Oregon State Bar Elder Law Newsletter

Volume 21
Number 1
January 2018

Significant changes to Medicaid-funded long term care support services in Oregon

By Andrea Ogston, Attorney at Law

The Portland Regional Office of Legal Aid Services of Oregon (LASO) frequently receives calls about elders who face termination from the long term care program or a drastic reduction in home care hours. The genesis of some of these changes can be traced to the U.S. Department of Labor's elimination of the availability of the companionship exemption to the Fair Labor Standards Act. The unavailability of this exemption had significant budgetary effects on the long term care system in Oregon because it required that home-care workers be paid overtime and travel time. In 2015, the Department of Human Services (DHS) began taking various steps to ameliorate the situation. These budget deficits were in addition to other statewide budget reductions and anticipated shortfalls subsequent to the Department of Labor rules. DHS underwent an analysis of how costs could be reduced and still meet the most pressing needs of long term care recipients. The major changes in long term care services can be viewed as falling into three categories: service priority levels, reduction in in-home care hours, and termination of the live-in program.

In this issue

Service priority level criteria changes

Service Priority Levels (SPL) one through 13 will continue to be served by DHS. OAR 411-015-0015(2). However, the criteria for meeting SPL one through thirteen were changed via new definitions of the activities of daily living (ADL). OAR 411-015-006. These changes went into effect October 1, 2017, and will be applied to individuals on a rolling basis as they become due for their annual recertification. With some exceptions, the new criteria are harder to meet and are expected to result in approximately fifteen percent of current clients being dropped from the program. In addition, the ADLs were reconfigured in various ways. For example, getting to and from the toilet is no longer captured under elimination, but is now considered in the ADL of mobility. OAR 411-015-0006(7). The ADL of cognition received significant revisions. OAR 411-015-0006(3). An online summary of frequently asked questions highlights some of the changes to the cognition criteria and may be an area where overworked caseworkers may benefit from family involvement in highlighting how the consumer meets the criteria. http://www.dhs.state.or.us/spd/tools/cm/October%202017%20Changes/Q%20and%20A%20October%20Changes%20171020.pdf .

In light of these more stringent criteria, unless there have been dramatic changes in needs, current participants should be discouraged from requesting a new evaluation prior to the annual certification in order to maximize the time that remains under their current service plan. Many who are reevaluated will face a reduction in hours and some may be found entirely ineligible for the program.

Extended waiver eligibility

For individuals facing termination from the long term care program, the availability of the Extended Waiver Eligibility (EWE) may provide relief. See OAR 411-015-0300. The EWE

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will allow individuals who currently receive Medicaid-funded long term care support services to remain eligible if they are assessed as an SPL 14 to 17 and meet the waiver's other criteria which include: "(a) Lack of access to shelter and support would cause the individual to deteriorate or decompensate; (b) Without supports, individual would lack access to safe housing or has a documented history of eviction or threats of eviction that would lead the individual to deteriorate or decompensate; or (c) Without supports, individual is at significant risk of abuse or exploitation." *Id*. Eligibility for the waiver can be extended so long as the individual continues to meet these criteria and demonstrates some progress in addressing the issues resulting in eligibility.

Availability of transition services

In addition, individuals transitioning to a lower level of care are eligible to receive "Transition Services." 411-035-0075. Under this DHS rule, clients can receive assistance for driving to view housing, application fees, deposits, first and last months' rent, furnishing for their new units, and other basic household goods.

Reduction in available in-home-care hours

DHS also issued rules effective October 1, 2017, that reduced the maximum number of in-home hours available for the assessed need level for each ADL and Instrumental ADL (IADL). As with the service priority level changes, these will be implemented on a rolling basis as individuals come due for their annual recertification. Significantly, caseworkers may now elect to grant fewer than maximum number of hours for the corresponding need level. However, if caseworkers elect to offer less than the maximum number of hours they must document the reason. 411-030-0020(c)(2).

There will be several challenges to understanding why, how, or if a client's hours have changed due to a change in need, or a rule change. First, the department changed frequency of vouchers to every two weeks, which means hours are issued under a new interval which resulted in hour changes that do not necessarily correspond to a reduction in hours. In addition, as explained above, certain tasks are now captured under a different ADL or IADL, which means that a reduction in one area may be captured under a different category of need.

Below is a summary of the changes made to OAR 411-030-0070: Maximum Hours of Assistance. The value in parentheses is the hours previously allocated for the ADL or IADL. For ease of comparison, these are divided in half to get a general sense of the reduction, but are not entirely accurate due to how DHS divides the weeks. See also: http://www.dhs.state.or.us/policy/spd/transmit/pt/2017/pt17031.pdf.

IADL/ADL	Minimal Assistance	Substantial Assistance	Full assistance
Eating	3 (2.5)	6 (10)	12 (15)
Dressing and Grooming	1(2.5)	3 (7.5)	6 (10)
Bathing and Personal Hygiene	2 (5)	7.5 (5)	9 (12.5)
Mobility	2 (5)	5 (7.5)	9 (12.5)
Elimination	5(5)	9 (11)	14 (12.5)
Cognition	3 (2.5)	6 (5)	12 (10)
Medication Management	1(1)	2(2)	5(3)
Transportation	1(1)	1(1.5)	2 (2.5)
Meal Transportation Breakfast Lunch Dinner	 1 (2) 1(2) 2(4)	 2(4) 2(4) 3(8)	 5 (6) 5 (6) 6 (12)
Shopping	1(1)	2(2)	3(3)
Housekeeping and Laundry	2 (2.5)	5(5)	9 (11)

The maximum hours available under an "hourly plan" is 62 for ADLS and 35 for IADLS. This means that an individual who has hourly needs greater than 97 hours per two weeks (194 hours per month) must qualify for "Shift Services" or qualify for an "exception" to have his or her needs met.

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Termination of the live-in program and transition into "shift services"

The live-in program, following a phase-out period, was fully terminated October 1, 2017. Leading up to the closure date, individuals who received 24-hour care through a live-in caregiver were transitioned to shift services. Shift services are defined as "hourly services provided by awake home-care workers... to an individual who is authorized to receive a minimum of 16 hours of services during a 24-hour work period... ." OAR 411-030-0020(50). The criteria for meeting eligibility for shift services are defined by OAR 411-030-0068. If individuals meet these criteria, they are defined as being eligible for shift services, meaning that they should be granted a minimum of 16 hours per day. There is no further guidance in the rules for allocating hours for an individual who meets the criteria under OAR 411-030-0068 and has needs that go above 16 hours per day.

If an individual does not meet the criteria for shift services under OAR 411-030-0068 but has needs that go above those allocated under the maximum allowed number of hours pursuant to OAR 411-030-0070, those needs are approved through an exception process. The rules that guide the exception process are scant. OAR 411-030-0020(24) defines an exception as an individual that has needs that exceed the maximum number of hours of service provided in OAR 411-030-0070 (in-home exception) and 411-027-0050 (HCBS exception). The office of Aging and People with Disabilities (APD) has developed a guide and various resources on the process, which can be found at http://www.dhs.state.or.us/spd/tools/cm/exceptions/index.htm. This opaque process, issued through a series of forms and case-manager training, is not reflected in the rules. Individuals may not be informed that they have been screened for an exception. They may also not know that they have a right to such a request. If caregivers find they cannot meet their clients' needs under the allocated hours, they should request an exception and verification that the request was made. If they disagree with the decision, they should ask for a hearing.

Areas for advocacy

The most devastating consequence of these changes is the clients' fear that they will no longer be able to live safely at home with caregivers they trust. Individuals have a right to choose, and DHS has pledged to support elders staying in their homes. Some people have expressed a sense that they are not being offered the option to stay at home and have been left with the impression that an adult foster home is their only option. This is not the case. While cost is a consideration, it is not the only consideration.

Furthermore, individuals in need of support have a right to receive appropriate, competent care. Foster home providers report they are receiving residents who have needs above and beyond what they feel they are equipped to handle. Family concerns that an adult foster home is not providing adequate care may be an emerging issue. Adult Protective Services and the Long Term Care Ombudsman can help with these issues.

There are additional concerns that notices sent to clients provide very little information regarding the reasons behind the reduction or meaningful information as to how or why they arrived at a specific service plan. In regard to suggested reliance on "natural supports," many elders feel they are burdening family members who cannot afford the time or lack the skills to provide the needed care, but they are left with a Hobson's choice: taking it or taking nothing. However, it remains the law that natural supports must be voluntary and are "required to have the skills, knowledge, and ability to provide the needed services and supports." OAR 411-030-0020(40); see also 411-030-0040(1).

(Editor's note: The topic of natural supports was covered in the January 2012 and July 2013 issues of this newsletter, available on the Section's website)

Advising clients

Clients have 45 days to request a hearing from the date of the notice, and ten days to ask that their benefits continue while they wait for a hearing. The ten days begin with the date of the notice, the effective date of the change, or ten days from receipt of the notice, whichever is later.

While clients' decisions to avail themselves of continuing benefits should be individualized, for the vast majority the state will have limited options for recovery should a client ultimately lose at hearing and be required to repay the benefits.

It is also worth advocating with the caseworker with regard to the service plan and how it fails to meet the client's needs. If the client's needs have changed recently, it may also make sense to request a new evaluation.

Finally, clients with long term care support services can be referred to Legal Aid Services of Oregon. ■

The basics of Medicaid estate recovery

by Kathryn F. Gapinski, Attorney at Law

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As part of the statutory requirements for probate administration, you sent notice to the Department of Human Services/Oregon Health Authority. Much to your surprise, the Department of Human Services files a claim for Medicaid estate recovery. You are confused because the deceased was not receiving Medicaid. You find out that his wife, who died in 2014, was a Medicaid recipient. Are you required to pay the claim? Before you advise the personal representative to allow or disallow the claim, you should determine if the claim is subject to any limitations and if it needs to be paid.

This article covers the basics of Medicaid estate recovery and provides a list of questions to help you determine whether a given claim is valid and the limitations to which the claim is subject. (Medicaid estate recovery is a complex area of law and this article covers only the basic issues.) "Medicaid" and "medical assistance" are used interchangeably.

What is Medicaid estate recovery?

Federal and state laws require the State of Oregon to recover medical assistance from the estates of recipients, and governs Medicaid estate recovery, specifically: 42 USC §§ 1396 – 1396w-5, Oregon Revised Statutes 416.310 – 416.351, and the Oregon Administrative Rules Chapter 461, Division 135. In Oregon, the Estate Administration Unit of the Department of Human Services (EAU) oversees Medicaid estate recovery. If the EAU believes it has a claim, it may file a claim in the decedent's probate estate or pursue non-probate assets (subject to limitations discussed below). Most commonly, the asset in question regarding estate recovery will be the family home.

The EAU's claim is a claim against the estate and not a lien. The State of Oregon is a creditor and is listed in the order of payment of expenses and claims in ORS 115.125 in a probate estate. The EAU's level of priority falls below expenses of administration and taxes, but above general creditors. See ORS 115.125 for the complete order of payment of claims and expenses.

Issue-spotting questions

When administering an estate that involves a Medicaid recipient or a spouse that survived longer, there are several questions you should ask to determine if the EAU has a valid claim and if there are any limitations on that claim:

- Did the decedent receive Medicaid? Did the decedent's predeceased spouse receive Medicaid?
- Was the Medicaid recipient permanently institutionalized? How old was the Medicaid recipient? When did the recipient receive Medicaid?
- Which definition of "estate" applies?
- Does the Medicaid recipient have a surviving spouse or registered domestic partner?
- Does the Medicaid recipient have children? Are any of the children under the age of 21, disabled, or visually impaired?
- Would estate recovery create an undue hardship for surviving family members?

Example

Let's walk through the husband and wife in your probate estate as an example. You have gathered some initial information. Here are the facts:

- The husband, who died in 2017, did not receive Medicaid. He was not married at the time of his death.
- The wife received Medicaid from 2010 to 2014, from ages 73 to 77, and lived in a nursing home.
- The probate estate consists of: (a) a bank account that is in the husband's name only; and (b) the family home (owned by both husband and wife, as tenants by the entirety before the wife's death, and owned solely by the husband at his death).
- The beneficiaries of the husband's estate are the couple's two adult children (both in their 50s). Neither is disabled or visually impaired. They are both financially secure.

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Did the decedent receive Medicaid? Did the decedent have a spouse who predeceased him and who received Medicaid?

You should first determine if the decedent received Medicaid.[1] You should also find out if the decedent has a predeceased spouse who received Medicaid, because the EAU can also recover against the estate of the surviving spouse of a Medicaid recipient.

In our example, the husband did not receive Medicaid. His predeceased spouse was a Medicaid recipient. Recovery of her medical assistance is the source of the EAU's claim.

How old was the Medicaid recipient? Was the Medicaid recipient permanently institutionalized? When did the Medicaid recipient receive benefits?

Whether or not the Medicaid recipient was permanently institutionalized affects which assets the EAU can recover.[2] The answer to this question is also intertwined with how old the Medicaid recipient was when she or he received benefits and the dates benefits were received.

Medicaid recipient was not permanently institutionalized

If the Medicaid recipient was not permanently institutionalized, the next questions to ask are: How old was the Medicaid recipient when she received the benefits? When did she receive the benefits?

OAR 461-135-0834(4)(f) breaks down what can be recovered from the estates of individuals who were ***not*** permanently institutionalized, as follows, based on their age when they received the benefits and the dates they received the benefits:

A. The amount of any payments or benefits paid prior to October 1, 1993 to or on behalf of a recipient 65 years of age, or older are a claim against the probate estate of any deceased recipient.

B. The amount of any payments or benefits, paid on or after October 1, 1993, and prior to July 18, 1995, to or on behalf of a recipient 55 years of age or older are a claim against the probate estate of any deceased recipient.

C. The amount of any payments or benefits paid on or after July 18, 1995, and prior to October 1, 2013, to or on behalf of a recipient 55 years of age or older are a claim against the estate of any deceased recipient. All correctly made payments on or after January 1, 2010, for Medicare cost sharing (see OAR 461-135-0832) are excluded from a claim.

D. The amount of any payments or benefits paid October 1, 2013, or later to or on behalf of a recipient 55 years of age or older, during the time the department was paying any of the cost of care of the individual in a nursing facility, home and community-based care (see OAR 461-001-0030), or in-home services through the State Plan Personal Care Services (see OAR 411-034-0010), are a claim against the estate of any deceased recipient. All correctly made payments on or after January 1, 2010 for Medicare cost sharing are excluded from a claim.

Medicaid recipient was permanently institutionalized

If the Medicaid recipient ***was*** permanently institutionalized, OAR 461-135-0834(4)(g) details which assets and medical assistance can be recovered based on the dates the benefits were received:

For permanently institutionalized individuals, a claim includes amounts calculated according to subsection (f) of this section and the following:

A. The amount of any payments or benefits before July 18, 1995, to or on behalf of a recipient who was permanently institutionalized is a claim against the probate estate of the deceased recipient.

B. The amount of any payments or benefits paid between July 19, 1995, through September 30, 2013, to or on behalf of a recipient who was permanently institutionalized is a claim against the estate of the deceased recipient.

C. The amount of any payment for services provided in a nursing facility, an intermediate care facility for an individual with intellectual or developmental disabilities, a psychiatric institution, or other medical institution (see OAR 461-135-0832) paid after September 30, 2013, to or on behalf of a recipient who was permanently institutionalized is a claim against the estate of the deceased recipient.

In our example, the wife was in a nursing home and therefore permanently institutionalized. Medical assistance was paid from 2010 through 2014. Repayment falls under both OAR 461-135-0834(4)(g)(B) and (C).

What definition of "estate" applies?

Answering the question of when the Medicaid recipient received assistance will enable you to determine which assets can be recovered. Prior to 1993, federal law limited the definition of the estate to each state's probate definition of the estate. Congress passed the Omnibus Reconciliation Act of 1993, which allowed states to expand the definition of "estate" for Medicaid estates.

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The definition of the "estate" of a Medicaid recipient is defined under federal law as follows:

42 USC § 1396p(b)(4): For purposes of this subsection, the term *estate* with respect to a deceased individual:

A. shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

B. may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i)[3] applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."

Effective July 18, 1995, the State of Oregon chose to exercise the option under federal law to expand the definition of *estate* for Medicaid recovery purposes. Under ORS 416.350(6)(a), Oregon's current definition of *estate* is: "All real and personal property and other assets in which the deceased individual had any legal title or interest at the time of death including assets conveyed to a survivor, heir or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other similar arrangement.

Estate is further defined in OAR 461-135-0832(13)[4] as follows:

13 "Estate" means with respect to the collection of payments made for medical assistance provided **on or after July 18, 1995,** all real property, personal property, or other assets, wherever located, in which a recipient had any legal title or ownership or beneficial interest at the time of death, including real property, personal property, or other assets conveyed by the recipient to, subsequently acquired by, or traceable to, a person, including the recipient's spouse and any successor-in-interest to the recipient's spouse, through:

(a) Tenancy by the entirety;

(b) Joint tenancy;

(c) Tenancy in common;

(d) Not as tenants in common, but with the right of survivorship;

(e) Life estate;

(f) Transfer on death deed;

(g) Living trust;

(h) Annuity purchased on or after April 1, 2001; or

(i) Other similar arrangement.

Assets not included on this list, such as life insurance paid to beneficiaries (and not to the estate) are not subject to Medicaid estate recovery. (***Practice Tip***: Naming a beneficiary for life insurance rather than naming the estate means the EAU will not be able to recover against the life insurance.)

With respect to tangible personal property, the EAU has stated, "these items may have great personal value to family and friends. Unless the items have significant monetary value, EAU will generally not enforce its claim against these items." *DHS Estate Administration Unit. Estate Recovery Program*. Salem: n.p., Rev. 08/2017. Print.

In our example, the wife received Medicaid after July 18, 1995. Therefore, the EAU can recover against the expanded definition of the estate, rather than just her probate estate. The assets in question are a house and a bank account.

The house was owned as tenants by the entirety between husband and wife. Under OAR 461-135-0832(13)(a), property owned as tenants by the entirety is included in the expanded definition of the estate. Therefore, the wife's interest in the house is subject to the EAU's claim.

The bank account in the husband's name only, however, is a different story. His wife did not have an interest in the bank account at her death and therefore this asset is not subject to estate recovery. The person who receives the property has the burden of establishing that the account is not traceable to the Medicaid recipient. ORS 416.350(4). You will need to provide information to the EAU which demonstrates that the wife did not have an interest in the bank account at the time of her death. Once you provide this information, the EAU will release its claim with respect to the bank account.

Does the Medicaid recipient have a surviving spouse or registered domestic partner?

If the deceased Medicaid recipient has a surviving spouse or registered domestic partner, the EAU may not recover against the estate until after the surviving spouse dies. 42 USC § 1396p(b)(2). ORS 416.350(2).

In our example, the EAU was unable to recover when the wife died, because her husband was still living. Now that he has died, the EAU may seek recovery.

Does the Medicaid recipient have children? Are any of the children under the age of 21, disabled, or visually impaired?

If the deceased Medicaid recipient has children under 21 or children of any age who are disabled or blind, the EAU may recover the claim "only at a time when the individual has no surviving child who is under 21 years of age or who is blind or permanently or totally disabled." 42 USC § 1396p(b)(2). ORS 416.350(2).

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OAR 461-135-085(2)(d) states, "the claim for correctly paid payments or benefits under OSIP may not be enforced if the deceased recipient is survived by a child under age 21 (see OAR 461-135-0832), a child with a disability (see OAR 461-135-0832), or a child with a visual impairment (see OAR 461-135-0832); **and the child survives to the closing of the probate estate**." (Emphasis added.)

In our example, the couple's children are over 21 and are not disabled or visually impaired. However, if they were under 21, disabled, or visually impaired, the EAU would have to wait to recover the claim until there were no longer any children under 21 or any children who were disabled or visually impaired.

Would estate recovery create an undue hardship for surviving family members?

If estate recovery would create an undue hardship for "the beneficiaries, heirs, or family members of the deceased client claiming entitlement to receive the assets of the deceased client," the EAU has discretion when it comes to enforcing the claim. OAR 461-135-0841. Under OAR 461-135-0841(2), in determining whether undue hardship exists, the EAU may consider if enforcing the claim would cause the person who applies for the waiver to be eligible for state assistance or become homeless. Whether or not there are other claims under ORS 115.125 may also affect the ability to use the undue hardship exception.

The EAU may forgive all or part of the claim or take a mortgage or trust deed rather than enforcing the claim. OAR 461-135-0841(3). The EAU has no interest in putting people out of their homes, except as a last resort.

In our example, the EAU enforcing the claim would not result in a hardship for the adult children. Both children are financially independent. But let's change the facts slightly. Let's say that one of the adult children is living in the home and is unemployed. He has been living in the home rent-free and relying on his father for support. Sale of the house to pay the claim would cause him to become homeless. He may be able to claim undue hardship and work with the EAU, perhaps to take out a mortgage or give the EAU a trust deed on the house.

Conclusion

In our example, by answering a series of issue spotting questions, we have determined that the EAU can recover against the house, but not against the bank account.

If you receive a claim from the EAU, consider the basic issue-spotting questions above to determine whether there are any limitations on recovery before allowing or disallowing the claim. ■

Footnotes

1. ORS 414.025(14): "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance and payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

   ORS 414.025(15): "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.
2. OAR 461-135-0832(28): "Permanently institutionalized means an individual, regarding of age, who, at the time of his or her death, had resided in a nursing facility, intermediate care facility for the mentally retarded, or medical institution, for 180 days or more."
3. 1396p(4)(b)(1)(C)(i): "In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services."
4. No discussion of Medicaid estate recovery would be complete without mention of the *Nay* decision. *Nay v. Dep't of Human Servs*., 360 Or 668 (2016). In 2008, the State of Oregon amended the Oregon Administrative Rules to include assets transferred to the non-Medicaid receiving spouse —within five years before the application for Medicaid— in the definition of *estate*. In *Nay*, the Oregon Supreme Court invalidated this rule as exceeding the Department of Human Service's authority. In August 2017, the State of Oregon amended the definition of *estate* to comply with the Court's decision in *Nay*.

Non-disqualifying transfers to a disabled child

By Darin Dooley, Attorney at Law

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Suppose that a parent wants to set aside assets for a child with disabilities without affecting his or her own eligibility for Medicaid long term care, either now or in the future. Such a transfer of assets would enable the parent to provide funds for items that improve the child's quality of life without harming the parent's own long term care planning. Is this possible?

To deter otherwise ineligible individuals from obtaining Medicaid benefits, Congress enacted penalties that apply to individuals who transfer their resources to others for less than fair market value. When a Medicaid applicant has transferred a resource for less than fair market value within sixty months of the application, the value of the resource is divided by the average monthly nursing home rate.[1] 42 U.S.C. § 1396p(c)(1)(A) & (B). The resulting quotient determines the period the applicant will be ineligible for benefits. However, Congress also intentionally excluded certain transfers from the transfer penalty rules. 42 U.S.C. § 1396p(c)(2)(B)(iii) states that "An individual shall not be ineligible for medical assistance ...to the extent that...the assets were transferred to, or to a trust . . . established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II) [defining blind and disabled children]."[2]

Disabled child

A parent may transfer an asset (including a home) to a child who is blind or disabled under the Social Security Administration (SSA) criteria or to someone else for the sole benefit of a child who is blind or disabled under the SSA criteria.[3] In some cases, there is no SSA determination of disability because the child may not be receiving Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Childhood Disability Benefit (CDB). For example, the child may be receiving a Veteran's Administration (VA) disability benefit or perhaps is not currently receiving any type of disability benefit. There are measures to determine eligibility under this criterion by either using an administrative medical examination[4] to complete a medical evaluation, or providing medical documentation of the disability.[5] A *child* is a biological child, an adopted child, or stepchild of any age and of any marital status.[6]

Transfers to another for the sole benefit of the child

A transfer is for the sole benefit of another individual only if it is (1) a written agreement, (2) that legally binds the parties, and (3) clearly expresses that the transfer is for the sole benefit of that individual. Examples of a written document include (a) a trust, (b) a deed which establishes that the grantee is the sole owner, or (c) a legally enforceable contract reciting that the transfer is for the sole benefit of the recipient.[7] Both the federal government and Oregon further clarify that a transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the child who is blind or has a disability under the SSA criteria is not considered to be established for the sole benefit of the child. Step transfers, for example the transfer of a resource to a disabled child, and subsequently to other family members, violate the sole benefit rule promulgated expressly for this purpose. For a transfer or a trust to be considered for the sole benefit of the child, the instrument or document must provide for the spending of the funds involved for the benefit of the child based on the child's life expectancy.[8] The child is prohibited from benefiting any other person with transferred resources. If the transfer document does not provide for a payout on a basis that is actuarially sound, the transfer penalty exemption is void.

If a trust is used, the attorney will want to include a provision regarding distribution of trust principal to meet the sole benefit requirement. DHS has approved the use of the following: "Trustee shall distribute trust principal... in such amounts that all trust principal will be distributed within the actuarial life expectancy of (beneficiary)."[9]

It is important to note that with respect to trusts, the sole-benefit requirement protects the parent who wants to assist a blind or disabled child without being penalized if the parent needs to apply for Medicaid within five years of the transfer. The trust may be one qualifying as "Medicaid trust exceptions in SI 01120.200 ff. (i.e., trusts established under Section 1917(d)(4)(A) and (C) of the Social Security Act)." POMS SI 01150.121(2).[10]

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However, a transfer can be made to any trust so long as the sole lifetime beneficiary of the trust is a blind or disabled child and the trust assets are directed to be distributed within the child's life expectancy. The trust does not have to be a d4A/payback trust or d4C/pooled trust,[11] although those are clearly listed as being allowed.

Planning to maintain child's means-tested benefits

Transfers to a blind or disabled child must be carefully planned to maintain the child's eligibility for means-tested benefits such as SSI and/or Medicaid, both currently and in the future. These two goals of benefiting a disabled child and maintaining the child's means-tested benefits can sometimes conflict. While using either a d4A/payback or d4C/pooled type of special needs trust may be appropriate, based on the nature and amount of the assets being transferred, it is not required.

Further, these types of trusts were intended to help preserve a disabled individual's means tested benefits when the individual has or receives assets above the resource limit. These types of trusts were never intended to be a receptacle for third-party funds. A standard third-party special needs trust (SNT) is also a viable option to receive a parent's transfer of assets, as long as the SNT assets are used only for the sole benefit of the blind or disabled child and the terms of the SNT direct that the assets are to be distributed within the actuarial life expectancy of the child.[12] For a child who is receiving or may need to qualify for means-tested benefits, choosing the appropriate trust to use will depend on the goals of both parent and child.

Transfers to an ABLE account

Achieving a Better Life Experience (ABLE) accounts[13] are relatively new. Practitioners question whether a transfer to an ABLE account would be treated as a non-disqualifying transfer by a parent for Medicaid eligibility purposes. Because an ABLE account can only be established for a disabled or blind beneficiary, distributions from the account are limited to qualified disability expenses (QDE) of the beneficiary, and the remaining balance in the account is subject to estate recovery, these accounts would appear to meet the sole benefit requirements under both federal and state requirements cited above.

If the child is eligible to open an ABLE account and could benefit from the somewhat broader distribution restrictions for an ABLE account over a SNT, the parent should be able to make annual gifts up to the maximum yearly contribution limit without endangering the parent's ability to qualify for long-term-care Medicaid benefits.

Assets transferred directly to a disabled child

Transfers of any resource directly to a blind or disabled child are allowed.[14] The Oregon Department of Human Services (DHS) is aware that if a home is being transferred under the disqualifying transfer exception, the home cannot reasonably be expected to be "spent" for the sole benefit of the child over the child's life expectancy. The deed that transfers the home from the parent to the child must simply name the child as the sole grantee. Since the home would be in the child's name at death, any valid estate-recovery claim for benefits received by the child would attach to the home.

Other assets can be transferred directly to the blind or disabled child under the disqualifying transfer exception as long as there is some form of legally binding written agreement that states the transfer is for the sole benefit of the child as discussed above. Further, assets that would be treated as exempt in the child's name—such as a vehicle, household goods, electronics, or furnishings—can easily be transferred to the qualifying child.

As a practical matter, however, because of management considerations transfers directly to the disabled child might not be in the best interest of the child. If the child is unable to manage assets easily, transfers to a trust for more valuable assets needing to be managed might be the better option. ■

Footnotes

1. Currently $8,425/month, OAR 461-140-0296(2)(i)
2. See also OAR 461-140-0242(2)(b)
3. OAR 461-140-0242(2)(b), 42 U.S.C. § 1396p(c)(2)(B), POMS SI 01150.122(A)(1)
4. OAR 461-125-0810
5. OAR 461-125-0830
6. POMS SI 01150.120(B)(4)
7. POMS SI 01150.120(C)
8. OAR 461-125-0830, CMS state Medicaid Manual section 3257(B)(6): *transmittal 64*
9. Although this language has been reviewed and approved by DHS staff, there is no OAR authorizing its use. DHS is not bound by the use of this language and may change its policy at any time.
10. See also 42 U.S.C. § 1396p(c)(2)(B)(iii)
11. 42 U.S.C. 1396p(d)(4)(A), 42 U.S.C. 1396p(d)(4)(C)
12. 42 U.S.C. § 1396p(c)(2)(B)(iii)
13. POMS SI 01130.740
14. 42 U.S.C. § 1396p(c)(2)(B)(iii), OAR 461-140-0242(2)(b)

Resources for elder law attorneys

Medicaid

Medicaid is a joint federal-state program. The Oregon Department of Human Services and the Oregon Health Authority administer a number of different benefits, including Oregon's Medicaid programs.

Oregon Supplemental Income Program—Medical (OSIPM) is the Medicaid program for people who receive federal SSI benefits based on age (65+), blindness or disability (as defined by the criteria used by the Social Security Administration), and financial need. OSIPM also covers long term care services for people who meet the sometimes-different financial and non-financial eligibility requirements for those services.

Qualified Medicare Beneficiary (QMB) is a Medicaid program that provides limited assistance to low-income Medicare beneficiaries.

Medicaid resources

42 USC §1396: U.S. code that covers Medicaid

42 CFR Parts 430-456: Federal medical asstance programs

Oregon Revised Statutes Chapters 411, 413, 414, and 416

In the Oregon Administrative Rules, Chapters 410 and 411 concern program administration and covered services and Chapter 461 contains eligibility requirements for OSIPM, QMB, and other benefits administered by the Oregon Department of Human Services (DHS). The OARs are available on the Secretary of State's website, http://sos.oregon.gov/archives/Pages/oregon_administrative_rules.aspx.

DHS has an online searchable version of OAR Chapter 461 at http://www.dhs.state.or.us/policy/selfsufficiency/ar_search.htm. The page includes links to temporary rules, rule-making notices, and agency transmittals about policy changes.

Supplemental Security Income (SSI) is a federal program that pays benefits to disabled adults and children who have limited incomes and resources. It also pays benefits to people over age 65 who are not disabled and who have limited incomes and resources. Some people receive part of their income from SSI benefits and part from Social Security disability or retirement benefits. People who get SSI benefits are automatically eligible for Medicaid in Oregon (OSIPM) and in most other states. There are some additional eligibility requirements for Medicaid for long term care services in Oregon. The Social Security Administration (SSA) administers the SSI program, www.ssa.gov. A number of the financial eligibility rules for OSIPM are based on SSI regulations.

SSI Resources

42 USC §1381 et seq

20 CFR 416.101 et seq

SSA Program Operations Manual System (POMS), chapter SI, https://secure.ssa.gov/apps10/poms.nsf/chapterlist!openview&restricttocategory=05

Elder Law (OSB Legal Pubs 2017), available on the Bar Books section of the Oregon State Bar website, www.osbar.org, Chapter 4, "Social Security Benefits"

Medicare

Medicare is the federal health insurance program for people age 65 and older and for people who have received Social Security disability (SSDI) benefits for at least 24 months (Note: There is no waiting period for people with end stage renal disease or ALS). Medicare eligibility is not tied to financial need. Medicare is administered by the Center for Medicare and Medicaid Services (CMS), part of the Department of Health and Human Services, www.medicare.gov.

Medicare Part A is commonly known as hospital insurance. There are no premiums for people with qualifying work records. There are co-payments and deductibles.

Medicare Part B is commonly known as medical insurance. There are monthly premiums, co-payments, and an annual deductible amount.

Medigap refers to a supplemental insurance policy that is often purchased by someone who has Original Medicare (Parts A and B, also called "fee for service"). It pays some or all of the co-payments and deductibles.

Medicare Advantage plans are authorized by Medicare Part C and are an alternative to Original Medicare. Those who enroll in Medicare Advantage plans get all their Medicare-covered services through their plans and may get additional services not covered by Original Medicare. Most Medicare Advantage plans charge monthly premiums.

Medicare Part D provides coverage for outpatient prescription drugs through plans issued by private insurance companies. They have monthly premiums, co-payments, and deductibles.

Medicare's Extra Help program helps Medicare beneficiaries with outpatient prescription drug plan (Part D) costs.

Continued on page 11

Resources for elder law attorneys (continued)

Medicare Resources

42 USC §§1395a et seq

42 CFR Parts 405-426

Center for Medicare Advocacy: http://www.medicareadvocacy.org

Extra Help program: https://www.ssa.gov/benefits/medicare/prescriptionhelp/

Senior Health Insurance Benefits Assistance (SHIBA) for Oregon, http://healthcare.oregon.gov/shiba/get-help/Pages/who-we-are.aspx ■

Bar Books

Elder Law (OSB Legal Pubs 2017), available on the Bar Books section of the Oregon State Bar website, www.osbar.org, Chapter 6, "Living with Long-Term Services and Supports," and Chapter 7, "Paying for Long-Term Care"

Elder Law 2016*: Advanced Concepts*, 2016 CLE materials available on the Bar Books section of the Oregon State Bar website, www.osbar.org, Chapter 3, "Complex Medicaid Planning"

Elder Law Elements: 2015 CLE materials available on the Bar Books section of the Oregon State Bar website, www.osbar.org, Chapter 1, "Medicaid Eligibility for Long-Term Care" ■

Events

30th Annual Elder Law Institute
Practising Law Institute
March 21, 2018
Atlanta, Georgia
https://www.pli.edu/Content/Seminar/30th_Annual_Elder_Law_Institute/_/N-4kZ1z10162?fromsearch=-false&Ns=sort_date%7c0&ID=325970

Aging in America
American Society of Aging Conference
March 26–29, 2018
San Francisco, California
American Society on Aging

Elder Law Section unCLE program
May 4, 2018
Eugene, Oregon ■

Websites

Elder Law Section website
https://elderlaw.osbar.org
A chart that shows the current income and resource limits for OSIPM and other useful elder law numbers is available on the Elder Law Section's website. The website has other relevant information, including links to information about federal government programs and past issues of the Section's quarterly newsletters.

National Academy of Elder Law Attorneys (NAELA)
www.naela.org
A professional association of attorneys dedicated to improving the quality of legal services provided to elders and people with special needs

National Center on Law and Elder Rights
https://ncler.acl.gov
One-stop support center for the legal services and aging and disability community to access trainings and technical assistance on a broad range of legal issues that affect older adults.

OregonLawHelp
www.oregonlawhelp.org
Helpful information for low-income Oregonians and their lawyers

Aging and Disability Resource Connection of Oregon
www.ADRCofOregon.org
Includes downloadable *Family Caregiver Handbook*, available in English and Spanish versions

Administration on Aging
www.aoa.gov
Information about resources that connect older persons, caregivers, and professionals to federal, national, and local programs.

Big Charts
http://bigcharts.marketwatch.com
Provides the price of a stock on a specific date

American Bar Association Senior Lawyers Division
http://www.americanbar.org/groups/senior_lawyers/elder_law.html

National Elder Law Foundation
http://www.nelf.org
Certifying program for elder law and special-needs attorneys

National Center on Elder Abuse
https://ncea.acl.gov
Guidance for programs that serve older adults. Practical tools and technical assistance to detect, intervene, and prevent abuse. ■

Elder Abuse Hotline: 855.503.7233

This toll-free number enables you to report abuse or neglect of any child or adult to the Oregon Department of Human Services.

Important elder law numbers

as of
January 1, 2018

Supplemental Security Income (SSI) Benefit Standards	Eligible individual ..... $750/month Eligible couple $1,125/month
Medicaid (Oregon)	Asset limit for Medicaid recipient ..... $2,000/month Long term care income cap ..... $2,250/month Community spouse minimum resource standard ..... $24,720 Community spouse maximum resource standard ..... $123,600 Community spouse minimum and maximum monthly allowance standards ..... $2,030/month; $3,090/month Excess shelter allowance ..... Amount above $609/month SNAP (food stamp) utility allowance used to figure excess shelter allowance ..... $454/month Personal needs allowance in nursing home ..... $61.38/month Personal needs allowance in community-based care ..... $167/month Room & board rate for community-based care facilities ..... $583/month OSIP maintenance standard for person receiving in-home services ..... $1,250 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2016 ..... $8,425/month
Medicare	Part B premium ..... $134.00/month* Part D premium ..... Varies according to plan chosen Part B deductible ..... $183/year Part A hospital deductible per spell of illness ..... $1,316 Skilled nursing facility co-insurance for days 21–100 ..... $167/day * Premiums are higher if annual income is more than $85,000 (single filer) or $170,000 (married couple filing jointly).

Oregon State Bar

Elder Law Section