

July 10, 2026

GENERAL LETTER NO. 8-D-114

ISSUED BY: Bureau of Economic Assistance
Division of Community Access and Eligibility

SUBJECT: Employees' Manual, Title 8, Chapter D, **Medicaid Resources**, 1 and 2, 5-7, 10-13, 18, 21-29, 33-35, 43, 46 and 47, 56, 60, 62, 65 and 66, 74 and 75, 77, 82, 90, 101, 110-112, 125-128, 132, revised.

Summary

This chapter is revised to update the average monthly statewide cost of nursing facility services. The average monthly statewide cost of nursing facility services is used to determine the penalty period for transfer of assets. The average cost of nursing facility services for state fiscal year 2027 is \$9,838.96 per month or \$323.65 per day.

Effective Date

July 1, 2026.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter D, and destroy them:

Page	Date
1 and 2, 5-7, 10-13, 18, 21-29, 33-35, 43, 46 and 47, 56, 60, 62, 65 and 66, 74 and 75, 77, 82, 90, 101, 110-112, 125-128, 132	May 22, 2026

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Overview

Pursuant to 42 CFR 435.603(g) and 441 IAC 75.70(249A), there is no resource test for MAGI-related Medicaid.

This chapter describes Medicaid resource requirements. Resource policies that apply to all coverage groups are described in the first part of the chapter:

- [Attribution of resources between an institutionalized spouse and a community spouse.](#)
- [Estate recovery for members who are over age 55 or in a medical institution.](#)
- [Transfers of assets.](#)
- [Trusts.](#)

The remaining part of this chapter provides resource requirements for [people whose eligibility is based on their relationship to the Supplemental Security Income program \(non-MAGI-related coverage groups\), including persons who are aged, blind, or disabled.](#)

Attribution of Resources

Legal reference: 441 IAC 75 (Rules in Process)

When one spouse enters a medical institution or applies for a home- and community-based services (HCBS) waiver or Programs for All-Inclusive Care for the Elderly (PACE) services, resources are “attributed” to the “community spouse” to protect sufficient resources for the community spouse’s maintenance.

A “community spouse” is a person who is not in an institution but who is the spouse of a person who is in an institution or applying for or receiving PACE or waiver services. The community spouse could live:

- In the couple’s own home.
- In a custodial home, such as a residential care facility.
- In an apartment.
- With relatives.
- In another nonfacility or noninstitutional setting.

Complete the attribution using the resources the couple had as of the first day of the month that:

- The institutionalized spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days or more, or
- The Medical Services Unit at the Iowa Medicaid or Managed Care Organization (MCO) determines that the Medicaid HCBS waiver or PACE applicant meets level of care.

Information needed to attribute resources is included on the Medicaid application forms. Use form **470-2577, Resources Upon Entering a Medical Institution** to attribute resources when:

- The month of entry to the institution and the month of application are different, or
- A married Medicaid member requests home- and community-based waiver or PACE services, or
- Either the institutionalized spouse or the community spouse requests attribution but does not apply for Medicaid.

Do not approve Medicaid until the attribution is completed. Complete the attribution within 45 calendar days.

Complete only one attribution per community spouse per case. After an attribution has been completed, do not complete a new attribution if:

- The institutionalized spouse is discharged after the 30 days but later reenters a medical institution.
- The attribution was completed for a waiver or PACE application but the application was denied.
- The attribution was completed for waiver or PACE services and the waiver or PACE spouse later enters a medical facility.
- A person whose attribution was completed in another state applies for institutional care in Iowa. However, if that state has a lower minimum community spouse resource allowance, recalculate the attribution and assign Iowa's minimum.

- Resources necessary for self-employment.
- Retirement funds if the member or the member's spouse has to quit a job or claim hardship in order to withdraw them.
- Shares of stock held by natives of Alaska in a regional or village corporation. Exclude for the 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claim Settlement Act.
- **Underpayment of SSI or Social Security** that is due either spouse for any month before the month it is received. Exclude for six months after receipt.
- **Victim's compensation** from a fund established by a state for victims of crime. Do not count the assistance for nine months from receipt. The applicant must prove that the payment was for expenses incurred or losses suffered as a result of a crime.

See [Specific SSI-Related Resources](#) for more descriptive information about these excluded resources. (Note that there are other types of resources described under that heading that are excluded for determining eligibility, but not for attribution.)

Resources affected by a prenuptial or antenuptial agreement are countable as resources unless excluded under the criteria listed above.

Calculating the Amount to Attribute to the Community Spouse

Legal reference: 441 IAC 75 (Rules in Process); P. L. 100-360,
P. L. 100-485

Use non-MAGI-related resource policies when determining which resources to count in completing an attribution. To calculate how much to attribute to each spouse:

1. Determine what resources the couple owned as of the first moment of the first day of the month of entry into the medical institution (or the month the HCBS waiver or PACE applicant meets the institutional level).

Count all resources that are owned by either spouse. It does not matter which spouse owns the resource. Include the value of resources that are for sale.

The applicant must provide verification of the value of the resources. Count **only** those resources that can be verified. If the applicant provides partial verification, use that documentation to determine the attribution.

Mr. and Mrs. G claimed resources of \$60,000 on the application for attribution. However, they could provide verification for only \$50,000. The attribution was based on the verified resources of \$50,000.

Count the uncompensated value of any divested resources owned by either spouse if the resource was owned on the first moment of the first day of the month. "Uncompensated value" is the fair market value of the asset minus the amount that was received for the asset.

NOTE: If either spouse transferred resources at less than fair market value to attain eligibility, see [Transfer of Assets](#) for procedures to handle such transfers when determining eligibility.

2. Add together all resources of both spouses.
3. Attribute one-half of the documented resources to each spouse. If necessary, adjust the division so that the community spouse will receive no less than \$32,532 (if there is that much) but no more than \$162,660.

Value of Combined Resources	\$0 - \$65,064	\$65,064.01 - \$325,320	\$325,320.01 or more
Amount attributed to:			
Community spouse	\$32,532	One-half	\$162,660
Institutionalized spouse	Remainder	One-half	Remainder

After the attribution is complete, send each spouse the results on form **470-2588, Notice of Attribution of Resources** with copies of the resource documents. The notice includes an explanation of the spouses' appeal rights. (See [If the Applicant Appeals the Attribution Amount.](#))

If a court or administrative appeal decision has ordered an amount greater than half the resources for the community spouse, or more than \$162,660, attribute the amount ordered.

1. Mr. A enters a medical institution and his wife remains at home. Mr. and Mrs. A furnish verification of a total of \$69,500 in resources. One-half of this is \$34,750. Mrs. A is attributed \$34,750 and Mr. A is attributed \$34,750.
2. Mr. B enters skilled care expecting to stay indefinitely. His wife remains at home. Their total resources are \$35,600. One-half of this is \$17,800. Since this result is less than \$32,532, the minimum amount of \$32,532 is attributed to Mrs. B. \$3,068 is attributed to Mr. B.

3. Mrs. D enters a hospital and is expected to stay over 30 days. Her husband remains at home. Their total resources are \$420,000. One-half of this is \$210,000.

The community spouse cannot be attributed more than \$162,660 without a court order or final appeal decision. Therefore, \$257,340 is attributed to Mrs. D and \$162,660 is attributed to Mr. D ($\$420,000 - \$162,660 = \$257,340$).
4. Mr. M enters a nursing facility and Mrs. M remains at home. The total value of their resources is \$50,000. However, the court has ordered that \$40,000 be transferred to Mrs. M for support. In this case, \$40,000 is attributed to Mrs. M, even though this amount exceeds the \$32,532 minimum; \$10,000 is attributed to Mr. M.

If the Applicant Appeals the Attribution Amount

Legal reference: 441 IAC 75 (Rules in Process)

The current minimum monthly maintenance needs allowance (MMMNA) for a community spouse is \$4,066.50. If the income available to the community spouse is less than the MMMNA, the applicant or the community spouse may file an appeal to set aside additional resources that would generate income equal to the difference between the income available to the community spouse and the MMMNA.

The appeal request must be filed within 90 days of the **Notice of Attribution of Resources** (NOA) or any **Notice of Decision** (NOD) regarding medical assistance. If the applicant does not file an appeal within 90 days of an NOA or NOD, the applicant loses the right to a hearing on the attribution for that application. If requested, help the applicant to complete form **470-0487** or **470-0487(S), Appeal and Request for Hearing**.

If the appeal is filed after one or more applications has been denied, and the appeal allows a substitution of resources that result in the institutionalized spouse now being eligible, the date of approval begins with the most recent application. Only one appeal to allow a substitution of resources will be conducted.

1. Mrs. B enters a facility in January 2006. Mr. B remains at home. The Bs file an application for medical assistance for Mrs. B in March 2006. An attribution of resources is completed. The worker totals all of the household resources as of January 1, 2006, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in April 2006.

Mrs. B files an appeal regarding the NOD. A hearing is granted. Since Mrs. B entered the facility before February 8, 2006, only Mr. B's income is used when the Bs provide a quote for the cost of an annuity to set aside additional resources for Mr. B.

2. Mr. C enters a facility on April 19, and files an application on April 21. Mr. C has a community spouse, Mrs. C. The Cs have combined total resources that are counted in the attribution, in the amount of \$35,400. \$32,532 was attributed to Mrs. C and that left \$2,868 for Mr. C.

Mr. C has \$1,410 Social Security and \$1,500 pension with a total income of \$2,910. Mr. C has Medicare and a Medicare supplement with a monthly premium of \$150. Mr. C has total unmet medical deductions in the amount of \$352.90 (\$202.90 Medicare premium + \$150 Medicare supplement = \$352.90). Mrs. C has \$2,100 Social Security.

The April application was denied since Mr. C's resources exceed the \$2,000 resource limit. Mr. C appealed the attribution and the denial.

Since Mr. C became institutionalized after February 8, 2006, Mrs. C's income, plus the income that will be made available from Mr. C is used when determining the shortfall of income between the MMMNA and Mrs. C's available income for the attribution process.

\$ 1,410	Social Security
+ <u>1,500</u>	Pension
\$ 2,910	
- <u>55</u>	Personal needs allowance
\$ 2,855	Total of Mr. C's income available to Mrs. C
+ <u>2,100</u>	Mrs. C's income
\$ 4,955	Total income available to Mrs. C when determining her shortfall for the annuity quote
\$ 4,066.50	MMMNA
- <u>4,955</u>	Total income available to Mrs. C
\$ 0	Shortfall of income used to determine the cost of an annuity for the attribution

Since there is not a shortfall of income for Mrs. C, additional resources cannot be attributed to Mrs. C. Mr. C remains ineligible until he spends down his resources to \$2,000.

If Mr. C is determined eligible, calculate the CP as follows:

\$ 1,410	Social Security
+ <u>1,500</u>	Pension
\$ 2,910	
- 55	Personal needs allowance
- <u>1,966.50</u>	Mrs. C's deficit
\$ 888.50	Client participation
\$ 4,066.50	MMMNA
- <u>2,100</u>	Mrs. C's Social Security
\$ 1,966.50	Mrs. C's deficit of income

Since Mr. C has income left after the spousal diversion, this is when you will allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums). Since there is \$888.50 left, Mr. C will have \$888.50 that he can use to pay towards his Medicare premium and health insurance premium.

3. Mr. D applied for waiver services in April and meets level of care for waiver services on May 5. Mr. D has a community spouse, Mrs. D. The Ds have combined total resources that are counted in the attribution, in the amount of \$78,000. \$39,000 was attributed to each spouse ($\$78,000 \div 2 = \$39,000$).

Mr. D has \$1,390 Social Security and \$233 pension with a total income of \$1,623. Mr. D has Medicare and a Medicare supplement with a monthly premium of \$100. Mr. D has total unmet medical deductions in the amount of \$302.90 (\$202.90 Medicare premium + \$100 Medicare supplement = \$302.90). Mrs. D has \$1,535 Social Security.

The April application was denied since Mr. D's resources exceed the \$2,000 resource limit. Mr. D appealed the attribution and the denial.

Since Mr. D became institutionalized after February 8, 2006, Mrs. D's income, plus the income that will be made available from Mr. D is used when determining the shortfall of income between the MMMNA and Mrs. D's available income for the attribution process.

\$ 1,390	Social Security
+ 233	Pension
\$ 1,623	
- 55	Personal needs allowance
\$ 1,568	Total of Mr. D's income available to Mrs. D
+ 1,535	Mrs. Ds income
\$ 3,103	Total income available to Mrs. D when determining her shortfall for the annuity quote
\$ 4,066.50	MMMNA
- 3,103.00	Total income available to Mrs. D
\$ 963.50	Shortfall of income used to determine the cost of an annuity for the attribution

If Mr. D is determined eligible, calculate the CP as follows:

\$ 1,390	Social Security
+ 233	Pension
\$ 1,623	
- 2,982	Mr. D's maintenance needs
\$ 0	Client participation
\$ 4,066.50	MMMNA
- 1,535.00	Mrs. D's Social Security
\$ 2,531.50	Mrs. D's deficit of income

In this situation for client participation, Mrs. D has a \$2,531.50 deficit of income and Mr. D has no income left to divert to Mrs. D. If Mr. D had income left after the spousal diversion, this is when you would allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums).

NOTE: Do not annualize the community spouse's income when determining the diversion to the community spouse in the client participation calculation.

The appellant must obtain one estimate of the cost of a single-premium lifetime annuity, based on the community spouse's age at the time of appeal, that would generate income equal to the difference between:

- The couple's available gross income and
- The MMMNA in effect when the appeal was filed.

Neither the applicant nor the community spouse has to purchase an annuity as a condition of Medicaid eligibility.

If the applicant is unable to obtain one estimate, assist the couple by contacting financial institutions. If the institution requires the identity of the applicant, obtain a release of information from the applicant.

If the financial institution is unable to provide an estimate, determine the shortfall between the couple's available gross income and the MMMNA. Multiply the shortfall by 12. Multiply this amount by the community spouse's "Life Expectancy in Years" row from the **Table for an Annuity for Life** from the Mortality Table issued by the Iowa Department of Revenue. (See next page.)

Formula: $(\text{MMMNA} - \text{couple's available gross monthly income}) \times 12 \times \text{community spouse's life expectancy in years} = \text{single-premium lifetime annuity quote}.$

Complete form [470-3144, Attribution of Resources Appeal Summary](#) according to instructions in [6-Appendix](#). Report the verified available income of the couple. Note and estimate the amount of any benefits for which the community spouse is eligible but is not receiving. Attach copies of the annuity bid to the form.

Send the form to the Appeals Section, 321 E. 12th Street, Des Moines, Iowa 50319.

1. When Mr. H enters a medical institution, the resources attributed to Mrs. H are \$40,828. When Mr. H applies for Medicaid, the resources of Mr. and Mrs. H are \$41,500 as of the first moment of the first day of the month of application.

The worker subtracts the \$30,828 attributed to Mrs. H from the total. Mr. H has \$672. He is resource eligible under any Medicaid coverage group.

2. Mr. and Mrs. J are SSI eligible. When Mrs. J enters a medical institution in November, Mr. and Mrs. J have \$2,997 in resources. All of the resources are attributed to Mr. J to meet the minimum protection of \$32,532. Mrs. J is resource eligible for Medicaid payment of nursing facility care.
3. Mr. and Mrs. K are eligible for Medically Needy. Their resources are \$9,800 when Mr. K enters skilled care in December. All of the resources are attributed to Mrs. K to meet the minimum protection of \$32,532. Mr. K is resource eligible for Medicaid payment of nursing facility care.
4. Mr. I enters a nursing facility in December. At that time, resources attributed to Mrs. I are \$32,532. Mr. I applies for Medicaid six months later. He reports that his resources have increased. The total is \$75,000 at the time of application. However, only \$32,532 can be attributed to Mrs. I. The other \$42,468 is countable to Mr. I.

If the institutionalized spouse's resources exceed limits for nursing facility coverage groups, check eligibility under the qualified Medicare beneficiary (QMB) group or Medically Needy coverage group. Review resource eligibility at redetermination to ensure that the coverage group continues to be correct.

Mr. D enters a nursing facility in November. Mrs. D remains at home. Their resources total \$34,950 in November. Mrs. D is attributed \$32,532 and \$2,418 is attributed to Mr. D. He is resource-eligible for Medically Needy coverage.

Mrs. D asks that the resources be reevaluated in February, since their resources have decreased. As of the first moment of the first day of the month, the combined resources of both spouses are \$33,100. Subtracting the \$32,532 attributed to Mrs. D, Mr. D has \$568 in resources. Mr. D is resource-eligible under any Medicaid coverage group.

1. Mr. W, the institutionalized spouse, has \$1,900 in resources attributed to him and is eligible for Medicaid. He jointly owns a CD valued at \$20,000. To remain eligible for Medicaid payment to the nursing facility, he must transfer \$18,000 of the CD to reduce his ownership down to \$2,000. He may transfer the total value if he wishes.
2. Mr. J is determined eligible for Medicaid in a medical institution. The amount of resources attributed to Mrs. J (the community spouse) and owned by Mrs. J is \$7,000, which is under the \$32,532 minimum.

A year later, Mr. J receives an inheritance of \$5,000. The IM worker verifies that when Mr. J received the inheritance, Mrs. J's resources were \$6,000. Mr. J intends to transfer \$4,000 to Mrs. J since her resources are under the \$32,532 minimum. He signs a statement to this effect.

Mr. J's remaining resources are \$1,000 (\$5,000 - \$4,000 = \$1,000). He is below resource limits for Medicaid and continues to be eligible.

When the member intends to transfer the resource, monitor the progress of the transfer. The transfer must take place within 90 days. The member must provide verification of the transfer. Send a notice similar to the following:

Medicaid has been approved effective _____, since your intent is to transfer resources to your spouse within 90 days of the date of this eligibility determination.

Failure to transfer the resource within 90 days will result in cancellation of Medicaid benefits unless unusual circumstances exist. Please notify this office when the resource is transferred and provide proof that the resource was transferred. [8-D, Transfers to Establish Ongoing Eligibility.](#)

Contact the member or authorized representative within 45 days of the notice to check the status of the transfer. Contact the member at the end of 90 days to see if the resources were transferred.

If the institutionalized spouse is not able to transfer excess resources because of circumstances beyond the member's control, you can allow another 90 days. If, at the end of this extended 90-day period, the resources have not been transferred, cancel the case.

In some cases, the transfer of resources may cause Medicaid ineligibility for the community spouse. After the transfer has been made, examine the effect of the transfer on the community spouse's Medicaid eligibility.

Mr. and Mrs. K are eligible for non-MAGI-related 503 program at home. Mrs. K enters a nursing facility in January. All \$2,900 of their resources are attributed to Mr. K, who actually owns them. Mr. K is ineligible for the 503 program if he retains the \$2,900 resources. However, he is eligible for the Medically Needy program.

Summary Examples

1. When Mr. R enters a nursing facility, Mrs. R files form **470-2577, Resources Upon Entering a Medical Facility**. The Rs list resources of a farm that includes their homestead, \$4,000 in bonds, \$20,000 in stock, two cars, and \$6,000 in a checking account.

Completing the Attribution

The following items are used to complete the attribution:

\$ 4,000	Bonds
20,000	Stocks
4,500	One car
+ 6,000	Checking account
\$ 34,500	Total resources

The worker divides \$34,500 by 2, which equals \$17,250. Because this is less than \$32,532, the amount attributed to Mrs. R (the community spouse) is \$32,532. The remaining amount of \$1,968 is attributed to Mr. R.

Appealing an Attribution

After the attribution is complete, Mrs. R files an appeal to set aside additional resources that would generate income equal to the difference between the couple's available income and the MMMNA. The deficit in income is \$1,622.

The cost of an annuity to generate \$1,622 per month is \$103,119. Because \$103,119 is more than the \$32,532 attributed to Mrs. R, the attribution will be modified to substitute \$103,119 for the \$32,532 previously attributed to Mrs. R. No resources are attributed to Mr. R.

Determining Eligibility After the Appeal

After the appeal, Mrs. R applies for Medicaid for Mr. R. The worker subtracts the community spouse allowance of \$103,119 from the couple's resources. This leaves no resources available to Mr. R. He is resource-eligible for Medicaid payment for nursing facility care. Mr. R has 90 days to transfer resources to Mrs. R to maintain his eligibility.

2. Mrs. J enters a nursing facility and files form **470-2577, Resources Upon Entering a Medical Facility**. The Js list resources of a \$150,000 farm, a homestead, \$10,000 in bonds, \$100,000 in CDs, one car, \$10,000 in a checking account, and \$65,000 in a savings account.

Completing the Attribution

The following items are used to complete the attribution:

\$ 150,000	Farm
10,000	Bonds
100,000	CDs
10,000	Checking account
+ 65,000	Savings account
\$ 335,000	Total resources

\$162,660 is attributed to Mr. J. \$172,340 is attributed to Mrs. J.

Appealing an Attribution

After the attribution is complete, Mr. J files an appeal to set aside additional resources to generate income equal to the difference between the couple's income and the MMMNA. The couple's available income is \$1,844 per month. $\$4,066.50 - \$1,844 = \$2,222.50$ unmet need.

The average estimate of the cost of an annuity to generate \$2,222.50 per month is \$101,000, which is less than the \$162,660 attributed to Mr. J. The attribution remains the same.

Determining Eligibility After the Appeal

After the appeal, Mr. J files an application for medical assistance for Mrs. J. The Js have the following resources at the time of application:

\$ 61,920	CDs
50,000	Bonds
20,000	Checking account
+ 40,000	Savings account
\$ 171,920	Total resources

The worker subtracts the community spouse allowance of \$162,660. This leaves \$9,260 in resources available to Mrs. J. She is ineligible for Medicaid payment for nursing facility care, because she is over the resource limit.

Estate Recovery

Legal reference: 441 IAC 75.28(7)

The cost of medical assistance is subject to recovery from the estate of certain Medicaid members. Members affected by the estate recovery policy are those who:

- Are 55 years of age or older, regardless of where they are living; or
- Are under age 55 and:
 - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
 - Cannot reasonably be expected to be discharged and return home. See [Establishing Whether a Member Under Age 55 Can Return Home](#).

Give a copy of [Comm. 123](#) or [Comm. 123\(S\)](#), **Important Information for You and Your Family Members About the Estate Recovery Program** to all Medicaid applicants at the time of the application.

An “estate” includes all real property, personal property, or any other asset in which the member had any legal title to or interest in at the time of the death of the member, to the extent of such interest. This includes, but is not limited to, interest in jointly held property, interest in trusts and retained life estates.

All assets included in the Medicaid member’s estate are subject to probate for the purpose of estate recovery. **NOTE:** It is not allowable for assets of a deceased member to be used to pay for travel expenses of family members of the deceased at the time of the member’s death.

Refer questions from members about estate recovery to the Iowa Medicaid Estate Recovery Unit at the toll-free number 1-888-513-5186 or in the Des Moines area, at (515) 246-9841. You may also give members [Comm. 266, Iowa's Estate Recovery Law](#), which gives detailed information about estate recovery procedures.

Establishing Whether a Member Under Age 55 Can Return Home

Legal reference: 441 IAC 75.28(7)

Presume that a member in a medical institution who is under age 55 is **unable** to return home. You are required to inform members of this policy by manually issuing form **470-2980, Estate Recovery Notice for New Approvals**, to all members who are **under age 55 and a resident of a medical institution** at the time of Medicaid approval.

If a member under age 55 is discharged before six months has elapsed, no further action is necessary. Estate recovery will not be pursued because the member was not permanently institutionalized.

A member in a medical institution who is under age 55 has the right to rebut this presumption. To do so, the member must make a written request to the Department after being in the institution for six months.

If a member dies before six consecutive months of institutionalization, the family or another interested party may submit a written request to the Department to rebut the presumption that the member could not have been reasonably expected to be discharged.

Inform members who are under age 55 of their rebuttal rights by manually issuing them form **470-3209, Estate Recovery Six-Month Follow-Up** six months after their admission into the medical institution. If the member dies in the medical institution after a stay of less than six months, issue the form to the family or someone acting on the member's behalf.

Send all rebuttal requests to the Medical Services Unit at the Iowa Medicaid either by using the local mail or by U.S. mail to PO Box 36478, Des Moines, Iowa 50315. The Medical Services Unit determines whether the member can reasonably be expected to return home and sends a copy of its decision to you and to the member.

If the Medical Services Unit determines that the member cannot reasonably expect to return home, the Unit will provide information to the member and to you about whether the member was ever able to return home within the first six months of institutionalization and the date the expectation and ability to return home ceased. File a copy of the determination in the case record.

A member may appeal an adverse decision. The member first appeals through the IME Medical Services Unit for reconsideration. If the member disagrees with the reconsideration decision, the member or someone acting responsibly for the member can appeal an adverse reconsideration decision by IME Medical Services Unit through normal DHS appeal procedures.

Requests for the IME Medical Services Unit determination are timely when filed within 30 calendar days from the date form **470-3209, Estate Recovery Six-Month Follow-Up** is issued. The member may still make a request later. However, if the decision then is that the member is reasonably able to return home, assistance received before the date the request was submitted to DHS is still subject to estate recovery.

Estate Recovery Agent

Estate recovery activities are conducted by the Revenue Collection Unit at the Iowa Medicaid.

The Revenue Collection Unit may request a copy of the member's first and last application or review form to determine if there are resources that could be subject to estate recovery. When sending a copy of the requested forms, record the member's name, state identification number, social security number, and case number on each sheet.

Additionally, the Revenue Collection Unit compares monthly Medicaid eligibility files against Vital Statistics records on reported deaths in Iowa to determine when estate recovery can be initiated for an individual.

Amount Due

Legal reference: 441 IAC 75.28(7)

The debt due the Department from the member's estate is equal to all medical assistance provided on the member's behalf on or after:

- The date the person attained age 55, or
- The date a person under age 55 entered a medical institution with no reasonable expectation of returning home.

However, no debt is due for assistance provided before July 1, 1994 (the beginning of the estate recovery program). Effective January 1, 2010, Medicaid payments for Medicare cost-sharing benefits are excluded from estate recovery for the following members:

- Qualified Medicare Beneficiaries (QMB)
- Specified Low-Income Medicare Beneficiaries (SLMB)
- Expanded Specified Low-Income Medicare Beneficiaries (E-SLMB)
- Qualified Disabled Working People (QDWP)
- Dually eligible for a full Medicaid coverage group and QMB
- Dually eligible for a full Medicaid coverage group and SLMB

Medicare cost-sharing benefits include Medicaid payments for Medicare Part A and Part B premiums, copayments, coinsurance, and deductibles.

If a member under the age of 55 is discharged from the facility and returns home before six consecutive months, no debt is assessed for Medicaid payments made on the member's behalf for the time of the institutionalization.

A claim against the estate of a member who was eligible for Medicaid because resources were disregarded under the Long-Term Care Asset Preservation program is computed differently. The amount of the assets disregarded under this program is not subject to estate recovery. EXCEPTION: Medicaid paid before the member attained eligibility due to long-term care asset preservation is still recovered from the estate.

Interest accrues on a debt due beginning six months after the death of a Medicaid member, surviving spouse, or surviving child, or upon the minor child reaching age 21. The Department does not use liens in the estate recovery program.

When Estate Recovery Is Waived

Legal reference: 441 IAC 75.28(7)

Waiver of collection from the estate based on undue hardship is determined on a case-by-case basis. Collection of the debt from the estate of a Medicaid member is waived when collection of the debt would result in:

- Reduction in the amount received from the member's estate by a surviving spouse, or by a surviving child who is under age 21, blind, or permanently and totally disabled at the time of the member's death, or
- Other undue hardship. Undue hardship exists when all of the following are true:
 - The household that claims hardship has gross monthly income, as defined by Family Investment Program (FIP) policy, of less than 200% of the poverty level for a household of the same size.
 - The household that claims hardship has total resources, as defined by FIP policy, that do not exceed \$10,000.
 - Application of estate recovery would deprive a person of food, clothing, shelter, or medical care such that the person's life or health would be endangered.

When a person claims undue hardship, refer the person to the program manager for Estate Recovery at the Iowa Medicaid.

If collection of all or part of a debt is waived for a surviving spouse or child, or for hardship, the amount waived creates a debt due from:

- The estate of the member's surviving spouse or blind or disabled child, upon the death of the spouse or child,
- A surviving child who was under 21 years of age at the time of the member's death, or upon the child reaching age 21,
- The estate of a surviving child who was under age 21 at the time of the member's death, if the child dies before reaching age 21, or
- The person who received the hardship waiver if the hardship no longer exists or from the estate of the person, whichever is first.

The debt owed by the surviving spouse, child, or person who received the hardship waiver will not exceed the amount in which recovery was waived.

Transfer of Assets

Legal reference: 441 IAC 75.23(249A), P. L. 100-360

When an individual attest to transferring assets on an application, Electronic Data sources will be requested to check for a potential transfer for less than fair market value.

“**Transfer of assets**” occurs when a person transfers resources or countable income for less than fair market value in order to become eligible or maintain eligibility for Medicaid. Transfer of assets includes, but is not limited to:

- Giving away property to someone else.
- Establishing a trust for the benefit of someone else.
- Removing a name from an asset.
- Disclaiming an inheritance on or after July 1, 2000.
- Failure to “take” against a deceased spouse’s will on or after July 1, 2000.
- Reducing ownership interest in an asset.
- Transferring or disclaiming the right to income not yet received.
- Use of funds to purchase some annuities.
- Use of funds to purchase some promissory notes, loans, and mortgages.
- Use of funds to purchase some life estates.

See [Determining the Value of a Resource](#) when establishing the fair market value or equity value of a resource. Assume that a person who transfers assets does so to become eligible for Medicaid unless they prove otherwise. See [Rebuttal of Transfer of Assets](#).

Some transfers do not result in a penalty. These are listed under [Transfers That Do Not a Cause Penalty](#). The penalty for transferring assets depends upon:

- The date the transfer occurred,
- To whom the assets were transferred, and
- How much the assets were worth at the time of the transfer.

The transfer of assets penalty affects Medicaid coverage of certain long-term care services. See [Penalties for Transferring Assets](#).

- The annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
 - The remainder beneficiary in the first position, **or**
 - The remainder beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form **470-4382, Notification Regarding Annuity Benefits** and send it to the annuity company.

- Purchase of an annuity on or after February 8, 2006, **with the spouse of a Medicaid applicant or member as the annuitant**, unless the annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
 - The remainder beneficiary in the first position, **or**
 - The remainder beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form **470-4382, Notification Regarding Annuity Benefits** and send it to the annuity company.

- Any purchase of a promissory note, loan, or mortgage made before February 8, 2006; or any purchase of a promissory note, loan, or mortgage made on or after February 8, 2006, unless the note, loan, or mortgage meets all of the following criteria:
 - It has a repayment term that is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (see [Loans and Promissory Notes](#));
 - It provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - It prohibits the cancellation of the balance upon the death of the lender.

- Establishing a promissory note, loan or mortgage needs to be examined to determine if a potential transfer of asset has occurred.
- Purchase of a life estate in another person's home for more than its fair market value, regardless of whether the life estate was:
 - Purchased before February 8, 2006; or
 - Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

Transfers That Do Not Cause a Penalty

Legal reference: 441 IAC 75.23(5)

In the following situations, the transfer is exempt and does not cause a penalty:

- A joint account is divided into separate accounts that reflect separate ownership, as long as the funds are divided equally in proportion of ownership. Funds not equally divided in proportion of ownership may be considered transferred and subject to penalty.

Mr. J and Ms. H have \$8,000 in a joint account (A) and \$3,000 in another joint account (B) that they cannot separate. Ms. H also has an account of \$500 in her name alone.

Mr. J enters a nursing home and applies for Medicaid. Ms. H has spent \$5,000 from account A and \$1,000 from account B on Mr. J's nursing home care. At that point, she removes Mr. J's name from the accounts.

Since Ms. H spent more than half of the accounts on Mr. J's care (\$6,000 out of \$11,000), she has rebutted the presumption of divesting. The account owned by Ms. H does not enter into the rebuttal of divesting.

- A transfer is made to the institutionalized person's child or adult child who is disabled as defined by Social Security Administration. The child is considered disabled if the child is:
 - Receiving SSI, Social Security disability benefits, or Railroad Retirement benefits as a disabled child, or
 - Declared disabled by a Department disability determination. See [8-C, When the Department Determines Disability](#).

Ms. E applies for Medicaid while living in a skilled nursing facility. She has transferred \$10,000 to her son. She says her son is disabled, but he is not receiving any disability benefits. The Department refers the son to apply for SSI, because he has no income.

Ms. E's application is approved for other medical services but is pended for facility payments due to the need to determine her son's disability. If the son does not apply for SSI, the Department determines disability. If the son is not determined to be disabled, transfer of asset penalties are applied.

- The applicant or member or the applicant or member's spouse transfers an asset that would have been exempt as a resource at the time of transfer.

Mr. and Mrs. D have \$11,000 in total assets in March. On April 14, they gave away \$5,000 in certificates of deposit to their daughter. Mrs. D enters a medical institution to stay on April 30.

Since the Ds owned total assets of less than \$32,532, the minimum protected amount for the community spouse in the month before the month of entry and attribution, the transfer is not for the purpose of qualifying for Medicaid.

EXCEPTION: Transfers of a home and surrounding property (including the transfer of a life estate interest only) are not exempt from transfer penalties.

- A transfer was made into a trust established solely for the benefit of:
 - The person's child or adult child who is blind or disabled, as defined by the Social Security Administration.
 - A person under 65 years of age who is disabled, as defined by the Social Security Administration.
- A transfer made between spouses or to another person for the sole benefit and support of the community spouse.

1. Mr. Q transfers his half of a \$25,000 certificate of deposit to his daughter on May 14, 2005, for Mrs. Q's benefit. Mr. Q then applies for Medicaid on May 20, 2005. On June 1, 2005, he enters a skilled nursing facility. Mr. Q furnishes a statement that the money was transferred because Mrs. Q is handicapped, and the daughter will be handling Mrs. Q's finances.

This transfer does not disqualify Mr. Q for payment of nursing facility services because the transfer was for the benefit of his spouse.

The value of the assets transferred is divided by the statewide average cost of nursing facility services at the time of application.

Time of Application	Average Monthly Statewide Cost of Nursing Facility Services	Average Daily Cost of Nursing Facility Services
July 1, 2026 – June 30, 2027	\$9,838.96	\$323.65
July 1, 2025 – June 30, 2026	\$9,702.77	\$319.17
July 1, 2024 – June 30, 2025	\$8,842.75	\$290.88
July 1, 2023 – June 30, 2024	\$8,581.61	\$282.29
July 1, 2022 – June 30, 2023	\$7,786.35	\$256.13
July 1, 2021 – June 30, 2022	\$7,710.66	\$253.64
July 1, 2020 – June 30, 2021	\$7,205.40	\$237.02
July 1, 2019 – June 30, 2020	\$6,799.88	\$223.68
July 1, 2018 – June 30, 2019	\$6,447.54	\$212.09
July 1, 2017 – June 30, 2018	\$6,269.63	\$206.24
July 1, 2016 – June 30, 2017	\$5,809.13	\$191.09
July 1, 2015 – June 30, 2016	\$5,407.24	\$177.87
July 1, 2014 – June 30, 2015	\$5,103.24	\$167.87
July 1, 2013 – June 30, 2014	\$5,057.65	\$166.37
July 1, 2012 – June 30, 2013	\$5,131.82	\$168.81
July 1, 2011 – June 30, 2012	\$4,853.36	\$159.65
July 1, 2010 – June 30, 2011	\$4,842.72	\$159.30
July 1, 2009 – June 30, 2010	\$4,598.61	\$151.27
July 1, 2008 – June 30, 2009	\$4,342.03	\$142.83
July 1, 2007 – June 30, 2008	\$4,173.92	\$137.30
July 1, 2006 – June 30, 2007	\$4,021.31	\$132.28
July 1, 2005 – June 30, 2006	\$3,697.55	\$121.63

If there were no penalty for transferring his assets for less than fair market value, Mr. Z could have been eligible for Medicaid payment of his facility care effective March 3, 2006. Since this date is later than the date he made the transfer, Mr. Z's period of ineligibility begins March 3, 2006, and lasts through April 23, 2008. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on May 24, 2008.

2. Mrs. G transfers \$3,000 to her daughter on February 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid nursing facility payment on June 9, 2006. The worker determines that the transfer was made to qualify for Medicaid. The transfer was made after February 8, 2006, so the partial month of ineligibility is not rounded down.

The penalty period is figured and results in a penalty for 24 days ($\$3,000 \div 121.63 = 24.66$). If there were no penalty for transferring her assets for less than fair market value, Mrs. G would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

Since this date is later than the date she made the transfer, Mrs. G's period of ineligibility begins March 3, 2006, and lasts through March 26, 2006. If she is otherwise eligible, she can be approved effective March 27, 2006.

The transfer period continues to run even if the individual stops receiving institutional level of care. The penalty period should not be stopped if an individual leaves the facility and then returns at a later time.

If the transfer period is determined and the community spouse later becomes eligible for Medicaid payment of facility care, divide the remaining period of ineligibility in half and apply one-half of the penalty period to each spouse. When the transfer was made before February 8, 2006, combine the two partial months of ineligibility to equal one month and apply that month to the spouse that initiated the transfer.

If one spouse dies before the penalty period is completed, apply the remaining period of ineligibility to the living spouse.

1. Mrs. L transfers \$71,000 in January 2005. Mr. L enters a nursing facility in March 2006, and files an application for nursing facility care. A 19-month period of ineligibility is determined ($\$71,000 \div \$3,697.55 = 19.2$). Since the transfer was made before February 8, 2006, the period of ineligibility begins on the first day of the month the transfer was made. Mr. L is ineligible from January 1, 2005, through July 31, 2006.

Mrs. L enters the facility on April 3, 2006. Sixteen months of the period of ineligibility have passed. The worker divides the remaining three months between the couple ($3 \text{ months} \div 2 = 1.5$). Because Mrs. L initiated the transfer, she is ineligible for two months and Mr. L is ineligible for one month. Mrs. L is ineligible for nursing facility care beginning April 1, 2006, through May 31, 2006. Mr. L's period of ineligibility is shortened to end May 31, 2006.

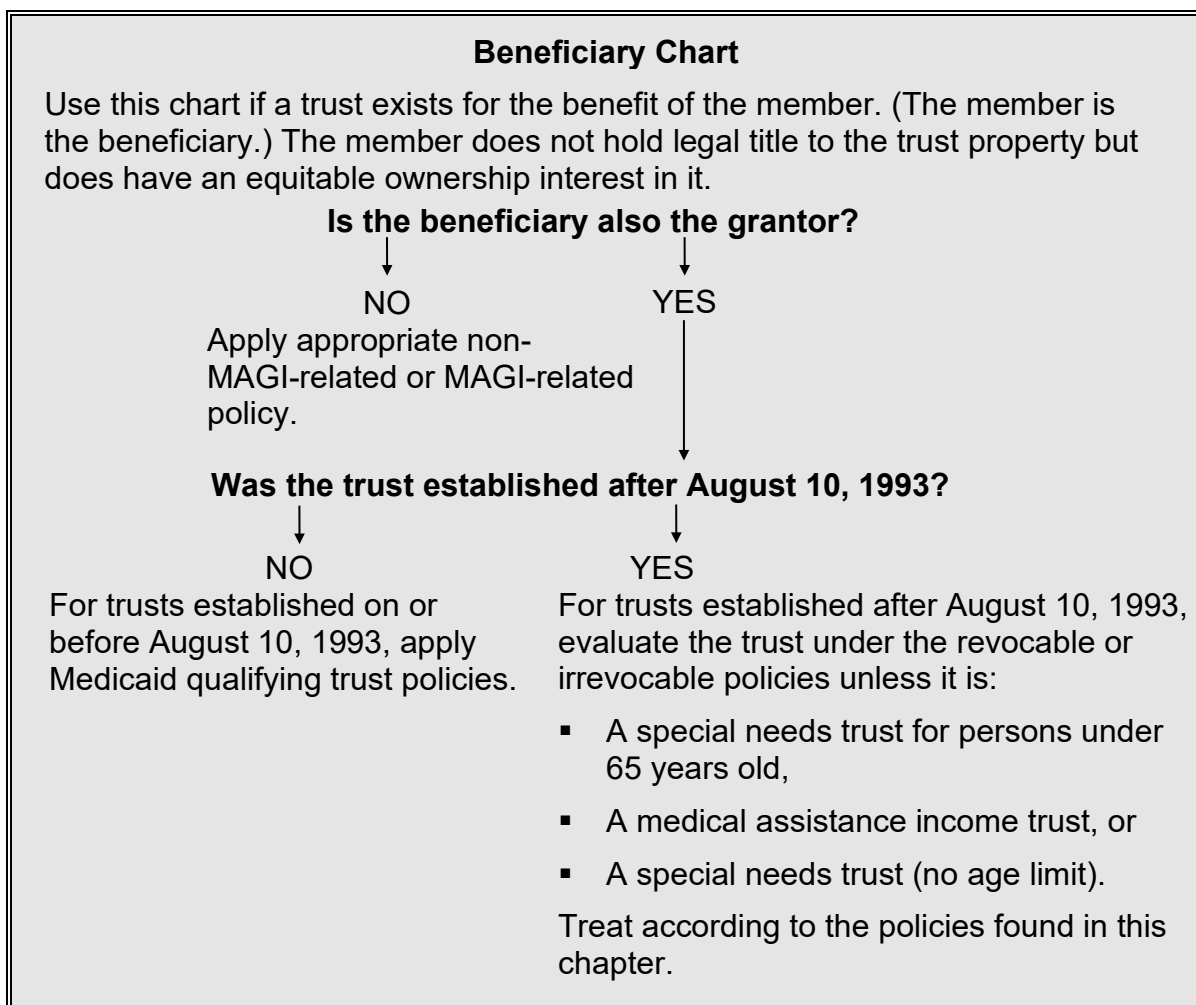
2. Mrs. S transfers \$71,000 on March 2, 2006. Both enter a nursing facility on April 1, 2006, and file an application for nursing facility care in June 2006. A 19-month period of ineligibility is determined ($\$71,000 \div \$3,697.55 = 19.2$, or 19 months + 6 days). The total period of ineligibility is divided between Mr. and Mrs. S ($19 \text{ months} + 6 \text{ days} \div 2 = 9 \text{ months} + 18 \text{ days each}$).

Since the transfer was made after February 8, 2006, the period of ineligibility begins on the first day that both would otherwise have been eligible for Medicaid payment of their facility care. The partial month of ineligibility is not rounded down. A period of ineligibility is imposed for both Mr. and Mrs. S beginning on March 1, 2006, through December 18, 2006.

Mrs. S passed away on April 3, 2006. One month and 2 days of her period of ineligibility have passed. The remaining 8 months and 16 days of ineligibility are imposed on Mr. S's period of ineligibility and is now extended to September 2, 2007.

Do not put a penalized member in a facility aid type. If the member has been receiving Medicaid under another coverage group, leave the aid type the same as it was before the member entered the facility. If the person is a Medicaid applicant who is eligible under a coverage group not contingent on living in a medical institution, use the nonfacility aid type for that coverage group.

Set a reminder in the system for the month before the end of the penalty period, and redetermine eligibility at that time.



Treatment of Resources in a Trust

When determining eligibility, first review the trust to see if it is accessible. If the principal and income are accessible, count the amounts toward the resource limits and use them when determining eligibility, client participation, and spenddown.

For eligibility purposes, there is no requirement that the beneficiary of a trust take legal action to attempt to gain access to the trust principal.

- Identify marital status.
- Indicate what program the client is applying for or is eligible under (MAGI, non-MAGI, Food Assistance, or FIP).
- Indicate whether this referral concerns a trust for third-party liability for medical expenses.
- Attach a copy of the legal document or trust agreement to the request.

Trust Program staff will first review each submitted document to determine whether it is a “pay-back” trust (defined as a special needs trust, an income trust, or a pooled trust).

- Trusts that are not “pay-back” trusts are returned to the eligibility policy staff for review. (See procedures below.)
- “Pay-back” trusts are kept for review by trust program staff. Of these, income trusts will be the priority for review.

Review procedure for income trusts:

1. The Trust Program will:
 - Determine whether the document meets the criteria for a medical assistance income trust; and
 - Send a response indicating whether the trust was approved or denied directly to the scanning center indicated on the **Clarification Request**. (If the request does not contain a case number, the response will be emailed to the requesting worker.)
2. When the trust is **approved**, the worker issues form **470-4488, Medical Assistance Income Trust**, to the client or the payee.
3. When the trust is **denied**, the Trust Program will:
 - Prepare a checklist indicating why the trust does not meet the criteria; and
 - Email the checklist to the scanning center indicated on the **Clarification Request** where it will be received in the electronic case file process list.

3. Eligibility policy staff will:

- Review the trust for eligibility;
- Respond to the **Clarification Request** indicating how the trust will affect eligibility; and
- Upload the response to the electronic case file indicated on the **Clarification Request** where it will be received in the case file process list.

Trusts Established with Assets Not Owned by Beneficiary

Legal reference: 441 IAC 75 (Rules in Process)

If the applicant or member is the beneficiary but not the grantor of a trust, Medicaid eligibility is determined by the terms of the trust. These trusts may be testamentary trusts or inter vivos trusts.

Examine the terms of the trust to determine if it is countable. Under both non-MAGI and MAGI-related policy, income and resources **are** available to an applicant or member who is the beneficiary as follows:

- Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **require the trustee** to pay or to make available to the beneficiary trust principal and income for the beneficiary's basic needs. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)
- Trust principal and income are countable income, but not a countable resource, to the beneficiary when the terms of the trust allow the trustee to make income or principal available to the beneficiary for basic needs, and the trustee makes either trust principal or income available to the beneficiary for basic needs.
- Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **allow the beneficiary** to withdraw trust principal and income for basic needs. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

Income and resources are **not** available to the beneficiary under both non-MAGI-related and MAGI-related policy if:

- The terms of the trust **prohibit** the trustee from making either trust principal or income available for the beneficiary's basic needs.
- The terms of the trust allow the trustee, at the trustee's discretion, to make income or principal available to the beneficiary for basic needs, but the trustee does not make either income or resources available for basic needs.

Trusts established for medical payments are a third-party resource. Do not count trust principal and income if the terms of the trust specify that they are available only for medical care. The principal and income for these trusts are not countable as income and resources in determining eligibility.

Compare the total countable resources, including the amount from the trust, to the resource limit of the coverage group under which the applicant seeks assistance. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

If the applicant is ineligible by counting income and resources of a Medicaid qualifying trust according to the policies of the coverage group, determine whether the applicant is eligible under any other coverage group.

1. Ms. P receives SSI. She has a Medicaid qualifying trust that provides for “care and keep.” Any of the principal of \$12,000 can be used to meet her living expenses, but no money is currently provided for her.

\$12,000 is added to Ms. P’s other countable resources. Ms. P is not eligible for Medicaid since \$12,000 is greater than any resource limit.

2. Ms. W, a non-MAGI applicant, has a Medicaid qualifying trust set up as the result of a malpractice suit. The trust pays only for medical care. There is \$100,000 in the trust. Since the trust provides for medical care only, it is not a resource. It is a third party medical resource.

Ms. W is evaluated for resources based on her other resources of \$500. She is income- and resource-eligible for Medicaid, based on the non-MAGI coverage group. The worker prepares and sends a memo to TPL stating the basic trust provisions and the name and address of the trustees.

3. Mr. N, a 503 applicant, has a Medicaid qualifying trust that provides payments of \$100 a month from trust income. No principal can be used. The trustee has not made the income available.

The worker determines whether Mr. N would qualify for SSI by adding all income together, including the \$100 a month, and disregarding his COLAs. His social security income at time of cancellation was \$230. He has no other income. $\$230 + \$100 - \$20 = \310 . He is eligible under the 503 group.

4. Mr. O is living in a nursing facility. He applies for non-MAGI-related Medicaid on May 6, 1993. His gross social security and VA income is \$965.30 monthly. He has \$1,700 in savings and checking accounts as of April 30, 1993, at midnight.

He also has a trust that he set up when he went into the nursing facility in May 1990. The trust was set up over 60 months ago, so divesting is not considered. According to the trust, money is available if he needs it, but he can have no more than one-third of the principal of the trust each year.

The trustee verifies the principal as of the first of the year to be \$99,000. Mr. O has used \$1,000 of the trust this year.

His resource from the trust is: \$99,000 divided by 3 = \$33,000 that can be withdrawn minus \$1,000 used = \$32,000 remainder.

Therefore \$32,000 plus his other resources of \$1,700 is counted toward the resource limit. He is not eligible.

5. Ms. J, an SSI recipient in a residential care facility, has a Medicaid qualifying trust for educational benefits that she set up with inheritance funds. Each year she receives \$2,500 for tuition, books, and living expenses.

Since SSI policy provides that the income for living expenses counts for eligibility and is included as income for SSI, there is no more income to count from the Medicaid qualifying trust.

Also since the only amount available from the trust is for education, the trust is not counted as a resource.

Client Participation

Legal reference: 441 IAC 75 (Rules in Process)

Consider all income, including countable income from the Medicaid qualifying trust, as available when determining client participation in a medical institution, unless the income is expressly exempt income, as listed in [8-E](#).

The resources of the ineligible spouse must be deemed to the eligible spouse. See [Deeming from a Spouse](#). Determine which resource limit to use, based on whether or not the ineligible spouse has income to deem to the eligible spouse (according to procedures in [8-E](#)).

- Use the resource limit for an individual when no income is deemed from the ineligible spouse.
- Use the resource limit for a couple when income is deemed from the ineligible spouse.

EXCEPTIONS:

- The resource limit is \$4,000 for an individual eligible as a qualified disabled and working person.
- The resource limit is \$6,000 for a married couple living together who are eligible as qualified disabled and working persons.
- The resource limit is \$9,950 for an individual eligible under one of the following coverage groups:
 - Qualified Medicare beneficiaries
 - Specified low-income Medicare beneficiaries
 - Expanded specified low-income Medicare beneficiaries
- The resource limit is \$14,910 for a couple eligible under one of the following coverage groups:
 - Qualified Medicare beneficiaries
 - Specified low-income Medicare beneficiaries
 - Expanded specified low-income Medicare beneficiaries
- The resource limit is \$10,000 for an individual or couple in the SSI-related Medically Needy coverage group.
- The resource limit is \$12,000 for an individual in the Medicaid for employed people with disabilities coverage group.
- The resource limit is \$24,000 for a couple in the Medicaid for employed people with disabilities coverage group.
- All household resources are disregarded in the eligibility determination of children in certain coverage groups. See [Resource Eligibility of Children](#).

What Resources to Count

Legal reference: 20 CFR 416.1201, 20 CFR 416.1208

“Resources” are liquid and nonliquid assets owned by a person that the person is not legally restricted from using for support and maintenance, and that could be converted to cash to use for support and maintenance. Unless specifically exempt, all resources are considered countable.

Guardianship, conservatorship, and power of attorney are not legal restrictions on a resource. Continue to count an adult’s resources if the person has (or is waiting for) a guardian, conservator, or person with power of attorney.

An applicant or a member is not required to start a lawsuit to access or sell a resource. However, a resource is counted if they (or their conservator) have to petition the court to request access, because this action is not a lawsuit. (See [Trust Definitions](#) for more information on conservatorships.)

Include the self-attested resources of everyone who is considered part of the non-MAGI-related household. See [8-C, Nonfinancial Non-MAGI-Related Eligibility](#), when establishing the non-MAGI-related household. Determine countable resources and resource eligibility as of the first moment of the first day of each month, including the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in [8-A, Definitions](#). If resource values change during the month, eligibility will not be affected until the next month. See [NJ A0068 Verifying Resources](#)

Nonliquid Resources

“Nonliquid resources” are assets that cannot be converted to cash within 20 days. Examples are:

- Homes and homesteads. See [Property in a Homestead](#).
- Nonhomestead property.
- Personal property, such as household goods, personal effects, tractors, motor vehicles, machinery, and livestock.

If only one of the account holders is a Medicaid applicant or member or a person whose income and resources must be considered for Medicaid eligibility, count the entire amount in a co-owned account unless the applicant or member can establish that they (or the deemer) cannot access the funds. See [Disputed Ownership](#).

Ms. G has \$3,000 in a joint checking account with her sister, Ms. H, and their mother, Mrs. I. Ms. G and Ms. H are both over the age of 21 and are both receiving non-MAGI-related Medicaid. Mrs. I has not applied for and does not receive Medicaid. Countable amounts are \$1,500 for Ms. G and \$1,500 for Ms. H, unless either can establish that they do not have access to the account.

- **Individual Retirement Accounts (IRA).** Use the value of the IRA if cashed in minus any penalties for early withdrawal. NOTE: The 10% tax penalty for early withdrawal would not be allowed as a deduction, since it is an additional tax on the income portion of the withdrawal.
- **Mutual funds.** Count the value for which the shares can be sold.
- **Oil leases.** The value must be established by a knowledgeable source, such as a brokerage firm or bank. The lease value can be excluded if it is under \$6,000 and the land earns a net income of 6% of equity, or if the land is being sold. The leasehold is the right to use the property for a specified period. It does not convey ownership of the property.
- **Promissory notes** that can be sold or discounted.
- **Stocks.** Use the closing price of the stock on the first moment of the first day of the month.

Do not count resources that have no cash value, that cannot be liquidated, or that the applicant or member does not have the right to liquidate and use for support and maintenance. NOTE: Do not count property jointly owned by spouses involved in a divorce when the property is unavailable until a decision on distribution has been made. Do not consider the terms of a prenuptial agreement when determining Medicaid eligibility.

Do not count a resource until ownership is known to the applicant or member. An applicant or a member who is not aware of owning a resource must prove that it was reasonable not to know about it. Forgetting a resource is not evidence. Count the value of the resource plus any interest as income in the month of discovery. Count it as a resource the next month.

- Consider the sale or transfer of a resource as a change in the form of the resource. Do not consider the transfer or sale of a resource as income.
- A court restriction may make all or part of the resource unavailable to the client. Consult your supervisor if you have questions about the legal restrictions. Legal restrictions on resources can be included in:
 - Liens.
 - Qualified domestic orders.
 - Divorce decrees.
 - Probate matters.
 - Bankruptcy proceedings.

Deeming Resources

Legal reference: 20 CFR 416.1160, 20 CFR 416.1163, 20 CFR 416.1202

Deeming is the process of assigning a specified amount of resources of an ineligible spouse, parent, or sponsor when determining Medicaid eligibility. An “ineligible spouse” is a spouse who is not receiving non-MAGI-related Medicaid. See [8-L, Aliens](#) when deeming resources from a sponsor to an alien.

Do not apply deeming policies if the applicant’s or couple’s resources alone are over the resource limits after including all appropriate disregards and exclusions.

Deem resources as of the first moment of the first day of the month of eligibility.

Deeming From a Spouse

Legal reference: 20 CFR 416.1202

To determine eligibility, include resources of an ineligible spouse when:

- An eligible person was living in the same household with the ineligible spouse at any time during the month, or
- An SSI eligible person was living with an SSI eligible spouse during the last six months unless:
 - The spouses have divorced,
 - One of them has died, or
 - One of them moved to a medical facility.

- Roth individual retirement accounts.
- Savings incentive matched plans for employees.
- Salary reduction simplified employee pension plans (also known as “SARSEPs”).
- Similar plans for retirement investments authorized under federal law after May 17, 1999.
- Retirement plans established pursuant to a “qualified domestic relations order” as defined by federal law (26 U.S.C. section 414).

If the type of plan is unclear from the documentation provided, verify it with the plan administrator or send a clarification request to central office.

Specific Non-MAGI-Related Resources

This section lists specific types of resources that are countable or excluded, in total or in part, when determining initial or ongoing eligibility for non-MAGI-related coverage groups. Some countable resources require calculations to determine the countable value to the applicant or member. Some resources are excluded only up to a certain limit, after which the remainder is countable.

And finally, some resources are exempt in the month of receipt and in some cases, the month following the month of receipt. Examples include:

- Death benefits
- Earned income credit
- Income tax refunds
- Retroactive cash payments
- Social services expenses
- Third party medical payments

See individual items for more information.

ABLE Account

The Achieving a Better Life Experience (ABLE) Act of 2013 was signed into law in December 2014. The ABLE Act amends Section 529 of the Internal Revenue Service Code of 1986 to create tax-free savings accounts for individuals with disabilities. These savings accounts are called ABLE accounts

Burial Funds (Cont.)

A client in a nursing home has \$1,400 in a burial fund, but spends \$1,000 in June. This \$1,000 is used for June eligibility, and client participation is adjusted for June.

Burial Funds' Increase in Value

20 CFR 416.1124(9),
20 CFR 416.1231(7)

Burial funds may increase in value due to interest income or to appreciation in the value of the burial arrangement. Do not count interest on or increases in the value of burial funds that are **excluded** as a resource.

Count interest on and increases in value of the **countable** portion of burial funds. To do this, determine the percentage of the burial funds that is countable based on the value of the burial funds at the time they were gathered and apply that percentage to the increase in value.

When a non-MAGI-related Medicaid member has excluded funds set aside for burial at the time of cancellation of SSI:

- Exclude increased funds at the time of cancellation if the member becomes eligible for non-MAGI-related Medicaid coverage within 12 months of cancellation.
- However, if the member loses SSI because the member is no longer disabled, allow the increased funds to be excluded only if the member becomes eligible for a non-MAGI-related Medicaid program within three months.
- Allow only the same percentage increase in funds that was allowed before cancellation if the burial fund account is only partially excluded because the member has other burial funds. This is subject to the same 12-month period.

Contact the SSI representative at the district Social Security office to determine the amount of funds excluded at the time of cancellation when an SSI person becomes ineligible and then goes to another non-MAGI-related Medicaid coverage group.

Insurance (Life) (Cont.)

Mr. B has a \$1,000 whole life policy that he purchased in 1942. His dividends purchased an extra \$3,000 in face value in 1976. Now, the total face value of the policy is \$4,000, the cash value is \$2,800, and dividends are \$800. Because the policy's face value, (not including the face value due to insurance purchased with dividends) is less than \$1,500, the cash value is excluded. However, the \$800 in dividends that were not used to buy additional insurance are countable resources.

Dividend accumulations may be considered as cash set aside for burial if all burial fund criteria are met. Do not automatically assume that the dividends are set aside for burial because the cash value of the life insurance is designated for burial.

If the life insurance policy is assigned to the funeral home in an irrevocable burial contract, do not count the cash value or the dividends as a resource.

If the funeral home is the beneficiary, the cash value of the policy may still be counted as a resource unless otherwise excluded. If the funeral home is the beneficiary and the client has an irrevocable burial contract, do not count the cash value of the policy, but count any accessible dividends as a resource to the client.

At the time of application the cash value can be verified by obtaining the cash surrender value page of the policy or verification from the company. Accept the cash value table when the individual is under the resource limit and the surrender value is not questionable.

If further verification is needed, 470-0444 Insurance report can be used to verify the:

- Total face value of the whole life insurance policy not including dividend additions.
- Amount of accumulated dividends not used to purchase additional insurance.
- Interest earned on accumulated dividends.

Insurance (Life) (Cont.) At annual reviews, review previous cash surrender values of life insurance. Accept the cash value table when the individual is under the resource limit and the cash surrender value is not questionable. If resource eligibility is questionable obtain verification by obtaining a written statement from the insurance company or by sending 470-0444 unless the total face value of all policies is \$1,500 or less and the last report indicated that the face values will not change. See [6-Appendix](#) for instructions on form [470-0444, Insurance Report](#).

Insurance (VA Term Life) People who are age 70 or older and have National Service Life Insurance (VA) term policies earn cash value when the term policy lapses or is canceled at their request.

When the policy lapses or is canceled, the cash value will be used to buy a limited amount of paid-up additional (PUA) insurance. With PUA insurance, the policyholder may:

- Receive insurance coverage without paying premiums.
- Borrow against the cash value.
- Surrender it for cash.
- Receive annual dividends that may be used to buy more PUA.

The VA term insurance policies will remain excluded as a resource after the policyholder reaches age 70, as long as the policyholder:

- Continues to pay the policy premiums and does not allow the policy to lapse; and
- Does not request cancellation of the policy.

If the policy lapses or if the policyholder requests cancellation, how the policy is subsequently treated depends on what the policyholder does with the PUA insurance. If the policyholder:

- Receives insurance coverage without a premium, the cash value of the insurance is countable as a resource the month after the change takes place.

Insurance (VA Term Life) (Cont.)

- Surrenders the policy for cash, the cash is countable income in the month received.

Life Estates or Remainderman Interest

20 CFR 416.1201,
IAC 75 (Rules in Process)

Policy: Property can be divided into two parts, the life estate and the remainder interest. This applies whether the property is real estate or personal property or is liquid or nonliquid.

The value of a life estate or remainder interest depends on the value of the underlying property and the life expectancy of the person whose life controls it (the original holder of the life estate).

Comment: Life estates and remainder interests generally count as resources for eligibility purposes. However, if the underlying property would be exempt, the life estate or remainder interest is also exempt.

For example, exclude real property in a life estate as a homestead if the owner of the life estate lives in the dwelling, or if the other exclusion policies for a homestead apply. See [Property in a Homestead](#).

People who receive or retain a **life estate** (“life tenants”) have the right to use the property during their lifetime, including the right to any income generated by the property during their life. Count income generated according to policy. See [8-E, Lump-Sum Income](#).

This right has a value and can be sold to someone else. If the original owner of the life estate transfers or sells the life estate to someone else, the recipient of the life estate gets the right to use the property during the life of the original holder. The “life” that determines the life estate does not change with the transfer.

The owner of a **remainder interest**, the remainderman, has the right to receive the property when the life estate ends. Before the life estate ends, the owner of the remainder interest has no right to use the property or to receive any income from it.

Property in a Homestead for People Requesting Long-Term Care
441 IAC 75 (Rules in Process)

A person is not eligible for payment of nursing facility services or other long-term care services, if the person has substantial equity interest in their homestead. This limit does not apply:

- If the spouse, or child who is under age 21, or the person's child who is blind or disabled, as defined by Social Security, resides in the home; or
- To people approved based on an application or request for payment of long-term care services filed before January 1, 2006.
- Use the following chart to determine the correct maximum equity amount based on the date of application.

Application filed on or after: Equity interest cannot exceed

January 1, 2014	\$543,000
January 1, 2015	\$552,000
January 1, 2017	\$560,000
January 1, 2018	\$572,000
January 1, 2019	\$585,000
January 1, 2020	\$595,000
January 1, 2021	\$603,000
January 1, 2022	\$636,000
January 1, 2023	\$688,000
January 1, 2024	\$713,000
January 1, 2025	\$730,000
January 1, 2026	\$752,000

Property Earning Six Percent of Equity
20 CFR 416.1222

Exclude real property as a resource if its equity value does not exceed \$6,000 and the net annual return earned on the property is at least 6% of the equity value. **Equity** is the current market value of the property minus any legal debt on the property. **Market value** is the amount an item can be sold for on the open market.

To determine if the property is earning 6% of equity, multiply the net monthly income by 12 months. This amount is the net annual return earned on the property. Then multiply the equity value by 6%. Compare the net annual return amount to the 6% of equity amount.

Property Earning Six
Percent of Equity
(Cont.)

If the net annual return is higher than 6% of the client's equity in the property, exclude the property if the equity value does not exceed \$6,000.

If the client's equity in the property exceeds \$6,000 and the property is earning at least 6% of equity, count only the amount of equity over \$6,000 as a resource.

Ms. T owns her home and rents it out for \$700 a month. The fair market value of the home is \$80,000 and she still owes \$50,000 on it. Ms. T's equity value is \$30,000. She files an application for medical assistance. Determine if the property is earning 6% of equity as follows:

$\$700 \times 12 = \$8,400$ net annual return

$\$30,000 \times 6\% = \$1,800$

Since Ms. T's equity amount exceeds \$6,000 and the property is earning at least 6% of equity, count only the amount of equity over \$6,000 as a resource.

$\$30,000 - \$6,000 = \$24,000$ countable resource value

If a property is not producing 6% of equity due to a client's illness, exclude the property as a resource for up to 24 months as long as the client plans to resume the business after the illness ends.

**Property Used for
Self-Support**
20 CFR 416.1224

Exclude equity in non-income-producing real property that is valued under \$6,000 and produces goods and services necessary to the applicant's or member's daily living. Liquid resources used for self-support are **not** excluded.

**Resource
Replacement**
20 CFR 416.1232,
P. L. 101-508

Exclude cash received for the replacement or repair of an excluded resource. Do not count the cash or the interest earned on the cash for nine months from the date it is received.

If the replacement or repair takes longer because of circumstances beyond the control of the member, exclude the cash for an additional nine-month period. Count it as a resource the first moment of the next month after the second nine-month period expires.

Retirement Funds

20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1244;
P. L. 101-508

Exclude retirement funds if the member has to quit a job to withdraw the funds.

If the retirement funds are not excluded:

- Count the verified net proceeds after penalties in the attribution and the eligibility process if the fund is owned by the member.
- Count the verified net proceeds after penalties in the attribution process if the fund is owned by the community spouse.
- Do not count retirement funds owned by the ineligible spouse in the deeming process when spouses live together.

NOTE: Taxes are not an allowable expense when determining net proceeds of retirement funds. The 10% early withdrawal penalty on an individual retirement account (IRA) is an additional tax.

A member who has a choice to withdraw retirement funds as a lump sum or as an annuity must choose the annuity.

Types of retirement plans include:

- **Defined benefit plan:** The employer promises the employee a specific monetary benefit at a specific age, based on factors such as salary and length of service. The employee cannot draw a pension until the employee meets certain requirements, such as being a certain age or being retired.
- **Defined contribution plan:** The employer and employee makes specific contributions to an employee's pension fund. The amount of the benefit depends on the amount saved and how well the employee's fund investments perform.

Most of these plans are 401(k) plans. Typically these plans can be accessed at age 59½ without a tax penalty or earlier with a tax penalty. Other withdrawal restrictions may apply depending on the plan.

Retirement Funds
(Cont.)

- **Individual Retirement Account (IRA):** The employee establishes and funds these accounts. The employee can liquidate these funds at any time.

Retroactive Cash Payments
P. L. 101-508

Exclude any retroactive cash payments paid to ineligible spouses or parents for providing in-home supportive services to the applicant or member. Exclude the payments in the month of receipt and the following month.

Retroactive SSI and Social Security Lump-Sum Payments
20 CFR 416.1233

Exclude SSI and Social Security retroactive lump-sum income as a resource for nine months after receipt, as long as the funds can be identified as the lump-sum funds. (See [8-E, Lump-Sum Income](#) for income guidelines.

Unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds but if this is done and the retroactive amount can no longer be separately identified, the amount will count towards the resource limit.

Verify that the funds are separate and represent a retroactive lump sum. Before the ninth month, the member must again verify resources. If resources exceed the limit, cancel the member, giving timely notice.

An unmarried member receives a social security lump sum of \$4,500 on October 12. The worker sets a reminder for June 1. On June 19, the worker verifies the resources are \$2,600.

On July 30, the member is canceled and is ineligible for non-MAGI-related coverage groups that have a \$2,000 resource limit. The worker completes a redetermination. Effective August 1, the member is eligible under Medically Needy.

**Worker's
Compensation
Medicare Set-Aside
Arrangements**

Treat a worker's compensation Medicare set-aside arrangement (WCMSA) as a trust created by a third party (the defendant in the worker's compensation claim). Exclude it as a resource when determining eligibility if the member does not have a legal authority to revoke it or to direct the use of the assets for the member's basic needs.

The funds in the WCMSA are available only to pay medical providers for future medical costs related to the work injury that would otherwise be paid by Medicaid. Therefore, the funds set aside in the account and any income generated by those funds are not available or countable as resources or income in determining non-MAGI-related Medicaid eligibility or benefits, unless they are actually used for basic needs.

If the trustee makes the trust principal or trust income available to the member for basic needs (in violation of the terms of the WCMSA), count the available funds as income in the month of receipt and as a resource the month after.

Refer the WCMSA to the Third Party Liability Unit.