



Elder Law Newsletter

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An introduction to long term care and Medicaid in Oregon

By Penny Davis, Attorney at Law, Portland; Chair, Newsletter Advisory Board

The phrase “long term care” is used to describe the help provided to people who are not able to live independently due to chronic medical problems or severe disabilities. The need for long term care increases with age. More than half of the people age 85 or older report difficulty performing basic activities of daily living (ADLs), such as preparing meals, shopping, doing housework, bathing, dressing, eating, getting around the house, managing money, and taking medication. Nationally, 4.5 percent of people age 65 and older live in nursing homes. For people age 85 and older, the figure is 18.2 percent.

Choices for long term care

Most long term care is provided informally

by family members and friends and through community programs, such as Meals on Wheels. In-home services can range from respite care to visits by home health nurses to housekeeping to round-the-clock care, and the costs vary according to the time spent and the type of services. In 2003, the average hourly charge for a home health aide in Oregon was about \$18.00. For more information about in-home care and the responsibilities of people who employ in-home caregivers, see the Winter 2003 issue of the Elder Law Section newsletter, which can be downloaded from the Section’s Web page at www.osbar.org.

While people tend to think of nursing homes when long term care is needed, Oregon has been a leader in developing alternatives to nursing home care. Adult foster homes care for five or fewer residents in a home-like environment. Residential care facilities (RCFs) offer room, board, care, and services for six or more residents, with 24-hour coverage. Assisted living facilities (ALFs) have six or more private apartments and provide several levels of service with 24-hour coverage. A survey done in 2003 found that ALFs charged between \$1,800 and \$2,800 per month.

Nursing facilities – sometimes called nursing homes, convalescent centers, or rehabilitation centers – provide regular nursing services as well as personal care and assistance with ADLs. In 2003, nursing home costs varied from \$3,100 to more than \$10,000 per month, with the higher amounts being charged for private rooms and for the more intensive “skilled nursing facility” or “SNF”

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Introduction to long term care and Medicaid

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care typically needed by people recently discharged from hospitals.

Adult foster homes, residential care facilities, assisted living facilities, and nursing facilities are licensed by the state Department of Human Services Seniors and People with Disabilities (SPD) office. In some counties, the county licenses adult foster homes. Information on choosing a facility is available on the SPD Web site: www.dhs.state.or.us/seniors.

Medicaid

People who do not have the income or resources to pay for expensive long term care turn to Medicaid, which is a complex federal-state program with ties to other government public assistance programs, such as Supplemental Security Income (SSI). The primary federal statute is 42 USC §1396, and the regulations appear at 42 CFR 430.0 *et seq.* It is important for lawyers who practice elder law to remain current, because the eligibility requirements and the services covered by Medicaid change from time to time and vary from state to state. Some of the figures discussed below are updated periodically on a chart which appears in the Elder Law Section newsletter and on the Section's Web page.

About half of the people in Oregon care facilities rely on Medicaid assistance to help pay for their care. People who receive SSI benefits are automatically entitled to Medicaid when they apply. Other people who are elderly (age 65 or older) or who have disabilities must meet strict financial eligibility standards. Applications are available from the local Area Agency on Aging office or SPD office. The location for local offices can be found on the SPD Web site.

The Oregon Medicaid program covers the full range of long term care services. Many (but not all) care facilities have contracts with the state and accept Medicaid reimbursement. Medicaid also pays for the Medicare Part B premium, prescription drugs, doctor visits, hospital stays, medical transportation, durable medical equipment, medical supplies, eyeglasses, dental care, hearing aids, and mental health services. The state statutes are ORS 414.018 *et seq.*, the financial eligibility rules are found in OAR chapter 461, the rules on coverage begin in OAR chapter 410, division 120, and the care facility requirements and service priority levels for long term care appear in OAR chapter 411. The acronym

used for Medicaid for the elderly and people with disabilities in some of the rules is "OSIPM," which stands for "Oregon Supplemental Income Program Medical."

Medicaid income limit

An individual will not be eligible for Medicaid assistance for long term care services if his or her income (gross income before any deductions for the Medicare Part B premium, taxes, union dues, etc.) is more than \$1,737 per month (in 2005). That amount changes in January of each year, and is 300 percent of the SSI federal benefit rate. OAR 461-155-0250(1). Because the average cost of nursing home care is more than \$4,700 per month, the income limit poses significant problems. Many people have income above \$1,737 per month, but not enough to cover the cost of long term care. The most common solution is to create a Medicaid income cap trust to receive and administer the income. The materials from the 2003 OSB CLE program *Elder Law Essentials* include a sample form for an income cap trust.

Post-eligibility treatment of income

Once an individual begins to receive Medicaid assistance, most of his or her income must be used to pay for care. OAR 461-160-0620. Medicaid recipients are allowed to keep a small personal needs allowance to cover clothing, stamps, snacks, cigarettes, transportation, and other personal items. The amount ranges from \$30 per month for most nursing home residents, to \$122 per month (in 2005) for a resident of a community-based care facility, to \$580.70 per month (in 2005) for someone who gets in-home services and has expenses for groceries, mortgage or rent, property taxes, and utilities. If the individual lives in a community-based care facility, he or she will pay \$458.70 per month (in 2005) for room and board charges. OAR 461-155-0270.

Medicaid resource limit for individuals

An individual who receives Medicaid can have assets of no more than \$2,000. OAR 461-160-0015(8). Certain assets, including the person's home, household goods, one car or truck, and a funeral or burial plan (within set limits) are generally exempt and are not counted in determining eligibility. Most assets – including bank accounts, stocks, bonds, IRAs, other vehicles, and real property – are counted and must be depleted before the person will qualify for Medicaid assistance. The rules for specific assets are in OAR chapter 461, section 145.

Resource limits for married couples

When a married person applies for Medicaid assistance, property and resources that belong to either spouse and to both spouses are counted. OAR 461-160-0580. The non-exempt resources are valued at the beginning of the ill spouse's continuous period of care. The resource limit for the ill spouse (who is referred to as the "institutionalized spouse" in the rules) is \$2,000, the same as for a single individual. However, the spouse who does not need care (also called the community spouse) can keep the largest of the following amounts of non-exempt resources (in 2005):

- \$19,020
- Or half of the non-exempt assets, up to a maximum of \$95,100
- Or the amount set by court order or administrative hearing.

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Medicare provides some benefits for post-hospitalization care

By Peggy Toole

Medicare provides limited benefits for skilled nursing facilities, hospice, and home health services. This article focuses on Medicare payment for skilled nursing facilities (SNF). For information regarding hospice and home health coverage, check the Medicare site, www.medicare.gov, and the Center for Medicare Advocacy, www.medicareadvocacy.org.

The following is a common scenario. Your client, 69-year-old Ann, was hospitalized January 8, 2005, after fracturing her hip. While in the hospital, she suffered a stroke, which resulted in weakness on one side and difficulty swallowing. On January 17, Ann was transferred to an SNF for three weeks of nursing care and physical therapy. She contacted you with questions about the SNF bill.

It is important first to identify your client's health care coverage. Do not assume an older client is enrolled in Medicare. As more people continue to work past the age of 65, their primary health coverage may be through an employer health plan or a spouse's employer health plan. Medicare may be secondary coverage. If an employer group health plan does not cover some services that Medicare covers, Medicare coverage is primary for those services. However, if an employer group health plan covers the service and Medicare also covers the service, the employer plan is primary.

Clients may confuse Medicare and Medicaid. Medicare provides limited health insurance benefits to individuals 65 or older who receive Social Security retirement benefits, individuals permanently disabled for the previous 24 months or longer, and those with end-stage renal disease. Unlike Medicaid, income and assets are not a consideration when enrolling for Medicare.

Medicare Part A covers a portion of hospital costs, related post-hospital care, some home health services, and hospice. The Part A deductible in 2005 is \$912. Most individuals are not required to pay Part A premiums, because of their work history. Medicare Part B covers a portion of physician care, some home health services, durable medical equipment, and outpatient services.

Medicare Part B is voluntary. In 2005, individuals pay a yearly deductible of \$110 and monthly premiums of \$78.20. In 2007, Part B premiums will be determined by income, pursuant to the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Some states, including Oregon and Washington, offer an additional option of combined Medicare and Medicaid programs, referred to as Programs of All-inclusive Care for the Elderly (PACE). Providence Elder Place in Portland and Seattle are PACE programs.

Your client may be enrolled in the original Medicare fee-for-service program or a Medicare Advantage Program (previously Medicare+Choice). Medicare Advantage programs must cover at least the same benefits covered under original Medicare Part A and B. If your client is enrolled in a Medicare Advantage program, it is necessary to review the plan, as there may be additional benefits or requirements.

Medicare programs do not pay for long term care. Medicare may pay for limited, intermittent care at an SNF after hospitalization. The criteria for coverage are:

- The beneficiary was hospitalized for three days (including the day of admission and excluding the day of discharge).
- SNF admission occurs within 30 days after hospital discharge.
- The SNF is a Medicare-certified facility.
- A physician certifies daily skilled nursing or rehabilitation services is necessary.
- The beneficiary has not exceeded the 100 days of in-patient care for each benefit period, referred to as a "spell of illness."

Let us assume that Ann is enrolled in original Medicare, Part A and B, and meets the first three criteria—hospitalized three days and admitted to an approved SNF within thirty days of discharge.

Coverage disputes often involve the fourth criterion: whether the individual required daily skilled nursing or rehabilitation. Daily has been interpreted as at least five days a week. Skilled nursing includes overall management and evaluation of an individual's care plan, observation and assessment of a patient's changing condition, and patient education services. See, 42 CFR §409.31 and 42 CFR §409.33(a)(1)–(3). Thus, skilled nursing may include monitoring services often considered custodial, such as bathing, eating, and dressing. Skilled rehabilitation includes physical therapy.

In our scenario, Ann's physician documented that skilled nursing and physical therapy was necessary Monday through Friday. Skilled care included monitoring Ann's condition and preventing aspiration.

Coverage is determined by every aspect of a patient's condition, not just the services provided. See *Breeden v. Weinberger*, 377 F. Supp. 734 (1974). The goal is to maintain the individual's current status and prevent deterioration. Recovery or potential restoration of function is not a factor. This is especially

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important for individuals with progressive diseases, such as dementia.

The physician is your best resource where the issue is skilled vs. custodial services. The physician's certification that skilled care is necessary is not conclusive, but has great weight on appeal. It may be necessary to obtain a release that allows you to meet with a client's physician to discuss the care plan. Home health services, rather than an SNF, may be considered. However, a spouse's ability or inability to be a caregiver is not a coverage factor.

The benefit period or spell of illness is especially important when there are multiple admissions over a short period of time. Spell of illness does not begin the first day of injury or illness. It begins the first day of inpatient care and ends when the beneficiary has spent sixty consecutive days outside the hospital or SNF or remains in hospital but does not receive Medicare benefits for sixty consecutive days. 42 USC §1395x(a). An individual is entitled to 100 days coverage per spell of illness. 42 USC §1395d. Ann has no previous hospitalization and is well within the 100 days.

Even when all of the SNF criteria are met, Medicare Part A pays only a portion of post-hospital care. Medicare pays 100 percent for the first twenty days. The individual must make a co-payment of \$114 per day in 2005 for days 21 through 100. In our scenario, Ann received 21 days of skilled nursing care and incurred a Medicare co-payment for one day.

In summary, although Medicare does not cover most long term care, it does provide important coverage for limited post-hospital services.

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Report from APR subcommittee

By Sam Friedenberg

The Agency and Professional Relations Subcommittee met with DHS representatives (Agency) on October 22, 2004. Summarized here are topics that may be of interest.

Medicaid application delays

Attorneys have reported Agency delays in processing applications for Medicaid. Agency representatives were unaware of the particular situations, acknowledged a shortage of staff, and were not surprised that attorneys were assisting to speed the process.

Date of eligibility

In discussion of a case that involved a disagreement over the date of Medicaid eligibility because of a tardy service priority assessment, Agency representatives confirmed that the date of eligibility is the date of first contact, not the date the service priority assessment is completed. In another case that involved a spousal support order, the Agency confirmed that the eligibility date was the date of the filing of the petition and not the date of the order. If 45 days have lapsed between filing and the order, a time extension should be requested.

Community spouse post-eligibility transfers

Changes have been carved into the new final rule, OAR 461-140-0242(3) and (4). In essence, such transfers are allowed and will disqualify the community spouse only.

Household contents

The Agency is proposing a new rule specifically making all household goods and personal belongings exempt for Medicaid eligibility.

Excess shelter allowance

We raised the issue that the excess shelter allowance (\$468 in 2005) is insufficient to maintain a home that has a mortgage on it, and advocated for a higher amount or a process to allow for a waiver. The Agency's position was that a person with a mortgage who must live on this sum simply cannot afford to live at home. There is currently no hardship waiver process.

Spousal pay

There is money for the spousal pay program and there is no waiting list. Note that it applies in four counties only. The client must be SSI eligible and not able to do four of six of the activities of daily living. There is no money for respite care in the program, although the Independent Choices program may provide some respite.

Redetermination of eligibility

The re-determination of eligibility form 539 C was raised because it still asks about the assets of the community spouse. Agency representatives acknowledged that they are not supposed to ask, except where the community spouse MMMNA is relevant.

Service priorities

Funding for service priorities through Level 13 is in place and there appears to be no change planned. There are no changes to the Oregon Health Plan or other aspects of the service priority determination. However, a large budget shortfall is likely in the next biennium, which will likely lead to another review of the matter.

Spousal refusal

We discussed the "spousal refusal" strategy that is sometimes used in other states and inquired whether or not the Agency had a policy on it. Agency representatives had no position.

Medicare part D

The part D Medicare prescription coverage that goes into effect in 2006 will affect Medicaid clients. They will be asked to voluntarily

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Paying family members for in-home care

By Leslie Harris, Dorothy Kliks Fones Professor, University of Oregon School of Law

A recent federal study found that of all chronically disabled elders living in the community, 96 percent receive at least some unpaid family care and two-thirds rely exclusively on such care. Of those who need help with three or more activities of daily living (ADLs), 86 percent live with others and receive on average 14 hours per week of help from paid helpers and 60 hours per week of unpaid care from family members. The value of in-home, family caregiving is estimated to be \$200 billion per year if professionals were to provide it. However, providing care to an elder can have a significant negative impact on the employment of the caregiver: 10 percent of caregivers leave work permanently, 11 percent take a leave of absence, and 7.3 percent go part-time or take a less demanding job.

Traditionally and even today it is presumed that family members provide care without expectation of payment. Nevertheless, under the right circumstances, it is possible for them to receive pay, enabling them to provide care when this would otherwise be impossible because of financial hardship.

Paying for care

In the private sector, caregivers are paid \$12 to \$17 per hour, depending on the time of work and skill required. Some newer long term care insurance policies allow payment for in-home care to family members, though most require that the care be provided by agencies. Elders eligible for Medicaid assistance with long term care may also be able to employ family members. Adult children whose parents live with them and who pay others, including other family members, to care for the parents may be able to offset some of the costs by claiming income tax benefits.

Paying family members for home care under Medicaid

Oregon's Medicaid waiver home and community-based services program will pay family members other than spouses for providing in-home care to an elder. The state-financed spousal pay program will pay an elder's spouse for care under very limited circumstances. The regulations that govern the programs make clear that "payments for community-based care services are not intended to replace the resources available to a client from their natural support system of relatives, friends, and neighbors." OAR 411-027-000(2)(b). The amount of paid care for which a person is eligible depends on the Department of Human Services (DHS) assessment of the client's needs for assistance with activities of daily living. Specifics are set out at OAR 411-030-0070. DHS establishes the rates that home workers are paid.

The Client-Employed Provider program (CEP), OAR Chapter 411, Division 31

This program, which is part of the home and community-based services program, permits a recipient of Medicaid long term care assistance to select and hire his or her own caregivers. Relatives other than spouses can be hired, as well as friends, neighbors, or strangers. Though the elder is legally the caregiver's employer, DHS pays the care provider directly, based on written claims submitted by the provider and signed by the elder. DHS also withholds the employee's FICA and unemployment taxes and pays the employer's share, but it does not withhold state or federal income taxes.

The care provider must pass a criminal records check, maintain a drug-free workplace, have the skills, knowledge, and ability to perform or to learn to perform the required work, and have verified authorization to work in U.S. The care provider can be as young as 16 if he or she provides care only for family members, friends, or neighbors; otherwise, the provider must be at least 18. The Seniors and People with Disabilities office must specifically approve the hiring of a worker younger than 18. OAR 411-031-0040(8)(d).

The spousal pay program, OAR 411-030-0080

Generally, spouses are expected to provide free care. Therefore, the DHS spousal pay program is quite limited and allows payment for care to a spouse only when the ill spouse requires full assistance in at least four ADLs and would require nursing facility placement without in-home services. The well spouse must have the capability and health to provide the services and actually provide the principal care. The spouse can be paid for fewer hours than other caregivers are paid.

Eligibility issues: avoiding disqualifying transfers

Gratuitous transfers, including cash payments, that an elder or the elder's spouse makes within three years of applying for Medicaid will trigger a period of ineligibility. OAR 461-140-0242. (See *An introduction to long term care and Medicaid in Oregon* on page one.) Given the general assumption that family members provide care without expecting payment, DHS is likely to claim that an elder who paid a family member for care within three years of applying for Medicaid made a disqualifying transfer. To counter this claim, the elder must present evidence to prove that he or she received fair market value for the payment. This evidence could include a written contract setting out the specifics of the parties' agreement regarding the care provided, including the caregiver's duties and rate of pay. This approach would meet one of the require-

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paying relatives *Continued from page 5*

ments set out in OAR 461-140-0250(3), which states that there must be a prior agreement to exchange the resource for services in order for the value of services provided to the client to be counted as compensation for the transferred resource.

Under OAR 461-140-0242(2)(c), a person who receives Medicaid benefits for long term care may transfer his or her home to a child who lives with the parent and who has provided care for at least two years without incurring a transfer penalty. DHS has taken the position that this exemption from the transfer rules is not available if DHS has paid the child for care. Therefore, an elder who wishes to transfer a home under this rule will have to either forgo paying the child under the CEP program until after making the transfer or else be prepared to challenge the DHS position.

Federal income tax benefits

If an adult child provides or pays another to provide care for a parent who lives in the adult child's home, he or she may be eligible for federal income tax benefits. First, the taxpayer may claim a personal exemption for the parent if the parent qualifies as the taxpayer's dependent. IRC 151. To qualify as a dependent, the parent must receive more than 50 percent of his or her support from the taxpayer. Any work for which the taxpayer is paid would not count toward this 50 percent, but paid caregiving provided by another family member that the taxpayer pays for would count. In addition, if the parent lives with the adult child and is his or her dependent, the adult child can claim a federal dependent care income tax deduction for caregiving-related expenses in excess of 7.5 percent of the taxpayer's gross income. IRC §213(a).

A third tax benefit is available for those whose employers provide their employees with dependent care assistance plans. These plans, which are more familiar as a way of paying for child care, allow individuals to exclude up to \$5,000 of caregiving expenses from their taxable income. IRC §129 (d)(1). To qualify, the taxpayer must be providing more than 50 percent of the parent's care-related expenses, and the parent receiving care must spend at least eight hours per day in the employee's home. While this benefit

would not be available to the taxpayer who is providing care in person, it would be available to the taxpayer who hires another family member to provide the care.

Applicability of employment laws

A person who works as a companion to an elderly or infirm person in the client's home is not subject to state and federal minimum wage and overtime laws. To fit within this exclusion, the worker must spend at least 80 percent of his or her time in companionship services, not general housekeeping or other work. This work is subject to wage withholding for FICA and for state unemployment taxes but not for worker's compensation. The employer must comply with federal immigration rules regarding documentation of eligibility to work and with state child support enforcement registration laws. For more information, see Dan Gringas, "Employment Laws Apply to In-Home Care Providers," *Elder Law Newsletter*, Winter 2003.

Protecting the elder from neglect or abuse

Any in-home care arrangement carries the risk that the caregiver will abuse the elder or, more commonly, provide inadequate care because the caregiver is too exhausted or the elder's needs become greater than the caregiver can provide. If the caregiver is a family member, the chances that abuse or neglect will be discovered decline, since the caregiver is likely to be the family member closest to the elder and the one who would discover mistreatment if another were providing the care.

If the family caregiver is privately paid and finances permit, hiring a geriatric care manager to do a monthly or quarterly assessment of the elder's situation provides good protection. The care manager's assessment should include unannounced home visits. Besides protecting the elder against abuse or neglect, the care manager also provides support to the caregiver, who may not realize he or she is getting burned out or needs help.

If Medicaid is paying for care, the high caseloads of DHS workers make it impractical for them to check on clients regularly. The most realistic alternative is to arrange for another family member, friend, or neighbor to check in regularly and to be instructed to contact DHS if he or she has concerns about the care the elder receives.

See also Stephanie A. Merhib, "How to Avoid Financial Exploitation by a Caregiver," *Elder Law Newsletter*, Winter 2003.

The need for a written contract

Even though many in-home caregiving arrangements are informal, virtually every authority recommends the parties have a written contract to clarify the expectations of the elder and caregiver, and to help them think through and plan for contingencies. Written contracts may also help avoid claims from other family members that caregivers have unfairly or even illegally received money from the elder.

In addition, because there is always the chance that an elder may need to apply for Medicaid long-term care assistance, it is important to have evidence that an elder's payments to a family member were not gratuitous, as discussed above.

For good lists of topics that contracts should cover, as well as suggested language, see Allyn E. Brown, "Private Home Care Contracts,"

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Oregon's state hospitals provide some options for mentally ill

By Bob Joondeph, Executive Director, Oregon Advocacy Center

The state of Oregon operates two hospitals that offer some options for people who need long-term mental health care: Oregon State Hospital (OSH) and Eastern Oregon Psychiatric Center (EOPC). The main campus of OSH is in Salem and a satellite campus is located in Portland. EOPC is located in Pendleton and has 60 adult psychiatric beds.

OSH has four treatment programs

Forensic Evaluation and Treatment Services (FETS) conducts psychological and psychiatric evaluations of criminal defendants whose competence to face criminal charges is in question. If the defendant is found unable to proceed to trial, FETS will "treat until fit" to return to court. This program provides acute psychiatric treatment for patients who have been placed under the jurisdiction of the Psychiatric Security Review Board (PSRB), having been found guilty of a crime except for insanity. FETS also serves patients who have been transferred from Department of Corrections facilities for acute psychiatric treatment. It is funded to have 156 beds.

Forensic Rehabilitation and Transition Services (FRTS) provides residential and hospital level services to patients who have been placed under the jurisdiction of the PSRB and whose psychiatric symptoms are stable, but who continue to need psychiatric rehabilitation, social skills training, and transition services to prepare for community living. It is funded to have 209 beds.

Child, Adolescent, and Geropsychiatric Treatment Services (CAGTS) is composed of one hospital ward (30 beds) that serves older children with emotional and psychiatric disorders, and four wards (133 beds) that serve older adults and individuals with brain injury who require intensive nursing care that is not available in less restrictive settings. This is the only program in the state hospital system that is certified by the Centers for Medicare and Medicaid Services (CMS) to bill Medicare for inpatient services.

Most patients in this program are admitted involuntarily by means of civil commitment or "voluntarily" by a parent, guardian, or state agency. The Oregon Youth Authority has an administrative process for transferring youth from its facilities to CAGTS for acute psychiatric treatment.

Adult Treatment Services (ATS) serves adult men and women over 18 years old with serious and persistent mental illness. Most patients are referred from acute care hospitals for intermediate to long-term lengths of stay pursuant to a civil commitment order. The program has 65 beds in Salem and 68 beds in Portland.

Paying for care in state hospitals

Medicaid law considers facilities that have more than 16 beds and are primarily engaged in providing mental health treatment to be "institutions for mental diseases" or IMDs. OSH and EOPC are IMDs, and Medicaid will not pay for services provided in an IMD to individuals who are age 21 to 64. (42 CFR 440.1008).

A person who is admitted to a state hospital or training center, or the person's estate, is considered liable to the state for the full cost of care. The state, however, requires a person to pay only the amount it determines the person is able to pay as determined by an administrative process. ORS 179.610 through 179.770 and OAR 309-012-0030 through 309-012-0035 set forth the standards and procedures used to determine a person's "ability to pay." OAR 309-012-0100 through 309-012-0110 provide additional standards for how the state treats income that a patient earns while institutionalized.

The state will request financial information from the person who receives institutional services and/or the person's "authorized representative", *i.e.*, guardian, conservator, or other person or entity holding funds or receiving benefits or income on behalf of the person. It may also obtain personal income tax returns and elderly rental assistance claims directly from the Department of Revenue. Based upon that information, the state will determine the person's ability to pay and issue an "ability-to-pay order." If the person or the person's authorized representative fails to provide information, the state may determine the person has the ability to pay the full cost of care. The factors that the state considers in making this determination are set forth in ORS 179.640 and OAR 309-012-0033(3).

The ability-to-pay order is to be provided to the person and the person's authorized representative. It sets forth the person's full liability and the person's determined ability to pay. A description of the person's appeal rights must be included with the order.

The appeal process is set forth in ORS 179.640(7) and OAR 309-012-0025. The procedures allow the person to request an "informal conference" for the purpose of seeking resolution short of a formal hearing. If the informal conference is not requested or does not resolve the dispute, a hearing will be conducted by a hearings officer in accordance with the procedures set forth in rule.

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State hospitals

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A person may petition the Department of Human Services (DHS) for administrative review of the order of the hearings officer. The order is not final until the review is granted or denied. Final orders may be appealed to the Oregon Court of Appeals per ORS 183.482.

ORS 179.653 provides that if a person or authorized representative refuses to pay for the cost of care as ordered by the DHS, the amount unpaid plus interest becomes a lien in favor of the State of Oregon upon the title to and interest in the real and personal property of the person's estate. Unless a distraint warrant has been issued pursuant to ORS 179.655, the lien is only valid against the property of the person, assets held by an authorized representative bound by the ability-to-pay order, and assets subject to lien held by any person or entity having actual knowledge of the ability-to-pay order or the lien.

Further, an authorized representative who is a trustee is bound to the extent that the final order specifically finds that the trust assets of a trust fund are subject to claim by the agency. If any authorized representative does not comply with a DHS demand for payment, the agency may file with the probate court a motion to require the authorized representative to comply. If the authorized representative is a conservator or guardian appointed under ORS chapter 125, the motion is to be filed in that proceeding.

ORS 179.655 provides that if any amount due the DHS is not paid within 30 days after it becomes due, and no other provision is made for payment, DHS may issue a distraint warrant directed to any county in Oregon. The amount of the warrant becomes a lien upon the title to and interest in any property owned or later acquired by the debtor against whom it is issued, and it may be enforced by the agency in the same manner as a judgment of the circuit court.

ORS 179.740 permits DHS to file a claim against a decedent's estate for any unpaid cost of care. This is to be done in the same manner as claims of creditors and with the priorities provided in ORS 115.125. DHS may also petition a court for the issuance of letters of administration or testamentary for the purpose of collecting unpaid cost of care.

It may not file this petition until at least 90 days after the death of the person who received care from the state institution and then only in the event that the person's estate is not otherwise being probated. In addition, ORS 179.745 permits the state to take title to real and personal property to collect the cost of care.

While it may seem unfair to some for the state to require payment from patients who neither request nor desire institutional care, the cost of care statutes and rules do offer a good deal of flexibility and even compassion. In determining a person's ability to pay, the state will give credit not only to the person's other legal obligations but also to his or her "moral obligations." It will not count the value of assets with "great sentimental value" to the person and will allow the person to retain funds necessary for personal support when she is discharged. A person can always ask for a modification of the determination of ability to pay if circumstances change. The state may waive some or all of its charges "based upon the best interest of the person or [DHS]." OAR 309-012-0033(6).

As noted above, some individuals arrive in a state hospital as the result of civil commitment. If a person is placed on a pre-commitment "hold" in a local hospital pending investigation and hearing, the treating hospital is to seek payment for its services from "the person, third party payers or other persons or agencies otherwise legally responsible." ORS 426.241. If the hospital cannot collect its costs in this manner, the payer of last resort is the county of which the person is a resident.

If the responsible payer believes that the person's condition did not meet the statutory criteria for placement of a pre-commitment hold, that person may make a request in writing to DHS for denial of payment for emergency psychiatric services. DHS is to review the request, which must be accompanied by supporting documentation. If DHS finds that the evidence does not reasonably support the belief that the person met commitment criteria, it "shall deny all or part payment" for the hospital services. OAR 309-033-0820; ORS 426.241(5).

White House Conference on Aging launches Web site

The White House Conference on Aging has a new Web site (www.whcoa.gov), which houses an array of information about the planning and progress of the 2005 White House Conference on Aging. The site also contains a calendar of events and links to other resources.

The WHCOA's new Web site will provide information about the conference, which is scheduled to take place October 23 through 26, 2005, in Washington, D.C. The mission of the WHCOA is to make policy recommendations to the President and Congress, and to assist the public and private sectors in promoting the dignity, health, independence, and economic security of current and future generations of older persons.

The site will publish results of Policy Committee meetings, including the development of the conference agenda, topic areas, delegate selection, and important regional, state, and local information related to the conference.

Benefits for veterans and their families

By Constance Sullivan

Assisting veterans is a time-honored tradition in the United States. In 1863, Abraham Lincoln spoke of the mission "to care for him who shall have borne the battle, and for his widow and his orphan."

When you explore long term care assistance options with your clients, do not forget to ask whether the client or the spouse is a veteran. If either is a veteran, assistance may be available from the federal Department of Veterans' Affairs (VA) and the Oregon Department of Veterans' Affairs (ODVA).

Approximately 70 million people—about a quarter of the nation's population—are potentially eligible for VA benefits and services because they are veterans, family members, or survivors of veterans. When your client is a veteran, be sure to inquire about benefits he or she already receives, and be prepared to refer the client to an appropriate veteran resource to assist in determining eligibility for benefits.

Brief overview of federal benefits for disability and health care

The federal VA offers two types of disability benefits: compensation and pension. Both pay monthly benefits to disabled veterans. Compensation—referred to as a service-connected disability—is a payment made to veterans who are at least 10 percent disabled as a result of military service. Payments are meant to compensate the veteran for loss of function and need not make him or her ineligible to work. Compensation is not a needs-based program.

Pension, on the other hand, is a needs-based program. It is an amount paid to wartime veterans¹ with limited income who are no longer able to work, or are age 65 or older. Pension is not tied into a service-connected disability. Currently a wartime veteran with less than \$80,000 in assets (not including a home) and income of less than \$824 per month can apply for pension benefits. A pension is also available for the widowed spouse of a veteran, even if the spouse is not disabled.

Aid and Attendance is a pension add-on benefit. It is available to a veteran, eligible spouse, or disabled grown child who was totally disabled prior to reaching the age of 18, if the VA determines the applicant needs in-home, nursing home, or assisted living care and meets the income and asset guidelines of the VA Pension program. This bene-

fit aids those who need assistance in daily living because of limited mobility.

There is no deadline to apply for federal disability benefits. A widowed spouse or eligible child can apply even after the veteran has died if it is later determined that a service-connected disability caused the veteran's death. An un-remarried widowed spouse of a veteran can apply for a pension if she meets the income and other eligibility requirements.

The federal VA also offers health care to eligible veterans: hospital, outpatient medical, dental, pharmacy, and prosthetic services, as well as domiciliary, nursing home, and community-based residential care. A veteran must be enrolled in the VA health care system and benefits are available based on priority group assignments mandated by Congress. The higher priority groups receive priority consideration to receive health care benefits. Co-payments may also be required depending on the veteran's income and extent of disability.

In Oregon, both the VA hospitals in Roseburg and Portland offer nursing skilled care units and the Roseburg hospital has an Alzheimer's unit and a respite care program.

There are no other federal long-term care nursing facilities in Oregon. However, the VA will pay for nursing care for an eligible veteran who is at least 70 percent disabled because of or related to a service-connected condition.

Oregon Department of Veterans' Affairs

The Oregon Veterans' Home is located in The Dalles, Oregon. It operates under the

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Constance Sullivan is a sole practitioner in Medford. Her practice emphasizes estate planning, probate, elder law, guardianships, and conservatorships.

Additional resources

VA Web sites: www.va.gov and www.vba.va.gov

The Oregon Veterans' Home, The Dalles, Oregon 800.846.8460 or www.odva.state.or.us

38 USC, chapters 11, 13, 15, and 17; 38 CFR parts 3 and 4

Emily J. "Jenny" Kaufmann's materials from the 2003 OSB CLE program *Elder Law Essentials*

Introduction to long term care and Medicaid

Continued from page 2

Options available for avoiding spousal impoverishment include planning the spend-down, transferring exempt assets and non-exempt assets to the community spouse, using non-exempt assets to provide income for the community spouse, and petitioning the court for a support order that awards additional assets to the community spouse.

Community spouse income allowance

Although the resources that belong to a married couple are counted together in the application process, each spouse's income is counted separately. OAR 461-160-0600(2). The community spouse can receive an allowance from the ill spouse's income to bring the community spouse's monthly income up to a standard of \$1,561.25 (as of July 1, 2004). OAR 461-160-0620(5). The standard is raised (up to a maximum of \$2,377.50) if the community spouse's shelter costs exceed \$468 per month. If the standard is not enough, the community spouse can petition the court for additional support or for a larger share of the couple's resources. However, the allowance is limited to the amount available from the ill spouse's income after the personal needs allowance and any room and board charges have been paid.

Effect of gifts and transfers

If the individual or his or her spouse gives money or property away, or transfers anything for less than fair market value, within three years before applying for Medicaid, he or she will not be eligible for a period of time based on the value of whatever was given away. OAR 461-140-0210 *et seq.* If the transfer was to a trust or from a trust, the "look back" period is five years instead of three years. The amount that was given away is divided by the average monthly cost of care (currently set at \$4,700 in Oregon). OAR 461-140-0296. The result is the number of months of ineligibility. The period of ineligibility begins with the month in which the gift was made. There are some gifts and transfers for less than fair market value which do not result in a period of ineligibility. For example, there is no penalty if the person transfers assets to his or her spouse.

Service priority levels

When someone applies for Medicaid for long term care services in Oregon, the person's care needs and ability to perform the activities of daily living are evaluated and a service priority level is assigned by SPD. OAR 411-015-0000 *et seq.* Medicaid assistance is currently available to people in service priority levels 1 through 13.

Estate recovery and liens

The state has a claim against the estate of the Medicaid recipient for the amount of Medicaid assistance paid after age 55. ORS 414.105. For the purpose of this claim, the estate is defined as any interest in money or property that the Medicaid recipient has at the time of his or her death. Therefore, it includes joint accounts and other assets which do not have to go through probate. The state's claim has a higher priority than claims of general creditors. ORS 115.125(1). The state cannot collect its claim while there is a surviving spouse or a minor or disabled child. However, the state can make a claim against the estate of the surviving spouse up to the amount that the surviving spouse received when the Medicaid recipient died. Oregon does not have the authority to file liens against real or personal property to recover Medicaid assistance.

Conclusion

Although Medicare, long term care insurance, and VA Aid and Attendance pensions can play a role for some clients, private resources and the Medicaid program are the main sources of payment for long term care. Elder law attorneys can be their clients' most valuable source of information and advice about current eligibility requirements for benefits that help pay for long term care and the process of qualifying for those benefits.

IRS allows use of general POA

By Sam Friedenberg

The IRS now allows agents appointed under a general power of attorney to sign income tax forms. The details can be found in IRS publication 947, *Practice Before the IRS and Power of Attorney*. The publication is available at www.irs.gov.

The new rules require the agent under a non-IRS power of attorney to complete form 2848 and to submit it with a copy of the general power of attorney. That general power of attorney must have specific language giving the agent all authority to handle tax matters. An affirmation will also be necessary. The old rule was that the principal had to sign IRS form 2848. This was a problem if the principal was already incapacitated.

This change in policy suggests that general powers of attorney should have language specifically authorizing the agent to sign and submit IRS form 2848 as well as other IRS forms. The details on the new policy are murky and practitioners are advised to review the publication.

Continuing care retirement communities are designed for elders looking for security

By Carole Barkley, Editor of the Elder Law Section Newsletter

A Continuing Care Retirement Community (CCRC) provides a way for a person to move easily from active retirement living to assisted living to skilled nursing, as his or her health care requirements change. This will have great appeal for an elder who wants to make a decision to move only once, without having to face another big upheaval in later life.

Although many other retirement communities offer multiple levels of care, the distinguishing characteristic of a CCRC is a contractual agreement with the resident to provide services and care for an extended period of time. In exchange for a guarantee that the resident will have this continuum of care, he or she must invest financially in the community through a buy-in or membership fee. CCRCs are operated by nonprofit organizations, and it is important for a CCRC to have a good track record as well as reserves in order to protect the stability of the residents' living situation.

In addition to the initial fee, there is a monthly service fee, which covers maintenance, various amenities, and often a meal program. A CCRC may be the perfect choice for your client, but it is not for everyone.

Buy-in costs

Your client's financial situation is obviously important. A CCRC is a fairly expensive choice, and is most appropriate for a person with a good stream of income and/or substantial assets. The initial buy-in cost depends on the type and location of living quarters the resident favors. An apartment with a good view, for example, will cost more than one elsewhere in the building. A two-bedroom apartment will cost more than a studio apartment. The average cost per square foot at a large facility in Portland, for example, is currently about \$132 per square foot. Many people use the proceeds from selling the family home to pay the buy-in fee.

Monthly fees

The second factor that comes into play is income stream. Because a CCRC charges a monthly fee, the prospective resident must

have a reliable source of funds to pay that fee. Fees vary widely, according to the services and amenities offered and the number of people living in a unit. The lowest fees are around \$800 per month and they go up from there. The monthly fee usually includes utilities and maintenance, housekeeping and laundry services, and transportation. Most also include meals—sometimes two, sometimes three per day. Some do not include meals in the monthly fee, but offer a dining room where residents can use meal cards they purchase. If an incoming resident has a need for additional services, such as assistance with personal care, the fee will be adjusted accordingly.

Contract options

Contracts vary, and it is very important to ask questions up front. Different contracts may :

- include unlimited long-term nursing care for little or no substantial increase in the resident's usual monthly payments.
- specify the amount of long-term nursing care that will be provided, with the resident responsible for payment beyond that point.
- require a resident to pay the going daily rates for all long-term nursing care required, but may offer a discount for long-time residents.

Another type of CCRC contract involves an equity sharing agreement in which a person purchases a residence, and when he or she leaves the community or passes away, a percentage of the entrance fee is refunded. In these cases, the entrance fee amounts and monthly services fees are much higher and there may be terms which specify how the money is returned to the resident or his or her estate. One should always ask about refund policies. People do change their minds.

It's important that the contract spells out what happens if a person outlives his or her money. People who cannot pay the monthly fees may have to move out of the CCRC. Some CCRCs accept Medicaid to help pay for care in the licensed portions of the CCRC; many do not. A CCRC may have a private foundation to cover the fees for those who live longer than might have been predicted. It's important that your client knows, though, that an application for foundation support is not automatically granted. A resident cannot give all his or her money away and then expect the foundation to pick up the cost of care.

Facilities

As the population of active elders grows, CCRCs have had to adjust their housing offerings. Thirty years ago, the typical resident moved into a small apartment. Today, he or she may prefer a duplex-style townhouse residence.

Upscale amenities are becoming more common. Many CCRCs have fitness and computer centers, hobby areas, shops, hair salons, libraries, guest facilities, and gardens. Some host college classes on site.

While the provision of meals is the norm, meal options are also changing, with residents demanding more flexibility and more variety.

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Continuing care retirement communities *Continued from page 11*

Health care services and how they are offered vary among CCRCs. Even though all commit to a continuum of care, not all will actually have all three levels of care (retirement living, assisted living, and skilled nursing) available on site. Nursing care at some level will always be available, but it may be through an agency. Some CCRCs offer in-home care as an option.

Regulation and admission

The state provides little regulation or oversight of CCRCs, although a portion of a CCRC that is operated as a nursing facility or assisted living facility has to comply with the applicable licensing requirements. Under ORS 101.010 *et seq.*, new CCRCs are required to register with the Oregon Department of Human Services, furnish certain disclosures to prospective residents, and maintain specified financial reserves.

All CCRCs have an application process that includes a review of the applicant's financial situation. The applicant's age is also a factor, because the facility wants to be reasonably certain that the person has the ability to pay for services throughout his or her expected life span. One applicant might have average assets, but a substantial income from pensions. Another may have modest income, but a substantial investment portfolio that can be tapped. CCRCs do not typically require a health care assessment, although a medical evaluation of the level of care needed is important if a person is entering the community at the assisted-living level.

Choosing to move to a CCRC is not something that should be done in a hurry. Although most CCRCs can usually come up with a place for a new resident on relatively short notice, the housing options at that time may be limited. It is not uncommon for people to move into a unit that is not their first choice and place themselves on a waiting list for a different size apartment. It is important to remember, though, that one is making what is in all probability a lifetime commitment, so it's important to do careful research and take the time to look around, ask questions, meet people, and get a feel for the place.

For clients who are considering a CCRC, a comprehensive checklist of factors to consider and questions to ask can be found on the CarePathways.com Web site at: www.carepathways.com/checklist-ccrc.cfm.

Why choose a CCRC?

CCRCs are ideal for people who want to plan ahead— who want to make a decision about where to live and know that they will not have to be uprooted if and when their health changes— and who have the financial resources to cover the initial investment as well the monthly charges. The average CCRC resident stays between seven and 15 years, which means long-term friendships are likely. Relationships with neighbors and staff create a real community.

CCRCs in Oregon

Portland

Holladay Park Plaza
1300 NE 16th Avenue
Portland, OR 97232
Phone: 503.280.2216 or
800.777.5517
Web site:
www.retirement.org/hpp

Rose Villa

13505 SE River Rd.
Portland OR 97222
Phone: 888.652.7673
E-mail: info@rosevilla.org
Web site: www.rosevilla.org

Terwilliger Plaza

2545 SW Terwilliger Blvd.
Portland, OR 97201
Phone: 503.299.4716 or
800.875.4211
E-mail:
debias@terwilligerplaza.com
Web site: www.terwilligerplaza.com

Willamette View

12705 S.E. River Road
Portland, OR 97222
Phone: 503.654.6581 or
800.446.0670
E-mail:
info@willametteview.org
Web site: www.willametteview.org

Newberg

Friendsview Manor
1301 Fulton Street
Newberg, OR 97132
Phone: 503.538.3144 or
866.307.4371 Ext. 2399
E-mail: fengle@friendsview.org
Web site: www.friendsview.org

Salem

Capital Manor
1955 Dallas Rd NW
Salem, OR 97304
503.362.4101 or 800.637.0327
E-mail: information@capitalmanor.com
Web site:
www.capitalmanor.com

Albany

Mennonite Home
5353 Columbus ST. SE
Albany, OR 97321
Phone: 541.928.7232

Eugene

Cascade Manor
65 West 30th Ave.
Eugene, Oregon 97405
Phone: 541.342.5901 or
800.248.2398
Web site:
www.retirement.org/cascade

Medford

Rogue Valley Manor
1200 Mira Mar Avenue
Medford, OR 97504
Phone: 541.857.7214 or
800.848.7868
Web site:
www.retirement.org/rvm

Recent developments in elder case law

By Garvin Reiter, Attorney at Law, Portland

Conservator appointed despite evidence of unsuitability

Without a doubt, the most significant recent Oregon elder law case is *Grimmett v. Brooks*. (*In re Grimmett*, 193 Or. App. 427, 2004). The petitioner, an Oregon attorney (but not acting as the respondent's attorney) and goddaughter of the respondent, filed a petition for guardianship, alleging an inability to comprehend and manage medical affairs due to alcoholism, dementia, memory loss, and confusion. The court visitor's report did not recommend a guardianship, so the petitioner withdrew that petition and filed an amended petition for conservatorship only. While competent, the respondent had named the petitioner as attorney-in-fact for health care and finances and sole beneficiary of her trust and annuity. The petitioner actively assisted the respondent in her financial and health care matters before the respondent's condition and memory began to worsen. When the petitioner intervened to try to curtail the respondent's drinking, the relationship between the two deteriorated to the point where the respondent considered the petitioner to be an "awful person." In fact, the respondent disinherited the petitioner and replaced her as a fiduciary in her estate planning documents. Despite the overwhelming evidence that the respondent did not want the petitioner to serve as her conservator, the Court of Appeals upheld the order doing just that.

This case resolves a few minor, but interesting, procedural issues. First, it clarified a point about pleadings. The original petition in this case requested guardianship only, and it alleged sufficient facts to support a guardianship. As noted, it was withdrawn and replaced with an amended petition seeking only conservatorship. The amended petition did not plead the facts stated in the original petition. Instead, it merely referred to the facts in the original petition and added the necessary facts regarding financial incapacity. The court held that the abbreviated conservatorship petition pled sufficient facts to avoid dismissal as it was "coupled" with the original guardianship petition.

Second, the case appears to put to rest a lingering question that stems from *Spady v. Hawkins*, 155 Or.App. 454 (1998). In *Spady*, the court considered a case where a guardianship petitioner gave notice to the respondent of intent to appoint Person 1 as guardian, but at the hearing substituted Person 2 as nominated guardian without giving notice to the respondent. This was error. Since then, there has been an open question of whether it is necessary to file a cross-petition and provide notice when the respondent wants Person 2 to serve as fiduciary. After all, notice to the respondent is not required in such a case.

In *Grimmett*, the respondent argued that it was error for the trial court to not appoint the person she preferred as conservator; the petitioner responded that it was not error, due to the absence of a cross-petition filed by the respondent. The court ruled that "under *Spady*, the probate court did not err when it refused to appoint Davis as conservator because Grimmett had not filed the appropriate cross-petition." 193 Or. App. at 444. This does not exactly resolve the notice issue, but the cautious practitioner will want to observe the formality of a cross-petition and, probably, notice.

These issues are interesting, but not groundbreaking. The importance of the case lies in its holding regarding the issue of suitability. ORS 125.200 provides that the court may appoint the most "suitable" person as a fiduciary after giving consideration to the wishes of the respondent. *Driscoll v. Jewell*, 37 Or. App. 529, 533, 588 P.2d 49 (1978), held that "given the delicate nature of the proceedings, the wishes and desires of the protected person, while certainly not binding upon

the court, should be accorded as much deference as possible." Does this provide a defense to the incapacitated respondent who simply detests the named fiduciary? Not under facts like these. Here, the evidence showed that the respondent and petitioner once had a trusting relationship, and that the petitioner took an active role in assisting the respondent before her condition declined. Most important, the court was sympathetic to the public policy argument that the petitioner should be appointed because she had been appointed fiduciary in the respondent's estate planning documents. This case should be cited for the proposition that the person named as fiduciary in estate planning documents should be appointed to serve as conservator or guardian over the objections of the principal, at least where the facts do not indicate malfeasance on the part of the fiduciary.

Guardian allowed to do Medicaid planning for protected person

There is a long-standing unofficial rule in Oregon that one of the downsides to a conservatorship is that the court order makes it impossible to do Medicaid planning on behalf of the protected person. Personal experience attests to the fact that judges have a hard time accepting the argument that it is in the protected person's best interest to award assets to family members.

The New Jersey Supreme Court held that a guardian can undertake Medicaid planning on behalf of the protected person. *In re Keri*, 181 N.J. 50 (2004). Ms. Keri's son had been appointed attorney-in-fact under a power of attorney that did not specifically authorize gifting for Medicaid purposes. The son therefore filed an action seeking a guardianship and court approval to sell his mother's house and transfer a portion of the proceeds to himself and his brother in equal shares as a means of accelerating her Medicaid eligibility. The son alleged that his mother would have wanted to do this and his brother did not object. The court held that where the Medicaid spend-down plan "does not interrupt or diminish an incompetent person's care, involves transfers to the natural objects of the person's bounty, and does not contravene an expressed prior intent or interest, the plan clearly provides for the best interests of the incompetent person and satisfies the law's

Continued on page 14

Recent case law *Continued from page 13*

goal to effectuate decisions an incompetent would make if he or she were able to act." This holding puts New Jersey in line with New York in allowing planning on behalf of incapacitated persons. It should be cited by practitioners who seek a similar rule in Oregon.

Federal protections may not apply to optional state benefits

In a troubling development, the Connecticut Court of Appeals has ruled that the federal SSI rules do not apply to an optional state funded program of supplemental income assistance: *Parkhurst v. Wilson-Coker*, 82 Conn.App. 877 (2004). While the holding itself is not terribly significant, the implications are. Like many states, Connecticut provides cash to SSI recipients above and beyond the SSI amount. The cash comes entirely from state coffers and is governed by state law. The benefits recipient had a properly funded (d)(4)(A) special needs trust and was receiving SSI. The state argued that under its rules, the assets in the trust disqualified the recipient from receiving the state supplement, and the court agreed.

Oregon's Medicaid program consists almost entirely of services provided by the state under a federal waiver. The implication of this case is that the state might be able to argue that it is exempt from federal Medicaid protections because its programs are optional. Keep in mind that the District Court of Oregon recently held that Medicaid beneficiaries do not have the right to sue the state under federal civil rights law when Oregon's optional waiver services are reduced. *Watson v. Thorne*, 2003 U.S. Dist. LEXIS 25635 (D. Or. 2003). These holdings raise concerns about the future viability of the waiver programs. (The *Watson* case is on appeal; see article at right.)

It is worth noting, however, that Oregon's services are funded with a combination of federal and state dollars. This would undercut the argument under the *Parkhurst* case that the state is free to disregard the federal protections.

Community spouse allowed to sell home encumbered by Medicaid lien

The Nevada Supreme Court has held the state may impose a lien on a deceased Medicaid recipient's interest in a home before the surviving spouse's death. However, the lien must provide that the state must release the lien upon the surviving spouse's demand in order to sell the home. *State Dept of Human Res. v. Estate of Ullmer*, 87 P.3d 1045 (Nev., 2004).

The home was owned jointly by the couple at the time of the Medicaid recipient's death, and the wife continued to live in the home thereafter. The lien did not state that it was limited to only the husband's interest in the

home, nor did it expressly state that the lien could be lifted to allow the sale of the home. Nevada's definition of "estate" for purposes of Medicaid estate recovery is similar to Oregon's, as both include non-probate assets.

The court held that although the state is prohibited from executing its interest until the surviving spouse's death, the wife took the property subject to the state's interest. Federal and state law forbid only "recovery" on the interest during the surviving spouse's lifetime, and the court found that the imposition of the lien was not a recovery.

However, the court ruled that Medicaid's spousal impoverishment protections require the state to allow the surviving spouse to sell or finance the property and use the proceeds for her needs during her lifetime. The court restricted the spouse's ability to transfer the property for less than market value, however.

This case makes clear that the home can be sold or refinanced for use by the surviving spouse. An unanswered question: Does the state have a claim against any amounts remaining from the sale of the property at the time of the surviving spouse's death?

Section requests amicus curiae appearance

On October 14, 2004, the Oregon State Bar Board of Governors approved the Section's request to appear amicus curiae in the case of *Watson v. Thorne*. The underlying case challenges the State of Oregon's decision to cut medically necessary nursing home care and home and community-based services for individuals ranked service priority levels 12 through 17, funded largely by federal Medicaid dollars in 2003. (Services were restored to levels 12 and 13 on July 1, 2004.) The state's decision affected more than 4,000 individuals who had been receiving home and community-based long term care services and 85 people in nursing facilities.

The *Watson* case was filed in federal court by Legal Aid Services of Oregon (LASO), the Oregon Law Center, (OLC), Lane County Law and Advocacy Center (LCLAC), and the National Senior Citizens Law Center (NSCLC) on behalf of seven individuals and the Oregon Advocacy Center as a representative plaintiff.

The plaintiffs sought immediate relief in the form of an order from the court that would require Oregon to continue to provide services to those people cut off from Medicaid services. The plaintiffs claimed that the decision to terminate services violated federal Medicaid law, by applying an "unreasonable" eligibility standard that cut off funding for medically necessary services which are required to be provided under the Medicaid Act. The District Court denied the motion for immediate relief, and later dismissed the entire case, on the basis that there is no cause of action under 42 USC §1983 to enforce any provision of the Medicaid Act.

The issue on appeal in the *Watson* case is whether the Medicaid Act is enforceable by Medicaid beneficiaries under 42 USC §1983. The Section Executive Committee voted to request approval to join in the amicus brief being prepared by the National Health Law Project because of the importance of this issue to Oregon elder law attorneys and their clients. If low-income elders and people with disabilities who need long term care and other medical services cannot turn to the courts to enforce the rights given to them under the federal Medicaid statutes and regulations, they are left without remedies when they are denied access to services in violation of the Medicaid Act. If the trial court's decision stands, the role of attorneys and courts in resolving Medicaid disputes would be reduced or eliminated.

This issue is being litigated in a number of cases around the country in the wake of the Supreme Court decision in *Gonzaga University v. Doe*, 536 US 273 (2002), which held that the nondisclosure provisions of the Family Educational Rights and Privacy Act (FERPA) cannot be enforced by a private right of action.

Several national groups, including the American Association of Retired Persons (AARP), plan to file amicus briefs in the *Watson* case. The initial briefing was due on November 29, 2004. — Mark Williams, Elder Law Section Chair

Elder Law Section holds CLE program, annual meeting

The Elder Law Section annual CLE program on October 8, entitled *Elder Law Connections*, drew 170 on-site registrants and another 50 video-replay attendees.

The program was designed as an advanced seminar focused on specific issues for elder law practitioners. The Section CLE subcommittee, co-chaired this year by Jane Patterson and Steve Heinrich, alternates between programs focused on advanced issues and programs geared to the beginning or occasional practitioner.

Tim McNeil and Mark Williams reported on relevant provisions from the new ethics code and recent attorney discipline cases. Margaret Madison Phelan detailed tips to "abuse-proof" your client, complete with office forms. Stephen Owen shared practical and litigation responses to elder financial abuse. Warren Deras gave his insight into the manifold pitfalls associated with notice to heirs in probate administration. Brian Haggerty and Katherine Zelko focused on tax issues for both the living and the deceased client. Geoff Bernhardt explored the vagaries of home ownership and public benefits, while Susan Ford Burns gave her insight into removing unwanted occupants of real property. Finally, an hour of elimination-of-bias credit was given for a presentation by Linda Nickolisen on communicating effectively with elders and people with disabilities. Tapes and videos are available from the Oregon State Bar CLE office.

Elder Law Section holds annual meeting

The Section's annual meeting took place during the noon break of the October 8 CLE seminar. Board chair Wes Fitzwater reported that the Section is 525 members strong, reflecting a steady increase since the Section's inception in 1997 with approximately 400 members.

It was agreed that our annual dues will remain at \$25 for 2005.

The nominating committee report was adopted. The committee worked to comply with the Oregon State Bar directive to maintain geographic diversity among board membership, in addition to adding attorneys of considerable accomplishment and experience to the Section leadership.



(Left to right) Section chair Wes Fitzwater, CLE Subcommittee co-chair Steve Heinrich, presenter Tim McNeil, presenter Mark Williams, and CLE Subcommittee co-chair Jane Patterson prepare for the ethics session at the Section's annual CLE program.



Steve Heinrich introduces Brian Haggerty and Katherine Zelko, who raised the participants' awareness of life, death, and tax issues.

The officers for 2005 are:

- Chair: Mark Williams
- Chair-elect: Jane Patterson
- Secretary: Steve Heinrich
- Treasurer: Kristianne Cox

Current board members elected to another term are: Hon. Claudia Burton, Wes Fitzwater, Sylvia Sycamore, and Alexis Packer. New board members are: Gary Vigna, Portland; Ryan Gibb, Salem; and Brian Haggerty, Newport.

Paying relatives for care *Continued from page 6*

in *Problem Prevention in Elder Law*, a CLE program sponsored by Oregon State Bar and Elder Law Section, October 2001 (includes sample contract), and Margaret Hall, "Care Agreements: Background Paper," available at www.bcli.org/pages/projects/elderly/BP_Care_Agreements.html.

Arrangements to avoid

Often, an elder does not have the cash to pay for care on an ongoing basis, but he or she has illiquid assets, such as a house, that can be transferred as payment for care. Two of the most obvious ways of paying for care by transferring a house or other asset—contracts to make wills and outright transfers of interests up front—can create a variety of problems. These mechanisms should, therefore, be approached with caution and avoided unless there is a very good reason for choosing them.

Contracts to make a will

Contracts to make wills generate many problems, largely deriving from people's varying memories about what agreements were made, what they meant, and what they required, as well as property owners' simple failure to do as they promised. In addition, contracts to make wills do not provide very good protection to family members who provide care. In Oregon, statutory shares for the protection of the surviving spouse take precedence over contracts to make wills. *Sheldon v. Sheldon*, 987 P.2d 1229 (Or. App.1999); *Patecky v. Friend*, 220 Or. 612, 350 P.2d 170 (1960). Further, even if a decedent dies with an estate plan in compliance with the contract, if his or her estate is subject to recovery for Medicaid benefits, the state's claim will be paid before the estate is distributed to the devisees, which means that little or nothing may be left for them. ORS 115.125.

Conveying the house up front or into joint ownership with right of survivorship

As a contributor to the Elder Law Section Internet discussion list recently observed, "Putting a child's name on a deed...is almost always a bad idea. If the child has an ownership interest in the property, the child's creditors can get to the property, and the parent cannot sell or refinance the property without the child's permission." In addition, if the elder transfers the home outright and comes

to disagree with the caregiver about the adequacy of the care provided, the elder has no bargaining power to improve the situation, and may even find himself or herself out on the street without home or care. These problems also arise to greater or lesser extents if the property is transferred into joint ownership with right of survivorship.

Moreover, if the elder needs to apply for Medicaid within three years after he or she conveys the house or an interest in the house, the conveyance may be a disqualifying transfer. Even if this is not an issue, when the elder dies, the state may seek to recover the elder's Medicaid debt from the house. For purposes of estate recovery, it is presumed that the value of the decedent's share of property jointly held with right of survivorship is the fractional share held by the person, unless they are spouses. If the parties are spouses, they are conclusively presumed to own the property half and half. OAR 461-135-0845.

An alternative to consider

Some attorneys recommend that the cash-poor elder who plans to pay for care with an interest in real estate give the caregiver a note with an increasing balance owed, based on the care provided and protected by a security interest in real property.

Planning and after-the-fact salvaging

Ideally, elder clients who plan to hire family members to provide in-home care will consult an attorney before they make arrangements, but this obviously does not always happen. Attorneys should consider incorporating a discussion of the basic issues into counseling of clients who come to them for estate or disability planning. Attorneys should also be attuned to the possibility that people who come to them asking only for help in conveying a house to a child alone or in joint ownership with a parent may be making such an arrangement. In this case, the attorney should make discreet inquiries to find out whether the conveyance is in return for a promise of care and, if so, help the client decide whether this is the best plan.

Additional Resources

OARs governing in-home care available from the DHS Web site at www.dhs.state.or.us/policy/spd/rules.htm and from the state archives Web site at arcweb.sos.state.or.us/banners/rules.htm

DHS CEP Program Guides for Employers and Care Providers available as pdf files at www.dhs.state.or.us/seniors/choosing_care/help_in_home.htm#cep

DHS help for caregivers: www.dhs.state.or.us/seniors/caregiving/index.htm

Oregon State Bar Elder Law Section, *Elder Law Newsletter* focusing on in-home care, Winter 2003 available at www.osbar.org/sections/elder/newsletters.html (Articles include detailed information on tax and employment law issues for private pay contracts.)

British Columbia Law Institute, *Private Care Agreements Between Older Adults and Friends or Family Members*, March 2002 www.bcli.org/pages/projects/elderly/Rep_Care_Agreements.html

Family Caregiver Alliance: www.caregiver.org/caregiver/jsp/home.jsp

THE RESOURCE CORNER**An interview with Rick Mills**

By Alexis Packer, Attorney at Law, Ashland

This issue of the Elder Law Section *Newsletter* looks at some ways to pay for long term care. One of these is Medicaid. When the Medicaid program pays, the deceased recipient's estate may have to reimburse the state for some or all of the benefits paid. It therefore seems fitting that the interviewee for this issue's *Resource Corner* is a person intimately involved in the affairs of the Estate Administration Unit of the State of Oregon (EAU), the Salem-based body of the Department of Human Services (DHS) charged with what is commonly known as Medicaid estate recovery.

Rick Mills is a member of the Elder Law Section, and has served as the assistant manager of the EAU since 2002. Before that, he spent 15 years in private practice and four years in other areas within DHS, including Medicaid eligibility.

The resources selected by Rick as invaluable for understanding Oregon Medicaid estate recovery are Oregon Administrative Rules (OAR) 461-135-0832 through 461-135-0845 and the statutes upon which those rules are based. In addition to identifying resources, I asked Rick about recurring problems his office sees, the causes of those problems, and practical advice for elder law practitioners who work with Medicaid estate recovery issues.

The first problem he identified was confusion about which assets are subject to Medicaid estate recovery. ORS 414.105(5) contains an expanded definition of what is included in an "estate." The statute was amended in 1995 to reflect federal changes to estate recovery made in the Omnibus Budget Reconciliation Act (OBRA) of 1993. It authorizes the EAU to make a claim for the amount of medical assistance paid when the recipient was 55 or older against all of the deceased Medicaid recipient's real and personal property, and any other assets in which the deceased recipient had any legal title or interest at the time of death, regardless of whether those assets are subject to probate. Life estates, real property held with a right of survivorship, and joint bank accounts are examples of non-probate property that may be subject to the state's claim. Rick added: "It is important to remember that only the portion considered to have belonged to the decedent will be subject to a claim, usually 50 percent for joint assets." OAR 461-135-0845 describes how the proportionate interests are determined.

He went on to remind practitioners that the EAU will not enforce its claim under ORS 414.105 if the person who received Medicaid benefits is survived by a blind or permanently and totally disabled child of any age, as defined in ORS 412.510(3), or a child under the age of 21. Further, if the deceased Medicaid recipient leaves a surviving spouse, "the EAU will not enforce its claim while the surviving spouse is alive. In either case EAU will submit a 'contingent' claim in the Medicaid recipient's estate. The claim is contingent on the child or spouse surviving the estate of the Medicaid recipient. When the surviving spouse passes away, EAU will submit a claim to the surviving spouse's estate for the amount of assistance provided to the predeceased spouse." Rick noted, however, that the Medicaid claim against the surviving spouse's estate is only payable to the extent the surviving spouse received assets by virtue of the Medicaid recipient spouse's death, whether through a probate, a payable-on-death designation, or by right of survivorship, as set out in ORS 414.105(2) and OAR 461-135-0835.

His second concern involved a change to probate procedure enacted in 2001. ORS 113.145(6) now requires the personal representative in every probate to provide DHS with the same information that must be provided to the heirs and devisees within the same 30-day period. A copy of the death certificate must accompany the notice to DHS. Rick requested that attorneys not block out Social Security numbers on the copy of the death certificate because EAU uses them to verify whether they have a match before submitting a claim. Similarly, in small estate proceedings, ORS 114.525(11) requires the EAU receive a copy of the affidavit showing the date of filing. OAR 461-135-0834 directs that the notices for both probates and small estate proceedings be delivered or mailed to Estate Administration Unit, P.O. Box 14021, Salem, OR 97309-5024. In small estate proceedings, the practical advice is to instruct the affiant not to distribute the proceeds to the devisees or heirs until the four-month period for EAU and other creditors to file claims under ORS 114.525(12)(a) has passed.

The responsibility to give notice to DHS exists even when an estate is opened solely for the purpose of pursuing a wrongful death action. "Some practitioners apparently believe that since wrongful death proceeds pursuant to ORS 30.030 are generally not available to pay creditors of the estate, there is no duty to provide the statutory notice to EAU. EAU and Department of Justice take the position that the duty to provide notice to EAU is required for any estate, including estates opened to pursue wrongful death claims. Some probate courts have been requiring proof of service on EAU even for these estates. It should be noted that EAU may have a claim for reimbursement against the proceeds for medical expenses paid by DHS. Furthermore, DHS may be entitled to place a lien on the proceeds." The lien that Rick mentioned is the lien created by ORS 416.510 *et seq* on a judgment or settlement for personal injuries to an applicant for or recipient of state assistance, including Medicaid.

Rick commented that, along with the notice, some attorneys request a release from EAU. "Because of the volume of notices the unit receives, we do not routinely provide releases. If we have a claim it will be submit-

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Interview with Rick Mills *Continued from page 17*

ted within the statutory time for claims. However, as a courtesy, the unit will frequently comply with requests if there are unique circumstances. It should also be noted that some probate courts are requiring showing of proof of service on EAU before the estates are closed." He continued, "If EAU does not receive notice, we may be able to petition the court to reopen the estate under ORS 116.233 or possibly bring an action against the personal representative or recipients of the estate under ORS 115.004. Whether these 'remedies' would work for the unit, however, is not clear since we have not found a case where we felt compelled to try and use them."

A third type of problem can occur in an estate in which the decedent's home is the only asset subject to probate. An attorney may ask a title company to issue title insurance, allowing the property to transfer without the time and expense of probate. Some companies will agree to issue the insurance for a larger premium, based on an affidavit of heirship. Rick counsels attorneys to consider the risk posed by a potential Medicaid estate recovery claim. "There have been instances where EAU had a claim in the decedent's estate, when the property was transferred using an affidavit of heirship. When EAU has not been able to resolve this informally, the agency has initiated probate proceedings, typically by nominating a personal representative who then files suit to quiet title. The usual result of these cases is the title company ends up paying money to the estate to satisfy EAU's claim." The practical advice here is to assure there is no potential Medicaid estate recovery claim before asking a title company to consider accepting an affidavit of heirship, in lieu of a probate, to transfer an interest in real property.

Rick identified a fourth problem area concerning the payment of funeral expenses in insolvent estates. ORS 115.125 sets out the order of priority for claims of an insolvent estate. Third on the list of claims is "expenses of a plain and decent funeral." Ninth on the list is the DHS claim for "the net amount of public assistance...paid to or for the decedent," which includes Medicaid benefits. EAU takes the position based on OAR 461-006-0452 that \$3,000 is generally sufficient for a plain and decent funeral, and can object to charges that exceed that amount. Rick pointed out that the Medicaid recipient (or the surviving spouse) can avoid this situation with prepaid arrangements for funeral and disposition of remains.

The notice requirements for final accountings give rise to the fifth problem. In a probate, if EAU presents a claim against the estate that is not paid in full, ORS116.093(4) requires that EAU, along with the heirs and devisees, be given notice and the opportunity to object to the final accounting. Rick commented, "The remedy for failing to provide the required notice is somewhat speculative because, fortunately, we have not found ourselves in a situation where we have felt compelled to seek a remedy."

The sixth problem is the lack of awareness of EAU's authority to waive its claim in undue hardship situations. If a beneficiary of an estate can show that he or she will suffer undue hardship – meaning if EAU pursues its claim, the beneficiary will have to go on public assistance and will become homeless – the beneficiary can submit a hardship waiver to request EAU to waive, reduce, or modify its claim pursuant to OAR 461-135-0841 and 461-135-0844. Rick reported that even if a beneficiary doesn't technically qualify for a hardship waiver, EAU is willing to discuss individual situations and, when appropriate, try to work out a livable compromise. Examples of compromises include negotiating installment payment plans and accepting a note and trust deed to real property, with no interest or payments due until the property is sold or transferred. Rick stressed that EAU tries to be flexible while still assuring that the Medicaid claim will be paid.

Rick concluded by adding, "One of the things I routinely do when I discuss estate recovery with people is emphasize an important caveat. I caution them that I can explain what the laws, rules, and policies are today. I cannot guarantee they will be the same in the future. This is important in the area of estate recovery, because a client may live for years before they pass away, and there is no way to promise that estate recovery will be the same when they pass away."

Recommended Resources

Attorneys with questions about an existing estate recovery claim can call EAU at 503.947.9975 or 800.826.5675. Give the decedent's name in order to reach the correct staff member.

The OSB CLE publications *Elder Law* (chapter 8 addresses estate recovery and includes practice tips) and *Administrating Oregon Estates* can be purchased on CD or in print form, with forms on disk (\$175 each) from the OSB (503) 620-0222, ext. 413 or online at www.osbar.org. An update to *Elder Law* is scheduled for late 2004.

Oregon Administrative Rules (OARs)

The official version of OAR Chapter 461 is included in the 2004 edition of the *Adult and Family Services Administrative Rules Manual*, which can be purchased from the Administrative Rules Unit of the Oregon Secretary of State's office for \$40.00 by calling 503.373.0701 ext. 240 and requesting an order form. New volumes are published annually, in February. The OARs are available online free of charge at the Secretary of State's Web site: arcweb.sos.state.or.us. The online version is updated monthly.

A searchable version of OAR Chapter 461 is available on the DHS Web site free of charge. Go to www.dhs.state.or.us/seniors, click on *Tools for Staff* at the bottom of the page, then on *Chapter 461* under *Administrative Rules* at the top of the next page. DHS usually posts rule changes on its site on the day a new rule takes effect.

The OARs are also available in Casemaker on the OSB Web site.

Veterans *Continued from page 9*

auspices of the ODVA, and provides long term nursing and Alzheimer’s care for Oregon veterans who have served on active duty in the armed forces and have been honorably discharged. Medicare and Medicaid have certified the Oregon Veterans’ Home for eligible veterans and their spouses. It has 151 beds, 25 of which are in the Alzheimer’s care unit. The cost to stay at Oregon Veterans’ Home is less than most other private nursing facilities in Oregon.

Hypothetical situation

The array of eligibility criteria and benefits under the federal VA system is somewhat daunting to anyone who does not work with them on a day-to-day basis. When you have a client who is a veteran, one of the best resources is a Veterans Service Officer accredited by ODVA. The Veterans Service Officer and assistants will help the veteran apply for all benefits for which he or she might be eligible, at no charge to the veteran. They frequently work out of the local Area Agency on Aging office or the local branch of the state Seniors and People with Disabilities office.

The following hypothetical situation is presented simply to give the readers an idea of how it might work.

The wife of a 59-year-old Vietnam veteran comes into your office to ask for help in getting her husband into a care facility. While serving in Vietnam, her husband received a head injury. Upon being honorably discharged he received a 50 percent disability rating because of his injury, and has been receiving compensation for it ever since. He has been able to work as a civil engineer most of his life. However, four years ago he was diagnosed with Alzheimer’s Disease, and is now at the point where his wife can no longer take care of him. His private doctor believes that the early onset of Alzheimer’s was directly related to his head injury received while serving in Vietnam.

Since this veteran has only a 50 percent rating for his service connected disability, the VA will not pay for his care at a long-term nursing care or Alzheimer’s facility. In this case, he could apply to stay at the Oregon Veterans’ Home, but he would have to pay the costs himself unless he was found eligible for Medicaid assistance.

Another alternative for this veteran would be to apply for an increase in the degree of his disability rating. If the VA increases his disability to 70 percent or higher based on the premise that his Alzheimer’s is directly related to his service-connected injury, the VA would pay for his stay in a nursing facility.

Footnote

1. A “wartime veteran” is one who served in the U. S. military during the following wars: WWI (12/7/1941 to 12/31/1946); Korean War (6/27/1950 to 1/31/1955); Vietnam War (8/5/1964 to 5/7/1975 (for veterans who served “in-country” in Vietnam before 8/5/1964, the beginning wartime date falls back to 2/28/1961); Gulf War (8/2/1990 to a date to be set by law or presidential proclamation.

Supplemental Security Income (SSI) Benefit Standards	Eligible individual \$579/month Eligible couple \$869/month
Medicaid (Oregon)	Long term care income cap. \$1,737/month Community spouse minimum resource standard. \$19,020 Community spouse maximum resource standard \$95,100 Community Spouse Minimum and Maximum Monthly Allowance Standards \$1,561/month; \$2,377/month Excess shelter allowance Amount above \$468/month Food stamp utility allowance used to figure excess shelter allowance \$287/month Personal needs allowance in nursing home \$30/month Personal needs allowance in community-based care \$122/month Room & board rate for community-based care facilities \$458.70/month OSIP maintenance standard for person receiving in-home services \$580.70 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2004 \$4,700/month
Medicare	Part B premium \$78.20/month Part B deductible \$110/year Part A hospital deductible per illness spell \$912 Skilled nursing facility co-insurance for days 21-100 \$114/day
Social Security	The 2005 cost of living increase for Social Security recipients is 2.7 percent. The full retirement age increases to 65 years and 6 months in 2005.

Important elder law numbers as of Jan. 1, 2005

APR subcommittee report

Continued from page 4

choose such coverage, and if they do not, the state will not pay for their prescriptions. The Agency is working on rules for the transition.

Estate recovery—surviving spouse

We questioned the estate recovery letter that states that a surviving spouse must live longer than the probate of the institutionalized spouse's estate in order to receive assets without a claim. We noted that under the ORS assets vested at death. The Agency intends to stick with its position because it claims the law is unclear.

Spousal elective share

We also asked whether or not there were any changes in policy governing the elective share of a spouse currently on Medicaid from the estate of the pre-deceased community spouse. There are no changes, and the procedures are somewhat covered by Executive Letter 01-020.

Estate recovery from life estate

The Agency is not going to change its policy of relying on the federal tables valuing life estates. These are now part of the OAR. However, the Agency did lower its claim in a case it did not want to discuss.

Miscellaneous

The transfer divider is \$4,700 as of October 1, 2004. The income cap is \$1,737 per month as of January 1, 2005. Expect new rules to be noticed that affect annuities.

Next meeting

Our next meeting will be February 4, 2005. Please send any issues to a member of the subcommittee.

Newsletter Board

The *Elder Law Newsletter* is published quarterly by the Oregon State Bar's Elder Law Section, Mark Williams, Chair. Statements of fact are the responsibility of the authors, and the opinions expressed do not imply endorsement by the Section.

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