ARKANSAS REGISTER

Transmittal Sheet

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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 §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Medical Services Policy Section A-116, H-100, H-400, H-600 and H-700

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other August 29, 2022
  (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)

Lisa Teague	lisa.teague@dhs.arkansas.gov	05/20/2022
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, Division of County Operations
Title

May 20, 2022
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-116 Premiums For The Adult Expansion Group

MS Manual 08/29/22

A program participant who has income of at least 100% of the federal poverty level will pay a premium of no more than 2% of their income to a health insurance carrier.

Individuals who are medically frail and receiving traditional Medicaid will not be required to pay a premium.

H-100 Long-Term Services and Supports

MS Manual 08/29/2022

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

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

H-110 Income Trusts

MS Manual 08/29/2022

An individual with income in excess of the income limit may establish an income trust for the purpose of becoming Health Care eligible. This type of trust is commonly referred to as a Miller Income Trust.

H-111 Requirements for an Income Trust

MS Manual 08/29/2022

A Miller Income Trust must meet the following conditions:

1. Terms and Other Conditions

   The trust must be irrevocable. It can be terminated or amended only by mutual agreement between the Department of Human Services (DHS) and the trustee.

   The trust may be used to establish Health Care eligibility for individuals determined to be medically in need of care in a nursing facility or assisted living facility or PACE.

   The trust must have been created either by the individual or by the individual's child, spouse, sibling, attorney-in-fact or Power of Attorney, guardian, or representative payee as determined by the Social Security Administration. Establishment of a Miller Income Trust by these individuals previously listed will be considered as valid for the purposes of Health Care eligibility.

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

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

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

2. Consideration of Income

An individual with gross monthly countable income (excluding VA A&A and CME/UME) that exceeds the federal cap of three (3) times the SSI payment for an individual living in their own home, may establish eligibility through an income trust.

Individuals are not required to place all their income into a Miller Income Trust to be eligible for Health Care. Any income other than VA A&A and CME/UME that exceeds the income limit must be placed into the trust.

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes but will be countable toward patient liability. Patient liability is calculated from all gross income regardless of whether or not it is placed in the trust.

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

Income in excess of the income limit that is received directly by an individual must be transferred to the trust immediately upon receipt. Any income that is not transferred into a Miller Income Trust in the month it is received will be counted when determining eligibility.

If in any month the individual's income that exceeds the income limit is not placed in the trust, the individual is not eligible for Health Care benefits or vendor payment in that month.

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

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

If an individual receives income paid jointly to themselves and another person(s), the facility resident's share of the income must be separated from the shares owned by the other person(s) before depositing the facility resident's share in the trust account. No income belonging to any other individual may be placed in the income trust of a Health Care recipient.

3. Fees and Other Disbursements

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

4. Trustee Responsibilities

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

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

After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Notice of Action with the post-eligibility budget completed by the system. (See MS H-410.)

Any disbursements made that are not for the benefit of the recipient, the community spouse, or other dependents as specified on the Notice of Action and in the electronic record will be considered a transfer of resources, and a penalty period may be applied.

Payments must be made from the trust each month only in the amounts specified on the Notice of Action and in the electronic record. The payments must be made directly to the designated recipient, i.e., to the recipient or responsible person for the personal needs allowance (PNA); to the community spouse or dependent(s) for their allowances; to the recipient or responsible party for the recipient's non-covered medical expenses; to the recipient of court-ordered child support or court-ordered spousal support or both; and to the facility for the patient's share of cost.

While an individual is receiving Health Care benefits in a facility, no disbursements other than those specified on the Notice of Action and in the electronic record may be made.

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

If the trustee becomes aware of any change in circumstances that will affect the recipient's eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the eligibility worker of such changes. Changes to be reported include without limitation income changes, increase or decrease of cost of non-covered medical expenses, recipient death or departure from the facility, community spouse entering a facility, etc.

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

H-112 Income Trust Application Process

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

Individuals with income above the federal cap who inquire regarding Health Care eligibility in a facility or for the Waiver program will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re. MS E- 500) if requested. Individuals with excess resources **cannot** establish eligibility through an income trust.

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

H-113 Post-Eligibility Procedures

MS Manual 08/29/2022

1. Post-Eligibility Consideration of Income

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

2. Begin Date of Eligibility

   Eligibility for facility care or Waiver services shall not begin prior to the month in which the trust is established. A trust is considered established when the completed document is signed by the applicant and the trustee.

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

3. Trust Balance Exceeds Divisor

   There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits that represent income for the following month and any spousal, dependent, or non-covered medical expenses amounts specified on the Notice of Action and in the electronic record that were not disbursed for the month) exceeds the amount of the current divisor used for transfer of resources (Appendix R), the individual will not be eligible again for facility care payment until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident.

   NOTE: This only applies to facility payments.

H-114 Changes to an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

1. Medicare and Other Third Party Payments

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

2. Individual Leaves Facility

   If an individual leaves a facility for a therapeutic home visit up to fourteen (14) days or for a hospital visit up to five (5) days, Health Care benefits and vendor payment will continue, and the trustee will make disbursements in that month as specified on the Notice of Action and in the electronic record.

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

3. Changes in Community Spouse or Dependent Status

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

H-115 Renewals with an Income Trust

MS Manual 08/29/2022

In addition to the required verification of other eligibility factors at annual renewal, the eligibility worker will verify that the amount required to make the client income-eligible has been placed in the trust and disbursements made as required since the last renewal. This may be done by viewing bank statements or other trustee records that may be available.

H-116 Termination of an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

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

- Office of Chief Council (OCC) determines an error was made in the establishment of the trust;

- The individual has repaid Health Care all payments made since the establishment of the income trust;
- Individual is moving out of state and will be establishing an income trust in the other state; or
- Other extraordinary circumstance.

H-400 Post-Eligibility

MS Manual 08/29/2022

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 a Miller Income Trust all require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

H-402 Consideration of Income

MS Manual 08/29/2022

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

    - 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.

    - 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.

    - If payment of income is made in the names of the IS or the CS or both 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 (1/2) 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. In the absence of a specific provision in the trust, the income will be considered available to each spouse as 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 that has no instrument establishing ownership (for example, income-producing heir's property), half of the income will be considered to be available to the IS and half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 08/29/2022

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, the IS or the representative must provide the following within thirty (30) days of the date on the Notice of Action:

1. A written, signed statement by the IS alleging ownership, the reason for the applicant's receipt of the income, or for their 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 that 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, the eligibility worker will obtain a written statement from the individual that documents their 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 the individual's eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined and the findings will be documented in the case record. The income from the actual ownership interest (that is, 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 their 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 Cost of Care

MS Manual 08/29/2022

Nursing facility recipients are required to contribute all of their monthly income, minus certain approved deductions, to the cost of their facility care. Health Care 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 or 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 in the eligibility system and a Notice of Action will be sent for the appropriate time period.

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.

- Court-ordered child support and court-ordered spousal support will be deducted from earned or unearned income.
- An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in ten-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 forty-dollar ($40) PNA for most facility residents.

     NOTE: Facility residents whose only income is SSI will be allowed to keep thirty dollars ($30) as their PNA. The PNA of an SSI recipient who also has other income is forty dollars ($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 ninety dollars ($90) as a personal needs allowance. An additional forty dollars ($40) will not be given. A ninety dollar ($90) PNA will not be given to any individual whose VA pension has not been reduced to ninety dollars ($90) by the Veterans Administration (VA). If VA later reduces the pension to ninety dollars ($90), an income adjustment will be made. Individuals should contact the Veterans Administration if they believe they are entitled to a ninety-dollar ($90) reduced pension.
   - For residents of ICF/IIDs and State Human Development Centers with earned income, forty dollars ($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, forty dollars ($40) may be given as a PNA in addition to a disregard of up to one-hundred dollars ($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 (for example, 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, meaning, 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 (3).

- The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income (that is, 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 Health Care. 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 eighteen (18) years of age 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

Non-covered medical expenses of all facility recipients that 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—

- Medicare and other health insurance premiums, deductibles, or coinsurance charges and
- Necessary medical or remedial care recognized under state law but not covered under the state's Health Care 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 Health Care:

- 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 (for example, a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic or elective procedures (for example, 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 Health Care, 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 Health Care, due to the service being medically unnecessary, are not allowed.
- Deduction is not allowed for procedures allowed by Health Care when prior authorization is denied due to the service being medically unnecessary.
- Expenses when a third party (including Health Care) 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 Health Care 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. 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:

- The items must be prescribed by a physician or other licensed medical practitioner.
- 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 they are able to utilize the item(s).
- The request must be approved by the facility's Quality Assessment and Assurance Committee.
- The cost of the item(s) must be determined.

- 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 without limitation: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Health Care formulary; and 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 Health Care formulary. Health Care facility recipients who are not certified for vendor payment are limited to three (3) 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:

- Monthly - Expenses regularly incurred each month such as the Medicare Part D enhanced plan portion of premiums above the benchmark;
- Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums; or
- 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, court-ordered child support, court-ordered spousal support, 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 zero dollars ($0).

   After the post-eligibility budget is completed, a copy of the information will be provided to each spouse. If the budget is completed prior to application, at the request of either spouse, the information will only be provided to the spouse making the request.

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

MS Manual 08/29/2022

Assisted Living Facility (ALF) Waiver recipients are allowed to keep a flat ninety and eight hundredths of a percent (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 (nine percent) 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. Court-ordered child support and court-ordered spousal support
4. Monthly medical insurance premiums
5. Non-covered medical expenses including over-the-counter medications and medical supplies
6. Spousal support payments for the community spouse and Family Member Allowance (MS H-410 #4-6)
7. Applicable income trust fees (MS H-111 #3)

8. 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 08/29/2022

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 Health Care. 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 in the electronic record. 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, family allowances, court-ordered child support, court-ordered spousal support, 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 Health Care limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTSS/PACE limit of three (3) 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-416 Verification or Refusal of Contributions

MS Manual 08/29/2022

Prior to certification of the Institutionalized Spouse (IS), the IS or representative must indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) and

the Family Member Allowance (FMA) specified on the Notice of Action during the period of institutionalization.

Otherwise, 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 may decline the income.

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

MS Manual 08/29/2022

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 forty dollars ($40)personal needs allowance.

Nursing facility residents with earnings may be given a disregard of up to one-hundred ($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 (for example, 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:

   - every six (6) months when earnings are fairly stable; or
   - more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than fifteen dollars ($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 08/29/2022

The effective date of eligibility of an applicant for nursing home and ICF/IID depends on three (3) 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 that classifies them 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 Health Care 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 Health Care 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 (3) 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, the begin date for Health Care 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.

4. Authorization of services cannot be made until all three (3) factors have been met.

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

MS Manual 08/29/2022

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Health Care 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 Health Care 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-481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual 08/29/2022

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 Health Care categories will be submitted to recover any Health Care 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 08/29/2022

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.

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 they desire, provided the visits are consistent with the recipient's required level of care and their attending physician's orders. This includes authorized home visits during the thirty (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 fourteen (14) consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than fourteen (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 fourteen (14) days, the County Office will take no action.

For home visits that exceed fourteen (14) consecutive days facilities will report the date left and a discharge on the fifteenth consecutive day of absence. When there is no indication that the recipient is expected to return to the facility within fourteen (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 nintety (90) days of the date left on home visit.
- 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 ninety (90) days, a new application will be required to reopen the case.

H-493 Operations Plan – Relocation of Recipients

MS Manual 08/29/2022

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 that 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 Health Care Program, or cancellation of agreement by the DPSQA. Since federal regulations require all program recipients to be relocated within thirty (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.

H-600 Estate Recovery

MS Manual 08/29/2022

The Omnibus Budget Reconciliation Act of 1993 and Arkansas Act 415 of 1993 mandate recovery of medical payments correctly made from August 13, 1993 and later from the estates of:

- Individuals of any age who were considered to be permanently institutionalized, who received medical services in a nursing or ICF/IID facility, and who were required to pay all but a minimal amount of income for their care, and
- Individuals fifty-five (55) years of age and older who received medical services in a nursing or ICF/IID facility or in a home and community based waiver program, whether or not they were considered to be permanently institutionalized.

Estate recovery will not be made from the estate of deceased individuals when:

- There is a surviving spouse, dependent children under twenty-one (21) years of age, or children who are blind or have a disability (as determined by SSA disability guidelines),
- Recovery will create an undue hardship for other surviving family members, or
- Recovery is not cost effective.

Estate recovery will not be made from resources that were protected as a result of the individual having a Qualified Long Term Care Insurance Partnership Policy. The maximum amount protected at estate recovery will be the amount protected when eligibility was established. If any of the protected resources have been spent or given away, only the amount remaining will be protected at estate recovery.

Estate recovery will not be made from interests acquired through grant of a beneficiary deed, per Arkansas Act 570 of 2021 when:

- The beneficiary deed was properly excuted and recorded; and
- Documentation has been provided to the entity seeking recovery.

H-630 Recovery Procedures

MS Manual 08/29/2022

State law requires in most cases that the appointed personal representative of the estate of a deceased person shall promptly mail to the creditors of an estate, including the Department of Human Services (DHS), a copy of the notice of their appointment that has been published in the newspaper. The published notice is to include the requirement that all claims against the estate

be submitted within six (6) months of the date of publication of the first notice. A copy of the petition for probate of a will or administration of an estate and the decedent's Social Security number will be attached to the notice forwarded to DHS.

After receiving notice of the opening of an estate or filing of an "Affidavit for the Collection of a Small Estate", the TPL Unit will check the MMIS System to determine if the decedent received Health Care benefits in a nursing facility, ICF/IID facility, or under a home and community based waiver program.

Property interest established by a properly excuted and recorded beneficiary deed are not subject to estate recovery.

TPL will not pursue recovery if:

1. There is a surviving spouse;
2. There are surviving minor children;
3. There are surviving children of any age who are blind or permanently and totally disabled as defined in 42 U.S.C. §§ 1381 et seq;
4. In cases of a home, there is a son or daughter currently lawfully residing in the home where they have been residing for at least two (2) years immediately before the recipient's admission to the medical institution, and who establishes to the satisfaction of the State that they provided care to the recipient that permitted the recipient to reside in the home rather than in an institution;
5. In cases of a home, there is a sibling currently lawfully residing in the home, and the sibling was residing in the home at least one (1) year immediately before the date of the recipient's admission to the medical institution; or,
6. The recovery is not cost effective.

For factors one (1) through five (5) of the above-listed (MS H-630), recovery is not waived. Instead, it may be postponed until the individuals identified in those factors die or move from the home.

If benefits were paid for services in a nursing facility, ICF/IID facility, or home and under a home and community based waiver program, TPL will mail to the personal representative or the distributee of a small estate a Notice of Estate Recovery (DHS-20), advising of the intent to recover Health Care payments and of the procedures for requesting a hardship waiver.

A payment profile for the decedent will be ordered from the Division of Medical Services (DMS). When the payment profile is received, a claim against the estate will be prepared for the

signature of the Director of DMS. The claim will be filed with the appropriate Probate Clerk and a copy mailed to the personal representative, attorney for the estate, or distributee of the estate.

If no benefits were paid, no further action will be taken.

H-640 Application for a Hardship Waiver

MS Manual 08/29/22

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within 30 days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver (DHS- 20). Refer to MS H-730 for procedures.

H-700 Undue Hardship Waiver

MS Manual 08/29/2022

An individual may request an Undue Hardship Waiver:

1. When denied eligibility due to excess home equity;
2. When denied nursing facility vendor payment due to a transfer of resources/income for less than fair market value; or
3. After receiving notice from the Department of Human Services (DHS) of intent to recover Health Care payments through the Estate Recovery process.

The individual or authorized representative will need to provide the eligibility worker verification to support the allegation of hardship.

H-710 Hardship Waiver for Home Equity

MS Manual 08/29/2022

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (Re. MS E-517) An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home.

The eligibility worker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the Division of County Operations LTSS Unit. A decision on the hardship waiver will be made by the Division of County Operations (DCO) Hardship Waiver Committee. The eligibility worker will send the committee decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, they may appeal the decision within thirty (30) days of receipt of the notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

MS Manual 08/29/2022

Once the eligibility worker has determined that this transfer does not meet an exception found at MS H-309 and it has been determined that the resource or income was not transferred exclusively for some other purpose through a rebuttal found at MS H-312-313, a hardship waiver may be pursued. An individual who is denied Waiver services or nursing facility vendor payment due to a transfer of resources or income for less than fair market value may request an Undue Hardship Waiver.

No penalty period for uncompensated transfer will be imposed upon an institutionalized or Waiver individual to the extent that it is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

1. Counting uncompensated value would make an individual ineligible;
2. Lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;
3. The individual's total resources are not great enough to pay for facility care for one (1) month; and
4. The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions would merely cause the individual inconvenience or would restrict their lifestyle without putting them at risk of serious deprivation.

The individual or the individual's authorized representative may apply for an undue hardship waiver. In addition, a representative from the facility in which an individual is residing may apply for an undue hardship waiver on behalf of the client with either the consent of the client or their personal representative. To ensure consistency with decisions regarding what constitutes a hardship, the eligibility worker will route all applications for an undue hardship waiver to the Division of County Operations LTSS Unit.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. The eligibility worker will send the committee's decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty (30) days of receipt of the notice about the decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 08/29/2022

The personal representative or distributee of an estate may apply for a hardship waiver at the time that notice of the estate is given to DHS or within thirty (30) days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver (DHS-20). To apply for a waiver, the representative or distributee must mail a statement setting forth the facts that constitute the undue hardship to:

Third Party Liability Unit
Attention: Decedents' Estates
P. O. Box 1437, Slot S296
Little Rock, AR 72203-1437

The statement must set forth the facts that constitute the undue hardship. Tax returns, income statements or other documents that support the position that estate recovery would work an undue hardship on the survivors must be submitted. The Third Party Liability Unit will send the hardship request and supporting documents to the DCO Hardship Waiver Committee. In determining the existence of an undue hardship, the DCO Hardship Waiver Committee will consider factors including, but not limited to the following:

1. The estate asset that is subject to recovery is the sole-income producing asset of a beneficiary of the estate;
2. Without receipt of the proceeds of the estate, a beneficiary would become eligible for federal or state benefits;
3. Allowing a beneficiary to receive the inheritance from the estate would enable a beneficiary to discontinue eligibility for federal or state benefits;
4. The estate asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of a home in the county where the homestead is located, as of the date of the decedent's death; and
5. Other compelling circumstances.

A determination that hardship does not exist will be made if the individual created the hardship through estate planning in which assets were divested in order to avoid estate recovery.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee.

The committee's decision and information about the right to appeal the decision will be sent by certified mail, return receipt requested, to the person who applied for the waiver. If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty (30) days of receipt of the notice about the decision (MS J-100).

If recovery is not made due to the determination of hardship, DHS may decide to recover at a later time if the conditions which caused the original hardship cease to exist.