ARKANSAS REGISTER

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Room 017
Little Rock, AR 72201-1094

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Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Joie Wallis

Statutory Authority for Promulgating Rules AR Code Ann. 25-15-201 et seq. and AR Code Ann. 20-76-201 et seq.

Intended Effective Date

- ☐ Emergency
- ☐ 20 Days After Filing
- ☒ Other

July 1, 1997

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Reviewed by Legislative Council	
Adopted by State Agency	7-1-97

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

Director, Division of County Operations
Title

April 21, 1997
Date

SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS

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NOTICE OF RULE MAKING

Pursuant to Title 42, Code of Federal Regulations, 435.725 (c) (1), the Director of the Division of Medical Services and the Director of the Division of County Operations within the Department of Human Services issues proposed rules to establish the Personal Needs Allowance for Medicaid residents of institutions (Nursing Facilities and ICFs/MR) at $40.00 per month effective July 1, 1997. This is an increase from the current $30.00 per month to $40.00 per month. The estimated increase in annual expenditures is $1,632,000 for Nursing Facility and ICF/MR residents.

Copies of the proposed changes may be obtained by writing the Office of Long Term Care, P.O. Box 8059, Slot 400, Little Rock, Arkansas 72203-8059 and/or Division of County Operations, P.O. Box 1437, Slot 1223, Little Rock, Arkansas 72203-1437. All comments must be submitted in writing within 30 days following the date of this newspaper notice.

Ray Hanley, Director
Division of Medical Services
Roy Hart, Director
Division of County Operations
PO #7000013298
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STATE OF ARKANSAS
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MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[X] Policy [ ] Form [ ] Policy Directive Issuance Number MS 97-5

Medical Services Policy Manual Issuance Date 07-01-97

From: Roy Hart, Director Expiration Date Until Superseded

Subj: Revised Policy

Pages to be Removed	Dated	Pages to be Added	Dated
MS 3000 - 3135	11-01-95	MS 3000 - 3135	11-01-95
MS 3140 - 3160	11-01-95	MS 3140 - 3160	07-01-97
MS 3336.9 - 3336.9	11-01-95	MS 3336.9 - 3336.9	11-01-95
MS 3336.9 - 3336.9	11-01-95	MS 3336.9 - 3336.9	07-01-97
MS 3338.2 - 3338.3	11-01-95	MS 3338.2 - 3338.3	07-01-97
MS 3338.3 - 3338.3	11-01-95	MS 3338.3 - 3338.3	11-01-95
MS 3338.7 - 3338.7	11-01-95	MS 3338.7 - 3338.7	07-01-97
MS 3338.7 - 3338.10	11-01-95	MS 3338.7 - 3338.10	11-01-95
MS 3341 - 3341	11-01-95	MS 3341 - 3341	07-01-97
MS 3341 - 3342	11-01-95	MS 3341 - 3342	07-01-97
MS 3342 - 3343.1	11-01-95	MS 3342 - 3343.1	07-01-97
MS 3343.1 - 3344.1	11-01-95	MS 3343.1 - 3344.1	07-01-97
MS 3350.5 - 3352	11-01-95	MS 3350.5 - 3352	07-01-97
MS 3400 - 3400	11-01-95	MS 3400 - 3400	07-01-97
MS 3400 - 3400	11-01-95	MS 3400 - 3400	07-01-97
MS 3400 - 3401	11-01-95	MS 3400 - 3401	07-01-97

Summary of Changes

The personal needs allowance (PNA) for most nursing facility recipients has increased to $40.00 per month, effective July 1, 1997. Recipients whose only income is SSI will continue to have their monthly payment reduced to $30.00, and will be allowed to keep this amount as their PNA. Veterans whose VA pensions are reduced to $90.00 will continue to receive this as their PNA.

Inquiries to: Terri Wright, 682-8258
Ann Dawson, 682-8254
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3000 Guidelines for the Long Term Care Program and Other AABD Categories

3100 General Information

3110 Facilities Which Provide Services

Facilities which provide medically necessary care and services 24 hours per day on a long term basis include private nursing facilities, Benton Services Center, Arkansas Human Development Centers, private intermediate care facilities for the mentally retarded (ICF/MR's), and ICF/MR facilities with both over and under 15 beds.

3120 Services Provided Under Medicaid

In addition to facility vendor payments, all services listed in the pamphlet, "Your Guide to Medicaid Services in Arkansas", are available to individuals under the Long Term Care Program, with the following exception: Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.

3130 Licensing and Classification of Facilities

To receive vendor payment under the Medicaid Program, a facility must be licensed and certified by the Office of Long Term Care (OLTC), and must execute a provider agreement with the Division of Medical Services.

The OLTC publishes a directory listing all participating facilities. Changes to the directory are issued periodically. The directory and updates are provided to each county office.

3135 Nursing Facility

Section 1919 (a) of the Social Security Act defines a nursing facility as an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care,
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- Health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases.

* 3140 Personal Allowance for Facility Residents

Each recipient in a facility is allowed to retain $40.00 per month from their income for personal expenses. (EXCEPTION: Recipients whose only income is SSI will have their monthly payment reduced to $30.00. They are allowed to keep this amount as a personal allowance.) Upon written authorization of a resident, the facility must hold, safeguard and account for the personal funds of the resident deposited with the facility. If the resident's personal funds are in excess of $50.00, the facility must deposit the funds in excess of $50.00 in an interest bearing account (or accounts), separate from any of the facility's operating accounts, that credits all interest earned on the resident's account to his or her account. Resident personal funds may not be commingled with facility funds or with any person's funds other than another resident. The resident's individual financial record must be available on request to the resident or his legal representative.

In addition to the $40 personal needs allowance, ICF/MR customers who have income from employment are allowed to keep up to $100 of their earnings each month for personal needs.

A customer with earnings and receiving intermediate care in a nursing facility may also keep up to $100 increased personal needs allowance if the customer's physician has stated that a period of employment activity is necessary as a therapeutic or rehabilitative measure. If a customer receiving skilled care in a nursing facility becomes employed, the Utilization Review Section of the OLTC should be contacted and requested to reevaluate medical necessity.

Certain SSI recipients whose stay in a nursing facility is not expected to exceed 3 months and who have a home to maintain will be allowed to retain full SSI benefits for personal expenses for three calendar months following the month of entry. The SSI payment, in these instances, will not be considered in eligibility or payment determination (Re. MS 3401).

A $90 personal needs allowance will be given to a single veteran receiving a VA pension in a facility who has no spouse or dependent children. A veteran's surviving spouse who has no dependents and who receives a VA pension will also be given a $90 allowance. The full $90 allowance will be allowed only when VA has reduced the pension to $90. (Re. MS 3348.1). Veterans receiving VA compensation do not qualify for the $90 PNA.

3150 Special Charges to Recipients in Facilities

The facility must inform the patient prior to or at the time of admission or application, and during his stay, of services available in the facility and of related charges, including charges for services not covered by Medicare or the per diem rate. Recipients may be charged only for optional services (services not necessary or consistent with the normal care of the patient). When such services are provided, documentation must be on file with the OLTC. The refusal of a recipient to accept optional services offered by a facility must not effect a decrease or alteration in the services required or necessitated by his condition or otherwise considered as normal care. Inquiries from recipients or family members concerning special charges will be referred to the OLTC.

3160 Nondiscrimination

The Division of County Operations complies with all provisions of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans With Disabilities Act of 1990. All facilities authorized to participate in the LTC program must also comply with these provisions. No person

5. Review by the Office of Chief Counsel

Prior to certification of eligibility, the county worker must submit the trust document to the Office of Program Planning and Development, Slot 1220, for review by the Office of Chief Counsel (OCC), to obtain an opinion that the trust document meets the requirements of a valid income trust in Arkansas.

6. Fees and Other Disbursements

CASES CERTIFIED PRIOR TO 11/1/95

A monthly fee may be paid out of the trust for the services of the trustee. A fee greater than the prevailing institutional charge may not be paid to an individual who is serving as trustee.

Other allowable disbursements from the trust may include monthly bank service charges, preparation of income tax returns for the trust, income taxes owed by the trust, and attorney's fees for preparation of the trust.

Trusts certified prior to 11/1/95 may continue to allow these distributions, as initially established. HOWEVER, NO INCREASES OVER THE INITIAL AMOUNTS ESTABLISHED WILL BE ALLOWED.

CASES CERTIFIED 11/1/95 AND LATER

Effective for cases certified for services 11/1/95 and later, fees for trustees (including trustee fees for banks), preparation of income tax returns and attorneys WILL NOT BE ALLOWED AS DISTRIBUTIONS FROM INCOME TRUSTS. THE ONLY FEES ALLOWED WILL BE THE BANK SERVICE CHARGES FOR MAINTAINING THE BANK ACCOUNT.

7. Trustee Responsibilities

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

Prior to any distribution from the trust, the trustee must notify the county 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, and the advance notice must be made no later than the month which precedes the month in which the disbursements will be made.

No disbursements of any kind can be made by the trustee until the trustee has been provided a current Post Eligibility Income Worksheet, DCO-712, completed by the county worker in charge of the case.

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

Payments must be made from the trust each month, during the first week of the month, and only in the amounts specified on the DCO-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 noncovered 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-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 county worker of such changes. Changes to be reported include income changes, increase or decrease of cost of noncovered medical expenses, recipient dies or leaves the facility, community spouse enters a facility, etc.

The trustee must notify the county worker if in any month the funds are not disbursed according to the DCO-712 or if the balance in the trust account exceeds the maximum allowed as specified in Number 11 below so that the worker can adjust the facility payment(s) for the month(s) in which the vendor payment is affected.

8. 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 $1500 net countable monthly income. For post eligibility purposes, the calculations will begin with $1500. The PNA, the spousal/dependent allowances (if applicable, but not in amounts greater than the maximum allowed on the DCO-712), and noncovered 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 county worker will be responsible for providing the trustee and the recipient or his representative with a copy of the DCO-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-712 mandated by the spousal laws.

9. Begin Date of Eligibility

Eligibility for facility care shall not be retroactive to the month which precedes the month of establishment of the trust. Eligibility may begin on the first day of the month in which the trust is established, provided that the individual's income has been placed in the trust that month, that no funds have been disbursed from the trust prior to certification during that month and that the individual is otherwise eligible. If funds have been disbursed from the trust during the month of establishment of the trust and prior to authorization of disbursements by the DCO-712, eligibility cannot begin until the first of the month following the month of establishment of the trust.

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

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.

3338.3 Determination of Nursing Home Net Income

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. Amounts will be rounded to the nearest dollar (Round 50¢ up). These amounts will be deducted from the IS's gross income, in the following order:

* 1. The $40.00 personal needs allowance.

2. The Community Spouse Monthly Income Allowance (CSMIA), which is determined by:

   a. Computing The Excess Shelter Allowance in Section 3a of the DCO-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 3b of the DCO-712 to the Excess Shelter Allowance. The total CSMNA amount may not exceed the maximum indicated on the Form DCO - 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 (Re. MS 3338.5). 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. MS 3338.7).

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 be not subject to the limit on the CSMNA.

3. A Family Member Allowance (FMA) for each 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 4 of the DCO-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. MS 3338.4).

   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.

4. Monthly noncoverable medical expenses of all facility recipients which are not subject to payment by a third party (including Medicaid). 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.

   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.

   Deduction of medical expenses is not allowed for nursing facility and ICF/MR 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, bandaids, bandages, peroxide, antiseptics, etc. Facilities are required to provide these items and services at no additional charge to the recipient.

such spouse is entitled to a hearing, if application has been made on behalf of the IS.

Any hearing regarding the determination of the CS's resource allowance shall be held within 30 days of the date of the request for the hearing.

REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE

Ifit is established that the CS needs income above the level provided by the minimum monthly maintenance needs allowance (CSMNA) due to exceptional circumstances resulting in significant financial duress, a greater allowance may be substituted by a hearing officer, but only to the extent the IS is willing to make the IS's income available to the CS.

"Exceptional circumstances resulting in extreme financial duress" are defined as circumstances other than those taken into account in establishing the maintenance standards for the CS, such as unreimbursed medical expenses or household repair and maintenance for which the income allowance calculated by the county worker on the DCO-712, along with the CS's income, is inadequate to pay.

* If an income allowance greater than the one calculated by the county worker on the DCO-712 is granted by a hearing officer, the greater amount cannot exceed the current maximum, as shown on the DCO-712. For example, in 1997 the maximum CSMNA is $1976. A CS's CSMNA computed on the DCO-712, based on rent and utilities, is $1400. The CS's income is $800 a month, and the IS is allowed to give the CS $600 per month, giving the CS a total of $1400. The CS establishes that her monthly expenses are $2000, due to exceptional circumstances. A hearing officer may allow the IS to give the remainder of the IS's income, if any, to the CS (excluding the $40 PNA). If the IS has $576 additional income, it may be given to the CS to bring the CS's income up to the maximum CSMNA ($800 + $600 + $576 = $1976, the maximum allowed). No additional amount can be granted to raise the CS's total income to $2000, because $2000 is over the maximum.

REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE

* If an IS is willing to contribute all of the IS's monthly income (less the $40 PNA) to the CS and the CS still does not have enough monthly income to raise the income to meet the needs of a CS when financial duress exists, a hearing officer may change the CS's resource allowance to bring the CS's income up to the maximum CSMNA. Any additional resources attributed to the CS must be income producing, otherwise the resources would not serve to increase the CS's income. In determining an increased resource allowance, no resources can be transferred which, along with the CS's other income (including the income from the IS) would generate total income to the CS in an amount greater than the current maximum CSMNA limit shown on the DCO-712.

If a greater CSMIA is awarded by a hearing officer due to extreme financial duress, the county may:

- Request the hearing officer to reopen and review the case when the county has reason to believe the exceptional circumstances no longer exist;

- Have the hearing officer schedule future hearings to review the circumstances and determine if financial duress still exists; and

- Monitor the case(s) to assure that exceptional circumstances still exist, and make adjustments when indicated.

3338.8 Certification

The procedures in MS 3400 will be followed in certifying the applicant for facility services. The sum of the CSMIA, FMA, and noncovered medical expenses will be entered in the Protected Maintenance Field of WNHU. The amount of the IS's income remaining after deduction of all allowances (the sum of the CSMIA, FMA, noncovered medical expenses, and the personal needs allowance) will be entered in the Nursing Home Net Income field.

Each Form DCO-86 and EMS-87 for IS's who have a CS will be marked in red in the upper right corner to assist in identifying these cases.

3338.9 Changes

The IS, CS, representative, and family members will be advised to report any changes in income, shelter costs, or medical expenses while the IS remains in the facility. Any of these changes will affect the amount that the IS is required to contribute toward the facility vendor payment.

The county office will not be required to make monthly adjustments to the net income. If the county has elected to project income and expenses for a period of six months (Re. MS 3338.4), the case will be flagged through WALR or DCO-87 for a net income adjustment, if necessary, at the end of the six month period. Adjustments must be made sooner than six months if changes are expected or reported.

A full reevaluation (completed DCO-777, etc.) will not be necessary at the six month review. Only changes in income, shelter costs, and expenses will be reverified, if reported as changed, and a new DCO-712 will be completed.

When the IS, CS, or individuals receiving an FMA are affected by the annual Cost of Living Adjustment made by SSA, the SSA income amount of each individual whose needs are included in the calculation of the Nursing Home Net Income Amount must be recomputed to determine if the allowance or the net income changes.

Each time the CSMIA, FMA, noncoverable medical expense deduction, or Nursing Home Net Income is adjusted, the reverse side of the DCO-712 will be completed and signed by the IS or representative, declaring that the IS intends to provide the CSMIA and FMA for the support of the CS and family members (or that the CS refuses to take the allowance). The CSMIA and FMA will only be deducted to the extent contributed by the IS.

Each time a DCO-712 is completed, a copy of the DCO-712 will be provided to each spouse.

3338.10 Retroactive Adjustments

When the county discovers that the income of an IS, CS, or other family member has changed, that the maintenance needs of the CS have changed, or that uncovered medical expenses have changed (any change that affects the net income applied to the cost of facility services), the retroactive fields of WNHU will be used to adjust the net income for retroactive periods.

in the advance notice that the case will be closed and that a new application will be required to reopen the case.

Anticipated income changes that will not result in case closure may be entered in WNHU no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the Medicaid claims processing agent (Re. DCOUM 3723 for procedure). The customer or his representative should be notified of his increased vendor payment responsibility by DCO-700 at least ten days prior to input of the change.

2. Irregularly Received Nonmonthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received (Re. DCOUM 3722, 3723, and 3724). The recipient or person acting on his behalf must be fully advised by DCO-700 of the amount of his vendor payment responsibility in these cases. Every effort should be made to anticipate nonmonthly income receipts so that advance action can be taken as specified under #1.

   As with regularly received nonmonthly income, if benefits will be terminated for only one month for receipt of irregular nonmonthly income, a new application will not be required and the customer will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS 3332.3 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

   When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. (Re. MS 3634.1 for procedures).

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer account. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

   Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

   In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three

if paid monthly) will be used to determine the countable monthly amount. If small interest/dividend amounts paid monthly or quarterly fluctuate slightly, counties may average and use the the average amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

* The county worker will provide the customer (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the $40 monthly allowance for personal needs is considered, the recipient will not receive the full month $40 monthly allowance unless he withdraws his interest/dividends as paid.

NOTE: Interest income (and recipient earned income) of State Human Development Centers and Benton Services Center customers will be used in determining initial eligibility, but will not be considered in determining net income. All recipient earnings and interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement.

Interest income (and recipient earned income) of customers in 10 bed ICF/MR facilities are counted in BOTH initial and posteligibility determinations, as semi-annual cost reporting is not done for these facilities.

3342 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

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 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 customer 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 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 contribution may be considered if one is made. The decision of whether to contribute or not contribute is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given to him. Any questions that the ineligible spouse/parent(s) has regarding the affects of a specific action will be answered.

Nonvoluntary 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.

3343 Determination and Verification of Earnings from Employment

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly. In cases where 5 pay periods during the month of application result in ineligibility, the application will not be denied (if otherwise eligible) but will be considered for eligibility in the following month when there will be only 4 pay periods. In ongoing cases where earnings are biweekly, the cases will be flagged (by DCO-88 or WALR) to make income adjustments on WNHU during the months when 5 paychecks are to be received.

If the earnings fluctuate, the worker will determine, by averaging or other means, an amount which fairly reflects the income actually currently available to the applicant on a monthly basis. The case narrative will clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the actual, current income available to the applicant.

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The worker will not automatically assume that one check stub accurately reflects earnings for an entire month. The latest month's verification will be required. If a person is paid weekly, then the latest 4 (or 5) consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest two check stubs will be required, and if paid monthly, then the latest check stub will be required. If the customer does not have the required verification, then verification from the employer will be required.

EXCEPTION: For cases in which applicant/recipient has just begun employment and a month's verification is not available, the county worker will compute the income from the best information available. In this instance the case will be flagged for a redetermination of earnings in the following month using full verification procedures.

3343.1 Earnings of ICF/MR Facility Residents

* Residents of ICF/MR facilities who have earned income may be given a disregard of up to $100 of their monthly earnings, in addition to the $40 personal needs allowance. The same disregard may also be given to nursing facility residents with earnings who receive intermediate care, 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 Utilization Control Committee of the OLTC should be contacted and requested to reevaluate medical necessity.

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

1. Human Development Centers and Benton Services Center

A semi-annual retrospective cost accounting of the earned income (and interest income) of residents of the Human Development Centers (Booneville, Jonesboro, Alexander, Conway, Warren, and Arkadelphia) and the Benton Services Center is processed by Central Office. When residents of these facilities with earned income have passed the gross income test for eligibility, only unearned income will be considered in determining the net income to be applied to the vendor payment. The earned income will not be considered.

2. Ten Bed ICF/MR Facilities

There is no retrospective cost accounting for residents of 10 bed ICF/MR facilities. Therefore, their earnings 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 additional $100 for personal needs. Refer to MS 3400 for consideration of earnings at certification.

3. Fluctuating Earnings

If the earnings of ICF/MR facility residents fluctuate, they may be averaged (MS 3343), provided the facility administrator will agree to report to the county:

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

b. More frequently if the customer loses employment or changes jobs, or earnings in any month rise more than $15 above the computed average.

3344 Determination and Verification of Earnings from Farm, Business or Self-Employment

Generally, it is necessary for the self-employed individual to estimate current income based on a projection from the tax return filed for the previous year and from current records kept in the regular course of business.

Because of the fluctuating nature of income receipts and self-employment expenses, current estimates for net income from self-employment will be based on the entire taxable year.

3344.1 Determining Amount of Net Earnings from Self-Employment

The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, use the first of the following

If a Medicaid recipient in a facility elects hospice care after a case has been certified by the county with a level of care code S, A, B, C, or D, the code will be system changed by OLTC, and the county will not be involved.

The county office is responsible for completing part III of the DCO-704 and distributing the DCO-704 to the appropriate parties at the time facility eligibility is authorized via the DCO-57 or DCO-765.

3351 Prompt Notice of Skilled Care Classifications

In any case that the county office cannot complete certification action promptly after the receipt of an DCO-704 which indicates a skilled care classification, the county worker will provide a machine copy of the DCO-704 to the facility where the patient is residing. This copy will be annotated with the following information at the top of the form:

"Information Copy for Utilization Control Requirements Only" and the name of the facility.

3352 Appeal of Utilization Control Committee Action

There are two types of appeal in the Utilization Control process:

1. Admission/Continued Stay Not Medically Necessary - The Utilization Control Committee will request comments and opinions from the attending physician in each case where admission/continued stay is determined not to be medically necessary. However, if the committee's decision is that continued stay is not medically necessary, this decision is final. The committee will make notification to the attending physician, the facility administrator and the county office when it has been determined that continued stay in a facility is not medically necessary.

   If the county office has a pending application, it will be denied (MS 3500).

   If the recipient has an active case, the County Office will provide advance notice of closure to the recipient and next of kin (when possible) by form DCO-700 and, at the end of the notice period, close the facility case by submitting a DCO-57 and/or DCO-765 with appropriate entries for data entry.

2. Reclassification - If the administrator and attending physician are not in agreement with the assigned level of care, they may appeal the decision within ten (10) days of receipt of Form DCO-704 (for applicants) or review report from OLTC by writing the Administrator, Utilization Control Committee, OLTC. The appeal should indicate why a reevaluation is being requested. It may be signed by the administrator or physician. The reviewing physician(s) in the OLTC will consider this information and, if warranted, the applicant/recipient will be reclassified. During the period of appeal, the facility will be paid at the rate of the latest classification. If the classification is changed by virtue of the appeal, payment adjustment will be made to the date of the previous classification.

3400 Determination of Net Income

When categorical eligibility and medical necessity have been established, the county worker will determine the amount of the individual's income that will be applied to the cost of care. Section 3 of the DCO-707 (and the DCO-712 when there is a CS) is used for the determination.

Using Section 3 of the DCO-707, determine the income to be applied to the cost of care as follows:

1. Total Earned and Unearned Income

   In Section 3, enter all income of the recipient by type and amount, with the following exception:

   State Human Development Centers (HDC) and Benton Services Center (BSC) residents - Do not enter the earned income and interest income. A semi-annual cost accounting will be made by these facilities which will take this income into consideration.

   Enter the unearned income of all recipients. Exclude VA Aid and Attendance payments and VA CME/UME, along with the interest income of HDC and BSC residents.

   From the earned income of all recipients (exclude earned income of HDC and BSC residents) deduct the actual mandatory deductions and work related expenses from gross earnings. From the earnings of 10 bed ICF/MR residents, up to an additional $100 may be deducted from earned income as a personal needs allowance.

   Total the unearned income and the net earned income and enter on Line 4.

2. Fees for Income Trusts

   For individuals whose cases were certified prior to November 1, 1995, deduct the fees which were approved - trustee fees, attorney fees, monthly bank services and preparation of income tax returns. Cases certified November 1, 1995, and later may have deducted ONLY the monthly service charges for maintaining the bank account.

* 3. Personal Needs Allowance

   a. Subtract a $40 personal needs allowance for most facility residents.

   b. Single veterans and spouses of single veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. They will not be given an additional $40. **EFFECTIVE 11/1/95, the $90 PNA will NOT BE GIVEN to any individual whose VA pension has not been reduced to $90 by VA.** If VA reduces a pension to $90, an income adjustment will be made on WNHU.

   c. For 10 bed ICF/MR residents with earned income, $40 may be given as a personal needs allowance, in addition to a disregard of earned income up to $100. The maximum disregard in these facilities for personal needs is $140.

   Effective 11/1/1995, it will NOT be the responsibility of the county to attempt to identify individuals who may be eligible for a $90 PNA or to