ARKANSAS REGISTER

Transmittal Sheet

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Department Division of County Operations

Contact Person Roy Kindle

Statutory Authority for Promulgating Rules Ark. Code Ann. 20-76-201 et Seq., and Ark. Code Ann. 25-15-201 et Seq.

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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

6/26/98
Date

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[X] Policy [ ] Form [ ] Policy Directive

Issuance Number MS 98-3

Medical Services Policy Manual

Issuance Date 04-01-98

From: Ruth Whitney, Director

Expiration Date Until Superseded

Subj: Revised Policy

Pages to be Removed	Dated	Pages to be Added	Dated
MS 2047 - 2047.2	8-1-94	MS 2047 - 2047.2	8-1-94
MS 2047.2 - 2047.3	4-1-97	MS 2047.2 - 2047.3	4-1-98
MS 2048.3 - 2048.4	4-1-97	MS 2048.3 - 2048.4	4-1-98
MS 2048.5 - 2048.6	8-1-94	MS 2048.5 - 2048.6	8-1-94
MS 2051.3 - 2051.4	4-1-97	MS 2051.3 - 2051.4	4-1-98
MS 2051.4 - 2051.5	1-1-95	MS 2051.4 - 2051.5	1-1-95
MS 2062.3 - 2062.4	4-1-97	MS 2062.3 - 2062.4	4-1-98
MS 2062.4 - 2062.6	8-1-94	MS 2062.4 - 2062.6	8-1-94
MS 2072 - 2073.2	1-1-98	MS 2072 - 2073.2	1-1-98
MS 2073.2 - 2073.3	1-1-98	MS 2073.2 - 2073.3	4-1-98
MS 2074.1 - 2074.3	1-1-98	MS 2074.1 - 2074.3	4-1-98
MS 2074.3 - 2074.5	1-1-98	MS 2074.3 - 2074.5	1-1-98
MS 2300 - 2330	9-1-97	MS 2300 - 2330	9-1-97
MS 2330	9-1-97	MS 2330	4-1-98
MS 5730 - 5740.1	4-1-97	MS 5730 - 5740.1	4-1-98
MS 5740.1 - 5740.2	5-1-94	MS 5740.1 - 5740.2	5-1-94

Summary of Changes

The 1998 Federal Poverty Level income guidelines are effective on April 1, 1998, for the following categories:

(a) Qualified Medicare Beneficiary (QMB) - Re. MS 2047.2 #7
(b) Qualified Disabled and Working Individuals (QDWI) - Re. MS 2048.3 #4
(c) Specified Low Income Medicare Beneficiaries (SMB) - Re. MS 2051.3 #7
(d) Transitional Medicaid (TM) - Re. MS 2062.3
(e) Qualifying Individuals - 1 (QI - 1) - Re. MS 2073.3 #7
(f) Qualifying Individuals - 2 (QI - 2) - Re. MS 2074.3 #7
(g) ARKids First - Re. MS 2330 #8
(h) SOBRA Pregnant Women, Infants and Children (SOBRA) - Re. MS 5730
(i) Family Planning Demonstration Waiver - Re. MS 5914 #1

Instructions for processing COLA changes for QMB, SMB, QI-1 and QI-2 cases are being issued under separate cover.

The Family Planning policy section was not updated as this section did not list specific income eligibility amounts. The related form, DCO-64, is updated to reflect correct amounts.

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2047 Qualified Medicare Beneficiaries Under the Medicare Catastrophic Coverage Act of 1988

Section 301 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, requires Medicaid buy-in of Medicare premiums and coverage of deductibles and coinsurance for Qualified Medicare Beneficiaries (QMBs) with income at or below specified percentages of the poverty level and resources at or below twice the SSI limit.

2047.1 Scope of Services

Qualified Medicare Beneficiaries under the Medicare Catastrophic Coverage Act are not eligible for the full range of Medicaid Services. QMBs are eligible only for payment of all Medicare premiums, deductibles, and coinsurance.

QMBs will not be eligible for any retroactive coverage as QMBs. Coverage of Medicare premiums, deductibles, and coinsurance will begin on the first of the month following the month of approval, where an individual is found eligible as a QMB. Individuals who apply for coverage as QMBs and who have medical expenses in prior
months may be considered in other Medicaid categories (including spend-down categories) for the retroactive coverage.

With the exception of spend-down categories, an individual may not be certified in a QMB category and in another Medicaid category for simultaneous periods. If an individual is eligible in a category other than QMB, he will be eligible for and receive the QMB benefits along with the other Medicaid benefits (Re MS 2047.8). If an individual could be eligible in either a QMB category or a non-QMB category, the individual should be approved in the non-QMB category. Example: An individual is eligible in both categories 41 and 48; the individual will be certified in category 41, but will receive full QMB benefits.

An individual may be approved for a spend-down and as a QMB for simultaneous periods. Example: An individual applies for QMB coverage and for other Medicaid categories on March 1 and has sufficient non-coverable medical bills for a spend-down period of March, April, and May. QMB coverage is approved on March 30. QMB coverage will begin April 1. For any concurrent months of QMB and spend-down eligibility, Medicare premiums may not be considered as a non-coverable medical expense.

2047.2 Eligibility Requirements

QMBs must meet the following eligibility requirements:

1. Categorical Relatedness: A QMB must be aged, blind, or disabled as specified in MS 3321 - 3323.

2. Medicare Part A Entitlement or Conditional Eligibility: A QMB must be entitled to or conditionally eligible for hospital benefits under Medicare Part A (Re. MS 2047.3). Entitled means that the individual has applied for, is eligible for, and is enrolled in Medicare Part A. Conditionally eligible means that an individual can be enrolled (entitled) for Part A Medicare only on the condition that he/she is eligible for QMB and, thus, eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits.

3. Citizenship or Alien Status: A QMB must meet the citizenship/alien status requirement as specified in MS 3324.

4. Enumeration: A QMB must meet the Social Security Enumeration requirement as specified in MS 1358.

5. Residency: A QMB must be an Arkansas resident (Re. MS 2200).

6. Resources: A QMB's countable resources may equal but cannot exceed twice the current SSI limitations (Re. MS 3310, #5). The current QMB resource standards are as follows:

Individual	$4,000
Couple	$6,000

Countable Resources are determined according to LTC guidelines (Re. MS 3330-3337). There will be no penalty imposed for transfer of resources.

* 7. Income: The QMB's monthly countable income may equal but cannot exceed 100% percent of the 1998 Federal Poverty Level.

Effective 4/1/98, the monthly income limits are as follows:

Individual	$670.83
Couple	$904.17

Countable Income is determined according to LTC guidelines (Re. MS 3340-3348). In-Kind Support and Maintenance is considered in QMB determinations. For a couple, total monthly countable income will be compared to the couple's standard in each case. If only one spouse can be a QMB, then the procedures for deeming of income in MS 2111-2111.5 will apply.

Individuals applying for QMB coverage only will not be required to apply for SSI if their income is less than the SSI SPA. If an individual does not wish to be referred to SSA and does not want to be certified for full Medicaid benefits in a non-QMB category, he may be certified for QMB coverage only.

8. Mandatory Assignment of Rights to Medical Support/Third Party Liability: Re. MS 1350.

9. CSE Referrals for Minors With Absent Parents: Re. MS 1355.

2047.3 Medicare Part A Entitlement

A QMB must be entitled to or conditionally eligible for hospital insurance benefits under Medicare Part A. Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who meet one of the following criteria:

   a. entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries; or

Verification that the individual's blindness or disability is continuing; that the individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA; that the individual has reenrolled for Medicare Part A; and the effective date of Medicare Part A coverage will be made by requesting the individual to provide any notices received from SSA. If the individual does not have the necessary verification, he/she will be instructed to obtain the needed verification from SSA. The County Office will contact SSA if the individual cannot obtain the necessary verification.

* 4. Income - Countable income cannot exceed 200% of the Federal Poverty Level. Income will be determined according to LTC guidelines (Re. MS 3340-3348).

Effective 4/1/98, the QDWI countable income limit will be:

Individual	$1,341.66
Couple	$1,808.34

5. Resources - Countable resources cannot exceed twice the SSI resource limit. Effective 7/1/90, the QDWI resource standards will be:

Individual	$4,000
Couple	$6,000

Resources will be determined according to LTC guidelines (RE. MS 3330-3337). There will be no penalty imposed for transfer of resources.

6. Social Security Enumeration - the individual must meet the Social Security Enumeration requirements specified in MS 1358.

7. Citizenship or Alien Status - the individual must meet the citizenship/alien status requirement specified in MS 3324.

8. Residency - the individual must be an Arkansas resident (Re. MS 2200).

9. Mandatory Assignment of Rights to Medical Support/Third Party Liability (Re. MS 1350).

10. Not Otherwise Eligible for Medicaid - the individual will not be eligible as a QDWI if eligibility can be established in any other Medicaid category.

Each eligibility factor will be verified by the Service Representative and documented in the case narrative.

2048.4 Income Determination

The income of an ineligible spouse will be deemed to the QDWI applicant (Re. MS 2111-2111.5) and the net income compared to the couple's QDWI limit.

The income of an eligible couple will be totaled, and SSI exclusions will be given (only one $20 exclusion). The net income for the couple will be compared to the couple's QDWI income limit.

The income of QDWI's may vary monthly due to their income from employment. MS 3343 will be utilized in the determination and verification of earnings from employment.

2048.5 Initial Enrollment Period (IEP) and General Enrollment Period for Medicare Part A

A QDWI applicant must reenroll for Medicare Part A, if he/she has not previously reenrolled prior to making application.

The Social Security Administration will send notices to those individuals who lost or will lose Medicare Part A solely due to SGA, advising them to contact the SSA office. Once reapplication has been made for Medicare Part A, SSA will refer potentially eligible individuals to the County Office to make a QDWI application.

If an individual applies at the County Office prior to reenrolling for Medicare Part A, the individual will be instructed to go to the SSA Office to reenroll for Medicare Part A and provide verification of reenrollment and the effective date of coverage.

The Individual Enrollment Period begins with the month in which the individual receives notice from SSA that his/her entitlement to Disability and Medicare will end solely due to SGA. The enrollment period ends 7 months later.

There will also be a General Enrollment Period each year from January 1 - March 31.

2048.6 Disposition and System Procedures

Approval:

If all eligibility factors have been met, and the case is approved, the Service Representative will perform the following tasks:

a. Complete Form EMS-57 for a Category 41 on WASM. When certifying an eligible couple, each will be entered on a separate EMS-57. The case will be entered in closed "C" status. An Action Type of "AF" or "BF" will be used with the appropriate Action Reason.

b. An "N" will be entered in the Client Notice Field.

c. A "9" must be entered in the Lock-in Indicator Field to identify QDWI recipients.

d. The Medicaid Begin Date will be based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A. QDWI eligibility can be effective up to 3 months prior to the date of application, if all eligibility factors were met during that 3 month period, but in no case can eligibility begin prior to July 1, 1990.

   For example, an individual applies for QDWI benefits on September 1, 1994, and the effective month of Medicare Part A is August. This individual's QDWI benefits could begin August 1, 1994.

   If, however, the individual has not reenrolled for Medicare Part A prior to making application, and his Medicare Part A entitlement will not be effective until October 1, 1994, QDWI benefits cannot be effective prior to 10/01/94.

5. Social Security Enumeration Requirement (MS 1358).

6. Resource Requirement - Countable resources may equal but cannot exceed twice the current SSI resource limitations:

Individual	$4,000
Couple	$6,000

Resources are determined according to Long Term Care guidelines (MS 3330 - 3337). No penalty will be imposed for transfer of resources.

7. Income Requirement - Countable income must be greater than (but not equal to) 100% of the current Federal Poverty Level, and less than (but not equal to) 120% of the current Federal Poverty Level (see note below).

Effective 4/1/98 these levels are:

	100%	120%
Individual	$670.83	$ 805.00
Couple	$904.17	$1,085.00

The LTC guidelines at MS 3340-3348 will be applied when determining countable income. The Supplemental Security Income Exclusions at MS 3348 will be given. Inkind Support and Maintenance will be considered, if applicable.

For couples, their combined net countable income, after all disregards and exclusions, will be compared to the couple's standard in determining the eligibility of each member of the couple. In determining eligibility for only one member of a couple, the procedures for deeming of income at MS 2111 - 2111.5 will apply.

Note: In determining eligibility each year between January 1st and April 1st for SMB applicants, the Social Security Cost of Living Adjustment (COLA) for the year will be disregarded until April 1st, i.e., an individual's or couple's SSA amount to be considered in the budget will be the amount for the previous year. The current year's SSA amounts will not be considered until April first when the new Federal Poverty Level Income limits become effective (Re. MS 2051.5).

2051.4 Period of Eligibility

A. Medicaid Begin Date

The beginning date of eligibility for payment of the Medicare Part B Premium will be the first day of the month following the month of SMB certification (i.e. completion of the DCO-57). For example, if an SMB application is certified on August 15th, the effective date of eligibility will be September 1st. Date specific eligibility will not change the effective begin date for SMB recipients.

B. Retroactive Coverage

Medicaid eligibility for SMBs cannot begin earlier than the first day of the month following the month of certification. Retroactive coverage will not be authorized for SMBs. If eligibility is to be established retroactively in another category, all eligibility requirements for that category must be met.

2051.5 Disposition and System Procedures

A. Approval - If all eligibility requirements are met, the application may be approved for SMB. The Service Representative will complete the following tasks:

1. Complete Form DCO-57 for a Category 88 approval and submit for data entry on WASM.

2. The Medicaid Begin Date entered on WASM will be the first day of the month following the month of certification.

3. In Field 49 on Form DCO-57, a unit size of one (1) will be entered for an individual applicant. For a couple, whether both members apply or not, a unit size of two (2) will be entered.

4. The current income will be entered in the appropriate fields. The total SSI exclusions will be entered in the Unearned Exclusion field, and a "Y" entered in the MU field. The current 120% FPL amount will be entered in the MNIL field. The net income will be entered in the Net Countable field. There must be a deficit of at least $.01 in the Deficit/Excess field.

5. Code Form DCO-87 for a yearly reevaluation or anticipated change.

6. Notify client of approval by Form DCO-700 or DCO-55.

B. Denial - If the applicant does not meet all the eligibility requirements, the application will be denied. The County Office Worker will complete the following tasks:

1. Record pertinent information in case narrative to verify the denial decision.

2. Complete denial data on DCO-777.

3. Notify applicant of denial by DCO-700 or DCO-55.

C. Withdrawal - If the applicant wishes to withdraw the application, a signed statement must be obtained from the applicant stating that he wishes to withdraw the application. The County Office Worker will then proceed with the steps for denying the application.

* 185% Federal Poverty Level (4/1/98)

Number in Standard	Monthly Standard
1	$1,241.03
2	1,672.71
3	2,104.37
4	2,536.03
5	2,967.71
6	3,399.37
7	3,831.03
8	4,262.71

Add $431.68/month for each additional member.

Note: The FPL is adjusted annually due to changes in the Consumer Price Index. For continuing eligibility, the average monthly gross income, as computed above, will be compared to the FPL in effect during the report month, if different from the preceding months.

If the family's average gross monthly earnings (less paid child care) do not exceed 185% of Federal Poverty Level, the family will remain eligible. The case will be documented.

If the family's average gross monthly earnings (less paid child care) exceed 185% of the FPL, the County will send a notice of closure to the family, and will key a closure to the Transitional Medicaid case on WATM and WACE with a Medicaid End Date effective the last day of the report month. Earnings that resulted in Transitional Medicaid closure will be entered in the budget section. Night Edit will convert all open members in category 25 to closed status.

2062.4 Changes in the Transitional Medicaid Period

Minor children entering the household, who were not in the budget group at the time the group became AFDC ineligible, will not be eligible for Transitional Medicaid and will not be added to the case. If an excluded child has earnings, they will not be considered in computing the family's average gross monthly earnings. The Service Representative will determine eligibility for this child in another category, counting only the child and the child's parent(s) in the unit, and considering only their income.

Minor children, who were in the home and included in the AFDC grant during the last month of AFDC eligibility, who later leave the home, will be dropped (a 10 day notice will be given). If he/she subsequently reenters the home while the family is receiving TM, he/she will be added to the Transitional Medicaid case. Any earnings that this child may have will be considered in computing the family's average gross monthly earnings.

The return of an absent parent to the home during Transitional Medicaid is not, in itself, a reason for closure (i.e., deprivation is not an eligibility factor for Transitional Medicaid). The absent parent who returns, if he/she was not in the budget group at the time of AFDC case closure, will not be eligible for Transitional Medicaid and will not be added to the case. Any earnings of the absent parent, however, will be used in computing the family's average gross monthly earnings.

If the only child in the home becomes eligible for SSI, the parent(s) (or non-parent specified relative) will remain eligible for Transitional Medicaid as long as the SSI child is under age 18. However, the County will receive a Systems Action Report notifying them that the case has been closed. The Service Representative will reopen the Transitional Medicaid case for the adults(s) by using a "B" action type and "096" action reason. The Transitional Medicaid Status on WATM will be changed to open status. The adult(s) must continue to meet all other eligibility requirements in order to remain eligible for Transitional Medicaid.

2062.5 System Closures, System Reports, and County Responsibilities

On the first workday of each month the system will search all Transitional Medicaid records for children who will reach the age of 18 that month. If the only child in the home is reaching age 18, the system will close the case and send a notice of case closure to the family. If there are other children under 18 in the home, the system will close only the 18 year old and leave the remaining individuals open.

The Counties will receive a Systems Action Report that will inform them of Transitional Medicaid 18 year olds and cases closed by the system.

When the system has closed an 18 year old, or at any time a member or a case is found ineligible for Transitional Medicaid, the County Office will make a determination and document the case record as to whether or not the ineligible member(s) meets the eligibility criteria in any other Medicaid Category (e.g., PW, MN-SD, etc.). If it appears that a member or the case would be eligible in another category, an application and notice of potential benefits will be sent to the individual(s).

The system will continue to close cases becoming AFDC ineligible due to the loss of the 1/3, or $30 earned income exclusions. A system notice will be generated to inform the individuals of Transitional Medicaid eligibility, and these cases will be converted by the system to Category 25 for Transitional Medicaid. These cases will also be listed on the Systems Action Report.

During the Additional 6 Months TM Extension Period (Second Six Months), a monthly report titled "Transitional Medicaid Cases" will be generated to the Counties to assist them in tracking the Transitional Medicaid cases. This report will list the Case Number, Casehead Name, Worker Number, Transitional Medicaid Begin Date, Current Month of Transitional Medicaid and the next month in which a Transitional Medicaid Report (DCO-124) is due.

At the end of the 12th month, the system will send a notice and close all Transitional Medicaid cases which remained open throughout both 6 month periods.

2062.6 Summary of Sequence of Notices/Reports in Transitional Medicaid

Found AFDC ineligible prospectively. Determined Transitional Medicaid eligible:

- Form DCO-123 manually issued to family.

Initial 6 months Extension Period

1st Month

- 1st month of AFDC ineligibility.

2072 County Office Responsibilities - Inpatient Psychiatric Care Referrals

The County Office is responsible for investigation and follow-up on each referral received from the State Hospital. An initial investigation will be made on all referrals to determine whether the patient is already eligible for Medicaid.

When it is determined that the patient is Medicaid eligible, a notice of the patient's eligibility status will be forwarded to the State Hospital by interagency memorandum. The notice will include the following items (if known): the recipient's name, his ten digit Medicaid ID Number, his aid category, date of birth, SSN, and Medicare Claim Number and/or other health insurer information. Correspondence will be mailed to: Director, Social Work Dept., State Hospital, 4313 W. Markham, Little Rock, AR 72201. No other action will be required for known Medicaid eligibles.

If a referred patient is not Medicaid eligible, the County Office will take steps necessary to secure and process an application for assistance in accordance with the requirements specified in MS 2071.

The State Hospital will be responsible for reporting when the patient is discharged. Discharge from the State Hospital by itself may not make the patient ineligible for Medicaid. The County Office will treat reported actions in accordance with the policies applicable to the category.

2073 Qualifying Individuals-1

Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33) created the Qualifying Individuals-1 group of Medicaid eligibles. These are individuals who would be QMBs except that their income exceeds the QMB income level, and is at least 120% but less than 135% of the Federal Poverty Level.

2073.1 Scope of Services

QI-1s will not be eligible for the full range of Medicaid benefits. QI-1s will be eligible for payment of their Medicare Part B premium only. No other Medicare cost sharing charges will be covered.

Unlike QMBs and SMBs, a QI-1 may not be certified in another Medicaid category for simultaneous periods. A QI-1 may not be approved for a spend down and as a QI-1 for simultaneous periods. An individual who is eligible for both QI-1 and spend down will have to choose which coverage is wanted for a particular period of time.

Individuals eligible for the QI-1 program will not receive a Medicaid card.

2073.2 Application Process

Application will be made on Form DCO-777 by the individual requesting assistance, his/her authorized representative, or a person acting responsibly on the applicant's behalf.

When both members of a couple apply, separate applications will be completed and registered for each individual.

Other forms to be completed during the application process are the DCO-86, DCO-662, DCO-707, and DCO-769.

Applications will be registered on WIMA in Category 58.

The county office worker will have a maximum of 45 days to dispose of the application by approval, denial, or withdrawal.

2073.3 Eligibility Requirements

To be certified as a QI-1, an individual must meet the same requirements as a Qualified Medicare Beneficiary (with the exception of income). Each eligibility requirement will be verified and documented in the case record.

1. Categorical Relatedness - A QI-1 must be aged, blind, or disabled as specified at MS 3321 - 3323.

2. Medicare Part A Entitlement - The individual must be entitled to and receiving Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance (MS 2047.3).

3. Citizenship or Alien Status - A QI-1 must meet the citizenship/alien status requirements as specified at MS 3324.

4. Residency - A QI-1 must be an Arkansas resident (Re. MS 2200).

5. Social Security Enumeration - A QI-1 must meet the Social Security enumeration requirement as specified at MS 1390.

6. Resources - Countable resources may equal but cannot exceed twice the current SSI resource limitations. The current QI-1 resource limits are:

Individual	$4,000
Couple	$6,000

Resources are determined according to Long Term Care guidelines (MS 3330 - 3337). No penalty will be imposed for transfer of resources.

* 7. Income - Countable income must be at least 120%, but less than 135% of the current Federal Poverty Level. (See note below.)

Effective 4/1/98 these levels are:

	120%	135%
Individual	$ 805.00	$ 905.62
Couple	$1,085.00	$1,220.63

The LTC guidelines at MS 3340 - 3348 will be applied when determining countable income. The Supplemental Security Income exclusions at MS 3348 will be given. Inkind Support and Maintenance will be considered.

For couples, their combined net countable income, after all disregards and exclusions, will be compared to the couple's standard in determining the eligibility of each member of the couple. In determining eligibility for only one member of a couple, the procedures for deeming of income at MS 2111 - 2111.5 will apply.

Individuals eligible for the QI-2 program will not receive a Medicaid card.

2074.2 Application Process

Application will be made on Form DCO-777 by the individual requesting assistance, his/her authorized representative, or a person acting responsibly on the applicant's behalf.

When both members of a couple apply, separate applications will be completed and registered for each individual.

Other forms to be completed during the application process are the DCO-86, DCO-662, DCO-707, and DCO-769.

Applications will be registered on WIMA in Category 78.

The county office worker will have a maximum of 45 days to dispose of the application by approval, denial, or withdrawal.

2074.3 Eligibility Requirements

To be certified as a QI-2, an individual must meet the same requirements as a Qualified Medicare Beneficiary (with the exception of income). Each eligibility requirement will be verified and documented in the case record.

1. Categorical Relatedness - A QI-2 must be aged, blind, or disabled as specified at MS 3321 - 3323.

2. Medicare Part A Entitlement - The individual must be entitled to and receiving Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance (MS 2047.3).

3. Citizenship or Alien Status - A QI-2 must meet the citizenship/alien status requirements as specified at MS 3324.

4. Residency - A QI-2 must be an Arkansas resident (Re. MS 2200).

5. Social Security Enumeration - A QI-2 must meet the Social Security enumeration requirement as specified at MS 1390.

6. Resources - Countable resources may equal but cannot exceed twice the current SSI resource limitations. The current QI-2 resource limits are:

Individual	$4,000
Couple	$6,000

Resources are determined according to Long Term Care guidelines (MS 3330 - 3337). No penalty will be imposed for transfer of resources.

* 7. Income - Countable income must be at least 135%, but less than 175% of the current Federal Poverty Level. (See note below.)

Effective 4/1/98 these levels are:

	135%	175%
Individual	$ 905.62	$1,173.95
Couple	$1,220.63	$1,582.30

The LTC guidelines at MS 3340 - 3348 will be applied when determining countable income. The Supplemental Security Income exclusions at MS 3348 will be given. Inkind Support and Maintenance will be considered.

For couples, their combined net countable income, after all disregards and exclusions, will be compared to the couple's standard in determining the eligibility of each member of the couple. In determining eligibility for only one member of a couple, the procedures for deeming of income at MS 2111 - 2111.5 will apply.

Note: In determining eligibility each year between January 1 and April 1, the Social Security Cost of Living Adjustment (COLA) for the year will be disregarded until April 1; i.e., the SSA amount to be considered in the QI-2 budget will be the amount for the previous year. The current year's SSA amounts will not be considered until April 1 when the new Federal Poverty Level income limits become effective.

2074.4 Period of Eligibility

A. Medicaid Begin Date

The beginning date of eligibility will be the first day of the month following the month of QI-2 certification (i.e., completion of the DCO-57). For example, if a QI-2 application is certified on June 15, the effective date of eligibility will be July 1.

B. Retroactive Coverage

QI-2 eligibility cannot begin earlier that the first day of the month following the month of certification. Retroactive coverage will not be authorized for QI-2's. If retroactive coverage is needed, eligibility will need to be determined in another category.

2074.5 System Procedures for Disposition of Application

A. Approval - If all eligibility requirements are met, the application may be approved for QI-2. The county office worker will complete the following tasks:

1. Complete Form DCO-57 for a Category 78 approval and submit for data entry on WASM.

2. The Medicaid Begin Date entered on WASM will be the first day of the month following the month of certification.

3. In Field 49 of Form DCO-57, a unit size of one (1) will be entered for an individual. For a couple, whether or not both members apply, a unit size of two (2) will be entered.

4. The current income will be entered in the appropriate fields. The total SSI exclusions will be entered in the Unearned Exclusion field, and a "Y" will be entered in the MU field. The current 175% FPL amount will be entered in the MNIL field. The net income will be entered in the Net Countable field. There must be a deficit of at least $ .01 in the Deficit/Excess field.

2300 ARKids First Waiver

The ARKids First category was established by Act 407 of 1997 (the ARKids First Program Act), and it was implemented by Arkansas on September 1, 1997. It is designed to provide Medicaid eligibility for uninsured children age 18 and under whose family's gross income is at or below 200% of the federal poverty level. Persons who are already eligible for Medicaid under another category cannot be eligible concurrently in the ARKids First category.

2310 Extent of Services

Participants in the ARKids First category are not eligible for the full range of Medicaid services. Copayments and coinsurance will apply, as appropriate, for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. Child Health Services (EPSDT) will not be offered. For a list of services provided, please refer to "<Insert Title of Brochure>."

2320 Nondiscrimination

No person will be prevented from participation, denied benefits, or subjected to discrimination on the basis of race, color, national origin, age, religion, disability, sex, veteran status, or political affiliation. The Agency will be in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations issued by the Department of Health and Human Services.

The Agency has the rsponsibility for informing applicants and recipients that assistance and services are provided on a nondiscriminatory basis and that they have a right to file a complaint with the Agency or federal government if it is thought that discrimination has occurred on the basis of race, color, national origin, age, religion, disability, sex, veteran status, or political affiliation.

2330 ARKids First Eligibility Criteria

To be eligible for services in the ARKids First category, the following criteria must be met:

1. Age: Each individual must be under age 19 (eligibility ends on the 19th birthday) to qualify. Proof of age is required (Re. MS 3321).

2. Relationship and Living with Specified Relative: An individual must meet these criteria (Re. FA 2252-2253.1), unless the individual has been removed from the custody of his or her parents by court order, has been court ordered to an institution, has b een emancipated, or legal custody has been given to someone else (e.g., a guardian) (Re. MS 6130). Provisions at MS 6270 and 6275 (except that resources are not considered) also apply to participants in the ARKids First category.

3. Citizenship or Alien Status: Each individual must be either a U.S. citizen or a qualified alien (Re. MS 3310 #3). Proof of citizenship or alien status is required (Re. MS 3324).

4. Social Security Enumeration Requirement: Each individual whose needs are included in the budget must be enumerated or must apply for enumeration (Re. MS 1390).

5. Mandatory Assignment of Rights to Medical Support/Third Party Liability: State and federal law make assignment automatic for Medicaid participants (Re. MS 1350). Failure to cooperate in identifying and billing other resources and medical benefits may result in termination of the ARKids First case.

6. Referral to OCSE: If a parent of an eligible child is absent, or if both parents are present but paternity has not been established, an OCSE referral must be made (Re. MS 1310). ARKids First participants who are pregnant are not required to cooperate with OCSE for their children, but an absent parent of a pregnant participant must be referred.

7. Residence: Each individual must be a resident of Arkansas to qualify (Re. MS 2200).

8. Income: Gross income for participants cannot exceed 200% of the Federal Poverty Income Guidelines for the appropriate number included in the budget (See chart that follows this section). Total gross income will be counted (i.e., no earned income deductions, exclusions, or child care will be allowed). The income disregards at FA 2351, however will apply. Earned income will be verified according to FA 2361, except that a maximum of 4 check stubs will be required. Earned income will be computed according to FA 2362.1 and 2362.2. Any countable and verified unearned income will be added to earned income to derive the total gross income.

   If a minor who is pregnant is living with her parent(s), then the gross income of the parent(s) will be counted in full to the pregnant participant.

   In minor parent (MP) households, the income of the parent(s) of the minor parent is counted in full in the MP's need determination, but is totally disregarded in the need determination of the MP's child.

   The income of an alien sponsor is disregarded.

   Lump sums are considered income in the month received when determining eligibility for each of the three months in the retroactive eligibility period up through the date of certification. Lump sums and other income changes which occur after the date of certification will be disregarded.

* Monthly Standards (4/1/98)

Number in Standard	200%
1	1,341.66
2	1,808.34
3	2,275.00
4	2,741.66
5	3,208.34
6	3,675.00
7	4,141.66
8	4,608.34
9	5,075.00
10	5,541.66

For each additional person, add $466.66.

* Monthly Standards (4/1/98)

Number in Standard	133% - PW/Children Under age 6	100% - Children ages 6 and up
1	$ 892.20	$ 670.83
2	1,202.55	904.17
3	1,512.88	1,137.50
4	1,823.20	1,370.83
5	2,133.55	1,604.17
6	2,443.88	1,837.50
7	2,754.20	2,070.83
8	3,064.55	2,304.17
9	3,374.88	2,537.50
10	3,685.20	2,770.83
For each additional person add,	$310.32	$233.00

5740 Periods of Eligibility

5740.1 Pregnant Woman Eligibility Period - Retroactive, "No Look Back" and Post partum Coverage

SOBRA eligibility for a pregnant woman may begin at any time during a medically verified pregnancy, and will be extended through the end of the month in which the 60th day postpartum falls. A PW who applies postpartum and is found SOBRA eligible in the month of delivery will be given the full postpartum coverage.

In determining eligibility for the PW, the worker must inquire if the PW had any medical bills of her own (paid or unpaid) in the 3 months prior to the date of application and, if so, determine retroactive eligibility for the retroactive period (there must be medical bills to give retroactive coverage and the medical bills must be verified - the bills must be for the PW - medical bills for other family members will not qualify the PW for retroactive PW coverage); if retroactive coverage is not given, the case record should be clearly documented to show that coverage was considered and why it was not given.

In conjunction with consideration of the retroactive coverage, if an applicant is found eligible in any of the 3 retroactive months, certify the case effective the earliest retroactive month of eligibility; there will be a "No Look Back" at later income increases, throughout the pregnancy and the postpartum period, even if the applicant is not income eligible in the month of application or in the month in which the 45th day of the application falls.

Example: Mrs. Smith applies for SOBRA coverage on November 1, and is not income eligible in November or in December (the month, in which the worker is ready to dispose of the application). However, Mrs. Smith was income eligible and had incurred medical bills in August, September and October. The County will certify Mrs. Smith for SOBRA coverage effective on the date of the earliest bill incurred during the retroactive period (but not more than 3 months prior to the date of application), and will not "look back" at her eligibility again (i.e., disregard the income increase that made her ineligible in November, the month of application).

When the PW is eligible, the full postpartum coverage must be provided, as mandated by law. Based on the expected date of delivery given by the PW, begin counting 60 days on the calendar, with the delivery date as day one; the end of Medicaid coverage will be the last day of the month in which the 60th day falls.

Example: Mrs. Jones' expected delivery date is November 15, and the 60th day after November 15th is January 13th. Coverage will be given through January 31st.

The client will be given the responsibility of reporting a premature delivery or delayed delivery.

5740.2 Infant/Child Eligibility Period

SOBRA eligible infants/children born after September 30, 1983, will remain eligible through the end of the month of their birthday, as specified below, as long as they remain income and resource eligible and as long as they reside with their parent(s), or other specified relatives (Re. FA 2250 - 2252). Children born prior to October 1, 1983, are not eligible under SOBRA.

If an infant/child is an inpatient on his/her birthday, as specified below, eligibility will continue until the end of the inpatient stay, provided the infant/child remains income and resource eligible. (Infants/children with severe disabilities will be referred to Social Security for SSI determination).

Application made after termination of a pregnancy does not prohibit coverage for the infant/child, i.e., a mother need not be a certified Medicaid recipient at the infant's birth in order for the infant/child to receive SOBRA coverage, as specified below. A mother need not remain Medicaid eligible in order for the infant/child to qualify for continuing coverage.

1. Children Up To Age Six - Children up to their sixth birthday will be covered at 133% of the Federal Poverty Income Guidelines.

2. Children Ages Six and Older - Coverage for children ages six and older, born after September 30, 1983, will be provided and extended as follows. Beginning:

October 1, 1990 - Eligibility may continue up to the eighth birthday;

October 1, 1991 - Eligibility may continue up to the ninth birthday;

October 1, 1992 - Eligibility may continue up to the tenth birthday;

October 1, 1993 - Eligibility may continue up to the eleventh birthday;

October 1, 1994 - Eligibility may continue up to the twelfth birthday;

October 1, 1995 - Eligibility may continue up to the thirteenth birthday;

October 1, 1996 - Eligibility may continue up to the fourteenth birthday;

October 1, 1997 - Eligibility may continue up to the fifteenth birthday;

October 1, 1998 - Eligibility may continue up to the sixteenth birthday;

October 1, 1999 - Eligibility may continue up to the seventeenth birthday;

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of County Operations
DIVISION DIRECTOR Ruth Whitney
CONTACT PERSON Roy Kindle
ADDRESS P.O. Box 1437, Slot 1220, Little Rock, AR 72203
PHONE NO. 682-8251 **FAX NO.** 682-1597

INSTRUCTIONS

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

Donna K. Davis
Committee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?
MS 98-3 - 1998 Federal Poverty Levels

2. What is the subject of the proposed rule?
Thr increase in the income eligibility limits for the QMB, QDWI, SMB, TM, QI-1, QI-2, ARKids First, SOBRA and Family Planning Medicaid categories.

3. Is this rule required to comply with federal statute or regulations? Yes X **No**
If yes, please provide the federal regulation and/or statute citation.

MCCA of 1988-P.L. 100-360; OBRA of 1989; OBRA of 1990; Family Support Act of 1988-P.L. 100-485; Balanced Budget Act of 1997-P.L. 105-33; Act 407 of 1997, the ARKids First Program; OBRA of 1989-P.L. 101-239; and Section 1115 (a) of the SSA Act.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes X **No** _____

If yes, what was the effective date of the emergency rule?
April 1, 1998

When does the emergency rule expire? 120 days after filing.

Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? Yes __X__ No _____

5. **Is this a new rule? Yes ____ No __X__**

Does this repeal an existing rule? Yes _____ No __X__
If yes, please provide a copy of the repealed rule.

Is this an amendment to an existing rule? Yes __X__ No ____ If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

6. **What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.** Not applicable

7. **What is the purpose of this proposed rule? Why is it necessary?** The purpose of this rule is the increase in the income eligibility limits for certain Medicaid categories due to the 1998 Federal Poverty Levels. This rule is necessary to be in compliance with federal requirements.

8. **Will a public hearing be held on this proposed rule? Yes _____ No __X__**
If yes, please give the date, time, and place of the public hearing.

9. **When does the public comment period expire?**
30 days after the newspaper notice has been published.

10. **What is the proposed effective date of this proposed rule?**
10 days after the public comment period ends.

11. **Do you expect this rule to be controversial? Yes ____ No __X__ If yes, please explain.**

12. **Please give the names of persons, groups, or organizations which you expect to comment on these rules? Please provide their position (for or against) if known.**
None

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of County Operations
PERSON COMPLETING THIS STATEMENT Roy Kindle
TELEPHONE NO. 682-8251 **FAX NO.** 682-1597

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE: **MS 98-3 - 1998 Federal Poverty Levels**

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?**
   Yes X **No** _____

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**

   Not Applicable

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.**

1998-99 Fiscal Year		1999-00 Fiscal Year	
General Revenue	$ 9,396,210.80	General Revenue	
Federal Funds	28,190,834.90	Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other		Other	
Savings Total		Savings Total	

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?**

1998-99 Fiscal Year	1999-00 Fiscal Year
None	None

5. **What is the estimated cost by fiscal year to the agency to implement this regulation?**

1998-99 Fiscal Year		1999-00 Fiscal Year
State	$ 9,396,210.80	State
Federal	28,190,834.90	Federal
Total	37,587,045.70*	Total

* This is the projected cost of Medicaid benefits for the increased numberof eligibles.

8801006

NOTICE OF RULEMAKING

Pursuant to Ark. Code Ann. 25-15-201 et Seq. and Ark. Code Ann. 20-76-201 et Seq., the Director of the Division of County Operations issues changes to the Medical Services Policy manual regarding the increase in the income eligibility limits for nine of Arkansas' Medicaid categories due to the issuance of the 1990 Federal Poverty Levels.

Copies of these changes may be obtained by writing the Division of County Operations, P.O. Box 1437, Little Rock, AR 72203, Attention: Slot 1223. All comments must be submitted in writing to the address indicated above no later than thirty days from the date of this publication.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

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

Ruth Whitney
Division Director

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NOTICE TO BIDDERS