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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 – MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 00 – LONG-TERM SERVICES

PART 2 – Long-term Services and Supports (LTSS) Medically Needy Eligibility Pathway

2.1 Scope and Purpose

A. Medically Needy (MN) eligibility for Medicaid long-term services and supports (LTSS), previously referred to as the "Flexible Test of Income", enables people with income above the Federal benefit cap to obtain Medicaid LTSS coverage in certain circumstances. The Federal benefit cap rate is three hundred percent (300%) of the Supplemental Security Income (SSI) benefit rate and is the income eligibility ceiling for both the "special income" and home and community-based services (HCBS) LTSS pathways identified in Part 1 of this Subchapter.

B. Under the Federal law, the LTSS MN pathway is for LTSS beneficiaries only without regard to type of care – institutional or HCBS settings. The provisions related to MN Non-LTSS Community Medicaid are set forth in Part 40-05-2 of this Title. LTSS MN is distinguished from MN Community Medicaid in that the spenddown is based on monthly projected expenses rather than the costs that must be incurred over a six (6) month budget period.

2.2 Legal Authority

A. Federal Authorities

1. Federal Law: Title XIX, of the Federal Social Security Act at: 42 U.S.C. §§ 1396a, 1396b, and 1396k;

2. Federal Regulations: These Regulations hereby adopt and incorporate 42 C.F.R. § 435.301 *et seq*. (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

3. The Rhode Island Medicaid State Plan and the Title XIX, Section 1115(a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

B. State Authorities: Among other statutes, R.I. Gen. Laws Chapters 40-6 and 40-8.

2.3 Definitions

A. As used in this Part, the following terms are defined as follows:

1. "Beneficiary liability" means the LTSS beneficiary's financial obligation toward the Medicaid LTSS cost of care, as determined monthly.

2. "Budget period" means the period of time in which an applicant's income is measured for the purpose of determining eligibility.

3. "Federal cap" means three hundred percent (300%) of the Federal Supplemental Security Income (SSI) Program monthly payment rate.

4. "LTSS beneficiary" means a person who meets all the general, clinical/functional, and financial eligibility requirements for LTSS, or a person receiving Medicaid LTSS of any type regardless of living arrangement. The LTSS beneficiary has been previously referred to as an "institutionalized" individual.

2.4 Medically Needy Eligibility Determination Process

A. To be considered for the medically needy pathway, an otherwise Medicaid eligible person must have income above the Federal cap of three hundred percent (300%) of the SSI rate. The LTSS eligibility requirements for Medicaid LTSS are outlined in § 1.9 of this Subchapter and are set forth in greater detail throughout this Part. All LTSS applicants with countable income above the Federal cap are automatically evaluated for the MN eligibility pathway. Total countable income must be at or below the projected cost for the type of LTSS the person is seeking or receiving, at the private pay rate, adjusted annually as set forth in § 2.4 of this Part.

B. Eligibility is determined in accordance with the following:

1. Excess income amount – The person's countable income for the month is determined based on the provisions set forth in Part 40-00-3 of this Title, pertaining to the SSI methodology. If income is above the Federal cap after all required disregards and exclusions have been applied, the medically needy income limit (MNIL) is deducted from remaining income. This is the total amount of excess income that must be absorbed to obtain MN eligibility for LTSS.

2. Income and Institutional Cost Comparison – The projected cost of LTSS at the private pay rate in the applicable health institution – nursing facility (NF), intermediate care facility for intellectually/developmentally disabled individuals (ICF/I-DD), or long-term hospital (LTH) – is deducted from the excess income.

a. If excess income is absorbed by the cost of LTSS, the person is MN eligible and the provisions related to the post-eligibility treatment of income (PETI), set forth in Part 8 of this Subchapter, are applied to determine the amount of the person's gross income that is available to be applied toward the cost of care each month.

b. If excess income is not absorbed, the remaining income provides the basis for determining the LTSS MN spenddown for the projected budget period once the PETI Rules are applied. Allowable expenses are deducted in accordance with § 2.5.1(B) of this Part below.

3. Spenddown – A MN LTSS spenddown is based on the amount of excess income remaining after all required reductions are taken in the PETI process. Income protected in the PETI process is unavailable and therefore is excluded in the calculation of the spenddown. Once protected income is subtracted, the total spenddown is the amount of allowable expenses a person must incur to meet the MNIL.

a. Otherwise Medicaid eligible due to a penalty. PETI does not apply when a person who is subject to penalty period for LTSS coverage is otherwise eligible for Medicaid. Therefore, during such a penalty period, in which Medicaid LTSS coverage is not available, all countable income is available for spenddown purposes.

b. Verification. The State determines whether the applicant/beneficiary has sufficient allowable expenses each month – both incurred and projected – to meet this spenddown. Proof that incurred allowable expenses meet the monthly spenddown may be required as indicated in § 2.5.1 of this Part below.

4. Monthly projected spenddown period – The State uses a one (1) month budget period to determine beneficiary liability and therefore the amount of the spenddown required to maintain eligibility.

a. Start date. A one (1) month budget period begins with the first (1st) calendar month during which the person receives LTSS for any part of the month, applies for Medicaid coverage for that month, and meets all other requirements for Medicaid eligibility.

b. End date. A one (1) month budget period ends with the last calendar month during which the person received LTSS for any part of the month and meets all other eligibility requirements.

C. LTSS MN coverage begins on the first (1st) day of the budget period in which allowable expenses meet or exceed the spenddown requirement when using health insurance cost and noncovered health expenses to meet the MNIL. Eligibility becomes effective later than the first (1st) day of the month when a

spenddown requirement is met using covered medical expenses. Medicaid LTSS coverage continues to the end of the budget period unless there is a change in income.

1. Penalty period and MN eligibility – The penalty start date for a person seeking LTSS MN eligibility is the date the spenddown is met. If the spenddown is not met in the month of application or the next month, the person is ineligible for LTSS MN coverage and the State must determine whether Community Medicaid MN eligibility is available based on a six (6) month spenddown period.

2. Overlapping providers – Applicants and beneficiaries are responsible for health expenses incurred before the date of eligibility. If receiving LTSS for more than one (1) provider on the date that coverage begins, the applicant/beneficiary must decide which services he or she will be responsible for paying and which providers Medicaid will cover.

2.5 LTSS Medically Needy Allowable Expenses

A. The health expenses of the LTSS beneficiary and spouse and dependents, if applicable, may be used to obtain or retain MN eligibility if they qualify as allowable under this Part. The expenses may be paid or incurred and not paid depending on the deduction sequence, the age of the health bills, and whether the expenses are predictable and/or used for other eligibility purposes such as reducing resources or beneficiary liability for the cost of care.

B. For an incurred health expense to qualify as allowable for a LTSS MN spenddown, the following apply:

1. No third-party liability – An allowable expense must not be eligible for payment by a third (3rd) party. For these purposes, a third (3rd) party could be individuals, entities or policies that are, or may be, liable to pay the expense including, but not limited to: other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system; automobile insurance; court judgments or settlements; or Workers' Compensation. Expenses incurred by the spouse or a financially responsible relative are NOT treated as a third (3rd) party liability if such expenses are allowable and the services are provided to the applicant or beneficiary.

2. Medically necessary – The expense must be medically necessary. A necessary medical expense is an expense rendered for any of these situations:

   a. In response to a life-threatening condition or pain;

b. Treat an injury, illness or infection;

c. Achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;

d. Provide care for a mother and child through the maternity period;

e. Prevent the onset of a serious disease or illness;

f. To treat a condition that could result in physical or behavioral health impairment; or

g. When such services are provided or ordered by a licensed health care professional or provider they are presumed to be medically necessary. In instances when such services are provided by some other person or entity, documentation of medical necessity may be required.

3. Single use – The total amount of a health expense may not be used more than once to meet an eligibility or spenddown requirement. However, if only a portion of a health expense is used to meet the spenddown requirement in a budget period, the portion of the allowable expense that remains is a current liability and may be applied toward a spenddown requirement in a future budget period.

4. Retroactive coverage – Allowable expenses incurred in the three (3) months prior to the date of application may be used to grant Medicaid MN coverage if all other eligibility criteria were met during the retroactive period. If not used to seek eligibility for this period, expenses incurred that are not used for this purpose may be applied in accordance with § 2.5.1(B)(4) of this Part below.

5. Deduction timeframes – Health costs may qualify as allowable expenses when incurred:

a. During the current budget period, whether paid or unpaid;

b. Before the current budget period and paid in the current period;

c. Before the current period, remain unpaid, and continuing has been established; or

d. Paid during the current budget period by a government entity or program that does not receive Medicaid funding.

6. Loans – Health expenses incurred before or during the budget period and paid for by a *bona fide* loan may be deducted if the expense has not been previously used to meet a spenddown requirement and the applicant or

beneficiary or a financially responsible person establishes continuing liability for the loan. To be an allowable expense, all or part of the principal amount of the loan must remain outstanding at some point during the budget period. For these purposes, a *bona fide* loan means an obligation, documented from its outset by a written contract and a specified repayment schedule. Only the amount of the principal outstanding during the budget period, including payments made on the principal during that period, may be deducted.

2.5.1 Types of Allowable Expenses and Sequence of Deductions

A. The types of health and remedial expenses that qualify as "allowable" for the purposes of a MN spenddown are the same for both community Medicaid and LTSS. 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; skilled nursing and subacute care if not otherwise covered; 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.

B. An expense is allowable for the Medicaid LTSS 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 sequence of deductions for allowable expenses is as follows:

1. Health insurance expenses – The costs for maintaining insurance coverage for health care services and supports for both the person seeking coverage and any dependents. This category includes, premiums, co-pays, co-insurance and deductibles including for Medicare and commercial plans. Premiums for optional supplemental plans are not allowable expenses.

2. 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.

3. 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 may 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).

4. 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.

   a. 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.

   b. When an applicant for LTSS 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 whether provided in an institution, such as an NF or hospital, or home and community-based setting, such as a DD group home, assisted living residence, etc.

4. Health institution expenses – Under the existing Medicaid State Plan, Rhode Island took 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 monthly Medicaid reimbursement rate projected to the end of the budget period when paid or incurred. These Regulations hereby adopt and incorporate 42 C.F.R. § 435.831(3)(g)(1) (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

2.6 Health Institution and Income Cost Comparison

A. The following table sets forth the projected monthly private pay rates associated with each institutional level of care that are used to determine whether a LTSS applicant or beneficiary with excess countable income qualifies for LTSS MN eligibility with or without a spenddown. Figures are based on average costs reported in the Genworth Financial, Inc. 201~~7~~9 survey of nursing facility providers (https://www.genworth.com/aging-and-you/finances/cost-of-care.html). ~~and the McKinsey survey of LTSS non-governmental payers and providers (https://healthcare.mckinsey.com/) in Rhode Island, including for-profit and not-for-profit entities, for a semi-private room as of May 1, 2018:~~

Rhode Island: Projected Monthly Private Pay Costs by Institutional Level of Care – ~~2018~~ 2020	
Type of LTSS	Monthly/Daily Rate
Nursing facility (average skilled)	~~$9,581/$319~~ $9,961.00 / $328.00
Intermediate Care Facility for I-DD	~~$37,858/$1,261~~ $21,600.00 / $720.00
Long-term hospital	~~$45,599/$1,519~~ $48,665.00 / $1,600.00

B. The following table shows the State reimbursement for LTSS only. Incurred and paid non-LTSS health care costs are excluded from the rates except in health institutions (NF, ICF/I-DD, and LTH) and may be added toward the required spenddown if allowable.

Rhode Island: State Medicaid LTS-only Monthly Reimbursement Rates by Service – ~~2018~~ 2020 (Medical Services not included)	
Service	Monthly Rate
Nursing facility (average skilled)	~~$6,700~~ $7,150.00
~~**Assisted Living Certification for Category D**~~	~~$1,400~~
~~**Assisted Living Certification for Category F (enhanced/specialize)**~~	~~$2,400~~
Assisted Living	$2,100.00
Shared Living	~~$2,400~~ $2,225.00
~~**HCBS in a Home**~~ **Home-Based Personal Care**	~~$1,700~~ $2,925.00
Adult Day Services Only	$1,250.00
Eleanor Slater – Hospital	~~$34,195~~ $48,665.00
~~**Zambarano/**~~**Tavares**	~~$21,932~~ $21,600.00
~~**Other hospital**~~ **Other Long-Term Care Hospital**	~~$24,000~~ $25,850.00
DD at Home	~~$2,561~~ $4,218.00

DD Share living	~~$5,001~~ $6,467.00
DD Group Home (Private)	~~$9,412~~ $11,026.00
~~**Adult Day Services – Non-DD**~~	~~$1,590~~