

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the county office or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or recipient shall cooperate with the county office in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The income maintenance unit in the county office shall make the determination of whether or not the client has cooperated.

75.14(2) Failure of the applicant or recipient to cooperate shall result in denial or cancellation of the person's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each applicant for or recipient of Medicaid who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each applicant for or recipient of Medicaid shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or recipient's own behalf or on behalf of any other family member for whom the applicant or recipient is applying. An assignment is effective the same date the county office enters the eligibility information into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Referrals to the child support recovery unit for Medicaid applicants or recipients. The county office shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

"*Prompt notice*" means within two working days of the date assistance is approved.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7)

Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) and 75.14(5) which require the applicant or recipient to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The county office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The county office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the county office believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.

- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each applicant for or recipient of Medicaid who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the county office shall notify the applicant or recipient on Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed and that if the county office determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the county office will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the county office shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. When the applicant or recipient chooses to claim good cause, Form 470-0170 shall be signed and dated by the client and returned to the county office. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the county office will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the county office shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the county office's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the county office determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the county office to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The county office shall determine whether good cause exists for each applicant for or recipient of the Medicaid program who claims to have good cause.

a. The applicant or recipient shall be notified by the county office of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the county office's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The county office may exceed this time standard only when:

(1) The case record documents that the county office needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the county office determines that good cause does not exist:

(1) The applicant or recipient shall be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The county office shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after it has examined the evidence and found that it actually verifies the good cause claim.

e. Prior to making a final determination of good cause for refusing to cooperate, the county office shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The county office shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the county office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the county office shall allow a reasonable additional period of time upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The county office shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The county office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the county office determines that it is necessary, it may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the county office shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the county office makes a determination that good cause exists, it shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the county office shall consider any recommendations from the unit.

b. The determination shall be in writing, contain the county office's findings and basis or the determination, and be entered into the case record.

c. When the county office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it shall notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity.

Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

This rule is intended to implement Iowa Code section 249A.4.

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

75.16(2) Allowable deductions from income. In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain \$50 of their monthly income for a personal needs allowance.

(1) If the client is a veteran or a surviving spouse of a veteran who receives a pension subject to limitation of \$90 after the month of entry pursuant to 38 U.S.C. Section 5503, the veteran or the surviving spouse of a veteran shall retain \$90 from the veteran's pension beginning the month after entry to a medical institution. The \$90 allowance from a veteran's pension is in addition to the \$50 allowance from any other income.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party. This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Persons who may be excluded from the eligible group in determining FIP-related Medicaid eligibility. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) Applicants receiving federal benefits. An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) Applicants not receiving federal benefits. When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) Time frames for decisions. Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) Redeterminations of disability. In connection with any independent determination of disability, the department will determine whether reexamination of the member's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

This rule is intended to implement Iowa Code section 249A.4.

441—75.21(249A) Health insurance premium payment program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care directly.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

- a. There was a serious illness or death of the parent or a member of the parent's family.
- b. There was a family emergency or household disaster, such as a fire, flood, or tornado.
- c. The parent offers a good cause beyond the parent's control.
- d. There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs \$50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs \$100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPPA Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of \$50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When it is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) Exceptions to payment. Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPPA program is made.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

75.21(6) Duplicate policies. When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

75.21(7) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the policyholder ten calendar days in which to provide it.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) Effective date of premium payment. The effective date of premium payments for cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875, is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) Method of premium payment. Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums. The department shall issue reimbursement to the policyholder five working days prior to the policyholder's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

75.21(10) Payment of claims. Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) Reviews of cost-effectiveness. Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department shall verify whether insurance may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying event which would otherwise result in termination of coverage.

75.21(12) Time frames for determining cost-effectiveness. The department shall determine cost-effectiveness of the insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) Notices. An adequate notice shall be provided to the household under the following circumstances:

- a. To inform the household of the initial decision on cost-effectiveness and premium payment.
- b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.
- c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) Rate refund. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) Reinstatement of eligibility.

a. When eligibility for the HIPP program is canceled because the persons covered under the policy lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the recipient's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs.

This rule is intended to implement Iowa Code section 249A.3.

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spend-down obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

This rule is intended to implement Iowa Code section 249A.4.

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. *Institutionalized individual.* When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. *Noninstitutionalized individual.* When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

75.23(2) Look-back date.

a. *Transfer before February 8, 2006.* For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. *Transfer on or after February 8, 2006.* For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2007, through June 30, 2008, this average statewide cost shall be \$4,173.92 per month or \$137.30 per day.

75.23(4) Reduction of period of ineligibility. The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) Exceptions. An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person'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:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. 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 long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"*Assets*" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.

2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"*Income*" shall be defined by 42 U.S.C. Section 1382a.

"*Institutionalized individual*" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"*Resources*" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

“*Transfer or disposal of assets*” means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) “b”(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) “c”);
5. Failure to take a share of an estate as a surviving spouse (also known as “taking against a will”) on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) “d”); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) Purchase of annuities.

a. The entire amount used to purchase an annuity on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in subparagraphs (1) through (4) of this paragraph.

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;
2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and
3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(4) Iowa is named as the remainder beneficiary either:

1. In the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
2. In the second position after the community spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

b. Funds used to purchase an annuity for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The annuity was purchased before February 8, 2006; or
- (2) The annuity was purchased on or after February 8, 2006, and a condition described in 75.23(9) “a”(1) to (4) was met.

75.23(10) Purchase of promissory notes, loans, or mortgages.

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

- (1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)“a” were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual’s home for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.