

A-100 General Program Information

MS Manual 01/01/23

The Health Care Program (Medicaid) is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services (DHS), Division of County Operations (DCO) and Medical Services have the responsibility for administration of the Health Care 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. DCO will accept all applications, verification documents, and make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include:

- Emergency Services;
- Home Health and Hospice;
- Hospitalization;
- Long Term Care;
- Physician Services;
- Prescription Drugs; and
- Transportation-(Refer to [Appendix B](#) for a description of Transportation Services).

Generally, there is no limit on benefits to individuals under twenty-one (21) years of age who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over twenty-one (21) years of age.

The Adult Expansion Group coverage for most individuals will be provided through a private insurance plan, this is, 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; and
- 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, or overly complex, or who would undermine continuity or effectiveness of care, will not enroll in a private QHP plan but will remain in Health Care.

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

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Health Care Programs could include out-of-pocket spending (cost sharing) on covered services that follow 42 CFR § 447.50. Examples of cost sharing can include: coinsurance, co-payments, premiums, and prescription costs.

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

1. Individuals under twenty-one (21) years of age receiving coverage through ARKids A or Newborn;
2. Pregnant women;
3. Family Planning services and supplies;
4. Individuals receiving Medically Frail or Alternative Benefit Plan (ABP);

5. Emergency services;
6. Services that are considered preventative or provider-preventable diseases;
7. Health Maintenance Organization (HMO) enrollees;
8. Services provided to individuals receiving hospice care;
9. PASSE enrollees;
10. American Indian/ Alaska Natives; and
11. Individuals that are at or below twenty (20) percent of the FPL.

A-115 Cost Sharing for Workers with Disabilities

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Recipients of Medicaid for Workers with Disabilities (WD) with gross income up to one hundred and fifty percent (150%) of the FPL for their family size will be subject to paying Health Care co-pays. Recipients with income greater than one hundred and fifty percent (150%) of the FPL will be assessed for co-payments up to twenty percent (20%) of Health Care maximum allowable, up to ten dollars (\$10) per visit.

NOTE: Transitional Medicaid will follow the same cost share guidelines as Workers with Disabilities.

A-116 Premiums for the Adult Expansion Group

MS Manual 08/29/22

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

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

A-120 Dual Eligibles-Medicare/Medicaid

MS Manual 07/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

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A 120 Dual Eligibles Medicare/Medicaid

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

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

Limitations for recipients with joint Medicare/Medicaid coverage:

1. Medicaid pays Part B deductible and coinsurance of allowable charges on assigned Medicare claims filed by a participating provider. Medicare determines covered services and allowed charges on all joint claims. Medicaid benefit limits do not apply to Medicare allowable services under Part B.
2. Medicaid covers all medically necessary days of hospitalization. This coverage may be in the form of deductible, coinsurance, and/or per diem payments.
3. Medicaid participates in payment of extended care and skilled nursing care coinsurance days which are allowed by Medicare.

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

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

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A 130 Disclosure of Information/Confidentiality

A-130 Disclosure of Information/Confidentiality

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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

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

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

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A 132 Medical Records

A-132 Medical Records

MS Manual 07/01/20

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

A-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

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

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

A-140 Retention of Medicaid Case Records

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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.

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A-100 General Program Information

A 150 Quality Assurance

A-150 Quality Assurance

MS Manual 07/01/20

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

A-160 Referral Process for Counties

MS Manual 07/01/20

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

A-161 Hospital/Physician Referral

MS Manual 07/01/20

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

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

MS Manual 07/01/20

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

A-163 Child Health Services Program (EPSDT)

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The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis, and treatment services.

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A-100 General Program Information

A 164 Client Representatives Services Program

A-164 Client Representative Services Program

MS Manual 07/01/20

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



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

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

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

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

A-165 Inpatient Psychiatric Services

MS Manual 07/01/20

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

A PCP referral is not required for emergency admissions.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

A 166 DDS Children with Chronic Health Conditions

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 [MSB-270](#).

A-166 DDS Children with Chronic Health Conditions

MS Manual 07/01/20

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

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

A-170 Expedited Services for Child Abuse Cases

MS Manual 07/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

A 180 Medicaid/Health Insurance Marketplace Interactions

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

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 categor

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 01/01/23

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 (3) months prior to the date of application, and the retroactive period must end no later than the last day of the month of delivery (for example, the applicant will not be eligible for the postpartum coverage).

(Refer to [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 Pregnant Woman as stated above.

Procedures for authorizing retroactive eligibility only (for example, “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 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 01/01/2024

Twelve (12) months continuous coverage means that children under nineteen (19) years of age are guaranteed twelve (12) months of continuous coverage regardless of changes in income and other eligibility criteria which could result in ineligibility.

There are eligibility groups that are ineligible to receive the twelve (12) months of continuous coverage. The groups that are ineligible to receive the twelve (12) months continuous coverage are:

1. Medically Needy Categories
2. Pregnant Woman Unborn
3. Foster Care Spenddown
4. Transitional Medicaid

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 twelve (12) month period is if the child dies, moves out of state, or reaches nineteen (19) years of age.

NOTE: Some categories require certain eligibility requirements to remain eligible for that category of assistance. (For example: eligibility for adoption subsidies) If the recipient no longer meets requirements to stay in that category, they will be transitioned to ARKids A for the remainder of their twelve (12) months of continuous coverage. (The categories listed above that are ineligible to receive continuous coverage are not eligible to switch to ARKids A if they do not meet requirements of their program.)

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A 200 Health Care Coverage Periods

For ARKids, the twelve (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 twelfth 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.)

EXAMPLE: Mary's ARKids 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 case will not be closed until December 31, 2014, unless she moves out of state or turns nineteen (19) years of age before the twelve (12) continuous months end.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-300 Identification Cards

A 310 Medicaid Identification Cards

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.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-300 Identification Cards

A 330 Adult Expansion Group Identification Cards

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 01/01/22

A Health Care eligibility group defines the eligibility requirements an individual must meet to be eligible for Arkansas Health Care 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' Health Care groups fall under one (1) of the following general groupings:

- Families and Individuals;
- Aid to the Aged, Blind, and Disabled;
- Foster Care & Adoption Assistance; or
- Emergency Services for Aliens.

Within these general groupings are more specific groups defined by specific individual characteristics, such as age or services needed (for example, Long Term Services and Supports). In addition, some groups are assigned two (2) 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 01/01/22

Most individuals under age sixty-five (65) years of age 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 (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 sixty-five (65) years of age 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) that are described below do not have a financial test and therefore, the MAGI methodology is not used. However, since these two (2) 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 01/01/22

The ARKids First group provides health insurance coverage for Arkansas children from birth to nineteen (19) years of age. There are two (2) categories of coverage in the ARKids First group – ARKids A and ARKids B. Along with the age requirement of being under the nineteen (19) years of age, relationship 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 nineteen (19) years of age with family income under one hundred and forty two percent (142%) of the Federal Poverty Level for the applicable household size (See [MS E-110](#)). ARKids A provides the full range of Health Care services. This is a mandatory eligibility group authorized and funded by Title XIX of the Social Security Act (Health Care).

ARKids B provides coverage to otherwise uninsured children under nineteen (19) years of age with family income equal to or over one hundred and forty-two percent (142%) but under two hundred and eleven percent (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 Health Care 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 (2) packages.

B-220 Newborns

MS Manual 01/01/22

This group consists of newborns up to one (1) year of age whose mothers were Health Care eligible at the time of their births. Newborns in this group are guaranteed Health Care coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of Health Care 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 one (1) year of age, 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](#)) are also eligible for the Newborn category.

B-230 Parent/Caretaker Relatives

MS Manual 01/01/22

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, they 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 Health Care such as TEFRA, or a private insurance plan.

Adults covered in the group receive the full range of Health Care benefits.

B-240 Pregnant Women

MS Manual 01/01/22

This group consists of women nineteen (19) years of age 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 Health Care up to three (3) months after birth of the baby.

There are two (2) 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 Health Care services; and
- 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 sixtieth day from the date of delivery falls.

B-250 Unborn Child (Pregnant Woman)

MS Manual 01/01/22

This group consists of non-citizen pregnant women who do not meet the alienage requirements for Health Care and whose household income is at or below two hundred and nine percent (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 five-year residency requirements or one (1) of the conditions listed in [MS D-224](#); or
- 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 sixtieth day from the date of delivery falls.

B-260 Former Foster Care Adults

MS Manual 01/01/23

This group consists of adults up to twenty-six (26) years of age who aged out of foster care in Arkansas. There is no income or resource test. Other than the general Health Care eligibility requirements that all Health Care 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 Health Care when aging out of foster care at eighteen (18) to twenty-one (21) years of age depending on the individual circumstances and is currently under twenty-six (26) years of age.

Individuals in this group receive the full range of Health Care benefits.

Note: If an individual has aged out of foster care in one state, and they move to another state, they are eligible for Former Foster Coverage if all other general Health Care eligibility requirements are met. This applies only to youth who reach eighteen (18) years of age on or after January 01, 2023.

B-270 Adult Expansion Group (ARHOME)

MS Manual 01/01/22

The Arkansas Works Program was amended to become ARHOME starting January 1, 2022. Throughout this policy manual the ARHOME Program will be referred to as the Adult Expansion Group.

This group consists of adults who are nineteen (19) through sixty-four (64) years of age with household income equal to or below one hundred and thirty three percent (133%) (one hundred and thirty-eight percent (138%) with five percent (5%) disregard applied) of the applicable federal poverty level ([MS E-110](#)) and are not eligible in either the Parent/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.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B 200 Families and Individuals Group (MAGI)

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 (1) of the pregnant women groups or in the Parent/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.

The ARHOME Program provides Health Care 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 Health Care (Re. [MS A-100](#)).

NOTE: If an individual in this group has a child(ren) under eighteen (18) years of age living in the home, the child(ren) must be covered in Health Care or have other health insurance coverage.

Individuals eligible in the Adult Expansion Group will be enrolled in a Qualified Health Plan (QHP); unless they fall under one (1) of the coverage types listed below:

Medically Frail: Individuals identified as disabled or blind will be enrolled in Health Care under the Alternative Benefit Plan (ABP).

American Indian (AI)/Alaskan Native (AN): Individuals identified as an American Indian or Alaskan Native will not be enrolled into a QHP but will be covered under ABP in Health Care. Individuals in this group may opt into a QHP if that is the preferred coverage.

Enrollment in a PASSE is mandatory for the adult expansion group (ARHOME) that have been identified as in need of Tier 2 or Tier 3 behavioral health services through the Independent Assessment (IA) system (Re. [Independent Assessment](#)).

NOTE: Individuals who are moving to a QHP will be enrolled in Health Care under the Alternative Benefit Plan (ABP) for an interim period until the QHP plan is selected or the individual is auto assigned into a QHP.

B-280 Presumptive Eligibility Pregnant Woman (PE-PW)

MS Manual 07/01/25

Agencies who have been designated by DHS as Qualified Entities* may determine women presumptively eligible for PE-PW Health Care based on preliminary information, subject to federal and state requirements, in order that the individual may receive temporary coverage until ongoing eligibility for Health Care is officially determined by DHS. The goal of the PE-PW process is to offer immediate health care coverage to pregnant women likely to be Health Care eligible before there has been a full Health Care eligibility determination.

* See the Medical Services Policy Glossary for more information on Qualified Entities for PE-PW.

If determined eligible for PE-PW, the individual will have temporary coverage during the PE-PW period. The PE-PW period begins on the day that a qualified entity determines the individual to be presumptively eligible. The individual must not be currently receiving Health Care coverage through Medicaid or the Children's Health Insurance Program (CHIP). Pregnant women are limited to one PE-PW determination per pregnancy. If a woman is pregnant more than once in a calendar year, they may have more than one presumptive eligibility period in a calendar year due to multiple pregnancies.

NOTE: PE-PW coverage is temporary and will end on the last day of the month following the month in which the client was determined presumptively eligible by the qualified entity.

Qualified Entities (QE), including DHS, are responsible for determining eligibility for PE-PW. The QE will make the PE-PW determination based on the following criteria:

- State residency
- Income

PE-PW Coverage will be determined based off self-attested information and may be approved while information is pending to determine eligibility for an ongoing Health Care coverage. Self-attestation of household income and state residency will be accepted for PE-PW. The income limit for the PE-PW category may be found in Appendix F.

Citizenship or immigration status, household income and state residency will be accepted for PE- PW. The income limit for the PE-PW category may be found in Appendix F.

Medicaid provides temporary Presumptive Eligibility Pregnant Woman (PE-PW). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.

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), including without limitation, cancer, AIDS, and end-stage renal disease, 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 Health Care 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.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-600 Medically Needy (Exceptional and Spend Down)

B 601 Exceptional Medically Needy

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](#).

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 705 Extent of Services

B-700 Transitional Medicaid

MS Manual 12/01/20

The Family Support Act of 1988 (Public Law 100-485), requires that certain Aid to Families with Dependent Children (AFDC) families (Category 20) who lost eligibility April 1, 1990, or later, due to earned income must be given six (6) months of Initial Transitional Medicaid (TM) benefits without an application for such assistance. These families may also qualify for an Additional 6 Months Transitional Medicaid Extension.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 extended this requirement to certain Medicaid families following replacement of the AFDC program with the Temporary Assistance for Needy Families (TANF) program. In Arkansas, families who lost eligibility for Parents/Caretaker Relatives (PCR), formerly TEA Medicaid, due to earnings are eligible for this extension.

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) extended this requirement to certain Medicaid families following replacement of the TEA Medicaid program with the Parents/Caretaker Relatives Medicaid (PCR) program.

B-705 Extent of Services

MS Manual 12/01/20

Individuals approved for Transitional Medicaid will be eligible for the full range of Medicaid services, including services under the Children's Health Services Program.

B-710 Eligibility Requirements

MS Manual 12/01/20

In addition to the standard Medicaid eligibility requirements of citizenship, enumeration and child support enforcement, the following requirements must be met in determining eligibility for the Initial 6 Months TM Extension Period:

1. The family must have become ineligible for PCR Medicaid due to increased wages or increased hours of employment.
2. The family must have received PCR Medicaid in at least 3 of the 6 months immediately preceding the first month of PCR Medicaid ineligibility. Retroactive months count for this purpose.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 715 Parents/Caretaker Relatives Medicaid Case Closure Due to Earnings

3. The family members must have been residents of Arkansas in the last month of PCR Medicaid eligibility and must continue to reside in Arkansas.
4. There must be a dependent child under age 18 in the home.

In addition to the eligibility criteria stated above, the following eligibility requirements must also be met in the Additional 6 Months TM Extension Period:

5. The family must have received TM in each month of the Initial 6 Months TM Extension Period.
6. There must continue to be a dependent child under age 18 in the home.
7. The parent (or non-parent specified relative) must have met the reporting requirements in the 1st and 4th months of the Additional TM Extension Period (Re: MS B-735 and MS B-750).
8. The parent or (non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd report periods of the Additional TM Extension Period, unless good cause exists.

The average monthly gross earnings of the eligible members cannot exceed 185% of the Federal Poverty Level (Re. [FPL Chart at Appendix F](#)).

Resources, deprivation, and unearned income are not eligibility factors for TM.

B-715 Parents/Caretaker Relatives Medicaid Case Closure Due to Earnings

MS Manual 12/01/20

The PCR Medicaid case closure must be solely due to increased wages or increased hours of employment. If a PCR Medicaid family becomes ineligible due to earnings and for another reason in the same month, the family will be ineligible for Transitional Medicaid (TM).

The increased earnings must be of the child's parent (or non-parent specified relative) who was included in the PCR Medicaid case as an eligible member in the last month of eligibility.

The Initial 6 Months TM Extension will begin with the first month following the last month of PCR Medicaid eligibility. Individuals included in the budget group in the last month of PCR Medicaid eligibility will be entitled to the Initial 6 Months TM Extension.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 720 Received Parents/Caretaker Relatives Medicaid in 3 of the Last 6 Months

B-720 Received Parents/Caretaker Relatives Medicaid in 3 of the Last 6 Months

MS Manual 12/01/20

The family must have received PCR Medicaid in at least 3 of the 6 months immediately preceding the first month of PCR Medicaid ineligibility in order to qualify for TM. Eligibility for retroactive PCR Medicaid can count toward the 3 months. This requirement must always be met.

The family will not be eligible for Transitional Medicaid if it is determined that the family was ineligible for PCR Medicaid at any time during the 6 months immediately preceding PCR Medicaid ineligibility due to fraud.

B-725 Residence

MS Manual 12/01/20

The family members must be residents of Arkansas at the time they became ineligible for PCR Medicaid and must continue to reside in Arkansas throughout the Transitional Medicaid Period.

B-730 Dependent Child

MS Manual 12/01/20

“Dependent Child” is defined, for TM purposes, as a child who is under age 18 who was living in the home in the last month of PCR Medicaid eligibility, and whose presence in the home helped establish PCR Medicaid eligibility. As a condition of TM eligibility, there must be a dependent child in the home in each month of TM. Eligibility for TM will terminate at the end of the first month in which the family ceases to include a dependent child. If the only dependent child leaves home and later returns after the TM case has been closed, the TM case may not be reopened, even if a portion of the 12-month TM period remains.

B-735 Reporting Requirements in the Initial 6 Months TM Extension Period (First Six Months)

MS Manual 12/01/20

First Report

At the end of the 3rd month of the Initial 6 Months Extension Period, a notice and report form will be sent to the family to be returned by the 5th day of the 4th month. The parent (or non-parent specified relative) must report the household composition, the amount of gross earnings

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 740 Determining Initial Eligibility When There Was an Untimely Report of Earnings

received, and other circumstances which existed in the first 3 months of the Initial 6 Months TM Period. The option for an Additional 6 Months Extension Period of TM will be, in part, dependent upon the timely return of the report form.

NOTE: If a report form is received untimely after the specified 10-day notice period, in order for the report requirement to be met, the client must establish good cause.

B-740 Determining Initial Eligibility When There Was an Untimely Report of Earnings

MS Manual 12/01/20

In the event the agency is not informed by a PCR Medicaid recipient of increased earnings in a “timely” manner, eligibility for Transitional Medicaid will be determined from the month the family actually became ineligible for PCR Medicaid.

If the agency is informed of a PCR Medicaid family’s increase in earnings as late as the 5th day of the 4th month of PCR Medicaid ineligibility, eligibility will be determined for TM in each of the months succeeding the last month of PCR Medicaid eligibility. If the eligibility requirements in the Initial 6 Months TM Extension Period ([MS B-710 #1-4](#)) are not met, no additional benefits will be authorized. If the eligibility requirements in the Initial 6 Months Extension Period ([MS B-710 #1-4](#)) are met, continuing TM benefits will be authorized.

If the earned income is reported or discovered after the 5th day of the 4th month of PCR Medicaid ineligibility, the family will not be entitled to receive any Additional TM benefits.

B-745 Six Months TM Extension Period (Second Six Months)

MS Manual 12/01/20

In addition to continuing to meet each eligibility factor listed in MS B-710 #1-4, the eligibility criteria specified in MS B-710 #5-8 must also be met for the Additional 6 Months of TM.

B-750 Reporting Requirements in the Additional 6 Months Extension Period (Second Six Months)

MS Manual 12/01/20

Second Report

At the end of the 6th month of the Initial 6 Months Extension Period, a notice and report form will be sent to those families who met the eligibility factors in the Initial 6 Months Extension

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 755 Employment Requirement

Period. This report should be returned by the 5th day of the 1st month of the Additional 6 Months TM Extension Period (the 7th month of TM). The parent (or non-parent specified relative) must again report the household composition, the amount of gross earnings received, and other circumstances which existed in the last 3 months of the Initial TM Extension Period.

If a complete report form is not returned timely, a second notice will be sent to advise the client that the report form must be returned in 10 days or the case will be closed.

Third Report

At the end of the 3rd month of the Additional 6 Months Extension Period (the 9th month of TM), if the case remains open, a notice and report form will be sent to the family to be returned by the 5th day of the 4th month of the Additional Extension Period (the 10th month of TM).

If a complete report form is not returned timely, a second notice will be sent to advise the client that the report form must be returned in 10 days or the case will be closed.

B-755 Employment Requirement

MS Manual 12/01/20

In order for extended benefits to continue in the second 6-month period, the parent (or non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd reports unless good cause exists.

B-760 The 185% Earned Income Test and Computation of Average Monthly Gross Earnings

MS Manual 12/01/20

The family's average monthly gross earnings cannot exceed 185% of the Federal Poverty Level (Re. [FPL Chart at Appendix F](#)).

B-765 Changes in the Transitional Medicaid Period

MS Manual 12/01/20

Minor children entering the household, who were not in the household at the time the determination for Transitional Medicaid was made will not be added to the case. If an excluded child has earnings, they will not be considered in computing the family's average gross monthly earnings. Eligibility for this child will be determined in another category.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-700 Transitional Medicaid

B 765 Changes in the Transitional Medicaid Period

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

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

If the only child in the home becomes eligible for SSI, the parent(s) (or non-parent specified relative) will remain eligible for Transitional Medicaid as long as the SSI child is under age 18. The adult(s) must continue to meet all other eligibility requirements in order to remain eligible for Transitional Medicaid.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-100 Application Process

C 105 Distinction between Application and Inquiry

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 assister 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

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-100 Application Process

C 112 Authorized Representatives

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 Assisters 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.

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 07/01/20

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

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

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

C-205 Pregnant Woman (PW) Period of Eligibility

MS Manual 01/01/23

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 sixtieth (60th) day postpartum falls. Postpartum coverage will be provided to women who are Health Care certified at the time of delivery and to women who have a Health Care 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 Unborn Child will be given full postpartum coverage.

If the pregnant woman has medical bills in the three (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 for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage.

D-200 General Citizenship and Alien Status Requirements

D 211 Citizenship of Children Born Outside of the U.S.

- 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.

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-200 General Citizenship and Alien Status Requirements

D 221 Alien Categories

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 ([MSD-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 03/02/2021

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 lawfully living in United States in accordance with the **Compacts of Free Association**. This only applies to: Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau ([116HR133SA-RCP-116-68](#)).
- 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**

D-200 General Citizenship and Alien Status Requirements

D 224 Aliens Exempt from Five Year Bar

- 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;

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-200 General Citizenship and Alien Status Requirements

D 226 Victims of Trafficking

- 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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-200 General Citizenship and Alien Status Requirements

D 230 Non Citizens Eligible for Emergency Services

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-200 General Citizenship and Alien Status Requirements

D 230 Non Citizens Eligible for Emergency Services

- 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 contractworkers.
- Members of foreign press, radio, film or other information media and their families.



NOTE: This is not an all-inclusive list.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 310 State Residency Determinations

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 320 Prohibited State Residency Determination

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

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D-330 Interstate Agreements

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 350 Juveniles in the Custody of Division of Youth Services (DYS)

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 DHS to process and approve Medicaid eligibility for ARKids A and B for DHS juveniles who have entered treatment facilities or have been released from DHS 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- [MS 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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D-370 Inmates of Public Institutions

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 [MS 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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 340 Medicaid for the Homeless

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 340 Medicaid for the Homeless

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.

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-300 State Residency

D 340 Medicaid for the Homeless

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

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. Individuals who Declare an SSN

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

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-400 Social Security Number Enumeration Requirement

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

MEDICAL SERVICES POLICY MANUAL, SECTION D

D-400 Social Security Number Enumeration Requirement

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-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.

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 01/01/2024

Below are the income and resource limits for all Health Care 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.

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E 100 Financial Eligibility

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 Health Care eligibility at child's birth	No Resource Test
Pregnant Women: Full Pregnant Woman	209% FPL*	No Resource Test
Unborn Child	209% of FPL *	
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 MSO-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

MEDICAL SERVICES POLICY MANUAL, SECTION E

E 100 Financial Eligibility

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 \$9,430 Couple \$14,130 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 08/03/2020

MAGI is a federal income tax term meaning **Modified Adjusted Gross Income**. 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, however, current monthly income is used to determine eligibility. This is true even when using MAGI methodologies. Detailed information on determining whether income is “current” and converting income amounts to monthly amounts can be found in [MS E-265](#).

E-220 Families and Individuals (MAGI) Groups

MS Manual 08/03/2020

MAGI methodologies are used to determine financial eligibility for the following groups:

1. Infants and children under age 19 (ARKids A & B);
2. Pregnant women;
3. Parents and caretaker relatives;
4. Adults age 19 through 64 who do not fall into another adult group, such as the Adult Expansion Group; or
5. Transitional Medicaid.

E-230 Steps in Determining MAGI Income Eligibility

MS Manual 08/03/2020

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 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 [MSE-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 refers to 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 Federal Poverty Level for the household size. See [MS E-267](#).
 - This step will determine each individual’s Medicaid eligibility.

E-240 Determining the Medicaid Household for Families and Individual Groups

MS Manual 08/03/2020

Under the Modified Adjusted Gross Income (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, individual Supplemental Security Income (SSI) recipients are counted. 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 08/03/2020

To determine an individual’s tax filing status or unit, two basic questions must be asked.



NOTE: Each person’s eligibility for Medicaid is determined individually, even if two or more individuals are living in the same household.

1. Does the individual expect to file taxes?
2. Does the individual expect to be claimed as a taxdependent?

If the answer to both 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.
Question 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 taxdependent.
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?	
<ul style="list-style-type: none"> • 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.

E-251 Non-Tax Filing Households

MS Manual 08/03/2020

Medicaid household composition will be determined in accordance with this section in the following situations:

1. The individual has not filed 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. The individual is a child under age 19 living with both parents, but the parents do not expect to file a joint tax return;
 - c. The individual 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 age 19 Siblings (biological, adopted, and step siblings) under age 19. If the individual is under age 19, his or her parent(s) (biological, adopted, and step-parents).
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E-260 Determining Countable Income for Families and Individuals Groups

MS Manual 08/03/2020

Once the Medicaid household composition has been established for the individual, each household member's countable income must be determined. Only the income of persons in an individual's Medicaid household is considered when determining financial eligibility.

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.
- Any portion of an educational scholarship, award or fellowship grant used for living expenses is countable income.

E-261 Income Included for Families and Individual Groups

MS Manual 08/03/2020

Although not an exhaustive list, the following are examples of taxable income included in MAGI calculations to determine Medicaid eligibility:

1. Earned Income: If the pay stub lists "Federal Taxable Wages" use that amount; if not, use "Gross Income" instead;
2. Self-employment income or "Net Self-Employment income": The amount after allowable income-producing costs are deducted. See [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, divorces, and separations finalized before January 1, 2019;
8. Pensions and annuities payments;
9. Rental income;
10. Lottery and gambling winnings (Income less than \$80,000 is countable income in month received. Income greater than or equal to \$80,000 to \$89,999 is countable income for two months, divided equally. For every additional \$10,000, add a month and divide equally. The maximum penalty cannot exceed 120 months or 10 years. Pro-

rated winnings only count for the individual receiving income;

NOTE: Individuals who receive lottery and gambling winnings may request an undue hardship exception to avoid a penalty. Please see [MS E-269](#);

11. Any portion of educational scholarships, awards, or fellowship grants used for living expenses; or
12. Student Loan Debt that has been “forgiven” unless it was due to death or permanent disability).

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, the income will be considered for Medicaid purposes if it was reported as taxable income for that tax year. If the income was excluded from 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 will be taxable or not.

E-262 Income Excluded for the Families and Individual Groups

MS Manual 08/03/2020

Although not an exhaustive list, the following examples of income that are excluded as taxable income for federal income tax purposes, and therefore are excluded as countable income for Medicaid purposes:

1. Child Support
2. Contributions
3. Worker’s Compensation
4. Veteran’s Benefits
5. Educational grants: Pell Grant, the Federal Supplemental Educational Opportunity Grant (FSEOG), the State Student Income Grant (SSIG) and college work study.
6. American Indian/Alaska Native
7. Public Assistance Benefits, such as Transitional Employment Assistance (TEA) or Supplemental Security Income (SSI)
8. Disaster Relief Payments
9. Gifts
10. Federal Tax Refunds
11. Alimony: divorces and separations finalized on or after January 1, 2019.
12. Moving Expenses (Active Military Duty only)
13. Outreach and Enrollment Grants
14. Combat pay for military personnel

E 263 Household Members Whose Income Will Not Be Counted for Families and Individuals (MAGI) Groups

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 Individual (MAGI) Groups

MS Manual 08/03/2020

The income of the following household members is not considered when determining Medicaid eligibility:

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 or her as a tax dependent.
3. Income of a Supplemental Security Income (SSI) recipient who is included in the Medicaid household size.

When determining MAGI eligibility, the income of a child must be counted and verified if the child must file a tax return because his or 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 to 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 or her as a tax dependent.

E-265 Determining Current Gross Monthly Income for The Families and Individuals Groups

MS Manual 08/03/2020

Current gross monthly income minus allowable deductions 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.

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, 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 ten percent (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, check stubs, 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, the annual income from the tax return will be 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 will be 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

Some situations require alternative methods to arrive at a 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. Self-employment income may also require an alternative method. [MSE-266](#) contains a more detailed discussion on self-employment income.

E-266 Self-Employment Income

MS Manual 08/03/2020

The current monthly amount of self-employment earnings is the best estimate of earned income for future months.

The individual's recent tax data can be used to determine 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 eligibility worker, such as sales receipts, business records, etc.

Costs directly related to producing self-employment income are subtracted from the annual gross income 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 08/01/14

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 according to the eligibility group the individual falls into with the lowest income standard. For example, 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 08/01/18

Each individual will be allowed a general gross income disregard in the amount of five percent (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 with

E 268 The 5% Gross Income Disregard

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 percent (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 five percent (5%) disregard effectively raises the income limits for the applicable eligibility group by five percentage points. For example, the income limit for the Adult Expansion Group is one hundred thirty-three (133%) See [MS E-110](#). To apply the five percent (5%) disregard, add five percent (5%) to one hundred thirty-three percent (133%) to raise the income limit to one hundred thirty-eight percent (138%) of the Federal Poverty Level . The Full Pregnant Women and Parent Caretaker Relative categories of assistance are not eligible to receive the five percent (5%) disregard.

Application of the 5% Disregard in the ARKids First groups

The five percent (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 five percent (5%) disregard can be allowed.

The five percent (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 five percent (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 eligibility.

E-269 Undue Hardship for Lottery/Gambling Winnings

MS Manual 08/03/2020

An individual who is assessed a penalty for lottery/gambling winnings outlined in [MS E-261](#) may request an undue hardship exception. The eligibility worker will consider factors including, but not limited to, the following:

1. The recipient is currently involved in an open or pending bankruptcy case;
2. The recipient or another household member is disabled;
3. The recipient is homeless;

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E-200 Determining Financial Eligibility Under the MAGI Methodology

E 269 Undue Hardship for Lottery/Gambling Winnings

4. The recipient or another household has a serious illness and the penalty could interrupt their health care coverage;
5. The recipient is the sole primary caretaker of minor children in the home;
6. The recipient is experiencing a life-changing event, such as divorce or domestic violence; and
7. Other compelling circumstances.

If an individual requests an undue hardship exception, the eligibility worker must verify the client's attestation. These cases will be handled on a case-by-case basis. If an undue hardship is granted for the recipient, a penalty will not be assessed.

E-300 Sponsor Affidavits of Support and Deeming

MS Manual 11/01/2021

PRWORA of 1996

Alien sponsor deeming established by the PRWORA (Personal Responsibility and Work Opportunity Reconciliation Act of 1996), 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); or
- *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

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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.
- When determining the sponsored immigrant's deemed income and resources from the sponsor consider the same disregards to the sponsor's income and/or resources that the sponsor would receive if they were applying.
- 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.
- Count the household size of the alien according to MAGI or SSI rules.

Deeming continues until one of the following conditions is met:

- The sponsored immigrant becomes a naturalized citizen.
- The sponsored immigrant achieves 40 qualifying work quarters, as defined by the Social Security Act (the Act).
- The sponsored immigrant or the sponsor dies.

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E-400 Determining Financial Eligibility for AABD Groups

E 405 Income

E-400 Determining Financial Eligibility for AABD Groups

MS Manual 07/01/20

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

E-405 Income

MS Manual 07/01/20

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

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

E-410 Income Evaluation

MS Manual 06/01/25

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

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

Non-monthly income receipts will be treated as follows:

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

If the anticipated income is in an amount great enough that is likely to result in two (2) or more months of ineligibility, the client will be informed in the advance notice that the case will be closed and that a new application will be required to reopen the case.

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

2. Irregularly Received Non-Monthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The advance notice of intended action will be given before any case closures or income adjustments resulting in changes in vendor payment are completed. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken.

As with regularly received non-monthly income, if benefits will be terminated for only one (1) month for receipt of irregular non-monthly income, a new application will not be required. Closures of two (2) or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at [MS E-523 #6](#). SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month.

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer. The frequency with which interest is computed is immaterial in determining when the income is received (For example: 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 (2) if paid quarterly, at least three (3) if paid monthly) will be used to determine the countable monthly amount. Small interest/dividend amounts paid monthly or quarterly which fluctuate slightly may be averaged until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

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

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

E-415 Determination and Verification of Earnings from Employment

MS Manual 07/01/20

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly.

If the earnings fluctuate, averaging or other means will be used to determine an amount which fairly reflects the monthly income actually available to the applicant.

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

E-420 Determination and Verification of Earnings from Farm, Business or Self-Employment

MS Manual 07/01/20

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 07/01/20

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

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

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

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

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

E-425 Unstated Income

MS Manual 07/01/20

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 07/01/20

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 07/01/20

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

1. Shelter or Living Quarters Cost (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.)
2. Clothing and Upkeep

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

6. Civil Service Benefits

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

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

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

In-Kind Support and Maintenance

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

Other In-Kind Income

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

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

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

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

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



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

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

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

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

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

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

- a. In-kind payments made in lieu of cash wages are not considered as in-kind support and maintenance except when paid to agricultural or domestic employees. In-kind payments made in lieu of cash wages to other types of employees are considered to be earned income instead of in-kind support and maintenance.

The value of support and maintenance provided in a nonmedical nonprofit retirement home or similar facility which does not receive full payment from the individual or which receives subsidy payments from a nonprofit organization is not considered as in-kind income of the individual.

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

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E-400 Determining Financial Eligibility for AABD Groups

E 434 Temporary Disregard of Cost of Living Adjustment (COLA) for Medicare Savings Program

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

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

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

Disabled Adult Child (DAC)

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

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

Temporary Disregard of Cost of Living Adjustment (COLA) for Medicare Savings Program

MS Manual 07/01/20

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.

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E-400 Determining Financial Eligibility for AABD Groups

E 441 Deeming of Income from Ineligible Spouse

Consider a couple to be married if they are:

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

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

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

Deeming of Income from Ineligible Spouse:

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



- NOTE:** For spouse-to-spouse deeming to apply, the applicant or recipient must be eligible based on his or her own income.
2. Determine the total income of the ineligible spouse by types, earned and unearned less any excluded from deeming. Refer to [MS E-446](#) to determine income excluded from deeming.
 3. From the ineligible spouse's income, a living allowance (refer to [Appendix S](#)) is deducted for each ineligible child (refer to Glossary) in the home. Income of the child is used to reduce this allowance unless it is excluded as student earned income. Refer to [MS E-446 #10](#). The living allowance is deducted from the unearned income first and any unused balance is then deducted from earned income. Total the remaining income.
 4. If the ineligible spouse's remaining income is equal to or less than his living allowance, there is no income to be deemed. The applicant is income eligible.
 5. If the ineligible spouse's remaining income exceeds his living allowance, the remaining income by type will be totaled with the applicant's gross earned and unearned income amounts.

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E-400 Determining Financial Eligibility for AABD Groups

E 445 Exceptions to Deeming for Alien's Sponsor

3. Reduce the excess income amount by a living allowance for each ineligible child in the home (i.e., those not blind or determined to have a disability). If this reduces excess income to zero, there is no income to deem to the eligible child. If not proceed to #4.
4. If excess income remains after deduction of living allowances, it is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to the SSI exclusions in his/her eligibility determination. Refer to [MS A-214](#).

Exceptions to Deeming for Alien's Sponsor

MS Manual 07/01/20

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

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

Items (Income) Not Included in Deeming

MS Manual 07/01/20

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

1. Assistance or Income based on need: Includes payments by any Federal Agency, State or political subdivision of SSI payments and any income which was considered in determining such assistance.
 - a. Exclusion applies to V.A. Pension but not to V.A. Compensation.
 - b. Also includes TEA payments and income which was considered in determining assistance (including all income of a step-parent in cases which involve a step-parent).
2. Portions of Grants, Scholarships or Fellowships used to pay tuition and fees at an educational institution or the cost of Vocational Technical training which is preparatory for employment.
3. Foster Care Payments received for an ineligible child.
4. SNAP and Department of Agriculture donated foods.
5. Home produce grown for personal consumption.
6. Refund of income taxes, real property taxes, or taxes on food purchased by the family.
7. Income used to comply with terms of court-ordered support and Title IV-D support payments.
8. The value of In-Kind Support and Maintenance provided to ineligible members of the household.
9. Income excluded by other Federal Statute.
10. Earned income of an ineligible child who is a student unless the child makes such income available (contributes) to the family. This income would not be used to offset the living allowance which is deducted from parental income in the deeming process. If a contribution is being made by the student, consider only the amount contributed as available income.

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E-400 Determining Financial Eligibility for AABD Groups

E 447 Deeming from a Non Qualified Alien Spouse

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

Deeming from a Non-Qualified Alien Spouse

MS Manual 07/01/20

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

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

E-450 Supplemental Security Income Exclusions

MS Manual 07/01/20

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

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

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E-500 Resources – AABD

E 515 Determining the Value of an Oil & Gas Lease

- b. Refer to [MS E-516](#) 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. $\$443.25 \times 5 = \$2,216.25$. 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. $\$272.50 \times 5 = \$1,362.50$. 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.

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. [MSE-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,

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E-500 Resources – AABD

E 516 Real Property Exclusions

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

MEDICAL SERVICES POLICY MANUAL, SECTION E

E-500 Resources – AABD

E 516 Real Property Exclusions

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.

MEDICAL SERVICES POLICY MANUAL, SECTION E

E-500 Resources – AABD

E 516 Real Property Exclusions

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.

MEDICAL SERVICES POLICY MANUAL, SECTION E

E-500 Resources – AABD

E 523 Personal Property Exclusions

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.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.

F-100 Non-Financial Eligibility Requirements

MS Manual 07/01/20

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 01/01/22

Most Health Care eligibility groups have an age range in which the individual must fall 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. 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:

First degree – Parent;

Second degree – Grandparent, sibling;

Third degree – Great-grandparent, uncle, aunt, nephew, niece;

Fourth degree – Great-great grandparent, great-uncle, great-aunt, first cousin; and

Fifth degree – Great-great-great-grandparent, great-great uncle, great-great aunt, first cousin once removed (that being, 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 their parents or other relative by court order, has been court ordered to an institution, has been emancipated, has reached eighteen (18) years of age, 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 01/01/22

42 U.S. Code § 1382c.

Some eligibility groups require an individual to either be 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 twenty degrees (20°) or less in the better eye.

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

1. Has lasted or is expected to last for a continuous period of at least twelve (12) months (thirty (30) days for the AFDC related categories, such as categories AFDC Medically Needy) or
2. Is expected to result in death.

Blindness and Disability must be established by one (1) of the following means:

1. Receipt of SSI (AB or AD) or receipt of a letter of entitlement to SSI with begin date of entitlement, if the individual has not received the first SSI payment.
2. Receipt of Social Security or Railroad Retirement (RR) based on disability or receipt of a letter of entitlement to Social Security or Railroad Retirement based on disability, showing a begin date of entitlement, if the individual has not received the first SSA or RR payment.

3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefit continuation, when an individual has requested continuation within ten (10) days of SSA determination that a physical or intellectual disability has ceased, has not existed, or is no longer disabling.
4. Non-receipt of SSI cash benefits for reasons other than disability, but verification of an established disability that is current and continuing (for example, TEFRA child).
5. Receipt of the DCO-0109, Report of Medical Review Team decision, when blindness or disability has been determined by the Medical Review Team.

Disability will either be established by Social Security Administration (SSA), Railroad Retirement (RR), or the Medical Review Team (MRT). The following disability guidelines will apply to all Health Care applicants where disability is an eligibility factor and disability has not been determined. A disability decision made by SSA on a specific disability is controlling for that disability until the decision is changed by SSA. When DCO makes a disability determination, a later contrary SSA determination will supersede the state determination. If SSA has made a decision that a person does not have a disability, that decision is binding on DCO for one (1) year with exceptions noted in [MS F-122](#).

F-121 Social Security Administration

MS Manual 06/01/25

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSA determinations must be presented to SSA for reconsideration or requests for reopening of the decisions.

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 Health Care.

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 Health Care.

F-122 Medical Review Team (MRT)

MS Manual 01/01/22

When an individual applies for Health Care and meets one (1) or more of the conditions below, required forms along with any medical records provided will be submitted to MRT, provided it appears that the other eligibility factors are met. Refer to [Appendix I](#) for required forms.

MRT will determine disability if any one (1) of the following conditions exists:

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

EXCEPTION: Individuals applying for ARChoices, Living Choices, or PACE, who require a determination of physical disability, will be referred to MRT even if receiving Social Security Disability IF SSA does not verify a primary type of disability that is physical. Refer to [MS B-312](#), [B-313](#), and [B-318](#).

4. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations.
5. More than twelve (12) months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA made the decision is worse or has changed, and he or she has not reapplied.
6. Less than twelve (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. They have 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 (for example, income).

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

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

EXAMPLE 2: Same family with less income reported.

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

Comparing income in Chart 1 in [Appendix P](#), the annual income is below the limit for a family size of five (5). 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 their 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 five thousand five hundred dollars (\$5,500). Families having more than one (1) child receiving TEFRA Waiver benefits will pay only one premium for all covered children. There will be no increase in premium amount for additional Waiver children.

F-172 Adjustment of Premiums

MS Manual 07/01/20

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-180 Other Health Insurance Coverage

MS Manual 04/01/26

For most eligibility groups, an individual may be covered by other health insurance without affecting their eligibility for Health Care. There are two (2) exceptions to this which are described below.

G-100 Verification Standards

MS Manual 01/01/22

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 Health Care 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 03/27/23

The following must be verified when determining eligibility for Health Care:

- 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 data sources, the applicant will be notified to provide verification of citizenship and identity. Refer to [MS G-133](#).

NOTE: If a client refuses to provide an attestation of their willingness to cooperate with the Office of Child Support Enforcement (OCSE), this will cause the parent's case to be sanctioned. The client's case will continue to be sanctioned (ineligible for Health Care coverage) until they cooperate with OCSE or the child(ren) in the home turn(s) eighteen (18) years of age. Refer to [MS F-130](#).

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 01/01/22

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); and
- Department of Homeland Security – Immigration status.

The Arkansas verification database is a multiple source database directly integrated with the eligibility system. Information provided includes:

- SOLQi - 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; and
- DMV (Department of Motor Vehicles).

Other sources of verification include:

- Paper Documentation provided by the individual;
 - ✓ Check Stubs
 - ✓ Employer Statements
 - ✓ Bank Statements
 - ✓ Collateral Statements
 - ✓ Legal Documents (for example, guardianship court order)
- SNAP – verified information in the individual's SNAP record; and
- TEA – verified information in the individual's TEA case record.

G-114 Reasonable Opportunity for Providing Verification

MS Manual 01/01/22

Verification must first occur through electronic sources. If unable to obtain verification through electronic sources, verification will be required from the client and a ten (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 01/01/22

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 eligibility worker, will however, view SOLQi 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 them ineligible, and the eligibility worker cannot determine if the resource is countable (such as a life insurance policy or burial plan), the eligibility worker 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 01/01/22

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 and the procedures in [Appendix C](#) will be followed to resolve the mismatch.

G-130 Verifying Citizenship

MS Manual 01/01/22

Federal Law and Regulations require that citizenship must be verified for all Health Care recipients declaring to be citizens or nationals of the United States.

Exceptions to the verification requirement

Citizenship verification is not required for the following:

- Individuals entitled to or enrolled in Medicare;
- Individuals in receipt of SSI payments;
- Individuals receiving SSDI benefits based on disability;
- Children who are in foster care; or
- Children who are recipients of foster care maintenance or adoption assistance payments under Title IV-E.

G-131 Methods of Citizenship Verification

MS Manual 01/01/22

Verification of citizenship will occur through the Federal Data Services Hub (FDSH) or SVES. 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.

NOTE: Citizenship verified through the FDSH or SVES also verifies identity.

G-132 Reasonable Opportunity for Verifying Citizenship

MS Manual 01/01/22

When citizenship cannot be verified through an electronic source or SVES, the agency will provide the applicant a “ninety (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 Health Care 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 Department of Homeland Security 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 ninety (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 (1) is the date of the notice). Eligibility for Health Care 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 fifth (5th) day, the ninety (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 (for example, homeless, mentally impaired, or physically incapacitated) and lacks someone who can act on their behalf, the eligibility worker 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 01/01/22

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 Health Care 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 (1) of the two (2) 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 five (5) years since the Health Care case was closed and the verification had been previously destroyed.

G-140 Alien Status Verification Requirements

MS Manual 01/01/22

Alien status will be verified through SAVE (Systematic Alien Verification for Entitlement). If verification cannot be completed through this process, refer to [MS Appendix C](#). When immigration status cannot be verified through SAVE, the agency will provide the applicant a "ninety (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
- 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 them to the Department of Homeland Security to obtain proof of status. Provide the individual with a ninety (90) day written notice requesting the information and extend notice if additional time is needed. If all other eligibility requirements are met, the Health Care 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 Health Care coverage, the individual will be eligible for emergency services only following the ninety (90) day reasonable opportunity period.

G-141 Reasonable Opportunity for Verifying Alien Status

MS Manual 01/01/22

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 “ninety (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 Health Care eligibility categories.

A notice will be sent to the applicant advising that verification of alien status must be provided within ninety (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 (1) is the date of the notice).

The Health Care begin date will be the first (1st) 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 fifth (5th) day, the ninety (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 (for example, homeless, mentally impaired, or physically incapacitated) and lacks someone who can act on their behalf, the eligibility worker should assist the recipient with obtaining the documentation of alien status.

G-150 Income Verification

MS Manual 01/01/22

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 electronic verification, data matches 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 01/01/22

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 (1) is above and one (1) is below the income limit but the difference between the two amounts is within ten percent (10%) of the one hundred percent (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 nine hundred dollars (\$900) per month. The FDSH provides data that the applicant has an income of nine hundred seventy-five dollars (\$975) per month. The one hundred percent (100%) Federal Poverty Level (FPL) for a household of one (1) is nine hundred fifty-seven dollars and fifty cents (\$957.50) per month. A ten percent (10%) Reasonable Compatibility Standard would equal an amount of ninety-six dollars (\$96) ($957.50 \times 10\% = 95.75$ rounded up to ninety-six (96)). The reported and verified amounts are within ninety-six dollars (\$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 (3) and a monthly income of one thousand six hundred dollars (\$1,600) per month. The FDSH provides data that the applicant has an income of one thousand eight hundred dollars (\$1,800) per month. The one hundred percent (100%) Federal Poverty Level (FPL) for a household of three (3) is one thousand six hundred twenty-seven dollars and fifty cents (\$1,627.50) per month. A ten percent (10%) Reasonable Compatibility Standard would equal an amount of one hundred sixty-three dollars (\$163) ($1627.50 \times 10\% = 162.75$ rounded up to one hundred sixty-three dollars (163)). The reported and verified amounts are not within one hundred sixty-three dollars (\$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 01/01/22

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 eligibility worker should not automatically assume that one (1) check stub accurately reflects earnings for an entire month. Verification of payment for the last thirty (30) days will be required if available.

EXCEPTION: For cases in which the individual has recently started employment and thirty (30) days of verification is not available, the eligibility worker will compute the income from the best information available. Verification of all, if any, paychecks already received by the individual or an employer's statement of anticipated earnings (for example, hourly wage or number of hours expected to work per week) should be obtained.

Verification of earnings from self-employment will be from the Federal Income Tax Return, purchase, sales, and account books or by any other source that 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, they will be advised of the necessity of keeping accurate records so that their income can be determined.

Verification of in-kind earned income (including without limitation, free rent and groceries) will be obtained from the employer. The verification must include the value of the in-kind benefit (including without limitation, the rent amount the client would otherwise pay the cost of groceries provided) and how often it is provided (for example, monthly or weekly). If the amount fluctuates from week to week or month to month, verification of the in-kind earned income paid during the last two (2) months should be obtained.

Verification of unearned income is normally obtained from documentary evidence from the source (for example, an 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 01/01/22

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 eligibility worker 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 [MSE-110](#). Examples of verification include bank statements, trust documents, deeds, etc.

G-181 Verification of Resources using the Asset Verification System

MS Manual 01/01/22

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:

- Nursing Facility;
- ARChoices in Homecare;
- Living Choices;
- Program of All-Inclusive Care for the Elderly (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, and Medically Needy Spend Down Disabled;
- Qualified Medicare Beneficiary (QMB);
- 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, and Disabled Adult Child (DAC);
- Qualified Disabled and Working Individuals (QDWI); and
- TEFRA and Autism.

EXCEPTION: AVS will not provide verification for SSI Categories.

The information provided by AVS is a tool to help locate any liquid resources that the household may have or has had in the three (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.

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G 100 Verification Standards

The balances that will be received will show the balance of the account as of the first (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 ten (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 after the processing of a re-evaluation has been completed is known to the agency and will require appropriate case action.

H-100 Long-Term Services and Supports

MS Manual 08/29/22

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 ([MSH-300](#));
4. Post-Eligibility rules ([MS H-400](#));
5. Long-Term Care Insurance Partnership Program ([MS H-500](#));
6. Estate Recovery ([MS H-600](#)); and
7. Undue Hardship Waiver ([MS H-700](#)).

H-110 Income Trusts

MS Manual 08/29/22

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

H-111 Requirements for an Income Trust

MS Manual 08/29/22

A Miller Income Trust must meet the following conditions:

1. Terms and Other Conditions

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

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

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

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

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

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

2. Consideration of Income

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

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

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

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

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

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](#), [H-402](#), [H-403](#), [H-410](#), [H-415-416](#), and [H-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

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H-200 Spousal Impoverishment

H 202 Initial Assessment

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.

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H-200 Spousal Impoverishment

H 203 Resource Eligibility

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.

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H-200 Spousal Impoverishment

H 205 Determining Resources of the IS After CSRA Computation

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

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H-200 Spousal Impoverishment

H 206 Spousal Protected Amount (CSMR)

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.

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H-200 Spousal Impoverishment

H 211 Rules for Transfer by the CS

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).

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.

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;

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H-300 Transfer of Resources

H 304 Transfers to Trusts

- 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

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H-300 Transfer of Resources

H 304 Transfers to Trusts

- 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

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H-300 Transfer of Resources

H 306 Determining the Value of Compensation Received

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

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H-300 Transfer of Resources

H 308 Determination of Uncompensated Value and Penalty Period

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

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H-300 Transfer of Resources

H 310 Imposing the Penalty

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.

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H-300 Transfer of Resources

H 315 Penalty Continues Without Interruption until Expiration

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

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H-300 Transfer of Resources

H 323 Income Received and Transferred in the Same Month

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 08/29/22

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

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

MS Manual 07/01/20

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

H-402 Consideration of Income

MS Manual 08/29/22

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

1. Income Not From A Trust
 - Income received solely in the name of either spouse will be considered income only to that spouse. Refer to [MS E-432 #5](#) for “Veteran’s Benefits” exceptions.
 - If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS.
 - If payment of income is made in the names of the IS or the CS or both and another person, the income will be considered available to each spouse in proportion to each spouse’s interest. If payment is made with respect to both spouses, and no such interest is specified, one half (1/2) of the joint interest will be considered available to each spouse.

2. Income From A Trust

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

3. Income Through Property With No Instrument Establishing Ownership

When income is from property that has no instrument establishing ownership (for example, income-producing heir's property), half of the income will be considered to be available to the IS and half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 08/29/22

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

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by [MS H-402](#), the IS or the representative will be given the opportunity to rebut the presumption of ownership. To successfully rebut the presumption of full or partial ownership, the IS or the representative must provide the following within thirty (30) days of the date on the Notice of Action:

1. A written, signed statement by the IS alleging ownership, the reason for the applicant's receipt of the income, or for their name appearing as an owner on the payment of the income;
2. Corroborating signed statements from the other owner(s);
3. A change in the instrument of ownership removing the IS's name from the instrument or a change that redirects the income to the actual owner(s); and
4. Copies of the original and revised documents reflecting the change.

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

If the individual elects not to rebut the consideration of ownership interest, the eligibility worker will obtain a written statement from the individual that documents their election.

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

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

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

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

H-410 Factors Used to Determine the Cost of Care

MS Manual 08/29/22

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

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

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the applicant or recipient, their spouse, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed in the eligibility system and a Notice of Action will be sent for the appropriate time period.

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

1. Total Earned and Unearned Income

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

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

2. Income Trust Fees (if applicable)

Deduct the applicable income trust fees. Refer to [MS H-111 #3](#).

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

3. Personal Needs Allowance

Deduct the personal needs allowance (PNA).

- Subtract a forty-dollar (\$40) PNA for most facility residents.
NOTE: Facility residents whose only income is SSI will be allowed to keep thirty dollars (\$30) as their PNA. The PNA of an SSI recipient who also has other income is forty dollars (\$40). Refer to [MS H-420](#).
- Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to ninety dollars (\$90) will be given the full ninety dollars (\$90) as a personal needs allowance. An additional forty dollars (\$40) will not be given. A ninety-dollar (\$90) PNA will not be given to any individual whose VA pension has not been reduced to ninety dollars (\$90) by the Veterans Administration (VA). If VA later reduces the pension to ninety dollars (\$90), an income adjustment will be made. Individuals should contact the Veterans Administration if they believe they are entitled to a ninety-dollar (\$90) reduced pension.

- For residents of ICF/IIDs and State Human Development Centers with earned income, forty dollars (\$40) may be given as a PNA in addition to a disregard of earned income up to the current SSI SPA.
 - For nursing facility residents with earned income, forty dollars (\$40) may be given as a PNA in addition to a disregard of up to one-hundred dollars (\$100) of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. Refer to [MS H-430](#).
4. Community Spouse Monthly Income Allowance (CSMIA)
- A community spouse (CS) may be entitled to a portion of the Institutionalized Spouse's (IS) income. The total amount of the IS's income to which the CS is entitled is the CSMIA. It is calculated by adding the Minimum Monthly Maintenance Needs Allowance (CSMNA) and the Excess Shelter Allowance and subtracting the community spouse's own income. The CSMNA is capped at a Maximum Monthly Maintenance Needs Allowance amount. The excess shelter allowance, CSMNA, and Maximum Monthly Maintenance Needs Allowance change annually. They are set by the federal government and are based on the Consumer Price Index.
 - Shelter costs may include rent or mortgage (including principal and interest), prorated taxes and insurance (including personal property taxes and insurance on household contents if paid yearly), condominium or cooperative fee (including maintenance charges), and the standard utility allowance.
 - Shelter costs must be verified. Utilities need not be verified.
- NOTE:** The standard utility allowance is not allowed if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (for example, water), the full utility allowance may be used.
- The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income, meaning, the actual contributions will be deducted instead of the computed CSMIA. Refer to [MS H-416](#).

- An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA. Refer to [MS H-208](#).
- If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will not be subject to the limit on the CSMNA.

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

- A dependent family member may be entitled to an allowance. See [MS Glossary](#) for definition of dependent family member.
- The FMA is computed for each dependent family member by deducting the family member's income from the CSMNA and by dividing the result by three (3).
- The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income (that is, the actual contribution) will be deducted instead of the computed FMA. Refer to [MS H-415](#).

NOTE: A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether to accept a CSMIA or FMA. The result of accepting an allowance may be reduction or termination of SSI benefits and Health Care. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

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

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

7. Non-covered Medical Expenses

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

- Medicare and other health insurance premiums, deductibles, or coinsurance charges and
- Necessary medical or remedial care recognized under state law but not covered under the state's Health Care plan, subject to reasonable limits the agency may establish on amounts of these expenses

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

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

The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future. Only the non-covered medical expenses for the facility recipient may be deducted.

When there is a contract between an applicant and a medical provider and regular payments on a medical bill are being made, the monthly payment will be deducted as a noncoverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

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

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

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

Other allowable medical expenses (if not subject to payment by a third party) include without limitation: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Health Care formulary; and physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility worker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, including proof of the cost. A copy of the health insurance bill can be used for proof of health insurance premiums, deductibles, and coinsurance.

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

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

Medical expenses can be of three types:

- Monthly - Expenses regularly incurred each month such as the Medicare Part D enhanced plan portion of premiums above the benchmark;
- Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums; or
- One-time - Expenses incurred such as hearing aids.

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

8. Net Income

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

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

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

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

MS Manual 08/29/22

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

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

1. Room and board payment

NOTE: If the individual is receiving assistance through HUD, the deduction can only be for the amount the individual is actually paying.
2. Personal needs allowance (PNA)
3. Court-ordered child support and court-ordered spousal support
4. Monthly medical insurance premiums
5. Non-covered medical expenses including over-the-counter medications and medical supplies

6. Spousal support payments for the community spouse and Family Member Allowance ([MS H-410 #4-6](#))
7. Applicable income trust fees ([MS H-111 #3](#))
8. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician

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

H-413 Contribution to the Cost of Care for PACE

MS Manual 08/29/22

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

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

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

For individuals in the community who are eligible through establishing an income trust, income in excess of the current LTSS Health Care limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTSS/PACE limit of three (3) times the current SSI standard payment amount (SPA), plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-415 Option to Estimate Net Income

MS Manual 07/01/20

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

H-416 Verification or Refusal of Contributions

MS Manual 08/29/22

Prior to certification of the Institutionalized Spouse (IS), the IS or representative must indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) and the Family Member Allowance (FMA) specified on the Notice of Action during the period of institutionalization.

Otherwise, no allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income.

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual 07/01/20

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

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

No extension beyond the three months will be allowed.

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

MS Manual 07/01/20

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to contribute to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

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

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

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

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

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

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

MS Manual 08/29/22

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

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

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

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

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

2. Fluctuating Earnings

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

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

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

- every six (6) months when earnings are fairly stable; or
- more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than fifteen dollars (\$15) above the computed average.

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

MS Manual 08/29/22

The effective date of eligibility of an applicant for nursing home and ICF/IID depends on three (3) factors:

1. Date of Entry

The individual's date of entry into a participating facility is indicated on the DCO-0702, Notice of Admission, Discharge or Transfer From a Facility, which is completed by the facility and forwarded to both the DPSQA Office of Long-Term Care and the County Office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity

Medical necessity is determined by the DPSQA Office of Long-Term Care. The medical necessity decision is transmitted to the County Office and the facility by the DHS-0704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-0704 is received by the County Office on an applicant that classifies them for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Health Care was made. However, if the patient is in an ICF/IID facility or was subject to Pre-Admission Screening and Annual Resident Review (PASARR), medical necessity begins on the DHS-0704 decision date for ICF/IID or PASARR date for PASARR residents, and Health Care and vendor payment cannot begin prior to this date.

3. Date of Categorical Eligibility

Categorical eligibility for facility care and services under the AABD criteria can be established to begin three (3) months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three-month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, the begin date for Health Care and vendor payment cannot be prior to the decision date on the DHS-0704 for ICF/IID applicants or PASARR date for individuals subject to PASARR.

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-200 Families and Individuals (MAGI) Groups Renewal Process

I 230 Newborns Renew in ARKids First

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.

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-300 AABD Eligibility Groups Renewal Process

I 320 Alternate Renewal Processes

I-300 AABD Eligibility Groups Renewal Process

MS Manual 07/01/20

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

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

See [Appendix O](#) for the specific renewal form that is used for each of the AABD groups.

I-320 Alternate Renewal Processes

MS Manual 07/01/20

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

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

The following sections describe their renewal processes.

I-321 ARChoices Waiver

MS Manual 07/01/20

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-300 AABD Eligibility Groups Renewal Process

I 322 Assisted Living Facility

I-322 Assisted Living Facility

MS Manual 07/01/20

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

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

I-323 PACE

MS Manual 07/01/20

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

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

I-324 Division of Developmental Services

MS Manual 07/01/20

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-300 AABD Eligibility Groups Renewal Process

I 325 TEFRA

I-325 TEFRA

MS Manual 07/01/20

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

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

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

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

A review by MRT is also necessary if the eligibility worker becomes aware of significant improvement and/or employment at or near the SGA level. Refer to [MS F-125](#).

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

I-326 Autism Waiver

MS Manual 07/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-300 AABD Eligibility Groups Renewal Process

I 327 Medicare Savings Program (MSP)

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

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

I-327 Medicare Savings Program (MSP)

MS Manual 07/01/20

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

Refer to [Appendix O](#) for a list of required renewal forms.

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-400 Foster Care and Adoption Assistance Eligibility Groups Renewal Process

I 400 Foster Care and Adoption Assistance Eligibility Groups Renewal Process

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 07/01/20

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

I-510 ARKids A & B

MS Manual 01/01/24

If information is provided that would cause the ARKids recipient to be ineligible, the ARKids recipient will not change coverage during their twelve (12) month continuous coverage period. (Refer to [MS A-230](#).)

I-520 Adult Expansion Group

MS Manual 07/01/20

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

I-530 Medicare Savings Programs

MS Manual 07/01/20

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-500 Categorical Changes

I 531 Medicare Savings Programs COLA Increases

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

I-531 Medicare Savings Programs-COLA Increases

MS Manual 07/01/20

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

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

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

I-532 Simultaneous Coverage In Other Categories

MS Manual 07/01/20

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-500 Categorical Changes

I 540 Alternating TEFRA and SSI Eligibility

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

I-540 Alternating TEFRA and SSI Eligibility

MS Manual 07/01/20

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

I-541 Autism Waiver

MS Manual 07/01/20

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

I-550 Money Follows the Person (MFP)

MS Manual 07/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-500 Categorical Changes

I 551 MFP Procedures for Medicaid Recipients Who Leave Facility Care

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

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

MS Manual 07/01/20

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

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

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

I-570 Workers with Disabilities Eligible to Receive ARChoices or CES Waiver Services

Refer to Health Care Procedures Manual for more information.

MS Manual 03/22/25

The ARChoices and Community Employment Support (CES) Waivers include the Workers with Disabilities category as a group that is eligible for services within the Waivers. In order to be eligible for ARChoices or CES Waiver services and the Workers with Disabilities category, applicants must meet both the functional need criteria of the ARChoices and CES Waiver program (MS F-155 and MS B-317) and the financial criteria of the Workers with Disabilities category (MS B-330).

MEDICAL SERVICES POLICY MANUAL, SECTION I


I-500 Categorical Changes

Services

Recipients will be able to access services through ARChoices or CES Waivers, provided that the medical criteria for ARChoices or CES 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.

ARChoices and CES Transition to the Workers with Disabilities Category

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-600 Changes

I 610 Loss of Eligibility

I-600 Changes

MS Manual 07/01/20

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

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

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

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I

I-600 Changes

I 610 Loss of Eligibility

I-610 Loss of Eligibility

MS Manual 07/01/20

Loss of eligibility occurs when the eligible individual:

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

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

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

I-620 Alternative Change/Closure Processes

MS Manual 07/01/20

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

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

- TEFRA
- Autism
- SSI Related Groups
- Pregnant Women

I-630 ARChoices Waiver

MS Manual 06/01/25

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

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the Waiver case will be closed. If the Waiver case is closed for any reason, the system will determine if the client is eligible for any other Health Care 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 (1) 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 (For example: land rent paid annually), procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted.

If the Waiver client will be ineligible for more than one (1) month, the case will be closed and a new application will be required.

A Waiver client may appeal an adverse decision made on their case as outlined in [MS L 100-173](#). If a timely appeal is received on or before the date listed on the Notice of the Action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

I-631 ARChoices Waiver Temporary Absences from the Home

MS Manual 07/01/20

Once an ARChoices Waiver application has been approved, Waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the County Office will be notified immediately by the DHS RN when Waiver services are discontinued and action will be initiated by the County Office to close the Waiver case.

1. Institutionalization

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

a) Hospitalization

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

b) Nursing Facility Admission

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


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

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

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

2. Absence from the Home - Non-Institutionalization

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

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

I-640 Living Choices (Assisted Living Facility)

MS Manual 06/01/25

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

If the Living Choices Waiver client loses eligibility for one (1) month only, the case may remain open with an overpayment submitted for the month of ineligibility. When DHS has advance knowledge of ineligibility in a future month, procedures at [MS E-410](#) will be followed, advance notice given, and the case adjusted at the appropriate time.

If the Living Choices recipient will be ineligible for more than one (1) month, the case will be closed and a new application will be required to reopen.

A Living Choices Waiver recipient may appeal an adverse decision made on their case as outlined in [MS Section L-100](#). If a timely appeal is received on or before the date listed on the Notice of the Action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out.

I-641 Temporary Absences from the Assisted Living Facility

MS Manual 07/01/20

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

1. Hospitalization

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

2. Nursing Facility Admission

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

If the individual does not return to the ALF, but stays in the nursing facility and requests nursing facility vendor payment, the Medicaid case may be left open while processing the nursing facility application. If found eligible for vendor payment, the vendor payments will be authorized beginning the date of entry to the nursing facility. If found NOT eligible for vendor or if after 30 days in a facility the individual does not apply for vendor payment, appropriate notice will be given for case closure.

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

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

I-650 DDS Waiver

MS Manual 06/01/25

Recipients will be required to report changes to DDS within ten (10) days. Eligibility will be redetermined when information is received about changes in a recipient's circumstances. When a change occurs that results in ineligibility, an advance notice will be given unless advance notice is not required. Refer to [MS J-130](#).

Eligibility will end at the end of the advance notice period, unless the recipient or their legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the notice period.

I-660 TEFRA

MS Manual 06/01/25

When a change occurs that affects eligibility, the applicant will be sent an advance notice, unless advance notice is not required. (Refer to [MS J-130](#).)

I-670 Autism Waiver

MS Manual 07/01/20

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

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

MS Manual 07/01/20

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

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

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

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

MS Manual 07/01/20

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

J-100 Notice of Action Requirements

MS Manual 06/1/25

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 or reduction of assistance. The following sections define these notice requirements and list when advance notice is not required.

J-110 Advance Notice for Termination of Assistance

MS Manual 06/01/25

When the Division of County Operations (DCO) proposes to terminate assistance for a recipient, advance notice will be sent to the recipient using a form called a "Notice of Action." The effective date of any reductions or terminations of service, as well as time for appeals, is counted from the date listed on the Notice of Action.

Advance Notice must contain all information listed in [MS J-100](#). To provide the recipient with time to appeal the adverse decision, the effective date of the action will be no earlier than thirty-five (35) days from the date listed on the Advanced Notice. If a hearing is not requested within thirty-five (35) days of the date listed on the Advance Notice, the adverse action indicated on the notice will be taken.

J-120 Advance Notice for Reduction of Assistance

MS Manual 06/01/25

Reduction of assistance means a change in vendor payment or a categorical change resulting in a reduction in benefits in the service package (For example: changing from ARKids A to ARKids B). When the recipient's income increases, an 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 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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

K 101 Extent of Services

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

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

K 103 Initial Determination of Eligibility

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. [MSG-130](#) and [MSG-134](#)). The SSN enumeration requirement, however, cannot be waived.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

K 105 DCFS Eligibility Unit Responsibilities for Initial Eligibility

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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

K 106 Reevaluations

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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

K 109 Transfers Out of State

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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-100 Medicaid Coverage of Foster Children

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](#)).

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-200 Non-Title IV-E Adoptive Children With Special Needs

K 203 Retroactive Coverage

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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-200 Non-Title IV-E Adoptive Children With Special Needs

K 204 Reevaluations

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.

MEDICAL SERVICES POLICY MANUAL, SECTION K

K-400 Procedures for IV-E Children Who Leave Arkansas

K 401 Family Service Worker and Adoption Specialist Responsibilities

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 06/01/25

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 Spouse (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 a reduction in medical assistance. A request for a hearing must be received in the Office of Appeals and Hearings (OAH) within 35 days of the Notice of Action date.

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.

MEDICAL SERVICES POLICY MANUAL, SECTION L

L-100 Administrative Hearings

L 111 DCO Administrative Hearing File



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

MEDICAL SERVICES POLICY MANUAL, SECTION O

O-500 SSI Related Treatment of Income (AABD-MN)

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



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.

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 [MSO-531 Deeming of Income from an Ineligible Spouse](#);
2. Compare the result derived from Step 4 of [MSO-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.

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

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

MS Manual 06/01/25

The system will automatically affect closure of current open Spend Down cases and all cases which are converted to SSI eligibility. With the exception of closed past Spend Down and Fixed Eligibility Certifications, the advance notice applies to all categories.

Eligibility for Health Care ceases at the end of the 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

MS Manual 01/01/14

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)

