MEDICAL SERVICES POLICY MANUAL

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MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 14-01

Medical Services Policy Manual | Issuance Date: January 1, 2014

From: Joni Jones, Director | Expiration Date: Until Superseded

Subj: Home Equity Limit and SSI and Quarters of Coverage Chart

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix R Appendix S	04-01-13 01-01-13	Appendix R Appendix S	01-01-14 01-01-14

Summary of Changes:

Appendix R, Transfer of Assets Divisor and Home Equity Limit and Appendix S (SSI and Quarters of Coverage Charts) have been updated for 2014. The changes are effective January 1, 2014.

Inquiries to:

Dave Mills, 501-682-8259, Dave.Mills@arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@arkansas.gov
Latoria Brooks, 501-682-8258, Latoria.Brooks@arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 14-02

Medical Services Policy Manual | Issuance Date: January 6, 2014

From: Joni Jones, Director | Expiration Date: Until Superseded

Subj: Medicare Savings Resource Limits

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-326 MS E-110	01-01-14 01-01-14	MS B-326 MS E-110	01-06-14 01-06-14

Summary of Changes:

MS B-326 and E-110 have been updated to reflect the new Medicare Savings resource limits for 2014. The change is effective January 1, 2014.

Inquiries to:

Dave Mills, 501-682-8259, Dave.Mills@arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@arkansas.gov
Latoria Brooks, 501-682-8258, Latoria.Brooks@arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 14-03

Medical Services Policy Manual | Issuance Date: April 1, 2014

From: Joni Jones, Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels and Transfer of Assets Divisor

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix F	10-01-13	Appendix F	04-01-14
Appendix P	04-01-13	Appendix P	04-01-14
Appendix R	01-01-14	Appendix R	04-01-14

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor, have been revised to provide the 2014 Federal Poverty Level income guidelines and the Transfer of Assets Divisor to be effective April 1, 2014.

Inquiries to:

Dave Mills, 501-682-8259, Dave.Mills@arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@arkansas.gov
Latoria Brooks, 501-682-8258, Latoria.Brooks@arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 14-04

Medical Services Policy Manual — Issuance Date: 08-15-2014

From: Joni Jones, Director — Expiration Date: Until Superseded

Subj: General Program Information

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS A-100 – A-340	01-01-14	MS A-100 – A-340	01-01-14 08-15-14

Summary of Changes:

Medical Services policy section A has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

A-105 – Added new section regarding nondiscrimination information.

A-115 – Added new section on cost sharing for Workers with Disabilities.

A-120 – Added descriptions of Part C and Part D Medicare plans.

A-190 – Changed the provider number for Medicaid claims to HP Customer Assistance Unit

A-200 – Added information for HCIP Medicaid end date for those turning 65 years old. Added clarification regarding ARKids continuation of coverage if individual is in hospital on 19th

birthday. Defined AABD groups Medicaid begin dates and begin date exceptions. Added additional information to #4 to define all Medically Needy categories.

A-210 – Added information identifying which groups are not eligible for retroactive Medicaid.

A-213 – Clarified when retroactive coverage may begin for QI-1. Added information about the begin date for QDWI retroactive coverage.

A-214 – Defined living in the household of someone else; how retro SSI will be authorized for a closed SSI case; changed "case file" to "electronic case file" and changed the application form from the DCO-777 to the DCO-95 for retro SSI.

A-215 – Added that deceased or denied SSI individuals would be approved in Aged, Blind or Disabled categories.

A-217 – Added new section regarding retroactive eligibility for pregnant woman.

A-230 - Added criteria for when an ARKids B child would lose eligibility; when the 12 months of continuous coverage for ARKids B would begin; and changed newborn coverage end date to the last day of the month of the child's first birthday.

A-330 – Added information about the process of receiving traditional Medicaid through the Health Care Independence Program.

A-340 – Added contact information for individuals seeking information about their Qualified Health Plan.

In addition, all references to ICF/MR have been revised to ICF/IID, Individuals with Intellectual Disabilities. Policy references have been updated and minor spelling issues corrected.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 14-05

Medical Services Policy Manual | Issuance Date: 08-15-2014

From: Joni Jones, Director | Expiration Date: Until Superseded

Subj: Eligibility Groups

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-100 – B-500	01-01-14	MS B-100 – B-602	01-01-14 08-15-14

Summary of Changes:

Medical Services policy section B has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

B-200 – Provided clarification regarding applicants enrolled or entitled to Medicare.

B-220 – Clarified that newborns born to pregnant women approved under the unborn child category are not eligible for the Newborn category.

B-230 - Children of Parent Caretaker Relative (PCR) recipients are enrolled in ARKids or a private insurance plan. Children are not enrolled in PCR.

B-250 – Added the information “income is at or below”.

B-270 – Changed “FFM” to “insureark.org”.

B-311 - Added the resource limits and reference for resources and spousal rules.

B-312 – Added physical to the requirement of having a disability.

B-313 – Added the available ElderChoices waiver services to policy.

B-314 – Added the information about Workers with Disabilities being able to access AAPD services. Also added the available AAPD waiver services. Added railroad disability as an acceptable disability determination.

B-318- Defined PACE.

B-321 – Added ARSeniors do not have to be entitled to Medicare, but if entitled must receive.

B-324 – Added the information that the individual eligible in QI-1 must be actually receiving Medicare Part A.

B-330 – Added the information about the $20 general exclusion and recipients will be able to access services through AAPD waiver services.

B-340 - Added "entitlement to or".

B-343 – Added COBRA to this title to distinguish from the other Widows and Widowers with Disabilities.

B-344 – Added OBRA '87 to this title to distinguish from the other Widows and Widowers with Disabilities.

B-345 – Added "resource eligible under AABD resource limits".

B-346 – Added marriage of a DAC recipient will automatically terminate DAC protection unless the marriage is to a SSI recipient.

B- 500 – Added the request for the discharge summary to be sent to OPPD.

B-600-602 - New sections regarding Medically Needy categories.

In addition, all references to ICF/MR have been revised to ICF/IID, Individuals with Intellectual Disabilities. Policy references have been updated and minor spelling issues corrected.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-01

Medical Services Policy Manual | Issuance Date: January 1, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Home Equity Limit and SSI and Quarters of Coverage Chart

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix R Appendix S	04-01-14 01-01-14	Appendix R Appendix S	01-01-15 01-01-15

Summary of Changes:

Appendix R, Transfer of Assets Divisor and Home Equity Limit, and Appendix S, SSI and Quarters of Coverage Chart, have been updated for 2015. The changes are effective January 1, 2015.

Inquiries to:

Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-02

Medical Services Policy Manual — Issuance Date: January 1, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Medicare Savings Resource Limits

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-326 MS E-110	08-15-14 01-06-14	MS B-326 MS E-110	01-01-15 01-01-15

Summary of Changes:

MS B-326 and E-110 have been updated to reflect the new Medicare Savings resource limits for 2015. The change is effective January 1, 2015.

Inquiries to:

Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-8258, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-03

Medical Services Policy Manual | Issuance Date: January 13, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Application Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-100 – C-300	01-01-14	MS C-100 – C-300	01-13-15

Summary of Changes:

Medical Services policy section C has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

C-135 – Removed the procedure for notifying the applicant when application is delayed.

C-150 – Added a reference to the Health Care Needs questionnaire.

C-205 – A new section incorporating MS 12310 “Period of Eligibility”.

C-210 – Removed references to DCO-645 and incorporated newborn application process utilizing access.arkansas.gov or DCO-152.

C-211 – Removed reference to DCO-645.

C-230 – Added a statement clarifying respite care in TEFRA. Added DCO-108C to the required MRT forms.

C-234 – Deleted the information about scanning the DCO-2602 and DCO-2603 into the case file.

C-240 –Added the procedure for verifying physical disability for an applicant.

C-245 – Clarified that the eligibility start date on the waiver portion is the same as the keying date.

C-246 – Added note about eligibility date.

C-249 - Added "no review date" to the list of when to certify an ElderChoices or AAPD waiver case and when to open the waiver portion of an EC or AAPD waiver case.

C-251 – Clarified instructions regarding how to register an ALF or SSI ALF application.

C-256 – Clarified the vendor effective date after leaving LTC, ElderChoices or AAPD waiver.

C-280 – Added the information from old policy MS 2049.3 to clarify the SSA referral process.

C-281 – Added COLA 20— for clarification.

C-282-284 – DCO-95 will be used for SSI Groups instead of the DCO-777.

In addition, all references to ICF/MR have been revised to ICF/IID, Individuals with Intellectual Disabilities, and policy references have been updated.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-04

Medical Services Policy Manual — Issuance Date: January 30, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: General Eligibility Requirements

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS D-100 – D-540	01-01-14	MS D-100 – D-540	01-30-15

Summary of Changes:

Medical Services policy section D has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

D-110 – Added the failure to apply for benefits information. (MS 3336.3)

D-201 – Removed the reference to the DCO-215 as it is no longer an application for Medicaid.

D-210 – Added under Note: including Palau and Micronesia.

D-224 – Added Iraqi and Afghan Special Immigrants under the “Aliens Exempt from Five-Year Bar”.

D-310 – Clarified residency status for non-institutionalized and institutionalized individuals.

D-380-381 – Added information about children entering custody of DYS and being released from DYS. (MS 16073-16073.1)

D-510 – Clarified where TPL information will be entered in the system.

In addition, policy references have been updated.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-05

Medical Services Policy Manual — Issuance Date: January 30, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Non-Financial Eligibility Requirements

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS F-100 – F-193	01-01-14	MS F-100 – F-193	01-30-15

Summary of Changes:

Medical Services policy section F has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

F-120 – Added the disability criteria for the AFDC categories. Added Railroad Retirement (RR) to the verification of disability.

F-122 – Added 108C as the MRT form for children. Added NOTE that a recipient for a hardship will have a disability determination completed if not receiving SSA, SSI or RR disability.

F-123 – Added exception to a denied Medicaid application for ALF and PACE which must be approved for facility payment.

F-124 – Added DCO-108C as the MRT form for children.

F–125 – Added statement about MRT sending a notice of action regarding the use of specific medical records used for determination.

F-130 – Added when cooperation is strictly voluntary. Added good cause requirements.

F-150 – Removed reference to TEA Medicaid. Added that hospitalization will count towards meeting institutional status if the individual enters a facility on the date of discharge from the hospital.

F-151 – Incorporated information from MS 3620, Utilization Control; 3621, Changes in Classification; 3622, Continued Stay in a Facility Not Medically Necessary, and 3625, Continued Stay in a Facility Not Medically Necessary (PASARR).

F-152 – Added "likely to remain" as meeting the institutionalization requirement.

F-153 – Added the correct categories that require "appropriateness of care".

F-156 – New section adding incapacitation information from MS 3330.2.

F-163 – Corrected the 1-800 number. Clarified who can key a PCP into the system.

F-171 – Updated the income to match Chart 1 on Appendix P (2013). Changed the word ANSWER to "the system".

F-180 – Changed the waiting period from 3 months to 90 days based on information from Jean Hecker. Also, included TEFRA in the waiting period change.

F-191 – Changed "wives" to "spouses".

In addition, all references to ICF/MR have been revised to ICF/IID, Individuals with Intellectual Disabilities, and policy references have been updated.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-06

Medical Services Policy Manual | Issuance Date: January 30, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Verification Standards

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS G-100 – G-180	01-01-14	MS G-100 – G-180	01-30-15

Summary of Changes:

Medical Services policy section G has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

G-111 – Removed the word "policy" from the hyperlink MS E-110.

G-113 – Added "guardianship court order" for clarification of legal documents.

G-115 – Added the self-declaration information from MS 23115.

G-140 – Added the immigration field offices and the Arkansas counties they serve.

G-151 – Added "reported" and "verified" to clarify the income listed in the example.

G-160 – Removed the reference to Appendix C because the age/date of birth mismatch information is not listed in Appendix C.

In addition, policy references have been updated.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-07

Medical Services Policy Manual | Issuance Date: February 3, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Medicaid for IV-E Children Who Enters Arkansas from Other States

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS K-204-303	01-01-14	MS K-204-303	02-03-15

Summary of Changes:

Medical Services policy section K-300 has been revised to add "whether or not an interlocutory or judicial decree of adoption has been issued" that was inadvertently omitted when the policy manual was updated in 2014.

Inquiries to: Dave Mills, 501-682-8259, dave.mills@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-08

Medical Services Policy Manual — Issuance Date: March 4, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Renewal and Changes

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS I-100-660	01-01-14	MS I-100-680	01-01-14 03-04-15

Summary of Changes:

Medical Services policy section I has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

I-220 – Changed “from the date of the renewal form” to “of the coverage termination date”.

I-320 - Added Autism and MSP to the Alternate Renewal Processes.

I-324 – Changed “ANSWER” to “the system”.

I-325 – Changed old dates to current dates. Removed “and” from “a MRT and disability determination” in the example.

I-326 – Added the Autism renewal process (formerly MS 26440).

I-327 – Added the MSP renewal process (formerly MS 23160 and MD 11-16).

I-532 – Added the Simultaneous Coverage for MSP in the Categorical Change section (formerly MS 23120).

I-550 & I-551 – Changed ICF/MR to ICF/IID.

I-570 – Added Working Disabled Eligible to Receive AAPD services (formerly MS 09-08).

I-600 – Removed "online" from the list of how changes can be reported because the system is not ready to process online changes. Removed the paragraph that described steps to take to process online changes.

I-620 – Added Autism to the Alternative Change/Closure Processes list.

I-670 – Added Autism to the list of groups with specific change processes.

I-680 – Added the SSI related groups who became eligible for or entitled to Part A Medicare (formerly MS 2049.9).

Inquiries to: Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-09

Medical Services Policy Manual | Issuance Date: April 1, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Application Form Table

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix I	01-01-14	Appendix I	04-01-15

Summary of Changes:

Appendix I, Application Form Table, has been updated to include the Medically Needy groups and to remove Form DCO-215 and PUB-408 from the table. The changes are effective April 1, 2015.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-10

Medical Services Policy Manual | Issuance Date: April 1, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels and Transfer of Assets Divisor

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix F	04-01-14	Appendix F	04-01-15
Appendix P	04-01-14	Appendix P	04-01-15
Appendix R	01-01-15	Appendix R	04-01-15

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor, have been revised to provide the 2015 Federal Poverty Level income guidelines and the Transfer of Assets Divisor effective April 1, 2015.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-11

Medical Services Policy Manual | Issuance Date: April 7, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Appendices

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix J	04-01-14	Appendix J Appendix W Appendix X	04-07-15 04-07-15 04-07-15

Summary of Changes:

Appendix J, Eligibility Table, has been revised to incorporate the Medically Needy groups. These groups were scheduled to be eliminated December 31, 2013 so they were not included in the January 2014 version of the appendix.

Appendix W, AAPD Waiting List Procedures, has been developed to provide guidance on the procedures for placing an individual on the AAPD waiting list.

Appendix X, Referrals for IndependentChoices, has been developed to describe the referral process for those individuals potentially eligible for the IndependentChoices program.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-12

Medical Services Policy Manual | Issuance Date: May 1, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Application Form Table

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix I	04-01-15	Appendix I	05-01-15

Summary of Changes:

Appendix I, Application Form Table, has been updated to replace the green dots with green "X's" to better accommodate those with color deficiency.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-13

Medical Services Policy Manual | Issuance Date: May 28, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Medical Services (MS) Glossary

Pages to be Deleted:	Date:	Pages to be Added:	Date:
		MS Glossary	05-28-15

Summary of Changes:

The Medical Services Glossary has been developed to clarify Medicaid terminology.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-14

Medical Services Policy Manual | Issuance Date: July 6, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Citizenship: Identity Verification

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix C	01-01-14	MS Appendix C	07-06-15
MS G-100-180	01-01-14	MS G-100-180	01-01-14
	01-30-15		01-30-15
			07-06-15

Summary of Changes:

MS Appendix C has been revised to incorporate acceptable documents that will prove identity.

MS G-111, G-131 and G-133 have been revised to clarify that identity must be verified if secondary or lower level documents are used to verify citizenship and that citizenship verified through the Federal Data Services Hub (FDSH) or State Verification and Exchange System (SVES) verifies identity.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-15

Medical Services Policy Manual — Issuance Date: July 13, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Long Term Services and Support

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS H-100 – 730	01-01-14	MS H-100 – 730	01-01-14 07-13-15

Summary of Changes:

Medical Services policy section H has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

H-100 – Added Long Term Care Insurance Partnership Program, Estate Recovery and Undue Hardship Waiver to the list of sub-sections included in Section H.

H-111 – Added Assisted Living to the requirement of establishing an income trust if over income limit. Added a reference to #4. Deleted that payments must be made from the trust the first of the month.

H-112 – Added information about income received from a LTC insurance policy. Added the address for submission of income trusts.

H-114 – Changed “immediately” to 10 days.

H-115 – Clarified that narration is completed in the electronic record.

H-201 – Clarified when a change in marital status is applied.

H-202 – Added “continuous” to the period of institutionalization. Updated the example.

H-206 – Added “current” to the state standard. Added the 2014 resource standard to the example.

H-300 – Added the PACE exception to the transfer of resources.

H-303 – Clarified when the penalty will be applied to institutionalized individuals and how the transfer penalty will apply to waiver individuals. Removed the SSI transfer and the WRTR screen as it is no longer applicable.

H-304 – Corrected the number reference in 1.c. and changed “asset” to “resource”.

H-310 – Clarified when the penalty period begins for HCBWs.

H-311 – Clarified the procedure for notifying HCBW applicants of ineligibility for the program because an uncompensated transfer has occurred.

H-315 – Removed the “Note” as this procedure is no longer applicable.

H-400 – Added a statement regarding categories that use post eligibility rules.

H-402 – Added Veteran’s Benefit exception to 1.a.

H-410 – Added information in “Note” Added #4. Added policy reference to the “Glossary” at #5. Corrected the section number for the DCO-712 where the family member allowance will be entered. Added hospice individuals have limited prescriptions at #7. Added the system enters the $50 plus additional non-covered medical expense. Clarified that vendor payment is also referenced as the cost of care.

H -412 – Added the procedures for the contribution to the cost of care for assisted living facilities and EC: Adult Family Home. Added the instructions for computing the cost of care for EC: Adult Family Home.

H-413 – Patient liability for PACE will be calculated using the DCO-712

H-416 – Described when the DCO-712 should be used for verification or refusal of contributions.

H-420 – Added information about the Personal Needs Allowance for SSI individuals applying for Long Term Care.

H-460 – Corrected the notice of action reference from DCO-700 to DCO-707.

H-481 – Corrected case adjustment for a non-income trust individual.

H-490 – Added policy from MS 3636, Absences from Long Term Care Facilities; MS 3637, County Office Responsibilities Following Report of Absence on Form DCO-702; MS 3637.1, Death or Discharge & MS 3637.2, Home Visits that was omitted in the January 2014 issuance.

H-491 – Added policy from MS 3637.3, Procedure for Reactivating a Suspension Case; MS 3637.4, Hospitalization; MS 3637.5, Hospitalization at the Arkansas State Hospital (Little Rock) or the George W. Jackson Center (Jonesboro); & MS 3637.6, Procedures for Suspension of Cases-State Hospital and George W. Jackson Center that was omitted in the January 2014 issuance.

H-492 - Added policy from MS 3637.7, Transfer & MS 3637.8, Transfer-Resident of Human Development Center that was omitted in the January 2014 issuance.

H-493 – Added policy from MS 3640, Operations Plan-Relocation of Recipients; MS 3641, Responsibility & MS 3642, Authority that was omitted in the January 2014 issuance.

H-494 – Added policy from MS 3643, Procedures, that was omitted in the January 2014 issuance.

H-510 – Added information that the resources will be disregarded for HCBWs also.

H-720 – Added waiver individuals to the list of who can ask for a hardship waiver.

In addition, ICF/MR was changed to ICF/IID, policy references were added and updated and addresses were updated throughout the policy section.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-16

Medical Services Policy Manual | Issuance Date: August 1, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Newborn Referral Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-210 – 300	01-13-15 01-01-14	MS C-210 – 300	01-13-15 08-01-15 01-01-14

Summary of Changes:

Medical Services policy section C has been revised to include the process that hospitals and physician providers will use to refer newborns for Medicaid coverage.

C-210 - The title of this section has been changed to "Newborn Referral Process". The policy section describes the DCO-645 newborn referral process.

C-211 – The title of this section has been changed to "Newborn Referral Disposal Process" and the DCO-645 has been added to the process guidelines.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-17

Medical Services Policy Manual — Issuance Date: August 10, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Penalty Period

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS H-306-311	01-01-14	MS H-306-311	01-01-14
	07-13-15		07-13-15
MS H-322-325	07-13-15		08-10-15
	01-01-14	MS H-322-325	07-13-15
			01-01-14
			08-10-15

Summary of Changes:

MS H-308, H-310 and H-323 have been revised to clarify when the penalty period will begin for an uncompensated transfer.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-18

Medical Services Policy Manual — Issuance Date: August 24, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Glossary

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Glossary (Pages 9 & 10)	05-28-15	MS Glossary (Pages 9 & 10)	05-28-15 08-24-15

Summary of Changes:

The MS Glossary has been revised to replace the term "husband and wife" in the definitions of "Living Arrangements and Marital Status" with "married couple".

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-19

Medical Services Policy Manual | Issuance Date: November 20, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Procedure for Inmates Being Released from Custody to Apply for Medicaid and Case Suspension While Incarcerated

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix C	07-01-15	MS Appendix C	08-01-15
MS D-350-381	01-01-14	MS D-350-381	01-01-14
	01-30-15		08-01-15
			01-30-15

Summary of Changes:

MS Appendix C has been revised to allow the use of a sentencing order as proof of identity.

MS D-370 has been revised to incorporate the policy reference regarding the exception for inmates to receive Medicaid.

MS D-371-D-373 have been developed to codify application procedures for an inmate being released from custody and the suspension of an inmate's case for up to a year while incarcerated.

The above changes were effective August 1, 2015.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-20

Medical Services Policy Manual | Issuance Date: September 29, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Autism Application Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-211-234	08-01-15 01-01-14 01-13-15	MS C-211-234	08-01-15 09-22-15 01-13-15 01-01-14

Summary of Changes:

MS C-220 has been revised to incorporate the age limit and the minimum and maximum years of coverage for children who are applying for the Autism Waiver. This information was inadvertently omitted when the manual was rewritten in 2014.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-21

Medical Services Policy Manual | Issuance Date: October 5, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: New Services Added for ARKids B

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix D	01-01-14	Appendix D	10-05-15
Appendix G	01-01-14	Appendix G	10-05-15
MS A-165	08-15-14	MS A-165	08-15-14
	01-01-14		10-05-15
			01-01-14
MS H-491	07-13-15	MS H-491	10-05-15

Summary of Changes:

Appendices D and G have been revised to reflect four new services now covered under ARKids B effective August 1, 2015: Orthodontia, Inpatient Psychiatric Hospital/Psychiatric Residential Treatment Facility Services, Occupational and Physical Therapy Services. MS sections A-165 and H-491 have also been revised to reflect this change in coverage.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-22

Medical Services Policy Manual | Issuance Date: October 8, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: 90 Day MAGI Application Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-100- MS C-150	01-01-14 01-13-15	MS C-100 – MS C-150	01-01-14 01-13-15 10-08-15
MS C-200 – MS C-205	01-01-14 01-13-15	MS C-200 – MS C-205	01-01-14 01-13-15

Summary of Changes:

Medical Services Section C-141 is a new section that describes when a new application is not required for those applications denied due to failure to provide verification information within the 10 day notice period as long as the requested information is provided within 90 days of the application denial date.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-23

Medical Services Policy Manual — Issuance Date: October 9, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: QDWI, Workers with Disabilities and Income Changes for Pregnant Women

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-318-343	08-15-14	MS B-318-343	08-15-14
	01-01-14		01-01-14
	01-01-15		10-09-15
MS I-210-230	01-01-14	MS I-210-230	01-01-14
	03-04-15		10-09-15
MS I-600-630	03-04-15	MS I-600-630	03-04-15
	01-01-14		10-09-15
MS I-641-680	01-01-14		01-01-14
	03-04-15	MS I-641-690	01-01-14
			03-04-15
			10-09-15

Summary of Changes:

Medical Services policy sections B and I have been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

MS B-325 – Added the age limit for QDWI eligibility.

MS B-326 – Removed “aged” from the categorical column for QDWI.

MS B-330 – Added that Individuals applying for Workers with Disabilities Medicaid must be working at the time of application.

MS I-610 – Added references, MS C-205 and I-690.

MS I-620 – Added SSI Related and Pregnant Women groups to the list of alternative change/closure processes.

MS I-690 – Added a new section “Continuing Eligibility for all Pregnant Women Who Are Medicaid Certified and Who Lose Eligibility Due to Income Changes” which explains the process of category change due to a change in income.

This information was not included when the manual was rewritten in 2014.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-24

Medical Services Policy Manual — Issuance Date: October 27, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Financial Eligibility

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS E-100 – 530	01-01-14 01-01-15	MS E-100 – 542	01-01-14 10-26-15

Summary of Changes:

Medical Services policy section E has been revised to update policy sections with current eligibility information. There are no changes to the eligibility determination process.

The policy sections that have been updated are as follows:

E-100 – Added reference to cost sharing in the Workers with Disabilities category.

E-110 – Added a notation that the 5% disregard option may be used to establish eligibility and clarified the Workers with Disabilities unearned income eligibility criteria.

E-262 – Added contributions to the list of excluded income.

E-263 – Clarified when a child's income is counted in the Medicaid household.

E-268 – Added a clarification example to the lowest income level group.

E-280 – Moved information previously in E-280, Sponsor Affidavits of Support and Deeming, to E-300.

E-300 – Moved information previously in E-300-340, Financial Requirements for Spend Down and U-18 and Pregnant Woman to Section O.

E-400 – Added PACE, SSI/COLA and PACE and ElderChoices: Adult Family Home to this methodology.

E-410 – Removed from #4 "All recipient interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement" because it is no longer applicable.

E-430 – Added NOTE about state and federal tax withholding.

E-431 – Added policy reference D-110. This information is being added to D-110.

E-432 – Added that reduction of SSA benefits for an overpayment is mandatory; changed the address for Railroad Retirement Board; removed clothing as in-kind support and added SSI/COLA, DAC and retro SSI determination to the groups that determine the valuation of in-kind income. Changed "wife" to spouse and added "widower".

E- 433 – Added the deeming requirement to "Widows and Widowers with a Disability (OBRA 1987)".

E-440 – Added SSI/COLA groups (except DAC) to the deeming procedures.

E-441 – Added Medicare Savings Program Standard as this group uses the deeming procedures. Added the carry over process at #6. Added definition of married couple.

E-447- Defined which group using the deeming from a non-qualified alien spouse.

E-451 – Removed the outdated VA information. Added federal tax refunds and advance payments to the list of excluded assets disregarded as income.

E-501 – Updated process for submission of OCC opinion requests to include DAAS.

E-502 – Defined when the couple standard would apply.

E-512 – Added the word "tenant" to 2a. Changed husband and wife to couple.

E-514 – Added the word "home" to the definition of equity value and rebuttal information to #1.

E-516 – Added groups that can use the property producing exclusion.

E-517 – Added PACE to the programs that fall under the home equity limit criteria.

E-518 – Added the 2013 home equity limit and clarified examples.

E-522 – Updated savings bond value resource.

E-523 – Added information about interest earned on excluded burial funds and funeral home ownership of irrevocably assigned life insurance or annuities. Added information about federal tax refunds and advance payments excluded as a resource for 12 months after receipt. Updated the process used to determine the value of vehicles.

E-540-542 – Added information about deeming of resources as it was not included when updating policy in 2014.

In addition, ICF/MR was changed to ICF/IID and policy references were added and updated throughout the policy section.

Inquiries to: Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-26

Medical Services Policy Manual | Issuance Date: October 30, 2015

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Pregnant Woman Period of Eligibility

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-145-C-205	01-01-14 01-13-15	MS C-145-C-205	01-01-14 01-13-15 10-30-15

Summary of Changes:

Medical Services Policy section C-205 has been revised to clarify that a woman who applies for coverage after the birth of a child and is found eligible in the birth month for Limited PW or Unborn Child will be given full postpartum coverage.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 15-27

Medical Services Policy Manual — Issuance Date: November 23, 2015

From: Delia Anderson, Director — Expiration Date: Until Superseded

Subj: Income Verification Process for Applications and Renewals

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS G-113-131	01-30-15	MS G-113-131	11-18-15
	01-01-14		01-01-14
	07-06-15		01-30-15
			07-06-15
MS G-140-180	01-30-15	MS G-140-180	01-30-15
	01-01-14		11-18-15
			01-01-14
MS I-100-690	01-01-14	MS I-100-690	01-01-14
	10-09-15		11-18-15
	03-04-15		10-09-15
			03-04-15

Summary of Changes:

MS G-113 has been revised to include verified information in an individual's TEA case record as a source of verification.

MS G-150 has been revised to include new logic in the MAGI income verification process to help provide a greater number of no touch cases.

MS I-210 has been revised to incorporate the renewal steps pertaining to attested income and verified income through SNAP and/or TEA.

MS I-220 has been revised to incorporate the renewal step when the household attests to income that is over the MAGI limit.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 15-29

Medical Services Policy Manual | Issuance Date: January 1, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: ARChoices in Homecare

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Table of Contents	None	Table of Contents	None
MS A-200 – A-320	08-15-14	MS A-200 – A-320	01-01-16
	01-01-14		01-01-14
			08-15-14
MS B-300 – B-602	01-01-14	MS B-300 – B-602	01-01-14
	08-15-14		08-15-14
	10-09-15		01-01-16
MS C-145 – C-205	01-01-14	MS C-145 – C-205	01-01-14
	01-13-15		01-13-15
	10-30-15		01-01-16
			10-30-15
MS C-235 – C-265	01-01-14	MS C-235 – C-265	01-01-14
	01-13-15		01-13-15
			01-01-16
MS E-100 – E-230	10-26-15	MS E-100 – E-230	10-26-15
	01-01-14		01-01-16

			01-01-14
MS E-400 – E-410	10-26-15	MS E-400 – E-410	01-01-16
	01-01-14		01-01-14
			10-26-15
MS E-425 – E-433	01-01-14	MS E-425 – E-433	01-01-14
	10-26-15		01-01-16
			10-26-15
MS E-434 – E-441	01-01-14	MS E-434 – E-441	01-01-14
	10-26-15		01-01-16
			10-26-15
MS F-121 – F-124	01-01-14	MS F-121 – F-124	01-01-14
	01-30-15		01-01-16
			01-30-15
MS F-140 – F-155	01-01-14	MS F-140 – F-155	01-01-14
	01-30-15		01-30-15
			01-01-16
MS H-114 – H-212	07-13-15	MS H-114 – H-212	07-13-15
	01-01-14		01-01-16
MS H-310 – H-311	08-10-15	MS H-310 – H-311	01-01-16
	07-13-15		07-13-15
MS H-410 – H-415	07-13-15	MS H-410 – H-415	01-01-16
	01-01-14		07-13-15
			01-01-14
MS I-320 – I-324	03-04-15	MS I-320 – I-324	01-01-16
	01-01-14		01-01-14
	07-13-15		03-04-15
MS I-532 – I-570	03-04-15	MS I-532 – I-570	03-04-15
	01-01-14		01-01-16
MS I-600 – I-690	03-04-15	MS I-600 – I-690	03-04-15
	10-09-15		10-09-15

	01-01-14		01-01-16
Appendix D	10-05-15	Appendix D	01-01-16
Appendix I	05-15	Appendix I	01-16
Appendix J	04-15	Appendix J	01-16
Appendix O	01-14	Appendix O	01-16

Summary of Changes:

Medical Services Policy has been revised to merge the ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) waiver programs into one waiver called ARChoices in Homecare. This action will not result in any eligibility rule changes. The eligibility criteria for both the elderly and adults with physical disabilities will remain the same as in the two previous waivers, but both groups will now be served through one waiver program.

References to ElderChoices and AAPD have been changed to ARChoices in Homecare or ARChoices throughout the manual. In addition, specific changes are listed below:

A-200 –Deleted the ElderChoices waiver section. Added "unless a prior date is authorized by the DHS RN" to the statement of when eligibility will begin.

A-211 – Merged AAPD and ElderChoices sections and changed the name to ARChoices in Homecare. Clarified that the DHS RN determines the begin date of eligibility for Assisted Living.

B-313 – Merged B-313 and B-314 into one section called ARChoices in Homecare.

C-240 – Clarified individuals aged 21-64 must have a physical disability and removed reference to AAPD waiting list.

C-253 – Changed reference to "medical assessment" to "functional need assessment".

C-256 - Clarified that individuals entering an ALF from a LTCF or ARChoices must receive a new functional need assessment by the DAAS RN in order to determine the individual's tier level.

I-560 – Revised this section to incorporate ANSWER procedures for when an ARChoices recipient turns age 65.

I-570 - Changed "medical criteria" to "functional need criteria" and removed “AAPD counselor” from the referral process.

Appendix D – Added descriptions for the ARChoices in Homecare waiver program. Deleted sections for AAPD and ElderChoices.

Appendix I – Combined ElderChoices and AAPD rows and formed an ARChoices row. Removed and added various forms to the LTSS section that were in error.

Appendix J - Combined ElderChoices and AAPD rows and formed an ARChoices row.

Appendix O - Combined ElderChoices and AAPD rows and formed an ARChoices row. Removed and added various forms to the LTSS section that were in error.

Inquiries to:

Jack Tiner, 501-320-6554, Jack.Tiner@dhs.arkansas.gov
Latoria Brooks, 501-320-6052, Latoria.Brooks@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-01

Medical Services Policy Manual | Issuance Date: January 1, 2016

From: Delia Anderson, Director | Expiration Date: Until Superseded

Subj: Home Equity Limit and SSI and Quarters of Coverage Chart

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix R Appendix S	04-01-15 01-01-15	Appendix R Appendix S	01-01-16 01-01-16

Summary of Changes:

Appendix R, Transfer of Assets Divisor and Home Equity Limit and Appendix S, SSI and Quarters of Coverage Chart, have been updated for 2016.

There was no change in the home equity limit on Appendix R. The quarters of coverage amount and the substantial gainful activity (SGA) amount were updated on Appendix S. The changes are effective January 1, 2016.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-02

Medical Services Policy Manual — Issuance Date: January 21, 2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: Begin Date for Autism Coverage Period

Pages to be Deleted:	Date:	Pages to be Added:	Date:
C-211-C-220	08-01-15 09-22-15	C-211-C-220	08-01-15 01-14-16

Summary of Changes:

MS C-220 has been updated to incorporate the coverage period start date for a child receiving Medicaid through the Autism waiver.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-03

Medical Services Policy Manual — Issuance Date: January 27, 2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: Medically Needy Program

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS O-100 – MS O-143	01-01-14	MS O-100 – MS O- 143	01-01-14 01-27-16
MS O-200 – MS O-230	01-01-14	MS O-200 – MS O-230	01-01-14 01-27-16
MS O-400 – MS O-451	01-01-14	MS O-400 – MS O-451	01-01-14 01-27-16
MS O-600 – MS O-620	01-01-14	MS O-600 – MS O-620	01-01-14 01-27-16
MS O-700 – MS O-730	01-01-14	MS O-700 – MS O-730	01-01-14 01-27-16

Summary of Changes:

MS Policy Section O has been revised to update policy references and to change references for TEA Medicaid to Parent Caretaker Relatives Medicaid.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-05

Medical Services Policy Manual | Issuance Date: January 27, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: Verification of Resources using the Asset Verification System

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS G-160 – MS G-180	01-30-15 01-01-14	MS G-160 – MS G-181	01-30-15 01-01-14 01-27-16

Summary of Changes:

Medical Services Policy Section G-181, Verification of Resources using the Asset Verification System, is a new section of policy providing information and instructions on using the Asset Verification System to locate and verify liquid resources for non-SSI AABD categories with a resource limit.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-06

Medical Services Policy Manual | Issuance Date: February 5, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: TEFRA Application Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-230 – MS C-234	01-13-15 01-01-14	MS C-230 – MS C-234	02-05-16 01-01-14 01-13-15

Summary of Changes:

Medical Services Section C-230, TEFRA Application Process, has been revised to remove a statement that is no longer applicable. Respite Services is no longer offered for TEFRA recipients.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-07

Medical Services Policy Manual — Issuance Date: February 24, 2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: MS Appendix N, Family Medically Needy Resource and Income Levels

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix N	01-01-14	MS Appendix N	02-24-16

Summary of Changes:

Medical Services Policy Appendix N has been revised to update processes and procedures regarding determining resource and income levels for the medically needy categories. There are no changes to the eligibility determination process.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-08

Medical Services Policy Manual | Issuance Date: March 7, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: MS Appendix W, ARChoices Waiver Application Tracking and Release Procedures

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix W	04-07-15	MS Appendix W	03-07-16

Summary of Changes:

Medical Services Policy Appendix W has been revised to update processes and procedures regarding the waiting list for ARChoices. Below are the specific changes:

- References to AAPD have been changed to ARChoices.
- "Waiting list" has been changed to "application tracking and release list".
- Position titles have been bolded and underlined to easily identify the party responsible for each action.
- More detailed instructions have been added for DCO County Offices regarding entry of information in ANSWER when applications are received.
- References to "DCO worker" have been changed to "LTSS Program Eligibility Specialist".

- Additional steps have been added for the LTSS Program Eligibility Specialist, DAAS RN and DAAS Central Office to add clarity. Some tasks that were previously the responsibility of the DAAS RN have been moved to the DAAS Central Office.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov
Jack Tiner, 501-320-6554, jack.tiner@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-09

Medical Services Policy Manual | Issuance Date: April 1, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels and Transfer of Assets Divisor

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix F	04-01-15	Appendix F	04-01-16
Appendix P	04-01-15	Appendix P	04-01-16
Appendix R	01-01-16	Appendix R	04-01-16

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor, have been revised to provide the 2016 Federal Poverty Level income guidelines and the Transfer of Assets Divisor effective April 1, 2016.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-10

Medical Services Policy Manual — Issuance Date: 04/29/2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: Procedures for Children in DYS Custody

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS D-350 – MS D-381	01/01/2014 08/01/2015 01/30/2015	MS D-350 – MS D-381	04/29/2016 08/01/2015

Summary of Changes:

Section D of the Medical Services Policy Manual is being updated to consolidate the policy regarding children in Division of Youth Services custody with the policy regarding incarcerated individuals in general. Children in DYS custody will now be able to utilize the coverage suspension procedures utilized for all other incarcerated individuals. Policy section D-360 is being removed as the procedures outlined in that section are no longer valid. Section D-380 and D-381 are being revised to update DYS and System procedures, and to remove the information regarding DCO procedures that are no longer valid.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-11

Medical Services Policy Manual — Issuance Date: May 5, 2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: Medicare Savings Program

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS E-434 – MS E-500	01-01-14 01-01-16 10-26-15	MS E-434 – MS E-500	01-01-14 05-05-16 01-01-16 10-26-15

Summary of Changes:

MS E-435, Medicare Savings Income Calculation, is a new section of policy that describes how income eligibility will be determined for an individual applying for the Medicare Savings Program.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-12

Medical Services Policy Manual | Issuance Date: June 1, 2016

From: Mary Franklin, Interim Director | Expiration Date: Until Superseded

Subj: Program of All-Inclusive Care for the Elderly (PACE)

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-315 – MS B-321	08-15-14	MS B-315 – MS B-321	08-15-14
	01-01-14		06-01-16
			01-01-14
MS C-260 – MS C-262	01-13-15	MS C-260 – MS C-262	06-01-16
	01-01-16		01-01-16
	01-01-14		01-01-14
Appendix K	01-01-14	Appendix K	06-01-16

Summary of Changes:

A new PACE provider, Complete Health with PACE, will begin providing PACE services in counties in Central Arkansas. The Division of Aging and Adult Services (DAAS) will begin accepting applications for PACE in these new counties beginning June 1, 2016. The following changes have been made to the Medical Services Policy manual.

MS B-318 – Removed the word "northeast" as PACE services will no longer be limited to Northeast Counties of Arkansas.

MS C-260 – Note is added stating a new application is not needed if an individual moves from one PACE site to another.

Appendix K – Zip codes are added for those cities served by the new PACE provider in Central Arkansas.

Inquiries to:

Jack Tiner, 501-320-6554, jack.tiner@dhs.arkansas.gov
Latoria Brooks, 501-320-6052, latoria.brooks@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-13

Medical Services Policy Manual — Issuance Date: June 8, 2016

From: Mary Franklin, Interim Director — Expiration Date: Until Superseded

Subj: Former Foster Care Adults

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-250 – MS B-270	08-15-14 01-01-14	MS B-250 – MS B-270	08-15-14 06-08-16

Summary of Changes:

Medical Services policy section MS B-260, Former Foster Care Adults, has been revised to incorporate the requirement that receiving Medicaid is an eligibility criteria for the former foster care adult category when the individual aged out of foster care.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-14

Medical Services Policy Manual — Issuance Date: July 8, 2016

From: Mary Franklin, Director — Expiration Date: Until Superseded

Subj: ARKids Age and Specified Relative Requirement

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-100 – MS B-250	01-01-14 08-15-14 01-14-14	MS B-100 – MS B-250	01-01-14 08-15-14 07-08-16
MS F-100 – MS F-120	01-01-14 01-30-15	MS F-100 – MS F-120	01-01-14 07-08-16 01-30-15

Summary of Changes:

Medical Services Policy Sections B-210 and F-110 have been revised to clarify the age requirement and the specified relative requirements for ARKids A and B.

Inquiries to:

Kristie Hayes, 501-682-8259, kristie.hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-15

Medical Services Policy Manual | Issuance Date: August 1, 2016

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Personal Property Exclusions

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS E-523 – MS E-542	10-26-15 01-01-14	MS E-523 – MS E-542	08-01-16 01-01-14 10-26-15

Summary of Changes:

Medical Services Policy Section E-523, Personal Property Exclusions, has been revised to allow the exclusion of one automobile regardless of the value during the resource assessment, to provide guidelines for determining the value of a vehicle, and to codify that the resource exclusion for household goods and personal effects no longer has a dollar limit amount.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-16

Medical Services Policy Manual — Issuance Date: October 2, 2016

From: Mary Franklin, Director — Expiration Date: Until Superseded

Subj: TEFRA Revisions

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-315 – B-321	08-15-14	MS B-315 – B-321	10-02-16
	06-01-16		06-01-16
	01-01-14		01-01-14
MS F-180 – F-191	01-30-15	MS F-180 – F-191	10-02-16
	01-01-14		01-01-14
Appendix P	04-01-15	Appendix P	10-02-16

Summary of Changes:

Medical Services Policy section B-315, TEFRA, has been revised to replace “acute care facility” with “hospital”. “Alternative Home Placement” has been removed.

Medical Services Policy section F-180, Other Health Insurance Coverage, has been revised to remove the reference to TEFRA. TEFRA applicants with insurance coverage other than Medicaid are no longer assessed a 90 day waiting period preceding the date of application. This section has also been revised to change “3 months” to “90 days”.

Appendix P has been revised to change (round down) specific TEFRA premium amounts because the amounts were greater than the percentage of income indicated.

Inquiries to:

Kristie Hayes, 501-682-8259, Kristie.Hayes@dhs.arkansas.gov
Carla Droughn, 501-682-8254, Carla.Droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, Renita.Honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 16-17

Medical Services Policy Manual | Issuance Date: October 6, 2016

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Medically Needy Program

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS O-753 – MS O-800	01-01-14	MS O-753 – MS O-800	01-01-14
MS O-900 – MS O-950	01-01-14	MS O-900 – MS O-950	01-01-14
			10-06-16
MS Appendix O	01-01-16	MS Appendix O	10-06-16

Summary of Changes:

MS O-910, Time Schedule for Reevaluations of Eligibility for Exceptional Medically Needy Cases, is being updated to replace the designated renewal form, DCO-215, with the DCO-95, Application for Family Medicaid Assistance, as the form used for renewals for the aged medically needy category.

MS Appendix O, Renewal Forms Chart, was updated with the above information and the reference to Pub-408 was removed as this publication is no longer required at renewals.

NOTE: MS O-753, Nonspecific Assignable Payments, is being reprinted as part of the last sentence of the last paragraph was deleted in the first print.

Inquiries to:
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 16-18

Medical Services Policy Manual — Issuance Date: October 21, 2016

From: Mary Franklin, Director — Expiration Date: Until Superseded

Subj: MRT Docushare Process

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS F-127 – MS F-193	01-01-14 01-30-15	MS F-127 – MS F-193	01-01-14 10-21-16 01-30-15

Summary of Changes:

MS F-128, Substantial Gainful Activity (SGA), has been revised to reflect the current SGA amount.

MS F-129, Request for MRT Disability Determinations, is a new section of policy that establishes the process for a caseworker to send a request for a disability determination to the Medical Review Team (MRT) through Docushare.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Honorable, 501-682-1562, renita.honorable@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-01

Medical Services Policy Manual | Issuance Date: January 1, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Cost of Living Adjustments (COLA) and Medicare Savings Programs (MSP) Resource Limits

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix R	04-01-16	MS Appendix R	01-01-17
MS Appendix S	01-01-16	MS Appendix S	01-01-17
MS B-321 – MS B-330	08-15-14	MS B-321 – MS B-330	08-15-14
	10-09-15		10-09-15
	01-01-16		01-01-17
			01-01-16
MS E-100 – MS E-110	10-26-15	MS E-100 – MS E-110	10-26-15
	01-01-16		01-01-17

Summary of Changes:

Medical Services Appendices R and S are being updated to reflect the new Cost Of Living Adjustment (COLA) amount for 2017.

Medical Services sections B-326, Medicare Savings Programs - Comparison Chart, and E-110, Income and Resource Limits for MAGI and Non-MAGI Groups, are being updated to reflect the MSP resource limits for 2017.

Inquiries to:

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-03

Medical Services Policy Manual | Issuance Date: January 10, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Arkansas Works Program

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS A-100 – MS A-190	01-01-14	MS A-100 – MS A-190	01-01-17
	08-15-14		08-15-14
	10-05-15		01-01-14
MS A-200 – MS A-230	01-01-16	MS A-200 – MS A-230	01-01-17
	01-01-14		01-01-16
	08-15-14		01-01-14
			08-15-14
MS A-300 – MS A-340	01-01-14	MS A-300 – MS A-340	01-01-14
	08-15-14		01-01-17
MS B-100 – MS B-270	01-01-14	MS B-100 – MS B-270	01-01-14
	08-15-14		01-01-17
	07-08-16		07-08-16
	06-08-16		08-15-14
			06-08-16
MS B-500 – MS B-500	08-15-14	MS B-500 – MS B-500	01-01-17
MS C-141 – MS C-205	10-08-15	MS C-141 – MS C-205	10-08-15
	01-01-14		01-01-14
	01-13-15		01-01-17
	01-01-16		01-01-16

	10-30-15		10-30-15
MS D-500 – MS D-530	01-01-14	MS D-500 – MS D-530	01-01-17
	01-30-15		01-30-15
			01-01-14
MS E-100 – MS E-230	10-26-15	MS E-100 – MS E-230	10-26-15
	01-01-17		01-01-17
	01-01-14		01-01-14
MS E-265 – MS E-270	01-01-14	MS E-265 – MS E-270	01-01-14
	10-26-15		01-01-17
MS F-173 – MS F-180	01-01-14	MS F-173 – MS F-180	01-01-14
	10-02-16		01-01-17
MS H-490 – MS H-500	07-13-15	MS H-490 – MS H-500	07-13-15
	10-05-15		01-01-17
	01-01-16		01-01-16
	01-01-14		01-01-14
MS I-600 – MS I-630	03-04-15	MS I-570 – MS I-630	03-04-15
	10-09-15		01-01-17
	01-01-16		01-01-16
MS I-690 – MS I-690	10-09-15	MS I-690 – MS I-690	01-01-17
MS O-131 – MS O-143	01-01-14	MS O-131 – MS O-143	01-01-14
	01-27-16		01-01-17
MS Appendix F	04-01-16	MS Appendix F	01-01-17
MS Appendix I	01-01-16	MS Appendix I	01-01-17
MS Appendix J	01-01-16	MS Appendix J	01-01-17
MS Appendix O	10-01-16	MS Appendix O	01-01-17
MS Appendix X	04-07-15	MS Appendix X	01-01-17

Summary of Changes:

The following sections of policy have revised to reflect the changes to the Health Care Independence Program which changed to the Arkansas Works Program effective January 1, 2017.

A-116 – “Premiums For The Adult Expansion Group” is a new section of policy that explains premiums being assessed to individuals whose income is at least 100% of the federal poverty level.

A-340 – Individuals in a QHP or employer sponsored insurance will contact their insurance provider for answers to plan questions.

B-270 – Individuals who are 21 years of age and working must enroll in employer health insurance coverage if the employer has elected to participate in the Arkansas Works Program.

C-150 – Explains the new process for enrollment in the Adult Expansion Group.

Throughout the policy manual, the Health Care Independence Program name has been replaced with the Adult Expansion Group. Employer Sponsored Insurance has been included as a private insurance plan.

Inquiries to:
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-04

Medical Services Policy Manual | Issuance Date: February 01, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Reasonable Opportunity Period for Immigration Status

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS G-131 – G-181	07-06-15 01-01-14 01-30-15 11-18-15 01-27-16	MS G-131 – MS G-181	07-06-15 01-01-14 02-01-17 11-18-15 01-30-15 01-27-16

Summary of Changes:

The following sections of policy have revised to reflect the changes to the alien immigration status verification process.

G-140 – "Alien Status Verification Requirements" has been revised to change the time given for an alien to verify immigration status from a 10-day notice to a 90-day notice.

G-141 – "Reasonable Opportunity for Verifying Alien Status" – is a new section of policy which describes the 90-day reasonable opportunity period for an alien to verify immigration status if that status cannot be verified through FDSH, SAVES or if the individual does not have immigration documentation.

Inquiries to:
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-05

Medical Services Policy Manual | Issuance Date: February 16, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Resources-AABD

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS E-500 – MS E-542	10-26-15 01-01-14	MS E-500 – MS E-542	10-26-15 02-16-17 01-01-14

Summary of Changes:

The following sections of policy have been revised to clarify policy and procedures in determining resource eligibility for the aged, blind and disabled groups of Medicaid.

- MS E-501 #7- replaced “record” with “folder in eDoctus”.
- MS E-513 #2.c.4 - added spousal impoverishment guidelines from H-200 regarding separated couples living in the community when one is applying for ARChoices or PACE. Added clarification regarding good faith effort to obtain information from estranged spouses.
- MS E-513 #3 - deleted “Held in Non-home Property” as this determination also applies to home property. Added procedures for determining life estate value when there are joint life estate holders and provided an example.
- MS E-515#2 - updated to bring in line with POMS regarding mineral rights on excess real property and added an example.
- MS E-515 #3 - added statement regarding rebuttal.

- MS E-516 #1 - added additional information regarding SSI recipients in a facility.
- MS E-516 #2 - added clarification to first paragraph that these exclusions apply to all AABD categories except QDWI.
- MS E-516 #2.a. - removed references to applicable categories; removed the statement "principal means of livelihood or support"; and added an example.
- MS E-516 #2.b. - removed references to "principal means of livelihood or support" and added IRS forms helpful to determine trade or business enterprise.
- MS E-517 - added more specific wording to clarify that if a HCBW/PACE applicant is over the home equity limit, their application will be denied.
- MS E-523 #2 – clarified that the disregard of the face value of life insurance policies owned by the individual is dependent on who the insured is; added 3 examples.
- MS E-530 #6 - added clarification regarding sale of a resource.
- MS E-540 – added "Note" regarding deeming in LTSS categories.

References to OPLS were replaced with Office of Chief Counsel (OCC) and references to PACE were added throughout policy E-500.

Inquiries to:
Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-06

Medical Services Policy Manual | Issuance Date: April 1, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels and Transfer of Assets Divisor

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix F	01-01-17	Appendix F	04-01-17
Appendix P	10-01-16	Appendix P	04-01-17
Appendix R	01-01-17	Appendix R	04-01-17

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor, have been revised to provide the 2017 Federal Poverty Level income guidelines and the Transfer of Assets Divisor effective April 1, 2017.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-07

Medical Services Policy Manual | Issuance Date: April 3, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Adult Expansion Group

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS I-500 – MS I-531	01-01-14	MS I-500 – MS I-531	01-01-14 04-03-17

Summary of Changes:

MS I-520 has been revised to change Healthcare Independence Program to the Adult Expansion Group.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Renita Whitley, 501-682-1562, renita.whitley@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 17-08

Medical Services Policy Manual — Issuance Date: May 12, 2017

From: Mary Franklin, Director — Expiration Date: Until Superseded

Subj: TEFRA Cost Effectiveness

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS C-232 – MS C-241	02-15-16	MS C-230 – MS C-241	02-15-16
	01-01-14		01-01-14
	01-13-15		05-12-17
	01-01-16		01-01-16
MS F-130 – MS F-150	01-30-15	MS F-130 – MS F-150	01-30-15
	01-01-14		05-12-17
MS F-152 – MS F-155	01-30-15	MS F-152 – MS F-155	01-30-15
	01-01-16		05-12-17
			01-01-16
MS I-324 – MS I- 327	03-04-15	MS I-324 – MS I-327	03-04-15
			05-12-17

Summary of Changes:

MS C-232, C-234, C-235, F-140, F-154 and I-325 have been revised to remove references to the Office of Long Term Care cost effectiveness determination. The cost effectiveness determination is completed on a yearly basis by the Division of Medical Services.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 17-09

Medical Services Policy Manual | Issuance Date: July 14, 2017

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Reasonable Opportunity for Verifying Citizenship & Alien Status

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS G-131 – MS G-141	07-06-15 01-01-14 02-01-17	MS G-131 – MS G-141	07-06-15 07-14-17 01-01-14

Summary of Changes:

Medical Services Policy sections G-132, G-140 and G-141 have been revised to provide details on what information is required to obtain verification from SAVE and to clarify that the reasonable opportunity period to supply verification of alien status will be provided for all Medicaid eligibility categories.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-01

Medical Services Policy Manual | Issuance Date: January 1, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Cost of Living Adjustments (COLA) and Medicare Savings Programs (MSP) Resource Limits

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix R	04-01-17	MS Appendix R	01-01-18
MS Appendix S	01-01-17	MS Appendix S	01-01-18
MS B-321 – MS B-330	08-15-14	MS B-321 – MS B-330	08-15-14
	10-09-15		10-09-15
	01-01-17		01-01-18
	01-01-16		01-01-16
MS E-100 – MS E-200	10-26-15	MS E-100 – MS E-200	10-26-15
	01-01-17		01-01-18
	01-01-14		01-01-14
			01-01-17

Summary of Changes:

Medical Services Appendices R, Transfer of Assets Divisor and Home Equity Limit, and S, SSI and Quarters of Coverage Chart, are being updated to reflect the new Cost Of Living Adjustment (COLA) amount for 2018.

Medical Services sections B-326, Medicare Savings Programs - Comparison Chart, and E-110, Income and Resource Limits for MAGI and Non-MAGI Groups, are being updated to reflect the MSP resource limits for 2018.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov

Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov

Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov

Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy — Issuance Number: MS 18-02

Medical Services Policy Manual — Issuance Date: January 1, 2018

From: Mary Franklin, Director — Expiration Date: Until Superseded

Subj: CHIPRA and 40 Qualifying Quarters

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix C	07-15	Appendix C	01-18
MS B-210 – MS B-270	07-08-16	MS B-210 – MS B-270	07-08-16
	08-15-14		08-15-14
	06-08-16		06-08-16
	01-01-17		01-01-18
MS D-200 – MS D-230	01-01-14	MS D-200 – MS D-230	01-01-14
	01-30-15		01-01-18
MS E-300 – MS E-300	10-26-15	MS E-300 – MS E-300	01-01-18
MS E-442 – MS E-450	10-26-15	MS E-442 – MS E-450	10-26-15
	01-01-14		01-01-14
			01-01-18

Summary of Changes:

Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration, has been updated to make the following changes:

1. Replaced all references to Immigration and Naturalization Services (INS) with the United States Department of Homeland Security (USDHS).

2. Updated Section III – Alien Status Verification – Using Save. This is now an electronic process and no longer done by phone.
3. Added a table for immigration status of lawfully present alien children under age 19 and pregnant women who are exempt from the five year bar waiting period.

MS B-250 Unborn Child (Pregnant Woman) – Added a statement to clarify that lawfully admitted aliens who do not meet one of the conditions listed in D-224 can be included in this eligibility group.

MS D-210 – Citizenship – Added a note that Marshall Island pregnant women and children who are lawfully residing in the United States may be approved for Medicaid if they meet all other eligibility criteria for the category being applied for.

MS D-220- Alien Status – Added references to MS E-300.

MS D-221 – Alien Categories – Added definition of non-immigrant.

MS D-223 – Aliens Subject to Five-Year Bar – Removed references to 40 qualifying quarters. Added Aliens paroled into the U.S. as Central American Minors for a period of at least two years. Changed INS to USDHS. Added note stating that pregnant women and children who meet the conditions at D-224 may be eligible without meeting the five year bar.

MS D-224 – Aliens Exempt from Five-Year Bar – Added Cuban or Haitian entrants in the Haitian Family Reunification Program. Removed Aliens who can be credited with 40 qualifying quarters of coverage. Added Pregnant Women and Children who are lawfully present may also be eligible without meeting the five-year bar.

MS D-225 – Establishing Qualifying Quarters – Removed this section.

MS D-230 – Non-Citizens Not Eligible for Emergency Services – Changed section title to Non-Citizens Eligible for Emergency Services. Changed statement regarding residency requirements. Added note that this is not an all-inclusive list.

MS E-300 – Removed reference to 40 quarters of work credits.

MS E-445 – Exceptions to Deeming for Alien's Sponsor – Removed reference to 40 qualifying quarters. Added pregnant women and children who are exempt from the five-year bar.

Changed INS to United States Department of Homeland Security (USDHS) throughout policy.

<u>Inquiries to:</u>

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov

Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-03

Medical Services Policy Manual | Issuance Date: February 1, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Assessment State for Federally Facilitated Marketplace Applications

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS A-166 – MS A-180	01-01-14	MS A-166 – MS A-180	01-01-14
	01-01-17		02-01-18
MS C-112 – MS C-200	01-01-14	MS C-112 – MS C-200	01-01-14
	01-13-15		02-01-18
	10-08-15		01-13-15
	01-01-17		10-08-15
	01-01-16		01-01-16
	10-30-15		10-30-15
MS E-263 – MS E-265	10-26-15	MS E-263 – MS E-265	10-26-15
	01-01-14		01-01-14
			02-01-18
MS E-268 – MS E-269	01-01-17	MS E-268 – MS E-269	01-01-17
	01-01-14		01-01-14

Summary of Changes:

Medical Services Policy sections A-180, C-120, C-130 and C-150 have been revised to change which entity will determine eligibility for Medicaid applications received through the Federally Facilitated Marketplace (FFM). Eligibility determinations for applications received through the FFM will now be processed by DHS.

Medical Services Policy section E-265 has been changed to remove the NOTE which referenced E-270. Medical Services Policy E-270 has been removed from policy because projected income will no longer be used to determine Medicaid eligibility.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-04

Medical Services Policy Manual | Issuance Date: March 16, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Life Expectancy Table

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix L	01-01-14	MS Appendix L	03-16-18

Summary of Changes:

Appendix L, Life Expectancy Table, has been updated for 2018.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-05

Medical Services Policy Manual | Issuance Date: April 1, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix F	04-01-17	MS Appendix F	04-01-18
MS Appendix P	04-01-17	MS Appendix P	04-01-18
MS Appendix R	01-01-18	MS Appendix R	04-01-18

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor and Home Equity Limit, have been revised to reflect the 2018 Federal Poverty Level income guidelines and the Transfer of Assets Divisor effective April 1, 2018.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-06

Medical Services Policy Manual | Issuance Date: April 1, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Autism

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix D	01-01-16	MS Appendix D	04-01-18
MS B-313 – MS B-321	01-01-16	MS B-313 – MS B-321	01-01-16
	10-02-16		10-02-16
	08-15-14		04-01-18
	06-01-16		08-15-14
	01-01-14		06-01-16
			01-01-14
MS C-211 – MS C-220	08-01-15	MS C-211 – MS C-220	08-01-15
	01-14-16		04-01-18
MS I-532 – MS I-551	03-04-15	MS I-532 – MS I-551	03-04-15
	01-01-14		01-01-14
	01-01-16		04-01-18
			01-01-16

Summary of Changes:

Medical Services Policy sections Appendix D, B-315, C-220 and I-541 have been revised. The changes are as follows:

- Appendix D – Autism services are available for children 18 months through seven (7) years with a diagnosis of autism.
- B-316 – A child will be eligible for autism services through the day before their 8th birthday.

- C-220 – A child 5 years old and 1 day is over the age limit for application because the minimum coverage is 2 years. Coverage will end the day before the child's eighth birthday.
- I-541 – Changed the maximum age to eight to receive services for autism.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-07

Medical Services Policy Manual | Issuance Date: April 6, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Appendix C, Verification of Citizenship, Alien Status, and SSN Enumeration

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix C	01-01-18	MS Appendix C	04-06-18

Summary of Changes:

Medical Services Appendix C, Verification of Citizenship, Alien Status, and SSN Enumeration has been updated to reflect the change in verifying alien status using SAVE.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-08

Medical Services Policy Manual | Issuance Date: April 16,2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Advance Notice Update

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS J-100 – MS J-140	01-01-14	MS J-100 – MS J-140	01-01-14 04-16-18

Summary of Changes:

Medical Services Policy section J-130 #7 has been revised to add missing language that states a "special allowance by the Office of Chief Counsel (exclusion of assets, etc.)."

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-09

Medical Services Policy Manual | Issuance Date: April 27, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Arkansas Works Updates

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS A-100 – MS A-110	01-01-17	MS A-100 – MS A-110	05-01-18
	08-15-14		08-15-14
			01-01-17
MS A-200 – MS A-340	01-01-17	MS A-200 – MS A-340	01-01-17
	01-01-16		01-01-16
	08-15-14		08-15-14
	01-01-14		01-01-14
			05-01-18
MS B-250 – MS B-270	01-01-18	MS B-250 – MS B-270	01-01-18
	06-08-16		06-08-16
	01-01-17		05-01-18
MS B-500 – MS B-500	01-01-17	MS B-500 – MS B-500	05-01-18
MS D-370 – MS D-381	08-01-15	MS D-370 – MS D-381	08-01-15
	04-29-16		05-01-18
			04-29-16
MS D-500 – MS D-530	01-01-17	MS D-500 – MS D-530	05-01-18
	01-30-15		01-30-15
	01-01-14		01-01-14
MS E-265 – MS E-269	02-01-18	MS E-265 – MS E-269	02-01-18
	01-01-14		01-01-14

	01-01-17		05-01-18
		MS F-200 – MS F-201	05-01-18
MS G-181 – MS G-181	01-27-16	MS G-181 – MS G-190	01-27-16
			05-01-18
MS I-570 – MS I-690	01-01-16	MS I-570 – MS I-690	01-01-16
	03-04-15		05-01-18
	01-01-17		01-01-14
	01-01-14		03-04-15
			01-01-17
MS Appendix X	01-01-17	MS Appendix X	05-01-18
		MS Appendix Y	05-01-18

Summary of Changes:

Medical Services Policy has been revised as follows:

Sections A-100, A-330, A-340, D-500, and Appendix X have been revised to remove references to Employer Sponsored Insurance (ESI).

A-210- If eligible, retroactive coverage for the Adult Expansion Group may start 30 days prior to the date of application.

B-270 has been revised to remove language referencing Employer Sponsored Insurance (ESI). Also, language was added to detail the Adult Expansion Group work and community engagement requirements.

B-500- If eligible, retroactive coverage for Emergency Medicaid may start 30 days prior to the date of application for individuals approved in the Adult Expansion Group. Removed example (e.g. the date of admission through the date of discharge from the hospital).

D-372- If eligible, retroactive coverage for incarcerated individuals who are eligible in the Adult Expansion Group may start 30 days prior to the date of application.

D-373- Changed Health Care Independence Program to Adult Expansion Group. Removed guidance that incarcerated individual cases should be closed due to incarceration status. Incarcerated individuals will now remain open with no Medicaid coverage, until coverage is requested for dates of treatment off the correctional facility grounds.

Sections E-268 and E-269 have been revised to clarify how income is calculated.

F-200 has been added to give details about the work and community engagement requirements for Arkansas Works.

F-201 has been added to define good cause and give details about good cause exemptions for months of non-compliance with the work and community engagement requirement for the Adult Expansion Program.

G-190 has been added to give verification requirements for the Adult Expansion Group work and community engagement requirements.

I-600 - Has been revised to add the citizen portal as a method of reporting a change.

I-610 – Has been revised to add changes in work and community engagement requirement activities as an eligibility factor that is required to be reported.

Appendix Y has been created to provide a chart to display how to manually compute work activity hours due to system malfunction.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Carla Droughn, 501-682-8254, carla.droughn@dhs.arkansas.gov
Latoria Brooks, 501-682-8258, latoria.brooks@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-10

Medical Services Policy Manual | Issuance Date: June 26, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: TEFRA Renewal Updates

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS I-325	05-12-17	MS I-325	07-01-18

Summary of Changes:

Medical Services Policy I-325 has been revised to update the due date for the TEFRA renewal packet. Clarification has been added that a TEFRA recipients guardian or authorized representative will now have until the last day of the 10th month to return the TEFRA renewal packet.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Andrew Rindahl 501-682-8254, andrew.rindahl@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy	Issuance Number: MS 18-11
Medical Services Policy Manual	Issuance Date: 10-18-2018
From: Mary Franklin, Director	Expiration Date: Until Superseded

Subj: MS Appendix W - ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix W	03-07-16	MS Appendix W	10-18-18

Summary of Changes

Appendix W, ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures, has been revised to include the tracking and release procedures for Assisted Living Facilities, to update language from Division of Aging and Adult Services to Division of Aging, Adult and Behavioral Health Services (DAABH), and to update current procedures when notification has been received from DAABH that the tracking/release procedures have been implemented.

Inquiries to:
Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Andrew Rindahl, 501-682-8254, andrew.rindahl@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-12

Medical Services Policy Manual | Issuance Date: October 18, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: ARKids B Exceptions

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS F-173 – MS F-193	01-01-14 01-01-17 01-30-15	MS F-173 – MS F-193	01-01-14 09-01-18 01-30-15

Summary of Changes:

Medical Services Policy F-180 has been revised to add additional exceptions to the 90 day waiting period for the ARKids B program. 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 exceptions listed at MSP F-180 is met.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Andrew Rindahl 501-682-8254, andrew.rindahl@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-13

Medical Services Policy Manual | Issuance Date: October 18, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: ABLE Accounts

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix R	04-01-18	MS E-600 Appendix R	10– 01-17 10-18-18

Summary of Changes:

Medical Services Policy E-600 has been added and Appendix R has been revised to provide information regarding Achieving a Better Life Experience (ABLE) accounts. Eligible individuals may open accounts in Arkansas beginning 10-25-18. Eligible individuals may begin opening accounts in Arkansas on **October 25, 2018**. Accounts can be opened by visiting ar.savewithable.com or by calling (888)-609-8874 Monday through Friday, 7:00 a.m. – 4:00 p.m. Accounts can be opened with as little as $25.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Andrew Rindahl 501-682-8254, andrew.rindahl@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-14

Medical Services Policy Manual | Issuance Date: December 21, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Appendix J - Eligibility Table

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix J	01-17	Appendix J	12-18

Summary of Changes:

Appendix J Eligibility Table has been updated to reflect current Child Support Referal and Long Term Services and Supports procedures.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118,sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 18-15

Medical Services Policy Manual | Issuance Date: December 28, 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Continuing Eligibility of Foster Care Children Placed for Adoption

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS K-109 – MS K-111	01-01-14 01-01-14 01-01-14	MS K-109 – MS K-111	01-01-14 01-01-14 01-01-19

Summary of Changes:

Medical Services Policy K-111, Continuing Eligibility of Foster Children Placed for Adoptions, has been revised to state that Medicaid coverage for Title IV-E Foster Care children who are adopted or on a pre-adoptive placement may continue provided the child remains eligible for IV-E regardless of whether or not IV-E payments are actually made for the child. A child that has been approved for a deferred adoption subsidy payment will now qualify for Medicaid coverage.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-01

Medical Services Policy Manual | Issuance Date: January 1, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Cost of Living Adjustments (COLA)

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix R	10-18-18	Appendix R	01-01-19
Appendix S	01-01-18	Appendix S	01-01-19

Summary of Changes:

Medical Services Appendices R, Transfer of Assets Divisor and Home Equity Limit, and S, SSI and Quarters of Coverage Chart, are being updated to reflect the new Cost Of Living Adjustment (COLA) amount for 2018.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-02

Medical Services Policy Manual | Issuance Date: January 10, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Home and Community Based Waiver Transfer of Resources Penalty
Special Needs Trust

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS H-300 – MS H-325	07-13-15 01-01-14 08-10-15 01-01-16	MS H-300 – MS H-325	01-01-19 01-01-14 07-13-15 08-10-15

Summary of Changes:

Medical Services Policy H-300 Transfer of Resources has been revised due to new federal guidance regarding the treatment of the penalty period for transfer of resources made by Home and Community Based Services (HCBS) waiver applicants. This revision also aligns policy with the 21st Century Cures Act which allows individuals with disabilities to set up a special needs trust on their own behalf.

Previously, individuals who applied for HCBS waiver services who had transferred resources within the look back period of 60 months could not have a penalty period applied. With the new federal guidance a penalty period can be imposed at the time the HCBS waiver applicant would otherwise become eligible for Medicaid.

The Cures Act allows individuals with disabilities to set up a special needs trust on their own behalf, rather than relying on a third party to do so. In the past, a special needs trust was usually set up by a family member or guardian for the individual.

Throughout the section, business processes have been removed, terminology has been updated, and formatting corrections have been made.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-03

Medical Services Policy Manual | Issuance Date: January 18, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: MSP Resource Updates

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS B-321 – MS B-330	08-15-14	MS B-321 – MS B-330	08-15-14
	10-09-15		10-09-15
	01-01-18		01-01-19
	01-01-16		01-01-16
MS E-100 – MS E-230	10-26-15	MS E-100 – MS E-230	10-26-15
	01-01-18		01-01-19
	01-01-14		01-01-14
	01-01-17		01-01-17

Summary of Changes:

Medical Services Policy B-326 and E-110 have been revised to update the Medicare Savings Program (MSP) resource limits for 2019. Online policy will be updated and hard copies will be mailed as appropriate within the next two weeks.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Tiffany Cooper, 501-682-8254,tiffany.cooper@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-04

Medical Services Policy Manual | Issuance Date: February 01, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Removal of Domiciliary Care as a Covered Service

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix B	01-01-14	Appendix B	01-01-19
Appendix D	04-01-18	Appendix D	01-01-19
Appendix G		Appendix G	01-01-19

Summary of Changes

Medical Services Appendix B, Transportation Procedures, Appendix D, Benefits Available Under Medicaid and ARKids First, and Appendix G, ARKids Extent of Services, are being updated to remove Domiciliary Care as a covered service.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov

Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov

Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

Tiffany Cooper, 501-682-8254, tiffany.cooper@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-05

Medical Services Policy Manual | Issuance Date: February 8, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Appendix Y, Work Activity Hours Chart

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix Y	05-01-18	Appendix Y	02-08-19

Summary of Changes

Medical Services Appendix Y, Work Activity Hours Chart has been updated. Going to school, job training, vocational, or other educational program hours will now count as 2.5 work activity hours for each 1 hour of instruction.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov

Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov

Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

Tiffany Cooper, 501-682-8254, tiffany.cooper@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-06

Medical Services Policy Manual | Issuance Date: March 19, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Appendix K, PACE Service Counties

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix K	06-01-18	Appendix K	03-19-19

Summary of Changes

Medical Services Appendix K, PACE Service Counties has been updated. PACE of the Ozarks has been added as an additional PACE provider. PACE of the Ozarks is located in Springdale, Washington County. The provider service area includes specific zip codes in Benton, Madison, and Washington counties.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov

Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov

Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov

Tiffany Cooper, 501-682-8254, tiffany.cooper@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-07

Medical Services Policy Manual | Issuance Date: April 1, 2019

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Federal Poverty Levels

Pages to be Deleted:	Date:	Pages to be Added:	Date:
MS Appendix F	04-01-18	MS Appendix F	04-01-19
MS Appendix P	04-01-18	MS Appendix P	04-01-19
MS Appendix R	01-01-19	MS Appendix R	04-01-19

Summary of Changes:

Appendix F, Federal Poverty Levels; Appendix P, TEFRA Premium Schedule; and Appendix R, Transfer of Assets Divisor and Home Equity Limit, have been revised to reflect the 2019 Federal Poverty Level income guidelines and the Transfer of Assets Divisor effective April 1, 2019.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Tiffany Cooper, 501-682-8254, tiffany.cooper@dhs.arkansas.gov

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

Policy | Issuance Number: MS 19-08

Medical Services Policy Manual | Issuance Date: April 11 , 2018

From: Mary Franklin, Director | Expiration Date: Until Superseded

Subj: Appendix I, Application Forms Chart

Pages to be Deleted:	Date:	Pages to be Added:	Date:
Appendix I	01-17	Appendix I	04-19

Summary of Changes:

Appendix I, Application Form Chart has been updated to agree with current processing standards. Please see below for a summary of changes:

Summary of Changes

- Added a column for DCO-0645 or DCO-0152 for Newborns
- Added a column for DCO-0090 and DCO-0105
- Added DCO-0701 with DCO-0107 for MRT
- Added DCO-0778 and DHS-0732 for LTSS Transfers
- Added DCO-0730 for LTSS MITs
- Deleted the DCO-0106 since it is no longer a valid form
- Deleted the DCO-0237, since the DCO-215 is no longer used for Medicaid applications
- Added a blue asterisk to signify forms that **may** be needed, depending on circumstances (e.g. DCO-0090)

- Formatted columns listed instead of colored rows
- Moved “Waivers” to second page
- Moved Workers with Disabilities under Miscellaneous

If you have any questions, please contact your Program Eligibility Analyst or the Medicaid Eligibility Unit.

Inquiries to:

Lisa Teague, 501-682-8259, lisa.teague@dhs.arkansas.gov
Jared Chesshir, 501-682-1562, jared.chesshir@dhs.arkansas.gov
Sharon Harrison, 870-972-1732 ext. 1118, sharon.harrison@dhs.arkansas.gov
Tiffany Cooper 501-682-8254, tiffany.cooper @dhs.arkansas.gov

Quick Reference

Apply for benefits on line at www.access.arkansas.gov.

Medicaid Eligibility

For an application form, contact your local county DHS office or call 1-800-482-8988.

Aged, Blind and Disabled Categories (AABD)

Program	Income Limit		Income Disregards	Resource Limit	Excluded From Resources	Counted Toward Resource Limit	Other Requirements
	Individual	Couple					
SSI DHS does not determine eligibility for this category. Individuals who qualify for SSI automatically receive Medicaid.	$771	$1,157	$20 General exclusion applied to unearned income first $65.00 + ½ of remainder of monthly earned income.	Individual $2000 Couple $3000	• A home • 1 car excluded A 2nd car can be excluded if it is essential to the means of self-support of the individual or couple. • Some non-home income producing properties • Life insurance without a cash surrender value • Burial spaces • Irrevocable burial arrangements • Personal effects (ex. antiques)	• Cash on hand and in bank (less income received that month) • Stocks and bonds • Real property other than the home • Personal property (ex. non-excludable car, trailers, boats, etc.) • Life insurance with a cash surrender value if face value is over $1500 • Revocable burial funds (less $1500 exclusion per spouse if $1500 exclusion is not used through application of other burial arrangements)	• Elderly, blind or disabled. Elderly is defined as age 65 or older • SSI recipient
AABD Adult Spend Down	$108.33 If income exceeds limit, deduct medical bills	$216.66 If income exceeds limit, deduct medical bills	Same as SSI	Same as SSI	Same as SSI	Same as SSI	• Must re-enroll for spend down every 3 months. The Spend Down will be set up for a fixed period of time, not to exceed 3 months.
Pickle (COLA)	$771	$1,157	Same as SSI Deduct all COLAs received since loss of SSI	Individual $2000 Couple $3000	Same as SSI	Same as SSI	• Current recipient of SSA • Previously entitled to SSA and SSI concurrently • Lost SSI for any reason and would be SSI eligible with deduction of all COLAs received since loss of SSI
Disabled Adult Child (DAC)	$771	$1,157	Same as SSI Deduct DAC entitlement or increase that made them SSI ineligible	Individual $2000 Couple $3000	Same as SSI	Same as SSI	• Age 18 or older • Became disabled or blind before age 22 • Lost SSI due to DAC entitlement or DAC increase
Widows/Widowers and Surviving Divorced Spouses with a Disability (OBRA '90)	$771	$1,157	Same as SSI Deduct all SSA income	Individual $2000 Couple $3000	Same as SSI	Same as SSI	• Current recipient of SSA Widow/ Widower or Disabled Surviving Divorced Spouse benefits • Not entitled to Medicare • Lost SSI due to entitlement of SSA Widows/Widowers/Surviving Divorced Spouse benefits

Program	Income Limit		Income Disregards	Resource Limit	Excluded From Resources	Counted Toward Resource Limit	Other Requirements
	Individual	Couple					
Long Term Services & Supports, Assisted Living, ARChoices & DDS Waiver	$2,313 (All applicants are treated as individuals for income purposes)		Income of spouse and children not counted.	Individual $2000 Couple $3000	Same as SSI, except when one spouse is institutionalized, the other may be able to keep a portion of the resources up to $126,420 based on a formula.	Same as SSI	• Functional eligibility • Categorical eligibility • Institutional status • Cost effective • Level of Care assessment
Medicare Savings Beneficiaries ARSeniors (Provides Full Medicaid) QMB (Pays Part B premiums, deductibles & copays) SMB (Pays Part B premium) QI-1 (Pays Part B premium)	$832.80 $1,041.00 $1,249.20 $1,405.35	$1,127.20 $1,409.00 $1,690.80 $1,902.15	Same as SSI	Individual $7,730 Couple $11,600	Same as SSI	Same as SSI	• Medicare beneficiary • Age 65 or older, blind or disabled • ARSeniors is only for individuals age 65 or older
PACE	$2,313 (All applicants are treated as individuals for income purposes)		Income of spouse and children not counted.	Individual $2000 Couple $3000	Same as SSI, except when one spouse is institutionalized, the other may be able to keep a portion of the resources up to $126,420 based on a formula.	Same as SSI	• 55 years old or older • Live in PACE area • Functional eligibility • Cost of care contribution
Workers with Disabilities	No earned income limit. Unearned income must be at or under the SSI individual limit. Total income will be used to determine cost sharing amount.		N/A	No Resource Limit	N/A	N/A	• Meet disability criteria • Eligible for SSI except for earned income • Working (as defined in policy)
TEFRA	$2,313 (Only child's income is counted)		N/A	$2000 (Only child's resources are counted)	Same as SSI	Same as SSI	• Functional eligibility • Children who would otherwise be institutionalized • Custodial parents with taxable income at or above the 150% of the FPL or over $25,000 in annual income, whichever is more, must pay a premium based on income
Autism	$2,313 (Only child's income is counted)		N/A	$2000 (Only child's resources are counted)	Same as SSI	Same as SSI	• Functional eligibility • Autism diagnosis • Disability determination • Age requirement

Quick Reference - Medicaid Eligibility

Family and Individuals Medicaid Categories (MAGI)

Program	Income Limit	Earned Income Deductions	Resource Limit	Excluded From Resources	Counted Toward Resource Limit	Other Requirements
ARKids A	142% of FPL Family Size Income 1 $1,478.22 2 $2,000.78 3 $2,524.76 4 $3,047.32 5 $3,569.88 Add $522.56 for each additional member	Additional 5% Income Disregard if child has insurance: 147% of FPL Family Size Income 1 $1,530.27 2 $2,071.23 3 $2,613.66 4 $3,154.62 5 $3,695.58 Add $540.96 for each additional member	No Resource Limit	N/A	N/A	• Children under age 19 • Relationship/Living arrangement criteria • Eligible for additional 5% Income Disregard if needed for eligibility and child has insurance
ARKids B Limited benefit package Co-pays required	211% of FPL Family Size Income 1 $2,196.51 2 $2,972.99 3 $3,751.58 4 $4,528.06 5 $5,304.54 Add $776.48 for each additional member	Additional 5% Income Disregard if needed: 216% of FPL Family Size Income 1 $2,248.56 2 $3,043.44 3 $3,840.48 4 $4,635.36 5 $5,430.24 Add $794.88 for each additional member	No Resource Limit	N/A	N/A	• Children under age 19 • Children are not eligible if they currently have or have had group or employer-sponsored health insurance within the past 90 days, unless insurance lost involuntarily • Relationship/Living arrangement criteria • Eligible for additional 5% Income Disregard if needed for eligibility
Limited Pregnant Woman (SOBRA)	209% of FPL Family Size Income 2 $2,944.81 3 $3,716.02 4 $4,485.14 5 $5,254.26 Add $769.12 for each additional member	Additional 5% Income Disregard if needed: 214% of FPL Family Size Income 2 $3,015.26 3 $3,804.92 4 $4,592.44 5 $5,379.96 Add $787.52 for each additional member	No Resource Limit	N/A	N/A	• Pregnant • Prenatal, delivery, postpartum and medical conditions that could complicate pregnancy only. Coverage ceases at the end of the month that the 60th day of postpartum falls. • The number of unborn child(ren) are counted in the family size.
Full Pregnant Woman	Family Size Income 2 $220.00 3 $276.00 4 $334.00 5 $388.00	No Income Disregards	No Resource Limit	N/A	N/A	• Pregnant • Full Medicaid coverage • Number of expected babies is included in household size

Program	Income Limit	Income Disregards	Resource Limit	Excluded From Resources	Counted Toward Resource Limit	Other Requirements
Parents/Caretaker Relatives	Family Size Income 1 $124.00 2 $220.00 3 $276.00 4 $334.00 5 $388.00 6 $448.00 7 $505.00 8 $561.00 9> $618.00	No Income Disregards	No Resource Limit	N/A	N/A	• Must be a child under age 18 in the home • Deprivation does not have to exist
Arkansas Works Program (Adult Expansion Group)	133% of FPL Family Size Income 1 $1,384.53 2 $1,873.97 3 $2,364.74 4 $2,854.18 5 $3,343.62 Add $489.44 for each additional member	Additional 5% Income Disregard if needed: 138% of FPL Family Size Income 1 $1,436.58 2 $1,944.42 3 $2,453.64 4 $2,961.48 5 $3,469.32 Add $507.84 for each additional member	N/A	N/A	N/A	• Must be between ages 19 - 64 • Cannot be pregnant • Not eligible for or enrolled in Medicare • Cannot be eligible for Parent/Caretaker Relative • Eligible for additional 5% Income Disregard if needed for eligibility
Former Foster Care	No Income Limit	N/A	No Resource Limit	N/A	N/A	• Must have aged out of the Arkansas Foster Care Program between the ages of 18 through 21
NON-MAGI Families Spend Down (a) Pregnant Woman (b) Under-18 (U-18) (c) Unemployed Parent (d) AFDC related	Family Size Income 1 $108.33 2 $216.66 3 $275.00 4 $333.33 Add $58.33 for each additional member Deduct outstanding medical bills if income exceeds limit for household size	Deduct $90 for work related expenses. Deduct actual childcare expenses up to $200 a month for a child under age 2 or $175 a month for a child age 2 or older.	Family Size 1 $2000 2 $3000 3 $3100 4 $3200 Add $100 for each additional person	• A home • Household and personal goods • Student loans and grants • Other bona fide loans • One burial plot per family member	• Cash on hand or in the bank (less income received that month) • Stocks and bonds • Accessible trust funds • Cash surrender value of life insurance policies • U.S. Savings Bonds • Other personal property • Equity value in excess of $1500 is counted for one car: Full equity value is counted for additional cars	(a) Pregnant Woman only (b) Under-18: Children under 18 years only (c) Deprivation due to unemployment of parent (d) Deprivation due to absence, death or disability of parent

* This is a brief summary of eligibility requirements. Other factors will also enter into determining your eligibility for a program. Unless otherwise noted, all categories receive "full" Medicaid. Benefit packages are defined by the Department of Human Services, Division of Medical Services. This information was current at the time this summary was prepared but changes may have been made subsequently due to federal regulations, state laws, court decisions or other factors. DHS cannot be bound by any information in this reference chart that conflicts with current policy or program requirements.

Arkansas' complete Medicaid Policy can be found at: https://ardhs.sharepointsite.net/DHSPolicy/DCOPublishedPolicy/Forms/MedicalServices.aspx
Additional information is available at: https://medicaid.mmis.arkansas.gov/

A-100 General Program Information

MS Manual 05/01/18

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-105 Nondiscrimination

MS Manual 08/15/14

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

The Agency has the responsibility for informing applicants and recipients that assistance is provided on a nondiscriminatory basis and that they may file a complaint with the Agency or federal government if it is thought that discrimination has occurred on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual 01/01/17

The types of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Medicaid recipients are responsible for paying a coinsurance amount equal to 10% of the per diem charge for the first Medicaid covered day per inpatient hospital admission. Medicaid recipients are also responsible for paying a copayment amount per prescription based on a graduated payment scale, not to exceed $3.00 per prescription.

The coinsurance and copayment policy does not apply to the following recipients and/or services:

1. Individuals under the age of 18 receiving coverage through ARKids A or Newborn
2. Pregnant women
3. Individuals residing in a nursing or ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities) facility who are approved for vendor payment
4. Emergency services
5. Health Maintenance Organization (HMO) enrollees
6. Services provided to individuals receiving hospice care
7. Adult Expansion Group enrollees with household income below 100% FPL for their household size are not required to pay co-pays or other cost-sharing.

A-115 Cost Sharing for Workers with Disabilities

MS Manual 08/15/14

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.

After certification, any increases in income that will cause the individual to exceed 100% of the FPL and possibly cause revision to the individual's cost sharing amount will not be processed until the next reevaluation. If the individual reports a decrease in income that puts him under

the 100% FPL, his income will be adjusted when reported to reflect the lower co-payment amounts. Any increase in co-payments determined at reevaluation will require a 10-day advance notice. A DCO-700 will be sent and the changes keyed after the notice has expired.

A-116 Premiums For The Adult Expansion Group

MS Manual 01/01/17

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.

Failure to pay the premium for three (3) consecutive months will result in a debt to the State of Arkansas.

A-120 Dual Eligibles-Medicare/Medicaid

MS Manual 08/15/14

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 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.

   The Division of Medical Services pays Medicare Part B premiums for eligible Medicare-Medicaid recipients on the basis of their Medicare claim number supplied in the system. For recipients who report that the premium is still being deducted from their monthly Social Security or Railroad Retirement check, the County Office will complete Form DCO-53, Report of Buy-In Problem Cases and fax (501-682-1597) or mail to the Buy-In Coordinator, Slot S333.

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 08/15/14

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 01/01/14

Information may be given to Authorized Representatives that have been named on the DCO-153, Consent for an Authorized Representative. In the absence of a completed DCO-153, 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. For example, if an Area Agency on Aging (AAA) employee helps an elderly person complete an application and the employee puts his name in the authorized representative blank, information should not be released to this person unless requested by the applicant/recipient. 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. For example, if a NF administrator completes the DCO-7781, Long Term Care Annual Renewal Notice, at reevaluation and the original representative was the

recipient's daughter, the recipient and/or daughter should be contacted to determine if the daughter will continue to act as representative to reestablish eligibility.

A-132 Medical Records and DCO-109s

MS Manual 01/01/14

Medical records and the DCO-109 are a part of an applicant's or recipient's case record and, as such, will be considered according to (MS A-130). The DCO-109 must be indexed in the recipient's electronic record and remain as proof of the disability determination made by MRT.

A-133 Medical Providers/Services Organizations

MS Manual 01/01/14

If a provider furnishes an individual's full name (including middle initial), date of birth, Social Security Number, and date of service, the County Office may release limited information. Information which may be released is limited to Medicaid ID #, beginning date of eligibility, whether or not a recipient was eligible on a specific date, services for which an individual is eligible, and TPL information (including policy numbers and type of coverage, if known). It will be an administrative decision whether or not time and staff are available to provide the information.

A-134 Collateral Information

MS Manual 01/01/14

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 caseworker 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 01/01/14

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 01/01/14

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

Upon notification from a QA reviewer that a Medicaid recipient has refused to cooperate, the caseworker will send a 10-day notice to the recipient stating that the Medicaid case will be closed for failure to cooperate with the QA reviewer. The notice will also specify that the family will be ineligible until the client cooperates with the QA reviewer.

EXCEPTION: A newborn case cannot be closed because of the parent's failure to cooperate with QA.

A-160 Referral Process for Counties

MS Manual 01/01/14

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 01/01/14

The hospital/physician should inform needy individuals of possible medical assistance available under the Medicaid Program. The hospital/physician should refer all interested individuals to the Arkansas Department of Human Services by means of Form DMS-630, Referral for Medical Assistance.

The hospital/physician should be prepared to provide itemized statements on all individuals referred to the Arkansas Department of Human Services for potential use in the eligibility determination. The hospital's/physician's representative is responsible for the accurate completion of the form DMS-630. After the required information has been entered on the form, the hospital/physician representative will read and explain the authorization section to the client before securing the client's signature. Once the signature is obtained, the hospital/physician representative will sign and date the form and forward it to the DHS Office in the client's county of residence.

Upon receipt of the DMS-630, the caseworker will contact the client. Action must be completed within forty-five (45) days on all applications taken during follow-up. Once a determination has been made, the caseworker will notify the hospital/physician by completing Section 2 of Form DMS-630. The three (3) types of dispositions are:

1. Did Not Respond or No Longer Interested - Client failed to respond to follow-up contact or client stated he/she was no longer interested.
2. Denied - Application taken, client was determined ineligible or eligibility could not be determined.
3. Approved - Application taken, client was determined eligible effective month/day/year.

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

MS Manual 01/01/14

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 Hospital/Physician Referral Form for Newborns (DCO-645) must be completed to report the birth of a Medicaid eligible infant. The referring providers must complete and mail the form to the DHS County Office where the baby will be residing within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant.

A-163 Child Health Services Program (EPSDT)

MS Manual 01/01/14

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).

The Division of Medical Services (DMS) administers the Child Health Services Program (EPSDT). Questions regarding eligibility and services should be directed to the Provider Relations Unit in DMS at 501-320-6220.

A-164 Client Representative Services Program

MS Manual 08/15/14

Client Representation is a program available through the Division of Aging and Adult Services (DAAS) 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.

Location of Area Agencies on Aging (AAA)

Region	Counties	Agency
REGION I	Serving Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy and Washington counties.	AAA of Northwest Arkansas Harrison, Arkansas **870-741-1144, Toll Free: 1-800-432-9721**
REGION II	Serving Cleburne, Fulton, Independence, Izard, Jackson, Sharp, Stone, Van Buren, White and Woodruff counties.	White River AAA Batesville, Arkansas **870-612-3000, Toll Free: 1-800-382-3205**

Region	Counties	Agency
REGION III	Serving Clay, Craighead, Crittenden, Cross, Greene, Lawrence, Lee, Mississippi, Phillips, Poinsett, Randolph and St. Francis counties.	East Arkansas AAA Jonesboro, Arkansas **870-930-2239, Toll Free: 1-800-467-3278**
REGION IV	Serving Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Grant, Jefferson and Lincoln counties.	AAA of Southeast Arkansas Pine Bluff, Arkansas **870-543-6300, Toll Free: 1-800-264-3260**
REGION V	Serving Faulkner, Lonoke, Monroe, Prairie, Pulaski and Saline counties.	Central Arkansas AAA (Care Link) North Little Rock, Arkansas **501-372-5300, Toll Free: 1-800-482-6359**
REGION VI	Serving Conway, Clark, Garland, Hot Spring, Johnson, Montgomery, Perry, Pike, Pope and Yell counties.	AAA of West Central Arkansas Hot Springs, Arkansas **501-321-2811, Toll Free: 1-800-467-2170**
REGION VII	Serving Calhoun, Columbia, Dallas, Hempstead, Howard, Lafayette, Little River, Miller, Nevada Ouachita, Sevier and Union counties.	Southwest Arkansas AAA Magnolia, Arkansas **870-234-7410, Toll Free: 1-800-272-2127**
REGION VIII	Serving Crawford, Franklin, Logan, Polk, Scott and Sebastian counties.	Western Arkansas AAA Fort Smith, Arkansas **479-783-4500, Toll Free: 1-800-320-6667**

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.

To refer an individual for Client Representation Services, the caseworker should complete form DCO-3350 and route to the AAA listed above which serves the county where the referral is located.

A-165 Inpatient Psychiatric Services

MS Manual 01/01/17

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 inpatient psychiatric care services at an approved facility without making an application.

Information on an approved facility may be obtained from:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105
Toll free 1-800-457-4454 or 501-376-2211

A primary care physician (PCP) referral is required before a Medicaid recipient under age 21 is eligible for inpatient psychiatric services. Exceptions for PCP referrals are listed at the following link: **https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/apdwvr.aspx**

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 for eligibility determinations.
2. Individuals Age 19-21-Apply the rules for the Adult Expansion Group. Refer to B-270.

A-166 DDS Children's Services

MS Manual 01/01/14

The Division of Developmental Disabilities Services (DDS) has the administrative responsibility for Children's Services (CS), formerly known as Children's Medical Services (CMS). Within the Division, the Children's Services (CS) section is charged with the administration of all such services to children with disabilities.

DDS Children's Services (CS) is limited to Children with Special Health Care Needs (CSHCN) under the age of 18 years, who will benefit from surgical or medical intervention or require extensive case coordination.

The county office will refer inquiries to DDS Children's Services Community Based Office located in the DHS County Office servicing the area where the applicant resides or by contacting DDS Children's Services Central Office at 501-682-2277.

A-170 Expedited Services for Child Abuse Cases

MS Manual 01/01/14

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. The caseworker will forward the application and a summary of why special consideration is requested to the supervisor or his/her designated representative along with a recommendation for immediate action.

The application will be reviewed by the supervisor or the designated representative. If the caseworker's recommendation for immediate consideration is approved by the supervisor or the designated representative, the application will be assigned for immediate disposition and have priority over all other pending applications.

If the supervisor does not accept the caseworker's recommendation, the application will be disposed of in regular, chronological order.

A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 02/01/18

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

The term "Insurance affordability program" includes the Medicaid program, premium tax credits including advance payment of the credit, and cost-sharing reductions. Only individuals who are determined ineligible for an appropriate Medicaid coverage group are potentially eligible for the premium tax credit and cost-sharing reductions. The upper income limit for any amount of premium assistance is 400% of the federal poverty level for the individual's household size.

When an individual applies for an insurance affordability program through the FFM, Medicaid eligibility will first be determined for all household members applying for coverage. If eligible, the FFM will notify the individual of the Medicaid eligibility and send the individual's electronic account to the State Medicaid agency (DHS) for enrollment in the applicable Medicaid eligibility group. If all members of the individual's household are Medicaid eligible, no further action to select or enroll in a Qualified Health Plan (QHP) is required of the individual, with the exception of individuals eligible for the Adult Expansion Group. Upon receipt of the Adult Expansion Group individual's electronic account from the FFM, DHS will notify the individual of the next steps to complete the enrollment process. See MS C-150.

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

Since Medicaid is one of the insurance affordability programs under the Affordable Care Act, an individual may apply directly to DHS for Medicaid eligibility. To coordinate and streamline the application process for the insurance affordability programs, DHS uses the same Single Streamlined Application used by the FFM. Although DHS will not make a determination of eligibility for the premium tax credit or cost-sharing reductions for individuals determined Medicaid ineligible, DHS will send the individual's electronic account to the FFM which will include the needed application data for the FFM to make those determinations.

In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

A-190 Twelve Month Filing Deadline on Medicaid Claims

MS Manual 08/15/14

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.

In order for Medicaid to consider the claim for payment, the case worker must key the eligibility dates in the system even if the date of service exceeds the 365 day filing deadline (e.g. SSA approves disability retroactively, an Administrative Appeal Decision ruled in the applicant's favor, etc.) If the age of the application prevents registration, the caseworker should contact System Support regarding updates for the period of coverage. Narrative documentation must support this action.

If the county made an error in processing the application and caused the claim process to go beyond 12 months, an email will be sent to the Assistant Director (AD) of Field Operations explaining the county error in causing the claim process to go beyond 12 months. If approved by the AD, the caseworker will send correspondence to the Division of Medical Services, Medical Assistance Unit, Slot S410 requesting special consideration and explaining the reason for the application processing delay.

NOTE: The above procedure is not a guarantee that the bills will be paid. Arkansas Medicaid only considers payment if billing is correct, the client has not exceeded his or her benefit limits and is eligible for the services.

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.

In cases where the recipient is reporting problems regarding Medicaid payment of claims to a provider, refer the recipient to the Medicaid Claims Unit at **501-682-8501** or **1-800-482-5431**. If the provider is reporting problems regarding Medicaid payment of claims, refer the provider to the HP Provider Assistance Unit at **501-376-2211 option 2** or **1-800-457-4454**.

A-200 Medicaid Coverage Periods

MS Manual 01/01/17

The coverage period is the period of time the individual has coverage for Medicaid. Once eligibility has been determined, the Medicaid coverage period begins from the point of application and generally is open-ended. Pregnant Woman and Newborn categories have a fixed eligibility period as do the Spend-Down categories. In addition, fixed eligibility may be authorized in any category. See MS A-220.

The effective first and last date of coverage is dependent on the eligibility group in which the individual is placed as identified below:

1. Families and Individuals Eligibility Groups (ARKids First, Parents/Caretaker Relatives, Former Foster Care Adults, Pregnant Woman and Adult Expansion Group)

   The effective first day of coverage is the first day of the month of application unless retroactive coverage is approved. Coverage will end on the last day of the month eligibility ceases.

   EXCEPTION: For individuals in the Adult Expansion Group, coverage will end the last day of the month before their 65th birthday.

   NOTE: When a caseworker is informed that an ARKids A recipient is an inpatient on his/her 19th birthday, eligibility will continue until the end of the inpatient stay, provided the recipient remains income eligible. Recipients with severe disabilities will be referred to Social Security for SSI determination. This special continuation of coverage only applies to ARKids A. ARKids B recipients cannot receive coverage past their 19th birthday.

2. AABD Eligibility Groups (Nursing Facility, Home and Community Based Waivers, TEFRA, Medicare Savings Program: ARSeniors and SSI Related Groups)

   An individual's coverage period may begin or end on any day of the month. When eligibility is established, the effective first day of coverage is the date of application, unless retroactive coverage is approved or one of the exceptions listed below applies. For most categories, coverage may be terminated at any time within the month eligibility ceases. The end date of eligibility will be the last day of the 10-day notice period, unless the recipient requests a hearing within the advance notice period.

3. Medicare Savings Program exceptions:

    a. QMB-The effective date of coverage is the first day of the month following the month of approval.

    b. SMB-The effective first date of coverage is the first day of the month of application. Coverage must always begin on the first day of the month.

    c. QI-1- The effective day of coverage is the first day of the month of application. Coverage must always begin on the first day of the month.

    d. QDWI-The effective day of coverage will be the first day of the month based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A.

4. Medically Needy Groups (Exceptional and Spend Down)

    With date specific eligibility, an individual's or family's eligibility for exceptional Medically Needy may begin or end on any day of a month. When found eligible, the certification period will begin on the day application was made, unless retroactive coverage is needed. If retroactive coverage is needed and if eligibility is established, the certification period may begin up to 3 months prior to the date of application (but not on the first day of a retroactive month, unless application was made on the first day of a month).

    Exceptional Medically Needy eligibility continues until terminated by the County Office. Termination may occur at the time of reevaluation or by reported changes that affect client eligibility.

    The spend down period is the three calendar months used in determining eligibility. The spend down quarter can be any continuous three calendar month period between the first day of the three month retroactive period (three calendar months prior to the application month) and the last day of the three month period beginning after the application month. The three months chosen for the spend down period should be the three months in which the applicant has the greatest medical expenses, or the three months in which he or she would receive the greatest benefit. See MS E 300-340.

    Refer to MS A-210 through MS A-215 for retroactive eligibility for each category listed above.

A-210 Retroactive Eligibility

MS Manual 05/01/18

The State is required to provide retroactive eligibility for up to three full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period; and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during the retroactive period. Retroactive eligibility is separate and apart from current eligibility, i.e., applicants not eligible for the current period may be eligible for the retroactive period. Retroactive eligibility determinations are required for all categories, except ALF, ARChoices, Autism, DDS Waiver, QMB and PACE.

NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.

NOTE: Beginning May 1, 2018, Adult Expansion Group recipients may be eligible for retroactive coverage 30 days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of September 15. He asks for retroactive coverage for a doctor bill with a service date of August 1. He is not eligible for retroactive coverage because his bill is for August 1 and retroactive coverage can only begin August 16.

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of December 31. He asks for retroactive coverage for a doctor bill with a service date of December 1. His regular coverage will begin December 1. As the 30th day is included in his regular coverage period, no coverage will be given for the previous month.

An application for retroactive eligibility may be made on behalf of deceased persons and eligibility will be provided if they were eligible when the services were received.

For cases in which an applicant has not resided in Arkansas for three full months prior to the date of application, the retroactive period begins with the date the individual established residency in Arkansas. The “previous state” is responsible for the retroactive period prior to the time the applicant established residency in Arkansas. The caseworker is responsible for

providing the "previous state" with information necessary to determine eligibility for its portion of the retroactive period.

Services for the retroactive period are subject to the same restrictions as services for the current period (i.e., utilization review, benefit limitations, medical necessity, etc.). Prior authorization cannot be a condition of payment for services received during the retroactive period. However, such services are subject to the same Utilization Review standards as all other services financed under the State's Medicaid program. The State is not required nor obligated to pay for services which have been retroactively determined by Utilization Review to be unnecessary.

For cases in which an applicant has made partial or full payment for services received during the retroactive period, the state will make payment to the servicing provider if:

1. The services were necessary and the applicant was eligible when the services were received; and
2. The provider is willing to refund the payment to the applicant and bill the State for the services.

A-211 Retroactive Eligibility-Long Term Services and Supports

MS Manual 01/01/16

For Long Term Services and Supports (LTSS) retroactive eligibility is determined according to the guidelines for each Long Term Services and Supports eligibility group as described below:

1. Nursing Facility (NF)

   For any month that an individual was in an NF during the retroactive period, the eligibility determination for retroactive LTSS is the same as the eligibility determination for current eligibility.

   The caseworker will indicate the begin date of retroactive eligibility in the system in conjunction with current facility vendor payment.

   The caseworker should be aware that eligibility for retroactive Medicaid based on LTC criteria can only be determined for applicants who were institutionalized prior to the month of application. Applicants who first qualify for LTC in the month of application will have to be determined eligible for retroactive Medicaid in another eligibility group.

   An ICF/IID case cannot be certified with an eligibility start date that precedes the decision date on the DCO-704 or the PASARR effective date.

2. ARChoices

   In some cases deemed critical by the DHS RN, the begin date of eligibility may be prior to the date of completion of the case if all eligibility criteria have been met, if the Waiver applicant and Waiver provider made a request for services to the DHS RN prior to certification, and if the provision of services was approved by the DHS RN. The waiver eligibility date will never be established retroactively by the caseworker unless the retroactive eligibility date is authorized by the DHS RN.

3. Assisted Living

   The DHS RN will provide the begin date based on the date of application, date of the assessment and Plan of Care is signed, and the date the client entered the facility.

A-212 Retroactive Eligibility-Other Waiver Programs

MS Manual 01/01/14

Retroactive eligibility is determined according to the guidelines for each Waiver eligibility group as described below:

1. TEFRA Waiver

   Retroactive coverage can begin three months prior to the date of application if all eligibility requirements are met.

2. Autism Waiver

   There is no retroactive coverage in this group.

3. DDS Waiver

   There is no retroactive coverage in this group.

A-213 Retroactive Eligibility-Medicare Savings Programs (MSP)

MS Manual 08/15/14

MSP does not follow the general rule for retroactive coverage. These retroactive coverage periods are described below:

1. For ARSeniors, retroactive coverage can begin three months prior to the date of application.
2. For QMB, there is no retroactive coverage for this group.
3. For SMB and QI-1, retroactive coverage can begin on the first day of the month, three months prior to the application month if all eligibility requirements are met.

4. For QDWI, retroactive coverage can be effective up to the first day of the 3 month period prior to the date of application if all eligibility factors were met during the 3 month period including eligibility and effective date of Medicare Part A.

NOTE: Retroactive coverage for QI-1 cannot begin before January 1 in the year of application.

A-214 Retroactive Eligibility-SSI Eligibles

MS Manual 08/15/14

The caseworker is notified of SSA Retroactive Blindness and Disability Determinations for SSI recipients on Form DCO-109A. The DCO-109A identifies the month(s) to be considered for retroactive eligibility determination.

The DCO-109A will be scanned into the electronic case file unless the caseworker receives notification of alleged medical expenses for the retroactive period. Notification of alleged medical expenses may be by means of:

1. Data processing printout (sent periodically as SSA makes information available); or
2. Direct contact by recipient.

When the caseworker has been notified of alleged medical expenses of AB or AD SSI recipients, but has not received a DCO-109A, the AB or AD SSI recipient will be referred to SSA to secure verification of blindness or disability. If difficulty is encountered in securing the DCO-109A, the Central Office Customer Assistance Unit may be able to assist.

The caseworker will also receive notification of AA SSI recipients who have alleged medical expenses for the retroactive period by the same means as described above. The caseworker will need to make retroactive eligibility determinations on these AA SSI recipients only if they reached age 65 prior to the month of application with SSA.

Once notification of alleged medical expenses and verification of age, blindness or disability for the retroactive period have been received, the County Office will contact the SSI recipient to make an appointment for the retroactive eligibility determination.

Eligibility for AA, AB or AD SSI recipients will be determined against LTSS criteria using MS E-400 thru E-451 for income and MS E-500 thru E-530 for resources. The caseworker will use the SSA application date for purposes of determining the retroactive period. Applications for retroactive eligibility by SSI recipients will be secured on form DCO-95. Income eligibility will be determined. Countable income will be compared to the SSI income standards for individuals or couples to determine income eligibility (Re. MS Appendix S).

NOTE: Individuals (or couples) living in the household of another may be considered to be living in their own household when it is documented that they pay an equal share of the total household expenses. Refer to MS Glossary "Definition of Living Arrangements".

Resource eligibility will be determined by verifying and evaluating the resources, if any, of the recipient.

Authorization of retro SSI will be completed and entered in the system by the caseworker.

When a SSI case is in closed status, the closed SSI budget unit will be reopened by DCO System Support. The caseworker will send an e-mail to the Program Eligibility Analyst which will include the Name of the Master Case, the Master Case Number and the Budget Unit Name/Client Name where the retro is needed. This email will be forwarded to DCO System Support. After the SSI budget unit is reopened, the caseworker will key the eligibility for retro SSI.

NOTE: The begin date cannot be more than three months prior to the SSI application date.

A-215 Retroactive Eligibility-Recipients Not Currently Eligible for SSI

MS Manual 08/15/14

Under current SSA regulations, an SSI application will not be completed for an applicant who dies before income and resource eligibility is determined and for an applicant who is not survived by an eligible spouse. Therefore, the caseworker will have the responsibility for the income and resource eligibility determination for the month of application and up until death, in addition to the retroactive period. An individual responsible for the medical debt of the deceased may make the application. Individuals who have been denied SSI for reasons other than disability may also apply for retroactive eligibility. In either case, the eligibility determination will be the same as the determination for eligible SSI recipients. The caseworker will need a DCO-109A from SSA on applications for AB or AD.

Applications for deceased individuals, or individuals denied by SSI, will be registered in the system in the Aged, Blind, or Disabled categories.

Deceased individuals or individuals denied by SSI who qualify for retroactive eligibility will be certified for fixed eligibility in the system in the appropriate category (Aged, Blind, or Disabled: Exceptional or Spend Down category).

A-216 Retroactive Eligibility-Foster Children

MS Manual 01/01/14

Retroactive coverage for foster children follows the rule for the coverage category in which the foster child is placed with the following exceptions:

1. Non-Title IV-E Adoptive Children with Special Needs-May be certified for retroactive coverage for up to three months prior to the month of application if all the conditions of eligibility are met and if there are unpaid medical bills for this period. If the adoption assistance agreement was not in effect in the retroactive months, then eligibility cannot be established under these provisions but must be established under other Medicaid guidelines.
2. Title IV-E Children who enter Arkansas from another State-May receive up to 3 months retroactive coverage if it is established the child did not receive Medicaid benefits from the sending state in the retroactive months and if the child incurred medical bills in Arkansas during the retroactive months.

A-217 Retroactive Eligibility-Pregnant Woman

MS Manual 08/15/14

Retroactive eligibility for Pregnant Women (PW) is determined according to the guidelines for current PW eligibility determination. The applicant should have alleged medical expenses for the retroactive period. (Refer to the "No Look Back" policy at MS C-205 and I-610).

The begin date of the retroactive period will be entered in the system at certification (when authorized in conjunction with current PW eligibility).

For Full PW, if application for retroactive PW coverage is made after termination of the pregnancy, the retroactive period may not begin more than three months prior to the date of application, and the retroactive period must end no later than the last day of the month of delivery (i.e., the applicant will not be eligible for the postpartum coverage). However, Limited PW may be given postpartum coverage when application is made after termination of the pregnancy (Re. MS C-205).

NOTE: Retroactive coverage for Unborn Pregnant Woman will follow the rules for the type of pregnancy coverage her eligibility falls in, Full or Limited Pregnant Woman as stated above.

Procedures for authorizing retroactive eligibility only, (i.e., "Fixed eligibility) are found in (MS A-220).

If application for retroactive PW coverage is made after termination of a pregnancy and coverage after the month of delivery (or after the end of the postpartum period for a Limited PW) is also requested, a separate application must be made in the appropriate category to provide coverage for the month(s) following the expiration of the PW coverage.

A-220 Fixed Eligibility

MS Manual 01/01/14

Applicants in any Medicaid category may qualify for "Fixed" eligibility (retroactive and/or current) under certain conditions. The State is required to provide "fixed" eligibility to applicants who:

1. Received medical services in the eligibility period (retroactive and/or current); and
2. Were eligible when the services were received;
3. Died before eligibility was determined; or
4. Became ineligible following the month of application, but before eligibility was determined.

The caseworker will certify an individual for fixed eligibility in the system by showing a begin date and end date.

A-230 Twelve Month Continuous Coverage

MS Manual 08/15/14

Twelve month continuous coverage means that the individual is guaranteed 12 months of continuous coverage regardless of income changes which could result in ineligibility.

The following eligibility groups are provided 12 months of continuous coverage:

1. ARKids B
2. Newborns

Changes in income and other eligibility criteria that occur during the year will not affect the child's eligibility. Therefore, participants are not required to report changes in income until renewal. The only time a child loses eligibility during the 12 month period is if he/she dies, moves out of state or an ARKids B child reaches the age of 19.

For ARKids B, the 12-months of continuous coverage will begin with the later of the last approval or last renewal date and will end on the last day of the 12th month. For Newborns, coverage will begin on the date of birth and will end on the last day of the month of the child's first birthday. (See MS I-230 for transitioning a newborn to ARKids First.)

EXAMPLE: Mary's ARKids B application date was January 2, 2014 and her application was approved on February 2, 2014. Her coverage will begin January 1, 2014. An income change occurs in July, which caused ineligibility. Mary's ARKids B case will not be closed until January 31, 2015 unless she moves out of state or turns 19 before the 12 continuous months end.

A-300 Identification Cards

MS Manual 01/01/14

Identification cards will be sent to all new eligible recipients at the time of approval. The recipient is responsible for presenting his/her identification card to the hospital/physician for billing purposes each time he/she receives a service.

A-310 Medicaid Identification Cards

MS Manual 01/01/17

Medicaid cards are produced and mailed directly to recipients by a card production facility. Cards are normally mailed within five business days of approval. Refer to MS A-330 for cards issued to those in the Adult Expansion Group.

The following information is imprinted on the Medicaid card:

- Identification Number-The Medicaid identification number is a ten-digit number (e.g., 0123456-001).
- Name of Eligible Recipient
- Date of Birth
- Date of Issuance-Identifies the date the ID card was originally issued.

A-320 ARKids Identification Cards

MS Manual 01/01/14

ARKids identification cards are produced and mailed directly to recipients as described in A-310 above. They also have the same information imprinted on the card. In addition, the ARKids identification card has the "ARKids 1st, Healthy Kids. Healthy Families." logo on the front of the card. A maximum of four cards can be mailed per envelope.

NOTE: For both Medicaid and ARKids identification cards, the recipient should be instructed to keep his or her identification card even after an eligibility period has ended, as the individual may use it again should he or she become eligible again in the future.

A-330 Adult Expansion Group Identification Cards

MS Manual 05/01/18

For those individuals who are enrolled in a Qualified Health Plan through auto assignment or by their own selection, an identification card will be mailed directly to the individual by the insurance carrier. For those individuals who are enrolled in Medicaid through the Adult Expansion Group (MS-C-150), a Medicaid card will be mailed within 5 business days of the individual being found eligible for traditional Medicaid.

A-340 Reissuance of Identification Cards

MS Manual 05/01/18

Replacement cards will be authorized through the system. The procedures are the same for SSI and non-SSI recipients.

1. Review recipient's case information in the system to verify that correct information (e.g., name, date of birth, mailing address, etc.) has been updated.

2. Select the ID button on the Budget Summary and then check the "Replace" box by the member(s) who needs the replacement card and then click the Save button.

   If the recipient is SSI eligible, locate the SSI case number in the system. If there is no record of the case, or the SSI recipient is not receiving a check, refer him or her directly to the local SSA Office. If the SSI recipient has been approved for 30 days or less, inform him or her that it is too early to have received a Medicaid card. It takes Social Security 30 days or more from the date of approval to forward the eligibility date through SDX.

   If the SSI case record is located on WASM, but information on the record is incorrect (e.g., wrong address), the caseworker should contact System Support or Client Assistance for correction(s) to the case.

NOTE: Adult Expansion Group recipients enrolled in a Qualified Health Plan will contact their insurance provider for answers to plan questions. Contact information will be printed on the insurance card and on the carrier information included with the card.

B-100 Eligibility Groups

MS Manual 01/01/14

A Medicaid eligibility group defines the eligibility requirements an individual must meet to be eligible for Medicaid coverage. The eligibility group also defines the benefit package or array of services the individuals in that group will receive.

Effective January 1, 2014, each of Arkansas' Medicaid groups fall under one of the following general groupings:

- Families and Individuals
- Aid to the Aged, Blind, and Disabled
- Foster Care & Adoption Assistance
- Emergency Services for Aliens

Within these general groupings are more specific groups defined by specific individual characteristics, such as age, and/or services needed, such as Long Term Services and Supports. In addition, some groups are assigned two or more categories of coverage due to differing benefit packages or federal funding match rates. These are described in more detail in the following sections.

B-200 Families and Individuals Group (MAGI)

MS Manual 01/01/17

Most individuals under age 65 will fall into the Families and Individuals general eligibility grouping. Most of the specific groups under this general grouping use the Modified Adjusted Gross Income or MAGI methodologies to determine financial eligibility for individuals. (See MS E-200 for specific policy regarding the MAGI methodology.) Therefore, this group is commonly called the "MAGI" group. Generally speaking, the MAGI groups cover children and non-SSI adults under age 65 who are not in need of specialized services or benefits related to a disability or blindness or who are not in need of long term care support or services (See MS E-220). A non-SSI individual with a disability or blindness who is not eligible for or covered by Medicare may be covered in the Adult Expansion Group if otherwise eligible.

NOTE: Two groups (Newborns and Former Foster Care Adults) which are described below do not have a financial test and therefore, the MAGI methodology is not used. However, since these two groups cover non-aged, blind, or disabled adults or children, they are included in the general grouping of Families and Individuals.

Individuals in all groups must meet the General Eligibility Requirements as outlined in MS D-100-540.

The sections that follow describe each of the specific Families and Individuals (MAGI) eligibility groups.

B-210 ARKids First

MS Manual 07/08/16

The ARKids First group provides health insurance coverage for Arkansas children from birth to age 19. There are two categories of coverage in the ARKids First group – ARKids A and ARKids B. Along with the age requirement of being under the age of 19, relationship and/or living with a specified relative must be established for eligibility in these categories. (See MS F-110).

ARKids A provides coverage to children under age 19 with family income under 142% of the Federal Poverty Level for the applicable household size (See MS E-110). ARKids A provides the full range of Medicaid services. This is a mandatory eligibility group authorized and funded by Title XIX of the Social Security Act (Medicaid).

ARKids B provides coverage to otherwise uninsured children under age 19 with family income equal to or over 142% but under 211% of the FPL for the household size (See MS E-110). ARKids

B provides a more limited range of services with limited co-pays for some services. (See Appendix G) ARKids B was authorized by Arkansas Act 407 of 1997 (the ARKids First Program Act) and was implemented as a Section 1115 Medicaid expansion program effective September 1, 1997. The program is currently funded by the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Because ARKids A and ARKids B have different benefit packages and have different federal funding match rates, it is necessary to designate separate categories of coverage for them.

Please see PUB-040, Arkansas Medicaid, ARKids First & You for a summary of the benefit packages which highlights the differences in the two packages.

B-220 Newborns

MS Manual 08/15/14

This group consists of newborns up to age 1 whose mothers were Medicaid eligible at the time of their births. Newborns in this group are guaranteed Medicaid coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of Medicaid services.

Although this group is considered part of the ARKids First group, Newborns also have a separate category of coverage to ensure no change in household circumstances affects their one-year of guaranteed coverage. At age 1, eligibility for ARKids First (A or B) is determined as for any other child (See MS I-230).

Newborns born to pregnant women approved under the Unborn child category (See MS B-250) will not be eligible for the Newborn category. Eligibility should be determined for ARKids.

B-230 Parents/Caretaker Relatives

MS Manual 08/15/14

This group consists of adults who have related minor children living in the home for whom the adult exercises care and responsibility (MS F-110) and whose household income is below the income limit for this group (See MS E-110).

Both natural or adoptive parents may be living in the home with the child. There is no "deprivation of parental care or support" requirement for the parents to be included in this group.

If an adult meets the criteria for this group, he or she must be assigned to this group even if eligibility exists in another MAGI eligibility group. Therefore, eligibility for this group is determined first before moving to other categories that may have higher income limits.

NOTE: Only adults are included in this group. Children will not be placed in this group. Their coverage will be in the appropriate ARKids program or some other type of Medicaid such as TEFRA, or a private insurance plan.

Adults covered in the group receive the full range of Medicaid benefits.

B-240 Pregnant Women

MS Manual 08/15/14

This group consists of women age 19 and above who are pregnant at the time of application and are not eligible in either the Parent/Caretaker Relative (MS B-230) or Former Foster Care (MS B-260) group. A pregnant woman can apply for retroactive Pregnant Women Medicaid up to 3 months after birth of the baby.

There are two categories of coverage within the Pregnant Woman group.

- Those with household income at or below the income limit for Low-Income Pregnant Woman Coverage (MS E-110) receive the full range of Medicaid services.
- Those with income above that limit but under the limit for High-Income Pregnant Woman Coverage (MS E-110) are provided services related to prenatal, delivery and postpartum care, and to other conditions that may complicate pregnancy.

Both levels provide postpartum coverage through the end of the month in which the 60th day from the date of delivery falls.

B-250 Unborn Child (Pregnant Woman)

MS Manual 01/01/18

This group consists of non-citizen pregnant women who do not meet the alienage requirements for Medicaid and whose household income is at or below 209% of the federal poverty level for the appropriate household size. This includes pregnant women who are either of the following:

- Lawfully admitted aliens who do not yet meet the 5 year residency requirements or one of the conditions listed in D-224;
- Undocumented aliens.

The purpose of this group is to provide pre-natal care to the unborn child who is expected to be born in the United States. As this coverage is intended to benefit unborn children who will be U.S. citizens at birth, the pregnant woman will not qualify for this coverage if she intends to leave the U.S. before the baby is born.

This group is also different from the other Pregnant Women groups in that it receives an enhanced federal match rate under the Children's Health Insurance Program (CHIP). The CHIP enhanced funding coverage is available only to pregnant women who have no other insurance that covers pregnancy related services.

The non-citizen pregnant woman will receive postpartum coverage. Postpartum coverage is through the end of the month in which the 60th day from the date of delivery falls.

B-260 Former Foster Care Adults

MS Manual 06/08/16

This group consists of adults up to age 26 who aged out of foster care in Arkansas. There is no income or resource test. Other than the general Medicaid eligibility requirements that all Medicaid eligibles must meet (MS D-100), the requirements for eligibility in this group are that the adult was in foster care in Arkansas, was enrolled in Medicaid when aging out of foster care at age 18-21 depending on the individual circumstances and is currently under age 26.

Individuals in this group receive the full range of Medicaid benefits.

B-270 Adult Expansion Group (Arkansas Works Program)

MS Manual 05/01/18

The Health Care Independence Program was amended to become the Arkansas Works Program starting January 1, 2017. Throughout this policy manual the Arkansas Works Program will be referred to as the Adult Expansion Group.

This group consists of adults who are 19 through 64 years of age with household income equal to or below 133% (138% with 5% disregard applied) of the applicable federal poverty level (MS E-110) and are not eligible in either the Parents/Caretaker Relatives group (MS B-230) or Former Foster Care group (MS B-260). Adults who are blind or who have a disability may be covered in this group unless they are determined eligible for coverage in another group on the basis of the need for long term care services (facility or waiver) or other disability related services.

A woman who is pregnant at the time of application cannot be included in this group until after the postpartum period. She must be enrolled in one of the pregnant women groups or in the

parents/caretaker relatives group if eligible. However, a woman who becomes pregnant after enrolling in this adult group may remain in the adult group throughout her pregnancy.

Individuals eligible in this group will participate in the Arkansas Works Program authorized by the Arkansas Works Act of 2016 and its amendment in 2017. The Arkansas Works Program provides Medicaid funding in the form of premium assistance to enable individuals to enroll in private health insurance plans.

EXCEPTION: Individuals eligible for the Adult Expansion Group, who have health care needs that make coverage through the Health Insurance Marketplace impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private Qualified Health Plan (QHP) but will remain in Medicaid (Re. MS A-100).

NOTE: If an individual in this group has a child(ren) under age 18 living in the home, the child(ren) must be covered in Medicaid or have other health insurance coverage.

Unless exempt, all Arkansas Works enrollees between the ages of 19 through 49 will be required to comply with the work and community engagement requirement for the Arkansas Works Program (Re. MS F-200 and F-201). All Arkansas Works Program recipients will be referred to the Arkansas Division of Workforce Services for free job assistance services to assist them in complying with the work and community engagement requirement.

NOTE: Individuals enrolled in the Arkansas Works Program are required to have a valid email address.

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

MS Manual 01/01/14

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 01/01/14

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 programs provide non-institutional long term care services to individuals as an alternative to institutionalization. Individuals eligible for waiver services must be potentially eligible for admission to a nursing facility.

B-311 Nursing Facility

MS Manual 08/15/14

This group consists of individuals who are aged, blind or have disabilities and are living in a Long Term Care Facility.

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 resources cannot exceed $2000 and a couple's resources cannot exceed $3000. 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 (Re. MS H-110).

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

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

EXCEPTION: Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.

B-312 Assisted Living Facilities

MS Manual 08/15/14

This group consists of individuals in 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 Medical Review Team 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 SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS H-110).

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

B-313 ARChoices in Homecare

MS Manual 01/01/16

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. 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 Utilization Review. The individual's income cannot exceed three (3) times the SSI payment standard and resources cannot exceed $2000. 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
- Adult Family Home - Requires a contribution to the cost of care. Refer to MS H-412.
- Respite Care
- Adult Day Services
- Environmental Adaptations/Adaptive Equipment

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

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 10/02/16

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 SSI/SPA. 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, see MS F 170-173. The resource limit is $2000. Only the child's resources are considered. Parent resources are disregarded. Recipients of TEFRA Waiver receive the full range of Medicaid benefits and services.

B-316 Autism

MS Manual 04/01/18

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 ICF/IID level of care. The income limit for the child is three (3) times the SSI/SPA 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 08/15/14

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 ICF/IID level of care. The income cannot exceed three (3) times the SSI/SPA. 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 06/01/16

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 or through the Medical Review Team 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 SPA. However, individuals with income over the limit may be eligible if they have established an income trust (Re. 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. For a list of these counties, see Appendix K.

B-320 Medicare Savings Programs (MSP)

MS Manual 01/01/14

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 08/15/14

This group consists of individuals aged 65 or over whose income is equal to or below 80% of 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. See MS F-190.

B-322 Qualified Medicare Beneficiaries (QMB)

MS Manual 08/15/14

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 FPL. QMB pays the Medicare premium, deductibles and coinsurances. See MS F-190.

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

MS Manual 08/15/14

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 FPL. SMB pays only the Medicare Part B premium. See MS F-190.

B-324 Qualifying Individuals 1 (QI-1)

MS Manual 08/15/14

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 FPL. QI-1 pays only the Medicare Part B premium. See MS F-190.

B-325 Qualified Disabled and Working Individuals (QDWI)

MS Manual 10/09/15

This group consists of individuals who are blind or have a disability 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. QDWI income limit is 200% of the FPL. QDWI's are eligible only for payment of their Medicare Part A-Hospital Insurance premium. See MS F-190.

B-326 Medicare Savings Programs - Comparison Chart

MS Manual 01/01/19

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
Income Limits MS E-110	Equal to or below 80% of FPL	100% of the Federal Poverty Level (FPL)	Between 100% and 120% of FPL	At least 120% but less than 135% of FPL	200% of FPL
Resource Limit MS E-110	Individual $7,730.00 Couple $11,600.00				Individual $4000 Couple $6000
Medicare Requirements MS F-190	Must receive Medicare if entitled to Medicare	Entitled to 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 01/01/16

This group consists of individuals who are working at the time of application, at least 16 years of age, but less than 65 years of age, who, except for earned income, would be eligible to receive Supplemental Security Income (SSI). The intent of this group is to allow SSI eligibles to go to work or increase their earnings without losing their eligibility for Medicaid. Refer to Glossary for definition of working.

Individuals who lose SSI and SSI related Medicaid due to earnings, are potentially eligible for Medicaid under the Workers with Disabilities policy. There is no requirement that an individual must have at one time been an SSI recipient to be eligible for Medicaid under this category. However, if an individual was not an SSI or SSA disability recipient, a disability determination must be made by MRT (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. Refer to Appendix S for SGA and SSI payment amount.

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 the caseworker 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 08/15/14

The SSI groups are SSI eligibles or special groups that lost their SSI due to SSA 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 01/01/14

The 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.

B-342 Eligible Due to Disregard of Social Security Cost of Living Adjustment (COLA) Increases (Pickle)

MS Manual 01/01/14

This group consists of individuals who become ineligible for SSI payments due to Social Security cost of living adjustment (COLA) increases. It also includes individuals who lost SSI for any reason, if the individual would be SSI eligible today by disregard of all COLA's received on SSA benefits since the loss of SSI. The individual must have previously been entitled to SSA and eligible for SSI concurrently in at least one month after April, 1977. Individuals in this group

must be current SSA recipients. They are eligible for the full range of Medicaid benefits and services.

B-343 Medicaid for Widows and Widowers with Disabilities (COBRA)

MS Manual 01/01/14

This group consists of widows and widowers with a disability who became entitled to receive SSA benefits between the ages of 50 and 59, entitled to SSA for December 1983 and lost SSI benefits after January 1984 due to an increase in SSA widow's or widower's benefits due to elimination of a benefits reduction factor. The individual must have continuously received widow's/widower's benefits since their SSI benefits were terminated and would be eligible for SSI if the amount of the 1984 reduction factor increase and any subsequent COLA increases were disregarded.

B-344 Widows and Widowers with Disabilities (OBRA 87)

MS Manual 01/01/14

This group consists of widows and widowers with a disability who were at least 60 on or after April 1, 1988 and not yet 65 years of age on April 1, 1988 and who were former recipients of SSI whose benefits were terminated due to entitlement to SSA widow's/widower's benefits. They must still be a current recipient of widow's/widower's benefits (may also receive concurrent other SSA benefits), not currently eligible for Medicare, would still be eligible for SSI if all SSA benefits were disregarded and otherwise income and resource eligible for Medicaid.

B-345 Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 90)

MS Manual 08/15/14

This group consists of widow/widowers with a disability and surviving divorced spouses with a disability who lost their SSI due to receipt of SSA widow/widower or disabled surviving divorced spouse benefits. The individual must currently be (1) receiving SSA widow/widower or disabled surviving divorced spouse benefits, (2) not entitled to Medicare Part A, (3) would still be eligible for SSI if all SSA benefits were disregarded as income and (4) resource eligible under the AABD resource limits in MS E-500. Individuals found eligible under these provisions are entitled to the full range of Medicaid benefits.

B-346 Disabled Adult Children (DAC)

MS Manual 08/15/14

This group consists of individuals who lost their SSI after July 1, 1987 due to SSA Disabled Adult Children (DAC) entitlements or due to increases in their DAC benefits.

An individual who may be eligible for Medicaid in this categorically eligible group is one who:

- Is age 18 or older,
- Was determined to be blind or have a disability before age 22,
- Was receiving SSI based on a disability determination or blindness, and
- Lost SSI on or after July 1, 1987 due to a DAC entitlement or a DAC increase.

Income included will be the current income, less the DAC entitlement or increase that resulted in the loss of SSI. Any other income other than the DAC entitlement or increase will be counted. Resources cannot exceed $2000.

NOTE: Medicaid eligibility as a "protected" DAC continues to be protected only if the individual would otherwise qualify for SSI. Marriage and a spouse's income included in the SSI eligibility determination which renders the DAC recipient not otherwise SSI eligible causes the loss of protection as a DAC. When the DAC protection is terminated, eligibility cannot be regained. However, if a DAC eligible marries an SSI recipient, the DAC status and eligibility are protected.

B-400 Foster Care Medicaid

B-400 Foster Care Medicaid

MS Manual 01/01/14

This group consists of children who are in the custody of the State of Arkansas because of removal from a parent or caregiver.

The eligibility criteria for this group are explained in MS Section K.

Children who "age out" of foster care at age 18 or 21 years old, if an agreement has been signed by the child to remain in foster care, will be eligible for the Former Foster Care category of Medicaid (MS B-260).

B-500 Emergency Medicaid Services for Aliens

B-500 Emergency Medicaid Services for Aliens

MS Manual 05/01/18

This group consists of:

- Nonqualified aliens living in the U.S. or
- Qualified aliens living in the U.S. for less than 5 years.

Medicaid benefits are available to pay for the cost of emergency services for aliens who do not meet the Medicaid citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, Medically Needy, Adult Expansion, ARKids A or B.

NOTE: Emergency Medicaid applicants, if eligible in the Adult Expansion Group, may be approved for retroactive coverage 30 days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James applies for Emergency Medicaid coverage on October 20 and requests coverage for September 15 through September 17. He is not eligible for retroactive coverage because his bill is for September 15 through 17 which is more than 30 days prior to the application date. Retroactive coverage cannot begin prior to September 20.

EXAMPLE: James applies for Emergency Medicaid coverage on October 30 and is found to be medically eligible for the Adult Expansion Group on October 1 through October 2. He asks for retroactive coverage for a medical bill with a service date of October 1. He is eligible for retroactive coverage because his bill for October 1 is within the 30 days prior to the application date.

To be eligible for emergency Medicaid, the applicant must have, or must have had within the last 3 months, an emergency medical condition. For the exception, see NOTE above. Labor and delivery is considered an emergency medical condition.

B-500 Emergency Medicaid Services for Aliens

Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily part or organ

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset, a sharp rise and last a short time. If the individual's condition is chronic (ongoing), such as cancer, AIDS, end-stage renal disease, etc., it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as **not** qualifying under emergency services.

Before eligibility can be determined, the existence of an emergency medical condition must be verified by a physician's statement that the alien met the conditions shown above. A physician's statement that the individual will die without medical treatment does not in and of itself, constitute an emergency. The eligibility determination must include a determination of whether the condition is acute or chronic. Verification that medical expenses were incurred for treatment of the condition must also be presented.

Payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services existed. The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the Medicaid begin and end dates entered in the system.

Emergency services are defined as services provided in a hospital, clinic, office or other facility equipped to furnish the required care after the onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

To determine if an applicant's doctor visit, emergency room visit or hospital stay was considered an emergency, the discharge summary for the medical visit will be sent to OPPD for an emergency medical determination.

B-600 Medically Needy (Exceptional and Spend Down)

MS Manual 08/15/14

The Medically Needy Program is intended to provide medical services for categorically related individuals or families whose income and/or resources exceed the limits for cash assistance but are insufficient to provide medical care.

The two types of coverage within the Medically Needy Program are Exceptional Medically Needy (EC) and Spend Down Medically Needy (SD).

B-601 Exceptional Medically Needy

MS Manual 08/15/14

This group consists of individuals or families whose income is within the Medically Needy Income Level and whose resources fall within the specified limits of the Medically Needy Program. Refer to MS Section O.

B-602 Spend Down Medically Needy

MS Manual 08/15/14

This group consists of individuals or families whose household income is above the Medically Needy Income Level (MNIL) and resources are within the Medically Needy Resource Limit (MNRL). The excess income that is above the MNIL must be obligated or spent for medical services. Refer to MS Section O.

C-100 Application Process

MS Manual 01/01/14

All individuals who wish to apply for Medicaid benefits will be given the opportunity to do so without undue delay. No application or inquiry will be ignored. The Agency has the responsibility to follow up on any request for medical assistance and to make arrangements for completion of the application.

NOTE: An application can be filed on behalf of a deceased person if the application is filed within the 3 months after the date of death.

Refer to MS C-200 for those eligibility groups that require an alternative application process.

C-105 Distinction between Application and Inquiry

MS Manual 01/01/14

The distinction between an application and an inquiry is as follows:

- An application is either an electronic, telephonic or written and signed request for assistance by an individual or his or her authorized representative.
- An inquiry is a request for information by an individual or his or her authorized representative.

C-110 Application Assistance

MS Manual 01/01/14

The agency must allow an individual or individuals of the applicant's choice to accompany and/or represent the applicant in the application process or a redetermination of eligibility. Such individuals may be a Navigator or an assistor or may be authorized by the applicant to act as an Authorized Representative.

C-111 Navigators, In-Person Assisters and Certified Application Counselors

MS Manual 01/01/14

A Navigator is a person authorized under federal law to assist individuals shopping for and selecting health insurance offered through the Health Insurance Marketplace. The Navigator will

provide information regarding health benefit plans or coverage offered through the Marketplace and will facilitate enrollment through the Marketplace.

An In-Person Assister will assist individuals enrolling through the Marketplace by educating people about the new system, helping them understand about their health plan choices and facilitating the selection of a plan that is right for them.

A Certified Application Counselor is a licensed person authorized to assist individuals in enrolling in different marketplace designated organizational settings including healthcare facilities.

It is the duty of Navigators, In-Person Assistors and Certified Application Counselors to assist individuals completing an application for healthcare benefits. They do not meet the definition of an Authorized Representative as outlined in MS C-112 unless the applicant has designated the individual as an Authorized Representative.

C-112 Authorized Representatives

MS Manual 01/01/14

An authorized representative is:

1. An individual or facility designated by the client, in writing, as authorized to request and receive confidential information that would otherwise be disclosed only to that client; or

2. An individual or facility identified by the court when the client is mentally, physically or legally unable to designate a representative; or

3. An individual designated by an inmate of the Department of Corrections, Community Corrections or a local correctional facility for purposes of filing a Medicaid application and complying with Medicaid requirements for determining eligibility; or

4. The Department of Corrections, Community Corrections or a local correctional facility when an inmate who has received medical services that meet the criteria for Medicaid coverage does not designate a representative within three business days following a request to designate a representative or the inmate's assigned representative does not file a Medicaid application within three business days after appointment as that inmate's representative.

See MS A-131 for more information regarding when information can be released to an Authorized Representative.

C-115 Emancipated Minors

MS Manual 01/01/14

An emancipated individual under age 18 will be allowed to file an application on his/her own behalf for Medicaid. Judicial and common law emancipation will be recognized.

A judicially emancipated minor is one who has been given the right by a court to manage his own affairs. A common law emancipated minor is one who has been given the right to manage his own affairs by voluntary or implied agreement between parent(s) and child. A common law emancipated minor must be demonstrating that he/she is responsible for the management of his/her own affairs by establishing an independent household or by sharing equally in payment of household expenses if living with parent(s)/family. The emancipation of a minor is revocable if the minor again becomes dependent upon and responsible to his parents or other individuals who have acted or are acting as his parents. This applies to any type of emancipation. Therefore, emancipation status must be determined on the actual current circumstances without regard to what has transpired in the past.

C-120 Submitting an Application

MS Manual 02/01/18

An application may be completed and submitted electronically via Access Arkansas or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.

NOTE: See Appendix I for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to DHS and DHS will process it. If the applicant is found to be eligible for Medicaid, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

C-130 Tracking Applications Upon Receipt

MS Manual 02/01/18

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM), that appear to be eligible for Medicaid, will be sent to DHS for processing. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

C-135 Time Limit for Disposition of Application

MS Manual 01/13/15

Medicaid applications must be disposed of within 45 days from the date of application unless a disability determination is required. Applications requiring a disability determination must be disposed of within 90 days from the date of application.

C-140 Eligibility Determination

MS Manual 01/01/14

Eligibility for all Medicaid categories will be determined in accordance with MS Section D, General Eligibility Requirements, and MS Section E, Financial Eligibility. Non-financial criteria (Re. MS Section F) will be determined depending on the category of coverage. Eligibility factors will be verified in accordance with MS Section G.

Generally speaking, the system will determine Medicaid eligibility according to a rules based engine utilizing the data entered into the system by the individual, agency staff or a combination of both. Specific eligibility determination process steps are as follows:

1. Once enough information has been entered, the system will screen the applicant's eligibility for Medicaid and if the individual appears eligible, will verify the applicant's data through various data matches.

2. If the applicant's data and data sources are "reasonably compatible" (MS G-151 and MS G-152) and eligibility exists, the system will approve the application, update all information regarding the case, and send a notification of approval to the individual.

3. If eligibility does not exist based on the information entered on the application, the system will deny the application and send a notice to the individual.

4. If additional information is required to process the application due to reasonable compatibility issues or missing data, the system will send a notification to the individual requesting the needed information.

5. An interview with the applicant is not required. The applicant will be contacted only if necessary to obtain necessary information.

6. When all requested information is supplied by the applicant, the caseworker will enter the information into the system which will then determine eligibility.

7. If the application is denied, the system will send a notification of denial and, if appropriate, provide the individual with referral information to the Health Insurance Marketplace to allow the individual to apply for services there.

C-141 90 Day MAGI Application Process

MS Manual 10/08/15

A new application will not be required in those instances in which an application for families and individuals (MAGI) groups was denied due to the applicant's failure to provide requested information within the 10 day notice period when the requested information is provided within 90 days of the application denial date. The original application will be reinstated and the information will be used to determine eligibility. A new application will be required if the requested information is returned after 90 days. This only applies to applications for the MAGI groups.

NOTE: When an applicant provides requested information after the application has been denied but within the 90 day window, the application will be considered as a reinstatement and will not be subject to the 45 day overdue guidelines. However, the reinstated application must be processed and eligibility determined within 10 days from the date the requested information was supplied.

Example: A verification request notice is sent to the individual on August 15 and it is due back in the office on or before August 25. The requested information is not returned and a system generated notice is sent informing the individual of the application denial. The application is denied on August 26. The individual provides the requested information by November 24th which is 90 days from August 26th. Therefore, the information will be used to process eligibility and if eligible, coverage will begin based on the original application date.

C-145 Application Disposal

MS Manual 01/01/14

Applications must be disposed of by one of the following actions: approval or denial.

Approval

When all eligibility requirements are determined to be met, the application will be approved and the individual enrolled in the appropriate Medicaid coverage group. An approval notice will be sent to the applicant advising that he or she has been approved for coverage with the effective beginning date of coverage.

Denial

An application will be denied in the following situations:

1. The applicant is determined to be ineligible due to an eligibility requirement not being met;
2. Eligibility cannot be established due to failure of the applicant to provide information necessary to determine eligibility; or
3. The applicant withdraws the application.

When an application is denied, a denial notice will be sent advising the applicant of the denial, reason for denial and the applicant's right to appeal the denial.

C-150 Enrollment

MS Manual 02/01/18

Each individual approved for Medicaid by DHS will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Adult Expansion Group requires that once eligibility is determined, the applicant will receive a letter explaining which coverage is suitable for their need. The Division of Medical Services will issue an eligibility approval notice for the Adult Expansion Group which will provide instructions regarding the next steps needed to complete the enrollment process.

C-200 Alternative Application Processes

MS Manual 01/01/16

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

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

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

C-205 Pregnant Woman Period of Eligibility

MS Manual 10/30/15

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 3 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 verified, and must be for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage. If retroactive coverage is not given, the record should be clearly documented to show that coverage was considered and why it was not given.

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 (MS I-610).

C-210 Newborn Referral Process

MS Manual 08/01/15

Hospital and physician providers use the DCO-645, 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-645 and send it to the DHS County Office of the mother's residence within five (5) days of the child's birth, when possible. The DCO-645 will serve as verification of the birth date of the child, as well as, documentation of relationship and citizenship.

NOTE: The DCO-152, Application for Health Coverage, will be used to refer those infants who will be living with someone else other than the biological mother following discharge from the hospital.

Upon receipt of the DCO-645, the worker will check the system to determine if the birth mother has any type of Medicaid coverage in the system. If the mother has been determined Medicaid eligible in any category, the DCO-645 will be processed as a change. If there is no record of the mother having any type of Medicaid coverage of if the newborn infant will be residing with someone other than the mother, the prospective caretaker should apply for coverage for the child on a DCO-152 or online at access.arkansas.gov.

The date of change will be the date the DCO-645 is received by the county office. If the newborn coverage is approved based on the DCO-645, the worker will complete Part III of the form and return it to the referring provider. If vital information (e.g., DOB or name) in either Part I or Part II of the form is missing, the form will not be added as a change but will be

returned to the provider within five working days from the date of recipt with a note to indicate what missing information is needed. If the mother of the child is not Medicaid eligible and has not made application for Medicaid, Part III of the DCO-645 will be completed and returned to the provider advising that the mother apply for the child on a DCO-152 or online at access.arkansas.gov.

If there is a pending Medicaid application for the mother when a DCO-645 is received, the DCO-645 will be held by the county until disposition is made of the mother's PW application, at which time the county will notify the provider by completing Part III of the form and returning it to the provider. The county should inform the provider within 5 days of receipt of the DCO-645 that eligibility for the mother is pending.

If all vital information is on the form when received and it is verified that the mother was Medicaid eligible at the time of delivery, the system will place the child in the newborn eligibility group within twenty working days from receipt of the completed DCO-645. The caseworker must then complete Part III of the form and return it to the provider within twenty-day period.

C-211 Newborn Referral Disposal Process

MS Manual 08/01/15

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:

1. The newborn coverage may be terminated only if the child no longer resides in the State of Arkansas.

2. Death of the child during the 12 month coverage period.

If the mother was a certified Medicaid eligible recipient or was later determined Medicaid eligible for the birth month in any category, Medicaid coverage of the child will be provided as follows:

1. Secure information necessary to open a Newborn Medicaid case.

2. The system will place the child in the newborn eligibility group with the DOB as the Medicaid begin date.

3. DCO-700S or system-generated notice will be sent to the person with whom the child will be residing. The person will be either the biological mother listed under Part II B of the DCO-645 or someone other than the biological mother if the DCO-152 is used. The notice will advise the caretaker of the Newborn approval (or denial, if applicable) and advise the caretaker to report all address changes for the family, and that application may be made for the newborn in another Medicaid eligibility group when the newborn's eligibility has expired under newborn coverage.

C-220 Autism Application Process

MS Manual 04/01/18

The Autism Waiver program is operated by Partners for Inclusive Communities (Partners) under the administrative authority of the Division of Medical Services.

To apply for services, the child must be between eighteen (18) months and 5 years old. A child 5 years and 1 day old is over the age limit for application. If approved, coverage will be for a maximum of 3 years. The 3-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 (8th) birthday, coverage will end the day before the child's eighth (8th) birthday.

The following describes the Autism application process:

If a parent or guardian inquires at the county office about the Autism Waiver, county office personnel will:

1. Provide the Autism Waiver brochure.
2. Inform the inquirer that he or she must contact Partners at the phone number listed on the brochure for more information or to start the application process.
3. If the child doesn't have a pending Medicaid application or an open Medicaid case, explain Medicaid/ARKids requirements and assist the parent or guardian if he or she wishes to apply for Medicaid or ARKids.

When the parent or guardian contacts Partners, Partners will:

1. Explain the program and program requirements.
2. Screen the applicant to determine if he or she meets the program criteria.
3. Send the following forms to the parent or guardian, if the child meets the therapeutic requirements:
    a. DCO-9700, TEFRA and Autism Waiver Application;

   b. If a disability determination is needed , a DCO-108C, Social Report for Children;
   c. DCO-106, Disability Worksheet; and
   d. DHS-4000, Authorization to Disclose Health Information.
4. Advise the parent or guardian to return completed forms to Partners.

Upon receipt of the application and documentation, Partners will:

1. Review the application and documentation to determine if the application should be denied based on Partners' autism diagnosis assessment.
2. Send the application and documentation to the Area TEFRA Processing Unit (ATPU).
3. Complete form DHS-703, Evaluation of Medical Need Criteria if the applicant meets Partners medical criteria and forward it to the Office of Long Term Care (OLTC). OLTC will document the level of care determination on the DHS-704 and return the form to Partners. Partners will forward the completed DHS-704 to the appropriate ATPU.
4. Send notification of ineligibility denial to ATPU via the DHS-3330 if the applicant does not meet medical criteria.

ATPU will:

1. Register all applications received from Partners in the Autism Waiver Service Program.
2. Deny application and send the applicant's parent or guardian a system generated notice of denial, if the applicant is determined not to be eligible based on Partner's medical criteria,
3. Determine financial eligibility, if the child meets the autism criteria.
4. Forward medical records (Forms DCO-106, DCO-108C and DHS-4000) to MRT while determining financial eligibility, if a disability determination is required.
5. Determine financial eligibility and if found not eligible:
   a. Deny the application.
   b. Send the parent or guardian a system generated notice of denial and a DHS-3330 to Partners.
   c. Notify MRT to stop the disability determination if the determination has not been received.
6. Approved the application, if the applicant is medically and financially eligible:
   a. The Medicaid begin date will be the date the application is approved.
   b. Send the parent or guardian a system generated notice of approval and a DHS-3330 to Partners.

C-230 TEFRA Application Process

MS Manual 02/05/16

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.

The application will be made by the adult responsible for the care of the child and will be processed in the child's county of residence.

TEFRA Waiver applicants should be screened for ARKids eligibility. The ARKids program should be explained to the parents so they can make an informed choice between ARKids and TEFRA. ARKids can generally be approved much more quickly than TEFRA as no disability or medical necessity determination is required.

The DMS-2602, Physician's Assessment of Eligibility, will be given to the individual to be completed by the child's physician. If disability is to be established by MRT, forms DCO-106, DCO-107, DCO-108C and DHS-4000(s), if needed, will also be completed. The TEFRA Waiver Brochure, PUB-405, should also be given to the applicant explaining the medical determination process and the premium process. (Refer to Appendix I.)

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

MS Manual 01/01/14

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 Eligibility Determination

MS Manual 05/12/17

With the exception of the Appropriateness of Care requirement, eligibility will be determined by the caseworker in the same manner as Long Term Services and Supports 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 LTC income limit and the child's countable resources are less than $2,000.00, 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.

C-233 Disability Determination

MS Manual 01/01/14

To qualify for TEFRA, a child must be considered an individual with a disability according to the SSI regulations that govern children with disabilities. 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 120-128.)

C-234 Determining Appropriateness of Care

MS Manual 05/12/17

When the completed DMS-2602 is returned to the county office by the child's physician, the DMS-2602 and DCO-2603 and any medical records that have been submitted will be sent to:

DMS
Attention: TEFRA Committee
P.O. Box 1437, Slot S-406
Little Rock, AR 72203

The TEFRA Committee will determine if the applicant meets the Appropriateness of Care criteria. If this criteria is met, and if the referral is otherwise appropriate, the TEFRA Committee will complete Sections III and IV of the DCO-2603. The TEFRA Committee will determine Medical Necessity and will be responsible for returning the DHS-704, DMS-2602 and DCO-2603 to the

county office for final approval or denial, pending MRT decision if applicable. The TEFRA Committee is coordinated by the Office of Long Term Care.

NOTE: An application will not be denied solely for failure of the physician to complete and return the DMS-2602 until an effort has been made to assist the client in obtaining the completed DMS-2602. The caseworker will remind the applicant of the necessity of the form and of his/her responsibility for obtaining the form. Assistance will be given whenever possible.

C-235 Disposition of Application

MS Manual 05/12/17

The DCO-2603, Summary of Case Eligibility/TEFRA will be reviewed for documentation that each eligibility requirement has been met. 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 01/01/16

A potential Waiver client will make application (DCO-777) 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. Separate applications will be registered when both individuals of a couple apply.

Applicants should be advised that if they accept services from ARChoices providers while their applications are pending, they will be responsible for paying the provider if the application is subsequently denied.

NOTE: If the applicant's income is under the SSI/SPA, he/she may be referred to SSA to make a SSI application. However, ARChoices eligibility is not contingent upon SSI eligibility, and the eligibility determination will not be delayed pending a SSI determination.

To qualify for the ARChoices waiver, the individuals aged 21-64 must be determined to have a physical disability through either MRT, Railroad Retirement (RR) or SSA. The individual may have a mental disability, but if so, it must be in addition to a physical disability to qualify for ARChoices.

To determine if the disability for SSA is physical, the caseworker will fax the request for verification to the local Social Security office that serves their county. The memo request must include the name and SSN of the ARChoices applicant, the county office address, telephone number, fax number, contact person and the request for verification of type of disability. If the individual is not receiving SSI or the SSA disability is based solely on mental disability, an MRT decision will be needed. When referring a case to MRT, it is important to make it clear that it is an ARChoices case so MRT will know that a physical disability determination is needed. The caseworker should write on the top of the Social Report "ARChoices".

To determine if the disability for RR is physical, contact the RR Board at 1-877-772-5772 or

1200 Cherry Brook Drive
Suite 500
Little Rock, AR 72211-4122.

C-241 ARChoices Waiver Assessment Process

MS Manual 01/01/16

All applicants will be referred to the DHS RN by DHS-3330 for coordination of the medical assessment within 2 days of the initial interview. If a physical disability determination is required for an ARChoices applicant, the referral will be made on the date the disability determination is received by the agency. The Office of Long Term Care will determine if the applicant meets the Intermediate Level of Care requirements.

The assessment results will be routed by the DAAS Central Office staff to the DHS RN and to the county office via Form DHS-704, Decision for Nursing Home/Waiver Placement.

If an individual meets the Intermediate Level of Care requirements, and if the individual is otherwise eligible, DAAS will work with the client, family, or other caregiver to ensure that the client receives services necessary to meet his/her needs according to the written Plan of Care. (Refer to MS C-247)

The DHS RN is required to make 3 attempts to contact the applicant through telephone contacts and home visits within an established timeframe of receiving the referral from the caseworker. The procedures below describe what happens when the RN fails to make contact:

1. If the DHS RN cannot contact the applicant after several attempts, a DHS-3330 will be sent to the caseworker informing him/her of the failed attempts.

   The caseworker will then send a DCO-700, Notice of Action, to the applicant and a copy to the DHS RN advising that the application will be denied if the applicant does not make contact with the RN within 10 days. The caseworker will provide the name and telephone number of the RN on the notice.

2. After 10 days, the caseworker will check with the DHS RN to see if the applicant made contact. If not, the application will be denied using reason “Other”. The caseworker will send a manual notice of action to the client explaining the reason of the denial and document all information in the narrative.

On pending applications, the caseworker will:

1. Check the Long Term Care Unit (LTCU) Screen within 30 days of application to determine if the assessment has been completed.

2. Contact the DHS RN if the LTCU Screen does not indicate the assessment has been completed.

3. Hold the application pending receipt of the DHS-704 if the DHS-703, DHS Evaluation of Medical Need Criteria has been completed by the DHS RN.

If notified that the application will be denied due to lack of medical information, it is ultimately the responsibility of the applicant to provide the required information.

If the caseworker learns the medical assessment has not been completed by the DHS RN, the caseworker will:

1. Send a DHS-3330 to the DHS RN and indicate "Second Request" for medical assessment, and

2. Fax a copy of the DHS-3330 to DAAS**, 501-682-8155,** ATTN: HCBS Nurse Manager.

On the 35th day, the caseworker will again contact the DHS RN. If the medical assessment has not been completed, the caseworker will contact his/her Program Eligibility Analyst. When possible, DAAS will take the necessary action to complete the medical assessment prior to the 35th day.

When a DHS RN receives a referral on a nursing facility resident who elects ARChoices:

1. The DHS RN will contact the individual to proceed with the assessment process to develop a Plan of Care.

2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care with the preceding 6 months. The necessity of completing a new assessment will be left to the professional judgment of the DHS RN.

3. If 6 months or more have elapsed since the last determination of Level of Care, or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to the Office of Long Term Care.

C-242 ARChoices Waiver Applications from Nursing Facility Residents

MS Manual 01/01/16

If the county is contacted regarding ARChoices for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, the County will send a DHS-3330 to the DHS RN who will initiate an assessment as outlined below.

When the RN proceeds with the assessment process:

1. A DHS-3330 will be sent to the county office, along with page 2 of the Plan of Care showing the recipient's election of Waiver services with signature.

2. The signed election of Waiver services will serve as the application for Waiver services.

3. It is not necessary to complete a DCO-777 or DCO-7781 unless it is time for the annual renewal of the LTC case.

4. The ARChoices Waiver application must be registered.

NOTE: When accepting Page 2 of the Plan of Care as described in this section, the Plan of Care must include the client's signature, the election of community services and the date. The date must be later than the date of nursing home admission. The DHS RN's signature is not required on the Plan of Care when used for this purpose. The name of the DHS RN will be included on the DHS-3330.

If an ARChoices Waiver application is received from a non-Medicaid eligible nursing facility resident:

1. The application must be registered.
2. The application will not be routinely denied because the individual is institutionalized.
3. The caseworker will send a DCO-3330 to the DHS RN who will initiate an assessment as described in MS C-241.

C-243 Residents of Residential Care Facilities

MS Manual 01/01/14

If an individual living in a residential care facility (RCF) applies for Waiver services and has no plans to move out of the RCF, the caseworker will explain to the applicant that, according to current LTC and RCF policy, he or 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 and the targeted relocation date will be documented. The caseworker will include the date that the applicant plans to move out of the RCF on the DHS-3330 that will be sent to the DHS RN. The normal application process at MS C-240 will then be followed. Eligibility for a Waiver program cannot begin until the individual has moved out of the RCF and all other eligibility criteria have been met.

At the end of the 45 day period, if the applicant has not relocated, the caseworker will send a 10 day notice advising that 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 01/01/16

Eligibility determinations for ARChoices Waiver cases will be conducted in the same manner as for AABD long term care 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 LTC 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. The DCO-710 will be used to compute the initial assessment.

C-245 Approval/Denial for New Applicants

MS Manual 01/01/16

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

If there is a closed case number on file for the client, this number will be used to open the ARChoices Waiver case.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of an eligible individual will be entered in the appropriate fields in the system. The total gross income will also be entered as Protected Maintenance, since Waiver recipients will not contribute to the cost of services.

The county office will notify DAAS of certifications and denials via the DHS-3330 on the date the action is taken. The DHS-3330 may be mailed, emailed, or faxed to the DHS RN or placed in a designated location at the DHS county office for the DHS RN to collect.

Denial reasons include, but are not limited to:

1. Failure to meet the nursing home admission criteria.
2. Withdrawal of the application by the applicant.
3. Ineligibility based on income or resources.
4. Death of the applicant when no Waiver services were provided.

If the caseworker denies the application for any reason, the DHS RN will be notified via a DHS-3330 and the RN will notify providers of service via the AAS-9511.

When denying an ARChoices application because the applicant refuses to receive at least one service, is not in need of a service or the service is not available in their area, denial code "Other" will be used. A manual notice will be sent, notifying the applicant of the denial.

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. If the individual wins the appeal and has no unpaid ARChoices charges, Medicaid coverage will begin the date the appeal is won. However, the Waiver portion of the case will not be opened until the date the caseworker completes the case. If the individual has unpaid ARChoices Waiver charges, and services were authorized by the DHS RN, eligibility for both Medicaid and Waiver services will begin the date service began. However, under no circumstances will Waiver eligibility begin prior to the date of application on the DCO-777 or before the Provisional Plan of Care is signed by the DHS RN and the applicant.

When the Office of Appeals and Hearings reverses an Agency decision that an individual did not meet medical necessity requirements, a new DHS-704 will not be issued. The final Agency decision will contain the determination of the Intermediate Level of Care. The Medicaid Begin Date will be the date of the hearing officer's decision and the Eligibility Start Date on the Waiver portion of the case will be the same as the Action Date. As no Level of Care Review Date will be given, the caseworker will enter a date 12 months after the date of the hearing officer's decision.

NOTE: If Waiver services were provided and the applicant dies prior to approval of the application, Waiver eligibility will begin the date services began and end the date of death if all other eligibility requirements are met.

C-246 Effective Date of Eligibility for ARChoices Waiver

MS Manual 01/01/16

After all eligibility criteria have been established, the effective date of ARChoices Waiver Medicaid eligibility will be the date of approval into the system. The effective date of eligibility cannot be prior to the date of approval of the case. (MS A-200)

NOTE: The ARChoices eligibility beginning before the date the application is approved by the DCO caseworker will be established only when the DHS RN has recommended the applicant for medical approval based on the medical criteria. The Waiver eligibility date will never be established retroactively by the DCO caseworker unless the retroactive eligibility date is provided by the DHS RN. In all other cases, the Waiver eligibility date will be the date the approval is entered into the system.

C-247 Provisional and Comprehensive Plan of Care ARChoices

MS Manual 01/01/16

The Provisional Plan of Care will include all Plan of Care information with the exception of the Medicaid number and Comprehensive Plan of Care expiration date. The Provisional Plan of Care will expire 60 days from the date the Plan of Care is signed by the DHS RN and the applicant.

A signed copy of the Provisional Plan of Care will be mailed to each provider included on the Plan of Care. The provider will begin services within an established timeframe and notify the DHS RN via the AAS–9510 that services have started. The DHS RN will track the start of care dates. If at least one Waiver service begins within 30 days of the development of the Provisional Plan of Care and the applicant is otherwise eligible, the Waiver eligibility date will be established retroactively effective the day the Provisional Plan of Care was signed by the DHS RN and the applicant. If no Waiver services begin within 30 days of the development of the Provisional Plan of Care, the effective date of service will be the date the approval is keyed into the system or the day a Waiver service started as verified by the DHS RN.

If an application is denied, a new Provisional Plan of Care must be developed when a subsequent application is made. Regardless of the reason for the denial and regardless of when a new Waiver application is made, a Provisional Plan of Care will only be utilized on a current Waiver application.

Prior to the Provisional Plan of Care expiration date, the DHS RN will mail the Comprehensive Plan of Care to the client and all providers included in the Plan of Care. If the Medicaid

application has been approved, the Comprehensive Plan of Care will include the Medicaid recipient's ID number, diagnosis, Waiver eligibility date and the Comprehensive Plan of Care expiration date. The new Plan of Care expiration date will be 365 days from the date the DHS RN and the applicant signed the Plan of Care. Once the application is either approved or denied, a Plan of Care including the Medicaid ID number or an AAS-9511 giving the date of denial will be sent to the providers.

C-248 Optional Participation for ARChoices

MS Manual 01/01/16

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 Plan of Care, 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.

NOTE: The provider is required to notify the DHS RN via the AAS-9510 regardless of the participation decision. The information reported by the provider on the AAS-9510 will document which services are being delayed and which services are beginning based on the provisional Plan of Care.

C-249 Approvals for Medicaid Recipients Who Leave LTC

MS Manual 01/01/16

The ARChoices case may be certified when the county is notified by the nursing facility that the recipient has left the facility if all the following conditions are met:

1. The county has received a DHS-3330 and Plan of Care signed by the recipient or if a Money Follow the Person (MFP) (MS I 540-541) participant, Form DCO-777 may be provided.
2. The system shows an Intermediate Level of Care.
3. The Level of Care was entered into the system in the previous 6 months.
4. There is a future Level of Care review date.

If the Intermediate Level of Care was entered by the county more than 6 months previously, or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DHS-704 verifying Intermediate Level of Care status.

To certify the ARChoices Waiver case, close the LTC vendor portion of the case but do NOT close Medicaid. The day after closure of the vendor portion of the case, the Waiver portion of the case may be opened.

To clear the pending application screen when approving Non-SSI recipients, counties will submit an email to DCO SYSTEM SUPPORT requesting the register number to be cleared. If the recipient is a MFP participant, the email should include this information.

For SSI recipients, the register number will be cleared by keying the approval reason in ANSWER.

When opening a case in which the Intermediate Level of Care was entered less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ARChoices Waiver eligibility. The Level of Care Review Date will be 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC case, use that Level of Care Review Date when opening the Waiver case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ARChoices eligibility.

Counties will review the records of recipients who leave facilities for ARChoices. If it is time for the annual reevaluation, a reevaluation will be done prior to Waiver certification.

No Waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a Provisional Plan of Care 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 01/01/14

Applications for ALF Waiver will be made on the LTC Application for Assistance, DCO-777 in the county DHS 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 in the applicant's home county before he/she enters the facility and the applicant enters a facility in another county, the application will be denied in the system. A notice will not be system generated for this denial. A DCO-700 will be completed and mailed by the caseworker, advising the client or representative that the application has been sent to the appropriate county. All documents will be scanned into the electronic case file and then transferred to the county where the facility is located. The transferring county will send an

email and task to the County Administrator and Program Eligibility Coordinator in the receiving county when the transfer in ANSWER is complete. A new application will not be needed by the receiving county and the original date of application will be entered when the application is reregistered.

If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.

The applicant 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-251 Registering the ALF Application

MS Manual 01/13/15

Applications will be registered as Assisted Living or SSI Assisted Living (SSI recipient). ALF Waiver recipients having SSI will retain their SSI Aged Individual, SSI Blind Individual or SSI Disabled Individual case numbers. Separate applications will be registered when both members of a couple apply.

C-252 Applications from Nursing Facilities, ARChoices Waiver Recipients

MS Manual 01/01/16

If the county is contacted regarding an ALF application for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, or an ARChoices Waiver recipient, the caseworker will notify the DHS nurse via the DHS-3330. The DHS nurse will visit the client on site to begin the assessment process to develop a Plan of Care. The county will be notified of the recipient's election of ALF Waiver services. The signed election of ALF Waiver services will serve as the application for ALF and a new DCO-777 or DCO-7781 need not be completed by the applicant, unless it is time for the annual reevaluation of the LTC or Waiver case.

If a non-Medicaid eligible nursing facility resident wishes to apply for ALF Waiver, the DCO-777, Application for Assistance, must be completed and registered. The caseworker will notify the DHS RN, who will initiate the assessment.

C-253 Assessment Process

MS Manual 01/01/16

All applicants will be referred to the DHS RN by DHS-3330 for coordination of the functional need assessment within 2 days of the date of application or the date the physical disability verification is received if a disability determination is required. The RN will visit the client on site to evaluate his or her physical, functional, mental, emotional and social status, as well as, to obtain a medical history. The DHS RN will develop a Plan of Care based on the assessment. The plan must include the medical and other services to be provided, their frequency and the type of provider to furnish the service. The client's choice of service provider must be specified by this time. The DHS RN will ensure that the applicant's degree of incapacity is reflected accurately.

The assessment will be submitted to the Office of Long Term Care for determination of nursing home level of care eligibility. The Decision for Nursing Home Placement Form, DHS-704, will be routed to the DHS RN and the county office.

If an individual meets the Intermediate Level of Care requirements and if the individual is otherwise eligible, DAAS will work with the client, family or other caregiver to ensure that the client receives the services necessary to meet his/her needs according to the Plan of Care.

Waiver services will not be provided where the cost of home and community based care exceeds, on an annualized basis, the cost of Intermediate Level of Care for the recipient in a nursing facility.

The DHS RN is responsible for monitoring for changes in the ALF client's service needs, referring clients for reassessment, if necessary, and reporting any client complaints of violations of rules and regulations to the appropriate authorities for investigation.

C-254 Eligibility Determination

MS Manual 01/13/15

Eligibility determination for ALF Waiver cases will be conducted in the same manner as for AABD Long Term Care 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 LTC limit. (Re. Appendix S). For an applicant with an ineligible spouse, only the income of

the applicant will be considered for eligibility. When there is a married couple and only one member of the couple applies the rules for spousal impoverishment (Re.MS H-200) regarding income will be applied. An individual with income over the current LTC income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust (Re. MS H-110- 116).

In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one-person limit. When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment (Re. MS H-200) regarding resources will be applied.

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

C-255 Approvals for New Applicants (Non-LTC)

MS Manual 01/01/14

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 Plan of Care is signed by the DHS RN and the applicant. The DHS RN will provide the Waiver eligibility date to the county via the DHS-3330. Eligibility will not be established prior to the development of the Assisted Living Plan of Care by the DHS RN. Applicants who desire Medicaid coverage for the time before admission to the ALF or before the Plan of Care is signed, must be determined in another category. The same application can be used but a separate application must be registered to determine coverage prior to eligibility for Assisted Living Facility Medicaid.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of the eligible individual will be entered in the appropriate fields in the system. The cost of room and board, as well as, the spousal support amount, health insurance premium amount, bank service charges for the income trust account, and other deductions, if applicable, will be entered as Protected Maintenance. The personal allowance will be shown in the PA field.

C-256 Approvals for Medicaid Recipients Who Leave LTC or ARChoices Waiver

MS Manual 01/01/16

If the county receives notice that the Nursing Facility or ARChoices Waiver recipient has elected to enter an ALF, the LTSS Eligibility Specialist will send a DHS-3330 to notify the DAAS RN of the election to transition. The DAAS RN will complete a new assessment in order to determine the individual's tier level. The ALF Waiver case can be approved once the ALF waiver begin date is received from the DAAS RN and a new DHS-704 is received.

To certify the ALF Waiver case, close the LTC vendor payment or Waiver portion of the case, but do NOT close Medicaid. Two days after the LTC vendor, ARChoices portion of the case is closed; the ALF Waiver portion of the case may be opened. The vendor effective date is the day after leaving the nursing home or ARChoices case closure.

When opening a case in which the Intermediate Level of Care was entered on the LTC vendor portion of the system less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility with a Level of Care Review Date 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC or Waiver case, use that Level of Care Review Date when opening the ALF case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility. Caseworkers should review the records of recipients who leave LTC facilities or other Waiver programs for the ALF Waiver program. If it is time for the annual reevaluation, the reevaluation should be done prior to ALF certification.

NOTE: If a LTC case was closed then reopened for ALF services and a retroactive adjustment must be made to the LTC case, send a memorandum to the **Office of Long Term Care, MMIS Unit, Slot S406, P.O. Box 1437, Little Rock, 72203**. The memorandum must include the name, case number, month(s) of retroactive changes(s), and the new net income amount(s).

As the providers are different for each Waiver program, the caseworker must notify the DHS RN any time that a Waiver recipient changes from one Waiver program to another, or when the case is closed or transferred.

C-260 PACE Application Process

MS Manual 06/01/16

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. The final determination of eligibility will be communicated to the PACE provider by the DHS RN.

When the initial application is made at the local DHS county office, the caseworker will begin the application process.

The caseworker will determine if the applicant resides in the service area approved for the PACE organization to which the applicant is seeking enrollment. See MS Appendix K. Application for PACE will be made on the DCO-777, LTC Application for Assistance. A DCO-727, Disposal of Assets Disclosure, must be completed for individuals entering a LTC facility. The DCO-710 and DCO-713 will be completed for individuals with ineligible spouses. The DCO-712 will be used only when the individual enters a nursing facility or when an Income Trust is established.

After verifying the applicant resides in the PACE service area, the caseworker will send a DHS-3330, Alternative Community Services Waiver Communications Form, to the DHS RN to request completion of a medical assessment. Because PACE eligibility may not begin until the medical assessment has been completed, it is very important to make the referral to the DHS RN as quickly as possible. Unless there are extenuating circumstances that cannot be avoided, the county office will send the DHS-3330 referring the applicant for medical assessment to the DHS RN within 2 days of registering the PACE application.

NOTE: A new application is not required when a PACE recipient moves from one PACE service area to another. As long as the PACE recipient signs an enrollment agreement with the new PACE provider before the first of the following month and there is not lapse in coverage, making the address change in the system is all that is required.

The financial eligibility process will continue and may be made before or after the medical determination.

If the prospective PACE recipient makes the initial inquiry with the PACE provider, the provider will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

If the initial inquiry for PACE is made with the DHS RN, the RN will instruct the recipient to make application at the local DHS county office for determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for medical assessment.

The DHS RN will complete the in-home medical assessment of the applicant after receiving the DHS-3330. The DHS RN will also verify that the applicant resides in the service area approved for the PACE organization. The DHS RN will then submit the DHS-3330 to the county office indicating that the assessment has been completed.

The DHS RN will submit the DHS-703 to the Office of Long Term Care (OLTC). OLTC will send a DHS-704, Decision for Nursing Home/PACE Placement, to DAAS if all necessary information is available. DAAS will then send a copy of the DHS-704 to the DHS RN and the county office.

The DCO caseworker will make the final decision to approve or deny the application when the financial eligibility determination is made.

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

MS Manual 01/01/16

When a DHS RN receives a referral on a nursing facility resident or an active ARChoices or Assisted Living Waiver participant who elects the PACE program:

1. The DHS RN will contact the individual to proceed with the assessment process.
2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care within the preceding 6 months. The necessity of completing a new assessment will be left to the professional judgment of the DHS RN based on the medical condition and circumstances of the applicant.
3. If 6 months or more have elapsed since the last determination of Level of Care or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to Utilization Review.

C-262 PACE Application Approval

MS Manual 01/01/14

If the application is approved, the caseworker will notify the applicant by system notice. The caseworker will notify the DHS RN on the DHS-3330 of the PACE eligibility date. 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. The county worker will establish the PACE eligibility date based on the information provided to them by the DHS RN via the DHS-3330. The DHS-3330 must include the date the medical assessment was completed or the county worker will not be able to process the approval. The PACE eligibility date will be established and keyed as the first day of the calendar month following the date of the medical assessment, as indicated on the DHS-3330 from the DHS RN. Once the approval is keyed, the county worker will notify the DHS RN via a DHS-3330, giving the effective date of approval and the Medicaid ID number. The participant will not receive a Medicaid card as benefits will be received through the PACE provider. A PACE applicant may complete an enrollment application prior to the final medical and financial eligibility determination. However, the capitation payments will only be paid if the enrollee is found to be medically and financially eligible for PACE. An ineligible applicant will be responsible for paying any charges for PACE services he or she has received.

A capitated monthly payment will be generated to the PACE organization based on data received from the ANSWER system that indicates the number of individuals having the PACE aid category. There are four different payment rates based on rate category:

1. Pre-65 Medicaid Only-Individuals under age 65 having Medicaid only
2. Pre-65 Dual Eligible-Individuals under age 65 having both Medicare and Medicaid
3. Post-65-Individuals over age 65
4. QMB Only-Individuals eligible for QMB but not currently eligible for PACE Medicaid

The caseworker will key the PACE approval to the ANSWER system. PACE providers will have service areas based on the client's Zip Code. ANSWER will assign the PACE provider to the eligible recipient. The PACE provider information will include a start date, stop date, provider number add date and last change date. The caseworker as well as the DHS RN will assess each individual and determine whether the individual's place of residence and zip code fall within the service area of the PACE organization prior to eligibility determination and keying to ANSWER.

Refer to MS C-263 for procedures for approving Waiver recipients to PACE and PACE participants to a Waiver group.

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

MS Manual 01/01/16

When the caseworker determines that a Waiver recipient was found to be medically and financially eligible for PACE, the Waiver case cannot be closed in ANSWER until the day before the PACE eligibility started as the participant's enrollment in the PACE program is effective on the first day of the calendar month (MS C-262). When a PACE participant applies for a Waiver category, the approval for the Waiver category cannot be submitted until two days after the closure.

EXAMPLE 1: Jane Hathaway is an ARChoices recipient who applied for PACE on 5/29. The DHS RN completed the DHS-3330 providing the PACE eligibility date as 6/15. The caseworker determined Ms. Hathaway to be medically and financially eligible for ARChoices. The caseworker closes the ARChoices case effective 6/30 as PACE eligibility cannot begin until 7/01. Approval for PACE cannot be submitted in ANSWER until two days after the closure of the ARChoices case in order to prevent billing errors.

EXAMPLE 2: Jack Jones is a dissatisfied PACE participant and wishes to disenroll from PACE. He applied for ARChoices on 6/15. The caseworker established that Mr. Jones is medically and financially eligible for ARChoices on 7/3. The caseworker submits in ANSWER closure of the PACE case on 7/3. The effective date to begin his ARChoices will be 7/4 in order for Mr. Jones not to lose any Medicaid coverage. However, approval for ARChoices must be submitted in ANSWER two days after the PACE closure to prevent billing errors.

C-264 PACE Enrollment

MS Manual 01/01/14

Participant enrollment into the PACE Program is voluntary. The Division of Aging and Adult Services (DAAS) 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 01/01/14

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.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Division of Aging and Adult Services with the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS-RN will review the request and corresponding documentation and will make a recommendation to the DHS-RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS-RN Supervisor, in consultation with PACE Program Management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS-RN.

The PACE Organization may appeal an adverse decision to the DAAS.

C-266 PACE Provider Post-Enrollment Assessments

MS Manual 01/01/14

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 Liaison.

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 DDS Waiver Application Process

MS Manual 01/13/15

The DDS worker will obtain a completed DCO-777 from each applicant or the parent/guardian/representative of the applicant UNLESS the applicant is a current Medicaid recipient residing in an ICF/IID and Nursing Home facility OR opened in a TEFRA case. Please refer to Appendix I for the required forms to be completed during the application process.

For current Medicaid recipients, who are residing in ICF/IID and Nursing Home facilities, refer to procedures in MS C-273.

When a TEFRA recipient completes ACS-102, Freedom of Choice form, requesting DDS waiver services, an additional application is not required as eligibility for Medicaid has been established. Please refer to Appendix I for the required application forms. For further guidance on approving the DDS waiver and closing the TEFRA case, refer to (MS C-272).

For other Medicaid categories (e.g. ARKids, etc.) form DCO-777 will be completed along with all the required forms necessary to process the application for DDS Waiver services.

Upon receipt of completed applications, the DDS Waiver Application Unit (WAU) will register in the appropriate category and determine eligibility.

EXCEPTION: Applications by SSI recipients need not be registered.

A DDS Medicaid Eligibility worker will have 45 days in which to process an application, or 90 days if a disability determination is needed. It will be the responsibility of the DDS Medicaid Eligibility worker to verify and document each eligibility requirement.

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

NOTE: If a Waiver applicant (or recipient) requests an Administrative Hearing at any time, the DDS Medicaid Eligibility worker will be responsible for preparing the Medicaid file, the county statement and will attend the hearing. MS L-100-173).

C-271 Approving the Application

MS Manual 01/13/15

When submitting approval for the Waiver Program the caseworker will register the application in ANSWER. If there is an existing case, the caseworker will be required to use the closed budget.

When the Budget Unit characteristic of Waiver-Nursing Home is selected, the ANSWER interface screen will display the number “2999” in the WVNO field to identify clients who have been moved from an ICF/IID facility to enter the Waiver Program. **The ICF/IID case must be closed before the Waiver case is opened, (ICF/IID case must be closed and allowed to edit over 72 hours before the Waiver case is opened). Waiver certification cannot be made on the same day of the ICF/IID closure.**

When the Budget Unit characteristic of Waiver-Community on the WAIV ANSWER interface screen shows the number “2900” on WVNO field, this identifies the client who has been living in the community prior to acceptance in the Waiver Program.

On the WAIV ANSWER interface screen the DDS Waiver recipient’s total gross income will be displayed.

If an applicant is currently open in a Medically Needy case all eligibility factors - including disability, if not previously established - will be determined prior to Waiver certification. The Medically Needy case will be closed or the individual dropped from the case prior to approval for the Waiver services.

If an individual found eligible for the Waiver program is currently certified in a Medically Needy Spend Down case, a Waiver certification will not be made until the Spend Down case has expired.

An open TEFRA child found eligible for the Waiver program will be certified in the appropriate category after closure of the TEFRA case.

C-272 DDS Waiver Applicants Currently Residing in ICF/IID Facilities

MS Manual 01/13/15

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. The approval request from DDS Waiver Unit is included in the file. The Waiver Services and Medicaid Income Eligibility files are separate.

If an eligibility determination is made before an applicant is discharged from the ICF/IID facility, the Waiver case cannot be opened before the individual leaves the facility.

For Medicaid eligible DDS Waiver applicants currently residing in ICF/MR Facilities, the following actions must be completed:

1. Upon notification that an individual in an ICF/IID facility is requesting DDS Waiver services, DDS staff (Intake Unit or HDC Admission Coordinator), will meet with the individual's guardian/legal representative and complete ACS-102, Freedom of Choice form. Along with the ACS-102, the DDS Staff will gather the following documentation to complete the Waiver packet:
    a. DHS-400-Release of information
    b. Current intellectual and adaptive assessments with scoring, written report and credentialed signature within Waiver prescribed timeframes
    c. DHS-703-Physician's diagnosis (current within 1 year)
    d. Completed Areas of Need form
    e. Current Social History

2. If the individual and/or his guardian are ready to select a provider, a provider choice form will be completed. DDS staff will also obtain a copy of the DHS-704 (Eligibility) form from the individual's file at the facility.
3. If the individual has not chosen a provider, the Waiver Unit Program Manager will assign a DDS Waiver Specialist to meet with the individual and/or his guardian to provide assistance in choosing a provider from the available choices.
4. Form ACS-102 and the DHS-704 will be submitted by the DDS staff to the DDS Waiver Application Unit (WAU) along with notification of the request for waiver services for further processing and distribution.
5. The WAU will send the ACS-102 and DHS-704 to the DDS Medicaid Income Eligibility Unit (MIEU) for Waiver eligibility determination.
6. Once a determination of eligibility has been made, the DDS MIEU will email form DCO-3330 to the WAU advising eligibility status under the waiver category.
7. Once a choice of provider has been selected, plan of care submitted and approved, and discharge date (determined by the ICF staff in cooperation with the receiving waiver provider) scheduled, the Waiver Application Unit will submit a copy of the DHS-702 to the DDS MIEU requesting the Medicaid case to be approved in waiver category upon date of discharge.
8. The Medicaid Income Eligibility Unit will forward a copy of the DHS-702 in email to the DCO Medicaid caseworker of the applicant (copying County Supervisor and County Administrator) and request he/she close the applicant on the WNHU interface screen.
9. Allow up to 72 hours edit; open on the WAIV interface screen, submit the DHS-3330 to the Waiver Application Unit verifying waiver approval and start date as well as send a DHS-700 or system generated approval notice to the individual or guardian/legal representative advising of approval.

For individuals in a nursing facility, the following procedures will be followed:

1. The DDS Intake Specialist and/or Admission Coordinator will notify and submit the waiver packet to the DDS WAU.
2. The individuals discharging from a nursing facility, the DDS Psychological Examiners will review current and past (if applicable) psychological evaluations to establish the ICF/IID level of care requirement is met.
3. The Psychological Examiner will complete the DHS-704 on eligible/ineligible individuals and submit to WAU.

4. Once the ICF/IID Level of Care has been determined, the WAU will then disperse ACS-102 and DHS-704 to the MIEU for eligibility determination.
5. WAU will submit DHS-702 verifying discharge date and request approval in DDS Waiver group.

If an eligibility determination is made before an applicant is discharged from the ICF/MR facility, the Waiver case cannot be opened before the individual leaves the facility. The 45 (or 90) day time frame for processing applications must be followed.

To certify the DDS waiver case, close the LTC vendor portion of the case, but do NOT close Medicaid. **72 hours after closure of the vendor portion of the case, the Waiver portion of the case may be opened.**

When the client has left the facility, DCO caseworker will close the ICF/MR case in ANSWER with a Nursing Home STOP DATE effective the date the individual left the facility. A MED END date should not be entered in ANSWER. After 72 hours if an individual who left an ICF/MR facility is to live in a community setting, the DDS worker will key the Waiver certification in ANSWER. The WAIVER START DATE cannot overlap, so it will be the day after the client left the ICF/MR facility. The address will be changed in ANSWER. It is not necessary to rekey or change the MED BEGIN DATE; the original date shown on the screen will remain.

C-280 SSA Referral Processes for Specific AABD Groups

MS Manual 01/13/15

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 potentally 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 01/13/15

The following procedures will be completed to insure that closed SSI recipients will continue to receive Medicaid.

Central Office Procedure:

Converted Cases

From a special lead file provided by the Social Security Administration, Baltimore, the Central Office will identify individuals losing SSI eligibility due to COLA increases. These individuals will be converted to the AABD No-grant category at the end of each calendar year, with a reevaluation due the following year in January.

At the time Central Office converts the individuals entitled to No-grant categories, they will produce a listing of the converted individuals by county entitled "SSI COLA Cases Converted to No-Grant Categories". This report will run in December of each year and will be located in Web Reports in the Share Site. The County Office will take appropriate steps if needed.

County Office Responsibilities

Converted Cases

Upon receipt of the county listing of individuals converted to AABD No-grant due to loss of their SSI eligibility, the county office will review each individual on the list which identifies them by name, category, case number, and by the indicator (COLA 20--, enter year converted) to identify their status as a former SSI case converted to AABD No-grant under provisions of the Pickle Amendment.

Each January the county office will mail form DCO-111, Notice of Conversion, to all individuals on the most recent "SSI COLA Cases Converted ..." listing to advise them of their current Medicaid eligibility status.

During the three-month period, January through March each year, the county office will conduct renewals on all converted No-grant cases on the county listing. The purpose of these reviews will be to build an electronic case record, to establish a new renewal date and to determine whether any individuals have been converted to AABD No-grant in error.

C-282 Identification of Stragglers

MS Manual 01/13/15

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.

As these individuals are identified to the Central Office, a listing will be on the NAS box/DCO Web Reports.

Upon receipt of the listing from the Report, the County Office will contact the identified individuals, advise them of their potential Medicaid eligibility, and arrange for an application interview. Application will be taken on Form DCO-95, and registered in ANSWER in the appropriate AABD budget unit on the Budget Unit Tab.

C-283 Disabled Adult Children (DAC)

MS Manual 01/13/15

The Social Security Administration will notify the Agency of DAC cases through SDX, and County Offices will receive printouts entitled "SSI Recipients Terminated Due to DAC Increases" through system generation. Within 5 working days from receipt of the printouts, the County Office will notify the listed individuals that application will be needed to determine continuing benefits. Application will be made on DCO-95 and registered in the appropriate category.

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

MS Manual 01/13/15

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 DCO-95 and registered in the appropriate category.

C-285 Individuals Who Have Remarried

MS Manual 01/01/14

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), DAC and Widows/Widowers Referral Letter

MS Manual 01/01/14

SSA 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. The referral letter contains the pertinent demographic and Medicaid benefit group information. The Medicaid Eligibility Unit then routes the referral letter to the DHS County Office of residence of the claimant and a caseworker will determine eligibility in the appropriate category.

C-300 Application Forms

MS Manual 01/13/15

Since many of the eligibility groups have specific application forms as well as other required forms necessary to determine eligibility, an application form table has been developed to show what forms are used for each eligibility group. Please refer to MS Appendix I.

D-100 General Eligibility Requirements

MS Manual 01/30/15

All Medicaid applicants must meet the general eligibility requirements listed below:

- Citizenship/Alienage,
- Arkansas State residency,
- SSN enumeration, and
- Assignment of medical rights.

Each requirement is explained in the following sections.

Refer to the Eligibility Chart in Appendix J for a general overview of the eligibility requirements for each Medicaid group.

D-110 Failure to Apply for Benefits

MS Manual 01/30/15

Federal regulations require that, as a condition of eligibility, an individual must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which the individual is entitled. If an individual fails to access any benefits to which he is entitled, he will not be eligible for Medicaid. Refer to MS H-321.

D-200 General Citizenship and Alien Status Requirements

MS Manual 01/01/14

Medicaid coverage will only be provided to those individuals verified to be citizens or nationals of the United States or an alien in satisfactory immigration status.

D-201 Declaration of Citizenship or Satisfactory Alien Status

MS Manual 01/30/15

The Immigration Reform and Control Act of 1986 (IRCA) requires that all Medicaid applicants and recipients must declare in writing under penalty of perjury that they are citizens or nationals of the United States, or that they are an alien in satisfactory immigration status.

For individuals declaring to be U.S. citizens or nationals, the declaration will be made at the time of application. If the application was made via an application form, then the application form itself will serve as the declaration of citizenship.

For applicants declaring to be aliens in satisfactory status, form DCO-9, Declaration of Citizenship or Satisfactory Immigration Status, must be completed regardless of the application form used. If the applicant is unable to sign, the authorized representative's declaration on the application form will be accepted as the declaration of citizenship.

In LTC cases where the recipient or legal guardian has completed an application form, no further action for this requirement is necessary. In instances where an authorized representative other than a legal guardian has signed the application, the applicant should sign the DCO-9, unless he or she is physically or mentally incompetent to do so. If the applicant is unable to sign, the authorized representative's declaration on the application form will be accepted as the declaration of citizenship.

Once an adult has provided the declaration of citizenship or satisfactory immigration status for himself, herself or others, a declaration will not be required again unless the individual loses eligibility. If the individual later applies, a new declaration of citizenship or satisfactory immigration status will be obtained.

D-210 Citizenship

MS Manual 01/01/18 48 U.S.C. 1806e

Consider any person born in the United States to be a citizen. People born abroad are considered U.S. citizens when at least one of the parents is a U.S. citizen. Also, consider a

person who is a U.S. national the same as a U.S. citizen. A U.S. national is a person who is born in one of the U.S. territories. The U.S. territories include:

- Puerto Rico
- Guam
- The Virgin Islands
- The Northern Mariana Islands
- American Samoa
- The Swains Island

People who are not citizens or nationals can become citizens through the process of naturalization.

NOTE: Citizens of the Marshal Islands including Palau and Micronesia are under a Compact of Free Association with the United States. They are free to travel to and from the U.S. without a visa. They are not U.S. citizens, nor are they under an alien status. Marshall Island pregnant women and children who are lawfully residing in the United States may be approved for Medicaid if they meet all other eligibility criteria for the category being applied for (MS D-224). However, other Marshall Island individuals are not eligible for Medicaid except for Emergency Medicaid Services (MS B-500).

Citizenship must be verified for all Medicaid applicants declaring to be U.S. citizens or nationals. Refer to MS G-130 for verification requirement.

D-211 Citizenship of Children Born Outside of the U.S.

MS Manual 01/01/18

A child born abroad to at least one parent who is a U.S. citizen automatically becomes a U.S. citizen at birth if the parent(s) reports the birth to an American Consular Office and registers for a Consular Report of Birth (FS-240). An original FS-240 is furnished to the parent(s) at the time the registration is approved.

The Child Citizenship Act of 2000 allows the automatic acquisition of U.S. citizenship for both biological and adopted children of U.S. citizens who are born abroad and who do not acquire U.S. citizenship at birth. Under this act, a child born outside of the United States automatically becomes a citizen when the following conditions are met:

- At least one parent is a U.S. citizen whether by birth or naturalization.

- The child is under the age of 18.
- The child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent after having been lawfully admitted into this country as an immigrant for lawful permanent residence.
- If the child has been adopted, the adoption must be final.

If a child's citizenship is questionable, the following documents can be used if needed to verify that the child has acquired U.S. citizenship:

- Certificate of Citizenship (N-560 or N-561).
- Certificate of Naturalization (N-550 or N-570).

If proof of citizenship is needed but documentation is not available, refer the person to the United States Department of Homeland Security (USDHS) for a determination of U.S. citizenship.

D-220 Alien Status

MS Manual 01/01/18 431 of PRWORA

This section contains policy relating to eligibility requirements for individuals who are aliens or immigrants. The immigration status of aliens who appear to be eligible for Medicaid must be verified. If the applicant claims alien status, he or she must provide documentation from the USDHS verifying their status. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P. L. 104-193, enacted August 22, 1996, changed Medicaid eligibility for individuals who are not citizens of the United States. This act divides immigrants into two basic categories:

- "Qualified Aliens" - those legally living in the United States and meeting one of the conditions at MS D-223 or MS D-224.
- "Nonqualified Aliens" - those living in the United States without meeting legal conditions or those admitted legally but not meeting one of the conditions at MS D-223 or MS D-224.

Medicaid eligibility for aliens is determined by whether the alien is qualified or nonqualified and whether the individual meets the other eligibility requirements for Medicaid. In addition to alien status, the individual must meet all eligibility factors for the category for which he/she is applying. Applicants must provide documentation of qualified alien status for each person for

whom Medicaid is being requested. Refer to MS G-140 for alien verification requirements. If an alien has a sponsor, the sponsor's income and resources may be deemed available to the alien when determining eligibility (MS E-300).

Qualified aliens who entered the United States before August 22, 1996 are generally eligible for Medicaid, provided they meet other eligibility criteria.

Qualified aliens who entered the United States on or after August 22, 1996, are barred from participation in Medicaid (with the exception of emergency services) for five years from the date of entry. After these individuals have been in the U.S. for five years, their sponsors' income may then be deemed available to them for determining income eligibility for Medicaid with some exceptions. Refer to MS E-300 and MS E-445. Certain groups of qualified aliens are exempt from this five-year bar. Refer to MS D-223 – MS D-224 for conditions of exemption.

Nonqualified aliens who meet the other Medicaid eligibility requirements are eligible for emergency Medicaid services only. Refer to MS B-500. A nonqualified (undocumented) alien woman who is pregnant may be eligible for Pregnant Woman Unborn Child (MS B-250).

D-221 Alien Categories

MS Manual 01/01/18

Any person who is not a citizen or national of the United States is termed an alien. Definitions for some of the different types of aliens are found below:

- **Non-immigrant** - an alien who seeks temporary entry to the U.S. for a specific purpose.
- **Asylee** - an alien living in the U.S. who is unable or unwilling to return to his/her country of origin, or the last place they lived, or unwilling or unable to seek protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear of persecution may be based on the alien's race, religion, nationality, social status, or political opinion.
- **Refugee** - an alien living outside his/her country of nationality who is admitted into the U.S. because the individual is unable or unwilling to return to that country (or to the place they last lived) because of fear of persecution. Fear of persecution may be based on the individual's race, religion, nationality, social status or political opinion.
- **Qualified Alien** - an alien lawfully admitted and lawfully accorded the privilege of residing permanently in the United States. Qualified aliens are ineligible for medical benefits, except emergency medical assistance, for five years from the date of entry to

the U.S., unless they are exempt from the five-year bar. Alien groups exempt from the five-year bar are discussed at MS D-224.

- **Non-qualified Alien** - an alien who is living in the U.S. as an illegal alien or a legal alien who does not meet one of the conditions at MS D-223 or MS D-224. Conditions of eligibility for emergency medical services for non-qualified aliens are discussed at MS B-500. For additional information regarding Non-Qualified Aliens see (MS D-230).

D-222 Public Charge

MS Manual 01/01/18

"Public Charge" has been a part of U.S. immigration law for more than 100 years as grounds for inadmissibility and deportation. Identification by the United States Department of Homeland Security (USDHS) as a public charge can be grounds for denying admission into the United States, for denying an application for permanent resident status, and in rare cases for deportation.

In 1999, the Justice Department issued regulations to clarify that receipt of most forms of Medicaid would not result in a public charge finding. To be considered a public charge by the USDHS, an alien must:

- Have become or be likely to become primarily dependent on the government for survival through receipt of public cash assistance, or
- Be institutionalized at government expense in a long-term care facility.

Institutionalization in a long-term care facility includes residing in a nursing home or mental health institution. Short-term institutionalization for rehabilitation is not considered as public charge.

The receipt of cash assistance or being institutionalized for long-term care does not automatically cause the individual to be considered a public charge. The USDHS also considers a number of other factors, such as the individual's age, health, financial status, education, and skills. Each determination is made on a case by case basis.

D-223 Aliens Subject to Five-Year Bar

MS Manual 01/01/18 431 of PRWORA

Individuals shown below, who entered the U.S. on or after August 22, 1996, are barred from receiving Medicaid except emergency services for five years. The five-year period begins on the date the individual entered the U.S. with one of the following statuses:

- Aliens **lawfully admitted for permanent residency.**
- Aliens **paroled** into the U.S as Central American Minors for a period of at least two years.
- Aliens **paroled** into the U.S. under section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of at least one year.
- Aliens granted **conditional entry** under section 230(a)(7) of the INA as in effect before April 1, 1980.
- **Battered** aliens under 8 USC 1641(c). For the alien and children to emigrate or remain in the United States, the alien's spouse must file a petition for lawful permanent residence status via USDHS Form I-130, Petition for Alien Relative. Unless the spouse files this petition, the alien and children have no lawful immigrant status and face being deported. Since the 1994 enactment of the Violence Against Women Act, a battered alien may self-petition for lawful permanent residency via USDHS Form I-360, Petition for Amerasian, Widow(er) or Special Immigrant, without the cooperation or knowledge of the abuser.

  The battered alien may be eligible for Medicaid if he/she entered the U.S. before August 22, 1996. If the date of entry is on or after August 22, 1996, the battered alien, spouse or child is subject to the five-year bar, except for emergency medical treatment .

  NOTE: Pregnant Women and children who are legally residing in the United States, may be eligible without meeting the five year bar if they meet one of the conditions listed at MS D-224.

  Due to the abusive relationship, battered aliens may not have access to the needed USDHS documents. Applicants without documentation should be referred to the USDHS Forms Request Line, **1-800-870-3676**.

D-224 Aliens Exempt from Five-Year Bar

MS Manual 01/01/18 431 of PRWORA

Aliens with the following statuses are potentially eligible for Medicaid from the date the status is obtained:

- **Refugees** admitted under section 207 of the Immigration and Nationality Act (INA).
- **Iraqi and Afghan Special Immigrants** admitted as lawfully permanent residents but treated as refugees.
- Aliens granted **asylum** under section 208 of the INA.
- Aliens whose **deportation or removal is withheld** under section 243(h) or section 241(b)(3) of the INA.
- **Cuban** or **Haitian** entrants under section 501(e) of the Refugee Education Assistance Act of 1980.
- **Cuban** or **Haitian** entrants in the Haitian Family Reunification Program.
- **Amerasian** immigrants.
- **Canadian born American Indians** who have treaty rights to cross the U.S. borders with Canada and Mexico.
- Aliens lawfully living in the United States on 8/22/96 who were receiving AABD Medicaid at that time may continue to receive Medicaid benefits. This applies only to AABD categories.
- Aliens lawfully living in the United States on 8/22/96 who subsequently become blind or disabled may receive Medicaid benefits in the future.
- Aliens lawfully admitted for permanent residence who are **veterans** honorably discharged for reasons other than alienage, and their spouses, surviving un-remarried spouses, and unmarried dependent children. This includes alien spouses, surviving un-remarried spouses, and unmarried dependent children of veterans who are U.S. citizens or deceased veterans.
- Aliens lawfully admitted for permanent residence who are **active-duty personnel of the United States Armed Forces** and their spouses, surviving un-remarried spouses, and

unmarried dependent children. This includes alien spouses, surviving un-remarried spouses, and unmarried dependent children of active duty personnel who are U.S. citizens or deceased active duty personnel. Active duty excludes temporary full-time duty for training purposes performed by members of the National Guard or Reserves.

- Pregnant Women and Children who are lawfully present. This includes but is not limited to pregnant women and children in the following statuses:

    1) A qualified alien as defined in 8 U.S.C. 1641 (b) and (c)

    2) An alien in a valid non-immigration status, as defined in 8 U.S.C. 1101 (a)(15) or otherwise under the immigration laws as defined in 8 U.S.C. 1101 (a) (17);

    3) An alien who has been paroled into the United States in accordance with 8 U.S.C. 1182 (d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

    4) An alien who belongs to one of the following classes:

        - Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
        - Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending application for TPS who have been granted employment authorization;
        - Granted employment authorization under 8 CFR 274a. 12c;
        - Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
        - Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
        - Granted Deferred Action status;
        - Granted an administrative stay of removal under 8 C.F.R.241;
        - Beneficiary of approved visa petition who has a pending application for adjustment of status;

5) An alien with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:
   - Has been granted employment authorization; or
   - Is under the age of 14 and has had an application pending for at least 180 days;
6) An alien who has been granted withholding of removal under the Convention Against Torture;
7) A child who has a pending application for Special Immigration Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8) Is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. 1806(e); or
9) Is lawfully present in American Samoa under the immigration laws of American Samoa.

EXCEPTION: An alien with deferred action under the USDHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered lawfully present with respect to any of the above categories.

NOTE: Documentation that is required to verify lawfully residing status is found at Appendix C.

D-226 Victims of Trafficking

MS Manual 01/01/14

Public Law 104-193 states that aliens who are certified as victims of trafficking by the Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) are eligible aliens for Medicaid purposes. Eligibility for victims of trafficking is determined in the same manner as Medicaid for refugees.

Trafficking is defined as all acts involved in the movement of human beings, usually women and children, from one country to another or within national borders for sexual exploitation or forced labor.

Adults who are certified as victims of trafficking receive an ORR certification letter. Children who are victims of trafficking receive an eligibility letter or an interim assistance letter. An interim assistance letter is given to a child who may have been subjected to trafficking to allow the child to be eligible to receive benefits and services for a 90-day period. Certification letters no longer contain an expiration date. A victim of trafficking is eligible to apply for Medicaid starting with the date of certification by ORR. If eligible, Medicaid coverage will be valid for one eight month period. If Medicaid coverage is needed beyond the initial eight months, the initial certification letter will be used to establish continued eligibility.

Follow the usual procedures for determining eligibility for refugees except:

- Accept the original ORR certification letter for adults or the eligibility or interim assistance letter for children under 18 in place of INS documentation.
- Contact the trafficking verification line at **202-401-5510** to confirm the validity of certification letters for adults and **202-205-4582** to confirm the validity of eligibility or interim assistance letters for children and to notify ORR of the assistance for which the individual has applied.

NOTE: Do not contact SAVE concerning victims of trafficking.

If the worker suspects that an applicant may be a victim of trafficking but does not have the required certification or eligibility letter, the worker will contact ORR at the above telephone numbers for verification of a certified letter.

D-230 Non-Citizens Eligible for Emergency Services

MS Manual 01/01/18 435.956(c)(2)

The USDHS issues non-immigrant visas to people who indicate that they are seeking entry for a temporary purpose. These non-immigrants are eligible for emergency services if they meet all other requirements including State residency. The following groups of people may be eligible in this category:

- Foreign government representatives on official business and their families and servants.
- Visitors for business or pleasure, including exchange visitors.
- Aliens traveling through the U.S.
- Crew members on shore leave.
- Treaty traders and investors and their families.

- Foreign students and their families who are here as dependents and are not otherwise eligible.
- International organization representatives and personnel and their families and servants.
- Temporary workers including agricultural contract workers.
- Members of foreign press, radio, film or other information media and their families.

NOTE: This is not an all-inclusive list.

D-300 State Residency

MS Manual 01/01/14

Residency regulations are intended to assure uniform application of residency rules and to assure that no otherwise eligible individual is denied Medicaid because no State recognizes him as a resident.

D-310 State Residency Determinations

MS Manual 01/30/15

State residency determinations are as follows:

1. An individual placed in an out-of-state institution is a resident of the State making arrangement for placement regardless of the individual's indicated intent or ability to indicate intent;

2. An individual receiving State Supplementation of SSI is a resident of the State making said payments;

3. A non-institutionalized individual age 21 or over is a resident of the State where he is living, and

    a. Intends to remain permanently or for an indefinite period of time, or
    b. which he entered with a job commitment or seeking employment.

EXCEPTION: An individual aged 18-22 and a full-time student at an Arkansas school, is not a resident of Arkansas if:

a) Neither parent lives in Arkansas,
b) The student is claimed as a tax dependent by someone in a state other than Arkansas, and
c) The student is applying on his or her own behalf.

4. An institutionalized individual who became incapable of indicating intent at or after age 21 is a resident of the State where the institution is located, unless another state arranged placement in the institution.

5. An institutionalized individual who became incapable of indicating intent before age 21 is a resident of the State of:
    i. His parents or legal guardian, if one has been appointed, at the time of placement; or
    ii. The parent applying on his behalf, if the parents reside in separate States and a legal guardian has not been appointed;

6. For any other institutionalized individual not covered by step #4 or #5 above, the individual is a resident where he/she is living and intends to reside.

   When more than one State could be an individual's residence, and you cannot determine the jurisdiction of residence based on the above rules, the residence is where the individual is physically located at present.

NOTE: For purposes of State residency – an institution is a Title XIX Long Term Care Facility and an individual is considered to be incapable of indicating intent to reside in the State if:

1. He has an IQ of 49 or less or a mental age of seven (7) or less, based on tests acceptable to the State's Division of Developmental Disabilities Services (DDS); or
2. He is judged legally incompetent; or
3. Medical or other documentation acceptable to the State supports a finding of incapability of indicating intent.

D-320 Prohibited State Residency Determination

MS Manual 01/01/14

Determinations specifically prohibited for State Residency are as follows:

1. An individual will not be denied Medicaid because he has not resided in the State for a specific period;

2. An institutionalized individual, who satisfies the residency rules set forth in this policy, will not be denied Medicaid because he did not establish residence in the State before entering the institution; and

3. An individual will not be denied Medicaid or have his Medicaid terminated because of temporary absence from the State if he intends to return when the purpose of the

absence has been accomplished, unless another State has determined that he is a resident there for purposes of Medicaid.

D-330 Interstate Agreements

MS Manual 01/01/14

Medicaid regulations provide for written agreements between States to resolve cases of disputed residency. These agreements may specify criteria for residency other than the aforementioned determinations provided:

1. They do not stipulate criteria which result in loss of residency in both States or criteria which are prohibited by regulation, and
2. They stipulate procedures for providing Medicaid to individuals whose cases are involved in disputed residency.

As the State of Arkansas enters into written agreement with other States to resolve cases of disputed residency, the County Office will be notified. The notification will identify the State(s) and the criteria of the agreement(s).

The County Office will contact the Medicaid Eligibility Unit when either of the following situations occurs:

1. A State, that has not entered into a written agreement with the State of Arkansas, contacts the County Office regarding Arkansas residents receiving care out-of-state, or
2. The County Office has cases involving possible out-of-state residency.

D-340 Medicaid for the Homeless

MS Manual 01/01/14

Public Law 99-509, the Omnibus Reconciliation Act of 1986, prohibits a State from denying any individual Medicaid benefits who does not have a fixed or permanent address, but who resides in the state and is otherwise eligible. If the applicant is considered an Arkansas resident and meets the other requirements for eligibility, the case may be approved using the address of choice for the applicant.

D-350 Juveniles in the Custody of Division of Youth Services (DYS)

MS Manual 04/29/2016

Juveniles committed to the custody of the Division of Youth Services may be detained in secure facilities or be placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care.

When juveniles in the custody of the Division of Youth Services are placed in juvenile detention centers and other facilities operated primarily for the detention of children who are determined to be delinquent, they are not eligible for a Medicaid payment.

When juveniles in the custody of the Division of Youth Services are placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care, they are eligible for a Medicaid payment.

The Division of Youth Services (DYS) and the Division of County Operations have entered into an inter-agency agreement which permits DYS to process and approve Medicaid eligibility for ARKids A and B for DYS juveniles who have entered treatment facilities or have been released from DYS custody.

D-370 Inmates of Public Institutions

MS Manual 08/01/15

An inmate of a public institution is not eligible for Medicaid payment. See exception at D-372.

Public institution means an institution that is the responsibility of a government unit or over which a governmental unit exercises administrative control.

"Public Institutions" include:

1. Institutions for the mental diseases which are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.

2. Institutions for tuberculosis, which are primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis.

3. Correctional or holding facilities for individuals, who are prisoners, arrested, or detained pending dispositions of charges, or are being held under court order as material witness or juveniles. Correctional facilities include prisons, jails, juvenile detention centers and other facilities operated primarily for the detention of children who are determined to be delinquent. Wilderness camps and boot camps are considered public institutions if a government unit has any degree of administration control.

If an individual in a public institution must be temporarily transferred to a medical treatment or evaluation facility, or if he/she is given temporary furlough, the individual is still considered to be under custody of the penal system and is not eligible for a Medicaid payment. See exception at D-372.

An individual will be considered in a public institution until the indictment against the individual is dismissed, or until he/she is released from custody either as "not guilty" or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.).

"Public institutions" do not include:

1. Inpatient psychiatric facilities for individuals under age 21 (22, if an inpatient on the 21st birthday) and over age 65.

2. Medical institutions which are organized to provide medical, nursing, and convalescent care, which have the professional staff, equipment and facilities to manage the medical, nursing and other health needs of patients in accordance with accepted standards, and which are authorized under State law to provide medical care. Medical institutions include hospitals and nursing facilities.

3. Intermediate care facilities for those individuals with intellectual disabilities which meet the standards under 42 CFR 483.440 (a) for providing active treatment for such individuals or individuals with related conditions.

4. Child-care institutions which are private, non-private, or public that accommodate no more than twenty five (25) children and are licensed by the State or approved by the State agency responsible for licensing or approval of such institutions.

5. Therapeutic Group Homes, Residential Treatment facilities, Emergency Shelters and Therapeutic Foster Homes which meet facility and staffing requirements of the Minimum Licensing Standards for Child Welfare Agencies published by the Child Welfare Agency Review Board.

6. Publically operated community residences that serve no more than 16 residents are facilities that provide some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. They cannot be on the grounds of or immediately adjacent to any large institution or multiple purpose complexes such as educational or vocational training institutions, correctional or holding facilities, or hospitals, nursing facilities or intermediate care facilities for individuals with intellectual disabilities.

D-371 Inmates Being Released from Custody

MS Manual 08/01/15

Individuals in the custody of the Arkansas Department of Correction (ADC), Arkansas Department of Community Correction (ADCC), county jail, city jail, juvenile detention facility or Division of Youth Services (DYS) will be allowed to submit an application for Medicaid up to 45 days prior to the individual's scheduled release date. Applications will be submitted online at www.access.arkansas.gov, or by paper application, DCO-151, Application for Health Coverage Single Adults, which will be submitted to the local DHS county office.

If eligible, Medicaid will not start until the individual is released from custody. The authorized representative from the facility will notify DHS of the actual release date.

D-372 Inmates Being Released for Inpatient Treatment

MS Manual 05/01/18

An individual in the custody of ADC, ADCC, or a local correctional facility who has been admitted and received treatment at an inpatient facility may be eligible for Medicaid payment provided all eligibility requirements are met. Eligibility will be determined in accordance with MS Sections D, E and F. Only the inmate will be included in the Medicaid household. The coverage period will begin on the hospital admission date and end on the hospital discharge date.

NOTE: Inmates may be approved for retroactive coverage 30 days prior to the date of application in the Adult Expansion Group, if eligible. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James applies for medical coverage on September 15. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of August 1. He is not eligible for retroactive coverage on this date because his bill is for August 1 and retroactive coverage can only begin August 16, thirty (30) days prior to the September 15 application date.

EXAMPLE: James applies for medical coverage on September 20. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of September 15. He is eligible for retroactive coverage on September 15, as this date is within the 30 days prior to the application date.

D-373 Suspension of Medicaid Coverage for an Inmate

MS Manual 05/01/18

The appropriate correctional facility will notify DHS when a Medicaid or Adult Expansion Group recipient enters the ADC, ADCC, the county jail, city jail, or a juvenile detention facility. When this notification is received, DHS will place that individual's Medicaid coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When an individual with suspended Medicaid eligibility receives eligible medical treatment off the grounds of the detention facility or is released from custody, the individual's case will be reinstated if the reinstatement date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those individuals receiving eligible treatment while off the correctional facility grounds, Medicaid will be re-instated for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

D-380 Child(ren) Entering Custody of Division of Youth Services (DYS)

MS Manual 04/29/16

The appropriate juvenile detention facility will notify the designated DYS staff when a Medicaid recipient enters the facility. When this notification is received, DYS designated staff will place that child's Medicaid coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When a child with suspended Medicaid eligibility receives eligible medical treatment off the grounds of the juvenile detention facility or is released from custody, the child's case will be reinstated if the reinstatement date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those children receiving eligible treatment while off the correctional facility grounds, Medicaid will be re-instated for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

If the child is in the juvenile detention facility when a redetermination occurs, the case will be closed if it is a single person household. If after the closure, the same individual requires overnight medical treatment off the correctional facility grounds, the juvenile detention center will submit a new application for the individual and once approved, the treatment stay will be approved for a fixed eligibility period and the case will be placed in suspended status for a new 12 month period.

D-381 Child(ren) Released from DYS

MS Manual 04/29/16

Children who leave DYS custody with their case in suspended status will have their coverage reinstated on the date of their release. Upon receipt of the permanent date of discharge, the following procedures will be followed by DYS designated staff.

- If the child is returned to the same home that he or she left prior to entering DYS custody and the Medicaid case is still open with other children, the child's coverage will be reinstated. This case action will be treated as a change and a new application will not be required.
- If the child is returned to the same home that he or she left prior to entering DYS custody and was the only Medicaid eligible child in the home, the case will be reopened. If it is within the renewal period, a new application will not be required.

NOTE: If the child is returned to a different home, an application will be needed to determine eligibility for the child in the new household. The application can be completed on line at www.access.arkansas.gov or the application can be turned in to the local county office.

D-400 Social Security Number Enumeration Requirement

D-400 Social Security Number Enumeration Requirement

MS Manual 01/01/14

To meet the Social Security enumeration requirement, each eligible person must either:

1. Declare a Social Security number or
2. Apply for a Social Security number if one has not been issued or if one has been issued but is not known.

EXCEPTIONS: A social security number is not required for an individual who:

a. Is not eligible to receive a SSN (e.g. Refugee);

b. Does not have a SSN and may only be issued a SSN for a valid non-work reason (e.g. Emergency Medicaid, Pregnant Women (unborn child);

c. Is eligible in the Newborn Infant Category or

d. Refuses to obtain a SSN because of well-established religious objections. Well-established religious objections mean that the individual:

1) Is a member of a recognized religious sect or division of the sect; and

2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

Note: Since most newborns are "enumerated at birth", a pseudo number assigned to the newborn will be updated in the eligibility system when a SSN is received.

1. <u>Individuals who Declare an SSN</u>

To declare an SSN, an individual must state the number. Verification is not required. When an individual declares an SSN, the caseworker will enter the SSN in the eligibility system for verification through the SVES system. (This verification process is described in MS D-200.) The caseworker will not attempt to verify the SSN declared. However, if the household presents documentary evidence such as a social security card, a copy will

D-400 Social Security Number Enumeration Requirement

be scanned into the electronic case record and used, if necessary, to clear any SSN discrepancies.

2. **SSN Application Process (No SSN or SSN Not Known)**

   a. **Aliens and Individuals age 12 or over**

   An alien regardless of age and an individual age 12 or over must apply in person at the local Social Security Administration Office. The caseworker will issue an SS-5, Application for a Social Security Card and a DCO-12, Enumeration Referral, along with the identifying information and pseudo-SSN to the applicant. The caseworker will not forward any evidence to SSA for the applicant unless SSA specifically requests such evidence. A photocopy of the SS-5 and DCO-12 will be retained in the county office until the DCO-12 is returned by SSA showing that a complete SSN application has been received.

   An individual who has been issued a number but does not know it can obtain a replacement SSN card by completing an SS-5 and taking or mailing it to SSA. If the DCO-12 is returned by SSA showing that a complete SSN application has not been received, the caseworker will send a DCO-700 advising the applicant that he must submit a complete SSN application to SSA within 10 days or the Medicaid application will be processed without that person's eligibility being considered.

   b. **Individuals under age 12**

   Form SSA-2853 (Receipt for Enumeration at Birth) will be accepted as proof of application for an SSN if an application for an SSN was made at the hospital when the baby was born. The caseworker will request the applicant provide the SSA-2853, and scan a copy into the electronic case record. The caseworker can accept this form as proof until the first reevaluation for continued eligibility. At that time, if a card has not been received, or a number is not on the system, the caseworker will complete an SS-5 and DCO-12 to forward to the SSA office, as described below.

   For other individuals under age 12 who must apply for an SSN, the caseworker must complete the SS-5 and DCO-12. The caseworker will inform the applicant of what are acceptable types of evidence to verify date of birth, identity and U.S. citizenship as listed on the SS-5 application.

   The original copies of evidence along with the SS−5 and DCO-12 will be submitted to the local Social Security Administration Office. A photocopy of the SS−5 and DCO-12

D-400 Social Security Number Enumeration Requirement

should be retained in the county office until the DCO-12 is returned by the SSA office indicating that a complete SSN application has been received.

If the DCO-12 is returned by SSA indicating that additional information or evidence is required, the caseworker will obtain the additional evidence, if available to the caseworker, and resubmit the entire SSN application and DCO-12. If additional evidence is not available to the caseworker, a DCO-700 will be sent to the applicant requesting the information and advising that if not provided within 10 days, the application will be processed without the person's eligibility being considered.

c. Qualified Aliens not Authorized to Work in the U.S.

SSA will not assign an SSN or a replacement card to an alien who does not have authorization of the Department of Homeland Security to work in the United States unless the alien has a valid non-work reason for needing an SSN. Meeting the eligibility requirements for Medicaid, in a category where an SSN is required of eligibles, would be a valid reason for SSA to authorize an SSN. To assign an SSN in this situation, SSA requires documentation from DCO that the individual meets all eligibility requirements for Medicaid except for an SSN. For these individuals, the caseworker must first determine that the individual meets all points of eligibility except for an SSN. If they are Medicaid eligible, the caseworker should complete the DCO-12, checking on the form that the non-work alien meets all eligibility requirements except for the SSN. The caseworker will issue the DCO-12 and SS-5 to the applicant or responsible party, following the procedures in 2(a) above, regardless of the age of the qualified alien. SSA requires an interview for enumeration of all non-citizens.

NOTE: Counties should only refer eligibles to SSA. Non-eligible, non-work alien parents applying only for their children should not be referred to SSA. They should be given a pseudo-SSN.

d. **Undocumented Alien**

An undocumented alien who is the casehead or included as an ineligible member in an open case will be assigned a pseudo number even if an SSN is provided. This includes an undocumented pregnant woman. More information regarding the procedures for applying for a SSN can be obtained through SSA's website: www.ssa.gov/ssnumber/ or by calling toll free at **1-800-772-1213**, deaf or hard of

D-400 Social Security Number Enumeration Requirement

hearing at **1-800-325-0778** from 7 a.m. to 7 p.m., Monday through Friday for specific questions.

3. **Non-Eligibles Included In the Medicaid Household Size**

   Non-eligible minor children, parents and other caretaker relatives, who meet the relationship criteria as outlined in MS F-110, may be included in the determination of Medicaid household size without enumeration. Every effort should be made to secure the SSN of non-eligibles in the Medicaid household, but eligibility cannot be denied or delayed for eligible individuals based on non-enumeration of non-eligibles.

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

MS Manual 05/01/18

As a condition of eligibility for Medicaid, recipients are required to assign their rights to Medical Support/Third Party Liability payments to the Department of Human Services. This means that any funds settlements or other payments made by or on behalf of third parties should be paid directly to the Arkansas Medicaid Program. In Arkansas, Third Party Liability payments are automatically assigned by state law.

The Medical Assistance Program is required by Federal and State Regulations to utilize all Third Party sources and to seek reimbursement for services which have been paid by both a Third Party and Medicaid.

Private insurance and Medicaid are complementary. A recipient's Medicaid eligibility, except for an ARKids B recipient, is not affected by having Third Party coverage (Re. MS F-180).

When a recipient has Third Party coverage in addition to Medicaid, which can be used for medical expenses, Third Party coverage must be utilized first. Medicaid will pay up to the Medicaid allowable charge. For example: A Medicaid recipient has insurance which paid 80%, or $80 of a $100 medical bill. The Medicaid allowable charge for the bill was only $60.00. A Medicaid payment was not due since the Medicaid allowable charge was less than the insurance payment. Third Party sources whose payments Medicaid will retrieve include private health insurance, automobile liability insurance where applicable, workmen's compensation, settlements for injuries, etc.

Tri-Care is considered to be a Third Party source. Whenever a Tri-Care beneficiary is also eligible for Medicaid, Tri-Care is in every instance the primary payer. This applies to all classes of Tri-Care beneficiaries, i.e., dependents of active duty members, retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

NOTE: The Third Party Liability policy does not apply to individuals enrolled in a private Qualified Health Plan through the Adult Expansion Group, however Assignment of Rights to Medical Support does apply.

D-510 DCO Responsibility

MS Manual 01/30/15

Third Party resources (if any) will be determined by completing the DCO-662 at the time of application and at each reevaluation when Third Party coverage is reported by the applicant/recipient.

Third Party information will be entered into a narrative note in the system.

NOTE: For cases involving Tri-Care, the name and Social Security Number of the service member/policyholder must be entered on the DCO-662. The TPL unit has an online system to check eligibility and addresses of insurance companies.

Upon determining that Third Party coverage exists, inform the recipient of the restrictions placed on the coverage by the Medicaid Program, (i.e., recipients are not entitled to any benefits and/or compensation from Third Party sources on services for which Medicaid has made or will make compensation). Instruct recipients who want Medicaid billed for services that they are to assign their TPL resource benefits to the provider before services are rendered.

D-520 Recipient Responsibility

MS Manual 01/01/14

Recipients are not entitled to any benefits and/or compensation from Third Party sources on services for which Medicaid has made or will make compensation. For this reason, recipients are responsible for assigning the TPL resource benefits to the provider before services are rendered if they want Medicaid billed for the services. This includes indemnity policies such as cancer policies, intensive care policies, etc.

If the provider elects not to accept Medicaid on the recipient, the recipient becomes a “private pay” patient and is responsible for the full cost of services rendered. Assignment is not required for non-Medicaid claims.

D-530 Provider Responsibility

MS Manual 01/01/14

If Medicaid has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for determination of the amount of liability.

It is the responsibility of the provider to file a claim for services with Third Party sources and to report the third party and receipt of funds received from the third party when filing a Medicaid claim.

When the amount of liability is determined, Medicaid will pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

The provider is to make no claims against a Third Party source for services for which a claim has been submitted to Medicaid.

D-540 Procedure for Failure to Cooperate

MS Manual 01/01/14

Recipients who are not cooperating with the Division of Medical Services Third Party Liability Unit will be subject to termination of Medicaid assistance. The Third Party Liability (TPL) Unit will notify the County Office when a recipient has been determined uncooperative.

When a notice is received from the Third Party Liability Unit that a recipient is not cooperating, the caseworker will:

1. Complete Form DCO-700 to give advance notice to the non-cooperating recipient that his/her Medicaid will be terminated due to failure to cooperate.
2. If no response from recipient, remove the non-cooperating recipient from his eligibility group in the system, effective the appropriate date for the eligibility group in which he/she resides (Re. MS A-200). This may require case closure if the recipient is in a one-person household.

The recipient who has not cooperated with the Third Party Liability Unit will remain ineligible for Medicaid until TPL determines that the recipient is cooperating. The Third Party Liability Unit will notify the County Office when a case or member can be reopened.

E-100 Financial Eligibility

MS Manual 10/26/15

Each individual applying for or receiving Medicaid benefits must have a financial eligibility determination made at application and, if eligible, on an on-going annual basis or when a change affecting eligibility occurs. Financial eligibility consists of an income test and if the category requires, a resource or asset test.

Most Medicaid eligibility groups have an income limit which an individual's countable income must fall under in order to be eligible for coverage in that group. Income limits and the manner in which countable income is determined vary by eligibility groups. The groups to which an income limit does not apply, and therefore no income determination is made, are the following:

- Newborns (MS B-220);
- Former Foster Care Adults (MS B-280);
- Workers with Disabilities (MS B-330).

NOTE: For the Workers with Disabilities category, before determining eligibility, the applicant must pass a pre-test screening to ensure his/her unearned income does not exceed the SSI individual benefit plus $20. If the applicant meets this criteria, all income is disregarded in the financial eligibility determination. However, both unearned and earned income will be used to determine cost sharing. See MS A-115.

A resource limit applies to most of the eligibility groups that do not use MAGI methodologies for financial eligibility. For these groups, the value of an individual's countable resources must be determined. There is no resource limit, and therefore no resource determination is made, for the following groups:

- Those using MAGI methodologies (MS E-110);
- Newborns (MS B-220);
- Former Foster Care Adults (MS B-260);
- Workers with Disabilities (MS B-330).

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual 01/01/19

Below are the income and resource limits for all Medicaid groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will

be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

Category	Income Limit	Resource Limit
ARKids A	142% of FPL *	No Resource Test
ARKids B	211% of FPL *	No Resource Test
Newborns	No Income Test Eligibility is based on mother's Medicaid eligibility at child's birth	No Resource Test
Pregnant Women: Full Medicaid Pregnant Woman Limited Medicaid Pregnant Woman Unborn Child	 1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5. 209% of FPL * 209% of FPL *	 No Resource Test
Parent and Caretaker Relative	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Adult Expansion Group	133% of FPL *	No Resource Test
Medically Needy: Exceptional (EC) Spend Down (SD)	 EC – may not exceed the monthly income limit SD – may exceed the quarterly income limit See MS O-710 for the monthly and quarterly income limit	 1 person: $2,000 2 person: $3,000 3 person: $3,100
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ARChoices,	3 times the SSI Payment Standard Appendix S	Individual $2000 Couple $3000

Assisted Living, and PACE		
Medicare Savings: ARSeniors QMB SMB QI-1 QDWI	Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	ARSeniors, QMB, SMB & QI-1: Individual $7,730 Couple $11,600 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	Unearned income may not exceed SSI individual benefit plus $20	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability (COBRA and OBRA '87)	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA '90)	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000
***May be eligible for an additional 5% disregard, MS E-268.**		

E-200 Determining Financial Eligibility Under the MAGI Methodology

E-210 What is MAGI

MS Manual 01/01/14

MAGI is a federal income tax term meaning **M**odified **A**djusted **G**ross **I**ncome. For purposes of determining Medicaid eligibility, MAGI is a methodology for determining how income is counted and how household composition and family size are determined. It is based on federal tax rules but it is **not** an amount on a specific line on an individual federal tax return. In addition to being used to determine Medicaid eligibility for certain eligibility groups, the MAGI methodology is also used to determine eligibility for and the amount of Advance Premium Tax Credits (APTC) and cost-sharing reductions available to individuals and families who are eligible to purchase health insurance through the Federally Facilitated Health Insurance Marketplace (FFM).

For tax purposes, the modified adjusted gross income reflects annual income for a specific tax year. For Medicaid purposes, though, current monthly income is used to determine eligibility. This is true even when using MAGI methodologies. See MS E-265 for more detailed information on determining whether income is "current" and for converting income amounts to monthly amounts.

E-220 Families and Individuals (MAGI) Groups

MS Manual 01/01/17

MAGI methodologies are used to determine financial eligibility for the following eligibility groups:

1. Infants and children under age 19-(ARKids A & B);
2. Pregnant women;
3. Parents and caretaker relatives; and
4. Adults age 19 through 64 who do not fall into another adult group (Adult Expansion Group)

E-230 Steps in Determining MAGI Income Eligibility

MS Manual 01/01/14

Below are the steps for determining income eligibility:

1. Determine the Medicaid household composition and size for each individual applying for assistance. See MS E-240-E-251.

    - "Medicaid household" means the household members whose income will be considered when determining eligibility and/or who will be included in the household size. For MAGI determinations, the Medicaid household is determined based on the individual's tax filing status. See MS E-250.
    - The "Medicaid household size" is the number of people who will be counted to determine the appropriate Federal Poverty Level (or other income standard) for the household.

2. Determine countable household income. See MS E-260-E-264.

    - Countable household income is the income of the Medicaid household members that will be counted in determining eligibility.

3. Determine current household income. See MS E-265-E-266.

    - The income used to determine Medicaid eligibility must reflect the income that a Medicaid household member is currently receiving.

4. Compare countable current household income to the appropriate FPL for the household size. See MS E-267.

    - This step will determine each individual's Medicaid eligibility.

The following sections describe each of the steps above in more detail. In addition, the following example scenario is used throughout these sections to illustrate the application of each step to a particular household.

Example Scenario: Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey's daughter), age 2, as tax dependents. Audrey works a few hours each week and Chloe's father pays child support. The household consists of these three only. All are applying for Medicaid.

E-240 Determining the Medicaid Household For Families and Individuals Groups

MS Manual 01/01/14

Under the MAGI methodology, the Medicaid household composition is based on federal income tax filing status. Household size is the number of individuals counted in the family size for the income standard. When determining the household size, SSI recipients are counted and in addition, a pregnant woman is counted as one (1) person plus the number of children she is expecting. In most situations, the Medicaid household is the same as the tax filing unit of which the individual is a member. The Medicaid household composition determines whose income will be considered in determining eligibility. If the family or individual has not filed a federal tax return for the most recent tax year and does not expect to file one, then the Medicaid household is determined as described in MS E-251.

E-250 Tax Filing Status

MS Manual 01/01/14

To determine an individual's tax filing status or unit, two basic questions must be asked in relation to the individual.

NOTE: Each person's eligibility for Medicaid is determined individually, even if two or more individuals are living in the same house/home.

1. **Does the individual expect to file taxes?**
2. **Does the individual expect to be claimed as a tax dependent?**

If the answer to both of these questions is "No", then the individual's Medicaid household is determined according to MS E-251 (Non-Tax Filing Households).

If the answer to either of the above questions is "Yes", then additional questions must be asked to determine the individual's Medicaid household as described in the table below.

Question 1. Does the individual expect to file taxes?	
Yes	Continue to Question 1a.
No	Continue to Question 2.
Q. 1a. Does the individual expect to be claimed as a tax dependent by anyone else?	
Yes	Continue to Question 2.
No	Household is: ▪ The taxpayer;

	▪ A spouse living with the taxpayer; and ▪ All persons the taxpayer expects to claim as a tax dependent.
Question 2. Does the individual expect to be claimed as a tax dependent?	
Yes	Continue to Question 2a.
No	Household composition is determined according to MS E-251.
Question 2a. Does the individual meet any of the following exceptions?	
• Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent) • Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return • Is a child under age 19 who expects to be claimed by a non-custodial parent	
Yes	Household composition is determined according to MS E-251.
No	Household is: ▪ The household of the taxpayer claiming the individual as a tax dependent; and ▪ The individual's spouse if married.

Example Scenario: Household Composition, i.e. Household Members

Example Scenario: Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey's daughter), age 2, as tax dependents. Audrey works a few hours each week and Chloe's father pays child support. The household consists of these three only. All are applying for Medicaid.

The table below shows how each individual's Medicaid household for the Example Scenario described above is determined based on each individual's tax filing status.

Bertha			
1.	Does Bertha expect to file a tax return?	Yes	Continue to Question 1a.
1a.	Does Bertha expect to be claimed as a tax dependent by anyone else?	No	
Bertha's Medicaid household is: Bertha (applicant and taxpayer) Audrey (tax dependent) Chloe (tax dependent)			
Audrey			
1.	Does Audrey expect to file a tax return?	No	Continue to Question 2.
2.	Does Audrey expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.

2a.	Does Audrey expect to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or stepparent)?	No	Audrey is being claimed by her mother.
	Is Audrey under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	Audrey is 20 years old living with her mother. Her mother has filed a tax return.
	Is Audrey under age 19 and expecting to be claimed by a non-custodial parent?	No	Audrey is 20 years old and being claimed as a tax dependent by her mother with whom she lives.
Audrey's Medicaid household is: Bertha (taxpayer) Audrey (tax dependent) Chloe (tax dependent)		Since Audrey does not meet any of the exceptions in Question 2a., her Medicaid household is the same as the household of the taxpayer claiming her as a dependent (Bertha).	
Chloe			
1.	Does Chloe expect to file a tax return?	No	Continue to Question 2.
2.	Does Chloe expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Chloe expect to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or stepparent?	Yes	See MS E-251 for how Chloe's household is determined.

Additional Tax Filing Unit Example Scenarios can be found in Appendix E. They include scenarios dealing with single adults, children claimed as a tax dependent by a non-custodial parent, non-filers, etc.

E-251 Non-Tax Filing Households

MS Manual 01/01/14

Medicaid household composition will be determined in accordance with this section in the following situations:

1. The individual has not filed and/or does not expect to file a federal income tax return for the current year AND does not expect to be claimed as a tax dependent for the current year; or
2. The individual meets one of the following tax dependent exceptions:
    a. Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive, or step-parent);

b. Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return;
c. Is a child under age 19 who expects to be claimed by a non-custodial parent.

When an individual is in one of the situations above:	The Medicaid household includes the following persons who live in the home with the individual: • Spouse • Children (biological, adopted and step children) under the age 19 • Siblings (biological, adopted and step siblings) under age 19. • If the individual is under age 19, his/her parent(s) (biological, adopted and step parents).

Example Scenario: Household Composition for a Non-Tax Filing Household

Since Chloe met one of the exceptions to using tax filing status to determine household composition, her household is determined in accordance with this section (Non-Tax Filing Households) as follows:

Question 2a exception: Chloe is under age 19 and is claimed as a tax dependent by her grandmother, Bertha.	
Chloe's Medicaid household includes the following person or persons who live in the home with her: Spouse Children (biological, adopted and step children) under the age 19 Parent(s) (biological, adopted and step parents) Siblings (biological, adoptive and step siblings) under age 19	 None None Yes (Audrey) None
Chloe's household is: Chloe (applicant) **Audrey (Chloe's parent living in the home with her)**	

E-260 Determining Countable Income for Families and Individuals Groups

MS Manual 01/01/14

Once the Medicaid household composition has been established for the individual, then each household member's countable income must be determined. Only income of the persons in an individual's Medicaid household is considered when determining financial eligibility. Generally

speaking, countable income sources using the MAGI methodology are the same as a tax filing unit's taxable income sources with a few exceptions. The exceptions are:

- Social Security benefits are counted in full;
- Income received as a lump sum is counted as income only in the month received; and
- Any portion of an educational scholarship, award and/or fellowship grant used for living expenses is countable income.

E-261 Income Included for Families and Individuals Groups

MS Manual 01/01/14

The following are some sources of income that are taxed and included in MAGI to determine Medicaid eligibility: (list not inclusive)

1. Earned Income
2. Self-employment income after allowable income-producing costs are deducted. Refer to MS E-266.
3. Social Security income (Title II) – counted in full for Medicaid even though only a portion (or none) may be taxable
4. Lump sum payments in month of receipt only
5. Dividends and interest income
6. Unemployment compensation
7. Alimony
8. Pensions and annuities payments
9. Rental income
10. Lottery and gambling winnings
11. Any portion of educational scholarships, awards, fellowship grants used for living expenses.

If an individual received income from a source not listed above and did file a tax return for the tax year in which the income was received, then the general rule to follow is the income will be considered for Medicaid purposes if it was reported as taxable income for that tax year. If the income was excluded for taxes, it will be excluded for Medicaid purposes. If the individual did not file a tax return for the applicable tax year, then a determination must be made as to whether the income would be taxable or not.

E-262 Income Excluded For the Families and Individuals Groups

MS Manual 10/26/15

The following are some sources of income that are excluded as taxable income for federal income tax purposes and therefore are excluded as countable income for Medicaid purposes: (list not inclusive)

1. Child Support
2. Contributions
3. Worker's Compensation
4. Veteran's Benefits
5. Educational grants (Basic Education Opportunity Grant (BEOG or PELL, Supplemental Educational Opportunity Grant (SEOG), College Work Study and Supplemental State Income Grant (SSIG))
6. American Indian/Alaska Native
7. Public Assistance Benefits (TEA Cash, SSI)
8. Disaster Relief Payments
9. Gifts
10. Federal Tax Refunds

Refer to MS E-261 to determine if a source of income not listed above can be excluded for Medicaid purposes or whether it must be counted.

E-263 Household Members Whose Income Will Not be Counted for Families and Individuals (MAGI) Groups

MS Manual 10/26/15

The income of the following household members is not considered when determining Medicaid eligibility for any person in the household:

1. Income of a child who is included in the parent's Medicaid household and is not expected to be required to file a tax return.

2. Income of a tax dependent who is not expected to be required to file a tax return and is in the Medicaid household of the person who is claiming him/her as a tax dependent.

3. Income of an SSI recipient who is included in the Medicaid household size.

E-263 Household Members Whose Income Will Not be Counted for Families and Individuals (MAGI) Groups

When determining MAGI eligibility, the income of a child must be counted and verified if the child must file a tax return because his/her income exceeds the IRS filing threshold. Once a household has been established, the MAGI-based income of every household member will be counted with one exception: the income for children and tax dependents whose income is below the filing threshold will be disregarded. This exception only applies for a child who is in the household with a parent or for a tax dependent who is in the household with the tax filer who claims him/her as a tax dependent.

Example: In a MAGI-based household that includes only a child (perhaps the child lives with a grandparent) that child's income will be counted because the child's parent is not in the household, even if the child's income is below the filing threshold.

Example: In a MAGI-based household that includes a child that lives with his or her parent(s) and the child is not required to file a tax return, the child's income is not counted.

Please refer to example at MS E-264 below.

To determine if a child is required to file a tax return, see the chart below.

2014 Filing Requirements for Dependents

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.
Single dependents—Were you **either** age 65 or older **or** blind?
No. You must file a return if **any** of the following apply.
• Your unearned income was over $1,000.
• Your earned income was over $6,200.
• Your gross income was more than the **larger** of—
• $1,000, or
• Your earned income (up to $5,850) plus $350.
Yes. You must file a return if any of the following apply.
• Your unearned income was over $2,550 ($4,100 if 65 or older **and** blind),
• Your earned income was over $7,750 ($9,300 if 65 or older **and** blind),
• Your gross income was more than the **larger** of—
• $2,550 ($4,100 if 65 or older **and** blind), or
• Your earned income (up to $5,850) plus $1,900 ($3,450 if 65 or older **and**
blind).

Example: Joe is 17 years old, single, not blind, and a full-time high school student. He does not provide more than half of his own support, and his parents claim an exemption for him on their income tax return. He received $200 taxable interest income and earned $2,750 from a part-

time newspaper delivery job. He does not have to file a tax return because his unearned income, $200, is under $1000 and his earned income, $2750, is not over $6200.

Example: Carlton is 16 years old, single, not blind, and a full-time high school student. He does not provide more than half of his own support, and his parents claim an exemption for him on their income tax return. He earned $7,500 from a part-time job doing TV commercials. He does have to file a tax return because his earned income, $7,500, is over $6200.

E-264 Household Members Whose Income Will Be Counted For The Families and Individuals Groups - Example Scenario

MS Manual 01/01/14

Continuing with the Example Scenario of Bertha, Audrey and Chloe, the table below shows how each person's income will be counted for each individual's Medicaid eligibility.

NOTE: Bertha's and Audrey's households are the same, so the income of each member will be considered in the same way for each of their households.

Bertha's and Audrey's Medicaid Household Composition (which determines whose income is counted)

Members	Income Type	Counted
Bertha	Full-time Earnings	Yes
Audrey	Part-time Earnings	No – Audrey is not expected to be required to file a tax return and she is in the household of her parent and a tax dependent of her parent. Therefore, her income is not counted in either Bertha's or her own household.
Chloe	Child Support	No – Chloe is not expected to be required to file a tax return and is Bertha's tax dependent; child support income is not counted.

Chloe's Household

Members	Income Type	Counted
Audrey	Part-time Earnings	Yes – Although Audrey is not required to file a tax return and is claimed as a tax dependent, her income **does** count in this household because she is not the child nor tax dependent of any of the other members of this household, i.e., Chloe.
Chloe	Child Support	No – Chloe is Audrey's child; child support income is not counted.

E-265 Determining Current Gross Monthly Income For The Families and Individuals Groups

MS Manual 02/01/18

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.

NOTE: Income received in a month for which retroactive eligibility is being determined will be considered for the retroactive month even if it is not considered for current or future months.

Once the household members' current income has been established and verified using the 10% reasonable compatibility standard as appropriate (See MS G-151-152), the monthly amount used to determine eligibility will be calculated. Depending on how the current income was established (e.g., tax return income via the Federal Data Services Hub, State Quarterly Wage Data, checkstubs, SOLQ, etc.,), the "verified" income amount may have to be reduced or increased to reflect a monthly amount. For example, if the most recent tax return reflects the income still currently available to the individual, then the annual income from the tax return is divided by 12 to arrive at a monthly amount. If the current income was established through the most recent weekly check stubs, the average weekly amount is multiplied by 4.334 to arrive at a monthly amount. Unless the verified amount is already a monthly amount, for example Social Security benefits, then some conversion to a monthly amount is required. The calculation will be documented in the individual's case file.

The chart below shows how income amounts larger or smaller than monthly amounts can be converted to a monthly amount.

Income Amount is	Convert to Monthly
Annual	Divide by 12
Quarterly	Divide by 3
Weekly	Multiply by 4.334
Bi-weekly	Multiply by 2.167
Semi-Monthly	Multiply by 2
Monthly	No conversion needed
More Often than Weekly	Total all Income Paid/Received in the Month

There may be situations in which an alternative method must be used to arrive at current monthly income. For example, if annual income included a lump sum payment that will not be paid again, then the lump sum payment will be excluded from the rest of the annual income before the conversion to monthly income is made. Self-employment income may also require an alternative method. See MS E-266 for a more detailed discussion on self-employment income.

Example Scenario: Bertha's and Audrey's current monthly income is determined as follows. Since Chloe's income is not considered in any of the three households, there is no need to determine her current income.

Bertha

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub ($96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income ($8000).

Audrey

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns $7.25 per hour. Her current monthly income is determined as follows:
$7.25 x 10 = $72.50
$72.50 x 4.334 = $314.22 ($314.22 x 12 = $3,770.64 annual)

E-266 Self-Employment Income

MS Manual 01/01/14

The monthly amount of self-employment earnings is the best estimate of earned income which will be available to the individual in a month or months. The individual's recent tax data may be

used to determine the monthly income. If the most recent tax data is not available or does not reflect current income, the individual's income will be determined by other means as determined appropriate by the caseworker, such as sales receipts, business records, etc.

Costs directly related to producing the income are subtracted from the self-employment annual gross before the monthly earnings are included in the budget. See Schedule C in Appendix Q for all allowable costs associated with self-employment income.

After allowable deductions from annual income, the remainder is then divided by 12 to determine the monthly income.

E-267 Comparing Income to Income Standard for Appropriate Household Size

MS Manual 01/01/14

After the Medicaid household composition, size and countable current income have been established, the Medicaid household's countable income will be compared to the household size income standard for the appropriate eligibility group to determine whether an individual is income eligible. Income eligibility will first be determined in the eligibility group the individual falls into with the lowest income standard, e.g., eligibility for a parent would first be determined in the Parent/Caretaker Relative group before a group with a higher income standard.

E-268 The 5% Gross Income Disregard

MS Manual 05/01/18

Each individual will be allowed a general gross income disregard in the amount of 5% of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category that has the highest income level in which an individual could be eligible. For example, if an individual is not income eligible in the lowest income level group (e.g., Parents/Caretaker Relatives), the five (5%) disregard will be applied to the higher income group (e.g., Adult Expansion Group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the 5% disregard effectively raises the income limits for the applicable eligibility group by five (5) percentage points. For example, the income limit for the Adult Expansion Group is 133% (MS E-110). To apply the 5% disregard, add 5% to 133% to raise the income limit to 138% of FPL. The eligibility groups with dollar amounts for income limits are not the highest

income limit groups for the individuals that fall into them. Therefore, the 5% disregard will never be applied to the dollar amount income limits.

Application of the 5% Disregard in the ARKids First groups

The 5% disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child and therefore, the 5% disregard can be allowed.

The 5% disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children and therefore, the 5% disregard is applied only if needed to achieve ARKids B eligibility.

Refer to MS F-180 for exceptions to health insurance coverage for ARKids B eligibles.

E-269 Who Is Eligible-Example Scenario

MS Manual 05/01/18

Continuing the example of Bertha, Audrey and Chloe to show whose income will be counted and who is eligible for Medicaid.

Bertha and Audrey's household are the same which includes Bertha, Audrey & Chloe.

- Bertha earns $8,000.00 per month, which equals $96,000 annually.
- Audrey earns $314.22 per month, which equals $3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income does not count. Bertha's income is counted.
- Bertha's household size is 3.
- Compare the $8,000.00 monthly income to the 133% + 5% = 138% standard for a household size of 3, $2,390.16.
- Bertha and Audrey are not eligible for Medicaid; therefore, the agency will electronically transfer their account to the FFM for possible eligibility for Advanced Premium Tax Credits and cost sharing reductions.

Chloe's household includes Chloe and her mother, Audrey.

- Audrey earns $314.22 per month, which equals $3,770.64 annually. Audrey's income will be counted because neither her mother, nor father is included in this household. Chloe's child support income is disregarded.
- Chloe's household size is 2.
- Compare the $314.22 monthly income to the ARKids A standard of 142% for 2, $1,948.24. **Note:** The 5% disregard was not needed for ARKids A eligibility and therefore was not applied.
- Chloe is eligible for ARKids A.

E-300 Sponsor Affidavits of Support and Deeming

E-300 Sponsor Affidavits of Support and Deeming

MS Manual 01/01/18 PRWORA of 1996

Alien sponsor deeming established by the PRWORA, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), P. L. 104-208, and the Balanced Budget Act of 1997 (BBA), P. L. 105-33 will apply to all Medicaid categories.

Alien sponsor deeming will be applied to those aliens who are Lawfully Admitted Permanent Residents (LAPRs) that have been in the United States for five years. Refer to MS E-445 for exceptions to deeming for an alien's sponsor.

Aliens who seek admission to the U.S. as LAPRs must establish that they will not become a public charge (Re. MS D-222). Many aliens enter the country by having a sponsor who pledges to support them to establish that they will not become a public charge.

A sponsor is a person who signs an Affidavit of Support agreeing to support an alien as a condition of the alien's admission for permanent residence in the U.S. An alien may have more than one sponsor. There are two versions of the Affidavit of Support:

- *Affidavit of Support*, form I-134 (Now unenforceable.)
- *Affidavit of Support*, form I-864 (Effective December 19, 1997.)

The process of counting the sponsor's income and resources for the sponsored alien is called deeming. Deeming will not apply when the sponsor is:

- An organization such as a church or service club,
- An employer who does not sign an Affidavit of Support, or
- The alien's eligible or ineligible spouse or parent whose income is otherwise considered in determining the alien's Medicaid eligibility.

A sponsored alien and the alien's spouse, if there is one, are responsible for providing information and documentation about the alien's sponsor and the sponsor's spouse. If the alien appears to be eligible for benefits but does not have the Affidavit of Support or does not know if there is a sponsor, instruct the alien to contact the United States Department of Homeland Security (USDHS) to obtain a copy of the Affidavit of Support. If the applicant requires

E-300 Sponsor Affidavits of Support and Deeming

assistance, the caseworker may request information from the USDHS by submitting Forms G-845 and G-845 Supplement.

The USDHS will certify whether an alien has a sponsor and if so, what kind of affidavit the sponsor signed. Do not deem income or resources from a sponsor that has signed the old version, I-134, Affidavit of Support, or I-361, Affidavit of Financial Support and Intent to Petition for Legal Custody, as these affidavits are not considered enforceable.

Deeming instructions are shown below for individuals applying for Medicaid having an I-864, Affidavit of Support:

- Count all income of the sponsor and sponsor's spouse living in the same household as if they were income and resources of the alien.
- Do not allow deductions from the sponsor's income or resources.
- Count the sponsor's income as the alien's unearned income and use it to determine the alien's eligibility.
- Do not count the sponsor's income when determining eligibility for the alien's eligible children.
- Do not include the sponsor in the alien's household size.

Deeming continues until one of the following conditions is met:

- The sponsored immigrant becomes a U.S. citizen.
- The sponsored immigrant leaves the U.S. permanently.
- The sponsored immigrant or the sponsor dies.

E-400 Determining Financial Eligibility for AABD Groups

MS Manual 01/01/16

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 Groups (i.e. Nursing Facility, ICF/IID, HCBS waivers and PACE). It will also be used to calculate the contribution to care for nursing and assisted living facilities, PACE and ARChoices: Adult Family Home.

E-405 Income

MS Manual 01/01/14

Income is defined as the receipt of assets by an individual in cash or in-kind (Re. 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 10/26/15

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 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 caseworker will begin processing case adjustment in the month prior to the receipt of the income. The caseworker will notify (via the DCO-707) the recipient or person acting on his behalf of case adjustment at least ten days prior to the month in which the income is to be received. 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. Advance notice to the client will state that the case is being suspended for a month and that it will be reinstated the following month without action from the client, provided the client is still resource eligible. To adjust the case for a month of ineligibility, refer to the ANSWER Desk Guide found on SHARE.

   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. Anticipated income changes that will not result in case closure may be entered on the WNHU interface no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the caseworker. The recipient or representative should be notified of the increased vendor payment responsibility by DCO-707 at least ten days prior to input of 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 ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received. The recipient or person acting on his/her behalf must be fully advised by DCO-707 of the amount of his/her vendor payment responsibility in these cases. 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 and the customer will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at

MS 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. (Re. MS H-481 for procedures).

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

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

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

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

NOTE: Interest income of State Human Development Centers and Benton Services Center customers will be used in determining initial eligibility, but will not be considered in determining net income.

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 SPA are disregarded.

E-415 Determination and Verification of Earnings from Employment

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

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

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

customer does not have the required verification, then verification from the employer will be required.

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

E-420 Determination and Verification of Earnings from Farm, Business or Self-Employment

MS Manual 01/01/14

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

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

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

MS Manual 01/01/14

The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, use the first of the following methods that is likely to give the most accurate estimate of current and future net earnings which may be allocated on a monthly basis.

1. When the individual has been carrying on the same trade or business for some time, net earnings from self-employment have been fairly constant from year-to-year, and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months would be substantially different from what it has been in the past, the estimate of earnings for the current taxable year should be the same as the net profit last year. Monthly income should be determined as one-twelfth of the net profit as shown on the tax return for the preceding year.
2. When the individual is engaged in the same business that he/she had the preceding taxable year and anticipates no change or can give no reason why the net earnings for current and future months would be substantially different from what it has been in the past, determine the ratio between his net profit and gross receipts for

the last year (e.g. net profit of $1,200 for $6,000 gross income, or 20%). Determine from his/her records the actual gross receipts for the current taxable year and project for the remainder of the year (e.g. $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year). Apply the previously determined gross-net ratio (e.g. 20% of $8,000 is $1,600) and the resulting estimated net profit would be allocated equally into each month of the taxable year. This method would not be suitable for a business which is seasonal or has income peaks at certain times of the year.

3. Have the self-employed individual supply a profit and loss statement or other business records for the taxable year to date so that a net profit can be projected for the year and allocated monthly.
4. Use the individual's best estimate based on his/her business records.
5. Consideration may be given to the individual's explanation as to why he/she believes his/her estimated net earnings for the current year will be substantially different from the information on tax returns for past years or business records for past periods. Some examples of satisfactory explanations include business loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic event which can be documented. Obtain documentation for the records (newspaper accounts, police reports, medical reports, etc.). With documentation, a lower estimate may be accepted.

After the estimated net income from self-employment has been determined, explain to the individual how it has been determined and the effect it has on eligibility. Advise the individual that he/she may appeal if he/she disputes the estimates, or that he/she may request a change or reapply if new evidence becomes available.

If the allocated amounts of income result in ineligibility, explain to the individual that 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, advise him/her that any substantial variation of net earnings should be reported promptly with appropriate evidence, so that overpayments and underpayments can be prevented. Explain also that he/she must provide a copy of the federal tax return as it becomes available.

When one of the methods under items 3, 4 or 5 has been used to determine net earnings, advise the individual that he/she 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-425 Unstated Income

MS Manual 01/01/14

Unstated income is income not reported or otherwise accounted for, but known to exist because living expenses exceed the income that has been reported.

An applicant, recipient or person whose income is subject to deeming may have unstated income.

The amount of unstated income to be considered as unearned income in determining eligibility is the difference between the declared monthly income and the monthly living expenses.

E-426 When to Develop Unstated Income

MS Manual 01/01/14

When an individual's stated income does not appear adequate to cover living expenses, it will be necessary to develop unstated income, unless there is a reasonable explanation to account for the difference; e.g., savings have been used or bills have not been paid.

If the previous year's income tax return of an individual engaging in self-employment activity shows "0" or only a small amount of net income, living expenses and unstated income must be explored.

E-427 Development of Living Expenses

MS Manual 01/01/14

When development of living expenses is required due to unstated income, explain to the individual what information will be needed to develop living expenses and why it is needed. Consider the living expenses of every member of the self-employed individual's household, and explain that all expenses must be considered. It is essential that a complete disclosure be obtained.

The following guide should be used in developing living expenses:

1. Prepare on a separate narrative sheet(s) a topical breakdown of pertinent monthly living expenses such as:

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

2. The reported living expenses will be considered as expenses in the actual time periods in which the expenses were paid by members of the household. Take into account the tendency to overlook expenses. Avoid averaging expenses between different months unless the monthly living expense total would be distorted if they were not averaged. If averaging is used, give an explanation of the reason on the narrative sheet.

3. Add the following statement to the narrative sheet(s) of living expenses: "I agree that this is a fair statement of monthly household living expenses".

4. Obtain the signature of the self-employed individual. If the self-employed individual does not provide the information, obtain the signature of the individual who does, and explain why the self-employed individual cannot or will not sign the statement.

E-428 Determination of Unstated Income

MS Manual 10/26/15

Determination of Unstated Income:

1. Reported Income - Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. The amount of reported income for a month is determined by adding to the allocated monthly portion of net income from self-employment, the amount of other monthly income for the self-employed individual and any other individual who is an applicant or whose income is

being deemed to the applicant, or who is an ineligible child taken into account because of deeming of income.

Reported income is the aggregate of unearned and earned income of the following people living together as one household.

a. Applicant(s)
b. Individual(s) whose income is deemed to the applicant; and
c. Ineligible children, if any, who would be taken into account in computing the amount of deemed income where there is a deeming situation.

2. Computation of Unstated Income:
   a. Applicant is self-employed - When an applicant or both applicants in a household (in the case of a couple) are self-employed, the computation of unstated unearned income, if any, requires that the amount of reported monthly income be subtracted from the amount of monthly living expenses, and the result, if greater than zero, be added to the amount of total unearned income of the applicant(s). Such income would be treated as other unearned income in the application.

EXAMPLE: The applicant reports earned income consisting of $100 per month net earnings from self-employment. The spouse, also an applicant, reports a pension of $100 per month. Living expenses are developed and total $400 per month. The total family income of $200 is subtracted from the $400 monthly living expenses, leaving $200 that will be counted as unstated unearned income for the couple to be divided as $100.00 for each member of the couple.

   b. Individual whose income is deemed is self-employed - When the self-employed individual(s) in a household with an applicant is an ineligible spouse or parent, the computation of unstated unearned income (reported income subtracted from living expenses) increases the amount of unearned income of the self-employed individual. The effect of the unstated unearned income on the applicant depends on the deeming computation. Refer to MS A-214 for SSI Retroactive Medicaid determinations.

3. Providing an Opportunity to Explain - When unstated unearned income is determined, discuss the matter with the individual and provide the individual with 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), adjust the amount of living expenses after obtaining a second (adjusted) statement of living expenses. If there are loans which account for the money used to pay living expenses, obtain a statement of specifics of the loan(s) and verify the 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.

4. Notice of Determination - When unstated unearned income is counted, explain on the notice of decision (DCO-707) 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

MS Manual 01/01/16

The following are possible sources of unearned income:

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

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

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

E-431 Determination and Verification of Unearned Income

MS Manual 10/26/15

The monthly amount of unearned income must be determined, verified, and included in the budget. Verification will normally be by documentary evidence obtained from the source of the income. Another means of verification may be used if it clearly establishes the source and amount of the income.

In addition, if the applicant or recipient is potentially eligible for any benefit, he/she will be required to apply for it and to accept the benefit if found eligible (MS D-110). Verification of his/her application for such benefits will be included in the case record. Once the applicant has applied for the benefit, his/her application or reevaluation may be completed, if otherwise eligible. If the applicant refuses to apply within 30 days of his application for any benefit for which he may be eligible, the application will be denied (or case closed).

E-432 Types of Unearned Income

MS Manual 01/01/16

1. Social Security Benefits

Social Security benefits are paid upon retirement, disability, or death of a covered wage earner. Retirement benefits are payable at age 62.

Social Security disability benefits are payable at any age. A spouse or widow/er is eligible at age 60, disabled widows/ers at age 50. A spouse, widow/er is eligible at any age if there are minor children of the wage earner living in their home. Children are covered until age 18, or until age 19, if attending school and an individual may receive a child benefit at any age if incapacitated prior to age 21. All unmarried children of a wage earner are covered, even though the wage earner and the mother of the children were later separated or divorced. Illegitimate children may be covered if the wage earner can be established as the parent.

Social Security benefits will be verified by SOLQ, SSA-1610, or by award letters.

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 institutionalized or HCBS individual's contribution toward the cost of care.

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.

Information on Railroad Retirement Benefits may be secured from:

U.S. Railroad Retirement Board
1200 Cherry Brook Drive, Suite 500
Little Rock, AR 72211-4122

4. Military Allowances or Allotments

If the applicant has a son, daughter, or spouse in the Armed Services, the Service Representative will explore the possibility of obtaining an allotment.

The address of the Army Finance Center is:

Army Finance Support Agency
Indianapolis, Indiana 46492

The address of the Navy Finance Center is:

Navy Finance Center
Federal Office Building
Cleveland, Ohio 44199

The address of the Air Force Finance Center is:

Air Force Finance Center
3800 York Street
Denver, Colorado 80205

5. Veterans Benefits

If the applicant is a veteran, or the spouse, widow/er, child, or other dependent of a veteran, full exploration will be made of potential eligibility for 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. Information on Veterans' Benefits should be requested on Form DCO-52 from:

VA Regional Office
Building 65, Fort Roots
North Little Rock, Arkansas 72205

The caseworker will not attempt to represent veterans or dependents in filing claims. Such persons should be referred to Service Officers of the local American Legion Post, County Offices, Veterans Administration Contact Offices, or:

Veterans' Service Office
American Legion Arkansas Department
1415 West 7th St.
Little Rock, Arkansas 72201

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.

Information on Civil Service Benefits may be secured from:

U.S. Office of Personnel Management
Retirement Operations Center
Boyers, PA 16017

7. In-Kind Support and Maintenance and Other In-Kind Income

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

<u>In-Kind Support and Maintenance</u>
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.

a. 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 (Re. 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 and retro SSI determinations.

Valuation of In-kind Income and In-kind Support and Maintenance

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.

Please 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 and must be advised of this right.

To rebut the presumed value:

a. The actual cash value of the in-kind support and/or maintenance must be established. For example, if the individual is receiving free room and board, living in the household of another, determine the actual cost necessary to maintain the household. Include mortgage payments, utilities, real estate taxes, insurance, and food for all members. Expenses should be verified by receipts. Determine the individual's pro rata share by dividing the actual monthly cost by the number of individuals living in the household. This will be the actual cost figure. If the individual purchases his own food, do not include this cost in determining the monthly household expenses.
   If the individual lives rent-free in the home of another or makes only token payments for rent compared to the value received, establish the rental value of the home. This can be established by securing a statement from the owner or through obtaining a verbal estimate from a rental agency. The payment made by the individual in return for in-kind support and maintenance is deducted as stated under step 2.

   If a third party makes payments on behalf of the individual for basic needs items such as rent, consider the actual amount paid as the cash value.

b. Any cash contributed by the individual(s) in return for in-kind support and/or maintenance received is subtracted directly from the established cash value (never the presumed value).
c. If the net amount derived is lower than the presumed value, the presumption is rebutted, and the net figure would be considered as unearned income.
d. If the actual net cash value of in-kind support and maintenance exceeds the presumed value, the presumed value is counted as unearned income.

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 LTC 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 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 individual's total amount of SSA income will be entered in the eligibility system on the individual's income tab along with an adjustment for any disregarded amount. Include the total of the 1984 Reduction Factor increase, which is received from SSA and all COLA's received since January 1984. The $20 general exclusion and any other applicable SSI exclusions will automatically be deducted in the budget summary. 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)

Income eligibility determination will be made by disregarding ALL current SSA income, regardless of type of benefit, when the benefit began, or amount of benefit. Any other income (Railroad Retirement (RR), VA, private pension, etc.) will be considered in the budget. After the $20 and other applicable SSI Exclusions (Re. MS E-450) are deducted from income, the resulting net income will be compared to the current SSI/SPA (Re. 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 (Re. 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 eligibility will be computed in the eligibility system. The income to be included in the budget will be the current 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.

Examples:

- If applicant previously had $446 SSI and was awarded $466 DAC, count "00" income;
- If applicant had $400 DAC, $66 SSI and was awarded $66 DAC increase, count $400 DAC;
- If applicant had $300 DAC, $100 VA, $66 SSI and was awarded $66 DAC increase, count $300 DAC and $100 VA.

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-434 Temporary Disregard of Cost of Living Adjustment (COLA) for Medicare Savings Program

MS Manual 01/01/14

The January SSA Cost of Living Adjustment will 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.

E-435 Medicare Savings Income Calculation

MS Manual 05/05/16

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 LTC guidelines. For LTC 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.

After all SSI exclusions (MS E-450) have been deducted from current income, the net countable income will be compared to the current ARSeniors income level for Aged individuals. If the individual's income is at or below the ARSeniors income level, he/she is eligible for Medicaid benefits as an ARSeniors recipient.

If the individual is not aged, or if the aged individual's income is above the ARSeniors level, income should be compared to QMB limits, and then to the SMB and QI-1 limits if necessary. If the individual has an ineligible spouse, countable income will be determined according to MS E-440-445, and the net income will be compared to the couple's ARSeniors, QMB, SMB or QI-1 income level.

If eligibility is to be determined for both members of a married couple, total their current income. Subtract the $20.00 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's ARSeniors, QMB, SMB or QI-1 income level to determine eligibility.

However, the caseworker will be responsible for viewing the State Online Query (SOLQ) before certification of the case. 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 01/01/16

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.

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 10/26/15

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.

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 Standard for the MSP

groups, the applicant is ineligible. If countable income is less than the individual SPA or MSP Standard, complete spreadsheet in ANSWER using #2 - #6c below to determine deemed income from the ineligible spouse.

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, deduct a living allowance (refer to Appendix S) for each ineligible child (refer to Glossary) in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). Income of the child is used to reduce this allowance unless it is excluded as student earned income; refer to MS E-446 #10 to determine whether any of the student earned income is used to reduce the living allowance. 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, total the remaining income by type 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.

   a. From the unearned income, the $20/mo. general exclusion is automatically deducted when the budget is submitted. Carry over any unused balance of the exclusion and deduct from earned income.

   b. From earned income deduct the $65/mo. work expense allowance plus one-half (1/2) the remaining balance;

   c. Total the remaining earned and unearned income 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.

NOTE: The following example reflects January 1, 2013 - December 31, 2013 amounts.

EXAMPLE: Deeming of Income from an Ineligible Spouse

An applicant has gross earned income of $585/mo. and unearned income of $390/mo. His ineligible spouse has gross earned income of $370/mo. and unearned income of $380/mo. His ineligible child has no income. Deemed income is determined as follows:

1. From the applicant's earned income deduct the work expense allowance, $65 plus one-half (1/2) the remaining balance (i.e. $585 - $65 = $520 divided by 2 = $260).

2. From the applicant's unearned income deduct the general exclusion (i.e. $390 - $20 = $370). Add the earned and unearned income amounts ($260 + $370 = $630).

   Since the applicant's total countable income is less than the individual SPA (i.e. $630 as compared to $710) complete #3 - #6C.

3. The ineligible spouse has total income of $370 earned income and $380 unearned income.

4. From the ineligible spouse's unearned income deduct the living allowance for the ineligible child (i.e. $380 - $356 = $24) Add this amount to the ineligible spouse's earned income ($370 earned income + $24 = $394).

5. The ineligible spouse's remaining income is not less than or equal to her living allowance (i.e. $394 as compared to $356);

6. Total the ineligible spouse's remaining income (after deeming) with the applicant's gross earned and unearned income (i.e., $370 + $585 = $955 (earned), and $24 + $390 = $414 (unearned);

   a. From the couple's total unearned income deduct the general exclusion (i.e. $414 - $20 = $394);
   b. From the couple's total earned income deduct the $65 work expense allowance plus one-half (1/2) the remaining balance (i.e. $955 - $65 = $890 divided by 2 = $445)
   c. Add the remaining unearned and earned income to arrive at countable income (i.e., $394 + $445 = $839; and

7. The countable income after deeming is less than the couple SPA (i.e. $839 as compared to $1,066); therefore, the applicant is eligible.

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

MS Manual 10/26/15

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 to determine whether any of the student earned income is used to reduce the living allowance. 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, the next step in the deeming determination from ineligible parent(s) will be as follows:

    a. From unearned income, deduct the $20/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
    b. From earned income, deduct the $65/mo. work expense allowance plus one-half (1/2) the remaining balance;
    c. Total remaining earned and unearned income;
    d. From total remaining income, deduct a living allowance for the ineligible parent(s) equal to the SSI SPA.
    e. Remaining Income (if any) is deemed to the child as unearned income. It is subject to the $20/mo. general exclusion in the child's countable income determination.

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

Examples: **Deeming of income from parent(s) to a child. (Examples reflect 1/1/13- 12/31/13 figures).**

EXAMPLE 1: A child has gross unearned income of $35/mo. His ineligible parents have gross earned and unearned income of $900/mo. and $223/mo., respectively. There is one ineligible child.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly earned and unearned income of $900 and $223, respectively. Proceed to #2.
2. From the ineligible parents' unearned income, deduct the living allowance for the ineligible child (i.e. $223 - $356 = $-133). The remaining income is ($900-133=$767, step 3 will be completed.
3. From remaining income;
    a. Deduct the $20 general exclusion (i.e. $767 - $20 = $747)
    b. Deduct $65 and ½ the remainder (i.e. $747 - $65 = $682 divided by 2 = $341)
    c. Deduct the ineligible parents' living allowance to equal to the couple's SSI Standard Payment Amount (i.e. $341 - $1,066 = 0),
    d. $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

EXAMPLE 2: A child has gross unearned income of $130/mo. His ineligible parents have gross unearned income of $800/mo. There is one ineligible child.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly unearned income of $800. Proceed to #2.
2. From the ineligible parents income, deduct the living allowance for the ineligible child (i.e., $800 - $356 = $444). Since remaining income is unearned only, step 3 will be completed.
3. From remaining income;
    a. Deduct the general exclusion (i.e., $444 – 20 = $424),
    b. Deduct the ineligible parents' living allowance (i.e., $424 – 1066 = 0),
    c. $0.00 is deemed to the child as unearned income. This amount will be added to the child's own income for his/her eligibility determination.

EXAMPLE 3: A child has gross unearned income of $35/mo. His ineligible parents have gross earned and unearned income of $685/mo. and $300/mo., respectively. There are no ineligible children.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly earned and unearned income of $685 and $300, respectively. Proceed to #2.

2. Calculate as follows:

   a. From unearned income deduct the general exclusion (i.e. $300 - $20 = $280).
   b. From earned income, deduct the work expense allowance plus one half (1/2) the remaining balance (i.e. $685 - $65 = $620 divided by 2 = $310).
   c. Total remaining earned and unearned income (i.e. $310 + $280 = $590).
   d. From the total remaining income deduct the ineligible parents' living allowance (i.e. $590 - 1066 = 0).
   e. $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

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

MS Manual 01/01/14

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 income). The 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 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 $20 per month general exclusion in his/her eligibility determination (Re. 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 01/01/14

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/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 $20.00 per month general exclusion in his/her eligibility determination (Re. MS A-214).

E-445 Exceptions to Deeming for Alien's Sponsor

MS Manual 01/01/18

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. (Re. 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:

  - ✓ The income the alien receives is less than the income limit for the category of Medicaid for which the individual would be eligible.
  - ✓ 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. (Re. 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 01/01/14

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 taken into account in determining such assistance. Exclusion applies to V.A. Pension but not to V.A. Compensation. Also includes TEA payments and income which was taken into account 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; and
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 10/26/15

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-72 is used to determine the deemed income from a non-qualified alien spouse.

E-450 Supplemental Security Income Exclusions

MS Manual 10/26/15

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; and
    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. Please 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, and
    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 Waiver (HCBW) and PACE, also 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 10/26/15

The following assets are disregarded as income in their entirety for all AABD categories, including LTSS (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 (Re. 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 LTC 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.

E-500 Resources – AABD

MS Manual 10/26/15

Resources are generally defined as those assets, including both real and personal property, which an individual, or couple, possesses. Resources include all liquid assets as well as those assets which are not presently in liquid form. Liquid assets are those assets that can be easily converted to cash such as checking or savings accounts, certificates of deposit or life insurance policies with a cash surrender value.

In order for assets to be considered as resources, property or an interest in property must have a cash value that is available to the individual upon disposition.

Countable resources will be determined on the first day of the month. When resource eligibility exists at the beginning of a month, it continues for the full month. A resource change that occurs during a month in which resource eligibility exists will not be considered for determination of countable resources until the first of the month following the change.

When an individual is ineligible at the beginning of a month due to excess resources, ineligibility due to resources exists for the full month.

NOTE: When an individual is unaware of ownership of an asset, the asset is not counted as a resource. A discovered liquid asset will be counted as income in the month of discovery and as a resource in the months following. Non-liquid assets will be counted as a resource in the month of discovery and thereafter.

Assets which have been received during the month and considered as income may not also be counted with resources during the same month (unless the income received is given away during the month it is received - Re. MS H-323). For example, if an individual had a checking account balance of $1,950 as of June 1, the receipt of a $300.00 SSA check during June would not cause the individual's $2,000 resource limit to be exceeded during June even if the entire check was deposited in the checking account. The individual's resource eligibility would not be affected by the receipt of income during the month. It would only be affected if the income was retained to the extent that it caused the $2,000 limit to be exceeded as of the beginning of July.

SSI lump sum benefits (never counted as income) will be excluded from resource consideration for 9 full months after the month of receipt (Re. MS E-410 #3 and E-523 #6). SSA lump sum payments also have the 9 month resource exclusion, but will count as income in the month of

receipt. Interest earned on the excluded funds will be counted as income in the month accrued and, if retained, as a resource in the month following.

Each individual must be advised of how countable resources are determined and how resource changes can affect eligibility.

NOTE: An amount up to the amount of benefits paid out by a Qualified Long Term Care Insurance Partnership policy may be used as a resource disregard when determining eligibility for Medicaid (Re. MS H-510).

E-501 Requests for Legal Opinions Regarding Resources

MS Manual 02/16/17

A legal opinion from the Office of Chief Counsel (OCC) will be requested when the caseworker, the Program Eligibility Coordinator, and the Program Eligibility Analysts are unsure of whether a resource should be considered or disregarded.

If the equity value of the questionable resource, when combined with other resources, appears to exceed the resource limit, OCC will be contacted if:

- Ownership of the resource is questionable, or
- The applicant's right to transfer the resource is questionable.

All such requests for a legal opinion will be submitted through eDoctus to The Division of Aging and Adult Services (DAAS) LTSS Support Unit according to the instructions below:

1. The cover memo will outline the issue to be determined and will include any relevant facts. Copies of any documents affecting the property such as deeds, wills and contracts must be attached. If the applicant does not have the necessary documents, he or she will be advised that it is his or her responsibility to obtain them.
2. The caseworker will scan the documents for the legal opinion request in the proper order into the eDoctus library, "County Request for Medicaid Decision." The proper order to scan documents into electronic record can be found on the OCC legal document review checklist. This will trigger an email message to the Program Eligibility Analysts (PEA) for the area that the county office is located in.

3. The PEAs of the specified area will check the "County Request for Medicaid Decision" library on eDoctus to determine if the request originated in one of the counties he/she is responsible for.

4. The appropriate PEA will review the documentation based on the guidelines provided by OCC legal document checklist to ensure that the documentation is complete, in the proper order and any discrepancies have been corrected. The PEA will select the option of submitting the request to DAAS. DAAS will handle all requests for LTSS categories. Non-LTSS requests will be forwarded to the DCO Medicaid Eligibility Unit for processing.

5. DAAS or DCO for non-LTSS will review and submit the request to OCC if needed. DAAS or DCO will provide an opinion on the requests that do not require an opinion from OCC.

6. All responses will be forwarded in an email message to the PEA and the caseworker who requested the opinion.

7. The caseworker will index the document in the client's electronic record. The DAAS or DCO Medicaid Eligibility Unit will scan the opinion into the client's electronic folder in eDoctus.

E-502 Excess Resource Determinations

MS Manual 10/26/15

To be eligible for assistance under AABD categories the countable resources of an individual or couple who are aged, blind or have a disability may not exceed certain limitations. Refer to MS E-110 for countable resource limitations.

NOTE: When one spouse enters a nursing facility (NF) and the other does not, the spousal rules at MS H-200 apply. When both spouses enter a NF, the couple's standard will apply for the month of entry, but the resources of each will be compared to the individual standard in the month after entry into a NF. For a married couple in Waiver cases, the couple's standard will apply if both apply for Waiver services. When only one spouse applies for waiver services, the spousal rules apply.

E-510 Real Property

MS Manual 01/01/14

Real property is land, including houses or immovable objects attached permanently to land. It also includes burial plots and crypts.

In order for real property to be a resource, it must be convertible to cash. If the individual has the right, authority, or power to liquidate the property or his share or interest in property, it is considered a resource unless otherwise excluded (Re. MS E-516). If a property right cannot be liquidated, it will not be considered a resource.

Certain types of property may have special restrictions, which include the following:

1. Burial Plot - Burial Plots or crypts which are not intended for the use of the applicant/recipient or his immediate family may be a countable resource. If the deed indicates that the contract is irrevocable, the plot or crypt is not a countable resource. If any co-owner refuses to permit sale of the plot or the burial company requires the individual to move from the state in order to sell the plot, it is not a countable resource. Document the file regarding restrictions with a statement from the co-owner or with a copy of the burial contract, whichever is applicable.

   If the deed indicates that the contract is revocable, it is a countable resource. In this case it will be necessary to contact the burial company, etc. (i.e., original seller of the plot) to determine the value of the specific plot. Document the file regarding value with a statement from the burial company, etc.

2. Land Held by a Member of Indian Tribe - Land which is held by an enrolled member of an Indian tribe may be excluded from resources if it cannot be sold or transferred without the permission of other individuals, the tribe, or a Federal Agency. If permission is needed, determine whether it can be obtained.

   - If permission to sell is granted, treat the property as a resource.
   - If permission to sell is not granted, the property is excluded as a resource.

E-511 Evidence of Ownership

MS Manual 02/16/17

The following official records will be utilized in establishing real property ownership:

1. Assessment Notice
2. Recent Tax Bill
3. Current Mortgage Statement
4. Deed

5. Report of Title Search.

Questions of title, ownership, and property interest which cannot be resolved by the county office will be submitted through eDoctus to the Medicaid Eligibility Unit for an opinion from the Office of Chief Counsel (OCC). (Re. MS E-501)

E-512 Forms of Ownership

MS Manual 10/26/15

The different forms of ownership are listed below:

1. Fee Simple Ownership - When property is held in fee simple, the owner has sole ownership interest. He alone (or his legal guardian if mentally incompetent) may sell or transfer ownership interest without conditions imposed by others.

2. Shared Ownership - Shared ownership means that ownership interest in property is vested with more than one person. There are three basic types of shared ownership.

    a. Joint Tenancy -In joint tenancy, each of two or more joint tenants has an equal interest in the whole property for the duration of the tenancy. On the death of one joint tenant, the survivor becomes sole owner.

    b. Tenancy-in-Common - In tenancy-in-common, two or more persons have an undivided fractional interest in the whole property for the duration of the tenancy. There is no right to survivorship to a tenancy-in-common.

    c. Tenancy-by-the-Entirety - Tenancy-by-the-entirety results when a conveyance is made to a couple. Each member of the couple is considered the owner of the entire estate. After the death of one, the survivor becomes owner of the entire estate. Real estate owned by a married couple by the entirety can be sold only by the consent of both parties. In the case of divorce, former spouses become tenants-in-common of the property, and either person can market his half share, unless conditions in the divorce decree specify otherwise.

3. Life Estates

    a. Life Estates – A life estate conveys to an individual or individuals certain rights in property which expire upon the death of the owner or of another person. The

owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his life estate interest. However, the document establishing the life estate may restrain one or more of the individual's rights. The owner of the life estate can only sell his or her life estate, and cannot sell any remainder interest. (Re. MS E-513 #3) See MS H-308 for guidelines regarding the transfer of a life estate.

b. Remainder Interest – When an individual conveys property to another for life (life estate) and to a second person(s) (remainder man) upon the death of the life estate holder, both a life estate interest and a remainder interest have been created in the property. Upon death of the life estate holder, the remainder man will own full title. Several individuals may be designated as remainder men who would hold ownership jointly or in common, as specified by will or deed.

4. Ownership Interest in Unprobated Estate

An individual may have ownership interest in an unprobated estate if he or she is an heir or relative of the deceased, or has acquired rights on the property due to the death of the deceased, in accordance with a will or state intestacy laws.

5. Dower/Curtesy

State law for dower and curtesy gives a spouse an interest in the other spouse's property. When the deceased leaves no will, dower or curtesy may be claimed. When the deceased leaves a valid will, a widowed spouse can elect to take against the will when he would have a greater right by dower or curtesy than the will provides.

If there are questions regarding the dower or curtesy interest, the DAAS LTSS Support Unit will be contacted to request a legal opinion, according to procedures established in MS E-501. When requesting an opinion, indicate whether or not there are direct descendants (children, grandchildren, etc.)

6. Rights to Use

An individual may have ownership of certain property rights such as:

a. Mineral Rights - A mineral right is an ownership interest in certain natural resources which are usually obtained from the ground such as coal, sulphur, petroleum, sand, natural gas, etc. (MS E-515)

b. Timber Rights - Timber rights permit an individual to cut and remove freestanding trees from property owned by another. A life tenant also has certain timber rights in keeping with good husbandry.

c. Easement - An easement is a property right whereby one has the right to use of the land of another for a special purpose.

d. Leasehold - A leasehold conveys to an individual, at the owner's will and usually for an agreed rent, the control of property for a definite period of time. It does not designate rights of ownership. Leaseholds may be carved out of life estates.

E-513 Determining Value of Ownership Interest

MS Manual 02/16/17

In determining the equity value (i.e. current market value less encumbrances) of real property, the type of ownership, the number of additional owners, and the individual's actual ownership interest must all be taken into consideration.

1. Fee Simple Ownership (Sole Ownership) - If the individual is the sole owner of property and has the right to dispose of it, the equity value of the property is a countable resource when the property is not an excludable resource.

2. Shared Ownership -If the property is jointly owned by two or more individuals, the equity value of the property is counted to the individual in proportion to his ownership interest.

   a. Joint Tenancy - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. When the individual's ownership interest plus other countable resources exceed the resource limit, determine if the individual is free to sell his interest.

      When consent to sell joint tenancy property can be obtained from the other owner(s), the property will be considered a countable resource.

      When it is established (in writing) that consent to sell joint tenancy property cannot be obtained from the other owner(s), the property will not be considered a countable resource.

b. Tenancy-in-Common - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. The value of the individual's interest will be considered a countable resource, regardless of the other owners' desire to sell.

c. Tenancy-by-the-Entirety (Applicable to a married couple)

1) Married Couple Living Together in the Community - For any month in which a married couple lives together in the community, the total equity value of non-excludable property held by the couple is a countable resource, whether one or both members of the couple apply for assistance. After the month in which one or both enter a facility, each member of the couple is considered individually as a married couple living apart.

2) Married Couple Living Apart in LTC or Assisted Living Facility (ALF) - When both members of a "living apart" married couple in a nursing facility (NF) or ALF are applying for or receiving Long Term Services and Support (LTSS) assistance, half of the equity value of non-excludable property is a countable resource to each individual.

When only one member of a "living apart" married couple in a NF is applying for or receiving LTSS assistance, half of the equity value of the tenancy-by-the-entirety property is a resource to that individual unless he alleges that he cannot obtain consent to sell from the spouse.

When the individual indicates that he wishes to sell his share of the property and indicates that he cannot obtain consent to sell from the spouse, request him to obtain a statement to that effect.

If it is established in writing that the spouse refuses to consent to the sale of the tenancy-by-the-entirety property, it cannot be considered a countable resource to the individual who has applied for LTSS.

3) Married Couple Living Apart - Only one in a NF or ALF - If only one member of a married couple is in a NF or ALF, the Spousal Impoverishment rules at MS H-200-212 will apply in determining the attribution of resources to each spouse. The equity value of non-excludable property will be included in the initial assessment and in the attribution of resources, regardless of the community spouse's consent or refusal to sell.

4) Married Couple Living Apart in the Community – Only one applying for PACE or ARChoices – If only one member of a legally married couple living in the community is applying for PACE or ARChoices, the Spousal Impoverishment rules at MS H-200-212 will apply in determining the attribution of resources to each spouse The equity value of non-excludable property will be included in the initial assessment and in the attribution of resources, regardless of the community spouse's consent or refusal to sell.

   When both members of a "living apart" married couple in the community are applying for or receiving Long Term Services and Support (LTSS) assistance, half of the equity value of non-excludable property is a countable resource to each individual.

   If there is difficulty determining resources or income due to inability to obtain information due to a legally married couple living separately, the applicant will need to make a good faith effort to contact the absent spouse and obtain the necessary information. The caseworker will document the efforts to contact the spouse if those efforts are unsuccessful. The applicant will not be denied eligibility due to the inability to contact the absent spouse as long as a good faith effort was made to do so.

3. Life Estate or Remainder Interest

   Examine the deed which granted the life estate or remainder interest. If there is a restriction which prevents the life estate holder or remainder holder from disposing of his interest, the value of the life estate or remainder interest is not a countable resource.

   If there is no restriction to prevent the disposal of the life estate interest or remainder interest, the following steps will be used to determine its resource value.

   a. Determine the equity value of the property (Re. MS E-514).

   b. Select the table at Appendix U for life estate or remainder interest as appropriate.

   c. If there are joint life estate holders, divide the equity value of the property by the number of owners (e.g. if there are 3 life estate owners, divide the equity value of the property by 3.)

d. Find the line for the life estate holder's age as of the last birthday.

e. Multiply the figure in the life estate column or remainder interest column for that age by the current equity value of the property to determine the life estate or remainder interest value for that individual.

f. The individual or person acting on his behalf will be given the opportunity to rebut the determined value. When the individual elects not to rebut, the value determined in item e. will be used. When the individual elects to rebut, proceed to item g.

g. To rebut the determined value, the individual or person acting on his behalf must secure an evidentiary statement from a knowledgeable source that the equity value of the interest held in the property is less than the value determined in item e. When the value determined by the knowledgeable source is less than the value determined in item e, the rebuttal value will be used. (Refer to Note 2.)

Example: Ten years ago, George and Marie transferred ownership of five acres of land in another state to their three sons and retained a life estate on the property. The Fair Market Value (FMV) of the property is verified at $24,000. There are no liens or encumbrances. George entered a facility last month and has applied for LTC. George is 82 and Marie is 68. Since the transfer did not occur in the look back period, no penalty must be calculated. The property does not meet the requirements of income producing home property to qualify for an exclusion as a resource (Re. MS E-516 #2.) The worker must determine the life estate value.

$24,000 divided by 2 = $12,000

George's age is 82. Multiply $12,000 x .40295 (Appendix U) = $4,835.40

Marie's age is 68. Multiply $12,000 X .63610 = $7,633.20

The total life estate value for both Marie and George is $12,468.60.

NOTE 1: Life estate and remainder interests which meet the requirements of income producing non-home property qualify for exclusion as a resource (Re. MS E-516).

NOTE 2: The knowledgeable source statement for rebuttal should be for the market value of the life or remainder interest only, not the market value of the property itself.

The market value of property often has little bearing on the market value of a "life estate" interest.

4. Dower/Curtesy

    a. Determine the current market value of the property.

    b. Find the line in the life estate tables (MS Appendix U) for the individual's age at his or her last birthday.

    c. Multiply the figure beside the individual's age in the life estate table by the current market value of the property.

    d. Divide the resulting amount by 3 to determine the value of the dower or curtesy interest.

5. Ownership Interest Held in Unprobated Estate

    An individual's ownership interest in an unprobated estate is considered to be a resource. When the property cannot be excluded as income producing property and inclusion of it would make the individual's resources exceed the countable resource limitations, ownership must be established.

    If ownership cannot be determined, the facts of the ownership interest will be submitted to the Medicaid Eligibility Unit for review by the Office of Chief Counsel (OCC) to obtain a legal opinion of the individual's ownership share, if any (Re. MS E-501).

    When the individual is determined to have an ownership interest in an unprobated estate, it will be necessary to determine its value through contact with a knowledgeable source. Knowledgeable sources include the following, shown in order of priority:

    - Real estate brokers;
    - Local office of the Farmer's Home Administration (for rural land);
    - Local office of Agricultural Stabilization and Conservation Service (for rural land);
    - County Extension Services;
    - Banks, savings and loan associations;

- Mortgage companies, and similar lending institutions or
- Officials of the local real property tax jurisdiction.

The full details of the individual's share of the ownership interest in the unprobated estate must be given to the knowledgeable source to obtain an accurate estimate of value. If a free estimate of the value cannot be obtained, it will be the individual's or his or her authorized representative's responsibility to obtain the estimate.

The costs of settling the estate including funeral expenses, payment of mortgages and other debts, attorney fees, etc. will be deducted from the value of the whole estate before determining the individual net interest. A knowledgeable source estimate of these costs will also be used in making this determination, if the actual costs are not known.

Document all findings in the electronic case record.

NOTE: If the consent of others who have an interest in an unprobated estate is required in order to sell an individual's interest in the estate, and the other owners refuse to give consent, then the individual's share is not counted as a resource.

6. Rights to Use
   Mineral rights, timber rights, easements or leaseholds may all be countable resources if they have a cash value available to the individual on disposition. However, in many cases, none of the above are saleable and, therefore, would not be a countable resource. Mineral rights can be leased and may be considered a resource. See MS E-515 for guidelines to use to determine the value of an Oil and Gas Lease.

E-514 Determining Equity Value

MS Manual 10/26/15

Equity value of either a home or non-home real property is determined by deducting outstanding encumbrances (e.g., liens, mortgages, etc.) from the current market value (CMV) of the property. CMV is the amount for which the property can be expected to sell on the open market. The equity value determination of property owned by the individual must be fully documented in the case record.

The individual's allegation of property value is accepted without further verification when the following conditions are met:

- The value would cause total resources to exceed countable resource limitations (Re. MS E-502);
- The individual can dispose of the property; and
- It does not qualify for exclusion.

If these conditions are met, with the exception of alleged value (i.e. the individual is unable to provide an estimate), the caseworker will ask if the property would sell for at least the individual/couple's resource limit, as appropriate. If he alleges that it would, the caseworker will initiate action to deny or close.

When the individual's alleged value does not cause resources to exceed countable resource limitations or result in potential conditional eligibility, determine property value using one of the methods indicated below:

1. Determine the value based on the tax assessment. Multiply the assessed value (AV) by five. The AV used in this determination will be the current assessed value on record at the County Assessor's Office in the county where the property is located. If the individual does not have documentation of the current AV, the caseworker will contact the County Assessor to obtain the current AV. If the value based on the AV results in eligibility, the caseworker will proceed with the determination. If the value based on the AV causes ineligibility, the caseworker will initiate action to deny or close unless the individual wishes to obtain a knowledgeable source estimate to rebut the value. If the individual obtains an estimate from a knowledgeable source, the CMV will be determined in accordance with #2 below.

2. Determine the CMV based on an estimate from a knowledgeable source. The individual will be asked to obtain the estimate. The estimate must be written, signed, and have enough information so the source can be identified. It must be specific as to the point in time for which the estimate is effective. Knowledgeable sources include:

    a. Real estate brokers;

    b. Local office of the Farmer's Home Administration (for rural land);

    c. Local office of the Agricultural Stabilization and Conservation Service (for rural land);

d. Banks, savings and loan associations, mortgage companies, and similar lending institutions;

e. County Agricultural Extension Service (for rural land);

f. Local newspaper real estate ads, "multiple listing" publications, etc.

NOTE: When there is a difference between the assessed value and the CMV based on a knowledgeable source estimate, the knowledgeable source estimate will be used.

Although it is the individual's responsibility to obtain an estimate, the caseworker will assist when necessary. If requested, the caseworker will attempt to obtain a free estimate.

If the CMV of non-excludable property (based on the knowledgeable source estimate), when combined with other countable resources, causes ineligibility, the caseworker will initiate action to deny or close. If the CMV allows eligibility, the caseworker will proceed with the determination. The caseworker may request/secure additional knowledgeable source estimates of value when necessary to clear property values. When multiple estimates are secured, the highest estimate will be used.

Net equity in non-home real property is a countable resource unless it is excludable as income producing property. Refer to MS E-516 to determine if the property is excludable.

E-515 Determining the Value of an Oil & Gas Lease

MS Manual 02/16/17

Mineral rights can be leased and may be considered a resource. A resource determination regarding the value of an oil and gas lease will be conducted at the initial application and each subsequent reevaluation. The following guidelines will be used to determine the value of an oil and gas lease.

1. Homestead Property
   If the oil and gas lease is for the mineral rights of the homestead property and the land contiguous to the home, the value of the lease will be disregarded as a resource for as long as the applicant continues to claim the same homestead.

2. Excess Real Property
   a. If the mineral rights are on excess real property, the value of the land will be assumed to include the value of the mineral rights. The value of the land will be used for the resource determination. Additional development is unnecessary.

b. Refer to MS E-516 a, to determine if the income producing property will meet the $6,000 exclusion.

Example: Mr. Piper owns 5 acres of non-home property. The current market value of the land is $5,000. It is earning $50 per month. In order to qualify for an exclusion per MS E-516 #2.a., it must be earning 6% of $5,000 or $300 per year. In this case, the land would meet the exclusion.

3. Owns Mineral Rights But Not Real Property

a) If a client owns the mineral rights for land that he/she does not own, the caseworker will calculate the value of the oil and gas lease by multiplying the most recent year's royalties by 5. The amount of yearly royalties for the previous year can be obtained on the income tax Form 1099, Miscellaneous Income. If the 1099 is not available, the total amount of revenue from the royalty checks received in the previous year will be used to calculate the lease's resource value. If the value causes ineligibility, the caseworker will initiate action to deny or close unless the individual wishes to obtain a knowledgeable source estimate to rebut the value. Such sources include, in addition to those found at MS E-514 #2, the Bureau of Land Management, the U.S. Geological Survey, and any mining company familiar with leases in the area.

The value of the mineral lease alone is the resource value.

Example: Per the 2011 Form 1099, the annual revenue from the royalties on the mineral lease for 2010 was $443.25. Multiply this number by 5. $443.25 X 5 = $2,216.25. This will be the value of the mineral lease.

Example: The client received royalty checks for $57.15, $115.32, and $100.03 for the year 2011. The total of these checks is $272.50. Multiply this number by 5. $272.50 X 5 = $1,362.50. This is the value of the mineral lease.

b) The caseworker will need to refer to MS E-516 to determine if the income producing property will meet the $6,000 exclusion.

Royalty payments from a mineral lease will be considered as unearned income in the month received and as a resource if retained the following month.

E-516 Real Property Exclusions

MS Manual 02/16/17

The following resource items qualify for special exclusions from resources when specific conditions are met.

1. Home

   The "home" is excluded as the principal place of residence as long as it is occupied by the individual, his spouse, or "dependent relative"; or, if unoccupied, as long as the individual states his intent to return to the home.

   a. The "home" is any shelter in which the individual (or spouse with whom the individual lives) has an ownership interest (e.g., title or life estate), and which is used by the individual (or spouse) as his principal place of residence. The home may be either real or personal property, fixed or mobile, and located on land or water. The home includes all contiguous land, the mineral rights for the land, and the buildings located on such land. Only one home can be considered the principal place of residence and qualify for exclusion.

NOTE: An individual with an equity interest in the home of greater than the home equity limit (Appendix R) is ineligible for nursing facility, PACE, and Home and Community Based services. This provision applies to the first determination of eligibility as well as future redeterminations. (Re. MS E-517). The limitation on home equity does not apply if the spouse of the individual, the individual's children under the age of 21, or the individual's child who is blind or has a disability is residing in the home.

Farm or other business resources located on the home property (e.g., tractors, trailers, cars, other equipment, inventory, seed, livestock, etc.) cannot be included under the home property exclusion. These resources are considered personal property and will be included with countable resources unless they can qualify for exclusion under #2 of this policy section.

NOTE: Livestock is defined as any animal(s) kept for use or profit. Livestock includes poultry, catfish, minnows, worms, crickets, etc.

   b. A "dependent relative" is defined as a son, daughter, grandson, granddaughter, stepson, stepdaughter, in-law, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle,

sister, brother, stepbrother, stepsister, or cousin who is dependent on the recipient's home for shelter. Dependency may be verified by the recipient's declaration or by contact with collateral sources knowledgeable of the circumstances. Actual documentation of relationship is not required unless relationship is questionable (i.e. doubt has been raised due to contact with collaterals, etc.).

Absence from the Home

Absence from the home does not affect the home exclusion, as long as the individual intends to return to his home. This exclusion may be given to all AABD applicants/recipients who are away from home but intend to return to their home. See below for consideration to be given to an out-of-state home.

Occupied Home

Intent to return is irrelevant if the home is occupied by the spouse or a dependent relative at any time while the applicant or recipient is residing in a medical institution. As long as the spouse or dependent relative resides in the home, it will be excluded.

Unoccupied Home

When an individual enters a facility and leaves his or her home unoccupied, a statement of his/her intent to return to that home will be sufficient to allow exclusion of the home as a countable resource. The statement should include the reason for being away from home and the intent to return.

The statement of intent to return will be accepted without challenge unless it is self-contradictory. For instance, if the individual states his or her intent to return, but also states he will talk to a realtor about listing the home for sale, the intent to return should be questioned. When the statement is contradictory or does not make the intent clear, or the individual's actions are contradictory to his statement, obtain clarification from a secondary source, such as a physician, relative, or other knowledgeable person.

The individual's intent to return home will be documented at 12-month intervals and the home exclusion will continue as long as the individual intends to return.

If at any time it is established that the individual has no intent to return home, the home will no longer be exempted from resource consideration. Putting the home up for sale and having no plans to invest the profits from the sale in another home indicates that the individual does not intend to return home. The individual's equity in the home will be a countable resource effective the first day of the month following the month in which it is determined that the home is no longer the principal place of residence.

NOTE: Statements concerning intent to return, allegation of dependency, and/or principal place of residence may be accepted from individuals who have the authority to act on behalf of the applicant/recipient when the applicant/recipient is incapable of providing the information.

Out-of-State Home

The out-of-state home of an individual who enters the state with the intent to reside permanently or for an indefinite period of time will not be excluded as the principal place of residence unless the home is occupied by a spouse or dependent relative. The out-of-state home cannot be disregarded using an intent to return statement as this conflicts with the individual's allegation regarding state residency.

Transfer of the Home

If an individual transfers his home for less than fair market value while institutionalized, refer to MS H-305, H-309 and H-317 for treatment.

Rental of the Home

If the home is rented while an individual is institutionalized, it may continue to qualify as the principal place of residence and be excluded from resources as long as the individual intends to return. See MS E-430-431 for guidelines on how to consider rental income.

The intent to return will be documented at 12-month intervals as long as the individual remains institutionalized.

Replacement of a Home

When an excluded home is sold and the intent is to purchase another home, the proceeds from sale of the original home may be excluded from resources if they are used or obligated to purchase the substitute home by the last day of the third full month following the month of receipt of the funds. If the home is not replaced during this period, then the proceeds will be counted as a resource beginning with the month following the month they were received.

Interest earned on the funds is not excluded, but will be treated as income in the month accrued, and as a resource in the month following.

The home replacement period begins in the month following the month in which the proceeds are received. However, if the funds were received prior to application, the replacement period begins the month of application.

The proceeds of a home sale will be the net payments received after deducting all encumbrances and sale expenses. All of the net proceeds must be used (or legally obligated) by the end of the exclusion period on the costs of the purchase and occupancy of the substitute home. Allowable costs may include the down payment (even if made before sale of the original home), loan fees and points, moving expenses, repairs or replacements to structure or fixtures, and mortgage payments prior to occupancy. The exclusion does not apply to that portion of the proceeds in excess of the funds used on the substitute home, i.e. if all of the proceeds from the sale of a home are not applied to the substitute home, the unused (unapplied) funds will be counted as a resource beginning with the month following the month they were received.

The intent to replace an excluded home must be documented by a signed statement from the individual or his representative. (For home replacement due to disaster, refer to MS E-530 #4).

Installment Sales Contract in Home Replacement

If an excluded home is sold, the seller has an installment sales contract for payment of the property, and all funds (down payment and periodic payments) are reinvested in the purchase of a replacement home, the CMV of the sales contract may be excluded from resources. In order for the exclusion to apply, the down payment and each installment payment must be applied to the

purchase of the replacement home within 3 calendar months of the date each payment is received (i.e., by the end of the last day of the third month after the month in which the proceeds are received).

The portion of any payment which is interest on the principal is counted as unearned income.

If an individual does not use the monies received as payments on the replacement home, the CMV of the sales contract and any payments made will count as resources in the month following the month of receipt of the contract.

If an individual ceases to use the installment payments to purchase the replacement home, any retained payments and the CMV of the contract will be considered countable resources in the month after the month of receipt of the first payment not used as intended within 3 months.

SSI Recipients in a Facility

The Social Security Administration will determine when the home becomes a countable resource for SSI recipients (i.e. those receiving reduced SSI benefits while in a facility). Vendor payments and Medicaid eligibility will continue as long as the individual receives SSI, unless the individual has made a prohibited resource transfer (which would result in only vendor payment ineligibility). If the county discovers a potentially countable resource unknown to SSA, report the resource to SSA for further determination. The individual will remain eligible for both vendor payment and the Medicaid card until SSA determines the individual is no longer eligible for SSI.

2. Non-Home Income-Producing Property

There are three categories of non-home income producing property which may be excluded from resources.

Any excluded property must be in current use or, if not in use for a reason which the individual cannot control, it must be expected that the usage will be resumed. Resumption of the use must be within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition.

These exclusions apply to all AABD categories except QDWI.

a. PROPERTY WITH EQUITY UP TO $6000 EXCLUDED IF PRODUCING A 6 PERCENT ANNUAL RATE OF RETURN

This exclusion applies to individuals who have an interest in mineral or timber rights, rented farmland, rented dwellings, etc., and they are not considered to be conducting a trade or business.

Up to $6000 equity may be excluded from the property described above if it is producing at least a 6 percent annual return on the amount of equity excluded. Any equity remaining after the exclusion is given will be included with other countable resources.

Example: A mobile home on non-home land with total combined equity value of $7000 is being rented for $60 month/$720 year. Six percent (6%) of $6000 is $360. Since the annual return ($720) is greater than 6 percent of $6000, $6000 of the equity value of this property may be excluded from resources. The remaining $1000 equity must be counted as a resource.

If an individual has more than one non-home income producing property interest, the total equity value excluded cannot exceed $6000, and the rate of return must equal at least 6 percent of the excluded equity for each activity.

Example: Mr. Patterson owns two non-home properties. One is pasture land with an equity value of $4000. It is leased for cattle grazing for $300 per year. Six percent (6%) of $4000 is $240. Since the annual return ($300) is greater than 6 percent of $4000, the entire $4000 equity value of this property may be excluded from resources. Only $2000 potential property exclusion remains for any additional properties under this exclusion.

The second property has an equity value of $3000. A neighbor pays $50 a year to plant his garden on it. Six percent (6%) of $2000 (the remaining potential equity exclusion) is $120. Since the annual return ($50) is less than 6 percent of $2000, the equity exclusion is not applied and the property's equity value of $3000 is a countable resource.

If the property is not excludable because the annual return is less than 6 percent of the excluded equity value, the total equity value of the property is a countable resource.

b. PROPERTY EXCLUDED REGARDLESS OF VALUE OR RATE OF RETURN

When non-home real or personal property is used in a trade or business essential to self-support (including personal property used by an employee for employment), the total equity value of the property may be excluded from resources.

All of the liquid resources used in the operation of a trade or business may also be excluded as property essential to self-support.

Some examples of property used for self-support are land and equipment used for farming; land, a building and equipment used for a dry cleaning establishment; or the land and multiple mobile homes being operated as a mobile home park business. Examples of property used by an employee to maintain employment are tools, safety equipment, uniforms, etc.

The most recent tax return available may be used to verify current use of the property as a trade or business enterprise. Schedule C (Profit or Loss from Business or Profession), Schedule SE (Computation of Social Security Self-Employment), Schedule F (Farm income and Expenses), Form 4562 (Depreciation and Amortization) and Form 1065 (U.S. Partnership Return of Income) can be helpful in determining the validity of the trade or business. If a tax return is not available, other means of verification such as purchase receipts, bank statements, proof of payments, etc., can be used.

The profit/loss shown on an income tax return is irrelevant in determining whether the individual is conducting a trade or business or whether the value of the property will be excluded from resources.

c. PROPERTY WITH UP TO $6000 EXCLUDED REGARDLESS OF RATE OF RETURN

Up to $6000 of the equity of non-home, nonbusiness real or personal property used to produce goods or services essential to daily living may be excluded from resources. There is no rate of return requirement. If the equity value exceeds $6000, only $6000 may be excluded; the remaining equity is a countable resource.

Some examples of the above exclusion are the land used for gardening or for grazing livestock when the product (vegetable or meat) is used only for personal consumption by the applicant/client and his household members. Equipment, such as a tractor or fishing boat, used in the production of food solely for home consumption may also be excluded. However, an automobile or truck may not be excluded under these provisions.

The current market value (See MS E-514) and the value of the individual's equity in the property must be verified in order to determine what portion of the equity value, if any, must be counted as a resource.

Only one $6,000 exclusion may be given under this policy that allows a $6000 exclusion regardless of rate of return.

E-517 Home Equity Limit – Long Term Services and Supports

MS Manual 02/16/17

The Deficit Reduction Act of 2005 established a home equity limit for individuals applying for Long Term Care Services beginning January 1, 2006. This limit applies only to eligibility for nursing facility vendor payments, Home and Community Based Waiver services and PACE. An individual ineligible for HCBW or PACE services due to the home equity limit is not eligible for Medicaid in either of these categories and his/her application will be denied. An individual ineligible for nursing facility vendor payments due to the home equity limit may still receive other Medicaid covered services.

EXCEPTIONS: The home equity limit does not apply to:

1. Individuals who applied and were determined eligible prior to January 1, 2006 and who have had no break in LTSS eligibility since January 1, 2006.

2. Individuals whose spouse, children under the age of 21, or child who is blind or has a disability is residing in the home.

The Center for Medicare/Medicaid Services in the federal Department of Health & Human Services annually reviews and revises the amount of the home equity limit. Changes to the amount go into effect on January 1 of the applicable year. Refer to MS Appendix R for the current year's home equity amount.

Home equity will be determined at application for those applying on or after January 1, 2006. Equity value in the home will be determined in the same manner as for non-home real property.

(See MS E-514). If the home is held in any form of shared ownership, only the applicant's fractional interest will be considered. (See MS E-512) The LTC application must be approved for Medicaid if all eligibility requirements other than the home equity limit have been met. The individual will not be eligible for a vendor payment until the equity in the home is below the current maximum but may receive other Medicaid services with the exception of PACE and Waiver services.

Request for Undue Hardship Waiver

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. 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. (Re. MS H-710)

E-518 Reverse Mortgage or Home Equity Loan

MS Manual 10/26/15

An individual may obtain a home equity loan or a reverse mortgage to reduce the total equity interest that he/she has in the home in order to qualify for Medicaid payment for facility care, PACE or Home and Community Based Services. A reverse mortgage is a type of loan that establishes a maximum Line of Credit that the homeowner is allowed to borrow using the home as collateral.

Any funds that the individual receives from the reverse mortgage or home equity loan are disregarded in the month received as proceeds from a loan. Any funds received from a reverse mortgage or home equity loan are counted as a resource if retained after the month of receipt.

NOTE: If the proceeds from a reverse mortgage or home equity loan are transferred during the month of receipt and the individual does not receive fair market value in return, the transfer will be considered an uncompensated transfer and a penalty period will be determined.

If on the first of the month an individual has retained a payment from a home equity loan for an amount greater than the resource limit, he/she would be ineligible to receive Medicaid until the resources are reduced to meet the resource eligibility limit. If the individual gives this money away, this would be considered an uncompensated transfer and a penalty period will be determined.

EXAMPLE: Mr. Smith is applying for nursing facility services. He is otherwise eligible except he has equity in his home in the amount of $537,000 which exceeds the $536,000 (2013 standard) home equity limit. He converts $1,000 of the home equity to cash. Mr. Smith reports no other resources. His home equity is now within the accepted limits and if his resources are below $2,000, he is now eligible for vendor payment or Home and Community Based Services.

EXAMPLE: Mrs. Jones, a LTSS applicant, has equity in her home of $550,000. She obtains a home equity loan of $25,000 thereby reducing her equity to $525,000. She now meets the home equity limit but is ineligible due to countable resources of $25,000 if she retains the loan proceeds in the month after she receives them.

If an individual has arranged a private reverse mortgage with an adult child instead of with a commercial lender, verification that the loan is "bona fide" will be required prior to the approval of a reduction in home equity value. If the applicant cannot prove that the loan is bona fide, then the loan cannot be used to reduce the equity value of the home.

In order to be considered a bona fide loan, each of the following requirements must be met:

- A bona fide loan is a contract that must be enforceable.
- The loan agreement must be in effect at the time that the cash proceeds are provided to the borrower. Money given to an individual with no obligation to repay cannot become a loan at a later date.
- A loan is an advance from a lender that the borrower must repay with or without interest and that must be acknowledged by both the lender and the borrower for a bona fide loan to exist.
- The loan must include a plan or schedule for repayment and must document the borrower's express intent to repay the loan by pledging either real or personal property for anticipated future income.
- The plan or schedule of repayment must be feasible. In determining the plan's feasibility, consider the amount of the loan and the borrower's income, resources and living expenses, as well as, other factors that may influence the repayment of the loan.

The individual applying for medical assistance will be required to provide a copy of the loan note which must include the following:

1. Verification of the loan balance,
2. The payment schedule, and
3. Verification of actual payments.

If the applicant cannot prove that the loan is bona fide, the caseworker will not use the loan to reduce the equity value of the home.

NOTE: Any costs paid out of the loan proceeds to enable the individual to obtain the reverse mortgage can be used to reduce the equity provided that the costs become part of the outstanding debt. If the individual pays the costs out-of-pocket, the equity value cannot be reduced by that amount.

EXAMPLE: An administrative cost of $3,000 is charged by the financial institution as part of obtaining a reverse mortgage for $85,000. If the client adds this amount to the balance of the outstanding loan, the total amount of the loan becomes $88,000. The total $88,000 can be used to reduce the client's home equity amount. If the client pays the $3,000 out-of-pocket, the additional $3,000 cannot be used to reduce the equity amount.

E-520 Personal Property

MS Manual 01/01/14

Personal property is property other than real property, consisting primarily of liquid assets.

Personal property which is accessible to the individual, or of which the individual is free to dispose, is a countable resource unless it meets the criteria for exclusion as specified under MS E-523.

E-521 Forms of Ownership

MS Manual 01/01/14

Generally, ownership of personal property can be in the same form as that of real property (Re. MS E-512).

E-522 Determining Value of Personal Property

MS Manual 02/16/17

Listed below are various types of commonly held assets which are countable resources. The listing also describes how their resource value is determined.

Verification of countable resources is required unless the client's declaration of the resource value would cause total countable resources to exceed the countable resource limit.

1. Cash - Cash consists of money which is on hand in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for United States issue. (Coin collections, however, are not considered to be cash, even though they are a resource. Their value is based on collector's value which is determined by contact with a knowledgeable source.)

   Cash on hand includes amounts that the individual has on his person, amounts that he has at home, and amounts being held for him elsewhere.

   The total amount of cash on hand (excluding amounts which were received during the month and counted as income) is a countable resource. The individual's allegation of actual cash on hand is accepted as verification.

2. Checking or Savings Accounts - Assets of an individually held checking or savings account (including patient fund accounts managed by a facility for an individual) will be considered a resource to the individual when he has unrestricted access to the account. The resources of a jointly held account are presumed to be fully available to an eligible individual when he is the only party to the account eligible for assistance. However, when all parties to a jointly held account are receiving or have applied for assistance under the same program, the resources of the account are presumed to be divided equally among the eligibles who have access to the account.

   An otherwise eligible individual, who is a joint account holder with unrestricted access to the account, will be offered an opportunity to rebut the presumption. To rebut the presumption of full or partial ownership, the individual must provide all of the following evidence within 30 days:

   a. A written statement by the individual giving his allegation regarding ownership of the funds for the applicable period, the reason for establishing the joint account, who made deposits to and withdrawals from the account, how withdrawals were spent, etc.;

   b. Corroborating written statements from the other account holders; and

   c. Proof of the change in the account designation removing the individual's name from the account (if he has no ownership), or restricting his access to the funds in the account.

   The caseworker will provide assistance in obtaining the evidence only when the individual is unable to do so.

If the co-holder of a joint account is incapacitated or a minor, it will not be necessary to obtain a corroborating statement from that individual. When this occurs, obtain a corroborating statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, make the rebuttal determination without a corroborating statement. The caseworker will document in the electronic case record an explanation as to why no corroborating statement was obtained.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the funds (if any).

If the individual elects not to rebut the presumption, obtain a written statement from the individual which documents his 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 presumed ownership interest will be used in his eligibility determination. When the individual is a joint account holder with an ineligible individual, any interest payments or deposits made to the account will be considered unearned income in his eligibility determination unless the deposit meets the income disregards listed in MS E-450. When the individual is a joint account holder with an eligible individual, any interest payments will be divided equally among the holders but deposits by one will not be considered income to the other.

If the individual submits all required evidence within the allotted time, determine his ownership interest (if any) and document the findings in the electronic case record. The actual ownership 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 funds in a joint account, deposits made by the other holder(s) will not be counted as income and interest payments will be counted in proportion to his or her ownership interest, if any.

If the value of a joint account will cause the individual to be ineligible because he or she is the only account member eligible for Medicaid, he or she must be advised of the reason for his ineligibility. Any questions that the individual may have regarding the effect of specific actions that he or she may take concerning the account will be answered.

Verification of a checking account balance is made by examining the checkbook record and the bank statement covering the month before application or reevaluation, or

written contact with the financial institution. Checks written and forwarded or delivered for payment prior to the first of a month but not cleared by the first day of the month will be deducted from the account balance.

Verification of a savings account balance is made by examining the passbook and/or bank statement or by written contact with the financial institution.

Verification of a patient fund account balance will be secured by contact with the facility.

If there is any question as to the accuracy of the passbook or checkbook record, secure a DHS-81, Consent for Release of Information, and request a written verification from the financial institution.

3. Certificates of Deposit - Certificates of deposit or time deposits are contracts between an individual and financial institutions whereby the individual deposits funds for a specified period of time in the form of a certificate of deposit, savings certificate, etc. In return, the financial institution agrees to pay the individual a higher interest rate than the maximum permissible passbook rate.

   To be considered a resource, funds invested in the CD or time deposit must be available to the individual. Generally, funds in a time deposit can be withdrawn prior to maturity of the certificate with penalties for early withdrawal. The resource value of a CD or time deposit is the net amount that would be received after imposition of penalties for early withdrawal.

   If after examining the certificate it cannot be determined whether the funds can be withdrawn, or if the resource value cannot be determined, contact the financial institution where the funds are deposited. The electronic case file will be documented as to the resource value of time deposits and the method used to determine value.

4. Promissory Notes - A promissory note is a written unconditional promise signed by a person who promises to pay a specified sum of money at a specified time or on demand to a person, company, corporation, or institution on the note.

   The caseworker will evaluate whether the individual has transferred resources for less than fair market value when an individual transfers a resource and receives a promissory note, loan, or mortgage as compensation. If the transfer of resources was for less than fair market value, the caseworker will refer to MS H-308 for guidance regarding determining a penalty period. If fair market value was received for the

transfer, the caseworker must consider whether the note, loan, or mortgage is a countable resource.

If an applicant transfers resources while providing the appearance of a loan and documenting the transfer as a promissory note, the funds will continue to be considered as a resource unless all of the following conditions are met:

- The repayment plan is actuarially sound and feasible,
- The repayment plan provides for equal payment amounts during the term of the loan with no deferral or balloon payments, and
- The repayment plan prohibits cancellation of the balance upon death of the lender.

Promissory notes may be discounted and sold, unless the terms of the note prevent it. If the terms of the note prevent its sale, it is not considered to be a resource.

Discounting refers to the interest deducted in advance by one who buys, or lends money on a bill or exchange or promissory note. For example, a bank may be willing to pay $450 for a $500 promissory note which is due in one year's time.

When the individual owns a promissory note which he could sell or discount, it is considered to be a resource in the amount for which it could be sold or discounted.

If by examination of the promissory note, it cannot be determined whether the promissory note is saleable, or its value cannot be determined, contact with a local bank or lending institution will be necessary. The bank may wish to examine the note before making a determination. When this is required, the individual or person acting on his behalf should personally submit the note to the bank for examination. When the note is determined not to be saleable until maturity, its value is not a countable resource until that time.

The cash payments received on a nonsalable promissory note are counted in full as unearned income.

The cash payments received on a saleable promissory note, which is considered to be a resource, are treated as follows: (1) payment which represents payment on principal is considered as a resource; (2) payment which represents payment on interest is

considered to be unearned income. An amortization schedule may be necessary to determine interest income.

Documentation in the electronic case record will be made to indicate a note's resource value and how it was determined.

5. Mortgage - A mortgage is a pledge of a particular property to a creditor as security for the payment of a debt (or the performance of some other obligation) within a prescribed time period.

   Generally, a mortgage can be sold or discounted like a promissory note.

   Determination of the value and salability of a mortgage is made in the same manner used for promissory notes.

6. Stock - Shares of stock represent ownership in a corporation. Stock value is determined by the closing price at the time of application or redetermination.

   Individuals who own stock must provide either the stock certificate for verification of ownership or a copy of the most recent account statement, if the stock is held by a securities firm.

   Verification of stock value may be made by consulting one of the following free web sites:

   - www.nyse.com (New York Stock Exchange)
   - www.nasdaq.com

   The financial section of a newspaper for stock that is listed on either the New York or American Stock Exchange may also be used to obtain a stock's value. Closing price is used. For stock not listed on either exchange that is traded "over the counter", the "bid" price for the stock is used to determine market value. If "bid" prices for "over the counter" stock are not listed in the newspaper, contact will be made with a local securities firm to verify value. Documentation of ownership and value will be entered in the case narrative.

7. Stock in Close Corporation - Stock held in a corporation wholly owned by one or more board members requires complete development to determine resource value.

   The value of stock in a close corporation which has elected not to trade its stock publicly is determined by subtracting the liabilities of the corporation from its assets and dividing the resulting net assets by the number of stock shares outstanding.

   Net assets of the corporation must be determined by examination of the corporate tax return for the most recent taxable year. The individual who owns stock in a close corporation must provide information necessary to determine its resource value.

8. Stock in Alaskan Native Corporation - Shares of stock held in an Alaskan Native regional or village corporation are excluded from resources.

9. Mutual Fund Shares - A mutual fund is a company that buys and sells securities and other property with funds obtained from its shareholders.

   Value determinations for mutual fund shares follows the procedure used in determining the value of stock.

10. Municipal, Corporate, and Government Bonds - A bond is a written agreement to pay a sum of money at a future specified date. Even though a bond must be held until its specified date of maturity to be redeemed for its stated value, it is saleable and transferable.

    A “municipal bond” is the obligation of a state or a locality (county, city, town, village, or special purpose authority like a school district). “Corporate bonds” are obligations of private corporations, and “government bonds” denote a transferable obligation backed by an agency of the federal government.

    Current market value is generally determined as it would be for stock. It is frequently necessary to contact a local securities dealer to establish the market value of a bond. Documentation of the value determined will be recorded in the case narrative.

11. U.S. Savings Bonds - A U.S. Savings Bond is an obligation of the federal government which is nontransferable. A U.S. Savings Bond can only be sold back to the government.

    U.S. Savings Bonds are usually registered in the name of the owner(s) shown on the front of the bond, and may be redeemed by the owner by completion of a form on the

back. If bond ownership is shared, each person's share as a resource is equal even though any one of the owners listed on the bond may dispose of it.

The value of a U.S. Savings Bond depends on the amount of time elapsed since issuance. There is a table of value on the reverse of many bonds; however, due to interest rate changes which may have occurred since issuance, it may not be accurate. Value determinations should be secured by contact with a bank or by visiting the US Treasury website at http://www.treasurydirect.gov/BC/SBCPrice.

Documentation of the value determination will be entered in the case narrative.

12. Prepaid Burial Contract - A prepaid burial contract is an agreement in which an individual prepays his burial expenses and the seller agrees to furnish the burial.

    Prepaid burial contracts may or may not be considered as countable resources for determinations of Medicaid eligibility, depending on the terms of the individual contract and depending on the legal authority of the seller to issue prepaid contracts (Re. MS E-523 #5 for treatment of burial funds).

13. Trusts - A trust is a right of property held by one party (the Trustee) for the benefit of another (the beneficiary). The trustee holds the legal title of property for the beneficiary. The term "trust" includes any legal instrument or device that is similar to a trust, and may include annuities.

    Generally, an appointed trustee cannot use funds within the trust for his own benefit, and it is therefore not a resource to him.

    If an individual is not legally competent and a trust is established for the individual by a guardian or legal representative (including a parent for a child), using the individual's resources, the trust will be treated as having been established by the individual, since he could not do it for himself.

    Two considerations to be given to trusts, when an individual has established a trust and/or when an individual is beneficiary of a trust, are:

    a. Whether or not the trust is a countable resource to the Medicaid applicant/recipient, and

b. Whether or not a period of ineligibility will be imposed on a nursing facility or Waiver Medicaid applicant/recipient due to the transfer of resources into a trust.

The resources of a trust may or may not be countable to a Medicaid applicant/ recipient depending upon who established the trust, who is beneficiary of the trust, whether the trust is revocable or irrevocable, when the trust was established, etc.

Trusts established by will are generally not considered to be trusts established for the purpose of making an individual eligible for Medicaid. However, an individual who is beneficiary to a trust established by a will may be ineligible for Medicaid if the trust resources are considered available and countable as income and/or resources to the individual.

Applicant/recipients who apply for nursing facility services or Waiver services and who have established a trust may be subject to a period of ineligibility as a result of the transfer of resources into a trust. Refer to MS H-304 for additional information regarding the transfer of resources to a trust.

In all cases, when an caseworker in a county office becomes aware of a trust, when established by a Medicaid applicant/recipient or by someone acting on behalf of the applicant/recipient, or when the applicant/ recipient is a beneficiary or potential beneficiary of a trust, the trust document along with all other pertinent data and a cover memorandum should be scanned into the electronic record with a request for review by the Office of Chief Counsel (OCC). See MS E-501 for the process to submit an electronic request for an OCC opinion.

14. Annuities - An annuity is a financial tool used to obtain an income amount paid at specific intervals for a fixed period of time, often for the individual's lifetime, in return for a premium paid either in installments or in a single payment. An individual applying for either Nursing Facility Care or Home and Community Based Services must follow these guidelines regarding annuities:

    1. The individual must disclose a description of any interest the individual or community spouse has in an annuity regardless of whether the annuity is irrevocable or is treated as a resource.

    2. The State of Arkansas must be named as the preferred remainder beneficiary of an annuity unless there is a Community Spouse and/or a minor child or a child

with a disability. If there is a Community Spouse and/or a minor child or a child with a disability, Arkansas may be named in the next position after these individuals. If Arkansas is not named as the remainder beneficiary in one of these positions, the purchase of the annuity is treated as a disposal of resources for less than fair market value.

3. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

With the exception of the annuities listed in the note below and pre-paid burial contract annuities, a complete copy of an annuity will be forwarded to The Division of Aging and Adult Services (DAAS) for submission to the Office of Chief Counsel (OCC). Based on OCC's opinion, DAAS will inform the caseworker whether the annuity is to be treated as a resource, as income or as a disposal of resources for less than fair market value.

NOTE: The caseworker will determine the value of APERS (Arkansas Public Employees Retirement System), ATRS (Arkansas Teachers Retirement System), OPM (Office of Personnel Management) and Railroad Retirement pension annuities. These pension annuities provide a scheduled amount of payment that will be income in the month received and a resource if retained in the following month.

Prepaid Burial Plan Annuities (Refer to MS E-523)

An annuity purchased to fund a pre-paid burial contract will not be a countable resource when the guidelines at MS E-523 #5(b) section 2 are met. When the caseworker can determine a pre-paid burial annuity meets these conditions, the annuity does not need to be sent to DAAS for an opinion. However, if there are questions or issues that cannot be handled at the county level, submit the request to DAAS for an opinion.

E-523 Personal Property Exclusions

MS Manual 02/16/17

Listed below are resource items that qualify for special exclusion from resources when specific conditions are met. Resource items which do not meet conditions for exclusion will be included with countable resources. When an excludable resource item has a value in excess of the exclusion limitation, the excess value will be included with countable resources.

1. Automobile

The term "automobile", as used here, applies to any vehicle which is used to provide necessary transportation, such as passenger cars, trucks, boats, and special vehicles (e.g., motorcycles, snowmobiles, animals, animal-drawn vehicles, etc.).

One automobile per household is excluded regardless of value if it is used for transportation by the individual or a member of his household.

NOTE: The case worker will assume that the automobile is used for transportation unless there is evidence to the contrary.

When an individual or household owns more than one automobile, the exclusion will be applied in the manner most advantageous to the individual. The exclusion will be given to the automobile with the highest equity value. The equity value of any other automobile owned by the individual or member of the household is a resource when:

a. It is owned by the individual or couple, and

b. The automobile cannot be excluded under any other policy provision.

When the above general exclusion has been given to an automobile, a second automobile can be excluded only if it is essential to the means of self-support of an individual or couple. If a second vehicle is normally used in the operation of a trade or business and if the first excluded vehicle cannot also fulfill the self-support function, then the second vehicle may be excluded from counting toward the resource limitation.

The following vehicles do not meet the definition of an automobile and therefore the general exclusion cannot be applied:

a. A vehicle that has been "junked";
b. A vehicle that is used only as a recreational vehicle (e.g., a boat used on weekends for pleasure).

The equity value of such a vehicle will be considered a resource. The personal effects exclusion does not apply to such vehicles. (Refer to MS E-516).

The equity value of all nonexcludable automobiles will be included with countable resources.

Determination of Current Market Value for a Non-Excluded Automobile - The determination of value for foreign and domestic passenger cars will be based on use of the "Trade-In" value in "Fair" condition as verified by one of the following free web sites:

- www.kbb.com (Kelley Blue Book)
- www.edmonds.com
- www.nada.com (Used for motorcycles, boats, RVs)
- www.collectorcarmarket.com (Used for vehicles too old to list on KBB or NADA)

When the Trade In value is not available, a comparable value (i.e., wholesale or loan value) may be used. The caseworker will print a copy of the web page showing the vehicle value and the copy will be scanned in the electronic case file.

Fair market value is the average trade-in value of the vehicle as listed on the selected web site unless the individual disputes the value and presents conclusive proof that the information obtained from the web site is inaccurate.

NOTE: The value of special or optional equipment or low mileage will not be considered when determining the average trade-in value of the vehicle.

The caseworker will determine the average trade-in or wholesale value for the auto as listed on one of the above approved websites. When a non-excluded vehicle is too new to appear on the approved web sites, the caseworker may determine the current average trade-in value by contacting a local car dealer or by consulting a recent newspaper ad for used cars of the same make, model and year. A copy of the ad should be scanned into the electronic case record. Information obtained from contracts for purchase may be inaccurate because vehicles decrease in value substantially once they become "used".

An individual may indicate that for some reason such as body damage, high mileage, inoperability due to motor failure or other major malfunction, a vehicle is in less than average condition. An individual is allowed to contest the website's value of the vehicle when its depreciated condition makes its value "less than average". The caseworker may accept statements from reputable repair shops to verify high mileage, motor failures or other major malfunctions. Police reports or insurance documents may be

accepted as proof of the current condition of a vehicle if it has been wrecked. Other proof may be accepted if it is conclusive in the caseworker's judgment.

If the value of the auto is not material to the eligibility determination (i.e., it is excluded or its countable resource value does not affect eligibility when combined with other countable resources), no further determination of exact value is necessary.

The value of an unexcluded automobile of obvious worth such as a Jaguar, Mercedes-Benz, Rolls Royce, Cadillac, Lincoln, Corvette, antique auto, or customized auto will be determined even when it is too old to be listed on kbb.com or nada.com. The value of these vehicles may be verified by a search on collectorcarmarket.com or by the use of the tax assessment method or by contact with a knowledgeable source. Knowledgeable sources include: automobile dealers, truck dealers or auto insurance companies. The tax assessment method of determining value consists of multiplying the county personal property tax assessment value of the vehicle by five.

> **EXAMPLE:** The county personal property tax value of a 1973 Lincoln Town Car is $200. Multiply $200 by five to obtain the current resource value of the vehicle. ($200 X 5 = $1,000) The value of the vehicle is $1,000. This amount will be regarded as a resource to the individual if the vehicle cannot be excluded.

When contacting a knowledgeable source, an estimate of the wholesale value will be requested. In all value determinations, it is essential to obtain a complete and accurate description of the vehicle being evaluated. Document the case narrative as to determined values and the means used to make the value determinations (including the name and address of dealers used in knowledgeable source contact). All documentation used to determine the value of the vehicle must be scanned and indexed in the electronic case file.

Applicant Disagrees with Determined Value - If the applicant disagrees with the value determined for a non-excluded automobile which is material to the case (affects eligibility), he will be afforded the opportunity to provide two knowledgeable source statements to establish a different value. These appraisals will be at the applicant's own expense. It should be explained to the applicant that the agency is not bound to honor the appraisals; however, the agency will recheck any provided appraisals for accuracy and, if they are accurate, establish a value based on the appraisals.

2. Life Insurance Policies

a. An individual is allowed to own policies with a combined face value of $1500 or less per insured individual without consideration of cash surrender value (CSV).

b. Only policies that generate CSV are considered against the $1500 limit. These include Whole Life, Straight Life, Endowment, Limited Payment Life, etc.

c. Policies which do not generate CSV are not counted as resources.

When the combined face value of policies with CSV owned by the individual is equal to or less than $1500 per insured, there is no resource to be considered. However, the face value of the policies in which the owner is also the insured must be considered in determining excluded burial funds.

When the combined face value of policies with CSV owned by the individual exceeds $1500 per insured, the CSV of the policies must be determined and counted as a resource. If the individual provides a written statement that the insurance policies are intended to cover burial expenses, the CSV of such policies in which the owner is also the insured may be designated as a burial fund.

Example: Mrs. Lambert, an aged individual, owns four life insurance policies on herself with the following values: $400 FV with $700 CSV; $500 FV with $1000 CSV; $25,000 FV with no CSV generated; and $200 FV with $400 CSV. The $25,000 FV policy is totally excluded from resources as it does not generate CSV. The remaining policies are excluded from resources because they are for the same insured person and the total combined FV ($400 + $500 + $200 = $1100) is less than $1500. However, their face values must be considered in determining excluded burial funds.

Example: Mrs. Lambert, from the previous example, also owns three additional life insurance policies on other individuals. In this case, calculate for each insured the total FV of those policies that generate a CSV. If the total FV of the policies owned on each of the other individuals is more than $1500 per insured, count the CSV as a resource to the owner.

She owns two policies on her son, Josh, with the following values: $2000 FV with $400 CSV and $500 FV with $25 CSV. The CSV of these life insurance policies ($425) must be counted as a resource to Mrs. Lambert because the total combined FV of Josh's policies ($2500) are over $1500.

She also owns a policy on her granddaughter, Mary, with a FV of $1500 and a CSV of $150. The CSV of this policy is excluded as a resource to Mrs. Lambert because the total FV of Mary's policy is $1500 or less.

Example: Mr. Coleman, an individual with a disability, owns two life insurance policies on himself and two on his son. The two policies on himself have the following values: $2000 FV with $157 CSV and $4000 FV with $987 CSV. Because the total combined FV ($6000) of the two policies exceed $1500, the CSV of the policies must be counted as a resource. If he provides a written statement that the insurance policies are intended to cover burial expenses, the CSV of such policies may be designated as a burial fund.

He also owns two policies on his son, Logan, with the following values: $1000 FV with $99 CSV and $500 FV with $245 CSV. The CSV of these policies is excluded as a resource to Mr. Coleman because the total combined FV ($1500) of Logan's policies is $1500 or less.

Most Whole Life policies come with a CSV chart which can be used to determine value. If the CSV cannot be determined from a chart provided with the policy or other available evidence, secure a DHS-81 from the client, and contact the insurance company to determine value. Any outstanding loans made against a policy's CSV will be deducted.

3. Household Goods and Personal Effects

Exclude household goods and personal effects from resources regardless of their dollar value. The resource exclusion for household goods and personal effects does not have a dollar limit. Household goods and personal effects will not be counted as a resource in determining an individual's eligibility.

4. Income Producing Non-home Property (Personal Property)

For the consideration of personal property used in conjunction with a trade or business, with employment, or with production of goods or services essential to daily activities, refer to MS E-516.

5. **Burial Spaces and Funds**

a. Burial Spaces

The term "burial space", as used here, applies to conventional burial plots, gravesites, crypts, mausoleums, urns, vaults, caskets, and other repositories which are customarily and traditionally used for the remains of deceased persons. Additionally, the term also includes necessary and reasonable improvements upon such burial spaces including headstones, markers, plaques, and arrangements for opening and closing the gravesite for burial of the deceased.

The value of burial spaces for the individual, his spouse or any member of the individual's immediate family will be excluded from resources. The term "immediate family", as used here, applies to the individual's children (minor and adult), including adopted children and stepchildren, his brothers, sisters, parents (natural or adoptive), and the spouse of those individuals. Dependency or living in the same household are not factors.

If a burial space item is included in a contract or policy which accrues interest, the interest retained is excluded from both income and resources as it increases the value of the excluded burial space. This exclusion is in addition to the burial fund exclusions specified in item "b" below.

If a burial contract or policy (item "b" below) separately identifies a burial space from the other items in the contract or policy, the amount for the burial space may be allowed in addition to the $1500 burial fund exclusion. For example, an individual has a $2700 burial contract which lists $900 for the casket and $400 for the gravesite. A total of $1300 may be excluded from resources under the burial space exclusion. The remaining $1400 will be applied to the $1500 burial fund exclusion.

b. Burial Funds and Other Burial Arrangements

Burial funds are defined as revocable or irrevocable burial contracts, burial trusts, other burial arrangements, cash accounts, or other financial instruments (documents which have a definite cash value) clearly designated for burial expenses. Property other than listed above will not be considered "burial funds."

The individual and his spouse can have an exclusion of $1500 each of funds specifically set aside for their burial arrangements. This exclusion is in addition to the burial space exclusion.

It is required that burial funds be kept in an account separate from other non-excluded funds. Burial funds and other funds may not be commingled in the same account.

Interest earned on excluded burial funds is excluded from income and resources, if left to accumulate and become a part of the burial fund.

If burial funds are commingled with other non-burial funds, all of the funds will be counted as a resource, and no exclusion of burial funds will be allowed. When an applicant agrees to (and does) separate his commingled funds, eligibility may begin effective the date of entry into a facility, provided the individual's total countable resources did not exceed $3500 ($2000 resources, $1500 cash for burial) on the first day of the month of entry and he is otherwise eligible.

If any excluded funds, or accumulated interest, set aside for burial expenses are used for a purpose other than the burial arrangements of the individual or his spouse for whom the funds were set aside, the amount used will be considered unearned income in the month in which it was accessed, and a resource (to the extent retained) in the following month.

The most common type of burial funds and burial arrangements are shown below, and must be considered in the order given in their application to the $1,500 burial exclusion.

1) Life Insurance Policies, other than those specifically designated for burial (See Item #3) - The total face value of all insurance policies on the life of an individual owned by the individual (or spouse) will reduce the $1500 burial exclusion if the cash surrender value of those policies was excluded in determining eligibility under the life insurance policy exclusion found under E-523 #2. If the total face value of policies considered here is $1500, no further exclusions are allowed.

NOTE: Life insurance policies with no cash surrender value will be totally disregarded as both resources and burial funds.

2) Irrevocable Contracts - Burial Association policies (membership through a funeral home) and some prepaid burial contracts (including those funded by deferred annuity and insurance policies) are considered irrevocable and are not treated as a resource, regardless of the value. Groups that issue prepaid burial contracts must have a permit to sell from the Arkansas Insurance Department,

and the contract must be written on an approved Arkansas Insurance Department form. Irrevocable trusts that have been established by the applicant/client or representative which are payable only upon death to a specified funeral home for burial of the client shall not be considered an irrevocable contract under this section unless the funeral home designated under the arrangement is licensed by the Arkansas Insurance Department to sell prepaid burial contracts.

All prepaid burial contracts, including those funded through annuities and life insurance policies, which are irrevocably assigned to a funeral home,

- Must include an itemized list of specified services and merchandise to be provided by the funeral home at the death of the individual.
- Each item on the list must show a value of the service or merchandise.
- The total value of the itemized services and merchandise must equal the cash payment made to purchase the arrangement.

If a partial payment has been applied to the prepaid burial plan by attaching insurance or cash payments, the prepaid plan may be worth more than the annuity. Any amounts itemized as "miscellaneous" or other unspecified services will not qualify for exclusion. Such amounts will be included with the amount paid for unspecified services and merchandise, and the total will be subject to a transfer of resources penalty (see 5d below). The total amount paid for the plan through insurance, annuities or cash payments must not be greater than the cost of the prepaid funeral plan. If the value of the annuity or the total amount paid is greater than the cost of the prepaid funeral plan, the difference is an uncompensated transfer.

NOTE: If there is an uncompensated transfer, check the date of the funeral plan and annuity. If the date is outside the look back period, disregard the transfer.

The local funeral home may be able to advise the county if a contract is irrevocable, if the county cannot make this determination by reading the policy. Irrevocable contracts will be counted toward the $1500 burial exclusion.

If face values of insurance policies in Item (1) are less than $1500, then the value(s) of irrevocable contracts in Item (2) will be applied toward the $1500

exclusion. If a combination of insurance (with face value less than $1500) and irrevocable contracts equals $1500 or more, no further burial exclusions will be allowed, and any combined amount in excess of $1500 will be totally disregarded.

When the caseworker can determine a pre-paid burial annuity meets these conditions, the annuity does not need to be sent to the DAAS for an opinion.

However, if there are questions or issues that cannot be handled at the county level, submit the request to the DAAS for an opinion.

3) Revocable Contracts

   a) Some Prepaid Burial Contracts may be revocable and, if the $1500 burial exclusion limit has been reached by the preceding funds in Item #1 or #2, the value of the revocable contract will be treated as a resource. If the limit has not been reached, the value of the revocable contract will be used to reduce the $1500 exclusion, with any amount over $1500 considered a resource after the funds are no longer commingled.

   b) An insured burial contract is a burial arrangement covered by a life insurance policy. These policies are normally considered revocable. If the $1500 burial exclusion limit has been reached by the preceding funds, the total cash surrender value of the burial insurance policy will be treated as a resource. If the limit has not been reached, the cash surrender value will be used to reduce the $1500 exclusion, with any cash surrender value over $1500 considered a resource after the funds are no longer commingled.

4) Cash, Checking, Savings Accounts, or Other Funds - If these funds are specifically designated as burial funds (by the client's written statement in case record), they may be used to reduce the $1500 burial exclusion. If the $1500 limit has been reached by funds in Items (1), (2), and (3), then the cash funds in Item (4) will be considered as a resource. If the limit has not been reached, then the cash funds may be used to reduce the $1500 exclusion, with any amount remaining to be treated as a resource after the funds are no longer commingled. The cash surrender value of life insurance policies, if designated for burial, may also be used to reduce the $1500 exclusion.

5) Contracts or Policies Purchased/Owned by Others- Some contracts or policies are purchased and owned by individuals who are not the applicant/client, but they designate the applicant/client, as beneficiary. These contracts/policies are not considered a resource to the applicant/client; however

   - Irrevocable contracts/policies owned by other individuals will count against the $1500 exclusion, but
   - Revocable contracts/policies owned by other individuals will not count in the $1500 exclusion.

   The above rule does not apply when the purchaser/owner declares the contract/policy was purchased with the applicant/client funds.

   Ownership can usually be determined by reading the policy/ contract. If the buyer's name shown is not the applicant/client, then the policy/contract is owned by someone other than the applicant/client.

c. Out-of-State Burial Arrangements

Some burial arrangements with out-of-state funeral homes may be excluded from resources. If it is verified that the arrangement is irrevocable, the value of the arrangement will not be countable. If questionable, submit a request for an opinion to DAAS. (Re. MS E-501)

d. Transfer of Resources Penalty Applicable to Irrevocable Burial Funds

RULE FOR APPLICATIONS APPROVED 11/1/95 AND LATER

Transfer of Funds to Funeral Homes - If the value of the merchandise and services itemized in a prepaid irrevocable funeral plan is equal to the payment made for the plan or to the face value of the life insurance or annuity irrevocably assigned to the funeral home as payment for the plan, the funeral home now has ownership of the policy and it can be assumed that the individual has purchased a funeral for fair market value. If the value of the itemized merchandise and services is less than the payment, a period of ineligibility will be imposed for an uncompensated transfer. For example, if an individual pays $15,000 to a funeral director but the contract specifies only $5000 worth of merchandise and services, there is a $10,000 uncompensated transfer for which a period of ineligibility will be imposed.

Transfer of Funds to a Trust, Certificate of Deposit or Other Instrument Designated for Burial If an individual has a revocable trust, certificate of deposit or other instrument and the fund is designated only for burial, any amount over the $1500 burial fund limit is a countable resource. If the fund is irrevocable, the amount over $1500 is also a countable resource. (Re. MS H-304) If the trust, CD, etc., is irrevocably assigned to a funeral home, a penalty for transfer of resources will be applied unless there is an agreement with the funeral home (which must be licensed by the Arkansas Insurance Department to sell prepaid burial contracts) to provide specified services and merchandise equal in value to the fund.

6. Any SSI or SSA retroactive payments that were due for one (1) or more prior months will be excluded from countable resources for nine (9) months. This rule is applicable to an eligible individual, an ineligible spouse, and/or any other persons whose resources are subject to deeming. (Interest accruing to the lump sum funds is not excludable).

   Once the money is spent, the exclusion does not apply to countable resources that were purchased with the money, even if the 9 months have not expired.

7. 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 excluded from countable resources. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also excluded from countable resources are 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.

8. Federal tax refunds and advance payments will be excluded for a period of 12 months after receipt.

NOTE: Interest earned by these lump sum funds and allowed to accrue is not excluded from countable resources.

E-530 Treatment of Resource Changes

MS Manual 02/16/17

Treatment of Resource Changes:

1. Increase in Value of Existing Resource

   The increase in value of an existing resource (such as a value increase in stock) is not considered to be income when it occurs. Value increases in resources are included with resources the month following the increase.

2. Receipt of New Resource

   The receipt of a new resource such as a cash gift is considered to be income for the month of receipt and, if retained, as a resource in the month following receipt.

3. Conversion of Resource

   Conversion of a resource from one form to another (cash to property or vice versa, etc.) can affect resource eligibility in the month following the change. For example, the conversion of an excludable automobile to non-excludable resources by sale or trade could cause the countable resource limitation to be exceeded the month following the change.

4. Repair/Replacement of Lost, Damaged or Stolen Resources

   Cash or in-kind payments received from any source for repair or replacement of lost, damaged or stolen resources are not counted as income, and are not considered countable resources until the month after 9 full months from the date of receipt. Any interest that accrues to these funds is also excluded from income and resource consideration for the 9 month period. The cash payments and interest should be maintained separate from other liquid resources. Cash received for personal injury or other purposes is not excluded from income and resources.

   If the excluded cash is used to purchase a nonexcludable resource during the 9 month period, the resource will be evaluated according to the applicable resource rules.

   When circumstances prevent the repair/replacement of the resource during the 9 month exclusion, a reasonable extension not to exceed 9 additional months may be granted, provided:

   a. It can be documented that a reasonable effort to repair/replace was made (at least 2 providers should be contacted for documentation), and

   b. The individual still intends to repair/replace the resource.

Change of intent to repair/replace is irrelevant during the 9 month exclusion but, if during an extension of the exclusion the individual's intent to repair/replace is changed, the funds and all of the accrued interest will become fully countable as a resource on the first day of the month following the month of changed intent.

When the exclusion period (and extension, if applicable) has expired and the individual has not repaired/replaced the resource, the cash funds and interest will be a countable resource the first day of the month following the month of expiration.

If the payment has been in-kind support and maintenance (e.g., an individual has been furnished shelter because his home was destroyed by fire and the individual decides not to replace the home), the in-kind support will be considered income in the month following the end of the 9 month period or, if an extension was granted, in the month following the month of changed intent.

5. Proceeds of Loan

   Proceeds of a loan which is subject to repayment are not income to the individual; however, unused loan proceeds accrued into the month following their receipt become a countable resource.

6. Proceeds from Sale of Resource

   Proceeds from the sale of a resource are not income to the individual; it is considered a conversion of a resource (see #3 above). Proceeds from the sale of a resource are countable for resource determination the month following their receipt if retained by the individual.

7. Reverse Mortgages & Home Equity Loans

   Any funds that the individual receives from the reverse mortgage or home equity loan are disregarded in the month received as proceeds from a loan. The funds received from a reverse mortgage or home equity loan are counted as a resource if retained after the month of receipt. (See MS E-518)

E-540 Deeming of Resources

MS Manual 02/16/17

When an eligible individual resides with his ineligible spouse or ineligible parent(s) (if the applicant is a child with a disability or a child who is blind), deeming of resources from the

ineligible spouse or parent(s) is required. The resource limits given in MS E-541 and MS E-542 are the current resource limits.

NOTE: Pension funds owned by an ineligible spouse or ineligible parent(s) are excluded from deeming. This includes any IRA, Keogh, or money held in a retirement fund under a plan administered by an employee or union.

NOTE: Deeming does not apply to Long-Term Services and Supports (LTSS) categories of Medicaid. Please see spousal provisions beginning at MS H-200. Parental resources are never counted toward a child in LTSS categories.

E-541 Resources of Ineligible Spouse

MS Manual 10/26/15

The applicant and his ineligible spouse are permitted a couple's countable resource limit, which can be found at MS E-110. Allow SSI Exclusions found at MS E-450; there is no actual deeming.

E-542 Resources of Ineligible Parent(s)

MS Manual 10/26/15

For purposes of resource deeming, a stepparent living in the home with an eligible child is not considered a parent. Do not deem a stepparent's resources to a stepchild.

1. Determine the child's countable resources (Allow SSI Resource Exclusions MS E-450). If countable resources exceed the individual resource limit ($2,000), the child is ineligible. If countable resources are less than or equal to the individual resource limit, proceed to #2.

2. Determine the ineligible parent(s) countable resources (Allow SSI Resource Exclusions MS-E-450). If countable resources are less than or equal to the appropriate resource limit ($2,000 for an ineligible parent or $3,000 for ineligible parents), there are no resources to be deemed and the child is eligible. If countable resources exceed the appropriate resource limit, deem the excess (i.e., countable resources above $2,000/$3,000) to the child, proceed to #3.

3. Compare the child's total countable resources, after deeming, to the individual resource limit ($2,000). If countable resources are less than or equal to individual resource limit, the child is eligible.

E-600 Achieving a Better Life Experience (ABLE) Program

MS Manual 10/01/17 **POMS SI 01130.740**

An Achieving a Better Life Experience (ABLE) account is a tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses of the account's designated beneficiary. The designated beneficiary must be blind or disabled by a condition that began before the individual's 26th birthday.

An ABLE program can be established and maintained by a State or a State agency directly or by the State contracting with a private company. An eligible individual can open an ABLE account through the ABLE program in any State. The Arkansas ABLE program is established and maintained through a collaboration of the Department of Human Services, Arkansas Rehabilitative Services and the State Treasurer.

An eligible individual can be the designated beneficiary of only one ABLE account, which must be administered by a qualified ABLE program. A person with signature authority can establish and control an ABLE account for a designated beneficiary who is a minor child or is otherwise incapable of managing the account. The person with signature authority must be the designated beneficiary's parent, legal guardian, or agent acting under power of attorney. The designated beneficiary is considered to be the owner of the ABLE account regardless of whether someone else has signature authority over it.

Upon the death of the designated beneficiary, funds remaining in the ABLE account, after payment of any outstanding, qualified disability expenses, will be used to reimburse the State(s) for Medicaid benefits that the designated beneficiary received.

E-610 ABLE Account Application Process

MS Manual 10/01/17

The Office of the Arkansas State Treasurer will administer the ABLE program for Arkansas residents and non-residents. The Office will:

- determine eligibility for ABLE accounts;
- process enrollments;
- process account maintenance transactions;
- maintain account payment and distribution history; and
- provide eligibility reports for Medicaid renewals.

Questions regarding the establishment of an ABLE account will be directed to the Office of the Arkansas State Treasurer, 1401 West Capitol Ave., Suite 275, Little Rock, AR 72201.

E-620 Eligibility Factors

MS Manual 10/01/17

The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, the individual must be:

a. eligible for Supplemental Security Income (SSI) based on either disability or blindness that began before age 26; or

b. entitled to disability insurance benefits, childhood disability benefits, or disabled widow's or widower's benefits based on either disability or blindness that began before age 26; or

c. someone who has certified, or whose parent or guardian has certified, that he or she:

- has a medically determinable physical or mental impairment meeting certain statutorily specified criteria; or,
- is blind; and,
- the disability or blindness occurred before age 26.

Those applicants applying for benefits under option C above must provide with their ABLE application packet a copy of a statement signed by a physician that includes the individual's diagnosis relating to the individual's relevant physical or mental impairment/s.

E-630 Contributions

MS Manual 10/01/17

A contribution is the deposit of cash funds into an ABLE account. Any person can contribute to an ABLE account. A contributing "person" may be an individual, trust, estate, partnership, association, company, or corporation. However, the Internal Revenue Service (IRS) limits the total annual contributions that any ABLE account can receive from all sources to the amount of the per-donee gift-tax exclusion in effect for a given calendar year. The amount of the gift-tax exclusion can be found in IRS Publication 559. For 2017, the annual exclusion limit is $14,000 (MS Appendix R).

E-640 Withdrawal from ABLE Account

MS Manual 10/01/17

A distribution is the withdrawal or issuance of funds from an ABLE account. The designated beneficiary or the person with signature authority determines when he or she makes distributions. A distribution from an ABLE account is not income but is considered as a conversion of a resource from one form to another. Distributions are only to or for the benefit of the designated beneficiary.

Money withdrawn from an ABLE account will not be countable income for the designated beneficiary, regardless of whether the money received is for non-housing Qualified Disability Expenses (QDE), housing QDE, or non-qualified expenses.

E-650 Allowable Expenses

MS Manual 10/01/17

Qualified disability expenses (QDE) are expenses related to the designated beneficiary's disability or blindness and are for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to the following types of expenses:

1. Education
2. Housing which includes:
    a. mortgage (including property insurance required by the mortgage holder)
    b. real property taxes
    c. rent
    d. heating fuel
    e. gas
    f. electricity
    g. water
    h. sewer
    i. garbage removal
3. Transportation
4. Employment training and support
5. Assistive technology and personal support services
6. Health
7. Prevention and wellness
8. Financial management and administrative services

9. Legal fees
10. Expenses for oversight and monitoring of the ABLE account
11. Funeral and burial expenses
12. Basic living expenses.

E-660 Income Exclusions

MS Manual 10/01/17

Exclude all contributions to an ABLE account from the countable income of the designated beneficiary. (Re. MS E-630) This includes rollovers from another family member's ABLE account.

NOTE: A rollover is the distribution of all or some of the funds from one ABLE account to the ABLE account of a member of the designated beneficiary's family. For purposes of this type of rollover, a member of the designated beneficiary's family means siblings, step-siblings and half siblings.

However, do not deduct contributions from the countable income of the individual who makes the contribution.

EXAMPLE: Contribution Kristie Mae has $100 automatically deducted from her paycheck and deposited into her daughter Sharon's ABLE account. The $100 will not be considered income for Sharon but will still be included as a portion of Kristie Mae's income.

EXAMPLE: Rollover Linda is determined to no longer be disabled so she transfers all of the funds in her ABLE account to her step-brother Scott's ABLE account. These funds will not be considered as income to Scott.

The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Earnings increase the account's balance. Interest accrued or dividends earned on the money in an ABLE account are excluded from the income of the designated beneficiary.

NOTE: Long Term Supports and Services transfer of resources rules apply to contributions made to an ABLE account (See MS policy section H-300-325).

E-670 Resource Exclusions

MS Manual 10/01/17

The amount of funds in an ABLE account that exceeds $100,000 will be counted as a resource. Only $100,000 of the balance of funds in an ABLE account can be excluded from the resources of the designated beneficiary.

Any distribution for a non-housing related Qualified Disability Expense (QDE) that has been retained beyond the month it was received will be excluded from the designated beneficiary's countable resources if:

- The designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account;
- The distribution is unspent;
- The distribution is identifiable (Excluded funds commingled with non-excluded funds must be identifiable); and
- The individual still intends to use the distribution for a non-housing related QDE.

EXAMPLE: Excluded Distribution Eric takes a distribution of $500 from his ABLE account in February 2017 to pay for a health related QDE. His health related expense is not due until May, so Eric deposits the distribution into his checking account in February. The distribution is not income in February. Eric maintains his ABLE account at all relevant times and the $500 distribution remains both unspent and identifiable until Eric pays his health related expense in May. Therefore, the $500 distribution will be excluded from Eric's countable resources in March, April and May.

NOTE: A distribution for a housing-related QDE or for an expense that is not a QDE will be counted as a resource if the beneficiary retains the distribution into the month following the month of receipt. Distributions for housing-related QDEs must be spent in the month of receipt. If the beneficiary spends the distribution within the month of receipt, there is no effect on eligibility.

If distribution for a non-housing related QDE that was retained into the following month is actually used for a non-qualified purpose or a housing related QDE, the amount of funds used for the non-qualified purpose or a housing related QDE will be considered a resource on the first day of the month in which the funds were spent. The caseworker will assume that the individual's intent to use the funds for a QDE changed as of the first of the month that the

individual spent the funds. If the individual's intent to use the funds for a QDE changes at any other time, but the individual has not spent the funds, the retained funds will be counted as a resource the first of the following month.

EXAMPLE: Previously Excluded Distribution Used for a Non-QDE Sam takes a distribution of $25,000 from his ABLE account with the intent to modify a specially equipped van in May. He pays a $10,000 deposit on the van modifications. While waiting for the delivery of the van, Sam takes a trip to a casino in July where he loses $1,000 of his ABLE distribution while gambling. The $1,000 he lost gambling is countable resource in July. The other $14,000 Sam retains continues to be an excluded resource as long as it meets the requirements in this section.

EXAMPLE: Previously Excluded Distribution Used for a Housing Related QDE Jennifer takes a $7,000 distribution from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. However, she has to make a $750 advance rent payment for her college apartment in August. She uses $750 of the distribution she took in June to make the rent payment which is a housing related QDE. The $750 is a countable resource in August. The remaining $6,250 continues to be an excluded resource as long as it meets the requirements in this section.

EXAMPLE: Change of Intent on the Use of a Distribution Jennifer takes a $7,000 distribution from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. In August, Jennifer gets a job offer and decides not to return to school. Since she no longer intends to use it for tuition, the $7,000 becomes a countable resource in September unless Jennifer redesignates it for another QDE or returns the funds to her ABLE account prior to September.

A special rule applies when the balance of an SSI recipient's ABLE account exceeds $100,000 by an amount that causes the individual to be over the resource limit whether by those funds alone or with other resources. When this situation occurs, the Social Security Administration will place the recipient into a special SSI suspension period where:

- Social Security will suspend the recipient's SSI benefits without a time limit as long as the individual remains otherwise eligible;
- The individual retains continued eligibility for Medicaid; and
- The individual's eligibility does not terminate after 12 continuous months of suspension.

During the period SSI benefits are suspended, the designated beneficiary will be treated as if the individual continued to be receiving payment of the SSI benefits. The individual's regular SSI

eligibility will be reinstated for any month in which the individual's ABLE account balance no longer causes the recipient to exceed the resource limit and the individual is otherwise eligible.

EXAMPLE: Excess Resources-Recipient is Suspended but Retains Medicaid Eligibility Paul is the designated beneficiary of an ABLE account with a balance of $101,000 on the first of the month. Paul's only other countable resource is a checking account with a balance of $1,500. Paul's countable resources are $2,500 and therefore exceed the SSI resource limit. However, since Paul's ABLE account balance is causing him to exceed the resource limit (i.e., his countable resources other than the ABLE account are less than $2,000), Social Security will suspend Paul's SSI eligibility and stop his cash benefits, but Paul will retain eligibility for Medicaid.

NOTE: The special suspension rule does not apply when the balance of an SSI recipient's ABLE account exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit but the resources other than the ABLE account alone would make the individual ineligible for SSI due to excess resources.

EXAMPLE: Combination of Resources-Recipient Loses SSI Eligibility Christine is the designated beneficiary of an ABLE account with a balance of $101,000 on the first of the month. Christine also has a checking account with a balance of $3,000. Christine's countable resources are $4,000 and exceed the SSI resource limit. However, because her ABLE account balance is not the cause of her excess resources, the special rule does not apply and Christine is no longer SSI eligible due to excess resources. The Social Security Administration will suspend her SSI benefits and her Medicaid benefits will end as well.

EXAMPLE: Sharon takes a distribution of $500 from her ABLE account in May to pay her rent for June. She deposits the $500 into her checking account in May and then withdraws $500 in cash on June 3 and pays her landlord. This distribution is a housing-related QDE and a part of Sharon's checking account balance on June 1st, which makes it a countable resource for the month of June.

F-100 Non-Financial Eligibility Requirements

MS Manual 01/01/14

Non-financial eligibility requirements are those eligibility requirements not related to income or resources. The requirements in this section may or may not be an eligibility factor for all eligibility groups. The non-financial requirements include:

- Age and Relationship
- Blindness and Disability
- Child Support Cooperation
- Categorical Relatedness
- Medical Care Requirements

F-110 Age and Relationship

MS Manual 07/08/16

Most Medicaid eligibility groups have an age range in which the individual must fall in order to become eligible for coverage in that particular group. ARKids A and ARKids B also require a relationship and living with a specified relative requirement. In order to be eligible for ARKids A or B, a child must be living with a relative who is within the following degrees of relationship to the child:

1. A blood or adoptive relative who is within the fifth degree of kinship. Such relatives by degree of kinship are as follows:

   1st degree – Parent

   2nd degree – Grandparent, sibling

   3rd degree – Great-grandparent, uncle, aunt, nephew, niece

   4th degree – Great-great grandparent, great-uncle, great-aunt, first cousin

   5th degree – Great-great-great grandparent, great-great uncle, great-great aunt, first cousin once removed (i.e., the children of one's first cousin)

   NOTE: Half-relationships will be considered the same as full relationships.

2. Stepfather, stepmother, stepbrother, stepsister

3. Spouses of any persons named in the above groups. Such relatives may be considered within the scope of this provision though the marriage is terminated by death or divorce.

   Relationship and living with the specified relative apply, unless the individual has been removed from the custody of his or her parents or other relative by court order, has been court ordered to an institution, has been emancipated, has reached age 18 or legal custody has been given to someone else. (For ARKids, See MS C-115, E-240 for procedures on who can apply in these situations.)

The particular age requirements for each eligibility group are listed in MS Section B.

F-120 Blindness and Disability

MS Manual 01/30/15

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-EC (26), AFDC-SD (27)], 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 10 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; or

5. Receipt of the DCO-109, Report of Medical Review Team decision, when blindness or disability has been determined by the Medical Review Team.

The type of documentation used will be indexed in the recipient's electronic record.

Disability will either be established by Social Security Administration (SSA) or Railroad Retirement (RR) or the Medical Review 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/DAAS for one year with exceptions noted in MS F-122.

F-121 Social Security Administration

MS Manual 01/01/14

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSA determinations must be presented to SSA for reconsideration within 60 days of the SSA denial notice. If the decision has not been appealed within 60 days, the individual may still request a reopening of the decision within one year.

Therefore, the Agency must refer to SSA all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled" for reconsideration or reopening of a determination, except in cases specified in MS F-122. When the conditions in MS F-122 are met, counties will be required to make an eligibility determination for Medicaid.

Counties may also refer to SSA, for SSI application, those individuals whose income and resources are below SSI limits, because it would be to their advantage to receive both cash assistance and Medicaid.

F-122 Medical Review Team (MRT)

MS Manual 01/01/16

When an individual applies for Medicaid and meets one or more of the conditions below, the DCO-106, Disability Worksheet; DCO-107, Confidential Report of Medical Examination of Patient; and/or DHS-4000, Authorization to Disclose Health Information and DCO-108, Medical Review Team Social Report (DCO-108C is used for children), along with copies of the Social Security Disability or SSI denial letter (if applicable and available) will be submitted to MRT (Re. MS F-124), provided it appears that the other eligibility factors are met.

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 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;
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; or
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. The DCO-106 will be used to document the individual's statements/allegations regarding his disability status.

NOTE: When a family member of a deceased Medicaid (ARChoices, Assisted Living, DDS, NF 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 01/01/16

When an individual applies for both Medicaid and Social Security Disability or SSI, and the application with SSA is still pending, the county should initiate a MRT determination of disability if the individual appears to meet all other eligibility requirements. The agency will have 90 days from the date of the Medicaid application to make this determination. While an MRT decision is pending, the caseworker should check the Social Security Disability or SSI status of the applicant 30 days after the Medicaid application has been made, and again at certification, if found eligible by MRT. If MRT finds that the individual meets the disability requirements and SSA has not yet made a decision, the caseworker may approve the case for Medicaid. To verify that no SSA decision has been made, SOLQ screens will be checked, if appropriate, and the individual or authorized representative will be contacted by mail or telephone prior to approval.

Additional case action is indicated as follows:

If application for Social Security Disability is approved first:

- Notify MRT
- Approve Medicaid application (if all other requirements have been met).

If application for SSI is approved first:

- Notify MRT
- Deny Medicaid application, except for ARChoices, Assisted Living, Autism, DDS, Nursing Facility (NF) and PACE which may be approved on WNHU/WAIV if all other requirements have been met.

If SSA determines the applicant is NOT disabled:

- Notify MRT
- Deny Medicaid application.

If the caseworker approves a case based on a MRT disability decision and later learns the individual has been 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 an approved Medicaid recipient is approved for SSI, the system will automatically convert the Medicaid case to an SSI category and no further action will be required of DCO except to notify MRT that no future reexamination is required, if appropriate.

If the caseworker denies an application based on a MRT decision and later learns that SSA has approved the disability, the original application will be re-registered regardless of the time frame as Medicaid claims will be paid if the provider files claims timely, refer to MS A-190. Process the application with the original application date provided all other eligibility criteria were met for this time period.

F-124 Procedures for Verification of Blindness and Disability by MRT

MS Manual 01/30/15

The following procedures will be followed for verification of blindness or disability through the Medical Review Team:

1. For Blindness:
    a. The caseworker will give the applicant or his representative a DCO-701, Report on Eye Examination, for completion by the ophthalmologist or optometrist who is to conduct the eye examination. In addition, a Business Reply Mail envelope will be provided for return of the DCO-701 after completion.

    b. Upon receipt of the completed DCO-701, the caseworker will check it to assure that all items of identifying information are completed. If necessary, the caseworker will complete the name, address, race, sex, and date of birth blanks on the form before forwarding to MRT. In addition to checking the DCO-701 for completeness, the caseworker will complete the DCO-108 or DCO-108C and attach it to the DCO-701 and forward it to MRT. A notation of the date that the forms are forwarded to MRT will be made in the electronic record.

2. For Disability:
    a. Determine if the individual is engaged in a substantial gainful activity (SGA), following the guidelines at MS F-128.

If the individual is found to be engaged in SGA, deny the application, using action reason "denied due to employment". Do not send the application to MRT.

b. If the applicant has been a patient in a private or state hospital, a VA hospital, or the University of Arkansas for Medical Sciences within the past year (the past five years for the Arkansas State Hospital), complete form DHS-4000. The Medical Review Team will request medical information from these institutions. A separate form DHS-4000 must be completed for each institution.

c. If the applicant has not been hospitalized within the past year and does not regularly see a physician, form DCO-107 must be completed. If the applicant has been hospitalized within the past year, form DCO-107 may also be completed if the applicant chooses to supply medical information in addition to that which can be obtained from the institution by form DHS-4000. If an applicant goes to a physician regularly, in lieu of another physical examination, form DHS-4000 may be used to obtain copies of the records from the physician (no DCO-107 needed).

   The caseworker will complete Part 1 of Form DCO-107 when the form is needed. The applicant must sign and date the form in Part 2. The form will then be given to the applicant to take to the medical practitioner of his or her choice. A Business Reply Mail envelope will be provided with the DCO-107. The medical practitioner will complete Part 3 of the form and return the form to the county office.

   If an applicant states he or she does not have the funds for payment of a physician's examination, the applicant should be informed that MRT can arrange and pay for an examination. If the applicant wishes MRT to do this, the caseworker should report this on the DCO-108 or DCO-108C.

d. Complete Forms DCO-106 and DCO-108 or DCO-180C. These must be completed for all cases submitted to the Medical Review Team.

e. Submit the following completed items to the Medical Review Team:

   i. DCO-108 or DCO-108C,

   ii. DCO-106,

iii. DCO-107,

iv. DCO-4000, and

v. Any other medical information which the applicant wishes to provide or which is available in the individual's electronic record.

F-125 MRT Decision

MS Manual 01/30/15

The Medical Review Team (MRT) will report the decision regarding physical or mental incapacity to the county office on Form DCO-109.

If an adverse action is taken on an individual's case, MRT will send a DCO-700 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-109. 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 01/01/14

If a reapplication is filed and the case has been closed within the past five years for reasons other than disability and the last DCO-109 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. In all cases of reapplication, a DCO-106 will be completed to determine the applicant's SSA disability status.

F-127 MRT-Reexamination of Disability

MS Manual 01/01/14

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 DCO-109.

It is the responsibility of the county office to initiate the re-exam by submitting current medical and social information (DCO-106, DCO-108A, and DCO-107 and/or DHS-4000) to MRT. The caseworker will contact the individual in a timely manner that will allow all necessary medical and social information to reach MRT by the first of the month of reexamination. When the reexamination decision is not received in the county office by the end of the month in which the reexamination was required, the case will remain open pending receipt of the MRT decision.

F-128 Substantial Gainful Activity (SGA)

MS Manual 10/21/16

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.

The following SGA Earnings Guidelines provide the basis for evaluating whether an individual is engaged in SGA:

1. Countable Earnings of Less Than $300 Per Month - When average countable monthly earnings are less than $300 per month, an assumption may be made that the work is not SGA. This assumption may be made for both sheltered and nonsheltered employment; specific evidence does not need to be developed for either sheltered or nonsheltered employment.

2. Countable Earnings of $300 to $1130 Per Month - When average countable monthly earnings from nonsheltered employment fall within the $300 to $1130 per month range, an assumption may be made that the work is not SGA unless:

   a. The work is comparable to that of unimpaired individuals engaged in similar occupations as their means of livelihood; or

   b. The work, although significantly less than that done by unimpaired individuals, is reasonably worth over $1130 per month according to pay scales in the community.

   When "a." or "b." occurs in a nonsheltered employment situation (or if gross earnings include a subsidy), current medical and social information will be submitted to MRT.

   When average countable monthly earnings from sheltered employment fall within the $300 to $1130 per month range, the work is not ordinarily SGA. However, if earnings include a subsidy, current medical and social information will be submitted to MRT.

3. Countable Earnings of More Than $1130 Per Month - When average countable monthly earnings are more than $1130 per month, an assumption may be made that the work is SGA unless impairment causes the individual to quit work or reduce employment within a short time (6 months or less) under circumstances that would justify the employment being termed an unsuccessful work attempt. Specific evidence must be developed for both sheltered and nonsheltered employment.

   When there is no subsidy involved in gross pay and when there is no marked discrepancy between the amount of pay and the value of the services, an assumption will be made that pay from employment is fully earned. Action will be taken to deny the application or close the case as the individual does not meet the criteria for disability (Re. MS F-120). Advance notice will be given on the DCO-700.

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

NOTE: If an applicant with a disability reports earnings of more than $1130 per month, the caseworker may deny the application due to employment without making a referral to MRT unless application is for Workers with Disabilities. If an applicant who is blind reports earnings of more than $1820 per month, the caseworker may deny the application due to employment without making a referral to MRT.

F-129 Request for MRT Disability Determinations

MS Manual 10/21/16

The caseworker will scan all forms requesting a MRT disability determination into Docushare according to the instructions below:

1. The forms will be scanned individually under the appropriate index selection.
2. After the information is scanned, the caseworker will send an email to the MRT unit notifying them that the MRT packet is scanned into Docushare and ready to be reviewed.
3. MRT will then print the appropriate MRT forms from Docushare and will prepare the MRT packet for review.
4. After the MRT decision has been made, MRT will upload the DCO-109 to Docushare and send an email to the individuals listed on the original request to inform them that the MRT decision is available.

Outstationed workers that do not have the ability to scan into Docushare will:

1. Scan and email the complete packet to the MRT distribution list.
2. MRT will print and scan the request packet into Docushare.
3. After the MRT decision has been made, MRT will upload the DCO-109 to Docushare and send an email to the individuals listed on the original request to inform them that the MRT decision is available.

F-130 Child Support Enforcement Services

MS Manual 01/30/15

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Medicaid-only persons/families who have assigned to the State their rights to medical support. Each applicant or recipient 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-only 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-only families 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 is receiving Medicaid or when the parent 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: Individuals 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 woman enters another group where cooperation with OCSE is required.

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

- parent(s) is not receiving Medicaid but the children are receiving Medicaid or
- when the parent is the only one receiving Medicaid and the children are not receiving Medicaid or
- the parent(s) 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.

When a referral for Newborn Coverage is received by the county, the caseworker will determine if there is an absent parent and obtain enough information to complete the referral in the system. Approval of the newborn in the 20-day period allowed for approval will not be delayed due to lack of absent parent information or due to non-cooperation by the newborn's mother.

If a child is removed from the custody of his or her parent(s) by court order {fault is assigned to the parent(s) due to abuse or neglect}, refer the parent(s) to the Office of Child Support Enforcement (OCSE). If the child is voluntarily placed in the facility (even if later a court order is established for the state to assume custody), or removed by court order with no fault assigned to parent(s) {e.g., the child is abusive}, only refer a parent if they were absent from the home at the time of placement. Custodial parents {parents present in the home at the time of placement} will only be referred to OCSE if the child was court ordered and the court assigns fault to the parent(s).

Absent parents of all foster children will be referred to OCSE by the Division of Children and Family Services worker.

2. Guidelines

The caseworker will explain the Assignment of Medical Support found on the Medicaid application and will explain the OCSE requirements if an in office interview is conducted.

The Absent Parent Information will be added to the system for each Medicaid eligible child who has an absent parent or when legal paternity must be established. Upon receipt of the referral, OCSE will initiate steps to contact the custodial and noncustodial parents.

An individual may have good cause not to cooperate in the state's efforts to collect child and/or Medical support. The individual 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 individual can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the individual 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 going on for adoption of the child.
- The individual is working with an agency helping to decide whether to place the child for adoption.

A DCO-90, Notice Concerning Good Cause for Refusal to Cooperate, will be completed at each in office application interview. If Good Cause is claimed, the DCO-105, Claim of Good Cause for Refusing to Cooperate in Child Support Enforcement Activities, will be completed and the system will be updated.

When Medicaid eligibility has ended, OCSE will notify the custodial parent that support services will continue. The custodial parent must advise OCSE in writing if they do not want these services to continue.

3. Refusal to Cooperate-Sanction

The County Office will be notified via an electronic interface when an individual fails to cooperate with the OCSE in establishing paternity and medical support. A task is assigned in the system for the caseworker to review and apply the sanction, if appropriate. A 10-day notice is not required. An adequate notice will be sent. If the custodial parent goes into the OCSE office after the sanction has been applied with all the information requested, OCSE will send a form FIN-39, Notice of Cooperation, to the county office requesting to lift the sanction. Cooperation in establishing child support payments is not a requirement for Medicaid-only cases.

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.

The needs of an adult relative who refuses to cooperate with OCSE will continue to be included in the need standard along with the child, but Medicaid for this individual will end after the appropriate notice period has expired. The status of the individual will be Active and the Medicaid coverage would have an end date. It is not necessary to obtain a protective payee for the child when the adult relative has refused to cooperate.

As the needs of an adult relative are never included in the need standard with an eligible child in Aid to the Blind or Disabled Medicaid categories, the failure of an adult relative to cooperate with OCSE will have no effect on the child's Medicaid eligibility.

F-140 Medical Care Requirements

MS Manual 05/12/17

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 LTSS

MS Manual 01/30/15

Current recipients of SSI and Foster Care (Category 91 or 92), for whom the Agency has legal responsibility, automatically meet the categorical eligibility requirement.

However, if, during the processing of an LTSS application, 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. The question and resolution should be documented in the electronic record.

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. If there appears to be a policy conflict between DCO and SSA, the DCO Medicaid Eligibility Unit (MEU) will be contacted by email to clear the discrepancy. Refer to Manual Transmittals for email addresses for the MEU.

Categorical eligibility for individuals other than SSI or Foster Care (Category 91 or 92) 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 (Re. 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 (Re. 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 (Re. MS F-120 and MS F-124).

F-151 Functional Need

MS Manual 01/01/16

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 DCO-703. The decision will be reported to the County Office on the DCO-704.

Functional need decisions for:

- Nursing facility applicants and recipients are made by the Office of Long Term Care (OLTC);
- Assisted Living, ARChoices Waivers and PACE applicants and recipients are made by the Division of Aging and Adult Services (DAAS);
- 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 OLTC, 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 DCO-704), unless emergency admission has been prior authorized by the 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 DCO-704.

Redetermination of Functional Need

The 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 the need for continued stay in a facility has been determined to be functionally necessary, a new review date is assigned and the approval/patient classification is valid through that date. The county office will not receive notice of change in classification, unless a change in functional need will require case closure, or transfer to another facility. The change in classification (if any), the decision date, and the new review date will be system entered by OLTC.

When the county office is notified by DCO-702 from a facility that an individual has entered another facility prior to the scheduled review date, the county office will complete a blank DCO-704 (Re. MS H-492) to advise the receiving facility of the scheduled review date, if any, and the current level of care.

When OLTC finds that reclassification of a recipient is warranted, the reclassification information will be provided to the facility and to the caseworker 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 DCO-704. 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 LTC eligibility to arrange for relocation.

The county office will:

1. Provide advance notice of discontinuance of services to the recipient or legal guardian and next of kin (when possible), giving the nature and effective date of the proposed action.
2. Close the LTC case.

F-152 DCO Institutional Status

MS Manual 01/30/15

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 (Re. 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 ICF/IID or was subject to PASARR (Re. MS H-440).

NOTE: The institutional status requirement does not apply to individuals who were certified for SSI or Foster Care (Category 91 or 92) in the month of facility entry.

Individuals who become ineligible for SSI or Foster Care (Category 91 or 92) 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-153 Appropriateness of Care

MS Manual 01/30/15

For TEFRA and Autism, the necessary medical services must be available to provide care to the individual in the home and it must be appropriate to provide such care outside an institution.

F-154 Cost Effectiveness

MS Manual 05/12/17

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 DAAS. If at any time DAAS determines that cost effectiveness is not met, the caseworker 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 01/01/16

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 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 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 ICF/IID level of care.

ARChoices, Assisted Living and PACE

To be determined an individual with a functional disability, an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:
    a. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person;
    b. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or
2. Medical assessment results in a score of three or more on Cognitive Performance Scale; or
3. Medical assessment results in Changes in Health, End–Stage Disease and Symptoms and Signs (CHESS) score of three or more.

DDS

To be determined an individual with a developmental disability, DDS will administer a comprehensive Diagnosis and Evaluation.

DDS determines ICF/IID eligibility on a schedule according to the individual's age:

1. For individuals aged 0-5, both IQ and Adaptive Functioning Level will be tested every year;
2. For minors age 5-21 or 18 years with certificate of high school completion, current IQ and adaptive functioning will be tested within 3 years of the date of referral; and
3. For adults age 22 and older, the IQ score obtained at age 22 years or over and an adaptive behavior assessment current within 5 years from date of referral will be used.

DDS will develop an individualized plan of care which will be reviewed within six (6) 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 01/30/15

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.

<u>Advance Notice</u>

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; and that

4. Any LTC 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 Policy and Legal Services (OPLS) 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 OPLS 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.

<u>Case Closures</u>

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, or

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

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

Advance notice of closure is not required.

Overpayments

If LTC 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 OPLS extension of time, or OPLS 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 LTC eligibility will not be made until disposition of the excess resources has been made.

F-160 Primary Care Physician Requirements

MS Manual 01/01/14

A Medicaid case can be approved before a Primary Care Physician (PCP) is selected; however, the PCP must be selected before most services can be accessed.

F-161 Primary Care Physician Managed Care Program

MS Manual 01/30/15

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 or ICF/IID facilities,
- 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 01/01/14

A PCP must be chosen for each family member who is a recipient. Each member may have a different physician.

The Medicaid recipient can choose a PCP:

- By calling the ConnectCare help line at 1-800-275-1131 (TDD: 1-800-285-1131),
- By visiting the website at www.seeyourdoc.org,
- At the doctor's office, or
- At the local DHS County Office.

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-163 County Office Responsibilities

MS Manual 01/30/15

The caseworker will provide and review Form DCO-2613, Notice to Medicaid Applicants/Beneficiaries, with the applicant if in the office. If requested by the applicant, the caseworker will assist in completing Form DMS-2609 or DCO-2609-County, Primary Care Physician Selection and Change Form, for each non-excluded family member. First, second, and third choice of physicians should be listed for each family member.

When a PCP is selected by the individual, the county staff uses the web-based program at http://207.169.228.130/ or a telephonic voice response system at 1-800-805-1512 to enroll the individual. If the individual's first choice has a full caseload, the worker will try the second choice and if necessary, the third choice. If all physicians selected by the individual have a full caseload, a notice will be mailed to the individual to select three more physicians. A new DCO-2609 must be completed.

NOTE: Counties may use either Form DMS-2609 or DCO-2609-County. However, if an individual requests a form for enrollment at a physician's office, a DMS-2609 will be provided. The DCO-2609-County is for county use only.

Form DCO-2609 will be scanned into the electronic record and the original will be mailed or given to the individual, if requested.

Each County Office will maintain a current listing of all participating physicians in the geographical area. All individuals will be given access to the listing when making physician selections. Counties will receive updates to the listings on a monthly basis.

F-164 Changes in Primary Care Physicians

MS Manual 01/01/14

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.

A recipient, including a SSI recipient, can change his/her primary care physician by:

- Calling the ConnectCare help line at 1-800-275-1131, (TDD:1-800-285-1131),

- Visiting the website at www.seeyourdoc.org, or
- Contacting the local DHS County Office.

F-170 TEFRA Premium

MS Manual 01/01/14

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 01/30/15

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 22 of the 2011 version of form 1040 or line 15 of the 1040A) 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 4 on the 2011 version of Schedule A).

EXAMPLE 1: Family consists of 5 people-mom, dad, waiver child, and 2 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 ($600x3)-$9,463.25=$54,154.23

Compare the adjusted income to Chart 1 in Appendix P. The income is above the limit. 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 ($600.00x3)-$9,463.25=$38,336.75

Comparing income in Chart 1 in Appendix P (2013), the annual income is below $41,355. 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.

The caseworker will key the income and household size along with the names of the TEFRA children living in the home to the TEFRA Web application found on the toolbar in the system. The system will figure the premium amount due for the household.

F-172 Adjustment of Premiums

MS Manual 01/01/14

Premiums will begin in the month after eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. Income will be reviewed annually for calculation of the premium, when there is a change that will make a difference of more than 10% in annual household income or a change in the number of family members. An adjustment can be made to the premium during the year if a significant change is reported in excess of 10% of the expected annual income or if there is a change in the household size. Verification of the income change must be provided. Income that fluctuates due to seasonal employment will not affect the monthly premium. The premium can only be adjusted a maximum of once every six months.

F-173 Payment of Premiums

MS Manual 01/01/14

Payments must be made through monthly bank drafts or quarterly payments in advance. For new recipients, premiums will be applied beginning with the month after the month of approval.

The TEFRA Premium Unit will collect the TEFRA Medicaid premium payments and send the premium invoices to TEFRA households. When a TEFRA case is approved, the TEFRA Premium Unit will send a TEFRA Premium Payment Selection Form to the recipient giving the option of

authorizing an automatic bank draft or making quarterly payments in advance. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check. The check must be sent in with the Payment Selection Form. The draft or quarterly payment will begin with the third month after the month of approval.

For those individuals who choose to pay through monthly bank drafts, the TEFRA Premium Unit will draft the account for the third month after approval and the following months. Each draft will be made on the first day of the covered month. The TEFRA Premium Unit will send monthly invoices that the bank account has been drafted.

For those who choose quarterly payments, the individual must initially pay for the month after the month of approval and the following month in advance by check, after which the TEFRA Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter.

If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the family will be reimbursed for the partial month.

Failure to provide the Payment Selection Form or make the two month initial payment will cause the child to be ineligible, and the case will be closed after proper advance notice. For ongoing cases, if the premium is not paid for three months, advance notice will be sent and the case will be closed. The TEFRA Premium Unit will notify the county office if the Payment Selection Form is not received.

Monthly aged reports will be sent to each county showing the cases with overdue premiums and the number of monthly payments in arrears. The caseworker will send a 10-day advance notice to each case showing three months of non-payment, advising that the case will be closed if payment is not made. At the end of the notice period, if payment of the premiums has not been made, the case will be closed. (Refer to C-231 for re-application when TEFRA case is closed due to non-payment of premiums.)

F-180 Other Health Insurance Coverage

MS Manual 09/01/18

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 5 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 ESI 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.

h. 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 caseworker 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 MSP Eligibility Groups

MS Manual 01/01/14

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 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.
- SMB-Individuals must be entitled to Medicare Part A.
- QI-1-Individuals must be entitled to Medicare Part A.
- QDWI-Individuals who lost Medicare Part A & SSA-DIB benefits due to SGA. The individual must be eligible to reenroll in Medicare Part A (Re MS F-192).

F-191 Medicare Part A Entitlement

MS Manual 01/30/15

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; or
   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); or
   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 5 years, and enrolled for Part B medical insurance or has filed a Part B enrollment request which will entitle the individual to Part B, or
   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 QMB, SMB or 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 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 in Part A Medicare.

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 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. If a County Office has an inquiry or application for QMB benefits from an individual receiving SSI, the individual should be informed that he/she is eligible for QMB benefits, and that the benefits will begin as soon as the automated system accretes him/her for these benefits. A QMB application from an SSI recipient will be denied by the County.

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 QDWI

MS Manual 01/01/14

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

1. Lost Medicare Part A and SSA-Disability (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. The County Office can also access the information through SOLQ if needed.

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

MS Manual 01/01/14

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

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

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

If an individual applies at the County Office prior to reenrolling for Medicare Part A, the individual will be instructed to 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 7 months later.

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

F-200 Work and Community Engagement Requirement for the Adult Expansion Group

F-200 Work and Community Engagement Requirement for the Adult Expansion Group

MS Manual 05/01/18

The Arkansas Works Program requires certain recipients of the Adult Expansion Group to meet the requirement of working 80 hours or more per month. Unless exempt, Adult Expansion Group recipients are ineligible to receive Medicaid benefits if, during any 3 months of the calendar year, they failed to meet the work and community engagement requirement. Adult Expansion Group recipients will fall in one of five categories for the work and community engagement requirement:

1. Enrollees age 50 or older – Work and community engagement requirement does not apply for this age group;
2. Enrollees age 19-49 that are employed or self-employed at least 80 hours per month on an ongoing basis – Exempt from the work and community engagement requirement;
3. Enrollees age 19-49 that are employed or self-employed on a one-time, not ongoing monthly basis - Complying with the work and community engagement requirement;
4. Enrollees age 19-49 that are not employed or self-employed at least 80 hours per month but meet an exemption to the work and community engagement requirement. Exemptions are:
    a. Currently receiving an exemption to the SNAP Requirement to Work;
    b. Receiving TEA Cash assistance;
    c. Receiving unemployment benefits;
    d. Has been determined medically frail;
    e. Caring for an incapacitated person;
    f. Living in home with a dependent minor;
    g. Being pregnant;

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h. Experiencing a short-term incapacitation; is medically certified as physically or mentally unfit for employment; or has an acute medical condition validated by a medical professional that would prevent complying with the requirements.

i. Participating in an alcohol or drug treatment program; or

j. Enrolled in full-time education, job training or vocational training;

5. Enrollees age 19-49 that are not employed or self-employed at least 80 hours per month but participate in any one or a combination of work activities for at least 80 hours per month to meet the work and community engagement requirement. (See MS G-190) Work activities include:

   a. Currently meeting SNAP Requirement to Work;

   b. Enrolled in education (less than full time);

   c. Participating in job training (less than full time);

   d. Participating in vocational training (less than full time);

   e. Participating in a health education class;

   f. Volunteering; or

   g. Conducting an independent job search and/or participating in job search training.

Example 1: Mary is currently attending UALR. She is currently enrolled in 9 credit hours this semester, which means she attends school 9 hours each week. Since Mary is taking 9 credit hours, these hours can be applied towards her weekly work activity hours. For 1 credit hour of school, Mary will be able to claim 2.5 work activity hours. In Mary's case, she would accrue a total 90 hours because 9 credit hours X 4 weeks = 36 x 2.5 work activity hours = 90 monthly work activity hours. Since Mary has accrued more than 80 hours, she would be exempt.

Example 2: Abbie is currently attending Pulaski Tech part-time and is enrolled in 4 hours this semester, which means she attends class 4 hours each week. Since Abbie is taking 4 credit hours, these hours can be applied towards her work activity. For 1 credit hour of school, Abbie will be able to claim 2.5 work activity hours. In Abbie's case, she would accrue a total of 40 work activity hours because 4 credit hours x 4 weeks = 16 hours x 2.5 work activity hours = 40

monthly work activity hours. Since Abbie has accrued less than 80 hours of work activity hours, she would not be exempt.

Example 3: James is currently conducting an independent job search and has completed 4 interviews this month. For each interview (job contact) James makes, he will be able to claim 3 work activity hours. In James' case, he would accrue 12 work activity hours because 4 interviews (job contacts) X 3 hours per contact = 12 work activity hours.

Example 4: Robert is currently volunteering for 40 hours monthly at his hometown Goodwill location. For each hour Robert volunteers, he will be able to claim 1 work activity hour. In Robert's case, he would accrue 40 work activity hours because 40 reported hours x 1 hour = 40 work activity hours.

NOTE: A combination of employment hours and work activities may be used to meet the work and community engagement requirement. See Appendix Y for a detailed chart on how to manually figure work activity hours.

Enrollees age 19-49 that are not employed at least 80 hours per month and do not meet an exemption or comply with work activities will lose Medicaid coverage for the remainder of the year after 3 consecutive or non-consecutive months of non-compliance with the work and community engagement requirement within the calendar year. Those Adult Expansion Group recipients who lose coverage for non-compliance with the work and community engagement requirement but meet an exemption later in the calendar year will not be allowed to regain coverage in Arkansas Works until the following calendar year. However, those Adult Expansion Group recipients who have lost coverage for non-compliance and turn 50 years old within the same calendar year will be allowed to apply to regain coverage the month the recipient turns 50. Those individuals who have lost Arkansas Works coverage due to non-compliance may be determined eligible for coverage in other Medicaid categories during the period of Arkansas Works ineligibility.

NOTE: Months of non-compliance with the work and community engagement requirement will not carry over into the next calendar year.

When the Adult Expansion Group work requirement starts on June 1, 2018, the requirement will apply to all new Adult Expansion Group recipients who are age 30-49. Those Adult Expansion Group recipients age 30-49 who were enrolled in the Adult Expansion Group prior to June 1, 2018 will be phased in from June to September 2018. All other Adult Expansion Group recipients who are subject to work and community engagement requirements will be phased in at later dates after proper advance notice is provided.

Enrollees who reach the age subject to the work and community engagement requirement during a calendar year will become subject to the requirement the month after their birthday.

F-201 Good Cause Exemptions

MS Manual 05/01/18

Good cause is defined as an adequate reason for failing to take a certain action prescribed by law. Good cause will be determined if a recipient's circumstances hindered them from being able to achieve the following:

- Completing their work activities;
- Reporting their work activities; or
- Reporting their exemptions.

Recipients who demonstrate good cause for failing to meet the work and community engagement requirement or failing to report work activities will not have a month of non-compliance accrued. The circumstances constituting good cause must have occurred during the month for which the recipient is seeking a good cause exemption. The recognized good cause exemptions include, but are not limited to, the following verified circumstances:

- The recipient has a disability and was unable to meet the work and community engagement requirement for reasons related to that disability; or has an immediate family member in the home with a disability and was unable to meet the requirement for reasons related to the disability of that family member; or the recipient or an immediate family member who was living in the home with the recipient experiences hospitalization or serious illness;
- The recipient experiences the birth, or death, of a family member living in the home with the recipient;
- The recipient experiences severe inclement weather (including a natural disaster); or
- The recipient has a family emergency or other life-changing event such as divorce or domestic violence.

If a good cause exemption is granted for reporting but not for compliance with the work and community engagement requirement, the beneficiary will remain responsible for completing

the required number of work activities in that month to avoid having it count as a month of noncompliance.

G-100 Verification Standards

MS Manual 01/01/14

Arkansas Act 1265 requires that the agency conduct electronic data matches first through the Federal sources and then through State sources if unable to obtain the required verification needed to determine eligibility for Medicaid through the Federal source. However, additional verification sources may be used if there is a discrepancy between the information provided by the individual and the electronic data source or the information can't be verified through the data matches.

G-110 Verification Requirements

MS Manual 01/01/14

Certain eligibility factors must be verified either through electronic sources or by the individual. See below which eligibility factors require verification and which factors do not require verification.

G-111 Eligibility Factors That Require Verification

MS Manual 07/06/15

The following must be verified when determining eligibility for Medicaid:

- Social Security Number (SSN)
- Citizenship
- Alien Status
- Income
- Age/Date of Birth
- Disability (when required)
- Resources (For categories that require a resource test refer to MS E-110).

NOTE: When citizenship cannot be verified via the electronic sources, the applicant will be notified to provide verification of citizenship and identity. Refer to MS G-133.

Refer to sections below for specific information regarding verification of the above eligibility factors.

G-112 Eligibility Factors That Do Not Require Verification

MS Manual 01/01/14

The following eligibility criteria do not require verification unless questionable:

- Residency
- Pregnancy
- Household Composition

G-113 Verification Sources

MS Manual 11/18/15

The primary source of verification is through electronic sources such as the Federal Data Services Hub (FDSH) and the Arkansas verification database, ARFinds. The FDSH is only available to the Family and Individuals Group.

The FDSH is a verification source that enables immediate access to multiple data bases via a single electronic transaction. Information provided by the individual will be verified through the federal data services by the following federal agencies:

- Social Security Administration (SSA) – Citizenship
- Internal Revenue Service (IRS) – Income (Most recent Federal tax return information)
- Department of Homeland Security (DHS) – Immigration status
- TALX (The Work Number) – Employment and income data from the employer.

The Arkansas verification database, ARFinds, is a multiple source database directly integrated with the eligibility system. It eliminates the need to access multiple screens. Information provided by ARFinds includes:

- SOLQ - Inquiry of SSA information
- WESD (Workforce and Employment Security Data) – Wage history and unemployment insurance benefits
- OCSE (Office of Child Support Enforcement) – Child support
- Vital Records – Births, deaths, marriages, and divorces
- DMV (Department of Motor Vehicle).

Other sources of verification include:

- Paper Documentation provided by the individual

- ✓ Check Stubs
- ✓ Employer Statements
- ✓ Bank Statements
- ✓ Collateral Statements
- ✓ Legal Documents (guardianship court order, etc.)

- SNAP – verified information in the individual's SNAP record.
- TEA – verified information in the individual's TEA case record.

G-114 Reasonable Opportunity for Providing Verification

MS Manual 01/01/14

Verification must first occur through electronic sources. If unable to obtain verification though electronic sources, verification will be required from the client and a 10 day notice will be sent requesting the required verification. Additional time to provide the verification will be allowed if requested. Information that is not necessary to determine eligibility will not be requested.

G-115 Self Declaration

MS Manual 01/30/15

For the Medicare Savings Program (MSP), self-declaration will be accepted for all eligibility requirements with the exception of alien status of non-citizens. Alien status must always be verified. If the declared income and resources are within the allowable amounts for the program, the client's declaration will be accepted. The caseworker, will however, view SOLQ on all applicants to confirm the accuracy of the gross benefits, Medicare claim number, and Medicare Part-A entitlement. If the applicant declares resources, the value of which would make him/her ineligible, and the caseworker cannot determine if the resource is countable (such as a life insurance policy or burial plan), the caseworker should then contact the applicant to determine if the resource is countable. The client's statement of the type of resource and the resource value will be accepted and documented. If it cannot be determined through contact with the client that the resource is countable, the client must be given the opportunity to provide a copy of the resource document.

G-120 Verifying the Social Security Number

MS Manual 01/01/14

The SSN will be verified via the Federal Data Services Hub (FDSH) or through the SSN enumeration process for all individuals that have been entered into the eligibility system. If all

match data agrees with SSA records, the system will be updated to reflect that the SSN has been verified.

If a mismatch occurs, an SSN mismatch report will be generated to the county office and the procedures in Appendix C will be followed to resolve the mismatch.

G-130 Verifying Citizenship

MS Manual 01/01/14

Federal Law and Regulations require that citizenship must be verified for all Medicaid recipients declaring to be citizens or nationals of the United States.

Exceptions to the verification requirement

Citizenship verification is not required for the following:

a. Individuals entitled to or enrolled in Medicare.

b. Individuals in receipt of SSI payments.

c. Individuals receiving SSDI benefits based on disability

d. Children who are in foster care

e. Children who are recipients of foster care maintenance or adoption assistance payments under Title IV-E.

G-131 Methods of Citizenship Verification

MS Manual 07/06/15

Families and Individuals Group

Verification of citizenship will occur through the Federal Data Services Hub (FDSH). If citizenship cannot be validated through the FDSH, the agency will conduct an electronic data match directly with Social Security Administration (SSA) or by obtaining acceptable documentation from the individual.

AABD and Other Groups

Verification of citizenship will occur directly through the SSA State Verification and Exchange System (SVES). The individual's name, Social Security Number (SSN) and date of birth (DOB) will be compared to the SSA master file. (Refer to Appendix C).

NOTE: Citizenship verified through the FDSH or SVES also verifies identity.

G-132 Reasonable Opportunity for Verifying Citizenship

MS Manual 07/14/17

When citizenship cannot be verified through an electronic source or SVES, the agency will provide the applicant a "90-day reasonable opportunity period" to provide the necessary documents to verify citizenship. (Refer to Appendix C).

NOTE: This reasonable opportunity period will be provided for all Medicaid eligibility categories.

Situations that may trigger the reasonable opportunity period:

- The individual is unable to provide a SSN, needed for electronic verification with SSA;
- Either the federal data services hub or SSA or DHS databases are temporarily down for maintenance or otherwise unavailable, thereby delaying electronic verification;
- There is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship which the agency must attempt to resolve, including by identifying typographical or clerical errors; or
- Electronic verification is unsuccessful, even after agency efforts to resolve any inconsistencies, and additional information, including documentation is needed.

A notice will be sent to the applicant advising that verification of citizenship must be provided within 90 days. The due date must be included on the notice. The reasonable opportunity begins on the date the notice is received by the individual. The date the notice is received is considered to be five (5) days from the date on the notice (day one is the date of the notice). Eligibility for Medicaid will begin on the same date the reasonable opportunity period begins.

NOTE: If the individual clearly shows that the notice was not received on the 5th day, the 90 days will start from the date the notice was actually received.

If the needed verification for an individual is not provided within the reasonable opportunity period, then benefits for that individual will be terminated. Timely and adequate notice must be provided. Other eligible members for whom citizenship is verified will remain eligible.

When the recipient tries in good faith to present satisfactory documentation, but is unable to obtain the necessary documents and needs assistance (e.g. homeless, mentally impaired, or

physically incapacitated), and lacks someone who can act on their behalf, the caseworker should assist the recipient with obtaining the documentation of U.S. citizenship.

G-133 Acceptable Documents for Proof of Citizenship

MS Manual 07/06/15

When citizenship cannot be verified via the electronic sources, the applicant will be notified to provide verification. If the documents provided by the applicant are in the secondary or lower level of verification used to verify citizenship, identity must be verified also. Refer to Appendix C for acceptable documents for proof of citizenship and identity.

G-134 Subsequent Citizenship Verification

MS Manual 01/01/14

Once an individual's citizenship is documented and recorded, any subsequent changes in eligibility should not require repeating the documentation of citizenship. If an individual's Medicaid case is closed and he later reapplies, the worker will not need to request additional verification as long as proper documentation has been retained in the case file or narrated properly in the electronic record. However, if one of the two exceptions below occurs, the individual's citizenship must be verified again.

1. If later evidence raises a question of a person's citizenship or identity; or,
2. If there is a gap of more than 5 years since the Medicaid case was closed and the verification had been previously destroyed.

G-140 Alien Status Verification Requirements

MS Manual 07/14/17

For the Families and Individuals group, verification will first occur through the FDSH. For other groups, alien status will be verified through SAVE (Systematic Alien Verification for Entitlement). If verification cannot be completed through these processes, refer to MS Appendix C. When immigration status cannot be verified through SAVE, the agency will provide the applicant a "90 day reasonable opportunity period" to provide the necessary documents to verify immigration status.

In order to obtain verification from SAVE, the alien must provide the following information regarding alien status:

- Biographic information (first name, last name and date of birth) and a
- Numeric identifier (alien number; form I-94, Arrival/Departure Record, number; Student and Exchange Visitor Information System (SEVIS) ID number; or unexpired foreign passport number).

If the alien does not have the required information, refer him/her to the United States Department of Homeland Security (USDHS) to obtain proof of status. Provide the individual with a 90-day written notice requesting the information and extend notice if additional time is needed. The USDHS National Customer Service Center phone number is 1-800-375-5283. The customer service center will answer all questions and schedule appointments for the USDHS field offices. The USDHS field office addresses and the Arkansas counties serviced by each office are listed below:

The Fort Smith field office is located at 4624 Kelley Highway, Fort Smith, AR 72904. This office services the following counties in Arkansas:

Ashley	Baxter	Benton	Boone
Bradley	Calhoun	Carroll	Clark
Columbia	Crawford	Franklin	Garland
Hempstead	Hot Spring	Howard	Johnson
Lafayette	Little River	Logan	Madison
Marion	Miller	Montgomery	Nevada
Newton	Ouachita	Pike	Polk
Scott	Searcy	Sebastian	Sevier
Union	Washington		

The Memphis Field Office is located at 842 Virginia Run Cove, Memphis, TN 38122. This office services the following counties in Arkansas:

Arkansas	Chicot	Clay	Cleburne
Cleveland	Conway	Craighead	Crittenden
Cross	Dallas	Desha	Drew
Faulkner	Fulton	Grant	Greene
Independence	Izard	Jackson	Jefferson
Lawrence	Lee	Lincoln	Lonoke
Mississippi	Monroe	Perry	Phillips
Poinsett	Pope	Prairie	Pulaski
Randolph	Saint Francis	Saline	Sharp
Stone	Van Buren	White	Woodruff
Yell			

If all other eligibility requirements are met, the Medicaid begin date will be the first day of the month of application.

If the individual does not provide necessary information of alien status for the person requesting Medicaid coverage, the individual will be eligible for emergency services only following the 90-day reasonable opportunity period.

G-141 Reasonable Opportunity for Verifying Alien Status

MS Manual 07/14/17

When alien status cannot be verified through an electronic source, Systematic Alien Verification for Entitlement (SAVE) or initial documentation provided by the individual, the agency will provide the applicant a "90-day reasonable opportunity period" to provide the necessary documents to verify alien status. (Refer to Appendix C).

NOTE: This reasonable opportunity period will be provided for all Medicaid eligibility categories.

A notice will be sent to the applicant advising that verification of alien status must be provided within 90 days. The due date must be included on the notice. The reasonable opportunity begins on the date the notice is received by the individual. The date the notice is received is considered to be five (5) days from the date on the notice (day one is the date of the notice).

The Medicaid begin date will be the first day of the month of application if all other eligibility requirements are met.

NOTE: If the individual clearly shows that the notice was not received on the 5th day, the 90 days will start from the date the notice was actually received.

If the needed verification for an individual is not provided within the reasonable opportunity period, then benefits for that individual will be terminated. Timely and adequate notice must be provided. Other eligible members for whom alien status is verified will remain eligible.

When the recipient tries in good faith to present satisfactory documentation, but is unable to obtain the necessary documents and needs assistance (e.g. homeless, mentally impaired, or physically incapacitated), and lacks someone who can act on their behalf, the caseworker should assist the recipient with obtaining the documentation of alien status.

G-150 Income Verification

MS Manual 11/18/15

Income verification for MAGI groups will occur in the following manner:

If a MAGI household attests to income over the MAGI income limit the system will accept the self-attestation and find the household ineligible due to income. The household will receive the appropriate notice and be referred to the Federally Facilitated Health Insurance Marketplace (FFM).

If the MAGI household has income (attested or previously verified) under the MAGI limit, the system will determine if a member of the MAGI household is on an open SNAP or TEA benefit case. If one MAGI household member is found on an open SNAP or TEA Cash case, the MAGI household income is considered verified.

If a member in the MAGI household is not found on an open SNAP or TEA Cash case, the system will continue the reasonable compatibility process and check available electronic data sources.

If the household attests to income under the MAGI limit (to include zero income) and the electronic data sources return no record of income or income less than the MAGI limit, the system will consider the MAGI household to meet reasonable compatibility and no further income verification is needed.

If the electronic data sources return an amount over the MAGI limit, the system will trigger a pending verification notice to the household for income verification.

For all other eligibility groups, sources for verification of income are ARFinds, verified information from the SNAP record and documentation provided by the individual. If the income reported by the applicant exceeds the income limit, it is not necessary to check the verification sources. The applicant's statement of income may be accepted without further verification.

G-151 Reasonable Compatibility Standards for Electronic Data Sources

MS Manual 01/30/15

Income is considered verified when the income reported by the individual is reasonably compatible with the income verified by the electronic data source.

Reasonable compatibility is met when the amount reported by the individual and the amount obtained through the electronic process are:

1. Both are equal to or below the income limit;
2. Both are greater than the income limit; or
3. If one is above and one is below the income limit but the difference between the two amounts is within 10% of the 100% Federal Poverty Level (FPL) for the appropriate household size.

The only time reasonable compatibility must be established is when the applicant's reported income is below the income limit and the verification source is above the income limit. See examples below.

EXAMPLE: The applicant reports a household size of one and a monthly income of $900 per month. The FDSH provides data that the applicant has an income of $975 per month. The 100% Federal Poverty Level (FPL) for a household of one is $957.50 per month. A 10% Reasonable Compatibility Standard would equal an amount of $96 (957.50 X 10% = 95.75 rounded up to $96). The reported and verified amounts are within $96 of each other ($975.00 [verified amount] - $900 [reported amount] = $75.00) and therefore meet the reasonable compatibility standard. No additional verification is required.

EXAMPLE: The applicant reports a household size of three and a monthly income of $1,600 per month. The FDSH provides data that the applicant has an income of $1,800 per month. The 100% Federal Poverty Level (FPL) for a household of three is $1,627.50 per month. A 10% Reasonable Compatibility Standard would equal an amount of $163 (1627.50 X 10% = 162.75 rounded up to $163). The reported and verified amounts are not within $163 of each other ($1,800 [verified amount] - $1,600 [reported amount] = $200) and therefore do not meet the reasonable compatibility standard. In this example, the client would need to provide proof of the reported income amount.

G-152 Reasonable Compatibility of Income Does Not Exist

MS Manual 01/01/14

If there is a discrepancy between the information provided and the electronic data, the individual must resolve the discrepancy by submitting verification of the income. For earnings, this can be verified with check stubs, pay slips, or a collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The caseworker should not automatically assume that one check stub accurately

reflects earnings for an entire month. Verification of payment for the last 30 days will be required if available.

EXCEPTION: For cases in which the individual has recently started employment and 30 days of verification is not available, the caseworker will compute the income from the best information available. Verification of all, if any, paychecks already received by the individual should be obtained and/or an employer's statement of anticipated earnings (e.g., hourly wage, number of hours expected to work/week, etc.).

Verification of earnings from self-employment will be from the Federal Income Tax Return, purchase, sales, and account books or by any other source which establishes the source and amount of income. As soon as an individual is known to be engaged in a farming business or other self-employment enterprise, he will be advised of the necessity of keeping accurate records so that his income can be determined.

Verification of in-kind earned income (e.g., free rent, groceries, etc.) will be obtained from the employer. The verification must include the value of the in-kind benefit (e.g., the rent amount the client would otherwise pay, the cost of groceries provided, etc.) and how often it is provided (e.g., monthly, weekly, etc.). If the amount fluctuates from week to week or month to month, verification of the in-kind earned income paid during the last 2 months should be obtained.

Verification of unearned income is normally obtained from documentary evidence from the source (e.g., award letter). However, another source may be used if it clearly establishes the source and amount of income.

G-160 Age/Date of Birth

MS Manual 01/30/15

Age and date of birth will be verified via the Federal Data Services Hub or other electronic sources. If there is a mismatch, a task will be generated and the caseworker will manually verify age and date of birth through birth certificate or other legal documents.

G-170 Disability

MS Manual 01/01/14

Verification of disability must be established either through information from the Social Security Administration (SSA) or a determination by the Medical Review Team. Refer to MS F-121 and MS F-122 for procedures.

G-180 Resources

MS Manual 01/01/14

Resources will be verified for all categories with a resource test. Refer to MS E-110. Examples of verification include bank statements, trust documents, deeds, etc.

G-181 Verification of Resources using the Asset Verification System

MS Manual 01/27/16

AABD applicant's and recipient's liquid resources will be verified using the Asset Verification System (AVS). Liquid resources include but are not limited to: checking and savings accounts, Certificates of Deposit, and bonds. The Asset Verification System will verify resource information for those categories with a resource limit. These categories include:

- Long Term Care Aged, Blind Long Term Care, Long Term Care Disabled
- ARChoices in Homecare
- Assisted Living (Living Choices)
- PACE
- Medically Needy Exceptional Category Aged, Medically Needy Exceptional Category Blind, and Medically Needy Exceptional Category Disabled
- Medically Needy Spend Down Aged, Medically Needy Spend Down Blind, Medically Needy Spend Down Disabled
- QMB-Aged, QMB Blind, and QMB Disabled
- ARSeniors
- Qualified Individual (QI-1)
- Specified Medicare Beneficiary (SMB)
- Disregard COLA Increase, Disregard (1984) Widow/Widower, Disregard SSA Disabled Widow/Widower, Disabled Widow/Widower Surviving Spouse, Disabled Adult Child.
- Qualified Disabled and Working Individuals
- TEFRA and Autism

EXCEPTION: AVS will not provide verification for SSI Categories.

AVS will be used at initial application and at re-evaluation. When a new AABD application is registered a request for resource verification will be sent to the Asset Verification System. If the application is for ARChoices and has a "Waiver App Received not Reg" characteristic selected, a

request for resource verification will be sent to AVS. The registration or the waiver characteristic selection will initiate the request to AVS at initial application. The generation of a re-evaluation task will initiate the request for resource verification to AVS at re-evaluation. AVS will provide verification of the balance of accounts as of the first of the month of application and first of the month balances for the 3 months prior to application. At re-evaluation AVS will provide account balances for the first of the month the re-evaluation task is created and the first of the month balances for the 3 months prior to the creation date of the task.

NOTE: If an application is denied or withdrawn, a request for asset verification will be resubmitted when another application is entered into the system regardless of the time of the initial request.

The information provided by AVS is a tool to help locate any liquid resources that the household may have or has had in the 3 months prior to application or re-evaluation. The information that is returned by AVS will be used to verify the liquid resources that the household may possess. The balances that will be received will show the balance of the account as of the 1st of the month. The AVS information received will be used as actual verification of liquid resources for the household.

NOTE: While the AVS information is “known to the Agency”, it is not considered verified information upon receipt for some benefit programs.

If the information that is returned from AVS causes ineligibility for the client, a 10 day advance notice will be sent to the household allowing an opportunity for them to rebut the information that was provided by AVS. This will allow the household time to explain if there is a valid reason that the resources should not be included in the eligibility determination.

Any information that is received from AVS after the eligibility determination for an application or the processing of a re-evaluation has been completed will be handled at the next re-evaluation.

G-190 Verification of the Adult Expansion Group Work and Community Engagement Requirement

MS Manual 05/01 /18

Those Individuals in the Adult Expansion Group that must meet the work and community engagement requirement can do so by:

1. being employed at least 80 hours per month; or
2. qualifying for an exemption to the work and community engagement requirement; or
3. completing a combination of sufficient work and work activities.

Employment: Individuals who earn the equivalent of Arkansas minimum wage for at least 80 hours per month through **ongoing** employment or self-employment will be considered exempt from reporting work activities on a monthly basis. The employment information will be verified by using the individual's reported income at application/renewal/change report to determine if the individual's reported earnings are equal to 80 hours monthly times the current minimum wage.

Individuals who earn the equivalent of Arkansas minimum wage for at least 80 hours monthly, on a one-time **not ongoing** basis will be considered compliant with the work and community engagement requirement and must report their work activities on a monthly basis.

Individuals who are employed less than the equivalent of Arkansas minimum wage for at least 80 hours monthly must combine their employment or self-employment with other allowed work activities for a combined total of 80 hours monthly to be considered compliant with the work and community engagement requirement and must report their work activities on a monthly basis.

Example 1: Joe is employed by a local grocery store and earns $800 monthly on an ongoing basis. $800 monthly wages divided by $8.50 (current Arkansas minimum wage) = 94 monthly hours. Joe is exempt from reporting monthly work activities until he has a change in circumstance reducing his employment below 80 hours monthly.

Example 2: Amy was paid $680 in June by a family friend to paint their home. Amy did this as a one-time job and is not employed or self-employed on an ongoing basis. $680 one-time wages divided by $8.50 (current Arkansas minimum wage) = 80 hours. Amy is compliant with the work and community engagement requirement for the month of June and must report again in July which work activities she completes to be compliant.

Example 3: Sue works at a local restaurant as a cook and earns $400 monthly on an ongoing basis. $400 monthly wages divided by $8.50 (current Arkansas minimum wage) = 47 hours. Sue must complete 33 additional hours in an allowed work activity to be considered compliant each month.

Exemptions: Exemptions are determined at application/renewal/change report. Initial exemptions will be determined at application based on information the applicant provides in the application. All other exemptions will be reported and validated by the individual through an online portal. Clients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will need to be revalidated. If it is determined that a recipient no longer meets the exemption, the individual must complete a combination of sufficient work and work activities in order to meet the work and community engagement requirement.

G-190 Verification of the Adult Expansion Group Work and Community Engagement Requirement

The following table lists exemptions and their validation schedule.

Criteria:	Validation Approach:
Currently receiving a SNAP Requirement To Work exemption	Validated against state data daily.
Receiving TEA Cash Assistance	Validated against state data every 30 days.
Caring for Incapacitated Person	Electronic demonstration of compliance required every two months and at renewal.
Short-term Incapacitation	Electronic demonstration of compliance required every two months and at renewal.
Participation in alcohol or drug treatment program	Electronic demonstration of compliance required every two months and at renewal.
Receiving Unemployment Benefits	Electronic demonstration of compliance required every 6 months and at renewal.
Full-time Education, Job Training, or Vocational Training	Electronic demonstration of compliance required every 6 months and at renewal.
Pregnancy	Electronic demonstration of compliance valid until end of post-partum period.
Employed or self-employed on an **ongoing** basis and earning the equivalent of Arkansas minimum wage for at least 80 hours per month.	Electronic demonstration of compliance valid until change of circumstance.
Living in home with dependent minor	Electronic demonstration of compliance valid until change of circumstance.
Medically Frail	Electronic demonstration of compliance valid until change of circumstance.

Work Activities: Work activities can be performed alone or in combination to comply with the work and community engagement requirement. Total monthly work activity hours must equal 80 at a minimum. A combination of employment hours and work activities may be used to meet the work and community engagement requirement. If the individual uses a combination of sufficient employment hours and work activities to meet the required 80 hours, monthly demonstration of compliance is required for each.

The following table lists approved work activities and their validation schedule.

Criteria:	**Validation Approach:**
Currently meeting SNAP Requirement to Work	Validated against state data daily.
Employed or self-employed and earning less than 80 hours monthly times the current Arkansas minimum wage on an **ongoing** basis	Electronic demonstration of compliance required monthly.
Education (less than full time)	Electronic demonstration of compliance required monthly.
Job Training (less than full time)	Electronic demonstration of compliance required monthly.
Vocational training (less than full time)	Electronic demonstration of compliance required monthly.
Volunteer	Electronic demonstration of compliance required monthly including agency name, address, and phone number.
Independent Job Search/Job Search Training	Electronic demonstration of compliance required monthly. Must be less than 50% of the required 80 hours.
Health Education Class	Electronic demonstration of compliance required monthly. Cannot account for more than 20 hours per year.

G-190 Verification of the Adult Expansion Group Work and Community Engagement Requirement

Recipients who are required to report employment hours, exemptions, or work activity, must report no later than the 5th of each month for the previous month's work activities or exemptions. If the recipient does not report by the deadline, a notice will be sent informing the recipient that a month of non-compliance has accrued. If the recipient accrues a second month of non-compliance, a notice will be sent informing the recipient of the second month of non-compliance and that their case will be closed at the end of the third month of non-compliance. This notice will serve as the notice of adverse action. If the recipient satisfactorily complies with reporting work activities by the 5th of the month following the third month of non-compliance, their case will be reinstated.

- Recipients cannot provide electronic demonstration of compliance retroactively after the 5th of the following month. For example, a recipient cannot provide electronic demonstration of compliance on April 7th for meeting the work and community engagement requirement in March.
- Recipients cannot provide electronic demonstration of compliance proactively for future months. For example, a recipient cannot provide electronic demonstration of compliance on April 25 for meeting the work and community engagement requirement in May.
- Demonstration of an exemption or work activity must be done electronically, except when information regarding a work activity or exemption is provided on an application.
- If the recipient provides false or incomplete information or fails to report a change, the individual will be subject to possible consequences such as repayment, disqualification, and/prosecution for fraud (MS M-210).
- Quality Assurance reviews will be conducted on a periodic basis. When a case is selected for a Quality Assurance review, additional verification may be required to be provided by the recipient.

H-100 Long Term Services and Supports

MS Manual 07/13/15

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

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

H-110 Income Trusts

MS Manual 01/01/14

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

H-111 Requirements for an Income Trust

MS Manual 07/13/15

An Income Trust must meet the following conditions:

1. Terms and Other Conditions

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

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

   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, which exceeds the federal cap of 3 times the SSI payment for an individual living in his own home, may establish eligibility through an income trust.

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

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

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

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

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

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

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

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

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

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

   After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Post Eligibility Income Worksheet, DCO-712, completed by the caseworker in charge of the case. 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 DCO-712, will be considered a transfer of resources and a penalty period may be applied.

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

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

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

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

The trustee must notify the caseworker if in any month the funds are not disbursed according to the DCO-712 or if the balance in the trust account exceeds the maximum allowed as specified in 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

MS Manual 07/13/15

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

1. Request for Eligibility Determination
   Individuals with income above the federal cap who inquire regarding Medicaid eligibility in a 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 him/her over the income limit, an income trust is not required unless the other countable income, without counting the LTC insurance payments, puts him/her over the income limit.

2. Application for Benefits
   At application for facility care or the Waiver program, the applicant, representative, guardian or other person responsible for the application, must inform the caseworker of the existence of an income trust, or that such a trust is to be established, and must provide the caseworker with a copy of the trust document.

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

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

H-113 Post Eligibility Procedures

MS Manual 07/13/15

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

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

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

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. The first possible beginning date of eligibility will be the first day of the month in which an approved trust was signed, provided that the individual's income has been placed in the trust account (bank account) that month, that no unauthorized funds have been disbursed during the month, and that the

individual is otherwise eligible. If funds that are not or will not be allowed by the DCO-712 have been disbursed from the trust during or after the month in which the trust is established, eligibility cannot begin until the first of the month in which all disbursements are correctly made.

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

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

NOTE: This only applies to facility payments.

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

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

H-114 Changes to an Income Trust

MS Manual 07/13/15

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

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

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

   If an individual has not returned to the facility after 14 days on a home visit or after 5 days of hospitalization, Medicaid will no longer pay the vendor payment, and the individual will be responsible for arrangements with the facility. Medicaid benefits other than the vendor payment may continue unless a formal notice of discharge is sent to the DHS County Office via DCO-702 and the recipient has not entered, nor is it anticipated that he will enter another facility. During any such period of extended home visit or hospitalization when Medicaid is not paying the facility vendor payment, the trustee may continue to disburse the spousal/dependent/non-covered medical expenses as specified on the DCO-712 and may disburse funds from the trust for medical expenses of the recipient which are not specified on the DCO-712 and not covered by Medicaid or other insurance.

   The caseworker must determine the residence of a recipient when receiving a DCO-702, Notice of Discharge from a facility, because facilities may erroneously send discharge notices when an individual has been hospitalized for more than 5 days. A facility may also correctly send notice of discharge when an individual has been transferred directly

from one facility to another, from a hospital to a second facility, or from a therapeutic home visit to a second facility. In any of the above situations, the case should not be closed and Medicaid benefits should not be terminated.

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

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

H-115 Reevaluations with an Income Trust

MS Manual 07/13/15

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

H-116 Termination of an Income Trust

MS Manual 07/13/15

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

- Send a Notice of Action to inform the trustee: That if disbursements as specified on the most recent DCO-712 were not made for the month in which death occurred, these disbursements may be made. After these disbursements have been made, no other disbursements may be made from the account until

the trustee has received instructions from the DHS Third Party Liability Unit section regarding termination of the trust (Form DCO-733).

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

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

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

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

- OPLS determines an error was made in the establishment of the trust, or
- The individual has repaid Medicaid all payments made since the establishment of the income trust, or
- Individual is moving out of state and will be establishing an income trust in the other state, or
- Other extraordinary circumstance.

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

H-200 Spousal Impoverishment

MS Manual 01/01/16

The following eligibility groups will use the spousal impoverishment guidelines listed in this policy section:

1. Long Term Services and Supports (LTSS)
    a. Nursing Facility care
    b. Assisted Living Facility (ALF)
    c. ARChoices in Homecare
    d. PACE program

H-201 Treatment of Income and Resources for Certain Institutionalized Spouses

Manual 07/13/15

As of September 30, 1989, the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P. L. 100-360) requires special treatment of the income and resources of institutionalized individuals who are legally married to spouses living in the community.

No comparable treatment of income and resources is required for non-institutionalized individuals or for institutionalized individuals who do not have a spouse living in the community. If there are changes in the marital status or other changes (e.g., the spouses divorce or the institutionalized spouse returns home), the rules do not apply in the month following the month in which the change occurred.

Except as specified in MS H-201-212 and H-402,403,410,415,416 and 470, this section does not affect the determination of what constitutes income or resources, or the methodology and standards used to determine or evaluate income or resources.

H-202 Initial Assessment

MS Manual 07/13/15

Upon application for LTSS or upon request by the Institutionalized Spouse (IS), Community Spouse (CS), or representative, the caseworker will assess and document the total value of

countable resources less exclusions specified in MS E-516 and MS E-523, to the extent that either the IS or the CS or both hold an ownership interest, as of the date on which the first continuous period of institutionalization begins.

The purpose of the initial assessment is to record the total amount of resources held by both the IS and CS at the first continuous period of institutionalization and to compute a spousal share of the total resources for the CS, which will be a protected amount and will remain constant as long as there is an IS/CS situation (Re. MS H-206).

For the purposes of this policy, an institutionalized individual is an individual who is an inpatient of a medical institution and/or a nursing facility for a period of 30 days. The term nursing facility includes all licensed nursing facilities and ICF/IID Facilities.

The IS, CS, or representative will be responsible for providing relevant documentation of the composition and value of all resources held by the couple as of the beginning of the first continuous period of institutionalization. The caseworker will assist in obtaining such documentation when requested. The assessment will be completed in all cases within 45 days unless pending receipt of information from the requesting party or a third party (bank, insurance company, etc.). A DCO-707, Notice of Action, will be given or sent to the requesting party to inform the party that the information should be provided as soon as possible but within 45 days and that the assessment cannot be completed until the information is provided.

If the request was for an assessment only, no further action is required by the county until the information has been provided.

At the time of the assessment, form DCO-710, Long Term Care Spousal Resources Assessment, will be completed to reflect all countable resources held by either the CS or IS, or both, at the beginning of the first continuous period of institutionalization. For HCBS and PACE, it will reflect countable resources as of the first date of application. The total value of these resources and the spousal share (equal to one-half of the total value) will be entered on the DCO-710. The resources owned solely by the CS will also be totaled on the form.

The caseworker will provide a copy of the DCO-710 to each spouse or representative and retain the original, regardless of whether an application for LTSS is made at that time. Only an applicant or applicant's spouse will have appeal rights if there is disagreement with the attribution of assets on the form. A person requesting only an assessment has no right to appeal if an application has not been made.

The DCO-710 will be indexed in the electronic record. If no application has been made, the DCO-710 will be indexed in the electronic record for future reference if the individual later makes application.

EXAMPLE: An individual enters a Nursing Facility and makes application on September 30, 2014, and an assessment of resources made on September 30, 2014, results in an ineligibility determination. A reapplication is made two years later, after two years of continuous residence in a Nursing Facility. The county must look at resources held at the beginning of that first continuous period of institutionalization, i.e., September 30, 2014. Reference to a form on file will be preferable to reconstructing the resources held two years earlier. If the applicant left the Nursing Facility at any time during the two year period but returned to a Nursing Facility, the county will use the assessment of resources made at the time of first entry in determining eligibility.

H-203 Resource Eligibility

MS Manual 01/01/14

At the time of application, all resources held by either the IS or CS shall be considered available to the IS to the extent that the resources exceed the Community Spouse Maximum Resources (CSMR), the maximum resources that are considered available to the CS.

When an application has been made the caseworker will compute the CSMR and the Community Spouse Resource Allowance (CSRA), and will determine resource eligibility on the DCO-713, Long Term Care Spousal Resource Eligibility Worksheet.

The CSRA is computed to determine the amount of the IS's resources which may be transferred to the CS. Resources of the IS may be transferred for less than fair market value to the CS (or to another for the sole benefit of the CS) only to the extent allowed by the CSRA. For rules regarding transfer by the IS, refer to MS H-209.

H-204 CSMR and CSRA Computation

MS Manual 01/01/14

The Community Spouse Maximum Resources (CSMR - the maximum amount of resources that a CS is allowed to retain) and the Community Spouse Resource Allowance (CSRA - the amount of resources that an IS may transfer to the CS in order to give the CS the maximum allowed) are computed on Form DCO-713.

By following the instructions on the DCO-713, the CSMR, Line 2 of the form, and the CSRA, Line 4 of the form, may be computed.

MCCA of 1988 set a maximum amount (the dollar amount shown in Section 1, #1 of the DCO-713) that a CS is allowed to keep under the law, and also allowed states to set a minimum amount (the dollar amount shown in Section 1, #2 of the DCO-713) that a CS could keep. These amounts are subject to change by the Consumer Price Index and will be changed annually on the DCO-713.

The total amount of resources that a CS is allowed to retain depends on the total amount of combined resources that a couple has and also on the current minimum state standard and the current maximum standard set by law.

RESOURCE RULE

1. If total combined resources are equal to or less than the state minimum standard, the CS may keep all.
2. If total combined resources are between the state minimum standard and twice the state minimum standard, the CS may keep an amount equal to the state minimum standard.
3. If total combined resources are in an amount of twice the state standard up to twice the maximum standard, the CS may retain one-half of all resources.
4. If total combined resources are greater than twice the maximum standard, the CS may still keep only the maximum standard allowed by law.
5. The CSRA may only be changed by a hearing officer or by a court order. (Re. MS H-208)

H-205 Determining Resources of the IS After CSRA Computation

MS Manual 07/13/15

To determine the IS's resource eligibility, Part II of the DCO-713 will be utilized. If the amount in Line 7 exceeds the one person resource limit, the IS is ineligible and the application will be denied.

If the amount in Line 7 is at or under the one person resource level, the IS will be considered resource eligible for the month of determination.

When determined eligible, it will be necessary for the IS or representative (guardian or power of attorney) to sign the statement on the reverse side of the DCO-713, agreeing to transfer the described property to the CS. If the IS or representative refuses to sign, then the combined

resources will be considered fully available to him/her and the IS will not be resource eligible at that time.

A copy of the DCO-713 will be provided to each spouse upon determination of eligibility, or to the spouse requesting the CSRA and eligibility determination, if a request by either spouse is made prior to application.

The DCO-713 will be indexed in the electronic case record.

H-206 Spousal Protected Amount (CSMR)

MS Manual 07/13/15

When resources exceed the limits, the IS will be ineligible until combined countable resources are reduced to the greater of the following:

1. The CSMR computed on the DCO-713 plus the one person resource amount for the IS;
2. Court ordered spousal allowance plus the one person resource amount for the IS; or
3. Spousal allowance determined necessary by a hearing officer plus the one person resource amount for the IS.

EXAMPLE: A couple's combined countable resources at the beginning of the first continuous period of institutionalization are $140,000; the spousal share is $70,000, the CSMR, which is the protected amount, and there is not a court order. At the time of application the combined countable resources are $90,000. (These dollar amounts are used for purposes of illustration only.)

Deduct from current combined countable resources ($90,000) the greater of the following:

$70,000, the spousal share (protected amount), or
$23,448, the minimum resource standard for 2014
($90,000 less $70,000 equals $20,000)

The remaining $20,000 is a countable resource used to determine eligibility of the IS, and the IS is not eligible. However, if the couple's combined resources are later reduced to $72,000, the IS will be resource eligible (protected amount of $70,000 for the CS plus $2000 for the IS).

If after the time of initial assessment ($140,000/$70,000 spousal share) and first application, there is a break in institutionalization, the initial assessment will be used at the time of reentry to re-determine eligibility for the IS. The $70,000 protected amount from the first assessment is still a protected amount for the CS, and a new amount need not be calculated.

EXAMPLE: The IS above left the Nursing Facility for 60 days and then reenters. The couple has combined countable resources of $65,000 at reentry; the spousal share earlier computed was $70,000. Since total combined resources are now only $65,000, which is less than the spousal share, all of the resources may be attributed to the CS, and the IS is eligible for LTSS.

H-207 Retroactive Eligibility

MS Manual 01/01/14

Retroactive eligibility may be given under these rules, provided all eligibility requirements are met. For example, application is made January 1, 2014, after entry into a Nursing Facility on October 1, 2013. The assessment of resources owned by the couple as of October 1, 2013, will be made and, if eligible, the case may be opened retroactively to October 1, 2013. (MS A-211)

H-208 Appeal Rights Regarding Changing the CSMNA and/or CSRA

MS Manual 07/13/15

If either spouse is dissatisfied with the determination of:

- the CS's monthly income allowance,
- the amount of monthly income otherwise available to the CS,
- the computation of the spousal share of resources, or
- the attribution of resources or the CS's resource allowance,

such spouse is entitled to a hearing, if application has been made on behalf of the IS. (Re. MS L-110). Any hearing regarding the determination of the CS's resource allowance shall be held within 30 days of the date of the request for the hearing.

REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE

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

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

If an income allowance greater than the one calculated by the caseworker on the DCO-712 is granted by a hearing officer, the greater amount cannot exceed the current maximum, as shown on the DCO-712. For example, in 2013 the maximum CSMNA is $2898. A CS's CSMNA computed on the DCO-712, based on rent and utilities, is $2600. The CS's income is $1800 a month, and the IS is allowed to give the CS $800 per month, giving the CS a total of $2600. The CS establishes that her monthly expenses are $3000, due to exceptional circumstances. A hearing officer may allow the IS to give the remainder of the IS's income, if any, to the CS (excluding the $40 PNA). If the IS has $298 additional income, it may be given to the CS to bring the CS's income up to the maximum CSMNA ($1800 + $800 + $298 = $2898, the maximum allowed). No additional amount can be granted to raise the CS's total income to $3000, because $3000 is over the maximum.

REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE

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

If a greater Community Spouse Monthly Income Allowance (CSMIA) is awarded by a hearing officer due to extreme financial duress, the county may:

- Request the hearing officer to reopen and review the case when the county has reason to believe the exceptional circumstances no longer exist;
- Have the hearing officer schedule future hearings to review the circumstances and determine if financial duress still exists; and
- Monitor the case(s) to assure that exceptional circumstances still exist, and make adjustments when indicated.

The CSRA may be changed by court order, or may be changed by the Agency in the following three instances:

1. By a hearing officer, when either the IS or CS establishes that income generated from the CSRA will be inadequate to meet the minimum monthly maintenance needs

allowance (CSMNA) as computed on the DCO-712 due to exceptional circumstances resulting in significant financial duress. There will be NO substitute CSRA made by a hearing officer when an IS does not make a living allowance (CSMIA) available to the CS.

2. By a hearing officer who confirms the allegation by either spouse that the initial determination was incorrect, or

3. By the county when it is determined that inaccurate information was provided and used in determining the CSMR.

   Refer to MS L-100 for additional information on Appeals and Hearings.

H-209 Rules for Transfer by the IS

MS Manual 01/01/14

If the IS or a representative acting on his/her behalf, transfers resources in an amount less than or equal to the CSRA for less than fair market value (FMV) to the CS or to another for the sole benefit of the CS, no penalty period will be applied to the IS.

If resources are transferred by the IS for less than FMV to anyone other than the CS or to another but not for the sole benefit of the CS, a penalty period will be applied according to the resource transfer provisions in effect at the time of the transfer. (Re. to MS H-308) The penalty period will apply to the vendor payment only. If the IS is otherwise eligible, he/she may be given eligibility for Medicaid ONLY. Prohibited transfers for uncompensated value will not affect eligibility for Medicaid.

H-210 Time Period for Transfer of CSRA to Community Spouse

MS Manual 01/01/14

The IS will be encouraged to transfer the CSRA to the CS as soon as possible. He/she will be given a period of 12 months (from the date the notice of approval is completed) to transfer the property in the amount of the CSRA to the CS.

If the transfer has not been made by the end of the 12 month period, the case will be closed, and the IS will not be eligible in the 13th month. No penalty will be applied, i.e., no overpayment will be written if the CSRA transfer was not made.

H-211 Rules for Transfer by the CS

MS Manual 01/01/14

If a spouse transfers property to his/her spouse before or after entry into a Nursing Facility and the receiving spouse transfers it to a third party for uncompensated value, a penalty period will be imposed on the IS. The transfer will be treated as if the IS had transferred directly to the third party.

EXAMPLE: A man transfers his home and land worth $40,000 to his wife on 11/1/13. His wife gives the property to her nephew without compensation on 3/1/14, and the man enters a Nursing Facility on 4/1/14. An assessment will be made at application, and the caseworker will inquire about transfers. A penalty period will be imposed on the IS. (Re. MS H-308)

H-212 Consideration of Resources After Eligibility is Determined

MS Manual 07/13/15

During the continuous period in which an IS is in an institution and after the month that the IS is determined eligible for LTSS, any resources owned solely by the CS which were considered available to the IS at determination of eligibility (i.e., any resources of the CS which exceeded the CSMR, and were considered available to the IS at determination of eligibility) will not be considered available following the month of eligibility determination. Resources will be considered available to each spouse according to actual ownership of those resources, except that the period for transfer specified in MS H-210 will be allowed.

H-300 Transfer of Resources

MS Manual 01/01/19

Transfer of resources applies to nursing facility, Home and Community Based Waivers (HCBS) including DDS and PACE (LTC) cases.

Exception to PACE: The transfer of resources policy (Re. MS H-308) will be reviewed with the PACE applicant at the time he or she enters the program. Transfer of resource provisions will apply only if the PACE participant enters a nursing facility. If assets have been transferred during the look back period from the time of entry into the nursing facility, a period of ineligibility for PACE services will be imposed for uncompensated value based on the current divisor. The look back period will begin with the date of entry to the facility, MS H-302. It will be necessary for the PACE recipient to drop out of the PACE program when he or she enters a nursing facility when under a penalty for non-compensated transfer. When the penalty period ends, the individual may be considered for readmission to the PACE program. The transfer of resources penalty does not apply to PACE individuals in the community.

H-301 Transfer of Resources Definition

MS Manual 01/01/19

A transfer of a resource occurs when an individual, the individual's spouse or an Authorized Representative of either of them gives away or sells property that belongs to the individual or spouse. Valid transfers of resource ownership may occur through any of the following types of transactions:

- Sale of property;
- Trade or exchange of one property for another;
- Spend-down of cash;
- Giving away cash;
- The establishment of or placement into a trust;
- Transferring any financial instrument (e.g., stocks, bonds); or
- Giving away property (including adding another person's name as an owner of the property).

The policy for the transfer of resources for less than fair market value (FMV) applies only to individuals applying for or receiving Long Term Services and Supports (Re. MS H-303). The treatment of resource transfers for less than fair market value made by an applicant/recipient, his/her eligible spouse, or his/her representative is governed by the date of transfer, the institutional or waiver status of the applicant/recipient, and whether the transfer was to the applicant/recipient's spouse.

A transfer of a resource made by an applicant/recipient, his/her eligible spouse, or a representative acting on their behalf must be verified and evaluated to determine:

1. Whether the transfer is validly irrevocable;
2. Whether any interest remains legally available to the individual or is declared by the current legal owner(s) to be available; and
3. Whether a resource was transferred for less than fair market value within the applicable look back period preceding the date of application/redetermination. (Re. MS H-303)

When it is determined that an applicant/recipient, his/her eligible spouse, or representative has the authority or ability to revoke the transfer and regain the transferred interest, the value of such interest will be included with countable resources.

When it is determined that an applicant/recipient or his/her eligible spouse has remaining interest or ownership in a transferred resource, the value of such interest will be included with countable resources.

NOTE: The above guidelines apply not only to an applicant/recipient or his/her eligible spouse but also to any fiduciary or individual legally authorized to act on their behalf, such as holder of power of attorney, parent of a minor child, guardian, etc. The guidelines also apply to other persons acting on behalf of the applicant/recipient or eligible spouse, e.g., an ineligible spouse.

H-302 The Look Back Period

MS Manual 01/01/19

The "Look Back Period" is the period of time prior to an individual's application for either nursing facility or Home and Community Based Waiver (including DDS) services during which a transfer of resources for less than FMV may affect the individual's current eligibility for vendor payment or waiver services. The length of the look back period is governed by federal law and regulations and thus is subject to change. The current look back period of 60 months was

established by the Deficit Reduction Act of 2005 (DRA) for transfers occurring on 2/8/2006 or later.

NOTE: For detailed instructions on transfers prior to 2/8/06, see Appendix H.

The eligibility worker will look at all transfers made during the look back period. The look back period is the 60 months immediately prior to the date on which an individual is both in an institution and has applied for medical assistance or, in the case of a Waiver individual, prior to the date the individual applies for Waiver assistance.

If an institutionalized or Home and Community Based Waiver (HCBS) individual is not eligible when he first applies for assistance and later reapplies, the eligibility worker will ask about transfers in the appropriate look back period from the date of the second application, or the dates of subsequent applications if the individual is not eligible at the second application.

H-303 Transfer for Less than Fair Market Value

MS Manual 01/01/19

Fair market value (FMV) is the amount for which property would sell on the open market if put up for sale in the ordinary course of business i.e. the actual or cash value of property. Fair market value is usually determined by the purchase price of similar goods or property in the same locality. A compensated transfer results when an individual receives compensation for transferred resources equal to the fair market value of the transferred resources in the form of money, stocks, bonds, material goods, services, etc.

When it is determined that an applicant/recipient, his/her eligible spouse, or their representative has transferred a resource at less than fair market value within the applicable look back period prior to application, the transfer will be presumed to be for the purpose of establishing eligibility and the amount of uncompensated value from the transfer(s) and the appropriate penalty period will be determined. Transfer(s) of resources presumed to be for the purpose of establishing eligibility will be subject to rebuttal (Re. MS H-312) and, in some cases, subject to exclusion based on other circumstances.

Individuals and/or their spouses who transfer resources for less than fair market value will be ineligible for nursing facility vendor payments for a period of time as specified at MS H-308.

A Home and Community Based Waiver applicant/recipient who transfers resources for less than fair market value will be ineligible for all Waiver Medicaid benefits and services for a period of time as specified at MS H-308.

H-304 Transfers to Trusts

MS Manual 01/01/19

A transfer to a trust occurs when an individual, the individual's spouse or the representative of either the individual or spouse transfers the ownership of the individual's resources to the corpus of a trust.

"Trust" means a trust, or similar legal device, established other than by will by an individual or an individual's spouse under which the individual may be a beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one or more trustees or other fiduciaries who are permitted to exercise any discretion with respect to the distribution to the individual, and shall include trusts, conservatorships, and estates created pursuant to the administration of a guardianship.

"Grantor" means the individual, institution or entity that established, created or funded the trust and shall also include fiduciaries as 1) defined by Arkansas Code 28-69-201 and third parties as contemplated by 2) Arkansas Code 20-77-301, et seq. Definition of a Trust.

TRUSTS ESTABLISHED PRIOR TO 8/11/93

1. State Law

   All transfers to trusts established on or before August 10, 1993, are governed by the terms of Act 1228 of 1993 and by federal law in #2 below. Act 1228 of 1993 provides the following guidelines:

   A provision in a trust, other than a testamentary trust, which limits the availability of, or provides directly or indirectly for the suspension, termination or diversion of the principal, income or beneficial interest of either the grantor or the grantor's spouse in the event that the grantor or grantor's spouse should apply for medical assistance or require medical, hospital or nursing care or long term custodial, nursing or medical care shall be void as against the public policy of the State of Arkansas, without regard to the irrevocability of the trust or the purpose for which the trust was created and without regard to whether the trust was created pursuant to court order.

2. Federal Law

   The following federal policy was applicable to trusts established prior to 8/11/93.

a. Trust Established by the Client or Spouse - Medicaid Qualifying Trust

A Medicaid Qualifying Trust is a trust or "similar legal device" established by an individual (or the individual's spouse) who is the beneficiary of the trust and who gives a trustee any discretion for use of the trust fund.

A "similar legal device" is defined as an arrangement, instrument, or other device which does not qualify as a trust under state law, but which has other characteristics of a trust (e.g., escrow account, savings account, pension fund, investment account or other account managed by a custodian, guardian or other individual with a fiduciary obligation). Any such legal device described above will also be considered a Medicaid Qualifying Trust.

If an individual is not legally competent and a trust is established for the individual by a guardian or legal representative (including a parent for a child), using the individual's resources, the trust will be treated as having been established by the individual, since he could not do it for himself.

With a Medicaid Qualifying Trust, consider as a resource to the beneficiary (for eligibility purposes) the maximum amount that a trustee could disburse if he exercised his full discretion allowed under the terms of the trust. This amount is deemed available to the individual whether or not the distribution is actually made. The amount actually distributed by a trustee is counted as income (if paid from the current monthly interest) or a resource (if paid from the principal or from past months' accumulated interest). This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of an individual with a developmental disability who resides in an ICF/IID facility.

1) <u>If Client is Trustee</u> - If the client is trustee of a trust established by himself or his spouse, consider the trust assets as a resource if he has legal authority to revoke or dissolve the trust, or to use the assets for the benefit of himself or his spouse.

2) <u>If Appointed Trustee with Full Discretion</u> - If the client is beneficiary of a trust with an appointed trustee who has full discretion for use of trust funds for the client's benefit, consider the trust assets as a resource to the client.

3) <u>If Appointed Trustee With Limited Discretion</u>
If the appointed trustee has limited discretion, the assets will be considered available to the maximum extent allowed by the trust, whether they are distributed or not.

b. Trust Established by Other(s) for Client

1) Consideration of Trust Principal - If the applicant, as beneficiary of the trust, has no access to the trust principal, it is not considered a resource to him. If the trust agreement provides for regular payments from the principal to the beneficiary, they are considered to be income in the month of their receipt and, if retained, to be a resource in the month(s) following.

When the beneficiary of the trust has direct access to the principal of a trust it is considered as a resource and withdrawals are not considered as income.

2) Consideration of Interest Income from Trust Principal - When the beneficiary has legal access to the income from the trust principal, it is considered to be income as it becomes available, whether used or not. If not used, the amount will become a resource in the month(s) following its availability.

When the beneficiary has no right to the interest income from the trust principal and it is added to the principal, it is not income to the beneficiary, and only the trust payments made to the beneficiary are considered to be income. If retained, the payment(s) will be considered a resource in the month(s) following.

If the trustee exercises authority over the use of trust payments, the payments are still considered to be income to the beneficiary whether received direct or "in-kind".

TRUSTS ESTABLISHED 8/11/93 AND LATER

1. General Provisions

All transfers to trusts established August 11, 1993, or later are governed by the terms of OBRA 1993 which, as federal law, supersedes Act 1228 and other applicable policy previously considered.

The consideration of trusts established August 11, 1993, or later is as follows:

a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust, other than by will:

1) The individual;

2) The individual's spouse;

3) A person, including any court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
4) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

b. If the corpus of a trust includes resources of an individual and resources of any other person(s), the provisions of this section shall apply to the portion of the trust attributable to the resources of the individual.

c. With the exception of a trust as described below in subsection No. 4 (Trusts Not Considered an Available Resource), this section (1a & b) shall apply without regard to:
   1) The purpose for which a trust is established;
   2) Whether the trustees have or exercise any discretion under the trust;
   3) Any restrictions on when or whether distributions may be made from the trust; or
   4) Any restrictions on the use of distributions from the trust.

2. Consideration of Revocable Trusts
   a. The corpus of the trust is considered available to the individual;
   b. Payments from the trust to or for the benefit of the individual are considered income to the individual; and
   c. Any other payments from the trust (e.g., to another individual) will be treated as a transfer of resources.
3. Consideration of Irrevocable Trusts
   a. If the trust permits payments, under any circumstances, to or for the benefit of the individual, the portion of the corpus from which payment to the individual could be made (or the income on the corpus from which payment to the individual could be made) shall be considered a resource available to the individual; and payments actually made from that portion of the corpus shall be considered as follows:
      1) Payments to or for the benefit of the individual shall be considered income of the individual; and

2) Payments for any other purpose shall be considered a transfer of resources by the individual.

b. Any portion of the corpus of a trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be a transfer of resources. The value of such trust shall be determined by including the amount of any payments made from such portion of the trust after such date.

4. Trusts Not Considered an Available Resource

A trust will not be considered an available resource to an individual if it meets the criteria of one of the 3 trusts described below:

a. A trust containing the resources of an individual under age 65 who is disabled, as determined by SSI or MRT, and which has been established for the benefit of the individual by the individual, a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual;

b. A trust (Re. MS H-110) established for the benefit of an individual receiving Social Security and other pension:

1) If the trust is composed ONLY of pension, Social Security, and other income to the individual (and accumulated income in the trust);

2) If the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual subsequent to establishment of the trust; and

3) As long as the state provides facility services to individuals in institutions under the federal income level (3 times the SSI payment level) but does not provide the same assistance to medically needy individuals.

c. A trust containing the resources of an individual who is disabled, as determined by SSI or MRT, that meets the following conditions:

1) The trust is established and managed by a non-profit association;

2) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;
3) Accounts in the trust are established solely for the benefit of individuals with disabilities (by SSI or MRT determination, including individuals age 65 and older) by the parent, grandparent, or legal guardian of such individuals, or by a court; and
4) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays the state from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

5. Hardship

   If it is determined that denial of eligibility due to the transfer of resources into a trust would work an undue hardship on an individual, the hardship provisions at MS H-720 may be applied.

6. Inquiries to the Office of Chief Counsel (OCC)

   When the eligibility worker becomes aware of the existence of a trust or of the transfer of resources into a trust, whether made by an individual, spouse, court of law, etc., the trust document along with other pertinent documents will be sent electronically to the Division of County Operations with a request for review by the Office of Chief Counsel. (Re. MS E-501).

H-305 Documentation of Resource Transfers

MS Manual 01/01/19

Each individual who is subject to a penalty for uncompensated transfers and who applies for Medicaid must complete Form DHS-727, Disposal of Assets Disclosure, in conjunction with his/her application for assistance. The eligibility worker will explain to each applicant/recipient (or to his/her representative) that transfers of any resources within the applicable look back period must be disclosed as a part of the eligibility determination.

Reported property transfers will be documented by copy of bill of sale, title transaction, deed, business records, receipts, account statements, etc. A signed statement from the receiving party of the transaction may also serve as evidence. The applicant/recipient or person acting on

his behalf must provide necessary documentation to verify the transfer. The eligibility worker will give assistance when necessary.

In addition to documenting the actual transfer, when a transfer has been made by an applicant/recipient, his/her eligible spouse, or another joint owner or account holder and fair market value compensation was not received, the eligibility worker must complete a Form DCO-778, Resource Inquiry, and forward it to the individual who received ownership of the resource. This inquiry is completed to document current ownership of the resource, the purpose of the transfer, and any expected compensation. If a complete Asset Inquiry Form cannot be obtained, the eligibility worker should attempt to gather the information through other means, e.g., direct from the client, etc. Assistance cannot be denied solely on the basis of not being able to obtain a completed Asset Inquiry Form.

H-306 Determining the Value of Compensation Received

MS Manual 01/01/14

The value of compensation received is based on the agreement and expectation of the parties at the time of transfer. For example, if the purchaser agreed to pay the individual $10,000 in 10 installments of $1,000 each, the compensation is valued at $10,000 regardless of the amount of any payment(s) actually received at the time of application or redetermination.

The value of compensation is the gross amount paid or to be paid in a tangible form (such as cash, real or personal property) by the purchaser (the value is not reduced by expenses attributed to a sale). When compensation is equal to or greater than the value of the resource transferred, the transfer will not be considered uncompensated. However, any balance of resources from the transaction will be counted toward the resource limit.

NOTE: A transfer for love and consideration is not considered a transfer for fair market value. It is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, any transfer for care or services provided for free is a transfer of resources for less than fair market value.

When uncompensated value exists, refer to MS H-308.

H-307 Ownership Held in Common with Others

MS Manual 01/01/14

When resources are held by an individual in common with another person or persons in joint tenancy, tenancy in common or other similar arrangements, the resource (or portion of the

resource) shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such resource. For example, Mrs. White adds her daughter's name to a bank account. Adding a name to a resource in itself does not necessarily constitute a transfer because, in this case, Mrs. White still has full access to her money. However, the daughter later withdraws the money. The withdrawal shall be viewed as if Mrs. White had directly transferred the money to her daughter, and a penalty period will be imposed on Mrs. White if she applies for facility or Waiver assistance. (Re. MS H-308)

If in the case of joint tenancy property ownership where an individual cannot access his interest in property due to the refusal of the other owners to give consent to sell the property, it should be determined when the joint tenancy ownership was established.

EXAMPLE: During the look back period an individual had full ownership of 10 acres of land but, prior to entering a facility, deeded the property to himself and two brothers as joint owners who will not consider sale of the property. In this situation, a transfer of resources should be considered, because an action occurred which eliminated or reduced the owner's access to a resource. If, on the other hand, the joint tenancy ownership has existed for a period of time longer than the look back period, a transfer of resources will not be considered and the applicant's interest in the property will not be considered a resource if the other owners will not consider sale of the property.

When a transfer was made in the look back period by a joint owner, which reduces or eliminates an individual's ownership or control of a resource, the individual will be given the right to rebut the presumption of ownership of joint accounts, if applicable, and to rebut the presumption that resources were transferred to establish eligibility (Re. MS H-312).

H-308 Determination of Uncompensated Value and Penalty Period

MS Manual 01/01/19

This section of policy provides guidelines on:

1. Determining the value of an uncompensated transfer;
2. Determining the appropriate penalty period;
3. Determining the penalty period for multiple transfers;
4. Determining the penalty period for an uncompensated transfer to an annuity; and

5. Determining the penalty period an uncompensated transfer due to the purchase of a life estate.

When an uncompensated transfer is made and an individual applies for nursing facility services, that individual will not be eligible for a vendor payment until the penalty period has expired. An individual in a nursing facility will be eligible to receive a Medicaid card during the penalty period, provided he/she is otherwise eligible.

The uncompensated value from a resource transfer is the difference between the fair market value of the resource at the time of transfer (Re. MS E-514 for real property and MS E-522 for personal property) and the value of compensation (cash, material goods, services, etc.) received for the resource (Re. MS H-306).

A Home and Community Based Waiver (HCBS) applicant and/or spouse who transfer resources for less than fair market value during the look back period will be ineligible for the Waiver program until one of the following is met:

- the applicant meets the criteria at MS H-310 to begin the penalty period, the penalty expires, and reapplication is made; or
- the date of the transfer is no longer in the look back period; or
- the applicant enters a nursing facility, an appropriate penalty period based on the transfer begins, the penalty expires, and reapplication is made for a HCBS Waiver.

A Waiver recipient and/or spouse who transfer resources for less than fair market value after approval, will be ineligible for the Waiver program during the penalty period. At the end of the penalty period, reapplication will be necessary and all eligibility factors must be verified prior to approval.

Determining the Penalty Period

The number of months of ineligibility will be determined by dividing the uncompensated value of all resources transferred by the individual or spouse on or after the look back date by the current divisor (see Appendix R). There is no cap on the total number of months of ineligibility. Any fraction remaining after dividing the total uncompensated value by the divisor will not be dropped. The remaining fraction will be multiplied by 30 (days) and the resulting number will be rounded up to calculate the additional number of days of ineligibility. The penalty period will begin on the first day of the month of the transfer or the date on which the individual is eligible for Medicaid, whichever is the later date.

Multiple Transfers – The eligibility worker will determine the penalty period for multiple resource transfers by treating the total cumulative, uncompensated value of the resources

transferred by the individual, the individual's spouse or the designated representative during all the months of the look back period as one transfer. This applies to all transfers regardless of the amount transferred. The eligibility worker will add the amount of all the transfers together to calculate the penalty period. The penalty period will begin on the first day of the month of the transfer or the date on which the individual is eligible for Medicaid, whichever is the later date.

Penalty for an Uncompensated Transfer to an Annuity - If an applicant with an annuity has not yet annuitized (i.e., started receiving regular payments) and the annuity is revocable, the principal of the annuity is a countable resource. If annuity payments have begun and the contract is irrevocable, the number of years of payout of the annuity must be equal to or less than the number of years of expected life remaining for the individual, based on the life expectancy tables at Appendix L. If the payout years are greater than the life expectancy years, a transfer of resources for less than fair market value has been made.

If an annuity is made irrevocable and there will be no payout during the life of the annuitant, the full purchase price of the annuity is subject to a penalty for transfer of resources.

Penalty for an Uncompensated Transfer Due to the Purchase of a Life Estate - The purchase of a life estate will be treated as an uncompensated transfer of resources if the purchaser does not live on the property for at least 12 consecutive months after the property is purchased. Also, if an individual purchases a life estate in someone else's home the individual must live in that home for a period of 12 consecutive months after the date of purchase. In either case, the full amount of the purchase price of the life estate will be considered as the uncompensated transfer.

If the transfer occurred after more than one year of occupancy, the eligibility worker will look at the purchase price of the life estate to determine if the purchase price was for fair market value. (See MS H-306). If the value of the life estate is less than the price of the life estate purchased, a transfer penalty is imposed for the difference between the value of the life estate interest and the purchase price.

NOTE: The Asset Transfer Worksheet is available to assist the eligibility worker in computing the correct penalty period.

H-309 Exceptions to the Penalty Period

MS Manual 07/13/15

A penalty period shall not be calculated according to MS H-308 if:

1. The resource transferred was a home, and title to the home was given to:

a. The individual's community spouse;
b. A child of the individual who is under age 21, or who is blind or has a disability (as determined by SSA or MRT);
c. A child of the individual (other than a child described in " b" above) who lived in the home for at least two years immediately before the individual was admitted to a medical institution, Waiver program or nursing facility and who provided care to the individual which allowed the individual to remain at home during that time rather than enter an institution; or
d. A sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year immediately before the individual was admitted to a Medical institution, Waiver program or nursing facility;

2. The resources were transferred:
   a. To the individual's spouse or to another for the sole benefit of the individual's spouse;
   b. From the individual's spouse to another for the sole benefit of the individual's spouse;
   c. To the individual's child who has a permanent disability or is blind as determined by SSA or MRT, solely for the benefit of that child, or to a trust, described at MS H-304, solely for the benefit of that child; or
   d. To a trust (including a trust described at MS H-304) established solely for the benefit of an individual under 65 years of age who has a disability (as determined by SSA or MRT or Railroad Retirement Board).

NOTE: Sole benefit means that it will benefit that individual only and that no other individual will derive benefit from the transferred resource during the lifetime of the individual to whom the resource was transferred. There must be a legal document executed to establish the transfer and evidence of "sole benefit", and it must be established that the transferred resource will have some immediately measurable monetary value which will benefit the spouse or child, e.g., a CD or other instrument which produces income, land or rental property which produces income, etc.

3. The individual intended to dispose of the resources either at fair market value or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance (the procedures for rebuttal of the presumption that resources were transferred to establish eligibility in MS H-312 are applicable);

4. All resources transferred for less than fair market value have been either returned directly to the client or used for the client's care; or
5. Denial of eligibility would cause an undue hardship (MS H-700).

H-310 Imposing the Penalty

MS Manual 01/01/19

For nursing home applicants/recipients the penalty period begins on the first day of the month of the transfer or the date on which the individual is eligible for Medicaid, whichever is the later date. Once a penalty period begins, it continues to run until expiration. (MS H-315) No penalty period will apply if the transfer can be excluded under the provisions listed in MS H-309. During the penalty period, the individual is not eligible for a vendor payment until the expiration of the penalty period but may receive other Medicaid services with the exception of Waiver services. The application must be approved for Medicaid without the vendor payment if all eligibility requirements have been met.

Even though the vendor payment has been closed for nursing home recipients, Medicaid will continue to cover services not covered under the vendor payment.

For Home and Community Based Services Waiver (HCBS) applicants, the penalty period begins on the date Medicaid would have been approved (MS C-200 section) if all the following criteria is met:

- The applicant meets the financial and nonfinancial requirements for Medicaid eligibility;
- The applicant meets the functional need (level-of-care) criteria for the waiver;
- A person-centered service plan has been developed for the individual; and
- A waiver slot is available for the individual's placement.

If the HCBS applicant does not meet the criteria, they are not eligible unless the individual enters a nursing facility or until the transfer date moves out of the look back period. If the individual enters a nursing facility, the penalty period will be determined and will begin when the individual meets the medical eligibility criteria and is determined Medicaid eligible. It will continue uninterrupted for the appropriate period of time even if the individual leaves and returns home. In that situation, Waiver services can resume when the penalty period is over.

For HCBS Waiver recipients the penalty period begins on the first day of the month of the transfer.

For both HCBS Waiver applicants and recipients, once a penalty period begins, it continues to run until expiration. (MS H-315) No penalty period will apply if the transfer can be excluded under the provisions listed in MS H-309.

H-311 Notifying Individual of Established Uncompensated Value and Penalty Period

MS Manual 01/01/19

If otherwise eligible, when uncompensated value is established, the individual must be advised of that fact before the application or redetermination is completed. The individual will be informed by letter (Form DHS-732) that he/she transferred a resource at less than fair market value and that the uncompensated value will result in a penalty period unless he/she can provide convincing evidence that the action was exclusively for some purpose other than establishing eligibility. A copy of the letter will be scanned in the electronic record.

For Home and Community Based Services Waiver (HCBS) applicants, when the criteria at MS H-310 is not met and no penalty period can be imposed, the individual will be sent a DHS-707 informing him/her, that the penalty for transferring a resource for uncompensated value will be total ineligibility for the Waiver program for five years from the date of transfer, unless the individual enters a nursing facility or meets the criteria at MS H-310.

If the individual does not respond to the letter, DHS-732, Notification of Asset Transfer at Less Than Fair Market Value, within 15 days, it will be assumed that he does not wish to rebut the presumption that the transfer was for the purpose of establishing eligibility.

H-312 Rebuttal of Presumption that Resources Were Transferred to Establish Eligibility

MS Manual 01/01/14

When an individual elects to rebut the presumption that the resource was transferred to establish eligibility, he will be informed that it is his responsibility to present convincing evidence that the resource was transferred exclusively for some other purpose.

The individual's statement concerning the circumstances of the transfer will be obtained and should include (but need not be limited to) the following points:

1. Purpose of transfer of resource;
2. Attempts to transfer resource at FMV;
3. Reasons for accepting less than FMV for the resource;
4. Means of or plans for supporting himself after the transfer; and
5. Relationship, if any, to the person(s) to whom the resource was transferred.

The individual will be required to submit any pertinent documentary evidence (e.g., legal documents, realtor agreements, relevant correspondence, etc.).

The individual's statement of purpose for transfer of the resources and any documentary evidence provided will be evaluated to determine if the transfer was exclusively for some purpose other than establishing Medicaid eligibility. Refer to MS H-313 for factors which indicate the transfer was for a purpose other than to establish Medicaid eligibility.

H-313 Factors Which Indicate Transfer Exclusively for Some Other Purpose

MS Manual 01/01/19

The presence of one or more of the following factors may indicate that resources were transferred exclusively for some purpose other than establishing eligibility:

1. The occurrence after transfer of the resource of:
    a. Unexpected (traumatic) onset of disability; or
    b. Unexpected loss of other resources which would have precluded eligibility at the time the resource was transferred; or
    c. Unexpected loss of income which would have precluded eligibility at the time the resource was transferred.
2. The resource (if retained) would not have caused total resources to exceed the resource limit at the time of transfer.
3. The transfer was court ordered for the purpose of satisfying an obligation in existence at the time of that transfer.

If the individual indicates that he had another purpose for transferring the resource but protection of the resource against use for medical or nursing home expenses was a factor in transferring it, the presumption that it was transferred to establish eligibility is not rebutted.

H-314 Apportionment of Penalty for Spouses

MS Manual 01/01/19

If the Institutionalized Spouse (IS) is serving a penalty period due to a transfer of resources for less than fair market value, the penalty period will be apportioned between spouses if the Community Spouse (CS) otherwise becomes eligible for medical assistance.

If a penalty has been apportioned between two institutionalized spouses and one spouse dies, the penalty period for the surviving spouse will be extended by the appropriate amount.

When an IS under a penalty dies or goes home, the CS of that individual later enters a facility and the penalty period of the IS has not yet expired, the CS entering the facility will inherit the remainder of the penalty previously imposed.

H-315 Penalty Continues Without Interruption until Expiration

MS Manual 01/01/19

If an institutionalized resident under a transfer penalty leaves the institution, the penalty period will continue to run. If the individual later reenters an institution and reapplies for Medicaid, the eligibility worker will not only inquire about transfers in the appropriate look back period from the date of reapplication, but will also check the case record to determine the length of the penalty previously imposed and whether or not that penalty has expired. The break in institutional status does not eliminate or disrupt a penalty previously imposed.

Even though the penalty for nursing facility services continues until expiration, an individual living in the community may still be found eligible for Medicaid in a Medicare Savings Program category.

H-316 Transfer of Resources Divisor Definition

MS Manual 01/01/19

The Transfer of Resources Divisor is one of the numbers used in the calculation to determine the penalty period resulting from a transfer of resources for less than fair market value.

The divisor is defined as the weighted average per diem Medicaid rate multiplied by 30.42 and rounded to the nearest dollar to obtain a monthly amount, calculated from cost reports submitted for the cost reporting period from July to June, and then applied to the following calendar year. The weighted average rate is calculated annually. Medicaid nursing facility resident days reported on each facility's cost report will be multiplied by each facility's per diem rate. The sum of the calculated amounts will be divided by the total resident days to get the weighted average rate. The divisor will be re-determined yearly by the Division of Medical Services with any resulting changes taking effect on April 1st. The divisor for the current year is indicated on MS Appendix R.

When there is a change in the divisor, the penalty period will be reassessed at the next reevaluation, or earlier if requested, or at reapplication.

If the client is currently eligible in a nursing facility Medicaid case, but not receiving a vendor payment due to penalty, the client will be reassessed at reevaluation or earlier if requested. If

the client is now eligible for vendor payment, vendor payment will be approved beginning the month of reassessment.

If the client is not currently receiving nursing facility or HCBS Medicaid but reapplies and is under a previously imposed penalty, the penalty period will be reassessed using the current divisor. If eligible, the nursing facility case will be approved with coverage not granted before April 1st or before the three-month retro period based on the recent application, whichever is later. If eligible, the HCBS case will be approved with coverage not granted before April 1st or before the allowed Medicaid begin date in the appropriate HCBS policy in section MS C-200.

H-317 Reacquisition of/or Additional Compensation Received on Resource Transfer at less than FMV

MS Manual 01/01/14

Resources that are either returned directly to the client or used for the client's care will reduce the penalty period. The eligibility worker must verify the value of resources that were either returned to the client or spent for the client's care, and make a determination as to the extent the returned resources should reduce the penalty period. This determination will include ensuring that the returned resources were returned from the individual to whom they were originally transferred.

If transferred resources are returned to the individual who transferred them, no penalty period will be imposed, i.e., the transfer will be considered as if it had never occurred. However, an individual who regains transferred resources may not be eligible for a period of time due to the value of the resources. If only a portion of the transferred resources are returned, a penalty period will be calculated based on the value of the resources not returned and will begin with the date of transfer of the first transferred resource not returned.

The receipt of additional compensation for a resource which was transferred at less than fair market value reduces the consideration of uncompensated value for that resource by the amount of additional compensation received. The additional compensation received plus remaining uncompensated value (if any) will be counted with the value of the other resources of the individual.

H-320 Income Transfers

MS Manual 01/01/14

As the definition of assets includes income to which an individual is entitled but does not receive, a penalty for transfer must be considered when, for example, an individual takes action to:

1. Irrevocably waive pension income;
2. Waive an inheritance;
3. Divert income to another recipient; or
4. Give away income during the month of receipt by the IS/CS.

The penalty period due to the uncompensated value of an income transfer is determined according to MS H-322. Amounts of uncompensated value and their periods of consideration may be affected by the receipt of compensation at a later time. Refer to MS H-317 for treatment.

H-321 Failure to Apply for Benefits

MS Manual 07/13/15

Federal regulations require that, as a condition of eligibility, an individual must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which the individual is entitled. These benefits include, but are not limited to, veterans' compensation and pensions, social security benefits, railroad retirement benefits, and unemployment compensation. If an individual fails to access any benefits to which he is entitled, he will not be eligible for Medicaid.

If otherwise eligible, Medicaid coverage will begin/resume on the first day of the month that the individual takes the necessary steps to obtain the other benefits.

H-322 Determination of Uncompensated Value and Penalty Period When Income Has Been Diverted or Waived

MS Manual 01/01/19

When income has been given away, the penalty period during which vendor payment will not be paid will be determined according to the amount of income not received, based on the life expectancy of the individual who is being penalized. (Re. Appendix L)

There is no penalty when an eligible Institutionalized Spouse gives part or all of his income to a Community Spouse in accordance with the methodology at MS H-200 and on the DHS-712.

H-323 Income Received and Transferred in the Same Month

MS Manual 08/10/15

If funds are received AND transferred in the same month, the funds are treated as income in the month received and also treated as a resource in that month when considering transfer of resources. The penalty period will begin on the first day of the month of the transfer or the date on which the individual is eligible for Medicaid, whichever is the later date.

H-324 When an Ineligible Spouse Gives Away Income

MS Manual 01/01/19

No penalty will be imposed on an Institutionalized Spouse (IS) if the individual's Community Spouse (CS) gives away income belonging to the CS or fails to access CS income, since the CS's income is not counted toward the IS's eligibility nor in the budget for vendor payment. However, if a CS takes such action, no payment will be made from the income of the eligible IS's income to compensate the CS for the income not received.

If the Ineligible Spouse of a Waiver applicant/recipient has given away income or refused to access income to which that spouse was entitled, no penalty will be imposed on the Waiver applicant/recipient, since the Ineligible Spouse's income has no effect on a Waiver applicant/recipient's eligibility.

However, if an ineligible CS later enters a facility or requests Waiver services, the CS will be penalized for the income he/she has given away.

H-325 Spousal Transfers in Excess of Community Spouse Minimum Resource Allowance (CSMRA)

MS Manual 01/01/14

If an IS transfers resources or income to the CS in amounts greater than the amounts allowed by the spousal rules (Re. MS H-200) no penalty period will be imposed on the IS. However, the assets will still be considered available in the eligibility determination of the IS.

H-400 Post Eligibility

MS Manual 07/13/15

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

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

MS Manual 01/01/14

Income eligibility for the IS will be determined in general following the procedures in MS H-402-430. Gross income of the IS cannot exceed the current LTC 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.

H-402 Consideration of Income

MS Manual 07/13/15

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

1. Income Not From A Trust

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

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

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

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

2. Income From A Trust

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

3. Income Through Property With No Instrument Establishing Ownership

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

H-403 Rebutting Consideration of Income

MS Manual 01/01/14

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

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

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

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

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

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

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

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

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

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

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

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

H-410 Factors Used to Determine the Cost of Care

MS Manual 01/01/16

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

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

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the IS, CS, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed on form DCO-712, Post Eligibility Income Worksheet, 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.
   - An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in 10-bed ICF/IID facilities and State Human Development Centers.

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

   Deduct the income trust fees.

   - Any applicable income trust fees.
   - The monthly service charge for maintaining the bank account and trustee fees may be deducted in cases certified November 1, 1995 and later. Refer to MS H-100.

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 $40.00. Refer to MS H-420.

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

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

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

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

If the individual has no spouse or dependents or noncovered medical expenses, the PNA will be the only allowance given to arrive at net income. If the individual has dependent children, but no spouse, refer to # 6 below. If the individual has a spouse or spouse and other dependents living in the community, refer to # 5 below.

4. **The Community Spouse Monthly Income Allowance (CSMIA)**, which is determined by:
   a. Computing the Excess Shelter Allowance in Section 5a of the DCO-712. Total shelter costs may include:
      1) Rent or mortgage, including principal and interest;
      2) Prorated taxes and insurance, including personal property taxes and insurance on household contents if paid yearly;
      3) Condominium or cooperative fee, including maintenance charges; and
      4) The standard utility allowance.
      Shelter costs must be verified. Utilities need not be verified.

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

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

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

The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA (Re. MS H-416). An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA (Re. 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. **A Family Member Allowance (FMA)** for each dependent family member. See MS Glossary for definition of dependent family member.

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

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

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

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

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

Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under the age of 18, the combined income of the children must be less than the Medically Needy Income Level for the appropriate number of children in the household to qualify for protected maintenance. (See MS O-710 for MNILs.)

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

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

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

If there are no noncovered medical expenses, the net income after deducting the protected maintenance for the child(ren) will be applied to the cost of facility care. If there are noncovered medical expenses, proceed to # 7 below.

7. **Non-covered medical expenses** of all facility recipients which are not subject to payment by a third party (including Medicaid) will be deducted.

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 caseworker with verification of the above. The recipient or authorized representative must not make the purchase or pay the medical bill until the caseworker 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 caseworker 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.

Deduction from income for cosmetic and elective procedures (e.g., face-lifts or liposuction) will not be allowed from the income of a facility recipient. Other expenses not allowed are the premiums for insurance, which pays cash to a recipient when medical expenses have been incurred and Medicare premiums deducted from SSA payments prior to buy-in. 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: As of January 1, 1990, 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. LTC 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 doctor visits and medical supplies;
b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly doctor visits;
c. One-time - Expenses incurred such as hospital bills.

If the caseworker 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

The total of any excluded earnings, income trust fees (when applicable), maintenance allowance and non-covered medical expenses (if any) will be entered in the system as

Protected Maintenance. The net amount remaining will be the amount the individual is expected to apply to the cost of care. The actual vendor payment will be determined by the eligibility system based on the net income entered by the caseworker.

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

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

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

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

MS Manual 01/01/16

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

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. Refer to MS H-410 #4-6.

6. Bank service charges on the Income Trust account. Refer to MS H-111 #3.

7. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician.

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

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

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

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

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

- DAAS will key the patient liability amount to the Recipient Waiver screen which provides this amount to MMIS and will notify the Adult Family Home provider.

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

H-413 Contribution to the Cost of Care for PACE

MS Manual 07/13/15

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long Term Care 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 caseworker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The patient liability amount will be calculated using the form DCO-712. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current LTC 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 LTC Medicaid limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTC/PACE limit of three times the current SSI/SPA, plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-415 Option to Estimate Net Income

MS Manual 01/01/14

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

H-416 Verification or Refusal of Contributions

MS Manual 07/13/15

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

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

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

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

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual 07/13/15

As of 7/1/88, those SSI recipients entering a medical or nursing facility:

a. who have a home to maintain, and
b. who obtain a medical statement for SSA to document that the medical confinement will not exceed 3 calendar months after the month of entry to the facility

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

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

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

When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered on the income tab. The $40 personal needs

allowance will be deducted from the countable income and the remaining income will be shown as NH Net Income (patient liability).

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

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

MS Manual 01/01/14

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

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

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

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

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

Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different ways that the contributions may be considered. The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of

action will be given. Any questions that the ineligible spouse/parent(s) has regarding the effects of a specific action will be answered.

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

H-430 Earnings of ICF/IID Facility Residents

MS Manual 07/13/15

Residents of ICF/IID facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI SPA in addition to the $40 personal needs allowance. Nursing facility residents with earnings may be given a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Office of Long Term Care (OLTC) should be contacted and requested to reevaluate medical necessity.

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

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

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

2. Fluctuating Earnings

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

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

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

a. every 6 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 LTC and ICF/IID Services

MS Manual 07/13/15

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

1. Date of Entry - The individual's date of entry into a participating facility is indicated on the DCO-702, Notice of Admission, Discharge or Transfer From A Facility, which is completed by the facility and forwarded to both the 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 Office of Long Term Care. The medical necessity decision is transmitted to the county office and the facility by the DHS-704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-704 is received by the county office on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/IID facility or was subject to PASARR, medical necessity begins on the DHS-704 decision date for ICF/IID or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.

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

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

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

MS Manual 01/01/14

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

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

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

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

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

H-460 When a LTC Recipient Transitions to a Medicare Bed

MS Manual 07/13/15

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

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

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

H-470 Quality Control Errors

MS Manual 01/01/14

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

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

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

H-480 Acquisition of Additional Income and Resources

MS Manual 07/13/15

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

Refer to: MS E-500 thru 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 CS.

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

MS Manual 07/13/15

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

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

Case adjustments in this situation will be made as follows:

1. Case Adjustment for LTC Ineligibility Period - To adjust the case for the month of ineligibility, an entry should be made on the WNHU interface for the month of ineligibility. The caseworker should key the start date as the first day of the month the client was income ineligible, and the stop date as the last day of the month the client was ineligible. The income amount keyed should be the total income received in the month or one dollar more than the maximum skilled care rate whichever is greater.
2. No System Case Adjustment is needed for Medicaid categories other than LTC.
3. Overpayments - Overpayment reports for LTC and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility (Re. MS Section M). If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

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

H-490 Absences from Long Term Care Facilities

MS Manual 07/13/15

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

Death or Discharge

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

1. Complete form DHS-707 to notify the recipient or his next of kin of the case closure or intended case closure and reason for action;
2. End facility services on WNHU and close case on WASM (SSI cases will be closed when notification is received from Customer Assistance that case should be closed);
3. Provide assistance to the next of kin in securing a deceased recipient's personal allowance funds and property (if assistance is requested).
4. Complete a DCO-734, Report of Case Closure Due To Death, for Estate Recovery purposes, and send to the Third Party Liability section.

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 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.

Long Term Care 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 on the DCO-702. When there is no indication that the recipient is expected to return to the facility within 14 days of the date left, the county office will initiate action to close the case as described below:

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

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

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

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

H-491 Procedure for Reactivating a Suspended Case

MS Manual 01/01/17

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

1. Facility Care
   a. Verify institutional status.
   b. Complete reevaluation, if due.
   c. Verify current income.

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

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

2. SSI Recipients

a. Complete reevaluation, if due.

b. Verify current income.

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

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

Hospitalization

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

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

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

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

Hospitalization at the Arkansas State Hospital (Little Rock)

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

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

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

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

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

Procedures for Suspension of Cases-Arkansas State Hospital

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

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

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

    b. Notify the State Hospital by interagency memorandum of the recipient's continued Medicaid eligibility including the recipient's name, his ten-digit Medicaid ID #, his aid

category, his residence county, D.O.B., SSN, Medicare Claim # and/or other health insurer, facility left, and date he left the facility. Address correspondence to:

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

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

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

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

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

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

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

H-492 Transfer

MS Manual 07/13/15

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

1. Complete the address change, NH number and NH county code (if different) in the eligibility system. See note below for SSI address changes. Do not enter NH Eligibility Start or End Dates on WNHU with a transfer action.
2. Complete Sections I, II (Date to be Reviewed, only), and III of a blank DHS-704, mail the original to the receiving facility and file a copy in the case record.

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

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

Resident of Human Development Center

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

1. The Center Administrator or designee should contact the county office to request assistance in locating a facility if necessary.
2. If a facility has already been selected by the center, the name of the resident, the name of a family member or responsible person, the name and address of the facility, and the effective date of transfer will be given to the county office on form DCO-702.
3. Upon receipt of the DCO-702 indicating transfer, change the address, the NH number and NH county (if different) in the eligibility system. Do not enter NH Eligibility Start or Stop Dates on WNHU with a transfer action.

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

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

H-493 Operations Plan - Relocation of Recipients

MS Manual 01/01/16

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

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

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

H-494 Relocation Procedures

MS Manual 01/01/16

The following procedures are applicable to designated elements of the Agency. It is essential that all personnel involved in the relocation of recipients observe these procedures and insure

that maximum effort is directed toward the orderly and safe relocation of all recipients. Patient safety and well-being will be of primary concern at all times.

1. Office of Long Term Care

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

   a. Notify the facility, DAAS Assistant Director, and county office of agreement cancellation.
   b. Allow 30 days for the orderly relocation of all recipients.
   c. Identify and maintain a list of facilities, by classification, with vacancies.
   d. Provide vacancy data to the appropriate county office.
   e. Make personal contact with the facility administrator/owner(s), and attending physicians to explain the purpose and actions involved in relocation of recipients.
   f. Alert the Division of Aging and Adult Services that their assistance may be needed.
   g. Provide Agency representatives to assist with inventory of personal effects and allowance and to instruct the facility to transfer these items with the recipient.
   h. Provide medical personnel (nurses and physicians, if required) to evaluate the physical status of each recipient to insure the individual's safety during the relocation.
   i. Coordinate with receiving facilities to insure they are prepared to accept incoming recipients.
   j. Provide maximum assistance to county offices to insure all relocation actions are accomplished in an orderly and timely manner.
   k. Provide weekly status reports to the Director, Division of Medical Services, and to the DAAS Assistant Director.
   l. Coordinate with the county office, data processing section, accounting section, and claims processing agent to insure that case records, payments and Medicaid cards are transferred in conjunction with recipients.

2. County Office

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

   a. Give priority attention to all relocation actions.

   b. Identify all recipients in the facility.

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

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

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

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

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

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

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

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

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

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

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

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

date. Request the hospital to give notice prior to discharging the recipient or when the recipient expires.

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

3. The Facility

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

a. Provide full cooperation with all Agency personnel.

b. Make available all records to Agency personnel.

c. Transfer personal belongings and allowances with each recipient.

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

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

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

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

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

H-500 Long Term Care Insurance Partnership Program

MS Manual 01/01/14

The Deficit Reduction Act of 2005, Pub. L. 109-171, Section 6021 allows for the expansion of a Qualified State Long Term Care (LTC) Partnership Program. This permits States when determining Medicaid eligibility to disregard as a resource an amount up to the total amount of benefits paid out of a LTC Insurance Partnership policy. The Arkansas General Assembly passed Act 99 on February 13, 2007 to establish the Arkansas Long Term Care Partnership Program.

The Qualified State LTC Partnership Program encourages individuals to accept personal responsibility for their future long-term care needs by purchasing insurance and reduces the incentive to transfer or hide resources that can be protected legally. It will help individuals better plan for long term care needs they may have in the future.

NOTE: Purchasing or owning a LTC Partnership policy does not guarantee Medicaid eligibility. Other eligibility factors must be met also.

H-510 Resource Disregard

MS Manual 01/01/14

A resource disregard in an amount up to the amount of benefits paid out by a Qualified Long Term Care Insurance Partnership policy will be allowed when determining eligibility for Medicaid. This is a "dollar for dollar" calculation for resource protection. The benefits will be disregarded in determining an individual's Medicaid eligibility for Facility Care as well as Home and Community Based Services.

EXAMPLE: An individual purchased a qualified policy with a benefit of $100,000. Application is made for Medicaid and the policy has paid out $90,000 in benefits. The policyholder's resources can be protected up to $90,000.

Only certified "partnership qualified" LTC insurance policies provide this resource protection. The resource disregard cannot be allowed for a non-qualified LTC insurance policy.

H-520 Policy Identifiers

MS Manual 01/01/14

The Arkansas Department of Insurance has established specific criteria that the qualified long term care insurance policy must meet. The criteria are:

1. The policy must cover a person who is a resident of the Qualified Partnership State when coverage first became effective.
2. The policy must meet the definition of a "qualified long term care insurance policy" established by the Internal Revenue Code of 1986.
3. The policy must not have been issued earlier than July 1, 2008.
4. The policy must include inflation protection which is established at the time of purchase. The inflation protection can be up to 5% but not less than 3%.

The resources to be protected will be designated during the initial application process and the value of the designated resources must be verified by the caseworker.

NOTE: Under the spousal impoverishment rule, only resources that belong to the institutionalized spouse (IS) are protected.

H-530 Disclosure

MS Manual 01/01/14

A statement disclosing partnership qualified status will not be included on the policy. A separate disclosure document will be sent to the individual by the insurance company after the purchase of the policy.

The content of the disclosure notice will include:

1. The insured's name, policy number, date of issue,
2. A statement that the disclosure form should be kept with the policy,
3. An overview of resource disregard,
4. Any policy changes that might affect partnership qualified status; and
5. A website address for more information.

When an individual applying for Medicaid states that he or she has a Qualified LTC Partnership policy, the caseworker will request the disclosure notice or other documents so that contact can be made to the insurer to verify the amount of the policy and benefits paid to determine the amount of the resource disregard.

H-540 Policy Exchanges

MS Manual 01/01/14

If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the effective/issuance date of the policy, individuals may exchange their current policies for partnership qualified policies through their insurance agents. If the policy is exchanged for another, the insurance company will provide the policyholder with a disclosure statement with a new effective/issuance date.

H-550 Exhaustion of Benefits

MS Manual 01/01/14

An individual who owns a Qualified Long Term Care Partnership policy can apply for Medicaid before the exhaustion of policy benefits.

The Qualified Partnership policy is treated as a third party liability and Medicaid will pay for services not covered. Medicaid will be payor of last resort.

H-560 State Reciprocity

MS Manual 01/01/14

If an individual purchased a qualified partnership policy in another state, it will be accepted in Arkansas. Qualified partnership policy status will be verified by the caseworker. The caseworker will request the disclosure notice or other documents so that contact can be made to the insurer to verify the amount of the policy and benefits paid to determine the amount of the resource disregard. The caseworker will request the individual to complete Consent for Release of Information form, so the insurer can release requested information.

H-570 Transfer Protection

MS Manual 01/01/14

A transfer of the protected resources will not be an uncompensated transfer and will not be subject to a penalty period. When disregarded resources are given away, the disregarded amount cannot be replenished nor can additional resources of the policyholder be eligible for protection.

EXAMPLE: Mrs. Jones, who bought and used a Qualified Partnership policy, applies for Medicaid after her long-term care insurance policy is depleted. Under her policy, she used $100,000 in insurance benefits and is eligible for a resource disregard of $100,000. The $100,000 is set aside in a separate savings account.

While on Medicaid, Mrs. Jones uses the funds in her account to buy gifts for family members, and to make other purchases. This is not considered an uncompensated transfer because the transferred resources were protected.

H-580 Effect of Resource Disregard in Estate Recovery

MS Manual 01/01/14

The initial amount of protected resources, if the policyholder still has ownership, will be disregarded from estate recovery when the policyholder dies. If a Qualified Partnership policyholder spends or transfers the disregarded resource prior to death, then only the disregarded amount remaining is exempt from estate recovery (Re. MS H-600).

EXAMPLE: Mrs. Jones was eligible for a resource disregard of $100,000. At the time of her death, there is $20,000 remaining in the account. During the estate recovery process, the state will allow an exemption of $20,000 from the amount that would otherwise be eligible for estate recovery.

H-600 Estate Recovery

MS Manual 07/13/15

The Omnibus Budget Reconciliation Act of 1993 and Arkansas Act 415 of 1993 mandate recovery of medical payments correctly made from 8/13/93 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 for
- Individuals age 55 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 age 21, or children that 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 which 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.

H-620 County Office Responsibilities

MS Manual 07/13/15

During the application process for nursing facility, ICF/IID, or waiver services, the caseworker will review the initial estate recovery notice on the back of the DCO-777 with the applicant or representative. The MS H-600-650 section can be used as the basis to provide additional information if needed. If the applicant or representative has questions which the caseworker cannot answer, a suggestion may be made to make further inquiries of an attorney.

The determination that an individual under age 55 is considered permanently institutionalized will be made based on the medical information submitted on the DHS-703 for nursing facility residents, or on the DHS-703A for ICF/IID residents.

Administrators of nursing and ICF/IID facilities have been requested to submit copies of the completed DHS-703s or DHS-703As to county offices for new applicants who are under the age of 55. If the estimated duration of need for facility care is checked "permanent" on page 3 of the DHS-703, or is checked "indefinite" on page 3 of the DHS-703A, the individual will be considered permanently institutionalized. If the DHS-703 or the DHS-703A has not been received prior to certification for services, a copy will be requested from the facility. Certification will not be delayed pending receipt of either form.

The determination need not be made again as long as the individual resides in a facility. The DHS-703 or DHS-703A will be indexed in the recipient's electronic record to show that a determination of permanent institutionalization was made.

Within 10 days of case closure due to the death of a Nursing Facility, ICF/IID, or Home and Community Based Waiver recipient, the caseworker will complete the "Report of Case Closure Due to Death (form DCO-734) and mail it to the **Third Party Liability Unit, Decedents' Estates, P. O. Box 1437, Slot S296, Little Rock, AR 72203-1437.**

H-630 Recovery Procedures

MS Manual 07/13/15

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 which has been published in the newspaper. The published notice is to include the requirement that all claims against the estate be submitted within six 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 shall 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 Medicaid benefits in a nursing facility, ICF/IID facility, or under a home and community based waiver program.

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 and was residing in the recipient's home for at least two years immediately before the recipient's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to the recipient which 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 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, 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 Medicaid 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 01/01/14

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 Medicaid payments and the procedures for requesting a hardship waiver (DHS-20). Refer to MS H-730 for procedures.

H-650 Appeal Rights

MS Manual 01/01/14

The waiver applicant may appeal the DHS decision regarding the hardship waiver by writing to the Office of Appeals and Hearings and requesting an administrative review of the decision. The request must be received no later than 30 days from the date of the notice of negative action.

H-700 Undue Hardship Waiver

MS Manual 01/01/14

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 DHS of intent to recover Medicaid payments through the Estate Recovery process.

The individual or Authorized Representative will need to provide the caseworker verification to support the allegation of hardship.

H-710 Hardship Waiver for Home Equity

MS Manual 07/13/15

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 caseworker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the Division of Aging and Adult Services LTSS Support Unit. A decision on the hardship waiver will be made by the Hardship Waiver Committee. The caseworker 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, he/she may appeal the decision within 30 days' receipt of the notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

MS Manual 07/13/15

Once the caseworker has determined that this transfer does not meet an exception found at H-309, and it's been determined that the resource/income was not transferred exclusively for some other purpose through a rebuttal found at H-312 – H-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/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 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 merely would cause the individual inconvenience, or would restrict his lifestyle without putting him 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 his/her personal representative. To ensure consistency with decisions regarding what constitutes a hardship, the caseworker will route all applications for an undue hardship waiver to the Division of Aging and Adult Services LTSS Support Unit.

A decision on the hardship waiver will be made by the Hardship Waiver Committee. The caseworker 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 DHS decision, he/she may appeal the decision within 30 days' receipt of the notice about the DHS decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 07/13/15

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 Medicaid 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 which 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 which constitute the undue hardship. Tax returns, income statements or other documents which 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 Division of Aging and Adult Services LTSS Support Unit, Central Office Hardship Waiver Committee. In determining the existence of an undue hardship, the Central Office Hardship Waiver Committee will consider factors including, but not limited to the following:

1. The estate asset subject to recovery is the sole-income producing asset of beneficiaries 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 homes 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 DHS Central Office Hardship Waiver Committee.

The DHS 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 DHS decision, he/she may appeal the decision within 30 days' receipt of the notice about the DHS 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.

I-100 Renewals and Changes

MS Manual 01/01/14

A renewal is a periodic redetermination of eligibility after initial eligibility has been established. Only factors of eligibility which are subject to change (e.g., financial) must be redetermined. Factors not subject to change such as age or citizenship will not be redetermined at renewal.

A change is a report of a difference in circumstances within the family household. Individuals are only required to report changes that may affect the individual's eligibility such as income that exceeds the applicable income limit. Changes should be reported within ten (10) days of the date the change occurred to avoid any potential overpayment. Eligibility will be redetermined when a change that may affect eligibility is reported.

The individual will not be asked to provide verification of information that is not relevant to ongoing eligibility, or that has already been provided and is not subject to change. This applies at both renewal and a change report.

I-110 Renewal Process

MS Manual 01/01/14

A renewal will be conducted once every 12 months and no more frequently than once every 12 months. Depending upon the Medicaid eligibility group, a renewal form completed by the individual may or may not be required in order to complete the redetermination of eligibility.

Renewals for individuals in the Families and Individuals (MAGI) groups may be completed without information from the family or individual as described in MS I 200-210.

Specific renewal forms are required to be completed by individuals in the AABD Eligibility Groups in order to redetermine eligibility and complete the renewal. See MS I-300 and Appendix O for those specific processes and forms.

I-200 Families and Individuals (MAGI) Groups Renewal Process

MS Manual 01/01/14

The renewal processes described in MS I-200-230 apply to all eligibility groups using the MAGI financial methodologies. See MS E-200.

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 E 200-270 and F 110.

Before requesting information from the individual, the agency must first attempt to make a redetermination of eligibility based on information available through the Federal Data Services Hub, ARFinds, and other information known to the agency (e.g., through the SNAP program.) This is called an *ex parte* renewal. If an *ex parte* renewal cannot be completed, then a renewal form pre-populated with the information known to the agency will be sent to the individual for review. This form must be signed and returned to the agency.

The system will initiate the renewal process in the *10th* month following the last renewal or application so that the renewal can be completed prior to the end of the 12th month. The first step will be to attempt to complete an *ex parte* renewal as described below.

I-210 *Ex Parte* Renewal

MS Manual 11/18/15

The system will take the following actions to complete an *ex parte* renewal:

1. Conduct an electronic review by collecting income information from available data sources such as the Federal Data Services Hub, ARFinds and other available programs (e.g., SNAP, TEA).

2. Determine continued eligibility if sufficient information is found through the data matches.

3. If the MAGI household has income (attested or previously verified) under the MAGI limit, the system will determine if a member of the MAGI household is on an open SNAP or TEA benefit case. If one MAGI household member is found on an open SNAP or TEA case, the MAGI household income is considered verified.

4. If a member in the MAGI household is not found on an open SNAP or TEA case, the system will continue the reasonable compatibility process and check available electronic data sources.

5. If the household attests to income under the MAGI limit (to include zero income) and the electronic data sources return no report of income or income less than the MAGI limit, the system will consider the MAGI household to meet reasonable compatibility and no further income verification is needed.

6. If the electronic data sources return an amount over the MAGI limit, the system will trigger a pending verification notice to the household for income verification.

7. Generate and send a notice to the individual advising of the renewal decision. The notice will include the information used to determine eligibility or ineligibility. The notice will advise the individual to review the information used to determine eligibility and respond to the agency only if any of the information is inaccurate. If the individual is no longer eligible, the notice will also serve as an advance adverse notice of action to terminate the individual's Medicaid eligibility.

8. Update the individual's record to reflect continued eligibility or effective date of ineligibility. If ineligible, trigger an Account Transfer to the Federally Facilitated Health Insurance Marketplace (FFM) as appropriate.

Caseworker Responsibilities

No action is required by the caseworker when an *ex parte* renewal is completed unless the individual responds to the eligibility decision notice indicating the information upon which the determination was made is inaccurate. When that occurs, the caseworker will review the information provided by the individual, request any necessary verification to validate the information, if validated, enter the new information to the system and trigger a new eligibility determination within the system. The system will then generate appropriate notices to the individual.

I-220 Regular Renewal

MS Manual 11/18/15

If the system cannot complete an *ex parte* renewal because sufficient information to determine eligibility is not available through existing data sources, then the individual will be required to provide the necessary information.

The system will take the following actions:

1. Generate and send to the individual a renewal form that is pre-populated with the information known to the agency. Specific information needed from the individual will be requested on the form. The individual will be given 30 days from the date of renewal form to provide any necessary information and return the form to the agency.

2. Set a due date in the system by which date the form must be returned.

3. Redetermine eligibility once the renewal form and any other necessary information has been returned and entered to the system and generate the same notices described in MS I-210 #3. Also see verification process at MS G-114.

4. If a MAGI household attests to income over the MAGI income limit, the system will accept the self attestation and find the household ineligible due to income. A closure notice will be sent to the household and the household members will be referred to the FFM.

   If the individual returns the renewal form after the case is closed but within 90 days of the coverage termination date, the form will be used to determine eligibility. A new application will be required if the renewal form is returned after 90 days.

   Example: A renewal form is sent to the individual on August 15 and it is due back in the office on or before September 15. The form is not returned and a 10 day notice is sent informing the individual of the case closure. The case is closed on September 30. The individual returns the renewal form by December 28. Therefore, the renewal form will be used to process eligibility. If eligible there will be no break in coverage for the individual.

5. Update the individual's record to reflect continued eligibility or effective date of ineligibility. If ineligible, trigger an Account Transfer to the FFM as appropriate.

6. Generate an adverse notice of action to the individual to terminate Medicaid eligibility when the form is not returned by the due date and update the individual's record to end Medicaid coverage. In this situation, no Account Transfer is made to the FFM.

Caseworker Responsibilities

The caseworker is responsible for the following actions to complete a regular renewal:

1. Ensure that the completed renewal form and any verification provided by the individual is scanned into the system upon receipt;
2. Review the information provided and request any necessary verification to validate the information; and
3. If validated, enter any new or changed information to the system and trigger a new eligibility determination within the system. The system will then generate appropriate notices to the individual and take action to continue Medicaid coverage or terminate it if eligibility no longer exists.

I-230 Newborns Renew in ARKids First

MS Manual 01/01/14

Newborn coverage ends the last day of the month of the child's first birthday. Prior to that date, an ARKids First eligibility determination using the *ex parte* renewal process described in MS I-210 will be attempted based on information already known about the newborn's household composition and income. If sufficient information is not available to determine the newborn's ARKids First eligibility, then a pre-populated form as described in MS I-220 will be sent to the newborn's parent or caretaker adult for completion. Upon the form's return, eligibility for either ARKids A or B will be determined and if eligible, the newborn will be enrolled in the appropriate ARKids group. If not eligible due to household income, then an Account Transfer will be made to the FFM for an eligibility determination for Advanced Premium Tax Credits (APTCs) and selection of a Qualified Health Plan (QHP).

The ARKids eligibility determination must be completed prior to the first day of the newborn's birth month to ensure the newborn can have uninterrupted coverage either through ARKids or enrollment in a QHP.

I-300 AABD Eligibility Groups Renewal Process

MS Manual 01/01/14

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)

A renewal form will be system generated to the individual, his or her spouse, or authorized representative requesting updated information for those factors of eligibility subject to change. The same renewal form is not used for all AABD eligibility groups. See Appendix O for the specific renewal form that is used for each of the AABD groups. The system generated form will include a date by which the form must be returned to the agency.

The system will initiate the renewal process in the *10th* month following the last renewal or application so that the renewal can be completed prior to the end of the 12th month. The system will take the following actions:

1. Generate the appropriate renewal form to the individual, his or her spouse, or authorized representative.
2. Set the due date for return of the form. This date will be the 10th day of the 11th month.
3. If the form has not been scanned or entered to the system as received by that date, generate a Notice of Adverse Action to the individual advising that his or her Medicaid eligibility will end at the end of the notice period for failure to return the renewal form unless the form is received prior to that date.
4. If the form has still not been scanned or entered as received in the system by the date in the Notice of Adverse Action, end the individual's Medicaid eligibility as of that date and close the case.

I-310 Caseworker Responsibilities

MS Manual 01/01/14

The caseworker is responsible for the following actions to complete an AABD renewal:

1. Ensure that the completed renewal form and any verification provided by the individual are scanned into the system upon receipt.

2. Review the information provided and request any necessary verification to validate the information.
3. Redetermine the individual's eligibility based on the information received from the individual and enter any new or changed information to the system.
4. Update the system to reflect continued eligibility, level of service, vendor payment, etc. or to end the individual's eligibility if no longer eligible.
5. Generate the appropriate notice to advise the individual of continued eligibility or of ineligibility.

I-320 Alternate Renewal Processes

MS Manual 03/04/15

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

- ElderChoices/AAPD Waiver,
- Assisted Living Facilities,
- PACE,
- DDS Waiver,
- TEFRA,
- Autism and
- Medicare Savings Program.

The following sections describe their renewal processes.

I-321 ElderChoices/AAPD Waiver

MS Manual 01/01/14

ElderChoices and AAPD Waiver renewals will be conducted annually by the Long Term Care Unit (LTCU). Form DCO‑7781, LTC Medicaid Annual Renewal, will be completed. After eligibility has been re-determined, the review date will be entered in the system.

Reassessment of medical necessity will be completed by the DHS RN. The Office of Long Term Care will review the assessment and assign the Level of Care.

I-322 Assisted Living Facility

MS Manual 01/01/14

Assisted Living Facility Waiver renewals will be conducted annually by the county office. Refer to Appendix O for the list of required forms to be used in the renewal process. After eligibility has been re-determined, the review date will be keyed to the system.

Reassessment of medical necessity will also be completed annually by DAAS.

I-323 PACE

MS Manual 01/01/14

Both financial and medical eligibility will be re-determined annually. Medical eligibility will be re-determined by the DHS RN. Financial eligibility will be conducted at each annual renewal by the county office. Form DCO-7781 and all other forms required at initial application will be completed. DAAS will complete an annual Level of Care assessment on all PACE participants using the same assessment instruments and review and approval processes as the initial assessment. DAAS 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 DDS

MS Manual 03/04/15

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. Please 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-109 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 (Re. MS F-120).

DDS will be responsible for securing the DHS-703s for timely redetermination of medical necessity.

The DDS Medicaid Eligibility worker will complete the renewal process in the system. If an income change is made, the total gross income amount must be entered in the system on the income tab. If a change is anticipated, then a task must be created.

I-325 TEFRA

MS Manual 07/01/18

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-109, 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 6 months in 2013 and then lost SSI due to increased parental income. The parent applies for TEFRA in September 2013 and the case is certified in November 2013 based on the previous SSI disability determination. The child has not received SSI benefits since certified. At the annual renewal in 2014, a MRT disability determination is required.

A review by MRT is also necessary if the caseworker becomes aware of significant improvement and/or employment at or near the SGA level (Re. MS F-124).

All forms completed for the initial application, including the DMS-2602 and DCO-2603, must be completed at renewal. 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 03/04/15

Autism Waiver cases will be renewed every 12 months by the Area TEFRA Processing Unit (ATPU). ATPU will mail the parent or guardian a DCO-7779, Annual Renewal Notice, to redetermine eligibility. 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-109 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.

If the renewal form is not returned, a DCO-700, Notice of Action, will be sent advising that the DCO-7779 must be received within 10 days or the case will be closed after the notice expires.

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 03/04/15

ARSeniors, QMB, SMB and QI-1 reevaluations will be conducted on an annual basis. Form DCO-811, SNAP/MSP Annual Review, will be used to complete the reevaluation. For MSP recipients with or without a SNAP case that has been certified for 24 months or 36 months, form DCO-811 will be system generated in the 11th month following the last review (6th work day from the end of the month). The recipient must complete all appropriate sections of the form and return the completed form to the address listed on the DCO-811 by the 10th of the following month. The information on the DCO-811 will be used to determine continued eligibility for both SNAP and MSP. If the recipient has both a SNAP and a MSP case, both reviews must be completed at the same time. If the spouse has a MSP case, his/her case must be reviewed at the same time as the casehead. If an individual is in the household who is not the spouse of the SNAP or MSP casehead, his/her MSP review will be completed as appropriate, based on the date of the last case review. Self-declaration will be accepted. An interview is not required for these households. Form DCO-662 should be completed (for ARSeniors and QMB only) when there has been a change in insurance coverage. The caseworker will mail the DCO-662 to the recipient to gather information on the reported change and to request a copy of the new insurance card. If additional information is needed, a DCO-103, Request for Information, will be sent to the client.

If the DCO-811 is not returned by the due date, form DCO-93, Notice of Action, will be issued to the recipient advising that his/her case will be closed. This notice is specific to MSP and SNAP 24/36 annual reviews. The notice will explain why the case is being closed and provide instructions on how to prevent the case closure. If the DCO-811 is not returned by the date specified on the form DCO-93, the caseworker will close the case.

If the SNAP case is closed and the continued eligibility for MSP can be established, the MSP review will be completed. 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 Medicare Savings Program Annual Review can be completed via the telephone and will not require a returned, signed DCO-811, 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. For example, the worker may be contacting the client for another reason or calling to remind the client to return the review form. Another example is if the client initiates the call for a replacement form. However, it is the worker's discretion as to whether an interview to obtain the information should be completed.

During the phone interview, the worker should review the client's information in the system and ask if there have been any changes since the last review. Workers should be alert to whether the individual has a spouse who is also receiving MSP benefits and if so be sure to obtain information and complete the spouse's review at the same time. The worker should document in the system using the narrative type "Annual Telephone Review" and verify information if necessary (e.g., SOLQ). The client should be advised that the annual review has been completed and that the form does not need to be returned.

I-400 Foster Care and Adoption Assistance Eligibility Groups Renewal Process

MS Manual 01/01/14

The Division of Children and Families Foster Care Unit is responsible for completing the renewals for foster children and those receiving adoption assistance subsidies. See MS K 100 for those procedures.

I-500 Categorical Changes

MS Manual 01/01/14

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 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 01/01/14

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 04/03/17

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 01/01/14

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 QMBs in addition to their other Medicaid benefits. County Offices need not take any action on these cases (for QMB eligibility or coverage) unless Medicaid eligibility in the other category ends.

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, SMB, or 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. When certifying the Medicare Savings case, re-key the original renewal date in the computer system.

EXAMPLE: A nursing facility recipient loses Medicaid eligibility upon returning home from a a nursing facility. He is entitled to Medicare Part A and appears to be income and resource eligible for QMB coverage. The county will determine QMB eligibility based on available information. If eligible, the individual's coverage will begin the month following certification as a QMB. A new application will not be obtained from the individual.

NOTE: When an individual previously closed in another category is reopened as a Medicare Savings category, the closed case number will be used as the Medicare Savings category case number.

I-531 Medicare Savings Programs-COLA Increases

MS Manual 01/01/14

When the annual SSA 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, based on revised poverty levels, 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, a DCO-700 will be sent as advance notice of closure and the case will be closed when the period expires.

The January SSA Cost of Living Adjustment 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 03/04/15

Individuals who apply for QMB or 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 Medical 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 (Re. 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.

EXAMPLE: An individual eligible for both an Aid to the Disabled and a Disabled QMB category will be certified in the Aid to the Disabled category, but will receive full QMB benefits. An individual may be approved for a spend-down and a QMB for simultaneous periods.

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

Unlike QMBs and SMBs, QI-1s 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 01/01/14

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 caseworker 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 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 04/01/18

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 01/01/16

Money Follows the Person allows Medicaid eligible individuals residing in an inpatient facility, including hospitalization, to receive long term care services 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 and Adult Services (DAAS) 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.

DAAS 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 1 day.

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

MS Manual 01/01/16

For MFP, a DAAS 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 DCO-777, Long Term Care Application for Assistance. The caseworker will receive the application from the

Transition Coordinator indicating this is a MFP application and the type of waiver requested. In situations in which a DHS RN has already been involved with a patient, the caseworker may receive a DHS-3330 and Page 2 of the Plan of Care signed by the applicant which is also sufficient. If the DHS-3330 and Page 2 of Plan of Care are received, procedures in MS C-250 will be followed.

Upon receipt of the DCO-777, the caseworker will send a DHS-3330 to the DHS RN to assess and develop a plan of care. The caseworker will write **MFP** in the right hand corner of the DHS-3330 prior to submitting to the DHS RN. This will make the DHS-3330 easily identified by the DHS RN that this is a MFP application. The caseworker will also inform the DHS RN which waiver category is being applied.

The DHS RN will proceed with the assessment process. The DHS RN will use the DCO-704 for medical eligibility determination if signed within the past 6 months. If the Intermediate Level of Care was entered by the county more than 6 months previously or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DCO-704 verifying Intermediate Level of Care status. The DHS RN will follow procedures outlined in MS C-241.

Refer to MS C-242 for procedures to approve an ARChoices Waiver application and closure of the nursing facility case.

Refer to MS C-256 for procedures to approve an Assisted Living waiver application and to close the nursing facility case.

Refer to MS C-272 for procedures to approve a DDS waiver application and to close the ICF/IID facility case.

I-560 ANSWER Procedures for ARChoices Recipients Turning Age 65

MS Manual 01/01/16

No action will be required when an ARChoices recipient who is in the ANSWER category ARChoices/AAPD turns age 65 as there is no difference in the services received through the ARChoices program. Additionally, a new assessment is not required. Behind the scenes, the ACES system will convert the individual automatically from category 41 to category 11, or an SSI person from a category 43 to category 13. At the next reevaluation, the LTSS Eligibility Specialist will process in ANSWER the budget unit change from ARChoices/AAPD to ARChoices/ElderChoices.

I-570 Workers with Disabilities Eligible to Receive ARChoices Services

MS Manual 01/01/16

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 county worker will complete a DHS-3330 within 2 days of the office interview for referral to the DHS RN for coordination of the medical assessment. 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. The application, reevaluation, or the request for ARChoices services on an active Workers with Disabilities case will be pended until receipt of the DHS-704 from the Home and Community Waiver Unit.

County Office Eligibility Determination

The caseworker will determine if the applicant meets the eligibility requirements of the Workers with Disabilities category (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 SGA 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 county worker must contact the local SSA office requesting verification of physical disability. If unable to verify if a physical disability exists through SSA, then a MRT determination is required.

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

caseworker (MS A-200) and approval submitted to the system unless a retroactive eligibility date is established by the DHS RN.

ARChoices Transition to the Workers with Disabilities Category

ARChoices recipients may also request to transition to the Workers with Disabilities category. Once the caseworker 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.

ARChoices recipients who have earnings that cause ineligibility for ARChoices should be reviewed before closing to see if they would meet the financial criteria of the Workers with Disabilities category. Once the caseworker 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. The ARChoices case will then be reopened manually by DCO System Support.

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. The county worker is not required to verify or request verification of income and resources. The DHS-704 is required to meet the medical necessity as well as verification that a physical disability exists.

I-600 Changes

MS Manual 05/01/18

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 Care Individuals who have a Community Spouse,
- Medical Cost for Long Term Care individuals, or
- Changes in work and community engagement requirement exemptions or activities.

Although an address change does not usually affect eligibility, caseworkers should encourage individuals 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.

When a change is reported by the client, the caseworker will:

- Review the information.

- Verify through electronic sources, if applicable. Request additional verification if required.
- Enter the changed information to the system so that eligibility can be redetermined.
- Ensure appropriate notice is sent to the individual if a change in eligibility results.

NOTE: A new application is not required to add a member, but the caseworker will need to obtain tax filing status of the added member.

I-610 Loss of Eligibility

MS Manual 05/01/18

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, or
- 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 or 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 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 01/01/16

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,
- DDS Waiver,
- TEFRA,
- Autism,
- SSI Related Groups and
- Pregnant Women.

I-630 ARChoices Waiver

MS Manual 01/01/16

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

If at any time DAAS or 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 by DHS-3330 or DHS‑704, and the Waiver case will be closed. If the Waiver case is closed for any reason, the caseworker 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 on the system at the appropriate time. In both instances, a DHS-3330 and a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

If the Waiver client will be ineligible for more than one month, the case will be closed and a new application will be required. If closure was due to a reason other than functional need, a new DHS-704 will not be required at reapplication if the following conditions are met:

1. The case is being reopened within 2 months of the closure date.
2. The DHS-704 was signed within 6 months prior to the new application date.
3. The DHS RN was notified by a DHS-3330 of the closure within 3 days of the action taken.
4. The DHS RN was notified by a DHS-3330 of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be needed to reopen the ARChoices case.

When closing an ARChoices case because a recipient refuses to receive at least one service, closure code "Refused Other Procedural Requirement" will be used. A manual notice will be sent to the recipient notifying him or her of the closure. If the client does not refuse services but the DHS RN determines that the recipient is no longer in need of services or that services are no longer available in the recipient's area, closure code "Other Non-Needs Related" will be used. A manual notice will be sent notifying the recipient of the closure.

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. Because it is the responsibility of the DHS RN to coordinate services in the client's home, he/she must be aware of planned adverse action and the request for an appeal. Therefore, when a Notice of Adverse Action is mailed to an ARChoices Waiver client, a copy will be emailed to the DHS RN the same day. Also, when the caseworker learns that request for an appeal has been submitted on a Waiver case, the caseworker will notify the DHS RN via DHS-3330 immediately. If the county office at any time finds the recipient ineligible for the Waiver program, the DHS RN will be notified immediately by DHS-3330 and the Waiver case will be closed.

I-631 ARChoices Waiver Temporary Absences from the Home

MS Manual 01/01/16

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

      When a Waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does not return home within 30 days from the date of entry. If after 30 days the recipient has not returned home, the DHS RN will notify the county office via Form DHS-3330 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 assessment and DHS-704 will not be required. A new DCO-777 or DCO-7781 will not be required unless it is time for the annual renewal. It is not necessary to register a new application in this situation.

      If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 or DCO-7781 must be obtained and registered, along with the assessment and DHS-704. 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 registered LTC application. If found eligible for vendor payment,

the case will be closed with a Waiver Stop Date using the date of entry into the nursing facility. 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 Plan of Care (e.g., the recipient has left the state and the return date is unknown), the DHS RN will notify the county office via DHS-3330 and action will be taken by the caseworker 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 01/01/14

ALF Waiver recipients will be advised to report any changes in income or resources to the county DHS office.

If at any time DAAS or DMS 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 caseworker 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 on the system at the appropriate time. In both instances, a copy of

the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

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. If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if all of the following conditions are met:

1. The case is being reopened within 2 months of the closure date.
2. The DHS-704 was signed within six months prior to the new application date.
3. The DHS RN was notified of the closure within 3 days of the action.
4. The DHS RN was notified of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be required to reopen the ALF Waiver case.

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. When the caseworker learns that request for an appeal has been submitted on an ALF case, the caseworker will notify the DHS RN immediately.

If at any time the county office finds the recipient ineligible for the ALF program, the DHS RN will be notified immediately and the county office caseworker will begin the process of closing the case.

I-641 Temporary Absences from the Assisted Living Facility

MS Manual 01/01/14

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

   When an ALF recipient enters a hospital, the county office will not be notified and no action will be necessary unless the recipient does not return to the ALF within 30 days. If the recipient does not return from the hospital within 30 days, dies during hospitalization, is

discharged to his home or elsewhere from the hospital, the ALF facility will report to the county on Form DCO-702 and the caseworker will initiate case closure. 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 on Form DCO-702 and the caseworker 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 DCO-777 must be obtained and registered and a new DHS-704 obtained. 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 registered LTC 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 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 Center - 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 Plan of Care (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 01/01/14

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 (Re. MS J-130). Notice is made to the individual/legal representative with copy to the DDS applicable area manager and authorized case management and direct service providers.

Eligibility will end at the end of the ten-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.

If the County Office is notified at any time by DDS that the client is no longer eligible for DDS Waiver Services, the County Office will determine if the client is eligible for any other Medicaid category.

I-660 TEFRA

MS Manual 01/01/14

When a change occurs that affects eligibility, the caseworker will notify the TEFRA Committee advising when the closure will be made. The applicant will be sent a 10-day advance notice using form DCO-700, unless advance notice is not required. (Re. MS J-130) A copy of the DCO-700, a memorandum or an email will be sent to the TEFRA Committee to inform of the closure.

I-670 Autism

MS Manual 03/04/15

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 03/04/15

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 QMB eligibility, all SSA income will be counted in the budget. The QMB income and resource calculations and documentation will be entered into the electronic case file. 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 application will be registered in the system and the same case number will be used for the QMB case in the appropriate category.

The individual should be notified in advance by DCO-700 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. Closure of the disability case will be considered an adverse action, since QMB recipients are not entitled to the full range of Medicaid benefits.

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

MS Manual 01/01/17

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.

In these cases, if the pregnant woman's original coverage is:

- Parent Caretaker Relative (PCR); the category will be switched to Full Pregnant Women (FPW). The income used for the PCR category will be used for the FPW category.
- Adult Expansion Group; the category will be switched to FPW or Limited Pregnant Women (LPW) based on the income used to determine eligibility for the Adult Expansion Group.
- ARKids A; the category will be switched to ARKids B.

- ARKids B; the category will remain ARKids B. If the woman is pregnant when the ARKids B 12 months of continuous coverage ends or she turns age 19, eligibility will be determined in the appropriate Pregnant Women category.
- FPW or LPW; the category can remain the same or LPW can be switched to FPW if income decreased to under the FPW limit.

J-100 Notice of Action Requirements

MS Manual 01/01/14

A notice of action is sent to an individual whenever an application has been approved or denied, a hardship request has been denied or assistance has been reduced or terminated. All notices must include:

- A statement of action the Agency intends to take,
- The effective date of the action,
- The reason(s) for the action,
- The manual policy reference(s) supporting the action,
- An explanation of the individual's right to request a hearing, and
- An explanation of the circumstances under which assistance is continued if a hearing is requested.

Federal regulations require an advance notice be given for termination of assistance and reduction of assistance. The following sections define these notice requirements and also list when advance notice is not required. For purposes of the notices described below, day one of the 10 day advance notice period is the day after the date of the notice.

J-110 Advance Notice for Termination of Assistance

MS Manual 01/01/14

When the Division of County Operations (DCO) proposes to terminate assistance for a recipient, advance notice will either be system generated or mailed to the recipient using Form DCO-700, Notice of Action.

Advance notice must contain all information listed in MS J-100. The advance notice given on the DCO-700 must be mailed to the recipient at least ten (10) days prior to the effective date of action unless probable fraud is indicated. Where probable fraud exists, five (5) days prior notice is required.

If a hearing is requested within the advance notice period, the caseworker will forward a copy of the DCO-700 with the DCO-1200, Appeal for Hearing, and the Hearing File to Central Office Appeals and Hearings and delay action pending outcome of the appeal. If a hearing is not

requested within the advance notice period, action will be taken by the caseworker on the date indicated on the DCO-700.

J-120 Advance Notice for Reduction of Assistance

MS Manual 01/01/14

Reduction of assistance means a change in vendor payment or a categorical change resulting in a reduction in benefits in the service package such as a change from ARKids A to ARKids B. When the recipient's income increases, a 10 day advance notice will be given. If the income change results in a change in vendor payment to the nursing facility, an information copy of the DCO-704, Decision for Nursing Home/Waiver Placement, will be provided to the nursing facility.

J-130 When Advance Notice is Not Required

MS Manual 04/13/2018

Advance notice is not required when:

1. The Agency has factual information confirming the death of a recipient.
2. The Agency receives a clear written statement signed by the recipient that he no longer wishes assistance or that gives information that requires termination or reduction of assistance, and the recipient has indicated in writing that he understands the consequences of supplying such information.
3. The recipient has been admitted or committed to a tax supported institution and is not eligible for continued Medicaid assistance.

NOTE: Individuals under age 21 may continue to qualify for Medicaid who are receiving inpatient psychiatric care in an approved psychiatric facility. Refer to MS A-165 for specific information.

4. The recipient's whereabouts are unknown and Agency mail directed to him has been returned by the Post Office indicating no forwarding address.
5. A recipient has been accepted for assistance in a new jurisdiction (State) and that fact has been established by the caseworker.
6. A change in the level of medical care is prescribed by the recipient's physician.
7. A special allowance by the Office of Chief Counsel (exclusion of assets, etc.) granted for a specific period is terminated and the recipient has been informed in writing at the

time of initiation that the allowance will automatically terminate at the end of a specific period.

8. Agency action does not propose to discontinue, terminate or reduce assistance.

NOTE: A denial does not require an advance notice, but does require an adequate notice i.e., provides the information listed in MS J-100.

J-140 Account Transfer to the Federally Facilitated Health Insurance Marketplace

MS Manual 01/01/14

When an individual is determined not eligible for Medicaid either during the application or renewal process, the agency must transfer the individual's electronic record via a secure electronic interface to the Federally Facilitated Health Insurance Marketplace for eligibility determination for advance payments of the premium tax credit and cost sharing reductions to purchase a qualified health plan. Notice text for these denials or closures must include notification to the individual that:

1. The individual's electronic account will automatically be transferred to the Federally Facilitated Health Insurance Marketplace (FFM) for eligibility determination for advance payments of the premium tax credit and cost sharing reduction to purchase a qualified health plan, and

2. The timeframe in which the individual/recipient has to complete the enrollment process.

K-100 Medicaid Coverage of Foster Children

MS Manual 01/01/14

The DCFS Eligibility Unit may authorize medical assistance for eligible Foster Children (FC) in:

- ARKids A;
- Non-IV-E;
- Category 92 - Title IV-E FC - AFDC related;
- Medically Needy – Exceptional (EC); and
- Medically Needy – Spend Down (SD).

K-101 Extent of Services

MS Manual 01/01/14

The services specified in the pamphlet "Arkansas Medicaid Beneficiary Handbook" are available to eligible individuals in any of the Foster Care categories, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and Family Planning Services. The exception is that EPSDT is not available to category 97 (FC-SD).

K-102 Identification of Eligibles

MS Manual 01/01/14

To be eligible for services in State FC (Cat. 91), the individual must meet the eligibility criteria of U-18 category (Re. MS E-300).

To be eligible in Title IV-E-FC (Cat. 92), the individual must meet Title IV-E eligibility requirements, as specified in the Title IV-E State Plan maintained by the Division of Children and Family Services.

To be eligible in State FC Medically Needy (Cat. 96 or Cat. 97), the individual must meet the U-18 MN requirements (Re. MS E-300).

To be eligible for services in ARKids A (category 61) the individual must meet ARKids eligibility requirements (RE. MS B-210).

Each child will be evaluated as a one person household unit against the appropriate criteria. Consideration of parental income/resources will cease effective the month a child enters Foster

Care and the Court awards custody to the Agency. If a parent voluntarily relinquishes custody of a child into foster care, that child will not be eligible for IV-E FC (Category 92).

A child taken into Foster Care on the basis of an emergency order only may be determined Medicaid eligible. If custody is later established by a judicial determination, the Family Service Worker will be required to provide a copy of the order to the DCFS Eligibility Unit.

NOTE: The exception to eligibility guidelines for State FC-U-18 Related (Category 91) and State FC-MN (Categories 96 and 97) is that eligibility for Foster Children in these categories may continue up to age 21, provided that the child has signed an agreement to remain in FC and that the Division of Children and Family Services continues to provide FC Services to these children.

K-103 Initial Determination of Eligibility

MS Manual 01/01/14

Children entering Foster Care will be referred by the Family Service Worker to the DCFS Eligibility Unit for initial determination of Medicaid eligibility. Referral should be made within one working day after the child's entry into Foster Care.

K-104 Family Service Worker Responsibilities

MS Manual 01/01/14

The Family Service Worker will complete placement information in the Children's Reporting Information System (CHRIS) and, upon approval of the placement information by the DCFS Supervisor, the CHRIS system will send an alert to the DCFS Eligibility Unit inbox that an application has been submitted. A separate application will be generated for every child.

If the identity of a child entering foster care is unknown and the Family Service Worker is unable to obtain birth verification through family, hospital, Vital Records, or other records, the court order placing the child in foster care may be used as acceptable verification of age and residence. Children in Foster Care, who are recipients of Foster care maintenance or adoption assistance payments under Title IV-E, are exempt from the citizenship verification requirement (RE. MS G-130 and MS G-134). The SSN enumeration requirement, however, cannot be waived.

K-105 DCFS Eligibility Unit Responsibilities for Initial Eligibility

MS Manual 01/01/14

The responsibilities of the DCFS Eligibility Unit during the initial determination of eligibility are as follows:

1. The DCFS Eligibility Unit will register the initial Medicaid application in the eligibility system.

2. In determining eligibility the following income and resource levels are applicable:

   a. Category 61 – ARKids A (Appendix F-Income)

   b. Category 91 – Appendix T

   c. Category 92 – Appendix T

   d. Category 96 - Medically Needy –EC (Appendix N)

   e. Category 97 - Medically Needy - SD (Appendix N)

   The appropriate income information will be entered in ANSWER. If the child has income greater than the applicable income level for the category, that child will not be eligible for Medicaid in that category.

3. After determination of eligibility, certification of eligible Foster Children will be done by entering the approval information in ANSWER.

4. If a Foster Care Medicaid case number has previously been obtained by the DCFS Eligibility Unit, this number will be the case number for the Medicaid case. If the Eligibility Worker approves the Foster Care Medicaid case, the Family Service Worker will be notified of the case number through the CHRIS system.

5. If an IV-E child has a child of his or her own living in the same household, the minor parent and his or her child will be set up in separate Medicaid cases. The eligibility requirements to be considered for the minor parent's child are:

   a. The minor parent is IV-E eligible, and

   b. The child is living with the minor parent.

6. If the application is denied, the denial information will be entered into ANSWER.

7. The DCFS Eligibility Worker will maintain a separate case file for each child in Foster Care.

K-106 Reevaluations

MS Manual 01/01/14

Reevaluations will be completed by the DCFS Eligibility Unit every 12 months based on the date of initial certification, or the date of the last reevaluation.

K-107 DCFS Eligibility Unit Responsibilities for Reevaluation

MS Manual 01/01/14

Responsibilities of the DCFS Eligibility Worker during the reevaluation:

1. The CHRIS system will notify the DCFS Eligibility Unit when a reevaluation is due for a non-IV-E Foster Care Medicaid case.
2. Determination of continuing eligibility will be made by the DCFS Eligibility Unit, using the same criteria that were used for determining initial eligibility.
3. If eligibility continues, the DCFS Eligibility Unit will update the information in ANSWER. If the child is ineligible, the DCFS Eligibility Unit will initiate closure of the case.
4. If the case is closed, eligibility will be determined in another Foster Care Medicaid category, if applicable.
5. The Family Service Worker will be notified by the CHRIS system of continuing eligibility or case closure.

K-108 Changes

MS Manual 01/01/14

The Family Service Worker will be responsible for notifying the DCFS Eligibility Unit of any change in the child's circumstances through the CHRIS system or form CFS 495. Notice will be made when there is a change in income, resources, Foster Care case status (closure), change of residence, or when an adoption is finalized.

The DCFS Eligibility Unit will narrate changes in ANSWER that affect the child's Medicaid eligibility.

K-109 Transfers Out-of-State

MS Manual 01/01/14

IV-E Foster or Adoptive Children

> When an IV-E child who receives foster care payments or who has an adoption assistance agreement in effect is placed out-of-state, the procedures found in MS K-400 through K-403 will be followed.

Non IV-E Foster or Adoptive Children

> When a non IV-E child (Category 61, 91, 96, or 97) is placed out-of-state, Medicaid coverage by Arkansas may be continued as long as Arkansas retains legal custody and continues to make a board payment. If the out-of-state placement is for adoption, the coverage may continue until the adoption is final. If the receiving State opens a Medicaid case, Arkansas Medicaid will be closed.

K-110 Placement with Parents

MS Manual 01/01/14

If a non IV-E foster child is returned to his natural/adoptive parent(s) on trial or temporary placement, the FC Medicaid case will be closed after an advance notice is sent. The parent(s) will need to apply for Medicaid for the child. If the child is returned to FC, the FC Medicaid case will be reinstated provided the child meets all eligibility requirements.

If an IV-E child is returned to the natural or adoptive parents for a trial or temporary placement, the case may remain open during the trial or temporary placement period.

K-111 Continuing Eligibility of Foster Care Children Placed for Adoption

MS Manual 01/01/14

Medicaid coverage for ARKids A (Cat. 61), State FC, U-18 Related (Cat. 91) and State FC Medically Needy (Cat. 96 or Cat. 97) may continue until the adoption is finalized, if eligibility requirements continue to be met. Prospective parents' income and resources will be disregarded.

The Adoption Specialist or Family Service Worker responsible for the case will provide all information relative to eligibility, reevaluations and changes, and will be responsible for notifying the DCFS Eligibility Unit when the adoption is final.

K-111 Continuing Eligibility of Foster Care Children Placed for Adoption

Medicaid coverage for Title IV-E-FC (Cat. 92) children who are adopted or in a pre-adoptive placement may continue provided the child remains eligible for IV-E subsidy payments. A reevaluation is not necessary for these children. The CHRIS system will notify the Adoption Specialist or Family Service Worker if the IV-E subsidy payment ends.

Once initial eligibility has been established for Title IV-E-FC (Cat. 92) children who are adopted or in a pre-adoptive placement, the agency does not have to redetermine eligibility provided the child remains eligible for IV-E subsidy payments. The CHRIS system will notify the Adoption Specialist or Family Service Worker if the IV-E subsidy ends.

K-200 Non-Title IV-E Adoptive Children With Special Needs

MS Manual 01/01/14

The Consolidated Omnibus Budget Reconciliation Act of 1985 allows states to provide medical assistance to non-Title IV-E adoptive children with special needs.

Medicaid eligibility can be determined, or continued, when an adoption agreement is entered into for non-Title IV-E foster children under age 18 who have special medical or rehabilitative needs that would preclude adoption placement if they were not Medicaid eligible. For the non-Title IV-E Special Needs Adoptive coverage to apply, a child must be receiving Medicaid (in any category) in the month in which the adoption assistance agreement is signed, or received Medicaid in any one of the three months preceding the month of the adoption agreement, or would have been eligible to receive Medicaid (in any category) in the month of the adoption agreement or in any of the three months retroactive to adoption, had application been made.

K-201 Medicaid Category for Non-Title IV-E Special Needs Adoptive Children

MS Manual 01/01/14

Medical assistance will be provided to eligible Special Needs Adoptive Children in category 91 - U-18 related.

K-202 Eligibility Requirements

MS Manual 01/01/14

The following requirements must be met to qualify for non-Title IV-E Special Needs Adoptive Children coverage.

1. Age- The non-Title IV-E Special Needs Adoptive Child must be under age 18 (eligibility may continue throughout the month of the 18th birthday) to qualify. Proof of age is required (e.g. birth certificate, court order).

2. Citizenship or alienage requirement (MS D-200).

3. Social Security enumeration requirement (MS D-400).

4. Residency requirement (MS D-300).

5. Assignment of rights to medical support/third party liability requirement (MS D-500).

6. Financial Need- It must be determined that the special needs adoptive child, if not Medicaid certified in the month the adoption agreement is signed or Medicaid certified in any one of the three months preceding the month of adoption, would have been Medicaid eligible in the month of adoption or in any one of the three months immediately preceding the month that the adoption agreement was signed, had an application been made.

   Only the income and resources of the child will be considered in making the eligibility determination for children who were not Medicaid certified in the month of adoption or in the three months preceding adoption. Any income or resources of the natural parent(s) or adoptive parent(s) will be disregarded. Once it has been established that financial eligibility exists in the month of adoption or in any month of the three month retroactive period, there will be no later income or resource redeterminations at subsequent reevaluations.

7. Special Needs- The non-Title IV-E Adoptive Child must have a special need for medical or rehabilitative care, as determined by the Division of Children and Family Services (DCFS) that would preclude adoption placement if the child were not Medicaid eligible. The special need must have existed prior to the adoption agreement (i.e., a child who develops a special need for medical or rehabilitative care after an adoption assistance agreement is in effect is not eligible for this category). Some examples of special medical or rehabilitative needs are cerebral palsy, spina bifida, Down's syndrome, psychiatric disorder, etc. Factors such as age, sex or race that might make an adoptive placement difficult do not qualify as Special Needs.

8. Adoption Agreement- A legally executed adoption agreement between the state and the adoptive parent(s) must exist before eligibility can be determined. An adoption agreement does not have to be the final decree in order for a child to receive assistance in this category. The adoption assistance agreement must remain in effect for the child to receive continuing Medicaid assistance as a Special Needs Child.

K-203 Retroactive Coverage

MS Manual 01/01/14

Non-Title IV-E Adoptive Children with special needs may be certified for retroactive coverage for up to three months prior to the month of application if all the conditions of eligibility are met and if there are unpaid medical bills for this period. If the adoption assistance agreement was not in effect in the retroactive months, then eligibility cannot be established under these provisions, but must be established under other Medicaid guidelines.

K-204 Reevaluations

MS Manual 01/01/14

Once initial eligibility has been established, the agency does not have to redetermine eligibility provided the adoption agreement remains in effect, the child continues to reside in Arkansas with the adoptive parents and a special need continue to exist. The CHRIS system will alert the Adoption Specialist or Family Service Worker if the adoption agreement ends, the child leaves Arkansas or the special need no longer exists.

K-205 Changes

MS Manual 01/01/14

The Adoption Specialist will have the responsibility of keeping the DCFS Eligibility Unit informed of any changes that might affect a non-Title IV-E child's eligibility. All changes should be reported to the DCFS Eligibility Unit (e.g., change of address, a return to foster care if the adoptive placement does not work out, etc.).

An adoption agreement will continue to remain in place for non Title-IV-E children even when the adoption decree has been finalized. Therefore, eligibility for non Title IV-E adoptive children with special medical and rehabilitative needs will not be affected by the finalization of an adoption decree.

K-206 Closures

MS Manual 01/01/14

The non-Title IV-E Adoptive Special Needs case will be closed when the adoption agreement terminates.

K-300 Medicaid for IV-E Children Who Enter Arkansas from Other States

MS Manual 02/03/15

The Consolidated Omnibus Reconciliation Act of 1985 requires that children with Title IV-E adoption assistance agreements in effect and children receiving Title IV-E foster care maintenance payments will be given Medicaid coverage by the state in which they are currently residing, even though the agreements and payments originated in another state. Children with IV-E adoption assistance agreements in effect will be Medicaid eligible whether or not an interlocutory (See Glossary) or judicial decree of adoption has been issued and whether or not the child actually receives an adoption assistance payment.

K-301 IV-E Adoptive Children

MS Manual 01/01/14

When a child under an IV-E adoption assistance agreement enters Arkansas, the sending state will notify the Interstate Compact on Adoption and Medical Assistance (ICAMA) Administrator of the child's entry on a Notice of Transfer (form CFS 6.01) that will include basic information needed for Medicaid certification.

K-302 IV-E Foster Children

MS Manual 01/01/14

When an IV-E eligible child in another state's custody enters Arkansas, the sending state will notify the Family Service Worker or ICPC Area Coordinator of the child's entry and will provide the basic information needed for Medicaid certification. The DCFS contact will refer the child to the DCFS Eligibility Unit through the CHRIS system and will also send a copy of forms ICPC-100A and ICPC-100B to the DCFS Eligibility Unit.

K-303 ICAMA/ICPC Responsibilities

MS Manual 01/01/14

The ICAMA Administrator will forward a copy of the Notice of Transfer (CFS 6.01) and/or other correspondence received from a sending state to the DCFS Eligibility Unit for ICAMA adoption cases. The ICPC Coordinator will serve as the liaison between Arkansas and the sending state provided the child remains Medicaid eligible in Arkansas.

K-304 Family Service Worker and Adoption Specialist Responsibilities

MS Manual 01/01/14

The ICAMA Coordinator will enter the identifying information into the CHRIS system for each ICAMA child, and will forward a copy of the Notice of Transfer and/or other correspondence received from the sending state to the DCFS Eligibility Unit. The ICPC Coordinator will refer the ICPC child to the DCFS Eligibility Unit through the CHRIS system and will forward a copy of the ICPC-100A, ICPC-100B, and CFS-597 to the DCFS Eligibility Unit. The appropriate ICPC Coordinator will have the additional responsibility of keeping the DCFS Eligibility Unit informed of any changes that might affect the IV-E child's eligibility.

K-305 DCFS Eligibility Unit Responsibilities

MS Manual 01/01/14

Upon receipt of the referral through the CHRIS system and related documents from the ICAMA Coordinator or ICPC Coordinator, the DCFS Eligibility Unit will register an application. The date of application will be the date the referral was made in the CHRIS system by the ICAMA Coordinator or DCFS worker.

CFS forms ICPC-100A and ICPC-100B and CFS-597 along with the attached documents will serve as an application for ICPC children. Form CFS-6.01 and other information in the CHRIS system will serve as an application for ICAMA children along with any other information received and will require no further verification.

K-306 Retroactive Coverage

MS Manual 01/01/14

Up to 3 months retroactive coverage may be provided if it is established that the child did not receive Medicaid benefits from the sending state in the retroactive months and if the child incurred medical bills in Arkansas during the retroactive months.

K-307 Time Limit for Application Processing

MS Manual 01/01/14

The application process must be finalized within a 45 day time period from the date of application by approval, denial or withdrawal.

K-308 IV-E Eligibility Requirements

MS Manual 01/01/14

The eligibility requirements for Category 92 IV-E children entering Arkansas from other states are:

1. Verification that the child has a Title IV-E adoption assistance agreement in effect, or is a Title IV-E eligible foster child from the sending state;
2. Verification that medical coverage in the sending state has terminated;
3. Assignment of rights to medical support; and
4. Social Security enumeration.

K-309 Certification

MS Manual 01/01/14

The application will be registered and approved in the eligibility system with the minimum requirements for a category 91 or 92 case.

Upon approval, a system generated notice will be sent to notify the adoptive parent or DCFS Family Service Worker of Medicaid approval.

K-310 Case File

MS Manual 01/01/14

The completed case file will consist of a Medicaid application and other documents provided by the DCFS staff.

K-311 Reevaluation

MS Manual 01/01/14

Continuing eligibility will be determined on an annual basis. Reevaluations should be scheduled for completion twelve months after initial certification or last reevaluation. Reevaluation will be limited to verification that the IV-E adoption assistance agreement or IV-E foster care eligibility continues and that the child continues to be an Arkansas resident.

The CHRIS system will generate a notice to the DCFS Eligibility Unit when a case is due for reevaluation.

K-400 Procedures for IV-E Children Who Leave Arkansas

MS Manual 01/01/14

The following procedures will be followed when a child who is IV-E eligible leaves the state of Arkansas.

K-401 Family Service Worker and Adoption Specialist Responsibilities

MS Manual 01/01/14

When a Title IV-E child under an Arkansas adoption assistance agreement or receiving a foster care maintenance payment is to be placed out of Arkansas, the Adoption Specialist or Family Service Worker will notify the Arkansas Interstate Compact on Adoptions and Medical Assistance (ICAMA) Administrator or the Arkansas Interstate Compact on the Placement of Children (ICPC) Unit of the proposed placement.

K-402 ICAMA/ICPC Responsibilities

MS Manual 01/01/14

The ICAMA Administrator or the Family Service Worker, when notified of an IV-E child's placement out of Arkansas, will provide the receiving state with ICAMA form 6.01 and will notify the adoptive or foster parent(s). The Family Service Worker will update the child's placement in the CHRIS system. This action will serve as notification to the DCFS Eligibility Unit that the child has been placed out of state.

K-403 DCFS Eligibility Unit Responsibilities

MS Manual 01/01/14

When notified, the DCFS Eligibility Unit will close the IV-E Medicaid case the date the child leaves Arkansas.

L-100 Administrative Hearings

MS Manual 01/01/14

The purpose of the administrative hearing process is to provide a procedure for DHS clients to appeal:

1. The denial of Medical Assistance,
2. The failure of the Division of County Operations (DCO) to process the application within specified timeframes,
3. When a petitioner disagrees with any DCO action resulting in suspension, reduction or discontinuance of assistance, or
4. When an Institutionalized Spouse (IS) or Community Souse (CS) is dissatisfied with the determination of:
    a. The CS's monthly income allowance,
    b. The amount of monthly income otherwise available to the CS,
    c. The computation of the spousal share of resources, or
    d. The attribution of resources or the CS's resource allowance.

A hearing will not be granted when either state or federal law requires reduction in medical assistance. A request for a hearing must be received in the Office of Appeals and Hearings (OAH) no later than 30 days from the date on the Notice of Adverse Action.

L-110 Appeal Process

MS Manual 01/01/14

A petitioner or his/her designated representative may request a hearing by:

1. Completing the reverse side of the Notice of Action.
2. Making the request by letter to OAH.
3. Completing, with assistance from DCO staff as needed, a DHS-1200, Appeal for a Hearing Form. The county office will assist the petitioner whenever necessary; however, the primary responsibility for providing all information relevant to the administrative appeal rests with the petitioner or his/her representative.

DCO will immediately forward requests for hearings to OAH.

NOTE: If the applicant/recipient indicates that he or she needs an interpreter, material in a different format or other special accommodations, DCO must immediately notify OAH.

When an appeal is received in OAH, DCO will be notified. A memorandum will be sent to the county office to:

1. Provide notification that the appeal has been received,
2. Require DCO to prepare and submit an administrative hearing file no later than seven (7) days after receiving the memorandum, if the appeal was timely filed. The hearing file must contain a County Statement (DHS-1203).
3. Require that within three (3) business days of its receipt of the memorandum, DCO will return a copy of the adverse Notice of Action to OAH with the memorandum signed by the responding caseworker if the appeal was not timely filed.

L-111 DCO Administrative Hearing File

MS Manual 01/01/14

When OAH notifies DCO that a petitioner has requested a hearing, and when the appeal was timely filed, the caseworker will prepare a county administrative hearing file which will be separate from the individual's case record. Each page in the hearing file shall be numbered. A copy of the DCO administrative hearing file will be submitted to OAH within seven (7) days after receiving the memorandum from OAH.

The DCO administrative hearing file shall contain the part of the case record that constitutes documentary evidence supporting the notice of adverse action from which the petitioner is appealing. The following information must be included in the administrative hearing file:

1. Notice of Action – The file must include all notices sent to the petitioner regarding the action under appeal. The administrative hearing can include only the action specified on the Notice of Action. The subject of the administrative hearing shall be limited to the action specified in the notice of action on which the appeal is based.

2. Documentary Evidence – The file must contain the part of the case record that constitutes documentary evidence relevant to the notice of adverse action on which the individual appealed. Examples of documentary evidence include, but are not limited to: verification obtained which resulted in the adverse action; any relevant

correspondence; a copy of the budget (if need is the issue); any information supplied by the petitioner; and any other pertinent information.

3. County Statement (DHS-1203) – The file must include a copy of the County Statement. The County Statement must state the issue and must contain a summary of all facts and evidence supporting the county office's position. All statements should be in simple language. Ambiguous and technical language must be avoided. DHS codes, abbreviations and acronyms should not be used. All information will be provided in an alternative format if requested.

The County Statement will summarize the basis for DCO's action. However, the County Statement is not evidence. Complete documentation is required in the DCO administrative hearing file to support the County Statement.

Five (5) copies of the DHS-1203 will be prepared and distributed to the following within seven (7) days of DCO's receipt of the memorandum from OAH (Slot N-420), if the appeal was timely filed:

1. The original will be mailed to the petitioner.
2. A copy will be sent to the appropriate Program Eligibility Analyst.
3. A copy will be sent to OAH along with the DCO administrative hearing file.
4. A copy will also be retained in the file at the DCO county office.
5. A copy will be sent to the Office of Policy and Legal Services (OPLS) (Slot S-260).

The petitioner or his or her representative will be advised by OAH that the DCO administrative hearing file can be reviewed at the county office.

L-112 Subpoenas

MS Manual 01/01/14

OAH will provide notice to the parties regarding the process by which subpoenas may be issued. Each party must provide to OAH the correct name and contact information for any witness for which a subpoena is requested.

At the time the county's administrative hearing file is sent, DCO must advise OAH of any witnesses to be subpoenaed to testify on behalf of DCO. The reverse side of the County Statement provides space for the caseworker to request subpoenas for witnesses. Department employees will attend hearings without the requirement of a subpoena. The caseworker will be

advised by OAH of any witnesses for which the petitioner has requested subpoenas. DCO will have five (5) days from receipt of this notice to request subpoenas for rebuttal witnesses.

The Department of Human Services, Office of Policy and Legal Services, will issue the subpoenas, pursuant to the terms of agreement and authority of A.C.A. §20-76-103. Each subpoena must be served by the party requesting the subpoena.

L-120 Continuation of Assistance or Services during Appeal Process

MS Manual 01/01/14

If a petitioner files an appeal for a hearing within the ten (10) day notice period, or five (5) days in the case of probable fraud, the case will remain open at the petitioner's request until the hearing decision is received from OAH.

At the conclusion of the hearing, the hearing official will decide whether the case should be closed or services reduced prior to the rendering of the hearing decision. The criteria for determining whether adverse action is taken prior to the rendering of the hearing decision will be based on whether or not a fact or judgment situation exists. If it is determined that the sole issue is one of state or federal law or policy, the proposed action will be taken.

Examples of issues of fact:

- Verified earned or unearned income which caused net income to be in excess of the maximum income limitations.
- Protest of Agency Policy-The recipient agrees that his income or resources exceed the limitation but feels that the policy imposing these limitations is unreasonable.

If the sole issue is one of judgment relating to a state or federal law or policy, no adverse action is taken prior to the hearing decision.

Examples of judgment are:

- Disability in MRT cases.
- Value of real or personal property.

The petitioner will be advised at the beginning of the hearing that a decision will be made at the conclusion of the hearing regarding whether the benefits will be reduced or terminated prior to the rendering of the hearing decision. If the decision by the hearing official is to reduce or

terminate benefits, a Notice of Action will be prepared by DCO and mailed for immediate action. This is not an additional ten (10) day notice.

If a subsequent change occurs that results in adverse action while the hearing decision is pending and the petitioner does not appeal such action within the ten (10) day notice period, appropriate action will be taken.

L-130 Scheduling, Place of Hearing and Assistance in Preparation of Appeal

MS Manual 01/01/14

OAH will schedule the hearing and send a letter to advise the petitioner of the time, date, and place of hearing, and the name of the hearing official who will conduct the hearing.

A hearing will be held by telephone at the DHS County Office in the county where the petitioner resides. The telephone hearing may be held in another location if, in advance of the hearing, the parties agree upon that location and notify OAH. Upon advance request, hearings may be held in OAH office at 7th and Main Street in Little Rock, Arkansas, or by video conference where available.

DCO will provide reasonable assistance to the petitioner in preparing for a hearing, if requested.

L-140 Abandonment of the Appeal

MS Manual 01/01/14

Regardless of whether the petitioner is represented, the petitioner must appear in person for all hearings regarding program eligibility or program services, or show good cause why he or she cannot be present. If any party fails to appear (either in person or by telephone) within fifteen (15) minutes after the hearing was scheduled to begin, OAH will confirm that the party had proper notice of the hearing and will attempt to contact the absent party. The hearing official may allow an additional fifteen minutes before beginning the hearing. When the hearing begins, the hearing official will identify for the record any party not present in person or by telephone. If the petitioner does not appear, the appeal shall be deemed abandoned, subject to reopening on a showing that the appellant exercised due diligence but was unable to appear due to circumstances beyond the petitioner's control. If DCO does not appear, the hearing official may proceed with the hearing and may consider any hearing statements or other documents submitted by the agency.

L-150 Withdrawal of Appeal

MS Manual 01/01/14

If a petitioner advises DCO that he/she wishes to withdraw the request for a hearing, he/she will be requested to sign a statement to this effect or to sign a DHS-1201, Withdrawal of Request for Fair Hearing. DCO will provide this documentation to OAH and to OPLS.

L-160 DCO Hearing Responsibilities

MS Manual 01/01/14

It is the responsibility of the County Office to provide an office with privacy in which a hearing can be conducted as well as necessary telephone and/or computer equipment for hearings by telephone or by video conference.

It is also the responsibility of DCO to designate a County Representative prior to the time of the hearing in all cases except those that involve a disability determination by the Medical Review Team (MRT). The representative will be familiar with the case and able to answer pertinent questions from the petitioner, the petitioner's representative and the hearing official. The County Representative will be prepared to represent the county office at the scheduled time for the hearing to comply with all applicable time frames.

The County Representative will assure that all parties, representative, and witnesses who have arrived at the DHS county office or other designated hearing location are escorted to the designated hearing room by the hearing start time. When a hearing is held in the DHS county office, the County representative will ensure that the speaker telephone or video conferencing equipment is operational, and that the petitioner is comfortably seated in the room where the hearing will be held.

DCO may request legal assistance to prepare for the hearing and for representation at the hearing by OPLS.

L-170 Conducting the Hearing

MS Manual 01/01/14

The hearing will be conducted by a hearing officer from OAH. No person having any part in making the decision being appealed may serve as the hearing official.

The petitioner may be accompanied by friends or other individuals and may be represented by a friend, attorney, or other designated representative. DCO will be represented by the caseworker responsible for the case, the county DCO Program Eligibility Coordinator, or OPLS.

The hearing official may not review the case record or other material either prior to or during the hearing unless such material is made available to the petitioner or his or her representative.

The hearing will be conducted in an informal but orderly manner and is recorded. The hearing official will explain the hearing procedure to the parties. The County Statement will be read by the County Representative.

The proponent of an adverse action shall have the burden of proof. The party with the burden of proof will present his/her case first.

When the petitioner presents his/her case, he/she may do so alone or with the aid of others. The petitioner or petitioner's representative will be given the opportunity to present witnesses, advance arguments, offer evidence, and question or refute any testimony or evidence. If the petitioner is unable to present evidence in an effective manner, the hearing official will assist as necessary to assure that the petitioner's evidence is communicated on the record.

When DCO presents its case, it will be given the opportunity to present witnesses, advance arguments, offer evidence, question or refute any testimony or evidence.

Each party will be allowed to cross examine the other party and any witnesses. Questioning of all parties will be confined to the issues involved. Other eligibility factors may be reviewed when appropriate.

When all relevant information has been obtained, the hearing official will issue a Final Order which will include a Finding of Facts, Conclusions of Law, and a Decision. The Final Order will be mailed to the petitioner and a copy provided to DCO.

The parties will also be advised of their right to judicial review in the event of any adverse ruling.

L-171 Additional Medical Assessment

MS Manual 01/01/14

If the hearing involves medical issues, such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing official considers it necessary to have a medical assessment other than that of the individual involved in making the

original decision, such a medical assessment must be obtained at agency expense and made part of the record.

L-172 Hearing Decision

MS Manual 01/01/14

The hearing official will prepare a Final Order based on the evidence accepted into the record and the sworn record of testimony of the proceedings. The format will include an Introduction, Findings of Fact, Conclusions of Law and a Decision. The final decision will be made by the hearing official who will sign the Final Order. Final administrative action must be completed within 90 days from the date of receipt of the appeal.

A client or representative or the DCO county office who would like reconsideration of the Final Order to correct a material misstatement of the record, a clear error of law, or both may request Reconsideration as outlined in DHS Appeals and Hearings Procedures Policy 1098.19-1098.23.

L-173 Judicial Review

MS Manual 01/01/14

When the hearing official has rendered a final agency action on a case and the petitioner or representative is not satisfied with the decision, he or she has the right to judicial review under Arkansas Administrative Procedure Act at A.C.A. § 25-15-212.

M-100 Overpayments

MS Manual 01/01/14

Any medical payment made on behalf of and to the benefit of an individual which is in excess (by at least $5.00) of the amount that should have been paid (if any) is an overpayment. It exists for each month that the individual received benefit of such payment.

An overpayment may result from an individual giving fraudulent information, withholding information, failing to report a change, etc. or from the Agency failing to exercise proper diligence, or a combination of factors.

The amount of overpayment will be determined using the budgetary procedures and allowances in effect at the time the overpayment occurred.

M-110 Overpayments Due to Ineligibility

MS Manual 01/01/14

- When ineligibility of a case or member occurs, the potential for Medicaid overpayment is created. To determine if an overpayment has occurred, the ineligible case/members will be evaluated using Medically Needy criteria. A potential overpayment has occurred when the Medically Needy evaluation results in:
- Excess Income;
- Excess Resources; or
- Individuals who cannot be included in an MN determination.
- For reporting of potential overpayments, refer to the following:
- When an understated liability exists in an LTC case, refer to MS M-120.
- When excess income exists, refer to MS M-130.
- When excess resources exist, refer to MS M-140.
- When individuals cannot be included, refer to MS M-160.

An overpayment occurs when medical payments have been made on behalf of individuals in any month the individuals are found not eligible.

In evaluating an overpayment and before submitting a report to the Overpayments Unit, the County Office should determine if the ineligible individual(s) would have been eligible in any other Medicaid category (e.g., a child found not income eligible for ARKids A would have been eligible in ARKids B). If eligibility would have existed in another category during the same period, document the electronic record, and do not submit information to the Overpayment Unit.

M-120 Overpayment Due to Understated Liability (LTC Cases)

MS Manual 01/01/14

When excessive payment has been made for the LTC vendor payment due to understated liability, the potential for Medicaid overpayment is created. To determine if an overpayment has occurred, it will be necessary to determine who received the benefit of the excessive payment.

When it is determined that the LTCF received the benefit of the excessive payment, there is no overpayment. An adjustment of vendor payment (to the effective date of change) will be keyed to WNHU instead of submitting an overpayment via a DHS-199.

When it is determined that the individual (his guardian, custodian or payee) received the benefit of the excessive payment (kept more than $30.00 (for SSI clients) and $40.00 (non-SSI client) per month for personal expense), an overpayment has occurred. The overpayment amount claimed for repayment is the amount of income that the individual received in excess of the $30/$40 per month personal expense allowance for the month(s) in which excessive payment was made. An adjustment of vendor payment will be made on WNHU to reflect the current income of the individual (if applicable).

M-130 Overpayment Evaluation - Excess Income

MS Manual 01/01/14

When an individual is ineligible due to income, the amount of excess income will be determined by deducting the appropriate MNIL (Re. Appendix N) for the month(s) of ineligibility from countable income for the period of ineligibility. The amount of the overpayment claimed for repayment will be determined by comparing the excess income for the period to the Medicaid payments for services obtained by the ineligible individual(s) during the period of ineligibility.

The amount claimed for repayment will be limited to the lesser of the amount of excess income or the cost of the medical services.

For LTC cases, the amount claimed for repayment will be limited to the LTC vendor payments made during the period of ineligibility when the amount of the LTCF's private payment rate for the month(s) of ineligibility exceeds the excess income. If the private pay rate is less than the excess income, then the amount claimed for recovery will be the LTC vendor payment plus the Medicaid payment for all medical services received during the period.

The procedure for determining the amount of overpayment to be recovered is as follows:

1. The County Office will compute net countable income for the entire period of ineligibility. Net countable income for each month in the period will be determined by applying all exclusions and deductions which would be applicable if computing Medically Needy eligibility for the individual(s) (add together the net countable income received in each month in the period).

2. The County Office will compute the total MNIL for the entire period of ineligibility (add together the monthly MNILs for each month in the period).

3. The County Office will compute excess income by deducting the MNIL for the period (Re. 2, above) from the net countable income for the period (Re. 1 above).

4. The Overpayments Unit will compare the medical expenses incurred during the period of ineligibility to the excess income for the period.

    a. For LTC cases, if the total private pay rate for the period of ineligibility (add together the private pay rate for the patient's level of care for each month in the period) is more than the amount of excess income, the amount claimed for repayment will be limited to the total vendor payments.

    b. If the total private pay rate for the period of ineligibility is less than the amount of extra income, then the amount claimed for repayment will be the total vendor payment plus any medical expenses incurred.

    c. For non-LTC cases, the amount claimed for repayment will be the lessor of the excess income or the amount of payment for medical services received during the period.

Overpayments and potential overpayments due to excess income will be reported by the County Office on Form DHS-199. The report will identify each individual by name and Medicaid ID number, the total excess income for ineligible month(s), and each month/year of ineligibility.

EXAMPLE 1: **Excess Income –** An individual was ineligible for nursing home care for 4 months due to income. The individual had unearned income of $1,150.00/month for the period. The facility had a private payment rate of $1,500.00/month for the period.

Determine the amount of excess income for the period of ineligibility as follows:

1. Calculate net countable income.
   $1,150.00/month - $20.00 (general exclusion) = $1,130.00 x 4 months = $4,520.00

2. Calculate appropriate MNIL.
   $108.33 (1 person MNIL) x 4 months = $433.32

3. Calculate excess income.
   $4,520.00 (net income) - $433.32 (MNIL) = $4,086.68

4. Determine private payment rate for the facility as follows:

   $1,500.00/month x 4 months = $6,000.00

Since the private payment rate ($6,000) exceeds excess income ($4,086.68), the amount of overpayment claimed for repayment will be limited to the amount of the LTC vendor payment.

EXAMPLE 2: **Excess Income –** An individual was ineligible for nursing home care for 4 months due to income. The individual had unearned income of $1,150.00/month for the period. The facility had a private payment rate of $900.00/month for the period.

Determine the amount of excess income for the period of ineligibility as follows:

1. Calculate net countable income
   $1,150 - $20.00 (general exclusion) = $1,130 X 4 months = $4,520.00

2. Calculate appropriate MNIL.
   $108.33 (1 person MNIL) X 4 months = $433.32

3. Calculate excess income
   $4,520.00 - $433.32 (MNIL) = $4,086.68

4. Determine private payment rate for the facility as follows:

   $900.00/month X 4 month = $3,600.00

Since the excess income exceeds the private payment rate, the amount of overpayment claimed for repayment will not be limited to the vendor payment, but will include all medical payments for the period (the amount of the vendor payment plus the amount of payment for other services received during the period).

M-140 Overpayment Evaluation - Excess Resources

MS Manual 01/01/14

The County Office will evaluate the case to determine the months of ineligibility due to excess resources by comparing the level of resources for each month to the appropriate resource level. For non-nursing home cases, use the appropriate MNRL. For nursing home cases use $2,000 or $3,000, whichever is applicable.

The Overpayments Unit will compare the highest level of excess resources for an ineligible month(s) to the total medical payments made on behalf of case members in the ineligible month(s) to determine the amount claimed for overpayment.

When the LTC vendor payment in the month of receipt is an amount greater than the excess resources, the amount of overpayment claimed for repayment will be limited to the amount of the excess resources.

When the LTC vendor payment is an amount less than the excess resources, the amount claimed will be the lesser of the excess resources or the total amount of medical payments (includes vendor payments).

Overpayments and potential overpayments due to excess resources will be reported by the County Office on the DHS-199. The report will identify each individual by name and Medicaid ID number, the highest dollar amount of excess resources for an ineligible month, and each month/year of ineligibility.

NOTE: There is no resource limit for the Families and Individuals (MAGI) eligibility groups.

EXAMPLE: **Excess Resources –** An individual was ineligible for 5 months due to resources. The individual had resources of $2,100, $2,200, $2,300, $2,400, and $2,500 for months 1 through 5, respectively, for the period.

Determine the highest level of excess resources for an ineligible month as follows:

1. Select appropriate resource level.
   $2,000 (1 person)

2. Calculate excess resources for each ineligible month.
   $2,100 - 2,000 = $100

   $2,200 - 2,000 = $200

   $2,300 - 2,000 = $300

   $2,400 - 2,000 = $400

   $2,500 - 2,000 = $500

3. Select highest level of excess.
   +$500 (month 5)

The amount of overpayment claimed for repayment will be limited to the lesser of the highest level of excess ($500) or the amount of medical payments (includes LTC vendor payments, if applicable) made on behalf of the individual in the period of ineligibility.

M-150 Other Ineligibility

MS Manual 01/01/14

When the individual is ineligible due to other criteria (e.g., categorical relatedness, citizenship, residency, medical necessity, etc.), the amount of overpayment claimed for repayment will be the amount of medical payments (includes LTC vendor payment) made on behalf of the individual in the month of ineligibility. Refer to MS M-160.

M-160 Overpayment Evaluation - Ineligible Individuals (Non - LTC)

MS Manual 01/01/14

All payments made on behalf of individuals who are ineligible to be included in a financial eligibility determination for Medicaid will be considered overpayments.

M-100 Overpayments

M-160 Overpayment Evaluation - Ineligible Individuals (Non - LTC)

Overpayments and potential overpayments for individuals totally ineligible will be reported on Form DHS-199. The report will identify each totally ineligible individual by name and Medicaid ID number and each month/year of ineligibility.

M-200 County Office Responsibilities

MS Manual 01/01/14

The following procedures outline county office responsibilities in reporting overpayments (includes potential overpayments), keeping the overpayments unit informed of any information that would have an effect on an established overpayment claim, and assisting clients or other persons with questions regarding the overpayment processes.

M-210 Record Information in Case Narrative

MS Manual 01/01/14

When an overpayment has occurred, enter the period of ineligibility/ understated liability, the reason(s) why the overpayment occurred, and any other pertinent information in the case narrative. All documents supporting the overpayment will be scanned into the electronic case file.

If the overpayment occurred because the individual provided false or incomplete information or failed to report a change, etc., the individual will be advised of the possible consequences (i.e., request for repayment and/or prosecution for fraud). The individual will be requested to explain his/her actions or failure to act and the explanation will be recorded in the electronic case file. Once recorded, the electronic case file will be referred to the Program Eligibility Coordinator for concurrence as to a reportable overpayment.

M-220 Referral to Central Office Overpayment Unit

MS Manual 01/01/14

All overpayments will be referred to the Central Office Overpayments Unit, Slot WG-2 on Form DHS-199. If fraud is suspected, Form DHS-1700 will be sent with the DHS-199.

The Overpayments Unit will register all referrals. After the DHS-1700 is registered, it will be sent to the Fraud Unit for investigation.

If the investigation indicates a prosecutable case, the Fraud Unit will refer the case to the Overpayments Unit (after the case has been adjudicated).

The Overpayments Unit will send a copy of the claim and any other pertinent information to the County Office.

M-230 Keeping Overpayment Unit Informed

MS Manual 01/01/14

The County Office will promptly report, by memorandum to the Central Office Overpayments Unit, any pertinent information (coming to its attention) which would have any effect on an established overpayment claim that has not been satisfied, such as, but not limited to:

1. Hardship situations (situation in which the clients is being deprived of basic subsistence needs – e.g., food, shelter, utilities, etc.);
2. Acquisition of resources or income that may increase the client's ability to repay;
3. Death;
4. Change of address;
5. Re-approval of case after closure.

M-240 Contacts with Clients

MS Manual 01/01/14

If clients or other interested persons have questions concerning recovery letters received directly from the Central Office, the County Office will refer them to the Central Office Overpayments Unit.

If clients wish to make arrangements for repayment, the County Office will explain that the final decision regarding recovery rests with the Central Office Overpayments Unit and give the mailing address:

Office of Finance and Administration
Attention: Overpayments Unit
P.O. Box 1437, Slot WG-2
Little Rock, AR 72203.

M-300 Responsibilities of Overpayment Unit and Central Office Accounting Section

MS Manual 01/01/14

The Overpayments Unit will make the decision concerning the feasibility of repayment for all overpayments and ineligibles, whether they resulted from:

- Administrative error.
- Misunderstanding of state policies or laws by the client.
- Willful withholding or incorrect statement of factual information by the client.
- The Overpayments Unit will:
    1. Review information submitted by the County Office via DHS-199 and DHS-1700 (if applicable) and request additional information (as necessary).
    2. Make a decision on the feasibility of seeking repayment from the client after reviewing available information.

M-310 Collections

MS Manual 01/01/14

The Central Office Overpayments Unit will make the determination relative to the disposition of the claim when collection and/or fraud referrals are indicated.

When an agreement is reached with the client either by the Fraud Unit or Office of Policy and Legal Services, the Central Office Overpayments Unit will be apprised of whether:

1. Client has been sentenced,
2. Client's sentence has been suspended contingent upon restitution by court order,
3. Voluntary agreement to repay has been reached,
4. Signed agreement to repay has been negotiated, or
5. Civil court action initiated and results.

M-320 Responsibility of Central Office Accounting Section

MS Manual 01/01/14

The Central Office Accounts Receivable Section will be responsible for receiving and processing all monies collected.

M-330 Recovery

MS Manual 01/01/14

Overpayments are subject to recovery action in accordance with federal regulations. The Overpayments Unit will decide if overpayments will be recovered. Recovery is regaining monies lost by the Agency as a result of overpayments. Restitution is securing payment (e.g., cashier's check or money order payable to the Agency) for overpayments received.

M-400 Willful Withholding of Information

MS Manual 01/01/14

Willful withholding of information is the deliberate misrepresentation or intentional concealment of information for the purpose of obtaining eligibility. Intentional concealment of information that affects eligibility must be clearly indicated. Overpayments resulting from "willful withholding" may be subject to prosecution for fraud.

"Willful" withholding of information includes:

- Willful misstatements, oral or written, made by a recipient in response to oral or written questions from the agency concerning the recipient's income, resources, or other circumstances that may affect eligibility. Such misstatements may include understatements of amounts of income or resources and omission of information regarding income and resources.
- Willful failure by the recipient to report changes in income, resources, or other circumstances that may affect eligibility if the agency has clearly notified the recipient of his obligation to report such changes.
- When a client signs the application/review form, he certifies that he understands that failure to fulfill his obligation to provide correct, complete information and to keep the agency informed of changes may be considered willful withholding of information and permit the agency to recover any overpayments.
- Willful failure by the recipient to report receipt of a payment (keying error and/or system error) which the recipient knew represented an overpayment.

M-500 State Income Tax Refund Interception (STRI)

MS Manual 01/01/14

Act 372 of 1983 as amended (Ark. Stats. Ann. § 84-4901 thru 84-4918) and Act 987 of 1985 authorizes the collection of debts owed the Department of Human Services (DHS) through the interception of State Income Tax Refunds.

The Office of Finance and Administration/Accounts Receivable will submit a list of households with a receivable balance of debts to the Department of Finance and Administration, Income Tax for State Tax Refund Intercept.

Act 987 requires notification to households who owe a debt to the State before this information is furnished to the Revenue Division of the Department of Finance and Administration. A notice of DHS intention to intercept refunds will be mailed by Central Office to the taxpayer prior to December 1 of each year.

The taxpayer has thirty (30) days from the date the notice is mailed to file a written request for a hearing. If no hearing is requested within (30) days, any refund determined to be available may be intercepted and mailed to the Office of Finance and Administration to be allocated within the Department of Human Services by priority.

M-510 Accounts Eligible for Interception

MS Manual 01/01/14

- In order for an account to be submitted for State (Income) Tax Refund Intercept, the following conditions must be met:
- The amount owed the State must be certified by the Submitting Department.
- The taxpayer must have been notified of the debt in at least one demand letter.
- The debt must be at least $20.00.

M-520 Requesting the Hearing

MS Manual 01/01/14

- The taxpayer has thirty (30) days from the mailing date of the Intent to Intercept Notice to file a written request for a hearing. All hearing requests should be sent to:

  Collection Unit of Accounts Receivable
  P.O. Box 1437, Slot #WG-2
  Little Rock, Arkansas 72203

The Collection Unit will maintain a chronological register of the hearing requests to ensure that each is acted upon in a timely manner. The Appeals and Hearings Section will be notified of all hearing requests and is responsible for conducting hearings for STRI cases in which a Medicaid overpayment is involved.

M-521 Designation of a Representative

MS Manual 01/01/14

A household may designate a representative to act in its behalf during the hearing process by providing a signed statement naming a representative; this individual will receive a copy of all correspondence and materials mailed or provided to the household regarding the Administrative Hearing Proceedings.

M-530 Beginning the STRI Hearing Process

MS Manual 01/01/14

When the Appeals and Hearings Section receives a request for a hearing from the Overpayment Unit along with documentation relative to the overpayment, this information is forwarded to the County DHS Office in the county in which the taxpayer resides so that a County Statement can be prepared. The statement will contain the basis for establishing whether the claimed sum asserted as due and owing is correct. The purpose of the hearing is to determine the validity of the overpayment.

The STRI Hearing Statement should be prepared and returned to the Appeals and Hearings Section within seven (7) days of receipt of the memorandum from Appeals and Hearings. The reverse side of the STRI Hearing Statement contains spaces for the County Office to request the subpoena of witnesses. If the County Office needs assistance in preparing the County Statement or in presenting the case at the hearing, the office should contact the Office of Policy and Legal Services (OPLS) who will determine if OPLS assistance will be provided.

M-531 Subpoena of Witnesses by Taxpayer

MS Manual 01/01/14

DCO will forward copies of the County Statement and the information received from the Overpayment Recovery Unit to the taxpayer for review.

The taxpayer and/or his representative have the right to subpoena witnesses to testify at the STRI hearing. When the subpoena is issued by the Office of Policy and Legal Services, the taxpayer and/or his representative will be responsible for serving the subpoena.

M-532 Notification of the Hearing

MS Manual 01/01/14

The Appeals and Hearings Section will provide written notice to all parties involved at least 10 days prior to the date of the hearing to allow for adequate preparation of the case. The notice will contain:

1. The address and telephone number of the Appeals and Hearings Section to notify if the taxpayer and/or his representative will not be able to attend;
2. A statement that the Appeals and Hearings Section will abandon the hearing request if the taxpayer or his representative fails to notify this office 24 hours prior to the date of the hearing that he/she will be unable to attend.

M-533 Postponement of the Hearing

MS Manual 01/01/14

The hearing may be postponed one time at the taxpayer's request.

M-534 Place of the Hearing

MS Manual 01/01/14

The hearing will be conducted in the county of residence of the taxpayer unless it is determined by the Appeals and Hearings Section that another location would be more convenient for this individual.

M-535 Hearing Officer

MS Manual 01/01/14

The Appeals and Hearings Section will designate all Hearing Officers. The Hearing Officer must not have had any personal interest or involvement in the case and must not have been involved in the contested action either as a caseworker or in a supervisory capacity.

The Hearing Officer may not review the electronic record or other material either prior to or at the hearing unless such material is made available to the taxpayer or his representative.

M-536 Conducting the Hearing

MS Manual 01/01/14

A Hearing Officer will conduct the hearing. The taxpayer may be accompanied by friends or other persons and may be represented by a friend, attorney or designated representative. The Department of Human Services will be represented by a County Office representative from the County DHS Office in which the taxpayer resides.

The hearing will be conducted in an informal but orderly manner. The STRI Hearing Statement will be read by the County Representative. This includes presenting evidence and presenting the County's witnesses. The County Representative may be cross-examined by the taxpayer and/or his representative.

The taxpayer or his representative will then present his case which includes presenting witnesses, advancing arguments, offering additional evidence, and questioning or rebutting any testimony or evidence. The taxpayer or his representative will be allowed to question the County Representative. The taxpayer is subject to cross-examination by the County Office. If the taxpayer is unable to present his evidence, the Hearing Officer will assist him. Questioning of all parties will be confined to the issue involved.

When all relevant information has been obtained, the Hearing Officer will summarize the issues, the evidence, the agency policy, and will explain that he will recommend a decision to the Administrator, Appeals and Hearings Section, who will make the final decision.

The taxpayer will also be advised of his right to judicial review in the event of an adverse ruling.

M-540 Administrative Hearing Decision

MS Manual 01/01/14

Prompt, definitive, and final administrative actions must be taken within 60 days of receipt of a request for an Administrative Hearing. The hearing decision is based upon documentary evidence contained in the Administrative Hearing file and the testimony presented at the hearing.

M-541 Contents of the Administrative Hearing Decision

MS Manual 01/01/14

The hearing decision will contain the following information.

1. An Introduction - This part of the decision will summarize the reason for the appeal. Any pertinent information regarding the appeal is included. The date and location of the hearing must appear. The participants in the hearing must be named.

2. Findings of Fact - The facts upon which the decision is rendered are contained in this section.

3. Conclusions of Law - This section will summarize the appropriate program policy which will either validate or invalidate the overpayment.

4. Decision - This section contains the decision. Based upon the facts presented and the appropriate conclusions of law, a decision is rendered. The decision will determine if the overpayment is valid. If so, then the tax refund would be intercepted, if not, then it would be released.

M-542 Notification of Decision

MS Manual 01/01/14

The Final Order will be issued to the taxpayer, the appropriate County DHS Office, and the Overpayment Recovery Unit.

M-543 Judicial Review

MS Manual 01/01/14

Hearing decisions adverse to the household are sent via certified mail, return receipt requested. This procedure ensures that timely filing for judicial review may be ascertained.

Households not satisfied with an Administrative Hearing decision have the right to judicial review under the Administrative Procedures Act.

The household must file a petition in the Circuit Court of the county in which the household lives or does business or in the Circuit Court of Pulaski County within 30 days from the date the household received the Administrative Hearing decision. Copies of the petition are served to DCO and other parties of record by personal delivery or mail.

M-543 Judicial Review

Within 30 days from the date of the service of the petition to DCO (or additional time granted by the Court, not to exceed 90 days total), the Office of Policy and Legal Services must transmit to the Court the original or a certified copy of the entire record of the hearing under review.

The review will be conducted by the Court without jury and will be confined to the record unless a question of irregularity in procedure exists which is not indicated in the record. Testimony may then be taken before the Court.

N-100 Fraud Investigation

MS Manual 01/01/14

The Fraud Investigations Unit identifies, investigates, and refers for prosecution any individual accused of committing Theft of Property or Theft of Public Benefits as defined by state law. This includes Agency staff, recipients or other persons who deliberately violate the rules and regulations of DHS to defraud the state. Fraud Investigations prepares the Administrative Disqualification File on persons accused of committing an intentional program violation. The Fraud Investigations Unit is organizationally located within the Office of Quality Assurance.

N-110 Functions

MS Manual 01/01/14

The Fraud Investigations Unit has the following major functions:

- Review the case record and independently verify information contained in the file to determine if a criminal investigation is warranted.
- Investigate to gather evidence in cases where there is a probability that a fraudulent act was committed.
- Refer to the prosecutor if facts are obtained which indicate that the accused person, by deception, received DHS monies/benefits to which he/she was not entitled.

N-120 Referral Sources

MS Manual 01/01/14

Reports of suspected fraud may be received from any source within the Department of Human Services, the general public, public officials or other public agencies, or by the Fraud Investigations Unit, itself.

N-130 Reporting Suspected Fraud

MS Manual 01/01/14

Criteria for reporting suspected fraud:

- The suspected fraudulent act(s) resulted in a cumulative overpayment of $200 or more.
- Cases in which the client is receiving assistance in two or more names, counties or states.

Referrals from DHS sources in which an overpayment has not been established are referred to the Fraud Investigations Unit via DHS-1700.

N-140 Review of Case

MS Manual 01/01/14

When a referral is made to the Fraud Investigations Unit, the circumstances will be reviewed to determine if the case warrants investigation toward criminal prosecution.

If one or more of the following facts are present, the case will not be referred for prosecution:

- Total amount of the overpayment resulting from the alleged fraud is $200 or less;
- Age/education of the suspect is not conducive to proving criminal intent;
- Statute of limitations has run on all evidence referred;
- Recipient is permanently residing out of state.

If one or more of the following facts are present, the decision to investigate lies with the Director of Fraud Investigations:

- Fraud not evident in referred material;
- Fraud resulted from failure to report child support payments;

N-150 Case Accepted for Investigation

MS Manual 01/01/14

The following procedures will be completed for reports of suspected fraud that warrant criminal prosecution:

1. The case documentation and any other pertinent information concerning the suspected recipient will be reviewed and printed from the system. DHS Offices, Sections and Units must release any requested information to the Fraud Investigations Unit. Original documents will be retained by the Fraud Investigation Unit for evidence, and copies of those documents will be indexed in the electronic case record or furnished to the document source.

2. The investigator assigned to the case will:

    a. Examine the electronic record and/or any other records on file within or outside DHS for suspected false statements of clients or other persons;

    b. Conduct a systematic inquiry to determine validity of allegations of criminal conduct; such investigation may entail interviewing caseworkers with knowledge of the case, division staff, and the suspect for any accounts of alleged conduct;

    c. After determination of a period of total ineligibility for Medicaid, request a Medicaid profile for purposes of establishing the Medicaid overpayment;

    d. Prepare a written, documented report at the completion of the investigation for referral to the Prosecutor;

    e. Administratively close the investigation if, at any stage of the inquiry, the investigative staff determines that the case is not suitable for prosecution;

    f. Notify the DHS referral source of the disposition of the investigation and return copies of the case record to the County Administrator.

N-160 Disposition of Investigations

MS Manual 01/01/14

The Fraud Investigations Unit will notify the County Administrator of the initial disposition of each referral.

For cases referred for prosecution, the Fraud Investigations Unit will:

- Request the Prosecuting Attorney to file charges and send a copy of the request to the County Office.
- Advise the Overpayment Unit of the factual basis for the overpayment as well as overpayment calculation documents.

For cases administratively closed, the Fraud Investigations Unit will:

- Forward a memo to the County Office and the Overpayment Unit explaining the reason for the closure. If an overpayment has been calculated, these documents will be forwarded to the Overpayment Unit.

The final disposition of cases adjudicated by the court will be furnished to the County Administrator and the Overpayment Unit by the memorandum from the Director of the Fraud Investigation Unit.

N-170 Decision to Prosecute

MS Manual 01/01/14

The Director of the Fraud Investigations Unit will present to the Prosecuting Attorney of jurisdiction the original investigative report of those cases deemed worthy of prosecution. The prosecutor has sole discretion to prosecute, accept repayment in lieu of prosecution, or decline to prosecute.

O-100 Medically Needy Program

The Medically Needy Program is intended to provide medical services for categorically related individuals or families whose income and/or resources exceed the limits for cash assistance but are insufficient to provide medical care.

O-110 Extent of Medical Services for Medically Needy

MS Manual 01/01/14

Medicaid services outlined in the MS Section B, with the exception of Long Term Care and Personal Care, are available to eligibles under the Medically Needy Program. Family Planning Services and Child Health Services (EPSDT) will be offered.

0-120 Identification of Eligible Recipients

MS Manual 01/27/16

The term "Medically Needy" refers to categorically related individuals or families whose income and/or resources are too high to qualify as categorically needy individuals but insufficient to provide for all or part of their medical care.

Individuals not eligible for the Medically Needy Program are:

1. Those currently receiving Medicaid through a non-medically needy category, such as Parents/Caretaker Relatives (PCR), ARKids, SSI, or are otherwise Medicaid eligible;
2. Aged and Blind individuals whose countable income and resources are below the SSI payment limitations;

> **NOTE:** Eligibility in the Medically Needy Categories for Aged, Blind and some individuals with a disability is limited to individuals with countable income in excess of SSI limitations, and deceased or other individuals for whom SSI retroactive eligibility cannot be completed (Re. MS O-141). Refer to MS F-120 for the consideration of AD-MN eligibility for certain individuals who allege a disability.

3. Individuals who allege a disability, whose countable income and resources fall below the SSI payment limitations, and whose disability has been denied by SSA (Re. MS F-120 for the criteria which govern the determination of disability by MRT and AD-MN Medicaid eligibility for an individual with a disability);
4. Persons age 21 and older who are inpatients of the Arkansas State Hospital or the Northeast Arkansas Community Mental Health Center formerly known as the George W. Jackson Center; and

5. Persons incarcerated under the penal system who have been charged with or found guilty of a criminal offense; this includes children under age 18 who are under the jurisdiction of the juvenile justice system and who are detained in juvenile detention centers or other alternative placements such as wilderness or boot camps. A person will be considered incarcerated or detained under the penal system until the indictment is dismissed or he is released from custody as not guilty or for some other reason (e.g. bail, parole or pardon). A person on furlough is still considered under custody of the penal system.

   Exception: An inmate in the custody of the Arkansas Department of Corrections or the Department of Community Corrections who has been admitted to and received treatment at an inpatient facility may be eligible for a Medicaid payment provided all eligibility requirements are met. Income, resources and categorical eligibility will be determined in accordance with MS E-110. Only the income and resources of the applicant will be considered.

Individuals who may be eligible for the Medically Needy Program are:

1. Those who are categorically related to Parents/Caretaker Relatives, ARKids, or SSI; and
2. Those who meet the income and resources criteria of the Medically Needy Program.

O-130 Medically Needy Group Designations

MS Manual 01/01/14

The two types of coverage within the Medically Needy Program are Exceptional Medically Needy (EC) and Spend Down Medically Needy (SD).

O-131 Exceptional Medically Needy

MS Manual 01/01/14

The Exceptional Medically Needy are those individuals or families whose income is within the Medically Needy Income Level and whose resources fall within the specified limits of the Medically Needy Program.

Eligibility for Exceptional Medically Needy continues as long as the individual or family meets the criteria for categorical relatedness and the income and resource requirements of the Medically Needy program.

Reevaluations are required every twelve months. The date for the initial reevaluation is counted from the date of case certification.

NOTE: Exceptional Medically Needy cases may be reevaluated along with a SNAP review.

O-132 Spend Down Medically Needy

MS Manual 01/01/14

The Spend Down Medically Needy are those individuals or families whose resources fall within the specified limits of the Medically Needy Program, but whose adjusted income is above the Medically Needy Income Level. Individuals or families qualify for Spend Down eligibility on the basis that their excess income (i.e., that above the MNIL for the determination period) is obligated or spent for medical services. Reevaluation of Spend Down Medically Needy individuals or families is not necessary. Spend Down Medically Needy cases have a "fixed" period of Medicaid Eligibility. Individuals or families may reapply for Spend Down Medically Needy after their eligibility period has ended.

O-140 Screening Applicants for Medically Needy Program

MS Manual 01/01/14

The caseworker will evaluate the individual or family circumstances to determine the proper category through which the individual or family may qualify for Medicaid services (Re. MS 0-210 - Multiple Applications).

O-141 Supplemental Security Income (SSI) Related Eligibility

MS Manual 01/01/14

Supplemental Security Income (SSI) Related Eligibility:

1. An individual or family receiving an SSI payment or covered by SSI is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual (or family) who seems likely to be eligible for Aged or Blind benefits through SSA and who has countable income and resources under the SSI payment limits will be referred to the Social Security Office. If a Medically Needy application has been made, it will be denied because SSI income and resource eligibles in the Aged and Blind categories are not eligible for the Medically Needy Program. This also applies to certain individuals with disabilities (Re. MS F-120).

EXCEPTIONS FOR THOSE WITH INCOME/RESOURCES WITHIN SSI PAYMENT LIMITS:

a. Retroactive eligibility will be determined for individuals whose SSI eligibility cannot be completed, i.e., deceased persons, etc.

b. Individuals in a Medicaid (non-LTC) institution who are subject to the $30.00 SSI countable income limit instead of the SSI full payment limit, with countable income greater than $30.00 but less than the MNIL, may be eligible as Medically Needy.

c. Individuals with disabilities with income and resources under the SSI limit may be found eligible for Medically Needy if one or more of the conditions listed at MS F-120 exist.

3. If an individual's countable income is above SSI limits and his resources are within the Medically Needy limits, the individual (or family) will be considered for Spend Down Medically Needy eligibility.

O-142 Parents/Caretaker Relatives Medicaid Eligibility

MS Manual 01/01/17

Parents/Caretaker Relatives (PCR) Medicaid Eligibility:

1. An individual receiving PCR Medicaid is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual who seems likely to be eligible for PCR Medicaid may make an application.
3. An individual denied or apparently not eligible for PCR Medicaid will be considered for Medicaid eligibility under the Adult Expansion Group and if not eligible under this group, as AFDC Exceptional Medically Needy and, if not eligible under this group, as AFDC Spend Down Medically Needy.

O-143 Under 18 Category Related Eligibility

MS Manual 01/01/14

Under-18 Category Related Eligibility:

1. An individual receiving services under the ARKids category is already eligible for Medicaid and need not apply for the Medically Needy Program.
2. An individual who seems likely to be eligible for the U-18 category may make an application.

3. An individual denied or apparently not eligible for the U-18 category will be considered for Medicaid eligibility under the Medically Needy Program as "Spend Down".
4. Foster children (Re. MS K-100) will be considered for eligibility in the Foster Care-EC, Foster Care MN-Spend down, if not eligible in Non-IV-E Foster Care, IV-E Foster Care or ARKids.

O-150 Special Cases - Medically Needy

MS Manual 01/01/14

Special Cases - Medically Needy

1. If an individual and spouse both qualify under the same or different SSI- related categories of the Medically Needy Program their categorical relatedness will be established separately; however, their income, resources, and medical expenses will be counted in each spouse's case and eligibility established on that basis. Each individual will be certified in a separate case.
2. When a family unit includes an SSI recipient(s), the SSI recipient's income, resources, and medical expenses are excluded from eligibility considerations. Only the income, resources, and medical expenses of the remaining family members are used in establishing Medically Needy eligibility. For purposes of Medically Needy eligibility the SSI recipient(s) is not included in the family count.
3. If there is a TEA cash ineligible child under the age of 18 living with a TEA cash family, the child can be considered for ARKids and if not eligible for ARKids, can be considered for U-18 Medically Needy.

O-160 Definition of Medically Needy Program Terms

MS Manual 01/01/14

The following sections of policy define terms that will be used within the Medically Needy policy section.

O-161 Medically Needy Income Level (MNIL)

MS Manual 01/01/14

The MNIL is the income standard used to determine an individual's or family's eligibility for Medically Needy program benefits. An individual or family is considered to be Exceptional Medically Needy if their net income is at or below the maximum specified for their family size.

Individuals or families whose income exceeds the MNIL will be considered for Spend Down Medically Needy. These individuals or families may qualify if their excess income (i.e., that above the MNIL) is obligated or spent for medical services.

O-162 Medicare Part B "Buy-In" Premium

MS Manual 01/01/14

The Medicare "Buy-In" Premium is the premium normally paid by insured Medicare individuals for Part B Medicare (medical insurance). The Department of Human Services (DHS) pays this premium for Exceptional Medically Needy individuals through a "Buy-In" agreement with the Social Security Administration. "Buy-In" is made on the basis of the individual's Social Security claim number (the Medicare number) which is entered in ANSWER at the time a case is certified. The Agency does not pay this premium for the Spend Down Medically Needy.

The cost of Part B Medicare will be treated as follows in Medically Needy determinations:

1. Exceptional Medically Needy - The cost of Part B Medicare will not be considered as a medical expense for the Exceptional Medically Needy since the Agency will assume the cost of the premium. If the premium has been withheld from the individual's Social Security check, it will be added back in for the eligibility determination.
2. Spend Down Medically Needy - The cost of Part B Medicare is considered a deductible expense for the Spend Down Medically Needy, since it is not paid by the Agency. The premium for Part B Medicare is included in the Spend Down as a non-covered medical expense.

NOTE: If the individual is receiving services through the Medicare Savings Programs that pays for the Part B premium, it will not be included as a non-covered medical expense as it is being paid by the Agency.

O-163 Excess Income

MS Manual 01/01/14

Excess income is the dollar amount by which the individual or family net income exceeds the Medically Needy Income Level.

O-164 Spend Down

MS Manual 01/01/14

Spend Down is the requirement that the individual or family obligate all excess income (i.e., that above the MNIL) for medical expenses before eligibility begins.

O-165 Spend Down Period

MS Manual 01/01/14

The Spend Down period is the three calendar months used in determining eligibility for the Medically Needy - Spend Down program.

The Spend Down quarter can be any continuous three calendar month period between the first day of the three month retroactive period (three calendar months prior to the application month) and the last day of the three month period beginning after the application month. The Spend Down quarter can be the three calendar months prior to the month of application; or two calendar months prior to the month of application and the application month; or one calendar month prior to the month of application, the application month, and one subsequent month; or the application month and two subsequent months; or the month after the application month and the two subsequent months.

EXAMPLE: The date of application is April 14, 2012. The Spend Down quarter can be: (1) January, February, and March; (2) February, March, and April; (3) March, April, and May; (4) April, May, and June; or (5) May, June and July.

The three months chosen for the Spend Down period should be the three months in which the applicant has the greatest medical expenses, or the three months in which he would receive the greatest benefit. A careful examination of dates and amounts of incurred medical expenses during the retroactive period and the application month will provide the facts necessary to select the quarter. The applicant will always be allowed to apply for the retroactive quarter if he chooses to do so.

Date specific eligibility has no effect on the three calendar months chosen for the Spend Down period, i.e., the three month period for consideration will always begin at the first of a calendar month and end on the last day of the third calendar month.

The only exception to a Spend Down period of less than three calendar months occurs when an individual did not qualify for reasons other than income during a portion of the period. For these cases, a one or two month determination will be made, as appropriate.

EXAMPLE: A man deserts his family on July 1st. His wife makes AFDC-MN application on July 21st for herself and their children. She requests medical assistance for June, July, and August. Due to a heavy workload, the caseworker does not complete the certification until September 2nd and, prior to certification, she learns the family moved from the state on September 1st. Given these circumstances, a 2 month Spend Down (July and August) will be worked, as eligibility does not exist for June (no deprivation) or for September (non-residence).

O-166 Spend Down Entitlement Period

MS Manual 01/01/14

The Spend Down entitlement period is a "fixed" period of Medicaid eligibility beginning either the first day of the Spend Down period if excess income is obligated by insurance premiums, copayments and/or uncovered incurred expenses (Re. MS O-742) or the day that the coverable medical expenses exceed the remaining excess income (Re. MS O-743) and ending the last day of the period. An entitlement period may cover up to one, two or three month(s).

Both beginning and ending dates of eligibility must be entered in ANSWER at certification.

The only effect date specific eligibility has on the entitlement period is that the end date for a period (last day of a month) may be changed after certification if a county worker becomes aware that an individual or family is no longer eligible for the remainder of the period, e. g., someone has inherited or has been awarded a large sum of money.

O-167 Unmet Liability (Date of SD)

MS Manual 01/01/14

The remaining excess income which is exceeded by deducting a daily total of incurred medical expenses included in the chronological spend down is the applicant's unmet liability (Re. MS O-741). This amount, rounded to the next lower dollar, is entered in ANSWER for the individual(s) who has medical expenses on the Spend Down date (Re. MS O-800). All claims for services incurred on the date of Spend Down will be processed against unmet liability until the liability has been satisfied (i.e., unmet liability is treated like a deductible).

The applicant is responsible for payment of the unmet liability amount.

O-168 Exceptional Medically Needy Duration of Eligibility

MS Manual 01/01/14

With date specific eligibility, an individual's or family's eligibility for exceptional Medically Needy may begin or end on any day of a month (Re. MS O-731). When found eligible, the certification period will begin on the day application was made, unless retroactive coverage is needed. If retroactive coverage is needed and if eligibility is established, the certification period may begin up to 3 months prior to the date of application (but not on the first day of a retroactive month, unless application was made on the first day of a month).

Exceptional Medically Needy eligibility continues until terminated at reevaluation or by reported changes that affect client eligibility. Any changes affecting eligibility must be reported within 10 days so that the caseworker can initiate necessary case action(s).

Termination of benefits does not affect the client's right to make subsequent applications.

O-170 Medically Needy Category Designations at Certification

MS Manual 01/01/14

Medically Needy cases are certified as one of the following categories:

Category	Description
AA(EC)	AA categorically related with income not greater than the MNIL. (see note below)
AA(SD)	AA categorically related with income greater than the MNIL
AFDC(EC)	AFDC categorically related with income not greater than the MNIL.
AFDC(SD)	AFDC categorically related with income greater than the MNIL.
AB(EC)	AB categorically related with income not greater than the MNIL. (see note below)
AB(SD)	AB categorically related with income greater than the MNIL
AD(EC)	AD categorically related with income not greater than the MNIL. (see note below)
AD(SD)	AD categorically related with income greater than the MNIL.
U-18(SD)	Under 18 categorically related with income greater than the MNIL
PW (EC)	Pregnant women with income not greater than the MNIL.
PW (SD)	Pregnant women with income greater than the MNIL.
UP (EC)	Unemployed Parent categorically related with income not greater than the MNIL
UP (SD)	Unemployed Parent categorically related with income greater than the MNIL.
RMA(EC)	Refugee under special eligibility period with income not greater than the MNIL.

Category	Description
RMA(SD)	Refugee under special eligibility period with income greater than the MNIL
FC(EC)	Foster child with income not greater than the MNIL
FC(SD)	Foster child with income greater than the MNIL

NOTE: Eligibility for AABD-EC is restricted to deceased individuals or other persons for whom SSI retroactive eligibility cannot be determined, and individuals in non-LTC institutions who are subject to the SSI $30.00 countable income limit (Re. MS O-141).

EXCEPTION: Some individuals may be found eligible for Cat.46-AD (EC) if certain conditions apply (Re. MS F-120).

O-200 Initial Requests for Medically Needy Services

MS Manual 01/01/14

Requests for Medically Needy Services must be made to DCO or to the Division of Children and Family Services (DCFS) for foster children. For SSI related categories (AABD) and emancipated minors, the individual, his legal guardian or his designated representative may apply. For AFDC related categories, the natural/adoptive parent, or specified relative or an individual, who has been awarded custody of a minor by court order, may apply. Applications for U-18 Medically Needy may be made by a parent or specified relative or by an individual who has been awarded custody of an un-emancipated minor by court order.

Applications will be accepted and processed for deceased persons. The application can be made by the person(s) responsible for medical debts of the deceased. The period of medical coverage cannot extend beyond the normal range of retroactive eligibility from the application date. With date specific eligibility, a Spend Down period can begin on the first day of the third month prior to the month of application, but eligibility for the Exceptional Medically Needy cannot begin more than 3 months prior to the date of application. Applications made for deceased person(s) whose date of death is prior to the limits of retroactive eligibility will be denied.

The Agency has the responsibility to follow up any request and to make arrangements for completion of the application. Medically Needy Services cannot be authorized until the application is approved.

Applications will be made in the county where the applicant resides. If a DCO employee or his relative applies for Medically Needy services in the Office where the employee works, the application will be processed by the next level supervisor.

Methods of verification used in eligibility determination will depend upon categorical relatedness.

All applications will be made on Agency documents. This requirement is necessary because: a legal document is needed to indicate the individual's intent to apply; the date of the application must be recorded; and a written application informs the applicant of his rights and responsibilities for giving the Agency accurate information for determination of eligibility. The application may be introduced in court in cases of fraud.

O-201 On-Site Applications

MS Manual 01/01/14

On-site applications are taken at Arkansas Children's Hospital (ACH) and the University of Arkansas for Medical Sciences (UAMS) from individuals residing in all counties of the State. Applications are also taken at numerous other hospitals and counseling centers around the state by out-stationed DCO workers.

O-210 Multiple Applications

MS Manual 01/27/16

Individuals applying for the Medically Needy Program who may be eligible for the Family Medicaid categories, such as PCR Medicaid, have the option of applying for these categories of Medicaid and/or the appropriate category under Medically Needy.

The caseworker has the responsibility of discussing the alternatives with the applicant in order that the applicant may make an informed decision. If there is more than one application for a family or individual, each application must be processed separately. All documents will be maintained in one electronic case file.

NOTE: There may be more than one case per household if there is more than one family in the home, or if there is a stepparent or grandparent in the home, etc. (Re. MS O-720).

O-220 Reapplication for Medically Needy Services

MS Manual 01/01/14

For the Medically Needy –Spend Down, application for services can be made every three months as needed. Application for a new quarter will be made in the same manner as the initial application. Previous documents will be reviewed.

O-230 Distinction Between Application and Inquiry

MS Manual 01/01/14

Every person has the right to apply for Medically Needy Services. No application or inquiry may be ignored.

The distinction between an application and an inquiry is as follows:

1. An application is a signed request for payment of medical services by an individual or his authorized representative.
2. An inquiry is a request for information. An inquiry is distinguished from an application by the intent of the person to receive information rather than to apply.

O-240 Initial Contact with Applicant in Person

MS Manual 01/01/14

After an application is submitted to DCO, the caseworker will determine if a face-to-face or telephone interview is required or if the application can be processed using previous documentation.

O-250 Steps in Application Process

MS Manual 01/01/14

MS Sections O-250 through O-257 describe the required steps in the Medically Needy initial application process.

O-251 Application Interview

MS Manual 01/01/14

If a face-to-face or telephone interview is required, the tasks to be completed during the interview are as follows:

1. Explanation of the Medically Needy Program and the Agency regulations that affect the applicant. The explanation will be in terms the applicant can understand.
2. Explanation of the Agency's responsibility for carrying out policy in determining eligibility; of the applicant's responsibility for cooperating in the establishment of eligibility; of the mandatory assignment of rights to Medical support/third party liability (Re. MS D-500); of the obligation to file third party resource claims within a reasonable period of time; of the applicant's obligation to cooperate in Child Support Enforcement Activities (Re. MS F-130); of the information needed to establish eligibility; and of the confidential way in which the Agency treats information.
3. Explanation of the requirement that the applicant and each person included in the MNIL must have or apply for, a Social Security Number as a condition of eligibility (Re. MS D-400).

4. Explanation of the right to a hearing if the applicant is dissatisfied with the Agency's handling of the application or of the case.
5. Explanation of the Agency time limits for completion of applications.
6. Explanation of Child Health Services (EPSDT), Family Planning, SNAP, the Medical Assistance Program, and Service Programs.

O-252 Nondiscrimination

MS Manual 01/01/14

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

The Agency has the responsibility for informing applicants, recipients, and clients that assistance and services are provided on a nondiscriminatory basis and of their right to file a complaint with the Agency or Federal Government if it is thought that discrimination has occurred on the basis of race, color, national origin, or handicap.

O-253 Securing Information to Determine Eligibility

MS Manual 01/01/14

The caseworker will secure essential social and financial information to determine eligibility.

The applicant will be relied upon as the primary source of information. However, when the applicant is unable to provide essential information and requests assistance, the caseworker will assist in obtaining the necessary verification.

If necessary, the caseworker will use form DHS-81, (Consent for Release of Information) to secure essential information from a collateral source. This form will be signed by the applicant so that information may be released to the Agency.

The caseworker will document each task completed during the interview and will also record in the narrative, and/or on the forms, essential social and financial information.

O-254 Completion of Application Forms

MS Manual 01/01/14

The applicant or his authorized representative will complete and sign the application form. If disability is to be established, the DHS-4000, DCO-106, DCO-107 (or DCO-701) and DCO-108 will be completed for MRT (Re. MS F-120 section). For SSN enumeration procedures, refer to MS D-400. At the conclusion of the interview, the applicant or representative will be given a DCO-002 to indicate the documents needed for the eligibility determination. At least 10 days will be given for return of the items needed, or longer if the applicant requests.

O-255 Registering the Application

MS Manual 01/01/14

An application will be registered in ANSWER using the date it is received by the County Office. A register number will be system assigned to each application. The categories are:

- 1M for Aged Individual-Exceptional and Aged Individual-SD
- 2M for AFDC-Exceptional and AFDC-SD
- 3M for Blind Individual-Exceptional and Blind Individual-SD
- 4M for Disabled Individual-Exceptional and Disabled Individual-SD
- 5M for U-18-SD
- 6M for Pregnant Woman-Exceptional and Pregnant Woman-SD
- 7M for Unemployed Parent-Exceptional and Unemployed Parent SD
- 8M for Refugee-Exceptional and Refugee-SD
- 9M for Foster Care-Exceptional and Foster Care-SD

Note: The Division of Children and Family Services (DCFS) Eligibility Unit will be responsible for completing and registering applications for Foster Care EC and Foster Care MN-SD.

O-256 Securing Information from Collateral Source

MS Manual 01/01/14

Collateral information is evidence provided by persons other than the applicant or by written documents. Items requiring collateral evidence are designated in sections dealing with specific eligibility requirements.

The caseworker will protect the rights of the applicant during collateral interviews and will give only the information necessary to enable the person interviewed to understand the need for the information requested.

When an original, photocopy, or certified copy of a document used as evidence is **not** a permanent part of the electronic case record, it will be necessary for the narrative to contain definitive information as follows:

1. The location of the document, (e.g., where or by whom the document is kept).
2. The pertinent facts which establish authenticity, when the document was made, where the document was registered or filed, registration or filing identification, serial number, etc.

Conflicting evidence will be resolved before approval of an application.

O-257 Time Limits to Dispose of Application

MS Manual 01/01/14

Except for those cases that require a disability determination, all Medically Needy cases will be disposed of within 45 days from the date of application by one of the following actions: approval, denial, or withdrawal.

AD Medically Needy cases, when an MRT disability determination is required, will be disposed of within 90 days from the date of application by one of the following actions: approval, denial, or withdrawal.

O-300 Disposition of Application

0-310 Approval

MS Manual 01/01/14

The caseworker will complete the following tasks when approving an application:

1. Record all pertinent information in the case narrative (information included on forms will not be repeated).
2. Process case approval in ANSWER. An existing case number should be used whenever possible.
3. Notify client by sending form DCO-700 or system generated notice. Approvals for Spend Down will include the amount of the recipient's unmet liability on the day of Spend Down.

O-320 Denial and Withdrawal

MS Manual 01/01/14

The caseworker will complete the following tasks when denying an application.

1. Record pertinent information in the case narrative (information included on forms will not be repeated). The factor that makes the applicant ineligible will be narrated; however, if verification of other factors of eligibility has been obtained, these will be electronically scanned into the record.
2. Notify client of denial by sending form DCO-700 or system generated notice.
3. For withdrawal only, obtain a signed written statement from the applicant that indicates he/she wishes to withdraw the application.

O-330 Transfer to Another County

MS Manual 01/01/14

When an applicant moves out of the county in which the application was taken, the caseworker who receives the notification of the transfer will:

1. Obtain from the applicant the new address, the name of the county to which the applicant has moved and any other pertinent information regarding the move.
2. Deny the application and electronically transfer the case to the receiving county in ANSWER.

3. Upon notification of the transfer, the receiving county will register the application using the original date of application in ANSWER and continue the eligibility determination.

O-340 County Office Delay

MS Manual 01/01/14

When action on an application will be delayed because of the County Office or MRT, the County Office will notify the applicant with a DCO-700 to explain the reasons for the delay and of his or her right to an appeal.

O-350 Applicant Delay

MS Manual 01/01/14

If the applicant has been instructed by DCO-002 or DCO-191 to provide information to establish eligibility but fails to do so by the end of the specified time, the application will be denied and the applicant will be mailed a DCO-700 or a system generated notice of denial. If the applicant is having difficulty providing essential information and requests additional time, the caseworker will acknowledge the request by sending a DCO-700 that clearly specifies the extended time period and what information is needed by the end of the extended time period; and will also assist the applicant in obtaining the information, if possible. If the information has not been provided by the end of the extended time period, the application will be denied and the applicant will be mailed a DCO-700 or system generated notice of denial.

O-400 Medically Needy Eligibility Determination

MS Manual 01/01/14

O-410 Categorical Relatedness - Medically Needy

MS Manual 01/01/14

To be eligible for the Medically Needy Program, an applicant must meet the basic categorical eligibility requirements outlined in the following paragraphs for AFDC, SSI (AABD), or ARKids. If it is obvious the applicant cannot meet the requirements for any category, the application will be denied without further processing.

O-420 Medically Needy - AFDC Categorical Relatedness (AFDC-MN and UP-MN)

MS Manual 01/27/16

The individual or family must meet the following factors of eligibility to be certified as AFDC-Medically Needy or UP-Medically Needy.

1. Age Requirement – under 18 years old.
2. Citizenship or Alienage Requirement (MS D-200).
3. Residence Requirement (MS D-300).
4. Social Security Enumeration Requirement (MS D-400).
5. Assignment of Rights to Medical Support/Third Party Liability Requirement (MS D-500).
6. Deprivation of Parental Care and Support Requirement (deprived by reason of death, continued absence from the home, or physical or mental incapacity). For UP-MN, refer to MS O-421.
7. Cooperation in Child Support Enforcement activities (MS F-130). (DOES NOT APPLY TO UP-MN.)
8. AFDC Relationship Requirement and Living with Specified Relative (MS F-110).
9. Standard of Need - In determining eligibility, parents will be included in the need standard with their natural/adoptive children. Normally, all of the full siblings in the household will be included in the budget with their natural/adoptive parents. However, a parent may choose to exclude a child and that child's income from a case budget if inclusion of that child and the child's income would cause ineligibility for the other children. Children may also be excluded for other reasons, and the parent who applies need not state the reason. (Re. MS O-720 for additional information on need standards).

a. Income Computation - Income computation is as follows:

   1) The Lump Sum Payment treatment does not apply - a lump sum payment received in the determination period (i.e. in the month for EC cases or in the quarter for SD cases), will be considered as income in the period and, to the extent retained, a resource in the following period.

   2) The income of an alien sponsor is disregarded (Re. MS E-300).

   3) The net earned income (gross earnings minus earned income deduction($90) and child care) plus unearned income (minus the first $50 of child support paid) is compared to the Medically Needy Income Level to determine income eligibility or the Spend Down liability of the AFDC-Medically Needy. For UP-Medically Needy the work and child care deductions, when applicable, will also be given.

b. Resource Limitations and Computation - Resource eligibility for the AFDC-Medically Needy and UP-Medically Needy is determined by computing countable resources as specified in MS Appendix N and comparing them with the Medically Needy Resource limitations specified under MS O-600. There is no applicable transfer of resource provision which applies to AFDC-MN or UP-MN, i.e., if uncompensated transfers have occurred, no periods of ineligibility will be imposed.

For AFDC-MN only (Not UP-MN), the Medical Review Team determination of disability or blindness will be required. Disability is verified based on submission to MRT of forms DHS-4000 and/or DCO-107 and DCO-108. Blindness is based on submission of forms DCO-701 (Report on Eye Examination of Applicant For or Receipt of Blind Assistance) and DCO-108. MRT reports its findings of approval or denial of disability on form DCO-109. Verification of disability based on receipt of an SSA or SSI disability payment or letter of entitlement may be used in lieu of the MRT procedure.

O-421 Factors Specific to Unemployed Parent Medically Needy

MS Manual 01/01/14

If a two parent family with dependent children meets all of the requirements for UP, except for income and/or resources, their income and resources should be compared to the Medically Needy standards for MN-SD eligibility.

O-422 Deprivation Due to Unemployment of the Principal Wage Earner

MS Manual 01/01/14

Deprivation due to unemployment must be based on the parent who has been the principal wage earner (PWE) for the past two years.

The PWE is the parent who earned the greater amount of income during the 24 month period which immediately precedes the month in which application for assistance is made. The earnings of each parent are considered in determining the principal wage earner regardless of when their relationship began. Only one parent can be the PWE.

Unemployed means:

1. The principal wage earner is not employed or is employed less than 100 hours a month; or
2. If 100 hours or more were worked in a particular month because the work was intermittent and the excess was temporary, the PWE must have been under the 100 hour standard for the two prior months and is expected to be under the standard for the following month.

The PWE must meet each of the following criteria at initial application, or during the month of application, in order for Medicaid coverage to begin in the month of application (see note below):

1. Must have been unemployed for at least 30 consecutive days or is employed less than 100 hours a month;
2. Must have had 6 quarters of work within any 13 calendar quarter period ending within 1 year prior to application or received unemployment compensation within 1 year prior to application. For the 6 quarters of work, education may be substituted for up to 4 of the 6 quarters;
3. Must not, without good cause, have refused a bona fide offer of employment or training for employment within the last 30 days;
4. Must not have refused to apply for or accept unemployment compensation if qualified.

NOTE: If an applicant does not meet the above criteria at application, or during the month of application, eligibility cannot begin until the first day of the month in which the criteria are met.

EXAMPLE: An individual loses his job on May 15th, and applies for UP-MN on May 16th. He worked 110 hours in May before losing his job. He will not have been

unemployed for 30 consecutive days by the end of May; therefore, his family will not be eligible for Medicaid during May. He will have been unemployed for 30 days on June 14th, however. Assuming all other eligibility criteria are met, Medicaid benefits could begin June 1st.

O-423 Reporting Requirements

MS Manual 01/01/14

There will be no periodic reporting requirements for UP-MN.

O-424 Retroactive Eligibility

MS Manual 01/01/14

If all of the UP requirements are met in any of the 3 months prior to UP-MN application and if there are unpaid Medical bills, retroactive coverage may be given for any of the 3 retroactive months.

O-425 UP-MN Spend Downs

MS Manual 01/01/14

If all of the eligibility requirements with the exception of income are met, e.g., countable earnings (at less than 100 hours per month) are over the MNIL and if there are unpaid Medical bills, a Medically Needy Spend Down may be considered.

O-430 Medically Needy Pregnant Women Categories

MS Manual 01/01/14

Pregnant Women (Re. MS B-230) may be considered for Medically Needy-EC or SD, if they do not meet the need requirements for PW No-Grant. If a pregnant woman's income and/or resources exceed the limits for PW No-Grant, the PW's income and resources will be compared to the Medically Needy MNIL and MNRL to determine eligibility in PW-EC or SD.

If a pregnant woman has income above the MNIL but below 200% of Poverty Level, then SOBRA PW eligibility will be determined prior to determining eligibility for Spend Down.

O-440 Medically Needy - SSI (AABD) Categorical Relatedness

MS Manual 01/01/14

Individuals will meet the following SSI (AABD) factors of eligibility to be certified as AABD-Medically Needy.

1. Categorical eligibility by reason of "age", "blindness" or "disability".
   a. "Aged" is defined as 65 years old or older.
   b. "Blindness" is defined as central visual acuity of 20/200 or less with best correction or a limited visual field of 20 degrees or less in the better eye (Re. MS F-120).
   c. "Disability" is defined as a physical or mental impairment which prevents the individual from doing any substantial gainful work (for a child under 18, an impairment of comparable severity) and which has lasted or is expected to last for at least 12 months or is expected to result in death (Re. MS F-120).
2. Citizenship or Alien Status Requirement (Re. MS D-200).
3. Residence Requirement (Re. MS D-300).
4. Social Security Enumeration Requirement (Re. MS D-400).
5. Assignment of rights to Medical Support/Third Party Liability requirement (Re. MS D-500).
6. Cooperation in Child Support Enforcement Activities (Re. MS F-130).
7. Countable income equal to or greater than SSI payment limitations (Re. MS O-141 for exceptions).
8. SSI Countable Resource Limitations and Resource Treatment (countable resource limits are: $2,000 for an individual and $3,000 for a couple "living together", one or both eligible. Re. MS O-600 for resource levels).

Methods of verification used for AABD Long Term Care cases apply to the AABD Medically Needy. Procedures used for verification of categorical relatedness is covered under MS G-100 through MS G-180; citizenship and alien status are covered under MS G-130; resource limitations and treatment are covered under MS E-500 through MS E-530; and computation of income is covered under MS E-400 through MS E-450.

O-450 Medically Needy - Under 18 Categorical Relatedness

MS Manual 01/27/16

The individual or family must meet the following factors of eligibility to be certified as U-18 Medically Needy.

1. Age Requirement - under 18 years old.
2. Relationship Requirement and Living with Specified Relative (Re. MS F-110). (These do not apply to individuals who are emancipated or who have been removed from the custody of their parents by court order).
3. Citizenship or Alienage Requirement (Re. MS D-200).
4. Residence Requirement (Re. MS D-300).
5. Social Security Enumeration Requirement (Re. MS D-400).
6. Assignment of rights to Medical Support/Third Party Liability Requirement (Re. MS D-500).
7. Cooperation in Child Support Enforcement Activities (Re. MS F-130).
8. Resource Limitations of the Medically Needy Program (Re. MS O-600).
9. Computation of Income - Earned and Unearned. (Re. MS O-420.)

Resource eligibility for the U-18 Medically Needy is determined by computing countable resources as specified under MS Appendix N and comparing them with the Medically Needy Resource limitations specified under MS O-600. There is no applicable transfer of resource provision which applies to U-18-MN, i.e., if uncompensated transfers have occurred, no periods of ineligibility will be imposed.

0-451 Medically Needy - Foster Care

MS Manual 01/01/14

Foster Children (Re. MS B-400) who do not meet the income and/or resource need requirements of State FC (U-18 criteria – Re. MS 0-143) or of Title IV-E-FC may be considered for Medically Needy FC - EC or SD by comparing income and resources to the Medically Needy MNIL and MNRL. The Division of Children and Family Services (DCFS) will determine IV-E and Medicaid eligibility for Foster Children.

Each child will be evaluated as a one person household unit against the appropriate criteria. Consideration of parental income/resources will cease effective the month a child enters Foster Care by the Court awarding custody to the Agency. A child taken into foster care on the basis of

an emergency order only may be determined Medicaid eligible. If custody is later established by a judicial determination, the DCFS Worker will be required to include a copy of the order in the foster care Medicaid record.

If a Foster Child reenters his parent's home, the child's Medicaid eligibility redetermination will include parental income and resources, even if the reentry is a trial placement and the Agency retains custody.

O-500 SSI Related Treatment of Income (AABD-MN)

MS Manual 01/01/14

Income is defined as the receipt of assets by an individual in cash or in-kind during a month. To be considered as income, the assets received by the individual must be something of value 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 receipt.

Income may be received in cash (including checks, money orders, etc.) or in- kind (including items such as free 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.

O-510 Income Evaluation

MS Manual 01/01/14

Evaluations of income for the AABD Medically Needy will be made as follows:

1. Individuals with countable income less than the SSI payment limitations are not eligible for Medically Needy consideration unless they are: (a) deceased or other persons for whom SSI retroactive eligibility cannot be determined; (b) individuals in non-LTC institutions who are subject to the SSI $30.00 countable income limit (Re. MS O-141); or (c) individuals with disabilities who meet the requirements at MS F-120. The net monthly income of an individual in any of the above groups will be compared to the monthly Medically Needy Income Level to determine EC eligibility.
2. Those individuals whose countable income is greater than the SSI payment limitations will be evaluated on a quarterly basis to determine Medically Needy Spend Down (SD) eligibility. The individual or couple's net quarterly income in these cases will be compared to the Quarterly Medically Needy Income Level to determine SD liability and eligibility.

The specific process for determining Spend Down eligibility is found in MS O-740.

O-520 SSI Relatedness

MS Manual 01/01/14

The criteria for determining countable income for the AABD Medically Needy are contained in the Section E of this manual (MS E-400 through E-450).

1. MS E-400 - MS E-410 specifies the general consideration of income and how it is evaluated.
2. MS H-421 specifies the extent of consideration of income involving separated couples, (i.e. those not living together in the same household).
3. MS E-415 specifies the means for determining and verifying earned income.
4. MS E-420 – E-421 specifies the means for determining income from self- employment.
5. MS E-430 specifies sources of unearned income.
6. MS E-431 - MS E-434 specifies procedures for determination and verification of unearned income.
7. MS E-432 defines in-kind support and maintenance and other in- kind income, specifies the value determination for each type, and specifies items excluded (not considered as in-kind support and maintenance).
8. MS E-450 - MS E-451 specifies income exclusions applicable to the AABD Medically Needy for determination of net countable income.

O-530 Income of Other Persons (Deeming)

MS Manual 01/01/14

For any month or portion of a month that the applicant (eligible) resides with his ineligible spouse or parent(s) (if the applicant is a child who is blind or has a disability), deeming of income from the ineligible spouse or parent(s) is required.

Current SSI Standard Payment Amounts (SPA) and Living Allowance amounts can be found in the SSI Chart at Appendix S.

Deeming procedures are specified in MS O-531 through MS O-535:

O-531 Deeming of Income from Ineligible Spouse (AABD-MN)

MS Manual 01/01/14

When an applicant/eligible resides with his ineligible spouse, deeming of income from the ineligible spouse is required.

1. Determine the applicant's countable income (allow SSI exclusions – Re. MS E-450). Determine if the countable income is equal to, above, or less than the individual SSI Standard Payment Amount (SPA); then proceed to Step 2 of the deeming process.
2. Determine the total income of the ineligible spouse by types, earned and unearned, less any excluded from deeming (Refer to MS O-535 to determine income excluded from deeming). Proceed to step 3.
3. From the ineligible spouse's income, deduct a living allowance for each ineligible child in the home (i.e. those not receiving TEA Cash Assistance or SSI as a child who is blind or has a disability.

NOTE: Any children under the TEA Cash family cap, not included in the TEA cash grant, are allowed the living allowance). Income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS O-535 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first, and any unused balance is then deducted from earned income; proceed to 4.

4. Total the ineligible spouse's remaining income by type, earned and unearned, with the applicant's gross earned and unearned income and treat the two totals of income as for an eligible couple:
   a. From unearned income, deduct the $20.00/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
   b. From earned income, deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;
   c. Total remaining earned and unearned income to arrive at countable income; proceed to 5.
5. Compare the countable income, after deeming, to the two person SSI payment standard. If countable income is less than the two person SPA, and the applicant's own income in step 1 was less than the individual SPA, the applicant cannot be considered for Medically Needy. Referral will be made to SSA for SSI eligibility determination (Re. MS O-141 #2 for exceptions). Any other combination of individual SPA eligibility (Step 1)

vs. the couple's SPA eligibility (Step 5) may be considered for Medically Needy Spend Down. To illustrate:

a. If countable income is under the 1 person SPA and under the 2 person SPA - Refer to SSA.

NOTE: For individuals who allege a disability, refer to MS F-120 before referring to SSA. If MRT will make the disability determination, do not refer to SSA, consider AD-MN.

b. If countable income is under the 1 person SPA and over the 2 person SPA - Consider MN-SD

c. If countable income is over the 1 person SPA and under the 2 person SPA - Consider MN-SD

d. If countable income is over the 1 person SPA and over the 2 person SPA - Consider MN-SD

6. To determine Medically Needy - SD liability, the countable income will be compared to the two person MNIL. The excess over the two person MNIL is the applicant's Spend Down liability.

O-532 Deeming of Income from Ineligible Parent(s) to a Child Who is Blind or Has a Disability

MS Manual 01/01/14

For purposes of income deeming, a stepparent living in the home with an eligible child is not considered the same as a parent. Do not deem a stepparent's income.

1. Determine the gross monthly income of the ineligible parent(s) by type, earned and unearned less income excluded from deeming (Refer to MS O-535 to determine income excluded from deeming).
2. From the ineligible parent(s)' income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a child who is blind or has a disability). Any income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to MS O-535 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first, and any unused balance is then deducted from earned income.

3. Continue the deeming process as follows:
   a. From unearned income, deduct the $20.00/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
   b. From earned income, deduct the $65.00/mo. work expense allowance plus one-half (1/2) the remaining balance;
   c. Total remaining earned and unearned income;
   d. From total remaining income, deduct a living allowance for the ineligible parent(s) equal to the SSI SPA.
   e. Remaining income (if any) is deemed to the child as unearned income. It is subject to the $20.00/mo. general exclusion in the child's countable income determination.
4. If parental income is deemed to more than one eligible child, prorate the deemed income equally to each child.

Examples

Deeming of income from Parent(s) to a child. (Examples reflect 1/1/2013 figures)

EXAMPLE #1: A child has gross unearned income of $35.00/month. His ineligible parents have gross earned and unearned income of $900.00/month and $223.00/month, respectively. There is one ineligible child. Deemed income is determined as follows:

a. The ineligible parents have gross monthly earned and unearned income of $900.00 and $223.00, respectively.
b. From the ineligible parents' unearned income, deduct the living allowance for the ineligible child i.e., $223.00 - $356.00 = $00.00; $900.00 earned income - $133.00 (the remainder of the living allowance for the ineligible child) = $767.00. Since remaining income is earned only, income computation will be as follows:
   1) From remaining income, deduct the $20.00 general exclusion and the $65.00 earned income deduction ($767.00 - $85.00 = $682.00).
   2) From the remainder of $682.00 deduct 1/2 ($682.00 - $341.00 = $341.00); then deduct the SSI SPA for a couple ($341.00 - $1,066.00 = $0.00).
   3) $0.00 is deemed to the child as unearned income. If the computation had resulted in an amount greater than zero, it would be added to the child's own income as unearned income for his eligibility determination.
   4) From the child's gross income deduct the $20.00 general exclusion ($35.00 - $20.00 = $15.00) to determine the child's countable income for eligibility.

EXAMPLE #2: A child has gross unearned income of $130.00/month. His ineligible parents have gross unearned income of $800.00/month. There is one ineligible child. Deemed income is determined as follows:

a. The ineligible parents have gross monthly unearned income of $800.00.

b. From the ineligible parents income, deduct the living allowance for the ineligible child ($800.00 - $356.00 = $444.00). Since remaining income is unearned only, computation will be as follows:

   1) From remaining income, deduct the general exclusion ($444.00 - $20.00 = $424.00).

   2) From remaining income, deduct SSI SPA for the ineligible parents ($424.00 - $1,066.00 = $0.00).

   3) $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.

   4) From the child's gross income deduct the $20.00 general exclusion ($130.00 - $20.00 = $110.00) to determine the child's countable income for eligibility.

EXAMPLE #3: A child has gross unearned income of $35.00 monthly. His ineligible parent has gross earned and unearned income of $685.00 monthly and $300.00 monthly, respectively. There are no ineligible children. Deemed income is determined as follows:

c. The ineligible parent has gross monthly earned and unearned income of $685.00 and $300.00, respectively.

   1) From unearned income deduct the general exclusion ($300.00 - $20.00 = $280.00).

   2) From earned income, deduct the work expense allowance plus one-half (1/2) the remaining balance ($685.00 - $65.00 = $620.00 divided by 2 = $310.00).

   3) Total remaining earned and unearned income ($310.00 + $280.00 = $590.00).

   4) From the total remaining income deduct the SSI SPA for the ineligible parent ($590.00 - $710.00 = $0.00).

   5) $0.00 is deemed to the child as unearned income. This amount would be added to the child's own income as unearned income for his eligibility determination ($0.00 + $35.00 = $35.00 less the $20.00 general exclusion leaves $15.00 as countable income to the child).

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-533 Deeming of Income to Individual Who Would Be Eligible Except for Excess Income to Eligible Child Who is Blind or Has a Disability

MS Manual 01/01/14

When there is a child who is blind or has a disability living in the home with his parents and one parent is categorically eligible (i.e., acceptable evidence exists that proves that the parent would qualify as aged, blind or disabled except for income), income of the ineligible parent is deemed first to the categorically eligible spouse and then to the eligible child. Deemed income to a child who is blind or has a disability under these circumstances is determined as follows:

1. Complete Steps 1 through 4 of Spouse to Spouse deeming as indicated in MS O-531 Deeming of Income from an Ineligible Spouse;
2. Compare the result derived from Step 4 of MS O-531 to the couple's SSI SPA.
3. If the couple's income determined under Spouse to Spouse deeming is equal to or less than the couple's SSI SPA, there is no income to deem to the child;
4. If the couple's income exceeds the couple's SSI 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 to each child. The amount deemed to the child as unearned income is subject to the $20/mo. general exclusion in his eligibility determination.

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-534 Deeming of Income to Eligible Child from Parent/Parents Who Would Be Eligible Except for Excess Income

MS Manual 01/01/14

When there is a child who is blind or has a disability in the home with a parent/parents who is/are eligible except for excess income (i.e., acceptable evidence exists that proves that the

parent/parents would qualify as aged, blind, or disabled except for income), only income above the parent(s)' SSI SPA is deemed to the child. Deemed income is determined as follows:

1. Determine the parent/parents' countable income as if no children were involved (allow SSI exclusions listed in MS E-450);
2. If the countable income is equal to or less than the SSI SPA, there is no income to deem to the child. If the countable income is greater than the SSI SPA, the amount above the SSI SPA is available for deeming to the child;
3. Reduce the excess income amount by the living allowance for each ineligible child in the home (i.e., those children who are not blind or disabled). 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's 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 $20/month general exclusion in his eligibility determination.

NOTE: If the child's countable income is under the SSI/SPA, refer to MS F-120 to determine whether SSA or MRT will make the disability determination, and whether or not to refer to SSA. If the allegation is blindness and the countable income is under the SSI/SPA, refer to SSA.

O-535 Items (Income) Not Included in Deeming

MS Manual 01/01/14

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 - Excludes payments by any Federal Agency, State or political subdivision, SSI payments and any income which was taken into account in determining such assistance. Exclusion applies to V.A. Pension but not to V.A. Compensation. Also excludes TEA cash payments and income which was taken into account in determining assistance (including all income of a stepparent in households where there is a stepparent).
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. Supplemental Nutrition Assistance Program (SNAP) benefits and Department of Agriculture donated foods.
5. Home produce grown for personal consumption.
6. Refund of income taxes, real property taxes, or tax refunds on food purchased by the family.
7. Income used to comply with the 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 Statutes.
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).

O-600 Medically Needy Resource Limitations and Resource Determination

MS Manual 01/01/14

The following countable resource limitations are in effect for the Medically Needy Program from 1/1/86.

O-610 Medically Needy Resource Limitations

MS Manual 01/27/16

Medically Needy Resource Limitations – Resource Limits

Household Size	1/1/86-12/31/86	1/1/87-12/31/87	1/1/88-12/31/88	From 1/1/89
1	$1,700	$1,800	$1,900	$2,000
2	$2,550	$2,700	$2,850	$3,000
3	$2,650	$2,800	$2,950	$3,100
4	$2,750	$2,900	$3,050	$3,200
5	$2,850	$3,000	$3,150	$3,300
6	$2,950	$3,100	$3,250	$3,400
7	$3,050	$3,200	$3,350	$3,500
8	$3,150	$3,300	$3,450	$3,600
9	$3,250	$3,400	$3,550	$3,700
10	$3,350	$3,500	$3,650	$3,800

NOTE: For Household Sizes Above 10, Add $100 For Each Additional Member.

1. Determination of Household Size for Medically Needy Resource Consideration
   Household size for MN Resource determination is made according to categorical consideration.
   a. SSI cash assistance recipients and their resources are excluded from AFDC and U-18 related cases. They cannot be considered in a second eligibility determination.
   b. AFDC and U-18 Related - Determination of household size for AFDC and U-18 related MN cases is made as follows. The resources of non-SSI individuals may be considered in more than one MNRL.

1) The eligible children and the natural/adoptive parent(s) in the home will be included in the MNRL unit. However, a parent may choose to exclude a child and that child's resources if inclusion of that child and that child's resources would cause ineligibility for the other children in the MNRL. A parent's needs will always be included when determining eligibility for his/her children.
2) The resources available only to a stepparent will be disregarded in the MNRL of his/her stepchild and his/her spouse (the stepchild's natural/adoptive parent) if that spouse requests assistance as caretaker relative of her deprived child. The stepparent will not be counted in their MNRL.
3) The resources available only to a grandparent, or any relative other than a parent, who is not included in the assistance unit, will be disregarded.

   If the grandparent, or other relative other than a parent, chooses to be included in the assistance unit, his/her resources will be included in full in determining resource eligibility for all those included in the MNRL.

   When the grandparent or other relative chooses to be included and when the grandparent/other relative has a spouse in the home, the resources available only to that spouse will be disregarded in determining resource eligibility.
4) In dependent child/minor parent/grandparent households, the rules in (3) above will apply, i.e., if the grandparent is to be included as an eligible, the grandparent's resources will be counted; and if the grandparent is not to be included, the grandparent's resources will be excluded.

NOTE: In U-18-MN cases, the resources of a parent(s) will always be counted in full in his/her child's MNRL and that parent(s) will be included in the MNRL, even though the parent(s) may be over age 18 and will not be a Medicaid eligible member(s) of the unit.
However, in dependent child/minor parent/grandparent households, even though the grandparent's resources must be counted toward the minor parent, they will be disregarded in the resource eligibility determination of the grandchild.

c. SSI Related (AABD) - The household size determination for SSI related is as follows:
   1) Household Size 1 ($2,000) limit: The one person or individual limit is used for AABD individuals not living with a spouse, and for a child who is blind or has a disability.
   2) Household Size 2 ($3,000) limit: The two-person limit is used for AABD couples and for individual AABD determinations when there is an ineligible spouse.

2. Medically Needy Resource Determinations
   Countable resources for Medically Needy are determined as follows according to categorical consideration.
   a. AFDC and U-18 Related - Countable resources are determined and verified in accordance with MS Appendix N. However, there is no applicable transfer of resource provision which applies to AFDC and U-18 related Medically Needy cases.
   b. SSI Related (AABD) - Countable resources are determined and verified in accordance with SSI related policy (Re. MS E-500- E-530). However, there is no applicable transfer of resource policy which applies to the AABD-MN categories.
   c. All resources are to be verified on the first day for each month of eligibility.

O-620 Resources of Other Persons (Deeming)

MS Manual 01/01/14

When an AABD applicant/eligible resides with his ineligible spouse or ineligible parent(s) (if the applicant is a child who is blind or has a disability), deeming of resources from the ineligible spouse or parent(s) is required.

1. Resources of Ineligible Spouse
   The applicant and his ineligible spouse are permitted a couple's countable resource limit of $3,000 (Allow SSI Exclusions); there is no actual deeming.
2. Resources of Ineligible Parent(s)
   For purposes of resource deeming, a stepparent living in the home with an eligible child is not considered a parent. Do not deem a stepparent's resources to his stepchild.
   a. Determine the child's countable resources (allow SSI exclusions). If countable resources exceed the one person Medically Needy Resource Limit (MNRL) the child is ineligible. If countable resources are less than or equal to the one person MNRL, proceed to b.
   b. Determine the ineligible parent(s) countable resources (allow SSI exclusions). If countable resources are less than or equal to the appropriate MNRL there are no resources to be deemed and the child is eligible. If countable resources exceed the appropriate MNRL, deem the excess (i.e., countable resources above $2,000 or 3,000) to the child, and proceed to c.
   c. Compare the child's countable resources, after deeming, to the one person MNRL. If countable resources exceed the one person MNRL, the child is ineligible. If

countable resources are less than or equal to the one person MNRL, the child is eligible.

O-700 Income Determination for Medically Needy Program

MS Manual 01/01/14

Income is the third consideration for Medically Needy applications. Categorical relatedness and resource eligibility should be reasonably established before income eligibility is considered.

Income is treated differently for the Exceptionally Needy (EC) and Spend Down (SD) groups; however, eligibility for both groups (EC and SD) is determined using the Medically Needy Income Levels below. All cases will first be considered for Exceptionally Needy and, if necessary, for Spend Down.

O-710 Medically Needy Income Levels

MS Manual 01/01/14

Size of Family Unit	Monthly Income	Quarterly Income	Annual Income
1	$108.33	$ 325.00	$ 1300
2	$ 216.66	$ 650.00	$ 2600
3	$ 275.00	$ 825.00	$ 3300
4	$ 333.33	$1000.00	$ 4000
5	$ 383.33	$1150.00	$ 4600
6	$ 441.66	$1325.00	$ 5300
7	$ 500.00	$1500.00	$ 6000
8	$ 558.33	$1675.00	$ 6700
9	$ 616.66	$1850.00	$ 7400
10	$ 675.00	$2025.00	$ 8100

Add $58.33 per month to the monthly income level or $175.00 per quarter to the quarterly income level for each additional member above family size 10.

O-720 Determination of Household Size Used for MN Income Consideration

MS Manual 01/27/16

Determination of Household Size Used for MN Income Consideration:

1. Household size for MN income determination is made as follows according to categorical consideration.

a. SSI cash assistance recipients and their income are excluded. They cannot be considered in a second eligibility determination.

b. AFDC and U-18 Related - Determination of household size for AFDC and U-18 related MN is made as follows. The income of non-SSI individuals may be considered in more than one MNIL.

1) The eligible child(ren) and the natural/adoptive parent(s) in the home will be included in the MNIL unit. A parent may choose to exclude a child and that child's income from a case budget if inclusion of that child and the child's income would cause ineligibility for the other children. Children may also be excluded for other reasons, and the parent who applies need not state the reason.

2) Step-parents may be included in the MNIL with their stepchildren as long as the step-parent's income does not cause ineligibility for the step-children.

3) If the step-parent is not included in the MNIL, the step-parent's income will be disregarded in the MNIL of his/her step-child. If the step-parent's spouse who is the natural/adoptive parent of the step-child requests assistance, the step-parent's income will be deemed, using form DCO-72, Deeming Worksheet, to the spouse.

EXAMPLE: A husband and wife have living in their home a child by his former marriage. Both the man and his child request assistance.
MNIL #1: To determine the child's eligibility use the 2 person MNIL to include the father and child and their income only. Disregard the wife's income.
MNIL #2: To determine the man's eligibility, use again the 2 person MNIL (father and child) with their income included. The income of the wife would be deemed, using form DCO-72, to the unit.

4) A step-child can be in the same MNIL with children of his/her step-parent.

5) In step-parent households when a natural/adoptive parent of the stepchild requests assistance and when the natural/adoptive parent and the step-parent have a child of their own, they all can be budgeted in the same case as long as the step-parent's income does not cause Medicaid ineligibility for the step-child(ren).

EXAMPLE: A husband and wife have a child, and the wife has a child by a former marriage. Assistance is requested for both children and the wife.
MNIL #1: Eligibility for their child in common will be determined in a 3 person MNIL, with all the income of the husband, wife, and their child considered. Only the child can be found eligible in U-18-MN, assuming that both parents are over

age 18.

MNIL #2: Eligibility for the stepchild will be determined in a 2 person MNIL that includes only the stepchild and the natural/adoptive parent. Their income will be considered in full. The stepparent's and half-sibling's income will be disregarded.

MNIL #3: Eligibility for the natural parent of the stepchild will be determined in an MNIL that includes only the natural parent and the stepchild, with their income considered along with the deemed, using form DCO-72, income of the step- parent. Disregard the half-sibling's income.

If there is a step-child who resides in an UP-MN household, the step-child would be set up in the case with his/her natural parent, step-parent and step-siblings. The UP-MN case will include the step-child, the step-child's natural parent, that parent's spouse, and their child(ren) in common. If the stepparent's income cause ineligibility for the step-child, the step-child can then be set up in a separate Medicaid case, other than UP-MN, with his/her natural parent included in the budget in closed status. The UP-MN case would be set up to include the step-child's natural parent, that parent's spouse, and their child(ren) in common but not the stepchild. There is no deeming of income in UP-MN determinations.

6) In minor parent households, deeming of the income of a grandparent not included in the assistance unit to a grandchild in the unit is prohibited. However, the grandparent's income will be deemed to the minor parent. Therefore, in minor parent situations where the grandmother is not included, there will be 2 MNIL's, and 2 Medicaid cases.

EXAMPLE: A grandmother applies for AFDC-MN for her minor daughter and the daughter's infant.

MNIL #1: For infant eligibility, the MNIL unit of 2 will include the minor parent and the infant, with only their income considered. Disregard the grandparent's income.

MNIL #2: For the minor parent's eligibility, include the minor parent and infant in a 2 person MNIL, with their income, plus the deemed income of the grandparent.

When the grandparent chooses to be included in the unit, the grandparent and the grandparent's full income will be included in the MNIL with the minor parent and infant and their income - one MNIL for 3 persons and one case.

If there are 2 grandparents in the home and one grandparent chooses to be included in the medical assistance unit, income of the excluded grandparent will be deemed to the MNIL that determines eligibility of the included grandparent/minor parent but will not be deemed to the MNIL that determines eligibility of the grandchild. In this situation, there will be 2 MNIL's and 2 Medicaid cases.

MNIL #1: For infant eligibility, the MNIL unit will include the grandparent, minor parent, and infant. Totally disregard the excluded grandparent's income, but include all other income.

MNIL #2: For grandparent and minor parent eligibility include the same 3 members as above, and their income. Also include the deemed income of the excluded grandparent.

The above rules will also apply to other relatives who care for a dependent child/ren, e.g., an aunt and uncle.

NOTE: In U-18-MN cases, a parent's income is always counted in full in his/her own child's case, i.e., there is no deeming of income from a parent to a minor parent in U-18-MN eligibility determinations. However the parent's income will be disregarded in the eligibility determination of the minor parent's child.
For certification instructions when there are multiple cases in one household, refer to MS O-810.

c. SSI Related (AABD) - The size of family unit for SSI related cases is as follows:

- One person unit: The one person or individual income level is used for AABD individuals not living with a spouse, or with a child who is blind or has a disability.
- Two person unit: The two person level is used for AABD couples and for individual AABD determinations when there is an ineligible spouse. If the ineligible spouse is an SSI recipient, that spouse's income is excluded from deeming. (Re. MS O-535)

O-730 Income Eligibility Determination for Exceptional Medically Needy

MS Manual 01/01/14

Income eligibility determinations for the Exceptional Medically Needy will be completed as follows:

O-730 Income Eligibility Determination for Exceptional Medically Needy

Determine the monthly income level applicable to the case according to the Medically Needy Income Levels from MS O-710.

Determine the net monthly income to be considered as follows:

1. For AABD-MN, determine net monthly income according to AABD policy (allow SSI exclusions in MS E-450 and E-451) as follows:
   a. From the unearned income of an individual or the combined unearned income of an eligible couple, deduct $20/month (general SSI exclusion). Do not allow the exclusion from income based on need (e.g. V.A. pension).
   b. Where there is no unearned income for the case or unearned income is less than $20/month, deduct the $20 exclusion or remainder thereof from gross earned income of the case before deducting the SSI earned income exclusion.
   c. From the earned income of an individual or the combined earned income of an eligible couple, deduct $65/month plus 1/2 of the remainder (SSI exclusion).
   d. Total remaining unearned and earned income to arrive at net income.
   e. If the net income is less than the SSI payment level, the individual or couple cannot be considered for Medically Needy, and referral will be made to SSI (Re. MS O-141 for exceptions). If the net income equals or exceeds the SSI payment level, a Spend Down eligibility determination will be made.
2. For AFDC-MN, UP-MN, PW-MN, and U-18-MN, determine net monthly income according to AFDC policy (see exceptions in MS O-420) as follows:
   a. Determine the unearned income for the case.
   b. From earned income, deduct $90 and child care expense.
   c. Total unearned and remaining earned income to arrive at net income.
   d. If the determined net income is less than the monthly Medically Needy Income Level at this point, the individual or family is eligible as Exceptionally Medically Needy and no further computation is necessary. If the net income exceeds the monthly Medically Needy Income Level, it will be necessary to make a Spend Down eligibility determination.

O-731 Establish Duration of Eligibility - Exceptional Medically Needy Cases

MS Manual 01/01/14

With date specific eligibility, eligibility for Exceptional Medically Needy cases begins on the day of application (current) and/or as far back as three months prior to the date of application (retroactive), provided eligibility requirements are met and there are incurred medical expenses for each month of the retroactive period of certification.

EXAMPLE: If application is made on May 3rd, eligibility may be given retroactively to February 3rd, if there are incurred medical expenses in each of the three months and if income/resources requirements are met in each of the months. A shorter retroactive period could be given if the only medical bill in the retroactive period was incurred on April 16th. In that case, eligibility would begin on April 16th.

Eligibility for the Exceptional Medically Needy continues until terminated by the County Office. Termination may occur at the time of reevaluation or at any other time that changes affect eligibility.

The end date of eligibility will be the last day of the 10 day advance notice period, unless a recipient requests a hearing within the advance notice period.

The recipient is required to report all changes within 10 days so that the County Office can initiate necessary case actions.

O-740 Income Determination for Spend Down

MS Manual 01/01/14

Income eligibility for Spend Down cases is determined on a quarterly basis. Use actual quarterly income when available. When actual quarterly income is not available, project income for the quarter as follows:

1. Determine average income per pay period (divide actual total income by actual total pay periods). When available use 8 pay stubs if paid weekly, 4 pay stubs if paid bi-weekly or twice a month, or 2 pay stubs if paid monthly.
2. Determine projected income for the remaining month(s) or portion thereof- (multiply average income per pay period by projected number of remaining pay periods).
3. Determine monthly income (total actual and/or projected income for each month).

Net monthly income, determined according to MS O-730, will be totaled to arrive at quarterly income. The amount of net quarterly income available to the individual/family is measured against the appropriate Medically Needy Income Level (MNIL) (MS O-710) to determine "excess income."

When eligibility cannot be determined for a full quarter (Re. MS O-165), the determination will be made for the balance of the retroactive period (i.e., one or two months). Net income for the shortened period as determined in MS 0-730 will be measured against the appropriate MNIL (MS O-710) to determine excess income.

O-741 Eligibility Based on Incurred Medical Expenses (Spend Down)

MS Manual 01/01/14

The eligibility determination based on incurred medical expenses is a two-step process:

1. Incurred medical expenses (i.e., those which were incurred at the time of application) which cannot be covered by Medicaid are deducted from excess income, first. When these expenses obligate all excess income, the individual is eligible beginning the first day of the Spend Down quarter being considered. When these expenses do not obligate all excess income, proceed to item #2. A list of these non-covered expenses is specified in MS O-742.
2. When excess income remains following deduction of incurred non-covered expenses, a chronological listing (by date of service) of coverable medical expenses must be prepared to determine Spend Down eligibility. Daily totals of these expenses will be deducted from remaining excess income. When remaining excess income is exceeded by a daily total, the Spend Down date (i.e., beginning date of eligibility) is established. The last excess income that was exceeded by the daily total on the Spend Down date is the applicant's "unmet liability". When excess income remains after deducting all coverable medical expenses, the application will be denied.

NOTE: When the applicant has incurred medical expenses which have been paid or will be paid within a reasonable period of time by a third party resource (i.e., insurance, etc.) refer to MS O-750.

O-742 Incurred Medical Expenses Not Coverable Under Medically Needy Program

MS Manual 01/01/14

Incurred medical expenses which are not coverable under the Medically Needy Program will be deducted in the following order. These expenses may include the expenses of an ineligible individual whose needs cannot be included in the MNIL, but whose expenses are the liability of the eligible individual (e.g. the expenses of a deceased spouse).

1. The cost of Health Insurance premiums, including the Part B Medicare premium, for the Spend Down period for all individuals whose needs are included in the MNIL.

2. The cost of any required copayments and/or deductibles for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. Only the cost of required copayments or deductibles on Medicare Part B (non-assigned) claims for the Spend Down period can be deducted for the eligible individual(s) (See Note B).

3. The cost of remaining incurred medical expenses for the Spend Down period for all ineligible individuals whose needs are included in the MNIL. This includes the expenses of an ineligible spouse (AABD related) and the expenses of the ineligible parent(s) (U-18 related) (See Note B).

4. The cost of any uncovered incurred medical expenses for the Spend Down period for the eligible individual(s).

5. The cost of any medical expenses which were incurred during the month of application and the three (3) preceding retro months for all individuals whose needs are included in the MNIL.

   Expenses incurred during the month of application and the three (3) preceding retro months must be deducted from excess income unless they have been paid by or are subject to payment by a legally liable third party, such as a health insurance plan. If the expenses have already been paid by the individual, family or legally responsible relative, the deduction will be allowed. This is true regardless of whether the expenses were incurred during the spend down period. Expenses incurred before the spend down period, but within the retro period, paid or unpaid, will be deducted as non-covered expenses. Any expenses incurred before the retro period, that have been paid cannot be deducted.

6. The cost of any unpaid medical expenses which were incurred outside the Spend Down period for all individuals whose needs are included in the MNIL.

   Proof of current liability (at the beginning of the Spend Down period) must be provided by the applicant for expenses incurred outside the period or the expenses cannot be used in Spend Down. When the applicant has made arrangements to repay any medical expenses, only the payments due in the Spend Down period can be deducted as non-covered, unless the bill was incurred during the Spend Down period. In that case, the bill may be used in the chronological Spend Down, rather than using the monthly payment amount to be made under the contract. Expenses sold or turned over to collection agencies may be deducted if they are verified to be from a medical source.

   When there is no formal agreement to pay non-coverable medical expenses, but regular payments are being made, only those payments made during the Spend Down quarter may be deducted as non-coverable. If payments are being made irregularly or only occasionally, then the entire expense may be deducted as non-coverable.

NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future Spend Down determinations, with the following exception. When only a portion of an incurred medical expense is used to achieve eligibility, the unused balance is available for use in the future Spend Down determinations if the applicant can prove continued liability.

NOTE B: In households with multiple cases, the medical expenses of an individual may be used in the Spend Down of each case in which he/she is included in the budget, whether the individual is eligible or not in the case. In households where a parent and child are eligibles in separate cases, the medical expenses of the parent and child will be considered as covered expenses in each other's Spend Down determination. If an application is made for the child only, and the parent does not qualify for Medicaid, the parent's expenses will be considered as non-covered in the child's Spend Down determination.

O-743 Incurred Medical Expenses Included in Chronological Spend Down

MS Manual 01/01/14

When excess income is not eliminated after deduction of non-covered incurred expenses, it will be necessary to conduct a daily Spend Down (i.e., eliminate remaining excess income through

chronological deduction of incurred expenses coverable in the Spend Down quarter). These expenses would be comprised of all services incurred during the Spend Down quarter for individuals potentially eligible for Medically Needy services and apparently coverable under the program (includes the cost of Medicare copayments and/or deductibles) on assigned claims and the cost of any prescribed drug(s) covered by the Medicaid program (name brand drugs must be certified by the physician as medically necessary if lower cost generic equivalent drugs are available).

For maternity expenses, any payments will be deducted on the date of such payments and the balance will be deducted on the date of delivery (if applicable).

NOTE A: Incurred medical expenses used to achieve eligibility cannot be used in future Spend Down Determinations, except as noted in MS O-742 #5.

NOTE B: Medical expenses paid by a credit card or loan within the spend down period and the client is still liable for the loan may be used in the chronological spend down to reduce excess income. Medical expenses incurred before the spend down period that were paid by a credit card or loan can be used as a non-coverable expense.

O-750 Treatment of Third Party Resources

MS Manual 01/01/14

A third party resource is insurance or some other form of entitlement which helps defray the cost of medical services. Third party resources recognized by the Medicaid program include Medicare, private health insurance, public and private liability insurance, workman's compensation, veteran's insurance, CHAMPUS, etc. Third party resources make specific payment for medical services and/or are assignable to a medical provider. Insurance which makes nonspecific payments (i.e., pay whether or not medical services are rendered) and is non-assignable to a medical provider (i.e., pays to the individual only) is not considered a third party resource. Payments from this type of insurance are considered as unearned income. However, insurance which makes nonspecific payments and is assignable will be considered a third party resource (Re. MS O-753).

Payments which are received from third party resources within a reasonable period of time will be applied to the cost of incurred medical expenses to determine the liability of the individual. Any portion of incurred medical expenses paid by third party resources is not the liability of the individual and cannot be deducted from excess income. Any portion of incurred medical

expenses not paid by third party resources is the liability of the individual and can be deducted from excess income.

Statements which are received from third party resources within a reasonable period of time can be used to determine the liability of the individual if they indicate either the amount of payment to be made or that no payment is to be made. When statements indicate the amount of payment to be made, the indicated amount of payment will be applied to the cost of incurred medical expenses to determine the liability of the individual (i.e., it will be treated as if it were an actual payment). When statements indicate that no payment is to be made, the total amount of incurred medical expenses is the liability of the individual and can be deducted from excess income.

When a third party resource has not made payment, does not indicate the amount of payment to be made, or indicates that no payment is to be made within a reasonable period of time, the actual liability of the individual cannot be determined and the incurred medical expenses cannot be deducted from excess income.

NOTE: For administrative ease, the time limit imposed for the disposition of the applicable Medically Needy application (45 or 90 days) will be considered to be "a reasonable period of time" to obtain verification of medical expenses paid by a third party.

The most common third party resources are Medicare and private health insurance. To facilitate an accurate determination of an individual's liability, these resources should be treated as follows:

O-751 Medicare Coverage Types

MS Manual 01/01/14

Medicare consists of two types of coverage:

1. Part A - Hospital Insurance - coverage is provided for inpatient hospital care, post hospital extended care and post hospital home health care and skilled nursing care. Part A pays Medicare per diem rate, less any unmet deductible(s) and/or coinsurance.

   Under Part A - Medicare pays direct to the hospital/supplier. The hospital/supplier agrees to accept the Medicare per diem rate. The actual liability of the individual is limited to the following, where applicable:

- Inpatient Deductible, and/or
- Blood Deductible, and/or
- Coinsurance.

NOTE: Medicare provides an unlimited number of hospital days after the annual Part A deductible.

2. Part B, Medical Insurance - coverage is provided for physician services, supplies, home health care, outpatient hospital services, therapy and other services. Part B pays 80 per cent of the Medicare amount approved, less any unmet deductible.

   Non-assignment - Under the non-assignment method, Medicare pays 80 per cent of their amount approved, less any unmet deductible, direct to the individual. The actual liability of the individual, (i.e., the difference between the amount billed by the physician/supplier and the amount paid by Medicare), is limited to the following, where applicable:

   - Difference between amount billed and amount approved, plus
   - Deductible, and/or
   - 20 per cent coinsurance.

   Assignment - Under the assignment method, Medicare pays 80 percent of their amount approved, less any unmet deductible, direct to the physician/supplier. The physician/supplier agrees to accept the amount approved by Medicare, (i.e., he discounts the difference between the amount billed and the amount approved by Medicare). The actual liability of the individual is limited to the following, where applicable:

   - Deductible, and/or
   - 20 per cent coinsurance.

NOTE: Some services are not covered under Part B. Where Medicare disallows a charge in its entirety (e.g. $10.00 billed, $0.00 allowed), the individual is liable for the full charge regardless of assignment.

O-752 Private Health Insurance

MS Manual 01/01/14

Private Health Insurance, like Medicare, consists of two types of coverage, Hospital and Medical.

For hospital care, private insurance makes reimbursement by means of per diem payments, percent of charge payments or a combination of the two.

Under the per diem method, the insurance will apply a fixed amount for each day of hospitalization, regardless of the total charges for the hospitalization.

EXAMPLE: A child is hospitalized for 4 days; daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. The child's parents have insurance which pays a $600 per diem less any unmet deductible. The insurance payment and client's liability are determined, as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$600	=	$600
7/2	$1100	-	$600	=	$500
7/3	$900	-	$600	=	$300
7/4	$650	-	$600	=	$50
Total 4	$3850		$2400		$1450 (Plus any unmet deductible)

Under the percent of charge method, the insurance will specify a fixed percent to be applied to the total charges for the hospitalization.

EXAMPLE: Mr. Doe is hospitalized for 4 days, daily charges are $1200, $1100, $900 and $650 for days 1-4, respectively. Mr. Doe has insurance which pays 80 percent of total charges, less any unmet deductible. The insurance payment and Mr. Doe's liability are determined as follows:

Days	Charges	-	Per Diem Payment	=	Liability
7/1	$1200	-	$960	=	$240
7/2	$1100	-	$880	=	$220
7/3	$900	-	$720	=	$180
7/4	$650	-	$520	=	$130
Total 4	$3850		$3080		$770 (Plus any unmet deductible)

The following is an example of a combination of the per diem and percent of charge methods:

EXAMPLE: Mr. Doe is hospitalized for 4 days; daily charges, less room charge, are $1325, $1000, $900 and $700 for days 1-4, respectively; the room charge is $250 a day. Mr. Doe has insurance which pays 80 per cent of total charge, less room charge, less any unmet deductible. The insurance also pays a $200 per diem on room charge. The insurance payment and Mr. Doe's liability are determined as follows:

	Unit Charges		-	Unit Payments		=	Unit Liability	
Days	**Room**	**Other**	**-**	**Room**	**Other**	**=**	**Room**	**Other**
7/1	$250	$1325	-	$200	$1060	=	$50	$265
7/2	$250	$1000	-	$200	$800	=	$50	$200
7/3	$250	$900	-	$200	$720	=	$50	$180
7/4	$250	$700	-	$200	$560	=	$50	$140
Unit Total 4	$1000	$3925		$800	$3140		$200	$785 (Plus any unmet Deductible)
Grand Total 4		$4925			$3940			$985 (Plus any unmet Deductible)

Some private insurance (e.g., Medipak, which only covers the deductible and coinsurance charges that Medicare does not pay) provides limited coverage only.

Although private insurance offers an infinite variety of coverage plans, most companies make payment using one of the methods described or a similar method.

Nonmedical charges (e.g., charge for telephone, television, etc. while hospitalized) cannot be deducted from excess income even though the charges are a liability of the individual.

O-753 Nonspecific Assignable Payments

MS Manual 01/01/14

When a third party resource makes or indicates that it will make a nonspecific assignable payment (method of calculating payment is not known), the payment will be applied in the following manner.

Divide the nonspecific payment by total charges to determine the percent of payment. For cases in which the charges are not itemized (i.e. only a total summary of charges is available), it will be necessary to divide the charges by the dates of service to determine an average daily charge. Apply the percent of payment to each daily charge to determine the amount of charge covered by the payment. The balance of each daily charge (if any) is the liability of the individual.

O-800 County Office Certification

MS Manual 01/01/14

0-810 County Office Certification Responsibility

MS Manual 01/01/14

When all factors of Medically Needy eligibility have been established, the case will be certified in ANSWER.

With date specific eligibility, the beginning date of medical eligibility for Exceptional Medically Needy cases (EC) will be the day of application unless retroactive eligibility is authorized. Retroactive eligibility may be authorized as far back as three months prior to the date of application, provided the individual or family meets the eligibility requirements for the retroactive period, and medical expenses were incurred during the period. Eligibility may be authorized for any one or all of the months during the retroactive period. Each period of retroactive eligibility must be keyed in ANSWER. Refer to ANSWER Desk Guide.

No termination date will be entered for Exceptional Medically Needy cases. Eligibility will continue until closure is authorized by the caseworker. With date specific eligibility, an end date can be entered to terminate coverage on any day of a month, after appropriate 10 day advance notice. For example, if a county is informed of an income increase on 10/13/2012 which makes an individual ineligible, the case may be closed effective 10/23/2012 after advance notice.

Both the beginning and end dates of eligibility are shown for Medically Needy Spend Down cases. The beginning date listed in ANSWER will always be the day of Spend Down. The ending date for Spend Down cases listed in ANSWER is the last day of the third month of the Spend Down quarter used. Once the entitlement period has been established and the certifying document has been submitted, no additional medical expenses can be considered for the entitlement period. The “unmet liability” amount will be rounded to the next lower dollar and entered in ANSWER. Date Specific Eligibility will not change the consideration of the Begin and End dates for the Spend Down certification period.

The begin and end dates will also be shown for fixed eligibility cases. If certifying for fixed eligibility, the begin and end dates may be any day of a month. For example, an individual who applies 5/15/2012 needs coverage for April and May, and is income/resource eligible for those months. Bills were incurred April 18th, and May 5th through 10th. The fixed eligibility period for this individual will begin April 18th and end May 10th.

In AFDC-MN and U-18 households that require separation of the eligible members into different cases (Re. MS O-710) each eligible member will be entered in open status in his/her case, and the other eligible members of the unit will be entered in closed status.

When an eligible member is entered in closed status in another eligible's case, the member's status will be "active" in the budget of the eligible's case to show that the income of the closed member is included in the budget.

EXAMPLE: In a stepparent household where a man, his wife, and her child live, if there are separate cases for the child and his/her natural/adoptive parent, with an open and closed member in each case, "active" will be entered for the natural/adoptive parent that is in closed status to show that the income of the closed member (the natural/adoptive parent) in this case is included in the budget.

In UP-MN cases, the principal wage earner will be added to the child's parent tab with the deprivation reason "unemployed".

When only one member of an AABD couple has expenses on the date of Spend Down, enter the unmet liability amount in ANSWER of that member. Where both members of an AABD couple had expenses on the date of Spend Down, prorate the unmet liability amount to each member on the basis of their percent of expenses on the date of Spend Down. For example, an AABD couple has $200 in unmet liability and $250 in expenses (i.e. $150 - Member A and $100 - Member B) on the date of Spend Down. The amount of unmet liability to be entered in ANSWER of each member is determined as follows:

1. Divide the expenses of each member by total expenses.

   Member A - $150 divided by 250 = 60%

   Member B - $100 divided by 250 = 40%

2. Multiply the unmet liability amount by each member's percent of expenses.

   Member A - $200 x 60% = $120

   Member B - $200 x 40% = $80

In AFDC or U-18 related cases when more than one member had medical expenses on the date of Spend Down, the total unmet liability will be prorated for each member and each individual's prorated unmet liability will be shown in the member segment in ANSWER.

EXAMPLE A: In an AFDC-SD case containing 3 members, medical expenses were incurred on the date of Spend Down by only one member and totaled $300.00. The unmet

liability on the date of Spend Down was $100.00 The total unmet liability should be entered in ANSWER for the member who had medical expenses on the date of Spend Down.

EXAMPLE B: In a U-18-SD case, three members had medical bills on the date of Spend Down. Child 201 incurred $150.00 on the date of Spend Down, child 202 incurred $75.00, and child 203 incurred $275.00. The total unmet liability was $100.00 on the date of Spend Down. To determine each member's unmet liability:

For each case:

1. Divide the expenses of each member by the total expenses.

   Member 201-$150 divided by $500 = 30%

   Member 202-$75 divided by $500 = 15%

   Member 203-$275 divided by $500 = 55%

2. Multiply the total unmet liability by each member's percent of the expenses.

   Member 201-$100 x 30% = $30.00

   Member 202-$100 x 15% = 15.00

Member 203-$100 x 55% = 55.00

O-900 Medically Needy Case Controls

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All applications for Medically Needy will be registered in ANSWER. Dispositions of applications will also be noted, as well as the date of disposition.

The DCO/OFO Web Reports (Mainframe Reports) will provide a monthly statistical application report to each County Office for reconciliation of pending and disposed applications on the register as well as overdue applications.

O-910 Time Schedule for Reevaluation of Eligibility for Exceptional Medically Needy Cases

MS Manual 10/06/16

Reevaluation of Exceptional Medically Needy cases will be completed twelve months from the month of certification or the last completed reevaluation. To insure that reevaluations are completed by the end of the twelfth month, they will be scheduled for the eleventh month.

For an AABD-EC reevaluation, the caseworker will mail a DCO-95 and the other forms required to the recipient specifying exactly what is needed (e.g., completed application, check stubs, collateral statement, etc.) and a date by which the forms and verification should be returned. The county offices and processing units will use the reevaluation lists that are on Share in the area folders to determine when a reevaluation is due for AABD-EC categories.

The County Office is responsible for completing the reevaluation and making any necessary changes in ANSWER at the time the reevaluation is completed.

At the time of reevaluation, the factors verified will vary according to the categorical relatedness of the case. Particular attention will be given to verification of items subject to frequent change such as income.

The caseworker will:

1. For AABD-EC cases, review the statements on the DCO-95.
2. Recompute income eligibility.
3. If additional information/verification is needed to establish continuing eligibility, the recipient will be given a DCO-700, Notice of Action, which will list the information that needs to be returned and the date it should be returned.

If the recipient fails to provide any information necessary to redetermine continued eligibility as requested, the caseworker will close the case at the end of the specified time. If the recipient requests additional time to provide the information, the caseworker will send a second DCO-700 that clearly states what information is needed by the end of the extended time period. "Failure to provide" by the end of the extended period will result in case closure.

O-920 Medically Needy Case Actions - Exceptional and Spend Down

MS Manual 01/01/14

Changes in Exceptional Medically Needy Cases may be made in ANSWER prior to reevaluation or between scheduled reevaluations. Changes in Spend Down cases can only be effected if they are completed before the expiration of the Spend Down entitlement period. Such changes can include the dropping or adding of a family member (for example, a newborn child) or a change in address.

O-930 Change Notification to Medically Needy Recipient by County Office

MS Manual 01/01/14

The ten day advance notice requirement applies to all categories of Medically Needy and is given in all instances of adverse action with the following exceptions.

Advance notice is not required when:

1. The agency has factual information confirming the death of the recipient.
2. The agency receives a written statement signed by a recipient that he or she no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and the recipient has indicated that he understands the consequences of supplying such information.
3. The recipient has been admitted or committed to an institution thereby making him ineligible except when special conditions are met. (Re. MS J-130).
4. The recipient's location is unknown and agency mail directed to him has been returned by the Post Office indicating no known forwarding address. The recipient's Medicaid card must be made available to him if his whereabouts becomes known during the eligibility period covered by the returned ID card.
5. A recipient has been accepted for assistance in a new jurisdiction (another state) and that fact has been established by the jurisdiction that previously granted assistance.

6. A child is removed from the home as a result of a judicial determination or voluntarily placed in foster care by his legal guardian.

The caseworker will notify the recipient by sending form DCO-700 or system generated notice regarding ineligibility of a member and/or closure of the Medically Needy case.

O-940 Medically Needy Case Closures

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The system will automatically affect closure of current open Spend Down cases and all cases which are converted to SSI eligibility. The County Office will affect all other closures by input into ANSWER.

With the exception of closed past Spend Down and Fixed Eligibility Certifications, the ten day advance notice applies to all categories. Recipient notifications will be made on form DCO-700 or system generated notice.

The reason for closure will be made in the narrative of each closed case and a copy of the Notice of Action will be filed electronically in the case file.

Eligibility for Medicaid ceases at the end of the 10 day advance notice period. Under date specific eligibility, eligibility may be terminated on any day of a month for Exceptional Medically Needy cases and for Spend Down cases.

O-950 Medically Needy Case Record

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The Medically Needy electronic case record will contain the following items required for proof that all conditions of eligibility are met.

1. Documentation of the eligibility factors that correspond with the Medically Needy category to which the case is related. (Refer to the section regarding categorical relatedness).
2. All medical bills/statements/receipts (and/or photo copies) used in determining Spend Down eligibility. Each bill must be:
    - Itemized by the date of medical services
    - Identified with the individual/family name(s)

Medical Services – Glossary

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Absent Parent –

A child's parent who does not live in the same home as the child.

Activities of Daily Living (ADL) –

Personal tasks that are ordinarily performed on a daily basis and include eating, mobility/transfer, dressing, bathing, toileting, and grooming.

Adequate Notice –

A notice mailed to the applicant/recipient no later than the date action is taken upon the case.

Advance Notice –

A notice of adverse action mailed to the applicant/recipient 10 days prior to taking the action and giving the applicant/recipient an opportunity to rebut the decision or to appeal the proposed action.

Adverse Action –

An agency action which results in a denial, reduction or termination of benefits.

Affidavit for Collection of Small Estates –

Allow the distributees of an estate that does not exceed $100,000 to receive the estate without the appointment of a personal representative or administration of the estate.

Alien –

An individual who is not a U.S. citizen or U.S. national.

Alien Sponsor –

An individual or organization that agreed to provide certain support to an alien as a condition of the alien's entry into the United States as a permanent resident.

Appeal –

A request for a fair hearing concerning a proposed agency action, a completed agency action or failure of the agency to make a timely determination.

A legal proceeding in which the applicant/recipient and the agency representative present the case being appealed before a hearing officer.

Applicant –

An individual who is requesting assistance from the agency.

Application –

A request for benefits made to the agency. An application may be received by mail, phone, fax, in person or electronically.

An application must include at a minimum the applicant's:

- name
- address (or other means of contacting the applicant if homeless); and
- signature.

Application Date –

The date a signed application is received by the agency either by phone, mail, fax, in person or electronically.

Authorized Representative –

One or more individuals designated by an applicant/recipient to act on his/her behalf with respect to a specific Medicaid application or renewal.

Beginning of a Period of Institutionalization –

The date of entry into a medical or nursing facility.

Buy-In Program –

A Medicaid program that pays Medicare Part A and Part B premiums for selected groups of Medicaid recipients.

Categorically Needy –

Individuals who fall into a specific category (or criteria) of mandatory Medicaid eligibility established by the federal government.

Co-pay –

A small fixed amount required by a health insurer to be paid by the insured for each outpatient visit or drug prescription.

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Coinsurance –

A set percentage of covered medical costs after the deductible has been paid.

Community Spouse (CS) –

The legal spouse of the Institutionalized Spouse (IS) who is not institutionalized.

Community Spouse Maximum Resources (CSMR) –

The total amount of resources which may be considered available to the CS; this amount includes resources held solely by the CS (in which the IS has no ownership interest) and the Community Spouse Resource Allowance. Compute on the DCO-713.

Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) –

The total income that the CS needs for his/her support. This amount may not exceed the limit shown on the DCO-712.

Community Spouse Monthly Income Allowance (CSMIA) –

The maximum amount that an IS may contribute toward the support of the CS. Compute on the DCO-712.

Community Spouse Resource Allowance (CSRA) –

The maximum amount of the IS's resources which may be transferred to the CS or to another for the sole benefits of the CS. Compute on the DCO-713.

Comprehensive Plan of Care –

The client has met functional/medical criteria as well as financial criteria for eligibility. The Plan of Care represents billable services. The comprehensive plan of care is good for a year and the Waiver eligibility date and the comprehensive plan of care expiration date are on the plan of care.

Conditionally Eligible –

An individual can be enrolled (entitled) for Part A Medicare only on the condition that he/she is eligible for QMB, and thus eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits.

Continuous Period of Institutionalization –

A period of residence in a medical institution and/or nursing facility of at least 30 consecutive days. Therapeutic visits during this period will be allowed.

Cost Effective (Estate Recovery) –

When the amount which can be recovered from an estate is greater than the cost of recovery.

Covered Service –

Service which is within the scope of the Arkansas Medicaid Program.

Current Market Value –

The amount for which property can be expected to sell on the open market.

Deductible –

The amount the individual must pay toward covered benefits before Medicare, Medicaid or insurance payment can be made for additional benefits.

Deeming –

When a portion of the ineligible spouse or ineligible parent(s) income is given to the eligible spouse or eligible child(ren) and all are residing in the same household.

Dependent Family Member (AABD related)–

Includes minor (under age 18) or dependent (age 18 or over) children, dependent parents, or dependent siblings (including half-brothers and half-sisters) of the IS or CS who live in the home of the CS. To qualify as a dependent, an individual must be claimed on the income tax return of the IS or CS as a dependent, which must be verified by viewing the tax return.

Deprivation –

When a child is not receiving parental support or care by reason of unemployment, death, continued absence from the home or physical or mental incapacity of a parent.

Distributee –

A person entitled to real or personal property of a decedent, either by will, as an heir, or as a surviving spouse.

Eating –

The intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition.

Eligible Child –

An unmarried, eligible individual who is not the head of household and who has met the age requirement for a specific Medicaid program.

Eligible Spouse –

A married individual who is eligible and receiving Medicaid and is living in the household with his/her spouse.

Emancipated Minor –

An individual under the age of 18 who has been given the right to manage his/her own affairs either by a court of law or by voluntary or implied agreement between parent(s) and child.

Entitled to Medicare –

An individual has applied for, is eligible for, and is enrolled in Medicare Part A.

Equity –

The current market value of a resource less any encumbrances such as liens, mortgages, etc.

Estate –

The term “estate” under Arkansas law, with respect to a deceased individual, means all real and personal property owned by the individual at his or her death.

Extensive Assistance –

The individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

Facilities which Provide Services –

Facilities which provide medically necessary care and services 24 hours per day on a long term basis include private nursing facilities, Benton Services Center, Arkansas Human Development Centers, private intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and ICF/IID facilities with both over and under 15 beds.

Fair Market Value –

The amount that a buyer is willing to pay for property and that the seller is willing to accept.

Family Member Allowance –

The amount of income an institutionalized spouse (IS) can give to a dependent family member when there is also a community spouse (CS) of the IS in the home. Compute on DCO-712.

Fraud –

The willful intent to obtain benefits or payments that an individual is ineligible to receive.

Home and Community Based Services Waiver –

Services provided by certain Medicaid eligibility groups to individuals living in the community rather than in a Nursing Facility.

Incapacitation –

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, the individual is lacking sufficient understanding or capacity to make or communicate decisions to meet the essential requirements for his or her health or safety or to manage his or her estate.

Ineligible Child -

An ineligible child, for deeming purposes, is a natural or adopted child of an eligible individual or the eligible individual's spouse; or a natural or adopted child of an ineligible parent or the ineligible parent's spouse who lives in the same household with the eligible individual, and is:

- not married;
- under age 18; or

- under age 22 and a student regularly attending school, college, or training designed to prepare him/her for a paying job. Home schooling is considered a form of regular school attendance.

Ineligible Spouse –

A married individual who is not eligible for Medicaid and is living in the household with his/her Medicaid eligible spouse.

Initial Resource Assessment –

An evaluation of resources and computation of the spousal share of resources at the beginning of the first continuous period of institutionalization (this does not apply if entry into the nursing facility was prior to 09/30/89). Compute on the DCO-710.

In-Kind Income –

Third party payments which do not result in an individual's direct receipt of a basic need (food, clothing or shelter), but provides an in-kind item that an individual can apply to meet his/her basic needs by sale or conversion.

In-Kind Support and Maintenance –

Third party payments that result directly to an individual's fulfillment of a basic need such as food, clothing and/or shelter.

Inquiry –

A request for information.

Institutionalized Spouse (IS) –

An individual who is an inpatient in a medical institution or nursing facility, who remains (or is likely to remain) in the institution or facility for 30 consecutive days, and who is legally married to a spouse who is not in a medical institution or nursing facility. The marriage must be verified and documented.

Intellectual Disability –

A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

Intent to Return Home –

An individual's statement that he or she will return to their home when he or she is medically able.

Interlocutory Decree –

A court judgment which is temporary and not intended to be final until either:

- other matters come before the judge, or
- there is a specified passage of time to determine if the interlocutory decree (judgment) is working (becomes accepted by both parties) and should become final.

Licensing and Classification of Facilities –

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

Licensed Medical Professional –

A licensed dentist, nurse, physician, physical therapist, or occupational therapist.

Likely to Remain –

With medical documentation (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 eligibility 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 (nor on the county by Quality Assurance) 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.

Limited Assistance –

The individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

Living Arrangements –

Living in Own Household - Consider an individual or couple to be living in own household if they pay all household expenses (i.e., have ownership interest, renting, etc.) or if living in household of another, they pay an equal share per member of total household expenses.

Living in Household of Another – Consider an individual or couple to be living in household of another if they pay less than an equal share per member of total household expenses.

Living in Institution/Facility – Consider an individual or couple living in Institution/Facility if they are in an Institution/Facility that is eligible to receive Title XIX reimbursement.

Members Resume Living Together – If spouses who previously lived together as a married couple resume living together, review the facts of the case to make a new marital relationship determination, if necessary.

Locomotion –

The act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

Lump Sum –

A one-time cash payment.

Marital Status –

Consider a couple to be married if they are:

- Legally married under State law, or
- Either determined to be the spouse of a Title II (Social Security) recipient or
- Living together and holding out to the community in which they live as a married couple (this does not apply to LTSS cases).

Medical Institution (LTSS) –

An institution (hospital) where care equivalent to that in a nursing facility is provided. Days in a medical institution may be considered a part of the continuous period of institutionalization when an individual enters a nursing facility directly from the medical institution.

If confined to a medical institution only, consider Medically Needy coverage. The spousal rules will not apply.

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Medical Necessity –

When a medical service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service.

Medically Needy –

Individuals whose income and resources exceed the levels for assistance established under a State or Federal plan for the categorically needy, but are insufficient to meet the cost of health and medical services.

Non-Covered Services –

Services not medically necessary, services provide for the personal convenience of the patient or services not covered under the Medicaid Program.

Non-Qualified Alien –

An alien who is not lawfully admitted and not lawfully given the privilege of residing permanently in the United States (U.S.) or one who is lawfully admitted to the United States but who has not resided in the U.S. for 5 years or one who is not exempted from the 5 year requirement.

Notice of Estate Recovery –

An initial notice of intent to recover from the estate of individuals who received Medicaid services in an institution or a waiver program will be given at the time of application for services.

A second notice, DHS-20 - Notice of Estate Recovery, will be sent to the personal representative of the deceased's estate or to a distributee of the estate who has signed an "Affidavit for Collection of Small Estates". The notice will inform the individual of the intent to recover, of the hardship and cost effectiveness provisions, and of appeal rights. The notice will be mailed by the Third Party Liability Unit (TPL).

Nursing Facility –

A facility that provides intermediate or skilled nursing care and ICF/IID facilities.

Patient Liability –

The amount a recipient residing in a facility is responsible for paying the provider for services.

Permanently Institutionalized –

When a medical determination is made which indicates there is no reasonable expectation that the individual is likely to return home.

The date on which an individual was determined to be permanently institutionalized is irrelevant. If services were provided prior to the time a decision was made regarding permanent institutionalization, recovery will include assistance provided prior to the decision.

Personal Needs Allowance –

An amount allowed the Nursing Facility recipient to cover the cost of personal items not covered by the facility fee.

Personal Representative –

The executor of a will or administrator of an estate who has been appointed to the position by a probate court.

Plan of Care (POC) –

A document utilized by a provider to plan, direct or deliver care to a patient to meet specific measurable goals.

Protected Maintenance Allowance –

An amount given by the institutionalized spouse (IS) to the dependent child(ren) living in the home when the IS does not have a community spouse (CS).

Provider –

A person, organization or institution enrolled to provide and be reimbursed for health or medical care services authorized under State Title XIX Medicaid Program.

Provisional Plan of Care –

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 begin. The provisional

plan of care is ONLY good for 60 days. If it expires, the assessment must be redone to re-determine need and/or establish eligibility date for ALF.

Qualified Alien –

An alien lawfully admitted and lawfully given the privilege of residing permanently in the United States.

Recipient –

Someone enrolled in Medicaid who actually received a health service for which Medicaid reimbursed the provider.

Renewal –

A periodic review of an approved Medicaid case to determine continued eligibility.

Serious Mental Illness or Disorder –

Schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder.

Skilled Level of Care –

Services required on a 24 hour a day basis, delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice, and in terms of duration and amount.

Spend Down (SD) –

The amount of money a beneficiary must pay towards medical expenses when income exceeds the Medicaid financial guidelines. A component of the medically needed program allows an individual or family whose income is over the Medically Needy Income Limit (MNIL) to use medical bills to spend excess income down to the MNIL.

Substantial Gainful Activity –

The performance of significant physical and/or mental work activities for pay, or profit or work activities generally performed for pay or profit.

Substantial Supervision –

The promoting, reminding or guidance of another person to perform the task.

Third Party –

An individual, institution, corporation or agency that is responsible for all or part of the medical costs for the Medicaid recipient.

Toileting –

The act of voiding of the individual's bowels or bladder, and includes the use of a toilet, commode, bedpan or urinal, transfers on and off a toilet, commode, bedpan or urinal, the cleansing of the individual after the act, changes of incontinence devices such as pads or diapers, management of ostomy or catheters and adjustment to clothing.

Total Dependence –

The individual needs another person to completely and totally perform the task for the individual.

Transferring –

The act of an individual in moving from one surface to another, and includes transfers to and from bed, chairs, wheelchairs, walkers and other locomotive aids.

Uncompensated Value –

The difference between the equity (fair market value less any amount owed) and the amount received for an item.

Undue Hardship –

Lack of assistance would deprive the individual of food, shelter and care determined to be medically necessary.

For estate recovery: compelling circumstances that would result in placing an unreasonable burden on an heir.

Utilization Review (UR) –

The section of the Division of Medical Services (DMS) which performs the monitoring and controlling of the quantity and quality of health care services delivered under the Medicaid Program.

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Vendor Payment –

Payment made by a third party including Medicaid on behalf of a recipient.

Waiver Services –

Services offered as an alternative to institutionalized services.

Working (Workers with Disabilities) –

Being employed in any ongoing work activity for which income is received and reported to the IRS. Employment must be verifiable by viewing paycheck stubs, tax returns, form 1099 or proof of Quarterly Estimated Taxes for self-employment. The individual with a disability must be working at the time of application.

If an individual stops working temporarily, and states that he/she intends to return to work, coverage can continue for up to six months. If the individual has not returned to work by the end of the sixth month, a ten-day advance notice will be given on form DCO-700, and the case closed after the tenth day. The caseworker will review the individual's circumstances to determine if he/she is eligible in another Medicaid category, and if so, certify the individual in that category.