249A.3 Eligibility.

The extent of and the limitations upon eligibility for assistance under this chapter is prescribed by this section, subject to federal requirements, and by laws appropriating funds for assistance provided pursuant to this chapter.

1. Mandatory medical assistance shall be provided to, or on behalf of, any individual or family residing in the state of Iowa, including those residents who are temporarily absent from the state, who:

a. Is a recipient of federal supplemental security income or who would be eligible for federal supplemental security income if living in their own home.

b. Is an individual who is eligible for the family investment program or is an individual who would be eligible for unborn child payments under the family investment program, as authorized by Tit. IV-A of the federal Social Security Act, if the family investment program provided for unborn child payments during the entire pregnancy.

c. Was a recipient of one of the previous categorical assistance programs as of December 31, 1973, and would continue to meet the eligibility requirements for one of the previous categorical assistance programs as the requirements existed on that date.

d. Is a child up to one year of age who was born on or after October 1, 1984, to a woman receiving medical assistance on the date of the child's birth, who continues to be a member of the mother's household, and whose mother continues to receive medical assistance.

e. Is a pregnant woman whose pregnancy has been medically verified and who qualifies under either of the following:

(1) The woman would be eligible for cash assistance under the family investment program, if the child were born and living with the woman in the month of payment.

(2) The woman meets the income and resource requirements of the family investment program, provided the unborn child is considered a member of the household, and the woman's family is treated as though deprivation exists.

f. Is a child who is less than seven years of age and who meets the income and resource requirements of the family investment program.

g. (1) Is a child who is one through five years of age as prescribed by the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §6401, whose income is not more than one hundred thirty-three percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

(2) Is a child who has attained six years of age but has not attained nineteen years of age, whose income is not more than one hundred thirty-three percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

h. Is a woman who, while pregnant, meets eligibility requirements for assistance under the federal Social Security Act, section 1902(l), and continues to meet the requirements except for income. The woman is eligible to receive assistance until twelve months after the date pregnancy ends.

i. Is a pregnant woman who is determined to be presumptively eligible by a health care provider qualified under the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, §9407. The woman is eligible for ambulatory prenatal care assistance until the last day of the month following the month of the presumptive eligibility determination. If the department receives the woman's medical assistance application by the last day of the month following the month of the presumptive eligibility determination, the woman is eligible for ambulatory prenatal care assistance until the department actually determines the woman's eligibility or ineligibility for medical assistance. The costs of services provided during the presumptive eligibility period shall be paid by the medical assistance program for those persons who are determined to be ineligible through the regular eligibility determination process.

j. Is a pregnant woman or infant less than one year of age whose income does not exceed the federally prescribed percentage of the poverty level in accordance with the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, §302.

k. Is a pregnant woman or infant whose income is more than the limit prescribed under the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, §302, but not more than two hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

l. (1) Is an infant whose family income is not more than two hundred fifteen percent of the federal poverty level, as defined by the most recently revised income guidelines published by the United States department of health and human services.

(2) Is a pregnant woman whose family income while pregnant is at or below two hundred fifteen percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services, if otherwise eligible.

m. Is a child for whom adoption assistance or foster care maintenance payments are paid under Tit. IV-E of the federal Social Security Act.

n. Is an individual or family who is ineligible for the family investment program because of requirements that do not apply under Tit. XIX of the federal Social Security Act.

o. Was a federal supplemental security income or a state supplementary assistance recipient, as defined by section 249.1, and a recipient of federal social security benefits at one time since August 1, 1977, and would be eligible for federal supplemental security income or state supplementary assistance but for the increases due to the cost of living in federal social security benefits since the last date of concurrent eligibility.

p. Is an individual whose spouse is deceased and who is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, due to the elimination of the actuarial reduction formula for federal social security benefits under the federal Social Security Act and subsequent cost of living increases.

q. Is an individual who is at least sixty years of age and is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of receipt of social security widow or widower benefits and is not eligible for federal Medicare, part A coverage.

r. Is an individual with a disability, and is at least eighteen years of age, who receives parental social security benefits under the federal Social Security Act and is not eligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of the receipt of the social security benefits.

s. Is an individual who is no longer eligible for the family investment program due to earned income. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

t. Is an individual who is no longer eligible for the family investment program due to the receipt of child or spousal support. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

u. As allowed under the federal Deficit Reduction Act of 2005, Pub. L. No. 109-171, §6062, is an individual who is less than nineteen years of age who meets the federal supplemental security income program rules for disability but whose income or resources exceed such program rules, who is a member of a family whose income is at or below three hundred percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, and whose parent complies with the requirements relating to family coverage offered by the parent's employer. Such assistance shall be provided on a phased-in basis, based upon the age of the individual.

v. (1) Beginning January 1, 2014, in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as codified in 42 U.S.C. §1396a(a)(10)(A)(i)(VIII), is an individual who is nineteen years of age or older and under sixty-five years of age; is not pregnant; is not entitled to or enrolled for Medicare benefits under part A, or enrolled for Medicare benefits under part B, of Tit. XVIII of the federal Social Security Act; is not otherwise described in section 1902(a)(10)(A)(i) of the federal Social Security Act; is not exempt pursuant to section 1902(k)(3), as codified in 42 U.S.C. §1396a(k)(3), and whose income as determined under 1902(e)(14) of the federal Social Security Act, as codified in 42 U.S.C. §1396a(e)(14), does not

exceed one hundred thirty-three percent of the poverty line as defined in section 2110(c)(5) of the federal Social Security Act, as codified in 42 U.S.C. §1397jj(c)(5) for the applicable family size.

(2) Notwithstanding any provision to the contrary, individuals eligible for medical assistance under this paragraph "*v*" shall receive coverage for benefits pursuant to 42 U.S.C. §1396u-7(b)(1)(B); adjusted as necessary to provide the essential health benefits as required pursuant to section 1302 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148; adjusted to provide prescription drugs and dental services consistent with the medical assistance state plan benefits package for individuals otherwise eligible under this subsection; and adjusted to provide habilitation services consistent with the state medical assistance program section 1915(i) waiver.

(3) (a) For individuals whose income as determined under this paragraph "*v*" is at or below one hundred percent of the federal poverty level, covered benefits under subparagraph (2) shall be administered consistent with program administration under this subsection.

(b) For individuals whose income as determined under this paragraph "*v*" is above one hundred percent but not in excess of one hundred thirty-three percent of the federal poverty level, covered benefits shall be administered through provision of premium assistance for the purchase of covered benefits through the American health benefits exchange created pursuant to the Affordable Care Act, as defined in section 249N.2.

w. Beginning January 1, 2014, is an individual who meets all of the following requirements:

(1) Is under twenty-six years of age.

(2) Was in foster care under the responsibility of the state on the date of attaining eighteen years of age or such higher age to which foster care is provided.

(3) Was enrolled in the medical assistance program under this chapter while in such foster care.

2. *a.* Mandatory medical assistance may also, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, other individuals and families who are not excluded under subsection 5 of this section and whose incomes and resources are insufficient to meet the cost of necessary medical care and services in accordance with the following order of priorities:

(1) (a) As allowed under 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII), individuals with disabilities, who are less than sixty-five years of age, who are members of families whose income is less than two hundred fifty percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, who have earned income and who are eligible for mandatory medical assistance or optional medical assistance under this section if earnings are disregarded. As allowed by 42 U.S.C. §1396a(r)(2), unearned income shall also be disregarded in determining whether an individual is eligible for assistance under this subparagraph. For the purposes of determining the amount of an individual's resources under this subparagraph and as allowed by 42 U.S.C. §1396a(r)(2), a maximum of ten thousand dollars of available resources for an individual and twenty-one thousand dollars of available resources for a couple shall be disregarded, and any additional resources held in a retirement account, in a medical savings account, or in any other account approved under rules adopted by the department shall also be disregarded.

(b) Individuals eligible for assistance under this subparagraph, whose individual income exceeds one hundred fifty percent of the official poverty guidelines published by the United States department of health and human services for an individual, shall pay a premium. The amount of the premium shall be based on a sliding fee schedule adopted by rule of the department and shall be based on a percentage of the individual's income. The maximum premium payable by an individual whose income exceeds one hundred fifty percent of the official poverty guidelines shall be commensurate with the cost of state employees' group health insurance in this state. The payment to and acceptance by an automated case management system or the department of the premium required under this subparagraph shall not automatically confer initial or continuing program eligibility on an individual. A premium paid to and accepted by the department's premium payment process that is

subsequently determined to be untimely or to have been paid on behalf of an individual ineligible for the program shall be refunded to the remitter in accordance with rules adopted by the department. Any unpaid premium shall be a debt owed the department.

(2) (a) As provided under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, individuals who meet all of the following criteria:

(i) Are not described in 42 U.S.C. §1396a(a)(10)(A)(i).

(ii) Have not attained age sixty-five.

(iii) Have been screened for breast and cervical cancer under the United States centers for disease control and prevention breast and cervical cancer early detection program established under 42 U.S.C. §300k et seq., in accordance with the requirements of 42 U.S.C. §300n, and need treatment for breast or cervical cancer. An individual is considered screened for breast and cervical cancer under this subparagraph subdivision if the individual is screened by any provider or entity, and the state grantee of the United States centers for disease control and prevention funds under Tit. XV of the federal Public Health Services Act has elected to include screening activities by that provider or entity as screening activities pursuant to Tit. XV of the federal Public Health Services Act. This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the state grantee of the United States centers for disease control and prevention funds under Tit. XV of the federal Public Health Services Act.

(iv) Are not otherwise covered under creditable coverage as defined in 42 U.S.C. §300gg(c).

(b) An individual who meets the criteria of this subparagraph (2) shall be presumptively eligible for medical assistance.

(3) Individuals who are receiving care in a hospital or in a basic nursing home, intermediate nursing home, skilled nursing home or extended care facility, as defined by section 135C.1, and who meet all eligibility requirements for federal supplemental security income except that their income exceeds the allowable maximum for such eligibility, but whose income is not in excess of the maximum established for eligibility for discretionary medical assistance and is insufficient to meet the full cost of their care in the hospital or health care facility on the basis of standards established by the department.

(4) Individuals under twenty-one years of age living in a licensed foster home, or in a private home pursuant to a subsidized adoption arrangement, for whom the department accepts financial responsibility in whole or in part and who are not eligible under subsection 1.

(5) Individuals who are receiving care in an institution for mental diseases, and who are under twenty-one years of age and whose income and resources are such that they are eligible for the family investment program, or who are sixty-five years of age or older and who meet the conditions for eligibility in paragraph *"a"*, subparagraph (1).

(6) Individuals and families whose incomes and resources are such that they are eligible for federal supplemental security income or the family investment program, but who are not actually receiving such public assistance.

(7) Individuals who are receiving state supplementary assistance as defined by section 249.1.

(8) Individuals under twenty-one years of age who qualify on a financial basis for, but who are otherwise ineligible to receive assistance under the family investment program.

(9) Individuals eligible for family planning services under a federally approved demonstration waiver.

(10) Individuals and families who would be eligible under subsection 1 or this subsection except for excess income or resources, or a reasonable category of those individuals and families.

(11) Individuals who have attained the age of twenty-one but have not yet attained the age of sixty-five who qualify on a financial basis for, but who are otherwise ineligible to receive, federal supplemental security income or assistance under the family investment program.

b. Notwithstanding the provisions of this subsection establishing priorities for individuals

and families to receive mandatory medical assistance, the department may determine within the priorities listed in this subsection which persons shall receive mandatory medical assistance based on income levels established by the department, subject to the limitations provided in subsection 4.

3. Optional medical assistance may, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, either of the following groups of individuals and families:

a. Only those individuals and families described in subsection 1.

b. Those individuals and families described in both subsections 1 and 2.

4. Discretionary medical assistance, within the limits of available funds and in accordance with section 249A.4, subsection 1, may be provided to or on behalf of those individuals and families described in subsection 2, paragraph *"a"*, subparagraph (11), of this section.

5. Assistance shall not be granted under this chapter to:

a. An individual or family whose income, considered to be available to the individual or family, exceeds federally prescribed limitations.

b. An individual or family whose resources, considered to be available to the individual or family, exceed federally prescribed limitations.

5A. In determining eligibility for children under subsection 1, paragraphs *"b"*, *"f"*, *"g"*, *"j"*, *"k"*, *"n"*, and *"s"*; subsection 2, paragraph *"a"*, subparagraphs (3), (5), (6), (8), and (11); and subsection 5, paragraph *"b"*, all resources of the family, other than monthly income, shall be disregarded.

5B. In determining eligibility for adults under subsection 1, paragraphs *"b"*, *"e"*, *"h"*, *"j"*, *"k"*, *"n"*, "s", and *"t"*; subsection 2, paragraph *"a"*, subparagraphs (4), (5), (8), (11), and (12); and subsection 5, paragraph *"b"*, one motor vehicle per household shall be disregarded.

6. In determining the eligibility of an individual for medical assistance under this chapter, for resources transferred to the individual's spouse before October 1, 1989, or to a person other than the individual's spouse before July 1, 1989, the department shall include, as resources still available to the individual, those nonexempt resources or interests in resources, owned by the individual within the preceding twenty-four months, which the individual gave away or sold at less than fair market value for the purpose of establishing eligibility for medical assistance under this chapter.

a. A transaction described in this subsection is presumed to have been for the purpose of establishing eligibility for medical assistance under this chapter unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

b. The value of a resource or an interest in a resource in determining eligibility under this subsection is the fair market value of the resource or interest at the time of the transaction less the amount of any compensation received.

c. If a transaction described in this subsection results in uncompensated value exceeding twelve thousand dollars, the department shall provide by rule for a period of ineligibility which exceeds twenty-four months and has a reasonable relationship to the uncompensated value above twelve thousand dollars.

7. In determining the eligibility of an individual for medical assistance under this chapter, the department shall consider resources transferred to the individual's spouse on or after October 1, 1989, or to a person other than the individual's spouse on or after July 1, 1989, and prior to August 11, 1993, as provided by the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, §303(b), as amended by the federal Family Support Act of 1988, Pub. L. No. 100-485, §608(d)(16)(B), (D), and the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §6411(e)(1).

8. Medicare cost sharing shall be provided in accordance with the provisions of Tit. XIX of the federal Social Security Act, section 1902(a)(10)(E), as codified in 42 U.S.C. §1396a(a)(10)(E), to or on behalf of an individual who is a resident of the state or a resident who is temporarily absent from the state, and who is a member of any of the following eligibility categories:

a. A qualified Medicare beneficiary as defined under Tit. XIX of the federal Social Security Act, section 1905(p)(1), as codified in 42 U.S.C. §1396d(p)(1).

b. A qualified disabled and working person as defined under Tit. XIX of the federal Social Security Act, section 1905(s), as codified in 42 U.S.C. §1396d(s).

c. A specified low-income Medicare beneficiary as defined under Tit. XIX of the federal Social Security Act, section 1902(a)(10)(E)(iii), as codified in 42 U.S.C. §1396a(a)(10)(E)(iii).

d. An additional specified low-income Medicare beneficiary as described under Tit. XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(I), as codified in 42 U.S.C. §1396a(a)(10)(E)(iv)(I).

e. An additional specified low-income Medicare beneficiary described under Tit. XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(II), as codified in 42 U.S.C. §1396a(a)(10)(E)(iv)(II).

9. In determining the eligibility of an institutionalized individual for assistance under this chapter, the department shall establish a minimum community spouse resource allowance in an amount which is the greater of twenty-four thousand dollars or the minimum required as a condition of receipt of federal funding pursuant to section 1924(f)(2)(A)(i) of the federal Social Security Act, as codified in 42 U.S.C. §1396r-5(f)(2)(A)(i)174, and as adjusted pursuant to section 1924(g) of the federal Social Security Act as codified in 42 U.S.C. §1396r-5(g).

10. Group health plan cost sharing shall be provided as required by Tit. XIX of the federal Social Security Act, section 1906, as codified in 42 U.S.C. §1396e.

11. *a.* In determining the eligibility of an individual for medical assistance, the department shall consider transfers of assets made on or after August 11, 1993, as provided by the federal Social Security Act, section 1917(c), as codified in 42 U.S.C. §1396p(c).

b. The department shall exercise the option provided in 42 U.S.C. §1396p(c) to provide a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual. For noninstitutionalized individuals, the number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual or the individual's spouse on or after the look-back date specified in 42 U.S.C. §1396p(c)(1)(B)(i), divided by the average monthly cost to a private patient for nursing facility services in Iowa at the time of application. The services for which noninstitutionalized individuals shall be made ineligible shall include any long-term care services for which medical assistance is otherwise available. Notwithstanding section 17A.4, the department may adopt rules providing a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual without notice of opportunity for public comment, to be effective immediately upon filing under section 17A.5, subsection 2, paragraph "*b*", subparagraph (1), subparagraph division (a).

c. A disclaimer of any property, interest, or right pursuant to section 633E.5 constitutes a transfer of assets for the purpose of determining eligibility for medical assistance in an amount equal to the value of the property, interest, or right disclaimed.

d. Unless a surviving spouse is precluded from making an election under the terms of a premarital agreement, the failure of a surviving spouse to take an elective share pursuant to chapter 633, subchapter V, constitutes a transfer of assets for the purpose of determining eligibility for medical assistance to the extent that the value received by taking an elective share would have exceeded the value of the inheritance received under the will.

12. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established on or before August 10, 1993, as available to the individual, in accordance with the federal Comprehensive Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, §9506(a), as amended by the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, §9435(c).

13. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established after August 10, 1993, as available to the individual, in accordance with 42 U.S.C. §1396p(d) and sections 633C.2 and 633C.3.

14. Once initial ongoing eligibility for medical assistance is determined for a child under the age of nineteen, the department shall provide continuous eligibility for a period of up to twelve months regardless of changes in family circumstances, until the child's next annual

review of eligibility under the medical assistance program, with the exception of the following children:

a. A newborn child of a medical assistance-eligible woman.

b. A child whose eligibility was determined under the medically needy program.

c. A child who is eligible under a state-only funded program.

d. A child who is no longer an Iowa resident.

e. A child who is incarcerated in a jail or other correctional institution.

[C62, 66, §249A.3, 249A.4; C71, 73, 75, 77, 79, 81, §249A.3; 81 Acts, ch 7, §15, ch 82, §1]

84 Acts, ch 1297, §3 – 5; 85 Acts, ch 146, §2; 89 Acts, ch 104, §2 – 4; 89 Acts, ch 304, §202; 90 Acts, ch 1258, §6; 90 Acts, ch 1270, §48; 91 Acts, ch 158, §3, 4; 92 Acts, ch 1043, §4; 92 Acts, 2nd Ex, ch 1001, §420; 93 Acts, ch 97, §37; 94 Acts, ch 1120, §1, 8, 9, 16; 95 Acts, ch 68, §1; 96 Acts, ch 1129, §64; 97 Acts, ch 41, §26 – 28; 98 Acts, ch 1218, §77; 99 Acts, ch 94, §1; 99 Acts, ch 203, §50; 99 Acts, ch 208, §50; 2000 Acts, ch 1060, §1 – 3; 2000 Acts, ch 1221, §6; 2000 Acts, ch 1228, §41; 2001 Acts, ch 184, §9; 2003 Acts, ch 62, §2; 2004 Acts, ch 1015, §1; 2005 Acts, ch 38, §1, 55; 2006 Acts, ch 1104, §1; 2006 Acts, ch 1159, §4, 8; 2007 Acts, ch 218, §41 – 43, 124, 126; 2008 Acts, ch 1014, §1; 2008 Acts, ch 1188, §2, 3, 55; 2009 Acts, ch 41, §242; 2009 Acts, ch 118, §16; 2009 Acts, ch 182, §132, 134; 2011 Acts, ch 98, §16; 2011 Acts, ch 120, §3; 2013 Acts, ch 138, §65 – 71, 77, 92, 93, 106, 177, 178, 187; 2014 Acts, ch 1092, §174; 2015 Acts, ch 30, §224; 2018 Acts, ch 1041, §127; 2019 Acts, ch 116, §1; 2024 Acts, ch 1141, §1, 4; 2025 Acts, ch 133, §7

Referred to in §217.34, 249N.2, 249N.5, 249N.6, 421.65

Spousal support debt for medical assistance to institutionalized spouse; community spouse resource allowance; chapter 249B

Elimination of monthly budget maximum or cap for individuals eligible for medical assistance program home and community-based services elderly waiver; department of health and human services required to track average expended per waiver recipient and report annually to general assembly by December 30; 2020 Acts, ch 1053, §1; 2022 Acts, ch 1109, §3; 2023 Acts, ch 19, §1358

Subsection 2, paragraph a, subparagraph (1), subparagraph division (a) amended