Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 75
"Conditions of Eligibility"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A.3 and 249A.4

State or federal law(s) implemented by the rulemaking: Iowa Code sections 249A.3 and 249A.4 and chapter 514I; Title XIX of the federal Social Security Act; 42 CFR 435 and 457

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

September 9, 2025 10 a.m.	Microsoft Teams Meeting ID: 267 668 396 724 6 Passcode: zz9uV3ja

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
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Purpose and Summary

This proposed chapter establishes the conditions of eligibility for the medical assistance program administered by the Department under Iowa Code chapter 249A and addresses related matters. This proposed chapter incorporates changes that were intended to be implemented but not taken up during a five-year review of rules performed in 2022. Those changes include incorporating a modified adjusted gross income (MAGI) methodology based on federal tax rules, implementing portions of the Affordable Care Act, and implementing the concept of reasonable compatibility for verifying resources and income.

This proposed chapter has undergone a Red Tape Review pursuant to Executive Order 10. As a result, the Department has removed restrictive terms, made minor wording changes, removed outdated language, and removed duplicative language where possible. The Department also took this opportunity to restructure the chapter, dividing coverage groups into separate divisions based on categories of coverage.

Finally, this proposed filing also implements sections 18 and 19 of 2025 Iowa Acts, House File 1049, which update the personal needs allowance for participants in the medical assistance program who are residents of facilities. The personal needs allowance was raised from $50 to $55.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Prospective and current recipients of benefits under the medical assistance programs outlined in Iowa Code chapter 249A will benefit from this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

The most recently available data shows that almost 700,000 individuals are enrolled in medical assistance programs. Each year, the Department receives an average of nearly 225,000 applications for medical assistance, which include both individual and household submissions. Recent program activity reflects that annually there are approximately 139,000 individuals approved for medical assistance at the time of application. Over the same period, the Department generally completes more than one million eligibility approval actions, including both initial approvals and redeterminations that result in continued or transitioned coverage. Additionally, nearly 122,000 eligibility determinations annually result in ineligibility, encompassing both application denials and terminations of existing coverage.

- **Qualitative description of impact:**

Iowans interested in applying for medical assistance will benefit from having guidance on eligibility.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to administer the State's medical assistance programs.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no impact on State revenues; there are no changes to existing eligibility requirements.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Not applicable. The proposed rulemaking is scheduled and required under Executive Order 10.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 75 and adopt the following **new** chapter in lieu thereof:

CHAPTER 75
CONDITIONS OF ELIGIBILITY

DIVISION I
DEFINITIONS, COVERAGE GROUPS, AND GENERAL CONDITIONS OF ELIGIBILITY

441—75.1(249A) Definitions. Unless otherwise specified, the definitions in this rule apply to 441—Chapters 74 through 88.

"Act" means the federal Social Security Act. All references to the Act herein are as amended to August 1, 2025.

"Aged" means a person 65 years of age or older.

"Applicant" means a person who is requesting medical assistance on the person's own behalf or a person for whom medical assistance is requested.

"AVS" or *"asset verification system"* means the use of an electronic asset data source to verify assets held in banks and other financial institutions for non-MAGI.

"Blind" means a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Caretaker" means an individual with whom a child is living and who assumes primary responsibility for the child's care. For this purpose, two individuals may be considered to have assumed primary responsibility for a child's care.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Child" means a natural or biological child, or an individual legally recognized as the child of a parent based on the conception, gestation, or birth of the child during a legal marriage; an adoptive child; or a child of an individual's spouse (stepchild) unless parental rights have been legally terminated.

"Client" means all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person whose income or assets are considered in determining eligibility for an applicant or member.

"Code of Federal Regulations" or *"CFR"* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

"Community spouse" means a noninstitutionalized spouse of an institutionalized spouse.

"Conditionally eligible" means that a person has been assigned but not met spenddown as defined in subrule 75.8(1), or has been assigned a monthly premium but has not yet paid the premium for that month pursuant to subparagraph 75.6(6)*"b"*(4).

"Coverage group" means a group of persons who meet certain common eligibility requirements.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable family-related coverage group.

"Electronic data sources" or *"EDS"* means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development (IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

"Family-related Medicaid" includes coverage groups that apply to children, parents and caretakers and pregnant women who are not aged, blind or disabled.

"Federal poverty level" or *"FPL"* means the levels published and updated periodically in the Federal Register by the United States Department of Health and Human Services (DHHS) under the authority of 42 U.S.C. 9902(2) and revised annually on April 1.

"General conditions of eligibility" means the eligibility criteria specified in the following provisions:

1. Rule 441—75.9(249A): furnishing of social security number.
2. Rule 441—75.10(249A): residency requirements.
3. Rule 441—75.11(249A): citizenship or alienage requirements.
4. Rule 441—75.14(249A): establishing liability and obtaining support.
5. Rule 441—75.15(249A): medical resources.
6. Rule 441—75.16(249A): medical assistance lien.
7. Rule 441—75.29(249A): investigation of eligibility.

"Income in-kind" means any gain or benefit that is not in the form of money payable directly to the applicant, member, or person whose income or assets are considered in determining eligibility for an applicant or member, including nonmonetary benefits such as meals, clothing, and vendor payments. Vendor payments are monetary payments to a third party and not to the applicant, member, or person whose income is considered in determining eligibility.

"Institutionalized person" means a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in subrule 75.6(8).

"Institutionalized spouse" means a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days and whose spouse is not in a medical institution or nursing facility.

"Local office" means the county office of the department or a state mental health institute.

"Medical institution," when used in this chapter, means a facility organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.

"Member" means any person who has been determined eligible and has been enrolled to receive medical assistance pursuant to 441—Chapter 75. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member." For the medically needy program, "member" means a person who has been determined eligible for Medicaid under the medically needy program, has been approved, and has countable income at or below the medically needy income level (MNIL) or has reduced the person's countable income to the MNIL during the

certification period through spenddown. Unless otherwise specified, a person is not a member for any month in which Medicaid for that person is subject to recoupment because the person was ineligible.

"Modified adjusted gross income" or *"MAGI"* means the tax-based methodology used to determine income eligibility and household size for family-related Medicaid and other coverage groups as prescribed by 1902(e)(14) of the Act (42 U.S.C. 1396a(e)(14) and 42 CFR 435.603).

"Non-MAGI-related" means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program administered by the SSA, except that income is considered prospectively. "Non-MAGI-related" also includes persons who would be eligible for SSI except for certain eligibility factors as specified in rule 441—75.6(249A).

"Nursing facility services" means the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rules 441—75.23(249A) and 441—75.85(249A).

"Parent" means a natural or biological parent, or an individual legally recognized as the parent of a child based on the conception, gestation, or birth of the child during a legal marriage; an adoptive parent; or the spouse of another parent (stepparent) unless parental rights have been legally terminated.

"Pay and chase" means that the state pays the total amount allowed under the department's payment schedule and then seeks reimbursement from a liable third party. The pay and chase provision applies to Medicaid claims for preventive pediatric services and all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in 20 CFR 416.601.

"Presumptive eligibility" means that a person is presumed to be eligible for Medicaid on a temporary basis based on statements provided by the person.

"Presumptive Medicaid" means immediate and temporary health care coverage based on a presumptive eligibility decision to pay for the cost of care during the presumptive period as described in subrule 75.7(4).

"Presumptive provider" means an organization approved by the department to conduct and authorize presumptive eligibility determinations pursuant to 441—subrule 76.7(1).

"Qualified entity" means an individual, under the supervision and authority of a presumptive provider, who has been determined by the department to be capable of making presumptive Medicaid eligibility determinations pursuant to 441—subrule 76.7(2).

"Reasonably compatible" or *"reasonable compatibility"* means the standard by which the total attested countable income or resources for each person's household size is compared with the total amount from available EDS or AVS used by the department. Attested income or resources must meet one of the following three criteria to meet the standards for reasonable compatibility:

1. Both the total attested income or resources and the total income or resources from the EDS or AVS are above, at, or below the applicable income or resource limit for Medicaid or hawki; or
2. The total attested income is within 10 percent of the total income from EDS or the total resources are below the resource limit for the applicable program; or
3. The total attested income or resources exceeds the total income or resources from EDS or AVS.

If the attested income or resources meet any of the reasonable compatibility criteria, the income or resources are considered to be verified.

"Reasonable opportunity period" means the 90-day period allowed for applicants and members to provide satisfactory documentation of citizenship, nationality, or qualified alien status pursuant to subparagraph 75.11(2)*"c"*(4).

"Refugee" means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42).

"Retroactive period" means the three calendar months immediately preceding the month in which an application is filed.

"Sibling" means an individual who shares at least one common parent with another individual.

"Spouse" means a party to a legally recognized marriage, including a common-law marriage.

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent. A stepparent is considered a parent under a coverage group that is subject to MAGI methodology pursuant to 42 CFR 435.603.

"Supply" or *"supplying"* means the requested information is received by the department by the specified due date.

"Tax dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Transfer of assets" means the transfer of resources or income for less than fair market value as provided in rule 441—75.23(249A).

"Unborn child" includes an unborn child during the entire term of pregnancy.

"United States Code" or *"U.S.C."* means the general and permanent laws of the United States. All references to the U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

441—75.2(249A) Categories of persons covered. Persons who meet the criteria of one of the categorical groups below receive Medicaid if they meet the eligibility requirements of a related coverage group described in rules 441—75.3(249A) through 441—75.8(249A) and the general conditions of eligibility described within this chapter.

75.2(1) *Family-related Medicaid.* Medicaid is available to the following categories of persons who meet the eligibility requirements of one of the family-related Medicaid coverage groups described in rule 441—75.3(249A), the general conditions of eligibility specified in Division I of this chapter, and the eligibility factors specific to family-related medical assistance described in Division II of this chapter unless stated otherwise within this chapter:

a. Children under the age of 19.

b. Parents and caretakers.

c. Pregnant women.

d. Persons in foster care, a subsidized adoption arrangement, or subsidized guardianship.

e. Former foster care youth.

f. Persons living in a medical institution.

75.2(2) *Persons who need breast or cervical cancer treatment.* Pursuant to rule 441—75.4(249A), Medicaid is available to persons who have been screened and found to need treatment for breast or cervical cancer.

75.2(3) *Persons aged 19 through 64.* Medicaid is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the Iowa health and wellness plan (IHAWP) as described in subrule 75.5(1) and 441—Chapter 74.

75.2(4) *Persons who are refugees.* Medicaid is available to refugees who meet the requirements described in subrules 75.5(3) and 75.5(4) and who do not meet the requirements of another Medicaid coverage group or hawki.

75.2(5) *Aged, blind, or disabled persons.* The following coverage groups are available to persons who are aged, blind, or disabled and who meet the eligibility criteria of a coverage group described in rule 441—75.6(249A) and the general conditions of eligibility specified in this chapter:

a. Persons receiving SSI or state supplementary assistance or eligible for, but not receiving, SSI.

b. Aged, blind or disabled persons ineligible for SSI or state supplementary assistance due to income or other requirements.

c. Certain persons essential to the welfare of an aged, blind, or disabled person.

d. Persons residing in a medical institution.

e. Persons participating in Medicare savings programs.

f. Working persons with disabilities.

g. Children with disabilities.

h. Persons who may be eligible for additional services that are not available through regular Medicaid, and a waiver of federal policy has been approved. These are known as waiver services and are defined in 441—Chapter 83.

441—75.3(249A) Family-related Medicaid. Medicaid will be available to children, parents and other caretakers and to pregnant women who meet the eligibility requirements of a coverage group described within this rule and the general conditions of eligibility described in this chapter.

75.3(1) *Family medical assistance program (FMAP).* Medicaid will be available to low-income children and to the children's parent or other caretaker if the following criteria are met:

a. Children must meet the requirements described in rule 441—75.50(249A), and the parent or other caretaker must meet the requirements described in rule 441—75.51(249A).

b. Countable household income must not exceed the FMAP limits prescribed in rule 441—75.74(249A). Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter.

75.3(2) *Pregnant women, infants, and children (mothers and children (MAC)).* Medicaid will be available to pregnant women, infants (under one year of age), and children who have not attained the age of 19 if the following criteria are met.

a. Income.

(1) Household income must not exceed the applicable limits for the MAC program as stated in rule 441—75.74(249A).

(2) In establishing eligibility for pregnant women, infants, and children, income and household size will be determined pursuant to rule 441—75.72(249A).

(3) In establishing eligibility for a pregnant woman or any person whose MAGI household size includes a pregnant woman, the unborn child (or children) will be considered when determining the number of persons in the household. Attestation of pregnancy will be accepted in accordance with subrule 75.72(5).

b. Eligibility for pregnant women under this rule will begin no earlier than the first day of the month in which conception occurred and will continue throughout the pregnancy when requirements described in rule 441—75.18(249A) are met.

c. The effect of age on eligibility for an infant or a child will be determined pursuant to rule 441—75.52(249A).

d. When determining eligibility under this coverage group, the requirement to live with a parent or other caretaker as specified at subrule 75.50(2) and the age and school attendance provisions specified in subrule 75.50(1) do not apply.

e. A woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends will be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.3(4).

f. If an infant loses eligibility under this coverage group at the time of the first birthday due to exceeding the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid will continue under this coverage group for the duration of continuous inpatient services.

75.3(3) *Newborn children.* Medicaid will be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for emergency services for labor and delivery for the child's birth. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department will accept any written or verbal statement as verification of the newborn's birth date unless the department determines the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility must be completed.

75.3(4) *Postpartum eligibility following pregnancy.* Medicaid will continue to be available for a period of 12 months beginning the first of the month following the end of pregnancy and continuing

for 12 months for a woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends.

a. Except as described in this subrule, the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements in rule 441—76.14(249A) during the 12-month postpartum period.

b. The woman will not be required to file an application.

c. Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

75.3(5) *Healthy and well kids in Iowa (hawki).* Hawki will be available to children under the age of 19 who are not eligible for Medicaid and who meet the provisions of 441—Chapter 86.

75.3(6) *Transitional Medicaid.*

a. Eligible persons. Transitional Medicaid will be available for a period of up to 12 months to the following persons:

(1) A dependent child who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker; and

(3) The following household members of persons described in subparagraph 75.3(6)*"a"*(1) or *"a"*(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who entered the home prior to FMAP discontinuance or during the transitional Medicaid period.

b. Increase in income from employment. Increased income from employment includes but is not limited to the following:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

c. Transitional Medicaid and continuous eligibility. Transitional Medicaid eligibility rules supersede continuous eligibility rules for a child as described in rule 441—75.19(249A).

d. FMAP received in three of six months. In order to receive transitional Medicaid coverage under the provisions of this subrule, at least one of the individuals described in subparagraph 75.3(6)*"a"*(1) or *"a"*(2) must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred. The months the member receives FMAP due to continuous eligibility as described in rule 441—75.19(249A) do not count toward the transitional Medicaid requirement of receiving FMAP for at least three of the last six months. If there is an increase in income from employment when a child's continuous eligibility is ending, the child will not be redetermined to the transitional Medicaid coverage group.

e. Period of transitional coverage. The 12 months of transitional Medicaid coverage begin the day following discontinuance of FMAP eligibility and will continue for a consecutive 12-month period without regard to income changes, subject to paragraphs 75.3(6)*"g," "h,"* and *"i."*

f. Reserved.

g. Fraud. Transitional Medicaid will not be allowed under the provisions of this subrule when it has been determined that the member received FMAP in any of the six months immediately preceding the month of discontinuance as the result of fraud. Fraud is defined in accordance with Iowa Code section 239B.14.

h. Eligible child. During the transitional Medicaid period, assistance will be discontinued at the end of the first month in which there is no longer an eligible child living in the household who meets the requirements in rule 441—75.50(249A).

i. Other conditions of eligibility. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

j. Transitional period ends. Transitional Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets the eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(7) *Extended Medicaid.*

a. Eligible persons. Extended Medicaid will be available for a period of up to four months to the following individuals:

(1) A dependent child who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support; and

(3) The following household members of persons described in subparagraph 75.3(7)*"a"*(1) or *"a"*(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who enter the home prior to FMAP discontinuance or during the extended Medicaid period.

b. FMAP received in three of six months. In order to receive extended Medicaid coverage under the provisions of this subrule, at least one member must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. Period of extended coverage. The four months of extended Medicaid coverage begins the day following discontinuance of FMAP eligibility and will continue for four consecutive months, subject to paragraph 75.3(7)*"f."*

d. Reserved.

e. Other conditions of eligibility. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

f. Extended period ends. Extended Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(8) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement not eligible under Title IV-E or Title XVI of the Act.* Medicaid will be available to persons under the age of 21 if the following criteria are met:

a. For the child medical assistance program (CMAP), the person is in foster care or a subsidized adoption arrangement in accordance with subparagraph 75.3(8)*"a"*(1), *"a"*(2), or *"a"*(3) and the person is not eligible for assistance under Title IV-E or Title XVI of the Act.

(1) The person is placed in licensed foster care for which the state pays foster care maintenance payments pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) The person is a special needs child in an adoption assistance agreement with the department pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

(3) The person is a special needs child who resides in Iowa in a private home with the child's adoptive parent(s) and is in an adoption assistance agreement with another state with which Iowa has a reciprocity agreement as follows:

1. The other state is a member of the interstate compact on adoption and medical assistance (ICAMA); and

2. The other state provides medical assistance benefits pursuant to a program funded under Title XIX of the Act under the optional group in Section 1902(a)(10)(A)(ii)(VIII) of the Act to children residing in that state (at least until aged 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Act.

b. For the subsidized guardianship medically needy program, the person resides in Iowa in a private home pursuant to a court-approved subsidized guardianship arrangement under 441—Chapter 204 and the person is not eligible for assistance under Title IV-E or Title XVI of the Act. As authorized under 42 CFR 435.308, this reasonable classification of individuals is a separate coverage group from the medical assistance available to medically needy persons described in rule 441—75.8(249A).

c. There are no financial eligibility requirements for these coverage groups.

d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(9) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement and eligible under Title IV-E.*

a. Medicaid will be available to a child under the age of 21 who is eligible under Title IV-E of the Act and for whom any of the following is provided:

(1) Foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) Guardianship assistance pursuant to rule 441—204.4(234), regardless of whether the guardianship assistance agreement provides for guardianship subsidy maintenance payments.

(3) Adoption assistance pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

b. IV-E assistance from another state. Medicaid will be available to children under the age of 21 who are eligible for federal foster care maintenance payments, adoption assistance, or guardianship assistance under Title IV-E of the Act from another state and live in Iowa, including children with an adoption or guardianship assistance agreement that does not provide for maintenance payments.

c. There are no financial eligibility requirements for these coverage groups.

d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(10) *State-only funded medical assistance for children in foster care or a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.*

a. When the department is responsible for foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234), or has negotiated an adoption assistance agreement pursuant to rule 441—201.5(600) for a child living in a private home regardless of whether the agreement provides for adoption subsidy maintenance payments, state-only funded medical assistance will be available to the child if:

(1) The child is under the age of 21, lives in Iowa, and is not otherwise eligible under a category for which federal financial participation is available; or

(2) The child is under the age of 21, lives in another state, and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the Act, notwithstanding the residency requirements of 441—75.10(249A).

b. There are no financial eligibility requirements for this coverage group.

c. The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

d. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(11) *State-only funded medical assistance for children in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.*

a. When the department has negotiated a subsidized guardianship agreement for a child pursuant to 441—Chapter 204, state-only funded medical assistance will be available to the child

under this subrule if the child is under the age of 21 and living in a private home pursuant to a court-approved subsidized guardianship agreement if:

(1) The child lives in Iowa and is not eligible for Medicaid under a category for which federal financial participation is available due to reasons other than:

1. Failure to provide information, or
2. Failure to comply with other procedural requirements; or

(2) Notwithstanding the residency requirements of rule 441—75.10(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the Act, due to reasons other than:

1. Failure to provide information, or
2. Failure to comply with other procedural requirements.

b. There are no financial eligibility requirements for this coverage group.

c. The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

d. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(12) *Medicaid for former foster care youth (EMIYA).* Medicaid will be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person, as provided in paragraph 75.3(12)*"c"*) and under 26 years of age. The effect of reaching the age of 26 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

b. The person is:

(1) Not described in and is not enrolled under any of subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Act; or

(2) Described in any of such subclauses but has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for Medicaid under such subclause.

c. The person was in foster care as defined in Iowa Code section 232.2(20B):

(1) Under the responsibility of Iowa or a tribe within Iowa on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

(2) Under the responsibility of any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Act on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

e. The person was enrolled in Medicaid in any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

f. There are no financial eligibility requirements for this coverage group.

75.3(13) *Persons under 21 receiving care in a medical facility who would be eligible under a special income standard.* Medicaid will be available to persons under the age of 21 who meet the requirements in paragraph 75.6(4)*"b."*

75.3(14) *Presumptive eligibility for family-related medical assistance.* Medicaid will be temporarily available to the following persons who are determined to be presumptively eligible for Medicaid pursuant to rule 441—75.7(249A):

a. Infants (within MAC income limits specified in rule 441—75.74(249A));

b. Children (within hawki income limits specified in 441—subrule 86.2(2));

c. Parents and other caretakers (within FMAP income limits specified in rule 441—75.74(249A));

d. Pregnant women (within MAC income limits specified in rule 441—75.74(249A)); and

e. EMIYA.

75.3(15) *Family-related medically needy.* Pursuant to rule 441—75.8(249A), Medicaid will be available to children under the age of 19 and pregnant women who would be eligible for a family-related coverage group except for excess income. The coverage group is also available to a "parent" and "caretaker" as defined in rule 441—75.1(249A) who meet the requirements described in rule 441—75.8(249A) and who would be eligible for a family-related coverage group or IHAWP except for excess income.

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

441—75.4(249A) Persons who have been screened and found to need breast or cervical cancer treatment (BCCT).

75.4(1) Medicaid is available to persons who meet the eligibility requirements described within this rule and the general conditions of eligibility described in this chapter.

a. Medicaid will be available to persons who:

(1) Are under the age of 65:

(2) Have been screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) established under Title XV of the Public Health Service Act as amended to August 1, 2025, and have been found to need BCCT (including a precancerous condition);

(3) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg-3(c)(1)). An individual is not considered to have creditable coverage just because the individual may receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian Organization; and

(4) Are not eligible for Medicaid under Iowa Code section 249A.3(1).

b. Eligibility established under this subrule continues until the person is:

(1) No longer receiving BCCT;

(2) Aged 65 or older; or

(3) Covered by creditable coverage or eligible for Medicaid under Iowa Code section 249A.3(1).

c. Persons applying for this coverage group are not subject to MAGI methodologies described in Division III of this chapter. Income eligibility is determined by the NBCCEDP.

75.4(2) Presumptive eligibility. Medicaid is temporarily available to persons who have been screened for breast or cervical cancer and found to need treatment for the cancer and who are determined to be presumptively eligible for Medicaid under BCCT pursuant to rule 441—75.7(249A).

441—75.5(249A) Persons under age 65; refugees. Medicaid is available to persons who are under age 65 and to persons admitted to the United States as refugees who meet the eligibility requirements of a coverage group described within this rule.

75.5(1) *Iowa health and wellness plan (IHAWP).* This coverage group is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the IHAWP as described in 441—Chapter 74 and who are not eligible for Medicaid under a family-related or non-MAGI-related coverage group.

75.5(2) *Presumptive eligibility for IHAWP.* Medicaid will be temporarily available to persons who are aged 19 or older and under the age of 65 who are determined to be presumptively eligible for IHAWP medical assistance pursuant to rule 441—75.7(249A).

75.5(3) *Refugee medical assistance (RMA).* RMA is available to refugees, subject to the time limit set forth in rule 441—60.7(217) and paragraph 75.5(3)*"a,"* when the requirements of this rule are met and eligibility does not exist under another Medicaid coverage group or hawki.

a. The time limit begins the month of entry, regardless of which day during the month is the refugee's date of entry. The time limit applies to each person, not to each case or household.

b. The refugee must meet the immigration status and other non-financial requirements described in 441—Chapter 60.

c. Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter. Countable household income must not exceed the FMAP limits prescribed at rule 441—75.74(249A).

d. For purposes of Medicaid, the refugee is not required to meet the work and training requirements specified in rule 441—60.9(217).

75.5(4) *Extended coverage for refugees.* RMA will be available to a refugee for the remainder of the time limit described in subrule 75.5(3) when the refugee, who is a member, becomes ineligible for RMA or Medicaid under another coverage group solely due to earnings of a household member and eligibility does not exist under another coverage group.

a. A refugee will not be required to meet any minimum program participation time frames to receive RMA coverage under this subrule.

b. A person who returns to the household after the family becomes ineligible for RMA or Medicaid may be included in the extended RMA household if the person was included in the RMA or Medicaid household the month the family became ineligible for RMA or other Medicaid.

441—75.6(249A) Aged, blind or disabled. Medicaid is available to persons who are aged, blind or disabled and who meet the eligibility requirements of a coverage group described within this rule, the general conditions of eligibility, and the eligibility factors specific to non-MAGI-related Medicaid described in Division IV unless stated otherwise within this chapter.

75.6(1) *Persons receiving SSI or state supplementary assistance; persons eligible for but not receiving SSI.*

a. SSI recipients. Medicaid will be available to all persons receiving SSI payments as authorized by the SSA under Title XVI of the Act.

b. State supplementary assistance recipients. Medicaid will be available to all recipients of state supplementary assistance as authorized by Iowa Code chapter 249, 441—Chapters 50 through 54 and 177, and Title XVI of the Act. This applies to mandatory and optional state supplementary assistance payments, whether administered by the department or the SSA.

c. Persons who meet the income and resource requirements of SSI. Medicaid will be available to aged, blind, or disabled persons as described below who meet the income and resource guidelines of SSI but who are not receiving SSI:

(1) Aged and blind persons, as defined in rule 441—75.1(249A).

(2) Disabled persons, as determined pursuant to rule 441—75.81(249A).

(3) In establishing eligibility for children for this coverage group, resources of the child and ineligible parent or stepparent, regardless of age, will be disregarded.

(4) In establishing eligibility for adults for this coverage group, resources of non-MAGI persons will be treated according to SSI policies.

d. Persons who do not receive an SSI payment but are considered as SSI recipients. Medicaid will be available to a person who is not receiving an SSI payment because the SSA has determined that the person exceeds the income limit when the department still considers the person to be an SSI recipient.

75.6(2) *Persons who are not eligible for SSI or state supplementary assistance.*

a. Persons who are ineligible for SSI because of requirements that do not apply under Title XIX of the Act. Medicaid will be available to persons who would be eligible for SSI except for an eligibility requirement used in that program that is specifically prohibited under Title XIX of the Act.

b. Persons who would be eligible for SSI or state supplementary assistance but for social security cost-of-living increases received. Medicaid will be available to all current social security recipients who meet the following conditions:

(1) They were entitled to and received concurrently in any month after April 1977 SSI and social security or state supplementary assistance and social security,

(2) They subsequently lost eligibility for SSI or state supplementary assistance, and

(3) They would be eligible for SSI or state supplementary assistance if all of the social security cost-of-living increases that they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and SSI (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

c. Persons who would be eligible for SSI or state supplementary assistance, except that they receive social security benefits from a parent's account based on disability. Medicaid will be available to persons who receive SSI or state supplementary assistance after their eighteenth birthday because of a disability or blindness that began before the age of 22 and who would continue to receive SSI or state supplementary assistance except that they become entitled to or receive an increase in social security benefits from a parent's account.

d. Persons ineligible due to October 1, 1972, social security increase. Medicaid will be available to persons and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these persons and families would be eligible for an assistance grant if the increase were not considered.

e. Persons who would be eligible for SSI or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received. Medicaid will be available to all current social security recipients who meet all of the following conditions:

(1) They were eligible for a social security benefit in December of 1983.

(2) They were eligible for and received a widow's or widower's disability benefit and SSI or state supplementary assistance for January of 1984.

(3) They became ineligible for SSI or state supplementary assistance because of an increase in their widow's or widower's benefit that resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

(4) They have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

(5) They would be eligible for SSI or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

(6) They submitted an application prior to July 1, 1988.

f. Widows and widowers who are no longer eligible for SSI or state supplementary assistance because of the receipt of social security benefits. Medicaid will be available to widows and widowers who meet the following conditions:

(1) They have applied for and received or were considered recipients of SSI or state supplementary assistance.

(2) They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

(3) They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

(4) They are no longer eligible for SSI or state supplementary assistance solely because of the receipt of their social security benefits.

g. Continued Medicaid for disabled children from August 22, 1996. Medicaid will be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104-193) as amended to August 1, 2025, and 42 U.S.C. 1382c(a)(3).

75.6(3) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medicaid will be available to the person living with and essential to the welfare of a Title XVI beneficiary, provided the

essential person was eligible for Medicaid as of December 31, 1973. The person will continue to be eligible for Medicaid as long as the person continues to meet the definition of "essential person" in effect for the Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled public assistance programs on December 31, 1973, and as determined by SSA.

75.6(4) *Persons residing in a medical institution.*

a. Persons who would be eligible for SSI or state supplementary assistance except for their institutional status. Medicaid will be available to persons receiving care in a medical institution who would be eligible for SSI or state supplementary assistance if they were not institutionalized.

b. Persons receiving care in a medical facility who would be eligible under a special income standard.

(1) Medicaid will be available to persons who:

1. Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.2(249A), 441—82.6(3) and 441—82.7(249A).

2. Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the intellectually disabled (ICF-ID), or Medicare-certified skilled nursing facility.

3. Have gross countable monthly income that does not exceed 300 percent of the federal SSI benefits for one.

4. Either meets all SSI eligibility requirements except for income or is under age 21 pursuant to subrule 75.3(14).

(2) For all persons in this coverage group, income will be considered as provided for non-MAGI-related coverage groups under rule 441—75.80(249A). In establishing eligibility for persons aged 21 or older for this coverage group, resources will be considered as provided for non-MAGI-related coverage groups.

(3) A person in this group will not be eligible until the person has been institutionalized for a period of 30 consecutive days, and eligibility will be effective no earlier than the first day of the month in which the 30-day period begins. A period of 30 days means beginning from 12 a.m. of the day of admission to the medical institution and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

1. A person who enters a medical institution and who dies prior to completion of the 30-day period will be considered to meet the 30-day period provision.

2. Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

3. A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain under the jurisdiction of the institution, a person must first have been physically admitted to the institution.

75.6(5) *Medicare savings programs.* The purpose of the coverage groups within this subrule is to assist low-income persons with the payments of Medicare premiums, coinsurance, and deductibles. These groups are known as Medicare savings programs.

a. Qualified Medicare beneficiary (QMB) program.

(1) Medicaid will be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance, and deductibles, providing the following conditions are met:

1. The person's monthly income does not exceed 100 percent of the FPL applicable to the family size.

2. The amount of income will be determined as under the SSI program.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of resources will be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility is the first of the month after the month of decision.

(5) Pursuant to 42 CFR 435.909(b), SSI recipients are automatically enrolled in the QMB group.

b. Qualified disabled and working persons. Medicaid will be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

(1) Qualified disabled and working persons are persons who meet the following requirements:

1. The person's monthly income does not exceed 200 percent of the applicable FPL for the family size.

2. The person's resources do not exceed twice the maximum amount allowed under the SSI program.

3. The person is not eligible for any other Medicaid benefits.

4. The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Act (as added by Section 6012 of the Omnibus Budget Reconciliation Act (OBRA) 1989).

(2) The amount of the person's income and resources will be determined as under the SSI program.

c. Specified low-income Medicare beneficiaries.

(1) Medicaid will be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

1. The person's monthly income exceeds 100 percent of the FPL but is less than 120 percent of the FPL applicable to a family of the size involved.

2. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in section 1905(p)(1)(C) of the Act.

(2) The amount of income and resources will be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

d. Expanded specified low-income Medicare beneficiaries.

(1) Medicaid benefits to cover the cost of the Medicare Part B premium will be available to persons who are entitled to Medicare Part A provided the following conditions are met:

1. The person is not otherwise eligible for Medicaid.

2. The person's monthly income is at least 120 percent of the FPL but is less than 135 percent of the FPL applicable to a family of the size involved.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of the income and resources will be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

75.6(6) *Medicaid for employed people with disabilities (MEPD).*

a. Medicaid will be available to persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.81(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the FPL for the family. Family income will include gross income of all family members, less SSI program disregards, exemptions, and exclusions, including the earned income disregards. The social security cost-of-living increase will be excluded in the current calendar year for January until April.

(4) They receive earned income from employment or self-employment or are eligible pursuant to paragraph 75.6(6)*"c."*

(5) They would be eligible for Medicaid under another coverage group set out in this rule (other than the medically needy coverage groups in rule 441—75.8(249A)), disregarding all income, up to $10,000 of available resources for an individual and $21,000 for a couple, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account.

(6) They have paid any premium assessed pursuant to paragraph 75.6(6)*"b."*

b. Persons whose gross income is greater than 150 percent of the FPL.

(1) For a person whose gross income exceeds 150 percent of the FPL for an individual, eligibility is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social security cost-of-living adjustment will be included only in determining premium liability based on a subsequently published FPL. A monthly premium will be assessed at the time of application and at the annual review. The premium amounts and the FPL increments above 150 percent of the FPL used to assess premiums will be adjusted annually on August 1.

(2) Beginning with the month of application, the monthly premium amount will be established based on projected average monthly income. The monthly premium established will not be increased for any reason before the next eligibility review. The premium will not be reduced due to a change in the FPL but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(3) Eligible persons are required to complete and return forms specified by the department with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(4) Premiums will be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$43
165% of Federal Poverty Level	$59
180% of Federal Poverty Level	$70
200% of Federal Poverty Level	$82
225% of Federal Poverty Level	$97
250% of Federal Poverty Level	$113
300% of Federal Poverty Level	$141
350% of Federal Poverty Level	$171
400% of Federal Poverty Level	$202
450% of Federal Poverty Level	$233
550% of Federal Poverty Level	$291

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
650% of Federal Poverty Level	$351
750% of Federal Poverty Level	$413
850% of Federal Poverty Level	$488
1000% of Federal Poverty Level	$586
1150% of Federal Poverty Level	$685
1300% of Federal Poverty Level	$790
1480% of Federal Poverty Level	$913

(5) Eligibility is contingent upon the payment of any assessed premiums. Medicaid eligibility will not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(6) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover.

EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility will be canceled.

(7) Payments received will be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments will be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess will be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs 75.6(6)*"b"*(7)"1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account will be refunded to the client after two calendar months of inactivity, or no longer being assessed a monthly premium, or upon request from the client.

(8) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(9) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to the MEPD billing statement.

(10) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(11) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will be provided in accordance with 441—Chapter 16 and will include reopening provisions that apply if payment is received, as well as appeal rights under 441—Chapter 7.

(12) A form specified by the department will be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment will remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit a form prescribed by the department to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

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

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices, or assistive technology services. Assistive technology accounts must be held separate from other accounts, and funds and 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 when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"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 address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual 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).

"Family," if the individual is under the age of 18 and unmarried, includes parents living with the individual, unmarried siblings under the age of 18 and living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under the age of 18 and unmarried. No other persons will be considered members of an individual's family. An individual living alone or with others not listed above will be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. §220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.6(7) *Medicaid for kids with special needs (MKSN).* Medicaid will be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.81(249A) based on the disability standards for children used for SSI benefits under Title XVI of the Act but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the FPL applicable to a family of that size.

(1) For this purpose, the child's household includes any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's unmarried siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph 75.6(7)*"d"*(1) will be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs is not considered to be "receiving Medicaid" for the purposes of subparagraph *"d"*(1). A child who lives alone or with persons not identified in subparagraph *"d"*(1) will be considered as having a household of one.

(3) For this purpose, all unearned and earned income of the household, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

75.6(8) *Persons eligible for waiver services.* Medicaid will be available to members eligible for waiver services as defined in 441—Chapter 83.

441—75.7(249A) Presumptive eligibility. Medicaid will be temporarily available to persons who are determined to be presumptively eligible for Medicaid pursuant to this subrule. Presumptive eligibility will be determined by a qualified entity (QE) and will be based solely on the applicant's attested circumstances as provided to the QE and entered by the QE directly online into the Medicaid Presumptive Eligibility Portal (MPEP) system. Verification cannot be requested or required for a presumptive eligibility determination.

75.7(1) *Application process.* Persons and families requesting assistance under this subrule shall apply with a QE using the methods described in 441—subrule 76.7(3). The requirements for filing date of application, effective date of coverage, signature on application, notice and appeal rights, and full Medicaid eligibility determinations described in 441—subrules 76.7(4) through 76.7(7) apply.

75.7(2) *Eligibility requirements applicable to all presumptive eligibility determinations except as stated otherwise within this rule.* The following eligibility requirements are applicable to all presumptive eligibility determinations, except as stated otherwise within this rule.

a. Household size. Household size will be determined using MAGI methodology as described in rule 441—75.72(249A).

b. Countable income. Countable income will be determined using MAGI methodology as described in rule 441—75.73(249A).

c. Citizenship or qualified noncitizen status. The person for whom assistance is requested must be a citizen of the United States or a qualified noncitizen as defined in 441—75.11(249A), except for a pregnant woman described in paragraph 75.7(3)*"c."*

d. Iowa residency. The person for whom assistance is requested must be a resident of Iowa as described in rule 441—75.10(249A).

e. Prior presumptive eligibility. A person will not be determined presumptively eligible more than once in a 12 calendar month period, except as allowed in paragraph 75.7(3)*"g."* The first month of the 12 calendar month period begins with the calendar month the application is received by the qualified entity.

75.7(3) *Categories of eligibility and specific requirements.* The following categories of persons are eligible for a presumptive determination. Persons applying for a presumptive determination must meet all specific requirements related to the category of coverage in addition to the requirements in subrule 75.7(2), except as stated otherwise within this subrule. For categories where age is an

eligibility factor, the effect of reaching an age limit on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

a. Presumptive eligibility for children. Presumptive eligibility is available to children who meet the following requirements:

(1) Age—the child must be under the age of 19 as described in rule 441—75.52(249A).

(2) Income limits—household income must not exceed:

1. The MAC program limit for infants and the applicable household size as specified in rule 441—75.74(249A) when the child is under the age of one; or

2. The hawki program limit for a household of the same size as specified in 441—subrule 86.2(2) when the child is aged 0 through 18.

b. Presumptive eligibility for parents and other caretakers. Presumptive eligibility will be available to a parent or other caretaker who meets the following requirements:

(1) Household income must not exceed the family medical assistance program income limits specified in rule 441—75.74(249A).

(2) The parent or caretaker lives with a dependent child as described in subrule 75.50(2) and has primary responsibility for the child's care as described in subrule 75.51(2).

c. Presumptive eligibility for pregnant women. Presumptive eligibility for ambulatory prenatal care is available to a woman who is pregnant and who also meets the following requirements:

(1) Household income must not exceed the MAC program limit for pregnant women specified at rule 441—75.74(249A) for the applicable household size.

(2) A pregnant woman will not be required to meet the citizen or noncitizen requirements of rule 441—75.11(249A).

d. Presumptive eligibility for IHAWP. Presumptive eligibility for IHAWP is available to a person who meets the following requirements:

(1) The non-financial eligibility requirements described in rule 441—74.2(249A,249N).

(2) Household income not exceeding 133 percent of the FPL based on the size of the household pursuant to rule 441—74.4(249A,249N).

e. Presumptive eligibility for former foster care youth. Presumptive eligibility will be available to a person who is under the age of 26, was formerly in foster care, and meets the requirements described in subrule 75.3(12).

f. Presumptive eligibility for persons who have been screened and found to need treatment for breast or cervical cancer. Presumptive eligibility is available to a person who has been screened and found to need treatment for either breast or cervical cancer, subject to the following:

(1) The person must be determined to meet the eligibility requirements described in subrule 75.4(1).

(2) The person will not be required to meet the eligibility requirements described in paragraph 75.7(2)*"a," "b,"* or *"c."*

g. Presumptive eligibility more than once in a 12 calendar month period. A person will be determined presumptively eligible only once in a 12 calendar month period beginning with the calendar month the application is received by the qualified entity, except as follows:

(1) A new period of presumptive eligibility will begin each time a person is screened as described in subparagraph 75.4(1)*"a"* and determined to need treatment for a new occurrence of breast or cervical cancer.

(2) A pregnant woman may be determined presumptively eligible for Medicaid once per pregnancy but no more than once per pregnancy.

75.7(4) *Presumptive eligibility period.* Presumptive eligibility is effective on the date that a qualified entity completes the presumptive eligibility determination pursuant to 441—subrule 76.7(5) and ends as described in the paragraphs below.

a. For persons determined presumptively eligible under paragraphs 75.7(3)*"b"* through *"f,"* presumptive eligibility will continue until:

(1) In the case of a person on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a person on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application. Withdrawal of a Medicaid application before a decision is made will not affect the person's eligibility during the presumptive period.

b. For children determined presumptively eligible under paragraph 75.7(3)*"a,"* presumptive eligibility will continue until:

(1) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a child on whose behalf a Medicaid (including hawki) application has been filed, the day the child is determined eligible for Medicaid, the last day of the month before the child is determined eligible for hawki, or the day the child is determined ineligible for both Medicaid and hawki. Withdrawal of a Medicaid (including hawki) application before a decision is made will not affect the child's eligibility during the presumptive period.

75.7(5) *Services covered.*

a. Persons determined presumptively eligible under paragraphs 75.7(3)*"a," "b," "e,"* and *"f"* will be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services for children. Payment of claims for Medicaid services provided during the presumptive period is not dependent upon the department's determination of Medicaid or hawki eligibility.

b. Covered services for pregnant women determined presumptively eligible under paragraph 75.7(3)*"c"* will be limited to ambulatory prenatal care services during the presumptive period. Payment of claims for ambulatory prenatal care services is not dependent upon a determination of Medicaid eligibility by the department. "Ambulatory prenatal care" means all Medicaid-covered services, except inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy).

c. Persons determined presumptively eligible under paragraph 75.7(3)*"d"* will be limited to all services offered under IHAWP pursuant to 441—Chapter 74. Payment of claims for services offered under IHAWP and provided during the presumptive eligibility period is not dependent upon the department's determination of IHAWP eligibility.

441—75.8(249A) Medically needy persons.

75.8(1) *Medically needy definitions.* For purposes of this rule, the following definitions apply:

"Break in assistance" for medically needy means the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Certification period" for medically needy means the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" for medically needy means all of the following:

1. A medically needy applicant;
2. A medically needy member;
3. A person who is conditionally eligible for Medicaid under the medically needy coverage group; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"Conditionally eligible" means that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period.

"Family-related medically needy" means those persons who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

"FMAP-related medically needy" means those persons who would be eligible for FMAP pursuant to subrule 75.3(1) except for excess income.

"Incurred medical expenses" for the medically needy program means:

1. Medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or
2. Unpaid medical expenses for which the client or responsible relative remains obligated.

"Member" for the medically needy program means a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown.

"Necessary medical and remedial services" for the medically needy program means medical services recognized by law that are currently covered under the Medicaid program.

"Needy specified relative" means a nonparental specified relative, as defined for the family investment program (FIP) in 441—subrule 41.3(1), who meets all of the eligibility requirements of the FMAP coverage group pursuant to subrule 75.3(1).

"Noncovered Medicaid services" for the medically needy program means medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones that are otherwise not covered under Medicaid, the bill is for a responsible relative who is not included in the Medically needy eligibility determination pursuant to subrule 75.8(3) or the bill is for services delivered before the start of a certification period.

"Obligated medical expense" for the medically needy program means a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for the medically needy program means that eligibility continues for an SSI-related, family-related, or FMAP-related medically needy person with a zero spenddown.

"Recertification" in the medically needy coverage group means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Responsible relative" for medically needy means a spouse, parent, or stepparent of the applicant or member who lives with the applicant or member.

"Retroactive certification period" for the medically needy program means one, two, or three calendar months prior to the date of application. When applicable pursuant to 441—subrule 76.13(3), the retroactive certification period begins with the first day of the first month within the three-month period that Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" means the three calendar months immediately preceding the month in which an application is filed and applies when applicable pursuant to 441—subrule 76.13(3).

"Spenddown" means the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related medically needy" means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program except for income or resources.

75.8(2) *Coverage groups.* Medically needy will be available to the following persons who meet the general conditions of eligibility described in this chapter:

a. Pregnant women. Pregnant women who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income. For family-related programs, pregnant women will have the unborn child or children counted in the household size as if the child or children were born and living with them pursuant to subrule 75.72(5).

b. FMAP-related persons under 19. Persons under the age of 19 who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

c. SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

d. FMAP-related parents and caretakers. Parents and caretakers who:

(1) Meet the requirements of rule 441—75.51(249A) and whose income exceeds the limits for FMAP; and

(2) Live with a dependent child who meets the requirements of rule 441—75.50(249A).

75.8(3) *Family-related eligible group.*

a. The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive SSI under Title XVI of the Act. There will be at least one eligible parent or needy specified relative and at least one dependent child in the eligible group, except when the only eligible child is receiving SSI. The parent or needy specified relative may be the only FMAP-related eligible group member receiving Medicaid if:

(1) The only dependent child receives SSI, or

(2) The dependent child is ineligible for Medicaid, or

(3) The parent or needy specific relative voluntarily chooses to exclude the dependent child or children in order to receive coverage for the parent or needy relative.

b. The following persons will be included (except as otherwise provided in these rules) without regard to the person's employment status, income, or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children if the parent is living in the same home as the dependent children.

c. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent licensed physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form specified by the department. When an examination is required and other resources are not available to meet the expense of the examination, the physician will be authorized to make the examination and submit the claim for payment on a form specified by the department. A finding of eligibility for social security benefits or SSI benefits based on disability or blindness is acceptable proof of incapacity.

75.8(4) *Resources and income of all persons considered.*

a. Resources of all parents and other caretakers and of all potentially eligible individuals living together, except as specified at paragraph 75.8(4)*"b"* or those excluded in accordance with the provisions of paragraph 75.8(4)*"d,"* will be considered in determining eligibility of adults. Resources of all parents and other caretakers and of all potentially eligible individuals living together will be disregarded in determining eligibility of children. Income of all parents and other caretakers and of all potentially eligible individuals living together, except as specified in paragraph 75.8(4)*"b"* or those excluded in accordance with the provisions of paragraph 75.8(4)*"d,"* will be considered in determining eligibility.

b. The amount of income of the responsible relative that has been counted as available to a family-related household other than the medically needy applicant or member household or SSI individual will not be considered in determining the countable income for the medically needy applicant or member household.

c. The resource determination will be according to subrules 75.82(3) and 75.82(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

d. Certain persons may be voluntarily excluded from the family-related medically needy eligibility determination as follows:

(1) Exclusions from the eligibility determination. In determining eligibility under the family-related medically needy coverage groups described in paragraphs 75.8(2)*"a," "b,"* and *"d,"* the following persons may be excluded from consideration when determining medically needy eligibility of other household members:

1. Siblings (of whole or half blood, or adoptive) of eligible children.
2. Self-supporting parents of minor unmarried parents.
3. Stepparents of eligible children.
4. Children living with a parent or caretaker.

(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded will also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent will not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent will be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the legally recognized natural or adoptive parent will not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent will be used in determining eligibility for the natural or adoptive parent's children.

(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination will not be entitled to Medicaid under this or any other coverage group.

(4) Situations where a parent's needs are excluded. In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent will be allowed the earned income deduction, child care expenses, and work incentive disregard as provided at paragraph 75.8(6)*"a."*

(5) Situations where a child's needs, income, and resources are excluded. In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subparagraph 75.8(4)*"d"*(2), and the child's income is not sufficient to meet the child's needs, the parent will be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted will be the difference between the schedule of basic needs of all potentially eligible individuals living together with the child included and the schedule of basic needs with the child excluded, in accordance with the FIP provisions in 441—subrule 41.9(2), minus any countable income of the child.

75.8(5) *Resources.*

a. The resource limit for adults in SSI-related households will be $10,000 per household.

b. Disposal of resources for less than fair market value by SSI-related applicants or members is governed by rule 441—75.23(249A).

c. The resource limit for family-related adults will be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the medically needy household, regardless of age, will be disregarded. In establishing eligibility for adults for this coverage group, resources will be considered according to rule 441—41.7(239B).

d. The resources of SSI-related persons will be treated according to SSI policies.

e. When a resource is jointly owned by SSI-related persons and family-related persons, the resource will be treated according to SSI policies for the SSI-related person and according to the policies described in paragraph 75.8(5)*"c"* for the family-related persons.

75.8(6) *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

a. Income policies for family-related medically needy coverage groups. MAGI income and household size policies do not apply to the family-related medically needy coverage groups described

in subrule 75.8(2). When determining eligibility for a family-related medically needy coverage group described in subrule 75.8(2), the department will determine countable income as described in the following subparagraphs.

(1) Earned income. "Earned income" means income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment.

(2) Earned income deductions. Deductions from earned income will be made as follows:

1. Each person in the household whose gross nonexempt earned income is considered in determining eligibility is entitled to one 20 percent earned income deduction from the monthly gross earnings. The deduction is intended to include work-related expenses other than child care such as taxes, transportation, meals, and uniforms.

2. Each person in the household is entitled to a deduction for child or incapacitated adult care expenses for employment-related hours subject to the following limitations:

- The going rate in the community up to $175 per month for each child aged two or older or each incapacitated adult.
- The going rate in the community up to $200 per month for each child under the age of two.
- No deduction is allowed for any portion of the cost of care that is paid for by a third-party such as but not limited to the child care assistance program.
- Stepparents and self-supporting parents on minor parent cases will be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.
- No deduction is allowed when both parents are in the home and one parent is not employed during the hours that care is needed if the parent at home during those hours is physically and mentally able to provide the care.
- A deduction is allowable only when the care covers the actual employment hours plus a reasonable period of time for commuting, or the period of time when the person who would normally care for the child or incapacitated adult is employed at such hours that the person is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.
- Any special needs of a physically or mentally handicapped child or adult will be taken into consideration in determining the deduction allowed.
- If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense will be allowed when paid to any person except a parent or legal guardian of the child or another member of the household.

(3) With respect to self-employment, a person is considered to be self-employed if the requirements of FIP in 441—paragraph 41.8(2)*"e"* are met. Income will be considered earned income when it is produced as a result of the performance of services by an individual.

1. Earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income as allowed for FIP pursuant to 441—paragraph 41.8(2)*"e"* for a non-home based enterprise.

2. In determining net profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the costs allowed for FIP pursuant to 441—paragraph 41.8(2)*"e"* will be allowed except deductions are limited to 10 percent of the total gross income to cover the costs of upkeep for the home.

(4) When the client is renting out apartments in the client's home, the following will be deducted from the gross rentals received to determine the profit:

1. Shelter expense in excess of that set forth on the chart of basic needs components for FIP in 441—subrule 41.9(2).

2. That portion of expense for utilities furnished to tenants that exceeds the amount set forth on the chart of basic needs components for FIP in 441—subrule 41.9(2).

3. Ten percent of gross rentals to cover the cost of upkeep.

(5) In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts will be deducted from the payments received:

1. $41 plus an amount equivalent to the monthly maximum Supplemental Nutrition Assistance Program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

2. Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

(6) Gross income from providing child care in the applicant's or member's own home will include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 as amended to August 1, 2025, for the cost of providing meals to children.

1. In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received will be deducted to cover the costs of producing the income unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

2. When the applicant or member requests to have expenses in excess of the 40 percent considered, profit will be determined in the same manner as specified at numbered paragraph 75.8(6) *"a"*(3)"2."

(7) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contributions Act as amended to August 1, 2025, state and federal income taxes). Net unearned income will be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction will be considered gross income available to meet the needs of the eligible group.

1. Social security income is the amount of the entitlement before withholding of a Medicare premium.

2. When the client sells property on contract, proceeds from the sale will be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined for FIP in 441—subrule 41.7(4). The interest portion of the payment is considered a resource the month following the month of receipt.

3. Support payments in cash will be considered as unearned income in determining initial and continuing eligibility.

- Any nonexempt cash support payment for a member of the eligible group made while the application is pending will be treated as unearned income.
- Support payments will be considered as unearned income in the month in which the IV-A agency (the department's income maintenance area) is notified of the payment by the IV-D agency (child support services). The amount of income to consider will be the actual amount paid or the monthly entitlement, whichever is less.
- Support payments reported by child support services during a past month for which eligibility is being determined will be used to determine eligibility for the month. Support payments anticipated to be received in future months will be used to determine eligibility for future months. When support payments terminate in the month of decision of a family-related application, both support payments already received and support payments anticipated to be received in the month of decision will be used to determine eligibility for that month.

(8) Income will be diverted to meet the unmet needs of ineligible children and to permit payment of court-ordered support to children not living with the parent as allowed for FIP pursuant to 441—subrule 41.8(4).

(9) The following FIP policies also apply to determining income eligibility for family-related medically needy: 441—subrules 41.8(3), 41.8(5), 41.8(6), 41.8(7), and 41.8(8) and 441—paragraphs 41.8(9)*"c," "g," "h,"* and *"i."*

b. Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

c. The monthly income will be determined prospectively unless actual income is available.

d. The income for the certification period will be determined by adding both months' net income together to arrive at a total.

e. The income for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

75.8(7) *Medically needy income level (MNIL).*

a. The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided for FIP in 441—subrule 41.9(2) with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158

Each additional person $116

b. When determining household size for the MNIL, all potentially eligibles and all individuals whose income is considered as specified in subrule 75.8(4) shall be included unless the person has been excluded according to the provisions of paragraph 75.8(4)*"d."*

c. The MNIL for the certification period will be determined by adding both months' MNIL to arrive at a total. The MNIL for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

d. The total net countable income for the certification period will be compared to the total MNIL for the certification period based on family size as specified in paragraph 75.8(7)*"b."* If the total countable net income is equal to or less than the total MNIL, the medically needy individuals will be eligible for Medicaid. If the total countable net income exceeds the total MNIL, the medically needy individuals will not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

e. Effective date of approval. Eligibility during the certification period, or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3), will be effective as of the first day of the first month of the certification period or the retroactive certification period when the MNIL is met.

75.8(8) *Verification of medical expenses to be used in spenddown calculation.* The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider.

a. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to Iowa Medicaid on a claim form. The applicant or member shall inform the provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the worker will obtain the claim form from the provider.

b. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) will be on forms specified by the department. Applicants who have not established that they met spenddown in the current certification period will be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

75.8(9) *Spenddown calculation.*

a. Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period will be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met:

(1) The expenses remain unpaid as of the first day of the certification period.

(2) The expenses are not Medicaid-payable in a previous certification period or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3).

(3) The expenses are not incurred during any prior certification period with the exception of the retroactive period, when applicable pursuant to 441—subrule 76.13(3), in which the person was conditionally eligible but did not meet spenddown.

(4) Notwithstanding subparagraphs 75.8(9)*"a"*(1) through *"a"*(3), paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

b. Spenddown will be adjusted under the following circumstances:

(1) When a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received.

(2) When a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service.

(3) When an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

c. Order of deduction. Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid but excluding those otherwise subject to payment by a third party, will be deducted in the following order:

(1) Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium will not be allowed as a deduction to meet the spenddown obligation of household members in the medically needy coverage group.

(2) An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility will be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication. The average statewide monthly standard deduction for personal care services will be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the consumer price index for all urban Consumers as published by the United States Bureau of Labor Statistics.

(3) Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

(4) Medical expenses for acupuncture, chronologically by date of submission.

(5) Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

d. When spenddown has been met and a bill is received with a service date after spenddown has been met, the bill will not be deducted to meet spenddown.

e. When incurred medical expenses have reduced income to the applicable MNIL, the individuals will be eligible for Medicaid.

f. Medical expenses reimbursed by a public program other than Medicaid prior to the certification period will not be considered a medical deduction.

75.8(10) *Medicaid services.* Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

a. Care in a nursing facility or an ICF-ID.

b. Care in an institution for mental disease.

c. Care in a Medicare-certified skilled nursing facility.

75.8(11) *Reviews.* Reviews of eligibility will be made for SSI-related and family-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance will the period of time between reviews exceed 12 months. Family-related medically needy persons and SSI-related needy persons shall complete forms specified by the department as part of the review process when requested to do so by the department.

75.8(12) *Redetermination.* When an SSI-related or family-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility will be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination will be effective the month the income exceeds the MNIL or the first month following timely notice.

a. The department will determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

b. All eligibility factors will be reviewed on redeterminations of eligibility.

75.8(13) *Recertifications.* A new application must be submitted when the certification period has expired and there has been a break in assistance as defined at subrule 75.8(1). When the certification period has expired and there has not been a break in assistance, the family-related members and SSI-related members shall use forms specified by the department to be recertified.

75.8(14) *Disability determinations.* An applicant receiving social security disability benefits under Title II of the Act or railroad retirement benefits based on the Act's definition of disability by the Railroad Retirement Board will be deemed disabled without any further determination. In other cases under the medically needy program, the department will conduct an independent determination of disability unless the applicant has been denied SSI benefits based on lack of disability and the applicant does not allege either (1) a disabling condition different from or in addition to that considered by the SSA or (2) that the applicant's condition has changed or deteriorated since the most recent SSA determination.

a. In conducting an independent determination of disability, the department will use the same criteria required by federal law to be used by the SSA in determining disability for purposes of SSI under Title XVI of the Act. The disability determination services division of Iowa workforce development will make the initial disability determination on behalf of the department.

b. For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign, and submit forms as specified by the department.

c. In connection with any independent determination of disability, the department will determine whether reexamination of the person'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 specified by the department as required in paragraph 75.8(14)*"b."*

441—75.9(249A) Furnishing of social security number.

75.9(1) *Requirement.* As a condition of eligibility, except as provided by subrule 75.9(2), a Medicaid client must provide to the department all social security numbers issued to each individual (including children) for whom Medicaid is sought.

75.9(2) *Exceptions to requirement.* The requirement of subrule 75.9(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR §422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.9(3) *Cooperation in obtaining social security number.* If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the SSA or in requesting the SSA to furnish the number.

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.* The following definitions apply for the purposes of this subrule:

a. Institution. "Institution" means an "institution" or a "medical institution" as those terms are defined in 42 CFR §435.1010. For purposes of state placement, "institution" also includes foster care homes licensed as set forth in 45 CFR §1355.20 and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. Incapable of expressing intent regarding residency. For purposes of this rule, an individual is considered to be "incapable of indicating intent regarding residency" if the individual:

(1) Has an IQ of 49 or less or has a mental age of seven or less;

(2) Has been judged legally incompetent; or

(3) Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

c. Iowa resident. An Iowa resident is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A person is a resident of Iowa when living there on other than a temporary basis. Residence will not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed.

75.10(2) *Determination of residency.* State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency.

a. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care maintenance payments or have a guardianship assistance agreement or have an adoption assistance agreement under Title IV-E of the Act are considered to be residents of the state where the child lives.

b. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

c. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence unless another state has determined that the person is a resident there for Medicaid purposes.

d. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and providing facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

e. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. §1382e (including payments from Iowa pursuant to 441—Chapters 50 through 54 and Chapter 177) are considered to be residents of the state paying the supplementary assistance.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is capable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is capable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

(1) Intends to reside, with or without a fixed address; or

(2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is capable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2)*"j."*

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2)*"k"* or *"l,"* the state of residence is:

(1) The state where the individual resides, with or without a fixed address; or

(2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2)*"j,"* with whom the individual resides.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.* For purposes of this rule, the following definitions apply.

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services will be limited to medical services that are required and directly related to the treatment of the emergency medical condition.

"Citizen" and *"citizenship"* includes both citizens of the United States and nationals of the United States as defined in 8 U.S.C. §1101(a)(22).

"Federal means-tested program" means all federal programs that are means-tested, with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act as amended to August 1, 2025.
4. Assistance or benefits under the Child Nutrition Act of 1966 as amended to August 1, 2025.
5. Public health assistance (not including any assistance under Title XIX of the Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part but only if the foster or adoptive parent (or parents) of the child is a qualified alien as defined in Section 431 of the Act.
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and

- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965 as amended to August 1, 2025, and Titles III, VII, and VIII of the Public Health Services Act as amended to August 1, 2025.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965 as amended to August 1, 2025.

10. Benefits under the Head Start Act, as amended to August 1, 2025.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"INA" means the Immigration and Naturalization Act as amended to August 1, 2025, unless another effective date is specified.

"Noncitizen" means the same as "alien" as defined in 8 U.S.C. §1101(a)(3).

"Qualified noncitizen" means the same as "qualified alien" as defined in 8 U.S.C. §1641(b) and (c). A qualified noncitizen is:

1. Lawfully admitted for permanent residence in the United States under the INA;
2. Granted asylum in the United States under Section 208 of the INA;
3. A refugee admitted to the United States under Section 207 of the INA;
4. Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. An individual whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA;
6. Granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. An Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. A Cuban/Haitian entrant to the United States as described in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422) as amended to August 1, 2025;
9. A battered noncitizen as described in 8 U.S.C. Section 1641(c);
10. Certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025;
11. An American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e);
12. Under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii); or
13. Lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Act worked by a parent of a noncitizen while the noncitizen was under the age of 18 and all of the qualifying quarters worked by a spouse of the noncitizen during their marriage if the noncitizen remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Act for any period beginning after December 31, 1996, may be credited to a noncitizen if the parent or spouse of the noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. Eligibility. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified noncitizen continuously present (as described in Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of the Personal Responsibility and

Work Opportunity Reconciliation Act (PRWORA) at 62 FR 61415 dated November 11, 1997, and as amended to August 1, 2025) in the United States since before August 22, 1996.

(3) A qualified noncitizen under the age of 21.

(4) A refugee admitted to the United States under Section 207 of the INA.

(5) A noncitizen who has been granted asylum under Section 208 of the INA.

(6) A noncitizen whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.

(7) A qualified noncitizen veteran who has an honorable discharge that is not due to alienage.

(8) A qualified noncitizen who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified noncitizen who is the spouse or unmarried dependent child of a qualified noncitizen described in subparagraph 75.11(2)*"a"*(7) or *"a"*(8), including a surviving spouse who has not remarried.

(10) A qualified noncitizen who has resided in the United States for a period of at least five years beginning on the date of the qualified noncitizen's entry into the United States with a status within the meaning of numbered paragraph "1," "4," or "9" under the definition of "qualified noncitizen" in subrule 75.11(1).

(11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).

(12) A Cuban/Haitian entrant as described in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422).

(13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025.

(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e).

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to August 1, 2025, or to Section 602(b)(8) of Public Law 111-8 as amended to August 1, 2025.

(16) An Afghan paroled into the United States treated as a refugee pursuant to Section 2502 of Public Law 117-43 as amended to August 1, 2025.

(17) A qualified noncitizen lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.

(18) A conditional entrant pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980.

b. Attestation of citizenship or qualified noncitizen status. As a condition of eligibility, each applicant and member shall attest in writing to the applicant's or member's citizenship or qualified noncitizen status by signing the applicable form identified in subparagraph 75.11(2)*"b"*(1), *"b"*(2), *"b"*(3), or *"b"*(4). The attestation may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative as defined in rule 441—76.1(249A), or, if the individual is a minor or incapacitated, by someone acting responsibly for the individual provided the person acting responsibly attests to having knowledge of the individual's status.

(1) All applicants for Medicaid shall attest to their citizenship or qualified noncitizen status by signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.

(2) Family-related Medicaid members and members subject to MAGI methodology shall attest to their citizenship or qualified noncitizen status by completing and signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.

(3) Non-MAGI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or qualified noncitizen status by signing the application form described in subparagraph 75.11(2)*"b"*(1) at time of review.

(4) The department will prescribe forms for an attestation of citizenship or qualified noncitizen status that will meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to rule 441—76.4(249A).

c. Verification of citizenship and identity or qualified noncitizen status. An applicant or member attestation of citizenship or qualified noncitizen status must be verified as a condition of eligibility for Medicaid. An applicant or member who attests to citizenship must also verify their identity. The verification of citizenship status is acceptable as identity verification, except as stated otherwise within this subrule.

(1) Verification by electronic data sources. The department will accept applicant or member attestation of citizenship or qualified noncitizen status as verified when the attestation is consistent with available EDS.

(2) Satisfactory documentation of citizenship and identity is required. Except for the persons identified in paragraph 75.11(2)*"i,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2)*"b"* shall present satisfactory documentation of the attested status and their identity when the attestation is not verified by available electronic data sources. Satisfactory documentation is identified in paragraphs 75.11(2)*"d," "e," "f," "g,"* and *"h."* The provisions of the reasonable opportunity period described in subparagraphs 75.11(2)*"c"*(4) and *"c"*(5) apply.

(3) Satisfactory documentation of qualified noncitizen status is required. Except for persons receiving SSI benefits under Title XVI of the Act, applicants or members for whom an attestation of a qualified noncitizen status has been made pursuant to paragraph 75.11(2)*"b"* shall present satisfactory documentation of the attested status when the attestation is not verified by available EDS. Satisfactory documentation of qualified noncitizen status is identified in paragraph 75.11(2)*"j."* The department will request documentation in writing from the applicant or member. The provisions of the reasonable opportunity period described in subparagraphs 75.11(2)*"c"*(4) and *"c"*(5) applies.

(4) Reasonable opportunity period for providing satisfactory documentation. Applicants and members will be allowed a reasonable opportunity period of 90 days to provide satisfactory documentation of citizenship and identity or qualified noncitizen status. The reasonable opportunity period begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)*"c"*(3) or *"c"*(7) above is issued to an applicant or member, whichever is later, and continues for 90 days.

(5) Medicaid approval pending reasonable opportunity period. Medicaid will be approved for new applicants and continue for members not previously required to provide documentation of citizenship and identity or qualified noncitizen status until the end of the reasonable opportunity period, subject to 441—subrule 76.16(1).

(6) No retroactive eligibility until citizenship and identity or qualified noncitizen status is verified. Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after citizenship and identity or qualified noncitizen status has been verified with EDS or documentation has been provided pursuant to paragraph 75.11(2)*"d," "e," "f," "g," "h,"* or *"j."* When applicable, the retroactive months are outside the reasonable opportunity period during which Medicaid coverage may be provided without required documentation of citizenship and identity or qualified noncitizen status.

(7) Verification of citizenship and identity or qualified noncitizen status not required. Applicants who reapply following a break in coverage and members who are subject to an eligibility review are not required to reverify citizenship and identity or qualified noncitizen status unless:

1. The individual reports a change in citizenship or qualified noncitizen status;

2. The individual's qualified noncitizen status is a type the department has determined is subject to change; or

3. The department receives information indicating a potential change in the individual's citizenship or qualified noncitizen status.

d. Standalone evidence of citizenship and identity. Any one of the documents described in 42 CFR 435.407(a) will be accepted as sufficient evidence of citizenship and identity. In addition, provision of an individual's name, social security number, and date of birth to the department will constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the SSA produces a data match response that substantiates the individual's citizenship and identity. If submission of the name, social security number, and date of birth to the SSA does not produce a data match response that substantiates the individual's citizenship and identity, the department will issue a written request for documentation or a notice to the applicant or member pursuant to subparagraph 75.11(2)*"c"*(4) giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted; to correct any errors in the SSA's records; or to provide other documentation of citizenship and identity pursuant to paragraphs 75.11(2)*"d"* through *"h."*

e. Combination evidence of citizenship.

(1) If an applicant does not provide documentary evidence of citizenship and identity from the list in paragraph 75.11(2)*"d,"* information or documentation as described in 42 CFR 435.407(b) will be accepted as satisfactory evidence to establish citizenship if accompanied by an identity document listed in paragraph 75.11(2)*"f"*:

(2) If the applicant does not have one of the documents listed in paragraph 75.11(2)*"d"* or *"e,"* they may submit an affidavit provided by the department, signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

f. Evidence of identity. Any of the following documents described in 42 CFR 435.407(c) or (d) will be accepted as proof of identify, provided the document has a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, race, height, weight, eye color, or address.

g. Reserved.

h. Documentary evidence. The department will accept documents in accordance with 42 CFR 435.407(f) and provide assistance in a timely manner to individuals who need assistance in securing satisfactory documentary evidence of citizenship or identity in accordance with 42 CFR 435.407(e).

i. Persons not required to verify citizenship and identity status. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2)*"b"* is not required to present documentation of citizenship and identity for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving SSI benefits under Title XVI of the Act.

(4) The person is or was exempted while assisted by child welfare services funded under Part B of Title IV of the Act on the basis of being a child in foster care as defined in Iowa Code section 232.2. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)*"c"* when services under Part B of Title IV were terminated due to failure to meet citizenship requirements.

(5) The person is or was exempted while assisted by foster care as defined in Iowa Code section 232.2 or adoption assistance funded under Part E of Title IV of the Act. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)*"c"* when services under Part E of Title IV were terminated due to failure to meet citizenship requirements.

(6) The person has previously presented satisfactory documentary evidence of citizenship and identity as specified by the United States Secretary of Health and Human Services.

(7) The person is or was deemed eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) on or after July 1, 2006, as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Act.

j. Satisfactory documentation of qualified noncitizen status. For the purpose of subparagraph 75.11(2)*"c"*(3), satisfactory documentation of qualified noncitizen status is documentation issued by the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security (formerly Immigration and Naturalization Service (INS)) that identifies the person's qualified noncitizen status.

75.11(3) *Deeming of sponsor's income and resources.* When a qualified noncitizen admitted for lawful permanent residence (including those who applied for an immigrant visa or for adjustment of status, other than those whose status was adjusted from refugee or asylee status under 8 U.S.C. §1159 on or after December 19, 1997) is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the qualified noncitizen, the income and resources of each sponsor will be deemed to determine eligibility only for the sponsored qualified noncitizen and not for any nonsponsored members of the sponsored qualified noncitizen's household as follows:

a. Income. For the family-related and non-MAGI-related coverage groups described in rules 441—75.3(249A) through 441—75.9(249A) applicable to the sponsored qualified noncitizen, the amount deemed to the sponsored qualified noncitizen will be the total gross countable income of each sponsor less the following deductions that will be applied to both family-related and Non-MAGI-related applicants or members:

(1) The deductions described at 20 CFR §416.1166a, except that the amount to be deemed from each sponsor will be divided by the number of noncitizens sponsored by that sponsor.

(2) Diversion from countable earned and unearned income of the sponsor for the following:

1. Alimony or child support payments to persons not living with the sponsor.

2. Payments made to persons not living with the sponsor but who are claimed (or could be claimed) by the sponsor for federal income tax purposes.

b. Resources for non-MAGI-related coverage groups. When the sponsored qualified noncitizen's coverage group is non-MAGI-related, the total gross countable resources of each sponsor will be deemed to determine eligibility of the sponsored qualified noncitizen pursuant to 20 CFR §416.1204 less the applicable following deduction: $2,000 if the sponsor does not live with a spouse, $3,000 if the sponsor lives with a spouse who is not a sponsor, or $4,000 if the sponsor lives with a spouse who is also the qualified noncitizen's sponsor. Resources are not considered for family-related coverage groups and therefore not deemed to a sponsored qualified noncitizen applying for or receiving under a family-related coverage group.

c. An indigent qualified noncitizen is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. A qualified noncitizen will be considered indigent if the following are true:

(1) The qualified noncitizen does not live with the sponsor; and

(2) The qualified noncitizen's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the FPL for the sponsored qualified noncitizen's household size.

d. A battered qualified noncitizen as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

e. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored qualified noncitizen attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA as amended to August 1, 2025.

(2) The sponsored qualified noncitizen has earned 40 qualifying quarters of coverage as defined in Title II of the Act or can be credited with 40 qualifying quarters as defined in subrule 75.11(1).

(3) The sponsored qualified noncitizen or the sponsor dies.

(4) The sponsored qualified noncitizen is a lawfully residing child under the age of 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

(5) For non-MAGI-related Medicaid, the sponsored qualified noncitizen becomes blind or disabled as defined under Title XVI of the Act after admission to the United States as a lawful permanent resident.

(6) For non-MAGI-related Medicaid, three years after the date the sponsored qualified noncitizen was admitted to the United States as a lawful permanent resident.

75.11(4) *Eligibility for payment of emergency medical services.* Noncitizens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their noncitizen status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision, the noncitizen must meet all other eligibility criteria, including state residence requirements in rule 441—75.10(249A), with the exception of rule 441—75.9(249A) and subrules 75.11(2) and 75.11(3).

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" mean the same as defined in 42 CFR Section 435.1010.

75.12(1) *Suspension.* Medical assistance will be suspended rather than canceled while a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A daily report that is provided to the department by the public institution and includes the person's first name and last name and the date the person entered the institution; or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) *Coverage during suspension.* While medical assistance is suspended, payment will be made only for services limited to inpatient hospital claims only.

75.12(3) *Reinstatement.* The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A daily report provided to the department by the public institution that includes the person's first name and last name and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

441—75.13 Reserved.

441—75.14(249A) Establishing liability and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested or received and for whom the applicant or member can legally assign rights for medical support, except when the member has good cause for refusal to cooperate as defined in subrule 75.14(7).

a. The adult applicant shall agree to cooperate in obtaining medical support at the time of application.

b. The adult member shall cooperate in the following:

(1) Identifying and locating parties liable for the support of household members receiving Medicaid.

(2) Establishing liability for the support of household members receiving Medicaid, including establishment of paternity if paternity has not previously been established.

(3) Obtaining medical support and payments for medical care for household members receiving Medicaid.

c. Cooperation is defined as including the following actions by the adult member upon request:

(1) Appearing at the child support services as defined in 441—Chapter 95 to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the member 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.

d. Upon request, the adult member shall cooperate with the department in supplying information with respect to potentially liable parties, the receipt of medical support or payments for medical care, and the establishment of liability for support to the extent necessary to establish eligibility for assistance.

e. Upon request, the adult member shall cooperate with child support services by supplying all known information and documents pertaining to the location of potentially liable parties and taking action as may be necessary to secure medical support and payments for medical care or to establish liability. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

f. Child support services will make the determination of whether or not the adult member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant to agree to cooperate or an adult member to cooperate will result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family-related Medicaid cases, all exclusions, expenses and deductions described in rule 441—75.73(249A) will be allowed when otherwise applicable.

75.14(3) Each Medicaid member who is required to cooperate with child support services shall have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(7) through 75.14(11) will be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid member 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 member's own behalf or on behalf of any other person in the household who receives Medicaid.

An assignment is effective the same date the notice of eligibility is issued and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support will not be assigned to the department.

75.14(5) Pregnant women establishing eligibility under the MAC coverage group as provided in subrule 75.3(2) will 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 75.3(4) will not be subject to the provisions in this rule until after the end of the month in which the postpartum period expires.

Pregnant women establishing eligibility under any other coverage groups, except those set forth in subrule 75.3(2) or 75.3(4), will 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 will lose eligibility under her current coverage group and her eligibility for Medicaid will be automatically redetermined under subrule 75.3(2).

75.14(6) Notwithstanding subrule 75.14(5), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.3(2) or 75.3(4) will not be exempt from the provisions of 75.14(4) that require an adult member to assign any rights to medical support and payments for medical care.

75.14(7) Good cause exists when it is determined that cooperation in establishing liability and securing support is against the best interests of the child.

a. The department will determine that cooperation is against the child's best interest when the member's cooperation in establishing liability or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought;

(2) Physical or emotional harm to the parent or other caretaker with whom the child is living which reduces the person's capacity to care for the child adequately.

b. The department will determine that cooperation is against the child's best interest when at least one of the following circumstances exists and the department believes that because of the existence of that circumstance, in the particular case, proceeding to establish liability 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 member 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 will 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 other caretaker, 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 liability establishment or support enforcement activity to be undertaken.

75.14(8) Each Medicaid member who is required to cooperate with child support services will have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing support payments.

a. Before requiring cooperation, the department will notify the member 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.

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

(1) Advise the member of the potential benefits the child may derive from the establishment of liability and securing support.

(2) Advise the member that by law cooperation in establishing liability and securing support is a condition of eligibility for the Medicaid program.

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

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

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

c. When the member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the department will issue a second notice. To claim good cause, the member shall sign and date a form prescribed by the department and return it. This form:

(1) Indicates that the member 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 member that, upon request, the department will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the member that on the basis of the corroborative evidence supplied and the department's investigation, when necessary, the department will 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 member that child support recovery services may review the findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the member that child support recovery services may attempt to establish liability and collect support in those cases where it is determined that this can be done without risk to the member if done without the member's participation.

d. The member 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 department to determine that good cause does not exist. The member shall:

(1) Specify the circumstances that the member 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(9) The department will determine whether good cause exists for each Medicaid member who claims to have good cause.

a. The department will notify the member of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether good cause exists will be made within 45 days from the day the good cause claim is made. The department may exceed this time standard only when:

(1) The case record documents that the department 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(10).

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

(1) The member will be so notified and be 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 department will make a good cause determination based on the corroborative evidence supplied by the member only after it has examined the evidence and found that it verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the department will:

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

(2) Consider any recommendation from child support services.

f. Child support services may participate in any appeal hearing that results from a member's appeal of a department action with respect to a decision on a claim of good cause.

g. Assistance will not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the member 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 department will:

(1) Periodically, but not less frequently than every six months, review those cases in which the department 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 liability and securing support.

75.14(10) The member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the department determines that the member requires additional time because of the difficulty in obtaining the corroborative evidence, the department will allow a reasonable additional period 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 that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that 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 that indicate that the potentially liable person might inflict physical or emotional harm on the child.

(4) Medical records that indicate emotional health history and present emotional health status of the parent or other caretaker or the children for whom support would be sought; also, written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the parent or other caretaker or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the member 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 member with knowledge of the circumstances that provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the member, the department wishes to request additional corroborative evidence needed to permit a good cause determination, the department will:

(1) Promptly notify the member that additional corroborative evidence is needed, and

(2) Specify the type of corroborative evidence needed.

c. When the member requests assistance in securing evidence, the department will:

(1) Advise the member how to obtain the necessary documents, and

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

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

(1) The department will investigate the good cause claim when it believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and investigation satisfies the department that the member has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by a supervisor and the findings will be recorded in the case record.

e. The department may further verify the good cause claim when the member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the department determines that it is necessary, the department may conduct an investigation of good cause claims to determine whether good cause exists.

f. When it conducts an investigation of a good cause claim, the department will:

(1) Contact the potentially liable person from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the member so the member may present additional corroborative evidence or information so that contact with the potentially liable person becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(11) Enforcement without parent or other caretaker's cooperation. When the department makes a determination that good cause exists, the department will also make a determination of whether child support services can proceed without risk of harm to the child, parent, or other caretaker when the enforcement or collection activities do not involve their participation.

a. Child support services will have an opportunity to review and comment on the findings and basis for the proposed determination and the department will consider any recommendations from child support services.

b. The determination will be in writing, contain the department's findings and basis for the determination, and be entered into the case record.

c. When the department excuses cooperation but determines that child support services may proceed to establish liability or enforce support, the department will notify the member to enable the individual to have the case closed.

441—75.15(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, services received through Title XVIII of the Act (Medicare), and other resources for meeting the cost of medical care that may be available to the member. These resources must be used when reasonably available.

75.15(1) The department will approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.1(249A) are applicable.

75.15(2) As a condition of eligibility for Medicaid, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department all rights to payments of medical care from any third party to the extent that payment has been made under the Medicaid program. The applicant's signature on the application form listed in 441—paragraph 76.2(1)*"c"* shall constitute agreement to the assignment. The assignment shall be effective for the entire period during which Medicaid makes payment for medical care.

b. Cooperate with the department in obtaining third-party payments. The member or someone acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the Medicaid program.

75.15(3) Good cause for failure to cooperate in the filing or processing of a claim or application will be considered to exist when the member, or someone acting on behalf of a minor or legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause will be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought;

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor or legally incompetent adult member, for whom medical resources are being sought.

75.15(4) Failure to cooperate as required in subrule 75.15(2) without good cause as defined in subrule 75.15(3) will result in the termination of Medicaid benefits. The department will make the determination of good cause based on information and evidence provided by the member or by someone acting on the member's behalf.

a. The Medicaid benefits of a minor or legally incompetent adult member will not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the Medicaid benefits of the parent or payee will be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.54.

441—75.16(249A) Medical assistance lien.

75.16(1) When the Medicaid program pays for a member's medical care or expenses, the department will have a lien upon all monetary claims that the member may have against third parties for those expenses. Monetary claims will include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien will be to the extent of the Medicaid payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for Medicaid is established. The notice of lien will be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including but not limited to notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member that fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications required by law shall be directed to the department. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.16(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this rule, upon the receipt of the judgment or settlement of the total claim, of which the lien for Medicaid payments is a part, the court costs and reasonable attorney fees will first be deducted from this total judgment or settlement. One-third of the remaining balance will then be deducted and paid to the member. From the remaining balance, the lien of the department will be paid. Any amount remaining will be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees that is in excess of the amount the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim

forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.16(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or someone acting on the member's behalf, Medicaid benefits will be terminated. The Medicaid benefits of a minor child or a legally incompetent adult member will not be terminated under this subrule. Subsequent eligibility for Medicaid benefits will be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense will not be paid by the Medicaid program.

a. The member, or someone acting on the member's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. The member or person acting on the member's behalf shall complete a form prescribed by the department, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved. A report will be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Act (Medicare) and other resources.

(3) The date the member, or someone acting on the member's behalf, files an insurance claim against an insured third party for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or someone acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or someone acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid. The member may report the change in person, by telephone, by mail, or by using forms prescribed by the department when annual reviews are completed and when the client requests a form.

c. The member, or someone acting on the member's behalf, shall complete a form prescribed by the department when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form or in giving complete and accurate information will result in the termination of Medicaid benefits.

d. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee will be terminated. When a parent or payee fails to cooperate in completing or returning any form required by the department, or fails to give complete and accurate information concerning the accident-related injuries of a minor legally incompetent adult member, the department will terminate the Medicaid benefits of the parent or payee.

e. The member, or someone acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so will result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee will be terminated.

75.16(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on Form CMS-1500 that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for Medicaid or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.16(1). The mailing and deposit in a U.S. post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.16(5) *Department's lien.*

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving Medicaid from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice. Any information released to an attorney, insurer or other third party by the health care services provider that indicates that reimbursement from the state was contemplated or received will be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider that indicates Medicaid involvement will be construed as showing involvement by the department under Iowa Code section 249A.54. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department will issue notice to that attorney of the department's lien rights.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department will issue notice to the insurer of the department's lien rights.

d. The mailing and deposit in a U.S. post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.16(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency that is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for Medicaid or a past or present Medicaid member.

75.16(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.54.

441—75.17 Reserved.

441—75.18(249A) Continuous eligibility for pregnant women.

75.18(1) A pregnant woman who was eligible and enrolled in Medicaid under the provisions of this chapter prior to the end of her pregnancy shall remain continuously eligible throughout the pregnancy and the 12-month postpartum period as provided in subrule 75.3(4), regardless of changes in circumstances, except if any of the following occur:

a. The woman requests voluntary termination of eligibility.

b. The woman ceases to be a resident of the state of Iowa.

c. Iowa Medicaid finds that the woman's eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury.

d. The woman dies.

75.18(2) Except as described in subrule 75.3(4), the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements at 441—paragraph 76.14(1)*"a"* during the pregnancy and 12-month postpartum period.

75.18(3) At the end of the 12-month postpartum period, the woman will be subject to the reenrollment requirements at 441—paragraph 76.14(1)*"b."*

75.18(4) Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid will retain that eligibility for up to 12 months regardless of changes in family circumstances, except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following:

a. Children whose eligibility was determined under the newborn coverage group described in subrule 75.3(3).

b. Children whose eligibility was determined under the medically needy coverage group described in rule 441—75.8(249A).

c. Children whose Medicaid is state-funded only.

d. Children eligible only in a retroactive month pursuant to 441—subrule 76.13(3).

e. Children whose U.S. citizenship and identity, or noncitizenship status, is not verified within the reasonable opportunity period described in paragraph 75.11(2)*"c."*

f. Children whose eligibility was determined under express lane procedures described in rule 441—76.4(249A).

g. Children whose initial eligibility was established incorrectly.

75.19(2) *Duration of coverage.* Coverage under this rule will extend through the earliest of the following:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19, except as stated in rule 441—75.52(249A);

c. The month when the child ceases to be a resident of Iowa or fails to provide the department with adequate information to determine whether the child meets residency requirements pursuant to rule 441—75.10(249A);

d. The month that voluntary termination of eligibility is requested; or

e. The month the child is determined to be deceased.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household will be assigned the same annual eligibility review date as that established for the household.

441—75.20(249A) Medical assistance corrective payments. If a decision by the department or SSA following an appeal on a denied application for any of the coverage groups set forth in 441—75.3(249A) through 441—75.8(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular Medicaid coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.20(1) These bills must be for services covered by the Medicaid program as set forth in 441—Chapter 78.

75.20(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.20(3) If a county relief agency has paid medical bills on the member's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the member.

75.20(4) Members and county relief agencies may file claims for payment under this subrule on forms prescribed the department. These forms are available from the county office. All requests for reimbursement will be acted upon within 60 days of receipt of the forms in the county office.

75.20(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department will pay for the cost of premiums, coinsurance, copayments, 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 through Medicaid, including managed care capitation fees. Payment will include only the cost to the Medicaid-eligible individual or household.

75.21(1) *Definitions.* For purposes of this rule, the following definitions apply:

"Absent parent" means a noncustodial parent or a parent who is not living with the member.

"Authorized representative" means an individual or organization authorized by a competent applicant or member; authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2); or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Capitation payment" means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care organization contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member's sex, age, and eligibility aid type.

"Cost-effective" means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.

"Cost sharing" means the member's portions of in-network health care costs not covered by an insurance plan. "Cost sharing" includes copayments, coinsurance and deductibles, which vary among health care plans.

"Custodian" means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.

"Employer-sponsored insurance" or *"ESI"* means any health insurance plan paid for by a business on behalf of its employees.

"High-deductible health plan" or *"HDHP"* means a health insurance plan that meets the definition found in Section 223(c)(2) of the United States Internal Revenue Code as amended to August 1, 2025.

"HIPP-eligible member" or *"HIPP enrollee"* means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP.

"Household" means the group of people who are used in the budgeting and size when determining Medicaid eligibility.

"Individual plan" means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.

"Insurance plan" means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended to August 1, 2025, a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

"Member" means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

"Policyholder" means the person in whose name an insurance policy is registered.

"Responsible person" means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"Wrap benefits" means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) *Insurance plans.* Participation in an insurance plan is not a condition of Medicaid eligibility. The department will pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

a. A member is enrolled in or can be added to the insurance plan; and

b. The insurance plan is cost-effective as described in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* An insurance plan shall be considered cost-effective when the amount the department would pay for the member's insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid, including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data will be considered:

a. The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. Costs paid by an employer or other plan sponsor will not be considered in the cost-effectiveness determination.

b. The cost of care through Medicaid, including managed care capitation fees, the department would pay for the member.

c. The estimated cost of wrap benefits per member based on the member's sex, age, and eligibility aid type.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire will be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:

(1) If the member is currently covered by the insurance plan, the department will request from the policyholder, or from the responsible person for the member, an insurance summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member's cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $150 per HIPP member covered under the health plan.

f. Whether the estimated savings to the department for members covered under the health insurance plan is at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When an insurance plan is determined to be cost-effective, the department will pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

a. The needs of the non-Medicaid-eligible family members will not be taken into consideration when determining cost-effectiveness; and

b. Payments for deductibles, coinsurances or other cost-sharing obligations will not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) *Insurance plans ineligible for reimbursement.* Premiums will not be paid for 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 that 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 the basis of attendance or enrollment at the school.

d. The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in rule 441—75.8(249A), 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 will be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium will 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 insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments will be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services.

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

i. Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).

j. The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.

k. The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

l. The health plan pays secondary to another plan.

m. The only Medicaid member is in foster care.

n. The member is active for Medicaid under Medicaid for children with disabilities (i.e., MKSN) pursuant to subrule 75.6(7). Any other Medicaid members in the household who are covered by the health plan will be determined for cost-effectiveness.

o. The insurance plan is limited due to preexisting conditions.

p. The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.

q. On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.

r. The insurance plan is an HDHP.

75.21(6) *Department evaluation of ESI plans.* When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department will pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan will be determined as follows:

a. Premium payments shall begin the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, HIPP Program Application, or the automated HIPP referral is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments will 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 health plan is dropped and reenrollment occurs at a later date), premium payments will not be made for any period of time before the current effective date of coverage.

d. In no case will payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage will be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer will be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier, except as follows:

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

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department will reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department will issue reimbursement to the employee five working days before the employee'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 those withdrawals.

d. Payments for COBRA coverage will be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) *Payment of claims.* Claims from medical providers for persons participating in this program will 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(10) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility will be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility will be completed using the HIPP Program Review form.

b. Annual review of individual health plan cost-effectiveness and eligibility will be the HIPP Private Policy Review form.

c. Failure of the household to cooperate in the annual review process will result in cancellation of premium payment.

d. Redeterminations will be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

(6) There is a decrease in the services covered under the policy; or

(7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)*"a,"* will be considered if they are available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department will verify whether coverage may be continued under the provisions of COBRA.

(1) The Employer Verification of COBRA Eligibility form may be used for this purpose.

(2) If it is cost-effective to do so, the department will pay premiums to maintain insurance coverage for members after the occurrence of the event that would otherwise result in termination of coverage.

75.21(11) *Time frames for determining cost-effectiveness.* The department will determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) *Notices.*

a. Adequate notice will be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department will provide timely and adequate notice as defined in rule 441—16.2(17A) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the insurance plan is no longer cost-effective; or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPP program.

75.21(13) *Rate refund.* The department is entitled to any rate refund made when the 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(14) *Reinstatement of HIPP eligibility.*

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

b. When HIPP eligibility is canceled because of the policyholder's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits will be reinstated the first day of the first month in which cooperation occurs if all other eligibility factors are met.

75.21(15) *Amount of insurance premium paid.*

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPP program will pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPP program will not pay the portion of the premium cost that is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program will pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program will pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of HIPP benefits.

a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change will be paid effective the first day of the month in which the change is reported.

75.21(17) *Discontinuation of premium payments.*

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

b. When only part of the household loses Medicaid eligibility, the department will complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment will be discontinued pending timely and adequate notice.

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

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

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

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

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

a. The person with AIDS or an 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 spenddown obligation under the medically needy program, as provided in rule 441—75.8(249A), 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 an HIV-related illness. The Physician's Verification of Diagnosis form shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the FPL for a family of the same size. The gross income of all family members will be counted using the definition of gross income under the 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, and certificates of deposit, excluding IRS-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 HIPP Application. The applicant shall be required to provide documentation of income and assets. The application will be available from and may be filed at any county office or the department.

An application will be considered as filed on the date an AIDS/HIV HIPP Application containing the applicant's name, address and signature is received and date-stamped in any county office or the department.

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, the department will deny pending applications. The department will mail a notice of decision within ten calendar days following the determination that funds have been obligated. The notice will 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 will 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 will 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 will be granted when all of the following occur:

a. The application is accompanied by a completed Physician's Verification of Diagnosis form.

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 will 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(8).

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

75.22(7) *Reviews.* The department will review circumstances of persons participating in the program quarterly to ensure eligibility criteria continue to be met. The AIDS/HIV HIPP Program

Review form 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 16.3(2) will 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 rule 441—16.2(17A) will 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 will 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 shall be signed by the recipient authorizing the department to make the contact.

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 subrule 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 subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)*"a"*(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)*"a"*(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins 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 will 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 subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)*"b"*(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)*"b"*(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins 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 will not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period will not be deducted as medical expenses in determining client participation pursuant to subrule 75.83(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. When assets were transferred 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. When assets were transferred 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 will 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 subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department will determine the

average statewide cost to a private-pay resident for nursing facilities and update the cost annually. Current average statewide costs will be published on the department's website.

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

75.23(5) *Exceptions.* An individual will 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 of the individual 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 child 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 that 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 child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(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 one of the following is true:

(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 exists only when all of the following conditions are met:

(1) Applying 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, will 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 that results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility will 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 will 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 will be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* For the purposes of this rule the following definitions apply:

"Assets" includes all income and resources of the individual and the individual's spouse, including any income or resources that 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" means the same as defined in 42 U.S.C. Section 1382a.

"Institutionalized individual" means 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" means the same as defined in 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 (subparagraph 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 633E.5 on or after July 1, 2000 (Iowa Code section 249A.3(11)*"c"*);

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value will be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant will be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9)*"b"* and also meets the condition described in paragraph 75.23(9)*"c."*

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986 as amended to August 1, 2025 (U.S. IRC).

(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 U.S. IRC;
2. A simplified employee pension (within the meaning of Section 408(k) of the U.S. IRC); or
3. A Roth IRA described in Section 408A of the U.S. IRC.

(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 SSA); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must have 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 institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the 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.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant will be treated as assets transferred for less than fair market value unless Iowa is 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 institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the 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.

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, will 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 subrule 75.23(1) unless the note, loan, or mortgage meets all of the following conditions:

(1) Has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA).

(2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) 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 will be treated as assets transferred for less than fair market value regardless of whether the note, loan, or mortgage was:

(1) Purchased before February 8, 2006; or

(2) Purchased on or after February 8, 2006, and the conditions described in paragraph 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, will 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 more than its fair market value will be treated as assets transferred for less than fair market value regardless of whether the life estate was:

(1) Purchased before February 8, 2006; or

(2) Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts (except

for trusts specified in subrule 75.24(3)) established after August 10, 1993, will be treated in accordance with subrule 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will:

(1) The individual,

(2) The individual's spouse, or

(3) A person, including a court or administrative body:

1. With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

2. Acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources that the individual or the individual's spouse is entitled to but does not receive because of action by:

(1) The individual,

(2) The individual's spouse, or

(3) A person, including a court or administrative body:

1. With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

2. Acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule apply to the portion of the trust attributable to the individual.

d. This rule applies without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust will be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual will be considered income of the individual.

(3) Any other payments from the trust will be considered assets disposed of by the individual subject to the penalties described in rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of or income on the principal from which payment to the individual could be made will be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual will be considered income to the individual. Payments for any other purpose will be considered a transfer of assets by the individual subject to the penalties described in rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual will be considered as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified in subrule 75.23(3) and 441—Chapter 89. The value of the trust will be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule does not apply to any of the following:

a. A trust that contains the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Act) and that is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust); the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code chapter 633C, the average statewide charges and Medicaid rates are updated annually and will be published on the department's website.

c. A trust containing the assets of an individual who is disabled (as defined in Section 1614(a)(3) of the Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in Section 1614(a)(3) of the Act) by the parent, grandparent, or legal guardian of the individuals; by the individuals; or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

441—75.25(249A) Treatment of Medicaid qualifying trusts.

75.25(1) A Medicaid qualifying trust is a trust or similar legal device established on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of an intellectually disabled person who resides in an ICF-ID are exempt.

75.25(2) The amount of income and principal from a Medicaid qualifying trust that will be considered available will be the maximum amount permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available will be counted as income.

b. Trust principal (including accumulated income) considered available will be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time will be counted as income for that period of time.

c. To the extent that the trust principal and income are available only for medical care, the principal or income will not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it will be used as a third-party resource.

441—75.26(249A) Conservatorships.

75.26(1) *Conservatorships established prior to February 9, 1994.* The department will determine whether assets from a conservatorship established prior to February 9, 1994, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance will be considered toward income limitations and resource limitations when applicable for the coverage group.

b. When assets in the conservatorship are not clearly available, the department may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

c. Funds in a conservatorship that are not clearly available will be considered unavailable until the conservator or court actually makes the funds available.

d. Payments received from the conservatorship for basic or special needs are considered income.

75.26(2) *Conservatorships established on or after February 9, 1994.* Conservatorships established on or after February 9, 1994, will be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

441—75.28(249A) Recovery.

75.28(1) *Definitions.* For the purposes of this rule, the following definitions apply:

"Administrative overpayment" means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

"Agency error" means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former Medicaid member.

"Client error" means medical assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. "Client error" also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.15(249A).

"Premiums paid for medical assistance" means monthly premiums assessed to a member or household for Medicaid or IHAWP coverage.

75.28(2) *Amount subject to recovery.* The department will recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the

department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) *Notification.* All clients will be promptly notified when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures will include:

(1) The person for whom assistance was paid;

(2) The period during which assistance was incorrectly paid;

(3) The amount of assistance subject to recovery; and

(4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums will include:

(1) The amount of the premium; and

(2) The month covered by the medical assistance premium.

75.28(4) *Source of recovery.* Recovery will be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) *Repayment.* The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an ICF-ID, or a mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department will then recover the funds from the facility through a vendor adjustment.

75.28(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

75.28(7) *Estate recovery.* Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, of the member's surviving spouse, or of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2)*"d."* The classification of the debt is defined in Iowa Code section 633.425(7).

a. Definitions. In addition to the definitions in subrule 75.28(1), the following definitions apply:

"Capitated payment/rate" means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

"Estate." For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes but is not limited to interest in jointly held property, retained life estates, and interests in trusts.

"Managed care organization" or *"MCO"* means an entity that:

1. Is under contract with the department to provide services to Medicaid recipients, and

2. Meets the definition of "health maintenance organization" in Iowa Code section 514B.1.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55;
2. Is a resident of a nursing facility, an ICF-ID, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department will presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due will be established. The department will notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due will be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due will be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests a determination, the department will determine if the member can or could have returned home.

(1) The department cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The department will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, Iowa Medicaid will establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The department will notify the member or the member's representative of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the department upon the death of a member residing in the facility by submitting a form prescribed by the department.

(2) Upon receipt of the form or a report of a member's death through other means, the department will request a statement of the member's assets from the member's personal representative. The representative shall sign and return a form prescribed by the department indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist.

EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened because those procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of debt.

(1) The department will waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the FPL for a household of the same size; total household resources do not exceed $10,000; and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" will be defined as being under FIP.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department will determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph 75.28(7)*"g,"* to the extent that the person received the member's estate, the amount waived will be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for Medicaid under subrule 75.82(5) will not be subject to a claim for Medicaid paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medicaid paid on behalf of the member before these conditions will be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest will accrue on a debt due under this subrule in accordance with Iowa Code section 249A.53(2)*"e."*

k. Reimbursement to a county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department will reimburse the county on a proportionate basis.

441—75.29(249A) Investigation of eligibility. An applicant or member shall cooperate when the applicant's or member's case is selected by the department or the department of inspections, appeals, and licensing for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect Medicaid eligibility. (More information is contained in 481—Chapter 72.) Failure to cooperate will serve as a basis for denial of an application or discontinuance of Medicaid unless the Medicaid eligibility is determined by SSA. Once a person's eligibility is denied or discontinued for failure to cooperate, the person may reapply but will not be determined eligible until cooperation occurs.

441—75.30 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO FAMILY-RELATED COVERAGE GROUPS

441—75.50(249A) Eligibility factors specific to child. A child must meet the requirements of this rule to be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14).

75.50(1) *Age and school attendance.* Medicaid will be available to a child under the age of 18 without regard to school attendance.

a. The effect of age on the child's eligibility will be determined pursuant to rule 441—75.52(249A).

b. Medicaid will also be available to a child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met:

(1) A child will be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child will also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption will be continued for a reasonable period of time to complete the adjustment.

75.50(2) *Residing with a parent or other caretaker.* The child shall be living in the home of a parent or other caretaker as defined in rule 441—75.1(249A). The parent or other caretaker must meet the requirements of rule 441—75.51(249A).

a. When the mother intends to place her child for adoption shortly after birth, the child will be considered as living with the mother until the time custody is actually relinquished.

b. Living with a parent or other caretaker implies the existence of a relationship involving an accepted responsibility on the part of the caretaker for the primary care of the child. A non-parental caretaker must attest to having primary responsibility for the child's care pursuant to paragraph 75.51(2)*"b."*

c. A child can receive Medicaid in one household only. In a joint custody situation, when a child lives in the home of one parent or other caretaker some of the time and also lives in the separate home of the other parent or another caretaker, who the child will be considered to be living with is determined as follows:

(1) As specified in a court order or binding separation, divorce or custody agreement, or,

(2) If there is no such order, the parent or other caretaker with whom the child spends most nights will be considered the custodial parent or other caretaker. When a child spends equal amounts of time in the home of each parent and both parents apply for Medicaid for the child, the parents must decide which parent will continue with the application. Likewise, when a child spends equal amounts of time in the home of a parent and the home of another caretaker, the parent or other caretaker must decide which caretaker will continue with the application. If the parents, or the parent and other caretaker, cannot reach a decision, the department will make the determination based on the totality of the available information.

d. Upon the determination that a child is living with a parent or other caretaker, the Medicaid household size for each applicant or member is determined according to rule 441—75.72(249A) for the purpose of determining eligibility.

441—75.51(249A) Eligibility factors specific to parents and caretakers.

75.51(1) *FMAP and other requirements.* To be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14), a parent or other caretaker must:

a. Meet the definition of "parent" or "caretaker" in rule 441—75.1(249A);

b. Live with an eligible child as defined in rule 441—75.50(249A); and

c. Satisfy the FMAP requirements specified in subrule 75.3(1) and the general conditions of eligibility specified in this chapter.

75.51(2) *Assumes primary responsibility for care of child.* To be eligible for FMAP, the parent or other caretaker living in the home with the child must assume primary responsibility for the care of the child.

a. A parent who is living with their child is presumed to have primary responsibility for the child's care.

b. For a child and a non-parental caretaker to meet the requirements of this subrule, the non-parental caretaker who is living with the child must attest to having primary responsibility for the child's care on an application or other document submitted to the department.

441—75.52(249A) The effect of age on eligibility. When age is an eligibility factor and a person has reached the age limit, the birth date impacts eligibility for the birth month.

75.52(1) A person is eligible for the entire month in which the person's birth date occurs, unless the birthday falls on the first day of the month. Ineligibility based on age will be effective the first of the month following the birth month.

75.52(2) A person whose birth date is on the first day of the month is not eligible for the age-limited coverage group for the birth month. Ineligibility based on age will be effective on the person's birth date.

75.52(3) This rule applies to the following coverage groups:

a. FMAP;

b. MAC;

c. Child medical assistance program (CMAP);

d. Subsidized guardianship medically needy program;

e. Children eligible under Title IV-E;

f. State-only funded medical assistance for children in foster care or subsidized adoption;

g. State-only funded medical assistance for children in subsidized guardianship; and

h. Medicaid for former foster care youth (EMIYA).

441—75.53(249A) Absence from the home.

75.53(1) A person who is absent from the home will not be included in the household, except when temporarily absent as described in subrule 75.53(2).

a. A parent who is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

b. A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

c. A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "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.

75.53(2) The needs of a person who is temporarily absent from the home are included in a household if otherwise eligible. A temporary absence exists in any of the following circumstances:

a. A person is anticipated to be in a medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the person no longer being included in the household;

b. A child is out of the home to secure education or training as defined in paragraph 75.50(1)*"b"* as long as the child remains a dependent;

c. A parent or other caretaker is temporarily out of the home to secure education or training and was in the household before leaving the home to secure education or training. For this purpose, "education or training" means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment; or

d. A person is out of the home for reasons other than reasons in paragraphs 75.53(2)*"a"* through *"c"* and intends to return to the home within three months. Failure to return within three months from the date the person left the home will result in the person no longer being included in the household.

441—75.54(249A) Pending SSI approval. When a person who would ordinarily be in the family-related Medicaid household has applied for SSI benefits, the person's needs will be included in the family-related Medicaid household pending approval of SSI.

441—75.55(249A) Resources not considered. There is no resource test to determine eligibility for family-related Medicaid coverage groups.

441—75.56(249A) Income eligibility. Unless otherwise stated within this chapter, income eligibility under family-related coverage groups will be determined using MAGI methodologies pursuant to Division III of this chapter.

441—75.57 to **75.69** Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on MAGI. Notwithstanding any other provision of this chapter, financial eligibility for Medicaid is determined using MAGI and household income pursuant to 42 U.S.C. §1396a(e)(14) to the extent required by that section as a condition of federal funding under Title XIX of the Act. For this purpose, financial eligibility for Medicaid includes any applicable purpose for which a determination of income is required for a coverage group that is subject to MAGI methodology as specified in rule 441—75.71(249A) and defined in rule 441—75.1(249A), including the imposition of any premiums or cost sharing.

441—75.71(249A) Coverage groups subject to MAGI methodology. Financial eligibility will be determined under MAGI methodology for the following coverage groups:

1. FMAP as described in subrule 75.3(1).
2. MAC program as described in subrule 75.3(2).
3. Hawki as described in 441—Chapter 86.
4. IHAWP as described in 441—Chapter 74.
5. RMA as described in subrule 75.5(3).

441—75.72(249A) MAGI household composition. For the purpose of determining financial eligibility, each applicant's or member's household is determined based on federal tax policy and with regard to the applicant's or member's federal tax status as described below.

75.72(1) *Applicant or member is a tax-filer.* An applicant or member who expects to file a federal tax return for the year in which the applicant or member requests Medicaid and does not expect to be claimed as a tax dependent by another taxpayer is considered a tax-filer. A tax-filer's Medicaid household includes:

a. The tax-filer,

b. The tax-filer's spouse, under either of the following circumstances:

(1) The tax-filer and spouse are living together, or

(2) The expected tax status is married filing jointly, regardless of whether the spouse is present in the home, and

c. Each dependent that the tax-filer expects to claim.

75.72(2) *Applicant or member is a tax dependent.* An applicant or member who expects to be claimed as a tax dependent on a federal tax return for the year in which the applicant or member requests Medicaid is a tax dependent. A tax dependent's Medicaid household is the same as the tax-filer who claims the dependent, except the dependent's household is determined pursuant to subrule 75.72(3) when the dependent:

a. Expects to be claimed by someone other than a spouse or parent.

b. Is a child under the age of 19 who expects to be claimed by one parent while living with two parents who do not expect to file a joint return.

c. Is a child under the age of 19 who expects to be claimed by a noncustodial parent in accordance with a court order or binding separation, divorce, or custody agreement establishing physical custody controls. If there is no such order or agreement, the custodial parent is the parent with whom the child spends most nights pursuant to subparagraph 75.50(2)*"c"*(2).

75.72(3) *Applicant or member is a non-filer (does not file taxes) and is not claimed as a tax dependent.*

a. This subrule applies to an applicant or member who:

(1) Does not expect to file a federal tax return for the year in which Medicaid is requested,

(2) Does not expect to be claimed as a tax dependent for the year in which Medicaid is requested, or

(3) Meets an exception described in paragraph 75.72(2)*"a," "b,"* or *"c."*

b. The household consists of the applicant or member and each of the following who is living with and in relation to the applicant:

(1) Parent, when the applicant or member is a child under the age of 19.

(2) Spouse.

(3) Child under the age of 19.

(4) Sibling under the age of 19, when the applicant or member is a child under the age of 19.

c. For the purpose of paragraph 75.72(3)*"b,"* "living with" must be in accordance with subrule 75.50(2).

75.72(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of federal tax status.

75.72(5) *Pregnancy.*

a. Household size. In establishing eligibility for a pregnant woman or any person whose household includes a pregnant woman, the unborn child (or children if more than one fetus exists) will be considered when determining the number of persons in the household.

b. Verification of pregnancy. The applicant's or member's attestation of the pregnancy, date of conception, due date, and number of children expected to deliver will serve as verification unless questionable as determined by the department.

75.72(6) *Applicant or member attestation of federal tax status.* The department will accept the applicant's or member's statement of the applicant's or member's federal tax status and claimed dependents or such statement from an adult who is living with and in the Medicaid household of an applicant or member who is a child.

441—75.73(249A) Income under MAGI methodology. The total countable earned and unearned income of the applicant or member included in the household as defined in rule 441—75.72(249A) will be considered when determining initial and ongoing Medicaid eligibility for coverage groups that are subject to MAGI methodology as specified in rule 441—75.71(249A). For eligibility to exist, the total countable monthly income of the applicant's or member's household must be at or below the income limit for the applicable coverage group pursuant to rule 441—75.74(249A).

75.73(1) *Household member income exclusions under MAGI.* The income of a household member that meets the requirements of paragraph 75.73(1)*"a"* or *"b"* is excluded from the household's total countable income.

a. Income of children under age 19.

(1) The income of a child under the age of 19 who is:

1. Included in the household of the child's parent, and

2. Not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined, regardless of whether a tax return is filed by the child for the tax year.

(2) A child with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

b. Income of tax dependent other than spouse or child.

(1) The income of a tax dependent other than a spouse or a child who is not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined is not included, regardless of whether a tax return is filed by the tax dependent for the tax year.

(2) A dependent with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

(3) Any cash support provided to the claimed dependent by the tax-filer.

75.73(2) *Countable income under MAGI.* For the purpose of determining initial and ongoing MAGI Medicaid eligibility, countable income is the amount that remains after allowable expenses and deductions have been subtracted from gross countable income as defined in paragraph 75.73(2)*"a."* Income described in paragraph 75.73(2)*"b"* is excluded as countable income. Allowable expenses and deductions are limited to those allowed in accordance with paragraphs 75.73(2)*"c"* and *"d."*

a. Gross countable income. Gross countable income under MAGI includes income types that are considered as gross income for federal tax purposes pursuant to 26 U.S.C. Sections 61 and 71 through 91 and calculated pursuant to 26 U.S.C. Section 36B(d)(2)(B), except as specified in paragraph 75.73(2)*"b."* Gross countable income for the purpose of Medicaid eligibility under MAGI includes but is not limited to the following income types:

(1) Earned income, including salaries, wages, tips and other compensation for services that include fees, commissions, fringe benefits such as sick pay, vacation pay, severance pay, and similar items, and including foreign earned income and housing expenses of a U.S. citizen or resident who lives abroad even though these types of income may not be taxable.

(2) Gross profit derived from a self-employment trade or business as defined in paragraph 75.73(2)*"e"* and 26 U.S.C. Section 1402;

(3) Capital gains derived from dealings in assets or property;

(4) Interest (taxable and non-taxable);

(5) Rental income, including room and board;

(6) Royalties;

(7) Taxable dividends;

(8) Alimony and separate maintenance payments;

(9) Taxable annuities;

(10) Income from life insurance and endowment contracts;

(11) Pensions;

(12) Income from discharge of indebtedness;

(13) Distributive share of partnership or S-corporation gross income;

(14) Income in respect of a deceased person;

(15) Income from an interest in an estate or trust;

(16) Deemed sponsor income;

(17) Social security benefits (taxable and nontaxable);

(18) Disability payments, including government, private, temporary and permanent payments;

(19) Unemployment Insurance Benefits (UIB);

(20) Gambling winnings;

(21) Survivor's benefits; and

(22) Strike pay.

b. Income types excluded from gross income. Income that meets the following criteria is not considered when determining countable gross income under MAGI despite the fact that the income may be considered for federal tax purposes. The exclusion of these income types is in accordance with 42 CFR Section 435.603(e).

(1) An amount received as a nonrecurring lump sum from a source that is considered in determining adjusted gross income for federal tax purposes pursuant to paragraph 75.73(2)*"a"* is counted only in the month received for determining Medicaid eligibility under MAGI. A nonrecurring lump sum received from a source that is not considered in determining adjusted gross income for federal tax purposes is entirely excluded.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance pursuant to 42 CFR Section 435.603(e)(3) is excluded from income.

(4) Student financial assistance provided under the Bureau of Indian Affairs education programs is excluded from income.

(5) Any other type of income that is not identified as countable in paragraph 75.73(2)*"a"* and is not otherwise included in "adjusted gross income" for federal tax purposes pursuant to 26 U.S.C. Section 62 is excluded from income.

c. Allowable expenses. Expenses that are allowed as deductions from gross income when determining a person's adjusted gross income for federal tax purposes pursuant to 26 U.S.C. Section 62 are subtracted from gross income as defined in paragraphs 75.73(2)*"a"* and *"b"* when determining countable income under MAGI. Allowable expenses include:

(1) Educator expenses.

(2) Certain business expenses of reservists, performing artists, and fee-based government officials.

(3) Health savings account contributions.

(4) Moving expenses for members of the Armed Forces.

(5) Deductible part of self-employment tax.

(6) Contributions to self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees of Small Employers (SIMPLE) and Qualified Plans.

(7) Self-employed health insurance contributions.

(8) Amount of penalty for early withdrawal of savings.

(9) Alimony payments made under a divorce or separation agreement executed before January 1, 2019.

(10) Certain individual retirement account (IRA) contributions.

(11) Student loan interest expense.

(12) Expenses directly related with the conduct of a self-employment trade or business, including but not limited to depreciation and capital losses.

d. MAGI Income Deduction. An amount equal to 5 percent of the FPL for the applicable household size will be subtracted from the total monthly countable MAGI income amount when:

(1) An applicant's monthly MAGI income exceeds the highest income limit of all of the coverage groups for which the applicant meets the categorical requirements, and

(2) Deducting 5 percent results in the applicant's income being within the income limit of the coverage group with the highest income limit for which the applicant meets categorical requirements.

e. Self-employment defined for MAGI purposes. A person is considered self-employed if the person:

(1) Carries on a trade or business with the goal of making a profit and is the sole proprietor of the trade or business, or

(2) Is an independent contractor and the person paying for the work has the right to control or to direct only the result of the work and not how the work will be done.

75.73(3) *Income verification.* The department will accept an applicant's or member's attestation of income and use the attested income to determine eligibility when the attested amount is reasonably compatible with electronic data sources as defined in rule 441—75.1(249A).

a. Verification not required. The department will not require the applicant or member to provide verification when attested income is reasonably compatible with EDS or verification is available to the department from other sources.

b. Verification required. When attested income is not reasonably compatible with EDS or verification is not available to the department from other sources, the applicant or member must provide verification of the income in accordance with 441—subrule 76.8(2) or provide a statement that reasonably explains the discrepancy between the attested income and electronic data sources.

75.73(4) *Budgeting procedures for determining financial eligibility under MAGI.* Initial and ongoing financial eligibility under MAGI is based on current monthly household composition and income with consideration given to any anticipated changes or fluctuation in income or expenses pursuant to 42 CFR Section 435.603(h). Total countable earned and unearned income of all persons in the applicant or member household after applicable expenses and deductions is considered in determining financial eligibility under MAGI in accordance with subrules 75.73(1) and 75.73(2).

a. Current monthly household income. Both initial and ongoing eligibility will be based on current monthly income when current income and any applicable expenses are a good indicator of future income except when the income is unemployment insurance benefits as described in paragraph 75.73(4)*"c."*

b. Change in current month's income. If the household indicates that current countable income is not indicative of future income due to a change that is reasonably expected to occur in the current or next month, the amount of monthly income used for initial and ongoing eligibility will be calculated based on the change. When the anticipated change is with unemployment insurance benefits, income will be budgeted as described in paragraph 75.73(4)*"c."*

c. Unemployment insurance benefits (UIB). When current income includes UIB, the monthly amount of UIB income used for initial and ongoing eligibility will be determined by annualizing the remaining balance according to the applicable item below:

(1) For applicants, the monthly amount is determined by using the remaining balance as of the first day of the month in which the application was filed and dividing the balance by 12. If the UIB will end in the application month, the annualized amount will be used for the application month only and no UIB income will be used for months thereafter.

(2) For members in the review process described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month of the new certification period and dividing the balance by 12. If the UIB will end in the first month of the new certification period, the annualized amount will be used for the first month and no UIB income will be used for months thereafter.

(3) For members reporting a change and not due for review as described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month in which the change can be acted upon in accordance with rule 441—76.16(249A).

d. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract will be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently will be prorated over the period covered by the income and applied to the eligibility determination for the same number of months.

EXCEPTION: Periodic or intermittent income from self-employment will be treated as described in paragraph 75.73(4)*"h."*

(3) Applicable expenses and deductions will be applied to the monthly prorated income.

e. Conversion of weekly or biweekly income to a monthly amount. When income received weekly or biweekly (once every two weeks) is projected for future months, it will be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result will be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

f. Self-employment income. Countable income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis will be annualized (annual income averaged over a 12-month period of time) to arrive at the monthly amount to be used to determine eligibility, even if the income is received within a short period of time during that 12-month period. Countable self-employment income is gross countable income as defined in paragraph 75.73(2)*"a"* less allowable expenses pursuant to subrule 75.73(2)*"c."* Any change in self-employment will be handled in accordance with subparagraph 75.73(4)*"f"*(3).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will be averaged over the period of time the enterprise has been in existence to arrive at a projected monthly amount to be used to determine eligibility. If the enterprise has been in existence for such a short time that there is very little income information or income in the period of time is not a good indicator of future income, the department will establish, with the cooperation of the applicant or member, a reasonable estimate of the projected monthly income to be used for eligibility.

(2) The policies outlined in this paragraph apply when self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established, permanent, ongoing change in the operating expenses of a self-employment enterprise that will result in a significant change in the person's annual net income. Change in self-employment income is defined as a change that will result in a significant change in the person's annual income.

1. When an applicant or member reports that change in operating expenses has occurred and the person's self-employment income has been annualized, the department will recalculate the expenses on the basis of the change.

2. When a change in self-employment income occurs and the person's self-employment income has been annualized, the department will recalculate income and expenses on the basis of the change.

3. A change in the cost of producing self-employment income or income received from self-employment that occurs as a result of seasonal business fluctuations is not considered a change for the purpose of this subparagraph.

g. Rounding procedures. The following rounding procedures apply when determining countable MAGI income.

(1) The third digit to the right of the decimal point in any calculation of income will be dropped.

(2) When the monthly countable income is converted to a percentage of the FPL and the resulting percentage is not a whole number, the FPL percentage is rounded up to the next whole percentage.

75.73(5) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member exclusively for the applicant's or member's needs are considered income, except as described at 75.73(1)*"b"*(3).

441—75.74(249A) Income limits. The following income limits apply to the MAGI-related coverage groups specified below, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
FMAP	441—subrule 75.3(1); 42 CFR Part 435.110 and 435.118; Title XIX of the Act, Section 1931	1	$447
		2	$716
		3	$872
		4	$1,033
		5	$1,177
		6	$1,330
		7	$1,481
		8	$1,633
		9	$1,784
		10	$1,950
		over 10	$1,950 plus $178 for each additional person
Mothers and Children (MAC) for pregnant women	441—subrule 75.3(2); 42 CFR Part 435.116 and 435.118; Title XIX of the Act, Section 1902	215% of the FPL for the household	
MAC for infants under one year of age		300% of the FPL for the household	
MAC for children aged 1 through 18	441—subrule 75.3(2); 42 CFR Part 435.118; Title XIX of the Act, Section 1902	167% of the FPL for the household	

441—75.75 to **75.79** Reserved.

DIVISION IV
ELIGIBILITY FACTORS SPECIFIC TO NON-MAGI-RELATED COVERAGE GROUPS, PERSONS IN MEDICAL INSTITUTIONS AND PERSONS RECEIVING LONG-TERM CARE SERVICES

441—75.80(249A) Categorical relatedness to supplemental security income (SSI). Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the SSI program administered by the SSA.

75.80(1) *SSI policy reference.* The statutes, regulations, and policy governing eligibility for SSI (collectively, "SSI policies") are found in Title XVI of the Act (42 U.S.C. Sections 1381 through 1383f), in the federal regulations promulgated pursuant to Title XVI of the Act (20 CFR 416.101 to 416.2227), and in Part 5 of the program operations manual system published by the SSA. The program operations manual system is available online; at SSA offices in Ames, Burlington, Carroll, Cedar Rapids, Coralville, Council Bluffs, Creston, Davenport, Des Moines, Dubuque, Fort Dodge, Marshalltown, Mason City, Ottumwa, Sioux City, Spencer, and Waterloo; and through the department.

75.80(2) *Income considered.* For non-MAGI-related Medicaid eligibility purposes, income will be considered prospectively.

75.80(3) *Trust contributions.* Income that a person contributes to a trust as specified in paragraph 75.24(3)*"b"* will not be considered for purposes of determining eligibility for non-MAGI-related Medicaid.

75.80(4) *Conditional eligibility.* For purposes of determining eligibility for non-MAGI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources found at 20 CFR Sections 416.1240 through 416.1245, is not considered an eligibility methodology.

75.80(5) *Valuation of life estates and remainder interests.* In the absence of other evidence, the value of a life estate or remainder interest in property will be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate. If a Medicaid applicant or member disputes the value determined using the following table, the applicant or member may submit other evidence and the value of the life estate or remainder interest will be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.80(6) *Resource eligibility for non-MAGI-related Medicaid for children.* Resources of all household members will be disregarded when determining eligibility for children under any non-MAGI-related coverage group except for those groups in paragraphs 75.6(1)*"a"* and *"b"*; 75.6(2)*"a," "b," "c," "d," "e,"* and *"g"*; 75.6(4)*"a"*; and 75.6(5)*"a," "b," "c,"* and *"d."*

441—75.81(249A) Disability requirements for non-MAGI-related Medicaid.

75.81(1) *Applicants receiving federal benefits.* An applicant receiving SSI on the basis of disability, social security disability benefits under Title II of the Act, or railroad retirement benefits based on the Social Security Act's definition of disability by the Railroad Retirement Board, will be deemed disabled without further determination of disability.

75.81(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 SSA, the department will determine eligibility for non-MAGI-related Medicaid based on disability as follows:

a. An SSA disability determination under either a social security disability (Title II) application or an SSI 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 that 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 that 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 non-MAGI-related Medicaid based on disability, initial determinations will be made by the department of workforce development's disability determination services division. The applicant or the applicant's authorized representative shall complete and submit forms as prescribed by the department.

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 will stay a decision on disability pending the SSA decision on disability.

75.81(3) *Time frames for decisions.* Determination of eligibility based on disability will 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.

75.81(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit forms as prescribed by the department.

75.81(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 will 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 will be canceled with timely notice in accordance with 441—Chapter 16. If there is an appeal to SSA within 65 days, the member will continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.81(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department will redetermine the member's disability after the member attains the age of 18 years. The member's disability will be redetermined:

a. Using the standards applicable to persons who are 18 years of age or older, and

b. Regardless of whether a review of the member's disability would otherwise be due.

441—75.82(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rules 441—75.3(249A) through 441—75.8(249A), certain factors must be considered differently for persons who reside in a medical institution, as follows.

75.82(1) *Determining income from property.*

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income will be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest will be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income will be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income will be considered available as provided in the trust. In the absence of specific provisions in the trust, the income will be considered as stated above for nontrust property.

75.82(2) *Division of income between married people for non-MAGI coverage groups.*

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized spouse's income will be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution will be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.6(4). Persons treated together as a couple for income must be treated together for resources, and persons treated individually for income must be treated individually for resources. Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.6(4).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, will be treated as individuals effective the month after the month the partners cease living together. Their income will be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.6(4).

75.82(3) *Attribution of resources to institutionalized spouse and community spouse.* The department will determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department will determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by a form prescribed by the department and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete a form prescribed by the department and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process will include a match of the IRS data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse, except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.3(1)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or by the department.

(6) For natives of Alaska, shares of stock held in a regional or village corporation, during the period of 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act as amended to August 1, 2025.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act as amended to August 1, 2025, or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefits due either spouse for one or more months prior to the month of receipt. This exclusion is limited to the first six months following receipt.

(9) A life insurance policy (or policies) whose total face value is $1,500 or less per spouse.

(10) An amount, not more than $1,500 for each spouse, that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1,500 will be reduced by an amount equal to the total face value of all insurance policies that are owned by the person or

spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 as amended to August 1, 2025, which is subject to the treatment required by Section 216 of that Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than the minimum set by the federal spousal impoverishment provisions, then the greater of $24,000 or the federally established minimum will be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance under the federal spousal impoverishment provisions, the amount over the maximum will be attributed to the institutionalized spouse. (The minimum and maximum limits are indexed annually according to the consumer price index.) The federal spousal impoverishment provisions are defined in Section 1924(f)(2)(A)(i) of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)). If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred will be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department will provide each spouse a notice of the attribution results. The notice will state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance. If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions are governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there will be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to paragraph 75.83(2)*"d"* will be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance will be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance will be based on the maintenance needs allowance as provided by these rules at the time the appeal is filed.

(4) To receive the substituted allowance, the applicant will be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity will be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there will be no substitution for the cost of the annuity and the attribution will remain as previously determined.

(6) The applicant will not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside will be determined using the following calculation: the difference between the community spouse's gross monthly income not generated by countable resources (multiplied by 12) and the minimum monthly maintenance needs allowance (multiplied by 12) will be multiplied by the annuity factor for the age of the community spouse. This amount will be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.82(3)*"f"*(5).

75.82(4) *Consideration of resources of married people.*

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses will be considered in determining initial Medicaid eligibility. When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.82(3) will be considered in determining initial eligibility for the institutionalized spouse. The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse will be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources that are owned wholly or in part by the institutionalized spouse and that are not transferred to the community spouse will be counted in determining ongoing eligibility. The resources of the institutionalized spouse will not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship. The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means. The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse will not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse will count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution will be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for Medicaid effective with the seventh month if one partner would be ineligible for Medicaid or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income, and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, will be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or would receive reduced benefits by considering them separately or if they choose to be considered together. In the month of entry into a medical institution, all resources of both spouses will be combined and will be subject to the resource limit for a married couple.

75.82(5) *Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to 191—Chapter 39 or 72.*

a. Eligibility. A person may be eligible for Medicaid under this subrule if:

(1) 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 pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for Medicaid under subrule 75.3(14), 75.3(15), 75.6(4), or 75.6(8), except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. Definition.

"Asset adjustment" means a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the Medicaid program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

441—75.83(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.

75.83(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income. Income is determined pursuant to the SSI program under Title XVI of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)), with the following exceptions.

a. MAGI-related clients. The income of a client and family whose eligibility is MAGI-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. Non-MAGI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by SSA, 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. Non-MAGI-related clients returning home within three months. If SSA 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 will 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 will be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage will 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 will be determined individually from each person's income.

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.

g. Clients receiving a VA pension. The amount of $90 of veteran's pension income will be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2); or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.83(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 $55 of their monthly income for a personal needs allowance. Iowa Code section 249A.30A contains information regarding potential state-funded personal needs supplements.

(1) If the client has a trust described in Section 1917(d)(4) of the Act (including Medicaid income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount will not exceed $10 per month except with court approval.

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

b. Personal needs in the month of entry.

(1) Single person. A single person will 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 will 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 will 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 will be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses will 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 will 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 will be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction will 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 will 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 will also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents will be considered in determining maintenance needs. The gross income of the spouse and dependent will include all monthly earned and unearned income and assistance from FIP, SSI, and state supplementary assistance. It will also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income will be considered as the SSI program considers income.

(3) Needs of spouse. The maintenance needs of the spouse will 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 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 will 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 will not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents will be established by subtracting each person's gross income from 150 percent of the monthly FPL for a family of two and dividing the result by three.

e. Maintenance needs of children (without spouse). When the client has children under the age of 21 at home, an ongoing allowance will 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 will be their gross income less the disregards allowed in FIP.

The children's maintenance needs will 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 will be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). 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.

441—75.84(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid will be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

75.84(1) The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

75.84(2) The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

75.84(3) The entrance fee does not confer an ownership interest in the community.

441—75.85(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 the limit set annually according to subrule 75.85(1), the individual will not be eligible for Medicaid with respect to nursing facility services or other long-term care services, except as provided in subrule 75.85(2).

75.85(1) *Equity interest limit.* The limit on the equity interest in the individual's home for purposes of this rule will be increased from year to year 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.

75.85(2) *Exception to disqualification.* Disqualification based on equity interest in the individual's home will 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 the age of 21 or is blind or disabled as defined in Section 1614 of the Act.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.