A-210 Retroactive Eligibility

MS Manual 01/01/22

Refer to Health Care Procedures Manual for more information.

The State is required to provide retroactive eligibility for up to three (3) 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, that is, applicants not eligible for the current period may be eligible for the retroactive period. Retroactive eligibility determinations are required for all categories, except ALF, ARChoices, Autism, DDS Waiver, QMB, and PACE.

> **NOTE:** Retroactive coverage for Newborns will not be given prior to the date of birth.
> **NOTE:** Beginning May 1, 2018, Adult Expansion Group recipients may be eligible for retroactive coverage thirty (30) days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

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

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

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

For cases in which an applicant has not resided in Arkansas for three (3) 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 eligibility worker 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 (that includes, without limitation: utilization review, benefit limitations, medical

necessity). 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 Health Care (Medicaid) program. The State is not required nor obligated to pay for services which have been retroactively determined by Utilization Review to be unnecessary.

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

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

B-100 Eligibility Groups

MS Manual 01/01/2022

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 01/01/2022

Most individuals under 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 orchildren, 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 01/01/2022

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 Health Care, ARKids First & You for a summary of the benefit packages which highlights the differences in the two (2) packages.

B-220 Newborns

MS Manual 01/01/2022

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 01/01/2022

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 01/01/2022

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 01/01/2022

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 01/01/2022

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.

B-270 Adult Expansion Group (ARHOME)

MS Manual 01/01/2022

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.

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 coverages 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-310 Long Term Services and Supports

MS Manual 01/01/2022

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

B-311 Nursing Facility

MS Manual 01/01/2022

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

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

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

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

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

B-312 Living Choices

MS Manual 01/01/2022

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

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

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

B-313 ARChoices in Homecare

Refer to Health Care Procedures Manual for more information.

MS Manual 01/01/2022

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

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

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

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

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

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

B-315 TEFRA

MS Manual 01/01/2022

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

The income limit is three (3) times the current SSI payment standard. Only the child's income is considered. Parental income is not considered in the eligibility determination but is considered for the purpose of calculating the monthly premium. For information regarding TEFRA premiums and calculation, refer to MS F-170-172. The resource limit is two thousand dollars ($2000). Only the child's resources are considered. Parental resources are disregarded. Recipients of TEFRA Waiver receive the full range of Health Care benefits and services.

B-316 Autism Waiver

MS Manual 01/01/2022

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

B-317 PACE-Program of All Inclusive Care for the Elderly

MS Manual 01/01/2022

This group consists of individuals fifty-five (55) years of age or older who need nursing facility care to live as independently as possible. PACE is a comprehensive health and social services program that provides and coordinates primary, preventive, acute and Long Term Care Services. Individuals under sixty-five (65) years of age must establish physical disability through SSI/SSA, through the DHS Medical Review Team (MRT), or Railroad Retirement. In addition to the general eligibility requirements, the individual must require one of the four levels of nursing facility care of skilled, Intermediate I, Intermediate II, or Intermediate III. The individual must also meet special medical criteria as defined in MS F-155.

The individual's income cannot exceed three (3) times the current SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. Spousal impoverishment policy for income MS H-400-H-430 and resources MS H-200-212 will apply to PACE participants both in the community and in a nursing facility.

Transfer of resources (MS H-300) will apply only if the PACE participant enters a nursing facility. The resource guidelines at MS E-500 will be followed. PACE services are provided in PACE Centers, in the home, and in inpatient facilities. The PACE program is only available in certain counties in Arkansas.

B-320 Medicare Savings Programs (MSP)

MS Manual 01/01/2022

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

B-321 ARSeniors

MS Manual 01/01/2022

This group consists of individuals sixty-five (65) years of age or over whose income is equal to or below eighty percent (80%) of the Federal Poverty Levels (FPL). Recipients do not have to be entitled to Medicare (for example, Qualified Aliens who have not worked enough quarters to qualify for Medicare can still be eligible for ARSeniors). If the individual is entitled to Medicare, they must receive Medicare. If the individual chooses not to enroll in Medicare (if eligible), they are not eligible for the ARSeniors program. ARSeniors provides full Health Care coverage. Refer to MS F-190.

B-322 Medicare Savings Programs - Comparison Chart

Refer to Health Care Procedures manual for more information.

MS Manual 01/01/2022

B-330 Workers with Disabilities

MS Manual 01/01/2022

This group consists of individuals who:

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

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

Substantial Gainful Activity (SGA) is not considered for the disability determination. In addition, the individual's total unearned income (minus the twenty dollar ($20) general exclusion) must be under the SSI payment amount for one (1) person to qualify for this group.

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

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

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

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

MS Manual 01/01/2022

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

B-341 Supplemental Security Income (SSI) Cash Eligibles

MS Manual 01/01/2022

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

B-342 Eligible Due to Disregard of Social Security Cost of Living Adjustment (COLA) Increases (Pickle)

MS Manual 01/01/2022

This group consists of individuals who become ineligible for SSI payments due to Social Security cost of living adjustment (COLA) increases. It also includes individuals who lost SSI for any reason, if the individual would be SSI eligible today by disregard of all COLA's received on SSA benefits since the loss of SSI. The individual must have previously been entitled to SSA and eligible for SSI concurrently in at least one (1) month after April 1977. Individuals in this group must be current SSA recipients. They are eligible for the full range of Health Care benefits and services.

B-343 Health Care for Widows and Widowers with Disabilities (COBRA)

MS Manual 01/01/2022

This group consists of widows and widowers with a disability who became entitled to receive SSA benefits between fifty (50) and fifty-nine (59) years of age, entitled to SSA for December 1983 and lost SSI benefits after January 1984 due to an increase in SSA widow's or widower's benefits due to elimination of a benefits reduction factor. The individual must have continuously received widow's or widower's benefits since their SSI benefits were terminated and would be eligible for SSI if the amount of the 1984 reduction factor increase and any subsequent COLA increases were disregarded.

B-344 Widows and Widowers with Disabilities (OBRA 87)

MS Manual 01/01/2022

This group consists of widows and widowers with a disability who were at least sixty (60) years of age on or after April 1, 1988 and not yet sixty-five (65) years of age on April 1, 1988 and who were former recipients of SSI whose benefits were terminated due to entitlement to SSA widow's or widower's benefits. They must still be a current recipient of widow's or widower's benefits (may also receive concurrent other SSA benefits), not currently eligible for Medicare, would still be eligible for SSI if all SSA benefits were disregarded, and otherwise income and resource eligible for Health Care.

B-345 Health Care for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 90)

MS Manual 01/01/2022

This group consists of widow or widowers with a disability and surviving divorced spouses with a disability who lost their SSI due to receipt of SSA widow or widower or disabled surviving divorced spouse benefits. The individual must currently be (1) receiving SSA widow or widower or disabled surviving divorced spouse benefits, (2) not entitled to Medicare Part A, (3) would still be eligible for SSI if all SSA benefits were disregarded as income and (4) resource eligible under the AABD resource limits in MS E-500. Individuals found eligible under these provisions are entitled to the full range of Health Care benefits.

B-346 Disabled Adult Children (DAC)

MS Manual 01/01/2022

This group consists of individuals who lost their SSI after July 1, 1987 due to SSA Disabled Adult Children (DAC) entitlements or due to increases in their DAC benefits.

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

An individual who may be eligible for Health Care in this categorically eligible group is one who:

- Is eighteen (18) years of age or older;
- Was determined to be blind or have a disability before twenty-two (22) years of age;
- Was receiving SSI based on a disability determination or blindness; and
- Lost SSI on or after July 1, 1987 due to a DAC entitlement or a DAC increase.

B-400 Foster Health Care

MS Manual 01/01/2022

This group consists of children who are in the custody of the State of Arkansas because of removal from a parent or caregiver.

The eligibility criteria for this group are explained in MS Section K.

Children who "age out" of foster care at eighteen (18) or twenty-one (21) years of age, if an agreement has been signed by the child to remain in foster care, will be eligible for the Former Foster Care category of Health Care (MS B-260).

B-500 Emergency Health Care Services for Aliens

Refer to Health Care Procedures Manual for more information.

MS Manual 01/01/2022

This group consists of:

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

Health Care benefits are available to pay for the cost of emergency services for aliens who do not meet the Health Care 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 Health Care applicants, if eligible in the Adult Expansion Group, may be approved for retroactive coverage thirty (30) days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

To be eligible for emergency Health Care, the applicant must have, or must have had within the last three (3) months, an emergency medical condition. For the exception, see NOTE above. 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; or
- 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), 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.

F-110 Age and Relationship

MS Manual 01/01/2022

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 bydegree 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 consideredwithin 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 removedfrom 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 01/01/2022 42 U.S. Code § 1382c.

Some eligibility groups require an individual to either be blind or have a disability. The particularblindness 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 (withcorrection) 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 individualfrom 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 ofentitlement, 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 RRpayment.
3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefitcontinuation, 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 isno longer disabling.
4. Non-receipt of SSI cash benefits for reasons other than disability, but verification of anestablished disability that is current and continuing (for example, TEFRA child).
5. Receipt of the DCO-0109, Report of Medical Review Team decision, when blindness ordisability 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 01/01/2022

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSAdeterminations must be presented to SSA for reconsideration within sixty (60) days of the SSA denial notice. If the decision has not been appealed within sixty (60) days, the individual may still request a reopening of the decision within one (1) year.

Therefore, the agency must refer to SSA all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled" for reconsideration or reopening ofa 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 cashassistance and Health Care.

F-122 Medical Review Team (MRT)

MS Manual 01/01/2022

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 itappears 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 RailroadRetirement (RR).
2. The individual has been found NOT eligible for Social Security Disability or SSI forreasons 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 additionto) 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 madethe 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.

F-123 Dual Applications

MS Manual 01/01/2022

When an individual applies for both Health Care and Social Security Disability or SSI, and the application with SSA is still pending, if the individual appears to meet all other eligibility requirements a MRT determination of disability will be initiated. The agency will have ninety (90) daysfrom the date of the Health Care application to make this determination. If application for Social Security Disability is approved first, the Health Care application may be approved (if all other requirements have been met.) If application for SSI is approved first, the Health Care application will be denied except for ARChoices, Living Choices, Autism, DDS, NursingFacility (NF) and PACE which may be approved. If SSA determines the applicant is NOT disabled,the Health Care application will be denied.

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

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

F-125 MRT Decision

MS Manual 01/01/2022

The Medical Review Team (MRT) will report the decision regarding physical or mental incapacityto the eligibility worker on a DCO-0109.

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

If MRT finds that the medical information is not adequate to make a decision, further medical, psychiatric, and psychological examinations may be recommended by MRT at the expenseof the agency.

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

F-130 Child Support Enforcement Services

MS Manual 01/01/2022

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Health Care recipients who have assigned to the state their rights to medical support. Each applicant or recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

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

1. Referrals

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

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

   NOTE: If the father's name is included on the birth certificate of a child born April 10, 1995, or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parentsare in the home, there is no need to make a referral in these instances.

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

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

- Parent, guardian, or caretaker relative is not receiving Health Care, but the children are receiving Health Care;
- Parent, guardian, or caretaker relative is the only one receiving Health Care and thechildren are not receiving Health Care; or
- Parent, guardian, or caretaker relative is receiving Health Care in an exempt category (that being, Limited Pregnant Woman).

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

2. Good Cause

An applicant or recipient may have good cause not to cooperate in the state's efforts tocollect child or Medical support. The applicant or recipient may be excused from cooperating if they believe that cooperation would not be in the best interest ofthe child, and if the applicant or recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that theapplicant or recipient has good cause for refusing to cooperate:

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

3. Refusal to Cooperate-Sanction

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

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

MS Manual 01/01/2022

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

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

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

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

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

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

2. Categorical Relatedness - To meet the requirement of categorical relatedness, the individual must meet one (1) of the following:

   Aged - Sixty-five (65) years of age or older (MS F-110);

   Blind - 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 (MS F-120); or

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

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

F-151 Functional Need

MS Manual 01/01/2022

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

Functional need decisions for:

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

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

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

Redetermination of Functional Need

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

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

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

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

F-152 DCO Institutional Status

MS Manual 01/01/2022

Evidence of institutional status includes without limitation, any written document or record from a hospitalor nursing facility that verifies that the individual was in the hospital or nursing facility for thirty (30) consecutive calendar days. Refer to MS F-150.

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

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

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

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

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

F-155 Functional Need Criteria

MS Manual 01/01/2022

Individuals requiring services in ARChoices or Living Choices must be classified as requiring an Intermediate(I-A, II-B, III-C) Level of Care as determined by the DPSQA Office of Long-Term Care (OLTC).

Individuals classified as Skilled Care patients are not eligible for ARChoices (or Living Choices).

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

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

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

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

ARChoices, Living Choices, and PACE

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

DDS

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

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

F-160 Primary Care Physician Requirements

MS Manual 01/01/2022

A Health Care case can be approved before a Primary Care Physician (PCP) is selected; however,the PCP must be selected before most services can be accessed.

F-161 Primary Care Physician Managed Care Program

MS Manual 01/01/2022

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

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

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

Generally, a recipient must receive medical services from only the PCP or from the medical provider referred to by the PCP. There are some services which are excluded from the Primary Care Case Management (PCCM) system. A recipient can receive these services without a referralfrom the PCP. Refer to Form DCO-2613, Notice to Health Care Applicants/Recipients, for a list of these excluded services.

F-171 Determining Monthly Premiums

MS Manual 01/01/2022

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

- Six hundred dollars ($600) per child, biological or adopted including the waiver child,who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents; and
- Excess medical and dental expenses as itemized on Schedule A of the Federal IncomeTax Return of the parents (for example, line four (4) on the 2018 version of Schedule A).

EXAMPLE 1: Family consists of five (5) people – mom, dad, TEFRA child, and two (2) minor siblings,living in the home. Total income on last year's Federal Income Tax Return showed sixty-five thousand four hundred seventeen dollars and forty-eight cents ($65,417.48). Excess medical and dental on Schedule A showed nine thousand four hundred sixty-three dollars and twenty-five cents ($9,463.25). All children in the home were included on the return.

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

Compare the adjusted income to Chart 1 in Appendix P. The income isabove the limit for a family size of five. Go to Chart 2. The premium range forthe adjusted income is from fifty-two dollars ($52.00) to seventy-eight dollars ($78.00).

EXAMPLE 2: Same family with less income reported.

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

Comparing income in Chart 1 in Appendix P, the annual income is belowthe 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 theFederal 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 amountto 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-180 Other Health Insurance Coverage

MS Manual 01/01/2022

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 describedbelow.

Adult Expansion Group

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

ARKids B

Children who have health insurance or who have been covered by health insurance other than Health Care in the ninety (90) days preceding the date of application will not be eligible for ARKids B unlessone of the following conditions is met:

a. The premium paid by the family for coverage of the child under the group health planexceeded five percent (5%) of household income.

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

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

c. The cost of family coverage that includes the child exceeds nine and five tenths percent (9.5%) of the householdincome.

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

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

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

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

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

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

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

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

MS Manual 01/01/2022

Medicare entitlement is an eligibility requirement for all Medicare Savings Programs (except ARSeniors), even though the requirement differs somewhat between the five groups. Medicareentitlement means that the individual has applied for, is eligible for, and is enrolled in MedicarePart A.

Conditionally eligible means that an individual can be enrolled (entitled) for Part A Medicare only on the condition that they are eligible for Qualified Medicare Beneficiaries (QMB), and thus eligible for the state agency to pay the Part A premium as part of the QMB benefits. The Medicare entitlements requirement is as follows:

- ARSeniors – Individuals do not have to be entitled to Medicare (for example, Qualified Aliens who have not worked enough quarters to Qualify for Medicare can still be eligible for ARSeniors). However, individuals who are entitled to Medicare and choose not to enrollin Medicare are not eligible for the ARSeniors program.
- Qualified Medicare Beneficiary (QMB) – Individuals must be entitled to or conditionally eligible for Medicare Part A.
- Specified Low-Income Medicare Beneficiaries (SMB) – Individuals must be entitled toMedicare Part A.

- Qualifying Individuals 1 (QI-1) – Individuals must be entitled to Medicare Part A.
- Qualified Disabled and Working Individuals (QDWI) – Individuals who lost Medicare PartA & SSA Disability Insurance Benefits (DIB) benefits due to Substantial Gainful Activity (SGA). The individual must be eligible to reenroll in Medicare Part A. Refer to MS F-192.

F-191 Medicare Part A Entitlement

MS Manual 01/01/2022

Medicare Part A beneficiaries include the following groups:

Persons sixty-five (65) years of age or older who are:

a. Entitled to monthly Social Security benefits on the basis of covered work underthe Social Security Act, or qualified Railroad Retirement beneficiaries;

b. Not entitled to monthly Social Security or Railroad Retirement benefits but meet the requirements of a special transitional provision (some individuals whoare not eligible for regular SSA or Railroad Retirement benefits still qualify for Part A hospital insurance);

c. Not entitled to monthly Social Security benefits and not a qualified Railroad Retirement beneficiary but enrolled and paying a monthly premium. To be eligible under this provision, an individual must be sixty-five (65) years of age or older, a U.S. resident, and a U.S. citizen or an alien lawfully admitted for permanent residence who has resided continuously in the U.S. for five (5) years, and enrolledfor Part B medical insurance or has filed a Part B enrollment request which willentitle the individual to Part B; and

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

2. Persons under sixty-five (65) years of age who are entitled to or deemed entitled to Social Security disabilitybenefits for twenty-four (24) months (included are workers with disabilities, widow(er)s with disabilities, surviving divorced spouses with disabilities, and individuals entitled to childhood disability benefits) beginning with the twenty-fifth (25^{th}) month of entitlement to such benefits, and certain individuals entitled to Railroad Retirement benefits due to a disability.
3. Persons of any age who have end-stage renal disease (ESRD) who require a kidney transplant or a regular course of dialysis and who are Social Security or Railroad Retirement recipients, or the spouse or a child of an SSA recipient when the spouse orchild has ESRD.

F-100 Non-Financial Eligibility Requirements

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

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

Individuals Entitled to Part A Without Payment of Part A Premium

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

An individual who fails to enroll for Medicare upon attainment of sixty-five (65) years of age may enroll during the General Enrollment Period (January through March of each year). If the individual enrolls duringthe General Enrollment Period (January through March), coverage starts on July 1 following enrollment.

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

1. SSI Recipients

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

2. Non-SSI Individuals Receiving Part B Medicare

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

3. Individuals Not Receiving Part A or Part B Medicare

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

F-193 Initial Enrollment Period and General Enrollment Period forMedicare Part A

MS Manual 01/01/2022

A Qualified Disabled and Working Individuals (QDWI) applicant must reenroll for Medicare PartA, if they have not previously reenrolled prior to making application.

The Social Security Administration will send notices to those individuals who lost or will lose Medicare Part A solely due to Substantial Gainful Activity (SGA), advising them to contact theSSA office. Once reapplication has been made for Medicare Part A, SSA will refer potentially eligible individuals to the County Office to make a QDWI application.

If an individual applies at the County Office prior to reenrolling for Medicare Part A, the individual will be instructed to contact the SSA Office to reenroll for Medicare Part A andprovide verification of reenrollment and the effective date of coverage.

The Individual Enrollment Period begins with the month in which the individual receives noticefrom SSA that their entitlement to Disability and Medicare will end solely due to SGA. The enrollment period ends seven (7) months later.

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

F-100 Non-Financial Eligibility Requirements

G-100 Verification Standards

MS Manual 01/01/2022

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-111 Eligibility Factors That Require Verification

MS Manual 01/01/2022

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

- Social Security Number (SSN);
- Citizenship;
- Alien Status;
- Income;
- Age and Date of Birth;
- Disability (when required); and
- Resources (for categories that require a resource test refer to MS E-110).

NOTE: When citizenship cannot be verified via the electronic sources, the applicant will be notified to provide verification of citizenship and identity. Refer to MS G-133.

Refer to sections below for specific information regarding verification of the above eligibility factors.

G-113 Verification Sources

MS Manual 01/01/2022

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 01/01/2022

Verification must first occur through electronic sources. If unable to obtain verification though 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 01/01/2022

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 01/01/2022

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 01/01/2022

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 01/01/2022

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 01/01/2022

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 (5^{th}) 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-134 Subsequent Citizenship Verification

MS Manual 01/01/2022

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 01/01/2022

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 01/01/2022

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 (1^{st}) 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 (5^{th}) 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 01/01/2022

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 01/01/2022

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 91) 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 X 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 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 X 10% = 162.75 rounded up to one hundred sixty-three (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 01/01/2022

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 and 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 01/01/2022

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-181 Verification of Resources using the Asset Verification System

MS Manual 01/01/2022

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 haveor 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.

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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of County Operations

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE AR Home Integration

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	

Other (Identify)		Other (Identify)	
Total	$0	Total	$0

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$113,306	General Revenue	$0
Federal Funds	$1,019,750	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 1,133,055	Total	$ 0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$

Next Fiscal Year
$

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ $113,306

Next Fiscal Year
$ $0

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

With the implementation of Arkansas Health and Opportunity for Me (ARHOME) and the implementation of the new integrated system it has become necessary to update the Medical Services Policy. The Medical Services Policy is being updated to reflect the replacement of ARWorks, the addition of new programs provided through ARHOME, and the removal of business processes. This will allow the business process to change independently of the Policy Manual. The Director of the Division of County Operations (DCO) amends the Medical Services Policy Manual, Sections A-210, B, G, & F. The implementation of ARHome as well as a new integrated system necessitates the changes.

DCO also makes technical and grammatical corrections and removes business processes that do not meet the statutory definition of a rule. DCO changes income verification concerning information received from the Asset Verification System.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**;**

With the implementation of Arkansas Health and Opportunity for Me (ARHOME) and the implementation of the new integrated system it has become necessary to update the Medical Services Policy. The Medical Services Policy is being updated to reflect the replacement of ARWorks, the addition of new programs provided through ARHOME, and the removal of business processes. This will allow the business process to change independently of the Policy Manual. The Director of the Division of County Operations (DCO) amends the Medical Services Policy Manual, Sections A-210, B, G, & F. The implementation of ARHome as well as a new integrated system necessitates the changes. DCO also makes technical and grammatical corrections and removes business processes that do not meet the statutory definition of a rule. DCO changes income verification concerning information received from the Asset Verification System.

This is required by statute.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

This system change is required for the implementation of AR Home.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; **This system change is required for the implementation of AR Home.**

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **None**

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **None**

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and **N/A**

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. **1115 Waivers require renewal and review every five years.**