August 2018: THE FOLLOWING RULE IS REPEALED IN ITS ENTIRETY:

~~0390 FLEXIBLE TEST OF INCOME~~
~~0390.05 USE OF EXCESS INCOME~~
~~REV:06/1994~~

~~An institutionalized individual who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.~~

~~During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.~~

~~0390.10 DETERMINE SPENDDOWN LIABILITY~~
~~REV:01/2000~~

~~CATEGORICALLY NEEDY~~

~~To be eligible as Categorically Needy, the gross income of an institutionalized individual (who is not an SSI recipient or receiving 1619(b) benefits) may not exceed the FEDERAL CAP set forth in Section 0386.05.~~

~~MEDICALLY NEEDY~~

~~An applicant who has countable income less than or equal to the Medically Needy Income Limit (MNIL) is eligible as Medically Needy, without regard to the cost of medical services.~~

~~If countable income is greater than the Medically Needy Income Limit, a flexible test calculation must be completed. The flex-test BUDGET PERIOD IS ONE MONTH for institutionalized individuals. (Although the budget period is one month, the APPLICATION PERIOD is the same as for other institutionalized individuals. A NEW APPLICATION IS NOT NEEDED FOR EACH MONTH.) The flex-test calculation is as follows:~~

~~From the applicant's monthly gross income, first deduct the $20 general disregard (from unearned income first), then any other applicable disregards ($65 and 1/2 the balance of wages, etc.) Compare the countable income to the MNIL for an individual set forth in Section 0386.05. If income exceeds the MNIL, deduct the MNIL from the countable income. The balance is the monthly excess income.~~

~~From the monthly excess income, deduct the PROJECTED cost of institutional care over the month, if any. The projected cost of institutional services is the number of days of institutional care (not covered by Medicare) multiplied by the PRIVATE per diem rate. If the excess income is absorbed, the applicant is eligible for Medical Assistance for the month. If the excess income is not absorbed, then deduct the documented monthly cost of Medicare and other medical insurance premiums, then the documented cost of incurred medical expenses (including coinsurance liabilities) for the month in question. If, after the previous deductions, a balance of excess income remains, the individual is ineligible because of excess income. The balance of excess income~~

becomes the flex-test spend down liability for the month. The individual does not become eligible until and unless s/he incurs costs for OTHER non-covered medical services which equal or exceed the remaining balance of income.

If, after the deduction of projected institutional expenses and incurred medical expenses, the individual still has excess income, s/he is ineligible. S/he must be notified that eligibility does not exist and notified in writing of the amount of excess income which must be absorbed each month in order to establish eligibility.

If eligibility is established for a month, the individual must be so notified. At the same time, if the case is being certified for the current month only, written notification is sent to notify the client of the closing.

If Medical Assistance payment is requested for an individual's institutional care expenses, the post-eligibility treatment of income described in Section 0392 must be followed to apply the individual's income to the cost of the institutional care. Those medical expenses actually INCURRED (not projected) for services in the current month that are used to establish flex-test eligibility are deducted from income before applying income to the cost of care

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, go to the discussion of Resource Transfers in Section 384. If not eligible for MA, the applicant must be notified in writing that eligibility does not exist.

0390.10.05 When Eligibility Begins
REV: 06/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

0390.15 RECOGNIZED MED/REMEDIAL CARE
REV: 06/1994

Care which is not being provided within the MA scope of services and which may be used to offset excess income includes:
o Adult Day Care;

o Respite Care; and,

o Home Health Aide/Homemaker Services.

~~0390.15.05 Adult Day Care~~
~~REV: 06/1994~~

~~The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:~~

~~o The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,~~

~~o The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well-being, or required close monitoring and supervision for health reasons.~~

~~0390.15.10 Respite Care~~
~~REV:06/1994~~

~~The cost of respite care may be used to offset a flexible test spenddown liability if the applicant receives overnight respite care at a licensed nursing facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).~~

~~0390.15.15 Home Health Aide/Homemaker Ser~~
~~REV:06/1994~~

~~The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:~~

~~o The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,~~

~~o At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the applicant does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,~~

~~If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible-test spenddown liability. Deductions in excess of this amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at 111 Fountain Street, Providence. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the agency representative, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services. The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.~~

0390.20 DEDUCT LOANS TO PAY MED BILLS
REV:06/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the three preceding months) may be applied against the spenddown liability for the current period IN PLACE OF the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability).

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a preceding period may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

o The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not deductible until after the proceeds have been paid to the provider); and,

o Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against spenddown liability or deducted from income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied.

However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.