Notice of Rule Making

Pursuant to Arkansas Code 20-76-201, the Director of Division of County Operations issues the following proposed changes to Medical Services Policy A-210, B-500 and D-372 effective September 1, 2017.

The proposed rule change revises Medical Services policy section A-210, B-500 and D-372 to remove the retroactive coverage option for the Arkansas Works Program.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-332, Little Rock, AR 72203, Attention: Office of Program Planning & Development. You may also access it on the DHS website http://humanservices.arkansas.gov/Pages/LegalNotices.aspx. All comments must be submitted in writing to the address indicated above no later than July 13, 2017.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 501-682-8922 (voice) or 501-682-8933 (TDD).

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

Mary Franklin,
Director, Division of County Operations

Date: 6/12/17

A-210 Retroactive Eligibility

MS Manual **09/01/17**

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

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

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

- NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.
- NOTE: **Beginning September 1, 2017, Adult Expansion Group recipients will not be eligible for retroactive coverage prior to the month of application.**

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

For cases in which an applicant has not resided in Arkansas for three full months prior to the date of application, the retroactive period begins with the date the individual established residency in Arkansas. The "previous state" is responsible for the retroactive period prior to the time the applicant established residency in Arkansas. The caseworker is responsible for providing the "previous state" with information necessary to determine eligibility for its portion of the retroactive period.

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

B-500 Emergency Medicaid Services for Aliens

MS Manual **09/01/17**

This group consists of:

- Nonqualified aliens living in the U.S or
- Qualified aliens living in the U.S. for less than 5 years.

Medicaid benefits are available to pay for the cost of emergency services for aliens who do not meet the Medicaid citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, **Medically Needy,** Adult Expansion, ARKids A or B.

NOTE: Emergency Medicaid applicants will not be approved for retroactive coverage prior to the month of application in the Adult Expansion Group.

To be eligible for emergency Medicaid, the applicant must have, or must have had within the last 3 months, an emergency medical condition. Labor and delivery is considered an emergency medical condition.

Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily part or organ

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset, a sharp rise and last a short time. If the individual's condition is chronic (ongoing), such as cancer, AIDS, end-stage renal disease, etc., it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as **not** qualifying under emergency services.

B-500 Emergency Medicaid Services for Aliens

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. (e.g. the date of admission through the date of discharge from the hospital). The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the Medicaid begin and end dates entered in the system.

Emergency services are defined as services provided in a hospital, clinic, office or other facility equipped to furnish the required care after the onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

To determine if an applicant's doctor visit, emergency room visit or hospital stay was considered an emergency, the discharge summary for the medical visit will be sent to OPPD, S333 for an emergency medical determination.

D-372 Inmates Being Released for Inpatient Treatment

MS Manual 09/01/17

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 will not be approved for retroactive coverage prior to the month of application in the Adult Expansion Group.

D-373 Suspension of Medicaid Coverage for an Inmate

MS Manual 09/01/17

The appropriate correctional facility will notify DHS when a Medicaid or Health Care Independence Program 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.