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
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.

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