

**0336**

**FLEXIBLE TEST OF INCOME**

**0336.05**

**USE OF EXCESS INCOME**

REV:01/2002

An applicant 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.

Flexible Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) RECEIPTS FOR MEDICAL SERVICES INCURRED DURING THE PERIOD OF DETERMINATION and/or 2) UNPAID BILLS incurred either during the CURRENT PERIOD of determination AND/OR PRIOR TO APPLICATION for which the individual is STILL LIABLE equal to the amount of such excess income. The only exception to the requirement of applicant liability for the medical expenses is in the case of medical expenses which are paid by or are the liability of other medical care programs that are funded 100% with State funds. For example, an applicant's medical expenses that have been paid (or are to be paid) by the RIPAE program are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spenddown liability. Medical expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.

In some cases, current payments ON THE PRINCIPAL BALANCES of loans to pay off old medical bills (i.e., bills incurred prior to the current budget period) are incurred health care expenses if certain conditions are met.

The Flexible Test of Income may be used to establish eligibility in a retroactive period.

If the applicant is determined eligible under a flexible test of income, the applicant is certified for SIX (6) MONTHS OR FOR THE BALANCE OF THE SIX (6) MONTH BUDGET PERIOD remaining when the excess income is absorbed.

**0336.05.05**

**When Eligibility Begins**

REV:07/1994

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.

If the applicant has excess income and there is no indication of medical expenses by which the excess can be absorbed, the case is rejected. However, if the applicant should present medical expenses within the same six (6) month period, the original application is used in determining whether the excess income for this same six- month period has been reduced to the income standard.

**0336.05.10**                      **Whose Expenses Are Used**  
REV:07/1994

The construction of the Financial Unit provides the basis for determining the applicable Medically Needy standards for a family case and the amount of excess income, if any, to be absorbed via a spenddown. The Financial Unit may include persons who are not applying for MA. Medical expenses incurred by non-applicant members of the Financial Unit may be counted toward the applicant's spenddown liability. However, once the excess income is absorbed, only the applicant is MA eligible.

**0336.10**                              **DEDUCT LOANS TO PAY BILLS**  
REV:07/1994

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 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.

**0336.15**

**DEDUCTING RECOGNIZED MEDICAL EXPENSES**

REV:04/1995

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid for by 100% State funded medical care programs).

Recognized medical expenses include medical insurance premiums, co-payments, deductibles and certain medical and remedial care

expenses recognized under state law (See section 0336.15.05 for recognized medical/remedial care expenses that are not provided within MA scope of services and which may be used to offset excess income). Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

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 3 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.)

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co-payments, co-insurance or deductibles under any health insurance program as they are incurred.

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Health Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided

within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

**0336.15.05                      Deducting Recognized Medical/Remedial Care**  
REV:04/1995

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.

**0336.15.05.05                  Adult Day Care**  
REV:07/1994

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.

**0336.15.05.10                  Respite Care**  
REV:07/1994

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/convalescent facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

**0336.15.05.15                  Home Health Aide/Homemaker Services**

REV:07/1994

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 client 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,
- o A physician must certify the client's need for personal care services, in writing, at least once in each flexible-test period (six (6) months). The certification must indicate the patient's diagnosis(es), and the type of services required.

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 C.O. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the eligibility technician, 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.

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**EXAMPLES**

REV:07/1994

EXAMPLE: The applicant has verified unpaid medical expenses for which the applicant is liable that were incurred prior to application but are still unpaid at the time of application. If the medical expenses absorb all the excess income, the applicant is eligible and is certified for a six (6) month period beginning with the month of application. The case must be redetermined at the end of the six (6) month period.

When the excess income is not absorbed by applying it to medical expenses incurred prior to the application and unpaid, the applicant must present receipts or bills for medical expenses incurred during the six (6) month period beginning with the month of application. The excess is then applied to those expenses. When the excess income is absorbed, ELIGIBILITY BEGINS ON THAT DAY WHICH IS THE DAY THE MEDICAL SERVICE WAS PROVIDED. The case is certified for the balance of that six (6) month period. At the end of this period, a new application must be submitted.

EXAMPLE: An applicant applies in July with countable income of \$7,200 a year (\$500 excess per year or \$250 excess for six (6) months). The applicant cannot be certified as eligible until bills or receipts for incurred medical expenses totalling \$250 are presented. If a receipt of \$50 is presented in July, and a bill for \$200 is presented in August, the applicant is then certified from the day in August that the medical service was provided, through December, the end of that six (6) month period.

If on the final day of the six (6) month period, the applicant has (1) no receipts or bills for incurred medical expenses; or (2) if the receipts and/or bills presented do not absorb the excess income; or (3) if the absorption of excess income in the exact amount of the excess income occurs on that final day, there is no eligibility.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six (6) months). The applicant cannot be certified as eligible until bills and/or receipts for incurred medical expenses totalling \$250 are presented. No bills or receipts for incurred medical expenses are presented.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six months). A receipt for \$50 is presented in July, \$100 in September, and \$50

in November - total \$200. No further bills or receipts are presented.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six months). A receipt for \$50 is presented in July, \$100 in September, \$50 in November, and \$50 on December 31 - total \$250. However, the excess income is absorbed on the final day of the six (6) month period. There is no eligibility for that period since there is no medical coverage to be met.

Had the receipts and/or bills totaled more than \$250, eligibility would have existed for MA coverage of the amount of any unpaid bills over \$250. Also, had the applicant been hospitalized on December 31, eligibility would have existed for any expenses on December 31 which exceeded \$250.

**0336.25**

**CERT OF FLEXIBLE TEST CASES**

REV:07/1994

Each individual determined to be ineligible for MA will receive notice of the basis of ineligibility. Those individuals ineligible on the basis of excess income will be informed of the amount of his/her spenddown liability.

When a recipient's case is discontinued on the basis of income exceeding the Medically Needy income standard, a review of the recipient's situation is completed under the Flex Test policy.

Such recipient is advised of the amount of excess income and the eligibility period during which such excess must be absorbed.

When such applicant/recipient presents unpaid bills (for which the individual remains liable) incurred at any time through the final day of the six (6) month period and/or receipts for bills incurred during the period for which eligibility is being determined which total or exceed the amount of the excess income, eligibility exists for the balance of the six (6) month period. A new application is not needed for that six (6) month period.

Any case certified, whether for a full six (6) month period or a balance of even only one (1) month, needs a new application at the end of each six (6) month period. The InRHODES system will trigger the mailing of a redetermination packet by sending a

notice to the field office. Each six (6) month period is determined separately.

Medical bills recognized in a previous Flexible Test period to reduce excess income must not be applied to reduce the excess income for the new application period. However, if the bills did not establish eligibility, then they were not used for spenddown and can be considered in a subsequent six (6) month period.

To certify a case where the recipient and Medical Assistance must share the expense, the InRHODES eligibility system will notify MMIS of the bills that were used to meet the spenddown. These bills will not be paid by MMIS and are the applicant's responsibility.

**0336.25.05**

**Controlling Flexible Test Cases**

REV:07/1994

The InRHODES on-line redetermination report lists all cases due for redetermination with flex-test cases highlighted. The system notifies workers two months before the month that certification ends that re-determination packets need to be sent out.

Flex-test cases by their nature are ineligible at the end of the certification period and will automatically close, and eligibility must be redetermined. The redetermination activities should be completed by the end of the six-month (or less) flex-test period.