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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 05 – COMMUNITY MEDICAID

PART 2 – Medically Needy Eligibility

2.1 Scope and Purposes

A. A medically needy (MN) spenddown, previously referred to as the "Flexible Test of Income", is a cost-sharing approach that provides a Medicaid eligibility pathway for certain people who have income above the limit for their applicable coverage group if they have high health expenses. Under the State's Medicaid State Plan, members of these populations become eligible for Medicaid by "spending down" their income to a limit established by the state - - known as the medically needy income limit or "MNIL" by deducting certain health care expenses. The following populations may be medically needy eligible under this section:

1. Elders and adults with disabilities with income above 100 percent of the FPL;

2. Children with income above the MACC limit of 266% of the FPL (includes the 5% disregard);

3. Pregnant women with income above the MACC limit of 258% of the FPL (includes the 5% disregard);

4. Parents/caretakers with income above the MACC limit of 138% of the FPL (includes the 5% disregard);

5. Non-qualified non-citizens seeking coverage for emergency Medicaid if ineligible under all other pathways. (See § 1.7.5 of this Subchapter); and

6. Certain refugees, as defined in § 1.7.3 of this Subchapter, who do not otherwise qualify for Medicaid health coverage or commercial insurance with financial help through HSRI.

B. This section describes the Community Medicaid (non-LTSS) MN eligibility pathway in general and establishes the provisions governing initial and

continuing eligibility for persons in these populations seeking Medicaid health coverage through this option.

2.2 General Provisions Eligibility Criteria

A. For the IHCC groups in this section, MN coverage is available to elders and persons with disabilities with high medical expenses who have income above the EAD income limit, but otherwise meet all of the general eligibility requirements for Medicaid set forth in § 1.9 of this Subchapter.

1. Determination process – Applicants who do not meet the income limits for Medicaid in the IHCC groups are automatically evaluated for MN coverage. Members of the MACC groups must contact an agency eligibility specialist if seeking MN coverage. The MN cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. NOTE: During the novel Coronavirus Disease (COVID-19) federal declaration of emergency, the state will temporarily extend the six (6) month eligibility period. This extension will last until the end of the federal emergency period. This extension supersedes all references to the six (6) month eligibility period for the duration of the COVID-19 federal declaration of emergency. Eligibility for Medicaid health coverage as MN is not established, however, until the applicant has presented proof of health expenses incurred and paid or that remain outstanding for the eligibility period. Any health expenses for which a beneficiary continues to be liable dating back to the retroactive period are also considered.

2. Continuing eligibility – The date of eligibility is the actual day of the month the applicant incurs a health expense – not the billing date – which reduces income to the MNIL. Eligibility may be renewed on a continuing basis if the beneficiary is liable for health care expenses that exceed current income. Otherwise, a re-evaluation of eligibility, based on the cost of health costs currently being incurred is required.

3. Agency responsibilities – The EOHHS must inform applicants who have income above the applicable limit for the appropriate IHCC group that MN coverage is an option and provide information about allowable health expenses for spenddown purposes and the scope and limits of obtaining coverage through this eligibility pathway. In addition, applicants must be informed of the impact of obtaining MN Medicaid health coverage for other programs, including the Supplemental Nutrition Assistance Program (SNAP) and the MPPP.

4. Applicant/beneficiary responsibilities – Eligibility and renewal is contingent upon the applicant/beneficiary providing bills and receipts related to allowable health care expenses that are not paid through a third party. Therefore, the chief responsibility of the applicant/beneficiary is to maintain and present this information, unless submitted directly by a provider, to the state agency.

2.3 Spenddown Calculation

A. For a person who has income above the income standard across applicable eligibility pathways, the spenddown standard for their eligibility coverage group is applied. For example, the appropriate spenddown standard for parents/caretakers is 138% of the FPL (ceiling for MACC eligibility when 5% disregard is applied) and 266% of the FPL for children (MACC ceiling including disregard). The appropriate spenddown standard for elders and adults with disabilities is the medically needy income limit adjusted for household size.

1. Spenddown Amount – The spenddown amount is calculated as follows:

    a. The beneficiary's anticipated monthly net income for each month of the eligibility period based on the criteria appropriate for the specific coverage group using the SSI methodology.

    b. Net income for all six (6) months.

2. FPL Comparison – The applicable six-month FPL standard is subtracted from the beneficiary's six-month net income. If the result is:

    a. Equal to or less than the FPL standard, the applicant is eligible for Medicaid without a spenddown, even if they exceed the monthly FPL standard in one or more months of the six-month period. No further calculation is necessary.

    b. Greater than the FPL standard continue, further calculations are required.

3. Six-month Spenddown Amount – The six-month spenddown amount is determined by subtracting the applicable six-month FPL spenddown standard from the total six-month net income. The result is the six-month spenddown amount.

4. Application of Allowable Expenses – Allowed health care expenses are applied to the six-month spenddown amount. If the applicant will incur bills to satisfy the spenddown after the date the application is processed, the final processing will be delayed until after the applicant has received the

health care services. Pre-approval of certain remedial and Medicaid LTSS services is required if the MN beneficiary does not qualify for an LTSS preventive level of care.

2.4 Six-Month Spenddown Renewal

Upon renewal, a six-month spenddown is calculated in the same manner.

2.5 Allowable Expenses

A. Allowable health care expenses are those that are incurred by the beneficiary or other allowable family member(s) that are not subject to payment by a third party and may be:

1. Paid or unpaid health care bills incurred in the current eligibility period; and

2. Unpaid bills incurred prior to the current eligibility period.

B. The portion of a bill used to meet a previous spenddown cannot be used again in future spenddown calculations, unless the entire eligibility period was denied.

1. Allowable health care expenses – Such expenses include, but are not limited to: physician /health care provider visits; health insurance premiums, co-pays, co-insurance, and deductibles; dental and vision care; chiropractic and podiatric visits; prescription medications; tests and X-rays; acute hospital and nursing care; home nursing care, such as personal care attendants, private duty nursing and home health aides; audiologists and hearing aids; dentures; durable medical equipment such as wheelchairs and protective shields; therapy, such as speech, physical, or occupational therapy; transportation for medical care, such as car, taxi, bus or ambulance; and LTSS expenses at home or in a health institution at the State Medicaid reimbursement rate.

2. Conditions on application -- An expense is allowable for the Medicaid spenddown if it is for health insurance costs or specific types of Medicaid non-covered and covered services. The scope, amount and duration of the service determines whether it qualifies as an allowable expense as a Medicaid covered or non-covered service and, therefore, the order in which it is deducted from excess income. The sequences of deductions for allowable expenses is as follows:

a. Health insurance expenses. The costs for maintaining insurance coverage for health care services and supports for both the person seeking coverage and any dependents. Includes, premiums, co-

pays, co-insurance and deductibles including for Medicare and commercial plans. Premiums for optional supplemental plans are not allowable expenses.

b. Non-Medicaid expenses. These are expenses incurred for health care and remedial services that are recognized under State law but are not covered under the Medicaid State Plan or the State's Section 1115 demonstration waiver such as home stabilization services and non-medical transportation.

c. Excess Medicaid expenses. Includes expenses incurred for Medicaid covered services that exceed limitations on amount, duration, or scope established in the State Plan or Section 1115 demonstration waiver. Expenses allowed in this category must be medically necessary and include both the costs incurred for an expanded service (such as dentures, in-patient behavioral health care for an extended period, contact lenses or a second pair of prescription reading glasses) and associated ancillary health costs (x-rays, needs assessments, lab tests, office visits and the like).

d. Covered Medicaid expenses. These are incurred expenses that do not exceed limitations on amount, duration, or scope allowed under current federal authorities. They are deducted in chronological order based on the date of service beginning with the oldest expense.

    (1) An expense incurred in a month for which MN eligibility is approved is presumed to be a Medicaid covered expense unless documentation is provided to the State that it is not a covered service.

    (2) When a person is receiving a service or set of services Medicaid pays for in a daily or bundled rate, the items and services included in that rate are not separate allowable expenses.

e. Health institution expenses. Under the existing Medicaid State Plan, Rhode Island has taken the option under 42 C.F.R. § 435.831(3)(g)(1) to allow LTSS expenses incurred for both HCBS and health institutional care to be deducted from excess income. In accordance with the applicable federal requirements therein, the maximum amount allowed is the State Medicaid reimbursement rate projected to the end of the budget period.

f. Costs related to LTSS level or remedial care, such as home nursing care/homemaker services, adult day and home stabilization may be applied to a spenddown when a beneficiary meets the LTSS preventive level of need. In all other instances, Community Medicaid MN beneficiaries must obtain per-authorization from an agency eligibility specialist to count these costs toward a spenddown.

2.6 Expense Exceptions

A. Certain health care expenses are not allowed to be deducted from income. Such expenses include, but are not limited to:

1. Premiums paid by Medicaid or paid by the MPPP as a health care expense. Applicants and beneficiaries should consider whether participation in the MPPP will adversely affect their ability to maintain MN eligibility and vice versa with the assistance of an eligibility specialist.

2. Health care expenses incurred before the first day of the six-month certification period are not eligible for Medicaid payment; the beneficiary remains responsible for those bills.