CHAPTER 20
NAVIGATING MEDICAID ISSUES IN MOTOR VEHICLE CASES: RESOLVING LIENS, PRESERVING ELIGIBILITY

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I. INTRODUCTION

1.1 The Medicaid Maze.

The Medicaid program, a public-assistance system providing medical care for certain disabled and low-income individuals, is exceptionally complicated. The complexity begins with the text of the federal Medicaid law, which the United States Supreme Court has described as "an aggravated assault on the English language, resistant to attempts to understand it." Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981). Another federal judge has commented: "The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize." Mertz v. Houston, No. 01-2627, (E. D. Pa. July 31, 2001).

Adding to the complexity, Medicaid is governed by both federal and state law. In every State, the Medicaid program is administered locally, through state Medicaid agencies. In Oregon, Medicaid is administered through the Oregon Department of Human Services. Each state is free to enact its own statutes and administrative rules to regulate its Medicaid program, provided those statutes and rules comport with the overarching federal law. 42 USC 1396(a).

Congress established Medicaid as Title XIX of the 1965 Amendment to the Social Security Act. Title XIX of the Social Security Act is found in 42 USC Chapter 7. A good reference for exploring the Social Security Act is the Compilation of the Social Security Laws found at http://www.socialsecurity.gov/OP_Home/ssact/comp-ssa.htm. The website is easy to use and includes citations to the Social Security Act and to Section 42 of the United States Code.

ORS Chapter 411 is the enabling statute that gives the Oregon Department of Human Services the authority to administer and supervise all public assistance programs and to set eligibility rules for those programs. The administrative rules that govern the eligibility standards for Medicaid are found throughout Oregon Administrative Rules (OAR) chapters 461 and 410.

Within chapter 461, divisions 110, 115, 135, 140, 145, and 160 contain the majority of the Medicaid eligibility rules. Divisions 001 and 101 of chapter 461 also provide helpful definitions and acronyms used throughout all the eligibility rules. Division 195 lays out the rules governing liens against personal injury proceeds.

Due to the expansion of Oregon's Medicaid program under the Affordable Care Act, additional Medicaid eligibility rules can be found in chapter 410. As the pool of individuals potentially eligible for Medicaid in Oregon has grown, new rules have been promulgated (and are continuing to be promulgated as of this writing) to lay out the eligibility standards for the newly eligible.

1.2 Medicaid Coverage.

As described above, Medicaid is a joint federal-state program of medical assistance. Medicaid is not a single program, but rather a group of programs, each of which has unique benefits, rules, and eligibility requirements. Medicaid pays for a variety of health care and long-term care services through its different programs, all of which are administered in Oregon by the Oregon Department of Human Services ("DHS") and the Oregon Health Authority ("OHA").

Among the most common of Oregon's Medicaid programs is the Oregon Health Plan ("OHP"), which provides basic health insurance to certain disabled and low-income individuals. Historically, OHP has been divided into several subprograms, including "OHP Standard" and "OHP Plus." With Oregon's expansion of Medicaid coverage under the Affordable Care Act, the OHP Standard benefit package was eliminated effective January 1, 2014. OAR 410-120-0003. Under the new rules, individuals who previously received OHP Standard will now qualify for the full benefit package formerly known as OHP Plus. OHP Plus covers doctor visits; mental health care; addiction treatment; basic dental services; durable medical equipment; physical, occupational, and speech therapy, and other services.

Another common Medicaid program is the Oregon Supplemental Income Program Medical ("OSIPM"), which provides both basic health insurance and, in some cases, assistance with long-term care costs. Disabled individuals who receive Supplemental Security Income ("SSI") through the Social Security Administration are

automatically eligible for basic health insurance through OSIPM.

In addition to basic health insurance for recipients of SSI, the OSIPM program provides eligible individuals with coverage for long-term care costs. Oregon is one of 48 states whose Medicaid programs operate under a waiver allowed by Section 1915(c) of the Social Security Act. This waiver allows participating states to cover "community-based" long-term care services in addition to traditional nursing home care. The goal of community-based care is to enable eligible individuals to remain in the least restrictive and least costly setting consistent with their service needs. Because of the waiver, elderly and disabled Oregonians who meet the income, resource, and disability criteria for OSIPM can receive assistance paying for adult foster homes, assisted living facilities, in-home services, residential care facilities, and other specialized living facilities.

1.3 Medicaid Eligibility.

Although the different Medicaid programs are all based on financial need, there are important differences between them. From the perspective of the personal injury lawyer handling a motor vehicle claim, detailed knowledge of the specific program details is not necessary. However, a working knowledge of the most basic eligibility rules is helpful in resolving Medicaid liens and helping accident victims preserve their eligibility for benefits after a settlement or judgment.

Eligibility for OHP is based on income. Prior to the implementation of the Affordable Care Act, eligibility for OHP was based on both income and resources, and in order to qualify, applicants could not have significant amounts of either. The resource limit for OHP was $2000 ($3000 for a couple), and only those individuals with income at or below the Federal Poverty Level ("FPL") were eligible. Beginning in 2014, however, there is no longer a resource test for OHP, and coverage is available to people who earn up to 138% of the FPL (in 2015, this equates to approximately $16,242/year for an individual or $33,465/year for a family of four).

Eligibility for OSIPM is based on income, resources, and disability. As mentioned above, disabled individuals who receive SSI are automatically eligible for basic health insurance through OSIPM. OAR 461-135-0010(5)(a). In other words, when an individual has met the income, resource, and disability criteria for SSI, the state of

Oregon does not separately assess eligibility. However, in order to qualify for SSI through the Social Security Administration, an individual must meet be disabled (i.e., incapable of engaging in "substantial gainful activity"); must have resources of less than $2000 ($3000 for a married couple); and must have income of less than the "federal benefit rate (hereafter "FBR"), which in 2015 is $733/month.

Many individuals who qualify for OSIPM do not receive SSI; generally, these individuals qualify on the basis of their need for long-term care. Eligibility for long-term care benefits through OSIPM is also based on income, resources, and disability. However, unlike recipients of SSI who receive OSIPM Medicaid benefits automatically, applicants for long-term care services are assessed by DHS to determine if they meet the eligibility criteria. In order to qualify for OSIMP for long-term care, an individual must meet stricter disability criteria than those applicable to SSI recipients. In general, an applicant must require significant assistance in carrying out his or her activities of daily living (mobility, eating, dressing, etc.). OAR 461-015-0006. Assuming the disability criteria are met, an applicant must show that he or she earns no more than three times the FBR ($2199/month in 2015) and has no more than $2000 in available resources ($3000 for a couple). OAR 461-135-750; OAR 461-160-0015(3)(a).

1.4 Medicaid and Motor Vehicle Claims.

It is not necessary or practical for personal injury lawyers to become experts in all aspects of Medicaid eligibility, and detailed descriptions of the eligibility rules for all the various Medicaid programs are beyond the scope of these materials. However, familiarity with a few general principles of Medicaid law is critical to competent representation of Medicaid recipients. At a minimum, attorneys handling motor vehicle cases for Medicaid recipients should be aware that: 1) Medicaid in Oregon is comprised of numerous different programs with varying eligibility rules; 2) all Medicaid programs are means-tested, imposing either income limits, resource limits, or both; 3) because Medicaid is a "payer of last resort," proceeds of motor vehicle settlements/judgments are subject to unique and specific rules for lien resolution that vary from ordinary personal injury liens; and 4) receipt of a settlement or judgment from a motor vehicle accident frequently affects a Medicaid recipient's continued eligibility for benefits.

The remainder of these materials will provide guidelines for resolving Medicaid liens against settlement/judgment proceeds and for preserving Medicaid recipients' eligibility for benefits once a motor vehicle claim is resolved. A note of caution is warranted here because Medicaid is a highly complex—and ever-changing—area of the law. Every effort is made in these materials to provide accurate and up-to-date information on handling Medicaid issues in motor vehicle cases; however, as of this writing, may aspects of the Medicaid program are in flux. In addition to the information presented here, readers are encouraged to review the always-evolving statutes and administrative rules directly for changes and amendments, and to confer with competent Medicaid counsel and/or OHA/DHS personnel when handling motor vehicle claims for Medicaid recipients.

II. MEDICAID LIENS

2.1 Statutory Authority.

Both federal and state laws make clear that Medicaid is the "payer of last resort." Federal law and regulations require states to ensure that recipients use all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid—including liability settlements with third parties. 42 USC 1396(a)(25); 42 CFR 433.139. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, workers' compensation, long-term care insurance, settlements from a liability insurer, and other state and federal programs (unless specifically excluded by federal statute).

In general, if a state has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. Whenever a state has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party.

Oregon's implementation of the federal mandate to pursue liable third parties is codified at ORS 416.510-416.610. The administrative rules implementing the ORS provisions are located at OAR 461-195-0301 et. seq. The most helpful starting point in

understanding Medicaid liens in Oregon is OAR 461-195-0305, which provides as follows:

> **Lien of the Department**
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> (1) Whenever a recipient has a claim for damages for a personal injury, the Department shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise as a result of that claim for all assistance received from the date of the injury to:
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> (a) The date of satisfaction of the judgment favorable to the recipient; or
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> (b) The date of the payment under the settlement or compromise.
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> (2) The person or public body, agency or commission bound by the judgment, settlement, or compromise shall be responsible for immediately informing the Department's Personal Injury Liens Unit when a judgment has been issued or a settlement or compromise has been reached so that the exact amount of the Department's lien may be determined. For the purposes of this rule, immediately means within ten calendar days. If the Department is not timely notified, the 180 day limitation in ORS 416.580(1) does not begin to run until the Department's Personal Injury Liens Unit has actual notice of a settlement, compromise, or judgment.
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> (3) The lien will not attach to the amount of any judgment, settlement, or compromise to the extent of the attorney fees, costs and expenses which the Recipient incurred in order to obtain that judgment, settlement, or compromise.
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> (4) The lien will not attach to the amount of any judgment, settlement, or compromise to the extent of medical, surgical and hospital expenses personally incurred by such recipient on account of the personal injury giving rise to the claim, for which assistance was not provided or paid. For purposes of OAR 461-195-0301 to 461-195-0350, personally incurred expenses are limited to those expenses not covered by the Department, and for which the client is personally liable at the time of judgment, settlement, or compromise.
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> (5) The Department's lien must be satisfied or specific approval must be given by the Department's Personal Injury Liens Unit's staff before any portion of the claim judgment, settlement, or compromise is released to the recipient. There is a rebuttable presumption that the entire proceeds from any judgment, settlement, or compromise, are, unless otherwise identified, in payment for medical services. The Department shall have a cause of action against any person, public body, agency, or commission bound by the judgment, settlement, or compromise who releases any portion of the claim judgment, settlement, or compromise to the recipient before meeting this obligation. "Whenever a [Medicaid] recipient has a claim for damages for a personal injury, the Department shall have a lien upon the

> amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise as a result of that claim for all assistance received from the date of injury to (a) [t]he date of satisfaction of the judgment favorable to the recipient; or (b) [t]he date of the payment under the settlement or compromise."

Some elements of this rule are self-explanatory, but others require elaboration, particularly in light of judicial and legislative developments since 2006. Properly satisfying the lien described in this rule requires compliance with the remaining provisions of Division 195, several of which are worth considering separately.

2.2 Reporting Requirements.

Personal injury lawyers are subject to reporting requirements separate from those described in Subsection (2) of the rule above, which applies only to entities *bound by* a judgment, settlement or compromise. For attorneys initiating a motor vehicle claim the operative reporting requirement is found in OAR 461-195-0310, which provides as follows:

> **Notice of Claim or Action by Applicant or Recipient**
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> (1) An applicant for or recipient of assistance who has a claim for a personal injury or begins an action to enforce such claim, ***or the attorney or authorized representative (see OAR 461-115-0090) for the applicant or recipient***, is required to notify the Department, the prepaid managed care health services organization, and the coordinated care organization (see OAR 410-141-0000) of the recipient, if the recipient is receiving services from the organization, within ten days of initiating that claim or action, unless the action was initiated prior to the application for assistance.
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> (a) If the action was initiated prior to the application for assistance, the applicant must notify the Department at the time of application.
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> (b) The notification must include:
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> (A) The names and addresses of all parties against whom the action is brought or claim is made;
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> (B) A copy of each claim demand; and
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> (C) If an action is brought, identification of the case number and the county where the action is filed.

(c) A parent, guardian, foster parent or caretaker relative must make the notification on behalf of a minor or incompetent adult.

(2) The reporting requirements in section (1) of this rule are mandatory reporting requirements.

(3) Notification by an attorney or authorized representative for an applicant or recipient or other person required to provide notification must be sent to the Personal Injury Liens Unit, Office of Payment Accuracy and Recovery, Department of Human Services, either by mail or fax.

(4) The mailing address for the Personal Injury Liens Unit is: Personal Injury Liens Unit, PO Box 14512, Salem OR 97309-0416.

(5) The Personal Injury Liens Unit's fax number is (503) 378-2577 and telephone number is (503) 378-4514.

(6) If an applicant for or recipient of assistance fails to give the notification as required by this rule, the Department or the prepaid managed care health services organization of the recipient, if the recipient is receiving services from the organization, will have a cause of action under ORS 416.610 against the recipient for amounts received by the recipient pursuant to a judgment, settlement, or compromise to the extent that the Department or the prepaid managed care health services organization could have had a lien against such amounts had such notice been given. At least 30 days prior to commencing an action under ORS 416.610, the Personal Injury Liens Unit and the prepaid managed care health services organization, if any, must consult with each other.

This is arguably the most important rule for personal injury attorneys handling motor vehicle claims on behalf of Medicaid recipients. Often, Medicaid recipients are unaware of the obligation to report the existence of a personal injury claim before any funds are received. And yet, failure to provide the notice required by this rule can subject Medicaid recipients to liability under ORS 416.610, which provides a statutory cause of action for DHS and/or OHA in cases where the required notice is not provided. Arguably, such causes of action have malpractice implications for personal injury lawyers who fail to either advise their clients of the reporting requirement or make the required report to DHS themselves.

As the rule above indicates, the group within DHS responsible for resolving Medicaid liens is the Personal Injury Liens Unit. For motor vehicle claims, the Personal Injury Liens Unit has developed a simple and convenient form that attorneys can use to

report claims. The form is available from the Personal Injury Liens Unit's website at: https://apps.state.or.us/Forms/Served/de0451.pdf. A copy of the form is included in these materials as Exhibit 1.

2.3 Avenues for Reducing Medicaid Liens.

Medicaid liens, and the avenues available for reducing them, have been the subject of significant confusion and controversy in recent years. The statutory provisions identified above lay out only two specific limitations on the amount of the lien. First is the limitation contained in Subsection (3) of OAR 461-195-0305, which provides that Medicaid liens "…will not attach…to the extent of the attorney fees, costs, and expenses which the Recipient incurred in order to obtain [the] judgment, settlement, or compromise." Second is the limitation contained in OAR 461-195-0320, which provides as follows:

> **Release of Lien for Future Medicals**
>
> (1) To qualify for consideration of a full or partial release of the State's share of the Department's lien (including the amount of an assigned lien) pursuant to ORS 416.600, the recipient must demonstrate, through documentation satisfactory to the Department, that:
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> (a) As a result of the personal injury for which the recipient has a claim, the recipient has a medical condition which will require future medical treatment;
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> (b) The nature of future medical treatment;
>
> (c) The date on which the future medical treatment can reasonably be expected to occur;
>
> (d) The anticipated cost of the future medical treatment;
>
> (e) The amount of the settlement, compromise, or judgment awarded the recipient;
>
> (f) Timely compliance by the recipient with the notification requirements; and
>
> (g) Any other documentation requested by the Department.
>
> (2) In considering a request for a full or partial release of a lien pursuant to ORS 416.600, the Department may take into account:

(a) Whether the recipient has provided the documentation required by section (1) of this rule;

(b) Whether the future medical treatment is likely to occur in the near future. The Department will evaluate this factor in light of the nature and certainty of the type of medical treatment anticipated;

(c) Whether the amount of the settlement, compromise, or judgment is sufficient to pay the future medicals and all or part of the Department's lien;

(d) Whether the recipient has or is likely to have another source for payment of the future medical expenses;

(e) The effect, if any, of the requested release on the continuing eligibility for future medical or public assistance of the recipient;

(f) Any other factor deemed relevant by the Department, including information received from a prepaid managed health care services organization;

(g) In the event the recipient is a minor, the provisions of OAR 461-195-0350 may apply.

(3) In no case will the Department consider a request for a partial or full lien release pursuant to ORS 416.600 unless the recipient and the liable third party have entered into a final, binding settlement or compromise agreement or the recipient has received a final judgment. In every case, the lien amount that represents the federal share of Title XIX or Title XXI payments must be repaid to the federal government and shall not be subject to partial or full lien release.

It is worth noting that in order to be considered for a release of part or all of a lien under this rule, a recipient must demonstrate timely compliance with the notification requirements described above. It is also worth noting that one of the factors DHS considers is whether the recipient is likely to have another source for payment of future medical expenses. If a Medicaid recipient intends to remain eligible for Medicaid post-settlement (as most do), a release under this rule is unlikely.

Unfortunately, the provisions described in this Section 2.3 do not provide avenues for significant lien reductions in most cases. Although other, more powerful avenues are available as of this writing (see Section 2.4), recent changes in federal law may well limit the avenues available for reducing Medicaid liens to those described here.

2.4. The Federal Anti-Lien Provision and the *Ahlborn* Decision.

Before passage of the Bipartisan Budget Act of 2013, federal Medicaid law—and a number of U.S. Supreme Court decisions interpreting it—provided a far more potent approach for limiting the reach of Medicaid liens than those described above. 42 USC 1396p, which is sometimes referred to as the "anti-lien provision" of the Medicaid law, generally prohibits states from placing liens against Medicaid recipients' property prior to their deaths. In a landmark case, *Arkansas Department of Health & Human Services v. Ahlborn,* 547 U.S. 268 (2006), the U.S. Supreme Court addressed the apparent contradiction between the anti-lien provision and the third party liability provisions of the Medicaid Act (located at 42 USC 1396(a)), which require state Medicaid agencies to seek reimbursement of Medicaid expenditures from liable third parties. In its unanimous decision, the Supreme Court resolved the apparent conflict, limiting the reach of state Medicaid agencies' liens against personal injury settlements and judgments.

In order to understand the current state of federal Medicaid law governing personal injury liens, it is necessary to trace the history of the *Ahlborn* decision and its implementation to the present day. Although *Ahlborn* appears to have been legislatively overruled (as described further below), it is not clear, as of this writing, how and when the federal law overruling it will be implemented. In order to provide accurate and effective advice to motor vehicle accident victims who receive Medicaid, both the *Ahlborn* rule and the new legislation obviating it must be considered.

2.4(a) *Ahlborn* Background.

In 1996, Arkansas resident Heidi Ahlborn suffered permanent brain damage resulting from a car accident. Lacking the resources to pay for her medical care, Ahlborn applied for Medicaid through the Arkansas Department of Health and Human Services (hereafter "ADHS"). As a condition of eligibility for Medicaid, Arkansas law required that Ahlborn assign to ADHS her right to any settlement, judgment, or award she might obtain against any third party, up to the full amount of Medicaid benefits she received. ADHS deemed Ahlborn eligible for benefits, and ultimately paid out $215,645.30 on her behalf.

Ahlborn sued the alleged third-party tortfeasors in state court, seeking damages for past and future medical costs; permanent physical injury; past and future pain, suffering, and mental anguish; and past and future loss of earnings. In 2002, her case settled out of court for $550,000.00, a sum representing approximately one-sixth of the total value of her claim. Initially, no allocation was made between the various categories of damages, but the parties later stipulated that only $35,581.47 of the total settlement represented compensation for past medical expenses. ADHS did not participate (nor did it ask to participate) in the settlement negotiations. Instead, acting pursuant to Arkansas statute, ADHS asserted a lien against the settlement proceeds for the full $215,645.30 it had paid on Ahlborn's behalf.

Ahlborn challenged the lien in federal court, relying on the "anti-lien provision" of the Medicaid Act. The anti-lien provision generally bars states from imposing liens against the property of Medicaid recipients prior to death. 42 USC 1396p(a)(1). Ahlborn argued that ADHS's lien violated the anti-lien provision to the extent that its satisfaction would force her to turn over settlement funds not allocable to past medical expenses. She maintained that the settlement was her property, and that the forced assignment to ADHS applied only to that portion of the settlement allocable to past medical expenses.

ADHS contended that the anti-lien provision did not prevent full recovery because, as a condition of Medicaid eligibility, Ahlborn had assigned to the State her right to any settlement paid by a third party who was liable for her medical costs. The agency invoked the third-party liability provisions of the Medicaid Act which, among other things, require states to:

- Ascertain the legal liability of third parties for the injury-related medical expenses of Medicaid recipients;
- Seek reimbursement of Medicaid costs from liable third-parties to the extent of their liability; and
- Enact laws empowering state agencies to recover injury-related medical costs (including forced assignments).

42 USC 1396a(a)(25); 42 USC 1396k(a).

ADHS's position rested on its assertion that the settlement proceeds remained the property of the third party tortfeasors until the Medicaid program was fully reimbursed for the funds it had expended on Ahlborn's medical care.

The District Court sided with ADHS, holding that it was entitled to a lien in the full amount expended on Ahlborn's behalf ($215,645.30). The Court found no conflict between the federal anti-lien provision and the Arkansas statute giving ADHS the right to recover the full amount of its expenditures, regardless of allocation. The Eighth Circuit reversed this decision, holding that ADHS could only recover from that portion of the settlement allocable to past medical expenses.

The Supreme Court unanimously affirmed the Eight Circuit, holding that the third-party liability provisions of the Medicaid Act cannot and do not trump the anti-lien provision. Addressing the arguments put forth by ADHS, the Court recognized that the anti-lien provision of the Medicaid Act cannot be read in isolation, as such a reading would bar all liens (including liens against settlement funds properly allocated to past medical care). The Court acknowledged that under the third-party liability provisions, states are specifically authorized to require "forced" assignments of third-party reimbursements as a condition of eligibility. However, the Court held that those provisions are exceptions to the anti-lien provision:

> To the extent that the forced assignment [of settlement proceeds] is expressly authorized by the terms of [the Medicaid Act], it is an exception to the anti-lien provision.... But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception... is limited to payments for medical care. Beyond that, the anti-lien provision applies.

The Court thus limited the reach of the third-party liability provisions of federal Medicaid law.

To ADHS's concern that parties to personal injury disputes might manipulate settlements and allocate away states' interests, the Court responded that the risk of manipulation could be avoided, either "...by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a

court for decision." This part of the opinion, though technically dictum, in some ways impacted the process of Medicaid lien negotiation and resolution more than the case's central legal holding.

2.4(b) Ahlborn's Impact Generally.

In the immediate aftermath of the decision, the Centers for Medicare and Medicaid Services ("CMS") issued a Memorandum clarifying the third-party recovery rules. The Memorandum, a copy of which is attached as Exhibit 2, advised Regional Medicaid Administrators of the *Ahlborn* ruling, and suggested that it could result in significant changes in the resolution of Medicaid liens. The Memorandum stated:

> Prior to the Supreme Court's decision in Ahlborn, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.

The Memorandum went on to include a list of "State Actions Prohibited Under Ahlborn," as well as a list of "State Actions Which Would Mitigate the Adverse Consequences of Ahlborn."

CMS's list of prohibited state actions can be summarized as generally precluding enforcement of state Medicaid laws (including forced assignment laws) to the extent that such laws purport to reach settlement funds properly allocated to non-medical damages. The list of suggested mitigating state actions—which is both longer and more specific--includes (but is not limited to) the following:

- Active involvement by state Medicaid agencies in the litigation and settlement process;
- Passage of state laws requiring mandatory joinder of a state when a Medicaid lien is at issue;

- Strengthening of notification and cooperation requirements for attorneys, such that non-compliance (i.e., failure to notify) could render settlements voidable;
- Passage of state tort and/or insurance laws giving priority to payment of medical expenses and/or permitting settlement only with state's consent;
- Use of cost-effectiveness criteria for determining which liability settlements should be pursued for recovery of Medicaid expenses;
- Pursuit of a lesser amount than the full cost of care in order to avoid litigation.

The Memorandum made clear that, in the view of CMS, all of these suggested mitigating actions comport with federal Medicaid law.

The *Ahlborn* decision was not uniformly interpreted and applied in every state. Some states enacted new laws specifically addressing *Ahlborn*, and setting out formal procedures for allocating settlements (see, for example, California Welfare and Institutions Code Section 14124.76). At least one state enacted a strict statute requiring the written consent of the state Medicaid agency before a claim involving a Medicaid recipient could be commenced or settled. Utah Code Ann. 26-19-7(1)(a). Still other states, including Oklahoma, Idaho, and Oregon, enacted laws or administrative rules creating a rebuttable presumption that all settlement proceeds are in payment for medical services. 63 Okla St. 5051.1(d); I.C. 56-209b; OAR 461-195-0305.

2.4(c) Oregon's Initial Position Vis-à-Vis Ahlborn.

Shortly after *Ahlborn* was decided, representatives of DHS's Personal Injury Liens unit circulated two letters commenting on the decision. (See Letters from Susie Smith and Angela Molthan, attached as Exhibit 3.) Although the first letter addressed the central holding of the case (i.e., the limitations on personal injury liens required by the anti-lien provision), its focus was the reporting obligation imposed by ORS 416.530 and OAR 461-195-0310. As explained above, these provisions of Oregon law require Medicaid applicants and recipients,

or their attorneys, to immediately notify DHS whenever a personal injury claim is made against a potentially liable third party. The second letter focused almost entirely on the reporting obligation.

In addition to shining a light on the statutory reporting obligation, the DHS letters suggested that, in the wake of *Ahlborn*, failure to timely notify DHS would have serious consequences. Specifically, the letters stated that in cases where DHS was not given timely notice of a claim, and was therefore not included in settlement negotiations regarding the claim, it would explore "any and all legal means for challenging any resulting settlement agreement." The letter cited ORS 416.610, 416.580, and 95.230 (attached as Exhibit 4) as possible avenues for such challenges.

Since *Ahlborn* was decided, Oregon DHS has sought to follow the advice of CMS and participate actively in the litigation and settlement process. The agency has made clear that unless it is included in settlement negotiations, it will challenge allocations it deems suspect. However, the extent to which the *Ahlborn* decision created opportunities for Medicaid lien reduction based on settlement allocation was never clearly defined.

Oregon law governing Medicaid liens in personal injury cases does not specifically address the *Ahlborn* ruling. The statutory provisions, located at ORS 416.510 through 416.610, are substantially reiterated in the implementing administrative rules, located at OAR 461-195-301 through 461-195-350, and neither source offers formal guidelines or procedures for proper allocation of settlements. However, the administrative rules, which generally provide greater detail than the statutes, do state DHS's default position with regard to allocation. OAR 461-195-0305(5) states: "There is a rebuttable presumption that the entire proceeds from any judgment, settlement, or compromise, are, unless otherwise identified, in payment for medical services."

Like several other states, Oregon has enacted a presumption that, if not successfully rebutted, will produce the same result as the Arkansas statute at issue in *Ahlborn* (i.e., full recovery of all Medicaid expenditures). Because the rule allows for the possibility of other allocations, it does not run afoul of the *Ahlborn*

holding. However, the circumstances in which settlement proceeds may be "otherwise identified" (i.e., allocated to damages other than past medical expenses) are nowhere defined.

This author has spoken repeatedly with Lien Coordinators and supervisors at the Personal Injury Liens Unit regarding DHS's interpretation and application of the *Ahlborn* decision, and has confirmed that DHS has no fixed methodology for lien valuation or approval of settlement allocation. On the contrary, DHS personnel have indicated that each case is evaluated individually, taking into account all relevant facts and circumstances. One Lien Coordinator followed up with a letter, attached as Exhibit 5, quoting Assistant Attorney General Gretchen Merrill as saying: "The Supreme Court in Ahlborn did not require any methodology for valuation; rather, that was a specific factual stipulation entered into by the parties, and it is not binding on the State of Oregon, absent any statute or law otherwise."

2.4(d) Post-Ahlborn Developments.

Seven years after the *Ahlborn* decision, the Supreme Court affirmed its holding by striking down a North Carolina statute imposing a mandatory Medicaid lien on up to one-third of a recovery. In *Wos v. EMA ex rel. Johnson*, 133 S. Ct. 1391 (2013), the Court stated that "[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses."

Although the *Wos* decision bolstered the principle laid out in Ahlborn, that principle may cease to apply as of October 1, 2016 when Section 202 of the Bipartisan Budget Act of 2013 ("BBA") takes effect. In late 2013, Congress inserted language into the BBA amending the federal Medicaid law to give states the right to recover from Medicaid beneficiaries' *entire* settlements. This legislation effectively negates the rulings in *Ahlborn* and *Wos*, eliminating the most effective avenue for reducing a Medicaid lien against a personal injury settlement.

As of this writing, it is not known exactly how or when Oregon DHS will implement the changes mandated by the BBA. In the initial legislation, the effective date was to be October 1, 2014, but congress has delayed it to October 1, 2016. One likely point of contention going forward will be the effect of the October 1, 2016 effective date. It is unclear whether the increased right to recover will apply to *settlements* that take place after October 1, 2016 or only to *beneficiaries* who assigned their recovery rights (i.e., applied for Medicaid) after October 1, 2016. If the latter, then presumably the rubric established under *Ahlborn* will continue to apply to a very large class of Medicaid recipients for a long time to come. If the former, the possibility of allocating settlements to minimize Medicaid lien exposure will be short-lived.

Although there is much uncertainty surrounding the resolution of Medicaid liens in the wake of the Biparisan Budget Act of 2013, some aspects of Medicaid lien resolution remain clear. First and most important, attorneys should be diligent in complying with the reporting obligation of ORS 416.530 and OAR 461-195-310. Second, in some cases DHS may be willing to reduce or waive its lien in consideration of a recipient's expected future medical expenses. Finally, settlements that take place prior to October 1, 2016 are subject to possible allocation (and resulting lien reduction) under *Ahlborn*.

Going forward, personal injury attorneys handling motor vehicle claims for Medicaid recipients should pay close attention to changes in the law but should not assume that a lien reduction under *Ahlborn* is not possible. In fact, until the operation of the BBA's effective date is more clearly defined, attorneys should analyze whether a lien reduction under *Ahlborn* is available in every case.

Of course, attorneys should bear in mind that DHS has emphasized the reporting obligation because it intends to prevent parties to personal injury disputes from allocating away its interest. In Oregon, where no formula or methodology exists to guide the *Ahlborn* process, it is critical to seek a negotiated agreement with DHS regarding the equitable allocation of the settlement. In cases where a negotiated agreement on allocation cannot be reached, it may be necessary to submit the matter to a court for decision, as the *Ahlborn* opinion

suggested. Although DHS is generally quite zealous in defending its positions, some factual circumstances (and the proposed allocations that stem from them) might inspire DHS to apply one of CMS's suggested mitigating actions and "[pursue] a lesser amount than the full cost of care in order to avoid litigation." In some cases, including those where negotiation proves difficult or court action appears necessary, it may be prudent to retain, or co-associate with, advisors who have experience dealing with Oregon DHS and expertise navigating the maze that is Medicaid law.

III. PRESERVING ELIGIBILITY

3.1 To Preserve or Not to Preserve.

When a Medicaid recipient receives a settlement or judgment as the result of a motor vehicle accident, careful planning is required to prevent a loss of medical coverage. This does not mean that in every case the individual *must* remain eligible for Medicaid; after all, in light of the Affordable Care Act, individuals who lose Medicaid coverage may have other affordable options available to them, such as private insurance through Cover Oregon, the new health insurance exchange under the ACA. However, any time a Medicaid recipient receives a settlement or judgment, his or her medical coverage situation should be analyzed to determine: 1) whether and how the funds will affect continued eligibility for benefits; 2) whether steps can (or should) be taken to preserve Medicaid eligibility; 3) whether the individual has viable health insurance options other than Medicaid; and 4) whether a special needs trust or other vehicle is available to shelter settlement funds for purposes of Medicaid. Although new alternatives are becoming available, Medicaid remains a crucial resource for most recipients. Any decision to forego eligibility should me made only after careful consideration.

3.2 Determining the Impact of a Settlement/Judgment.

As explained above, Medicaid comes in many shapes and sizes, and every Medicaid program has different eligibility rules. Accordingly, there is no simple answer

to the question of how a personal injury settlement or judgment will affect continued eligibility for benefits. In addition to the variety of different Medicaid programs, other factors influence whether a settlement will affect eligibility, including whether the client opts for a lump-sum payout or a structured settlement annuity. Although the many variables and permutations of each individual case will always require analysis, following are some general guidelines for determining the impact of both lump-sum and structured settlements for two of the most common Medicaid programs in Oregon:

3.2(a) OHP. If an individual receives OHP based on having income of less than 138% of the FPL, a lump-sum settlement or judgment will not necessarily impact his or her continued eligibility. Because eligibility for OHP is now entirely income-driven (i.e., because there is no longer a resource test for this particular type of Medicaid assistance), the receipt of lump-sum settlement funds, for many individuals, is no longer a benefit-ending event. However, there are potential impacts on eligibility that should be considered.

The first potential impact of a lump-sum settlement on an OHP recipient has to do with the distinction in federal and state Medicaid law between "income" and "resources." Money is considered to be "income" in the month it is received, and a "resource" thereafter. Thus, in the month that a Medicaid applicant or recipient receives a lump-sum settlement or judgment, his or her income will likely exceed one-twelfth of 138% of the FPL, rendering him or her ineligible. However, in the following month, the settlement funds will be counted as a "resource" rather than as "income." Since there is no longer a resource test for OHP, the applicant or recipient should become eligible again the month after receiving a lump sum settlement or judgment.

As of this writing, it is not clear how DHS and OHA intend to handle situations in which an OHP recipient becomes temporarily ineligible due to receipt of lump-sum settlement funds. It is possible that for such temporary spikes in income, it will be too administratively costly and complicated for the agency to process a termination and quick renewal of eligibility. However, the new OAR provisions implementing the ACA do provide a mechanism for

temporary ineligibility. Accordingly, personal injury attorneys representing Medicaid recipients should advise their clients to seek advice from competent Medicaid counsel and/or agency caseworkers prior to finalizing a case.

Another, more serious potential impact of a lump-sum settlement or judgment on an OHP recipient is the income derived from the lump-sum. Although the lump-sum itself will be treated as a resource the month after it is received, all interest, dividends, and other income attributable to the lump-sum will constitute countable income. Under the new rules governing the expanded Medicaid, income is determined using "…the same financial methodologies used to determine MAGI [modified adjusted gross income] as defined in section 36B(d)(2)(B) of the [Internal Revenue] Code." OAR 410-200-0010(49). Because interest and dividend income are includable in MAGI, they are countable for purposes of OHP. Thus, an OHP recipient whose pre-settlement income approaches 138% of FPL may find him or herself ineligible as a result of the marginal increase in MAGI income resulting from interest and dividends. Determining the impact of investment income on lump-sum settlement or judgment funds requires careful analysis, and personal injury attorneys representing Medicaid recipients should advise their clients to seek legal advice from competent Medicaid counsel and financial advice from knowledgeable financial planners prior to finalizing a case.

If a client who receives OHP chooses a structured settlement annuity in lieu of a lump-sum payout, the eligibility analysis may be more straightforward. This is because both the initial settlement amount (i.e., the amount used to fund the structured settlement annuity) and the interest earned over the life of the annuity are excluded from the client's MAGI so long as the structure qualifies for tax exempt treatment under Section 104(a)(2) of the Internal Revenue Code. Most structured settlement annuities established in cases of personal, physical injury qualify for this tax-exempt treatment. Thus, if an individual has pre-settlement income of 137% of FPL, an annuity payment that increases his monthly income will not result in a termination of benefits, even if the annuity payment is significant. Although the annuity funds might increase the client's

monthly income over 138% of FPL in pure dollar terms, they do not increase MAGI income (taxable income), and thus do not affect the client's ongoing Medicaid eligibility.

At first blush, it might appear that structured settlement annuities are a panacea, but as with other aspects of Medicaid, attorneys should avoid making this assumption. While structured settlements may be a useful approach for many OHP recipients, they can pose just as much of a threat as lump-sum settlements for clients who receive other types of Medicaid (see Section 3.2(b) below). Also, a decision to structure a settlement should only be made after considering the entirety of client's post-injury financial and life circumstances. Since lump-sum settlements are also an option for some OHP recipients under the newly expanded Medicaid, all options should be considered, and their ramifications weighed, before finalizing a settlement plan.

3.2(b) OSIMP. If an individual receives OSIPM based on either "assumed eligibility" (i.e., automatic eligibility as a result of entitlement to SSI) or long-term care needs, both lump-sum and structured settlements are likely to impact eligibility. A lump-sum settlement is likely to place the individual over the $2000 resource limit applicable to OSIPM, and a structured settlement annuity may well place the individual over the applicable income limit ($733/month for SSI recipients, and $2199/month for long-term care recipients in 2015). Either of these results can be disastrous for OSIPM recipients, all of whom are disabled and many of whom have no other means for covering their medical and long-term care costs.

For clients who receive Medicaid assistance through the OSIPM program, settlement planning is critical. Unlike eligibility for OHP, which is based on income alone, eligibility for OSIPM is based in income, resources, and—importantly—disability. This group faces stricter eligibility rules, and often has a greater need to preserve eligibility, than recipients of other types of Medicaid.

3.2(c) Obtaining Accurate Benefits Information. Unfortunately, clients are frequently unaware of exactly which program provides their benefits. Many public benefits programs have names that sound similar to each other (Medicare/Medicaid; SSDI/SSI), and clients routinely confuse them. Clients enrolled in the Oregon Health Plan may not even realize that they are receiving Medicaid assistance. Also, many Medicaid recipients receive benefits from multiple programs simultaneously, and may not be aware of the distinct sources of those benefits.

Because Medicaid recipients and their families are often confused about exactly which programs they are enrolled in, attorneys must not rely solely on clients' statements in identifying benefits. Instead, this information should be obtained by asking the client questions that will elicit "clues" as to the nature of the benefits received. For example, an attorney can ask about the disabled person's resources. If the individual has assets (other than a home, a car, and certain other "exempt" assets) in excess of $2000, there is a strong possibility that the client is receiving OHP and not OSIPM. The key point is that follow-up questions are required in every case, since clients are not always able to provide accurate information about the benefits being received.

After informally soliciting additional information about the benefits received by the disabled individual, an attorney should always follow up and verify the information by communicating directly with the agencies providing the benefits. This generally requires a Release signed by the disabled individual or his or her legal representative. However, obtaining a Release and requesting confirmation of benefits from the relevant agencies is time well spent, as it can avoid costly errors. Accurately identifying the benefits in a particular case is a prerequisite to choosing an appropriate plan for preservation of eligibility.

3.3 Options for Minimizing the Impact of Settlement/Judgment.

Medicaid recipients who receive a settlement or judgment from a motor vehicle claim have a number of options for preserving their eligibility, and the options available depend on the specific Medicaid benefit received. Some of these options allow the

Medicaid recipient to remain eligible indefinitely while at the same time allowing them ongoing use and benefit of the funds. These options, and the prerequisites for employing them, are summarized below.

3.3(a) OHP Recipients: Income Planning. As discussed above in Section 3.2(a), OHP recipients whose eligibility is based solely on income can often take both lump-sum and structured settlements with minimal impact on their eligibility for benefits. Although planning is required in all cases to determine whether a settlement will place a client over 138% of the FPL, the planning is focused entirely on analysis of income. While there is some risk of a temporary interruption in eligibility due to a spike in income in the month a settlement is received, careful financial planning should avoid ongoing eligibility issues in most cases.

3.3(b) OSIPM Recipients: Spend-Down. For recipients of OSIPM, preserving eligibility is more complicated because they are subject to income limits, resource limits, and disability requirements. The resource limit, in particular, creates a dilemma for OSIPM recipients, because any settlement or judgment in excess of $2000 places them at risk of losing their benefits.

One of the simplest, if not always the most desirable, approaches to preserving Medicaid eligibility is the "spend-down." Medicaid rules that govern the OSIPM program draw a distinction between "available" resources and "excluded" resources. Excluded resources are not considered when a client's eligibility and benefits level are determined. OAR 461-140-0010. Thus, one simple planning option for a recipient of a settlement or judgment is to "spend-down" the funds on resources that are excluded and will not affect Medicaid eligibility.

The list of excluded resources is fairly short and straightforward. All resources not specifically identified as being excluded count toward the $2000 resource limit. Excluded resources include the following:

- The Home: The home is not counted for Medicaid eligibility purposes if the client or the spouse of the client occupies the home and the equity in the home is $536,000 or less. OAR 461-145-0220(2)(a)(B);
- The Car: The value of one car is excluded from the resource calculation. The total value of the vehicle is excluded if "used for employment or necessary and continuing medical treatment." OAR 461-145-0360. This definition is interpreted broadly. Medicaid caseworkers generally automatically exclude the value of one car during the resource assessment. If a client has two cars, Medicaid allows the client to exclude the value of the more expensive car.
- Burial Plans: The value of an irrevocable burial plan is excluded, regardless of the value.
- Burial space/merchandise: Pre-paid burial spaces and merchandise are also excluded resources. OAR 461-145-0050. The burial space can be designated for the client, the spouse, children, siblings, parents, and the spouse of any of these people.
- Personal Property: Personal belongings are excluded resources. OAR 461-145-0390. Personal belongings include household furnishings, clothing, heirlooms, keepsakes, and hobby equipment. There is no limit on the value of personal property that is excluded.

In some cases, a spend down can make good practical and financial sense for a client. For example, in the case of a modest settlement, a disabled person who is able to drive may choose to buy a vehicle (or trade in an existing vehicle for a newer model) with the settlement funds. Alternately, an OSIPM recipient might pre-pay his or her burial expenses or purchase new furniture, computer/electronic equipment, or adaptive technologies not covered by Medicaid. In cases involving larger settlements, clients may choose to purchase a home, thereby eliminating their monthly rent payment and dramatically improving their financial situation.

It should be noted that regardless of the type of excluded resources purchased with settlement funds, there are issues of timing and documentation

that need to be carefully considered in order for a spend-down plan to successfully preserve Medicaid eligibility. Additionally, in the case of a home purchase, careful consideration must be given to the costs of maintenance and property taxes and the wherewithal of the disabled person to cover these on a fixed income. Most OSIPM recipients will need the assistance of competent Medicaid counsel in order to properly implement a spend-down plan.

3.3(c) OSIPM Recipients: Special Needs Trusts. Probably the best-known vehicle for preserving Medicaid eligibility in the wake of a motor vehicle settlement or judgment is the special needs trust (hereafter "SNT"). It is important to note that while SNTs are extremely useful in appropriate cases, they are not available to, or appropriate for, all Medicaid recipients. As described more fully below, SNTs are narrowly defined by federal and state law as being available only to *disabled* Medicaid recipients. Thus, they are not an option for the new class of Medicaid recipients whose eligibility is based solely on income (i.e., those with incomes under 138% of the FPL who are receiving OHP under the Affordable Care Act).

SNTs come in many shapes and sizes, influenced by a variety of factors. To begin with, every disabled person faces a different set of health challenges and care needs. Added to that natural variation is the complexity and ever-changing nature of the law relevant to SNTs, which includes federal and state statutes and administrative rules, Social Security regulations, and local court rules. Although SNTs comprise only one part of the settlement planning equation, they are a world unto themselves. These materials are not intended as an exhaustive guide to the full array of SNT issues, but rather as an introductory primer on the appropriate use of SNTs.

3.3(c)(1) When to Use Special Needs Trusts. The primary purpose of a special needs trust is to provide a fund for a disabled person that will enhance his or her quality of life while simultaneously protecting entitlement to means-tested government benefits such as Medicaid. SNTs frequently have other purposes as well, such as providing financial

management and oversight for individuals whose disabilities preclude self-management. However, what sets SNTs apart from other trusts is their ability to protect assets from being considered "available" for purposes of Medicaid and other means-tested public benefits.

In general, "means-tested" public benefits are any government programs that limit the pool of eligible recipients by imposing financial eligibility rules. Eligibility for means-tested benefits is determined after a review of the assets and income of the person applying for help. If assets and income are available to the person for basic needs, such as food and shelter, then generally the person is expected to use the available funds for those basic needs, thus reducing his or her need for government benefits.

Originally, SNTs were developed by lawyers who realized that if a trust, by its terms, makes the trust estate unavailable for basic needs such as food and shelter, the existence of the trust should not affect an individual's eligibility for needs-based public benefits. Today, federal and state laws contain specific provisions governing SNTs, setting out criteria under which SNT assets will be treated as unavailable.

Because a primary function of a SNT is to preserve eligibility for Medicaid and other means-tested public benefits, and because not all disabled individuals receive such benefits, SNTs are not always necessary or appropriate. In order to properly plan for a disabled person, an attorney must have a basic understanding not just of Medicaid, but also of the various other government benefit programs available, including the level of services provided and the eligibility rules applicable to each one.

3.3(c)(2) Primary Types of Special Needs Trusts. There are two primary types of special needs trusts: "first-party" trusts and "third-party" trusts. They share many common features, but they differ in important ways. The most important distinction between first-party and third-party SNTs is the source of the funds comprising the trust estate: first-party trusts are funded with money that belongs to the beneficiary (i.e., the

disabled person), and third-party trusts are funded with money that belongs to someone else, such as a parent or family member of the beneficiary. There are several varieties of each type of trust, but broadly speaking, all SNTs fall into one of these two categories. Because these materials are geared toward situations involving motor vehicle settlements and/or judgments, the focus will be on "first-party" trusts funded with the proceeds of such settlements and/or judgments.

3.3(c)(3) General Requirements for First-Party SNTs. As discussed above, SNTs were originally developed informally, by lawyers, based on principles of general trust law. In the Omnibus Reconciliation Act of 1993 ("OBRA '93"), however, Congress enacted new provisions specifically addressing the use of trusts designed to preserve (or establish) eligibility for certain means-tested public benefits (specifically, Medicaid).

OBRA '93 restricted the use of many types of trusts created by (or on behalf of) a Medicaid recipient using the recipient's own funds—namely, first-party trusts. However, in that same Act, Congress specifically created a new type of trust that can be funded with a Medicaid recipient's own funds, and in which the assets are not considered available for purposes of Medicaid eligibility. Under the provisions of OBRA '93, in order for the assets in a first-party trust to be considered unavailable, the trust must:

- be created for the benefit of a disabled person as defined by the Social Security Administration;
- be created for the benefit of an individual under age 65;
- contain the disabled person's own assets;
- be established by a parent, grandparent, legal guardian (or Conservator in Oregon), or a court;
- provide that any State that has provided Medicaid assistance to the disabled person will receive all amounts

remaining in the trust upon the disabled person's death, up to the total amount of Medicaid assistance provided.

These requirements are codified in the Medicaid Act at 42 USC Sec 1396p(d)(4)(a), and many people now refer to first-party SNTs as "(d)(4)(a) trusts," referring to this provision.

In the Foster Care Independence Act of 1999 ("FCIA '99"), Congress enacted provisions similar to those of OBRA '93, this time applying them to trusts intended to qualify an individual for SSI. Today, as a result of OBRA '93 and FCIA '99, federal law specifically allows the creation of first-party SNTs by (or on behalf of) individuals receiving means-tested benefits such as Medicaid and SSI, provided they meet the criteria cited above. These trusts have many names, but the most common of them are "first-party special needs trusts," "payback trusts," and "(d)(4)(a) trusts."

3.3(c)(4) Applying the (d)(4)(A) Criteria. First-party SNTs are best understood by separately examining each of the statutory criteria listed above.

3.3(c)(4)(A) Disability Requirement. First-party SNTs must be established for an individual who is disabled as defined in the Social Security Act. If the beneficiary is receiving either SSI or SSDI benefits, this requirement is met. Sometimes, however, disabled individuals receive (or want to apply for) only Medicaid. In these cases, the State Medicaid caseworker must make an independent determination of disability.

3.3(c)(4)(B) Under Age 65. The beneficiary of a first-party SNT must be under 65 when the trust is created and funded. Medicaid and other public benefits agencies have made clear that first-party SNTs remain "exempted" for individuals over the age of

65 (i.e., a payback trust created for an individual at age 60 does not suddenly become available to that individual when he or she reaches the age of 65). However, in order to be treated as unavailable, a first-party SNT must be initially created and funded prior to the beneficiary's 65th birthday. Once the beneficiary reaches the age of 65, he or she can no longer transfer assets into the SNT without jeopardizing eligibility for Medicaid and other means-tested benefits.

3.3(c)(4)(C) Beneficiary's Assets. The purpose of a first-party SNT is to protect assets belonging initially to the beneficiary. Most recipients of Medicaid and other means-tested assistance do not have significant assets, given the strict financial eligibility rules applicable to such programs. However, the need for a first-party SNT commonly arises when a recipient of means-tested benefits comes into a sum of money through a motor vehicle settlement or judgment.

Receipt of personal injury funds can result in termination of Medicaid and other means-tested benefits if the disabled individual retains funds in excess of $2000. However, if a payback trust is created, the individual can retain his or her benefits and enjoy the benefit of the SNT funds (subject to the strictures of the trust). In many cases, funds received from a personal injury settlement by recipients of public benefits are not sufficient to replace the benefits, so simply retaining the funds is not a viable option. There are alternatives to creation of a first-party SNT, such as spending down on "exempt assets" (see Section 3.3(b) above) or creation of a first-party pooled trust (see Secrtion 3.3(d) below). However, in many cases, a first-party SNT provides an ideal vehicle for holding a disabled individual's own assets, when those assets might otherwise cause a loss of benefits.

3.3(c)(4)(D) Created by Parent, Grandparent, Guardian/Conservator, or Court. Although the disabled individual is the party contributing the trust assets in first-party SNT cases, he or she is not permitted to act as the settlor or trustor. The trust must be created by a parent, grandparent, legal guardian or court. The term "legal guardian" is presumably intended to include a conservator in States like Oregon. ORS 125.440 specifically allows a conservator to create a trust, but only with prior court approval.

This aspect of the (d)(4)(a) criteria for first-party SNTs creates a number of planning issues. Since the disabled person cannot create the trust him or herself, attorneys need to determine the most appropriate, cost-effective way to create the trust. If the disabled individual has a living parent or grandparent who is willing and able to act as the settlor, this is often a first choice because it avoids the need to seek probate court approval for creation of the trust, thereby reducing attorney fees, court costs, and complications. Note, however, that even in cases where a parent or grandparent is available, court involvement is sometimes required. If the beneficiary is a minor, or lacks capacity and cannot consent to the transfer of his or her funds into the SNT, the probate court will have to authorize the transfer.

If there is no parent or grandparent available to create a first-party SNT, a petition or motion must be filed with the probate court to establish, or authorize the establishment of, the trust. Such petitions can take several forms, depending on a number of factors. In some cases, a disabled person will already have a guardian or conservator, and that fiduciary may be able to file a motion under ORS 125.440 for authority to create the trust. In cases where there is no existing guardian or conservator, a petition can be filed,

seeking both the appointment of the fiduciary and the authority to create the SNT.

Under the (d)(4)(a) criteria, it is possible to ask a court to create a first-party SNT directly and to appoint a trustee, without the separate appointment of a guardian or conservator. Oregon law provides a mechanism for this in ORS 125.650, which authorizes the court to issue a protective order conferring any of the powers of a guardian and conservator, without actually appointing one. This practice is not commonly allowed by Oregon courts, however (under ORS 125.650, courts have discretion on whether to issue such protective orders).

In cases where court approval must be obtained for the creation of a payback SNT, local court rules and practices must be considered. In some Oregon counties, the probate courts will appoint a conservator on a temporary basis for the limited purpose of establishing and funding a payback SNT. This can be very advantageous to a client, as it avoids the costs and complications of an ongoing conservatorship, such as annual court accountings, etc. Alternatively, if the disabled person is in need of a guardian, some counties will appoint the proposed guardian and authorize him or her to create the payback SNT, also avoiding the complications of ongoing conservatorship.

Of course, in some cases, ongoing conservatorship is desirable (for example, in cases involving larger sums of money, or involving a professional fiduciary who wants the protection of court-approved annual accountings). Even if an ongoing conservatorship is not desired, however, it may be required in some counties and in some situations. Several Oregon courts have long interpreted ORS 125.440 as requiring ongoing conservatorships in cases where approval of a payback SNT is

sought, because of language in the statute barring court approval of a trust that "has the effect of terminating a conservatorship." Id.

The 2007 amendments to ORS 125.440(2) now specifically lay out circumstances under which a court may approve a trust that "has the effect of terminating a conservatorship" (or, as applied here, which has the effect of avoiding an ongoing conservatorship). The amended statute provides that a court may approve such a trust if:

- The trust is created for the purpose of qualifying the protected person for needs-based government benefits or maintaining the eligibility of the protected person for needs-based government benefits;
- The value of the conservatorship estate, including the amount to be transferred to the trust, does not exceed $50,000;
- The purpose of establishing the conservatorship was to create the trust; or
- The conservator shows other good cause to the court.

The amended statute authorizes approval of SNTs without an ongoing conservatorship, but only in the court's discretion. Because of this discretion, the statute is not interpreted or applied the same way in every county. Attorneys should obtain a clear understanding of a given county's procedure before requesting the creation of a payback SNT. However, if local court rules and practices allow the above-mentioned alternatives to ongoing conservatorship, and if the alternatives represent a benefit to the disabled individual, they should be considered.

3.3(c)(4)(E). Payback. The most salient feature of a first-party SNT is the payback requirement. All first-party SNTs must provide that upon the death of the beneficiary, any remaining trust assets will be distributed to the State(s) that have provided Medicaid assistance to the disabled person, up to the total amount of Medicaid assistance provided. When the individual has received Medicaid benefits in more than one State, the trust must provide that the funds remaining in the trust are distributed to each State in which the individual received Medicaid, based on the State's proportionate share of the total amount of Medicaid benefits paid by all of the States on the individual's behalf. (Note that FCIA '99 does not require payback of SSI, but does require the payback of Medicaid.)

3.3(c)(4) Restrictions on Use of Funds in SNTs. In order for Medicaid and other public benefits agencies to treat SNT funds as "unavailable" to the beneficiary (thereby preserving eligibility), there must be restrictions on the beneficiary's use and control of the trust funds. A SNT will not achieve its purpose if the beneficiary has the ability to compel a distribution from the trust. Accordingly, all SNTs are written to give the trustee sole discretion regarding distributions.

While trustee discretion is critical to having a SNT treated as an "exempt" resource, it is generally not sufficient. In order to avoid having a SNT treated as an available resource, the trust must contain language restricting the use of the trust assets. There are a variety of "distribution standards" used in different types of SNTs, but the most common standard for first—party SNTs is the "special needs only" or "strict" distribution standard. This standard restricts distributions to special needs and may expressly prohibit distributions for basic needs (i.e., food and shelter).

The term "special needs" suggests needs particular to the person and his or her disability such as medical equipment or rehabilitative

treatment, and many SNTs include specifically tailored distribution guidelines. However, a trust limiting distributions to special needs can be drafted to allow distributions for *anything* other than food and shelter. This "strict" distribution standard, despite its name, actually encompasses many things that are not related to a disability or medical treatment, and which may not even be properly classified as a "need." For example, under a strict distribution standard, a trustee can make distributions for a cable television bill, internet services, or vacation expenses. In fact, it is generally more useful to focus on what is *not* considered a special need (i.e., what distributions are prohibited) than what is. Under a strict distribution standard, a special need is any distribution that is not cash, and is not for shelter or food.

A special needs trust with a strict distribution standard is the safest course of action to preserve eligibility for Medicaid and other public benefits. The strict distribution standard provides clear guidelines that will not require significant analysis of public benefits law when distributions are made. Perhaps most importantly, since the strict distribution standard is a common standard in first party SNTs, government agency workers reviewing the trust are more likely to recognize that the trust meets the criteria to qualify as a special needs trust. Thus, the strict distribution standard is the surest way to achieve the primary goal of a SNT—protecting eligibility for means-tested public benefits.

There are situations in which a more liberal distribution standard (i.e., a standard that *allows* distributions for food and shelter in some circumstances) can be included in a SNT without jeopardizing the beneficiary's eligibility for Medicaid and other benefits. Competent Medicaid counsel should always be consulted in establishing SNTs to ensure that the distribution standard for a particular SNT is appropriate for a particular beneficiary.

3.3(d) Pooled Trusts. One alternative to a special needs trust is a "pooled trust." Pooled trusts, like payback trusts, are creatures of statute. OBRA '93 created pooled trusts, and set out the criteria under which assets can be transferred into them without affecting means-tested government benefits. Pooled trusts, as their name implies, provide a vehicle for multiple disabled beneficiaries to pool their funds for purposes of investment and management, while offering the same primary benefits as standard SNTs (namely, preservation of eligibility for Medicaid and other means-tested government benefits). The statute defining pooled trusts requires that they:

- be established and managed by a non-profit association;
- maintain separate accounts for each beneficiary of the trust;
- provide that each account in the trust be established for the sole benefit of a disabled person as defined by the SSI program;
- provide that each account in the trust be established by a parent, grandparent, legal guardian (or conservator in Oregon), or a court; and
- provide that, to the extent amounts remaining in the beneficiary's account upon death are not retained by the trust, the State(s) will receive the remaining assets, up to the amount of Medicaid assistance provided to the beneficiary. 42 USC Sec 1396p(d)(4)(C).

There are several pooled trusts available to Oregon residents that meet all of these statutory criteria:

- The ARC of Oregon: http://www.arcoregon.org/
- The Good Shepherd: http://www.goodshepherdfund.org/index.html
- Secured Futures: http://www.securedfutures-snt.org/

Pooled trusts can be a good option for Medicaid recipients who receive modest amounts of assets from a motor vehicle settlement or judgment. Although pooled trusts charge management fees, those fees are often less than the cost of establishing an individual SNT, especially if the individual SNT would require ongoing conservatorship. Pooled trusts are also sometimes a good choice in

situations where the disabled person does not have a suitable family member or trusted friend to serve as trustee of a SNT, and does not want to incur the expense of a professional trustee.