

Summary of Changes  
Sections A-180, C-120, C-130, C-150, E-265 and E-270

A-180, C-120, C-130 and C-150 – These sections of policy are being revised to change which entity will process applications received through the FFM. Applications received through the FFM will be processed by DHS.

E-265 – Removed the NOTE which referenced E-270.

E-270 – Removed this section of policy because projected income will no longer be used to determine Medicaid eligibility.

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**QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS**  
**WITH THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT/AGENCY Arkansas Department of Human  
DIVISION County Operations  
DIVISION DIRECTOR Mary Franklin  
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PRESENTER E-MAIL [lisa.teague@dhs.arkansas.gov](mailto:lisa.teague@dhs.arkansas.gov)

**INSTRUCTIONS**

- A. Please make copies of this form for future use.  
B. Please answer each question **completely** using layman terms. You may use additional sheets, if necessary.  
C. If you have a method of indexing your rules, please give the proposed citation after “Short Title of this Rule” below.  
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

**Donna K. Davis**  
**Administrative Rules Review Section**  
**Arkansas Legislative Council**  
**Bureau of Legislative Research**  
**One Capitol Mall, 5<sup>th</sup> Floor**  
**Little Rock, AR 72201**

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1. What is the short title of this rule? Medical Services Policy Manual Sections A-180, C-120, C-130, C-150, E-265 and E-270.

2. What is the subject of the proposed rule? The proposed rule change revises Medical Services policy to switch Arkansas from a “determination” state to an “assessment” state and to remove the process of using projected income to determine Medicaid eligibility.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐  
If yes, please provide the federal rule, regulation, and/or statute citation. 42 CFR 431.10 and 45 CFR 155.302

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? \_\_\_\_\_

When does the emergency rule expire? \_\_\_\_\_

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐

No ☐

5. Is this a new rule? Yes ☐ No ☒

If yes, please provide a brief summary explaining the regulation. \_\_\_\_\_

Does this repeal an existing rule? Yes ☐ No ☒

If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. \_\_\_\_\_

Is this an amendment to an existing rule?

Yes ☒ No ☐

If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled “mark-up.”**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?  
The proposed rule change revises Medical Services policy to switch Arkansas from a “determination” state to an “assessment” state and to remove the process of using projected income to determine Medicaid eligibility.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

<http://humanservices.arkansas.gov/Pages/LegalNotices.aspx>

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒

If yes, please complete the following:

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Place: \_\_\_\_\_

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

December 13, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

February 1, 2018

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See Attached
13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.
14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. \_\_\_\_\_

## FINANCIAL IMPACT STATEMENT

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

**DEPARTMENT** Department of Human Services

**DIVISION** Division of Medical Services

**PERSON COMPLETING THIS STATEMENT** David McMahon

david.mcmahon

**TELEPHONE** 501-396-6421 **FAX** 501-682-8367 **EMAIL:** @dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

**SHORT TITLE OF THIS RULE** Medical Services Policy Manual Sections A-180, C-120, C-130, C-150, E-265 and E-270

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

If an agency is proposing a more costly rule, please state the following:

- (a) How the additional benefits of the more costly rule justify its additional cost;

\_\_\_\_\_

- (b) The reason for adoption of the more costly rule;

\_\_\_\_\_

- (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

\_\_\_\_\_

- (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

\_\_\_\_\_

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

- (a) What is the cost to implement the federal rule or regulation?

**Current Fiscal Year**

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u></u>
Special Revenue	<u></u>
Other (Identify)	<u></u>

**Next Fiscal Year**

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u></u>
Special Revenue	<u></u>
Other (Identify)	<u></u>

Total                      0

Total                      0

(b) What is the additional cost of the state rule?

**Current Fiscal Year**

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u>          </u>
Special Revenue	<u>          </u>
Other (Identify)	<u>          </u>
 Total	 <u>0</u>

**Next Fiscal Year**

General Revenue	<u>0</u>
Federal Funds	<u>0</u>
Cash Funds	<u>          </u>
Special Revenue	<u>          </u>
Other (Identify)	<u>          </u>
 Total	 <u>0</u>

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

**Current Fiscal Year**

\$ 0

**Next Fiscal Year**

\$ 0

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

**Current Fiscal Year**

\$ 0

**Next Fiscal Year**

\$ 0

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐      No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
  - (a) justifies the agency's need for the proposed rule; and
  - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
  - (a) the rule is achieving the statutory objectives;
  - (b) the benefits of the rule continue to justify its costs; and
  - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

### A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 02/01/18

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

The term "insurance affordability program" includes the Medicaid program, premium tax credits including advance payment of the credit, and cost-sharing reductions. Only individuals who are determined ineligible for an appropriate Medicaid coverage group are potentially eligible for the premium tax credit and cost-sharing reductions. The upper income limit for any amount of premium assistance is 400% of the federal poverty level for the individual's household size.

When an individual applies for an insurance affordability program through the FFM and appears to be Medicaid eligible, the FFM will send a file to DHS and DHS will process it. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. DHS will notify the individual of the next steps to complete the enrollment process. See MS C-150.

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

Since Medicaid is one of the insurance affordability programs under the Affordable Care Act, an individual may apply directly to DHS for Medicaid eligibility. To coordinate and streamline the application process for the insurance affordability programs, DHS uses the same Single Streamlined Application used by the FFM. Although DHS will not make a determination of



## MEDICAL SERVICES POLICY MANUAL, SECTION A

### A-180 Medicaid/Health Insurance Marketplace Interactions

eligibility for the premium tax credit or cost-sharing reductions for individuals determined Medicaid ineligible, DHS will send the individual's electronic account to the FFM which will include the needed application data for the FFM to make those determinations.

In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

## MEDICAL SERVICES POLICY MANUAL, SECTION A MARKUP

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### A-180 Medicaid/Health Insurance Marketplace Interactions

#### A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 021/01/187

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

The term "Insurance affordability program" includes the Medicaid program, premium tax credits including advance payment of the credit, and cost-sharing reductions. Only individuals who are determined ineligible for an appropriate Medicaid coverage group are potentially eligible for the premium tax credit and cost-sharing reductions. The upper income limit for any amount of premium assistance is 400% of the federal poverty level for the individual's household size.

When an individual applies for an insurance affordability program through the FFM and appears to be Medicaid eligible, the FFM will send a file to DHS and DHS will process it. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. ~~Medicaid eligibility will first be determined for all household members applying for coverage. If eligible, the FFM will notify the individual of the Medicaid eligibility and send the individual's electronic account to the State Medicaid agency (DHS) for enrollment in the applicable Medicaid eligibility group. If all members of the individual's household are Medicaid eligible, no further action to select or enroll in a Qualified Health Plan (QHP) is required of the individual, with the exception of individuals eligible for the Adult Expansion Group. Upon receipt of the Adult Expansion Group individual's electronic account from the FFM, DHS will notify the individual of the next steps to complete the enrollment process. See MS C-150.~~

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

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### A-180 Medicaid/Health Insurance Marketplace Interactions

Since Medicaid is one of the insurance affordability programs under the Affordable Care Act, an individual may apply directly to DHS for Medicaid eligibility. To coordinate and streamline the application process for the insurance affordability programs, DHS uses the same Single Streamlined Application used by the FFM. Although DHS will not make a determination of eligibility for the premium tax credit or cost-sharing reductions for individuals determined Medicaid ineligible, DHS will send the individual's electronic account to the FFM which will include the needed application data for the FFM to make those determinations.

In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

# MEDICAL SERVICES POLICY MANUAL, SECTION C

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## C-120 Submitting an Application

### C-120 Submitting an Application

MS Manual 02/01/18

An application may be completed and submitted electronically via [Access Arkansas](#) or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.



**NOTE:** See [Appendix I](#) for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to DHS and DHS will process it. If the applicant is found to be eligible for Medicaid, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

### C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to

## MEDICAL SERVICES POLICY MANUAL, SECTION C

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### C-130 Tracking Applications Upon Receipt

the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

### C-130 Tracking Applications Upon Receipt

MS Manual 02/01/18

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM), that appear to be eligible for Medicaid, will be sent to DHS for processing. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

he denial.

### C-150 Enrollment

MS Manual 02/01/18

Each individual approved for Medicaid by DHS will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Adult Expansion Group requires that once eligibility is determined, the applicant will receive a letter explaining which coverage is suitable for their need. The Division of Medical Services will

## MEDICAL SERVICES POLICY MANUAL, SECTION C

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### C-150 Enrollment

issue an eligibility approval notice for the Adult Expansion Group which will provide instructions regarding the next steps needed to complete the enrollment process.

PROPOSED

## MEDICAL SERVICES POLICY MANUAL, SECTION C MARKUP

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### C-120 Submitting an Application

#### C-120 Submitting an Application

MS Manual 021/01/184

An application may be completed and submitted electronically via Access Arkansas or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.



**NOTE:** See Appendix I for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to DHS and DHS will process it. If the applicant is found to be eligible for Medicaid, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. a Medicaid eligibility determination will be made by the FFM. If the applicant is determined to be eligible for Medicaid, the FFM will notify DHS of eligibility. At that time, the system will automatically enroll the applicant in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS in this situation.

## MEDICAL SERVICES POLICY MANUAL, SECTION C MARKUP

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### C-125 Date of Application

#### C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

#### C-130 Tracking Applications Upon Receipt

MS Manual 021/01/184

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM), that appear to be eligible for Medicaid, will be sent to DHS for processing. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. ~~tracked and monitored by the FFM. DHS will not receive these applications for processing. Therefore, applications submitted through the FFM will not be registered as an application in the DHS system. However, when an applicant is determined eligible for Medicaid benefits by the FFM, the applicant's electronic account with all appropriate data will be transmitted to the DHS system which will accept all data and enroll the individual in Medicaid.~~



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### C-150 Enrollment

#### C-150 Enrollment

MS Manual 021/01/187

Each individual approved for Medicaid by DHS or the FFM will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Adult Expansion Group requires that once eligibility is determined, the applicant will receive a letter explaining which coverage is suitable for their need. The Division of Medical Services will issue an eligibility approval notice for the Adult Expansion Group which will provide instructions regarding the next steps needed to complete the enrollment process.

## MEDICAL SERVICES POLICY MANUAL, SECTION E

### E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

#### E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

MS Manual 02/01/18

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.



**NOTE:** Income received in a month for which retroactive eligibility is being determined will be considered for the retroactive month even if it is not considered for current or future months.

Once the household members' current income has been established and verified using the 10% reasonable compatibility standard as appropriate (See [MS G-151-152](#)), the monthly amount used to determine eligibility will be calculated. Depending on how the current income was established (e.g., tax return income via the Federal Data Services Hub, State Quarterly Wage Data, checkstubs, SOLQ, etc.), the "verified" income amount may have to be reduced or increased to reflect a monthly amount. For example, if the most recent tax return reflects the income still currently available to the individual, then the annual income from the tax return is divided by 12 to arrive at a monthly amount. If the current income was established through the most recent weekly check stubs, the average weekly amount is multiplied by 4.334 to arrive at a monthly amount. Unless the verified amount is already a monthly amount, for example Social Security benefits, then some conversion to a monthly amount is required. The calculation will be documented in the individual's case file.

The chart below shows how income amounts larger or smaller than monthly amounts can be converted to a monthly amount.

Income Amount Is	Convert to Monthly
Annual	Divide by 12

## MEDICAL SERVICES POLICY MANUAL, SECTION E

### E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

Quarterly	Divide by 3
Weekly	Multiply by 4.334
Bi-weekly	Multiply by 2.167
Semi-Monthly	Multiply by 2
Monthly	No conversion needed
More Often than Weekly	Total all Income Paid/Received in the Month

There may be situations in which an alternative method must be used to arrive at current monthly income. For example, if annual income included a lump sum payment that will not be paid again, then the lump sum payment will be excluded from the rest of the annual income before the conversion to monthly income is made. Self-employment income may also require an alternative method. See [MS E-266](#) for a more detailed discussion on self-employment income.

**Example Scenario:** Bertha's and Audrey's current monthly income is determined as follows. Since Chloe's income is not considered in any of the three households, there is no need to determine her current income.

#### Bertha

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub (\$96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income (\$8000).

#### Audrey

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns \$7.25 per hour. Her current monthly income is determined as follows:

$$\$7.25 \times 10 = \$72.50$$

$$\$72.50 \times 4.334 = \$314.22 \quad (\$314.22 \times 12 = \$3,770.64 \text{ annual})$$

## MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

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### E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

#### E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

MS Manual 021/01/184

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

~~**NOTE:** There is an exception to using current monthly income in which projected annual income will be used. This is discussed further in MS E-270.~~

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.

**NOTE:** Income received in a month for which retroactive eligibility is being determined will be considered for the retroactive month even if it is not considered for current or future months.

Once the household members' current income has been established and verified using the 10% reasonable compatibility standard as appropriate (See MS G-151-152), the monthly amount used to determine eligibility will be calculated. Depending on how the current income was established (e.g., tax return income via the Federal Data Services Hub, State Quarterly Wage Data, checkstubs, SOLQ, etc.), the "verified" income amount may have to be reduced or increased to reflect a monthly amount. For example, if the most recent tax return reflects the income still currently available to the individual, then the annual income from the tax return is divided by 12 to arrive at a monthly amount. If the current income was established through the most recent weekly check stubs, the average weekly amount is multiplied by 4.334 to arrive at a monthly amount. Unless the verified amount is already a monthly amount, for example Social Security benefits, then some conversion to a monthly amount is required. The calculation will be documented in the individual's case file.

The chart below shows how income amounts larger or smaller than monthly amounts can be converted to a monthly amount.

## MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

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### E-270 When Projected Annual Income is Used for Medicaid Eligibility

Income Amount is	Convert to Monthly
Annual	Divide by 12
Quarterly	Divide by 3
Weekly	Multiply by 4.334
Bi-weekly	Multiply by 2.167
Semi-Monthly	Multiply by 2
Monthly	No conversion needed
More Often than Weekly	Total all Income Paid/Received in the Month

There may be situations in which an alternative method must be used to arrive at current monthly income. For example, if annual income included a lump sum payment that will not be paid again, then the lump sum payment will be excluded from the rest of the annual income before the conversion to monthly income is made. Self-employment income may also require an alternative method. See [MS E-266](#) for a more detailed discussion on self-employment income.

**Example Scenario:** Bertha's and Audrey's current monthly income is determined as follows. Since Chloe's income is not considered in any of the three households, there is no need to determine her current income.

#### Bertha

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub (\$96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income (\$8000).

#### Audrey

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns \$7.25 per hour. Her current monthly income is determined as follows:

$$\$7.25 \times 10 = \$72.50$$

$$\$72.50 \times 4.334 = \$314.22 \quad (\$314.22 \times 12 = \$3,770.64 \text{ annual})$$

### **E-270 When Projected Annual Income is Used for Medicaid Eligibility**

MS Manual 01/01/14

## MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

Error! No text of specified style in document.

### E-270 When Projected Annual Income is Used for Medicaid Eligibility

When the agency determines an individual is Medicaid ineligible based on current monthly income, the individual's information is electronically sent to the FFM. If the FFM determines the individual is Medicaid eligible because his or her projected annual income is less than 100% of the FPL, the FFM will transfer the individual's account information back to DHS. The agency will then enroll the individual in Medicaid for the remainder of the current calendar year based on the projected annual income.

**Example:** Jane Doe has recently obtained a higher paying job. Her household size is 2 and her new monthly income is \$1,939.00. She submits a DCO-152 Application for healthcare coverage through DHS who determines she is ineligible for Medicaid based on her current monthly income. Her information is sent to the FFM where her eligibility for the ATPC is determined. ATPC eligibility is based on the individual's projected annual income. The FFM determines her projected annual income for the current calendar year to be \$14,400. The FFM determines she is ineligible for the ATPC because her annual income for the current year is below the 100% FPL. Therefore, the FFM sends the information back to DHS as Medicaid eligible. The agency will enroll her in Medicaid for the remainder of the current calendar year based on her projected annual income as determined by the FFM.



# Medicaid Administration

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR-17 – 015

Expiration date:

## State Plan Administration Designation and Authority

A1

42 CFR 431.10

### Designation and Authority

State Name:

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Type of Agency:

- ☐ Title IV-A Agency
- ☐ Health
- ☐ Human Resources
- ☒ Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

The single state agency supervises the administration of the state plan by local political subdivisions.

☐ Yes ☒ No

☒ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

**An attachment is submitted.**

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

☐ Yes ☒ No



# Medicaid Administration

- ☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

☒ Yes ☐ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 12/18/13

The type of responsibility delegated is (check all that apply):

- ☐ Determining eligibility  
☒ Conducting fair hearings  
☐ Other

Name of state agency to which responsibility is delegated:

Arkansas Insurance Department

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

For Private Option enrollees only, the Arkansas Department of Human Services intends to delegate to the Arkansas Insurance Department the final administrative adjudication of appeals regarding covered services, including appeals related to medical necessity and scope and duration. An interagency agreement or memorandum of agreement between the Arkansas Insurance Department and the Arkansas Department of Human Services will assure that final administrative adjudications conducted by the Arkansas Insurance Department comply with all requirements for due process and the hearing rights afforded Medicaid applicants and beneficiaries and comply with state and federal Medicaid laws, rules, and regulations. The Arkansas Department of Human Services retains oversight of the State Plan and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by the Arkansas Insurance Department.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Arkansas Department of Human Services will enter into a written memorandum of understanding with the Arkansas Insurance Department (that will be made available to the Secretary of Human Services upon request) that will include the following provisions: (1) the relationships and respective responsibilities of both entities to effectuate coverage of fair hearings; (2) quality control and oversight by the Medicaid agency, including reporting requirements needed to facilitate control and oversight; and (3) assurances that the Arkansas Insurance Department will: (a) comply with all federal and state Medicaid laws, regulations and policies; (b) prohibit conflicts of interest and improper incentives; and (c) ensure privacy and confidentiality safeguards. AID will ensure that every beneficiary is informed, in writing, of the appeals process and how to contact AID and how to obtain information about appeals from that agency.

Add

- ☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:





# Medicaid Administration

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☒ Medicaid agency

☐ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☒ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

☐ Yes ☒ No

## State Plan Administration Organization and Administration

42 CFR 431.10  
42 CFR 431.11

### Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Director of the Department of Human Services is charged with the responsibility of providing leadership to all divisions within the Department. The following offices and units provide support for the Department: The Office of Finance and Administration (OFA) supports the programs within the Department of Human Services (DHS) by providing financial and administrative management in the areas of human resources, contract support and accounting. The Office of Systems and Technology provides, coordinates, and manages information technology solutions. The Communications unit is responsible for press releases and communications with the media. The Policy and Planning unit functions include: 1) Coordinating the DHS policy agenda; 2) Anticipating state and federal policy changes, new demographic trends, or proposed program changes and their effects; 3)



# Medicaid Administration

Facilitating cross-division projects or opportunities of importance; and 4) Creating strategies to improve data use and analysis. The Office of Quality Assurance (OQA) is responsible for developing and establishing work priorities, standards of performance, reviewing and approving managerial decisions, and monitoring budgetary needs and expenditures. The Office of Policy and Legal Services provides extensive legal, investigative and hearing services to the Department. The Director of the Division of Medical Services (DMS) is responsible for the formulation and implementation of medical services policy and payment of claims. All administrative authority over the Medicaid program is within the Division of Medical Services, with the Division of County Operations performing the administrative function of Medicaid eligibility determination for all Medicaid eligible groups. The Director of the DMS supervises the following sections: (1) Program and Administrative Support, (2) Office of Long Term Care (3) Medicaid Information Management, (4) Medical Services and (5) Health Care Innovation. The Program and Administrative Support Section consists of the following units: (1) Financial Activities, (2) Provider Reimbursement, (3) Third Party Liability & Estate Recovery Contract Oversight, and (4) Program Budgeting and Analysis. The Office of Long Term Care is responsible for providing the continuum of regulatory oversight of Long Term Care Facilities under Federal and State laws and regulations. The office of Long Term Care consists of the following units: (1) Regulations and Data, (2) MDS/RAI/Analytics, (3) Survey, Certification and Licensure, (4) Survey and Certification of Nursing Homes, (5) Special Programs, (6) State Regulated Facilities/ Processes and (7) Training and Staff Development. The Medical Services section consists of the following units: (1) Provider Management and Vision Dental Programs, Surveillance Utilization Review (2) Prescription Drug Program, (3) Program Development and Quality Assurance, (4) Utilization Review and Medical Programs, Behavioral Health, (4) Electronic Health Records and (5) Continuity and Coordination of Care. The Medicaid Information Management Section is responsible for data security and MMIS support. The Health Care Innovation Section consists of the following units: (1) Infrastructure Development and Implementation, (2) Episode Design and Delivery, (3) Population Based Health, and (4) Patient-Centered Medical Home and Transportation Programs.

The DHS Office of Policy and Legal Services is responsible for all appeals and fair hearings conducted on behalf of Medicaid applicants and beneficiaries. Appeals of adverse Private Option eligibility determinations and Private Option beneficiary appeals concerning wrap-around services are conducted by the Office of Appeals and Hearings, an office within the Arkansas Department of Human Services, Office of Policy and Legal Services. This appeals entity will enter final administrative adjudications concerning: 1) eligibility to participate in the private option; and 2) appeals brought by Private Option beneficiaries regarding Private Option wrap-around Medicaid services.

Upload an organizational chart of the Medicaid agency.

**An attachment is submitted.**

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

DMS works with the Arkansas Insurance Department (AID) which is under the Governor. The AID will conduct the final administrative adjudication of appeals regarding covered services, including appeals related to medical necessity and scope and duration. AID will ensure that every beneficiary is informed, in writing, of the appeals process and how to contact AID and how to obtain information about appeals from that agency.

See Ark. Code Ann. § 20-77-1704, which provides that an administrative law judge employed by the Arkansas Department of Health shall conduct all Medicaid provider administrative appeals of adverse decisions having a direct monetary consequence to the provider. The Appeals and Hearings Section provides administrative hearings for the appeal of adverse agency actions. Appeals may concern Child Maltreatment, SNAP, TEA, Medicaid, Fraud, Intentional Program Violations, Estate Recovery, Adult Protection and a variety of other areas. The Arkansas Department of Health will enter final administrative adjudications of appeals brought by Medicaid providers concerning payment for wrap-around services delivered to Private Option beneficiaries. Arkansas code §20-77-2103 created the Office of Medicaid Inspector General (OMIG) in 2013. The OMIG office is within the office of the Governor and is independent from the Arkansas Department of Human Services. OMIG assumed the duties of the Medicaid Program Integrity unit. The OMIG 1) prevents, detects, and investigates fraud and abuse within the medical assistance program; 2)



# Medicaid Administration

refers appropriate cases for criminal prosecution; 3) recovers improperly expended medical assistance funds; 4) audits medical assistance program functions; and 5) establishes a medical assistance program fraud and abuse prevention.

## Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

[Remove](#)

Type of entity that determines eligibility:

- ☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to the State and the DHS eligibility system will process it. If the applicant is found to be eligible for Medicaid, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

[Remove](#)

Type of entity that determines eligibility:

- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

[Add](#)

## Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

[Remove](#)

Type of entity that conducts fair hearings:

- ☒ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The DHS Office of Policy and Legal Services is responsible for all appeals and fair hearings conducted on behalf of Medicaid applicants and beneficiaries. Appeals of adverse Private Option eligibility determinations and Private Option beneficiary appeals concerning wrap-around services are conducted by the Office of Appeals and Hearings, an office within the Arkansas Department of Human Services, Office of Policy and Legal Services. This appeals entity will enter final administrative adjudications



# Medicaid Administration

concerning: 1) eligibility to participate in the private option; and 2) appeals brought by Private Option beneficiaries regarding Private Option wrap-around Medicaid services.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

☐ Yes ☒ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

☐ Counties

☐ Parishes

☐ Other

Are all of the local subdivisions indicated above used to administer the state plan?

☐ Yes ☐ No

## State Plan Administration Assurances

A3

42 CFR 431.10  
42 CFR 431.12  
42 CFR 431.50

### Assurances

☒ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☒ All requirements of 42 CFR 431.10 are met.

☒ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☒ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☒ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:



# Medicaid Administration



The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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