - TRUSTEE POWERS AND AUTHORITIES
Chapter 2—Medicaid Planning with Irrevocable Trusts

**TYPES OF TRUSTS**

- **IRREVOCABLE – INCOME ONLY:** Mandatory income distribution standard to or on behalf of settlor(s). Discretionary principal distribution standard to or on behalf of non-settlor beneficiary or beneficiaries.

- **IRREVOCABLE – NO INCOME, NO PRINCIPAL:** Discretionary distributions to non-settlor(s) beneficiaries during lifetime of settlor(s).

- **TESTAMENTARY SPECIAL NEEDS TRUST FOR SPOUSE:** Special needs trust created pursuant to deceased spouse’s will for the primary benefit of the surviving spouse and secondary benefit of the couple’s children and more remote descendants.

- **TRUST LIKE INSTRUMENTS:** See POMS: SI 01120.201.B.5 and 001120.201.G.

**INCOME TAXATION**

**Grantor Trust**

Grantor Trust (where trust income, deductions and credits are attributable to the grantor and must be reported on that individual’s income tax returns (see Internal Revenue Code ("IRC") §§ 671 – 679)).

**Non-Grantor Trust**

Non-Grantor Trust (where trust is recognized and subject to income tax as a separate legal entity and the trustee must prepare and file fiduciary income tax returns for the trust (generally, see IRC §§ 641 – 668)).
Chapter 2—Medicaid Planning with Irrevocable Trusts

STEPPED UP BASIS
SEE IRC § 1014(B)

As to an irrevocable trust, one way to ensure a stepped-up basis is to have the settlor(s) retain a testamentary limited (or special) power of appointment over the trust assets.

For Example: A retained testamentary limited power of appointment to change remainder beneficiaries of the trust by the settlor will cause the property to be included in their gross estate for estate tax purposes pursuant to IRC § 2036(a)(2), which triggers IRC § 1014(b)(9).

GIFT AND ESTATE TAXATION

Completed Gift
Removed from gross estate for estate tax purposes, but no stepped-up basis at death. Need to file IRS Form 709 by April 15 in the year after the gift(s) were made.

Incomplete Gift
Included in gross estate for estate tax purposes but entitled to receive stepped-up basis at death.
TRUSTEE SELECTION

• Grantor as Trustee
  o Concern: Trust assets will be deemed available resources for purposes of Medical Assistance eligibility.

• Individual or entity other than Settlor:

• Grantor as a directing party?
  o Can the grantor serve as a directing party as to investments?
  o Can the grantor serve as a directing party as to distributions?
  o Same concern as above.

• Grantor holding the power to veto distributions?
  o Same concern as above.

RETAINED TESTAMENTARY LIMITED (OR SPECIAL) POWER OF APPOINTMENT


Estate and gift tax impact. See IRC § 2511 and more importantly see 26 Code of Federal Regulations § 25.2511-2 entitled “Cessation of donor’s dominion and control.”
TRUSTEE POWERS AND AUTHORITIES

• Power to sell and purchase – sales and purchases between settlor(s) and trust must be for fair market value.

• Power to borrow and lend – should the trustee be able to borrow money from the settlor(s) or lend money to the settlor(s)?

• Life insurance – if life insurance is owned by the trust, the trustee should be required to update beneficiary designations if the beneficiary is the settlor(s), creditors of the settlor(s), the estate of the settlor(s), or creditors of the estate of the settlor(s) AND the trustee should be expressly prohibited from being able to designate any of the above as a beneficiary of the policy.

• Non-qualified tax-deferred annuities – same advice as for life insurance.

• General trustee limitation – the trust should contain a general clause that prohibits the trustee from possessing any power or taking any action that causes or would cause the assets to be deemed available resources as to the settlor(s) for medical assistance purposes; this should also be made to apply to a “special trustee” if the trust document has language authorizing the appointment of a special trustee.

QUESTIONS?
Chapter 3

Maintaining Medicaid Eligibility

DARIN DOOLEY
Draneas Huglin Dooley LLC
Lake Oswego, Oregon

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Chapter 3—Maintaining Medicaid Eligibility

I. Introduction

The Medicaid program is a main source of payment for long-term care in Oregon. Medicaid is a joint Federal and State program that covers the full range of long-term care services, including skilled, intermediate and custodial care, adult foster home, and in-home services.

Because Medicaid payment for long-term care and in-home services is so important to many Oregonians, it is critical to maintain eligibility once it has been achieved. Once the spouse needing care has been determined eligible for Medicaid benefits, there is no need for future assessment of the community spouse's resources. OAR 461-110-0530(4)(c). The community spouse may accumulate additional resources without affecting eligibility for the Medicaid recipient. However, changes to the Medicaid recipient’s circumstances can cause the recipient to lose their benefits unless appropriate steps are taken in a timely manner.

II. Duty to Report Change in Circumstances Affecting Medicaid Eligibility

Questions about maintaining Medicaid eligibility can arise in many situations. Medicaid programs must redetermine eligibility at least annually and whenever changes in circumstances are reported. Post Medicaid eligibility, an individual must report all changes that may affect eligibility or benefit level within 10 days of occurrence, including a change in resources. OAR 461-170-0011(3)(d)(F). Failure to report a change in circumstances that would make an individual ineligible can result in immediate recovery of the overpayment / receipt of benefits the individual is no longer eligible to receive. Oregon DHS may establish a fraud overpayment when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining eligibility. OAR 461-195-0501(3)(c). A client error overpayment includes an overpayment caused by the failure of a filing group, ineligible student, or authorized representative to declare or report information or a change in circumstances as required under OAR 461-170-0011, including information available to the Department, that affects the client's eligibility to receive benefits or the amount of benefits. OAR 461-195-0501(4)(b)(A). There is no compromise or adjustment for a fraud overpayment claim. OAR 461-195-0561.

Note – For Veteran’s aid-and-attendance and housebound payments, if the OSIP and OSIPM client receives a payment covering a previous period of eligibility, the client is required to turn over to Oregon DHS the full amount of the payment up to the cost of institutional and home and community-based care provided to the client during the months covered by the payment. A client's failure to reimburse Oregon DHS in this instance constitutes an overpayment of public assistance in accordance with OAR 461-195-0501 and 461-195-0521 and ORS 411.640 and 411.690.

III. Source of Change in Resources

Because a recipient of SSI and Medicaid can only have $2,000 in available resources, the receipt of a lump sum from any source can be disqualifying for continued eligibility. Changes in resources can come from the following sources:
A. An unplanned inheritance. A noncash inheritance is treated according to the policy for the specific type of asset inherited. A cash inheritance is counted as period or lump-sum income in the month of receipt. OAR 461-145-0270. Lump-sum income not excluded is income in the month of receipt, and any amount remaining in future months is a resource. OAR 461-140-0120(4)(a).

Elective share. When a community spouse predeceases a Medicaid recipient, the Medicaid recipient spouse of a decedent may elect to receive the elective share provided by ORS 114.600 to 114.725. The elective share amount is based on the length of the marriage. A Medicaid (OSIPM) applicant or recipient must make a good faith effort to obtain assets to which he or she has a legal claim. An individual is ineligible for benefits if the individual fails to comply with the requirements of this rule. This penalty is effective until the individual complies with the requirements of the rule. OAR 461-120-0330. This condition of eligibility is separate from the rules that penalize gifts and transfers for less than fair market value.

Practice Tip: Updating the community spouse’s estate planning is important to prevent losing Medicaid eligibility if the community spouse predeceases the Medicaid recipient spouse. This planning should address the elective share right and include a third party special needs trust.

Practice Tip: Under the Omnibus Reconciliation Act of 1993 (OBRA '93) the definition of disqualifying transfer of assets for Medicaid were expanded to include a disclaimer as a disqualifying transfer. See 42 U.S.C. 5 1396p(c). Disclaiming the right to receive an inheritance is viewed as a disqualifying transfer. A prenuptial agreement may be enforceable, but a postnuptial agreement could raise problems. Any disqualifying transfers post eligibility would result in a penalty period being assessed.

B. A Settlement. A personal injury settlement is treated as unearned income and/or periodic or lump-sum income. OAR 461-145-0400. Workers compensation payments are treated similarly under OAR 461-145-0590. Lump-sum income not excluded is income in the month of receipt, and any amount remaining in future months is a resource. OAR 461-140-0120(4)(a). Proper planning using a special needs trust or other method of spend down discussed below is important if a Medicaid recipient is party to any litigation resulting in a settlement.

  o Note – Agent Orange Disability Benefits / Settlement funds are excluded under OAR 461-145-0005.

C. The Sale of a Primary Residence. The net sale proceeds from the sale of a primary residence are excluded for three full calendar months from the date of receipt if the financial group intends to use the proceeds to purchase another primary residence, or for associated costs including:

  o Down payments.
  o Settlement costs.
  o Loan processing fees and points.
o Moving expenses.
o Necessary repairs to or replacement of the new home's structure or fixtures (including roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy.
o Mortgage payments.

Proceeds from the sale of a home that are not reinvested in another home are counted as a resource, with one-half of the net proceeds being treated as the Medicaid recipients. (OAR 461-145-0460(3)(d), (f))

Practice Tip: The new home should be purchased in the name of the community spouse alone. This is for estate planning purposes only and will not protect the Medicaid recipient’s deemed one-half interest in the new home from estate recovery. Planning for the community spouse should include consideration of spousal elective share right and third party special needs trust planning for the Medicaid recipient spouse.

Practice Tip: The receipt of some resources or income are excluded. Federal tax refunds are excluded from income and resources in the month of receipt and then for 12 full months starting with the month following receipt OAR 461-145-0530. State tax refunds are excluded as income in the month received and counted as a resource in the month after the month received. OAR 461-145-0530. Retroactive Social Security benefits (SSB) and Supplemental Security Income (SSI) payments are treated in accordance with OAR 461-145-0490 and 461-145-0510. OAR 461-140-0120(4).
  o 461-145-0490 - in general, retroactive [SSB] payments are counted as unearned income in the month of receipt and any remaining amount from a retroactive payment after the month of receipt is excluded as a resource for nine calendar months following the month in which the payment is received.
  o 461-145-0510 - a retroactive SSI payment is excluded as a resource for nine months after the month of receipt.

IV. Planning Options

When receiving a lump sum over the resource limit, a Medicaid recipient can choose to keep the sum and go off benefits, transfer the funds to a qualifying trust, including types of special needs trusts, or maintain/regain eligibility by spending down. Resources cannot be given away unless an exception to the disqualifying transfer rules applies.

A. Private Pay. Depending on the amount of the lump sum received, the Medicaid recipient could simply decide to keep the excess resources, lose Medicaid coverage, and pay privately for their long term care costs.

B. Spend Down. Persons who have assets over Medicaid’s resource limit can ‘spend down’ excess resources on non-countable ones. Spending the excess sums in the month of receipt allows the person to maintain benefits.
Chapter 3—Maintaining Medicaid Eligibility

o Note that while spending down in the month of receipt can preserve eligibility for SSI and Medicaid (OSIPM), the SSI recipient will likely need to repay some or all of their SSI benefit for the month the lump sum was received, because the SSA considers a lump sum to be income in the month received. Any income not spent in the month of receipt will be countable as a resource in the following month by the SSA.

Examples of items to spend down on include:
  o purchasing a home, paying off a mortgage on a home, remodeling, or deferred maintenance, home modifications (wheelchair ramps, roll-in showers, and stair lifts)
  o purchasing a new vehicle, vehicle modifications (wheelchair lifts, adaptive control devices to allow one to drive from a wheelchair)
  o prepaying funeral and burial expenses for the Medicaid recipient and community spouse
  o paying off legally enforceable debt, credit card debt, loans, etc. (OAR 461-140-0220(4))
  o purchasing a Medicaid compliance annuity (OAR 461-145-0022(10))
  o paying for uncovered medical expenses, dental expenses, eye glasses, physical therapy, support services
  o electronics, computer, cell phone, TV
  o Paying attorney for estate planning and Medicaid planning
  o Etc.

Practice Tip: It is important to have a plan in place prior to receipt of the lump sum. To reduce/eliminate the loss of Medicaid/SSI, goods and/or services need to be paid for in the month the lump sum was received. Oregon DHS caseworkers can be helpful in allowing some additional time if you have a plan for spending down and can show a good faith effort to complete the spend down.

Practice Tip: When spending, document receipt of the lump sum, receipts for how the sum was spent as evidence that no disqualifying transfers were made. Transferring assets for less than fair market value, unless allowed as discussed further below, will result in a penalty being assessed. OAR 461-140-0242, OAR 461-140-0296. Payments by certified check or cashier’s check can ensure funds have cleared the account.

C. Reimbursement for Benefits Already Received. If a spend down option is being used, and there are no other options for spending down for the Medicaid recipient’s benefit, the recipient can work with the caseworker to reimburse the state for benefits the recipient has already correctly received. While this is not a current claim, it is an option to help complete a spend down and avoid a disqualifying transfer.

D. Allowable Transfers. The following transfers are allowed and will not result in a penalty to the donor:

1) Spouse – Post eligibility interspousal transfers are allowed. OAR 461-140-0242(2)(b). Generally, the State wants to ensure that the transfer between spouses is for the sole benefit of the community spouse. Either a Medicaid compliant annuity or
sole benefit trust, structured to pay out over the community spouse’s life expectancy, will be treated as for the sole benefit of the community spouse. If a home is being transferred under this disqualifying transfer exception, Oregon DHS is aware the home cannot reasonably be expected to be ‘spent’ for the sole benefit of the community spouse over the spouse’s life expectancy.

- Note that the limit on the amount of an interspousal transfer under OAR 461-140-0220 refers to a court ordered transfer. See OAR 461-140-0220(7)(b).


3) Disabled or Blind Child of Any Age. An individual or the spouse of the individual may transfer an asset (including a home) to a child of any age who is blind or has a disability under the Social Security Administration (SSA) criteria. The rule prohibits the child from benefiting any other person with transferred resources and requires a spend-down of the resource during the recipient’s lifetime. OAR 461-140-0242(2)(b), 42 U.S.C. § 1396p(c)(2)(B), POMS SI 01150.122(A)(1).

Transfers to a blind or disabled child need to be carefully planned to maintain the child’s eligibility for means tested benefits. The two goals of benefiting a disabled child and maintaining the child’s means tested benefits can sometimes conflict.

Practice Tip: It is possible to medically meet the SSA criteria for blindness and/or disability and to not meet the administrative requirements to receive SSI and/or SSDI. For example, an individual may never have worked to earn enough credits to qualify for SSDI, and yet have resources that disqualify them from receiving SSI. Such an individual may still meet the medical blindness or disability criteria of the SSA and medically qualify as a “disabled child.” If the disabled child is not receiving SSI or SSDI, Oregon DHS may still make its own determination of disability. If this is the case, you need to provide documentation of the disability to Oregon DHS and, if accepted, the child would be deemed disabled for the transfer rule. (See OAR 461-125-0810 and OAR 461-125-0830).

Practice Tip: Oregon DHS is aware that if a home is being transferred under the disqualifying transfer exception the home cannot reasonably be expected to be ‘spent’ for the sole benefit of the child over the child’s life expectancy. The deed transferring the home from the parent to the child would simply need to name the child as the sole grantee. Since the home would be in the child’s name at death, any valid estate recovery claim for benefits received by the child would attach to the home.

4) Transfers to another for the sole benefit of the spouse or blind or disabled child. For a transfer or a trust to be considered for the sole benefit of a spouse or blind/disabled child, the instrument or document must provide for the spending of the funds involved for the benefit of the recipient based on the recipient’s life expectancy. OAR 461-140-0242(2)(b).
Chapter 3—Maintaining Medicaid Eligibility

Practice Tip: If a trust is used, the attorney will want to include a provision regarding distribution of trust principal to meet the sole benefit requirement. DHS has approved the use of the following: “Trustee shall distribute trust principal . . . in such amounts that all trust principal will be distributed within the actuarial life expectancy of _________.”

Practice Tip: Other sections of OAR 461-140-0242(2)(c) also contemplate transfers to a trust. The trust may be one qualifying as "Medicaid trust exceptions in SI 01120.200 ff. (i.e., trusts established under Section 1917(d)(4)(A) and (C) of the Social Security Act)." POMS SI 01150.121(2). See also 42 U.S.C. § 1396p(c)(2)(B)(iii). However, a transfer can be made to any trust so long as the sole lifetime beneficiary of the trust is a blind or disabled child, and the trust assets are directed to be distributed within the child’s life expectancy. The trust does not have to be a first party/d4A/payback trust or d4C/pooled trust, although those are clearly listed as being allowed. 42 U.S.C. 1396p(d)(4)(A) and OAR 461-145-0540(10)(a); 42 U.S.C. 1396p(d)(4)(C) and OAR 461-145-0540(11).


6) Medicaid Recipient’s Pooled Trust. If the Medicaid recipient is age 65 or older, transfers to a pooled/d4C trust can help maintain Medicaid eligibility. OAR 461-140-0242(2)(d), OAR 461-145-0540(11), 42 U.S.C. 1396p(d)(4)(C).

E. Planned Disqualifying Transfers. The penalty period for disqualifying transfers for an individual who transfers an asset while they are already receiving Medicaid for long-term care or home and community-based care in a nonstandard living arrangement, is the month following the month the asset was transferred. OAR 461-140-0296(4)(c)(A). There are a few options for intentional disqualifying transfers that can be used if a Medicaid recipient’s inheritance or other resources received are significant enough to be able to afford to pay privately for long term care during the penalty period. If the monthly out of pocket expenses for care costs (monthly care costs – monthly income = monthly out of pocket expenses) is less than the divisor, currently $9,551, for calculating the penalty period, then the economics of this plan work out. Once the penalty period is completed, they can reapply for Medicaid benefits as needed.

- Note that the transfer of a resource by a Medicaid recipient falls squarely under the holding in Hobart (a person receiving Medicaid benefits transfers property without adequate consideration). State of Oregon, DHS v. Henry L. Hobart and Rose E. Jimenez 318 Or App 52 (2022), 507 P.3d 299. However, if there is expected to be a child under age 21 or a blind or disabled child of any age surviving the Medicaid recipient and community spouse this type of planning may be viable.

- Note the other transfer addressed in Hobart is when a person transfers property with the specific intent to hinder or prevent Medicaid estate recovery.
Maintaining Medicaid Eligibility

Darin J. Dooley

I. Introduction

II. Duty to Report Change in Circumstances Affecting Medicaid Eligibility

III. Change in Resources

IV. Planning Options
Introduction

Duty to Report Chance in Circumstances Affecting Medicaid Eligibility

- must report all changes that may affect eligibility or benefit level within 10 days of occurrence, including a change in resources. OAR 461-170-0011(3)(d)(F)

- recovery of the overpayment / receipt of benefits the individual is no longer eligible to receive. OAR 461-195-0501(3)(c)
Change in Resources

Unplanned Inheritance

Settlement

Sale of Primary Residence

Planning Options

- Private pay
- Spend down
- Reimbursement to Oregon DHS for benefits already received
- Allowable transfers
  - Spouse
  - Minor Child
  - Disabled or Blind Child of Any Age
- Transfers to another for the sole benefit of the spouse or blind or disabled child
- Planned disqualifying transfers
Chapter 4
Estate Recovery Issues in Light of DHS v. Hobart, 318 Or App 52 (2022)

Garvin Reiter
Law Offices of Nay & Friedenberg LLC
Portland, Oregon

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I. CASE AND GOVERNING STATUTES

DHS v Hobart, 318 Or App 52 (2022):

Facts: Decedent and husband were joint owners of home until decedent transferred title to husband two months prior to her death. The court accepts a finding of fact from the trial court that a) there was no consideration for the transfer and b) the transfer was made with intent to hinder or delay estate recovery. There is no discussion in the opinion as to what constitutes “intent to hinder or prevent” estate recovery. Decedent resided in a nursing home and was on Medicaid at the time of the conveyance. Decedent died August, 2016, and the Medicaid claim amount was $326,403. Husband died December, 2016. The opinion says he created a testamentary trust during his lifetime and conveyed the property to that trust [it was actually a revocable trust], and the trustees of that trust, who were also the beneficiaries, conveyed the property to themselves in 2017.

DHS brought an action against the trust beneficiaries to recover half of the value of the home, in the amount of $108,000 under ORS 416.350(2), ORS 411.630(2) and ORS 411.620(2). It won at the trial court; affirmed on appeal.

HOLDING: “When a person transfers real property with the specific intent to “hinder or prevent” estate recovery in violation of ORS 411.630(2), or when a Medicaid recipient transfers real property “without adequate consideration” under ORS 416.350(2), ORS 411.620(2) expressly provides for the setting aside of the transfer. We agree with DHS that, when the court set aside the April 2016 transfer as provided in ORS 411.620(2), the decedent’s interest reverted to her estate. Moreover, because the April 2016 transfer was voidable at the time it occurred, the decedent retained an interest in the home at the time of her death. Although it may not be possible to turn back time in fact, one can turn back time in a legal sense. Once set aside, it was as if the transfer had never occurred… In defendants’ view, there are literally no circumstances in which a pre-death transfer may be set aside and the asset treated as one in which the decedent had legal title or interest at the time of death. In the absence of more nuanced arguments, we will not speculate as to the exact limits of the legislature’s authority to provide for the set aside of real property transfers under state law—or whether they have been reached with the existing statutes. The only issue before us is whether enforcing the existing statutes—ORS 411.620(2), ORS 411.630(2), and ORS 416.350(2)—is inconsistent with the definition of “estate” in ORS 416.350(6)(a) and 42 USC section 1396p(b)(4)(B). It is not.”

The court also rejected defendants’ argument that the claim was unenforceable because it was preempted by federal law that defines the “estate” that is subject to an estate recovery claim as consisting only of property held by the decedent at the time of death, pursuant to 42 USC section 1396p(b)(4)(B). It also rejected the argument that because federal law at 42 USC section 1396p(c)(2) expressly allows the conveyance of assets to a spouse with no effect on eligibility, it therefore also prohibits states from asserting estate recovery claims against those conveyed assets. “There is no apparent reason that married recipients would be allowed to avoid estate recovery and pass on the family home to nondependent adult children, by passing it through a spouse, when unmarried recipients cannot do so.”

It is worth noting that “Defendants argue that, if the trial court’s judgment is upheld, it will “allow voiding and setting aside of any predeath asset transfers, not just a home, between Oregon spouses, made for any reason, at any time during a marriage, not just five years before a Medicaid application.” (Emphases in original.) That is not so, because, for purposes of recovering properly paid Medicaid benefits, the statutes allow a court to set aside a transfer only in two narrowly prescribed circumstances. One is when a person receiving Medicaid benefits transfers property without adequate consideration. ORS 416.350(2); The other is when a person transfers property with the specific intent to hinder or prevent Medicaid estate recovery. ORS 411.630(2)(b); ORS 411.620(2).”
The court also stated in a footnote that “We are similarly unpersuaded by defendants’ assertion that affirming the judgment means that “any attorney advising a married or unmarried Oregonian to lawfully convey property to a spouse, or any other person, for any reason would violate ORS 411.630(3),” which provides that “[a] person may not knowingly aid or abet any person to violate any provision of this section.” To the extent that is meant as a statutory-context argument, we reiterate that transfers may be set aside only in very limited circumstances and note that ORS 411.630(3) is limited to knowing aiding and abetting.” This may provide only limited assurance to the attorney who counsels a client to make what is otherwise a lawful conveyance of property.

II. STATUTES

A. ORS 416.350(2):

Except as prohibited by ORS 178.380 (Establishment of qualified ABLE program),

medical assistance pursuant to ORS chapter 414 paid to or on behalf of an individual who was 55 years of age or older when the individual received the assistance, or paid to or on behalf of a person of any age who was a permanently institutionalized inpatient in a nursing facility, intermediate care facility for persons with intellectual disabilities or other medical institution,

Estate recovery claims are only an issue for Medicaid services provided after age 55. Any payments made by Medicaid during the time the decedent was receiving long term care services are recoverable, as well as certain prescription drug charges. OAR 461-135-0835(4)(f)(D)

may be recovered from the estate of the individual or from any recipient of property or other assets held by the individual at the time of death including the estate of the surviving spouse.

Claim for such medical assistance correctly paid to or on behalf of the individual

[there is a separate recovery procedure with different rules for Medicaid improperly provided under ORS 416.350(1) and the typical defenses – survival by a disabled child or spouse – do not apply]

may be established against the estate, but the claim may not be adjusted or recovered until after the death of the surviving spouse, if any, and only at a time when the individual has no surviving child who is under 21 years of age or who is blind or permanently and totally disabled.

[Practice tip: always determine whether the Medicaid recipient was survived by a blind or disabled child or any age, or a child under 21, as this will be a total defense against the claim. Claims are deferred until after the death of the surviving spouse]

Transfers of real or personal property by recipients of such aid without adequate consideration are voidable and may be set aside under ORS 411.620(2).

[This part of the statute gives DHS the greatest authority to void a conveyance, as intent is irrelevant. It only applies to transfers made by current Medicaid recipients.]

B. ORS 411.630(2):

A person may not transfer, conceal or dispose of any money or property with the intent:
(a) To enable the person to meet or appear to meet any requirement of eligibility prescribed by state law or by rule of the department or the authority for any type of public assistance or medical assistance; or

(b) Except as to a conveyance by the person to create a tenancy by the entirety, to hinder or prevent the department or the authority from recovering any part of any claim it may have against the person or the estate of the person.

[This is not limited to interspousal transfers, and there is no 5 year lookback provision. However, there must be intent — specific intent under Hobart — to hinder or prevent estate recovery as provided in 411.630(2). This is not limited to current Medicaid recipients.

QUERY: What about (a) of this statute? Does it prohibit, as a matter of eligibility, the transfer of assets, even asset transfers made more than 5 years ago?]

C. ORS 411.620(2):

Except with respect to bona fide purchasers for value, the department, the authority, the conservator for the recipient or the personal representative of the estate of a deceased recipient may prosecute a civil suit or action to set aside the transfer, gift or other disposition of any money or property made in violation of any provisions of ORS 411.630 (Unlawfully obtaining public assistance or medical assistance), 411.708 (Recovery of supplemental income program assistance from certain estates) and 416.350 (Recovery of medical assistance) and the department or the authority may recover out of such money or property, or otherwise, the amount or value of any public assistance or medical assistance obtained as a result of the violation, with interest, together with costs and disbursements incurred in recovering the public assistance or medical assistance.

III. TRANSFERS TO SPOUSE BY MEDICAID RECIPIENT:

Worst case scenario, only need to show lack of adequate consideration. (If transferor is not currently a Medicaid recipient, there must be intent to hinder/prevent recovery).

A. Is Way to Show That There Is Consideration for a Transfer?

ORS 416.350(4): Legal burden of person who receives property to establish extent and value of recipient’s legal title or interest.

OAR 461-140-0242(4): compensation must be tangible form with intrinsic value [like a house]; presumption that services provided for free in past intended to be free; transfer to individual for services provided for free in past is disqualifying. But, rebuttable with express agreement to provide services as time services provided, average market rate at time provided.

Query: Will a spousal caregiving agreement entered into at time spouse begins to provide care, where impaired spouse’s interest in home is consideration, be a defense to a claim under ORS 416.350(2) to set aside the conveyance?

B. Community Spouse Resource Allowance. The community spouse is entitled to a certain resource allowance, and to the extent those resources are owned by the impaired spouse at the time Medicaid is approved, it is required that those assets be conveyed to the community spouse within 90 days of eligibility. OAR 461-160-0580(3). This is a conveyance without consideration. QUERY: Is the CSRA also subject to estate recovery for Medicaid provided to impaired spouse on death of community spouse?
IV. TRANSFERS TO SPOUSE PRIOR TO MEDICAID ELIGIBILITY

These can be set aside under ORS 411.630(2) but only if there is specific intent to hinder/prevent estate recovery. Note: Hobart: “Very limited circumstances”; “there are no doubt express or implied limits on legislature’s authority to set aside”; “specific intent”)

What are other reasons to transfer home and other assets to spouse? i.e. how to establish intent to support spouse?

- Actual sale of home by community spouse post-transfer?
- Sale of transferred home and purchase of new home by community spouse?
- Caregiving Agreement?
- Does timing matter (years before Medicaid vs months?)
- Petition for spousal support ORS 108.110?
- Petition to allow conservator to convey to spouse for support?
- Conveyance to actuarial life expectancy trust for benefit of spouse, with actual distributions of impaired spouse’s half interest in home to spouse over life expectancy? OAR 461-140-0242(2)(b).

V. EXEMPT TRANSFERS TO SOMEONE OTHER THAN SPOUSE—How to distinguish from transfer to spouse, which is also exempt?

Examples:

- Transfer of home to caregiving child under 461-140-0242(3)
- Transfer of any asset to disabled child under 461-140-0242(2)(b)
- Transfer of home to sibling with equity interest under 461-140-0242(3)(b)

A. By Medicaid Recipient:

Policy reasons that approve conveyance – keep donor off Medicaid for two years, support disabled children?

Is the caregiving provided by child adequate consideration? Should there be an agreement to this effect? Tax implications?

B. By Person Prior to Medicaid:

Does intent to reward caregiving child, or support a disabled child demonstrate intent other than to hinder/prevent estate recovery?

VI. NONEXEMPT TRANSFERS TO SOMEONE OTHER THAN SPOUSE—How to rebut intent to hinder/prevent?

Kids spend the gifted money? (but how to pay the claim if unsuccessful?)

Educational trust for grandkids? Pay for grandchildren’s college? Buy a house for child?

Does time make a difference? Prior to 5 years?

Gifts to trust, with specific purpose of supporting donee beneficiary, are recommended.

QUERY: Is there federal preemption of ORS 411.630(2)(a)?
VII. IF PERSON, PRIOR TO MEDICAID, DOES CONVEY TO SPOUSE, HOW TO DO IT?

Not recommended: H&W, as tenants by entirety, convey to W. H goes on Medicaid. W dies first. Even if W has a will that leaves only ½ to H, the transfer to W can be set aside. Result is that on W’s death, H owns 100%. Entire house subject to claim.

Alternative? First step deed to create tenancy in common. Not a “transfer.” Second step to transfer entire interest to W. Now if transfer set aside, on W’s death, she has ½ as tenant in common, and her interest doesn’t automatically pass to H by ROS, provided she has adequate estate planning in place. Limits recovery to half interest in home?

QUERY: Does W still do a will leaving ½ to H, ½ to special needs trust or kids? Should be OK if support argument works. If support argument doesn’t work, do the kids still get half the house?

What about just keep the house owned by H&W, no transfer? At least do a deed to convert to Tenancy in Common. W now can do a will leaving 100% to kids or SNT, don’t worry about elective share.

VIII. WHAT HAPPENS TO ALL THE PEOPLE WHO DID CONVEY HOUSE TO COMMUNITY SPOUSE?

A. Claim Can Only Be Collected from Assets Owned by Recipient at Death.

Hobart stands for proposition that assets transferred prior to death can be pulled back to estate; doesn’t expand collection beyond assets owned at death.

B. Rules Regarding Collection Not in Line with Post-Hobart World. If H transfers home to W prior to death, at his death, is this a claim for an asset H owns at his death (half interest in home) that is deferred until W’s death? It could be, as a Hobart claim is based on setting aside the conveyance, which reverts title back to tenancy by the entirety, meaning H did own a half interest at death. Or is it a claim recoverable from another person, W’s estate? (“person” includes estate under OAR 461-135-0832(28)).

This distinction can matter if the home is conveyed to the spouse, who sells it and spends down a portion of the proceeds. Consider this Hypo:

H & W own house, tenancy by entirety, H conveys to W, H goes on Medicaid. H dies first. After H dies, W sells the home for $600,000. Wife spends the proceeds down to $100,000, and dies. The Medicaid claim is $300,000.

If 461-135-0845 (14) controls, the value of the half interest in the home at the time H conveyed it to W was $300,000. If “the value of the real property, personal property, or other assets received by the person from the recipient of assistance” means the value at the time of the conveyance, the claim is $300,000, less half the liens and encumbrances, divided by 2. That’s roughly $150,000. There is only $100,000 remaining from the sale proceeds. DHS gets all of the $100,000 remaining sales proceeds. This expands estate recovery beyond the remaining half interest in the home proceeds, and would not be the case under 461-135-0845 (13) where the value is assessed at the time of the probate of W’s estate. The only way under the rules to limit the claim to half of the remaining home proceeds is to interpret “the value of the real property, personal property, or other assets received by the person from the recipient of assistance” to refer to value at the time of the claim, which is $100,000, less liens and encumbrances, divided by 2, or $50,000. Is that what the rule says?

461-135-0845(13) Notwithstanding anything to the contrary in this rule, if a claim under OAR 461-135-0835 is deferred until a recipient’s spouse dies; the value of any real
property, personal property or other assets, subject to the deferred claim, is established as follows:

1. For real property, personal property, or other assets in the probate estate of the deceased spouse; the value is the current value at the time of probate; or

2. For real property, personal property, or other assets not in the probate estate of the deceased spouse; the value is determined on the later of the date of the claim or the sale of the real property, personal property, or other assets.

(14) The amount of a claim of the department that is recoverable from a person other than the recipient of assistance is calculated through the following steps:

1. Step One: Determine the value of the real property, personal property, or other assets received by the person from the recipient of assistance.

2. Step Two: Deduct from the value the amount of any liens or encumbrances.

3. Step Three: Multiply the result by the fraction or percentage that constitutes the interest received from the recipient of assistance.

C. When Community Spouse Dies First

Consider this Hypo:

H & W own house, tenancy by entirety, H conveys to W, H goes on Medicaid. W dies first. Her will leaves her estate to H. Shortly thereafter H dies. The home has a value in H’s estate of $600,000. The Medicaid claim is $400,000.

Clearly, DHS gets $400,000 because H owns the entire home at his death.

What if W’s will leaves her estate to children? Same result under Hobart, because now DHS can file suit to set aside the conveyance from tenants by the entirety to W. Title reverts back to tenants by the entirety. Therefore, on W’s death, title is held by H, in spite of the terms of W’s will.

Query: Does it matter if H filed an elective share claim against W’s estate on his death? Would that limit the claim to the remaining elective share funds at H’s death?
Chapter 5

Never Ending Math Equation

JOEL SMITH
Jordan & Williams, LLC
Junction City, Oregon

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The Elective Share

*WHY, WHEN AND HOW TO USE IT...*
Elective Share of the Spouse

What is it?

Why is it?

When to use it?

How to calculate it?

Whom to tell about it?

Best Practices

Life after Hobart

What’s the point?

To protect the surviving spouse against disinheritation by giving him or her a minimum share of the testator’s probate estate.
A little background…

Under the prior law (see former ORS 114.105–114.165), because the elective share was limited to 25% of the decedent's net probate estate, a spouse's elective-share rights could be defeated through the use of nonprobate transfers.

Under the current law (and for all deaths occurring on or after January 1, 2011), the elective share applies to the augmented estate, which generally includes all probate and nonprobate assets of both the deceased spouse and the surviving spouse.

Who’s the Client?

The elective share may be exercised by:

- The disinherited surviving spouse, personally;
- A guardian, conservator, or agent acting under a power of attorney on behalf of the disinherited surviving spouse;
- The personal representative of the disinherited surviving spouse, but only if the election was timely filed prior to the death of the surviving spouse;
- The DHS/OHA Estate Administration Office on behalf of the surviving spouse, in order to effect Estate Recovery.
Watching the Clock…

It must be timely and in the right form (ORS 114.610):
◦ The Election must be made within 9 months of the decedent’s death.
◦ It must be by a form that is proper – a motion or petition filed in the probate proceeding

The Personal Representative’s job:
◦ Make sure the claim was timely made and proper
◦ Make no distributions until all claims are fully understood

Calculating the Elective Share: A Case Study

RIC OCASEK AND PAULINA PORIZKOVA
Ric & Paulina

- They met on the set of the music video for “Drive” in 1984 and married in 1989.
- The couple separated in 2017, though they never legally divorced and continued cohabitating.
- On August 28, 2019, in advance of surgery, Ric rewrote his will to disinherit Paulina and their two sons, saying:
  
  “I have made no provision for my wife Paulina Porizkova (‘Paulina’) as we are in the process of divorcing. Even if I should die before our divorce is final ... Paulina is not entitled to any elective share ... because she has abandoned me.”

- While recuperating from surgery, Ric died September 15, 2019 at the age of 75.
- After finding out she had been disinherited, Paulina elected against the will...

The Asset Picture

At his death, Ric owned or controlled the following assets:

- The residence in Astoria, Queens, Oregon, jointly with Paulina
- A joint bank account with Paulina
- A vacation home in Malibu, California, jointly with Paulina
- A vacation home in Aspen, awarded to him solely in his first divorce (in his own name)
- A 40% copyright interest in the Cars music catalog (bandmates Hawkes, Easton & Robinson each hold 20%)
- A brokerage account with Hawkes and Easton designated as beneficiaries
- An IRA with Universal Music Group, TOD – and disclaimed by - Paulina
- Paulina had her own Money Market Account
Let’s Do the Numbers...

Except as otherwise provided in ORS 114.600 (Elective share generally) to 114.725 (Effect of separation), the amount of the elective share is a dollar amount determined by multiplying the augmented estate by the percentage provided in ORS 114.605:

<table>
<thead>
<tr>
<th>If the decedent and the spouse were married to each other</th>
<th>...the elective share percentage is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than two years</td>
<td>5% of the augmented estate</td>
</tr>
<tr>
<td>2 years but less than 3 years</td>
<td>7% of the augmented estate</td>
</tr>
<tr>
<td>3 years but less than 4 years</td>
<td>9% of the augmented estate</td>
</tr>
<tr>
<td>4 years but less than 5 years</td>
<td>11% of the augmented estate</td>
</tr>
<tr>
<td>5 years but less than 6 years</td>
<td>13% of the augmented estate</td>
</tr>
<tr>
<td>... for every additional year</td>
<td>...add 2%... UNTIL</td>
</tr>
<tr>
<td>15 years or more</td>
<td>33% of the augmented estate</td>
</tr>
</tbody>
</table>

The Augmented What?

The “Augmented Estate” includes:

- The decedent’s probate estate (as described in ORS 114.650)
- The decedent’s non-probate estate (as described in ORS 114.660 and 114.665)
- The surviving spouse’s estate (as described in ORS 114.675)
The Probate Estate (ORS 114.650)

- For purposes of the elective share, a decedent’s probate estate is the value of all estate property that is subject to probate and that is available for distribution after payment of claims and expenses of administration.
- A decedent’s probate estate includes all property that could be administered under a small estate affidavit.
- A decedent’s probate estate does not include any property that constitutes a probate transfer to the decedent’s surviving spouse under ORS 114.685.

The Non-Probate Estate (ORS 114.660 and 114.665)

- The decedent’s fractional interest in property held by the decedent in any form of survivorship tenancy, to the extent the fractional interest passes by right of survivorship at the decedent’s death to a surviving tenant other than the decedent’s surviving spouse. (1)
- The decedent’s ownership interest in property or accounts held immediately before death under a payable on death designation or deed, under a transfer on death registration, or in co-ownership registration with a right of survivorship, to the extent the decedent’s ownership interest passed at the decedent’s death to any person other than the decedent’s estate or surviving spouse (or for the benefit thereof). (2)
- Property owned by the decedent for which the decedent had the power to designate a beneficiary, but only to the extent that the decedent could have designated the decedent, or the spouse of the decedent, as the beneficiary. (3)
- Property that the decedent could have acquired by the exercise of a revocation, without regard to whether the revocation was required to be made by the decedent alone or in conjunction with other persons. (4)
The Non-Probate Estate  
(ORS 114.660 and 114.665)

- A decedent’s nonprobate estate does not include the present value of any life insurance policy payable on the death of the decedent to anyone but the surviving spouse. (5)
- The nonprobate estate consists of the property described in ORS 114.665 that is not included in the decedent’s probate estate and that does not constitute a transfer to the decedent’s surviving spouse.
- The value of the decedent’s nonprobate estate is reduced by all debts and liabilities of the decedent that are not paid in probate, and by all costs of administering the decedent’s nonprobate estate (including settling claims and distributing property).

The Surviving Spouse’s Estate  
~ ORS 114.675

- The decedent’s probate transfers to the spouse (ORS 114.685)
- The decedent’s nonprobate transfers to the spouse (ORS 114.690)
- All other property of the spouse, as determined on the date of the decedent’s death.
- Any property that would have been included under paragraph (a), (b) or (c) of this subsection except for the exercise of a disclaimer by the spouse after the death of the decedent.
- Trust property - ORS 114.675(2)
### Let’s Table That…

<table>
<thead>
<tr>
<th>RIC</th>
<th>PAULINA</th>
<th>JOINT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacation Home in Aspen (to charity) ($6 Million) 114.650</td>
<td>Personal Money Market Account ($1 Million) 114.675(1)(c)</td>
<td>“Astoria” Residence ($10 Million) 114.675 via 114.690 (1)(a)</td>
</tr>
<tr>
<td>Interest in The Cars $5M music catalog ($2 Million) 114.665(1)</td>
<td>Disclaimed IRA ($3 Million) 114.675(1)(d)</td>
<td>Joint bank account ($50,000) 114.665(1) 114.690 (1)(b)</td>
</tr>
<tr>
<td>Brokerage Account ($500,000) 114.665(2)</td>
<td></td>
<td>Vacation Home in Malibu ($4 Million) 114.635</td>
</tr>
</tbody>
</table>

### Looked at another way…

<table>
<thead>
<tr>
<th>Asset</th>
<th>Value</th>
<th>Estate</th>
<th>Statute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence</td>
<td>$10,000,000</td>
<td>Spouse’s</td>
<td>114.675 via 114.690</td>
</tr>
<tr>
<td>Joint Bank Account</td>
<td>$50,000</td>
<td>Spouse’s</td>
<td>114.690(2)</td>
</tr>
<tr>
<td>Paulina’s MM Account</td>
<td>$1,000,000</td>
<td>Spouse’s</td>
<td>114.675(1)(c)</td>
</tr>
<tr>
<td>Vacation Home, Aspen</td>
<td>$6,000,000</td>
<td>Probate</td>
<td>114.650</td>
</tr>
<tr>
<td>Copyright Interests</td>
<td>$2,000,000</td>
<td>Nonprobate</td>
<td>114.665(1)</td>
</tr>
<tr>
<td>Brokerage Account</td>
<td>$500,000</td>
<td>Nonprobate</td>
<td>114.665(2)</td>
</tr>
<tr>
<td>Ira</td>
<td>$3,000,000</td>
<td>Spouse’s</td>
<td>114.675(1)(d)</td>
</tr>
<tr>
<td>Vacation Home, Malibu</td>
<td>($4,000,000)</td>
<td>Not Augmented Estate</td>
<td>114.635</td>
</tr>
<tr>
<td><strong>Total (not incl. Malibu)</strong></td>
<td><strong>$22,550,000</strong></td>
<td><strong>Election Multiplier (0.15)</strong></td>
<td><strong>$7,441,500</strong></td>
</tr>
</tbody>
</table>
Where does it come from?

- The surviving spouse’s estate shall be applied first to satisfy the dollar amount of the elective share and to reduce or eliminate any contributions due from the decedent’s probate estate and recipients of the decedent’s nonprobate transfers to others.

- If after application of the surviving spouse’s estate under subsection (1) of this section the elective share amount is not fully satisfied, the following amounts shall be applied to the extent necessary to satisfy the balance of the elective share amount:
  - (a) Amounts included in the decedent’s probate estate.
  - (b) Amounts included in the decedent’s nonprobate estate.

Where does it come from?

- Amounts applied against the unsatisfied balance of an elective share amount shall be collected from both the probate and nonprobate estates of the decedent in a manner that ensures that the probate and nonprobate estates bear proportionate liability for the amounts necessary to pay the elective share amount.

- Amounts applied against the unsatisfied balance of an elective share amount must be apportioned among all recipients of the decedent’s probate estate in a manner that ensures that each recipient bears liability for a portion of the payment that is proportionate to the recipient’s interest in the decedent’s probate estate.
Notice
Requirements

WHO’S IN THE WILL? WHO ELSE?

Tell me about it…

- The Personal Representative of the Estate
- Heirs, devisees, interested persons, DHS/OHA
- Distributees and recipients of the augmented estate
Avoiding the Traps
COUNSELLING THE CLIENT ON BOTH SIDES OF THE GRAVE

Who is the Client, again?
Counselling and best practices may vary depending on whom you represent:

- The attorney representing the decedent’s estate
- The attorney representing the disinherited spouse
- The attorney representing the guardian, conservator, agent or estate of the disinherited spouse
- The estate planner counselling the couple who swear they would never do this to each other
The Attorney for the Estate of…

If you are the attorney representing the estate:

- Did the decedent have a spouse who is NOT your client?
  - If so, you should at least be prepared for the possibility that the surviving spouse will elect against the will.

- When you receive the notice of the motion or petition being filed, review the election for:
  - Is it Timely: any election not made within 9 months of the date of death is waived
  - Is it Proper: did it come through the proper channel?
  - Possible defense: were they together or separated at the end? (ORS 114.725) Is there a valid pre- or post-nuptial agreement in which the surviving spouse may have waived such rights?

- Keep your other liabilities in mind
  - The Personal Representative is personally responsible for errors, so resist making distributions until you fully understand all claims

Repping the Survivor…

If you are representing the surviving spouse, your job is largely to make sure the motion or petition you are using to exercise the election is filed timely, in the appropriate case and court, using the procedure spelled out in ORS 144.720.

Prior to doing so, however, make sure that your client has not waived their right of election:

- The right of election may be waived, wholly or partially, before or after marriage by a written contract, agreement or waiver signed by the surviving spouse. ORS 114.620(1)

- Unless specifically provided otherwise, a written agreement that waives all rights in the property or estate of a present or prospective spouse, using the phrase “all rights” or other equivalent language, or a complete property settlement entered into after, or in anticipation of, separation or divorce, is a waiver of all rights to an elective share. ORS 114.620(2)
“I would never do that…”

If you hear this in the initial consultation or design phase of an estate plan, you have an obligation to your client to explain that, whilst THEY might never dream of doing that to the other, THEY may not always be the ones in control. As implied by the previous slide, sometimes such decisions are put in the hands of others – well meaning loved ones who may not share our convictions (or our love for our spouse).

As always, if that is how the client really feels, perhaps they should put it in writing...

But, before you do, keep in mind that a valid post-nuptial agreement that waives a legitimate and potentially valuable property interest may be viewed by certain state agencies (ahem...Medicaid) as voluntarily surrendering a property interest (or “available resource”).

Before you sign that waiver...

Even in a non-Medicaid estate planning case, a couple considering a waiver of spousal rights should absolutely have separate counsel preparing their documents. This is an ethical requirement per the Oregon Rules of Professional Conduct (ORPC 1.7). An uncounseled waiver would certainly be disregarded by the probate court.
Life After *Hobart*…

If I could turn back time…

Any transfer of an interest in property

• with intent to hinder or prevent estate recovery;
• without adequate consideration

...may be set aside.

What does this mean for the as yet pre-institutionalized spouse who “waives” their right to elect against the estate plan with a valid post-nuptial agreement?

What about a disinherited Medicaid-recipient spouse?
Questions, Comments, or Experience
Surviving Spouse’s Rights to Share in Deceased Spouse’s Estate

California

https://www.actec.org/assets/1/6/Surviving_Spouse%e2%80%99s_Rights_to_Share_in_Deceased_Spouse%e2%80%99s_Estate.pdf?hssc=1#page=6

Idaho

https://www.actec.org/assets/1/6/Surviving_Spouse%e2%80%99s_Rights_to_Share_in_Deceased_Spouse%e2%80%99s_Estate.pdf?hssc=1#page=16

Oregon

https://www.actec.org/assets/1/6/Surviving_Spouse%e2%80%99s_Rights_to_Share_in_Deceased_Spouse%e2%80%99s_Estate.pdf?hssc=1#page=53

Washington

https://www.actec.org/assets/1/6/Surviving_Spouse%e2%80%99s_Rights_to_Share_in_Deceased_Spouse%e2%80%99s_Estate.pdf?hssc=1#page=68
2022 Updates in Oregon Administrative Rules

- Aging and People with disabilities receiving In Home Care Services will be able to keep their entire income effective 1/1/2022

Prior to the updated fee schedule, effective January 1, 2022, Aging and People with Disabilities (APD) had to contribute a portion of their income in order to receive Medicaid services ($1,341 as updated rate schedule 12/2021). With this new change, APD will be able to keep their entire income.

Regulation: 461-160-0610
Notice APD-PT-21-041 updated APD-PT-22-001

- PACE - state has eliminated the pay-in fee for PACE participants effective 1/1/2022

Previously, PACE participants were required to pay in $1,159 per month. PACE is now free for people who qualify for Medicaid. The average cost for a person with Medicare but who is not eligible for Medicaid is $4,350 a month, plus $850 a month for the PACE Medicare Part D premium ($5,200/month —$62,000/year).

*The Program of All-Inclusive Care for the Elderly (PACE) is a that allows older adults stay in their homes for as long as possible instead of moving into nursing homes. PACE offers comprehensive care and in-home support for people who qualify for Medicare and Medicaid without charging monthly premiums or out-of-pocket costs, but who want to remain at their homes. PACE provides a wide range of services.

Regulation: 411-045-0050
Notice: APD-PT-22-001 Updated Effective 01/13/22

- Change to the equity limits for the primary residence $636,000.00

Effective January 1, 2022, the Home Equity Exclusion Limit is $636,000.00. Previously, the Home Equity Exclusion Limit was $603,000.

Regulation 461-145-0220
Notice APD-PT-21-041
• Rate Schedule changes effective July 1, 2022.

The Oregon Legislature approved a 5% rate increase for six months beginning January 1, 2021, for some services operated by ODDS. Through American Rescue Plan Act funds, ODDS is extending this increase to support front line, direct support professionals who have worked to care for people with intellectual/developmental disabilities throughout the pandemic. Due to the length of the PHE period the ODDS intends to temporarily extend this increase to September 30, 2022.

The increase applies to ODDS services and settings such as:

• Adult Group Homes,
• Behavioral Support Services,
• Group Care Homes for Children,
• Children’s Developmental Disability Foster Care, and
• Day Support Activities.

The increase will be effective through September 30, 2022, or until the COVID-19 Public Health Emergency (PHE) ends, whichever is first.

Caregivers received a starting wage of $15 per hour for all caregivers during 2021, with an increase to $15.50 per hour effective July 1, 2022.

Providers who meet the criteria shall receive an add-on of 10% of the Medicaid rate, as authorized in OAR 411-027-0170, during the effective dates of the Program. A HCBS provider may be eligible to apply between October 1, 2021 and June 30, 2023.

Regulation: OAR 411-027-0160 and OAR 411-070-0438.
Notice
http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf
## Updated 10/1/2022

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min. Monthly Maintenance Needs Allowance</td>
<td>$2,288.75</td>
<td>07/01/2022</td>
</tr>
<tr>
<td>OAR 461-160-0620(3)(d)(A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max. Monthly Maintenance Needs Allowance</td>
<td>$3,435.00</td>
<td>01/01/2022</td>
</tr>
<tr>
<td>OAR 461-160-0620(3)(d)(A)</td>
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</tr>
<tr>
<td>Min. Community Spouse Resource Allowance</td>
<td>$27,480.00</td>
<td>01/01/2022</td>
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<tr>
<td>OAR 461-160-0580(2)(c)(B)</td>
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<tr>
<td>Max. Community Spouse Resource Allowance</td>
<td>$137,400.00</td>
<td>01/01/2022</td>
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<td>OAR 461-160-0580(2)(c)(A)</td>
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<tr>
<td>Monthly Personal Needs Allowance (Nursing)</td>
<td>$68.77</td>
<td>01/01/2022</td>
</tr>
<tr>
<td>OAR 461-160-0620(3)(c)(A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly Personal Needs Allowance (Other)</td>
<td>$187.00</td>
<td>01/01/2022</td>
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<tr>
<td>Resource Allowance for an Individual</td>
<td>$2,000.00</td>
<td>01/01/2015</td>
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<tr>
<td>OAR 461-160-0015</td>
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<tr>
<td>Room &amp; Board</td>
<td>$654.00</td>
<td>01/01/2022</td>
</tr>
<tr>
<td>OAR 461-155-0270</td>
<td></td>
<td></td>
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<tr>
<td>Room &amp; Board – In-home Care</td>
<td>$1,341.00</td>
<td>01/01/2022</td>
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<tr>
<td>OAR 461-155-0270</td>
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<td></td>
</tr>
<tr>
<td>Shelter Standard</td>
<td>$686.53</td>
<td>07/01/2022</td>
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<tr>
<td>OAR 461-160-0620(3)(d)(A)</td>
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<td></td>
</tr>
<tr>
<td>Heating &amp; Utility Allowance</td>
<td>$452.00</td>
<td>10/01/2022</td>
</tr>
<tr>
<td>OAR 461-160-0420(2)(d)(A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divestment Penalty Divisor</td>
<td>$9,551.00</td>
<td>10/01/2020</td>
</tr>
<tr>
<td>OAR 461-140-0296</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Cap for Applicant</td>
<td>$2,523.00</td>
<td>01/01/2022</td>
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<tr>
<td>Home Equity Limit</td>
<td>$636,000.00</td>
<td>01/01/2022</td>
</tr>
<tr>
<td>SSI Income</td>
<td>$863.00</td>
<td>01/01/2022</td>
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</tbody>
</table>
VA War Dates:

<table>
<thead>
<tr>
<th>War</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>World War I</td>
<td>April 6, 1917 – November 11, 1918</td>
</tr>
<tr>
<td>World War II</td>
<td>December 7, 1941 – December 31, 1946</td>
</tr>
<tr>
<td>Vietnam War</td>
<td>August 5, 1964 – May 7, 1975</td>
</tr>
<tr>
<td>Gulf War</td>
<td>August 2, 1990 – TBD by Presidential Proclamation</td>
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VA Benefits:

<table>
<thead>
<tr>
<th></th>
<th>2022</th>
<th>2021</th>
<th>2020</th>
<th>2019</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>$2,050</td>
<td>$1,936</td>
<td>$1,911</td>
<td>$1,881</td>
<td>$1,829</td>
<td>$1,794</td>
</tr>
<tr>
<td>Veteran &amp; Spouse</td>
<td>$2,431</td>
<td>$2,295</td>
<td>$2,266</td>
<td>$2,230</td>
<td>$2,169</td>
<td>$2,127</td>
</tr>
<tr>
<td>Surviving Spouse of Veteran</td>
<td>$1,318</td>
<td>$1,244</td>
<td>$1,228</td>
<td>$1,209</td>
<td>$1,176</td>
<td>$1,153</td>
</tr>
<tr>
<td>Healthy Veteran with Ill Spouse</td>
<td>$1,610</td>
<td>$1,520</td>
<td>$1,500</td>
<td>$1,477</td>
<td>$1,436</td>
<td>$1,408</td>
</tr>
</tbody>
</table>

VA Benefit Requirements:

1. Active duty for 90 days, with at least one day in war time
2. Disability (or 65+)
3. Care Needs (ADLs)
4. Limited Income
5. Limited Assets
RATE SCHEDULE - Effective July 1, 2022
Rates apply to Medicaid Services funded by Aging and People with Disabilities.

<table>
<thead>
<tr>
<th>Room &amp; Board</th>
<th>In-Home Allowance</th>
<th>Personal Incidental Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>$654.00</td>
<td>As of January 1, 2022, APD will be able to keep their entire income.</td>
</tr>
<tr>
<td>AD/OAA</td>
<td>$654.00</td>
<td>NF $68.77</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CBC $187</td>
</tr>
</tbody>
</table>

**Community-Based Care (CBC) Monthly Rates**

<table>
<thead>
<tr>
<th></th>
<th>Residential Care Facilities</th>
<th>Adult Foster Homes</th>
<th>Assisted Living Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>$2,071</td>
<td>$1,932</td>
<td>Level 1</td>
</tr>
<tr>
<td>Base plus 1 add-on</td>
<td>$2,473</td>
<td>$2,283</td>
<td>Level 2</td>
</tr>
<tr>
<td>Base plus 2 add-ons</td>
<td>$2,875</td>
<td>$2,634</td>
<td>Level 3</td>
</tr>
<tr>
<td>Base plus 3 add-ons</td>
<td>$3,277</td>
<td>$2,985</td>
<td>Level 4</td>
</tr>
<tr>
<td>Hourly Exception Rate</td>
<td>$17.46 / Hr.</td>
<td>$17.77 / Hr.</td>
<td>Level 5</td>
</tr>
<tr>
<td>Standard Ventilator</td>
<td></td>
<td>$11,131</td>
<td></td>
</tr>
</tbody>
</table>

**Memory Care (Endorsed Units Only)**

<table>
<thead>
<tr>
<th>Nursing Facility</th>
<th>Daily Rate</th>
<th>Monthly Comparable</th>
<th>AFH Specific Needs Contract Types</th>
<th>Homecare Workers (HCW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>$440.82</td>
<td>$12,791.42</td>
<td>Advanced $8,903</td>
<td>HCW Hourly $16.67</td>
</tr>
<tr>
<td>Bariatric</td>
<td>$815.52</td>
<td>$24,188.67</td>
<td>Adv. Vent. $22,521</td>
<td>Enhanced $17.67</td>
</tr>
<tr>
<td>Complex</td>
<td>$617.15</td>
<td>$18,154.85</td>
<td>Bariatric $8,903</td>
<td>Professional Development $17.17</td>
</tr>
<tr>
<td>Enhanced</td>
<td>$617.15</td>
<td>$18,154.85</td>
<td>Basic $7,790</td>
<td>Enhanced with PDC $18.17</td>
</tr>
<tr>
<td>Pediatric</td>
<td>$1,123.19</td>
<td>$33,547.07</td>
<td>Complex $11,434</td>
<td>Mileage – Non-Medical $.56/Mile</td>
</tr>
<tr>
<td>Ventilator</td>
<td>$1,035.93</td>
<td>$30,892.88</td>
<td>Dementia $6,198</td>
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<tr>
<td></td>
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<td></td>
<td>ECOS $3,490</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospice $9,535</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TBI $8,201</td>
<td></td>
</tr>
</tbody>
</table>

**Other Services**

| Home Delivered Meals: | $12.25 / meal |
| Long Term Care Community Nursing Services: | $20.00 / 15-minute unit of service |
| In-Home Agencies: | $32.92/Hr. |
| Service Assessment: | $98.76 |
| Mileage, Non-Medical: | $.56/Mile |
| HK Shelter: | $59.09/Mo. $1.94/Day |
| Adult Day Services: | Refer to ADS Rate Table |

**ICP Monthly Benefit Calculation**

Multiply Total Assessed Hours by:
- HCW Rate $16.67 ($19.67 if VDQ) +
- FICA = 7.65% +
- FUTA = .6% +
- SUTA = 1.97% +
- WBF = $.011/Hr.

Add:
- Assessed Mileage x $.56/Mile

= Total Service Payment

Contact List for Specific Needs Contracts

Advanced Elder Law 2022—“Thinking Out Loud” (Ed Sheeran) 6–5
The Oregon Legislature approved the Enhanced Wage Add-on Program to support Home and Community-Based Services (Assisted Living, Residential Care, Memory Care—endorsed units only and In-Home Care Agencies) providers and nursing facilities. The purpose of the program is to support providers with retention of caregivers and CNAs by providing a Medicaid Enhanced rate to providers who pay wages at a specific threshold. Providers may be eligible for these increases between October 1, 2021, and June 30, 2023. The goal of the program is to maintain a stable work force and maintain quality services by paying higher wages to caregivers and CNAs. Please refer to OAR 411-027-0160 and OAR 411-070-0438.

Rates apply to Medicaid Services funded by Aging and People with Disabilities

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<td>$2,279</td>
</tr>
<tr>
<td>Base plus 1 add-on</td>
<td>$2,722</td>
</tr>
<tr>
<td>Base plus 2 add-ons</td>
<td>$3,165</td>
</tr>
<tr>
<td>Base plus 3 add-ons</td>
<td>$3,608</td>
</tr>
<tr>
<td>Hourly Exception Rate</td>
<td>$19.21 / Hr.</td>
</tr>
<tr>
<td>Level 1</td>
<td>$1,830</td>
</tr>
<tr>
<td>Level 2</td>
<td>$2,268</td>
</tr>
<tr>
<td>Level 3</td>
<td>$2,846</td>
</tr>
<tr>
<td>Level 4</td>
<td>$3,574</td>
</tr>
<tr>
<td>Level 5</td>
<td>$4,298</td>
</tr>
</tbody>
</table>

**Memory Care (Endorsed Units Only)**

<table>
<thead>
<tr>
<th>Nursing Facility</th>
<th>Daily Rate</th>
<th>Monthly Comparable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>$458.45</td>
<td>$13,327.67</td>
</tr>
<tr>
<td>Bariatric</td>
<td>$848.14</td>
<td>$25,180.87</td>
</tr>
<tr>
<td>Complex</td>
<td>$641.84</td>
<td>$18,905.85</td>
</tr>
<tr>
<td>Enhanced</td>
<td>$641.84</td>
<td>$18,905.85</td>
</tr>
<tr>
<td>Pediatric</td>
<td>$1,168.11</td>
<td>$34,913.40</td>
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<tr>
<td>Ventilator</td>
<td>$1,077.37</td>
<td>$32,153.36</td>
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**In-Home Care Agencies (IHCA)**

| IHCA Hourly       | $36.24    |
| Service Assessment| $108.72   |
Chapter 7

Medicaid Eligibility for Unmarried Partners

MONICA PACHECO
Douglas Conroyd Gibb & Pacheco PC
Salem, Oregon

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A. MEDICAID ELIGIBILITY

1. Resource Test For a Single Person
   a. The State counts all of the person's available resources. This does not include exempt resources. The home is exempt only if the person resides in the home. It would be unavailable if a co-owner refuses to sell the home.
   b. The balance after subtracting the exempt assets must be spent down to $2,000 before that person is eligible for Medicaid.

2. The Medicaid rules are geared to protect spouses from impoverishment. We saw, earlier, that spouse is a defined term in OAR 461-110-000, under Definitions, as two legally married persons. Therefore, unmarried partners are both treated as single individuals.

B. NOW WHAT?

1. So is the answer – get married?
   a. Maybe
   b. Maybe Not

2. The elder law attorney must delve into an evaluation and assessment of potential care needs, assets, ownership, and the partners wishes and reasons for wanting to remain single or enter into marriage. Each unmarried couple will bring their own story and varied assets and title. Each will need to be evaluated to determine the unmarried couple’s best next steps.

3. Hypothetical #1
   a. Two unmarried partners, they call themselves friends, understand that they have been for ever and ever. They come to the office to figure out what they may need to know for their future care needs. The older friend, Thelma, has an early diagnosis – the beginning of dementia. The younger friend, Louise, does not. They own their home together as joint tenants with the right of survivorship, forever and ever, but they maintain separate bank accounts and have listed one another as beneficiaries on life insurances. They are each other’s agents for all things. They carry on together, saying that every moment they are the reasons to carry on. Thelma has substantially higher Social Security benefits than Louise. In fact, Louise could not survive in the home without Thelma’s income. Thelma believes she will need long term care in the future and wants to make sure that Louise is going to be okay and be able to take care of herself and remain in their home.
b. In beginning the analysis, it is important to remain mindful of their wishes and goals. We know that because they are not married that they will be treated as individuals for Medicaid application purposes.

i. As an individual, Thelma’s income will be consumed by paying for her care and will not be available to Louise and the household.

ii. Thelma will need to spend her bank accounts, countable resources, down to $2,000 before she will qualify for benefits.

iii. The house – Louise will probably be able to remain in the home because she is a co-owner, who may refuse to sell. See OAR 461140-0020(2)(b). There will, however, be an EAU claim to manage after Thelma’s death.

c. Pay Privately – Thelma could use her income and assets to pay for her care privately until she reaches the $2,000 threshold. Louise can probably keep the house until she can no longer live independently. If she is not able to maintain the home, and decides to sell it, the EAU may very well have a claim on half of the house. It is possible that the State could consider a hardship waiver for the home, but would probably only defer their claim until the second death or sale of the home.

d. Receive in-home care – As we learned earlier, if Thelma receives care at home, she can keep additional monies in the household. This would benefit Louise. Thelma could keep the $800 plus $500 in the home, with any remaining income to be paid toward care. Of course this will require that Louise either employ an in-home care company or become an employer. If Thelma’s care was not able to be managed in the home, they would be back to square one.

e. Gifting – should Thelma gift a portion or all of the assets to Louise? This is tricky. With the 5 year look back period, one would have to be relatively certain that there are enough assets to withstand a 60 month penalty, or be able to manage a two application approach. Furthermore, any gifting would carry over the basis in the home to Louise. After Thelma’s death,

f. Marriage – should there be a wedding? Getting married would provide for Thelma’s long term care costs, but would further protect Louise with up to $137,400 as her CSRA, potentially an annuitized annuity, and a minimum of almost $2,800 per month in monthly income. Much more than her current $700 per month. Louise would receive the increased income for the remainder of her life, and would enjoy the benefits of the home, as well.
g. Other things to consider:

i. VA Aid & Attendance – if the partner needing care is a veteran and meets the eligibility requirements for VA, it may provide enough additional income to pay for in-home care.

ii. Long term care insurance – is there long term care insurance that would cover the cost of care either in the home or in a community setting without having to apply for Medicaid benefits?

iii. In-home care contract – does it make sense for the non-ill unmarried partner to become the in-home caregiver, to be paid privately with the assets of the ill partner, and potentially including a deed of trust against the home, up to the amount of asset owned by the ill partner, or to be paid by Medicaid for the care for the ill partner? Is the partner capable of providing care?

h. In this hypothetical, Thelma and Louise got married. They did not go over the cliff together and Thelma needed long term care within a year of the marriage. Thelma passed away within a year of that. Louise is still alive, living in the family home, with sufficient income from the increased Social Security and annuity payments, and has the house and about $160,000 saved in the bank for her future needs.

4. Hypothetical #2

a. Ray and Jenny are married. They have been married for about 6 months.

b. Ray has a history of mental illness and he has now suffered a stroke. His long term care monthly expense is in excess of $24,000 per month. Ray receives SSDI and has no assets of his own.

c. Jenny is a professional who takes home $9,000 per month in income. She owns her business building outright, valued at about $600,000. She owns the home with a $500,000 mortgage on it, with monthly payments of about $3,500 per month. Jenny has a retirement account with $600,000, and personal accounts with about $300,000. Jenny is 48 years old.

d. Jenny wanted to be able to get health insurance coverage for Ray when his mental illness worsened and after his stroke. She did not seek legal advice prior to marrying. She married Ray so that she could get him on her insurance policy through her business.

e. Marriage is not always the answer. Had Jenny sought legal advice, she would have learned that once married, her separate assets would be considered available assets of the married couple. Had they remained
single, Ray would have qualified for Medicaid for his long term care needs, resulting from the stroke. He would have also started to receive Medicare within a few months because he had qualified for SSDI 22 months prior to marriage.

f. In this hypothetical, Jenny had the ability to increase her monthly income to pay for care privately while she –

i. found the right buyer to purchase her business building and allow her to rent the building back for her practice;

ii. she used the proceeds from the sale of the business building to pay off the mortgage on her home. Since Ray never owned the home, there was not a claim from EAU on the house.

iii. Jenny was able to keep her retirement fund intact because she was under the age of retirement, and the State did not make her liquidate under its rules.

iv. Jenny purchased a Medicaid-compliant annuity with the extra cash from the sale of her business building and personal accounts that exceeded the CSRA.

v. After about 8 months of work to restructure her assets, Ray qualified for Medicaid. He died three years later.

vi. Jenny found her soulmate, sold the house and her business, retired early, purchased a small property and is spending the rest of her days with the one she calls friend.