Chapter 5

UNDERSTANDING MEDICAID AND LONG-TERM CARE

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I. INTRODUCTION

A basic understanding of Medicaid is important for any attorney advising elderly or disabled clients. These materials provide a basic overview of Medicaid eligibility requirements. For more advanced planning techniques, please review the Elder Law CLE materials from 2008 titled "Advancing the Plan." These materials also highlight important changes to Medicaid eligibility rules since the passage of the Deficit Reduction Act of 2005.

A. Medicaid—General Overview

Medicaid is a health insurance program that provides medical insurance to certain aged, blind, and disabled individuals and families with dependent children whose income and resources are insufficient to meet the costs of necessary medical services. Since Medicaid was originally enacted, Congress has expanded coverage to other groups of people including children and pregnant women. Medicaid now covers the majority of the nation's long-term care costs.

Medicaid is a joint program funded and administered through a partnership between the state and federal governments. The Centers for Medicare & Medicaid Services (CMS) is the federal agency charged with working with states to administer Medicaid services. Oregon is one of 48 states that operates its Medicaid program under a waiver allowed by section 1915(c) of the Social Security Act. This waiver allows the state of Oregon to offer community-based long-term care services with the goal of enabling individuals eligible for services to remain in the least restrictive and least costly setting consistent with their service needs. OAR 461-015-0000. Community based care in Oregon includes adult foster care, assisted living facilities , in-home care services, residential care facilities, specialized living facilities, and independent choices. OAR 461-001-0000(17).

B. Medicaid Coverage

Medicaid covers a wide variety of services and has a variety of program names in Oregon. For example, the Oregon Health Plan (OHP) provides important health insurance for Supplemental Security Income (SSI) recipients, children, and certain disabled adults and pregnant women. Another Medicaid program, Oregon Supplemental Income Program Medical (OSIPM) assists individuals who need assistance with long-term care costs. Although the different Medicaid programs share many basic eligibility requirements, there are important differences between them. These materials will focus on individuals who are in need of assistance with long-term care, otherwise referred to as OSIPM.

C. Controlling Law and Administrative Rules

Congress established Medicaid as Title XIX of the 1965 Amendment to the Social Security Act. Title XIX of the Social Security Act is found in 42 USC Chapter 7. A good reference for exploring the Social Security Act is the Compilation of the Social Security Laws found at *http://www.ssa.gov/OP_Home/ssact/ssact.htm*. The website is easy to use

and includes citations to the Social Security Act and to Section 42 of the United States Code.

ORS Chapter 411 is the enabling statute that gives the Oregon Department of Human Services the authority to administer and supervise all public assistance programs and to set eligibility rules for those programs. The administrative rules that primarily govern the eligibility standards for Medicaid are found throughout Oregon Administrative Rules (OAR) chapter 461. Within chapter 461, divisions 110, 115, 135, 140, 145, and 160 contain the majority of the Medicaid eligibility rules. Divisions 001 and 101 of chapter 461 also provide helpful definitions and acronyms used throughout all the eligibility rules. OAR chapter 411, division 015, also contains important eligibility requirements related to disability.

Practice Tip: The best way to stay informed regarding the frequent changes in the administrative rules is to sign up to receive notices of temporary and permanent rulemaking for chapters 461 and 411. This can be done through the Department of Human Services website or by contacting Annette Tesch at annette.tesch@state.or.us. The notices arrive in e-mail format and there is a summary on page 1 of the notice listing the rules that are affected by the action.

II. BASIC ELIGIBILITY REQUIREMENTS FOR MEDICAID

Individuals who need Medicaid assistance with long-term care costs (OSIPM) must qualify under three eligibility tests in order to receive assistance from Medicaid in Oregon. Those three eligibility tests include disability, income, and resources. In the following discussion of the eligibility tests, all references to "Medicaid" refer to OSIPM program requirements.

A. Disability

The Medicaid application process should be completed within 45 days. During this time period, the caseworker assigned to assess eligibility will visit the applicant and evaluate need for long-term care based on the applicant's disabilities. This assessment is called the Client Assessment and Planning System (CA/PS assessment). The assessment reviews the applicant's ability to complete the activities of daily living ("ADLs"), including eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination, and cognition/behavior. OAR 461-015-0006(1). The assessment is time limited, in that it only takes into consideration the applicant's ability to perform ADLs during the thirty days prior to the assessment date, along with a projection of how well the applicant is likely to perform ADLs in the thirty days following the assessment date. OAR 461-015-0006(2)(b).

Practice Tip: Although the time frame is thirty days prior to the assessment date and thirty days looking forward, evidence of how the applicant functioned without support from caregivers can and should be considered. When assessing cognition, the caseworker should consider how the individual would function without supports. OAR 461-

015-0006(5)(a). A common example of this is an applicant who moves into a foster home two months prior to the assessment and, by the time of the assessment, has improved due to assistance received from a care provider in the home. Information about how the applicant was functioning prior to entering the foster home is important evidence regarding the applicant's need for care related to cognition. For example, weight loss due to skipping meals is evidence of lack of judgment because the applicant no longer has insight into his or her health and safety needs. Leaving burners on after every meal is evidence of lack of memory because the applicant needs prompting from a caregiver to turn off the burners.

Activities of daily living are defined at OAR 461-015-0006. Some of the activities of daily living are broken down into sub-categories. For example, cognition includes eight different categories: adaptation, awareness, judgment/decision-making, memory, orientation, demands on others, dangers to self or others, and wandering. Within each of these categories an individual is assessed as being either an assist or a full assist. The use of assist and full assist is consistent throughout the activities of daily living except in the area of mobility. Within mobility, the sub-category of ambulation has three different possibilities: minimal assist, substantial assist, and full assist. During the assessment, the caseworker assigns a need for assistance to each activity of daily living. The different need levels are combined and the CAPS computer program gives the applicant a score, also called a service priority level.

The classification of an activity of daily living is important because a slight change can influence the service priority level assigned to the individual. There are 18 possible service priority levels that can be assigned and currently only levels 1-13 are eligible for long-term care services. OAR 411-015-0015(1). Levels 1-13 include the following:

1. Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.
2. Requires Full Assistance in Mobility, Eating, and Cognition.
3. Requires Full Assistance in Mobility, or Cognition, or Eating.
4. Requires Full Assistance in Elimination.
5. Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.
6. Requires Substantial Assistance with Mobility and Assistance with Eating.
7. Requires Substantial Assistance with Mobility and Assistance with Elimination.
8. Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.
9. Requires Assistance with Eating and Elimination.
10. Requires Substantial Assistance with Mobility.
11. Requires Minimal Assistance with Mobility and Elimination.

12. Requires Minimal Assistance with Mobility and Assistance with Eating.

13. Requires Assistance with Elimination.

Individuals who require assistance with only bathing and dressing are no longer covered because they are ranked at levels 16 and 17. For this reason, it is very important to accurately report the need for care in mobility, eating, elimination and cognition at the assessment.

Practice Tip: Medicaid applicants commonly underreport care needs because of embarrassment or memory loss. If you believe this may occur, consider having a family member or care provider who is familiar with the actual care needs present at the assessment. The family member or care provider can provide supplemental information to the caseworker if the applicant is unable to speak accurately. This can often prevent a needless denial of services.

The caseworker completes a disability assessment annually; even after the initial approval for Medicaid benefits. If the caseworker denies benefits based on a service priority level, it is a good idea to immediately request and review a copy of the CAPS assessment. If the client chooses to appeal a disqualification, and is currently receiving benefits, they have only 10 days to request "aid paid pending." Aid paid pending allows the individual to continue receiving benefits pending the outcome of the appeal and can be very important in maintaining continuity of coverage during the appeal. The risk of requesting aid paid pending is that the individual has to repay benefits received from the date of disqualification if the appeal is not successful. If aid paid pending is not requested there are only 45 days to request an appeal. Appeals are handled through the Office of Administrative Hearings.

B. Income

The second test for Medicaid eligibility involves income. In order to qualify for Medicaid services in Oregon, an individual must have income which is at or under 300% of the SSI standard. OAR 461-135-0750. 300% of the SSI standard is referred to as the "income cap" and is currently set at $2,022. The income cap is adjusted each year. The current cap is published on the Elder Law Section page of the Oregon State Bar website at *http://www.osbar.org/sections/elder/elderlaw.html*. If an individual has income over the income cap they can qualify for Medicaid by creating an income cap trust. OAR 461-145-0540.

1. Income Defined

For Medicaid purposes, all assets are divided into two general categories; income and resources. When deciding if an income cap trust is necessary, the first step is to correctly identify all assets that are income. There is no general definition of income in the Oregon Administrative Rules. Instead division 145 of chapter 461 lists specific types of assets and classifies the particular asset as either a resource or income.

The definitions often classify income as both earned and unearned. For purposes of the income cap, this distinction is not important because both sources of income are counted towards the income cap.

Practice Tip: Clients often do not accurately identify their income. In order to correctly identify income sources and amounts, it is helpful to have clients break down each income source by type and frequency of receipt. Clients often identify resources such as IRAs as income, since they receive regular monthly or yearly distributions. However, under the relevant rules, IRAs are correctly classified as a resource and the required minimum distributions do not count towards the client's income.

2. VA Aid and Attendance Benefits Excluded

Generally, an income cap trust is necessary if the client's gross income exceeds the income cap. The gross income should include all income sources. However, veterans' benefit payments are excluded from gross income when determining eligibility for long term care of Title XIX waivered services. OAR 461-145-0580(2)(a)(A). If the veterans' benefit payment puts the client over the income cap, then an income cap trust is not necessary. The client does not get to keep the entire veterans' benefit payment, however. Like other income, it must be applied toward the cost for care each month.

3. Income Cap Trust

If a client's gross income exceeds $2,022 per month (in 2009), an income cap trust is required in order for the client to qualify for Medicaid. Keep in mind that you must consider gross income, not net income. A client can be under the $2,022 income cap after taxes and deductions of health insurance premiums, but still require an income cap trust because the gross income is over $2,022. A sample income cap trust published by the State of Oregon is attached as Appendix A.

Practice Tip: Although the sample trust is helpful, I recommend removing articles 4.2 and 4.3 from the trust and instead attaching the initial and anticipated distribution plans as schedules to the trust. Updating a schedule to an irrevocable trust is easier than amending the trust. It is not uncommon to discover a change in the distribution plan after the irrevocable trust is executed. For example, a client may discover incurred medical bills that can be added to the distribution plan. Another common mistake is for the client to discover that the gross income reported on the distribution plan is actually the net income. In either case, an update is required.

4. The Distribution Plan

The content of the income cap trust is fairly straightforward. The bulk of the work in drafting an income cap trust comes in calculating the distribution schedules, which can be thought of as budgets that detail the permissible uses of a Medicaid recipient's income. The distribution schedules should include the following:

a. Personal Needs Allowance

Nursing home residents are allowed to keep only $30 of their income per month for personal needs allowance. This amount has not changed for many years. Clients in community based care are allowed to keep $152 per month. The personal needs allowance for community based care is indexed up yearly. A client who receives Veterans' benefits

is allowed a $90 per month personal needs allowance. OAR 461-160-0620(3)(c)(B).

b. Room and Board

Nursing home residents do not pay room and board. Clients in community based care currently pay $523.70 per month. This amount is indexed up yearly. This amount is also published on the Elder Law Section page of the Oregon State Bar website. It is important to identify whether the applicant is receiving skilled nursing care or community based care because clients may not understand the distinction.

c. Reasonable Administrative Costs

Administrative costs allowed in an income cap trust include trustee fees, reserve for administrative fees including bank service charges, copy charges, postage, accounting and tax preparation fees, future legal expenses, income taxes attributable to trust income, and conservatorship and guardianship fees and costs. However, the reasonable administrative costs may not exceed a total of $50 per month. Practically speaking, this is usually included on the distribution schedule as a trustee fee of $50 per month. It is almost impossible to allow other administrative costs since the cap of $50 is so low.

d. Community Spouse and Family Monthly Maintenance Needs Allowance

The "community spouse" is the term used to refer to the spouse who is not receiving Medicaid benefits and is living independently. The community spouse is guaranteed a Minimum Monthly Maintenance Needs Allowance (MMMNA), which is currently $1,822. The Department can increase this amount to $2,739 if there are additional shelter costs. These minimum and maximum monthly maintenance needs allowances are indexed up annually. If the community spouse's income is under the MMMNA, income from the Medicaid recipient may be transferred to the community spouse each month.

Example: Santiago has moved to a foster home and needs assistance with his care costs. Santiago has gross income of $3,296.40 per month. Santiago's income includes Social Security and two different pensions. Santiago's wife, Michelle, is living in the home and has Social Security income of $760.40 per month. Michelle has monthly expenses exceeding $1,822 per month due to a mortgage on the home and high prescription costs for her medications. A review of her monthly expenses shows that she needs at least $2,739 per month to pay her bills. The income cap trust should include a deduction for a community spouse monthly maintenance needs allowance of $1,978.60 per month. $1,978.60 + $760.40 = $2,739 (the maximum monthly maintenance needs allowance). Do not automatically assume that the community spouse only needs the minimum amount of $1,822 per month. Increasing the community spouse allowance to an appropriate amount can significantly improve the quality of life for the community spouse. The formula for determining the exact amount of the community spouse's income allowance is found at OAR 461-160-0620(3)(d).

e. Medicare and Other Private Medical Insurance Premiums

A Medicaid recipient can deduct from his or her gross income any health insurance premiums for supplemental health insurance policies. Most clients have a supplemental private policy through Medicare. The Medicaid recipient can deduct the Medicare Part A premium of $96.40 per month for the first few months until Medicaid starts paying this premium. Medicaid also allows the trust to pay the health insurance premiums for the community spouse.

Continued Example: Santiago and Michelle both have a supplemental Medicare insurance policy that costs $167 per month each. Santiago has sufficient income to pay both premiums out of his income. Santiago's income cap trust can also pay his Medicare part A premium of $96.40 per month and Michelle's part A premium of $96.40 per month. After two months, Santiago will not pay his Medicare part A premium because Medicaid will take over payment of the premium. However, he can continue to pay Michelle's part A payment.

f. Other Incurred Medical Costs

The income cap trust can pay for medical costs allowed under OAR 461-160-0030 and 461-150-0055. The costs that can be deducted include medical and dental care, psychotherapy, rehabilitation services, hospitalization, outpatient treatment, prescription drugs and over-the-counter medications, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses. The costs can also cover private pay costs of community based care and nursing home care. Generally, most medical expenses are covered by this rule. If the medical expenses cannot be paid off in one month the schedules should allow for installment payments over as many months necessary in order to pay off the medical bills in full.

g. Contributions to Reserves for Child Support, Alimony, and Income Taxes

If a Medicaid recipient has child support or alimony obligations, these should also be deducted from the gross income. Income taxes can also be deducted, especially if automatically withheld from the income source.

h. Monthly Contributions to Reserves of Payments for the Purchase of an Irrevocable Burial Plan

The Department recently changed the administrative rules to limit the value of the irrevocable burial plan, purchased with funds from an income cap trust, to $5,000. OAR 461-145-0540(9)(c)(G).

Practice Tip: If the client is considering the purchase of an irrevocable funeral plan valued over $5,000, the client should purchase that plan as part of the spend-down prior to the creation of the income cap trust. If the irrevocable plan is under $5,000 it is better practice to include it as part of the income cap trust. This will free up funds for the client to use on other needs during the spend-down period.

i. Contributions for Home Maintenance

The income cap trust can make contributions to a reserve or payments for home maintenance if the client plans to return to the home.

In order to make deductions for this expense, the client must meet the criteria found in OAR 461-155-0660 or OAR 461-160-0630. It is this author's opinion that OAR 461-155-0660 and OAR 461-160-0630 are contradictory as currently drafted. However, in practice, OAR 461-160-0630 is the rule currently applied to determine if this deduction is allowed. OAR 461-160-0630 allows a home maintenance deduction for up to six months if a physician has documented that the client is likely to return home within six months, the amount of the deduction is reasonable in relation to the applicable shelter standard, and the Department determines that maintaining the home is an essential part of the plan for the client's relocation to a less restrictive living situation.

This test is more restrictive than the test used when determining whether or not the home can be excluded as a resource. In order to exclude the home as a resource, the client only needs to have a subjective intent to return to the home. Therefore, you can have a situation where the home is excluded as a resource because the client intends to return after a temporary absence, but a maintenance deduction is denied because lack of documentation from a physician. It is not clear if this strict standard is lawful. Oregon can be no more restrictive than the SSI program with its rules regarding eligibility. 42 USC §1396a(r)(2)(A).

5. Tax Identification Number

There is no clear rule as to whether or not a taxpayer identification number is required for an income cap trust. Some practitioners obtain a tax identification number because banks require the number for irrevocable trusts. Having a number for the income cap trust can assist the trustee when working with bank representatives to open the account. Other practitioners do not obtain a tax identification number because an income cap trust is a grantor trust and the income cap trust account should use the beneficiary's Social Security number.

C. Resources

The third and most complicated eligibility test for Medicaid eligibility in Oregon is the resource test. These materials will cover how to determine basic resource eligibility under the Oregon administrative rules. For more advanced planning techniques, please review the Elder Law CLE materials from 2008 titled "Advancing the Plan."

The first step in determining eligibility under the resources rules is to calculate the amount of available resources. Medicaid rules separate available resources from excluded resources. Excluded assets are not considered in determining an applicant's eligibility and benefits level. OAR 461-140-0010. It is helpful to understand what resources to exclude first, since this list is shorter and fairly straightforward. Once you know what resources to exclude, all other resources are considered available and count towards eligibility.

1. Excluded Resources.

If an asset is excluded, the applicant, or the applicant's spouse, may keep the asset and still qualify for Medicaid. The following resources are excluded:

a. The Home

The home is not counted for Medicaid eligibility purposes if the client or the spouse of the client occupies the home and the equity in the home is $500,000 or less. OAR 461-145-0220(2)(a)(B). Generally speaking, the tax assessed value of the home can be used to determine the equity of the home. In recent months, where equity values have fallen below the tax assessed value, a comparative market analysis or professional assessment could be used to show a value of under $500,000.

A home can now be counted as a resource if the client has equity in the home of more than $500,000, unless one of the following requirements is met:

i. the spouse of the client occupies the home;

ii. the child[1] of the client occupies the home;

iii. the client is legally unable to convert the equity value in the home to cash;

iv. the home equity is excluded under OAR 461-145-0250 (rule for income producing property).

Even if over $500,000 in value, the exceptions to home equity rule are broad enough to allow exclusion of the entire equity value in most cases. However, this rule should be monitored for future changes as the equity limit is relatively new.

Next, the home is also excluded if the applicant is absent to receive care in a medical institution and they have provided evidence that they will return to the home. OAR 461-145-0220(3)(c)(A). The evidence must reflect “the subjective intent of the client, regardless of the client’s medical condition.” A letter from a doctor is not necessary and a written statement from a competent applicant is sufficient to prove the requisite intent. This subjective standard directly contradicts the objective standard for the income cap trust deduction discussed above.

The home may also be excluded if the client is temporarily absent to receive care in a medical institution and the home is occupied by the client’s spouse, child or relative dependent on the client for support. OAR 461-145-0220(3)(c)(B). The child must be less than 21 years of age, or, if over the age of 21, blind or an individual with a disability as defined by SSA criteria.

Finally, the value of the home is excluded pending the sale of the home. The client needs to make a good faith effort to sell the home at fair market value.

Practice Tip: In the current real estate market it is increasingly common for clients to go on Medicaid pending the sale of the residence. Upon the sale of the property, the Department may request payment of its claim for benefits provided to the Medicaid recipient. This is a voluntary payment and the Department has no claim until the death of the client and the client’s spouse. I have seen title companies include the claim in the closing statements and identifying it as a “lien.” The claim

[1] OAR 461-145-0220 has a narrow definition of “child.” A child in the section of the rule means a biological or adoptive child who is under the age of 21, or a child who is disabled according to Social Security criteria.

is not a lien and repayment is completely voluntary. Most clients choose to take control of the sale proceeds and defer payment of any claim until after their death.

b. The Car

The value of one car is excluded from the resource calculation. The total value of the vehicle is excluded if "used for employment or necessary and continuing medical treatment." OAR 461-145-0360. This definition is interpreted broadly. Medicaid caseworkers generally automatically exclude the value of one car during the resource assessment. If a client has two cars, Medicaid allows the client to exclude the value of the more expensive car.

c. Burial Plans

The value of an irrevocable burial plan is excluded, regardless of the value. An exception to this is if the plan is purchased after Medicaid eligibility and is paid for through an income cap trust deduction. If this is the case, the plan is limited to $5,000. For this reason, if the client is considering a more expensive irrevocable plan, he or she should purchase the plan prior to Medicaid eligibility. Clients can convert a revocable burial plan to an irrevocable burial plan. This is often done during the Medicaid application process.

If a client does not wish to purchase a plan he or she can set aside up to $1,500 as a burial fund in a separate account. OAR 461-145-0040(3)(a)(D). A burial fund for up to $1,500 can also be established for the client's spouse.

Burial space and burial merchandise are also excluded resources. OAR 461-145-0050. The burial space can be designated for the client, the spouse, children, siblings, parents and the spouse of any of these people.

d. Personal Property

Personal belongings are excluded resources. OAR 461-145-0390. Personal belongings include household furnishings, clothing, heirlooms, keepsakes, and hobby equipment. There is no limit on the value of personal property that is excluded. Older administrative rules limited the value of personal property to $2,000.

e. Term Life Insurance

All term life insurance that has no cash surrender value is excluded. OAR 461-145-0320. Clients are often unaware of the difference between the face value and the cash value of the life insurance policy. This should be clarified as quickly as possible to avoid creating a period of ineligibility due to excess resources from cash value on life insurance.

f. Other Circumstances

Resources are also considered unavailable in the following circumstances:

i. the client has a legal interest in the resource, but the resource is not in the client's possession and the client is unable to gain possession of it;

ii. the resource is jointly owned with others not in the financial group who are unwilling to sell their interest in the resource, and the client's interest is not reasonably saleable;

iii. the client verifiably lacks the competence to gain access to or use the resource and there is no legal representative available to act on the client's behalf;

iv. the client is a victim of domestic violence and attempting to use the resource would subject the client to risk of domestic violence or the client is using the resource to avoid the abusive situation;

v. the resource is included in an irrevocable or restricted trust and cannot be used to meet the basic monthly needs of the financial group. OAR 461-140-0020(2).

These circumstances should always be reviewed in cases where the client does not have access to funds. For example, Medicaid eligibility can be established during the time a conservatorship is in process in order to gain access to assets the client is incapable of managing. This rule may also be applicable in cases of elder abuse when the money has been unlawfully transferred to an abuser.

Finally, resources are not considered available during the time the owner does not know he or she owns the resource. OAR 461-140-0020(3). This rule is important when clients, in good faith, forget about the existence of a resource. This is not uncommon if a client has declining capacity and does not accurately report all assets to a caseworker.

2. Available Resources

An asset that is not excluded is countable, and its value is used in determining the eligibility and benefit level of a client. OAR 461-140-0010(6). To determine the total amount of available resources, add up all available resources as of the date continuous care started. The total amount of available resources as of the date continuous care started is then used to determine the total amount of resources the client can keep. The resource test for unmarried individuals is different than the resource test for married couples.

a. Unmarried Clients

An unmarried applicant is subject to a resource limit of $2,000. OAR 461-160-0015(4)(a). This amount has not changed for many years and previous CLE materials are helpful in describing how an unmarried applicant can permissibly spend-down his or her resources to reach the $2,000 limit.

b. Married Clients

Congress enacted the Medicare Catastrophic Coverage Act of 1988 in part to protect the community spouse from impoverishment. This law protects the healthy/community spouse from impoverishment by allowing the community spouse to retain his or her own income and also an increased amount of resources. The amount of resources the community spouse can maintain is referred to as the community spouse resource allowance (CSRA).

i. Resources of Community Spouse

Medicaid uses a formula found at OAR 461-160-0580 to determine the amount of resources a community spouse is allowed to maintain. The first step in determining the community spouse resource allowance is to determine the total amount of available/countable resources for both spouses as of the first date of continuous care. The second step is to divide this amount in half. The third step is to see if this amount is subject to the minimum or maximum resource allowance. The current maximum resource allowance is $109,560. The current minimum resource allowance is $21,912. These numbers are indexed up annually. This formula is best understood through examples.

Example 1: Salvador and Isabel have $100,000 in available resources as of the date Salvador enters a nursing facility. Half of $100,000 is $50,000. $50,000 is more than $21,912 and less than the maximum of $109,560, so the community spouse resource allowance is $50,000. Isabel will need to spend down $48,000. Salvador will be eligible for Medicaid when Isabel has $50,000 in her name. Salvador can retain $2,000 in his name.

Example 2: Diego and Frida have $300,000 in available resources as of the date Frida enters a foster care home. Half of $300,000 is $150,000. $150,000 is over the maximum allowed, so Diego is allowed a community spouse resource allowance of $109,560. Diego and Frida will need to spend down $192,440 (the difference between $300,000 and $109,560 plus $2,000). Frida will be eligible for Medicaid when Diego has $109,560 in his name. Frida can retain $2,000 in her name.

Example 3: Nestor and Cristina have $30,000 in available resources as of the date the Nestor enters an assisted living facility. Half of $30,000 is $15,000. This is under the minimum amount required, so Cristina is allowed a community spouse resource allowance of $21,912. Nestor and Cristina will need to spend down $6,088 (the difference between $30,000 and $21,912 plus $2,000). Nestor will be eligible for Medicaid when the Cristina has $21,912 in her name. Nestor can retain $2,000 in his name.

Practice Tip: In the above examples assume that we have neatly moved joint assets into separate ownership between the community spouse and the Medicaid spouse by the time Medicaid benefits start. In reality this is not usually the case. The spend-down process can be messy and traumatic for couples and often assets are still jointly owned at the time of the Medicaid application. The ill spouse can still go onto Medicaid at this point. Simply point out to the caseworker that the total resources in the bank accounts are the community spouse resource allowance plus the $2,000 for the Medicaid spouse. OAR 461-160-0580(3) states that the client and/or the client's spouse have 90 days to finish transferring the community spouse resource allowance to the community spouse's name. The 90 days can be extended for good cause. An example of good cause is a court ordered transfer of resources through a conservatorship.

ii. Income of Community Spouse

The income of the community spouse is not counted when determining eligibility for an institutionalized spouse. However, the income of the community spouse is relevant to the total amount of resources the community spouse can retain.

It is possible to increase the amount of resources the community spouse can retain above the community spouse resource allowance. This is important in situations where the community spouse resource allowance is not sufficient to support the community spouse. To determine whether or not the community spouse can keep additional resources we have to apply the "income first-rule." Currently, federal law mandates that the states apply the income-first rule to *agency* calculations. Whether or not the income-first rule must be applied to court ordered spousal support is an open question that is unresolved in Oregon. The State of Oregon is currently requiring the use of the income-first rule in all court orders to increase the community spouse resource allowance, unless a waiver is granted by the department (this is determined on a case by case basis as described below in section iv). This author is unaware of any successful challenges to this policy. For more information and background on the income first rule, please review the Elder Law CLE materials from 2007 titled "Changes and Trends in Oregon Medicaid Rules and Policies."

iii. The Income-First Rule and Increasing the CSRA

The community spouse's income is not subject to any cap when determining eligibility for an ill spouse. However, it is subject a minimum amount in order to avoid spousal impoverishment. Currently, the minimum monthly maintenance needs allowance (MMMNA) is $1,822. OAR 461-160-0620. This amount can be increased up to $2,739 through agency approval, without the need for a court order. The monthly maintenance needs allowance can be increased above $2,739 with a court order. If there is insufficient income to reach $2,739, a community spouse can keep additional resources, effectively increasing the community spouse resource allowance.

The Income-First Rule, Example 1: Juan enters a nursing facility with an income of $1900. Eva has income of $700 per month. Juan keeps $30 per month for his personal needs allowance and pays a health insurance premium of $60 per month, leaving $1,810 available to deem to Eva. Juan moves $1,122 of his income each month to Eva in order to bring her income up to the monthly maintenance needs allowance of $1,822 ($1,122 + $700 = $1,822). Juan pays his remaining $688 to the nursing facility each month as his "patient liability"

The Income-First Rule, Example 2: Same facts as above except that Eva has a mortgage of $1,000 per month. She also has high prescription costs to manage her own health care needs. A review of her monthly expenses shows that she needs at least $2,510 per month to meet her basic needs. In this case, Juan moves all of his remaining income of $1,810 to Eva each month. This brings Eva's income up to $2,510 each month and

Juan no longer has a patient liability. Juan and Eva do not need a court order to accomplish this transfer of income.

The Income-First Rule, Example 3: Same facts as above except that Eva now has monthly costs of $2,739 per month. If Juan moves all his remaining available income of $1,810 per month, Eva's income of $2,510 is still not enough to meet her monthly expenses. Eva has a previously set community spouse resource allowance of $90,000, based on $180,000 in available resources as of the date Juan entered continuous care. The Department calculates that this amount of resources will generate $141.75 in additional income per month, bringing Eva's monthly income to $2,651.75 per month.[2] There is still a deficit of $87.25 per month ($2,739 - $2,651.75 = $87.25). Resources of $55,397 would generate additional monthly income of $87.25 per month.[3] The community spouse resource allowance should be administratively raised to $145,397 ($90,000 + $55,397 = $145,397). Juan and Eva do not need a court order for Medicaid to approve the increased community spouse resource allowance.

Example 4: Same facts as above except that Eva has monthly expenses of $3,000 per month. The community spouse resource allowance can be raised even after application of the income-first rule as described above. However, since Eva is requesting a monthly maintenance needs allowance of over $2,739 she will need a court order to approve the increase in both the monthly maintenance needs allowance and the community spouse resource allowance.

Practice Tip: The example above relies on a situation where a spouse is in a nursing home. For practical purposes, it is more common to increase the community spouse resource allowance in cases where the ill spouse is in community based care. This is because less income is available to the community spouse because of room and board ($523.70 per month) and personal needs allowance ($152 per month). With more of the Medicaid spouse's income accounted for, there is less to deem to the community spouse.

iv. Exception to the Income-First Rule

OAR 461-160-0620(4) now allows a waiver of the income-first rule "if the Department determines that the resulting community resource allowance would create an undue hardship on the spouse of the client." Although there are no standards set forth in the rule, things to consider when requesting a waiver include:

1) The age of the community spouse. A younger age argues in favor of a waiver because he or she is likely to outlive the ill spouse and therefore suffer a reduction in income upon the death of the ill spouse;

2) A source of income that will disappear. If the ill spouse has a source of income that will end upon his or her death then the community spouse is more likely to face impoverishment. It is help-

[2] $90,000 invested in a one-year CD at a rate of 1.89 percent generates $1701 in income per year or $141.75 per month.

[3] $55,397 invested in a one-year CD at a rate of 1.89 percent generates $87.25 in income per month.

ful to know if pensions will continue upon the death of the recipient, or if the pension will be reduced.

3) High monthly expenses. If the community spouse has high monthly expenses that will continue upon the death of the ill spouse and the reduction in income upon the death of the ill spouse will not be enough to cover those expenses.

4) Other Factors. Is the community spouse likely to need long-term care in the future? Is the community spouse resource allowance on the lower end?

There is no formal procedure for requesting a waiver of the income-first rule. A written request should be sent directly to a policy analyst in Salem for a quicker result. Since the waiver is new, OAR 461-160-0620(4) should be carefully monitored for future changes.

3. Is it Income or a Resource?

Assets are divided into two categories, income and resources. An asset may not be counted as a resource and as income in the same month. OAR 461-140-0010(7). Therefore, we classify the asset as discussed above and determine eligibility for services. Unfortunately, two types of assets are now subject to a great deal of confusion. In some instances the assets are treated as income and in other cases they are treated as resources.

a. Promissory Notes and Loans

This rule has undergone frequent changes since the passage of DRA 2005. The most recent change to the rule was on July 1, 2009. The current rule is attached as appendix B. The entire Notice from the Department is attached because it contains the prior version (crossed out) and the new version (bold). The Need for the Temporary Rule states that:

OAR 461-145-0330 needs to be amended to comply with recent federal legislation (The American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5)), that provides the Department with enhanced federal matching funds for its Medicaid programs. The amended rule will comply with this legislation by stating that effective July 1, 2009 a loan made by a married client receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program that exceeds the resource allowance of the client's spouse is not counted as a resource when the Department is determining a client's eligibility. The rule had treated proceeds of loans, loan repayments, and interest earned by a client lender as resources when determining a client's eligibility.

Although the updated rule is improved over the older version, the updated rule still contains ambiguous language. The primary problem with the rule is that it gives the Department discretion to treat the transfer of assets to the borrower as a transfer for less than fair market value. Specifically, subsection (6)(a)(B) of the rules states:

> If the loan does not qualify under paragraph (A) of this subsection, the transfer of assets to the borrower ***may be considered a transfer for less than fair market value*** (*see* OAR 461-001-0000).

In conversations with the Department, policy analysts have said that they *will* treat the loan as a transfer of assets for less than fair market value if the loan was made for the purpose of Medicaid planning. This is true even where the transaction meets all requirements listed in subsection (7). This standard applied by the policy analysts is not set forth in the rule and is essentially adding an additional requirement that a loan and/or promissory note cannot be executed after an ill spouse enters continuous care. This standard also appears to contradict subsection (7) of the rule which states:

> If a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan, the balance of the payments owing to the client or spouse of the client is a transfer of assets for less than fair market value, unless all of the following requirements are met:
>
> (a) the total value of the transaction is being repaid to the client or spouse of the client within the individual's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.
>
> (b) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.
>
> (c) The contract is not cancelled upon the death of the client or the spouse of the client who made the transaction.

If a loan is structured to comply with the requirements set forth in subsection (7) of OAR 461-145-0330, then the balance of the payments owing should be treated as income and not a resource. However, proceed with caution in this area given the discretionary language in subsection (6) of the same rule.

Update as of 9/1/09 to OAR 461-145-0330.

The changes discussed immediately above have been rescinded as of September 1, 2009. The changes are found in the Notice of Rulemaking Action attached as Appendix C. The old restrictive standards have been reinstated and all promissory notes/loans will be treated as a disqualifying transfer of assets for less than fair market value if:

(i) the financial group includes a client in a nonstandard living arrangement and the client's spouse;

(ii) the transaction is on or after the date of the first continuous period of care, and

(iii) the amount of the loan plus other resources transferred exceeds the community spouse resource allowance.

The Department takes the position that the changes are bringing the Oregon administrative rules into compliance with existing federal

law. However, all the changes to OAR 461-145-0330 have added additional restrictions on the use of promissory notes/loans that are nonexistent in federal law.

The updates to OAR 461-145-0380 have also been rescinded as of September 1, 2009. Careful review of this rule is necessary when dealing with retirement and pension plans.

b. Annuities

OAR 461-145-0022 has been changed frequently since the passage of DRA 2005. The most recent version of the rule is attached as Appendix D. Department policy analysts planned to amend the rule on October 1, 2009. In order to amend the rule on this date the changes would have been included in the notice of temporary rulemaking published July 1, 2009. However, no changes were published on July 1, 2009 and it appears that the Department is reconsidering its changes. One reason the Department may have reconsidered its plan to amend the rule is the CMS guidance issued on June 17, 2009, attached as Appendix E. The guidance deals with treatment of stimulus funds states are receiving. The guidance clearly states that "a State is not eligible for these increases if it has restricted its Medicaid eligibility standards, methodologies, or procedures after July 1, 2008." Any change to the annuity rule would have made Medicaid eligibility standards in Oregon more restrictive, therefore, placing federal stimulus funds at risk.

Although the current rule was not changed, the existing rule is still highly restrictive. For annuities purchased after October 1, 2006, the Department treats the annuity as a resource instead of income if the annuity does not meet the requirement listed OAR 461-145-0020(2)(C)(i)-(v).

Practice Tip: Clients often purchase annuities without the advice or assistance of an elder law attorney. If you have a disqualifying annuity, work with the caseworker to try and fix the problem retroactively. Sometimes it is possible to update the beneficiary designations so that the Department is named as the first remainder beneficiary and avoid a notice of disqualification.

The Department has probably exceeded its rulemaking authority in adding restrictions not contained in the federal law. For a comprehensive review of the problem areas with the current annuity rule please reference the 2008 Elder Law CLE, "Advancing the Plan."

APPENDIX A—SAMPLE INCOME CAP TRUST

IRREVOCABLE LIVING TRUST AGREEMENT

__________________________, BENEFICIARY
Living Trust Agreement, dated__________________, 20XX

___________________________, Trustee
Address: ___________________
____

For the Benefit of
___________________, Beneficiary

Tax Identification Number of Trust:______________________

Prepared by:
Jane Doe
Attorney at Law
County Legal Aid Service
1234 Main St
Anytown, OR 12345

________________________INCOME CAP TRUST

Irrevocable Living Trust Agreement, dated _________________,20XX

RECITALS:

This declaration of Trust is made this ____ day of 20XX, by ______________________, Grantor. The initial Trustee is ________________________. The life beneficiary is ________________________.

.

ARTICLE 1

NAME OF TRUST

This irrevocable trust shall be known as the ________________________ INCOME CAP TRUST.

ARTICLE 2

PURPOSE OF THE TRUST

The purpose of this Trust is to provide for the administration and disposition of the trust estate during and after the lifetime of the beneficiary, in accordance with the terms and conditions of the Trust. This Trust is created pursuant to Section 1917 (d) (4) (B) of the Social Security Act [42 USC 1396p]. This trust document is created in order to enable the beneficiary to qualify for Medicaid, and any provisions of this trust which are deemed to be inconsistent or contrary to the intent of the above-referenced federal law shall be deemed to be void and of no further force or effect. All interpretations and actions taken by the trustee pursuant to this Trust shall be done for and with the purpose of creating, establishing, and maintaining the beneficiary's eligibility for Medicaid benefits.

ARTICLE 3

TRUST FUNDING

3.1 INITIAL FUNDING. Grantor will cause to be transferred to trustee the monthly income of the beneficiary beginning in the month of ______________, 20XX. Grantor intends that the income funding this trust, together with all accretions and additions thereto, shall be used, handled, and disposed of by the trustee and by any successor or substitute trustee as described in this instrument.

3.2 NO OTHER ASSETS IN TRUST. No property other than the beneficiary's shall be placed in this trust. The trustee shall place no other money in the trust bank account.

ARTICLE 4

DISTRIBUTION DURING BENEFICIARY'S LIFE

4.1 GENERAL DISTRIBUTION PLAN. During the lifetime of the beneficiary, the trustee shall use the beneficiary's income placed in the trust to pay:

a. Personal Needs Allowance. The beneficiary's personal needs allowance or applicable OSIP standard;

b. Administrative Costs. Reasonable administrative costs associated with the maintenance of this trust of up to $50 per month to cover trustee fees, bank service charges, copy charges, postage, accounting and tax preparation fees, income taxes attributable to trust income, and guardianship or conservatorship fees and costs.

c. Spouse and Family. Monthly maintenance needs allowance for spouse and family.

d. Health Insurance Premium. The health insurance premiums of the beneficiary, the beneficiary's spouse, and the beneficiary's dependents.

e. Other Reserves. Other incurred medical care costs that are not reimbursed by a third party. Contributions to reserves limited to child support, alimony, and income taxes. Contributions to reserves for the purchase of an irrevocable burial plan with a maximum value of $5000. Contributions to reserves for a home maintenance allowance may be made on a monthly basis if the client meets the criteria of OAR 461-155-0660 or OAR 461-160-0630.

f. Patient Liability. Patient liability not to exceed the cost of waivered services or nursing home care.

g. Excess. Any excess income may be distributed to or on behalf of the beneficiary only to the extent allowed under the Oregon Administrative Rules governing Medicaid assistance. Excess income may be distributed to the State to repay it for any Medicaid assistance that it provided to the beneficiary, even if recovery for the past assistance is not required by federal or state law.

4.2 INITIAL DISTRIBUTION PLAN. The initial distribution plan of the trustee, beginning with the month of ______________ 20XX, is as follows:

Total Monthly Income: $__________________

Distributions:

a. Personal Needs Allowance $__________________
b. Room & Board (if applicable) $__________________
c. Administrative Costs $__________________
d. Community Spouse, Family $__________________
e. Health Insurance Premiums $__________________
f. Other Reserves $__________________
g. Patient Liability $__________________
h. Excess $__________________

4.3 ANTICIPATED DISTRIBUTION PLAN CHANGE. The trustee anticipates that the distributions will change as follows beginning _____________ 1, 20XX.

Total Monthly Income: $_________________

Distributions:
a. Personal Needs Allowance $_________________
b. Room & Board (if applicable) $_________________
c. Administrative Costs $_________________
d. Community Spouse, Family $_________________
e. Health Insurance Premiums $_________________
f. Other Reserves $_________________
g. Patient Liability $_________________
h. Excess $_________________

4.4 CHANGES ARE ANTICIPATED. The cost of care will vary with changes in the beneficiary's income, the income cap amount, tax withholding, and allowable expenses. The representative of the state Medicaid program may from time to time notify the trustee of changes in the rules that affect the contribution to the cost of care. If the trustee determines that a change in the distribution plan is warranted, the trustee shall notify the worker assigned to the beneficiary's case.

ARTICLE 5

DISTRIBUTION AT TERMINATION

5.1 REMAINDER BENEFICIARIES NAMED. This trust shall cease and terminate at the death of the beneficiary, or earlier if the trustee determines that the existence of the trust is no longer necessary to establish or maintain Medicaid eligibility for the beneficiary. Upon the termination of this trust, the remaining trust property shall be distributed as follows:

a. To any State that may have provided the life beneficiary with medical assistance up to an amount equal to the total medical assistance paid on behalf of the life beneficiary by a state plan for Medicaid assistance or through an approved waiver program; this provision is intended to meet the requirements of 42 USC 1396p as amended by OBRA '93; and

b. Any remainder after the state's claim has been paid shall pass outside of probate to those residuary beneficiaries named in the beneficiary's will or trust; however, if the beneficiary leaves no will or trust, then the remainder shall be distributed outside of probate to those heirs as determined by the Oregon law of intestate succession.

5.2 WINDING UP AFFAIRS OF TRUST. At the termination of this trust, trustee shall wind up the affairs of the trust before distribution, paying for all administrative costs and for preparation of the final tax return. The trustee shall have the sole discretion to claim any tax deductions useful to reduce the taxation of the living trust. After winding up the trust, the trustee shall distribute the remainder, if any, as provided above.

ARTICLE 6

It is the intent of the parties hereto that this Income Cap Trust be construed as a "grantor trust" under Internal Revenue Code Section 677(a). All income received, distributed, held, or accumulated by this trust shall be taxable to the grantor. The trustee may distribute directly to the taxing authority such amounts of income or principal of the trust as are necessary to satisfy the beneficiary's tax obligations.

ARTICLE 7

AUTHORITY OF TRUSTEE

The trustee's discretion in choosing which non-support disbursements to make is final as to all interested parties. The trustee's sole and independent judgment, rather than any other person's determination, is intended to be final.

ARTICLE 8

SPENDTHRIFT/NONASSIGNMENT

No interest in the principal or income of this trust shall be anticipated, assigned or encumbered, or be subject to any creditor's claim or to legal process prior to its actual receipt by the beneficiary. No beneficiary shall have the power to sell, assign, transfer, encumber, or in any other manner anticipate or dispose of the beneficiary's interest in the trust or the income produced thereby, prior to its actual distribution by the trustee for the benefit of the beneficiary in the manner authorized by this agreement. No beneficiary shall have any assignable interest in any trust created under this agreement or in the income therefrom. Neither the trust principal nor income shall be liable for any debts of the beneficiary. The limitations herein shall not restrict the exercise of any power of appointment or disclaimer.

ARTICLE 9

Grantor retains no right to modify, change, alter, or revoke this trust, as it is intended to be an irrevocable trust. The beneficiary has no power to modify, change, alter, or revoke the trust.

ARTICLE 10

GOVERNING LAW

The validity and construction of this agreement shall be determined under Oregon law in effect on the date this agreement is signed.

ARTICLE 11

POWERS OF TRUSTEE

The trustee shall have all powers granted to trustees by Oregon law as now existing or later amended, except to the extent limited by the other provisions of this trust. In addition, the trustee shall have the power:

11.1 MANAGE ASSETS. To manage and distribute assets.

11.2 RETAIN ASSETS. To retain assets.

11.3 MANNER OF MAKING DISTRIBUTION. To make any distribution on behalf of the beneficiary, directly to the person or organization.

11.4 PRINCIPAL AND INCOME. The trustee may allocate items of income or expenditure to either income or principal and create reserves out of income all as provided by law, and to the extent not so provided, to allocate to income or principal or create reserves, on a reasonable basis, and the fiduciary's decision made in good faith with respect thereto shall be binding and conclusive upon all persons.

11.5 UNDISTRIBUTED INCOME. Income accrued or undistributed at the termination of a beneficiary's interest in a trust shall be added to and become part of the principal of that trust, and the rights of the beneficiary to that income shall terminate.

11.6 EMPLOYMENT OF AGENTS. The trustee may engage persons, including attorneys, auditors, investment advisors, tax advisors or agents to advise or assist the fiduciary at the cost of the trust estate.

11.7 DO OTHER ACTS. Except as otherwise provided in this instrument, to do all acts that might legally be done by an individual in absolute ownership and control of property and which in the trustee's judgment are necessary or desirable for the proper and advantageous management of the trust estate.

11.8 TRUSTEE LIABILITY; USE OF FUNDS TO RESEARCH PROGRAMS. It is recognized that the trustee is not licensed nor skilled in the field of Social Services. The trustee may seek the counsel and assistance of the beneficiary's guardian or conservator, if any, and any State and local agencies that have been established to assist the elderly or disabled in similar circumstances. The trustee may use these resources to aid the beneficiary, or the beneficiary's guardian or conservator, as appropriate, in identifying programs which may be of social, financial, and/or developmental assistance to the beneficiary. However, the trustee shall not in any event be liable to beneficiary, the remainder beneficiaries of the trust, or any other party for the trustee's acts as trustee hereunder so long as the trustee acts reasonably and in good faith. For example, the trustee, the beneficiary, and the beneficiary's guardian or conservator, if any, shall not be liable for the failure to identify each program or resource that might be available to the beneficiary.

11.9 POWER TO AMEND. The trustee may amend the trust to conform with future changes in federal or state law, to better effect the purposes of this trust.

ARTICLE 12

TRUST ADMINISTRATION AND COURTS

This trust shall be administered according to its terms expeditiously and without order, approval or other action by any court. However, the trustee or any interested person may petition the court as allowed in this trust agreement, or by Oregon law. A court, however, shall have the continuing jurisdiction to modify any provision of this trust to the extent necessary to maintain the eligibility of the beneficiary for medical assistance or other public benefits under applicable law.

ARTICLE 13

TRUSTEE SUCCESSION AND GENERAL ADMINISTRATIVE PROVISIONS

13.1 RESIGNATION OF TRUSTEE. The trustee may resign the trusteeship at any time. Any resignation shall be in writing, and shall become effective only after thirty (30) days from the date of mailing of the written notice to the beneficiary and to the first remainder beneficiary, and to the successor trustee named herein, mailed to the most current addresses known to the trustee; now the addresses are:

Beneficiary's Address: ___________________________

____

Telephone:___________________________

First Remainder Beneficiary:
State of Oregon
Department of Human Services
Estate Administration Unit
PO Box 14021
Salem, OR 97309-5024

Trustee's Address _____________________
____

or the most current addresses then known to the trustee.

13.2 DESIGNATION OF SUCCESSOR TRUSTEE. The successor trustee shall be___________________________. The second nominated successor trustee shall be ___________________________. Any named trustee may nominate and appoint additional successor trustees to serve if the persons initially nominated as successors are unavailable or unwilling to serve.

13.3 NO TRUSTEE. If the trust at any time has no trustee, and no successor has been nominated as described above, then a Court having jurisdiction may appoint, after notice to the beneficiary and an opportunity to be heard, a successor trustee at the request of any person interested in the trust, including the trust beneficiary.

13.4 TRANSFER TO SUCCESSOR TRUSTEE. Every successor trustee shall have all the rights, title, powers, privileges and duties conferred on or imposed upon the original trustee, without any conveyance or transfer. All right, title and interest to the trust property shall immediately vest in the successor trustee, upon the successor trustee executing a document accepting the office. The prior trustee shall, without warranty, transfer the existing trust property to the possession and control of the successor trustee. The successor trustee shall not have any duty to examine the records or actions of any former trustee, and shall not be liable for the consequences of any act or failure to act of any former trustee.

13.5 REMOVAL OF TRUSTEE. Any interested person herein may petition any Oregon Circuit Court for removal of any trustee. While any interested person may petition for removal of any trustee, the decision on whether to remove any trustee shall be in the exclusive discretion and control of an Oregon Circuit Court.

13.6 REPLACEMENT OF TRUSTEE. Any trustee may be replaced by a successor trustee, upon the death, resignation, removal or incapacity of the prior trustee. Also, should no successor trustee have been nominated, any Oregon Circuit Court shall have the power to fill any vacancy in the trusteeship resulting from the death, resignation, removal, or incapacity of a trustee.

13.7 TRUSTEE'S REPORTING RESPONSIBILITY. The trustee shall report, at least every twelve months, to the beneficiary and his/her legal representative, if any, and to the next successor trustee, at the most recent address then known to the trustee. The trustee's report shall advise of any change in the beneficiary's eligibility for public benefit programs and shall list all of the receipts, disbursements, and distributions occurring during the reporting period, along with a complete list of the assets held by the trust. A copy of the most recent bank ac-count statement and a copy of the most recently filed trust tax return shall be attached to the accounting. The account shall be deemed to have been delivered when it has been placed in the United States Mail addressed to that person at the person's last known address.

13.8 AVAILABILITY OF RECORDS. The records of the trustee, such as all trust documentation and annual accountings, shall be made available to the trust beneficiary, and/or the beneficiary's legal representative, and the trust remaindermen, including but not limited to the State of Oregon, Department of Human Services, within 10 days of notice to the trustee.

13.9 TRUSTEE COMPENSATION. The trustee may receive reasonable compensation and reimbursement for expenses such as travel costs (if automobile, at the then-current IRS mileage expense allowance), postage, copy and fax charges, and long distance telephone charges required to administer the trust estate.

13.10 TRUSTEE INDEMNIFICATION. Trustee is entitled to be indemnified, to his or her reasonable satisfaction, against liabilities lawfully incurred in the administration of this trust, at the cost of the trust.

13.11 BOND. No bond shall be required of any trustee.

DATED this _____ day of ________________, 20XX

____
,GRANTOR

____
,TRUSTEE

APPENDIX B—NOTICE OF RULEMAKING ACTION—ADOPTED JULY 29, 2009

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on July 29, 2009 by the
Date prior to or same as filing date.

Department of Human Services - Children, Adults and Families — 461
Agency and Division — Administrative Rules Chapter Number

Annette Tesch — Human Services Building, 500 Summer St NE - E48, Salem, OR 97301-1066 — (503) 945-6067
Rules Coordinator — Address — Telephone

to become effective July 29, 2009 through January 25, 2010
Date upon filing or later — A maximum of 180 days including the effective date.

RULE CAPTION

Changing OARs affecting public assistance, medical assistance or food stamp clients
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

ADOPT:
AMEND: 461-145-0330
SUSPEND:

ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stat. Auth.

American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5), 42 USC 1396a
Other Authority

ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stats. Implemented

RULE SUMMARY

OAR 461-145-0330 about how the Department treats proceeds of loans, loan repayments, and interest earned by a lender when determining a client's eligibility is being amended to state that a loan made by a married client receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program that exceeds the resource allowance of the client's spouse is not counted as a resource. This change complies with recent federal legislation (The American Recovery and Reinvestment Act of 2009, Section 5001, Pub. L. 111-5) that provides the Department with enhanced federal matching funds for its Medicaid programs.

Authorized Signer

Robert Trachtenberg
Printed Name — Date

*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in the Rulemaking Action, and electronic copy of rules.
ARC 940-2005

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Human Services - Children, Adults and Families 461
Agency and Division Administrative Rules Chapter Number

In the Matter of: Amending OAR 461-145-0330

Rule Caption: Changing OARs affecting public assistance, medical assistance or food stamp clients

Statutory Authority: ORS 411.060, 411.816, 412.014, 412.049, 414.042

Other Authority: American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5), 42 USC 1396a

Statutes Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042

Need for the Temporary Rule(s):

OAR 461-145-0330 needs to be amended to comply with recent federal legislation (The American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5)), that provides the Department with enhanced federal matching funds for its Medicaid programs. The amended rule will comply with this legislation by stating that effective July 1, 2009 a loan made by a married client receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program that exceeds the resource allowance of the client's spouse is not counted as a resource when the Department is determining a client's eligibility. The rule had treated proceeds of loans, loan repayments, and interest earned by a client lender as resources when determining a client's eligibility.

Documents Relied Upon (and where they are available): None

Justification of Temporary Rule(s):

The Department finds that failure to act promptly by amending OAR 461-145-0330 will result in serious prejudice to the public interest, clients of the Department's Medicaid programs, and the Department. Effective July 1, 2009, states are eligible for enhanced federal matching funds for Medicaid programs if the states comply with certain federal requirements. The amended rule allows the Department to comply with these requirements.

Authorized Signer

Robert Trachtenberg
Printed Name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 945-2005

461-145-0330
Loans and Interest on Loans

(1) This rule covers proceeds of loans, loan repayments, and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the other rules in this division of rules.

(2) For purposes of this rule:

(a) In the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) "Bona fide loan agreement" means an agreement that --

(i) Is enforceable under state law;

(ii) Is in effect at the time the cash proceeds are provided to the borrower; and

(iii) Includes an obligation to repay and a feasible repayment plan.

(B) "Negotiable loan agreement" means a loan agreement in which the instrument ownership and the whole amount of money expressed on its face can be transferred from one person to another (i.e., sold) at prevailing market rates.

(b) In all programs:

(A) "Reverse-annuity mortgage" means a contract with a *financial institution* (see OAR 461-001-0000) under which the *financial institution* provides payments against the equity in the home that must be repaid when the homeowner dies, sells the home, or moves.

(B) The proceeds of a home equity loan or *reverse-annuity mortgage* are considered loans.

(3) For payments that a member of the *financial group* (see OAR 461-110-0530) receives as a borrower to be treated as a loan:

(a) In the FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, there must be an oral or written loan agreement, and this agreement must state when repayment of the loan is due to the lender.

(b) In programs other than the FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, there must be a written loan agreement, and this agreement must be signed by the borrower and lender, dated before the borrower receives the proceeds of the loan, and state when repayment of the loan is due to the lender.

(4) Payments for a purported loan that do not meet the requirements of section (3) of this rule are counted as unearned income.

(5) When a member of a *financial group* receives cash proceeds as a borrower from a loan that meets the requirements of section (3) of this rule:

(a) In all programs, educational loans are treated according to OAR 461-145-0150.

(b) In the ERDC, EXT, FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF programs, the loan is excluded. If retained after the month of receipt, the loan proceeds are treated in accordance with OAR 461-140-0070.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) If the loan is a *bona fide loan agreement*, the money provided by the lender is not income but is counted as the borrower's resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).

(B) If the loan is not a *bona fide loan agreement*, the money provided by the lender is counted as income in the month received and is counted as a resource if retained in the month following the month it was received.

~~(6) In the OSIPM program, if a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan:~~

~~(a) In a transaction occurring on or after July 1, 2006:~~

~~(A) The balance of the payments owing to the client or spouse of the client is a transfer of assets for less than *fair market value*, unless all of the following requirements are met:~~

~~(i) The total value of the transaction is being repaid to the client or spouse of the client within three months of the client's life expectancy per that person's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.~~

~~(ii) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.~~

~~(iii) The contract is not cancelled upon the death of the individual receiving the payments under this transaction.~~

~~(B) If the loan results in a disqualification and the disqualification period has been served, payments against the principal and interest are treated as unearned income.~~

~~(b) In a transaction occurring before July 1, 2006 or for a transaction occurring on or after July 1, 2006 that does not result in a disqualification in subsection (a) of this section, the loan is treated as follows:~~

~~(A) Interest income is treated as unearned income.~~

~~(B) The loan is counted as a resource if:~~

~~(i) The *financial group* includes a client in a *nonstandard living arrangement* (see OAR 461-001-0000) and the client's spouse;~~

~~(ii) The transaction is on or after the date of the first *continuous period of care* (see OAR 461-001-0030); and~~

~~(iii) The amount of the loan plus other resources transferred exceeds the largest amount in OAR 461-160-0580(2)(f).~~

~~(C) For all other loans:~~

~~(i) If the loan is both a negotiable loan agreement and a bona fide loan agreement, the loan is counted as a resource valued at the outstanding principal balance.~~

~~(ii) If the loan does not qualify under subparagraph (i) of this paragraph, payments against the principal are counted as unearned income.~~

~~(7) In the GA, GAM, OSIP, and QMB programs:~~

~~(a) Interest income is treated as unearned income.~~

~~(b) If the loan is both a *negotiable loan agreement* and a *bona fide loan agreement*, the loan is counted as a resource of the lender valued at the outstanding principal balance.~~

~~(c) If the loan does not qualify under subsection (b) of this section, the payments against the principal are counted as income to the lender.~~

~~(8) In all programs other than the GA, GAM, OSIP, OSIPM, and QMB programs:~~

~~(a) The interest payment is counted as unearned income.~~

~~(b) The payment of principal is excluded.~~

(6) Unless the loan is considered a transfer of assets for less than *fair market value* (see section (7) of this rule), when a member of a *financial group* is the lender, effective July 1, 2009 the loan is treated as follows:

(a) In the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) If the loan is both a *negotiable loan agreement* and a *bona fide loan agreement*, the loan is counted as a resource of the lender valued at the outstanding principal balance.

(B) If the loan does not qualify under paragraph (A) of this subsection, the transfer of assets to the borrower may be considered a transfer for less than *fair market value* (see OAR 461-001-0000). If the transfer is not disqualifying, payments against the principal are counted as income to the lender.

(C) Interest income received by the lender is counted as unearned income regardless if the loan is a *bona fide loan agreement*.

(b) In all programs other than the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) The interest payment is counted as unearned income; and

(B) The payment of principal is excluded.

(7) In the GA, GAM, OSIP, OSIPM, and QMB programs, in a transaction occurring on or after July 1, 2006, if a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan, the balance of the payments owing to the client or spouse of the client is a transfer of assets for less than *fair market value*, unless all of the following requirements are met:

(a) The total value of the transaction is being repaid to the client or spouse of the client within that individual's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.

(b) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.

(c) The contract is not cancelled upon the death of the client or the spouse of the client who made the transaction.

Stat. Auth: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042

APPENDIX C—NOTICE OF RULEMAKING ACTION—ADOPTED SEPTEMBER 1, 2009

Secretary of State
Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on September 1, 2009 by the
Date prior to or same as filing date.

Department of Human Services - Children, Adults and Families — 461
Agency and Division — Administrative Rules Chapter Number

Annette Tesch — Human Services Building, 500 Summer St NE - E48, Salem, OR 97301-1066 — (503) 945-6067
Rules Coordinator — Address — Telephone

to become effective September 1, 2009 through January 25, 2010
Date upon filing or later — A maximum of 180 days including the effective date.

RULE CAPTION

Changing OARs affecting public assistance, medical assistance or food stamp clients
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

ADOPT:

AMEND:

SUSPEND: 461-145-0330(T), 461-145-0380(T)

ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042
Stat. Auth.

Other Authority

ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042
Stats. Implemented

RULE SUMMARY

OAR 461-145-0330 how the Department treats proceeds of loans, loan repayments, and interest earned by a lender and OAR 461-145-0380 about how the Department treats pension and retirement plans when determining a client's eligibility are being suspended to rescind the amended July 29, 2009 temporary versions of these rules and restore the underlying permanent versions of these rules. The suspension of the July 29, 2009 changes complies with the most recent federal Center for Medicare and Medicaid Services interpretation of recent federal legislation (The American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5)) that provides the Department with enhanced federal matching funds for its Medicaid programs.

OAR 461-145-0330 is being suspended to no longer state that a loan made by a married client receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program that exceeds the resource allowance of the client's spouse is not counted as a resource.

OAR 461-145-0380 is being suspended for the Oregon Supplemental Income Program (OSIP), Oregon Supplemental Income Program Medical (OSIPM), and Qualified Medicare Beneficiary (QMB) programs to no longer state that certain annuities are considered pension and retirement plans, and to restore the requirement (in order for the equity value of the pension or retirement plan to be excluded as a resource) that an individual eligible for periodic or monthly payments under the terms of certain pension and retirement plans must select the payment option that provides for payments commencing on the earliest possible date with payments completed within the individuals actuarial life expectancy.

Authorized Signer

Kym Gasper

Printed Name Date

*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in the Rulemaking Action, and electronic copy of rules. ARC 940-2005

Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Human Services - Children, Adults and Families 461
Agency and Division Administrative Rules Chapter Number

In the Matter of: Suspending Temporary Rules

Rule Caption: Changing OARs affecting public assistance, medical assistance or food stamp clients

Statutory Authority: ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042

Other Authority:

Statutes Implemented: ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042

Need for the Temporary Rule(s):

OAR 461-145-0330 and 461-145-0380 need to be suspended to rescind the amended July 29, 2009 temporary versions of these rules and restore the underlying permanent version of these rules to comply with the most recent federal interpretation of recent federal legislation (The American Recovery and Reinvestment Act of 2009, Section 5001 (Pub. L. 111-5)), that provides the Department with enhanced federal matching funds for its Medicaid programs. OAR 461-145-0330 had stated that a loan made by a married client receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program that exceeds the resource allowance of the client's spouse is not counted as a resource. The restored permanent rule will comply with this new federal interpretation of the new legislation by treating proceeds of loans, loan repayments, and interest earned by a married client lender receiving long term care services in the Oregon Supplemental Income Program Medical (OSIPM) program as resources when determining a client's eligibility. OAR 461-145-0380 had stated that in the Oregon Supplemental Income Program (OSIP), Oregon Supplemental Income Program Medical (OSIPM), and Qualified Medicare Beneficiary (QMB) programs, certain annuities are treated as pension and retirement plans and the value of certain pension or retirement plans is excluded as a resource when determining a client's eligibility. The restored permanent rule will comply with the new federal interpretation of the new legislation by not allowing the OSIP, OSIPM, and QMB programs to treat certain annuities as pension or retirement plans and requiring clients to choose specific payout options for pension and retirements plans to have the equity value of those plans excluded as a resource.

Documents Relied Upon (and where they are available): State Medicaid Director Letter SMD #09-005, available at: http://www.cms.hhs.gov/SMDL/downloads/SMD081909.pdf

Justification of Temporary Rule(s):

The Department finds that failure to act promptly by suspending OAR 461-145-0330 and 461-145-0380 will result in serious prejudice to the public interest, clients of the Department's Medicaid programs, and the Department. Effective July 1, 2009, states are eligible for enhanced

federal matching funds for Medicaid programs if the states comply with certain federal requirements. The suspended temporary rules restore the underlying permanent versions of these rules, allowing the Department to comply with the federal requirements.

Authorized Signer

Kym Gasper

Printed Name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 945-2005

461-145-0330
Loans and Interest on Loans

(1) This rule covers proceeds of loans, loan repayments, and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the other rules in this division of rules.

(2) For purposes of this rule:

(a) In the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) "Bona fide loan agreement" means an agreement that --

(i) Is enforceable under state law;

(ii) Is in effect at the time the cash proceeds are provided to the borrower; and

(iii) Includes an obligation to repay and a feasible repayment plan.

(B) "Negotiable loan agreement" means a loan agreement in which the instrument ownership and the whole amount of money expressed on its face can be transferred from one person to another (i.e., sold) at prevailing market rates.

(b) In all programs:

(A) "Reverse-annuity mortgage" means a contract with a *financial institution* (see OAR 461-001-0000) under which the *financial institution* provides payments against the equity in the home that must be repaid when the homeowner dies, sells the home, or moves.

(B) The proceeds of a home equity loan or *reverse-annuity mortgage* are considered loans.

(3) For payments that a member of the *financial group* (see OAR 461-110-0530) receives as a borrower to be treated as a loan:

(a) In the FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, there must be an oral or written loan agreement, and this agreement must state when repayment of the loan is due to the lender.

(b) In programs other than the FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, there must be a written loan agreement, and this agreement must be signed by the borrower and lender, dated before the borrower receives the proceeds of the loan, and state when repayment of the loan is due to the lender.

(4) Payments for a purported loan that do not meet the requirements of section (3) of this rule are counted as unearned income.

(5) When a member of a *financial group* receives cash proceeds as a borrower from a loan that meets the requirements of section (3) of this rule:

(a) In all programs, educational loans are treated according to OAR 461-145-0150.

(b) In the ERDC, EXT, FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF programs, the loan is excluded. If retained after the month of receipt, the loan proceeds are treated in accordance with OAR 461-140-0070.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs:

(A) If the loan is a *bona fide loan agreement*, the money provided by the lender is not income but is counted as the borrower's resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).

(B) If the loan is not a *bona fide loan agreement*, the money provided by the lender is counted as income in the month received and is counted as a resource if retained in the month following the month it was received.

(6) In the OSIPM program, if a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan:

(a) In a transaction occurring on or after July 1, 2006:

(A) The balance of the payments owing to the client or spouse of the client is a transfer of assets for less than *fair market value*, unless all of the following requirements are met:

(i) The total value of the transaction is being repaid to the client or spouse of the client within three months of the client's life expectancy per that person's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.

(ii) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.

(iii) The contract is not cancelled upon the death of the individual receiving the payments under this transaction.

(B) If the loan results in a disqualification and the disqualification period has been served, payments against the principal and interest are treated as unearned income.

(b) In a transaction occurring before July 1, 2006 or for a transaction occurring on or after July 1, 2006 that does not result in a disqualification in subsection (a) of this section, the loan is treated as follows:

(A) Interest income is treated as unearned income.

(B) The loan is counted as a resource if:

(i) The *financial group* includes a client in a *nonstandard living arrangement* (see OAR 461-001-0000) and the client's spouse;

(ii) The transaction is on or after the date of the first *continuous period of care* (see OAR 461-001-0030); and

(iii) The amount of the loan plus other resources transferred exceeds the largest amount in OAR 461-160-0580(2)(f).

(C) For all other loans:

(i) If the loan is both a negotiable loan agreement and a bona fide loan agreement, the loan is counted as a resource valued at the outstanding principal balance.

(ii) If the loan does not qualify under subparagraph (i) of this paragraph, payments against the principal are counted as unearned income.

(7) In the GA, GAM, OSIP, and QMB programs:

(a) Interest income is treated as unearned income.

(b) If the loan is both a *negotiable loan agreement* and a *bona fide loan agreement*, the loan is counted as a resource of the lender valued at the outstanding principal balance.

(c) If the loan does not qualify under subsection (b) of this section, the payments against the principal are counted as income to the lender.

(8) In all programs other than the GA, GAM, OSIP, OSIPM, and QMB programs:

(a) The interest payment is counted as unearned income.

(b) The payment of principal is excluded.

Stat. Auth: ORS 411.060, 411.816, 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.816, 412.014, 412.049, 414.042

461-145-0380
Pension and Retirement Plans

(1) Pension and retirement plans include the following:

(a) Benefits employees receive only when they retire. These benefits can be disbursed in lump-sum or monthly payments.

(b) Benefits that employees are allowed to withdraw when they leave a job before retirement.

(c) The following retirement plans if purchased by a client with funds from the plans authorized by section 401 of the Internal Revenue Code of 1986:

(A) Traditional Defined-Benefit Plan.

(B) Cash Balance Plan.

(C) Employee Stock Ownership Plan.

(D) Keogh Plan.

(E) Money Purchase Pension Plan.

(F) Profit-Sharing Plan.

(G) Simple 401(k).

(H) 401(k).

(d) Retirement plans purchased by a client with funds from plans authorized by section 403 of the Internal Revenue Code of 1986 at subsections (a) or (b).

(e) The following retirement plans and annuities if purchased by a client with funds from the plans authorized by section 408 of the Internal Revenue Code of 1986 at subsections (a), (b), (c), (k), (p), or (q), or at section 408A:

(A) Individual Retirement Annuity.

(B) Individual Retirement Account (IRA).

(C) Deemed Individual Retirement Account or Annuity under a qualified employer plan.

(D) Accounts established by employers and certain associations of employees.

(E) Simplified Employee Pension (SEP).

(F) Simple Individual Retirement Account (Simple-IRA).

(G) Roth IRA.

(f) The following retirement plans offered by governments, nonprofit organizations, or unions:

(A) 457(b) Plan.

(B) 501(c)(18) Plan.

(C) Federal Thrift Savings Plan under 5 USC 8439.

(g) In all programs except the OSIP, OSIPM, and QMB programs, an annuity purchased by a client with funds from a plan authorized under subsection (c), (d), or (f) of this section.

(2) An annuity purchased by the *spouse* (see OAR 461-001-0000) of a client with funds from a retirement plan described in subsection (1)(e) of this rule is not considered a retirement plan and is treated in accordance with OAR 461-145-0020 and OAR 461-145-0022.

(3) Benefits the client receives from pension and retirement plans are treated as follows:

(a) Monthly payments are counted as unearned income.

(b) All payments not covered by subsection (a) of this section are counted as periodic or lump-sum income (see OAR 461-140-0110 and 461-140-0120).

(4) In the OSIP, OSIPM, and QMB programs:

(a) Except for an annuity purchased with funds from a retirement plan described in subsection (1)(e) of this rule:

(A) The *equity value* (see OAR 461-001-0000) of a pension or retirement plan is excluded as a resource if the individual is eligible for monthly or periodic payments under the terms of the plan and has applied for those payments. When an individual is permitted to choose or change a payment option, the individual must select the option that --

(i) Provides payments commencing on the earliest possible date; and

(ii) Completes payments within the actuarial life expectancy, as published in the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration, of the individual.

(B) The *equity value* of all pension and retirement plans not covered by paragraph (A) of this subsection that allow clients to withdraw funds, minus any penalty for withdrawal, is counted as a resource.

(b) The *equity value* of an annuity purchased with funds from a retirement plan described in subsection (1)(e) of this rule is excluded as a resource if it meets the payout requirements of OAR 461-145-0022(10)(c). Otherwise, the *equity value* is counted as a resource.

(5) In the FS program, the value of retirement accounts identified in sections 401(a), 403(a), 403(b), 408, 408(k), 408(p), 408A, 457(b), or 501(c)(18) of the Internal Revenue Code, or in a Federal Thrift Savings Plan account are excluded resources.

(6) In the OHP program, the *equity value* of a pension or retirement plan that allows a client to withdraw funds before retirement is excluded as a resource.

(7) In all programs except the FS, OHP, OSIP, OSIPM, and QMB programs, the *equity value* of a pension and retirement plan that allows a client to withdraw funds before retirement, minus any penalty for early withdrawal, is counted as a resource.

Stat. Auth.: ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.070, 411.816, 412.014, 412.049, 414.042

APPENDIX D—OAR 461-145-0022

Annuities; OSIPM

In the OSIPM program:

(1) For the purposes of this rule:

(a) "Actuarially sound" means a commercial annuity which pays principal and interest out in equal monthly installments over the actuarial life expectancy of the annuitant. For purposes of this definition, the actuarial life expectancy is established by the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration, and, for transactions (including the purchase of an annuity) occurring on or after July 1, 2008, the payout period must be within three months of the actuarial life expectancy.

(b) For a client, an annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether maintained in the original account or used to purchase an annuity, if the Internal Revenue Service recognizes the account as dedicated to retirement or pension purposes. (The treatment of pension and retirement plans is covered in OAR 461-145-0380.)

(c) The definition of "child" in OAR 461-001-0000 does not apply.

(d) "Child" means a biological or adoptive child who is:

(A) Under age 21; or

(B) Any age and meets the Social Security Administration criteria for blindness or disability.

(e) "Commercial annuity" means a contract or agreement (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.

(2) An annuity that does not make regular payments for a lifetime or specified number of years is a resource.

(3) When a client applies for medical benefits, both initially and at periodic redetermination (see OAR 461-115-0050 and 461-115-0430), the client must report any annuity owned by the client or a spouse of the client.

(4) By signing the application for assistance, a client and the spouse of a client agree that the Department, by virtue of providing medical assistance, becomes a remainder beneficiary as described in sections (8) and (10) of this rule, under any commercial annuity purchased on or after February 8, 2006, unless the annuity is included in the community spouse's resource allowance under OAR 461-160-0580(2)(c).

(5) If the Department is notified about a commercial annuity, the Department will notify the issuer of the annuity about the right of the Department as a preferred remainder beneficiary, as described in sections (8) and (10) of this rule, in the amount of medical assistance provided to the client.

(6) If a client or a spouse of a client purchases or transfers a commercial annuity prior to January 1, 2006, the following applies:

(a) If the client is in a nonstandard living arrangement (see OAR 461-001-0000), the transaction may be subject to the rules on asset trans-

fers at OAR 461-140-0210 and following. For an annuity that is not disqualifying or the disqualification period has already been served, the annuity payments are counted as unearned income to the payee.

(b) If the client is in a standard living arrangement, the annuity payments are counted as unearned income to the payee.

(7) Sections 8 and 9 of this rule apply to a commercial annuity if:

(a) The client is in a nonstandard living arrangement, and the client or the spouse of the client purchases an annuity from January 1, 2006 through June 30, 2006; or

(b) The client is in a standard living arrangement (see OAR 461-001-0000), and the client or the spouse of a client purchase an annuity on or after January 1, 2006.

(8) A commercial annuity covered by section (7) of this rule is counted as a resource unless the annuity is excluded by meeting the following requirements:

(a) If an unmarried client is an annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:

(A) The Department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(B) The child of the client, if the Department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the client, in the event that the child does not survive the client.

(b) If a spouse of a client is the annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that, upon the death of the spouse of the client, the first remainder beneficiaries are either of the following:

(A) The client, in the event that the client survives the spouse; and the Department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(B) A child of the spouse; and the client in the event that this child does not survive the spouse.

(c) An annuity covered by section (7) of this rule may not be excluded unless the annuity meets all of the following requirements:

(A) The annuity is irrevocable.

(B) The annuity must be actuarially sound.

(C) The annuity is issued by a business that is licensed and approved to issue a commercial annuity by the state in which the annuity is purchased.

(9) If an annuity is excluded as a resource under section (8) of this rule, the annuity payments are counted as unearned income to the payee. If an annuity is a countable resource under section (8) of this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any

earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

(10) This section lists the requirements for a commercial annuity purchased by the client or the spouse of the client on or after July 1, 2006, when a client is in a nonstandard living arrangement, and the annuity names the client or the community spouse as the annuitant. Annuities that meet all of the requirements of this section are counted as unearned income to the payee. The treatment of annuities that do not meet all requirements of this section is covered in sections (11) and (12) of this rule.

(a) The annuity must comply with one of the following paragraphs:

(A) The first remainder beneficiary is the spouse of the client, and in the event that the spouse transfers any of the remainder of the annuity for less than fair market value (see OAR 461-001-0000), the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(B) The first remainder beneficiary is the annuitant's child, and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than fair market value, the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(C) The first remainder beneficiary is the Department for up to the total amount of medical benefits paid on behalf of the client.

(b) The annuity must be irrevocable and nonassignable.

(c) The annuity must be actuarially sound.

(d) The annuity is issued by a business that is licensed and approved to issue a commercial annuity by the state in which the annuity is purchased.

(11) If the client is the annuitant and a commercial annuity does not meet all of the requirements of section (10) of this rule, or the spouse of the client is the annuitant and a commercial annuity does not meet the requirements of subsection (10)(a) of this rule, there is a disqualifying transfer of assets under OAR 461-140-0210 and following. See OAR 461-140-0296(6) and (7) for calculation of the disqualification period.

(12) Regardless of whether a commercial annuity is a disqualifying transfer of assets, if the annuity does not meet all of the requirements of section (10) of this rule, the annuity is counted as a resource with cash value equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

Hist.: SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 17-2008, f. & cert. ef. 7-1-08

APPENDIX E—CMS GUIDANCE

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMD# 09-003
ARRA # 3

June 17, 2009

Dear State Medicaid Director:

This letter is one of a series designed to provide guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5. It summarizes most sections of ARRA that impact titles XIX (the Medicaid program) and XXI (the Children's Health Insurance Program, or CHIP) of the Social Security Act (the Act) and provides detail on the sections specific to payments that should not be counted for purposes of eligibility for Federal programs. Future State Medicaid Director letters and other technical guidance will be issued in the coming weeks and months, providing details on the implementation of all other sections, including the Health Information Technology (HIT) provisions and provisions that directly affect American Indian and Alaska Natives enrolled in Medicaid and CHIP.

ARRA is divided into two parts: Division A and Division B. All of the detailed sections in this letter are part of Division B; however, there are many sections in Division A with implications for State Medicaid programs, albeit less direct. We welcome questions from the States on any part of ARRA that impacts titles XIX or XXI and we commit to working with States on any sections of the new law that raise concerns or challenges for States. Please continue to submit questions to CMSOARRAQuestions@cms.hhs.gov. We will post the questions and answers on a continual basis at http://www.cms.hhs.gov/Recovery/09_Medicaid.asp#TopOfPage.

Division B, Title I —Tax, Unemployment, Health, State Fiscal Relief, And Other Provisions, Section 1001 – Making Work Pay Tax Credit

Section 1001 of ARRA provides for a credit against the taxes paid by most working individuals. The credit is the lower of 6.2 percent of the earned income of the taxpayer, or $400 ($800 for a joint return), and is available for the 2009 and 2010 tax years. Subsection 1001(c) of ARRA further provides that any credit or refund made under section 1001 will be disregarded for purposes of all Federal and federally-assisted programs, including both the Medicaid and CHIP programs. Enclosure A provides more detailed guidance with regard to implementing this section.

Title II—Assistance for Unemployed Workers and Struggling Families Section 2002 – Increase in Unemployment Compensation Benefits

Section 2002 of ARRA provides for an increase in unemployment compensation benefits for individuals. Subsection 2002(h) of ARRA further provides that the monthly equivalent of any additional compensation paid under section 2002 shall be disregarded when considering the amount of income of an individual for any purpose under the Medicaid and CHIP programs. Enclosure B provides detailed guidance with regard to implementing this section.

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Section 2201 – Economic Recovery Payment to Recipients of Social Security, Supplemental Security Income, Railroad Retirement Benefits, and Veterans Disability Compensation or Pension Benefits.

Section 2201 of ARRA provides for a one-time payment of $250 to individuals who are eligible for benefits under any of the programs listed above, and who meet certain other requirements described in section 2201. Subsection 2201(c) of ARRA further provides that the payments made under section 2201 will be disregarded for purposes of all Federal and federally-assisted programs. This includes both the Medicaid and CHIP programs. Enclosure C provides specific guidance with regard to implementing this section.

Section 2202 - Special Credit for Certain Government Retirees

Section 2202 of ARRA provides for a credit against taxes of $250 ($500 in the case of a joint return where both spouses are eligible) for recipients of pensions or annuities for service performed for the Federal Government or any State government. Subsection 2202(d) of ARRA further provides that any credit or refund made as a result of this provision cannot be taken into account as income or resources for two months for purposes of any Federal or federally-assisted programs, including the Medicaid and CHIP programs. Enclosure D provides specific guidance with regard to implementing this section.

Title V—State Fiscal Relief
Section 5001 – Temporary Increase of Medicaid FMAP

As States are aware, Section 5001 of ARRA increased the higher of each State's 2008 or 2009 Federal Medical Assistance Percentage (FMAP) rate by 6.2 percentage points. Similarly, the increase will be applied in the next two fiscal years to the higher of the current or previous year's FMAP (e.g. FY 2010 will be based on the higher of the FY 2009 rate or the FY 2010 rate, FY 2011 will be based on the higher of FY 2010 or FY 2011) for the duration of the recession adjustment period (October 1, 2008 to December 31, 2010). The FMAP rate is further increased for any calendar quarter in which the State experiences a greater than 1.5 percentage point increase in unemployment according to the Bureau of Labor Statistics.

A State is not eligible for these increases if it has restricted its Medicaid eligibility standards, methodologies, or procedures after July 1, 2008, or if the State deposits or credits any amounts attributable (directly or indirectly) to the increased FMAP to any reserve or rainy day fund of the State. States are also ineligible if the State requires political subdivisions within the State to contribute for quarters beginning October 1, 2008, and ending December 2010, a greater percentage of the non-Federal share of Medicaid. Additionally, the increased FMAP is not available for any claims received by the State on days they are out of compliance with the practitioner prompt pay requirements. These prompt pay requirements are then extended to hospital and nursing facility provider claims effective June 1, 2009.

Guidance concerning the eligibility maintenance of effort (MOE) requirements was released on March 25, 2009. That guidance should be viewed as the beginning of the dialogue between CMS and the States on this provision, but it requires further clarification. Please see Enclosure E for two such clarifications.

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Section 5002 - Temporary Increase in Disproportionate Share Hospitals (DSH) Allotments During Recession

Section 5002 of ARRA increases the State Medicaid DSH allotments for fiscal year (FY) 2009 by 2.5 percent. Section 5002 further provides that the FY 2010 State Medicaid DSH allotments would then be 102.5 percent of the FY 2009 increased allotment, unless the pre-ARRA calculation of the State's FY 2010 Medicaid DSH allotment would have resulted in a higher allotment.

Section 5003 - Extension of the Moratoria on Certain Medicaid Final Regulations

The Congressional moratoria that were placed on the interim final regulation relating to optional case management services and the final regulation on allowable provider taxes under the Supplemental Appropriations Act of 2008 (P.L. 110-252) are extended until July 1, 2009 in Section 5003 of ARRA. Similarly, the Congressional moratorium placed on the final regulation concerning school-based administration and transportation services is extended until July 1, 2009. Additionally, CMS is prohibited from taking any action on expenditures made for services between December 8, 2008, and June 30, 2009 implementing the final regulation relating to the Medicaid definition of outpatient hospital facility services published in the *Federal Register* on November 7, 2008.

This section also expressed the "sense of Congress" that the following proposed regulations not be promulgated as final regulations: Medicaid Cost Limit for Certain Providers, Medicaid Payments for Graduate Medical Education, and Rehabilitative Services.

On May 6, 2009, CMS proposed in the *Federal Register* a full rescission of the School-Based Services Final Rule and the Outpatient Services Definition Final Rule, and a partial rescission of the Case Management Services Interim Final Rule (CMS 2287-P2). The provisions of the Case Management Services Interim Final Rule that would be rescinded include the definition of case management services for individuals transitioning from institutional to community services, the single case manager requirement, the requirement for payment methodologies based on 15 minute units of service, and the prohibition of providers authorizing services. Additionally, the rescission removed restrictions on Medicaid Federal Financial Participation for case management services that are a component of another Medicaid covered service, integral to the administration of other non-medical programs, or are Medicaid administrative activities. All other provisions would remain in effect.

Additionally, CMS published a proposed rule to delay enforcement of certain portions of the final rule on allowable provider taxes (CMS 2275-P2). The provisions of the provider tax rule where enforcement would be delayed include only the hold harmless clarifications. The revisions to the threshold levels under the regulatory indirect guarantee hold harmless arrangement test to reflect provisions of the Tax Relief and Health Care Act of 2006 and the amended definition of the class of managed care organization services in accordance with the Deficit Reduction Act of 2005 would remain in effect.

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Section 5004 - Extension of Transitional Medical Assistance (TMA)

On April 6, 2009, CMS issued a State Medicaid Director letter that provides guidance on section 5004 of ARRA which extends the Transitional Medical Assistance program for 18 months effective July 1, 2009, through December 31, 2010. The letter also provides guidance on the new option in ARRA for States to modify TMA eligibility requirements. Specifically, ARRA allows States to extend families' Medicaid eligibility under TMA for an initial period of 12 months, rather than an initial period of six months followed by a second 6-month period. ARRA also allows States to revise the requirement for previous receipt of Medicaid. The letter advises States of new ARRA requirements for reporting the average monthly enrollment and participation rates for TMA for adults and children and notes that the format, timing, and frequency of the reports will be specified at a later time. Finally, the letter includes a draft State plan pre-print to assist States in submitting an amendment to revise their State plans to reflect the new TMA requirements.

Section 5005 – Extension of the Qualified Individual (QI) Program

Section 5005 of ARRA extends the Qualified Individual (QI) program through December 2010. Section 5005 also provides for the following allocation amounts:

- For the period from January 1, 2010, through September 30, 2010, the total allocation amount is $412,500,000.
- For the period from October 1, 2010, through December 31, 2010, the total allocation amount is $150,000,000.

Section 5006 - Protections for Indians under Medicaid and CHIP

This provision directly affects Indian Tribes and, pursuant to the HHS Tribal Consultation policy, CMS will issue additional guidance after consultation with Tribes. The provision is effective July 1, 2009, so we will be working in the next few months to issue guidance in a timely manner. The following is a brief summary of the section:

Subsection (a) prohibits premiums and cost-sharing for Indians who are provided services by Indian Health providers (including Urban Indian organizations) or through referral by contract health services. Similarly, payments to Indian Health providers cannot be reduced by the amount of any enrollment fee, premium, or cost-sharing in Medicaid or CHIP.

Subsection (b) requires that States must disregard property, including real property and improvements, held in trust or under supervision of the Secretary of the Interior, from resources when determining eligibility for Medicaid or CHIP. Additionally, States must disregard ownership interests and usage rights in federally protected natural resources and items with unique cultural significance or that support maintaining traditional lifestyles according to tribal law or custom.

Subsection (c) codifies sections of the Medicaid Manual instructions regarding protecting Indian property from estate recovery under Medicaid. This section reinforces current policy.

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Subsection (d) sets forth several provisions regarding managed care entities. Managed care entities serving Indians that include Indian Health primary care providers are required to allow Indian members to choose the Indian health care provider as their primary care provider. Additionally, contracts with managed care entities must demonstrate that access to Indian health care providers is sufficient for Indian enrollees to receive services, and payment to Indian providers must be at a rate equal to non-Indian health care providers. Managed care entities must make prompt payment to Indian providers consistent with section 1932(f) of the Act.

Section 5006(d) also requires managed care entities to pay Indian federally qualified health centers (FQHCs) that are not participating providers at the same rate as a participating FQHC. Non-FQHC Indian Heath care providers under managed care must be paid by the managed care entity or the State, at a rate that is at least equal to what the provider would be paid under the State plan. Lastly, Indian managed care entities may restrict enrollment to include only Indians in the same manner that Indian Health Programs (including the Indian Health Service) restrict enrollment to include only Indians.

Finally, subsection (e) codifies and strengthens existing responsibilities for consultation by CMS and the States with Indian tribes, Indian health programs, and Urban Indian organizations, specifically clarifying the application of these responsibilities under the CHIP program.

We look forward to working with you as you implement these provisions of ARRA.

Sincerely,

/s/

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

cc:

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