OFFICE OF THE SECRETARY OF STATE
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SECRETARY OF STATE

ARCHIVES DIVISION
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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 461
DEPARTMENT OF HUMAN SERVICES
SELF-SUFFICIENCY PROGRAMS

FILED
04/18/2019 10:03 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Changing rules affecting APD medical programs

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 05/24/2019 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Meorah Solar
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DHS - SSP
500 Summer Street NE, E-48
Salem,OR 97301

Filed By:
Robert Trachtenberg
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 05/15/2019
TIME: 9:30 AM - 11:00 AM
OFFICER: Meorah Solar
ADDRESS: Human Services Building
500 Summer Street NE
Room164
Salem, OR 97301
SPECIAL INSTRUCTIONS:
The hearing will adjourn at 9:50 a.m. if no one is present or remains to testify.

NEED FOR THE RULE(S):

OAR 461-025-0315 about expedited hearings needs to be amended to align the rule with federal requirements and Form MSC 0447 by indicating that expedited hearings are allowed for challenges to some application denials in the OSIP, OSIPM, and QMB program.

OAR 461-115-0090 about authorized representatives needs to be amended to align with the Integrated Eligibility system. This amendment defines the term authorized representative, revises who can be an authorized representative, who can appoint an authorized representative, how many authorized representatives may be designated when an individual is receiving multiple types of benefits, what functions the authorized representative can fulfill, what programs allow an authorized representative, and the requirements to which an authorized representative is subject. Finally, this amendment clarifies that an individual's long-term care provider may not serve as that individual's designated representative for long-term care services.

OAR 461-115-0140 about authorized representatives and alternate payees in the SNAP program needs to be repealed because this topic will be covered in OAR 461-115-0090 and OAR 461-165-0035, reducing the number of rules on these topics and making them easier to follow.

OAR 461-115-0430 about periodic redeterminations needs to be amended to align the rule with federal policy.by indicating that eligibility determinations must be completed at least once every 12 months.

OAR 461-135-0750 about individuals applying for or receiving long-term care or home and community-based care needs to be amended to clarify the rule by removing effective date language that already exists in OAR 461-180-0090, updating terms, and making other minor, including correcting references to rules from Chapter 411 pertaining to Children's Intensive In-Home Services programs.

OAR 461-145-0210 about gifts and winnings needs to be amended to fit the programming for Integrated Eligibility and for consistency with federal policy (Program Operations Manual SI 00830.522) by
making some gift cards and certificates countable as income in the OSIP, OSIPM, and QMB programs.

OAR 461-145-0440 about reimbursement needs to be amended to align polices in the OSIP, OSIPM, QMB, and SNAP programs on this topic for purposes of Integrated Eligibility by counting as earned income reimbursements from a business entity that benefit a principal in the OSIP, OSIPM, and QMB programs and limit counting these expenditures in the SNAP program to reimbursements.

OAR 461-160-0030 about whether or not costs are deductible needs to be amended with respect to medical costs in the OSIP and OSIPM programs to fill gaps in treatment of medical costs and align the rule with Integrated Eligibility by allowing payments to a credit card for allowable medical expenses to be used as a deduction to reduce the liability for service eligible individuals, by providing specific information about when and how one-time and ongoing medical costs are used to reduce client liability. This rule also needs to be amended to make the rules easier to follow by removing language that belongs in the effective date rule (OAR 461-180-0020).

OAR 461-160-0855 about excluded resources in the OSIPM program for payments received under a qualified partnership policy (QPP) needs to be amended to correct an error made when amending this rule permanently effective April 1, 2019. This error resulted in the QPP exclusion amount not applying to other countable resources, when in fact the opposite is true. This amendment maintains the correct conditions for excluding other countable resources.

OAR 461-165-0035 about alternate payees needs to be amended to decrease the number of rules addressing this topic to make them easier to follow. The amendment broadens the scope of the rule to apply to all benefits rather than only those issued by Electronic Benefit Transfer (EBT), revises who can serve as an alternate payee, who can designate an alternate payee, and what requirements and responsibilities apply to those who serve as an alternate payee.

OAR 461-165-0040 about assigning payees needs to be repealed because this topic will be covered in OAR 461-165-0035, reducing the number of rules on this topic and making them easier to follow.

OAR 461-180-0020 about effective dates when considering changes in income or income deductions that cause increases needs to be amended to clarify the rule by revising, in the OSIPM and QMB programs, when reductions to client liability are effective due to medical costs allowed in accordance with OAR 461-160-0030.

OAR 461-180-0040 about effective dates for special needs and services needs to be amended to align the rule with current practices by revising the effective date of in-home services and clarifying that the effective date for long-term care services is contingent on when a disqualification period (if any) ends.

OAR 461-195-0521 about the calculation of overpayments needs to be changed to correspond with how the Integrated Eligibility system treats authorized representatives. The amendment removes outdated program names and clarifies overpayment liability in OCCS medical programs related to the actions of an authorized representative.

OAR 461-195-0541 about liability for overpayments needs to be amended to align with the authorized representative rules for Integrated Eligibility. The changes update rule cross-references and indicate when authorized representatives are liable for overpayments.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Form MSC 0447, Your Hearing Rights, is available at https://aix-xweb1p.state.or.us/es_xweb/FORMS/

Social Security Administration, Program Operations Manual System (POMS) SI 00830.522 available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830522

FISCAL AND ECONOMIC IMPACT:

The Department estimates that amending OAR 461-025-0315, OAR 461-115-0430, OAR 461-135-0750, OAR 461-145-0210, OAR 461-145-0440, OAR 461-160-0855, OAR 461-165-0035, OAR 461-180-0040 and repealing OAR 461-115-0140 and OAR 461-165-0040 will have no fiscal impact on clients, the public, the Department, other state agencies, local government, and business, including small business. No small businesses are subject to this rule. There is no cost of compliance for small business.

The Department estimates that amending OAR 461-115-0090 will have no fiscal impact on clients, authorized representatives, providers, the public, state agencies (except as noted below) local government, and business, including small business. The Department estimates that by facilitating only one authorized representative this amendment (in conjunction with related amendments) will allow the Department and Oregon Health Authority to avoid $16 million in programming expenses for the Integrated Eligibility system. A small business is subject to this rule only if it acts as an authorized representative for Department clients in the Self-Sufficiency programs or Aging and People with Disabilities medical programs. The Department lacks sufficient information to estimate the number of such businesses. There is no cost of compliance for small business.

The Department estimates that amending OAR 461-160-0030 and OAR 461-180-0020 will have a positive impact on many service eligible individuals who have out-of-pocket medical costs. These individuals will be better able to cover those costs paid by credit card as they can now divert funds from liability payment to credit card payment. This amendment will also have a positive impact to service clients by allowing costs reported in the same month to still be allowed as a deduction. There will be a corresponding negative fiscal impact on the Department. The Department is unable to estimate these fiscal impacts because it does not centrally track denials of medical costs. The Department estimates that these amendments will have no fiscal impact on other state agencies, local government, and business, including small business. No small businesses are subject to this rule. There is no cost of compliance for small business.

The Department estimates that amending OAR 461-195-0521 and OAR 461-195-0541will have a positive fiscal impact on individuals who act as an authorized representative and unknowingly or unintentionally provide information that creates an overpayment of benefits (and a corresponding negative fiscal impact on the Department and the Oregon Health Authority). The Department estimates that these changes will have a negative fiscal impact on persons who act as an authorized representative or alternate payee and knowingly give incorrect or incomplete information or intentionally withhold information that creates an overpayment of benefits (and a corresponding positive fiscal impact on the Department and the Oregon Health Authority). The Department is unable to estimate the extent of these impacts because it lacks sufficient centralized information on these topics. The Department estimates that these amendments will have no fiscal impact on clients, providers not acting as authorized representatives, the public not acting as authorized representatives, other state agencies, local government, and business not acting as authorized representatives, including small business. There is no cost of compliance for small business. A small business is subject to this rule only if it acts as an authorized representative for Department clients in the Self-Sufficiency programs or Aging and People with Disabilities medical programs. The Department lacks sufficient information to estimate the number of such businesses.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

see above under Fiscal and Economic Impact

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were not involved in the development of these rules but are invited to provide input during the public comment period.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

461-025-0315, 461-115-0090, 461-115-0140, 461-115-0430, 461-135-0750, 461-145-0210, 461-145-0440, 461-160-0030, 461-160-0855, 461-165-0035, 461-165-0040, 461-180-0020, 461-180-0040, 461-195-0521, 461-195-0541

AMEND: 461-025-0315

RULE SUMMARY: OAR 461-025-0315 about expedited hearings is being amended to indicate that expedited hearings are allowed for challenges to some application denials in the OSIP, OSIPM, and QMB programs. This amendment is intended to align the rule with federal requirements and Form MSC 0447.

CHANGES TO RULE:

461-025-0315
Expedited Hearings ¶

(1) A claimant has the right to an expedited hearing in each of the following situations:¶
(a) The Department denies or fails to issue a timely decision on claimant's request for:¶
(A) Emergency assistance; or¶
(B) TA-DVS (see OAR 461-135-1235).¶
(b) The claimant contests the form or amount of a TA-DVS or an emergency assistance payment.¶
(c) The claimant has the right to a hearing over a reduction, suspension, or closure and disagrees with the Department's decision to deny the continuation of one or more of the following pending a requested hearing:¶
(A) Cash benefits.¶
(B) Supplemental Nutrition Assistance Program benefits.¶
(C) Medical benefits.¶
(D) Nursing Home services or home and community-based care (see OAR 461-001-0030) that have been reduced or closed as a result of a service re-assessment conducted in accordance with OAR Division 411-015.¶
(d) The claimant's request for expedited SNAP service or DSNAP is denied, or the claimant is aggrieved by an action of the Department that affects the expedited participation of the household in the SNAP program.¶
(e) In the JOBS program, the Department denies an application for a support service payment or a payment for a basic living expense authorized by OAR 461-190-0211, or the Department reduces or closes a support service payment authorized by 461-190-0211, or the Department does not issue a JOBS support service payment within the time frames required under 461-115-0190.¶
(f) In the OSIP, OSIPM, and QMB programs, when following the final order timeline in OAR 461-025-0375(1)(a) could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function.¶
(2) Public assistance and medical assistance programs: An expedited hearing is a telephone hearing held within five working days of the Department's receipt of a properly submitted hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service, by overnight mail, or if the claimant agrees by electronic mail. The final order must be issued within three working days from the date the hearing closes.¶
(3) Supplemental Nutrition Assistance Program: An expedited hearing is a telephone hearing held within five working days of the receipt of a verbal or written hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service, by overnight mail, or if the claimant agrees by electronic mail. Following the expedited hearing, a final order must be issued not later than the ninth working day after the hearing was requested.¶
(4) If the Office of Administrative Hearings grants a face-to-face hearing, the hearing may be postponed or continued as necessary to accommodate the claimant. However, the hearing must be held not later than 21 days following the receipt by the Department of the request for hearing if the claimant lives within 100 miles of Salem, Oregon, and not later than 35 days in all other cases.
Statutory/Other Authority: ORS 411.060, 411.095, 411.404, 411.816, 412.049, 409.050
Statutes/Other Implemented: 411.117, 411.404, 411.816, 412.049, ORS 411.060, 411.095, 411.099, 411.103, 409.010, 42 CFR 431.224

AMEND: 461-115-0090

RULE SUMMARY: OAR 461-115-0090 about authorized representatives is being amended to make permanent temporary rule changes effective March 1, 2019 establishing that an authorized representative designated for one Department program must be the authorized representative for all Department programs, except the TA-DVS program and long-term care services. This amendment also defines the term authorized representative, revises who can be an authorized representative, who can appoint an authorized representative, what functions the authorized representative can fulfill, and the requirements to which an authorized representative is subject. Finally, this amendment clarifies that an individual's long-term care provider may not serve as that individual's designated representative for long-term care services. These changes are part of the shift to the use of an Integrated Eligibility system.

CHANGES TO RULE:

461-115-0090
Authorized Representatives; General ¶

(1) ~~The head of household, spouse (see OAR 461-001-0000), or any other responsible member of the household may designate an authorized representative to act on behalf~~"Authorized representative" means an individual or organization permitted by this rule to act on behalf of an applicant or beneficiary in assisting the applicant or beneficiary with their application, renewal of eligibility, and other on-going communications with the Department.¶
(2) "Department" in this rule refers to the Department of Human Services and the Oregon Health Authority.¶
(3) "Eligibility determination group" in this rule refers to all individuals whose financial and non-financial information are considered in determining program eligibility.¶
(4) In the TA-DVS program, an authorized representative (see section (1) of this rule) may not be established.¶
(5) An authorized representative designated for one program is the authorized representative for all programs and benefits of the head of household ~~in making application for the program~~(see OAR 461-001-0015), primary person (see OAR 461-001-0000), or primary contact (see OAR 410-200-0015), excluding the TA-DVS program and not when the exception in subsection (6)(c) of this rule applies.¶
(6) Unless limited elsewhere in this rule, ~~i~~an ~~reporting changes, in obtaining benefits, or in using~~authorized representative may do any of the following:¶
(a) With the exception of the authorized representative designation form and subject to the exception in subsection (c) of this section: complete, sign, and submit any applications, renewals, or documents on behalf of the applicant or benefi~~ts~~ciary.¶
(~~2~~b) ~~In all programs except the SNAP program, the Department must allow a person or persons of the applicant's choice to act as the~~Receive copies of notices and other communications from the Department for the applicant or beneficiary.¶
(c) Act on behalf of the applicant or recipient by reporting information and submitting requests to the Department, except an individual's long-term care (see OAR 461-001-0000) services provider may not serve as the designated representative (see OAR 411-004-0010) or representative (see OAR 411-028-0010 and OAR 411-030-0020) of the individual for long-term care services.¶
(7) The following individuals may appoint an authorized representative ~~unless the person may cause harm to~~on a form designated by the Department subject to the limitations listed in sections (4), (5), and (8) - (12) of this rule, unless the individual is included in the ~~c~~celi~~ent or may be considered as having a conflict of interes~~gibility determination group (see section 3 of this rule) solely for the purpose of determining eligibility based on tax filing status:¶
(a) The head of household, primary person, or primary contact of any age.¶
(b) Any individual age 18 and older who is included in each eligibility determination group of the head of household, primary person, or primary contact.¶

(3c) IAn all programs except the SNAP and TA-DVS programs, if an authorized representative is needed but individual given legal guardianship or power of attorney for an individual age 18 and older who is included in each eligibility determination group of the head of household, primary person, or primary contact.¶
(d) If the Department has determined that an authorized representative is needed based on the physical or mental capacity of an individual to handle their own affairs, and an authorized representative has not been designated by the clientindividual, the Department willmay appoint one.¶
(48) In the SNAP program:¶
(a) Except as limited by sections (5) and (6) this rule, the sThe Department may accept a designation of an authorized representative via any of the following methods, which must include either a handwritten or electiron of an authorized representative must be made in writing by an adult member of the householdic signature of both the individual designating the authorized representative and the authorized representative:¶
(a) The Internet.¶
(b) E-mail.¶
(c) Mail.¶
(d) Telephonic recording.¶
(e) In person.¶
(f) Other electronic means.¶
(9) The following may not serve as an authorized representative: ¶
(a) An individual serving an Intentional Program Violation (see OAR 461-195-0601), unless the Department determines no one else is available to serve as the authorized representative.¶
(b) Homeless meal providers (see 7 CFR 271.2) for homeless SNAP recipients.¶
(c) A person who may cause harm to the individual.¶
(d) A person who may have a conflict of interest.¶
(be) The selection and authority of an authorized representative is further limited by OAR 461-115-0140 Department employees or an employee of a contractor involved in the certification or issuance processes for Department program benefits, unless a designated Department official determined no one else is available to serve as an authorized representative and has given approval.¶
(f) Retailers who are authorized to accept Department Electronic Benefit Transfer (EBT) cards, unless a designated Department official determined no one else is available to serve as an authorized representative and has given approval.¶
(510) A clientn individual who resides in a drug addiction or alcoholicor alcohol residential treatment centerfacility identified in OAR 461-135-0550(2) may apply for SNAP program benefits only through an authorized representative. The authorized representative must be an designated employee of andthe treatment center. The employee must complete the authorized representative form designated by the center.¶
(6) A clientDepartment. ¶
(11) An individual with a disability (see OAR 461-001-0015) who participates in the SNAP program while residing in a group living facility (see OAR 461-001-0015) may participatearrangement (GLA) may apply through an authorized representative or on his or hetheir own behalf, at the option of the group living facility (see OAR 461-135-0510(2)(e)).¶
(7) In the TANF program, a person not related to the dependent child may serve as. The GLA must determine if a resident may apply on their own behalf based on the physical and mental ability of the resident to handle their own affairs. If the authorized representative or alternate payee for not more than 60 days.¶
(8) A designee of a correctional facility may apply for OSIPM and QMB on behalf of an individual, wis a designated employee of the GLA, the employee must complete the authorized representative form designated by the Department.¶
(12) While the individual is residing in a correctional facility, for the purpose of es or during a temporary period of hospitablishing eligibility for medical assistance until the release of the individual from the correctional facility or during a period of hospitalization that occurs outside of the correctional facilityzation that occurs outside of the correctional facility, a designee of a correctional facility may apply for the OSIPM and QMB programs on behalf of

an individual for the purpose of establishing eligibility for medical assistance.¶
(a) The designee may obtain information necessary to determine eligibility for medical assistance, including the person's Social Security number or information that is not otherwise subject to disclosure under ORS 411.320 or ORS 413.175.¶
(b) The information obtained under subsection (a) of this section may be used only for the purpose of assisting the person in applying for medical assistance and may not be re-disclosed without the authorization of the individual.¶
(~~9) In the TA-DVS program, a person may only serv~~13) The authorized representative must maintain the confidentiality of any information provided by the Department regarding the represented individual.¶
(14) An individual or organization ceases to be a~~s~~n authorized representative ~~during the 90-day eligibility period. If the eligibility period closes before 90 days, the authorized representative is no longer able to act on behalf of the household. A new authorized representative must be designated at each new eligibility period~~when:¶
(a) A represented individual notifies the Department that the designation is terminated;¶
(b) A represented individual appoints a different authorized representative;¶
(c) The authorized representative notifies the Department that the designation is terminated;¶
(d) The Department determines the authorized representative is no longer permitted to be the authorized representative; or¶
(e) There is a change in the legal authority upon which the individual or organization's authority was based.¶
(15) An authorized representative may be subject to an overpayment (see OAR 461-195-0501 and OAR 461-195-0541) in addition to other penalties. These other penalties include:¶
(a) In GLA or drug or alcohol residential treatment facilities, the facility may be prosecuted under applicable federal or state law.¶
(b) For an authorized representative not covered by subsection (a) of this section, the Department may prohibit the person from serving as an authorized representative for one year.
Statutory/Other Authority: ORS 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, 413.085, 414.685, 329A.500
Statutes/Other Implemented: ORS 409.010, 411.060, 411.404, 411.447, 411.816, 412.014, 412.049, 411.117, 329A.500

REPEAL: 461-115-0140

RULE SUMMARY: OAR 461-115-0140 about authorized representatives and alternate payees in the SNAP program, which was suspended effective March 1, 2019, is being repealed because this topic will be covered in OAR 461-115-0090 and OAR 461-165-0035.

CHANGES TO RULE:

~~461-115-0140~~
~~Authorized Representative or Alternate Payee; SNAP~~
~~In the SNAP program:¶~~
~~(1) None of the following may serve as authorized representative (see OAR 461-115-0090) or alternate payee:¶~~
~~(a) An individual serving an Intentional Program Violation, unless the Department determines no one else is available to serve as the authorized representative.¶~~
~~(b) A landlord or a vendor of goods or items who deals directly with the client, including a retailer authorized to accept SNAP benefits.¶~~
~~(c) Employees of the Department or an employee of a contractor involved in the certification and issuance processes for SNAP benefits, unless authorized in writing by the designee of the Department's SNAP Program Manager. The designee must determine no one else is available to serve as the authorized representative.¶~~
~~(d) A provider of meals for the homeless.¶~~
~~(2) An authorized representative or alternate payee who knowingly misrepresents the circumstances of the filing group (see OAR 461-110-0370) or misuses SNAP benefits is subject to penalty as follows:¶~~
~~(a) In group living (see OAR 461-001-0015) situations or treatment programs for drug addiction or alcohol abuse, the facility may be prosecuted under applicable federal or state law.¶~~
~~(b) For other authorized representatives and alternate payees not covered by subsection (a) of this section, the Department may prohibit the person from serving as a representative or payee for one year.¶~~
~~(3) Except as provided by this rule or by OAR 461-115-0090, a client may select his or her authorized representative or alternate payee.~~
~~Statutory/Other Authority: ORS 411.816~~
~~Statutes/Other Implemented: ORS 411.816~~

AMEND: 461-115-0430

RULE SUMMARY: OAR 461-115-0430 about periodic redeterminations is being amended to indicate that eligibility determinations must be completed at least once every 12 months, aligning the rule with federal policy.

CHANGES TO RULE:

461-115-0430
Periodic Redeterminations; Not EA, ERDC, SNAP, or TA-DVS ¶

The Department periodically redetermines the eligibility (see OAR 461-001-0000) of clients for benefits and assigns a redetermination date by which the next determination is required. The Department selects the redetermination date based on the client's circumstances and according to the following requirements:¶
(1) In the GA program, the Department redetermines eligibility at least once every 12 months.¶
(2) In the OSIP and OSIPM programs, the Department determines eligibility ~~each~~at least once every 12 months for clients who are not eligible for SSI. No redetermination is required for clients who are eligible for SSI.¶
(3) In the QMB program, the Department determines eligibility ~~each~~at least once every 12 months for clients who are not eligible for SSI. For QMB recipients who are also eligible for OSIPM, a redetermination for QMB is completed with the redetermination of OSIPM.¶
(4) The REF and REFM programs are time limited programs; therefore, no periodic redeterminations are made.¶
(5) In the SFPSS program, the Department redetermines eligibility at least once every 12 months. The Department redetermines program eligibility by redetermining eligibility for the TANF program.¶
(6) In the TANF program, benefits will end the last day of the certification period (see OAR 461-001-0000). The Department redetermines eligibility according to the following schedule:¶
(a) At least once every six months for each of the following:¶
(A) Clients not participating in an activity (see OAR 461-001-0025) of an open case plan (see OAR 461-001-0025).¶
(B) Clients who are currently serving a JOBS disqualification.¶
(b) At least once every 12 months for all other clients.
Statutory/Other Authority: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 412.014, 412.049, 413.085, 414.685, 414.826, 414.839, 409.050
Statutes/Other Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 412.014, 412.049, 413.085, 414.685, 414.826, 414.839, 409.010, 42 CFR 435.916

AMEND: 461-135-0750

RULE SUMMARY: OAR 461-135-0750 about individuals applying for or receiving long-term care or home and community-based care is being amended to remove effective date language that already exists in OAR 461-180-0090, update terms, and make other minor, including correcting references to rules from Chapter 411 pertaining to Children's Intensive In-Home Services programs. These changes clarify the rule.

CHANGES TO RULE:

461-135-0750
Individuals Applying for or Receiving Long-Term Care or Home and Community-Based Care ¶

~~(1) A~~In the OSIPM program, an individual who does not meet the income requirements for OSIPM under sections (3) or (5) of OAR 461-155-0250 and who meets the following requirements ~~of subsections (a) and (b) of this section~~ is subject to the OSIPM income limit specified in OAR 461-155-0250(2):¶
(~~a~~1) The individual meets at least one of the following eligibility standards:¶
(~~A~~a) The criteria in OAR 411-015-0100 (except subsection (1)(b)) regarding eligibility for nursing facility care or home and community-based care (see OAR 461-001-0030).¶
(~~B~~b) The level-of-need criteria for an ICF-ID.¶
~~(C) The service eligibility standards for medically fragile children in OAR 411-350-0010.¶~~
(~~D~~c) The service eligibility standards for the CIIS (Children's Intensive In-Home Services) ~~behavioral~~ programs in OAR 411-300-0100 to 411-300-0220.¶
~~(E) The service eligibility standards for the Medically Involved Children's Waiver in OAR chapter 411, division 355.¶~~
(~~b~~2) The individual resides in or will reside in one of the following locations for a continuous period of care (see OAR 461-001-0030) and is applying for or receiving long-term care services authorized by the Department ~~(eligibility for OSIPM is not effective prior to the first day of the month that includes the effective date for long-term care under OAR 461-180-0040)~~:¶
(~~A~~a) A Medicaid-certified nursing facility.¶
(~~B~~b) An intermediate care facility for ~~the me~~individuals with inta~~e~~ll~~y retarded~~ectual disabilities (ICF-ID).¶
(~~C~~c) A home and community-based care setting.¶
(~~2~~3) ~~A~~For an individual who resides or will reside in a home and community-based care setting ~~must~~, the individual receives Title 1915(c) waivered services.
Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.404

AMEND: 461-145-0210

RULE SUMMARY: OAR 461-145-0210 about gifts and winnings is being amended to make some gift cards and certificates countable as income in the OSIP, OSIPM, and QMB programs. This change is needed to fit the programming for Integrated Eligibility and for consistency with federal policy (Program Operations Manual SI 00830.522).

CHANGES TO RULE:

461-145-0210
Gifts and Winnings ¶

(1) For the purposes of this rule:¶
(a) "Gifts" are items given to or received by an individual on or for a special occasion, such as a holiday, birthday, graduation, or wedding. "Gifts" are not given or received on a regular basis.¶
(b) "Winnings" are prizes given to an individual in a contest, game of chance, or similar event. "Winnings" in the form of money may be distributed periodically (such as monthly) or in a lump-sum.¶
(2) In the ERDC program, gifts (see section (1) of this rule) and winnings (see section (1) of this rule) are excluded.¶
(3) In all programs except the ERDC program and except as provided otherwise in sections (4) and (5) of this rule:¶
(a) In-kind gifts and winnings are treated according to the rule applicable to the specific type of asset. In the OSIP, OSIPM, and QMB programs, if an individual is offered a choice between an in-kind item and cash, the cash amount is considered unearned income, even if the individual chooses the in-kind item and regardless of the value, if any, of the in-kind item.¶
(b) Gifts and winnings in the form of money or credit card company gift cards are treated as periodic or lump-sum income (see OAR 461-140-0110 and 461-140-0120). In the OSIP, OSIPM, and QMB programs, gambling losses are not subtracted from gambling winnings in determining the individual's countable (see OAR 461-001-0000) income.¶
(c) ~~E~~In all programs except the OSIP, OSIPM, and QMB programs, establishment-specific gift cards are excluded as income and not considered a resource.¶
(d) In the OSIP, OSIPM, and QMB programs, the value of a gift card or certificate is considered income in the month it is received if the gift card or certificate can be used to purchase food or shelter or can be resold. There is a rebuttable presumption that the gift card can be resold.¶
(4) For employment-related items, see OAR 461-145-0130.¶
(5) In the OSIP, OSIPM, and QMB programs, monetary gifts given for educational purposes are treated in accordance with OAR 461-145-0145.
Statutory/Other Authority: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.404, 411.700, 411.706, 411.816, 412.014, 412.049

AMEND: 461-145-0440

RULE SUMMARY: OAR 461-145-0440 about reimbursement is being amended to count as earned income reimbursements from a business entity that benefit a principal in the OSIP, OSIPM, and QMB programs and limit counting these expenditures in the SNAP program to reimbursements. These changes align polices in the OSIP, OSIPM, QMB, and SNAP programs on this topic for purposes of Integrated Eligibility.

CHANGES TO RULE:

461-145-0440
Reimbursement ¶

(1) For the treatment of USDA meal reimbursements, see OAR 461-145-0570.¶
(2) The reimbursement (see OAR 461-001-0000) of a business expense for an individual who is self-employed is treated as self-employment income (see OAR 461-145-0910, 461-145-0915, and 461-145-0920).¶
(3) Except as provided in sections (1) and (2) of this rule, a reimbursement is treated as follows:¶
(a) In the ERDC program, a reimbursement is excluded, except that a reimbursement for child care from a source outside of the Department is counted as unearned income.¶
(b) In the SNAP program:¶
(A) A reimbursement in the form of money for a normal household living expense, such as rent or payment on a home loan, personal clothing, or food eaten at home, is unearned income.¶
(B) Any other reimbursement is treated as follows:¶
(i) An in-kind reimbursement is excluded.¶
(ii) A reimbursement in the form of money is excluded if used for the identified expense, unless the expense is covered by program benefits.¶
(iii) A reimbursement is counted as periodic income (see OAR 461-001-0000 and 461-140-0110) or lump-sum income (see OAR 461-001-0000 and 461-140-0120) if not used for the identified expense.¶
(iv) A reimbursement for an item already covered by the benefits of the benefit group (see OAR 461-110-0750) is counted as periodic income or lump-sum income.¶
(c) In the OSIP, OSIPM, QMB, and SNAP programs, ~~an expenditure by~~ reimbursement from a business entity that benefits a principal (see OAR 461-145-0088) is counted as earned income (see OAR 461-145-0130).¶
(d) In all programs except the ERDC and SNAP programs, a reimbursement is treated as follows:¶
(A) An in-kind reimbursement is excluded.¶
(B) A reimbursement in the form of money is excluded if used for the identified expense, unless the expense is covered by program benefits.¶
(C) A reimbursement is counted as periodic income or lump-sum income if not used for the identified expense.¶
(D) A reimbursement for an item already covered by the benefits of the benefit group is counted as follows:¶
(i) In all programs except the OSIPM and QMB programs, it is counted as unearned income.¶
(ii) In the OSIPM and QMB programs, it is counted as unearned income unless the payment is turned over to the Department (see OAR 461-120-0315).¶
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Statutory/Other Authority: 329A.500, ORS 409.050, 411.060, 411.070, 411.404, 411.816, 412.049, 413.085, 414.685
Statutes/Other Implemented: 659.830, 743B.470, 329A.500, ORS 409.010, 409.050, 411.060, 411.070, 411.404, 411.816, 412.049, 413.085, 414.685

AMEND: 461-160-0030

RULE SUMMARY: OAR 461-160-0030 about whether or not costs are deductible is being amended with respect to medical costs in the OSIP and OSIPM programs to allow payments to a credit card for allowable medical expenses to be used as a deduction to reduce the liability for service eligible individuals. This rule is also being amended to provide specific information about when and how one-time and ongoing medical costs are used to reduce client liability and to remove language that belongs in the effective date rule (OAR 461-180-0020). These amendments fill gaps in treatment of medical costs and align the rule with Integrated Eligibility.

CHANGES TO RULE:

461-160-0030
Overview of Costs ¶

(1) Costs incurred by the filing group that the filing group has a legal responsibility to pay are deductible from income in accordance with the rules in this division of rules.¶
(2) The following costs are not deductible:¶
(a) A cost paid by someone outside the filing group through a reimbursement, vendor payment, or in-kind benefit.¶
(b) A cost that is paid by a person or company outside the filing group or that is written off by a medical facility. These are referred to as third-party payments.¶
(c) The cost for a service provided by someone in the filing group, such as child care provided by the father while the mother works.¶
(d) A cost used as an income deduction in one budget month or averaged over several months cannot be used again.¶
(e) In the OSIPM program, a cost that the client incurred while the client was serving a disqualification from Medicaid under OAR 461-140-0210 to 461-140-0300 for a transfer of assets for less than fair market value.¶
(3) In the OSIP and OSIPM programs, ~~to determine~~ the medical deduction allowed under OAR 461-160-0620~~, the Department uses the following methods:¶~~
~~(a) Costs are considered incurred when they are either paid by the individual or billed by the provider.~~is determined as follows:¶
(~~b~~a) In order to be allowed as a deduction, a cost~~s must be reported within 10 days of the date they are incurred (see OAR 461-180-0020)~~ or portion of a cost that has already been paid must be reported in the month it is paid or within 10 days of the date it is paid.¶
(~~c~~b) ~~O~~For one-time ~~medical expenses are treated as~~costs that have been incurred but not paid in ~~f~~ollo~~ws~~:¶
(A) ~~If the individual reports an expense that was paid in full, the cost is allow~~Any amount already paid when reported is allowed if it was reported in the month ~~in which~~that it was paid ~~(see OAR 461-180-0020).¶~~
~~(B) If the expense was billed but not paid in full:¶~~
~~(i) T~~or within 10 days of the date it was paid.¶
(B) For amounts not already paid, the amount allowed as a deduction is the amount the individual expects to pay each month, not to exceed the total amount due at the time the ~~expense~~cost is reported.¶
~~(ii) Additional deductions are not allowed if the individual fails to pay the cost.¶~~
~~(iii) T~~ ¶
(c) Deductions for one-time medical expenses that have been paid with a credit card are allowed as follows:¶
(A) The amount allowed as a deduction is the amount the individual expects to pay or is currently paying each month on the card until the outstanding balance of the ~~d~~med~~uction begins the month the individual reports they will begin making payment~~ical cost would be paid in full.¶
(B) For costs charged prior to the month reported, the outstanding balance is the amount of the original cost charged to the card less any subsequent payments to the card.¶
(C) Count all payments made to the credit card toward the principal balance of the medical cost.¶

(D) Additional deductions are not allowed if the individual incurs interest or fees.¶
(d) Recurring costs, such as those for ongoing prescription medications, may be anticipated and allowed until the total amount of the cost has been allowed or through the next annual redetermination (see OAR 461-115-0430), whichever occurs first.¶
(A) The amount anticipated should reflect actual and verified costs.¶
(B) Recurring ~~expense~~costs may not be averaged.¶
(e) The effective date for an allowable cost is determined in accordance with OAR 461-180-0020.¶
(f) Additional deductions are not allowed if the individual fails to pay the cost.
Statutory/Other Authority: ORS 409.050, 411.060, 411.400, 411.816, 412.014, 412.049, 411.404, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.400, 411.816, 412.014, 412.049, 411.404

AMEND: 461-160-0855

RULE SUMMARY: OAR 461-160-0855 about excluded resources in the OSIPM program for payments received under a qualified partnership policy (QPP) is being amended to make permanent a temporary rule change effective April 1, 2019 correcting an error made when amending this rule permanently effective April 1, 2019. This error would have resulted in the QPP exclusion amount not applying to other countable resources, when in fact the opposite is true.

CHANGES TO RULE:

461-160-0855
Excluded Resources for Payments Received Under a Qualified Partnership Policy; OSIPM ¶

In the OSIPM program:¶
(1) When a ~~client~~n individual in a non-standard living arrangement (see OAR 461-001-0000) applies for medical benefits, the Department excludes as a resource an amount equal to the insurance payments received under a Qualified Partnership Policy (see OAR 461-001-0000) as of the initial month (see OAR 461-001-0000) of eligibility, unless the Qualified Partnership Policy was purchased in a state that has elected not to participate in reciprocity.¶
(2) The exclusion in section (1) of this rule is subject to all of the following:¶
(a) It does not apply when home equity exceeds the limit in OAR 461-145-0220(2)(a).¶
(b) It ~~does not~~ appl~~y~~ies to all other resources (not covered by subsection (a) of this section), notwithstanding other rules in this chapter of rules that designate the resources as countable (see OAR 461-001-0000).¶
(3) For the amount of resources excluded under this rule, the Department will not establish a claim against the ~~deceased person's estate~~estate of the deceased individual in accordance with OAR 461-135-0835.
Statutory/Other Authority: 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.708, 414.025, ORS 409.050, 413.085, 414.685
Statutes/Other Implemented: 411.060, 411.070, 411.083, 411.404, 411.704, 411.706, 411.708, 414.025, ORS 409.010

AMEND: 461-165-0035

RULE SUMMARY: OAR 461-165-0035 about alternate payees is being amended to broaden the scope of the rule to apply to all benefits rather than only those issued by Electronic Benefit Transfer (EBT) and make permanent temporary rule changes effective March 1, 2019. The changes revise who can serve as an alternate payee, who can designate an alternate payee, and what requirements and responsibilities apply to those who serve as an alternate payee.

CHANGES TO RULE:

461-165-0035
Alternate Payees; EBT ¶

(1) An "alternate payee ~~may be used~~" is an individual or organization authorized by another individual to obtain and use benefits for and in the best interests of the benefit group (see OAR 461-110-0750) ~~when benefits are issued by el~~.¶
(2) In the TA-DVS program, an alternate payee (see sectrion~~ic benefit transfer (EBT)~~ (1) of this rule) may not be established.¶
(~~2~~3) ~~Except as provided in section (5) of this rule, an alternate payee may be used any time the primary person, the spouse of the primary person,~~The following individuals may appoint an alternate payee in writing on a form designated by the Department. The form must include the signatures of both the individual designating the alternate payee and the alternate payee:¶
(a) In all programs, the head of household (see OAR 461-001-0015) of any age, primary person (see OAR 461-001-0000 and OAR 461-001-0015) of any age, primary contact (see OAR 410-200-0015) ~~or~~f an~~other responsible adult member of the filing group names one in writing~~y age, authorized representative (see OAR 461-115-0090), and any other member age 18 or older of the group applying.¶
(b) An individual given legal guardianship or power o~~n~~f a ~~form designated by the Department~~ttorney for an individual age 18 and older.¶
(~~3~~c) ~~The branch office may appoint an emergency~~In the OSIP and OSIPM programs, a community spouse (see OAR 461-001-0030).¶
(4) If an alternate payee i~~f the adult filing group members are temporarily unable to act as~~s needed and all responsible members of the group applying are temporarily unable to act as a payee, the Department may appoint an emergency alternate payee.¶
(~~4~~5) When an alternate payee is ~~nam~~authorized, the Department may issue~~s an EBT card and personal identification number (PIN) for that person~~ a Department Electronic Benefit Transfer (EBT) card or other program benefits to the alternate payee.¶
(6) The following may not serve as an alternate payee:¶
(a) An individual serving an Intentional Program Violation (see OAR 461-195-0601), unless the Department determines no one else is available to serve as the alternate payee.¶
(b) Homeless meal providers (see 7 CFR 271.2) for homeless SNAP recipients.¶
(c) A person who may cause harm to the individual.¶
(d) A person who may have a conflict of interest.¶
(~~5~~A) ~~For child care benefits in the ERDC, JOBS, JOBS Plus, and TANF programs, an alternate payee may not be a Department-approved child care provider or acting on behalf of a Department-approved child care provide~~ Department employees or an employee of a contractor involved in the certification or issuance processes for Department program benefits, unless a designated Department official determined no one else is available to serve as an alternate payee and has given approval.¶
(B) Retailers who are authorized to accept Department EBT cards, unless a designated Department official determined no one else is available to serve as an alternate payee and has given approval.¶
(7) The power to act as an alternate payee for an individual ends when:¶
(a) The represented individual notifies the Department that the designation is terminated;¶
(b) The alternate payee notifies the Department that the designation is terminated;¶

(c) The Department determines the alternate payee is no longer permitted to be the alternate payee; or¶
(d) There is a change in the legal authority upon which the individual or organization's authority was based.¶
(8) An alternate payee who misuses Department benefits is subject to penalty as follows:¶
(a) In a group living (see OAR 461-001-0015) arrangement or a drug or alcohol residential treatment facility identified in OAR 461-135-0550, the facility may be prosecuted under applicable federal or state law.¶
(b) For any other alternate payee not covered by subsection (a) of this section, the Department may prohibit the person from serving as a payee for one year.
Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.816, 412.049, 329A.500, 411.404, 412.014, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.816, 412.049, 329A.500, 411.404, 412.014

REPEAL: 461-165-0040

RULE SUMMARY: OAR 461-165-0040 about assigning payees, which was suspended effective March 1, 2019, is being repealed because this topic will be covered in OAR 461-165-0035.

CHANGES TO RULE:

~~461-165-0040~~
~~Assigning Payee; Not EBT~~
~~When benefits are not issued by EBT, a person may be payee for a case regardless of whether they receive benefits on that case. They may be the payee for more than one program or case. The payee is:¶~~
~~(1) The primary person; or¶~~
~~(2) An authorized representative.~~
~~Statutory/Other Authority: ORS 411.060~~
~~Statutes/Other Implemented: ORS 418.040, 412.049~~

AMEND: 461-180-0020

RULE SUMMARY: OAR 461-180-0020 about effective dates when considering changes in income or income deductions that cause increases is being amended to revise, in the OSIPM and QMB programs, when reductions to client liability are effective due to medical costs allowed in accordance with OAR 461-160-0030. These changes clarify the rule.

CHANGES TO RULE:

461-180-0020
Effective Dates; Changes in Income or Income Deductions That Cause Increases ¶

For all programs in Chapter 461, except the ERDC program, this rule is used to determine the effective date when a change in income or income deductions causes an increase in benefits. For all changes, the effective date is one of the following:¶
(1) In the GA, REF, SFPSS, and TANF programs, the effective date for an anticipated change reported before the payment month is the first of the payment month in which it will occur. If the change is not reported until the month it occurs or later, the effective date is the first of the month following the month in which the change was reported.¶
(2) In the SNAP program:¶
(a) The effective date when verification is not requested is the first of the month following the date the change was reported.¶
(b) The effective date if verification is requested is:¶
(A) The first of the month following the date the change was reported if verification is received no later than the due date for the verification.¶
(B) The first of the month following the date the verification is received by the Department, if received after the verification due date.¶
(3) In the OSIPM and QMB programs, the effective date for increases resulting from reported changes is determined as follows:¶
(a) If, based on the reported change, the individual is determined eligible for a new program with a higher benefit level, the effective date for the new program is determined in accordance with OAR 461-180-0090.¶
(b) For changes in income that reduce liability or the OSIPM-EPD participant fee:¶
(A) If the change was reported timely, the change is effective the month the change occurred.¶
(B) If the change was not reported timely, the change is effective the month it is reported or discovered.¶
(c) For ~~changes in medical deductions~~medical costs allowed in accordance with OAR 461-160-0030 that reduce liability:¶
(A) ~~For both ongoing and one-time expenses, the change is effective the month the change occurred,~~One-time and ongoing costs that have already been paid when the change is reported are allowed i~~f~~n the ~~change was reported timely.¶~~
~~(B) For~~month they were paid. ¶
(B) For one-time and ongoing ~~expenses that are not reported timely, the change is effective the month the change is reported.¶~~
~~(C) One-time expenses that have~~costs that have been incurred but not paid, the change is effective the month the individual reports they will b~~een paid in full but are not reported timely will not be used.~~gin making payments. ¶
(d) When the decrease in liability is caused by increased deductions due to a change to an individual's marital status or number of eligible dependents, the effective date is:¶
(A) The first of the month the change occurred, if the change was reported timely.¶
(B) The first of the month the change was reported or discovered, if the change was not reported timely.¶
(e) When the decrease in liability is caused by a higher maintenance standard due to a change in service setting, the effective date is the date the individual moves into the new service setting.¶
(f) When a decrease in liability is caused by a change in income and a change in service setting that occurs in the same month, the effective date is the day the individual moves into the new service setting.

Statutory/Other Authority: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.706, 411.816, 412.014, 412.049

AMEND: 461-180-0040

RULE SUMMARY: OAR 461-180-0040 about effective dates for special needs and services is being amended to revise the effective date of in-home services. This amendment also clarifies that the effective date for long-term care services is contingent on when a disqualification period (if any) ends. These changes align the rule with current practices.

CHANGES TO RULE:

461-180-0040
Effective Dates; Special and Service 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~~in-home services (see OAR 411-030-0020) and independent choices program (ICP) benefits (see OAR 411-030-0020) is determined as follows:¶
(a) For individuals currently receiving Medicaid OHP Plus benefits, the effective date is the ~~d~~later of 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~~following:¶
(A) The date of request for in-home services or ICP.¶
(B) The date the individual meets all eligibility requirements for in-home services or ICP in accordance with OAR 411-030-0040.¶
(C) The expiration date of a disqualification period resulting from a transfer of assets (see OAR 4~~1~~61-~~015-0015). An authorized service plan must:¶~~
~~(A) Specify the date when services will begin (this date cannot be prior to~~140-0296).¶
(b) For individuals not already receiving Medicaid OHP Plus benefits, the effective date is the ~~d~~late ~~that the service plan is completed) and the maximum number of hours authorized; and¶~~
~~(B) Identify the enrolled homecare worker~~r of the following:¶
(A) The effective date of the Medicaid OHP Plus benefit package (see OAR 411-0~~3~~15-00~~20 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~~15).¶
(B) The date of the initial assessment.¶
(C) The date the individual meets all eligibility requirements for in-home services or ICP in accordance with OAR 411-030-0040.¶
(D) The expiration date o~~r~~f a~~gency has agreed to provide the services as authorized by the service plan~~ disqualification period resulting from a transfer of assets (see OAR 461-140-0296).¶
(~~b~~3) ~~For a client residing in, or who will reside~~The effective date for Title XIX services in a licensed community-based setting or Medicaid-certified nursing facility ~~the effective date~~ is the later of the following:¶
(~~A~~a) The date of request for services~~;~~.¶
(~~B~~b) The date the individual begins residing in the community-based setting or nursing facility~~; or~~.¶
(~~C~~c) The effective date of the Medicaid OHP Plus benefit package (see OAR 411-015-0015).¶
(~~3~~d) The expiration date of a disqualification period resulting from a transfer of assets (see OAR 461-140-0296).¶
(4) 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~~5~~) The effective date for a reduction or termination of an on-going special need is the end of the timely continuing benefit notice period.
Statutory/Other Authority: ORS 411.060, 409.050, 411.404, 413.085, 414.685
Statutes/Other Implemented: ORS 411.060, 409.010, 411.404

AMEND: 461-195-0521

RULE SUMMARY: OAR 461-195-0521 about the calculation of overpayments is being amended to make permanent temporary rule changes effective March 1, 2019 removing outdated program names and clarifying overpayment liability in OCCS medical programs related to the actions of an authorized representative. These changes are part of updating authorized representative rules for Integrated Eligibility.

CHANGES TO RULE:

461-195-0521
Calculation of Overpayments ¶

This rule specifies how the Department calculates an overpayment (see OAR 461-195-0501).¶
(1) The Department calculates an overpayment by determining the amount the client received or the payment made by the Department on behalf of the client that exceeds the amount for which the client was eligible.¶
(2) When a filing group, OCCS Medical programs household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) fails to report income, the Department calculates and determines the overpayment by assigning unreported income to the applicable budget month without averaging the unreported income, except:¶
(a) A client's earned income reported quarterly from the Employment Department is considered received by the client in equal amounts during the months identified in the report.¶
(b) In the ERDC, ~~MAA, MAF,~~ REF, SNAP, and TANF programs, a client's actual self-employment income is annualized retrospectively to calculate the overpayment.¶
(c) In the OCCS Medical programs, if actual income is not available for the months in which an overpayment occurred, a client's actual self-employment income (see OAR 410-200-0015) received during the year when an overpayment occurred is annualized to calculate an overpayment.¶
(3) When using prospective budgeting (see OAR division 461-150) and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a client error overpayment (see OAR 461-195-0501) only when the filing group, ineligible student, or authorized representative withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an overpayment.¶
(4) When using anticipated income for the OCCS Medical programs and the actual income differs from the amount determined under OAR 410-200-0310, there may be a client error overpayment only when the OCCS Medical programs household group (see OAR 410-200-0015) or authorized representative (see OAR 410-200-0015) knowingly withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an overpayment.¶
(5) When a filing group, ineligible student, or authorized representative fails to report all earned income within the reporting time frame, the earned income deduction (see OAR 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) is applied as follows:¶
(a) In the OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.¶
(b) In the ~~MAA, MAF,~~ REF~~,~~ and TANF programs, the Department allows the earned income deduction when good cause (see section (6) of this rule) exists.¶
(c) In the SNAP program, no deduction is applied to earned income if the amount or source of income was not timely reported.¶
(6) For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.¶
(7) When support is retained:¶
(a) In the TANF program, the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine eligibility (see OAR 461-001-0000). When a client is not eligible for TANF program benefits, the overpayment is offset by the support the Department of Justice retains as a current reimbursement.¶

(b) In the medical programs, the amount of the cash medical support the Department retains each month is excluded income and not used to determine eligibility for medical program benefits. When a client has incurred a medical program overpayment, the overpayment is offset by the amount of the cash medical support the Department retains during each month of the overpayment.¶
(8) In the REF and TANF programs, when a client directly receives support used to determine eligibility or calculate benefits, the overpayment is:¶
(a) If still eligible for REF or TANF program benefits, the amount of support the client received directly; or¶
(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the client received.¶
(9) When an overpayment occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the overpayment is limited to the lesser of the following:¶
(a) The amount of the payment from the Department;¶
(b) Cash medical support; or¶
(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.¶
(10) Benefits paid during a required notice period (see OAR 461-175-0050, OAR 410-200-0120) are included in the calculation of the overpayment when:¶
(a) The filing group, OCCS Medical programs household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) failed to report a change within the reporting time frame under OAR 461-170-0011 or OAR 410-200-0235; and¶
(b) Sufficient time existed for the Department to adjust the benefits to prevent the overpayment if the filing group, OCCS Medical program household group (see OAR 410-200-0015), ineligible student, or authorized representative (see OAR 461-115-0090 and OAR 410-200-0015) had reported the change at any time within the reporting time frame.¶
(11) In the SNAP program:¶
(a) If the benefit group (see OAR 461-110-0750) was categorically eligible, there is no overpayment based on resources.¶
(b) For a filing group (see OAR 461-110-0370) found eligible for SNAP program benefits under OAR 461-135-0505(1)(a) to (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for SNAP program benefits as long as the eligibility requirement under OAR 461-135-0505(1)(d) is met. A benefit group of one or two individuals would be entitled to at least the minimum SNAP program benefit allotment under OAR 461-165-0060.¶
(c) For a filing group found eligible for SNAP program benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the filing group is no longer categorically eligible. The overpayment is the amount of SNAP program benefits incorrectly received.¶
(12) In the OSIP and OSIPM programs, when a client does not pay his or her share of the cost of services (see OAR 461-160-0610) or the OSIP-EPD or OSIPM-EPD program participant fee (see OAR 461-160-0800) in the month in which it is due, an overpayment is calculated as follows:¶
(a) All payments made by the Department on behalf of the client during the month in question are totaled, including but not limited to any payment for:¶
(A) Capitation;¶
(B) Long term care services;¶
(C) Medical expenses for the month in question;¶
(D) Medicare buy-in (when not concurrently eligible for an MSP);¶
(E) Medicare Part D;¶
(F) Mileage reimbursement;¶
(G) Special needs under OAR 461-155-0500 to 461-155-0710; and¶
(H) Home and community-based care (see OAR 461-001-0030), including home delivered meals and non-medical transportation.¶

(b) Any partial or late liability payment made by a client receiving home and community-based care in-home services or participant fee paid by an OSIP-EPD or OSIPM-EPD program client is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the overpayment.¶
(13) When a client's liability is unreduced pending the outcome of a contested case hearing about that liability the overpayment is the difference between the liability amount determined in the final order and the amount, if any, the client has repaid.¶
(14) In the OCCS Medical programs, OSIPM, QMB, and REFM programs if the client was not eligible for one program, but during the period in question was eligible for another program:¶
(a) With the same benefit level, there is no overpayment.¶
(b) With a lesser benefit level, the overpayment is the amount of medical program benefit payments made on behalf of the client exceeding the amount for which the client was eligible.¶
(15) When an overpayment is caused by administrative error (see OAR 461-195-0501), any overpayment of GA, OSIP, REF, SFPSS, or TANF program benefits is not counted as income when determining eligibility for the OCCS Medical programs, OSIPM, and REFM programs.¶
(16) Credit against an overpayment is allowed as follows:¶
(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless the Department authorized the procedure prior to its completion.¶
(b) In the SNAP program, if the overpayment was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.¶
(c) In the SFPSS and TANF programs, if the overpayment is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets eligibility under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF program benefits.¶
(d) In all programs, for an underpayment of benefits in the program in which the overpayment occurred.¶
(17) In the SNAP program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the overpayment amount unless the filing group was ineligible for SNAP program benefits. [~~Table not included. See ED. NOTE.~~see attached table]¶
(18) In the REF program, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(8)(a), the amount of the overpayment is the amount of cash benefits the client used or accessed.¶
(19) In the SFPSS and TANF programs, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(9)(a), the amount of the overpayment is the amount of cash benefits the client used or accessed.¶
~~[ED. NOTE: Tables referenced are available from the agency.]~~
Statutory/Other Authority: 329A.500, 413.085, 414.685, ORS 409.050, 411.060, 411.070, 411.404, 411.660, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231~~, HB 2089 (2013, Section 10)~~
Statutes/Other Implemented: 329A.500, ORS 409.010, 411.060, 411.070, 411.404, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231, 416.350

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

461-195-0521 Eff. ~~9-1-16~~7-1-19

Calculation of Overpayments

This rule specifies how the Department calculates an *overpayment* (see OAR 461-195-0501).

(1) The Department calculates an *overpayment* by determining the amount the client received or the payment made by the Department on behalf of the client that exceeds the amount for which the client was eligible.

(2) When a filing group, OCCS Medical programs *household group* (see OAR 410-200-0015), ineligible student, or *authorized representative* (see OAR 461-115-0090 and OAR 410-200-0015) fails to report income, the Department calculates and determines the *overpayment* by assigning unreported income to the applicable budget month without averaging the unreported income, except:

(a) A client's earned income reported quarterly from the Employment Department is considered received by the client in equal amounts during the months identified in the report.

(b) In the ERDC, ~~MAA, MAF,~~ REF, SNAP, and TANF programs, a client's actual self-employment income is annualized retrospectively to calculate the *overpayment*.

(c) In the OCCS Medical programs, if actual income is not available for the months in which an *overpayment* occurred, a client's actual self-employment income (see OAR 410-200-0015) received during the year when an *overpayment* occurred is annualized to calculate an *overpayment*.

(3) When using prospective budgeting (see OAR division 461-150) and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a *client error overpayment* (see OAR 461-195-0501) only when the filing group, ineligible student, or *authorized representative* withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an *overpayment*.

(4) When using anticipated income for the OCCS Medical programs and the actual income differs from the amount determined under OAR 410-200-0310, there may be a *client error overpayment* only when the OCCS Medical programs *household group* (see OAR 410-200-0015) or *authorized representative* (see OAR 410-200-0015) knowingly withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an *overpayment*.

(5) When a filing group, ineligible student, or *authorized representative* fails to report all earned income within the reporting time frame, the earned income deduction (see OAR

461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) is applied as follows:

(a) In the OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.

(b) In the ~~MAA, MAF,~~ REF~~,~~ and TANF programs, the Department allows the earned income deduction when *good cause* (see section (6) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income if the amount or source of income was not timely reported.

(6) For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.

(7) When support is retained:

(a) In the TANF program, the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine *eligibility* (see OAR 461-001-0000). When a client is not eligible for TANF program benefits, the *overpayment* is offset by the support the Department of Justice retains as a current reimbursement.

(b) In the medical programs, the amount of the cash medical support the Department retains each month is excluded income and not used to determine *eligibility* for medical program benefits. When a client has incurred a medical program *overpayment*, the *overpayment* is offset by the amount of the cash medical support the Department retains during each month of the *overpayment*.

(8) In the REF and TANF programs, when a client directly receives support used to determine *eligibility* or calculate benefits, the *overpayment* is:

(a) If still eligible for REF or TANF program benefits, the amount of support the client received directly; or

(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the client received.

(9) When an *overpayment* occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the *overpayment* is limited to the lesser of the following:

(a) The amount of the payment from the Department;

(b) Cash medical support; or

(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.

(10) Benefits paid during a required *notice period* (see OAR 461-175-0050, OAR 410-200-0120) are included in the calculation of the *overpayment* when:

(a) The filing group, OCCS Medical programs *household group* (see OAR 410-200-0015), ineligible student, or *authorized representative* (see OAR 461-115-0090 and OAR 410-200-0015) failed to report a change within the reporting time frame under OAR 461-170-0011 or OAR 410-200-0235; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the *overpayment* if the filing group, OCCS Medical program *household group* (see OAR 410-200-0015), ineligible student, or *authorized representative* (see OAR 461-115-0090 and OAR 410-200-0015) had reported the change at any time within the reporting time frame.

(11) In the SNAP program:

(a) If the *benefit group* (see OAR 461-110-0750) was categorically eligible, there is no *overpayment* based on resources.

(b) For a *filing group* (see OAR 461-110-0370) found eligible for SNAP program benefits under OAR 461-135-0505(1)(a) to (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for SNAP program benefits as long as the *eligibility* requirement under OAR 461-135-0505(1)(d) is met. A *benefit group* of one or two individuals would be entitled to at least the minimum SNAP program benefit allotment under OAR 461-165-0060.

(c) For a *filing group* found eligible for SNAP program benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the *filing group* is no longer categorically eligible. The *overpayment* is the amount of SNAP program benefits incorrectly received.

(12) In the OSIP and OSIPM programs, when a client does not pay his or her share of the cost of services (see OAR 461-160-0610) or the OSIP-EPD or OSIPM-EPD program *participant fee* (see OAR 461-160-0800) in the month in which it is due, an *overpayment* is calculated as follows:

(a) All payments made by the Department on behalf of the client during the month in question are totaled, including but not limited to any payment for:

(A) Capitation;

(B) Long term care services;

(C) Medical expenses for the month in question;

(D) Medicare buy-in (when not concurrently eligible for an MSP);

(E) Medicare Part D;

(F) Mileage reimbursement;

(G) Special needs under OAR 461-155-0500 to 461-155-0710; and

(H) *Home and community-based care* (see OAR 461-001-0030), including home delivered meals and non-medical transportation.

(b) Any partial or late liability payment made by a client receiving *home and community-based care* in-home services or *participant fee* paid by an OSIP-EPD or OSIPM-EPD program client is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the *overpayment*.

(13) When a client's liability is unreduced pending the outcome of a contested case hearing about that liability the *overpayment* is the difference between the liability amount determined in the final order and the amount, if any, the client has repaid.

(14) In the OCCS Medical programs, OSIPM, QMB, and REFM programs if the client was not eligible for one program, but during the period in question was eligible for another program:

(a) With the same benefit level, there is no *overpayment*.

(b) With a lesser benefit level, the *overpayment* is the amount of medical program benefit payments made on behalf of the client exceeding the amount for which the client was eligible.

(15) When an *overpayment* is caused by *administrative error* (see OAR 461-195-0501), any *overpayment* of GA, OSIP, REF, SFPSS, or TANF program benefits is not counted as income when determining *eligibility* for the OCCS Medical programs, OSIPM, and REFM programs.

(16) Credit against an *overpayment* is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the *overpayment*, in an amount not to exceed the Department fee schedule for the service, but credit is not

allowed for an elective procedure unless the Department authorized the procedure prior to its completion.

(b) In the SNAP program, if the *overpayment* was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(c) In the SFPSS and TANF programs, if the *overpayment* is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets *eligibility* under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF program benefits.

(d) In all programs, for an underpayment of benefits in the program in which the ~~overpayment~~ *overpayment* occurred.

(17) In the SNAP program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the *overpayment* amount unless the filing group was ineligible for SNAP program benefits.

Normal TFP for October 1, 2008 - September 30, 2009
SNAP Payment Standard (TFP)

No. in Need Group	Monthly Amount
1	$ 176
2	323
3	463
4	588
5	698
6	838
7	926
8	1,058
Each additional individual	132

(18) In the REF program, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(8)(a), the amount of the *overpayment* is the amount of cash benefits the client used or accessed.

(19) In the SFPSS and TANF programs, when an individual used or accessed cash benefits in violation of OAR 461-165-0010(9)(a), the amount of the *overpayment* is the amount of cash benefits the client used or accessed.

Stat. Auth.: ORS 329A.500, 409.050, 411.060, 411.070, 411.404, 411.660, 411.706, 411.816, 412.014, 412.049, 412.124, 413.085, 414.231, ~~HB 2089 (2013, Section 10)~~414.685

Stats. Implemented: ORS 329A.500, 409.010, 411.060, 411.070, 411.404, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231, 416.350

AMEND: 461-195-0541

RULE SUMMARY: OAR 461-195-0541 about liability for overpayments is being amended to make permanent temporary rule changes effective March 1, 2019 updating cross-references and indicating when authorized representatives are liable for overpayments. These changes are part of updating the authorized representative rules for Integrated Eligibility.

CHANGES TO RULE:

461-195-0541
Liability for Overpayments ¶

(1) In all programs except the OCCS Medical, OSIP, OSIPM, QMB, REFM, and SNAP programs or a child care program, the following persons are liable for repayment of an overpayment (see OAR 461-195-0501):¶
(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who did not reside with and did not know he or she was included in the filing group.¶
(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.¶
(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.¶
(d) An individual determined liable for an overpayment remains liable when the individual becomes a member of a new filing group.¶
(e) An authorized representative (see OAR 461-115-0090) when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information resulting in the overpayment.¶
(2) In the OCCS Medical and REFM programs, the following persons are liable for repayment of an overpayment:¶
(a) Each individual in the filing group, the OCCS Medical programs household group (see OAR 410-200-0015), or required to be in the filing group and the payee when the overpayment was incurred, except an individual who~~;~~ ---¶
(A) Was a child or dependent child (see OAR 461-001-0000) at the time of the overpayment; or¶
(B) Did not reside with and did not know he or she was included in the filing group.¶
(b) A caretaker relative and his or her spouse who were not part of, but resided with, the filing group or OCCS Medical programs household group (see OAR 410-200-0015) when the overpayment was incurred.¶
(c) A parent or caretaker relative of a child in the filing group or OCCS Medical programs household group (see OAR 410-200-0015) and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group or OCCS Medical programs household group when the overpayment was incurred.¶
(d) An authorized representative (see OAR 461-~~001~~115-00~~0~~90 and OAR 410-200-0015) when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.¶
(3) In a child care program:¶
(a) An overpayment caused by administrative error is collectible as follows:¶
(A) The provider is liable for a provider overpayment made on behalf of a client eligible for child care payments.¶
(B) Each adult in the filing group or required to be in the filing group is liable for an overpayment if the client was not eligible for the payment.¶
(b) Each adult in the filing group or required to be in the filing group is liable for a client overpayment, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged provider overpayment, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.¶

(c) An adult who cosigned an application with a minor provider applicant is liable for an overpayment incurred by the minor provider.¶
(d) An authorized representative (see OAR 461-115-0090) is liable for an overpayment when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.¶
(4) In the GA, OSIP, OSIPM, and QMB programs, the following persons are liable for repayment of an overpayment:¶
(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who; ---¶
(A) Was a child or dependent child at the time of the overpayment; or¶
(B) Did not reside with and did not know the or she was were included in the filing group.¶
(b) A caretaker relative and his or hetheir spouse who were not part of, but resided with, the filing group when the overpayment was incurred.¶
(c) A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.¶
(d) An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.¶
(5) In the SNAP program, the following persons are liable for repayment of an overpayment or a claim that results from trafficking (see OAR 461-195-0601(2)) of SNAP benefits:¶
(a) The primary person (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults (see OAR 461-001-0015) who were members of or required to be in the filing group (see OAR 461-110-0370) when excess benefits were issued.¶
(b) A sponsor of a non-citizen household member if the sponsor is at fault, for payments prior to November 21, 2000.¶
(c) A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the client.¶
(d) An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.¶
(e) For a claim that results in trafficking, the payee and the authorized representative when they actually traffic the benefits.¶
(6) Except as provided otherwise in section (7) of this rule, in all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had good cause (see OAR 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.¶
(7) In the SNAP program, the sponsor of a non-citizen is not liable under section (6) of this rule for payments on or after November 21, 2000.¶
(8) In the OCCS medical programs, the November 2013 amendments to OAR 461-195-0501, 461-195-0521, 461-195-0541, and 461-195-0561 apply as of October 1, 2013.
Statutory/Other Authority: ORS 409.050, 411.060, 411.404, 411.816, 412.014, 412.049, 2013 HB 2089 Sec. 10 329A.500, 413.085, 414.685
Statutes/Other Implemented: ORS 409.010, 411.060, 411.087, 411.404, 411.630, 411.635, 411.640, 411.690, 411.816, 412.014, 412.049, 416.350, 329A.500