Notice of Rule Making

Pursuant to Arkansas Code 20-76-201 and Arkansas Act 892, the Director of Division of County Operations issues the following proposed changes to Medical Services Policy E-430, H-100 through H-116 and H-400 through H-494; and SPA #2018-006, effective December 1, 2018.

The proposed rule revises Medical Services policy to clarify how to determine the net income for post-eligibility determinations; Long-Term Care insurance policies are included with the net-income for post-eligibility determinations; nursing facility, assisted living, PACE and ARChoices applicants/recipients with income in excess of the income limit may establish an income trust for the purpose of becoming Medicaid eligible; and, to provide more detailed guidance on non-covered medical offsets, setting reasonable limits in both policy and the Medicaid State Plan.

A public hearing is scheduled for 2:00 p.m. on October 10, 2018, at the Donaghey Plaza South Bldg., Conference Room A, 700 South Main Street, Little Rock. Check-in with the security desk in the lobby of the Donaghey Plaza South Building and present some form of picture identification.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-332, Little Rock, AR 72203, Attention: Office of Program Planning & Development. You may also access it on the DHS website http://humanservices.arkansas.gov/resources/legal-notices. All comments must be submitted in writing to the address indicated above no later than October 13, 2018.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 501-682-8922 (voice) or 501-682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin.

SUMMARY FOR

Medical Services Policy Manual Section E-430, H-100 through H-116 and H-400 through H-494. SPA #2018-006.

Section MS E-430 is being updated to clarify how to determine net-income for post-eligibility determination of the liability amount for vendor payments.

Section MS H-100 is being updated to more clearly state that nursing facility, assisted living, PACE, and ARChoices applicants/recipients with income in excess of the income limit may establish an income trust for the purpose of becoming Medicaid eligible. Other terminology corrections have been made throughout.

Section MS H-400 is being updated to provide more detailed guidance on non-covered medical offsets per Arkansas Act 892 and to make corrections and clarifications.

MS E-430 #1 *Sources of Unearned Income* added the following regarding post-eligibility determinations of the liability amount for vendor payment:

- Net income will be considered in post eligibility determination if the withholding is mandatory.
- Gross income will be considered in post eligibility determination if the withholding is voluntary.
- Payments from Long Term Care insurance policies are included with the net income for post-eligibility determinations.

MS H-110 *Income Trusts:* added "in a Long Term Services and Supports (LTSS) category."

MS H-111#1 *Requirements for an Income Trust:* added "ARChoices."

MS H-112 #1 and #2 *Income Trust Application Process:* added "nursing" and "assisted living facility, PACE, and ARChoices in Homecare."

MS H-113 *Post Eligibility Procedures:* added "PACE and ARChoices."

MS H-116 *Termination of Trust:* added form DCO-730.

MS H-410 *Factors Used to Determine the Cost of Care* has been changed to section MS H-404 and each numbered item previously in that section has been given a separate section (MS H-405 through MS H-411) as listed below and on the following page.

- MS H-405 *Earned and Unearned Income*
  - Instructions added for earnings of nursing facility residents (previously only found in MS H-430)
  - Instructions added for how to consider LTC insurance payments
- MS H-406 *Income Trust Fees (if applicable)*
  - Added *commercially reasonable administrative fees charged by the commercial institution serving as trust* (previously only found in MS H-111 #3)
- MS H-407 *Personal Needs Allowance*

- MS H-408 *Community Spouse Monthly Income Allowance (CSMIA)*
- MS H-409 *Family Member Allowance (FMA)*
- MS H-410 *Non-Covered Medical Expenses* additions include:
  - Whose expenses may be included for offset
  - Who may submit the request for offset
  - Reference to MS H-415 for projection of expenses option
  - List of common non-covered medical expenses considered for offset and verification required in order to offset (health insurance premiums, LTC insurance premiums, Medicare premiums, prescription drugs)
  - Reasonable limits criteria and cap for non-covered medical expenses considered for offset and verification required in order to offset (deductibles and coinsurance, dental expenses excluding dentures)
  - Additional offset procedures for non-covered medical expenses which meet the reasonable limits criteria/cap considered for offset and verification required in order to offset (dentures, durable medical equipment, hearing services, vision care, other non-covered expenses)
  - List of non-covered medical expenses not allowed for offset
- MS H-411 *Net Income*

MS H-415 *Option to Estimate Net Income*: procedures added for projecting income, allowances, and medical expenses

MS H-490 *Absences from Long Term Care Facilities:* additions and corrections include:

- TPL address
- Submission of DCO-730
- Hospitalization, Hospitalization at the Arkansas State Hospital, and Procedures for Suspension of Cases-Arkansas State Hospital moved from MS-491

SPA #2018-006 – Income Offsets - Reasonable Limits for non-covered medical expenses.

E-430 Sources of Unearned Income

MS Manual ~~01??~~11/~~01??~~01/~~16~~ 18

The following are possible sources of unearned income:

1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, Civil Service, ~~m~~Military ~~a~~Allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, Black Lung benefits, and Veterans Benefits (exclude V.A. Aide and Attendance and CME/UME payments. Re. MS E-451)~~, Civil Service, military allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, and Black Lung benefits~~. Count gross income when determining eligibility.

NOTE: For nursing facility, ICF/IID, ALF, Adult Family Home, and PACE cases where there is a patient liability, if taxes are withheld or other deductions are taken from the income prior to receipt, it must be verified if the withholding/deduction is mandatory or voluntary. Once verified, the withholding/deduction will be handled as below:

- If the withholding/deduction is mandatory, consider the net income in the post-eligibility determination of the liability amount for vendor payment. **Example**: Mrs. Anderson has gross income of $1500 SSA. She has a mandatory withholding of $150 for SSA overpayment. Her gross income of $1500 will be used to determine eligibility. The net income of $1350 ($1500 - $150 SSA overpayment) will be used to determine her liability amount for vendor payment.
- If the withholding/deduction is voluntary, consider the gross income in the post-eligibility determination of the liability amount for vendor payment. If income taxes are owed at the end of the tax year, an offset will be allowed. **Example**: Mr. Bates has gross income of $1300 SSA and $2000 pension. He has a voluntary withholding of $200 monthly from his pension for Federal and State ~~i~~income taxes. His gross income of $3300 will be used to determine eligibility and his liability amount for vendor payment.
- If there are both mandatory and voluntary withholdings/deductions from income, subtract the mandatory withholdings/deductions and consider the net income in the post-eligibility determination of the liability amount for vendor payment. If income taxes are owed at the end of the tax year, an offset will be allowed. **Example**: Ms. Carter has gross income of $1850 SSA and $250 pension. She has a mandatory withholding of $185 from her SSA for an SSA overpayment and a voluntary Federal income tax withholding of $165 from her pension. Her gross income of $2100 will be used to determine eligibility. The net income of $1915

($2100 - $185 SSA overpayment) will be used to determine her liability amount for vendor payment.

NOTE: ~~If state and federal taxes are withheld, count the gross income when determining eligibility for nursing facility and ICF/IID cases. Consider the net income in the post eligibility determination of the vendor payment.~~ Payments from Long Term Care insurance policies, whether paid to the client or paid directly to the facility, are not counted as income in determining eligibility, but are included with net income for post-eligibility determination of the liability amount for vendor payment. If the client has a Miller Income Trust, LTC insurance payments do not have to be placed into the trust account. Payments received in subsequent months will be handled in a similar fashion as reimbursements and the budget will be adjusted for the month the payment is intended to cover. LTC insurance payments that pay the same amount each month should be included in the budget. Per diem payments may be estimated for a period not to exceed six months if they meet the criteria at MS H-415.

2. Payments received for the rental of rooms, apartments, dwelling units, buildings, or land. If paid regularly, taxes, insurance, interest on loans, and the expense of upkeep may be deducted.

NOTE: In Waiver and TEFRA cases, the deductions are not given for eligibility determinations. In nursing facility, ALF, ARChoices (Adult Family Homes), PACE, and ICF/IID cases, the deductions are not given in the initial OR post eligibility determinations, and neither for home nor for non-home rental properties.

3. Interest, dividends, and income from capital investments, insurance policies, etc.
4. Royalty income from oil, gas or other mineral leases.
5. Regular payments from estates, trust funds (Re. MS E-522 #13), or other personal property which cannot be converted into cash because of legal provisions.
6. Child support payments.
7. Regular contributions from organizations, churches, friends, relatives, or social agencies.
8. Income or support and maintenance received in-kind.

H-100 Long Term Services and Supports

MS Manual 07/13/15

The policies located in Section H of this manual describe programs and procedures that are unique to the Long Term Services and Supports eligibility groups. These sections include:

1. Income Trusts, (MS H-110-116)
2. Spousal Impoverishment Rules, (MS H-200)
3. Transfer of Resources, (MS H-300)
4. Post Eligibility rules, (MS H-400)
5. Long Term Care Insurance Partnership Program, (MS H-500)
6. Estate Recovery, (MS H-600) and
7. Undue Hardship Waiver. (MS H-700)

H-110 Income Trusts

MS Manual 11/~~??~~01/18

An individual with income in excess of the income limit may establish an income trust for the purpose of becoming Medicaid eligible in a Long Term Services and Supports (LTSS) category. This type of trust is commonly referred to as a Miller Income Trust.

H-111 Requirements for an Income Trust

MS Manual ~~07/13/15~~~~??~~11/~~??~~01/18

An Income Trust must meet the following conditions:

1. Terms and Other Conditions

   The trust must be irrevocable. It can be terminated or amended only by mutual agreement between DHS and the trustee.

   ~~—~~The trust may be used to establish Medicaid eligibility for individuals determined to ~~–~~be medically in need of care in a nursing facility, assisted living facility, ~~in a home and community-based waiver program, such as Living Choices (Assisted Living~~

Facility), ARChoices in Homecare, and DDS Waiver or assisted living facility or PACE, or in the PACE (Program of All Inclusive Care for the Elderly) program.

The trust must have been established on or after August 11, 1993.

The trust can only be funded from Social Security, pension, and all other income payable to an individual, including income earned by the trust account. If assets other than income, such as real or personal property, are placed in the trust, the individual cannot be eligible for facility services under the income trust provisions.

The trust must contain a provision that all assets remaining in the trust at the individual's death will be transferred to DHS up to an amount equal to medical payments made by DHS on behalf of the individual subsequent to establishment of the trust.

2. Consideration of Income

An individual with gross monthly countable income, excluding VA Aid &and Attendance (VA A&A) and VA reimbursements for cContinuing or uUnusual mMedical eExpenses (CME/UME), which exceeds the federal cap of 3 times the SSI payment for an individual living in his own home, may establish eligibility through an income trust.

All of an individual's income must be placed in the trust, except VA A&A and/or CME/UME.

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes. Income which is received directly by an individual must be transferred to the trust immediately upon receipt.

The income (other than income accumulated by the trust) must be income payable to the individual, and the income must first be received by the individual before being placed in the trust. If the individual assigns the right to receive any or all of the income to the trust, the income assigned is no longer considered income to the individual under SSI rules. Such an assignment will be considered a disqualifying transfer. However, for purposes of this section, if an individual authorizes the income to be paid into the trust by direct deposit from the payorpayer, the direct deposit will not be considered an assignment (disqualifying transfer).

If in any month the income is not placed in the trust, the individual is not eligible for Medicaid benefits or vendor payment in that month.

The income must be placed into and maintained in a single trust account.

If an individual receives income on an irregular basis, (such as royalty or farm rental income, or lump sum payments such as SSA retroactive benefits) the income must be placed into the trust when it is received.

If an individual receives income paid jointly to him and another person(s), the facility resident's share of the income must be separated from the other owner(s) share(s) before depositing his share in the trust account. No income belonging to any other individual may be placed in the income trust of a Medicaid recipient.

3. Fees and Other Disbursements

When no relatives are available to serve as the trustee, a commercial institution such as a bank can be named as trustee. Commercially reasonable administrative fees that are charged by the commercial institution may be allowed as trustee fees. The fee will be considered commercially reasonable if the fee is consistent with administrative fees charged to other customers for similar services. Trustee fees will not be allowed except in these instances. The bank service charges for maintaining the bank account are allowable fees.

4. Trustee Responsibilities

A trustee may serve without bond or supervision of any court.

Prior to a distribution from the trust, the trustee must notify the ~~caseworker~~ eligibility worker responsible for the case of any fees, income taxes or other payments which must be made from the trust before these disbursements can be made. The advance notice must be made no later than the month which precedes the month in which the disbursements will be made.

After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Post Eligibility Income Worksheet, ~~DCO~~DHS-712, completed by the ~~caseworker~~ eligibility worker in charge of the case. ~~See~~ Refer to MS H-410.

Any disbursements made that are not for the benefit of the recipient, the community spouse or other dependents, as specified on the ~~DCO~~DHS-712, will be considered a transfer of resources and a penalty period may be applied.

Payments must be made from the trust each month only in the amounts specified on the ~~DCO~~DHS-712. The payments must be made directly to the designated recipient, i.e., to the recipient or responsible person for the personal needs allowance (PNA); to the community spouse and/or dependent(s) for their allowances; to the recipient or responsible party for the recipient's non-covered medical expenses; and to the facility for the patient's share of cost.

While an individual is receiving Medicaid benefits in a facility, no disbursements other than those specified on the ~~DCO~~DHS-712 may be made.

The trust records shall be open to inspection and for copying by DHS, and periodic reporting may be required at the discretion of DHS.

If the trustee becomes aware of any change in circumstances which will affect the recipient's eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the ~~caseworker~~ eligibility worker of such changes. Changes to be reported include income changes, increase or decrease of cost of non-covered medical expenses, recipient dies or leaves the facility, community spouse enters a facility, etc.

The trustee must notify the ~~caseworker~~ eligibility worker if in any month the funds are not disbursed according to the ~~DCO~~DHS-712 or if the balance in the trust account exceeds the maximum allowed as specified in MS H-113, Post Eligibility Procedures, so that the eligibility worker can adjust the facility or provider payment(s) for the month(s) in which the vendor payment is affected.

H-112 Income Trust Application Process

MS Manual ~~07/13/15~~??11/~~??~~01/18

The process of applying for a Miller Income Trust consists of the following steps:

1. Request for Eligibility Determination

   Individuals with income above the federal cap who inquire regarding Medicaid eligibility in a nursing facility, assisted living facility, ~~for~~ PACE, or for ARChoices in Homecare, ~~the home and community based Waiver programs~~ will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re~~.~~fer to MS E-500) if requested. Individuals with excess resources **cannot** establish eligibility through an income trust.

   NOTE: If an individual receives income from a LTC insurance policy that puts him/her over the income limit, an income trust is not required unless the other countable income, without counting the LTC insurance payments, puts him/her over the income limit.

2. Application for Benefits

   At application for nursing facility care, assisted living facility, PACE, or ~~the a Waiver program~~ARChoices in Homecare, the applicant, representative, guardian or other person responsible for the application, must inform the ~~caseworker~~ eligibility worker of the existence of an income trust, or that such a trust is to be established, and must provide the ~~caseworker~~ eligibility worker with a copy of the trust document.

   An application will not be held longer than 45 days to permit the finalization of an income trust. If all eligibility requirements have been met with the exception of income in excess of the federal cap and the trust has not been finalized within 45 days since the date of application, the application will be denied and the individual or responsible party will be informed that reapplication may be made when the trust agreement is finalized.

3. Review for Validity

As soon as possible after receiving the trust document, the ~~caseworker~~ eligibility worker must submit it through eDoctus to obtain an opinion that the trust document meets the requirements of a valid income trust in Arkansas. Refer to MS E-501.

H-113 Post Eligibility Procedures

MS Manual ~~07/13/15~~??11/??01/18

1. Post Eligibility Consideration of Income

The total net countable income of an individual will be included in the post eligibility consideration. Net income will be calculated as for all other Medicaid eligible individuals in the post eligibility process.

For example, an individual has $2500 net countable monthly income. For post eligibility purposes, the calculations will begin with $2500. The PNA, income trust fees, the spousal/dependent allowances (if applicable, but not in amounts greater than the maximum allowed on the ~~DCO~~DHS-712), and non-covered medical expenses of the recipient will be deducted. The balance remaining must then be applied to the individual's cost of care in the facility.

The ~~caseworker~~ eligibility worker will be responsible for providing the trustee and the recipient or his/her representative with a copy of the ~~DCO~~DHS-712 at initial certification and each time it is necessary to make a revision in the post eligibility budget due to income changes or other changes such as those made on the ~~DCO~~DHS-712 mandated by the spousal laws.

2. Begin Date of Eligibility

Eligibility for a nursing facility, ~~care,~~ assisted living facility, PACE, or ~~Waiver~~ARChoices in Homecare services shall not begin prior to the month in which the trust is established. A trust is considered established when the completed document is signed by the applicant and the trustee. The first possible beginning date of eligibility will be the first day of the month in which an approved trust was signed, provided that the individual's income has been placed in the trust account (bank account) that month, that no unauthorized funds have been disbursed during the month, and that the individual is otherwise eligible. If funds that are not or will not be allowed by the ~~DCO~~DHS-712 have been disbursed from

the trust during or after the month in which the trust is established, eligibility cannot begin until the first of the month in which all disbursements are correctly made.

It must be verified prior to beginning eligibility that the individual's income has been placed in the trust.

3. Trust Balance Exceeds Divisor

There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits which represent income for the following month and any spousal/-dependent/non-covered medical expenses amounts specified on the ~~DCO~~DHS-712 which were not disbursed for the month) exceeds the amount of the current divisor used for transfer of resources (Appendix R), the individual will not be eligible again for facility care payment until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident. During any such month(s) of ineligibility the spousal, dependent, and non-covered medical allowances may be paid according to the ~~DCO~~DHS-712, and Medicaid benefits other than the facility vendor payment will be continued.

NOTE: This only applies to facility payments.

EXAMPLE: In October 2014, an ~~caseworker~~ eligibility worker learns that an income trust had a $7,208 balance at the end of the preceding month which included a $1,200 SSA check deposited the last day of September, representing payment for October. The trustee failed to make any disbursements for September, including $40 PNA, $600 to the community spouse and $200 for non-covered medical expenses. When the October SSA check and the non-payments for September are subtracted from $7,208 ($7,208 - $1,200 - $40 - $600 - $200 = $5,168), the remainder is greater than the current divisor. Therefore, the individual is not eligible for vendor payment in September and the vendor payment will be stopped for that month.

For any such month(s) of ineligibility, the ~~caseworker~~ eligibility worker will send a ~~DCO~~DHS-707, Notice of Adverse Action, to the recipient or representative, and a copy of the notice to the trustee.

H-114 Changes to an Income Trust

MS Manual ~~07/13/15~~ ~~22~~11/~~22~~01/18

1. Medicare and Other Third Party Payments

If in any month or part of a month a patient is in a Medicare bed or has other third party coverage which lessens or eliminates the obligation of the trustee to pay the facility for the patient's share of cost as computed on the ~~DCO~~DHS-712, the funds which would have been paid to the facility in that month shall remain in the trust and may not be disbursed for reasons other than for the recipient's medical care for which there is no other third party liability.

If a trustee has paid the patient's share of vendor payment at the first of a month and later is reimbursed the funds from the facility due to payments from other third party coverage, the reimbursement must be returned immediately to the trust. If the facility does not make the refund to the trustee, i.e., places the payment(s) in the patient's facility account, the funds placed in the account will be countable toward the $2000 resource limit.

2. Client Leaves Facility

If an individual leaves a facility for a therapeutic home visit (up to 14 days) or for a hospital visit (up to 5 days), Medicaid benefits and vendor payment will continue, and the trustee will make disbursements in that month as specified on the ~~DCO~~DHS-712.

If an individual has not returned to the facility after 14 days on a home visit or after 5 days of hospitalization, Medicaid will no longer pay the vendor payment, and the individual will be responsible for arrangements with the facility. Medicaid benefits other than the vendor payment may continue unless a formal notice of discharge is sent to the DHS County Office via DCO-702 and the recipient has not entered, nor is it anticipated that he will enter another facility. During any such period of extended home visit or hospitalization when Medicaid is not paying the facility vendor payment, the trustee may continue to disburse the spousal/dependent/non-covered medical

expenses as specified on the ~~DCO~~DHS-712 and may disburse funds from the trust for medical expenses of the recipient which are not specified on the ~~DCO~~DHS-712 and not covered by Medicaid or other insurance.

The ~~caseworker~~ eligibility worker must determine the residence of a recipient when receiving a DCO-702, Notice of Discharge from a facility, because facilities may erroneously send discharge notices when an individual has been hospitalized for more than 5 days. A facility may also correctly send notice of discharge when an individual has been transferred directly from one facility to another, from a hospital to a second facility, or from a therapeutic home visit to a second facility. In any of the above situations, the case should not be closed and Medicaid benefits should not be terminated.

If an individual improves to the extent that he or she is able to return home and is deemed unlikely to need continuing care in a facility according to written medical statement, the Medicaid case must be closed. However, the trust must be maintained according to the terms of the trust, i.e., the individual's income must continue to go into the trust; no other individual's income may be put into the trust, etc. Disbursements may be made only for medical care, food, clothing, transportation and shelter for the individual.

3. Changes in Community Spouse or Dependent Status

If a community spouse or dependent who has been receiving a monthly income allowance from the facility resident enters a facility, has an income change, divorces the recipient or dies, the ~~caseworker~~ eligibility worker in charge of the case must be notified within 10 days by the recipient, representative, trustee or other responsible party. No additional disbursements for the spouse or dependent can be made until the ~~caseworker~~ eligibility worker has revised the ~~DCO~~DHS-712 and provided the trustee with a copy.

H-115 Reevaluations with an Income Trust

MS Manual 07/13/15

In addition to the required verification of other eligibility factors at annual reevaluation, the caseworker will verify and narrate in the electronic record that the individual's income has been placed in the trust and disbursements made as required since the last reevaluation. This may be done by viewing bank statements, or other trustee records that may be available.

H-116 Termination of an Income Trust

MS Manual ~~07/13/15~~??11/~~??~~01/18

Within 10 days of receiving a notification of the death of an individual certified under the income trust provision, the ~~caseworker~~ eligibility worker will:

- Send a Notice of Action to inform the trustee~~:~~ ~~T~~that if disbursements as specified on the most recent ~~DCO~~DHS-712 were not made for the month in which death occurred, these disbursements may be made. After these disbursements have been made, no other disbursements may be made from the account until the trustee has received instructions from the DHS Third Party Liability Unit section regarding termination of the trust (Form DCO-733).

- Complete Form DCO-734, Report of Case Closure Due to Death, and Form DCO-730, Report of Income Trust, and send the form to:

Arkansas Department of Human Services
~~**Division of Medical Services**~~
Third Party Liability
PO Box 1437 Slot- S-296
Little Rock, AR 72203-1437

The Third Party Liability Unit will use the information provided in the DCO-734 and DCO-730 to complete and mail the trustee the DCO-733 with instructions regarding termination of the trust.

Since income trusts are irrevocable, income trusts cannot be terminated while the individual is still alive, except when:

- The Office of Chief Counsel (~~OPLS~~ OCC) determines an error was made in the establishment of the trust, or

- The individual has repaid Medicaid all payments made since the establishment of the income trust, or

- Individual is moving out of state and will be establishing an income trust in the other state, or

- Other extraordinary circumstance.

In all cases, ~~OPLS~~ OCC must authorize the termination of the income trust.

H-400 Post Eligibility

MS Manual 07/13/15

The eligibility groups Nursing Facility, Assisted Living Facility, PACE recipients in a nursing facility and individuals receiving waiver services in an Adult Family Home require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

H-401 Income Eligibility Determination for the Institutionalized Spouse (IS)

MS Manual ~~01/01/14~~??11/~~??~~01/18

Income eligibility for the IS will be determined in general following the procedures in MS H-402-430. Gross income of the IS cannot exceed the current ~~LTC~~ LTSS income limit in determining eligibility, unless an income trust has been established. Income of the Community Spouse (CS) will not be deemed to the IS in any month or partial month of institutionalization. If an IS is receiving full SSI payment for the first three months of institutionalization, the SSI payment will be disregarded as income. (Refer to MS H-420.)

H-402 Consideration of Income

MS Manual 07/13/15

After the IS has been determined to be resource eligible for Long Term ~~Care~~Services and Supports, income of the IS and CS will be considered as follows:

1. Income Not From A Trust

    a. Income received solely in the name of either spouse will be considered income only to that spouse. Refer to MS E-432#5 for "Veteran's Benefits" exceptions.

    b. If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS;

    c. If payment of income is made in the names of the IS and/or the CS and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and

no such interest is specified, one half of the joint interest will be considered available to each spouse.

2. Income From A Trust

   Income from a trust will be considered available to each spouse as provided by the trust or, in the absence of a specific provision in the trust, according to the rules in 1. a-c above. If the IS or CS established the trust, refer to MS H-304 for consideration of income from the trust.

3. Income Through Property With No Instrument Establishing Ownership

   When income is from property which has no instrument establishing ownership (i.e. unprobated, income-producing heir property), one half of the income will be considered to be available to the IS and one-half to the CS.

H-403 Rebutting Consideration of Income

MS Manual ~~01/01/14~~ ~~??~~11/~~??~~01/18

The ~~caseworker~~eligibility worker will advise the applicant or representative of the income that will be considered in the gross income test of the IS.

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. In order to successfully rebut the presumption of full or partial ownership, he/she must provide the following within 30 days of the date on the ~~DCO~~DHS-712, Post Eligibility Income Worksheet:

1. A written, signed statement by the IS giving his/her allegation regarding ownership, the reason for the applicant's receipt of the income or for his/her name appearing as an owner on the payment of the income;

2. Corroborating, signed statements from the other owner(s);

3. A change in the instrument of ownership removing the IS's name from the instrument or a change which redirects the income to the actual owner(s); and

4. Copies of the original and revised documents reflecting the change in 3.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the income.

If the individual elects not to rebut the consideration of ownership interest, obtain a written statement from the individual which documents his/her election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the income produced from the presumed ownership interest will be used in his/her eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined and the findings documented in the case record. The income from the actual ownership interest (i.e., the interest determined by the rebuttal) will be used in the eligibility determination.

When the individual has successfully rebutted ownership of all or a portion of the income, income payments will be considered available to the IS in proportion to his/her interest (if any).

NOTE: This section does not apply to federal, state or other entitlements, pensions or retirement benefits. For example, ownership of a $600 Social Security income entitlement for an IS cannot be rebutted.

H-~~410~~ 404 Factors Used to Determine the Cost of Care~~Factors Used to Determine the Cost of Care~~

MS Manual ~~01/01/16~~??1/~~??~~01/18

Nursing facility recipients are required to contribute all of their monthly income, minus certain approved deductions, to the cost of their facility care. Medicaid pays the balance of the monthly charges due based on a per diem rate according to the individual's Level of Care.

NOTE: ARChoices (except those who participate in the Adult Family Home service) and DDS Waiver recipients do not make a contribution to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living, ARChoices-Adult Family Home and PACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the IS, CS, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be

computed on form ~~DCO-712~~DHS-712, Post Eligibility Income Worksheet, for the appropriate time period.

NOTE: If there are dependent children but no spouse in the home, the child's allowance will be calculated on the Protected Maintenance Worksheet. Use of the DHS-712 in this case is not required unless the recipient has an irrevocable income trust (Miller Income Trust.)

Steps for determining the amount of income to be applied to the cost of care are shown ~~below~~in the following sections:

- MS H-405 Earned and Unearned Income
- MS H-406 Income Trust Fees (if applicable)
- MS H-407 Personal Needs Allowance
- MS H-408 Community Spouse Monthly Income Allowance (CSMIA)
- MS H-409 Family Member Allowance (FMA)
- MS H-410 Non-Covered Medical Expenses
- MS H-411 Net Income

H-405 Earned and Unearned Income

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~~Total Earned and Unearned Income~~

Total all income of the recipient by type and amount with the following exceptions:

- For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget.
- VA Aid and Attendance payments and VA CME/UME will not be counted as income.
- Mandatory deductions and work related expenses will be deducted from gross earnings.
- An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in 10-bed ICF/IID facilities and State Human Development Centers.
- An additional amount of up to $100 will be deducted from the earnings of nursing facility residents, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home

resident receiving skilled care reports earnings, the Office of Long Term Care (OLTC) should be contacted and requested to reevaluate medical necessity.

- LTC insurance payments, whether paid to the facility or directly to the recipient, are not considered in the eligibility process, but are counted toward cost of care.

H-406 Income Trust Fees (if applicable)

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~~**A. Income Trust Fees (if applicable).**~~

Deduct the applicable income trust fees.

- ~~Any applicable income trust fees.~~
- The monthly service charge for maintaining the ~~bank~~ trust account.
- ~~and~~Commercially reasonable administrative fees charged by the commercial institution serving as trustee ~~trustee fees may be deducted in cases certified November 1, 1995 and later~~. Refer to ~~MS H-100~~MS H-111 #3.

H-407 Personal Needs Allowance

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~~**Personal Needs Allowance.**~~

Deduct the personal needs allowance (PNA).

- Subtract a $40 PNA for most facility residents.

NOTE: Facility residents whose only income is SSI will be allowed to keep $30 as their PNA. The PNA of a SSI recipient who also has other income is $40.00. Refer to MS H-420.

- Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. An additional $40 will not be given. A $90 PNA will not be given to any individual whose VA

pension has not been reduced to $90 by the Veterans Administration (VA). If VA later reduces the pension to $90, an income adjustment will be made.

It will not be the responsibility of the ~~caseworker~~eligibility worker to attempt to identify individuals who may be eligible for a $90 PNA or to allow a $90 PNA when the VA benefits have not been reduced to $90. If a single veteran or surviving spouse of a veteran with no dependents is receiving VA pension and the benefits have not been reduced to $90 at certification, only a $40 PNA will be given. The case will be adjusted when the ~~caseworker~~eligibility worker learns that the pension has been reduced to $90.

Individuals may be instructed to contact the Veterans Administration if they believe they are entitled to a $90 reduced pension.

- For residents of ICF/IIDs and State Human Development Centers with earned income, $40 may be given as a PNA in addition to a disregard of earned income up to the current SSI/SPA.
- For nursing facility residents with earned income, $40 may be given as a PNA in addition to a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure.

If the individual has no spouse or dependents or non-covered medical expenses, the PNA will be the only allowance given to arrive at net income. If the individual has dependent children, but no spouse, refer to ~~# 6~~MS H-409.B. ~~below.~~ If the individual has a spouse or spouse and other dependents living in the community, refer to MS H-408 and MS H-409.A.~~# 5 below.~~ If the individual has non-covered medical expenses, refer to MS H-410 below.

H-408 ~~The~~ Community Spouse Monthly Income Allowance (CSMIA)~~,~~

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The CSMIA ~~which~~ is determined by:

A. Computing the Excess Shelter Allowance in Section 5a of the ~~DCO-712~~DHS-712. Total shelter costs may include:
   1) Rent or mortgage, including principal and interest;
   2) Prorated taxes and insurance, including personal property taxes and insurance on household contents if paid yearly;
   3) Condominium or cooperative fee, including maintenance charges; and
   4) The standard utility allowance.

Shelter costs must be verified. Utilities need not be verified.

NOTE: Do not add the standard utility allowance in computation if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (Ex. - water), the full utility allowance may be used.

B. Computing the Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) by adding the amount shown in 5b of the ~~DCO 712~~DHS-712 to the Excess Shelter Allowance. The total CSMNA amount may not exceed the maximum indicated on the ~~DCO~~ DHS--712 (the maximum will be adjusted annually according to the Consumer Price Index).

C. Computing the Community Spouse Monthly Income Allowance (CSMIA) by subtracting the CS's gross income from the CSMNA. (VA A&A and CME/UME are not countable income to the CS.)

The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA (Refer to~~.~~ MS H-416). An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA (~~Re.~~Refer to MS H-208).

If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will not be subject to the limit on the CSMNA.

A CS who is an SSI recipient will have the right to choose whether or not to accept a CSMIA. It should be explained to the CS that the result of accepting an allowance may be reduction or termination of SSI benefits and Medicaid.

~~A~~ H-409 Family Member Allowance (FMA)

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A. FMA when a Spouse is in the Home

Mark-up

A H-409 Family Member Allowance (FMA)

If the individual has a spouse and other dependents living in the community, a FMA will be deducted for each dependent family member. See MS Glossary for definition of dependent family member.

The FMA is computed for each dependent family member by deducting the family member's income from the amount shown in Section 6 of the ~~DCO-712~~DHS-712 and by dividing the result by 3.

The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income, i.e., the actual contribution will be deducted instead of the computed FMA (~~Re.~~Refer to ~~MS H-415~~MS H-416).

A CS ~~who is an SSI recipient, or~~ who has children receiving SSI, will have the right to choose whether or not to accept a ~~CSMIA or~~ FMA. It should be explained to the CS that the result of accepting an allowance may be reduction or termination of SSI benefits and Medicaid. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

If there are no non-covered medical expenses, the net income, after deducting the family member allowance, will be applied to the cost of facility care. If there are non-covered medical expenses, proceed to MS H-410 below.

B. ~~6. Protected Maintenance Allowance from NF Eligibles Income~~ FMA for Dependent Children When There is No Spouse in the Home~~.~~

In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.

Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under the age of 18, the combined income of the children must be less than the Medically Needy

Income Level for the appropriate number of children in the household to qualify for protected maintenance. (See MS O-710 for MNILs.)

In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance. Actual amounts allowed for protected maintenance are determined as follows:

- Determine the children's maintenance level using the appropriate MNIL for the children.
- Total any income that the children may have. If the total gross income equals or is greater than the maintenance level in the step above, no protected maintenance from the institutionalized individual's income will be allowed. If the children's income total is less than the maintenance level, their total gross income will be subtracted from the maintenance level to arrive at the amount that will be given from the individual's income for protected maintenance.

  EXAMPLE: Two dependent children each have $75 monthly income, for a total of $150. The $150 income will be subtracted from the 2 person MNIL of $216.66, leaving $66.66. $66.66 of the institutionalized individual's income will be given to the children as protected maintenance.

If there are no ~~noncovered~~non-covered medical expenses, the net income after deducting the ~~protected maintenance~~family member allowance for the child(ren) will be applied to the cost of facility care. If there are non-covered medical expenses, proceed to ~~# 7~~MS H-410 ~~below~~.

H-410 Non-Covered Medical Expenses

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Non-covered medical expenses which are not subject to payment by a third party (including Medicaid) will be deducted from the income of all LTSS recipients who must contribute to their cost of care. This deduction is referred to as an offset. Only non-covered medical expenses for the recipient may be deducted. Medical expenses of family members cannot be deducted. This offset applies only to recipients with a patient liability other than zero. The request for an offset for non-covered medical expenses must be submitted by the client, their authorized representative, or facility representative.

H-400 Post Eligibility

Mark-up

H-410 Non-Covered Medical Expenses

Medical expenses can be of three types:

- Monthly - Expenses incurred regularly each month, such as the Medicare Part D enhanced plan portion of premiums above the benchmark;
- Non-monthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums; and
- One-time - Expenses incurred on a one-time basis, such as hearing aids.

The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future. If the eligibility worker is unable to determine within a fair degree of certainty what the non-covered medical expenses will be, then no medical expenses will be used to offset the income.

If expenses occur regularly, but fluctuate, they may be estimated for a period not to exceed six months. The estimated projection will be based on the six month period immediately preceding the projection. At the end of the projection period, the budget must be reconciled each month of the projection period to determine if an overstated or understated liability has occurred. (See MS H-415.)

1. General Offsets Not Subject to the Reasonable Limit Cap

Following is a list of the most common non-covered medical expenses. It is not all inclusive, but will serve as a general guide.

Health Insurance Premiums

A medical expense deduction is allowed for health insurance premiums (including assignable dental and vision policies) for which the recipient is responsible. Assignable means the benefits are paid directly to the provider. Premiums for insurance which pays cash to a recipient when medical expenses have been incurred are not allowed. In order for a premium to be allowed as a deduction, the insurance company must be regulated and licensed to sell insurance in Arkansas. If questionable, a company's status will be verified with the Arkansas Insurance Department.

Allow a deduction for health insurance premiums when a recipient provides the following: their responsibility for the payments, proof that the policy is assignable, the coverage effective date, the premium amount, and frequency of premium payment. Assignable health insurance policies must be reported to the Third Party Liability Unit via the Third Party Resource/Medical Insurance form DCO-662. (Refer to MS D-510)

If family coverage is included in the recipient's health insurance premium and the premium is deducted from the recipient's income before receipt, the entire premium is allowed. If the family coverage premium is paid from the recipient's account or a joint account, only the recipient's portion is an allowed deduction. If the premium is paid by the community spouse or someone else, the medical expense is not allowed.

Long Term Care (LTC) Insurance Premiums

LTC Insurance premiums for policies that pay the facility or directly to the recipient will be allowed as a non-covered medical expense. However, the eligibility worker must verify that the recipient continues to be responsible for payment of the premium as many policies have a waiver of premium benefit once payout begins.

Medicare Premiums

Medicare premiums are not allowed as non-covered medical expenses as buy-in will occur for LTSS Medicaid recipients. (Refer to MS A-120 for buy-in information.) An exception will

be made for the amount which exceeds the current premium benchmark for Medicare D. When an institutionalized full benefit dual eligible (Medicare/Medicaid) individual is enrolled in a Medicare Part D enhanced plan, the portion of the premium that remains the individual's responsibility is an allowable deduction in the post eligibility calculation.

Prescription Drugs

Medicaid does not cover prescriptions for dual eligible (Medicare/Medicaid) individuals. They must obtain their prescriptions through Medicare Part D coverage. If the individual is entitled to Medicare D, but not enrolled, they should be advised to enroll as soon as possible. No deduction will be given for prescriptions when the individual has failed to enroll or has voluntarily dropped their Medicare Part D coverage.

If an individual has creditable coverage through a former employer or union, they may lose their employer or union health coverage if they join a Medicare Prescription Drug Plan. Creditable coverage means it pays, on average, at least as much as Medicare's standard prescription drug coverage. In these instances, they are not required to join a Medicare D plan, but they must provide verification of creditable coverage.

When a recipient has Medicare Part D, before allowing an expense for prescriptions, the recipient or their authorized representative must provide verification that an exception for coverage of the drug was requested and denied by the Medicare Part D plan. LTSS dual eligibles should not incur a cost for prescription drug co-payments and deductibles. However, if buy-in has occurred and the client reports continued out-of-pocket Medicare D co-pays and deductibles, allow the deduction.

For Medicaid-only (i.e. non-dual eligible) nursing facility recipients receiving vendor payment, there is no monthly limit on the number of medically necessary prescription drugs as long as the prescribed medicine is within the Medicaid formulary. Medicaid-only facility recipients who are not certified for vendor payment and LTSS hospice recipients are limited to three (3) prescriptions per month with the option of receiving an additional three (3) prescriptions with prior authorization.

Medicaid-only ALF recipients may receive up to three (3) prescriptions per month with the option of receiving an additional three (3) prescriptions with prior authorization plus another three (3) prescriptions with their waiver benefit for a total of nine (9) prescriptions.

Medicaid-only ARChoices recipients for whom a cost of care must be determined are limited to three (3) prescriptions per month with the option of receiving an additional three (3) prescriptions with prior authorization.

PACE recipients have no limit on prescriptions authorized by the PACE provider interdisciplinary team.

2. Reasonable Limits

The following reasonable limit cap will be placed on deductions for **all other** incurred medical expenses not listed above in the post-eligibility treatment of income. The maximum annual limit for the total of all expenses in the following section will be capped at the transfer of assets divisor for the year in which they occur. (See Appendix R.)

A. The service or item claimed as a deduction must:

1) Be for a medical or remedial care service recognized under state law;

2) Be medically necessary;

3) Be subject to annual limits as established by Medicaid or other third party payer (such as the number of dental cleanings allowed per year);

NOTE: If the limit has been met, it will not be allowed as an offset.

4) Have been incurred no earlier than the three month period preceding the month of application;

5) Have not been used to gain eligibility in a Medically Needy spend down; and

6) Not be covered by Arkansas Medicaid or other third party.

B. For medically necessary care, services and items not paid for under Arkansas Medicaid or other third party, the actual billed amount will be used as the deduction, not to exceed the least of the fee recognized by Medicaid, Medicare, commercial payers, or any other third party payer for the same or similar care, service or item.

Example: On 7/23/18 Larry Smith submits an invoice of $69.75 for cleaning of his teeth. He has already exceeded his annual Medicaid dental limit. It is verified that his 2018

cumulative offsets do not exceed the cap and all criteria in section A have been provided. Per the 2018 Medicaid dental fee schedule, the allowable fee for the service is $48.45. This is the amount eligible to be offset.

C. Other third party payers, such as medical or health insurance policies, Medicare, medical trust funds, etc., will be treated as first payer or the individual will have to demonstrate that the other insurance payer has not/will not cover the expense. A copy of the explanation of benefits or denial letter from Medicare, other third parties, or Medicaid indicating the claim was denied for a valid reason can serve as verification. Valid reasons of denial would include benefit limit exceeded for the expense, etc. Failure to obtain prior authorization or to submit the claim correctly is not a valid reason of denial.

D. Medical and remedial care expenses that were incurred either as the result of imposition of a transfer of assets penalty or any amounts owed to the facility for a period prior to eligibility are not an allowed deduction.

When there is a contract between an applicant and a medical provider and regular payments on a medical bill are being made, the monthly payment will be deducted as a noncoverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

Deductibles and Coinsurance

Deductibles and coinsurance for the recipient are allowable expenses if they meet the reasonable limits criteria and are not paid by Medicaid, Medicare, or other third party. A copy of the provider bill and a copy of the explanation of benefits/denial letter from Medicaid or other third parties indicating the claim was denied for a valid reason can serve as verification of the expense. The expense must be verified as having been incurred no earlier than the three month period preceding the month of application and be currently due and unpaid.

Dental Expenses (Excluding Dentures)

Dental expenses must meet the reasonable limits requirements. Also, prior to allowing dental expenses, proof must be provided: that Medicaid and any other applicable third party provider was billed including the reason why the claim was denied (for example, over the benefit limit for the year and/or lifetime, prior authorization not obtained); that it was

prescribed by a physician or other licensed medical practitioner; date of service; that the bill is unpaid; and the cost. If a claim was denied for failure to obtain prior authorization, no expense will be allowed. The allowed expense cannot exceed the limits based on the current Medicaid dental fee schedule.

The Arkansas Medicaid Program covers dental services for Medicaid-eligible recipients under the age of 21 years through the Child Health Services (EPSDT) Program. Recipients 21 years of age and older have limited coverage of services and an annual benefit limit of $500, not including extractions or removable full or partial dentures. Beginning January 1, 2018, two Managed Care Organizations (MCO) will administer the Arkansas Medicaid dental program for waiver recipients. Providers not currently enrolled in Medicaid must enroll and become a provider with the appropriate MCO before providing the service in order to have their claims reimbursed by Medicaid. Dental expenses for nursing facility residents will continue to be based on a fee-for-service.

NOTE: If the service would be paid by Medicaid, but the benefit limit has been exhausted for the year, the expense may be allowed as a deduction from the individual's income based on the maximum allowable Medicaid Dental fee. Verification that the Medicaid benefit limit has been met is required before allowing the offset.

3. Additional Offset Procedures

In addition to the **reasonable limits criteria, all other** incurred medical expenses not listed above must meet the following **additional offset** procedures in the post-eligibility treatment of income.

a. The items must be prescribed by a physician or other licensed medical practitioner.

b. The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that he or she is able to utilize the item(s).

c. The request must be approved by the facility's Quality Assessment and Assurance Committee.

d. The cost of the item(s) must be determined.

e. The recipient or authorized representative must provide the eligibility worker with verification of the above. The recipient or authorized representative must not make

the purchase or pay the medical bill until the eligibility worker has made an adjustment to the patient liability.

Dentures

For adults 21 and over, there is a lifetime limit of one set of dentures through Arkansas Medicaid. The replacement of dentures or partials must follow the **reasonable limits criteria** and the **additional offset procedures**.

Durable Medical Equipment (DME)

DME is equipment that can withstand repeated use and is used to serve a medical purpose. It includes prostheses and motorized wheelchairs.

Medicare Part B covers some doctor-prescribed medically necessary durable medical equipment, including power mobility devices.

With prior authorization, Medicaid covers specialized wheelchairs and wheelchair seating systems for individuals age two through adulthood.

An income offset for the purchase of durable medical expenses can be made only if it meets the **reasonable limits criteria** and the **additional offset procedures** are followed.

Hearing Services

Medicare B covers cochlear implants and certain other surgically implanted prosthetic devices if medically necessary and ordered by a Medicare-enrolled doctor or health care provider. Medicare covers medically necessary diagnostic hearing and balance exams if ordered by a Medicare-enrolled doctor or other health care provider. Medicare does not cover hearing exams, hearing aids, or exams for fitting hearing aids.

Medicaid covers hearing services for eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program when prescribed by a physician. Medicaid does not cover hearing aids for recipients 21 years of age and older.

An income offset for the purchase of hearing aids can be made only if it meets the **reasonable limits criteria** and the **additional offset procedures** are followed.

- For initial requests, an unaltered manufacturer's invoice must be submitted as verification of the cost of the item and the doctor or audiologist should indicate that the type of hearing device is appropriate for the client's needs.
- If the request is for a different or stronger type of hearing aid, submitted documentation should establish that the audiology report indicates a noted difference from the previous audiogram.

- If the request is for a replacement, verification should be submitted that the last set was either no longer under warranty or, if under warranty, circumstances requiring the replacement did not meet warranty criteria.

Vision Care

Medicare B provides one pair of conventional eyeglasses or contact lenses after a cataract operation if ordered by a doctor or other health care provider enrolled in Medicare.

One visual examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made. The Medicaid Program will not reimburse for replacement glasses, with the exception of post-cataract patients, which will require prior authorization. Adults aged 21 and older will have to pay a co-payment. Nursing home and group home residents are exempt from the co-pay requirement. Arkansas Medicaid makes contact lenses available when they are medically necessary and prior authorization has been obtained.

An income offset for the purchase of eyeglasses and contact lenses can be made only if it meets the **reasonable limits criteria** and the **additional offset procedures** are followed.

Other Non-Covered Expenses

Other allowable medical expenses (if not subject to payment by Medicaid or any other third party) include: physician or hospital charges, etc. Deductions will not be allowed for anything covered by Arkansas Medicaid, even if incurred with a non-Medicaid provider. Prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility worker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, proof of the cost, and proof that any other applicable third party, including Medicare and Medicaid, have denied the expense as either not coverable or that benefits for the service have been exceeded for the year.

Deduction from income for cosmetic and elective procedures (e.g., face-lifts or liposuction) will not be allowed. When prior authorization is denied for procedures allowed by Medicaid (e.g. some gastric restrictive procedures), an offset will not be allowed.

If the offset must be given over several months and/or if it results in a zero patient liability, the budget must be tracked and the offset ended in the appropriate month. The initial

DHS-707 notice sent notifying the recipient/ authorized representative of the offset should include the total amount allowed for the offset, the number of months the offset will be in place, and when patient liability will return to the regular amount. The recipient should also be advised to pay the provider in a timely manner, to report if the offsets are not made, and advised that their resources must remain under $2,000 each month.

4. Non-Covered Medical Expenses Which Are Not Allowed

Deduction of medical expenses is not allowed for nursing facility and ICF/IID residents for items and services included in the state's Reimbursement Cost Manual as allowable cost items (items the facility will provide). Examples of these include wheelchairs, canes, crutches, walkers, ambulance services or enrollment fees for ambulance services (unless there is not a Medicaid enrolled ambulance provider in the area), other transportation services, over-the-counter pain killers, antacids, laxatives, cough syrups, suppositories, anti-diarrhea medication, diapers, band-aids, bandages, peroxide, antiseptics, etc. Facilities are required to provide these items and services at no additional charge to the recipient.

(The following list of unallowable costs is not all inclusive. The absence of a particular item does not necessarily mean that it is an allowable cost.)

- Amounts owed to the facility for a period prior to eligibility;
- Cosmetic and elective procedures;
- Expenses incurred as the result of imposition of a transfer of assets penalty;
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid;
- Expenses which would be covered by a third party (including Medicaid), even if provided by an out-of-network provider;
- General health insurance premiums paid by someone other than the recipient (e.g. community spouse);
- Items and services the facility is required to provide;
- Medicare premiums except Medicare D costs above the benchmark;
- Non-assignable health insurance premiums, including disease specific policies;

- Premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies; and
- Prescriptions when Medicare D coverage was dropped.

5. Request for Hardship Waiver Due to Emergencies

An individual who is denied an offset due to expenses exceeding the maximum annual limit may request a Hardship Waiver when the requested offset is due to an emergency. An example of a situation in which an undue hardship may exist would be if the client had received offsets for hearing aids and dental expenses earlier in the year that met the yearly cap. Later, they lost their dentures. If verification is provided that it is medically necessary for the individual to receive a replacement of their dentures in order to maintain their weight and receive proper nutrition, a hardship waiver might be granted.

The client or their authorized representative must request the hardship waiver after the offset request has been denied. The request for a hardship waiver should be forwarded to OPPD Medicaid Eligibility Unit for a determination.

H-411 Net Income

MS Manual ~~22~~11/~~22~~01/18

The total of any excluded earnings, income trust fees (when applicable), maintenance allowance, and non-covered medical expenses (if any) will be entered in the system as ~~Protected Maintenance~~the appropriate expense. The net amount remaining will be the amount the individual is expected to apply to the cost of care. The actual vendor payment will be determined by the eligibility system based on the ~~net~~ income and expenses entered by the ~~caseworker~~eligibility worker.

For active cases where the VA pension has been reduced by VA to $90, $90 will be entered as VA pension. ~~$50 plus any additional amounts considered as non-covered medical expense will be populated by the system from previously entered information.~~ The system will automatically ~~exclude the $40 PNA resulting in~~allow the full $90 ~~being given~~as a PNA to the recipient.

If all of the IS's gross income is depleted at any step in the computation, the amount applied to the ~~LTC~~ LTSS vendor payment (cost of care) will be $0.

After the ~~DCO-712~~DHS-712 is completed, a copy will be provided to each spouse. If the form is completed prior to application, at the request of either spouse, the ~~DCO-712~~DHS-712 will only be provided to the spouse making the request.

H-412 Contribution to the Cost of Care for Assisted Living Facilities and ARChoices: Adult Family Home

MS Manual ~~01/01/16~~~~22~~11/~~22~~01/18

Assisted Living Facility (ALF) Waiver and ARChoices: Adult Family Home recipients are allowed to keep a flat 90.8% rounded up of the SSI/SPA for room and board. This will allow the individual to purchase food from the facility, or elsewhere, if they prefer. In addition to the charge for room and board, a monthly personal allowance will be deducted. The personal allowance will be based on 9% of the SSI/SPA and rounded up. Both will increase each January with the SSA/SSI Cost of Living Increases. See Appendix S for current amounts.

H-400 Post Eligibility

Mark-up

H-412 Contribution to the Cost of Care for Assisted Living Facilities and ARChoices: Adult Family Home

The following expenses are to be deducted from the cost of care for the ALF recipient in the following order:

1. Room and board payment.

NOTE: If the individual is receiving assistance through HUD, the deduction can only be for the amount the individual is actually paying.

2. Personal needs allowance (PNA).
3. Monthly medical insurance premiums.
4. Non-covered medical expenses including over the counter medications and medical supplies. Refer to MS H-410.
5. Spousal support payments for the community spouse and Family Member Allowance. Refer to MS H-4~~10 #4-6~~09.
6. Bank service charges on the Income Trust account. Refer to MS H-111 #3.
7. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician.

The ALF and ARChoices: Adult Family Home recipient's income, minus room and board, personal allowance and certain other expenses, will be contributed to their cost of care each month.

Computing the recipient's cost of care for ARChoices: Adult Family Home

A spreadsheet "ARChoices Liability Worksheet" was developed which can be accessed in the system to determine the patient liability for ARChoices: Adult Family Home. This spreadsheet was developed only to assist the ~~caseworker~~eligibility worker to compute the patient liability. This does not require the applicant/recipient's signature and should not be given to the applicant/recipient.

The following provides the procedures in completing the task of computing the recipient's cost of care:

- The ~~DAAS~~ DHS RN will send the ~~caseworker~~eligibility worker a DHS-3330 requesting patient liability to be calculated for a potential recipient of the Adult Family Home service.

- The ~~caseworker~~eligibility worker will compute the patient liability using the current income by accessing the spreadsheet. If additional information is required from the applicant/recipient, the ~~caseworker~~eligibility worker will send a DHS-3330 informing the ~~DAAS~~ DHS RN of this action.
- The ~~caseworker~~eligibility worker will send a 10 day notice via the DHS-707 when additional information is needed to determine the patient liability. The DHS-707 will explain what information is needed to determine the patient's liability for the Adult Family Home service. If not received by the 10th day, then the patient liability will be computed without allowing these expenses and narrated in the system.
- The ~~caseworker~~eligibility worker will send the DHS-3330 providing the liability amount under "other". If this amount was computed without allowing any expenses as the ~~caseworker~~eligibility worker had not received a response from the applicant/recipient, this must also be noted on the DHS-3330.
- The ~~caseworker~~eligibility worker will send a DHS-707 to the applicant/recipient providing the patient liability amount which is the applicant/recipient's contribution of care.
- ~~DAAS~~ The eligibility worker will ~~key~~ enter the expenses in ANSWER, run, and submit the budget~~patient liability amount to the Recipient Waiver screen which~~. This provides ~~this~~ the patient liability amount to ~~MMIS~~Interchange. The eligibility worker ~~and~~ will notify the Adult Family Home provider of the patient liability amount.

Any action taken on an active ARChoices case record that changes the amount of patient liability must be reported to the ~~DAAS~~ DHS RN the same day as the new liability amount and the effective date of the change.

H-413 Contribution to the Cost of Care for PACE

MS Manual ~~07/13/15~~~~22~~11/~~22~~01/18

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long Term ~~Care~~ Services and Supports Medicaid. Refer to MS H-404 through H-~~410~~411. For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust. For income trust guidelines, refer to MS H-110.

The ~~caseworker~~eligibility worker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust.

The patient liability amount will be calculated using the form ~~DCO~~DHS-712. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current ~~LTC~~ LTSS PNA, any applicable community spouse allowances and/or family allowances and excess medical expenses will be deducted from the PACE participant's monthly income. Refer to MS H-404 through H-411. ~~Refer to MS H-410.~~

For individuals in the community who are eligible through establishing an income trust, income in excess of the current ~~LTC~~ LTSS Medicaid limit will also be paid to the PACE provider. A personal needs allowance equal to the current ~~LTC~~LTSS/PACE limit of three times the current SSI/SPA, plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-415 Option to Estimate Net Income

MS Manual ~~01/01/14~~??11/??01/18

The ~~caseworker~~eligibility worker may elect to estimate for a period not to exceed six months any or all of the following: the income of the IS and CS, the spousal and family member maintenance allowances, and the medical expenses. The six month projection will show reasonable income and expenses, based on the six month period immediately preceding the projection and may be preferable when income or living/medical expenses fluctuate.

The budget should be tracked and the projection ended in the appropriate month. A DHS-707 must be sent notifying the recipient or authorized representative of the projection. The notice should include the income, allowances, and medical expenses allowed in the projection, the number of months the offset will be in place, when actual income and medical expenses for those months will be requested for reconciliation and the future projection period. The recipient should also be advised to report within ten days if there are changes in the income and medical expenses used in the calculation.

At the end of the projection period, the worker will obtain copies of actual income, spousal and family member allowances, and medical expenses for each of the months to determine if the projection for the previous period was correct. Based on the information provided, the budget must be reconciled to determine if an overstated or understated liability has occurred. After adjusting retroactive months with actual income, medical expenses, and spousal allowances, the worker can then use the verified income and expenses to calculate a new projection period.

H-416 Verification or Refusal of Contributions

MS Manual ~~07/13/15~~??11/~~??~~01/18

Prior to certification of the IS, the IS or representative must complete and sign the statement on the reverse of the ~~DCO~~DHS-712 to indicate that the IS plans to contribute the CSMIA and the FMA specified on the front of the ~~DCO~~DHS-712, during the period of institutionalization.

If the ~~DCO~~DHS-712 is not completed and signed, no allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income by completing the appropriate section on the ~~DCO~~DHS-712.

NOTE: Use the ~~DCO~~DHS-712 for the current year for which eligibility is being determined.

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual ~~07/13/15~~??11/~~??~~01/18

As of 7/1/88, those SSI recipients entering a medical or nursing facility will be allowed to retain their full SSI benefits if:~~:~~

a. ~~who~~ they have a home to maintain, and

~~a.~~b. ~~who~~ they have obtained a medical statement for SSA to document that the medical confinement will not exceed 3 calendar months after the month of entry to the facility.

~~will be allowed to retain their full SSI benefits for a period up to 3 full months.~~ No extension beyond the 3 months will be allowed.

When aware of the extension of SSI benefits for facility applicants/recipients, the ~~caseworker~~eligibility worker will totally disregard the SSI benefits for determination of facility eligibility and vendor payment. If the applicant/recipient has income from any other source (e.g. VA, SSA, RR Retirement, etc.), that income will be included in the facility budget.

For applicants receiving the full SSI benefit (who have no other income), only a $30 personal needs allowance will be entered into the system and the remaining SSI income will be disregarded.

When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered on the income tab. The $40 personal needs allowance will be deducted from the countable income and the remaining income will be shown as NH Net Income (patient liability).

If the SSI recipient's stay in the facility actually exceeds three months, no adjustment in the budget will be required, as it remains correct.

H-421 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

MS Manual ~~01~~1/01/1~~48~~

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to make a contribution to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

If, however, the ineligible spouse/parent(s) indicates that he/she will voluntarily contribute any income, determine whether the contribution is made directly to the eligible person in the facility or directly to the facility for partial vendor payment.

Contributions made directly to the eligible person in the facility will be considered as unearned income both in determination of eligibility and in determining the net income to be applied to the vendor payment.

Contributions made directly to the facility as partial vendor payment will only be considered for the individual's share of the facility vendor payment, and will not be considered for recipient eligibility. The payment made by the ineligible spouse/parent(s) must be for covered services under the ~~LTC~~ LTSS program to be considered available to apply toward the vendor payment. Payments made by the ineligible spouse/parent(s) for special charges or additional services and items not covered by the facility vendor payment will not be considered. This includes payments made by the family of the facility recipient to the facility for the cost of a private room.

Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different

ways that the contributions may be considered. The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given. Any questions that the ineligible spouse/parent(s) has regarding the effects of a specific action will be answered.

Non-voluntary contributions can only be effected by court order, and only considered when actually paid by the ineligible spouse/parent(s). The eligible person in a facility is not required to seek support from the ineligible spouse/parent(s) to remain eligible for facility care.

H-430 Earnings of ICF/IID Facility Residents

MS Manual ~~07/13/15~~??11/~~??~~01/18

Residents of ICF/IID facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI SPA in addition to the $40 personal needs allowance. (Refer to Appendix S.)

Nursing facility residents with earnings may be given a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Office of Long Term Care (OLTC) should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/IID residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Ten Bed ICF/IID Facilities and State Human Development Centers

   Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations~~.~~. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (e.g., federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS H-410 for consideration of earnings at certification.

2. Fluctuating Earnings

   If the earnings of ICF/IID facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

   The facility administrator will report to the ~~caseworker~~eligibility worker any month in which a resident's earnings exceed the SSI SPA.

   If earnings consistently stay above the SSI SPA, they may be averaged (MS E-415), provided the facility administrator will agree to report to the ~~caseworker~~eligibility worker:

   a. every 6 months when earnings are fairly stable, or

~~a.~~b. more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than $15 above the computed average.

H-440 Effective Eligibility Dates for ~~LTC~~ Nursing Facility and ICF/IID Services

MS Manual ~~07/13/15~~~~??~~11/~~??~~01/18

The effective date of eligibility of an applicant for ~~LTC~~ nursing facility and services in an ICF~~-~~/~~MR~~ IID depends on three factors:

1. Date of Entry - The individual's date of entry into a participating facility is indicated on the DCO-702, Notice of Admission, Discharge or Transfer ~~From~~ from ~~A~~ a Facility, which is completed by the facility and forwarded to both the Office of Long Term Care and the ~~county office~~County Office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity - Medical necessity is determined by the Office of Long Term Care. The medical necessity decision is transmitted to the ~~county office~~County Office and the facility by the DHS-704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-704 is received by the ~~county office~~County Office on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/IID facility or was subject to PASARR, medical necessity begins on the DHS-704 decision date for ICF/IID or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.

3. Date of Categorical Eligibility - Categorical eligibility for facility care and services under the AABD criteria can be established to begin three months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, however, the begin date for Medicaid and vendor payment cannot be prior to the decision date on the DHS-704 for ICF/IID applicants or ~~PASSAR~~ PASARR date for individuals subject to PASARR.

Authorization of services cannot be made until all three factors have been met.

H-450 Approval of an Applicant Who is in a Medicare Bed

MS Manual ~~01/01/14~~??11/~~??~~01/18

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Medicaid coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized on the WNHU interface in ANSWER until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened on the WASM interface in ANSWER. Therefore, Medicaid for Medicare eligible individuals will be authorized on the WASM interface in ANSWER so that all other Medicaid covered services may be paid. The ~~caseworker~~eligibility worker will use the characteristic code of "entered LTC as Medicare" on the Budget Unit characteristic tab when approving Medicaid only.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third party resource to be applied to the cost of care in a facility.

When Medicare approves an individual for skilled nursing care, the facility should notify the ~~caseworker~~eligibility worker of the Medicare admission via the DCO-702. Refer to MS H-460.

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the ~~caseworker~~eligibility worker of the change in status via the DCO-702. On the day following termination of Medicare benefits, the ~~caseworker~~eligibility worker may authorize facility services on the WNHU interface in ANSWER to be effective on that date, provided the individual continues to meet all ~~LTC~~ LTSS requirements.

H-460 When a ~~LTC~~ Nursing Facility Recipient Transitions to a Medicare Bed

MS Manual ~~07/13/15~~??11/~~??~~01/18

When an individual transitions from a Medicaid bed to a Medicare bed, the nursing facility will send the ~~county office~~County Office a DCO-702, Notice of Admission, Discharge or Transfer from a Facility, with the date of the transition.

The ~~caseworker~~eligibility worker will close the vendor payment in ANSWER by entering a vendor end date on the budget summary tab. The Medicaid portion will remain open. A notice will be sent via the DHS-707 to the recipient or authorized representative stating that the bank account or patient fund account at the facility will accumulate additional income due to the vendor payment being suspended and this could result in excess resources. A copy of the notice will be provided to the facility.

If the ~~caseworker~~eligibility worker receives notification from the facility via a DCO-702 stating that the recipient has moved back to a Medicaid bed, a resource assessment must be done prior to reopening the vendor portion of the case.

H-470 Quality ~~Control~~ Assurance Errors

MS Manual ~~01/01/14~~??11/??01/18

The amount computed as net income to be applied to the vendor payment will be subject to Quality ~~Control~~ Assurance error.

If a contribution or medical expense is deducted from gross income and the IS is not actually meeting the contribution or expense, this will be an understated liability and a dollar error.

If the contribution (or full contribution) or medical expense is not being deducted from the income, and the IS has agreed to pay the contribution, or has incurred a medical expense, this will be an overstated liability but no dollar error.

H-480 Acquisition of Additional Income and Resources

MS Manual ~~07/13/15~~??11/??01/18

The acquisition of additional income and resources by a recipient will be verified in the same manner used for determination of initial eligibility. Necessary income adjustments or closures will be entered in the eligibility system. Advance notice will be given when required for terminations of assistance or increased vendor payment liability.

Refer to: MS E-500 ~~thru~~ through E-530 and MS Section H for specific information regarding resource evaluations, changes, etc.; MS E-400 ~~thru~~ through MS E-451 for specific information regarding income treatment; and ~~MS H-410~~ MS H-404 through MS H-411 for specific information regarding the net income determination or when there is a CS.

H- 481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual ~~07/13/15~~??11/~~??~~01/18

When an ~~caseworker~~eligibility worker learns that a recipient, who does not have an Income Trust, received a lump sum benefit in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed and a new application will be required.

EXAMPLE: The ~~caseworker~~eligibility worker learns in March 2013 that the recipient received a lump sum payment in January 2013 which caused ineligibility due to excess income but, in February 2013, the recipient's income and resources were below the limits again. The case will not be closed and a new application will not be required because the recipient regained eligibility the month following receipt of the lump sum.

Case adjustments in this situation will be made as follows:

1. Case Adjustment for ~~LTC~~ LTSS Ineligibility Period - To adjust the case for the month of ineligibility, an entry should be made on the WNHU interface for the month of ineligibility. The ~~caseworker~~eligibility worker should key the start date as the first day of the month the client was income ineligible, and the stop date as the last day of the month the client was ineligible. The income amount keyed should be the total income received in the month or one dollar more than the maximum skilled care rate whichever is greater.

2. No System Case Adjustment is needed for Medicaid categories other than ~~LTC~~LTSS.

~~1.~~3. Overpayments - Overpayment reports for ~~LTC~~ LTSS and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility (Re~~-~~fer to MS Section M). If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

When the ~~caseworker~~eligibility worker has advance knowledge of lump sum payments (e.g., land rent paid annually) that will result in one month of ineligibility, procedures at MS E-410 #1 will be followed, advance notice given, and the case adjusted at the appropriate time.

H-490 Absences from Long Term Care Facilities

MS Manual ~~07/13/15~~??11/~~??~~01/18

All facilities are required to report to the ~~county office~~County Office certain recipient absences from the facility on Form DCO-702. Absences will be reported for death, discharge, and transfer. Overnight home visits and hospitalizations will not be reported. Admissions to the Arkansas State Hospital (Little Rock) will be reported as discharges (Re~~.~~fer to MS H-491).

Death or Discharge

Upon receipt of Form DCO-702 from the facility reporting the death or discharge of a recipient, the ~~county office~~County Office will initiate action to close the recipient's case. Advance notice is not required for closure due to death. The ~~county office~~County Office will:

1. Complete form DHS-707 to notify the recipient or his next of kin of the case closure or intended case closure and reason for action;

~~1.~~2. End facility services on WNHU and close case on WASM (SSI cases will be closed when notification is received from Customer Assistance that case should be closed);

~~2.~~3. Provide assistance to the next of kin in securing a deceased recipient's personal allowance funds and property (if assistance is requested).

4. Complete a DCO-734, Report of Case Closure Due To Death, for Estate Recovery purposes, and send the form to:

Arkansas Department of Human Services
Division of Medical Services
Third Party Liability
Decedents' Estates
PO Box 1437, Slot S296
Little Rock, AR 72203-1437

~~3.~~5. If the recipient had an Income Trust, complete a DCO-730, Report of Income Trust, to report the death, and send the form to Third Party Liability at the address above.~~purposes, and send to the Third Party Liability section.~~

Home Visits

A recipient receiving ~~long term care services~~Long Term Services and Supports has the right to make overnight home visits whenever he desires, provided they are consistent with his required level of care and his attending physician's orders. This includes authorized home visits during the 30 days in which institutional status is achieved.

The Office of Long Term Care (OLTC) is responsible for monitoring recipient home visits and their consistency with the patient's required level of care. For example, a skilled care patient who makes overnight home visits might require reclassification action by ~~Long Term Care~~OLTC.

Long Term ~~Care services~~Services and Supports may continue during a recipient's absence due to therapeutic home visit without regard to the cumulative number of days absent during a calendar year. However, a 14 consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than 14 days will not be reported by facilities to the ~~county office~~County Office. The date left counts as the first day of absence. When there is an indication that the recipient is expected to return to the facility within 14 days, the ~~county office~~County Office will take no action.

For home visits, which exceed 14 consecutive days, facilities will report the date left and a discharge on the 15th consecutive day of absence on the DCO-702. When there is no indication that the recipient is expected to return to the facility within 14 days of the date left, the ~~county office~~County Office will initiate action to close the case as described below:

1. Facility Care
    a. Complete Form DHS-707 to provide advance notice of Medicaid closure.
    b. Complete WNHU entry to show the End Date effective the 15th day of absence and to close on WASM for termination of Medicaid.
2. SSI Recipients
    a. Advance notice by DHS-707 is not required since their Medicaid status is based on receipt of SSI rather than ~~LTC~~ LTSS assistance.
    ~~a.~~b. Key the End Date effective the 15th day of absence for WNHU entry. SSI cases will not be keyed for closure on WASM.

Cases suspended or closed using this procedure can be reinstated without new application if the recipient returns to the facility within 90 days of the date left on home visit (~~Re.~~Refer to MS H-491).

If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.

If the individual does not reenter the facility within 90 days, the case record will be placed in closed files. A new application will be required to reopen the case.

Hospitalization

Hospitalizations will not be reported to the ~~county office~~County Office (Exception: Arkansas State Hospital admissions) by the facility, but will be reported to the claims processing agency for payment adjustments.

If a recipient dies during hospitalization, is discharged to his home or elsewhere from the hospital, or reenters another facility following hospitalization, the facility will report to the county on Form DCO-702 for appropriate ~~county office~~County Office action (Re~~.~~fer to MS H-490).

Any terminations due to death or discharge will be made effective the date of death or discharge. The number of hospital days for which the facility will be reimbursed is a determination of the claims processing agent. In all instances of termination following hospitalization, the End Date in ANSWER should coincide with the date of death or discharge shown on the DCO-702.

If the ~~county office~~County Office is notified of a transfer from the hospital to another facility, the ~~county office~~County Office will not end services.

Hospitalization at the Arkansas State Hospital (Little Rock)

All admissions to the Arkansas State Hospital (Little Rock) will be reported as a discharge by the facility on the DCO-702 to the ~~county office~~County Office.

In all cases of reported recipient absence to the State Hospital, facility services will be discontinued effective the date the recipient left the facility and will remain suspended until the recipient returns to the facility.

Cases of recipients who are absent to the State Hospital will be suspended and be maintained in the county of last facility residence for up to 60 days. For those recipients who return to the

facility within 60 days, facility services will be restarted effective the date of reentry. Cases of recipients who do not return to the facility within 60 days will be either closed or transferred to the county of domiciliary residence.

Even though nursing home services may not continue, recipients under age 21 and recipients age 65 or over may qualify for continued Medicaid assistance while at the State Hospital under the same eligibility criteria used for ~~Long Term Care Services~~LTSS eligibility. Adult Expansion Group recipients aged 19 through age 64 will qualify for continued Medicaid while at the State Hospital.

Procedures for suspending cases of recipients who have been admitted to the State Hospital are contained in the following paragraphs.

Procedures for Suspension of Cases-Arkansas State Hospital

The procedure used to suspend a case during a recipient's absence to the State Hospital depends on the recipient's aid category and whether continued Medicaid assistance is authorized. Two procedures are employed to account for differences between ages.

1. Medicaid recipients under age 21 or age 65 or over are eligible for continued Medicaid assistance while receiving inpatient psychiatric care at the State Hospital. In order to continue Medicaid assistance to these individuals without a disruption of eligibility, the ~~county office~~County Office will:

   a. End nursing home services on WNHU effective the date the recipient left the facility.

   b. Notify the State Hospital by interagency memorandum of the recipient's continued Medicaid eligibility including the recipient's name, his ten-digit Medicaid ID #, his aid category, his residence county, D.O.B., SSN, Medicare Claim # and/or other health insurer, facility left, and date he left the facility. Address correspondence to:

      Director
      Social Work Dept.
      AR State Hospital
      4313 W. Markham
      Little Rock, AR 72201

   c. Maintain the case record in the county of last facility residence until notice is received from the State Hospital by DHS-3300 of readmission to a long term care facility or of other action, or until 60 days of continuous hospitalization.

d. For recipients who return to a long term care facility prior to 60 days continuous hospitalization, reinstate ~~LTC~~LTSS services with the eligibility start date as the date of readmission. The level of care, level of care decision date, and level of care review date, if applicable, as shown on WNHU will be entered, along with current net income, NH county, and NH number. If the level of care review date has passed, a new DHS-704 is required. If the patient is readmitted to a facility other than the one left, the address will be changed on WASM, and the case record transferred on WNHU to the county where the facility is located (~~Re.~~Refer to MS H-492). (Addresses will not be changed for SSI recipients).

e. Case records of recipients who remain at the State Hospital for more than 60 days will be transferred to Pulaski South or Craighead County, and the recipient's address will be changed on WASM to that of the appropriate State Hospital. A new DHS-704 will be required before ~~Long Term Care Services~~LTSS can be reinstated when the recipient has been hospitalized for more than 60 days and subsequently reenters a long term care facility.

If a recipient is discharged from a State Hospital and does not return to a long term care facility or becomes ineligible for assistance for any other reason, the ~~county office~~County Office will initiate action to terminate assistance. Advance notice will be given on form DHS-707 where required.

SSI recipients are included in this section because the Agency cannot terminate their Medicaid status. If termination of Medicaid is required, it will be received from SSA through the State Data Exchange (SDX).

2. Adult Expansion Group recipients age 19 through 64 will be eligible for continued Medicaid assistance while in the State Hospital.

H-491 Procedure for Reactivating a Suspended Case

MS Manual ~~01/01/17~~~~22~~11/~~22~~01/18

When a recipient returns from an extended home visit, the facility will notify the ~~county office~~County Office of his return on Form DCO-702. To reactivate the suspended or closed case, the ~~County Office~~County Office will:

1. Facility Care
    a. Verify institutional status.

b. Complete reevaluation, if due.

c. Verify current income.

d. Verify patient classification, the level of care decision date, and a future level of care review date, if applicable, by requesting DHS-704 from OLTC, if a current DHS-704 is not on file.

e. Reopen Medicaid on WASM and reopen facility services on WNHU with the Nursing Facility (NF) county, NF number, patient classification, level of care decision date, level of care review date, if applicable, NF eligibility start date, NF net income, income start date, and any budget changes entered.

2. SSI Recipients

a. Complete reevaluation, if due.

b. Verify current income.

~~b.~~c. Verify patient classification, level of care decision date and a future level of care review date, if applicable, by requesting DHS-704 from OLTC if a current DHS-704 is not on file.

~~c.~~d. Reopen facility services on WNHU with the NF County, NF Number, patient classification, level of care decision date, level of care review date, if applicable, NF eligibility start date, NF net income, income start date and any budget changes entered. Update WNHU prior to WASM.

~~**Hospitalization**~~

~~Hospitalizations will not be reported to the county office (Exception: Arkansas State Hospital admissions) by the facility, but will be reported to the claims processing agency for payment adjustments.~~

~~If a recipient dies during hospitalization, is discharged to his home or elsewhere from the hospital, or reenters another facility following hospitalization, the facility will report to the county on Form DCO-702 for appropriate county office action (Re. MS H-490).~~

~~Any terminations due to death or discharge will be made effective the date of death or discharge. The number of hospital days for which the facility will be reimbursed is a determination of the claims processing agent. In all instances of termination following hospitalization, the End Date in ANSWER should coincide with the date of death or discharge shown on the DCO-702.~~

~~If the county office is notified of a transfer from the hospital to another facility, the county office will not end services.~~

~~**Hospitalization at the Arkansas State Hospital (Little Rock)**~~

~~All admissions to the Arkansas State Hospital (Little Rock) will be reported as a discharge by the facility on the DCO-702 to the county office.~~

H-400 Post Eligibility

Mark-up

H-491 Procedure for Reactivating a Suspended Case

~~In all cases of reported recipient absence to the State Hospital, facility services will be discontinued effective the date the recipient left the facility and will remain suspended until the recipient returns to the facility.~~

~~Cases of recipients who are absent to the State Hospital will be suspended and be maintained in the county of last facility residence for up to 60 days. For those recipients who return to the facility within 60 days, facility services will be restarted effective the date of reentry. Cases of recipients who do not return to the facility within 60 days will be either closed or transferred to the county of domiciliary residence.~~

~~Even though nursing home services may not continue, recipients under age 21 and recipients age 65 or over may qualify for continued Medicaid assistance while at the State Hospital under the same eligibility criteria used for Long Term Care Services eligibility. Adult Expansion Group recipients aged 19 through age 64 will qualify for continued Medicaid while at the State Hospital.~~

~~Procedures for suspending cases of recipients who have been admitted to the State Hospital are contained in the following paragraphs.~~

~~**Procedures for Suspension of Cases-Arkansas State Hospital**~~

~~The procedure used to suspend a case during a recipient's absence to the State Hospital depends on the recipient's aid category and whether continued Medicaid assistance is authorized. Two procedures are employed to account for differences between ages.~~

1. ~~Medicaid recipients under age 21 or age 65 or over are eligible for continued Medicaid assistance while receiving inpatient psychiatric care at the State Hospital. In order to continue Medicaid assistance to these individuals without a disruption of eligibility, the county office will:~~

   a. ~~End nursing home services on WNHU effective the date the recipient left the facility.~~

   b.a. ~~Notify the State Hospital by interagency memorandum of the recipient's continued Medicaid eligibility including the recipient's name, his ten-digit Medicaid ID #, his aid category, his residence county, D.O.B., SSN, Medicare Claim # and/or other health insurer, facility left, and date he left the facility. Address correspondence to:~~

      ~~**Director**~~
      ~~**Social Work Dept.**~~
      ~~**AR State Hospital**~~

~~4313 W. Markham~~
~~Little Rock, AR 72201~~

~~c.a. Maintain the case record in the county of last facility residence until notice is received from the State Hospital by DHS-3300 of readmission to long term care or of other action, or until 60 days of continuous hospitalization.~~

~~d.a. For recipients who return to long term care prior to 60 days continuous hospitalization, reinstate LTC services with the eligibility start date as the date of readmission. The level of care, level of care decision date, and level of care review date, if applicable, as shown on WNHU will be entered, along with current net income, NH county, and NH number. If the level of care review date has passed, a new DHS-704 is required. If the patient is readmitted to a facility other than the one left, the address will be changed on WASM, and the case record transferred on WNHU to the county where the facility is located (Re. MS H-492). (Addresses will not be changed for SSI recipients).~~

~~e.a. Case records of recipients who remain at the State Hospital for more than 60 days will be transferred to Pulaski South or Craighead County, and the recipient's address will be changed on WASM to that of the appropriate State Hospital. A new DHS-704 will be required before Long Term Care Services can be reinstated when the recipient has been hospitalized for more than 60 days and subsequently reenters long term care.~~

~~If a recipient is discharged from a State Hospital and does not return to long term care or becomes ineligible for assistance for any other reason, the county office will initiate action to terminate assistance. Advance notice will be given on form DHS-707 where required.~~

~~SSI recipients are included in this section because the Agency cannot terminate their Medicaid status. If termination of Medicaid is required, it will be received from SSA through the State Data Exchange (SDX).~~

~~2.1. Adult Expansion Group recipients age 19 through 64 will be eligible for continued Medicaid assistance while in the State Hospital.~~

H-492 Transfer

MS Manual ~~07/13/15~~??11/??01/18

H-400 Post Eligibility

Mark-up

H-492 Transfer

Upon receipt of a DCO-702 from a facility indicating a transfer of a patient from one facility to another, the ~~caseworker~~eligibility worker will:

1. Complete the address change, NH number and NH county code (if different) in the eligibility system. See note below for SSI address changes. Do not enter NH Eligibility Start or End Dates on WNHU with a transfer action.

~~1.~~2. Complete Sections I, II (Date to be Reviewed, only), and III of a blank DHS-704, mail the original to the receiving facility and file a copy in the case record.

A patient may not be transferred from one facility to another within a chain of facilities without approval of the patient (or his responsible relative or guardian where necessary) and the approval of the Office of Long Term Care.

NOTE: For transfer of SSI cases from one facility to another, no address change will be entered on WASM, but the NH number and NH county code (if different) will be entered on WNHU.

Resident of Human Development Center

When transfer from an Arkansas Human Development Center to a nursing facility is required, the following procedures apply:

1. The Center Administrator or designee should contact the ~~county office~~County Office to request assistance in locating a facility if necessary.

2. If a facility has already been selected by the center, the name of the resident, the name of a family member or responsible person, the name and address of the facility, and the effective date of transfer will be given to the ~~county office~~County Office on form DCO-702.

~~1.~~3. Upon receipt of the DCO-702 indicating transfer, change the address, the NH number and NH county (if different) in the eligibility system. Do not enter NH Eligibility Start or Stop Dates on WNHU with a transfer action.

~~2.~~4. The ~~county office~~County Office will complete Sections I, II (Date to be Reviewed, only - when applicable) and III of a blank DHS-704, mail the original to the receiving facility and file a copy in the case record.

Mark-up

H-493 Operations Plan - Relocation of Recipients

NOTE: OLTC has policy and procedures for allowing HDC patients to recuperate at the Conway HDC in certain instances when medically prescribed. The practice does not require transfer of the case record, as the recuperation period is for a limited number of days.

H-493 Operations Plan - Relocation of Recipients

MS Manual ~~01/01/16~~??11/??01/18

This Plan describes procedures for relocation of Agency recipients in facilities which are closed for any reason other than a disaster. Such reasons include: decertification by the federal government or the Division of Medical Services, loss of licenses, voluntary withdrawal from the Medicaid Program, or cancellation of agreement by the Division of Medical Services. Since federal regulations require all program recipients to be relocated within 30 days of the termination date, it is essential that specific procedures be established to insure that recipients are relocated with maximum safety and well-being.

The Office of Long Term Care of the Division of Medical Services will initiate all relocation actions. OLTC Personnel will provide written notification to the facility, ~~DAAS Assistant~~LTSS Area Director, ~~county office~~County Office, data processing, accounting section, and the claims processing agent advising of the 30 day advance notice, the date relocation of recipients will begin, and the final date for vendor payment. A representative of OLTC will make personal contact with facility personnel to explain the Agency purpose and to arrange for necessary relocation action. Health personnel (nurses and physicians) assigned to the Office of Long Term Care will be responsible for evaluating the physical condition of all recipients to insure they are physically capable of being relocated without serious consequences to their health condition.

Authority to initiate, direct and monitor all relocation actions is delegated to the Assistant Director of the Office of Long Term Care, by the Director of the Division of Medical Services.

H-494 Relocation Procedures

MS Manual ~~01/01/16~~??11/??01/18

The following procedures are applicable to designated elements of the Agency. It is essential that all personnel involved in the relocation of recipients observe these procedures and insure that maximum effort is directed toward the orderly and safe relocation of all recipients. Patient safety and well-being will be of primary concern at all times.

1. Office of Long Term Care

H-400 Post Eligibility

Mark-up

H-494 Relocation Procedures

The Office of Long Term Care will initiate non-disaster relocation actions as follows:

a. Notify the facility, ~~DAAS Assistant~~LTSS Area Director, and ~~county office~~County Office of agreement cancellation.

b. Allow 30 days for the orderly relocation of all recipients.

c. Identify and maintain a list of facilities, by classification, with vacancies.

d. Provide vacancy data to the appropriate ~~county office~~County Office.

e. Make personal contact with the facility administrator/owner(s), and attending physicians to explain the purpose and actions involved in relocation of recipients.

f. Alert the Division of Aging and Adult Services that their assistance may be needed.

g. Provide Agency representatives to assist with inventory of personal effects and allowance and to instruct the facility to transfer these items with the recipient.

h. Provide medical personnel (nurses and physicians, if required) to evaluate the physical status of each recipient to insure the individual's safety during the relocation.

i. Coordinate with receiving facilities to insure they are prepared to accept incoming recipients.

j. Provide maximum assistance to ~~county office~~County Offices to insure all relocation actions are accomplished in an orderly and timely manner.

k. Provide weekly status reports to the Director, Division of Medical Services, and to the ~~DAAS Assistant~~LTSS Area Director.

l. Coordinate with the ~~county office~~County Office, data processing section, accounting section, and claims processing agent to insure that case records, payments and Medicaid cards are transferred in conjunction with recipients.

2. ~~County Office~~County Office

Upon receipt of written notification that an agreement will be cancelled and relocation action will be implemented, the ~~county office~~County Office will:

a. Give priority attention to all relocation actions.

b. Identify all recipients in the facility.

c. Provide the Office of Long Term Care with a list of applicants who reside in the facility but who are not yet certified.

d. Provide casework services to recipients and families. This will include:

1) Interviewing recipients and families to explain the reason for relocation, obtain a preference for a new facility or area of the state and match the preference facility or area against vacancy lists.

2) Contacting the new facility and setting a date for receiving recipients. Request the new facility to provide transportation, if available. If not, request local Area Agency on Aging to provide transportation. If unsuccessful in either case, request transportation assistance from the Central Office, Office of Long Term Care.

3) Insuring that ambulance service is provided when indicated by OLTC.

e. Insure that the sending facility submits a discharge on form DCO-702 for each recipient.

f. Enter the new county code for each transferred recipient in ANSWER. (~~Re.~~Refer to MS H-492).

g. Submit a report of completed action to the Assistant Director, Office of Long Term Care.

h. If relocation is declined, insure that the recipient, a family member, or responsible person, specifies in writing that he does not desire relocation to another facility.

i. Use form DHS-707 to advise all recipients, family, or responsible person(s) declining relocation to another facility that long term care payment will be discontinued.

j. After advance notice period, take immediate action to close those cases of clients who decline relocation, and submit appropriate documents to the terminal operator and recipients.

k. Contact all recipients who are out of the facility because of hospitalization or home leave to ascertain their relocation preferences. Contact the attending physician for hospitalized recipients and obtain his approval for discussing relocation actions prior to talking with the recipient. If the attending physician recommends against discussing this action until a later time, follow-up actions will be insured at a later date. Request the hospital to give notice prior to discharging the recipient or when the recipient expires.

l. Priority will be given to hospitalized recipients for relocation in the local area.

3. The Facility

The facility will be requested to provide maximum assistance to include the following:

~~m.~~a. Provide full cooperation with all Agency personnel.

~~n.~~b. Make available all records to Agency personnel.

~~o.~~c. Transfer personal belongings and allowances with each recipient.

~~p.~~d. Provide the receiving facilities a copy of the most recent DHS-704, and a discharge plan for each recipient.

~~q.~~e. Insure maximum assistance is provided in all relocation actions.

~~r.~~f. Insure that all Agency recipients are identified and relocated in an orderly and timely manner.

~~s.~~g. Submit a DCO-702 for each recipient to the ~~county office~~County Office and Office of Long Term Care, Central Office.

~~t.~~h. Within seven (7) days after the last recipient has been relocated, submit a final adjustment form to show all recipients (relocated, deceased, hospitalized, or on home leave during the 30-day relocation period).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

- An annual cap equal to the amount of the current transfer of assets divisor, which is the average Medicaid monthly payment amount for nursing facility services.
- Amounts owed to the facility for a period prior to eligibility, are not allowed.
- Must be incurred no earlier than the three-month period preceding the month of application.
- The expense was not used to gain eligibility in a Medically Needy Spend Down.
- The non-covered expenses must be prescribed by a Medical professional (e.g., a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic/elective procedures (e.g., face lifts or liposuction) will not be allowed.
- Amount is the least of the fee recognized by Medicaid, Medicare, or other third-party payers.
- Expenses incurred as a result of the imposition of a transfer of assets penalty, are not allowed.
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, are not allowed.
- Deduction is not allowed for procedures allowed by Medicaid when prior authorization is denied.
- Expenses which would be covered by a third party (including Medicaid), even if provided by an out-of-network provider, are not allowed.
- General health insurance premiums paid by someone other than the recipient (e.g., community spouse), are not allowed.
- Non-assignable health insurance premiums, including disease specific policies, are not allowed.
- Premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies, are not allowed.
- Prescriptions when Medicare Part D coverage was dropped voluntarily, are not allowed.

~~**October 1, 1989**~~ **November 1, 2018**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID
FOR SPOUSAL IMPOVERISHMENT REQUIREMENTS

~~For individuals covered under Section 1924, Arkansas has imposed no limits.~~

- An annual cap equal to the amount of the current transfer of assets divisor, which is the average Medicaid monthly payment amount for nursing facility services.
- Amounts owed to the facility for a period prior to eligibility, are not allowed.
- Must be incurred no earlier than the three-month period preceding the month of application.
- The expense was not used to gain eligibility in a Medically Needy Spend Down.
- The non-covered expenses must be prescribed by a Medical professional (e.g., a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic/elective procedures (e.g., face lifts or liposuction) will not be allowed.
- Amount is the least of the fee recognized by Medicaid, Medicare, or other third-party payers.
- Expenses incurred as a result of the imposition of a transfer of assets penalty, are not allowed.
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, are not allowed.
- Deduction is not allowed for procedures allowed by Medicaid when prior authorization is denied.
- Expenses which would be covered by a third party (including Medicaid), even if provided by an out-of-network provider, are not allowed.
- General health insurance premiums paid by someone other than the recipient (e.g., community spouse), are not allowed.
- Non-assignable health insurance premiums, including disease specific policies, are not allowed.
- Premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies, are not allowed.
- Prescriptions when Medicare Part D coverage was dropped voluntarily, are not allowed.