STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter D

Revised March 31, 2023

Medicaid
Resources

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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.

In specific circumstances, attribution guidelines may be different:

- If both spouses entered an institution but one goes home, complete an attribution for the month the spouse who remains institutionalized entered the institution.
- If the previously institutionalized spouse goes home and then the community spouse enters a medical institution expecting to stay for 30 days or more, complete a new attribution for the new institutionalized spouse.
- If either spouse dies in the month of application or died in the retroactive period, attribute resources for the month of entry to the institution. Use the attributed resources to determine eligibility for months the spouse was living.
- If the applicant marries **after** entering the institution but **before** Medicaid eligibility is determined, complete an attribution of resources for the community spouse. Complete the attribution for the month of entry.
- If a single member or a member who was widowed after the attribution marries **after** entering the institution and **after** Medicaid eligibility for institutional care has been established, do not complete an attribution. If the institutionalized spouse later becomes ineligible for Medicaid and reapplies for Medicaid benefits, complete an attribution for the month of entry.

Revise attribution results when:

- A final appeal establishes a greater amount of protected resources for the community spouse. See If the Applicant Appeals the Attribution Amount.
- The member is later able to verify resources that were owned at the date of entry to the institution. See Calculating the Amount to Attribute to the Community Spouse.
- The amount of resources used in the original attribution was not correct.

If a person who requests an attribution without filing a Medicaid application fails to cooperate in determining attribution, a new determination is not necessary when you receive an IRS report. (However, do complete the attribution and consider the IRS report when the person later applies for Medicaid if you receive verification and can establish what resources existed when the person entered the institution.)

Further details on the attribution procedure are organized as follows:

Resources Excluded From Attribution

Legal reference: 441 IAC 75 (Rules in Process)

Some resources are not considered for attribution, whether owned by one or both spouses. Resources that do not count in the attribution process also do not count when determining eligibility. Do not count for either the attribution process or eligibility:

- One vehicle regardless of value.
- Burial and related expense funds for each spouse that are separately identified and set aside for that purpose. Each spouse may have a fund or multiple funds but no more than $1,500. Subtract from this $1,500 limit the total face value of excluded whole life and term life insurance policies and any amounts in irrevocable trusts or arrangements available to meet burial and related expenses.
- Burial spaces held for either spouse or any other member of the immediate family.
- Disaster Relief Act Assistance and Emergency Act Assistance or other assistance provided because of a Presidential declaration of disaster. Exclude these resources and any interest earned on the funds for nine months, beginning with the date of receipt. (These funds may be excluded for a longer period, if good cause is shown.)
- Household goods and personal effects, regardless of value.
- Housing assistance paid by HUD or FMHA for housing occupied by the community spouse.
- Life insurance policies with a total face value of $1,500 or less for each spouse.
- Property in a homestead, including the home and related land.
- Property used for self-support of either spouse if it would be excluded by SSI.
- Real property up to $6,000 if it is earning six percent of equity.
- Relocation assistance provided by a state or local government which is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- Resources of a blind or disabled person who has a Plan for Achieving Self-Support, as determined by the Division of Vocational Rehabilitation, the Department of Human Services, or the Department for the Blind.
- 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 $29,724 (if there is that much) but no more than $148,620.

Value of Combined Resources	$0 - $59,448	$59,448.01 - $297,240	$297,240.01 or more
Amount attributed to:			
Community spouse	$29,724	One-half	$148,620
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 $148,620, 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 $30,600. One-half of this is $15,300. Since this result is less than $29,724, the minimum amount of $29,724 is attributed to Mrs. B. $876 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 $300,000. One-half of this is $150,000.

   The community spouse cannot be attributed more than $148,620 without a court order or final appeal decision. Therefore, $151,380 is attributed to Mrs. D and $148,620 is attributed to Mr. D ($300,000 - $148,620 = $151,380).
4. Mr. M enters a nursing facility and Mrs. M remains at home. The total value of their resources is $40,000. However, the court has ordered that $30,000 be transferred to Mrs. M for support. In this case, $30,000 is attributed to Mrs. M, even though this amount exceeds the $29,724 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 $3,715.50. 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. Mr. Q enters a facility in January 2002. Mrs. Q remains at home. The Qs file an application for medical assistance in March 2002. An attribution of resources is completed, and the application is denied in April 2002. Another application is filed for Mr. Q in February 2003.

   The worker totals all of the household resources 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 March 2003.

   A third application is filed for Mr. Q in March 2004. The worker again totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. Again the remaining resources continue to exceed the resource limit. The worker issues an NOD denying benefits in March 2004.

   Mr. Q files an appeal in April 2004 regarding the March 2004 NOD. A hearing is granted. Mrs. Q's income is low enough that the cost of an annuity is used to set aside additional resources for Mrs. Q. The final appeal decision attributes additional resources to Mrs. Q.

   The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. Q. The March 2004 application decision is reversed. The prior decisions on the March 2002 and March 2003 applications stand as issued.

2. Mrs. Z enters a facility in August 2013. Mr. Z remains at home. The Zs file an application for medical assistance for Mrs. Z in August 2013. An attribution of resources is completed, and the application is denied in September 2013. Another application is filed for Mrs. Z in January 2017.

   The worker totals all of the household resources, 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 February 2017.

   Mrs. Z appeals the NOD in February 2017. A hearing is granted. Mr. and Mrs. Z are unable to obtain an annuity quote. The worker assists them in getting the quote. The administrative law judge issues a decision upholding the original attribution. Once this decision becomes final, no other hearings regarding the attribution will be granted, as the Zs were granted a hearing on the attribution of resources.

3. Mr. M enters a facility in January 2016. Mrs. M remains at home. The Ms file an application for medical assistance for Mr. M in August 2016. An attribution of resources is completed. Mrs. M is attributed $24,000. The Ms have $6,000 in resources. The application is approved.

   The review form is sent out in January 2017 and not returned. The case is canceled effective February 1, 2017. Another application is filed in March 2017. The Ms now have $42,000 in resources.

   The worker subtracts the current year's community spouse resource allowance. The remaining resources exceed the resource limit.

   The worker issues an NOD denying the application in March 2017. Mr. M files an appeal regarding the NOD. A hearing is granted. The final appeal decision attributes additional resources to Mrs. M. The couple's income is low enough that the average of the annuities, $99,424, is used to set aside additional resources for Mrs. M.

   The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. M. The March 2017 decision to deny the application based on excess resources is reversed.

Verify the couple's available gross monthly income. Do not count income that is earned by resources used in the attribution process.

When determining gross monthly income, include any income the community spouse or institutionalized spouse may be entitled to but is not receiving. When the community spouse works only part of the year and received income only during the time worked, annualize the income as directed in 8-E, *Determining Income From Self-Employment*.

For couples where one spouse entered an institution before February 8, 2006, county only the community spouse's income.

For couples where one spouse entered an institution on or after February 8, 2006, consider the institutionalized spouse's income that can be made available to the community spouse according to the facility client participation calculation. See 8-I, *Deductions From Client Participation*. Allow a $50 personal needs allowance deduction from the gross countable income of the institutionalized spouse for facility, HCBS waiver, **or** PACE applicants.

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 $32,000. $29,724 was attributed to Mrs. C and that left $2,276 for Mr. C.

   Mr. C has $1,410.90 Social Security and $1,500 pension with a total income of $2,910.90. 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 $314.90 ($164.90 Medicare premium + $150 Medicare supplement = $314.90). Mrs. C has $1,100.90 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.

$	1,410.90	Social Security
+	1,500.00	Pension
$	2,910.90	
-	50.00	Personal needs allowance
$	2,860.90	Total of Mr. C's income available to Mrs. C
+	1,100.90	Mrs. C's income
$	3,961.80	Total income available to Mrs. C when determining her shortfall for the annuity quote

$	3,715.50	MMMNA
-	3,961.80	Total income available to Mrs. C
$	.00	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:

$	1,410.90	Social Security
+	1,500.00	Pension
$	2,910.90	
-	50.00	Personal needs allowance
-	2,614.60	Mrs. C's deficit
$	246.30	Client participation

$	3,715.50	MMMNA
-	1,100.90	Mrs. C's Social Security
$	2,614.60	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 only $246.30 left, Mr. C will have $246.30 that he can use to pay towards his Medicare premium or 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 ÷ 2 = $39,000).

   Mr. D has $1,390.90 Social Security and $233 pension with a total income of $1,623.90. 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 $264.90 ($164.90 Medicare premium + $100 Medicare supplement = $264.90). Mrs. D has $535.90 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.

$	1,390.90	Social Security
+	233.00	Pension
$	1,623.90	
-	50.00	Personal needs allowance
$	1,573.90	Total of Mr. D's income available to Mrs. D
+	535.90	Mrs. Ds income
$	2,109.80	Total income available to Mrs. D when determining her shortfall for the annuity quote

$	3,715.50	MMMNA
-	2,109.80	Total income available to Mrs. D
$	1,605.70	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:

$	1,390.90	Social Security
+	233.00	Pension
$	1,623.90	
-	2,742.00	Mr. D's maintenance needs
$	.00	Client participation

$	483.00	MNIL for one-person household
-	535.90	Mrs. D's Social Security
$	.00	Mrs. D's deficit of income

   In this situation for client participation, Mrs. D does not have a deficit of income and Mr. D has no income left to allow any other deductions. 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: (MMMNA – couple's available gross monthly income) x 12 x community spouse's life expectancy in years = 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, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114.

If the annuity quote is greater than the original attribution amount, the administrative law judge will order that the annuity quote be used instead of the original amount. Send a new *Notice of Attribution of Resources* reflecting the revised amount. (The 90-day transfer policy applies as of the date of Medicaid approval. See Transfers to Establish Ongoing Eligibility.)

If the annuity quote is equal to or less than the original attribution amount, the original attribution is left as is.

TABLE FOR AN ANNUITY FOR LIFE

2001 CSO-D mortality table based on blending 50% male-50% female (pivotal age 45)
age nearest birthday **Source:** Iowa Department of Revenue

Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years
0	78.65	41	39.22	82	7.84
1	77.73	42	38.28	83	7.38
2	76.78	43	37.35	84	6.94
3	75.81	44	36.42	85	6.52
4	74.84	45	35.49	86	6.13
5	73.86	46	34.57	87	5.75
6	72.87	47	33.65	88	5.41
7	71.89	48	32.74	89	5.09
8	70.91	49	31.84	90	4.79
9	69.92	50	30.94	91	4.51
10	68.94	51	30.04	92	4.23
11	67.95	52	29.15	93	3.94
12	66.97	53	28.27	94	3.67
13	65.99	54	27.4	95	3.43
14	65.01	55	26.54	96	3.21
15	64.04	56	25.68	97	3.03
16	63.07	57	24.84	98	2.88
17	62.11	58	24.01	99	2.71
18	61.15	59	23.19	100	2.53
19	60.19	60	22.38	101	2.35
20	59.23	61	21.57	102	2.18
21	58.27	62	20.78	103	2.02
22	57.32	63	20	104	1.87
23	56.36	64	19.24	105	1.72
24	55.4	65	18.49	106	1.59
25	54.45	66	17.75	107	1.47
26	53.49	67	17.02	108	1.35
27	52.53	68	16.31	109	1.25
28	51.58	69	15.6	110	1.16
29	50.63	70	14.91	111	1.08
30	49.67	71	14.23	112	1
31	48.72	72	13.56	113	0.93
32	47.76	73	12.91	114	0.86
33	46.81	74	12.28	115	0.79
34	45.85	75	11.66	116	0.73
35	44.9	76	11.06	117	0.67
36	43.95	77	10.47	118	0.61
37	43	78	9.91	119	0.56
38	42.05	79	9.36	120	0.5
39	41.11	80	8.83		
40	40.16	81	8.32		

Increase in the Minimum and Maximum Allowance for Community Spouse

The minimum and maximum resource allowance for the community spouse increases each year beginning in 2017. This fact is noted on form 470-2588, *Notice of Attribution of Resources*. No further notice or action is necessary unless the household applies for Medicaid or requests a revision of the attribution based on the increase in the minimum or maximum allowance.

When a household with the minimum or maximum community spouse attribution files an application or requests a revision of the attribution, assess the case to determine if the revised minimum or maximum must be attributed to the community spouse. (You do not need to increase attributed resources if the institutionalized spouse's eligibility is already established.)

If the new minimum or maximum applies, complete a revision and send a written statement. Do not send a *Notice of Attribution*. Suggested wording is as follows:

> The Department of Human Services completed an attribution of resources for your household in (**month**, **year**). At that time, the community spouse was attributed the maximum (or minimum) resource allowance of (**amount**). You have (filed an application *or* requested a revision of the attribution).
>
> We have revised the attribution, based on an increase in the maximum (or minimum) community spouse resource allowance to (**amount**). As of (**date**), the community spouse is attributed (**current maximum (or minimum)**).
>
> We subtract this amount from your household's total resources at the time of the Medicaid application to determine the institutionalized spouse's countable resources.
>
> If you have questions, please contact me.

Processing a Medicaid Application After Attribution

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

When determining eligibility for the institutionalized spouse, the amount of resources to count is the difference between the couple's total resources at the time of application and the amount attributed to the community spouse.

Follow the requirements of 8-B to process a Medicaid application. However, do not approve Medicaid before completing an attribution of resources.

If the couple does not have an attribution, total the countable resources of both spouses at the first moment of the month of entry. Exempt only those resources listed under Resources Excluded From Attribution. Complete the attribution as directed under Calculating the Amount to Attribute to the Community Spouse.

Determine and verify countable resources of both spouses as of the first moment of the first day of the month for which application is being made (if this is a different month). Subtract the amount of resources attributed to the community spouse as of the date of entry to the facility from the couple's total resources in the month of application. Count the remaining balance towards the Medicaid resource limit for the institutionalized spouse.

Mr. Z enters a nursing facility on May 22, 1994. Mrs. Z files a Medicaid application for him in September 1995. She lists resources of their homestead, one car, a $20,000 CD, a checking account of $55,000, and $5,000 in a savings account.

When Mr. Z entered the facility, the Zs owned the following resources: their homestead, one car, $60,000 in CDs, a checking account of $65,000, and $15,000 in a savings account. Of these resources, the following items are used in completing the attribution:

$	60,000	CDs
	65,000	Checking account
+	15,000	Savings account
$	140,000	Total resources

The worker divides $140,000 by two, which equals $70,000. This amount is attributed to each spouse.

When determining Mr. Z's eligibility, the worker uses the Zs' resources at the time of application:

$	20,000	CD
	55,000	Checking account
+	5,000	Savings account
$	80,000	Total resources

The worker then subtracts the community spouse resource allowance ($70,000 for Mrs. Z) from the total resources. This leaves $10,000 available for Mr. Z. He is not resource-eligible for Medicaid payment of nursing facility care.

The attributed amount protected for the community spouse is maintained from the month of entry through the initial determination of the institutionalized spouse's Medicaid eligibility. Even if the total resources have increased or decreased by the time the spouse applied for Medicaid, the amount protected for the community spouse is the value of the resources attributed when the other spouse entered the institution.

However, if resources attributed to the community spouse are below the minimum allowance, and the couple later acquires resources that were not counted for attribution, these resources can be transferred to the community spouse to bring that spouse's resources up to the minimum.

1. When Mr. H enters a medical institution, the resources attributed to Mrs. H are $29,724. When Mr. H applies for Medicaid, the resources of Mr. and Mrs. H are $31,500 as of the first moment of the first day of the month of application.

   The worker subtracts the $29,724 attributed to Mrs. H from the total. Mr. H has $1,776. 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 $29,724. 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 $29,724. 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 $30,000. 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 $30,000 can be attributed to Mrs. I. The other $45,000 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 $33,950 in November. Mrs. D is attributed $29,724 and $4,226 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 $30,100. Subtracting the $29,724 attributed to Mrs. D, Mr. D has $376 in resources. Mr. D is resource-eligible under any Medicaid coverage group.

When Spouses Are Estranged

Legal reference: 441 IAC 75 (Rules in Process)

Attribute resources for estranged couples. "Estrangement" means a breakdown to the point that the spouses would not be living together if one was not institutionalized or were not living together before one spouse entered the institution. Determine estrangement by talking with the applicant.

If the institutionalized spouse is estranged from the community spouse, do not deny eligibility because of excess resources or failure to provide verification if the applicant can show hardship. To prove hardship, the applicant must demonstrate that:

- The applicant cannot get information about the community spouse's resources after exploring all legal means.
- The applicant is unable to access the estranged community spouse's resources after exploring all legal means, even though the community spouse's resources cause the applicant to be ineligible.

Assignment of Support Rights

Legal reference: 441 IAC 75 (Rules in Process)

Do not deny Medicaid for the institutionalized spouse if the resources owned by the institutionalized spouse are less than eligibility limits and the institutionalized spouse either:

- Has assigned any rights to support from the community spouse to the state, **or**
- Lacks the ability to execute an assignment because of physical or mental impairment.

To decide if the applicant lacks the ability to assign support rights, determine if the applicant has a guardian or conservator. If the applicant did not voluntarily choose to have a guardian or conservator, the client lacks the ability to assign support rights. No further verification is required.

If the applicant chose to have a guardian or conservator but it is alleged that the applicant lacks the ability to assign support rights, verify the lack of assignment ability with a physician's statement.

If you approve eligibility for an applicant who voluntarily or involuntarily has a guardian or conservator, send the following information to the Bureau of Financial, Health and Work Supports:

- The names and addresses of both spouses.
- The amount of the community spouse resource allowance.
- The amount of resources owned by the community spouse.

The Department will pursue support from the community spouse on a case-by-case basis. The state has the right to bring a support proceeding against a community spouse without an assignment.

The applicant is ineligible if the applicant owns resources that exceed limits, even if the applicant assigns support rights or lacks the ability to assign support rights.

Transfers to Establish Ongoing Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

After the month the institutionalized spouse is determined eligible, do not consider the resources **owned** by the community spouse to be available to the institutionalized spouse.

Resources that are owned wholly or in part by the institutionalized spouse and are not transferred to the community spouse **are** counted when determining ongoing eligibility.

However, do not consider these resources if the institutionalized spouse has declared, in writing, the intent to transfer ownership of the resources to the community spouse. Issue form 470-4888, *Institutional Spouse Intent to Transfer Resources*, to document the member's intent. The member can chose to sign and return the form or can provide a written statement.

If the institutionalized spouse does not intend to transfer resources, establish eligibility for the month of application only. Deny ongoing eligibility at the end of that month.

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 $29,724 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 $29,724 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 $3,000 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 $29,724, the amount attributed to Mrs. R (the community spouse) is $29,724. The remaining amount of $4,776 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 $29,724 attributed to Mrs. R, the attribution will be modified to substitute $103,119 for the $29,724 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 $35,000 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
+	35,000	Savings account
$	305,000	Total resources

   $148,620 is attributed to Mr. J. $156,380 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. $3,715.50 - $1,844.00 = $1,871.50 unmet need.

   The average estimate of the cost of an annuity to generate $1,871.50 per month is $45,000, which is less than the $148,620 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
	10,000	Checking account
+	35,000	Savings account
$	156,920	Total resources

   The worker subtracts the community spouse allowance of $148,620. This leaves $8,300 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 Enterprise (IME) 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 Enterprise (IME) either by using the local mail or by U.S. mail to PO Box 36478, Des Moines, Iowa 50315. The IME 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 IME 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 though 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 Enterprise (IME).

The IME 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 IME 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 Enterprise.

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

"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.

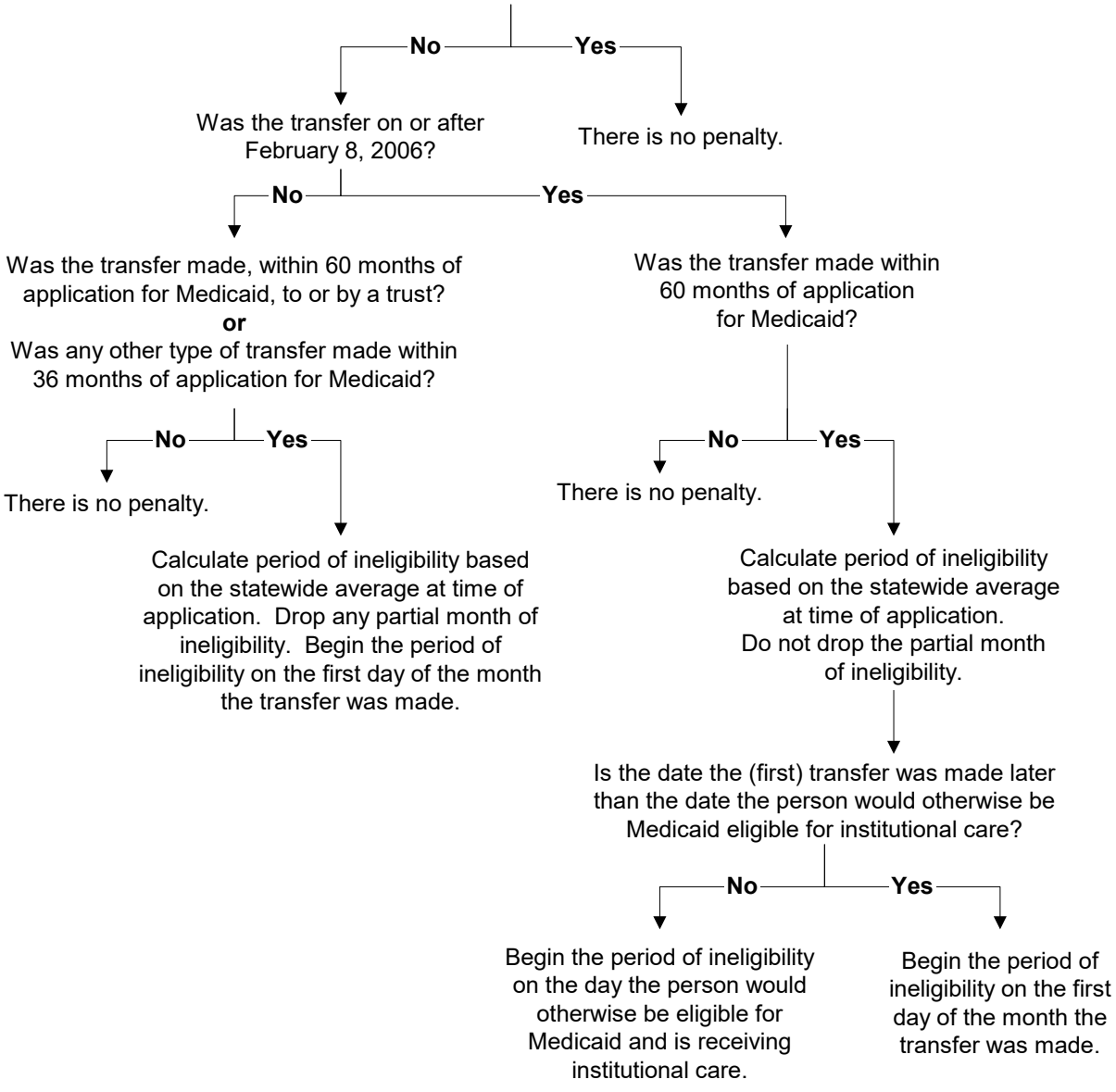
See Determining the Value of a Resource when establishing the fair market value or equity value of a resource. Assume that a person who transfers assets does so to become eligible for Medicaid unless they prove otherwise. See Rebuttal of Transfer of Assets.

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.

Transfer of Assets Flow Chart



Transfers That Cause a Medicaid Penalty

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

Transfers that currently may result in a Medicaid penalty being applied are:

- Transfers by an applicant or an applicant's spouse to someone other than a spouse that are made on or after February 8, 2006, and within 60 months before the Medicaid application is filed or on or after the date of application. This includes:
  - The disclaimer of an inheritance, and
  - Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") if the value received by taking against the will would exceed the inheritance received under the will
- Transfers by an applicant or an applicant's spouse involving funds in a trust that are made after August 10, 1993, and during the 60 months before the Medicaid application is filed and after institutionalization.

Purchases Considered Transfers for Less Than Fair Market Value

Legal reference: 441 IAC 75.23(9), (10), and (11)

A transfer of assets for less than fair market value includes, but is not limited to, the following actions:

- Purchase of an annuity **before** February 8, 2006, if the expected return on the annuity is not commensurate with a reasonable estimate of life expectancy, also referred to as "actuarially sound."

  When an annuity purchased before February 8, 2006, is "actuarially sound," then it is not considered a transfer of assets for less than fair market value. The annuitant has just converted the resources to income.

  To determine whether the annuity is "actuarially sound," use the life expectancy tables compiled from information published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

  The average number of years of expected life remaining for the annuitant must coincide with the life of the annuity. If the annuitant is not reasonably expected to live as long as or longer than the guarantee period of the annuity, the annuitant will not receive fair market value for the annuity based on the projected return.

  In that case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place. The penalty is assessed based on a transfer of assets that is considered to have occurred at the time the annuity was purchased or the date the annuity became available as a countable resource, whichever is later.

1. Mr. W, at age 65, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy according to the table is 17.19 years. Thus, the annuity is actuarially sound.
2. Mr. A, at the age of 80, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy is only 7.9 years. Thus, a payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and the amount is subject to penalty.

- Purchase of an annuity on or after February 8, 2006, by a **Medicaid applicant or member as the annuitant**, unless the annuity also meets **one** of first three conditions **and** the fourth condition described below:
  - The annuity is an annuity described in subsection (b) or (q) of section 408 of the United States Internal Revenue Code of 1986, or
  - The annuity is purchased with proceeds from:
    - An account or trust described in subsection (a), (c), or (p) of section 408 of the United States Internal Revenue Code of 1986;
    - A simplified employee pension (within the meaning of section 408(k) of the United States Internal Revenue Code of 1986); or
    - A Roth IRA described in section 408A of the United States Internal Revenue Code of 1986; or
  - The annuity:
    - Is irrevocable and nonassignable;
    - Is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration (see Annuities); and
    - Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; **and**
  - 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.
- 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 $29,724, 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.
2. Mr. W transfers his car, valued at $25,000, to Mrs. W while living at home. Mr. W applies for Medicaid. This is not a disqualifying transfer, since the car was transferred to the spouse, and the spouse did not transfer it.

- A transfer is made in response to a court order that the institutionalized spouse provide support for the community spouse, and the assets are transferred for:
  - The support of the community spouse, or
  - The support of a minor or dependent child, dependent parent, or dependent sibling of the institutionalized spouse or community spouse who lives with the community spouse.

When Mr. P enters a nursing facility, there is a court order stating that Mr. P should transfer $10,000 to First National Bank for the support of his son, Pat, who lives with Mrs. P. Since Pat lives with Mrs. P, and there is a court order requiring this transfer, it is not a disqualifying transfer. Mr. P is eligible for payment for nursing facility services.

- The transfer results in denial of eligibility that causes an undue hardship to the applicant or member. Undue hardship exists only when all of the following conditions are met:
  - Application of the transfer of asset penalty would deprive the applicant or member of food, clothing, shelter, medical care, or other necessities of life, such that the applicant's or member's health or life would be endangered.
  - The client who transferred the resource or the client's spouse has exhausted all means to recover the resource, including legal remedies and consultation with an attorney.
  - The client's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:
    - The home, if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

- Household goods.
- A vehicle required by the applicant or member for transportation.
- Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for nursing facility services.

> Mr. C transfers his home, with an equity value of $75,000, to his nephew and applies for Medicaid payments in a nursing home. The IM worker determines that Mr. C is ineligible for Medicaid for 30 months.
>
> Mr. C replies that he does not have the money to pay for care. He goes to his lawyer, who writes to the nephew requesting that the nephew return the home. The nephew refuses to return the home, and the attorney advises that no further legal recourse is available.
>
> Mr. C has met the requirement of exhausting legal means. Mr. C has the following assets: $500 cash and a burial fund of $1,500. The $500 is countable because it is available. Since the $1,500 is earmarked for burial and under $4,000, it is not available.
>
> Because Mr. C's available assets are less than the average statewide cost of nursing facility services, he also meets the second requirement and a hardship exception is granted.
>
> Because the transfer of asset penalty will not be applied and Mr. C is otherwise eligible, Medicaid nursing facility payments are approved from the date of entry.

- The applicant or member who transferred the asset makes a satisfactory showing that the applicant or member intended to dispose of the asset either at fair market value or for other valuable consideration equal to the fair market value. The client must verify the attempts to sell the asset for fair market value through an independent source.
- The applicant or member who transferred the asset makes a satisfactory showing that the asset was transferred exclusively for another purpose other than to establish eligibility for Medicaid. See Rebuttal of Transfer of Assets.
- The applicant or member who transferred the asset makes a satisfactory showing that all assets transferred for less than fair market value have been returned to the applicant or member.
- The applicant's or member's home is transferred to one of the following:
  - The spouse of the institutionalized applicant or member.
  - A child of the institutionalized person who is under age 21, or who is blind or totally disabled as defined by the Social Security Administration. The child is considered disabled if the child is:
    - Receiving SSI or Social Security benefits or Railroad Retirement benefits as a blind or disabled person, or
    - Declared disabled by a Department disability determination. See 8-C, *When the Department Determines Disability*.

- A sibling of the institutionalized applicant or member who has an equity interest in the home and who lived in the home at least one year immediately before the applicant or member became institutionalized or eligible for HCBS waiver or PACE services.

  Verify that the sibling has an equity interest and lived in the home for the required period of time.

- A son or daughter who was living in the parent's home for at least two years immediately before the date the parent became institutionalized, and who provided care to the parent that allowed the parent to live at home rather than in a medical institution. The parent can be either a biological parent or stepparent.

  Verify with a third party the length of time that the parent was able to stay home due to the care of the son or daughter.

1. On September 17, while Mr. W is living at home on his farm, he transfers his farm to his son, age 51. Mr. W enters a nursing facility on September 29. His son is not disabled, and did not provide care to Mr. W while Mr. W was at home.

   The worker determines Mr. W is subject to a penalty, because the son to whom the farm was transferred did not meet the criteria for exempting the transfer.

2. Ms. O has a 32-year-old daughter who has always lived with her, but does not provide care to Ms. O to enable her to stay at home rather than in a medical institution. She wants her daughter to have the home and transfers it after her entry to the skilled nursing facility.

   The daughter does not receive SSI, Social Security, or Railroad Retirement, but alleges a disability. Disability Determination Services determines that the daughter is disabled. The transfer of the home is not a disqualifying transfer.

3. Mr. E, who lives in a skilled nursing facility, transfers his share of his home to his brother. They inherited the home from their father and had lived there together for 20 years.

   This transfer does not disqualify Mr. E for payment of nursing facility services, since the brother had an equity interest and they had lived together more than one year before Mr. E's entry to a nursing facility.

Rebuttal of Transfer of Assets

Legal reference: 20 CFR 416.1246, IAC 75.23(5)"c"(249A)

Assume all applicants or members who transfer assets do so to become eligible for Medicaid unless the applicant or member proves otherwise. The burden of proof is on the applicant or member to prove assets were **not** transferred to meet eligibility requirements. The applicant or member must:

- Explain why the asset was transferred.
- Explain the applicant's or member's relationship to the person who received the transferred asset.
- Establish the fair market value and the equity value of the resource.
- Verify an attempt to dispose of the asset for a fair market value.

- Explain why less than the fair market value was accepted.
- Establish that an agreement, contract, or expectation was created at the time of transfer stating the applicant or member received or will receive compensation for the value of the transfer. Compensation is money, real or personal property, food, shelter, or services received by an owner in exchange for an asset.
- Explain how the applicant or member planned for self-support after the asset was transferred.

Include in the case record documents or letters made at the time of the transfer as evidence to verify that a transfer was not done to qualify for Medicaid.

Certain factors **may** indicate that a transfer was done for some reason other than to obtain Medicaid eligibility, such as:

- The transfer was made before the applicant or member was diagnosed with a previously undetected disabling condition or became suddenly traumatically disabled (for example, due to a car accident).
- The transfer that would have prevented eligibility was made before the applicant or member unexpectedly lost other assets or income. For example, at the time the assets were transferred, the applicant or member had enough income or assets to meet the applicant's or member's own needs without the use of Medicaid but then unexpectedly lost that income or asset.

  In July, Mr. J sells property valued at $8,000 for $5,000. He applies for Medicaid in October. Mr. J explains that he sold the property to pay medical bills of $3,900 incurred by his recently deceased wife. Although he was asking $8,000 for the property, he accepted less than fair market value because he needed the money quickly.

  At the time of the sale, Mr. J was receiving $1,500 in Social Security, $200 from a private pension, $200 in dividends from a company in which he owned stock, and $1,000 monthly cash support from his son.

  But in August, Mr. J's son died and the cash support payments ceased. In September, the company from which he had been drawing dividends went bankrupt, rendering his stock worthless, and removing that source of income.

  Mr. J presents as evidence copies of paid medical bills, a March agreement with a realtor to sell the property, copies of canceled checks showing monthly $1,000 payments to Mr. J, a copy of his son's death certificate, and newspaper clippings regarding the bankruptcy of the dividend-paying company.

  Mr. J has established that he sold the property exclusively for some other purpose than establishing Medicaid eligibility. The transfer does not affect Medicaid eligibility.

  The rationale for this determination is that Mr. J attempted to sell the property at fair market value and at the time of the sale had income that would have made him ineligible to receive Medicaid. He could not reasonably have expected to become entitled to Medicaid as a result of the sale.

- The transfer was of an asset that was excluded on the date of transfer and would continue to be excluded even if retained. Property that was excluded as a homestead property is considered an asset for this purpose.

If an excluded home is transferred for less than fair market value, the fact that it was excluded on the date of transfer and would continue to be excluded even if retained is not sufficient to establish that the transfer was done for some reason other than to obtain Medicaid eligibility.

- The transfer was a gift and a pattern has been established of giving gifts or contributing to a charity.

> Mr. Z applies for Medicaid on November 6. He has given his son $500 for Christmas every year since the son was born. Mr. Z shows convincing evidence that he made such gifts to his son every year at Christmas. The presumption that the assets were transferred to qualify for Medicaid is rebutted.

- The transfer was in exchange for support, maintenance, or services provided to the applicant or member as part of a binding agreement at the time of transfer. Determine the fair market value of the services received and the length of time the services will be provided.

> Mrs. H transferred her savings account of $5,000 to her son in July 1996, pursuant to a written agreement they made in October 1995 for him to provide her care until she went in the nursing home.
>
> The $5,000 was determined by the son charging $500 a month for 10 months of care. She rebutted the presumption that the transfer was made to attain eligibility.

If services will be provided for the client's lifetime, use the table of Average Number of Years of Life Remaining under Purchases Considered Transfers for Less Than Fair Market Value to determine if the resources were transferred for less than they are worth. This table comes from the Social Security Administration Office of the Actuary.

To determine the total value of support and maintenance for the client, multiply the current market value of the support and maintenance by the figure for average years of life remaining opposite the client's age. If the client's age is not on the chart, use the next lowest age on the chart.

If the value of the service is equal to or more than the asset, there is no transfer of assets.

Penalties for Transferring Assets

Legal reference: 441 IAC 75.23(1)

Transfer of assets after August 10, 1993, for less than fair market value by either a Medicaid applicant or member or the applicant or member's spouse disqualifies the applicant or member for Medicaid payment for:

- Nursing facility services.
- Level of care in a medical institution equivalent to that of nursing facility services.
- Home- and community-based (HCBS) waiver services. (A person receiving HCBS waiver services is considered as an institutionalized person.)

- Program for All-Inclusive Care for the Elderly (PACE) services. (A person receiving PACE services is considered as an institutionalized person.)
- Home health care services.
- Home and community care for functionally disabled elderly people.
- Personal care services.
- Other long-term care services.

The penalty period for transferring assets depends on when the assets were transferred and how much the assets were worth at the time the transfer occurred.

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, 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

To establish the penalty period for transfers made **before** February 8, 2006:

1. Determine the equity value of all assets transferred in the 36 months before the client applied for Medicaid, other than those transferred to or by a trust.
2. Determine the equity value of all assets transferred into or by a trust in the 60 months before the client applied for Medicaid.
3. Divide the total equity value of the transferred assets by the average monthly cost of nursing services at the time of application to determine the number of months of penalty. Drop any fraction remaining, so the result is in whole months.
4. Start the penalty on the first day of the month assets were transferred.

1. Mr. T transfers $100,000 to his next-door neighbor on April 11, 2005. He enters a nursing facility and applies for Medicaid on June 3, 2006. The worker determines that the transfer was made to qualify for Medicaid. The penalty period is figured by dividing $100,000 by $3,697.55, with a result of 27.05 months.

   Since the transfer was made before February 8, 2006, the partial month of ineligibility is rounded down to 27 months. Also, the penalty period begins on the first day of the month the transfer was made. Mr. T's period of ineligibility begins April 1, 2005, and lasts through June 30, 2007. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on July 1, 2007.

2. Mrs. A transfers $3,000 to her daughter on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on June 9, 2006.

   The worker determines that the transfer was made in order to qualify for Medicaid. The penalty period is figured by dividing $3,000 by $3,697.55, with a result of 0.811. Since the transfer was made before February 8, 2006, the result is rounded down and there is no period of ineligibility.

To establish the penalty period for transfers made **on or after** February 8, 2006:

1. Determine the equity value of all assets transferred in the 60 months before the client applied for Medicaid.
2. Divide the amount from step 1 above by the average monthly statewide cost of nursing facility services.
3. Multiply the full number of months from step 2 by the average monthly statewide cost of nursing facility services to determine the amount of the transfer that would be used to cover the full months.
4. Subtract (result of step 3) from the total assets transferred (amount in step 1) to determine the balance or partial month amount.
5. Divide the partial month amount (result from step 4) by the daily average statewide cost of nursing facility services to come up with the number of additional days for the partial month penalty.

6. Start the penalty on:
   - The date the applicant or member would otherwise be eligible for Medicaid payment of long-term care services, or
   - The level of care effective date for Medicaid HCBS waiver applicants, or
   - The level of care effective date for PACE enrollees, or
   - The first day of the month assets were transferred, whichever is later.

1. Mr. Z transfers $95,000 to his best friend on February 11, 2006. He 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 in order to qualify for Medicaid.

   Since the transfer took place after February 8, 2006, the partial month of ineligibility is not rounded down. The penalty period is figured as follows:

   a. Divide the total transferred by the statewide monthly cost of nursing facility services ($95,000 ÷ $3,697.55 = 25.69).

   b. Figure the amount used in the full 25 months of penalty (25 months × $3,697.55 = $92,438.75).

   c. Subtract this from the total transferred to come up with the partial month balance ($95,000 – $92,438.75 = $2,561.25).

   d. Take the partial month balance and divide by the statewide daily average cost of nursing facility services ($2,561.25 ÷ $121.63 = 21 days).

   The penalty period is 25 months and 21 days.

   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 ÷ 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.

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 ÷ $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 months ÷ 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 ÷ $3,697.55 = 19.2, or 19 months + 6 days). The total period of ineligibility is divided between Mr. and Mrs. S (19 months + 6 days ÷ 2 = 9 months + 18 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.

Code the COPAY field on TD03 to reflect the penalty period. (See instructions in 14-B-Appendix.) Set a reminder in the system for the month before the end of the penalty period, and redetermine eligibility at that time.

Multiple Transfers

Transfers Before February 8, 2006

When an applicant or member makes more than one transfer of assets for less than fair market value before February 8, 2006, determine ineligibility as follows:

- If the penalty periods would not overlap, consider each transfer separately. Drop the partial month of ineligibility and begin each period of ineligibility on the first day of the month when the transfer was made.
- If the penalty periods would overlap, consider the total uncompensated value as one transfer. Drop the partial month of ineligibility and begin the period of ineligibility on the first day of the month when the first transfer was made.

Transfers on or After February 8, 2006

When there are multiple transfers made on or after February 8, 2006, total all of the transfers made on or after February 8, 2006, and within the 60 months before application. Consider the total uncompensated value as one transfer.

Begin the period of ineligibility in the month of the first transfer or in the month the person would otherwise have been eligible for Medicaid payment of facility care, whichever is later.

- When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is later than the date the transfer was made, the period of ineligibility begins on the date the applicant or member would have been eligible.
- When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is earlier than the date the first transfer was made, the period of ineligibility begins on the date the first transfer was made.

1. Mrs. B transfers $3,000 to her daughter on November 25, 2005, and another $3,500 to her son on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on March 9, 2006.

   The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made before February 8, 2006, partial months of ineligibility are rounded down. No penalty is imposed because the amounts transferred are less than the statewide average cost of nursing facility services and the penalty is less than one month.

2. Mrs. M gave her granddaughter $60,000 in January 2005 and another $60,000 in January 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid in June 2006.

   The penalty period is figured by dividing $60,000 by $3,697.55, with a result of 16.23. The 16-month-period of ineligibility for the transfer made in 2005 would overlap the date of the next transfer made in 2006. The transfers were made before February 8, 2006. Total the two transfers and treat them as one transfer.

The penalty period is figured by dividing $120,000 by $3697.55, with a result of 32.45. The partial month of ineligibility is rounded down and the period of ineligibility is started on the first day of the month of the first transfer. The period of ineligibility begins on January 1, 2005, and runs through August 31, 2007. Mrs. M can reapply and, if otherwise eligible, be approved effective September 1, 2007.

3. Mrs. D gave her daughter $6,000 on February 1, 2006, and another $6,000 in March 2006. Mrs. D entered a nursing facility on March 3, 2006, and applied for Medicaid in June 2006. The worker determined the transfers were made in order to qualify for Medicaid. The first transfer was made before February 8, 2006, and the second one was made after February 8, 2006.

   The penalty period for the first transfer is one month. The partial month of ineligibility is rounded down ($6,000 ÷ $3,697.55 = 1.62 or 1 month). This period of ineligibility is started on the first day of the month of the transfer (February 2006).

   Mrs. D's period of ineligibility for the second transfer is determined to be 1 month and 19 days. It is started on March 3, 2006, and runs through April 20, 2006. If otherwise eligible, Mrs. D can be approved effective April 21, 2006.

4. Mrs. C transfers $3,000 to her daughter on February 25, 2006. She enters a nursing facility on March 3, 2006. On April 3, 2006, Mrs. C inherits $3,500 and transfers it to her son. On June 10, 2006, she applies for Medicaid payment of her nursing facility care.

   The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made after February 8, 2006, the worker totals the two transfers and treats them as one transfer.

   The penalty period is figured by dividing the total of $6,500 by $3,697.55, with a result of 1.76 months or 1 month and 23 days. If there were no penalty for transferring her assets, Mrs. C would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

   Since the date the first transfer was made is earlier than the date she would otherwise have been eligible, Mrs. C's period of ineligibility begins on March 3, 2006 (the day she would have been eligible). The penalty period lasts through April 25, 2006. If Mrs. C is otherwise eligible, she can be approved effective April 26, 2006.

Return or Partial Return of the Transferred Asset

Legal reference: 20 CFR 416.1246(a)(2), 441 IAC 75.23(5)"c"

If the transferred asset is returned, there is a change in the period that the uncompensated value of the asset affects eligibility. If the asset is returned in its entirety, the transfer penalty is expunged as of the first moment of the first day of the month after the return.

If the asset is partly returned, the period of ineligibility is determined by the difference in the value of the property transferred and the value of the property returned. Determine the changed period of ineligibility and apply it beginning the first month the transfer penalty was imposed.

The increase or decrease in value of the property transferred that may have occurred due to inflation or deflation from the time of transfer to the time of return does not affect the length of the period of ineligibility.

Changing the disqualification period does not necessarily establish eligibility.

Assets returned are not considered income, but are a countable resource if retained in the month following the month they were returned.

Trusts

Legal reference: 20 CFR 416.1201, 441 IAC 75.24(249A)

Treatment of resources in a trust depends on:

- When the trust was established.
- Whether the trust was established with the member's assets or with someone else's assets.
- What use of the trust income and principal is allowed by the terms of the trust.
- The member's role in relation to the trust.
- Whether the trust is revocable or irrevocable.
- The coverage group under which eligibility is being explored or established when a child is the grantor or beneficiary of the trust. (See Resource Eligibility of Non-MAGI Children later in this chapter, and 8-F, *Coverage Groups*, for more information.)

A person is considered to have "established" a trust if:

- The person's assets were used to form all or part of the principal of the trust, **and**
- The trust was set up by any of the following:
  - That person,
  - That person's spouse, or
  - A person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of that person or that person's spouse.

"Assets" means all income and resources of the person and the person's spouse. This includes any income or resources that the person or the person's spouse is entitled to but does not receive, because of action taken by:

- The person or the person's spouse.
- Another person, court, or administrative body acting at the direction or upon the request of the person or the person's spouse.
- Another person, court or administrative body with legal authority to act in place of or on behalf of the person or the person's spouse.

Trusts established with assets not owned by the beneficiary include testamentary trusts (established by a will) and inter vivos trusts (established by one living person to another).

Policy on trusts is organized as follows:

- Definitions of the basic terms used in describing trusts.
- How to evaluate a trust, depending on a client's roles in relation to the trust.
- Treatment of assets in a trust, including a comparison of the major kinds of trusts.
- More information on specific kinds of trusts.

Trusts established with assets owned by the beneficiary are treated differently depending on whether they are revocable or irrevocable and whether they were established after August 10, 1993. Irrevocable trusts established on or before August 10, 1993, are known as "Medicaid qualifying trusts."

Certain kinds of irrevocable trusts established after August 10, 1993, provide that the assets go to reimburse the state for the member's Medicaid expenses after the member's death. Trusts that are subject to different treatment because of these provisions are:

- Medical assistance income (MAIT) trusts.
- Special needs trusts for persons under 65.
- Special needs trusts with no age limit.

Trust Definitions

A **trust** is an arrangement whereby one or more persons (the trustees) hold property for the benefit of one or more others (the beneficiaries). Trusts include two types of assets:

- **Trust principal** is the property placed in trust by the grantor that the trustee holds, subject to the rights of the beneficiary, plus any trust earnings paid into the trust and left to accumulate the month following the month of receipt.
- **Trust earnings or income** are amounts earned by trust principal, such as interest, dividends, royalties, or rents. These amounts are unearned income to the beneficiary if the beneficiary is legally able to use them for personal support and maintenance.

A trust can be established by a written document, including a will. A trust can also be established by a verbal understanding between the grantor and the trustee when the property has been transferred to the trustee.

No court involvement is necessary to establish a trust. The grantor and the beneficiary can be the same person, and the grantor can be the trustee, but the trustee and the beneficiary cannot be identical. If the trustee and the beneficiary are identical, the trustee/beneficiary owns the property outright.

NOTE: The trustee and the beneficiary are not identical if the state is a residuary beneficiary. The trustee and the life-time beneficiary may be the same person on a qualifying special needs or MAIT trust where the state is a residuary beneficiary.

A **grantor** is a person who sets up a trust. A person may be a grantor if an agent or someone legally empowered to act on behalf of the person or the person's spouse (such as a legal guardian, representative payee, person acting under a power of attorney, or conservator) establishes the trust with the person's funds or property. The terms grantor, trustor, and settlor may be used interchangeably.

A **trustee** is a person or entity who holds legal title to property for the use or benefit of another person. In most instances, the trustee has no legal right to revoke the trust or use the property for the trustee's own benefit. However, if the member is a trustee and has the legal ability to revoke the trust and use the money for the member's own benefit, the trust is a resource to the member.

A **beneficiary** is a person who benefits from the principal or income. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. A trust may have more than one beneficiary.

A **residual or residuary beneficiary** benefits from the income and principal after the primary beneficiary is no longer involved, for example, due to the death of the primary beneficiary. The residuary beneficiary receives no benefit from the trust until certain conditions are met.

A **Totten trust** is a tentative trust in which a grantor makes himself or herself trustee of the grantor's own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Therefore, consider the principal and income of a Totten trust available to the member. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

A **conservatorship** is similar to a trust. A conservatorship is always established by a court, which explicitly appoints a conservator to act on the ward's behalf for the ward's financial affairs. Treat a conservatorship established on or after February 9, 1994, as a trust. See Revocable Trusts and Irrevocable Trusts to determine availability and whether transfer of asset policies apply.

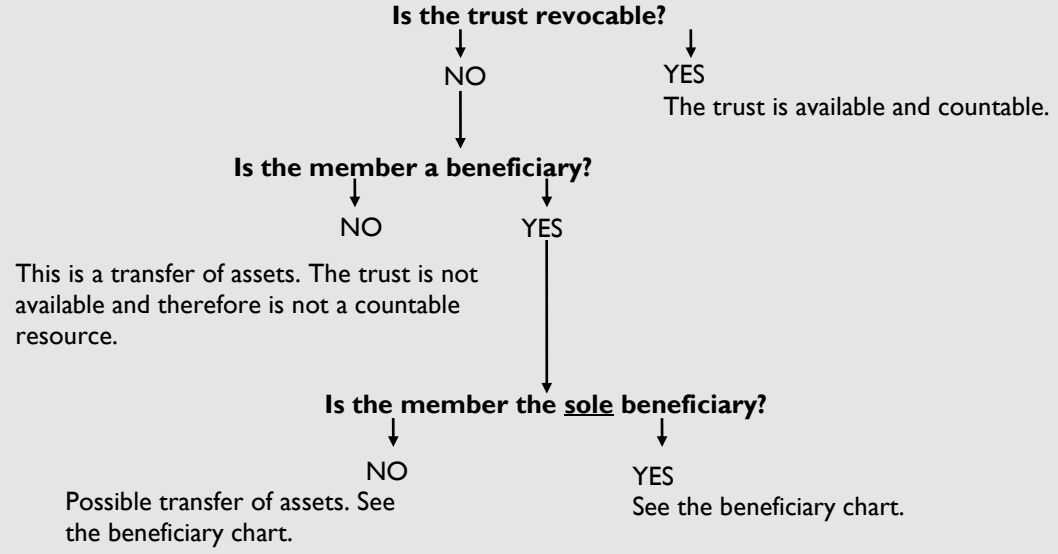
Evaluating a Trust

The following charts provide a guide to understanding trusts. Use the appropriate chart depending on whether the member is the grantor, the trustee, or the beneficiary. The member may occupy more than one role.

1. Mr. J is the grantor and also the beneficiary of a trust. Use the grantor and the beneficiary trust charts to determine availability and accessibility of the trust principal and income when determining Medicaid eligibility.
2. Mr. D is the grantor and trustee of a trust that names his niece as the beneficiary. Use the grantor and trustee charts to determine the availability of the trust principal and income when determining Mr. D's Medicaid eligibility.
3. Ms. M is the beneficiary of a trust. Use the beneficiary chart to determine the availability of the trust principal and income when determining her eligibility.

Grantor Chart

Use this chart if the member created the trust, or an agent or someone else legally empowered to act on the member's behalf established the trust with funds or property belonging to the client. (The member is the grantor.)



Trustee Chart

Use this chart if the member holds legal title to property for the use or benefit of another. (The member is the trustee.)

Does the trustee have power to revoke and use the trust principal and income for the trustee's own benefit?

NO

Is the trustee also a beneficiary?

NO

The trust principal and income are not available. Look for trustee fees.

YES

Is the member both sole trustee and sole beneficiary (or are all trustees also all beneficiaries)?

NO

See the beneficiary chart. Refer the trust to the Medicaid trust program at: trust@dhs.state.ia.us.

YES

The principal and income are available to the client or to all trustees as a joint asset. Refer the trust to the Medicaid trust program at: trust@dhs.state.ia.us.

YES

The trust is available to the trustee. The trust principal and income are countable as income and resources to the trustee.

Beneficiary Chart

Use this chart if a trust exists for the benefit of the member. (The member is the beneficiary.) The member does not hold legal title to the trust property but does have an equitable ownership interest in it.

Is the beneficiary also the grantor?

NO

Apply appropriate Non-MAGI-related or MAGI-related policy.

YES

Was the trust established after August 10, 1993?

NO

For trusts established on or before August 10, 1993, apply Medicaid qualifying trust policies.

YES

For trusts established after August 10, 1993, evaluate the trust under the revocable or irrevocable policies unless it is:

- A special needs trust for persons under 65 years old,
- A medical assistance income trust, or
- A special needs trust (no age limit).

Treat according to the policies found in this chapter.

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.

	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Established by:	Someone other than the member is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.
Established with:	Funds not owned by the beneficiary before trust was established.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.
Availability of principal and income	Discretionary: Principal and income are not necessarily available to the beneficiary. Principal and income available to the beneficiary for basic needs is countable as resources and income when determining eligibility, client participation, and spenddown. Principal and income available for nonbasic needs only are not countable as resources and income.	Discretionary: The maximum amount that may be made available by the trustee under the terms of the trust, assuming the trustee exercises full discretion in the distribution of the income and principal is countable in determining eligibility, client participation, and spenddown. See Transfer of Assets for any principal or income not available to the grantor.	The principal and income are considered available and countable to the extent they could be made available, under any circumstances or for any purpose, according to the terms of the trust. See Transfer of Assets for any principal or income not available to the grantor.	Principal and income are available and countable to the beneficiary when determining eligibility, client participation, and spenddown. See Transfer of Assets Any payments from the trust not for the benefit of the client are assets transferred for less than fair market value.
Use in Medicaid and State Supplementary Assistance	Count amounts available according to the terms of the trust.	Amounts that count toward FIP, SSI, or SSA cash payments are not used in determining Medicaid eligibility.	Any available principal or income counts toward resource and income limits. If not available, see transfer of asset policy.	Count principle and income as available.

Procedure: Refer trusts and conservatorships, including MAITS, for review by the Medicaid Trust Program. Even if clarification is not needed for Medicaid eligibility purposes, the referral is needed for proper tracking of Medicaid payback trusts. A referral should also be made when requested by Trust Program staff even if there is no Medicaid case.

Referring trusts and conservatorships is also needed to:

- Clarify how the terms of the trust impact eligibility;
- Make Trust Program staff aware when an inaccessible trust is held by an active member, a trustee is not abiding by the terms of the trust, or the trustee has the authority to use the principal of the trust for medical expenses but has not done so.

Make the referral for initial review by sending form 470-0116, *Clarification Request*, to trust@dhs.state.ia.us. (See 1-B-Appendix for form instructions.)

In the clarification request:

- Identify the client by name (if the trust beneficiary is a child, provide the child's name, not the case name), social security number, date of birth and state identification number. (This information is essential because program staff do not have access to the ABC system, Online Narrative, or electronic case files.)
- Provide all the case numbers of the files where you want the response placed.
- Identify relationship of client to the grantor or trustor.
- 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.

Review procedure for other "pay-back" trusts:

When the trust has been **approved**:

1. The Trust Program will:
   - Forward the request to eligibility policy staff for eligibility review; and
   - Email a status update to alert the worker that the trust is now at central office.
2. The worker should make a note in the on-line narrative in case another worker has questions.
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.

When the trust has been **denied**, the Trust Program will:

1. Send a letter to the attorney or trustee explaining that the trust does not meet the criteria; and
2. Email a copy of the letter to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list. (If the request does not contain a case number, the response will be emailed to the requesting worker.)

Review procedure for non-"pay-back" trusts:

1. The Trust Program will:
   - Forward the request to the eligibility policy staff for review; and
   - Email a status update to alert the worker that the trust is now at central office.
2. The worker should make a note in the on-line narrative in case another worker has questions.

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.

In both cases, any payments from either trust principal or trust income that are made to the applicant or member or made for the applicant's or member's basic needs are countable income in the period of intended use and a resource thereafter. (EXCEPTION: Do not count resources for MAGI-related Medicaid.) If payments are made to vendors for basic needs, see policies in 8-E, *Non-MAGI-Related In-Kind Income* or *In-Kind Unearned Income*.

Medicaid Qualifying Trusts

Legal reference: 441 IAC 75 (Rules in Process), P. L. 99-272, P. L. 99-509, section 9435(c)

A Medicaid qualifying trust is a trust or similar legal device which:

- Was established on or before August 10, 1993.
- Is not established by a last will and testament.
- Is established by an applicant or member, the applicant's or member's spouse, or someone acting for them.
- Is established from funds belonging to the applicant or member or the spouse.
- Allows or names the applicant or member to be the beneficiary of payments from the trust.
- Has one or more trustees determine the distribution of payments.
- Permits the trustees to exercise discretion with respect to the distribution of trust principal and income to the beneficiary.

When someone with power of attorney, a conservator, a guardian, a lawyer, or a court acts on behalf of the applicant or member to set up the trust, treat it as though the applicant or member set up the trust.

The amount of income and principal from a Medicaid qualifying trust that is considered available is the maximum amount that may be permitted under the terms of the trust, assuming the trustees exercise full discretion in the distribution of the income and principal.

EXCEPTION: Trusts or initial trust decrees established before April 7, 1986, solely for the benefit of a person with an intellectual disability who lives in an intermediate care facility for persons with an intellectual disability are exempt.

Evaluate an irrevocable trust established on or before August 10, 1993, under this policy. The terms of the trust that specify the available income and principal determine the amount counted as available to the applicant or member, regardless of whether any payments are actually being made. Treat a trust established for medical payments as a third-party resource.

1. Miss T established a trust in July 1985 as the result of a settlement of a malpractice suit. Since she has an intellectual disability and lives in an intermediate care facility for persons with an intellectual disability (ICF/ID), and since the trust was established before April 7, 1986, this is not a Medicaid qualifying trust.
2. Mr. D established a trust for himself and his wife in 1972. Mrs. D applies for Medicaid and she is a co-beneficiary of the trust. This is a Medicaid qualifying trust.

A trust established by the last will and testament of a spouse is not a Medicaid qualifying trust. Trusts set up with funds not owned by the member or spouse are not Medicaid qualifying trusts. Burial trusts set up by a member or spouse, are not Medicaid qualifying trusts when the funds are available only upon death, and the member is not the beneficiary of the trust.

Trusts set up by charity or a fund raising activity are not Medicaid qualifying trusts unless the money is given to the member, who then creates the trust. NOTE: If the charity or fund raising present the proceeds to the person and the receiver sets up a trust on or before August 10, 1993, this is a Medicaid qualifying trust.

Counting Income or Resources

Legal reference: 441 IAC 75 (Rules in Process)

Consider trust income available as specified by the terms of the trust, even if the trustees do not actually pay the income according to the terms of the trust.

Count trust principal (including accumulated income) available to the member as a resource. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

EXCEPTION: If the terms of the trust explicitly limit the amount of principal that is made available on an annual (or specified less frequent) basis, the principal is countable income beginning the month it becomes available. Prorate it for the period of accessibility and intended use.

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.

Mrs. P, an NF resident, has social security income of $245. She also has civil service income of $310. She has a Medicaid qualifying trust that could pay $120 a month for expenses if she needed the money.

Eligibility for Medicaid is determined as follows:

$ 120.00	Trust income
245.00	Social Security Income
+ 310.00	Civil Service income
$ 675.00	To compare to the 300% income limit (Medicaid cap)

Her income used to determine client participation is $675.00.

Trusts Established After August 10, 1993

When the client or someone acting on the client's behalf created a trust using the client's assets after August 10, 1993, determine whether the client is a beneficiary of the trust. If the client is not a beneficiary, investigate the trust as a transfer of assets.

If the client is a beneficiary, treatment of the trust depends on whether the trust is revocable or irrevocable. Three special kinds of irrevocable trusts (Medical Assistance Income Trusts (MAITs) and two special needs trusts) also receive different treatment.

Revocable Trusts

Legal reference: 441 IAC 75.24(2)"a"

When an applicant or member establishes a revocable trust established after August 10, 1993, the **principal** of the trust is an available **resource**. **Payments** from the trust to or for the benefit of the applicant or member (as beneficiary) are countable **income** to the applicant or member in the period of intended use when determining income eligibility for Medicaid.

Any payments from the trust other than those made to or for the benefit of the applicant or member (beneficiary) are assets transferred for less than fair market value.

Irrevocable Trusts

Legal reference: 441 IAC 75.24(2)"b"

If the applicant or member or that person's spouse establishes an irrevocable trust after August 10, 1993, which names the applicant or member as a beneficiary, determine what payments are allowed from the trust.

If payment could be made to or for the benefit of the applicant or member (as beneficiary) for any purpose, count the portion of the **principal** from which that payment could be made as a **resource**. Also count any income earned on the principal from which payment could be made.

Payments from the trust principal or income to or for the benefit of the applicant or member (beneficiary) are countable **income** in the period of intended use and a countable resource the following month.

Payments from trust principal or income for any other purpose are a transfer of assets for less than fair market value. Determine the period of ineligibility according to Penalties for Transferring Assets.

Any portion of the trust or any income on the principal from which no payment could be made to the applicant or member (beneficiary) under any circumstances is a transfer of assets for less than fair market value. The transfer occurred on the later of the date the trust was established or the date on which payment to the beneficiary was no longer available.

Determine the value of the transfer by including the amount of any payments made from the trust after the date of foreclosure. Determine a period of ineligibility according to Penalties for Transferring Assets.

Payments made on behalf of the beneficiary are countable income in the month the payment is made despite the purpose of the payment. FIP and SSI rules do not apply to irrevocable trusts established with an applicant's or a member's own assets after August 10, 1993.

Special Needs Trust for Persons Under 65 Years Old

Legal reference: 441 IAC 75.24(3)"a," Iowa Code 633C.1, 633C.2

A special needs trust for persons under 65 years old must meet the following conditions:

- The trust is an irrevocable trust.
- The trust is established after August 10, 1993.
- The trust is created with the assets of a person who is under the age of 65 and is disabled as defined by the Social Security Administration.
- The trust is established for the benefit of the beneficiary by a parent, grandparent, legal guardian of the beneficiary, or a court.
- The trust provides that the state of Iowa will receive all amounts remaining in the trust upon the death of the beneficiary, up to an amount equal to the total Medicaid paid on behalf of the beneficiary.

When the Social Security Administration or the Railroad Retirement Board has not determined a person disabled, the Department must determine disability for this policy to apply. Send a referral to the Disability Determination Services Bureau. See 8-C, *When the Department Determines Disability*.

The principal of a special needs trust is not a countable resource. Income paid into the trust is not countable. Count only the income paid from the trust or made available to the member as income. Payments from the trust follow the same rules as described in 8-E, *Medical Assistance Income Trusts (MAITs)*.

When a member with a special needs trust reaches age 65, the trust retains its exempt status. However, any additions to the trust after the member reaches age 65 (other than those generated by the preexisting trust assets) are countable assets. Also:

- The income generated by any such additions is countable income.
- These additions will be considered a transfer of assets for less than fair market value.

Medical Assistance Income Trust (MAIT)

Legal reference: 441 IAC 75.24(3)"b," Iowa Code 633C.1, 633C.3

A medical assistance income trust (MAIT) must meet the following conditions:

- The trust is an irrevocable trust established after August 10, 1993.
- Only the beneficiary's earned and unearned income is deposited into the trust.
- The state will receive the remaining balance in the trust upon the death of the beneficiary, up to the amount Medicaid paid out for the beneficiary.
- The trust may be revocable, if a clause is added that upon revocation or termination, the trust and income will be paid back to the state up to the amount of medical assistance paid on behalf of the beneficiary.

The principal of a medical assistance income trust is not a countable resource. Determine available income as directed in 8-I, *Members With a Medical Assistance Income Trust*, and 8-E, *Medical Assistance Income Trusts (MAIT)*.

Special Needs Trust (Pooled Trust)

Legal reference: 441 IAC 75.24(3)"c," Iowa Code 633C.1, 633C.2

A special needs trust or pooled trust for persons under 65 years of age is a trust that meets the following conditions:

- The trust is established after August 10, 1993, and provides that the state will receive the remainder of the trust principal and income upon the death of the beneficiary.
- The trust contains the assets of a person who is disabled as defined by Social Security Administration.
- The trust is established and managed by a nonprofit association.
- The association maintains a separate account for each beneficiary of the trust, but pools these accounts for purposes of investment and management of funds.
- Accounts in the trust are established solely for the benefit of people who are disabled (as defined by Social Security Administration).

- Accounts are established by the parent, grandparent, or legal guardian of the beneficiary, by the beneficiary, or by a court.
- Upon death of the beneficiary, all amounts remaining in the beneficiary's account not retained by the trust are paid to the state of Iowa up to the amount of medical assistance paid on behalf of the beneficiary.

For this policy to apply to a person who has not been determined disabled by the Social Security Administration, the Department must determine disability. See 8-C, *When the Department Determines Disability*.

When a trust qualifies as a special needs trust, count the principal and income as available according to the terms of the trust.

Any additions made to the trust after the trust beneficiary reaches age 65 will be considered a transfer of assets for less than fair market value.

Resource Eligibility of Non-MAGI-Related Children

Legal reference: 441 IAC 75 (Rules in Process)

Disregard the resources of all household members when determining eligibility for children in certain coverage groups. Continue to count resources when determining eligibility for children in all other coverage groups according to the policies in this chapter.

The age limit for determining if a person is a child or an adult is the age limit for the coverage group under which Medicaid is being received or under which eligibility is being explored or established. See 8-F, *Coverage Groups*, for more information.

The following chart lists all coverage groups under which children can establish eligibility and whether household resources are disregarded or counted in determining children's eligibility.

Coverage Group Name	Are Resources An Eligibility Factor For Children?
SSI recipients in their own homes and recipients of mandatory supplements	Yes
SSI recipients in medical institutions	Yes
People eligible for SSI benefits but not receiving them	No
Essential persons	Not applicable. A child cannot be an essential person.
Ineligible for SSI or SSA due to requirements that do not apply to Medicaid	Yes
Ineligible for SSI or SSA due to Social Security COLAs (503 medical only)	Yes
Ineligible for SSI or SSA due to Social Security benefits paid from a parent's account	Yes
Ineligible for SSI or SSA due to Social Security increase of October 1972	Yes

Coverage Group Name (Cont.)	**Are Resources An Eligibility Factor For Children?** (Cont.)
Ineligible for SSI due to substantial gainful Activity (1619b)	Yes
Ineligible for SSI or SSA due to actuarial change for widowed persons	Yes
Ineligible for SSI or SSA due to receipt of widow's social security benefits	Yes
Ineligible for SSI due to residence in a medical institution	Yes
People in medical institutions under 300% income level	No
Medicaid for Kids with Special Needs	No
Medically Needy	No
Qualified disabled and working persons (QDWP)	Yes
Qualified Medicare beneficiaries (QMB)	Yes
Specified low-income Medicare beneficiaries (SLMB)	Yes
Expanded specified low-income Medicare beneficiaries (expanded SLMB)	Yes
Medicaid for employed people with disabilities	Yes

1. The C family applies for the HCBS ID waiver for Child C. Child C is the grantor and beneficiary of a trust with a countable value of $197,345. Income produced by the trust is countable, not excluded. If all other eligibility factors are met, Child C is eligible under the 300% group, since household resources are disregarded in determining children's eligibility under this group.

2. Child B, age 15, lives in an ICF/ID and is eligible for Medicaid and facility care under the coverage group for people who are ineligible for SSI due to residence in a medical institution. Child B has countable monthly income of $100 and countable resources of $1,800.

   At the annual review, the worker determines that Child B's countable resources now total $2,100. Since Child B is no longer eligible under this coverage group, the worker completes an automatic redetermination. Child B can be determined eligible under the 300% group, since resources are not an eligibility factor for children in the 300% group and because Child B's income exceeds the SSI maximum for a person in a medical institution ($30).

General Non-MAGI-Related Resource Policies

The following sections describe SSI-related policies on:

- Resource limits.
- What resources to count.
- Joint ownership of real property.
- Disputed ownership.
- Determining the value of a resource.
- Deeming resources from a spouse or parent.
- Eligibility while trying to sell a nonliquid resource.
- Long-term care asset protection.
- Resources exempt for Medicaid for Employed People with Disabilities.

Non-MAGI-Related Resource Limits

Legal reference: 20 CFR 416.1205, 441 IAC 50.2(1), 75 (Rules in Process)

For SSI-related Medicaid eligibility, the resource limit is:

- $2,000 for an individual, and
- $3,000 for a married couple living together.

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 $9,090 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 $13,630 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 $13,000 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 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.

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.

Liquid Resources

"Liquid resources" are assets that can be converted to cash within 20 days. Following are examples of liquid resources.

- **Annuities**. Count the salable value of an annuity or the amount the company will pay back to the applicant or member if the annuity is cashed in. Ask the client to obtain a statement from the company regarding the lump sum and the cash-in amount.

If the annuity cannot be cashed in but is assignable or can be transferred, ask three knowledgeable sources what its value is. Average the three values.

Most annuities allow benefits to be assigned or ownership sold. An applicant or a member who claims that an annuity cannot be sold or transferred must obtain verification.

- **Bonds**. The countable value of the bond is its redemptive value on the first moment of the first day of the month.
- **Cash**, unless it was counted as income for the month or specifically excluded as a resource, such as a retroactive SSI lump sum.
- **Checking and savings accounts**. Subtract verified outstanding checks and any funds included in the accounts that are specifically excluded as a resource.

  If funds intended for the following month are direct deposited or deposited by the applicant or member before the intended month, do not count the funds as a resource in the month they were intended to cover. Remember to count the funds as income.

> Mrs. J has $2,000 in checking as of midnight on May 31. She receives her social security check of $700 June 1. This check is not a factor in determining resources, because $2,000 was countable as of the first moment of the first day of the month.

For co-owned accounts, if two or more account holders are either Medicaid applicants or members or are people whose income and resources must be considered for Medicaid eligibility (such as spouses or parents of minor children), count an equal share of the account for each.

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.

> Mr. N's grandfather had transferred land to Mr. N in October but had not told him. Mr. N was told the following May. Mr. N provides verification with a letter from his uncle establishing that there was no prior knowledge. The $5,000 value of the land is income to Mr. N in May. The land is a resource in June unless it is sold.

If the applicant or member has the legal ability to convert a resource to cash, it is not necessary that they have possession of the resource for it to be counted. EXCEPTION: An applicant or a member must possess a savings bond for it to be counted. Savings bonds have no resource value for six months from the issue date.

Joint Ownership of Real Property

Legal reference: 20 CFR 416.1201, 20 CFR 416.1201(a), 20 CFR 416.1245(a)

If real property is owned by more than one person, assume all persons have equal shares, unless you are able to determine differently. If a client does not own an equal share in a resource, count only the portion owned by the client.

If the client jointly owns real property, evaluate the details of ownership and the particulars of the situation to determine how shared ownership affects the value of the property as a resource.

In Iowa, people who jointly own property and wish to dispose of their interest in the property may do so. The refusal of one owner does not preclude any other owners from selling their ownership interest. (After the sale of the property, the new owners can petition the court for a partition action.) So, joint ownership does not preclude the property from being a countable resource, but it may affect the countable value of the seller's interest.

If a client jointly owns real property in another state, state law there may require the co-owner to move if the property is sold. If so, exclude it as a resource if the disposal of this property would cause undue hardship to the co-owner due to lack of housing. Obtain verification of the joint ownership and the applicable state law. The co-owner must use the property as the principal place of residence and have no other housing readily available.

Mr. J owns 40% of a 100 acre farm as tenant in common with his brother. The interest is referred to as "undivided." Specific acres are not identified as belonging to Mr. J, but he could sell his 40% interest. If Mr. J dies, his ownership passes to his heirs.

"Joint tenancy" means that two or more persons own an interest in and possession of the entire property. An owner's portion can be sold. If an owner dies, the ownership passes **to the other owner**.

Mr. J owns 40% of the 100 acre farm with Mr. T in joint tenancy. His interest is undivided but he could sell his 40% interest. If Mr. J dies, his ownership interest passes to Mr. T.

"Leasehold" means the lessee has the right to the use of the property for a specified period of time. A lessee may sell that right. Verify the countable value with a statement from a knowledgeable source.

Disputed Ownership

Legal reference: 20 CFR 416.1201, 20 CFR 416.1208

Count jointly owned resources unless the client rebuts ownership. Allow the client to rebut ownership of all or part of jointly owned liquid and nonliquid resources. To do this, the client must establish:

- That the client's money is not deposited in the resource, or the proportion of money deposited by the client in relation to the total money deposited.
- The reason for the joint ownership.
- Whether the client made any withdrawals from the resource for the client's own use, or made withdrawals proportional to the client's share of the money.
- Whether the resource was altered to reflect true ownership interest.

If the client successfully shows either no ownership or partial ownership and changes the resource to reflect this, the ownership is then established at the beginning of the financial arrangement. Count only the part that the client could not prove belonged to another person. See Liquid Resources for countable amounts of co-owned checking and savings accounts.

Mrs. N and Mr. F, who are brother and sister, jointly own a bank account. Mrs. N has her name on the account to handle Mr. F's business, since he is not able to do so. Mr. F is not a Medicaid applicant or recipient.

Mrs. N applies for Medicaid on October 11. She lists the account, which has $6,000 as of October 1. She proves that all the deposits were Mr. F's and she did not use any of the withdrawals. She changes the name on the account to show the true ownership. This account is not countable to Mrs. N.

Determining the Value of a Resource

Legal reference: 20 CFR 416.1201

Policy: The **countable value** of a resource is the equity value. The **equity value** is the current fair market value minus any legal debt on the item. To be considered a debt against the resource, the debt must be legally recognized as binding on the resource's owner. The **current fair market value** is the amount an item can be sold for on the open market.

Procedure: If a client is trying to sell property:

- The client should provide verification of the fair market value of the property.
- If the client provides verification that the client has tried to sell the property at the fair market value and it did not sell, consider a lower amount to be fair market value as long as it seems reasonable.
- Use the prudent-person concept when determining if the lesser fair market value amount is reasonable.

When property is sold at an auction, the current fair market value is considered to be the highest bid, as long as the client has provided verification that both:

- Attempts to sell the property at fair market value have been unsuccessful; **and**
- The auction was advertised to the public.

If either of these criteria has not been met, assess a transfer of assets penalty for the difference between the fair market value and what the property sold for.

1. Mr. M applies for nursing facility assistance. He has listed his home on the market in January at the assessed value of $125,000. By May, he has not had an offer. Mr. M then lowers the price of his home to $120,000. In July there are still no offers on the home. In August, he again lowers the asking price to $116, 000. In September, the home sells for $112,000.

   As long as Mr. M can provide verification of the listings, sale of the home is not considered to be a transfer of assets, because Mr. M tried to sell the home for fair market value. The fair market value is considered to be the amount that the home sold for.

2. Ms. J applies for Medicaid. She has a home with a current assessed value of $95,000. She lists her home for $95,000 and after two months has not yet had an offer. Ms. J drops the listing on her home to $45,000 and sells her home two weeks later.

   The sale is considered to be a transfer of assets for less than fair market value.

When determining the equity value of a resource:

- Deduct from the current market value only the principal amount of the debt and any prepayment penalties required. Do not consider any future interest owed.

- Determine the ownership of jointly held resources, such as joint checking or savings accounts and jointly held real estate, according to the intent of the parties who created the joint interests upon the creation of the joint interest.

  If the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, divide the fair market value of the entire resource between the joint owners according to the shares specified.

  If the shares of the joint owners are not specified, assume equal shares for all joint owners, unless evidence of intent shows unequal shares. Examples of evidence of intent showing unequal shares include:

  - The source of the funds used to purchase or create the joint resource.
  - The use made of the joint resource.
  - The inclusion of one of the joint owners as a caretaker for the convenience of the other, etc.

- If excluded funds are combined with countable resources, assume the countable resources are spent first.
- 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.

When an applicant is living in the same household with an ineligible spouse, include the resources of the ineligible spouse in determining the application's eligibility. Do not, however, deem pension funds controlled by an employer or union, or IRA or Keogh accounts.

See 8-D, *Non-MAGI-Related Resource Limits*, to determine which resource limit to apply.

If spouses who are both eligible for Medicaid separate, including when one spouse enters a medical facility, discontinue deeming the month after the month of the separation. Separation means that the spouses are not expected to be living together for a full calendar month.

Before entering a nursing facility, Mrs. L was living at home with her spouse. She will be in the facility for less than 30 days. Their countable resources are as follows:

$ 1,800	Savings account in Mr. L's name only
+ 500	Vacant lot owned by Mr. L
$ 2,300	Total resources of Mr. and Mrs. L
- 3,000	Limit for a couple
$ .00	Excess resources

Since resources deemed to Mrs. L do not exceed the resource limit for a couple, eligibility exists.

Deeming From a Parent to a Child

Legal reference: 20 CFR 416.1856, 20 CFR 416.1202

Before deeming resources from a parent to a child, see 8-D, *Resource Eligibility of Children*. If the child's eligibility is determined under a coverage group where resources are exempt, there is no need to deem resources from the parents.

A "child" is a person who is:

- Not married,
- Not the head of the household, and
- Either under age 18 or under age 22, if a student regularly attending a school, college, university, or course of vocational or technical training to prepare for gainful employment.

When an eligible child is living in the household with an ineligible parent or stepparent, include the parent's and stepparent's resources when determining the child's eligibility unless the stepparent is the only person living with the child. If the child lives with the stepparent and not the biological parent, there is no deeming.

Do not deem a parent's resources to other ineligible children. Do not count or deem resources of ineligible children to the eligible child.

The child's resources are any resources the child owns plus any resources deemed from the parents. Determine the child's resources independently of the parents' resources. Consider household goods and personal effects owned by the child separately from those owned by the parents. Do not exclude more than one home and one vehicle for the family.

To deem the parents' resources to a child:

1. Allow the parents all the exclusions for which they would be eligible if they were eligible for Medicaid. Do not deem an ineligible parent's pension funds if they are controlled by the employer or by the union or are in an IRA or Keogh account.
2. Deduct $2,000 for an individual (if one parent) or $3,000 for a couple (if two parents) before deeming to the child.
3. Deem the remaining countable resources to the child.

A child is not eligible if the child's own resources plus the value of the resources deemed from the parents exceeds the $2,000 resource limit unless the child is eligible under QMB, SLMB, or Medically Needy. See 8-F.

Sam, age 17, was living with his parents and two brothers before entering a residential care facility (RCF). Sam has a $50 savings account in his own name. The parent's resources are as follows:

$	30,000	Value of home they live in
$	3,200	Parent's joint savings account

The home is excluded. $200 resources are available for deeming. ($3,200 minus $3,000 SSI exclusion for a couple.)

$	200	Deemed from parents
+	50	Sam's own resources
$	250	Total resources

Since resources deemed to Sam plus Sam's own resources do not exceed the resource limit for an individual, Sam meets the resource standard.

Do not deem parents' income or resources to a child the month following the month of entry into a medical institution or RCF.

Eligibility While Trying to Sell a Nonliquid Resource

Legal reference: 20 CFR 416.1240-416.1245, 441 IAC 50.5(249A)

Applicants or members who have countable nonliquid resources that exceed the applicable resource limit may not receive Medicaid under a "Medicaid only" coverage group while they are attempting to sell the resource.

However, such applicants or members may be able to receive State Supplementary Assistance (SSA) or Supplemental Security Income (SSI) benefits until the resource is sold. These benefits are called "conditional benefits." Persons who are conditionally eligible for SSI are not eligible for Medicaid but persons who are conditionally eligible for SSA may receive Medicaid in the same manner as any other SSA recipient.

If the person has been approved for conditional SSI or federally administered State Supplementary Assistance benefits, there will be a "C" code in the COND PAY CODE field on the State Data Exchange (SDX).

There is usually no retroactive Medicaid eligibility for a recipient who has been approved for conditional SSI or State Supplementary Assistance benefits. However, the recipient's countable resources, including the excess resources, may have been under the Medically Needy limits. Also, some resources may not have been countable in the retroactive period, e.g., a house in which the recipient was living.

> Ms. A, a six-month-old child, is approved for SSI effective August 1, 2018. Her parents receive 10 acres of land on August 6 as an anniversary gift. The land has a value of $6,000. In October, her parents sign an agreement to sell the land and repay SSI.
>
> The IM worker evaluates resources of Ms. A and her family for the Medicaid retroactive period of May, June, and July, to determine if resources were under the limit. Since they did not own the land before August, retroactive eligibility is not affected by the 10 acres. The conditional benefits period begins in November (the month after the agreement was signed). For the months of September and October, the land value of $6,000 is a countable asset.

Long-Term Care Asset Preservation

Legal reference: 441 IAC 75 (Rules in Process), Iowa Code Chapter 514H

Policy: A person may be eligible for Medicaid when the person meets **all** of the following conditions:

- The person is aged 65 or older.
- The person:
  - Is the beneficiary of a qualified long-term-care insurance policy, or
  - Is enrolled in a prepaid health care delivery plan that provides long-term-care services.

- The person is eligible for Medicaid under one of the following coverage groups except for excess resources:
  - Ineligible for SSI or SSA due to residence in a medical institution,
  - In the 300% group, or
  - Receiving home- and community-based waiver services.
- The excess resources do not exceed the amount of long-term-care insurance benefits paid out under the person's qualified long-term-care insurance policy. (This amount is called the asset adjustment.)

The asset adjustment is exempt from estate recovery for the member and the member's spouse.

Comment: The Long-Term Care (LTC) Partnership program is a cooperative effort between private insurers and state government to encourage people to plan ahead and provide for their long-term health needs. An LTC partnership policy:

- Must meet the minimum standards established for long-term care insurance policies and certificates as established by the Iowa Insurance Division.
- Has identifying information included in the policy or attached to the policy to indicate that it is a qualifying long-term insurance policy.

The insurer provides the beneficiary a quarterly report which includes the amount paid in the last quarter and total amount paid on behalf of the insured.

In addition, the insurer is required to report data on each partnership policy sold under the Long-Term Care Partnership program to a national database. The national database then reports this information to each state's insurance department. The information reported includes:

- Notice of when benefits are paid under the policy,
- The amount of those benefits, and
- Notice of termination of the policy.

Iowa participates in a national reciprocity agreement with other states. If a person moves to Iowa and has a partnership policy that was purchased in another state, the policy can carry over to Iowa for the person to be eligible for an asset adjustment if the person applies for Medicaid in Iowa.

Procedure: The amount of the disregard is equal to the amount of the insurance benefits paid to or on the behalf of the person. The insurance benefits do not have to be fully exhausted before the disregard can be applied. If the person is approved for Medicaid and the policy continues to pay benefits, the asset adjustment can continue to increase.

Subtract the total amount the policy has paid on the person's behalf from the person's total resources. Compare the remaining resources to the resource limit to determine Medicaid resource eligibility. If the person's remaining resources exceed the resource limit, issue a *Notice of Decision* denying or canceling Medicaid.

1. Mr. J buys a long-term-care partnership policy. The policy provides for $100,000 in long-term-care coverage. Several years later, Mr. J needs nursing home care. His partnership policy covers most of the costs for three years before the $100,000 benefits are exhausted by payment for his care.

   Mr. J applies for Medicaid. He is able to protect $100,000 for his resources and still qualify for Medicaid to help pay for his long-term care if he meets the other eligibility criteria.

2. Mr. S buys a long-term care partnership policy that provides $100,000 in coverage. Several years later, Mr. S needs long-term care services and his policy begins to pay him a monthly benefit. Eventually, Mr. S applies for Medicaid home- and community-based waiver services.

   At the time of application, Mr. S has $90,000 in countable resources. His long-term care policy has paid out $88,000 in benefits with $12,000 remaining. The worker calculates his resources for Medicaid as:

$	90,000	Mr. S's resources
	88,000	Benefits paid out under the LTC policy
-	2,000	Medicaid resource limit
$	0	Remaining countable resources

   Mr. S is eligible for Medicaid because the amount paid under his partnership policy ($88,000) combined with the Medicaid resource limit ($2,000) equals his total countable resources ($90,000). If his partnership policy continues to pay benefits, Mr. S can protect additional resources.

Exempt Resources for Medicaid for Employed People With Disabilities

Legal reference: 441 IAC 75 (Rules in Process)

Additional resources are exempt for persons who qualify for Medicaid eligibility under Medicaid for employed people with disabilities. They are:

- **Assistive technology accounts**: Assistive technology accounts include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value that are set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology services or assistive technology devices.

  These accounts must be held separate from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology, assistive technology services, or assistive technology devices for the working person with a disability.

  "Assistive technology" is defined as the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by people with disabilities in areas such as education, rehabilitation, technology devices, and assistive technology services.

  An **"assistive technology device"** is any item, piece of equipment, product system, or component part (whether acquired commercially, modified, or customized), that is used to increase, maintain, or improve functional capabilities or to address or eliminate architectural, communication, or other barriers confronted by people with disabilities.

"Assistive technology service" means any service that directly assists a person with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

Require the member to provide written verification from a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist that the technology being saved for is medically necessary and that the technology, device, or service can reasonably be expected to enhance the client's employment. Also require verification of an estimated cost for the technology.

- **Medical savings accounts.** These are accounts exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220). A person who has such an account will have documentation from the bank or other financial institution that set it up.
- **Retirement accounts.** This includes any retirement or pension fund or account listed in Iowa Code section 627.6(8)"f" as exemption from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account. The following are exempt under this provision:
  - Pension or retirement plans authorized under federal law, as follows:
    - Retirement plans qualified under the Employee Retirement Income Security Act of 1974 ("ERISA-qualified plans").
    - Simplified employee pension plans.
    - Self-employed pension plans.
    - Keogh plans (also known as "H.R. 10 plans").
    - Individual retirement accounts.
    - 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

Assets in an ABLE account and distributions from the account for qualified disability expenses would be disregarded when determining the designated beneficiary's eligibility for Medicaid.

SSI excludes up to and including $100,000 of the balance of funds in an ABLE account from resources of the designated beneficiary. If an ABLE account exceeds $100,000, SSI will not terminate the recipient, however they will suspend them.

For Medicaid, a beneficiary will not lose eligibility for Medicaid based on the assets held in their ABLE account, even during the time that SSI benefits are suspended (as described above for the account with over $100,000).

A distribution from an ABLE account is not income but is a conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

AIDS/HIV Settlement Payments

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

Payments from the original settlement or the Ricky Ray Hemophilia Relief Act of 1998 are exempt as a resource.

Annuities
20 CFR 416.1201

An annuity is a contract in which a person receives fixed payments for a specified time period. The person who receives the payments is referred to as the annuitant. The term of the annuity contract can be for either:

- The lifetime of the buyer;
- The lifetime of the buyer, with a minimum return of principal to a residual beneficiary if a specified portion of the principal is not returned before the buyer's death; or
- A certain number of years, with a guaranteed payment amount if the annuitant dies before the specified period has expired.

Review a copy of each annuity to determine the terms of the contract. Annuity contracts may be assigned, transferred, or cashed in for a lump sum. Or the contract may state that once payments are being made to the annuitant, the contract cannot be assigned, transferred, or cashed in for a lump sum.

- If the annuity can be assigned, transferred, or cashed in for a lump sum, the loan value or the amount the company will pay back to the annuitant is a countable resource.
- If the annuity may be assigned or transferred, but not cashed in, the annuitant must verify the amount that the annuity can be assigned or transferred for. The annuitant should obtain three estimates from knowledgeable sources. Use the average of these to determine the countable resource value of the annuity.
- If the annuity is counted as a resource and the annuitant is eligible for Medicaid, obtain verification of the portion of the payment that is interest and the portion of the payment that is principal.

  Count the interest portion of the annuity payments as income to the annuitant when determining eligibility, spenddown, and client participation. Do not count the principal portion of the payment; this is already counted as a resource.

- If the annuity cannot be assigned, transferred, or cashed in and the annuitant verifies that the annuity has no cash value, the annuity is not a countable resource. Count the total annuity payment as income to the annuitant when determining eligibility, spenddown, and client participation.

Annuities must also be reviewed to determine if the purchase of the annuity constitutes a transfer of assets for less than fair market value. See Transfers That Cause a Medicaid Penalty.

Request a copy of the contract and use the *Annuity Release of Information*, form 470-4699, to gather information on the annuity. If you need help interpreting the information provided on the form or the contract, send the form and contract to the DHS, SPIRS Help Desk.

Burial Contracts
20 CFR 416.1201,
20 CFR 416.1231 (See also Transfer of Assets.
20 CFR 416.1246, 42 USC 1396p(d))

Exclude a prepaid burial contract as a resource if it meets one of the following conditions:

- The contract is irrevocable and the applicant or member can't access the funds.
- Mutual consent of the applicant or member and the contract seller is required to revoke or access the contract, and the seller's consent can't be obtained.
- Liquidation of the contract would create a significant hardship to the applicant or member. Usually, the only hardship considered significant is requiring the applicant or member to move out of Iowa to access the funds.

Unless the contract clearly indicates that the burial contract is irrevocable, obtain a written statement from the contract seller that the funds committed to the contract are unavailable to the applicant or member.

Investigate a contract drawn up in another state to determine whether the law in that state permits irrevocable burial contracts and whether the contract is irrevocable under that law.

If a certificate of deposit or another form of funds is tied to the irrevocable contract, only the amount specified in the irrevocable contract is excluded.

If the burial contract is set up by purchasing a life insurance policy, check if the funeral home either owns the policy or is the irrevocable beneficiary.

If the funeral home owns the policy, both the whole cash value and the dividends are unavailable. However, if the funeral home is the beneficiary, only the cash value is unavailable. Count dividends that are available to the applicant or member.

Since there is no limit on the amount of money in the burial contract, some applicants or members may use prepaid burial contracts to protect assets. If the amount of the burial contract exceeds $13,125, which is the average cost of a funeral in Iowa, ask for an itemized list of funeral costs.

If the amount is less than or equal to the cost of the funeral, exclude the contract from resource consideration. If the amount in the burial contract exceeds the itemized listing, consider the excess deposits or payments as a transfer of assets for less than fair market value. See Transfer of Assets.

The amount of money considered transferred is the amount designated for the contract minus the specified cost of the burial. Determine whether transferring has occurred rather than determining how much of the irrevocable burial contract is a countable resource.

If a relative changes the selection of services in the burial contract at the time of the funeral, this is not a transfer of resources.

The following charts provide a guide to understanding burial contracts and how to count as a resource or consider as a transfer of asset.

Burial Contracts		
If the client has…	Countable resource?	Transfer of asset?
Paid cash and burial contract is: ▪ **Revocable** ▪ **Irrevocable**	Yes. See below on how to count. No	No No
No burial contract and burial funds are: ▪ **Revocable** ▪ **Irrevocable**	Yes No	No Yes. See transfer of asset chart.
Revocable burial contract funded by: ▪ **Revocable** burial funds ▪ **Irrevocable** burial funds ▪ Life insurance policy with funeral home as the beneficiary ▪ Life insurance policy **irrevocably** assigned to funeral home	Yes. See below on how to count. No Yes, unless otherwise excluded. No	No Yes. See transfer of asset chart. No Yes. See transfer of asset chart.
Irrevocable burial contract funded by: ▪ **Revocable** burial funds ▪ **Irrevocable** burial funds ▪ Life insurance policy with funeral home as the beneficiary ▪ Life insurance policy **irrevocably** assigned to funeral home	Yes No Do not count cash value, but count any accessible dividends as a resource. No	No See transfer of asset chart. See transfer of asset chart. See transfer of asset chart.
Burial funds may include annuity proceeds, a certificate of deposit, a bank account, or a trust at a financial institution. If a countable resource: Exclude up to $1,500 for the client and up to $1,500 for the client's spouse when funds are held in a separate account designated for burial purposes.		

Burial Contracts – Transfer of Assets		
Transfer of Asset	**Penalty**	**Amount**
Irrevocable burial funds not in a burial contract	Yes	Penalty is the amount of the irrevocable burial funds. If the client sets up an irrevocable burial contract, the transfer of assets penalty can be expunged as of the first of the following month.
Revocable burial contract funded by **irrevocable** burial funds	Yes	Penalty is the amount of the irrevocable burial funds. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Revocable burial contract funded by life insurance policy **irrevocably** assigned to funeral home (either ownership or beneficiary)	Yes	Penalty is the amount of cash value and dividends of the life insurance policy. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Irrevocable burial contract funded with **irrevocable** burial funds OR assigned life insurance policy (either ownership or beneficiary) If the amount of contract is:		
▪ **Less than** average cost of funeral in Iowa.	No	None
▪ **More than** the average Iowa funeral cost, ask for an itemized list of funeral costs.		
• If burial contract amount is **less than or equal to** itemized list.	No	None
• If amount **exceeds** the itemized list.	Yes	Penalty is the amount in excess of the burial contract.

Burial Funds
20 CFR 416.1231
(See also Transfer of Assets.
20 CFR 416.1246, 42 USC 1396p(d))

Exclude up to $1,500 for the client and up to $1,500 for the client's spouse when funds are held in a separate account designated for burial purposes. Examples of funds set aside for burial are:

- Revocable burial contracts.
- Trusts.
- Cash value of any life insurance policies.
- Any account or resource designated by the applicant or member for burial, cremation, or other funeral arrangements. An account or resource designated for burial could be bank accounts, CDs, etc.

Burial funds must be in separately identifiable accounts. If funds are combined with other funds that are not for burial purposes, the client must separate the funds.

The client must sign a statement designating the funds for burial purposes. File a copy of the statement in the case record and give a copy to the applicant or member. Exclude the fund as of the first of the month in which the fund is separated and designated as a burial fund.

Reduce the amount the client set aside for burial by any excluded whole life, term life, and irrevocable burial contracts. For policies on burial space, see Burial Space. To determine the amount of burial funds that can be applied under this exclusion:

1. Obtain copies of irrevocable burial arrangements and life insurance policies to determine what burial funds the applicant or member owns.
2. If the irrevocable contract is over $1,500, no other burial funds can be excluded. (The irrevocable burial contract is an excluded resource, but it does have an effect on whether any other funds can be set aside for burial.)
3. If the burial contract is less than $1,500, determine the face value of any **excluded** whole life and term life insurance policies designated for burial funds. (Life insurance with a face value of $1,500 or less is excluded. Life insurance with a face value of more than $1,500 is not excluded.)
4. Add together the face value of excluded life insurance and the burial contract. Subtract this amount from the $1,500 set-aside amount. If there is no remainder, no additional funds can be set aside for burial.

   If the total amount set aside in the burial contract and excluded life insurance is under $1,500, the client can designate additional funds for burial to make up the difference. The total cannot exceed $1,500.

1. Mr. N has $2,500 in a burial fund that is revocable. He has no other burial funds. The maximum excluded from resource consideration is $1,500. $1,000 is a countable resource.

2. Mrs. B has life insurance with a face value of $3,000. The cash value is $1,800. This policy is not exempt and she has no other funds set aside for burial. Mrs. B has no funds set aside for burial and provides a written statement designating this policy for burial. The worker excludes $1,500 of the $1,800 cash value for burial. $300 is a countable resource.

3. Mrs. H has a $2,000 burial fund that is revocable. She has life insurance with a face value of $800. $700 of the burial fund that can be excluded and the interest earned on this $700 are exempt as income and a resource.

   The remaining $1,300 is countable as a resource. The interest on the $1,300 is also counted, subject to policies on infrequent and irregular income.

4. Mrs. P has $1,000 in a savings account that she has designated for burial. She also has a $1,000 face value life insurance policy.

$ 1,500	Maximum exclusion
- 1,000	Life insurance
$ 500	Can be excluded for burial
$ 1,000	Designated burial account
- 500	Remaining exclusion
$ 500	Countable resource

5. Mr. Q has a $1,600 life insurance policy and a $1,000 irrevocable burial contract. The cash value of the life insurance policy is $1,975. Mr. Q designated the cash surrender value of his life insurance as funds set aside for burial.

$ 1,500	Maximum potential exemption
- 1,000	Burial contract
$ 500	Remaining potential exemption
$ 1,975	Cash surrender value of life insurance
- 500	Remaining exemption
$ 1,475	Countable resource

   Mr. Q's worker informs him that he could irrevocably assign the life insurance ownership to the irrevocable burial contract, at which point it would no longer count as a resource.

If the client spends any of the burial fund, count the amount spent as income during the period it was spent.

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.

Burial Space
20 CFR 416.1231(a)

Do not count the value of a burial space that is **owned** by the client and is intended for the client, the client's spouse, or any other member of the client's immediate family.

The "immediate family" includes a client's:

- Children, stepchildren, adopted children
- Brothers, sisters
- Parents, adoptive parents, and
- Spouses of the above

The "immediate family" does not include members of an ineligible spouse's family. If a space is not intended for the use of an immediate family member, count it as a resource.

Exclude only one space for each person. Document in the case record for whom each space is intended.

A "burial space" includes:

- A conventional grave site, including opening and closing the grave.
- A crypt, vault, or mausoleum.
- The casket, urn, burial containers, and items traditionally used for the remains of a deceased person.
- Headstones, markers, or plaques.

A space can be all items that traditionally go with the burial space. For example, a space can include both a lot and a casket, but not an urn in addition to the lot and casket.

Child Tax Credit
20 CFR 416.1235

Exclude the child tax credit as a resource for nine months following the month of receipt.

Continuing Care Retirement and Life Care Community Entrance Fees
441 IAC 75 (Rules in Process)

Entrance fees paid by persons residing in continuing care retirement communities or life care communities that collect an entrance fee on admission are considered a resource available to the person if:

- The person has the ability to use the entrance fee, or the contract between the person and the community provides that the entrance fee may be used to pay for care;
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the community contract; and
- The entrance fee does not confer an ownership interest in the community.

Dedicated Accounts
20 CFR 416.546,
20 CFR 416.640,
20 CFR 416.1247

Exclude the funds in a dedicated account as a resource for people receiving SSI. When past-due benefit payments are paid for an eligible person under age 18, the Social Security Administration requires the representative payee to establish a dedicated account.

The dedicated account may be used only for:

- Medical treatment, education, and job skills training.
- Personal needs assistance, special equipment, housing modification, and therapy or rehabilitation if related to the child's impairment.
- Other items and services related to the child's impairment approved by the Social Security Administration.

Stop excluding the funds in a dedicated account when the person loses SSI eligibility, even if the person later reapplies and is approved.

Disaster Assistance
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1237;
P. L. 101-508

Exclude disaster assistance from a state, federal or local programs as a resource.

Earned Income Credit

Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Exclude the earned income credit in the month it was received as well as in the following month. Funds remaining are countable resources after the end of the second month.

NOTE: Exclude for 12 months from the date of receipt all EITC payments as part of a federal tax refund between January 1, 2010, and December 31, 2012.

Educational Assistance
20 CFR 416.1236(7), 20 CFR 416.1236(14),
20 CFR 416.1250

All student financial assistance received under Higher Education Act (HEA) or under Bureau of Indian Affairs (BIA) student assistance programs is excluded as a resource, regardless of use and regardless of how long the assistance is held. Examples of HEA (Title IV) programs are:

- PELL grants
- State Student Incentives
- Academic Achievement Incentive Scholarships
- Byrd Scholars
- Federal Supplemental Educational Opportunities Grants (FSEOG)
- Federal education loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)

- Upward Bound
- Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)
- LEAP (Leveraging Educational Assistance Partnership)
- SLEAP (Special Leveraging Educational Assistance Partnership)
- Work-study programs
- Other grants, scholarships, fellowships, or gifts used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from resources for nine months beginning the month after the month the assistance was received.

  This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter.

"Necessary educational expenses" include the following:

- Laboratory fees
- Student activity fees
- Transportation
- Stationery supplies
- Books
- Technology fees
- Impairment-related expenses necessary to attend school or perform schoolwork (special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.)

Grants, scholarships, fellowships, and gifts that are retained after the nine-month exclusion are countable resources beginning the month after the exclusion period ends.

Excluded educational assistance becomes countable as income in the earliest of:

- The month any portion of the excluded assistance is used for something other than tuition, fees, or other necessary educational expenses, or
- The month the member no longer intends to use the funds to pay educational expenses.

Emergency Energy Conservation Assistance
20 CFR 416.1124(b)

Exclude any cash or in-kind assistance provided under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, including:

- Winterization of old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted.)
- Insulation.
- Emergency loans and grants to install energy conservation devices.
- Alternative fuel supplies and special fuel vouchers or stamps.
- Alternative transportation activities designed to save fuel and guarantee continued access to training, education, and employment.
- Legal or technical training relating to the energy crisis.
- Fuel to operate food preparation appliances, or meals provided because utilities have been shut off.

Food Programs
20 CFR 416, Subpart K Appendix

Exclude the value of:

- Allotment paid under the Food Stamp Act
- Food provided under WIC
- School lunches or breakfasts
- Congregate meals
- Federally donated food

Verification is not required.

Gifts Made Under Uniform Gift Act
20 CFR 416.1201

A gift given to a child under 21 is not considered an available resource under the Uniform Gift Act. When the child turns 21, the gift becomes a countable resource. Verify the amount of the gift before excluding it. See 8-E for how to treat all other types of gifts.

Household Goods and Personal Effects
20 CFR 416.1216

Household goods and personal effects are excluded as a resource.

"Household goods" are items used to maintain the home as well as to accommodate, comfort and entertain the occupants.

"Personal effects" are belongings of family members, including clothing, books, and grooming aids. Do not count one set of a client's wedding and engagement rings.

Exclude items required by any household member because of the person's medical or physical condition, regardless of value. For example, exclude prosthetic devices, dialysis machines, wheel chairs, and hospital beds.

Exclude household goods and personal effects that were excluded in the attribution of resources. In spousal impoverishment cases, the household goods and personal effects retained by the community spouse are excluded as resources to the institutionalized spouse when determining Medicaid eligibility.

Housing Assistance Provided by HUD or FMHA
20 CFR 416.1124(b); U.S. Housing Act of 1937, Section 8; U.S. Housing Act of 1959, Section 202(h); National Housing Act; Housing Act of 1949, Title V; Housing and Urban Development Act of 1965, Section 101; (Section 1701 of 12 USC, section 1451 of 42 USC)

Do not count rent subsidies, cash toward utilities, or indirect assistance (guaranteed loans, mortgages, and mortgage insurance) provided to homebuyers by the Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture/World Development.

Do not count any rent reduction to a person in low-income housing when the assistance is under the U.S. Housing Act of 1937, as amended.

Verify the authority for the client's federal or federally assisted housing. If the client cannot get verification, contact the local public housing authority. If HUD and a private owner have entered into a contract directly, contact the owner or manager of the project to verify the nature and authority for the housing assistance payments. Record the findings in the client's case record.

Income Tax Refunds
Public Law 111-312
Public Law 112-240

Federal income tax refunds are excluded for 12 months from the date of receipt.

Exclude state income tax refunds as a resource for the month of receipt and the month following the month of receipt.

Individual Development Accounts
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1236;
P. L. 105-285, Section 415,
P. L. 106-554

Contributions that are deposited in a Demonstration Project IDA are excluded from resources. Any matching funds that are deposited in a Demonstration Project IDA and interest earned are excluded from resources.

Indian Assistance
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1236;
P. L. 101-508,
P. L. 92-254,
P. L. 94-114,
P. L. 103-66

Exclude judgment funds distributed to members of Indian tribes and payments that were received from certain lands and subsurface mineral rights, then distributed to tribal members.

Exclude up to $2,000 in interest payments per year from Indian trusts or restricted lands. Exclude any land that the client or spouse cannot dispose without the consent of the tribe, a federal government agency, or other persons.

Insurance (Death Benefits)
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1230;
P. L. 101-508

Exclude in the month of receipt and the following month life insurance or death benefits not spent on the insured's last illness or burial. If the money is reimbursement for expenses of the last illness or burial, exclude it only for the month of receipt.

Insurance (Life)
20 CFR 416.1230

Exclude the cash surrender value of life insurance policies with a combined face value totaling $1,500 or less per owner. If the total face value of life insurance owned by the applicant or member is more than $1,500, count the cash surrender value toward the resource limit.

Exclude the face value all life insurance that has no cash surrender value, such as term insurance.

For purposes of this comparison, the countable face value of a life insurance policy is the total face value minus any face value purchased with dividends from the policy. If the face value of the policy increases in other ways, use the adjusted face value. Do not include additional sums payable if the member dies in an accident.

The **cash surrender value** is the amount that the insurance company will pay if the policy is canceled before death (this value usually increases with the age of the policy). The cash surrender value may include dividends and may decrease with loans.

Funds paid as accelerated payments from the policy do not change the value of the resource. These payments, called **accelerated death benefits**, are counted as income.

1. Mr. X owns two life insurance policies, one with a face value of $750 and the other with a face value of $500. Since the total face value of life insurance is $1,250, the policies are exempt from resource consideration.
2. Mr. Y owns three life insurance policies with face values of $1,000, $750, and $500, totaling $2,250. Mrs. Y owns one life insurance policy with a face value of $1,000.

   Mrs. Y's policy is ignored in the computation because its face value is less than $1,500 per owner. Since Mr. Y's policies total $2,250, the cash surrender value of each policy must be determined.
3. Mr. and Mrs. Q and their child have life insurance with a face value of $4,000. Mr. Q owns the policy. The cash value is counted towards the resource limit.

Count accumulated dividends that are not used to purchase additional insurance as a resource in the same manner as money in a bank account. Count the accumulated dividends even if the countable face value of the policy is less than $1,500 and the cash value of the life insurance is excluded.

Do not include the face value of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, include the cash surrender value of dividend additions in determining the resource value of the policy.

> 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, send form 470-0444, *Insurance Report*, 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.

At annual reviews, send 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.
- 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.

The right to receive the property when the life estate ends also has value and can be sold. As with a transfer of the life estate, the transfer of the remainder interest does not change the life that controls the life estate. When the life estate ends, the remainderman then owns the entire property. It is no longer divided into a life estate and remainder interest.

> Mrs. A, a nursing facility resident, has a life estate. She reports that the property held in the life estate was sold. Request documentation to determine if both the life estate and the remainder interest were sold, or if just the life estate or the remainder interest was sold.
>
> If just the remainder interest was sold, Mrs. A continues to hold a life estate in the property. If both the life estate and the remainder interest were sold, Mrs. A is entitled to that portion of the sale proceeds that represent the value of the life estate. If only the life estate was sold, Mrs. A is entitled to all of the proceeds.

The owner of the entire, undivided property can divide the property into the two parts and can:

- Keep the life estate and transfer the remainder interest;
- Transfer the life estate and keep the remainder interest;
- Transfer both the remainder interest and the life estate to two different people.

If the life controlling the life estate is likely to be short, the value of the life estate is smaller and the value of the remainder interest greater. Conversely, if the life controlling the life estate is likely to be long, the value of the life estate is greater and the value of the remainder interest smaller.

Procedure: Request verification of:

- What portion of the life estate the client owns,
- Which portion has been sold or transferred, and
- The date of the transaction.

To determine the value of a life estate or remainder interest, first determine the fair market value of the entire underlying property as if it was not divided into a life estate and remainder interest.

Obtain verification of the fair market value of the underlying property from a disinterested, knowledgeable source, in the same way as for any other undivided property. This could be an appraisal, a real estate fair market analysis, or an offer on the property from a disinterested knowledgeable source.

For **real estate**, the fair market value of the underlying property is the amount it could be sold for on the open market. A disinterested, knowledgeable source can be a real estate broker, Farmer's Home Administration, bank, mortgage company, or other lending institution.

For **farm land**, obtain the average value of an acre of land in the area from the Iowa State University Extension office.

For **liquid** resources such as a certificate of deposit or bank account, the fair market value is the amount that would be received if the resource were cashed in.

To determine the value of the **life estate** when the applicant or member is the life estate holder:

1. Determine the fair market value of the entire underlying property (as if it was not divided into a life estate and a remainder interest).
2. Find the line on the life estate column corresponding with the age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined. (If a couple owns the life estate, use the age of the younger spouse.)
3. Multiply the fair market value by the figure in the life estate column.

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.