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 rule 441—40.21(239B), 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 41.28(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—41.26(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—subrule 41.27(2) 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—subrule 41.27(2) 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—subrule 41.27(2) 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 41.28(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 41.28(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 41.26(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 41.27(4).

(9) The following FIP policies also apply to determining income eligibility for family-related medically needy: 441—subrules 41.27(3), 41.27(5), 41.27(6), 41.27(7), and 41.27(8) and 441—paragraphs 41.27(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 41.28(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."*

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