ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of County Operations

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Statutory Authority for Promulgating Rules Arkansas Code Annotated §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Medical Services Policy Sections A-100; B-300; C-200; E-400; F-100; H-400; I-300; I-500; I-600; SPA# 2019-0007 to Update Income Offsets pursuant to Acts 2017, No. 892

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other 07/01/2020 (Must be more than 10 days after filing date.)

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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Jack Tiner	jack.tiner@dhs.arkansas.gov	05/19/2020
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Mary Franklin
Signature

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Director
Title

June 19, 2020
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

A-100 General Program Information

MS Manual 07/01/20

The Medicaid Program is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services, Divisions of County Operations and Medical Services have the responsibility for administration of the Medicaid Program. The purpose of Medical Services is to provide medical assistance to low income individuals and families and to insure proper utilization of such services. The Division of County Operations will accept all applications, verification documents, etc. and will make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include, but are not limited to the following:

- Emergency Services
- Home Health and Hospice
- Hospitalization
- Long Term Care
- Physician Services
- Prescription Drugs
- Transportation-Refer to Appendix B for a description of Transportation Services

Generally, there is no limit on benefits to individuals under age 21 who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over age 21. Consult "Arkansas Medicaid, ARKids First & You, Arkansas Medicaid Beneficiary Handbook" (PUB-040) for specific information and covered services.

The Adult Expansion Group coverage for most individuals will be provided through a private insurance plan, i.e., a Qualified Health Plan (QHP). QHP coverage will include:

- Outpatient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care

- Mental Health and Substance Abuse
- Prescription Drugs
- Rehabilitative and Habilitative Services
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Pediatric Services, including Dental and Vision Care

EXCEPTION: Individuals eligible for the Adult Expansion Group who have health care needs that make coverage through a QHP impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private QHP plan but will remain in Medicaid.

A-115 Cost Sharing for Workers with Disabilities

MS Manual 07/01/20

Recipients of Medicaid for Workers with Disabilities with gross income under 100 percent (100%) of the Federal Poverty Level for their family size will be subject to the usual Medicaid co- pays. Recipients with gross income equal to or greater than 100 percent (100%) of the FPL will be assessed co-payments at the point of service for medical visits and prescription drugs according to the following schedule:

1. Physician's visits - $10.00 per visit;
2. Prescription drugs - $10.00 for generic, $15.00 for brand name;
3. Inpatient Hospital - 25% of the first day's Medicaid per diem rate;
4. Orthotic appliances, prosthetic devices and augmentative communication devices - 10% of the Medicaid maximum allowable amount;
5. Durable medical equipment – 20% of Medicaid maximum allowable amount per item;
6. Occupational, physical and speech therapy, & private duty nursing - $10.00 per visit, with a cap of $10.00 per day.

A-120 Dual Eligibles-Medicare/Medicaid

MS Manual 07/01/20

Medicare is a Federal Insurance Program which pays part of hospital and medical costs for persons 65 years of age and over, certain disabled persons and others determined eligible by the Social Security Administration. Medicare Insurance in Arkansas is processed by Arkansas Blue Cross and Blue Shield. Medicare consists of 4 types of coverage, Part A - Hospital Insurance, Part

A-100 General Program Information

B - Medical Insurance, Part C - Medicare Advantage Plans and Part D - Prescription Drug Coverage.

Part A Hospital Insurance – Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Other individuals who are aged, blind or have a disability may purchase Part A for a premium. Medicare Part A provides hospital insurance coverage for inpatient hospital care, post-hospital extended care, post-hospital home health care and hospice. The Medicaid Agency (DHS) purchases this coverage for individuals entitled as Qualified Medicare Beneficiaries (QMB) (MS B-322) and Qualified Disabled Working Individuals (QDWI) who must pay the Part A premium (MS B-325).

Part B Medical Insurance – Most people pay a monthly premium for Part B. Medicare Part B helps cover physician services, supplies, home health care, outpatient hospital services, therapy, and other medical services that Part A does not cover. The Medicaid Agency (DHS) purchases this coverage for individuals entitled as Qualified Medicare Beneficiaries (QMB) (MS B-322), Specified Low Income Medicare Beneficiaries (SMB) (MS B-323) and for Qualifying Individuals-1 (QI-1) (MS B-324) who must pay the Part B premium.

Limitations for recipients with joint Medicare/Medicaid coverage:

1. Medicaid pays Part B deductible and coinsurance of allowable charges on assigned Medicare claims filed by a participating provider. Medicare determines covered services and allowed charges on all joint claims. Medicaid benefit limits do not apply to Medicare allowable services under Part B.

2. Medicaid covers all medically necessary days of hospitalization. This coverage may be in the form of deductible, coinsurance, and/or per diem payments.

3. Medicaid participates in payment of extended care and skilled nursing care coinsurance days which are allowed by Medicare.

Part C-Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. Plan members receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not original Medicare.

Part D- Prescription drug coverage is offered to everyone with Medicare. Full benefit dual eligibles (FBDE), those who are receiving Medicaid and Medicare, are entitled to premium free Part D enrollment, however, they may elect enrollment in an enhanced plan. Those who enroll in an enhanced plan are responsible for that portion of the premium attributable to the enhancement. When an institutionalized FBDE is enrolled in an enhanced plan, the portion of the premium that remains the individual's responsibility is an allowable deduction in the post eligibility calculation.

A-130 Disclosure of Information/Confidentiality

MS Manual 07/01/20

Generally, information concerning an applicant or recipient will not be released to other parties

without the individual's written consent. Upon reasonable notice to the county and during County Office hours, an applicant or recipient has the right to view copies of the information in his or her electronic case file. The applicant/recipient can only obtain copies of information that he or she provided to the County Office.

Information may be released without an individual's written consent to:

1. Authorized employees of the Agency and the Social Security Administration;
2. The individual's attorney, legal guardian or someone with power of attorney;
3. An individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility (i.e., bank statements, income verification);
4. A court of law, when the case record is subpoenaed.
5. The Federally Facilitated Health Insurance Marketplace (FFM) when the individual is determined Medicaid ineligible for specific reasons, e.g., income, in one of the Families and Individuals Eligibility groups.

Confidential information should not be released over the telephone unless county workers are assured that they are talking with individuals who are entitled to the information being requested.

A-131 Authorized Representatives

MS Manual 07/01/20

Information may be given to Authorized Representatives that have been named on the Authorized Representative form. An Authorized Representative is one or more individuals designated by an applicant/recipient to act on his/her behalf with respect to a specific Medicaid application or renewal. In the absence of a completed authorization form, the fact that a person's name is in the authorized representative space on an application form does not necessarily mean that he or she is an authorized representative or that information should be released to him or her. If the applicant/recipient is incapacitated, if the person who completed the application has supplied information for the case record, and if the person has a need to use information in that record to act in some capacity for the benefit of the applicant/recipient, then information can be released.

An authorized representative may change, i.e., the authorized representative who helped to establish original eligibility may not necessarily be the same person who will help reestablish eligibility at reevaluation.

A-132 Medical Records and DCO-109s

MS Manual 07/01/20

Medical records and the Medical Review Team (MRT) reports are a part of an applicant's or recipient's case record and, as such, will be considered according to (MS A-130).

A-134 Collateral Information

MS Manual 07/01/20

Collateral information (evidence provided by persons other than the applicant/ recipient or by written documents) will be obtained only when necessary to establish eligibility. The applicant or recipient will be informed that the source of collateral information will be contacted.

The eligibility worker will protect the rights of the applicant/recipient during collateral interviews, and will give only the information necessary to enable the collateral to understand the need for the information requested.

A-140 Retention of Medicaid Case Records

MS Manual 07/01/20

The Medicaid electronic case record must be kept for a minimum of five (5) years after case closure.

EXCEPTION: If an audit by or on behalf of the Federal Government has begun but is not completed at the end of the five year period, or if audit findings have not been resolved at the end of the five year period, the records will be retained until resolution of the audit findings. (Central Office will notify the County Office when an audit by the Federal Government is to be conducted, of the cases to be audited, and when the audit has been completed.)

Documents provided to the County Office that do not have to be returned to the applicant will be destroyed by burning or shredding once scanned into the electronic case record.

A-150 Quality Assurance

MS Manual 07/01/20

As a condition of eligibility, all Medicaid recipients are required to cooperate with the Quality Assurance (QA) Unit during their review process.

A-160 Referral Process for Counties

MS Manual 07/01/20

There are several standardized processes for hospitals/physicians to refer needy individuals to the County Office. There are also several programs that receive referrals from the County Office. These processes and County Office responsibilities are described in the sections below.

A-161 Hospital/Physician Referral

MS Manual 07/01/20

The hospital/physician should inform needy individuals of possible medical assistance available under the Medicaid Program.

A-162 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns

MS Manual 07/01/20

A-100 General Program Information

Federal law mandates Medicaid coverage for a period of 12 months for a newborn infant whose mother is certified for Medicaid at the birth of the infant, or is determined Medicaid eligible after the birth for the birth month. The newborn is not required to reside with the mother during this period but must be an Arkansas resident. Refer to (MS C-210) for additional information on hospital/physician/certified nurse-midwife referral of a newborn.

A-163 Child Health Services Program (EPSDT)

MS Manual 07/01/20

The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis and treatment services at no cost to Medicaid eligible individuals under age 21 (including parents under age 21).

A-164 Client Representative Services Program

MS Manual 07/01/20

Client Representation is a program available through the Division of Aging, Adult and Behavioral Health Services (DAABHS) for eligible persons age 60 and over. It is designed to individualize and coordinate delivery of social and health care services for the person being served.

NOTE: This program should not be confused with the Title XIX Targeted Case Management Program which is funded by Medicaid.

Client Representation includes developing individual service plans, arranging for necessary care and services, doing follow-up, monitoring client and service delivery, and periodically reviewing and revising overall service plans.

Client Representation services are administered through the State's Area Agencies on Aging.

Services which are arranged for or provided by the Client Representation Program are: Advocacy Assistance, Adult Day Care, Chore Services, Companionship, Congregate Housing, Congregate Meals, Emergency Life Response, Escort, Home Delivered Meals, Home Health Services, Home Repair/Modification/Maintenance, Homemaker Services, Information and Assistance, Job Placement, Medical Transportation, Outreach, Personal Care, Respite Care, Protective Services, referral for Legal Assistance, providing information on and determining eligibility for public benefits such as QMB and SMB, assistance with completion of applications and paperwork, and attending meetings on behalf of client. Note, not every service is available in every region and a service available within a region may not be available in every location.

A-165 Inpatient Psychiatric Services

MS Manual 07/01/20

The Arkansas Medicaid Program provides coverage of inpatient psychiatric care for eligible individuals. Individuals under age 21 who are already eligible for Medicaid can be covered for acute inpatient psychiatric care services at an approved facility without making an application. Stays that extend beyond what is considered acute are available only for Medicaid beneficiaries who have received a Behavioral Health Independent Assessment and have been found eligible for services contained in the 1915 (i) state plan amendment.

A PCP referral is not required for emergency admissions.

Individuals under age 21 who are not eligible for Medicaid when they enter one of these facilities will be referred to the County DHS Office in the individual's county of last residence or parent's residence for eligibility determination.

Individuals admitted into an approved psychiatric facility from an in-home or non-institutional setting will be evaluated against the following criteria:

1. Individuals Under Age 19-Apply the rules of ARKids or U-18 spend down foreligibility determinations.
2. Individuals Age 19-21-Apply the rules for the Adult Expansion Group. Refer to B-270.

A-166 DDS Children with Chronic Health Conditions

MS Manual 07/01/20

The Division of Developmental Disabilities Services (DDS) has the administrative responsibility for Arkansas's Title V Children with Special Health Care Needs (CSHCN) program, Children with Chronic Health Conditions (CHC), which was formerly known as Children's Services (CS). Within the Division, the Children with Chronic Health Conditions (CHC) section is charged with the administration of services to children with eligible medical and developmental conditions.

DDS Children with Chronic Health Conditions (CHC) is limited to CSHCN under the age of 18 years, who have medical needs that are not covered by health insurance, Medicaid, or the Medicaid EPSDT program. Care coordination is offered to CSHCN up to age 21 years or completion of high school, whichever occurs first. CHC works with families and providers to assist in addressing their concerns related to CSHCN by promoting assessment, intervention, education, and coordination of services. Eligibility determination (medical and financial) is determined by CHC staff.

A-170 Expedited Services for Child Abuse Cases

MS Manual 07/01/20

Special consideration for immediate action will be given to cases involving child abuse (where the perpetrator has left the home) that are identified by the DCFS worker as needing expedited

services.

A-190 Twelve Month Filing Deadline on Medicaid Claims

MS Manual 07/01/20

The Medicaid Program has a twelve month filing deadline from the date of service for all Medicaid claims, (e.g., claims with a 7/1/12 date of service must be received by the Claims Processor on or before 7/1/13 if payment is to be made). Claims which are not received within the twelve-month period will be routinely denied. Recipients are not liable for payment of any claim denied due to the timely filing policy.

In situations when the recipient's Medicaid eligibility has not been determined until after the service has been rendered, the provider must still submit the claim within twelve months from the date of service. If the claim is denied for recipient ineligibility, the provider may resubmit the claim when eligibility is determined. If the initial claim for payment was submitted within the filing deadline, the claim will be considered timely filed, regardless of when the eligibility determination is finalized for the date of service.

Medicare determines covered services and allowed charges on all joint Medicare/ Medicaid claims. Medicaid is only responsible for the deductible and/or coinsurance on the allowed charges. For dually eligible recipients, a claim filed with Medicare will serve as the claim for Medicaid payment of the deductible/coinsurance amounts. The provider must submit the claim to Medicare within twelve months from the date of service in order to meet the Medicaid filing deadline. If the provider submits the claim to Medicare within twelve months from the date of service, the claim will be considered timely filed, regardless of when Medicare crosses the claim to Medicaid for payment of the deductible/coinsurance.

B-300 Aid to the Aged, Blind and Disabled (AABD) Eligibility Groups

MS Manual 07/01/20

The AABD Eligibility Groups are categorized below under Long Term Services and Supports, Medicare Savings Program, Workers with Disabilities, and Supplemental Security Income (SSI)/SSI related groups. A brief description follows.

B-310 Long Term Services and Supports

MS Manual 07/01/20

The Long Term Services and Supports group provides coverage to eligible individuals in nursing facilities, home and community-based waivers, and the PACE program. Home and community-based waivers and PACE community programs provide non-institutional long term services and supports to individuals as an alternative to institutionalization. Individuals eligible for waiver and PACE services must be potentially eligible for admission to a nursing facility.

B-311 Nursing Facility

MS Manual 07/01/20

This group consists of individuals who are aged, blind, or have disabilities and are living in a Long Term Care Facility including an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Nursing Facility coverage is provided to individuals who meet both categorical eligibility and medical necessity requirements. Refer to MS F-150-151. The individual's income cannot exceed three (3) times the current SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. The individual's resources cannot exceed $2000 and a couple's resources cannot exceed $3000.

NOTE: Refer to MS E-500 for resources and MS H-200-MS H-430 for spousal rules.

NOTE: A period of ineligibility will be imposed for uncompensated transfers. Refer to the MS H-300 section.

In addition to facility vendor payments, nursing facility eligibles receive the full range of Medicaid benefits and services with the following exception:

B-312 Assisted Living Facilities (Living Choices)

MS Manual 07/01/20

This group consists of individuals in licensed Level II Assisted Living Facilities (ALF) who are aged (age 65 or older), or 21 years of age or over and blind or have a physical disability as established by SSI/SSA or by the DHS Medical Review Team (MRT) or by Railroad Retirement. Assisted Living Services are provided to eligible individuals to allow them to maintain their independence and dignity while receiving a high level of care and support. ALF coverage is provided to individuals who meet both categorical eligibility and medical necessity requirements. The individual's income cannot exceed three (3) times the current SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. The individual's resources cannot exceed $2000 and a couple's resources cannot exceed $3000.

NOTE: Refer to MS E-500 for resources and MS H-200-MS H-430 for spousal rules.

NOTE: A period of ineligibility will be imposed for uncompensated transfers. Refer to the MS H-300 section.

B-313 ARChoices in Homecare

MS Manual 07/01/20

This group consists of individuals aged 21 or over. Individuals aged 21-64 must have a physical disability according to SSA/SSI guidelines, Railroad Retirement, or the DHS Medical Review Team (MRT).

Services under ARChoices may be provided to individuals who meet both categorical and functional need requirements including requiring an intermediate level of care designation as determined by the Office of Long Term Care (OLTC). The individual's income cannot exceed three (3) times the SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. The individual's resources cannot exceed $2000 and a couple's resources cannot exceed $3000.

NOTE: Refer to MS E-500 for resources and MS H-200-MS H-430 for spousal rules.

NOTE: A period of ineligibility will be imposed for uncompensated transfers. Refer to the MS H-300 section.

Recipients of ARChoices receive the full range of Medicaid benefits and services. However, the individual must accept the Waiver services provided by the program.

Services available through this program include:

- Attendant Care
- Home Delivered Meals
- Personal Emergency Response System
- Adult Day Health
- Prevocational Services for persons with physical disabilities
- Respite Care
- Adult Day Services
- Environmental Adaptations/Adaptive Equipment

NOTE: Recipients of Medicaid in the Workers with Disabilities group will be able to access services under ARChoices provided the functional need criteria for ARChoices have been met as well as the financial criteria of the Workers with Disabilities group.

B-315 TEFRA

MS Manual 07/01/20

This group consists of children 18 years of age or younger with disabilities that must meet the medical necessity requirement for institutional placement in a hospital, a skilled nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or be at risk for future institutional placement. Medical services must be available to provide care to the child in the home, and it must be appropriate to provide such care outside an institution.

The income limit is three (3) times the current SSI payment standard. Only the child's income is considered. Parental income is not considered in the eligibility determination, but is considered for the purpose of calculating the monthly premium. For information regarding TEFRA premiums and calculation, refer to MS F 170-173. The resource limit is $2000. Only the child's resources

are considered. Parental resources are disregarded. Recipients of TEFRA Waiver receive the full range of Medicaid benefits and services.

B-316 Autism

MS Manual 07/01/20

This group consists of children ages 18 months through seven (7) years who have a diagnosis of autism. In addition to the autism diagnosis, the waiver participant must have a disability determination and meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care. The income limit for the child is three (3) times the current SSI payment standard and the resource limit is $2000. Parental income and resources are disregarded. Autism recipients will receive the full range of Medicaid benefits and services in addition to intensive early intervention treatment.

B-317 Division of Developmental Disabilities Services (DDS) Alternative Community Services Waiver Program

MS Manual 07/01/20

This group consists of individuals of any age who have developmental disabilities as determined by the Division of Developmental Disabilities Services (DDS). DDS waiver services are provided to individuals who meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care. The income cannot exceed three (3) times the current SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. If the waiver applicant is living in the home of his/her parents, the parental income and resources will be disregarded. Any contributions made to the applicant by the parents will be counted as unearned income. In-Kind Support and Maintenance will not be considered as income. Resources cannot exceed $2000. A period of ineligibility will be imposed for uncompensated transfers.

B-318 PACE-Program of All Inclusive Care for the Elderly

MS Manual 07/01/20

This group consists of individuals 55 years of age or older who need nursing facility care to live as independently as possible. PACE is a comprehensive health and social services program that provides and coordinates primary, preventive, acute and long term care services. Individuals under age 65 must establish physical disability through SSI/SSA, through the DHS Medical Review Team (MRT), or Railroad Retirement. In addition to the general eligibility requirements,

the individual must require one of the four levels of nursing facility care of skilled, Intermediate I, Intermediate II, or Intermediate III. The individual must also meet special medical criteria as defined in MS F-155.

The individual's income cannot exceed three times the current SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. Spousal impoverishment policy for income MS H-400-H-430 and resources MS H-200-212 will apply to PACE participants both in the community and in a nursing facility. Transfer of resources (MS H-300) will apply only if the PACE participant enters a nursing facility. The resource guidelines at MS E-500 will be followed. PACE services are provided in PACE Centers, in the home, and in inpatient facilities. The PACE program is only available in certain counties in Arkansas.

B-320 Medicare Savings Programs (MSP)

MS Manual 07/01/20

The MSP groups provide Medicare savings by paying the Medicare premium(s) and possibly the Medicare deductibles and coinsurance. Except for ARSeniors, these categories do not provide for the full range of Medicaid services. The groups are described below.

B-321 ARSeniors

MS Manual 07/01/20

This group consists of individuals aged 65 or over whose income is equal to or below 80% of the Federal Poverty Levels (FPL). Recipients do not have to be entitled to Medicare (e.g. Qualified Aliens who have not worked enough quarters to qualify for Medicare can still be eligible for ARSeniors). If the individual is entitled to Medicare he/she must receive Medicare. If the individual chooses not to enroll in Medicare (if eligible), he or she is not eligible for the ARSeniors program. ARSeniors provides full Medicaid coverage. Refer to MS F-190.

B-322 Qualified Medicare Beneficiaries (QMB)

MS Manual 07/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to or conditionally eligible for Medicare Part A. The income limit is 100% of the Federal Poverty Levels (FPL). QMB pays the Medicare premium, deductibles, and coinsurances. Refer to MS F-190.

B-323 Specified Low-Income Medicare Beneficiaries (SMB)

MS Manual 07/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to (actually receiving) Medicare Part A. The income limit is between 100% and 120% of the Federal Poverty Levels (FPL). SMB pays only the Medicare Part B premium. Refer to MS F-190.

B-324 Qualifying Individuals 1 (QI-1)

MS Manual 07/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to (actually receiving) Medicare Part A. These individuals would be eligible for SMB except their income exceeds the SMB level. QI-1's must have income of at least 120% but less that 135% of the Federal Poverty Levels (FPL). QI-1 pays only the Medicare Part B premium. Refer to MS F-190.

B-325 Qualified Disabled and Working Individuals (QDWI)

MS Manual 07/01/20

This group consists of individuals who are blind or have a disability and who lost Medicare Part A entitlement solely due to the individual's earnings that reached or exceeded the Substantial Gainful Activity (SGA) amount. Individuals who are 65 years of age or older will not qualify as a QDWI. The QDWI income limit is 200% of the Federal Poverty Levels (FPL). QDWI's are eligible only for payment of their Medicare Part A-Hospital Insurance premium. Refer to MS F-190.

B-326 Medicare Savings Programs - Comparison Chart

MS Manual 07/01/20

The following comparison chart provides a brief overview of the five categories including the coverage provided and eligibility requirements.

	AR Seniors	QMB	SMB	QI-1	QDWI
Benefits MS A-100	Full Range of Medicaid Benefits	Pays Medicare Premium(s), deductible and coinsurance	Pays Part B Premium	Pays Part B Premium	Pays Part A Premium
Categorical MS F-110 thru 120	Aged Only	Aged, Blind, or Disabled	Aged, Blind, or Disabled	Aged, Blind, or Disabled	Blind or Disabled

	AR Seniors	QMB	SMB	QI-1	QDWI
Income Limits MS E-110;	Equal to or below 80% of FPL	100% of the (FPL)	Between 100% and 120% of FPL	At least 120% but less than 135% of FPL	200% of FPL
Resource Limits MS E-110	Updated Annually				
Medicare Requirements MS F-190	Must receive Medicare if entitled to Medicare	Entitled to (actually receiving) or conditionally eligible for Medicare Part A	Entitled to (actually receiving) Medicare Part A		Lost Medicare Part A & SSA-DIB benefits due to SGA Entitled to reenroll in Medicare Part A

B-330 Workers with Disabilities

MS Manual 07/01/20

This group consists of individuals who:

- Have a disability
- Are working at the time of application (Refer to Glossary for definition of working.)
- Are at least 16 years of age, but less than 65 years of age and
- Except for earned income, would be income eligible to receive Supplemental Security Income (SSI).

If an individual was not an SSI or SSA disability recipient, a disability determination must be made by the DHS Medical Review Team (MRT). Refer to MS F 122.

Substantial Gainful Activity (SGA) is not considered for the disability determination. In addition, the individual's total unearned income (minus the $20 general exclusion) must be under the SSI payment amount for one person to qualify for this group.

Recipients will be able to access services through ARChoices Waiver provided the medical criteria for ARChoices have been met as well as the financial criteria of the Workers with Disabilities group. Refer to MS C-240 for guidance and procedures regarding the medical assessment process.

Applicants will be advised by their eligibility worker that if they accept services from ARChoices Waiver providers while their applications are pending and are subsequently denied for ARChoices Waiver, they will be responsible for paying the provider.

Recipients of Medicaid in the Workers with Disabilities category will be eligible for the full range of Medicaid services.

B-340 Supplemental Security Income (SSI)/SSI Related Groups

MS Manual 07/01/20

The SSI groups are SSI eligibles or special groups that lost their SSI due to SSA cost of living adjustment (COLA) increases, receipt of widow/widowers benefits, or entitlement to or an increase in their Disabled Adult Child (DAC) benefits. These groups are described below.

B-341 Supplemental Security Income (SSI) Cash Eligibles

MS Manual 07/01/20

This group consists of individuals who have been determined eligible for SSI benefits by the Social Security Administration (SSA). They are eligible for the full range of Medicaid benefits and services.

C-200 Alternative Application Processes

MS Manual 07/01/20

The following eligibility groups do not follow the standard application processes as described in C-100:

- Newborn
- Autism Waiver
- TEFRA
- ARChoices Waiver
- PACE
- DDS Waiver Alternative Community Services
- Referral processes for Eligibles Who Lose SSI due to SSA COLA Increases, Disabled Adult Children, and Disabled Widow/Widowers and Disabled Surviving Divorced Spouses

The application process for the above eligibility groups are described below.

C-205 Pregnant Woman (PW) Period of Eligibility

MS Manual 07/01/20

An individual found eligible may receive PW Medicaid coverage only during the period of pregnancy and through the end of the month in which the 60th day postpartum falls. Postpartum coverage will be provided to women who are Medicaid certified at the time of delivery and to women who have a Medicaid application pending at the time of birth and are later found eligible for PW coverage.

An individual who applies for Pregnant Woman – Full or Medically Needy Medicaid after termination of a pregnancy may be given benefits to the end of the birth month, if eligible, but may not be given postpartum coverage. A pregnant woman who applies after the birth of the child and is found eligible in the birth month for Limited PW or Unborn Child will be given full postpartum coverage.

If the pregnant woman has medical bills in the three months prior to the date of application, retroactive eligibility will be determined. There must have been medical bills incurred to give retroactive coverage. The medical bills must be for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage.

If a PW applicant is not income eligible in the month of application or the month in which the 45th day falls, but is income and otherwise eligible in one of the retroactive months, the application will be approved beginning in the earliest month of retroactive eligibility. Eligibility will then continue through the end of the month in which the 60th day postpartum falls, if the applicant is eligible for the postpartum coverage, with disregard of any income changes which occurred after the beginning month of eligibility.

There will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period, even if the applicant is not eligible in the month of application or in the month when the 45th day of the application falls. Refer to MS I-610.

C-210 Newborn Referral Process

MS Manual 07/01/20

Hospital and physician providers use the DCO-0645, Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage, to refer children who are born to and will reside with their Medicaid eligible mothers following discharge from the hospital. The referring provider is requested to complete the DCO-0645 and send it to the DHS County Office of the mother's residence within five days of the child's birth, when possible.

NOTE: In the following situations, coverage for the infant should be made on a DCO-0152, Application for Health Coverage, or online at access.arkansas.gov:

- If the mother of the child is not Medicaid eligible and has not made application for Medicaid to cover her pregnancy or
- If the mother of the child is approved under the Unborn Child category (refer to MS B-220) or
- If the infant will be living with someone else other than the biological mother following discharge from the hospital

C-211 Newborn Referral Disposal Process

MS Manual 07/01/20

Once a newborn is eligible, the newborn will remain eligible until the last day of the month of the child's first birthday regardless of whether the mother continues to be eligible.

The only exceptions to a full year of coverage are:

- If the child no longer resides in the State of Arkansas
- If the child dies during the 12-month coverage period

C-220 Autism Waiver Application Process

MS Manual 07/01/20 1915 (c) of the Social Security Act

The Autism Waiver program is operated by a contracted entity under the administrative authority of the Division of Medical Services. The Autism Waiver brochure and the telephone number for the contracted entity are available at local DHS County offices. Interested individuals should contact Partners for more information or to start the application process.

To apply for services, the child must be between eighteen months and five years old. A child five years and one day old is over the age limit for application. If approved, coverage will be for a minimum of two years and a maximum of three years. The three-year coverage period starts on the first (1st) date of a billable service by a provider. If coverage has not ended prior to the child's eighth birthday, coverage will end the day before the child's eighth birthday.

C-230 TEFRA Application Process

MS Manual 07/01/20 P.L. 97-248

TEFRA applications (DCO-9700) will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers. Information will be available through the Division of Developmental Disabilities (DDS) Services Coordinators and Providers. Information will also be available on the DHS/DMS website.

To complete the eligibility determination, the following steps must be completed:

- The application must be made by an adult responsible for the care of the child.
- A DMS 2602, Physician's Assessment of Eligibility, must be completed by the child's physician to determine Medical Necessity and Appropriateness of Care.

If disability has not previously been established by the Social Security Administration, a Medical Review Team (MRT) disability review must be completed.

C-231 TEFRA Re-Application When Case Closed Due to Non-Payment of Premiums

MS Manual 07/01/20

When the TEFRA case is closed due to non-payment of premiums, a new application must be made before eligibility can resume. Eligibility will be redetermined at the time the new application is made.

If the case has been closed less than 12 months because of failure to pay premiums, the past due premiums must be paid in full before the child can be re-approved for TEFRA Waiver services.

If a case is closed 12 months or more due to failure to pay premiums, payment of the past due premiums will not be required to reopen the case.

C-232 TEFRA Eligibility Determination

MS Manual 07/01/20

With the exception of the Appropriateness of Care requirement, eligibility will be determined by the eligibility worker in the same manner as Long-Term Services and Supports (LTSS) cases.

A child who would not be eligible or potentially eligible for Medicaid in an institution cannot be considered for TEFRA. If the child's countable income is less than the current LTSS income limit (Appendix S) and the child's countable resources are less than the current resource limit, he/she will meet the TEFRA income and resource requirements. Parental income and resources will be disregarded when determining eligibility. However, parental income will be considered when calculating the monthly premium amount. Refer to MS F-170 through MS F-173.

C-233 TEFRA Disability Determination

MS Manual 07/01/20

To qualify for TEFRA, a child must be considered an individual with a disability according to the SSI regulations that govern children with disabilities. Disability for a child will either be established by the Social Security Administration (SSA) or the DHS Medical Review Team (MRT). If a child received SSI within one year prior to making TEFRA Waiver application but was terminated for reasons other than lack of disability, (e.g. parental income or resources), documentation will be obtained for the case record. A disability decision made by SSA on a specific disability is controlling for that disability, until the decision is changed by SSA. The child

will be considered an individual with a disability based on the previous SSA disability determination. Refer to MS F 120-129.

C-234 Determining Appropriateness of Care for TEFRA

MS Manual 07/01/20

Based on information provided on the DMS 2602, Physician's Assessment of Eligibility, and any medical records submitted, the TEFRA Committee will determine medical necessity and if the applicant meets the Appropriateness of Care criteria. If the applicant is having difficulty obtaining the Physician's Assessment of Eligibility, the County Office should provide assistance to obtain the required form.

C-235 Disposition of TEFRA Application

MS Manual 07/01/20

If at any point in the eligibility determination the child fails to meet eligibility requirements, the application will be denied.

The begin date for TEFRA Waiver eligibility will be the date of application, unless retroactive coverage is needed. If needed, the eligibility begin date can be as early as three months prior to the date of application, provided all eligibility requirements are met.

A child cannot be approved for retroactive coverage before the onset of his/her disability as he/she would not meet the TEFRA disability or medical necessity requirements prior to the onset of disability. A child who had been residing in an institution would not be eligible for any retroactive coverage while still residing in the institution as TEFRA Waiver coverage is for non-institutionalized children only. For any retroactive coverage needed, it can be assumed that medical necessity and appropriateness of care have been met unless there is evidence to the contrary.

C-240 ARChoices Waiver Application Process

MS Manual 07/01/20

A potential Waiver client will make application (DHS-0777) at the DHS County Office in his/her county of residence for a financial eligibility determination. Refer to Appendix I for other forms to be completed during the application process.

If an applicant accepts services from an ARChoices provider while the application is pending, he/she will be responsible for paying the provider if the application is subsequently denied.

To qualify for the ARChoices waiver, the individual aged 21-64 must be determined to have a physical disability through the Social Security Administration (SSA), the DHS Medical Review Team (MRT), or Railroad Retirement Board (RR). The individual may have a mental disability, but if so, it must be in addition to a physical disability to qualify for ARChoices. Individuals requiring services in ARChoices must be classified as requiring an Intermediate Level of Care. Individuals classified as Skilled Level of Care are not eligible for the ARChoices Program. Refer to MS F-155.

C-243 Residents of Residential Care Facilities Applying for ARChoices Waiver

MS Manual 07/01/20

If an individual living in a residential care facility (RCF) applies for Waiver services and has no plans to move out of the RCF, he/she does not meet the required Level of Care to receive Waiver services and the application will be denied.

When the applicant gives a date that he or she plans to move out of the RCF and the relocation date is within the next 45 days, the application will be taken. At the end of the 45 day period, if the applicant has not relocated, the application for Waiver services will be denied if the relocation does not occur within the next 10 days.

C-244 ARChoices Waiver Eligibility Determination

MS Manual 07/01/20

Eligibility determinations for ARChoices Waiver cases will be conducted in the same manner as for Long Term Services and Supports (LTSS) nursing facility cases.

The SSI related income and resource criteria located in section MS Section E will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

When determining an applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income will be compared to the current LTC limit. Only the income of the applicant will be considered for eligibility.

In determining resource eligibility, the current LTSS resource limits will apply.

- A single applicant's resources will be compared to the one-person limit.
- When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit.
- If only one individual of a couple applies for ARChoices, the rules for spousal resources

at MS H-200 will apply.

C-245 Approval/Denial for New ARChoices Waiver Applicants

MS Manual 07/01/20

The policy and procedures outlined in MS C 246-249 that determine the Waiver eligibility date will apply to applicants entering Waiver programs from both the community and from institutions.

If the ARChoices Waiver application is denied for any reason and Waiver services were provided during the period of ineligibility, any charges incurred will be the financial responsibility of the applicant.

If the ARChoices application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section.

C-246 Effective Date of Eligibility for ARChoices Waiver

MS Manual 07/01/20

After all eligibility criteria have been established, the effective date of ARChoices Waiver Medicaid eligibility will be the date of approval.

NOTE: The ARChoices eligibility date will not be established prior to the date of approval unless an earlier date is provided by DHS RN based on the Provisional Service Plan of Care (see C-247 and C-248) .

C-247 Provisional and Comprehensive Service Plan for ARChoices Waiver

MS Manual 07/01/20

A Provisional Service Plan is developed when, based on the assessment, the individual has met functional/medical criteria, but financial eligibility has not yet been determined. The client and

the provider assume the responsibility of liability should the client not meet all criteria for eligibility and services to begin.

C-248 Optional Participation for ARChoices Waiver

MS Manual 07/01/20

Neither Waiver providers nor Waiver applicants are required to begin or receive services prior to the establishment of Medicaid eligibility. Participation is offered by the DHS RN at the time of assessment. If services are started based on the receipt of a Provisional Service Plan, it is the responsibility of each provider to explain the process and the financial liability to the applicant and/or family members prior to beginning services. The decision to begin services prior to eligibility must be a joint decision between the provider and the applicant.

C-249 ARChoices Waiver Approvals for Medicaid Recipients Who Leave a Nursing Facility

MS Manual 07/01/20

No Waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a Provisional Service Plan is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest Waiver eligibility date will be the day the applicant was discharged home.

C-250 Assisted Living Facility (ALF) Application Process

MS Manual 07/01/20

Applications for ALF Waiver will be made on the Long-Term Services and Supports Application, DHS-0777 in the DHS County Office where the facility is located. Applications can be made by the applicant, designated representative, next of kin, or person acting responsibly for the individual.

If application is made before the applicant enters a facility, he/she will have 30 days from the date of approval to move into a Medicaid approved Assisted Living Facility. If the individual has not moved into the ALF within the 30-day time period, the application will be denied.

C-252 ALF Applications from Nursing Facilities or ARChoices Waiver Recipients

MS Manual 07/01/20

Medicaid certified nursing facility residents who are classified Intermediate Level of Care and ARChoices Waiver recipients who wish to apply for ALF will be referred to the DHS RN for coordination of a new medical assessment. Once functional need is established, the DHS RN will develop a person-centered Service Plan.

If a non-Medicaid eligible nursing facility resident wishes to apply for ALF Waiver, the DHS-0777, Application for Assistance, must be completed and submitted. The caseworker will notify the DHS RN, who will initiate the assessment process.

C-254 ALF Eligibility Determination

MS Manual 07/01/20

Eligibility determination for ALF Waiver cases will be conducted in the same manner as for Long Term Services and Supports (LTSS) nursing facility cases.

The SSI related income and resource criteria located in MS E-400-530 will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

In determining an ALF applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income compared in his/her budget to the current LTSS limit. Refer to Appendix S. An individual with income over the current LTSS income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust. Refer to MS H-110- 116. When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment regarding income will be applied. Refer to MS H-200.

In determining resource eligibility, the current LTSS resource limits will apply.

- A single applicant's resources will be compared to the one-person limit.
- When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit at application.
- When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment (MS H-200) regarding resources will be applied.

For information regarding contribution to the cost of care, refer to MS H-412.

C-255 Approval/Denial for New ALF Applicants (Non-Nursing Facility)

MS Manual 07/01/20

After all eligibility criteria have been established, the effective date of ALF Waiver eligibility is established by the DHS RN based on the latter of the date of application, date of admission to the assisted living facility, or the date the person-centered Service Plan is signed by the DHS RN and the applicant. The DHS RN will provide the Waiver eligibility date to the County Office.

If financial or non-financial criteria are not met, the application will be denied. If the application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section.

C-256 ALF Approvals for Medicaid Recipients Who Leave a Nursing Facility or ARChoices Waiver

MS Manual 07/01/20

The ALF Waiver case can be approved once verification of an Intermediate Level of Care and the ALF waiver begin date from the DHS RN is received.

C-260 Program of All Inclusive Care for the Elderly (PACE) Application Process

MS Manual 07/01/20

Prospective PACE recipients can apply for PACE services through their local DHS County Offices. Applicants may apply by referral from the PACE provider, by referral from the DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective recipient must meet the medical and financial eligibility criteria outlined in MS E-400 and F-155 and reside in a PACE service area. Refer to Appendix K for PACE providers and the zip codes they serve.

Applicants residing in a PACE service area will be referred to the DHS RN for coordination of the medical assessment.

The eligibility worker will approve or deny the application based on financial and non-financial eligibility requirements. The final determination of eligibility will be communicated to the PACE provider by the DHS RN.

C-261 PACE Assessment Process for Nursing Facility Residents, ARChoices, or Assisted Living Facility Participants

MS Manual 07/01/20 42 CFR § 460

Nursing facility residents, ARChoices Waiver recipients, or Assisted Living Facility (ALF) participants who wish to apply for PACE will be referred to the DHS RN for coordination of a medical assessment.

C-262 Approval/Denial for PACE Applicants

MS Manual 07/01/20

A participant's enrollment in the PACE program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement; but it may not be prior to the date of application at the County Office or prior to the date the medical assessment was completed by the DHS RN.

If financial or non-financial criteria are not met, the application will be denied. If the application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section.

C-263 Approvals for Waiver Recipients to PACE and PACE Participants to Waiver

MS Manual 07/01/20

When a Waiver recipient is found to be medically and financially eligible for PACE, the Waiver case will close the day before the PACE eligibility is started as the participant's enrollment in the PACE program is effective on the first day of the calendar month. Refer to MS C-262.

C-264 PACE Enrollment

MS Manual 07/01/20

Participant enrollment into the PACE Program is voluntary. The Division of Aging, Adult and Behavioral Health Services (DAABHS) must assess the potential enrollee and concur that the client meets the requirements for nursing facility care prior to enrollment. The DHS-RN must certify that an assessment has been completed.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and that enrollment requires the

completion of an intensive assessment that includes a minimum of one home visit and one visit by the potential PACE enrollee to the PACE center.

C-265 PACE Disenrollment

MS Manual 07/01/20

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

1. The participant's failure to pay if he/she has a payment responsibility
2. The participant's disruptive or threatening behavior
3. The participant moving out of the PACE service delivery area
4. The participant no longer meeting the nursing facility Level of Care requirement
5. The participant' death
6. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers
7. A PACE program agreement is not renewed

The PACE Organization may appeal an adverse decision to the Division of Aging, Adult and Behavioral Health Services (DAABHS).

C-266 PACE Provider Post-Enrollment Assessments

MS Manual 07/01/20

Upon enrollment, it is required that each PACE provider have an interdisciplinary team in place that is responsible for the overall assessment of care needs and subsequent management, supervision and provision of care for PACE participants. The team's membership consists of a primary care physician (PCP), registered nurse, social worker, physical therapist, occupational therapist, recreational therapist/activity coordinator, dietician, PACE center supervisor, home care coordinator, personal care attendant/aid, and a transportation staff/driver.

The interdisciplinary team is responsible for the assessment, treatment planning and care delivery of the PACE participant. PACE regulations establish the following assessment requirements:

1. An initial in-person assessment must be completed by the Primary Care Physician, RN, Social Worker, Physical Therapist and/or Occupational Therapist, Dietician, and the Home Care Liaison.
2. At least semi-annually, an in-person assessment and treatment plan must be completed by the Primary Care Physician, RN, Social Worker, and Recreational Therapist/Activity Coordinator.
3. An annual in-person assessment and treatment plan must be completed by the Physical Therapist and/or Occupational Therapist, Dietician and Home Care Coordinator.

PACE organizations will consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan will then be discussed and finalized with the PACE participant and his or her significant others. Reassessments and Treatment Plan changes will be completed when the health or psycho-social situation of the client changes.

C-270 Division of Developmental Disabilities Services (DDS) Waiver Application Process

MS Manual 07/01/20

The DDS eligibility worker will obtain a completed DHS-0777 from each applicant or the parent/guardian/representative of the applicant **unless** the applicant is a current Medicaid recipient residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), a nursing facility, or open in a TEFRA case. Refer to Appendix I for the required forms to be completed during the application process.

Refer to the Business Process Manual.

A Medicaid eligibility worker will have 45 days in which to process an application, or 90 days if a disability determination is needed.

Refer to MS A-200 and MS A-212 for information regarding the Medicaid coverage period and retroactive eligibility.

C-272 DDS Waiver Applicants Currently Residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

MS Manual 07/01/20

Eligibility determinations may be made for applicants who request Waiver services and who are currently residing in an ICF/IID facility, when there is a plan to move them to a community setting.

C-280 SSA Referral Processes for Specific AABD Groups

MS Manual 07/01/20

The Social Security Administration has several referral processes that are used to notify DCO when Medicaid may be extended when individuals lose their SSI eligibility. SSA will determine which individuals are potentially eligible based on their disability and marital status and will refer those individuals to DCO for eligibility determinations under the provisions described in the sections below.

C-281 Eligible Due to Disregard of Social Security COLA Increases (Pickle)

MS Manual 07/01/20

The Social Security Administration notifies the Division of County Operations (DCO) of individuals losing SSI eligibility due to COLA increases. These individuals will receive a notice regarding this change and will be given an opportunity to provide information to establish that they remain Medicaid eligible. Refer to MS B-342 for eligibility requirements.

C-282 Identification of Stragglers

MS Manual 07/01/20

The Social Security Administration will notify Central Office of any individuals who qualify for continued Medicaid coverage under the Pickle Amendment who were not identified on the lead file transmitted from Baltimore.

Application will be made on the DCO-0095, Application for Medicaid Assistance.

C-283 Disabled Adult Children (DAC)

MS Manual 07/01/20

The Social Security Administration will notify the agency of DAC cases. Application will be made on the DCO-0095, Application for Medicaid Assistance. Refer to MS B-346 for eligibility requirements.

C-284 Disabled Widows, Widowers, and Disabled Surviving Divorced Spouses

MS Manual 07/01/20

The Social Security Administration will determine which individuals are potentially eligible, based on their disability and marital status, and will refer those individuals to DCO for eligibility determinations under these provisions. Application will be made on the DCO-0095, Application for Medicaid Assistance. Refer to MS B-345 for eligibility requirements.

C-285 Individuals Who Have Remarried

MS Manual 07/01/20

It is possible that some of the individuals referred by SSA will have remarried and will have a spouse in the home. In that case, the spouse will be considered an ineligible spouse, and the deeming of income rules at MS E-440 will apply in determining eligibility. The resulting net income will be compared to the couple's SSI/SPA for eligibility. Resources will be compared to the couple's resource limit.

In the event SSA refers both members of a married couple for eligibility determination, the SSA income of both individuals will be disregarded, along with the SSI exclusions, before comparing their net income to the SSI/SPA for a couple in the eligibility determination. The couple's resource limit will apply.

C-286 COLA (Pickle), Disabled Adult Child (DAC), and Widows/Widowers Referral Letter

MS Manual 07/01/20

The Social Security Administration mails a referral letter directly to the DCO Medicaid Eligibility Unit when an individual may be a candidate for preservation of Medicaid eligibility under the provision of COLA, DAC, or Widow/Widowers benefits.

E-400 Determining Financial Eligibility for AABD Groups

MS Manual 07/01/20

The methodology in the following sections will be used to determine financial eligibility for Medicare Savings Program (MSP), TEFRA, Autism, SSI/COLA groups, and the Long-Term Services and Supports (LTSS) groups (i.e. Nursing Facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Home and Community-Based Services Waivers, and PACE). It will also be used to calculate the contribution to care for nursing and assisted living facilities and PACE.

E-405 Income

MS Manual 07/01/20

Income is defined as the receipt of assets by an individual in cash or in-kind (MS E-432 #7) during the month. To be considered as income, the assets received must be something of value received by the individual for his own use and benefit in providing the basic requirements of food, clothing, and shelter. Lump sum or one-time payments are considered as income for the month of their receipt.

Income may be received in cash (including checks, money orders, etc.) or in-kind (including items such as rent, free food, etc.). The cash value of items received in-kind must be determined. The value of infrequently and irregularly received items such as small gifts of clothing will not be considered as income.

E-410 Income Evaluation

MS Manual 07/01/20

Determination of income eligibility will be based on an applicant/recipient's monthly income. The recipient's gross monthly income will be compared to the monthly income eligibility standard to make this determination. Exclude VA Aid and Attendance and Continuing or Unusual Medical Expense reimbursements (CME/UME) in this computation.

Income which is received on a basis other than monthly (annually, semiannually, etc.) will be considered as income for the month of receipt only. (Do not count dividends received from insurance policies as income in eligibility determinations). Amounts carried over into the following month will be considered as resources.

Non-monthly income receipts will be treated as follows:

1. Regularly Received Non-Monthly Income - When income that will affect eligibility is regularly received by the individual in an established amount and at a set time, the case will be adjusted in the month prior to the receipt of the income after an advance notice. If the increased income will result in only one month of ineligibility, the case may be reinstated effective the first day of the month following the month of ineligibility without taking a new application.

   If the anticipated income is in an amount great enough that is likely to result in two or more months of ineligibility, the client will be informed in the advance notice that the case will be closed and that a new application will be required to reopen the case.

   If the anticipated income change will not result in case closure, the recipient or representative will be notified of the increased vendor payment at least 10 days prior to the change.

2. Irregularly Received Non-Monthly 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 10 day advance notice of intended action will be given before any case closures or income adjustments resulting in changes in vendor payment are completed. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken.

   As with regularly received non-monthly income, if benefits will be terminated for only one month for receipt of irregular non-monthly income, a new application will not be required. 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 E-523 #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.

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. 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. Small interest/dividend amounts paid monthly or quarterly which fluctuate slightly may be averaged 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.

- **NOTE:** Interest income of State Human Development Centers and Arkansas Health Center residents will be used in determining initial eligibility, but will not be considered in determining net income. Interest income of residents in 10 bed ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities) facilities is counted in BOTH initial and post-eligibility determinations, as semi-annual cost reporting is not done for these facilities.

  Gross earned income is counted in determining initial eligibility for ICF/IID residents including residents of State Human Development Centers. In post eligibility determinations earnings less mandated deductions up to an amount equal to the current SSI Standard Payment Amount are disregarded.

E-415 Determination and Verification of Earnings from Employment

MS Manual 07/01/20

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.

If the earnings fluctuate, averaging or other means will be used to determine an amount which fairly reflects the monthly income actually 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 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 individual does not have the required verification, then verification from the employer will be required.

E-421 Determining Amount of Net Earnings from Self-Employment

MS Manual 07/01/20

The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, an alternate method that is likely to give the most accurate estimate of current and future net earnings which may be allocated monthly will be used.

The individual may appeal if he/she disputes the estimates or he/she may request a change or reapply if new evidence becomes available.

If the allocated amounts of income result in ineligibility, he/she may reapply if the remaining current year receipts or expenses or a new accounting of net earnings from self-employment result in lower net earnings.

If the individual is eligible for assistance, he/she should report promptly any substantial variation of net earnings with appropriate evidence, so that overpayments and underpayments can be prevented. He/she must provide a copy of the federal tax return as it becomes available.

When an alternate method has been used to determine net earnings, the individual should maintain monthly records of ongoing receipts and expenditures until the federal tax return is available so that substantial variations of income can be identified and reported immediately to avoid erroneous eligibility.

E-427 Development of Living Expenses

MS Manual 07/01/20

When development of living expenses is required due to unstated income, it is necessary to consider the living expenses of every member of the individual's household. It is essential that a complete disclosure of the following be obtained:

1. Shelter or Living Quarters Cost (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.)
2. Clothing and Upkeep
3. Medical Expense Not Reimbursed by Insurance (doctor bills, dentist bills, drugs, health insurance premiums, etc.)
4. Transportation (car loan payments, insurance premiums, gasoline, tires, oil, mass transportation fares, etc.)
5. Food, Meals and Household Supplies (groceries, cleaning supplies, restaurant meals, etc.)
6. Credit Purchases and Loans (furniture bill payments, finance company payments, etc.)
7. Other (life insurance premiums, legal services, traffic fines, cigarettes, alcoholic beverages, etc.)

E-428 Determination of Unstated Income

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The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. Reported income is the aggregate of unearned and earned income of the following people living together as one household:

1. Applicant(s)
2. Individual(s) whose income is deemed to the applicant and
3. Ineligible children, if any, who would be considered in computing the amount of deemed income where there is a deeming situation

When unstated unearned income is determined, the individual will have an opportunity to explain how living expenses are met. If the stated living expenses include obligations which do not represent actual expenditures (because bills are not being paid), the amount of living expenses will be adjusted. If there are loans which account for the money used to pay living

expenses, the individual should provide a statement of specifics of the loan(s) and verification of loan transaction(s). Verified proceeds from loans received and used for living expenses can be subtracted from the amount of unstated unearned income left after subtracting reported income from living expenses. The use of resources may also be used to explain how living expenses are met.

When unstated unearned income is counted, the individual will receive a notice of decision that an inclusion of unstated income was made based on a comparison of living expenses with reported income because of excess living expenses.

E-430 Sources of Unearned Income

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The following are possible sources of unearned income:

1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, Civil Service, Military Allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, Black Lung benefits, and Veterans Benefits. Exclude V.A. Aide and Attendance and Continuing or Unusual Medical Expense reimbursement(CME/UME) payments. Refer to MS E-451. Count gross income when determining eligibility.

NOTE: If state and federal taxes are withheld, count the gross income when determining eligibility for nursing facility and ICF/IID cases. Consider the net income in the post eligibility determination of the vendor payment.

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

- **NOTE:** In Waiver and TEFRA cases, the deductions are not given for eligibility determinations. In Long Term Services and Supports (LTSS) cases where there is a patient liability, the deductions are not given in the initial OR post eligibility determinations, and neither for home nor for non-home rental properties.

3. Interest, dividends, and income from capital investments, insurance policies, etc.
4. Royalty income from oil, gas or other mineral leases.

5. Regular payments from estates, trust funds (MS E-522 #13), or other personal property which cannot be converted into cash because of legal provisions.
6. Child support payments.
7. Regular contributions from organizations, churches, friends, relatives, or social agencies.
8. Income or support and maintenance received in-kind.

E-432 Types of Unearned Income

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1. Social Security Benefits

   Social Security benefits are paid, according to Social Security rules, to a covered wage earner, their spouse or widow/er, and/or their minor children.

2. Reduction of SSA Benefits

   The withholding from Title II benefits by SSA for the recovery of SSI or SSA overpayments is mandatory. The money withheld will not be considered as available income for the individual's contribution toward the cost of care in Long Term Services and Supports (LTSS) cases where there is a patient liability.

3. Railroad Retirement Benefits

   Railroad Retirement Benefits are paid to individuals and spouses covered under the Railroad Retirement Act. An individual may receive both Railroad Retirement and Social Security, if covered under both programs, and the spouse of a Railroad Retirement beneficiary may receive a spouse's benefit while drawing Social Security.

4. Military Allowances or Allotments

5. Veterans Benefits

   Only the portion of the VA Benefit attributable to the veteran/surviving spouse will be counted as his/her income. The dependent's portion of the VA Benefit will be counted as income to the dependent(s). It will be necessary to determine the portion of the VA Benefit that is attributable to the applicant/recipient. Veterans, widows/ers and other

surviving dependents eligible for higher benefit payments under the Veteran's Pension Improvement Act must agree to apply for and accept those benefits.

6. Civil Service Benefits

   Civil Service Benefits are paid to individuals and to surviving spouses of individuals who retired from civilian government jobs (e.g., Internal Revenue Service, Postal Service, etc.). These benefits include regular retirement and disability retirement.

7. In-Kind Support and Maintenance (ISM) and Other In-Kind Income

   There are two types of unearned in-kind income: in-kind support and maintenance, and other in-kind income.

   In-Kind Support and Maintenance

   When an individual receives an item of food and/or shelter outright, or when someone else pays for (or makes a payment on) food and/or shelter for the individual, the individual receives in-kind support and maintenance (ISM). Generally, ISM is counted when the individual has use of the food and/or shelter item. Mortgage payments made by a third party on the home where the individual resides will be considered ISM; or an individual living rent free (or making only token payments) in the home of another is considered to be receiving ISM.

   Other In-Kind Income

   When an individual receives something outright (other than food and/or shelter) which can be sold or converted to cash, the individual receives other in-kind income. Other in-kind income is counted when received. The use of a car is not considered other in-kind income, as it cannot be sold or converted to cash. However, if the individual is given a car outright, it is considered other in-kind income in the month received, unless the car (or other item) would be a partially or totally excluded non-liquid resource if retained into the month following the month of receipt.

   Someone else's payments to a vendor on behalf of the individual (other than ISM), even if it increases equity value, is not considered unearned in-kind income. However, the equity value is considered in the determination of total resources.

   For example, car payments for an individual are not other in-kind income, even though the equity value increases; but the equity value may be counted as a resource. Premium payments made for an individual on health insurance, life insurance, credit life, or credit disability insurance are not counted as other in-kind income (There is no equity value

increase in these examples). However, the cash surrender value of a life insurance policy may be counted as a resource. Refer to MS E-523 #2.

Cash payments which are made directly to an individual are counted in full as unearned income. This would be true even if the cash payment is given to the individual for the purpose of his meeting a basic need.

NOTE: In-kind support and in-kind income are not considered in Nursing Facility, ARChoices, Assisted Living Facility, PACE, DDS, Autism, or TEFRA determinations. In-kind support and maintenance are considered in ARSeniors, QMB, SMB, QI-1, SSI/COLA groups, DAC, (AABD) Medically Needy categories, and retro SSI determinations.

Valuation of In-kind Income and In-kind Support and Maintenance (ISM)

The value of other in-kind income is determined by its current market value. The value of in-kind support and maintenance is determined by presumed value. The presumed value of in-kind support and maintenance is based on one third of SSI standard payment amount plus $20.00. Refer to Appendix S for presumed values of in-kind support and maintenance.

Individuals receiving in-kind support and maintenance always have the right to rebut the presumed value by establishing the actual cash value of the ISM.

8. Third Party Payments Excluded as In-Kind Support and Maintenance

   Third-party payments that are excluded as in-kind support and maintenance:

   a. In-kind payments made in lieu of cash wages are not considered as in-kind support and maintenance except when paid to agricultural or domestic employees. In-kind payments made in lieu of cash wages to other types of employees are considered to be earned income instead of in-kind support and maintenance.
      The value of support and maintenance provided in a nonmedical nonprofit retirement home or similar facility which does not receive full payment from the individual or which receives subsidy payments from a nonprofit organization is not considered as in-kind income of the individual.

   b. The value of support and maintenance in such facilities is considered as in-kind support and maintenance for individuals who have acquired rights to life care in

the facility by turning over all of their assets to the home or through membership in a fraternal group or union.

The value of support and maintenance provided in public or private non-profit institutions for educational or vocational training is considered as income of the individual.

c. Support and maintenance provided during a medical confinement and paid to a medical provider by a third party is excluded from income for eligibility determinations. This could be in a hospital or facility.

   Third party payments made directly to a facility as payment for items covered by the facility vendor payment will be considered as income in the computation of the patient's share of the vendor payment. If third party payments are made to cover special charges or additional services and items not covered by the LTSS program, they will not be considered as income.

d. The value of support and maintenance provided by a private for profit nonmedical retirement home or similar facility which does not receive third party payments on behalf of an individual is not considered as income of the individual.

   The value of support and maintenance in such facilities is considered if third party payments are being made on behalf of the individual.

e. Occasional in-kind items of little value (not exceeding $20.00 in a month) are excluded when they are received irregularly or infrequently.

E-433 Determining Financial Eligibility for the SSI/COLA Groups

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In determining income eligibility, the SSI related income criteria in the MS E-400-451 section will be used to determine eligibility for the following groups:

PICKLE

All SSA COLA increases received since loss of SSI benefits will be disregarded, including the initial SSA COLA increase which resulted in loss of SSI. (Other types of SSA benefit increases and other changes in income and resources will not be disregarded.) The $20 general exclusion and other SSI exclusions (Re. MS E-450) will also be deducted from current income.

If an ineligible spouse or other family member (e.g. parent of a child with a disability) has income that must be deemed to the applicant, their COLA increases since the applicant lost SSI will also be disregarded. For deeming procedures, refer to MS E-440-451 section.

After all COLA disregards and SSI exclusions have been deducted from current income, the net countable income will be compared to the current SSI standard payment amount (SPA). Refer to Appendix S. If the individual's income is under the SPA, he/she is eligible for continuing Medicaid benefits.

If the individual has an ineligible spouse, countable income will be determined according to MS E-440-451, allowing COLA disregards, and the net income compared to the couple's SPA.

If eligibility is to be determined for both members of a married couple, total their current income, subtract their combined COLA disregards, a $20 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's SSI SPA to determine Medicaid eligibility.

Widows and Widowers with Disabilities (COBRA 1985)

The total of the SSA 1984 Reduction Factor increase and all COLA's received since January 1984 will be disregarded from current SSA income. The $20 general exclusion and other SSI exclusions (Re. MS E-450) will also be deducted from current income. Only those individuals with net income under the SSI SPA will be eligible. If there is an ineligible spouse, deem according to MS E-440-451, and compare the resulting income to the couple's SSI/SPA. Refer to Appendix S.

Widows and Widowers with a Disability (OBRA 1987)

ALL current SSA income, regardless of type of benefit, when the benefit began, or amount of benefit will be disregarded. Any other income (Railroad Retirement (RR), VA, private pension, etc.) will be considered in the budget. After the $20 and other applicable SSI Exclusions (MS E-450) are deducted from income, the resulting net income will be compared to the current SSI/SPA. Refer to Appendix S. If the income is under the current SSI/SPA, the individual will be eligible for Medicaid. If there is an ineligible spouse, deem according to MS E-440-451, and compare the resulting income to the couple's SSI/SPA. Refer to Appendix S.

Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 1990)

In determining income eligibility, all SSA income currently received by the widow/er with a disability or surviving divorced spouse with a disability will be disregarded. All other types of

countable income will be counted in the budget, as required by the MS E-400 section. The SSI exclusions will be allowed. After all exclusions and disregards from gross income have been made, the net income will be compared to the current SSI/SPA level. Refer to Appendix S. If net income is at or below the individual SSI/SPA, the individual will be eligible.

It is possible that some of the individuals referred by SSA will have remarried and will have a spouse in the home. In that case, the spouse will be considered an ineligible spouse, and the deeming of income rules at MS E-440-451 will apply in determining eligibility. The resulting net income will be compared to the couple's SSI/SPA for eligibility. Resources will be compared to the couple's resource limit.

In the event SSA refers both members of a married couple for eligibility determination, the SSA income of both individuals will be disregarded, along with the SSI exclusions, before comparing their net income to the SSI/SPA for a couple in the eligibility determination. The couple's resource limit will apply.

Disabled Adult Child (DAC)

Income to be included in the budget will be the current SSA income, less the DAC entitlement or increase that resulted in loss of SSI. Any income other than the DAC entitlement or increase will be counted.

The $20 general exclusion and other SSI exclusions will also be deducted from current income. Net countable income will be compared to the current SSI SPA limits for eligibility.

E-435 Medicare Savings Income Calculation

MS Manual 07/01/20

The Medicare Savings Program (MSP) recipient's monthly countable income must meet the appropriate Federal Poverty Level (FPL) for the specific category. Refer to Appendix F for the MSP FPLs. Countable income is determined according to LTSS guidelines. For LTSS guidelines, refer to sections MS E-405-451, MS H-421 and MS H-430. Self-declaration will be accepted. Refer to MS G-115. SSI exclusions (MS E-450) will be deducted from current income to determine income eligibility.

In-Kind Support and Maintenance will be considered in ARSeniors, QMB, SMB, and QI-1 determinations. For a couple, total monthly countable income will be compared to the couple's standard in each case. If only one spouse is eligible, the procedures for deeming of income at MS E-440-445 will apply.

Individuals applying for only Medicare Savings coverage will not be required to apply for SSI if their income is less than the SSI/SPA. Refer to Appendix S. If an individual does not wish to be referred to SSA and does not want to be certified for full Medicaid benefits in another Medicaid category, he/she may be certified for Medicare Savings coverage only.

E-440 Deeming Procedures

MS Manual 07/01/20

For the Medically Needy, Medicare Savings Program, and SSI/COLA groups (except DAC), when the eligible applicant resides with his or her ineligible spouse or ineligible parents, deeming of income from the ineligible spouse or parent(s) is required. Deeming is the process of considering another person's income to be available for meeting an applicant's or recipient's basic needs of food and shelter.

For the Nursing Facility, ARChoices, Assisted Living Facility, PACE, TEFRA, Autism, and DDS categories, deeming is not required.

- **NOTE:** For deeming procedures for an alien sponsor, refer to MS E-300 and E-445. For deeming procedures for the Medically Needy, refer to MS O-531 through MS O-535.

E-441 Deeming of Income from Ineligible Spouse

MS Manual 07/01/20

Consider a couple to be married if they are:

1. Legally married under State law or
2. Either determined to be the spouse of a Title II (Social Security) recipient or
3. Living together and holding out to the community in which they live as a married couple

NOTE: A married couple no longer living together as spouses will be considered as individuals the month after they separate.

An ineligible spouse is one of the couple as defined above that is not receiving medical assistance as an individual who is aged, blind, or as an individual with a disability.

Deeming of Income from Ineligible Spouse:

1. Determine the applicant's countable income allowing the SSI exclusions at MS E-450. If countable income is equal to or exceeds the individual SSI Standard Payment Amount (SPA) for the SSI/COLA groups or Medicare Savings Program (MSP) Standard for the MSP groups, the applicant is ineligible. If countable income is less than the individual SPA or MSP Standard, income will be deemed from the ineligible spouse.

NOTE: For spouse-to-spouse deeming to apply, the applicant or recipient must be eligible based on his or her own income.

2. Determine the total income of the ineligible spouse by types, earned and unearned less any excluded from deeming. Refer to MS E-446 to determine income excluded from deeming.

3. From the ineligible spouse's income, a living allowance (refer to Appendix S) is deducted for each ineligible child (refer to Glossary) in the home. Income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS E-446 #10. The living allowance is deducted from the unearned income first and any unused balance is then deducted from earned income. Total the remaining income.

4. If the ineligible spouse's remaining income is equal to or less than his living allowance, there is no income to be deemed. The applicant is income eligible.

5. If the ineligible spouse's remaining income exceeds his living allowance, the remaining income by type will be totaled with the applicant's gross earned and unearned income amounts.

6. Treat the two totals of income, earned and unearned, as you would for an eligible couple. The SSI exclusions at MS E-450 are deducted and the remaining earned and unearned income totaled to arrive at countable income.

7. Compare the countable income after deeming to the appropriate SSI SPA or MSP Standard for a couple. If the countable income is less than the couple's SPA or MSP Standard, the applicant is eligible. If the countable income is equal to or greater than the couple's SPA or MSP Standard, the applicant is ineligible.

E-442 Deeming of Income from Ineligible Parent(s) to Child

MS Manual 07/01/20

For purposes of deeming, a stepparent's needs and income will be disregarded.

1. Determine the gross monthly income of the ineligible parents(s) by type, earned and unearned less income excluded from deeming. Refer to MS E-446 to determine income excluded from deeming.

2. From the ineligible parent(s)'s income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). Any income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS E-446 #10. The living allowance is deducted from unearned income first. Any unused balance is then deducted from earned income.

3. After deduction of living allowance(s) from income, deduct SSI exclusions. (MS E-450).

4. Total remaining earned and unearned income and deduct a living allowance for the ineligible parent(s) equal to the SSI standard payment amount (SPA). (Appendix S).

5. Any remaining income (if any) is deemed to the child as unearned income. It is subject to the SSI exclusions at MS E-450.

6. If parental income is deemed to more than one eligible child, prorate the deemed income equally to each child.

E-443 Deeming of Income from a Parent Who Would Be Eligible Except for Excess Deemed Income to an Eligible Child

MS Manual 07/01/20

When there is a blind child or child with a disability living in the home with his or her parents and one parent is categorically eligible, the income of the ineligible parent is deemed first to the categorically eligible spouse and then to the eligible child. For this condition to apply, there must be acceptable evidence provided that proves that one parent would qualify as aged, blind or as an individual with a disability except for incomeThe deemed income to a blind or disabled child under these circumstances is determined as follows:

1. Complete steps 2 through 7 of spouse-to-spouse deeming as indicated at MS E-441. Deeming of Income from the Ineligible Spouse.

2. If the couple's income determined under spouse-to-spouse deeming is equal to or less than the couple's SSI standard payment amount (SPA), there is no income deemed to the child.

3. If the couple's income exceeds the couple's SPA, all of the countable income above the SPA is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally among each child. The amount deemed to the child as unearned income is subject to the SSI exclusions in his/her eligibility determination. Refer to MS A-214.

E-444 Deeming of Income to an Eligible Child from Parent/Parents Who Would Be Eligible Except for Excess Income

MS Manual 07/01/20

When there is a blind child or child with a disability living in the home with his or her parent(s) who would be eligible except for excess income, only the income above the parents' SSI standard payment amount (SPA) is deemed to the child. For this condition to apply, there must be acceptable evidence provided that proves that the parent/parents would qualify as aged, blind, or as an individual with a disability except for income. Deemed income is determined as follows:

1. Determine the parent/parents' countable income as if no children were involved. Allow the SSI exclusions listed at MS E-450.

2. If the countable income is equal to or less than the SPA, there is no income to deem to the child. If the countable income is greater than the SPA, the amount above the SPA is available for deeming to the child.

3. Reduce the excess income amount by a living allowance for each ineligible child in the home (i.e., those not blind or determined to have a disability). If this reduces excess income to zero, there is no income to deem to the eligible child. If not proceed to #4.

4. If excess income remains after deduction of living allowances, it is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to the SSI exclusions in his/her eligibility determination. Refer to MS A-214.

E-445 Exceptions to Deeming for Alien's Sponsor

MS Manual 07/01/20

Deeming from the alien's sponsor can be suspended for some aliens. The following aliens are not subject to deeming:

- Aliens who do not have sponsors.
- Aliens who have been battered or subject to extreme cruelty in the United States, and their children or parents who have been battered or subject to extreme cruelty. The abuse may be perpetrated by a U.S. citizen or lawful permanent residence spouse, parent, or their family members living in the same household in the U.S. This exception applies for 12 months from the date of determination that the alien has been battered. Refer to MS D-223.
- Aliens who are indigent. An alien with a sponsor who signed form I-864, Affidavit of Support and the alien is unable to obtain food and shelter. If the alien lives with the sponsor, it will be assumed that the sponsor is providing food and shelter and the indigence exception will not be granted and deeming will apply. If the alien is living apart from the sponsor, consider the alien unable to obtain food and shelter if:
    a. The income the alien receives is less than the income limit for the category of Medicaid for which the individual would be eligible.
    b. The resources available to the alien are under the resource limit for the Medicaid category for which the alien would be eligible.
- Aliens who can attain citizenship.
- Aliens qualifying for Emergency Medicaid services only. Refer to MS B-500.
- Pregnant women and children who meet one of the conditions in MS D-224.

E 446 Items (Income) Not Included in Deeming

MS Manual 07/01/20

The items listed below are excluded from income of the ineligible spouse or ineligible parent(s) before determination of deemed income.

1. Assistance or Income based on need: Includes payments by any Federal Agency, State or political subdivision of SSI payments and any income which was considered in determining such assistance.

    a. Exclusion applies to V.A. Pension but not to V.A. Compensation.

    b. Also includes TEA payments and income which was considered in determining assistance (including all income of a step-parent in cases which involve a step-parent).

2. Portions of Grants, Scholarships or Fellowships used to pay tuition and fees at an educational institution or the cost of Vocational Technical training which is preparatory for employment.

3. Foster Care Payments received for an ineligible child.

4. SNAP and Department of Agriculture donated foods.

5. Home produce grown for personal consumption.

6. Refund of income taxes, real property taxes, or taxes on food purchased by the family.

7. Income used to comply with terms of court-ordered support and Title IV-D support payments.

8. The value of In-Kind Support and Maintenance provided to ineligible members of the household.

9. Income excluded by other Federal Statute.

10. Earned income of an ineligible child who is a student unless the child makes such income available (contributes) to the family. This income would not be used to offset the living allowance which is deducted from parental income in the deeming process. If a contribution is being made by the student, consider only the amount contributed as available income.

11. Income necessary for a plan to achieve self-support (i.e., Approved Plan through Rehabilitation Services).

E-447 Deeming from a Non-Qualified Alien Spouse

MS Manual 07/01/20

When processing a Pregnant Woman Medically Needy spend down, the income of a non-qualified alien spouse will be deemed to the applicant, but his or her needs will not be included in the needs standard. A citizen or qualified alien spouse's income must be counted in full, with his or her needs included. The income and needs of non-qualified alien children will be disregarded. A citizen or qualified alien child's income and needs may be included if needed.

The form DCO-0072 is used to determine the deemed income from a non-qualified alien spouse.

E-450 Supplemental Security Income Exclusions

MS Manual 07/01/20

When the income limit for AABD Medicaid categories, such as the Medicare Savings categories or SSI/COLA categories, is below the Federal maximum (300% of SSI), the below SSI exclusions are allowable for the purpose of determining initial and continuing eligibility.

1. Refunds on real property taxes, food taxes or income taxes.
2. Assistance based on need (State Supplementation of SSI, Interim General Assistance).
3. The tuition and fees portion of grants, scholarships, and fellowships.
4. Home produce for personal consumption.
5. Irregular income or infrequent income which:
    a. Cannot be predicted with any regularity.
    b. Is received less than twice per year.
    c. Does not exceed $10 per month earned income or $20 per month unearned income.
    d. Income exceeding these amounts is considered in full.
6. The full amount of foster care payments made to an adult individual or eligible spouse.
7. One third of child support payments as income to a child.
8. The Student Earned Income Exclusion for a working student under the age of 22 who is enrolled in an educational institution attending a course of study preparatory for gainful

work. This exclusion will be adjusted annually based on increases in the cost of living index. There may be years when no increases result from the calculation. Refer to Appendix S for current amount.

9. $20 monthly may be excluded from any income not based on need (Per individual or per each couple determination), but

    a. Is not allowed from VA pension or payments made by Bureau of Indian Affairs.
    b. Is always applied to unearned income first, the balance, if any, is then applied to earned income.

10. $65 plus 1/2 of the remainder of monthly earned income.

11. Income to cover work expenses for the blind (FICA, federal withholding, state income tax, transportation, lunches, expenses for a seeing eye dog, etc.).

12. Income to fulfill a self-support plan for blind or disabled recipients. (Approved plan through Rehabilitation Services).

13. Home Energy Assistance and Support and Maintenance Assistance provided by private non-profit organization, state or federal government body, a supplier of home heating oil or gas, or a municipal utility providing home energy.

14. Support and Maintenance and other assistance received as a result of a presidentially declared disaster.

15. Agent Orange Settlement Payments (also excluded from resources).

Exceptions: The above SSI exclusions do not apply to LTSS categories including Nursing Facility, Home and Community Based Services (HCBS) Waivers, and PACE. These exclusions also do not apply to Autism and TEFRA cases because the income limit for these categories are at the Federal maximum of three times the SSI payment limit for an individual in his own home.

E-451 Assets Disregarded as Income

MS Manual 07/01/20

The following assets are disregarded as income in their entirety for all AABD categories, including Long-Term Services and Supports (LTSS) categories (i.e. Nursing Facility, Home and Community-Based Waivers, and PACE), also TEFRA and Autism:

1. Credit disability insurance payments made on home or automobile loans.

2. Personal services performed for the individual (mowing grass, house cleaning, etc.).
3. Funds received from any source for the repair or replacement of lost, damaged or stolen goods (Refer to MS E-530 #4 for resource consideration).
4. The sale of a resource (proceeds continue to be a resource) does not constitute income, but does represent a change in form of a resource.
5. Benefits received under other federal programs (Disaster Relief Program, Child Nutrition Act, etc.).
6. Dividends from insurance policies are not counted as income in determining eligibility, but are counted in determining net income for LTSS patient liability.
7. VA Aid and Attendance payments in the full amount (i.e., not reduced to $90) are excluded in making initial eligibility determinations and are also excluded as income to be applied to the vendor payment in a nursing or ICF/IID facility.
8. VA pension benefits reduced to $90 monthly and paid to single veterans with no dependents, or surviving spouses of veterans with no dependents, who are certified Medicaid eligibles in Medicaid facilities.

   The $90 payment is considered Aid and Attendance for eligibility purposes, and the full $90 is allowed as a personal needs allowance in facility cases. Individuals receiving VA compensation are not subject to the $90 reduction and they will not be given a $90 Personal Needs Allowance (PNA).
9. VA reimbursements for continuing medical expenses (CME) resulting in an increased monthly pension or for unusual medical expenses (UME) resulting in lump sum payments. These payments are not income in the initial eligibility determination and individuals are not required to apply these payments toward the vendor payment.
10. Any payments, including gifts and inheritances, made to an applicant/recipient due to the death of another person may be excluded from unearned income to the extent that the payments are spent on the deceased person's last illness and burial. If an applicant/recipient is unable to make payment of last expenses in the month that the funds are received, the funds will not be considered a countable resource until after one calendar month following the month of receipt (e.g., Funds received on July 15th may be excluded during July and August. If not spent, the funds will be a countable resource September 1st.) Any interest accruing to the unspent funds is countable unearned income in the month accrued.

11. Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) states that payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are not considered income in determining Medicaid eligibility. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also, payments made pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made are not income in determining Medicaid eligibility.

- **NOTE:** Any interest earned by these funds is countable unearned income in the month in which it is added to the account.

12. Federal tax refunds and advance payments

F-120 Blindness and Disability

MS Manual 07/01/20 42 U.S. Code § 1382c.

Some eligibility groups require an individual to be either blind or have a disability. The particular blindness and disability requirement for each eligibility group is listed in Appendix J.

Blindness is defined as having central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye.

Disability is defined as having a physical or intellectual disability which prevents the individual from doing any substantial gainful work (for a child under age 18, the disability should be of comparable severity), and which meets the following criteria:

1. Has lasted or is expected to last for a continuous period of at least 12 months (thirty days for the AFDC related categories, such as categories AFDC Medically Needy) or
2. Is expected to result in death

Blindness and Disability must be established by one of the following means:

1. Receipt of SSI (AB or AD), or receipt of a letter of entitlement to SSI with begin date of entitlement, if the individual has not received the first SSI payment.
2. Receipt of Social Security or Railroad Retirement (RR) based on disability, or receipt of a letter of entitlement to Social Security or Railroad Retirement based on disability, showing a begin date of entitlement, if the individual has not received the first SSA or RR payment.
3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefit continuation, when an individual has requested continuation within ten days of SSA determination that a physical or intellectual disability has ceased, has not existed, or is no longer disabling.
4. Nonreceipt of SSI cash benefits for reasons other than disability, but verification of an established disability that is current and continuing (e.g. TEFRA child).
5. Receipt of the DCO-0109, Report of Medical Review Team decision, when blindness or disability has been determined by the Medical Review Team.

Disability will either be established by Social Security Administration (SSA), Railroad Retirement (RR), or the Medical Revew Team (MRT). The following disability guidelines will apply to all Medicaid applicants where disability is an eligibility factor and disability has not been

determined. A disability decision made by SSA on a specific disability is controlling for that disability until the decision is changed by SSA. When DCO makes a disability determination, a later contrary SSA determination will supersede the state determination. If SSA has made a decision that a person does not have a disability, that decision is binding on DCO for one year with exceptions noted in MS F-122.

F-122 Medical Review Team (MRT)

MS Manual 07/01/20

When an individual applies for Medicaid and meets one or more of the conditions below, required forms along with any medical records provided will be submitted to MRT, provided it appears that the other eligibility factors are met. Refer to Appendix I for required forms.

MRT will determine disability if any one of the following conditions exists:

1. The individual has NOT applied for Social Security Disability or SSI or Railroad Retirement (RR).
2. The individual has been found NOT eligible for Social Security Disability or SSI for reasons other than disability (e.g., income).
3. The individual has applied for Social Security Disability or SSI, and SSA has NOT made a determination.

   EXCEPTION: Individuals applying for ARChoices, Assisted Living, or PACE, who require a determination of physical disability, will be referred to MRT even if receiving Social Security Disability IF SSA does not verify a primary type of disability that is physical. Refer to MS B-312, B-313, and B-318.
4. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations.
5. More than 12 months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA made the decision is worse or has changed, and he or she has not reapplied.
6. Less than 12 months have elapsed since the most recent Social Security Disability or SSI denial, and the individual alleges that the condition upon which SSA made the decision has changed or deteriorated, AND

   a. He or she has asked SSA for a reconsideration or reopening of its previous determination and SSA has refused to consider the new allegations

OR

b. The individual no longer meets the non-disability Social Security Disability or SSI requirements (e.g., income)

Individuals who do not meet a criterion specified above will be denied without further development.

NOTE: When a family member of a deceased Medicaid (ARChoices, Assisted Living, DDS, Nursing Facility, or PACE) recipient has applied for a hardship for estate recovery and is stating he or she has a disability but does not receive SSA, RR, or SSI disability, a social report will be submitted to MRT for a disability determination.

F-123 Dual Applications

MS Manual 07/01/20

When an individual applies for both Medicaid and Social Security Disability or SSI, and the application with SSA is still pending, if the individual appears to meet all other eligibility requirements a MRT determination of disability will be initiated. The agency will have 90 days from the date of the Medicaid application to make this determination.

If application for Social Security Disability is approved first, the Medicaid application may be approved (if all other requirements have been met.) If application for SSI is approved first, the Medicaid application will be denied except for ARChoices, Assisted Living, Autism, DDS, Nursing Facility (NF) and PACE which may be approved. If SSA determines the applicant is NOT disabled, the Medicaid application will be denied.

If the Medicaid application is approved based on a Medical Review Team (MRT) disability decision and later the individual is denied by SSA, the Medicaid case will be closed after appropriate notice, unless the recipient appeals the closure. If the appeal is made within the 10-day time frame, the Medicaid case will remain open pending the outcome of the DHS appeals process. In no case will the Medicaid case remain open pending the outcome of the SSA appeals process if the recipient has appealed the SSA decision.

If the Medicaid application is denied based on a MRT decision and later SSA approves the disability, when the applicant notifies DCO, the original application will be reinstated regardless of the time frame. If the provider files claims timely, Medicaid claims will be paid. Refer to MS A-190. The application will be processed with the original application date provided all other eligibility criteria were met for this time period.

F-125 MRT Decision

MS Manual 07/01/20

The Medical Review Team (MRT) will report the decision regarding physical or mental incapacity to the County Office on Form DCO-0109.

If an adverse action is taken on an individual's case, MRT will send a notice to the individual listing the specific medical records that were used in making the determination and the criteria that was not met.

If MRT finds that the medical information is not adequate to make a decision, further medical/psychiatric/psychological examinations may be recommended by MRT at the expense of the Agency.

Arrangements for such evaluations will be made by MRT only. When medical and social evidence has been resubmitted on questioned cases, the Medical Review Team will make a decision as to disability and notify the County Office on Form DCO-0109. This decision of MRT will be final, subject to the regular appeal process, unless a later decision by SSA finds the individual not disabled.

F-126 Reapplication that Requires a Disability Determination

MS Manual 07/01/20

If a reapplication is filed and the case has been closed within the past five years for reasons other than disability and the last Medical Review Team Report (MRT) stated, "Reexamination not necessary" or the date for reexamination has not yet been reached, new medical and social information will not be submitted to MRT. If the case has been closed for more than five years, new medical and social information must be submitted.

F-127 MRT-Reexamination of Disability

MS Manual 07/01/20

Reexamination of disability will be required by MRT when:

1. Medical and social information indicates that an individual may recover in a year or more and/or be rehabilitated to the point where he could meet substantial gainful employment.
2. The County Office requests reexamination at any time for the aforementioned reasons.
3. Reexamination is indicated on the Medical Review Team Report DCO-0109.

F-128 Substantial Gainful Activity (SGA)

MS Manual 07/01/20

Substantial gainful activity (SGA) is defined as the performance of significant physical and/or mental work activities for pay or profit, or work activities generally performed for pay or profit.

Countable monthly earnings are obtained by deducting any employer subsidy and any impairment related work expense (not payroll deductions) from the gross income (gross income includes payment in-kind for the performance of work in lieu of cash). Then, if earnings are irregular, they will be averaged over the period of months being considered to obtain countable monthly earnings.

Employer subsidy is the payment of wages that is more than the value of the actual services performed.

If the work is sheltered or if there is marked discrepancy between the amount of pay and the value of services, there exists the strong possibility of a subsidy that requires development of specific evidence.

Sheltered Employment is work performed by individuals with disabilities in a protected environment under an institutional program; nonsheltered employment is any work performed by individuals in an unprotected environment.

Impairment Related Work Expenses are items or services needed in order to maintain employment, such as attendant services, prostheses, or other devices. Drugs and medical services are not deductible unless it can be shown they are necessary to control the disability to enable the individual to work. Deductible expenses must be paid for by the individual and cannot be reimbursable from any source. Legitimate expenses may include installation, repair, or maintenance. The payments may be deducted in one month or prorated over 12 months.

The expenses must be considered “reasonable,” i.e., not more than Medicare would allow or than would ordinarily be charged in the individual’s community.

Refer to MS Appendix S for the current SGA amount for disability and blindness.

F-130 Child Support Enforcement Services

MS Manual 07/01/20

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Medicaid recipients who have assigned to the State their rights to medical support. Each applicant or

recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Medicaid applicants/recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Medicaid recipients are received and distributed to the custodial parent through the Central Office Child Support Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   An OCSE referral will be made at initial approval for children when a parent,guardian, or caretaker relative is receiving Medicaid or when the parent,guardian, or caretaker relative voluntarily requests a referral to be made. Refer to Exception and Note below.

   Act 1091 of 1995 amended by Act 1296 of 1997 requires that both parents sign an affidavit acknowledging paternity or obtain a court order before the father's name will be added to the birth certificate.

NOTE: If the father's name is included on the birth certificate of a child born 4/10/95 or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

EXCEPTION: Recipients in the Limited Medicaid Pregnant Woman eligibility group will not be required to cooperate with the OCSE on Medicaid certified children until after their postpartum period has ended and the recipient enters another group where cooperation with OCSE is required.

NOTE: For child-only cases, cooperation with OCSE is voluntary. The only time referral to OCSE is necessary is when a parent,guardian, or caretaker relative is eligible in another Medicaid eligibility group in which cooperation with OCSE is mandatory. Cooperation with OCSE will be strictly voluntary, when a:

- Parent,guardian, or caretaker relative is not receiving Medicaid but the children are receiving Medicaid or

- Parent,guardian, or caretaker relative is the only one receiving Medicaid and the children are not receiving Medicaid or
- Parent,guardian, or caretaker relative is receiving Medicaid in an exempt category (i.e., Limited Medicaid Pregnant Woman)

A parent is considered to be absent for Medicaid purposes when the absence is due to divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home or military service, regardless of support, maintenance, physical care, guidance or frequency of contact.

2. Good Cause

An applicant/recipient may have good cause not to cooperate in the State's efforts to collect child and/or Medical support. The applicant/recipient may be excused from cooperating if he or she believes that cooperation would not be in the best interest of the child, and if the applicant/recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant/recipient has good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child.
- Cooperation is anticipated to result in physical or emotional harm to the individual which is so serious it reduces the ability to care for the child adequately.
- The child was born as a result of forcible rape or incest.
- Court proceedings are in progress for the adoption of the child.
- The individual is working with an agency helping to decide whether or not to place the child for adoption.

3. Refusal to Cooperate-Sanction

For Medicaid, a child's benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support. However, Medicaid for the parent or caretaker relative will end after the appropriate notice has expired.

F-140 Medical Care Requirements

MS Manual 07/01/20

For facility care, the individual must meet the categorical eligibility and medical necessity requirements. Refer to MS F-150 and F-151.

For Home and Community-Based Waivers, Autism, DDS and PACE, the individual must meet the medical necessity, appropriateness of care, and cost effectiveness requirements. Refer to MS F-151, MS F-152, MS F-153, and MS F-154.

For TEFRA, the individual must meet the medical necessity and appropriateness of care requirements. Refer to MS F-151 and MS F-153.

F-150 Establishing Categorical Eligibility for Long-Term Services and Supports (LTSS)

MS Manual 07/01/20

Current recipients of SSI and Foster Care, for whom the Agency has legal responsibility, automatically meet the categorical eligibility requirement.

However, if any question regarding the categorical eligibility of these individuals should arise, the question will be resolved with either Agency or SSA personnel before proceeding further with the application. If the eligibility of an SSI recipient is questionable, a statement will be obtained from SSA (preferably written) to document its awareness and treatment of the eligibility factor.

Categorical eligibility for individuals other than SSI or Foster Care will be determined according to SSI-related AABD facility eligibility criteria as follows:

1. Institutional Status (Nursing Facility Only) - It must be verified that the individual has been institutionalized for 30 consecutive calendar days (an exception to the 30 days is made when death occurs prior to 30 days). Refer to MS F-152. The period of 30 days is defined as being from 12:01 a.m. of the day of admission to 12:00 midnight of the 30th day following admission.

   Hospitalization will count toward meeting the institutional status requirement if the individual enters a facility on the date of discharge from the hospital. This includes hospitalization at Arkansas State Hospital in Little Rock. It also applies to individuals who enter an Arkansas institution directly from an out-of-state institution.

EXAMPLE: An individual enters a facility anytime on July 18th. The 30-day count begins at 12:01 a.m. of the morning of July 18th and ends at midnight of August 16th.

2. Categorical Relatedness - In order to meet the requirement of categorical relatedness, the individual must meet one of the following:

   Aged - Age 65 or older (MS F-110) or

   Blind - Central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye (MS F-120) or

   Disabled - Physical or mental impairment which prevents the individual from doing any substantial gainful work (for a child under age 18, an impairment of comparable severity), and which meets the following criteria:

   - Has lasted or is expected to last for a continuous period of at least 12 months or
   - Is expected to result in death (Refer to MS F-120 and MS F-124.)

F-151 Functional Need

MS Manual 07/01/20

Before nursing facility, waiver services or PACE can be authorized, it must be determined that the patient's condition warrants facility care or waiver services. Functional need decisions are made based on the information submitted on the DHS-0703. The decision will be reported to the County Office on the DHS-0704.

Functional need decisions for:

- Nursing facility applicants and recipients are made by the Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC)
- Assisted Living, ARChoices Waivers and PACE applicants and recipients are made by the Division of Aging, Adult and Behavioral Health Services (DAABHS)
- DDS waiver applicants and recipients are made by the Division of Developmental Disabilities Services
- TEFRA applicants and recipients are made by the TEFRA Committee and
- Autism applicants and recipients are made by the DPSQA Office of Long Term Care, Utilization Review

Applicants for nursing facility admission with indicators or diagnoses of mental retardation or mental illness must be evaluated under Pre-Admission Screening and Annual Resident Review (PASARR) requirements for determination of appropriate placement prior to entering a nursing facility. Persons requiring pre-admission evaluations for mental retardation or mental illness shall not be eligible for Medicaid reimbursement of nursing facility services prior to the date that a determination is made (the PASARR effective date on the DHS-0704), unless emergency admission has been prior authorized by the DPSQA Office of Long Term Care PASARR Coordinator or Utilization Control Committee.

ICF/IID applicants are exempt from PASARR evaluation, but they are not eligible for services prior to the decision date on the DHS-0704.

Redetermination of Functional Need

The DPSQA Office of Long Term Care (OLTC) will periodically review and redetermine patient classification and necessity for continued stay in a facility when required. Classification and functional need reviews will be made only for individuals whose condition changes and for those admitted for convalescent care.

When OLTC finds that reclassification of a recipient is warranted, the reclassification information will be provided to the facility and to the eligibility worker who will make an adjustment to the vendor payments.

When continued stay in a facility is determined not to be functionally necessary including a determination due to a PASARR evaluation, OLTC will notify the facility administrator and the County Office by sending the DHS-0704. If it is a PASARR determination, OLTC will notify the recipient or his or her legal guardian by letter.

Recipients determined not in need of facility services will be allowed thirty (30) calendar days continued facility eligibility to arrange for relocation.

F-152 DCO Institutional Status

MS Manual 07/01/20

Evidence of institutional status includes any written document, record, etc. from a hospital and/or nursing facility which verifies that the individual was in the hospital and/or nursing facility for 30 consecutive calendar days. Refer to MS F-150.

When an individual cannot meet the institutional status requirement, the application will be denied, unless the individual dies before meeting the 30-day requirement. In that case, certification may be made for the actual days spent in the facility.

With medical documentation, such as a physician's statement, hospital records, etc., that the patient is "likely to remain" in the institution and/or facility for a period of 30 days, the rules may be applied and the individual may be certified, if the individual is otherwise eligible, before a period of 30 days has passed. If the case was opened and the patient does not remain institutionalized 30 days, no penalty will be imposed on the patient if there is likely to remain documentation in the case record. "Likely to remain" applies only to individuals in facilities with community spouses. Single individuals must meet the 30 day institutionalization requirement.

When an individual has met the institutional status requirement of 30 consecutive days, eligibility for facility services will be effective the date of entry into the facility if all other eligibility requirements are met, unless the individual is in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or was subject to PASARR. Refer to MS H-440.

NOTE: The institutional status requirement does not apply to individuals who were certified for SSI or Foster Care in the month of facility entry.

Individuals who become ineligible for SSI or Foster Care following the month of nursing facility entry, will have their categorical eligibility determined according to SSI-related AABD facility eligibility criteria, with the exception of the institutional status requirement. Refer to MS F-150.

F-154 Cost Effectiveness

MS Manual 07/01/20

The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution.

For ARChoices, PACE, and Assisted Living, this determination will be made by the Division of Aging, Adult and Behavioral Health Services (DAABHS). If at any time DAABHS determines that cost effectiveness is not met, the eligibility worker will be notified by DHS-3330 and the case will be closed after the appropriate notice is sent to the individual.

For DDS, the Division of Developmental Disabilities Services is responsible for monitoring cost effectiveness.

For Autism and TEFRA, the Division of Medical Services is responsible for monitoring cost effectiveness.

F-155 Functional Need Criteria

MS Manual 07/01/20

Individuals requiring services in ARChoices or ALF must be classified as requiring an Intermediate (I-A, II-B, III-C) Level of Care as determined by the DPSQA Office of Long Term Care (OLTC). Individuals classified as Skilled Care patients are not eligible for ARChoices or ALF.

Individuals requiring services in a nursing facility or PACE must be classified as requiring a Skilled, Intermediate I-A, Intermediate II-B or Intermediate III-C Level of Care as determined by the DPSQA Office of Long Term Care.

No individual who is otherwise eligible for Waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic functional condition or disqualifying episodic change of functional condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive Waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.

If an individual has a serious mental illness or has mental retardation, the individual will not be eligible. However, the diagnosis of severe mental illness or mental retardation will not bar eligibility for individuals having functional needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting all other eligibility criteria.

Individuals requiring services in DDS must be classified as requiring an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care.

ARChoices, Assisted Living, and PACE

To be determined an individual with a functional disability, a licensed medical professional must determine an individual meets the criteria established by the Division of Aging, Adult and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care.

DDS

To be determined an individual with a developmental disability, DDS will administer a comprehensive Diagnosis and Evaluation. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) eligibility is determined based on a schedule according to the individual's age.

DDS will develop an individualized plan of care which will be reviewed within six months of the initial assessment and, again, prior to 12 months from admission to the program. Thereafter, DDS Plan of Care reviews will be completed annually.

F-156 Incapacitation

MS Manual 07/01/20

A person is presumed to possess legal capacity unless declared incapacitated by a probate court.

Arkansas Statutes define a person as "incapacitated" when by reason of minority or of impairment due to a disability such as mental illness, mental deficiency, physical illness, chronic use of drugs, or chronic intoxication, he is lacking sufficient understanding or capacity to make or communicate decisions to meet the essential requirements for his health or safety or to manage his estate.

Whenever a person is incapable of caring for himself or his property, a need for a guardian is indicated. A guardian of the estate may be appointed if the person is incapable of managing property, money or his legal affairs. Guardianship of the person is indicated if the person is incapable of taking care of his person.

Normally, the question of incapacitation will not be considered in an eligibility determination. If a person has been adjudicated incapacitated and has had a guardian appointed for him, it will be necessary for the guardian to make application for benefits since the individual does not have that legal power.

If a person's incapacitation has not been determined, it will not be considered in an eligibility determination as long as the person is able to make his wants or application known. If a person has excess resources and a claim is made that his resources are not available due to incapacitation, it will be the responsibility of the person alleging the incapacitation to furnish proof of the incapacitation and to find a person able and willing to serve as guardian of the person and/or estate. The person alleging the incapacitation will be required to provide a medical affidavit attesting to the incapacitation of the individual.

Advance Notice

When the medical statement has been obtained, the County Office will inform the person alleged to be incapacitated and the person who has made the allegation that:

1. A period of 120 days will be allowed to find a person who will serve as guardian, to present the guardianship request to probate court, and to finalize the guardianship proceedings.

2. The resources in question will be excluded for 120 days or until the first day of the month following the month in which the court order establishing guardianship is filed, whichever occurs earlier.

3. A copy of the court order establishing guardianship must be given the County Office within ten days of filing the order.

4. Any Long-Term Services and Supports (LTSS) payments made on behalf of the person alleged to be incapacitated during the exclusion period will be subject to recovery in accordance with overpayment policy if the probate court fails to find the individual incapacitated or if the person alleging incapacitation fails to initiate and finalize action for the appointment of a guardian within the allotted time.

   If the guardianship has not been finalized within 120 days and if the parties involved maintain that diligent and good faith efforts have been taken to obtain the guardianship, the County Office will submit the case record to the Office of Chief Counsel (OCC) along with all related documents and a cover memorandum summarizing the facts and requesting a review to determine if an extension of time is warranted.

   If the written opinion obtained from OCC states that circumstances justify an extension of the 120-day period and specifies the duration of time for the extension, the extension will be granted.

   If no time extension is found justifiable, the county will proceed as instructed below.

Case Closures

Case closures, when applicable, will be made on the first day of the month following the month in which:

1. The court order establishing guardianship is filed and reported.

2. The allotted 120 days has ended (when OCC did not grant an extension or when no guardianship action was initiated).

3. The time extension granted by OCC has expired and guardianship has not been finalized.

Advance notice of closure is not required.

Overpayments

If LTSS services have been paid, an overpayment will be written when:

1. The individual was not found to be incapacitated by the court.
2. The person making the allegation failed to initiate action and to establish guardianship within the allotted time, or to finalize guardianship within the OCC extension of time, or OCC did not find an extension of the 120 days was warranted.

No overpayments will be written when the court has found that the individual is incapacitated. A copy of the court order will be obtained by the County Office for the case record, and the guardian will be responsible for petitioning the court to dispose of excess resources. A redetermination of LTSS eligibility will not be made until disposition of the excess resources has been made.

F-161 Primary Care Physician Managed Care Program

MS Manual 07/01/20

ConnectCare is the Arkansas Medicaid Primary Care Case Management (PCCM) system. In ConnectCare, a Medicaid recipient chooses a physician or single-entity provider, such as Area Health Education Centers (AHEC), Federally Qualified Health Centers (FQHC), or family practice and internal medicine clinics at the University of Arkansas Medical Sciences campus, who is responsible for the management of the recipient's total care.

Each Medicaid recipient must choose a Primary Care Physician (PCP) except those who:

- Have Medicare as their primary insurance
- Are in nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Are Medically Needy Spend Down only
- Have retroactive eligibility only or
- Are temporarily absent from the State

Generally, a recipient must receive medical services from only the PCP or from the medical provider referred to by the PCP. There are some services which are excluded from the Primary

Care Case Management (PCCM) system. A recipient can receive these services without a referral from the PCP. Refer to Form DCO-2613, Notice to Medicaid Applicants/Recipients, for a list of these excluded services.

F-162 Recipient Responsibilities

MS Manual 07/01/20

A Primary Care Physician (PCP) must be chosen for each family member who is a recipient. Each member may have a different physician.

The recipient must choose a physician who provides services in the recipient's county of residence, in a county which adjoins the county of residence, or in a county which adjoins the adjoining county. A recipient who lives in a county which borders another state may choose a physician in the bordering state.

If a recipient chooses to see a health care provider other than the primary care physician, or other than a provider to whom the primary care physician has made a referral, the recipient will be responsible for payment for any services received.

F-164 Changes in Primary Care Physicians

MS Manual 07/01/20

A change in a recipient's Primary Care Physician can be made in the following circumstances:

1. A physician moves from the county, closes his office, or withdraws from the program
2. A recipient moves from the county
3. A recipient finds his relationship with the physician unacceptable

   If there is an allegation of substandard care, the recipient may report it to the Utilization Review Section, Division of Medical Services (**501-682-8340**). In this situation, no change in physician will be made until the County Office is authorized to do so by the Utilization Review Section.
4. A physician finds his relationship with the recipient unacceptable; the recipient is abusive to the physician; or the recipient fails to comply with medical instructions

F-170 TEFRA Premium

MS Manual 07/01/20

TEFRA households with annual income after allowable expenses above 150% of the Federal Poverty Level for their household size will be required to pay monthly premiums as described in the sections below.

F-171 Determining Monthly Premiums

MS Manual 07/01/20

The amount of the premium will be determined based on the custodial parent(s) total gross income as reported on the applicable Federal Income Tax Return (e.g., line six of the 2018 version of form 1040) less the following deductions:

- Six hundred dollars ($600) per child, biological or adopted including the waiver child, who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents
- Excess medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parents (e.g., line four on the 2018 version of Schedule A)

EXAMPLE 1: Family consists of five people – mom, dad, TEFRA child, and two minor siblings, living in the home. Total income on last year's Federal Income Tax Return showed $65,417.48. Excess medical and dental on Schedule A showed $9,463.25. All children in the home were included on the return.

- $65,417.48 - $1,800.00 ($600 x 3) - $9,463.25 = $54,154.23

Compare the adjusted income to Chart 1 in Appendix P (2018). The income is above the limit for a family size of five. Go to Chart 2. The premium range for the adjusted income is from $52.00 to $78.00.

EXAMPLE 2: Same family with less income reported.

- $46,500.00 - $1,800.00 ($600 x 3) - $9,463.25 = $38,336.75

Comparing income in Chart 1 in Appendix P (2018), the annual income is below the limit for a family size of five. Therefore, no premium is required.

If the custodial parent alleges that household income has decreased significantly since filing the Federal Income Tax Return, additional verification can be submitted to determine current income.

NOTE: A stepparent living in the home will be considered a custodial parent and his or her income will be included when determining the premium amount.

See Appendix P for the amount of premiums to be paid. The maximum annual premium amount to be paid by any family is $5,500. Families having more than one child receiving TEFRA Waiver benefits will pay only one premium for all covered children. There will be no increase in premium amount for additional Waiver children.

F-180 Other Health Insurance Coverage

MS Manual 07/01/20

For most eligibility groups, an individual may be covered by other health insurance without affecting his or her eligibility for Medicaid. There are two exceptions to this which are described below.

Adult Expansion Group

An individual who is eligible for or enrolled in Medicare is not eligible for the Adult Expansion Group.

ARKids B

Children who have health insurance or who have been covered by health insurance other than Medicaid in the 90 days preceding the date of application will not be eligible for ARKids B unless one of the following conditions is met:

a. The premium paid by the family for coverage of the child under the group health plan exceeded five percent of household income.

NOTE: A group health plan means an employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

b. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the Employer Sponsored Insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

c. The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

d. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.

e. A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).

f. The child has special health care needs. Special health care needs are defined as the health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

g. The child lost coverage due to the death or divorce of a parent. Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out of state and covers the child on his or her HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the eligibility worker based on information provided by the applicant.

If a parent or guardian voluntarily terminates insurance within the 90 days preceding application for a reason other than those listed above, the children will **not** be eligible for ARKids B.

The applicant's declaration regarding the child's health insurance coverage will be accepted.

This is a special requirement for ARKids B only and does not apply to ARKids A or other Medicaid categories.

F-190 Medicare Entitlement Requirements for Medicare Savings Programs (MSP) Eligibility Groups

MS Manual 07/01/20

Medicare entitlement is an eligibility requirement for all Medicare Savings Programs (except ARSeniors), even though the requirement differs somewhat between the five groups. Medicare entitlement 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 Qualified Medicare Beneficiaries (QMB), and thus eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits. The Medicare entitlements requirement is as follows:

- ARSeniors – Individuals do not have to be entitled to Medicare (e.g., Qualified Aliens who have not worked enough quarters to Qualify for Medicare can still be eligible for ARSeniors). However, individuals who are entitled to Medicare and choose not to enroll in Medicare are not eligible for the ARSeniors program.
- QMB – Individuals must be entitled to or conditionally eligible for Medicare Part A.
- Specified Low-Income Medicare Beneficiaries (SMB) – Individuals must be entitled to Medicare Part A.
- Qualifying Individuals 1 (QI-1) – Individuals must be entitled to Medicare Part A.
- Qualified Disabled and Working Individuals (QDWI) – Individuals who lost Medicare Part A & SSA Disability Insurance Benefits (DIB) benefits due to Substantial Gainful Activity (SGA). The individual must be eligible to reenroll in Medicare Part A. Refer to MS F-192.

F-191 Medicare Part A Entitlement

MS Manual 07/01/20

Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who are:
    a. Entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries.
    b. Not entitled to monthly Social Security or Railroad Retirement benefits, but meet the requirements of a special transitional provision (some individuals who are not eligible for regular SSA or Railroad Retirement benefits still qualify for Part A hospital insurance).
    c. Not entitled to monthly Social Security benefits and not a qualified Railroad Retirement beneficiary, but enrolled and paying a monthly premium. To be eligible under this provision, an individual must be age 65 or older, a U.S. resident, and a U.S. citizen or an alien lawfully admitted for permanent residence who has resided continuously in the U.S. for five years, and enrolled

for Part B medical insurance or has filed a Part B enrollment request which will entitle the individual to Part B.

d. Conditionally eligible except that they are not receiving Part A Medicare because they cannot afford to pay the premium for Part A.

2. Persons under age 65 who are entitled to or deemed entitled to Social Security disability benefits for 24 months (included are workers with disabilities, widow(er)s with disabilities, surviving divorced spouses with disabilities, and individuals entitled to childhood disability benefits) beginning with the 25th month of entitlement to such benefits, and certain individuals entitled to Railroad Retirement benefits due to a disability.

3. Persons of any age who have end-stage renal disease (ESRD) who require a kidney transplant or a regular course of dialysis and who are Social Security or Railroad Retirement recipients, or the spouse or a child of an SSA recipient when the spouse or child has ESRD.

Entitlement to Part B Medical Insurance is not an eligibility requirement for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SMB), or Qualifying Individuals 1 (QI-1). An individual must be entitled to Part A for SMB or QI-1 and entitled to or conditionally eligible for Part A to be eligible for QMB.

For QMB, SMB, and QI-1, if an individual is receiving Part A Medicare but not receiving Part B Medicare, the application will be approved, if eligible. Being enrolled in Part B Medicare is not an eligibility requirement. After the approval and the individual's name appears on the buy-in rolls, the Centers for Medicare and Medicaid Services (CMS) will receive notice that the individual is eligible and entitled to Part B Medicare. The individual will not be assessed a late filing penalty.

Individuals Entitled to Part A Without Payment of Part A Premium

A person entitled to Social Security retirement benefits or a qualified Railroad Retirement beneficiary is automatically eligible for Medicare Part A (hospital insurance) beginning with the first day of the month of attainment of age 65, but the individual must apply with SSA in order to be enrolled.

An individual who fails to enroll for Medicare upon attainment of age 65 may enroll during the General Enrollment Period (January through March of each year). If the individual enrolls during

the General Enrollment Period (January through March), coverage starts on July 1 following enrollment.

Individuals Who Would Be Entitled to Medicare Part A if They Could Pay Part A Premiums:

1. SSI Recipients

   Ordinarily, the Social Security Administration will refer these individuals directly to the DHS Central Office for accretion to the system and, thus, for QMB benefits, including payment of Part A Premium.

2. Non-SSI Individuals Receiving Part B Medicare

   An individual already receiving Part B Medicare may have a QMB eligibility determination made without going to SSA to apply for Part A. If found QMB eligible and certified by the County, the individual will become entitled to Part A Medicare (and all other QMB benefits) when the system accretes the individual and the State Medicaid Agency begins paying the Part A Medicare premiums. The system accretions for these individuals and for SSI QMB eligibles may be made at any time of the year (i.e., they do not have to be done during a general enrollment period or at any other specified time).

3. Individuals Not Receiving Part A or Part B Medicare

   An individual not receiving Part A or Part B Medicare must first go to SSA to apply for Medicare benefits. If SSA determines an individual meets the Medicare requirements, SSA may refer the individual to DHS for a QMB eligibility determination.

F-192 Medicare Entitlement Requirements for Qualified Disabled and Working Individuals (QDWI)

MS Manual 07/01/20

The following requirements must be met by an individual to qualify for benefits as a QDWI:

1. Lost Medicare Part A and SSA-Disability Insurance Benefits (SSA-DIB) due to Substantial Gainful Activity (SGA) – The individual must have previously received and lost entitlement to SSA-DIB and Medicare Part A solely due to earnings that exceed the SGA amount, as determined by the Social Security Administration. If the individual's loss of SSA-DIB and Medicare Part A was for another reason (e.g., no longer has a disability), the individual will not qualify as a QDWI.

2. Entitled to Reenroll in Medicare Part A – The individual must be entitled to reenroll for Medicare Part A and must reapply for coverage with the Social Security Administration prior to QDWI certification.

   The following information must be verified:

   a) Individual's blindness or disability is continuing

   b) Individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA

   c) Individual has reenrolled for Medicare Part A

   d) Effective date of Medicare Part A coverage.

The individual will be asked to provide any notices received from SSA or to obtain the needed information directly from SSA.

F-193 Initial Enrollment Period and General Enrollment Period for Medicare Part A

MS Manual 07/01/20

A Qualified Disabled and Working Individuals (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 Substantial Gainful Activity (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 contact 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 seven months later.

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

H-400 Post Eligibility

MS Manual 07/01/20

The eligibility groups Nursing Facility, Assisted Living Facility, PACE recipients in a nursing facility, and PACE recipients in the community who have met income eligibility by establishing an irrevocable income trust require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

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

MS Manual 07/01/20

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

H-402 Consideration of Income

MS Manual 07/01/20

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

1. Income Not From A Trust

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

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

    c. If payment of income is made in the names of the IS and/or the CS and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and no

such interest is specified, one half of the joint interest will be considered available to each spouse.

2. Income From A Trust

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

3. Income Through Property With No Instrument Establishing Ownership

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

H-403 Rebutting Consideration of Income

MS Manual 07/01/20

The eligibility worker will advise the applicant or representative of the income that will be considered in the gross income test of the institutionalized spouse (IS).

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. To successfully rebut the presumption of full or partial ownership, he/she must provide the following within 30 days of the date on the DHS- 0712, Post Eligibility Income Worksheet:

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

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

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

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

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

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

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

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

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

NOTE: This section does not apply to federal, state or other entitlements, pensions or retirement benefits.

H-410 Factors Used to Determine the Cost of Care

MS Manual 07/01/20

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

NOTE: ARChoices and DDS Waiver recipients do not contribute to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living and PACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the applicant/recipient, their spouse, 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 DHS-0712, Post Eligibility Income Worksheet, for the appropriate time period.

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

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

1. **Total Earned and Unearned Income**

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

   - For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget.
   - VA Aid and Attendance payments and VA CME/UME will not be counted as income.
   - Mandatory deductions and work related expenses will be deducted from gross earnings.
   - An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in 10-bed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and State Human Development Centers. Refer to MS H-430.
   - LTC insurance payments, whether paid to the facility or directly to the recipient, are not considered in the eligibility process, but are counted toward cost of care.

2. **Income Trust Fees (if applicable)**

   Deduct the applicable income trust fees. Refer to MS H-111 #3.

   - The monthly service charge for maintaining the trust bank account and
   - Commercially reasonable administrative fees charged by the commercial institution serving as trustee

3. **Personal Needs Allowance**

   Deduct the personal needs allowance (PNA).

   - Subtract a $40 PNA for most facility residents.

   NOTE: Facility residents whose only income is SSI will be allowed to keep $30 as their PNA. The PNA of a SSI recipient who also has other income is $40. Refer to MS H-420.

   - Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. An additional $40 will not be given. A $90 PNA will not be given to any individual whose VA pension has not been reduced to $90 by the Veterans Administration (VA). If VA later reduces the pension to $90, an income adjustment will be made.

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

- For residents of ICF/IIDs and State Human Development Centers with earned income, $40 may be given as a PNA in addition to a disregard of earned income up to the current SSI SPA.

- For nursing facility residents with earned income, $40 may be given as a PNA in addition to a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. Refer to MS H-430.

4. Community Spouse Monthly Income Allowance (CSMIA)

- A community spouse (CS) may be entitled to a portion of the Institutionalized Spouse's (IS) income. The total amount of the IS's income to which the CS is entitled is the **CSMIA**. It is calculated by adding the Minimum Monthly Maintenance Needs Allowance (**CSMNA**) and the Excess Shelter Allowance and subtracting the community spouse's own income. The CSMNA is capped at a Maximum Monthly Maintenance Needs Allowance amount. The excess shelter allowance, CSMNA, and Maximum Monthly Maintenance Needs Allowance change annually. They are set by the federal government and are based on the Consumer Price Index.

- Shelter costs may include rent or mortgage (including principal and interest), prorated taxes and insurance (including personal property taxes and insurance on household contents if paid yearly), condominium or cooperative fee (including maintenance charges), and the standard utility allowance.

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

NOTE: The standard utility allowance is not allowed if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (e.g. water), the full utility allowance may be used.

- The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA. Refer to MS H-416.

- An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA. Refer to MS H-208.

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

5. Family Member Allowance (FMA) When There is a Spouse in the Home

- A dependent family member may be entitled to an allowance. See MS Glossary for definition of dependent family member.

- The FMA is computed for each dependent family member by deducting the family member's income from the **CSMNA** and by dividing the result by three.

- 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. Refer to MS H-415.

NOTE: A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether to accept a CSMIA or FMA. 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.

6. Protected Maintenance Allowance for Dependent Children When There is No Spouse in the Home

- In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.
- Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under the age of 18, the combined income of the children must be less than the Medically Needy Income Level (MNIL) for the appropriate number of children in the household to qualify for protected maintenance. Refer to MS O-710 for MNILs.
- In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance.

7. Non-covered Medical Expenses **42 CFR § 435.725; Arkansas Act 892**

Non-covered medical expenses of all facility recipients which are not subject to payment by a third party will be deducted. Per 42 CFR § 435.725, this includes incurred expenses for medical or remedial care that are not subject to payment by a third party, including —

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses

Reasonable limits on amounts for necessary medical or remedial care not covered under Medicaid:

- The non-covered expenses must be incurred no earlier than the three-month period preceding the month of application.
- The non-covered expenses must be prescribed by a Medical professional (e.g., a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic/elective procedures (e.g., face lifts or liposuction) will not be allowed except when prescribed by a medical professional.

- The expense amount is the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Arkansas.
- Expenses incurred as a result of the imposition of a transfer of assets penalty are not allowed.
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary, are not allowed.
- Deduction is not allowed for procedures allowed by Medicaid when prior authorization is denied due to the service being medically unnecessary.
- Expenses when a third party (including Medicaid) is liable for the expenses, even if provided by an out-of-network provider, are not allowed.
- General health insurance premiums paid by someone other than the recipient (excluding the community spouse) who is not a financially responsible relative and repayment is not expected to be paid back to the third party by the recipient, are not allowed.

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. Only the non-covered medical expenses for the facility recipient may be deducted.

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

An income offset for the purchase of eyeglasses, contact lenses, hearing aids, prostheses, and dentures can be made only if the following procedure is followed:

1) The items must be prescribed by a physician or other licensed medical practitioner.
2) The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that he or she is able to utilize the item(s).
3) The request must be approved by the facility's Quality Assessment and Assurance Committee.
4) The cost of the item(s) must be determined.
5) The recipient or authorized representative must provide the eligibility worker with verification of the above. The recipient or authorized representative must not make the purchase or pay the medical bill until the eligibility worker has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Medicaid formulary; physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility worker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, including proof of the cost. A copy of the health insurance bill can be used for proof of health insurance premiums, deductibles, and coinsurance.

Medicare premiums deducted from SSA payments prior to buy-in are not allowed as they will be reimbursed. The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

NOTE: There is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the Medicaid formulary. Medicaid facility recipients who are not certified for vendor payment are limited to three prescriptions per month. Nursing facility hospice recipients are eligible for three (3) prescriptions drugs per month, with the option of receiving up to six (6) prescriptions with prior authorization.

Medical expenses can be of three types:

a. Monthly - Expenses incurred regularly each month such as the Medicare Part D enhanced plan portion of premiums above the benchmark

b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums

c. One-time - Expenses incurred such as hearing aids

If the eligibility worker is unable to determine within a fair degree of certainty what the non-covered medical expenses will be, then no medical expenses will be deducted from the income.

8. Net Income

After deduction of any applicable excluded earnings, income trust fees, personal needs allowance, maintenance allowances, and non-covered medical expenses, the net amount remaining will be the amount the individual is expected to apply to the cost of care.

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

After the DHS- 0712 is completed, a copy will be provided to each spouse. If the form is completed prior to application, at the request of either spouse, the DHS-0712 will only be provided to the spouse making the request.

H-412 Contribution to the Cost of Care for Assisted Living Facilities

MS Manual 07/01/20

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

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

1. Room and board payment

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

2. Personal needs allowance (PNA)
3. Monthly medical insurance premiums
4. Non-covered medical expenses including over the counter medications and medical supplies
5. Spousal support payments for the community spouse and Family Member Allowance (MS H-410 #4-6)
6. Applicable income trust fees (MS H-111 #3)
7. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician

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

H-413 Contribution to the Cost of Care for PACE

MS Manual 07/01/20

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long-Term Services and Supports (LTSS) nursing facility Medicaid. Refer to MS H-410.

For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust. For income trust guidelines, refer to MS H-110.

The eligibility worker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The patient liability amount will be calculated using the form DHS-0712. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current nursing facility PNA, any applicable community spouse allowances and/or family allowances, and excess medical expenses will be deducted from the PACE participant's monthly income. Refer to MS H-410.

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

H-415 Option to Estimate Net Income

MS Manual 07/01/20

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

H-416 Verification or Refusal of Contributions

MS Manual 07/01/20

Prior to certification of the Institutionalized Spouse (IS), the IS or representative must complete and sign the statement on the reverse of the DHS-0712 to indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) and the Family Member Allowance (FMA) specified on the DHS-0712, during the period of institutionalization.

If the DHS-0712 is not completed and signed, **no** allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income by completing the appropriate section on the DHS-0712.

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual 07/01/20

SSI recipients entering a medical or nursing facility will be allowed to retain their full SSI benefits if:

a. they have a home to maintain and

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

No extension beyond the three months will be allowed.

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

MS Manual 07/01/20

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 contribute to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

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

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

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

The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make.

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

H-430 Earnings of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facility Residents

MS Manual 07/01/20

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

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

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

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

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

2. Fluctuating Earnings

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

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

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

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

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

H-440 Effective Eligibility Dates for Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services

MS Manual 07/01/20

The effective date of eligibility of an applicant for nursing home and ICF/IID depends on three factors:

1. Date of Entry – The individual's date of entry into a participating facility is indicated on the DCO-0702, Notice of Admission, Discharge or Transfer From a Facility, which is completed by the facility and forwarded to both the DPSQA Office of Long Term Care and the County Office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.
2. Date of Medical Necessity – Medical necessity is determined by the DPSQA Office of Long Term Care. The medical necessity decision is transmitted to the County Office and the facility by the DHS-0704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-0704 is received by the County Office on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/IID facility or was subject to Pre-Admission Screening and Annual Resident Review (PASARR), medical necessity begins on the DHS-0704 decision date for ICF/IID or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.
3. Date of Categorical Eligibility – Categorical eligibility for facility care and services under the AABD criteria can be established to begin three months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, however, the begin date for Medicaid and vendor payment cannot be prior to the decision date on the DHS-0704 for ICF/IID applicants or PASARR date for individuals subject to PASARR.

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

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

MS Manual 07/01/20

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

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened.

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

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the eligibility worker of the change in status. On the day following termination of Medicare benefits, the eligibility worker may authorize facility services to be effective on that date, provided the individual continues to meet all Long-Term Services and Supports (LTSS) requirements.

H-470 Quality Assurance Errors

MS Manual 07/01/20

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

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

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

H-480 Acquisition of Additional Income and Resources

MS Manual 07/01/20

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

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

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

MS Manual 07/01/20

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

Overpayment reports for Long-Term Services and Supports (LTSS) and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility. Refer to MS Section M. If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

H-490 Absences from Long Term Care Facilities

MS Manual 07/01/20

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

Death or Discharge

Upon notification from the facility reporting the death or discharge of a recipient, the County Office will initiate action to close the recipient's case. Advance notice is not required for closure due to death.

Home Visits

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

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

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

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

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

- Cases suspended or closed can be reinstated without new application if the recipient returns to the facility within 90 days of the date left on home visit. Refer to MS H-491.
- If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.
- If the individual does not reenter the facility within 90 days, a new application will be required to reopen the case.

H-493 Operations Plan - Relocation of Recipients

MS Manual 07/01/20

The Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) will initiate all relocation actions of Agency recipients in facilities which are closed for any reason other than a disaster. Such reasons include: decertification by the federal government or the DPSQA, loss of licenses, voluntary withdrawal from the Medicaid Program, or cancellation of agreement by the DPSQA. Since federal regulations require all program recipients to be relocated within 30 days of the termination date, it is essential that specific procedures be established to ensure that recipients are relocated with maximum safety and well-being.

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

I-300 AABD Eligibility Groups Renewal Process

MS Manual 07/01/20

The renewal processes described below apply to all eligibility groups using the AABD eligibility requirements. See MS B-300 and Section F.

For those factors of eligibility subject to change, eligibility will be redetermined during the renewal process in accordance with the applicable eligibility requirements described in MS Sections D, E, F and H. Factors which are subject to change include income, resources, disability, and medical necessity. (MS Sections E and F)

See Appendix O for the specific renewal form that is used for each of the AABD groups.

I-320 Alternate Renewal Processes

MS Manual 07/01/20

Some AABD eligibility groups do not follow the standard renewal process as described in MS I-300 above. These groups include:

- ARChoices
- Assisted Living Facilities
- PACE
- DDS Waiver
- TEFRA
- Autism
- Medicare Savings Program

The following sections describe their renewal processes.

I-321 ARChoices Waiver

MS Manual 07/01/20

ARChoices Waiver renewals will be conducted annually by the Long Term Services and Supports Unit (LTSSU). Refer to Appendix O for the list of required forms to be used in the renewal process.

The DHS RN will coordinate an annual reassessment of medical necessity.

I-322 Assisted Living Facility

MS Manual 07/01/20

Assisted Living Facility Waiver renewals will be conducted annually by the Long Term Services and Supports Unit. Refer to Appendix O for the list of required forms to be used in the renewal process.

The DHS RN will coordinate an annual reassessment of medical necessity.

I-323 PACE

MS Manual 07/01/20

Both financial and medical eligibility will be re-determined annually. Financial eligibility will be conducted at each annual renewal by the Long Term Services and Supports Unit. Refer to Appendix O for the list of required forms to be used in the renewal process.

The DHS RN will coordinate an annual reassessment on all PACE participants. The Division of Aging, Adult and Behavioral Health Services (DAABHS) may "deem eligible" those individuals who are determined to no longer meet the nursing facility Level of Care requirement, but who would reasonably be expected to meet nursing facility Level of Care within the next six months in the absence of continued coverage under PACE.

I-324 Division of Developmental Services

MS Manual 07/01/20

The DDS worker will be responsible for renewals. Renewals will be scheduled for completion 12 months from the date of the last approval or renewal, or at any time when a change occurs which affects eligibility. Refer to Appendix O for a list of required renewal forms. All eligibility factors, with the possible exception of disability and medical necessity, will be redetermined.

A reexamination by MRT is necessary when indicated by the DCO-0109, Medical Review Team Report, or when a non-SSI or non-SSA client was initially accepted for Waiver Services based on a disability determination made by SSA more than one year prior to the renewal. A review by MRT is also necessary if the DDS Medicaid Eligibility worker or DDS Provider Case Manager or Specialist becomes aware of significant improvement and/or employment at or near the Substantial Gainful Activity (SGA) level. Refer to MS F-120.

I-325 TEFRA

MS Manual 07/01/20

TEFRA Waiver cases will be renewed every 12 months. To insure that renewals are completed by the end of the twelfth month, the renewal process should be started in the 9th month from the date of the last approval or renewal. The eligibility worker will generate the appropriate renewal forms and send the packet to the individual's guardian or authorized representative. The due date for return of the TEFRA renewal packet will be the last day of the 10th month.

If the child's SSI eligibility has fluctuated due to changing parental income since the last certification or renewal, medical necessity and appropriateness of care will not be determined until the case is in, or nearing, the 9th month since completion of the last TEFRA renewal or certification.

At renewal, all eligibility factors including appropriateness of care will be redetermined. A MRT disability redetermination may or may not be necessary at the time the TEFRA case is reevaluated. A reexamination by MRT is necessary when indicated on the DCO-0109, or one year after the initial certification for TEFRA when the certification was made based on a previous SSI determination of disability and there has been no SSI payment or subsequent redetermination by SSA.

EXAMPLE: A child received SSI for six months in 2018 and then lost SSI due to increased parental income. The parent applies for TEFRA in September 2018 and the case is certified in November 2018 based on the previous SSI disability determination. The child has not received SSI benefits since certified. At the annual renewal in 2019, a MRT disability determination is required.

A review by MRT is also necessary if the eligibility worker becomes aware of significant improvement and/or employment at or near the SGA level. Refer to MS F-124.

Refer to Appendix O for a list of required renewal forms. In addition, the premium amount will be redetermined at renewal. If the premium changes, the parent will be notified of the new amount by the TEFRA Premium Unit.

I-326 Autism

MS Manual 07/01/20

Autism Waiver cases will be renewed every 12 months by the Area TEFRA Processing Unit (ATPU). Refer to Appendix O for a list of required renewal forms.

A MRT disability redetermination may or may not be necessary at the time of the renewal. A need for a disability redetermination by MRT will be indicated on the DCO-0109 received during the initial determination and case renewals, if applicable. When approval was made based on a previous SSI determination of disability and there have been no SSI payments or subsequent redetermination by SSA, a MRT disability redetermination will be made one year after the initial approval for the Autism Waiver. All eligibility factors, except the autism diagnosis, will be redetermined at renewal.

To insure that renewals are completed by the end of the 12th month, the renewal process should be started in the 9th month from the date of the last approval or renewal.

I-327 Medicare Savings Program (MSP)

MS Manual 07/01/20

ARSeniors, QMB, SMB, and QI-1 reevaluations will be conducted on an annual basis. If the spouse has a MSP case, his/her case must be reviewed at the same time as the casehead. Self-declaration will be accepted. An interview is not required for these households.

Refer to Appendix O for a list of required renewal forms.

If the MSP case is closed for failure to provide information and the requested information is returned within 30 days after closure, the MSP case will be reinstated and eligibility determined.

A MSP annual review can be completed via the telephone and will not require a returned, signed DCO-0811, Annual Review. The telephone review may be completed at anytime during the review process to obtain information needed to complete the review. The call can be initiated either by the worker or the client.

I-500 Categorical Changes

MS Manual 07/01/20

Some changes in a family's or individual's circumstances may result in an individual moving from one eligibility group to another. This can occur in conjunction with a renewal, when an income change is reported, when an individual reaches a certain age, or when a Social Security cost of living adjustment (COLA) occurs, etc. To ensure that the individual has uninterrupted coverage, the move from one group to another must be processed in a timely manner and according to certain processes. The most common categorical changes are described in the following sections.

I-510 ARKids A & B

MS Manual 07/01/20

If information is provided that would cause the ARKids A recipient to be ineligible for ARKids A or B, an advance notice will be sent, and the case closed after expiration of the notice. If the information provided will cause ineligibility for ARKids A and the recipient is determined to be eligible for ARKids B, the case will be certified in ARKids B and the recipient notified of the case change.

I-520 Adult Expansion Group

MS Manual 07/01/20

When individuals aged 19-64 lose eligibility in other lower income MAGI-related groups, eligibility should be redetermined in the Adult Expansion Group.

I-530 Medicare Savings Programs

MS Manual 07/01/20

Persons who are Medicaid eligible in a category that provides full Medicaid coverage and who are entitled to Medicare Part A will receive the same Medicare cost-sharing coverage as Qualified Medicare Beneficiaries (QMBs) in addition to their other Medicaid benefits.

When Medicaid eligibility in a category other than a Medicare Savings category ends for an individual who is still entitled to Medicare Part A, eligibility for Medicare Savings will be determined based on information available to the County Office. A new application will not be obtained from the individual. ARSeniors, QMB, Specified Low Income Medicare Beneficiaries (SMB), or Qualifying Individuals-1 (QI-1) eligibility should be determined and the case certified (if

eligible) in the month that the non-QMB related case was closed. If eligible, coverage will begin on the first of the month following certification.

I-531 Medicare Savings Programs-COLA Increases

MS Manual 07/01/20

When the annual SSA cost of living adjustment (COLA) increases are received in January each year by Medicare Savings recipients, the COLA increase is disregarded until the new Federal Poverty Limits are issued in that year even if the SSA COLA increase puts the individual or couple over the current allowable income limits.

When the new Medicare Savings income eligibility limits are received, the individual's or couple's current countable income (including the January COLA increases) will be compared to the revised Medicare Savings income levels to determine if eligibility will continue for April 1st and beyond.

If the individual or couple is ineligible due to the COLA increase, an advance notice of closure will be sent, and the case will be closed when the notice expires. The January SSA COLA will also be disregarded in determining initial eligibility for Medicare Savings applicants for the period of January 1st through March 31st of each year. Eligibility must then be redetermined for April 1st and beyond using the new Medicare Savings income limits and the increased SSA amount which includes the January SSA COLA amounts.

I-532 Simultaneous Coverage In Other Categories

MS Manual 07/01/20

Individuals who apply for Qualified Medicare Beneficiaries (QMB) or Specified Low Income Medicare Beneficiaries (SMB) coverage and have medical expenses in prior months may be considered in other Medicaid categories (including spend-down categories) for the retroactive coverage.

Except for Medically Needy Spend-downs, an individual may not be certified in a QMB or SMB category and in a full coverage Medicaid category for simultaneous periods. If an individual is eligible in a full coverage category other than QMB, he will be eligible for and receive the QMB benefits along with other Medicaid benefits. Refer to MS I-530. If an individual could be eligible in either a QMB category or a non-QMB full coverage category, the individual should be approved in the non-QMB category.

Unlike QMBs and SMBs, Qualifying Individuals-1 (QI-1) may not be certified in any other Medicaid category for simultaneous periods. An individual who is eligible for QI-1 and a spend-down will have to choose which coverage is wanted for a particular period of time.

I-540 Alternating TEFRA and SSI Eligibility

MS Manual 07/01/20

Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. In these instances, the eligibility worker must redetermine TEFRA eligibility for each month in which the child is not SSI eligible. Children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months. If fluctuating parental income causes a child's SSI eligibility status to change from month-to-month and less than 10 months have passed since the last full TEFRA Waiver certification or renewal, only a new DCO-9700 (TEFRA and Autism Application for Assistance) and a redetermination of income and resource eligibility are required to reopen the TEFRA Waiver case. Redetermination of other eligibility factors will not be required.

I-541 Autism

MS Manual 07/01/20

Since coverage for the Autism Waiver eligibility group is time and age limited, once a child has reached the maximum coverage period of three years or the maximum age of eight, Medicaid eligibility should be redetermined in either the TEFRA or ARKids eligibility groups.

I-550 Money Follows the Person (MFP)

MS Manual 07/01/20

Money Follows the Person allows Medicaid eligible individuals residing in an inpatient facility, including hospitalization, to receive long-term services and supports in the settings of their choice and reduce reliance on institutional care. The MFP grant allows for payment of claims for services up to 365 days. Participation in the MFP program is limited but the maximum number allowed to participate will increase yearly.

The Division of Aging, Adult and Behavioral Health Services (DAABHS) has administrative responsibility for the MFP program to provide each participant placement through the existing Medicaid Waiver (ARChoices, Assisted Living, DDS) which best suits the participant's desires and needs. DAABHS will contact individuals designated as potential transitions or who expressed a desire to live in the community. To be eligible to participate, the individual must have resided in an institution (nursing home or ICF/IID) for a period of not less than 90 consecutive days and have received Medicaid for inpatient services for at least one day.

I-551 MFP Procedures for Medicaid Recipients Who Leave Facility Care

MS Manual 07/01/20

For MFP, a Division of Aging, Adult and Behavioral Health Services (DAABHS) Transition Coordinator will be responsible with assisting the individual who is interested in transitioning from facility care to a home and community-based waiver. This includes assisting the individual with applying for the appropriate program, accessing services, and preparation for being discharged from the nursing facility.

The Transition Coordinator will assist the client with completing and submitting form DHS-0777, Long-Term Services and Supports Application for Assistance.

Upon receipt of the application in the County Office, the DHS RN will be notified to coordinate an assessment of medical necessity and develop a service plan.

I-570 Workers with Disabilities Eligible to Receive ARChoices Services

MS Manual 07/01/20

The ARChoices Waiver has been amended to include the Workers with Disabilities category as a group that is eligible for services within the Waiver. In order to be eligible for the ARChoices Waiver services and the Workers with Disabilities category, applicants must meet both the functional need criteria of the ARChoices Waiver program (MS F-155) and the financial criteria of the Workers with Disabilities category (MS B-330).

Referral for Assessment

When an applicant or recipient of the Workers with Disabilities category applies for the services available within the ARChoices category, the DHS RN will be notified to coordinate an assessment of medical necessity (functional need) and develop a service plan. For a recipient of the Workers with Disabilities category, completion of a new application is not necessary unless it

is time for the annual reevaluation of the Workers with Disabilities category. The assessment process in MS C-241 will be followed.

County Office Eligibility Determination

The eligibility worker will determine if the applicant meets the eligibility requirements of the Workers with Disabilities category. Refer to MS B-330 and E-110.

For Workers with Disabilities/ARChoices cases, disability will be determined using the Workers with Disabilities criterion which allows an individual to earn over the Substantial Gainful Activity (SGA) level at the time of application. MS F-120 provides guidance on when to refer to MRT for a disability decision. A referral to MRT is not necessary for an applicant who received SSI or SSA disability within the last year and lost entitlement solely due to employment or when an applicant is still considered as an active SSI or SSA disability recipient whose cash benefits were suspended due to earnings. However, to be eligible for ARChoices Waiver, the disability must be determined as physical.

The applicant or recipient may be eligible for retroactive eligibility, if needed, for the Workers with Disabilities category (MS A-200). However, the individual will not be eligible for the ARChoices Waiver until the day of the month in which the Waiver eligibility is finalized by the eligibility worker (MS A-200) unless a retroactive eligibility date is established by the DHS RN. Refer to MS C-247.

ARChoices Transition to the Workers with Disabilities Category

ARChoices recipients may also request to transition to the Workers with Disabilities category. Once the eligibility worker determines eligibility for the Workers with Disabilities category, the ARChoices category will be closed and the Workers with Disabilities category will be approved effective with the day after closure.

NOTE: An ARChoices applicant or recipient may still be eligible for ARChoices when employed as long as his/her total income (earned + unearned) does not exceed the Waiver income limit. Also, an individual can remain categorically eligible for the ARChoices Waiver when SSI eligible but no longer in payment status. Social Security Disability rules allow beneficiaries to earn over SGA during their Trial Work Periods and Extended Periods of Eligibility. In this case, verification of income and resources is not required; however, medical necessity must be met as well as verification that a physical disability exists.

I-600 Changes

MS Manual 07/01/20

When a change occurs that will affect eligibility, the client is required to report the change within 10 days. The agency will be required to act on changes that may affect eligibility within 10 days from receipt of the change. Changes can be reported:

- In person
- By telephone
- By mail or
- Through the citizen portal

Dependent upon the eligibility group of which the individual is a member, changes which could affect eligibility and therefore must be reported include the following:

- A change in income that causes ineligibility or causes a change in vendor payment
- Changes in household members
- Death
- End of pregnancy
- Admission to or discharge from an institution (including a nursing facility)
- Approval or discontinued disability
- Resource changes, including the receipt of a lump sum payment or settlement
- Shelter and expense changes for Long Term Services and Supports individuals who have a Community Spouse
- Medical cost for Long Term Services and Supports individuals or
- Changes in work and community engagement requirement exemptions or activities

Although an address change does not usually affect eligibility, individuals are encouraged to report any address changes immediately to ensure renewal notices or other correspondence is sent to the individual's current address and not returned as Undeliverable. Any mail returned as Undeliverable could result in immediate case closure.

I-610 Loss of Eligibility

MS Manual 07/01/20

Loss of eligibility occurs when the eligible individual:

- Moves from Arkansas
- Requests closure
- Dies
- Is found to be over the income limit
- Is found to be over the resource limit if applicable
- Reaches the age limit for the eligibility
- Leaves the nursing facility
- No longer meets medical necessity
- Has three (3) months of non-compliance with the Adult Expansion Group work requirement within a calendar year

Depending upon the change, the individual may be eligible in another eligibility group. For example, if a child ages out of ARKids, he/she may be eligible in an adult group such as the Adult Expansion Group. When possible, eligibility in another group should be determined at the time ineligibility for the current group is established.

EXCEPTION: Once eligibility is established for a pregnant woman (PW) in any Medicaid category, there will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period. The PW will remain Medicaid eligible through the end of the postpartum period regardless of increases in income. Refer to MS C-205 and MS I-690.

I-620 Alternative Change/Closure Processes

MS Manual 07/01/20

Some eligibility groups have specific processes that must be followed when a change or closure occurs. These groups include:

- ARChoices in Homecare Waiver
- Assisted Living Facility (Living Choices) Waiver
- Division of Devlopmental Disability Services Waiver

- TEFRA
- Autism
- SSI Related Groups
- Pregnant Women

I-630 ARChoices Waiver

MS Manual 07/01/20

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the County Office will be notified, and the Waiver case will be closed. If the Waiver case is closed for any reason, the eligibility worker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ARChoices Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at MS E-410 will be followed, advance notice given, and the case adjusted.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required.

A Waiver client may appeal an adverse decision made on his/her case as outlined in MS L 100-173 of the Medical Services Policy manual. If the client chooses, the ARChoices Waiver case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the service provider.

I-631 ARChoices Waiver Temporary Absences from the Home

MS Manual 07/01/20

Once an ARChoices Waiver application has been approved, Waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the County Office will be

notified immediately by the DHS RN when Waiver services are discontinued and action will be initiated by the County Office to close the Waiver case.

1. Institutionalization

An individual cannot receive ARChoices services while in an institution. However, the following policy will apply to active Waiver cases when the individual is hospitalized or enters a nursing facility.

a) Hospitalization

If after 30 days the recipient has not returned home, the DHS RN will notify the County Office and action will be initiated by the County Office to close the Waiver case. For ARChoices services to resume after discharge from the hospital and after the Waiver case has been closed, the individual must make a new application.

b) Nursing Facility Admission

When a Waiver recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the Waiver client returns home within 30 days, a new medical assessment will not be required. A new application will not be required unless it is time for the annual renewal.

If the individual requests payment for the temporary stay in the nursing facility, a signed application must be obtained along with a new medical assessment. If it is time for the annual renewal, the renewal must be completed prior to certifying the vendor payment. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ARChoices Waiver recipients are considered to be “institutionalized” for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30-day institutionalization requirement.

If the individual does not return home, i.e., stays in the facility and requests nursing facility vendor payment, the Medicaid case may be left open while processing the nursing facility application. Vendor payments will also be authorized beginning the date of entry.

If found ineligible for vendor payments or if after 30 days in a facility the individual does NOT apply for vendor payment, appropriate notice will be given for case closure.

2. Absence from the Home - Non-Institutionalization

When a Waiver recipient is absent from the home for reasons other than institutionalization, the County Office will not be notified unless the recipient does not return home within 30 days. If after 30 days the recipient has not returned home and the providers can no longer deliver services as prescribed by the service plan (e.g., the recipient has left the state and the return date is unknown), the DHS RN will notify the County Office and action will be taken by the eligibility worker to close the Waiver case.

NOTE: The DHS RN may reassess an individual any time it is deemed appropriate. If, in the professional judgment of the nurse, circumstances have changed or an individual's overall medical condition has changed, a reassessment will be performed.

I-640 Assisted Living Facility (ALF)

MS Manual 07/01/20

ALF Waiver recipients will be advised to report any changes in income or resources to the DHS County Office. If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or the Office of Long Term Care determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the County Office will be notified and the ALF case will be closed. If the case is closed for any reason, the eligibility worker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month, procedures at MS E-410 will be followed, advance notice given, and the case adjusted at the appropriate time.

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen.

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in MS Section L. If the client chooses, the ALF case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the facility.

I-641 Temporary Absences from the Assisted Living Facility

MS Manual 07/01/20

Once an ALF Waiver application has been approved, Waiver services must be provided in the facility for eligibility to continue. The County Office will be notified by the DHS RN when Waiver services are discontinued and action will be initiated by the County Office to close the Waiver case with the following exceptions:

1. Hospitalization

   If the recipient does not return from the hospital within 30 days, dies during hospitalization, or is discharged to his home or elsewhere from the hospital, the ALF facility will report to the County and case closure will be initiated. If the recipient reenters another facility after discharge from the hospital or if the individual is reassessed and no longer meets the Intermediate Level of Care, the facility will also report to the County and the eligibility worker will take appropriate action.

2. Nursing Facility Admission

   When an ALF recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the individual requests payment for the temporary stay in the nursing facility, a signed application must be obtained along with a new medical assessment. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ALF recipients are considered institutionalized for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30 day institutionalization requirement.

   If the individual does not return to the ALF, but stays in the nursing facility and requests nursing facility vendor payment, the Medicaid case may be left open while processing the nursing facility application. If found eligible for vendor payment, the vendor payments will be authorized beginning the date of entry to the nursing facility. If found NOT eligible for

I-600 Changes

When an ALF recipient is absent from the facility for reasons other than institutionalization, the County Office will not be notified unless the recipient does not return within 30 days. If the recipient has not returned to the facility after 30 days and t

vendor or if after 30 days in a facility the individual does not apply for vendor payment, appropriate notice will be given for case closure.

3. Absence From the Assisted Living Facility - Non-Institutionalization

When an ALF recipient is absent from the facility for reasons other than institutionalization, the County Office will not be notified unless the recipient does not return within 30 days. If the recipient has not returned to the facility after 30 days and the providers can no longer deliver services as prescribed by the service plan (e.g. the recipient has left the state and the return date is unknown), the DHS RN will notify the County Office to close the ALF Waiver case.

I-650 DDS Waiver

MS Manual 07/01/20

Recipients will be required to report changes to the DDS Medicaid Eligibility worker within 10 days. The DDS Medicaid Eligibility worker will promptly redetermine eligibility when information is received about changes in a recipient's circumstances. When a change occurs that results in ineligibility, a 10 day advance notice will be given unless advance notice is not required. Refer to MS J-130.

Eligibility will end at the end of the 10-day advance notice period, unless the recipient or his/her legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the 10 days.

I-660 TEFRA

MS Manual 07/01/20

When a change occurs that affects eligibility, the applicant will be sent a 10-day advance notice, unless advance notice is not required. Refer to MS J-130.

I-670 Autism

MS Manual 07/01/20

All changes (addresses, income decrease or increase, resources, etc.) will be processed by the Area TEFRA Processing Unit (ATPU).

I-680 SSI Related Groups Who Became Eligible for or Entitled to Part A Medicare

MS Manual 07/01/20

If an individual certified under these provisions, Widows and Widowers with Disabilities (OBRA 1987) and Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 90), becomes eligible for or entitled to Part A Medicare, case closure must be considered. Before closing the case, however, it should be determined whether or not the individual would be eligible for coverage in another category.

In determining Qualified Medicare Beneficiaries (QMB) eligibility, all SSA income will be counted in the budget. It will not be necessary to obtain a new application unless it is time to make the annual reevaluation of the disability case. If an individual is found QMB eligible, the existing disability case will be closed.

The individual should be notified in advance of closure of the disability case because of Part A Medicare eligibility or entitlement, but that the case will be reopened as a QMB with benefits limited to payment of Medicare premiums, deductibles and coinsurance.

I-690 Continuing Eligibility for all Pregnant Women Who Are Medicaid Certified and Who Lose Eligibility Due to Income Changes

MS Manual 07/01/20

Pregnant women certified in any Medicaid category will not lose eligibility due to a change of either personal or household income. A pregnant woman whose increased income makes her ineligible for the category in which she was originally certified will be considered continuously PW eligible throughout the pregnancy and the postpartum period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

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

- **Must be incurred no earlier than the three-month period preceding the month of application.**
- The non-covered expenses must be prescribed by a Medical professional (e.g., a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic/elective procedures (e.g., face lifts or liposuction) will not be allowed **except when prescribed by a medical professional**.
- **Amount is the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Arkansas.**
- **Expenses incurred as a result of the imposition of a transfer of assets penalty, are not allowed.**
- **Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary, are not allowed.**
- **Deduction is not allowed for procedures allowed by Medicaid when prior authorization is denied due to the service being medically unnecessary.**
- **Expenses when a third party (including Medicaid) is liable for the expenses, even if provided by an out-of-network provider, are not allowed.**
- **General health insurance premiums paid by someone other than the recipient (excluding the community spouse) who is not a financially responsible relative and repayment is not expected to be paid back to the third party by the recipient, are not allowed.**