Secretary of State
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PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies are true, full and correct copies of the PERMANENT Rule(s) adopted on

September 30, 2016 by the

Department of Human Services, Office of Self-Sufficiency Programs			461
Agency and Division			Chapter Number
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to become effective October 1, 2016.

Rulemaking Notice was published in the August 2016 Oregon Bulletin.

Rule Caption: *Amending rules relating to public and medical assistance programs*

AMEND: 461-120-0030, 461-135-0010, 461-135-0835, 461-160-0015, 461-180-0040

ORS 409.050, 411.060, 411.070, 411.404, 411.706, 413.042, 413.085, 414.231, 416.340, 416.350
Stat. Auth.

42 CFR 435.403, Social Security Act 1902e(12)
Other Auth.

ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.706, 413.042, 413.085, 414.231, 416.340, 416.350, Or Laws 2016, ch 93
Stats. Implemented

Rule Summary

OAR 461-120-0030 about the state of residence for an individual in a medical facility is being amended to change the criteria for determining the state of residence in the Oregon Supplemental Income Program Medical (OSIPM), the Qualified Medicare Beneficiary (QMB) program, and the Refugee Medical (REFM) program to align with federal policy.

OAR 461-135-0010 about assumed eligibility for medical programs is being amended to clarify that in the OSIPM program, continuous eligibility for children can apply at initial eligibility and at redetermination. It is also being amended to state that continuous eligibility does not apply if the child is eligible for any other Medicaid program that provides OHP Plus benefits. Previously there was no requirement that other programs be evaluated prior to providing continuous coverage under OSIPM.

OAR 461-135-0835 about limits on estate claims is being amended to clarify which Department personnel are authorized to present, file, and resolve estate recovery claims. It is also amended to authorize Estate Administration Unit managers to designate additional personnel with the authority to present, file, or resolve

estate recovery claims. The rule is also amended to comply with Oregon Laws 2016, chapter 93, exempting certain general assistance benefits from estate recovery under ORS 411.795.

OAR 461-160-0015 about resource limits is being amended to align the Department with federal policy regarding the resource limits for QMB-DW and eliminate an outdated reference to OSIP resource limits.

OAR 461-180-0040 about effective dates for special or service needs is being amended to clarify that eligibility for special needs and services is contingent on OSIPM and OHP Plus eligibility. Specifically, the rule is amended to state that the effective date for a special need is either the date of request for the special need item or the effective date for OSIPM, whichever is later, and that the effective date for long-term care is the date for Department authorizes the service plan, except that the service plan may not be authorized prior to the effective date for Medicaid OHP Plus benefit package.

In addition, non-substantive edits were made to these rules to: ensure consistent terminology throughout self-sufficiency program rules and policies; make general updates consistent with current Department practices; update statutory and rule references; correct formatting and punctuation; improve ease of reading; and clarify Department rules and processes.

461-120-0030 ~~Eff. 9-1-16~~ Eff. 10-1-16
State of Residence for an Individual in a Medical Facility

In the OSIPM, QMB, and REFM programs, the residency of an individual living in a state or private medical facility such as a hospital, mental hospital, nursing home, or convalescent center is determined as follows:

(1) An individual 21 years of age or older who is capable of indicating intent to reside is considered to be~~—~~

~~(a) A~~ a resident of the state where the individual is living with the intention to remain permanently or for an indefinite period~~, except when subsection (b) of this section indicates otherwise~~.

~~(b) When a state agency of another state places the individual (other than a child funded under Title IV-E), the individual is considered to be a resident of the state that makes the placement.~~

(2) An individual 21 years of age or older who became incapable of indicating intent to reside (see OAR 461-120-0050) after attaining 21 years of age is considered to be a resident of the state where the facility is located unless the individual was placed in the facility by a state agency of another state. When a state agency of another state places an individual, the individual is considered to be a resident of the state that makes the placement.

(3) For an individual age 21 or older who became incapable of indicating intent to reside before attaining 21 years of age, the state of residence is one of the following:

(a) The state of residence of the parent applying on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(b) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(c) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's).

(d) The state of residence of the individual or party who files an application if the individual has been abandoned by his or her parents, does not have a legal guardian, and is institutionalized in that State.

(e) Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981, or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

(~~3~~4) For an individual less than 21 years of age who is ~~incapable of forming an intent to reside, or an individual of any age who became incapable of forming that intent before attaining 21 years of age (see OAR 461-120-0050),~~ legally emancipated or married and capable of indicating intent to reside the state of residence is determine in accordance with section (1) of this rule. For other individuals under age 21, the state of residence is one of the following:

(a) The state of residence of the individual's parent or legal guardian at the time of ~~application~~ placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's).

(b) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state or residence of the guardian is used instead of the parent's).

(~~b~~c) The state of residence of the party who applies for benefits on the individual's behalf if ~~there is no living parent or the location of the parent is unknown, and there is no legal guardian~~ the individual has been abandoned by his or her parents, does not have a legal guardian, and is institutionalized in that state.

(~~c~~d) Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981, or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

~~(d) When a state agency of another state places the individual, the individual is considered to be a resident of the state that makes the placement.~~

(e) Notwithstanding any other provision of this section, for individuals receiving federal payments for foster care and adoption assistance under title IV-E of the Social Security Act, the state of residence is the state where the individual lives.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, ~~411.816, 412.006, 412.014, 412.049, 412.124,~~ 414.231
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706, ~~411.816, 412.006, 412.014, 412.049, 412.124,~~ 414.231

461-135-0010 ~~Eff. 7-1-14~~ Eff. 10-1-16
Assumed Eligibility for Medical Programs

(1) This rule sets out when a client is assumed eligible for certain medical programs because the client receives or is deemed to receive benefits of another program.

(2) A pregnant woman who is eligible for and receiving benefits the day the pregnancy ends is assumed eligible for the OSIPM program until the last day of the calendar month in which the 60th day after the last day of the pregnancy falls.

(3) A pregnant woman who was eligible for and receiving medical assistance under any Medicaid program and becomes ineligible while pregnant is assumed eligible for Medicaid until the last day of the calendar month in which the 60th day after the last day of the pregnancy falls.

(4) A *child* (see OAR 461-001-0000) born to a mother eligible for and receiving OSIPM benefits is assumed eligible for medical benefits under this section until the end of the month the *child* turns one year of age.

(5) The individuals described in subsection (a) and (b) of this section are assumed eligible for OSIPM (except OSIPM-EPD) unless subsection (c), (d), or (e) of this section applies:

(a) A recipient of SSI benefits.

(b) An individual deemed eligible for SSI under Sections 1619(a) or (b) of the Social Security Act (42 U.S.C. 1382h(a) or (b)), which cover individuals with disabilities whose impairments have not changed but who have become gainfully employed and have continuing need for OSIPM.

(c) An individual described in subsection (a) or (b) of this section who is in a *nonstandard living arrangement* (see OAR 461-001-0000) is not eligible for *long-term care* (see OAR 461-001-0000) services if the individual would otherwise be ineligible for OSIPM due to a disqualifying transfer of assets (OAR 461-140-0210 to 461-140-0300 regulate the effect of a transfer of assets on a client).

(d) An individual described in subsection (a) or (b) of the section who is in a *nonstandard living arrangement* is not assumed eligible for long-term care services if *countable* (see OAR 461-001-0000) resources exceed the limit after performing the calculation under OAR 461-160-0580.

(e) An individual described in subsection (a) or (b) of the section who does not meet the pursuit of assets requirements (see OAR 461-120-0330), the health care coverage requirements (see OAR 461-120-0345), or the residency requirements (see OAR 461-120-0010) is not assumed eligible for OSIPM.

(6) For the purposes of this section the definition of a "child" means an unmarried individual under age 19 and includes natural, step, and adoptive children. A child found eligible for OSIPM is assumed eligible until the end of the twelfth month following the determination of the child's OSIPM eligibility or redetermination of eligibility unless the child:

(a) No longer meets the definition of a child given in this section;

(b) Moves out of state; ~~or~~

(c) Voluntarily ends benefits~~.~~; or

(d) Is eligible for any other Medicaid program that provides OHP Plus benefits.

(7) A client who receives both benefits under Part A of Medicare and SSI benefits is assumed eligible for the QMB-BAS program unless the individual does not meet the pursuit of assets requirements (see OAR 461-120-0330), the health care coverage requirements (see OAR 461-120-0345), or the residency requirements (see OAR 461-120-0010).

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404~~, 412.049~~, 413.085, 414.685
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404~~, 412.049~~, 413.085,~~414.025~~ 414.685

461-135-0835 ~~Tech. Eff. 2-1-16~~ Eff. 10-1-16
Limits on Estate Claims

(1) The Estate Administration Unit is designated and authorized to administer the estate recovery program for the Oregon Health Authority and the Department of Human Services, and to present and file claims for payment. The Manager and Assistant Manager of the Estate Administration Unit, Estate Administrators, Assistant Estate Administrators, and Accounts Receivable Specialist are authorized to present, file, and resolve claims for the Estate Administration Unit. The Manager or Assistant Manager may designate other individuals to present, file, or resolve claims. This rule sets out some of these claims.

(2) For the OSIP program (see OAR 461-101-0010):

(a) The amount of any payments or benefits, including ~~overpayments~~an *overpayment* (see OAR 461-195-0501), are a claim against the *probate estate* (see OAR 461-135-0832) of any deceased recipient.

(b) The claim for correctly paid payments or benefits under OSIP are deferred until the death of the *spouse* (see OAR 461-001-0000) or *domestic partner* (see OAR 461-135-0832), if any, of the deceased recipient.

(c) If the deceased recipient has no *probate estate*, the enforcement of the claim has been deferred, or there are insufficient resources in the *probate estate* to pay the claim in full, the *probate estate* of the *spouse* or *domestic partner* of the deceased recipient, if any, is charged for any payments or benefits paid under OSIP to the deceased recipient, the *spouse*, or *domestic partner*.

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

(e) Transfers of real or personal property without adequate consideration, by recipients of payments or benefits under OSIP, are voidable and may be set aside under ORS 411.620.

(f) Except when there is a surviving *spouse* or *domestic partner*, or a surviving *child under age 21*, a *child with a disability*, or a *child with a visual impairment*, the amount of any payments or benefits provided is a claim against the *estate* (see OAR 461-135-0832) in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(3) For *General Assistance* (see OAR 461-135-0832):

(a) The amounts of any payments or benefits, including overpayments, are a claim against the *probate estate* of any deceased recipient. The amount includes the state's monthly contribution, paid prior to January 1, 2014, to the federal government for the recipient's Medicare Part D prescription drug coverage. Effective July 1, 2016, any correctly paid benefits under Oregon Laws 2016, chapter 93, section 1 are excluded, except than an *overpayment* of benefits under Oregon Laws 2016, chapter 93, section 1 is included in a claim against the *probate estate*.

(b) The claim for correctly paid payments or benefits under the *General Assistance* program is deferred until the death of the *spouse* or *domestic partner*, if any, of the deceased recipient.

(c) If the deceased recipient has no *probate estate*, the enforcement of the claim has been deferred, or there are insufficient resources in the *probate estate* to pay the claim in full, then the *probate estate* of the *spouse* or *domestic partner* of the deceased recipient, if any, is charged for any payments or benefits to the deceased recipient, the *spouse*, or *domestic partner*.

(d) The claim for correctly paid payments or benefits under the ~~OSIP~~ *General Assistance* program may not be enforced if the deceased recipient is survived by a *child under age 21*, a *child with a disability*, or a *child with a visual impairment*; and the child survives to the closing of the *probate estate*.

(e) Except when there is a surviving *spouse* or *domestic partner*, or a surviving *child under age 21*, a *child with a disability*, or *child with a visual impairment*, the amount of any assistance paid is a claim against the *estate* in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(4) For *Medical Assistance* (MA, as defined in OAR 461-135-0832):

(a) In determining the extent of the *estate* resources subject to the claim of the Department for correctly paid benefits, except as provided in subsection (b) of this section, the Department must disregard resources in an amount equal to the *value* (see OAR 461-135-0832) of resources excluded in the most recent eligibility determination under OAR 461-160-0855, based on payments received under a *qualified partnership policy* (see OAR 461-001-0000). The disregard of resources specific to the estate recovery claim applies to MA benefits received after the effective date of the MA eligibility determination in which a *qualified partnership policy* was considered and approved. The amount of any MA incurred in a prior MA eligibility period where *qualified partnership policy* benefits were not considered is not subject to the estate resource disregard.

(b) There is no disregard of resources under subsection (a) of this section if the recipient, or the *spouse* of the recipient, at any time transferred the *value* of the *qualified partnership policy* excluded resource amount to another individual for

less than fair market value prior to the death of the recipient or the recipient's *spouse*, or exhausted the disregarded resource amount by purchasing things of *value* to the recipient or the recipient's *spouse* while either was living.

(c) The amount of any incorrectly paid payments or benefits, excluding an administrative error *overpayment* ~~(see OAR 461-195-0501)~~, are a claim, against the *probate estate* of any deceased recipient.

(d) The claim for correctly paid payments or benefits under MA is deferred until the death of the surviving *spouse*, if any, of the deceased recipient. After the death of a surviving *spouse*, the deferred claim of the deceased recipient is a claim against the following *assets* (see OAR 461-135-0832) or their proceeds in the *probate estate* of the *spouse*.

(A) For a recipient who died prior to October 1, 2008, the Department has a claim against the *probate estate* of the *spouse* for *medical assistance* (see OAR 461-135-0832) paid to the recipient, but only to the extent that the *spouse* received property or other *assets* from the recipient through any of the following:

(i) Probate.

(ii) Operation of law.

(B) For a recipient who dies on or after October 1, 2008, the Department has a claim against the *probate estate* of the recipient's *spouse* for *medical assistance* paid to the recipient, but only to the extent that the recipient's *spouse* received property or other *assets* from the recipient through any of the following:

(i) Probate.

(ii) Operation of law.

(iii) An *interspousal transfer* (see OAR 461-135-0832), including one facilitated by a court order, which occurs:

(I) Before, on, or after October 1, 2008; and

(II) No earlier than 60 months prior to the first *date of request* (see OAR 461-135-0832) established from the applications for MA of the recipient and the recipient's *spouse*, or at any time thereafter, whether approved, withdrawn, or denied.

(e) The claim for correctly paid payments or benefits under MA may not be enforced if the deceased recipient is survived by a *child under age 21*, a *child with a disability*, or a *child with a visual impairment*.

(f) For recipients who are not *permanently institutionalized* (see OAR 461-135-0832):

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

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

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

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

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

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

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

(C) The amount of any payment for services provided in a nursing facility, an intermediate care facility for an individual with intellectual or developmental disabilities, a psychiatric institution, or other *medical institution* (see OAR 461-135-0832) paid after September 30, 2013 to or

on behalf of a recipient who was *permanently institutionalized* is a claim against the *estate* of the deceased recipient.

(5) The amount paid, for a recipient age 55 or older, after December 31, 2013, to the federal government for the recipient's Medicare Part D prescription drug coverage is a claim against the *estate* of the deceased recipient.

(6) For trusts that comply with OAR 461-145-0540(10) and (11), the maximum distribution to the Department is the total of all MA payments or benefits paid to or on behalf of the deceased recipient. Subsections (4)(d) and (4)(e) of this rule do not apply to this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 413.042, 413.085, 416.340, 416.350
Stats. Implemented: ORS 93.969, 125.495, 411.404, 411.620, 411.630, 411.708, 411.795, 413.085, 416.310, 416.350, Or Laws 2016, ch 93

461-160-0015 ~~Eff. 9-1-16~~ Eff. 10-1-16
Resource Limits

(1) In the EA program, all *countable* (see OAR 461-001-0000) resources must be used to meet the emergent need.

(2) In the ERDC program, the limit is $1,000,000.

(3) In the REFM program, there is no resource limit.

(4) In the OSIP and OSIPM programs, the resource limit is as follows:

(a) $2,000 for a one-person *need group* (see OAR 461-110-0630) and $3,000 for a two-person *need group*.

~~(b) $1,000 for an OSIP *need group* eligible under OAR 461-135-0771. The total cash resources may not exceed $500 for a one-person *need group* or $1,000 for a two-person *need group*.~~

(~~c~~b) $5,000 for the OSIP-EPD and OSIPM-EPD programs (see OAR 461-001-0035 and 461-145-0025 for funds that may be excluded as approved accounts).

(5) In the QMB-BAS, QMB-SMB, and QMB-SMF programs, all resources are excluded.

(6) In the QMB-DW program, the resource limit is ~~amended in January of each year based on the low income subsidy for Medicare Part D as published by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Effective January 1, 2015 the resource limit is $7,280~~ $4,000 for a one-person *need group* and ~~$10,930~~ $6,000 for a *need group* containing two or more individuals.

(7) In the REF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new REF applicant for benefits.

(B) REF *need group* that has at least one *mandatory* (see OAR 461-130-0305) participant in an employment program who is:

(i) Receiving REF and not progressing in a required activity of an open case plan; or

(ii) Serving a current employment program disqualification (see OAR 461-130-0330).

(b) $10,000 for a *need group* not covered under subsection (a) of this section.

(8) In the SNAP program, the resource limit is:

(a) $3,250 for a *financial group* (see OAR 461-110-0530) with at least one member who is *elderly* (see OAR 461-001-0015) or an individual with a *disability* (see OAR 461-001-0015).

(b) $2,250 for all other financial groups.

(9) In the TANF program, the resource limit is:

(a) $2,500 for any of the following:

(A) A new TANF applicant for benefits.

(B) TANF *need group* that does not have at least one *caretaker relative* (see OAR 461-001-0000) or *parent* (see OAR 461-001-0000) who is receiving TANF.

(C) TANF *need group* that has at least one JOBS participant who is:

(i) Receiving TANF and not progressing in an *activity* (see OAR 461-001-0025) of an open JOBS *case plan* (see OAR 461-001-0025); or

(ii) Serving a current JOBS disqualification (see OAR 461-130-0330).

(b) $10,000 for a *need group* not covered under subsection (a) of this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.083, 411.404, 411.706, 411.816, 412.049, 413.085, 414.685
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.816, 411.837, 412.049, 413.085, 414.685, 414.839

461-180-0040 ~~Eff. 7-1-08~~ Eff. 10-1-16
Effective Dates; Special Needs and Service~~s Needs~~

(1) The effective date for a special need is the later of the following:

(a) The *date of request* (see OAR 461-115-0030) for the special need item~~.~~; or

(b) The effective date for OSIPM.

(2) The effective date for long-term care is determined as follows:

(a) For in-home services the effective date is the date the Department authorizes the service plan. The service plan may not be authorized prior to the effective date of the Medicaid OHP Plus benefit package (see OAR 411-015-0015). An authorized service plan must:

(A) Specify the date when services will begin (this date cannot be prior to the date that the service plan is completed) and the maximum number of hours authorized; and

(B) Identify the enrolled homecare worker (see OAR 411-031-0020 and 411-031-0040) or contracted in-home care agency (see OAR 411-030-0090) the client has *employed* to provide the authorized services. For the purposes of this paragraph, *employed* means that the homecare worker or agency has agreed to provide the services as authorized by the service plan.

(b) For a client residing in, or who will reside in a licensed community-based setting or Medicaid-certified nursing facility the effective date is the later of the following:

(A) The *date of request* for services; ~~or~~

(B) The date the individual begins residing in the community-based setting or nursing facility~~.~~; or

(C) The effective date of the Medicaid OHP Plus benefit package (see OAR 411-015-0015).

(3) The effective date for a reduction or termination in services is the later of the following:

(a) The end of the ten-day notice mailing period; and

(b) The termination date of a service plan.

(4) The effective date for a reduction or termination of an on-going special need is the end of the timely continuing benefit notice period.

Stat. Auth: ORS 411.060
Stats. Implemented: ORS 411.060