



Arkansas Department of Health and Human Services

Division of Medical Services



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OFFICIAL NOTICE

DMS-2005-W-3

TO: Health Care Provider – All Providers

DATE: September 29, 2005

SUBJECT: Medical Treatment for Hurricane Katrina Evacuees

I. Introduction

Arkansas has requested and received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a Medicaid waiver to enable the state to reimburse providers for services provided to Hurricane Katrina evacuees. The covered services are those available to Arkansas Medicaid beneficiaries who qualify for the full range of Medicaid services. These beneficiaries will receive Medicaid ID cards the same as any other beneficiaries.

The primary care physician (PCP) referral requirements are waived and do not apply to this population. All other Medicaid requirements are applied to this group, e.g. prior authorization, extension of benefits, co-payments, etc. Claims should be submitted as providers would submit for any other Medicaid beneficiaries.

NOTE: The information in this notice does not apply to persons who evacuated their homes solely as a result of Hurricane Rita.

II. Waiver Eligibility Criteria

The term evacuee refers to an individual who is a resident of the counties/parishes declared as disaster areas as a result of damage inflicted by Hurricane Katrina, has no private health insurance and has income within the limits shown in this document.

The income limits for Medicaid coverage within the waiver are:

Children Under Age 19	up to and including 200% FPL
Pregnant Women from Louisiana, Mississippi and Florida	up to and including 185% FPL
Pregnant Women from Alabama	up to and including 133% FPL
Individuals with Disabilities	up to and including 300% SSI
Low-income Medicare Recipients	up to and including 100% FPL
Low-income Individuals in need of Long Term Care	up to and including 300% SSI
Low-income Parents of Children Under Age 19	up to and including 100% FPL

Monthly Income limits per family size are:

Family Size	100%	133%	185%	200%
1	797.50	1060.68	1475.38	1595.00
2	1069.17	1422.00	1977.96	2138.34
3	1340.83	1783.30	2480.54	2681.66
4	1612.50	2144.63	2983.13	3225.00
5	1884.17	2505.95	3485.71	3768.34
6	2155.83	2867.25	3988.29	4311.66
7	2427.50	3228.58	4490.88	4855.00
8	2699.17	3589.90	4993.46	5398.34
9	2970.84	3951.22	5496.05	5941.68
10	3242.51	4312.54	5998.64	6485.02
For each additional member add:	271.67	361.32	502.59	543.34

Evacuees who appear to be eligible based on the criteria described in section II above, must be referred to the county Department of Health and Human Services office to file an application. Providers should collect the information normally documented for Medicaid beneficiaries for the patient's file. Patient files must support actions taken by the provider when reviewed during a federal audit.

III. Medicaid Application Process

The Department of Health and Human Services, Division of County Operations staff in the local state DHHS offices are responsible for taking and processing assistance applications. They have been instructed to expedite the process for this population so beneficiaries and providers have access to information regarding eligibility quickly.

Applications may be filed no later than January 31, 2006. Approvals will be for a five-month period beginning the date of eligibility. Retroactive eligibility may be approved, but the retroactive period will count as part of the five months.

Example 1: If an application is filed December 1, 2005 and the applicant alleges medical expenses beginning October 1, 2005, the five-month period will begin 10-1-05 and end February 28, 2006.

Example 2: If an application is filed January 31, 2006 for services beginning 1-31, the five-month period will begin January 31, 2006 and end June 30, 2006.

As with the regular Medicaid population, providers are encouraged to verify eligibility each time a service is provided. If the patient is not eligible at the time of the service, continue to access the EDS system to verify the eligibility period.

Claims should be filed as quickly as possible after the service is provided.

IV. Uncompensated Care Pool

In addition to evacuees covered within the waiver, Arkansas is submitting a plan to cover evacuees who are not otherwise eligible for Medicaid, reside in a federally declared disaster area, have no comprehensive health insurance and have income that does not exceed an amount to be determined by CMS. Coverage for the uncompensated care group will be for one five-month period as determined by the state.

More information will be made available to providers when DMS receives approval of the uncompensated care plan. Another notice will be posted to DMS' web site at www.medicaid.state.ar.us. Providers should collect the information normally documented for Medicaid beneficiaries for the patient's file. Patient files must support actions taken by the provider when reviewed during a federal audit.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8365 (voice) or (501) 682-6789 (TDD).

Thank you for your participation in the Arkansas Medicaid Program.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and out-of-state at (501) 376-2211.

Roy Jeffus, Director