

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

A-100 General Program Information

MS Manual 07/01/2005/01/18

The Medicaid Program is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services, Divisions of County Operations and Medical Services have the responsibility for administration of the Medicaid Program. The purpose of Medical Services is to provide medical assistance to low income individuals and families and to insure proper utilization of such services. The Division of County Operations will accept all applications, verification documents, etc. and will make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include, but are not limited to the following:

- Emergency Services
- Home Health and Hospice
- Hospitalization
- Long Term Care
- Physician Services
- Prescription Drugs
- Transportation-Refer to Appendix B for a description of Transportation Services

Generally, there is no limit on benefits to individuals under age 21 who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over age 21. Consult "Arkansas Medicaid, ARKids First & You, Arkansas Medicaid Beneficiary Handbook" (PUB-040) for specific information and covered services.

The Adult Expansion Group coverage for most individuals will be provided through a private insurance plan, i.e., a Qualified Health Plan (QHP). QHP coverage will include:

- Outpatient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

- Mental Health and Substance Abuse
- Prescription Drugs
- Rehabilitative and Habilitative Services
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Pediatric Services, including Dental and Vision Care

EXCEPTION: Individuals eligible for the Adult Expansion Group who have health care needs that make coverage through a QHP impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private QHP plan but will remain in Medicaid.

A-115 Cost Sharing for Workers with Disabilities

MS Manual 07/01/2008/15/14

Recipients of Medicaid for Workers with Disabilities with gross income under 100 percent (100%) of the Federal Poverty Level for their family size will be subject to the usual Medicaid co-pays. Recipients with gross income equal to or greater than 100 percent (100%) of the FPL will be assessed co-payments at the point of service for medical visits and prescription drugs according to the following schedule:

1. Physician's visits - \$10.00 per visit;
2. Prescription drugs - \$10.00 for generic, \$15.00 for brand name;
3. Inpatient Hospital - 25% of the first day's Medicaid per diem rate;
4. Orthotic appliances, prosthetic devices and augmentative communication devices - 10% of the Medicaid maximum allowable amount;
5. Durable medical equipment - 20% of Medicaid maximum allowable amount per item;
6. Occupational, physical and speech therapy, & private duty nursing - \$10.00 per visit, with a cap of \$10.00 per day.

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

the 100% FPL, his income will be adjusted when reported to reflect the lower co-payment

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

~~amounts. Any increase in co-payments determined at reevaluation will require a 10-day advance notice. A DCO-700 will be sent and the changes keyed after the notice has expired.~~

A-120 Dual Eligibles-Medicare/Medicaid

MS Manual 07/01/2008/15/14

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

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

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

Limitations for recipients with joint Medicare/Medicaid coverage:

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

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

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

A-130 Disclosure of Information/Confidentiality

MS Manual 07/01/2008/15/14

Generally, information concerning an applicant or recipient will not be released to other parties without the individual's written consent. Upon reasonable notice to the county and during County Office hours, an applicant or recipient has the right to view copies of the information in his or her electronic case file. The applicant/recipient can only obtain copies of information that he or she provided to the County Office.

Information may be released without an individual's written consent to:

1. Authorized employees of the Agency and the Social Security Administration;
2. The individual's attorney, legal guardian or someone with power of attorney;
3. An individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility (i.e., bank statements, income verification);
4. A court of law, when the case record is subpoenaed.
5. The Federally Facilitated Health Insurance Marketplace (FFM) when the individual is determined Medicaid ineligible for specific reasons, e.g., income, in one of the Families and Individuals Eligibility groups.

Confidential information should not be released over the telephone unless county workers are assured that they are talking with individuals who are entitled to the information being requested.

A-131 Authorized Representatives

MS Manual 07/01/2001/01/14

Information may be given to Authorized Representatives that have been named on the DCO-153, Consent for an Authorized Representative form. An Authorized Representative is one or more individuals designated by an applicant/recipient to act on his/her behalf with respect to a specific Medicaid application or renewal. In the absence of a completed authorization form completed DCO-153, the fact that a person's name is in the authorized representative space on an

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

application form does not necessarily mean that he or she is an authorized representative or that information should be released to him or her. ~~For example, if an Area Agency on Aging (AAA) employee helps an elderly person complete an application and the employee puts his name in the authorized representative blank, information should not be released to this person unless requested by the applicant/recipient.~~ If the applicant/recipient is incapacitated, if the person who completed the application has supplied information for the case record, and if the person has a need to use information in that record to act in some capacity for the benefit of the applicant/recipient, then information can be released.

An authorized representative may change, i.e., the authorized representative who helped to establish original eligibility may not necessarily be the same person who will help reestablish eligibility at reevaluation. ~~For example, if a NF administrator completes the DCO-7781, Long-Term Care Annual Renewal Notice, at reevaluation and the original representative was the~~

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

A-132 Medical Records and DCO-109s

MS Manual 07/01/2001/01/14

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

A-134 Collateral Information

MS Manual 07/01/2001/01/14

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

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

A-140 Retention of Medicaid Case Records

MS Manual 07/01/2001/01/14

The Medicaid electronic case record must be kept for a minimum of five (5) years after case closure.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

EXCEPTION: If an audit by or on behalf of the Federal Government has begun but is not completed at the end of the five year period, or if audit findings have not been resolved at the end of the five year period, the records will be retained until resolution of the audit findings. (Central Office will notify the County Office when an audit by the Federal Government is to be conducted, of the cases to be audited, and when the audit has been completed.)

Documents provided to the County Office that do not have to be returned to the applicant will be destroyed by burning or shredding once scanned into the electronic case record.

A-150 Quality Assurance

MS Manual 07/01/2001/01/14

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

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

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

A-160 Referral Process for Counties

MS Manual 07/01/2001/01/14

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

A-161 Hospital/Physician Referral

MS Manual 07/01/2001/01/14

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

representative will sign and date the form and forward it to the DHS Office in the client's county of residence.

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

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

~~Approved~~ Application taken, client was determined eligible effective month/day/year.

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

MS Manual 07/01/2001/01/14

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

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

A-163 Child Health Services Program (EPSDT)

MS Manual 07/01/2001/01/14

The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis and treatment services at no cost to Medicaid eligible individuals under age 21 (including parents under age 21).

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

A-164 Client Representative Services Program

MS Manual 01/01/2008/15/14

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

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

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

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

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

Location of Area Agencies on Aging (AAA)

Region	Counties	Agency
REGION I	Serving Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy and Washington counties.	AAA of Northwest Arkansas Harrison, Arkansas 870-741-1144, Toll Free: 1-800-432-9721
REGION II	Serving Cleburne, Fulton, Independence, Izard, Jackson, Sharp, Stone, Van Buren, White and Woodruff counties.	White River AAA Batesville, Arkansas 870-812-3000, Toll Free: 1-800-382-3205

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

REGION VIII	Serving Crawford, Franklin, Logan, Polk, Scott and Sebastian counties.	Western Arkansas AAA Fort Smith, Arkansas 479-783-4500, Toll Free: 1-800-320-6667
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Services which are arranged for or provided by the Client Representation Program are: Advocacy Assistance, Adult Day Care, Chore Services, Companionship, Congregate Housing, Congregate Meals, Emergency Life Response, Escort, Home Delivered Meals, Home Health Services, Home Repair/Modification/Maintenance, Homemaker Services, Information and Assistance, Job Placement, Medical Transportation, Outreach, Personal Care, Respite Care, Protective Services, referral for Legal Assistance, providing information on and determining eligibility for public benefits such as QMB and SMB, assistance with completion of applications and paperwork, and attending meetings on behalf of client. Note, not every service is available in every region and a service available within a region may not be available in every location.

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

A-165 Inpatient Psychiatric Services

MS Manual 07/01/2001/01/17

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

Information on an approved facility may be obtained from:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105
Toll free 1-800-457-4454 or 501-376-2434

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

A PCP referral is not required for emergency admissions.

Individuals under age 21 who are not eligible for Medicaid when they enter one of these facilities will be referred to the County DHS Office in the individual's county of last residence or parent's residence for eligibility determination.

Individuals admitted into an approved psychiatric facility from an in-home or non-institutional setting will be evaluated against the following criteria:

1. Individuals Under Age 19 Apply the rules of ARKids or U-18 spend down for eligibility determinations.
2. Individuals Age 19-21 Apply the rules for the Adult Expansion Group. Refer to B-270.

A-166 DDS Children's Services with Chronic Health Conditions

MS Manual 07/01/2001/01/14

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

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

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

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

A-170 Expedited Services for Child Abuse Cases

MS Manual 07/01/2001/01/14

Special consideration for immediate action will be given to cases involving child abuse (where the perpetrator has left the home) that are identified by the DCFS worker as needing expedited services. The caseworker will forward the application and a summary of why special consideration is requested to the supervisor or his/her designated representative along with a recommendation for immediate action.

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

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

A-190 Twelve Month Filing Deadline on Medicaid Claims

MS Manual 07/01/2008/15/14

The Medicaid Program has a twelve month filing deadline from the date of service for all Medicaid claims, (e.g., claims with a 7/1/12 date of service must be received by the Claims Processor on or before 7/1/13 if payment is to be made). Claims which are not received within the twelve-month period will be routinely denied. Recipients are not liable for payment of any claim denied due to the timely filing policy.

In situations when the recipient's Medicaid eligibility has not been determined until after the service has been rendered, the provider must still submit the claim within twelve months from the date of service. If the claim is denied for recipient ineligibility, the provider may resubmit the claim when eligibility is determined. If the initial claim for payment was submitted within the filing deadline, the claim will be considered timely filed, regardless of when the eligibility determination is finalized for the date of service.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

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

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

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

Medicare determines covered services and allowed charges on all joint Medicare/Medicaid claims. Medicaid is only responsible for the deductible and/or coinsurance on the allowed charges. For dually eligible recipients, a claim filed with Medicare will serve as the claim for Medicaid payment of the deductible/coinsurance amounts. The provider must submit the claim to Medicare within twelve months from the date of service in order to meet the Medicaid filing deadline. If the provider submits the claim to Medicare within twelve months from the date of service, the claim will be considered timely filed, regardless of when Medicare crosses the claim to Medicaid for payment of the deductible/coinsurance.

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

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-310 Long Term Services and Supports

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

MS Manual 01/01/1407/01/20

The AABD Eligibility Groups are categorized below under Long Term Services and Supports, Medicare Savings Program, Workers with Disabilities, and Supplemental Security Income (SSI)/SSI related groups. -A brief description follows.

B-310 Long Term Services and Supports

MS Manual 07/01/2001/01/14

The Long Term Services and Supports group provides coverage to eligible individuals in nursing facilities, home and ~~community~~-community-based waivers, and the PACE program. -Home and community-based waivers and PACE community programs provide non-institutional long term ~~care 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 07/01/2008/15/14

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 resources cannot exceed \$2000 and a couple's resources cannot exceed \$3000.~~ 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 \$2000 and a couple's resources cannot exceed \$3000.

NOTE: ~~See~~ 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.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-312 Assisted Living Facilities (Living Choices)

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

EXCEPTION: ~~Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.~~

B-312 Assisted Living Facilities (Living Choices)

MS Manual 07/01/2008/15/14

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

NOTE: See 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

MS Manual 01/01/1607/01/20

This group consists of ~~individuals~~ individuals aged 21 or over. -Individuals aged 21-64 must have a -physical disability according to SSA/SSI guidelines, Railroad Retirement, or the DHS Medical Review Team (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 Utilization Review the Office of Long Term Care (OLTC). -The individual's income cannot exceed three (3) times the SSI payment standard ~~and resources cannot exceed \$2000.~~ 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 \$2000 and a couple's resources cannot exceed \$3000.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-315 TEFRA

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 Medicaid benefits and services. However, the individual must accept the Waiver services provided by the program.

Services available through this program include:

- Attendant Care
- Home Delivered Meals
- Personal Emergency Response System
- Adult Day Health
- ~~Adult Family Home - Requires a contribution to the cost of care. Refer to MS H-412.~~
- Prevocational Services for persons with physical disabilities
- Respite Care
- Adult Day Services
- Environmental Adaptations/Adaptive Equipment

~~NOTE: See MS E-500 for resources and MS H-200-MS H-430 for spousal rules.~~

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

B-315 TEFRA

MS Manual ~~10/02/16~~ 07/01/20

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

The income limit is three (3) times the current SSI payment standard SSI/SPA. -Only the child's income is considered. -Parental income is not considered in the eligibility determination, but is considered for the purpose of calculating the monthly premium. -For information regarding

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-316 Autism

TEFRA premiums and calculation, ~~see~~ refer to MS F 170-173. -The resource limit is \$2000. -Only the child's resources are considered. -Parental resources are disregarded. -Recipients of TEFRA Waiver receive the full range of Medicaid benefits and services.

B-316 Autism

MS Manual 04/01/1807/01/20

This group consists of children ages 18 months through seven (7) years who have a diagnosis of autism. -In addition to the autism diagnosis, the waiver participant must have a disability determination and meet the 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 SSI/SPA and the resource limit is \$2000. -Parental income and resources are disregarded. -Autism recipients will receive the full range of Medicaid benefits and services in addition to intensive early intervention treatment.

B-317 Division of Developmental Disabilities Services (DDS) Alternative Community Services Community and Employment Support Waiver Program

MS Manual 8/15/1407/01/20

This group consists of individuals of any age who have developmental disabilities as determined by the Division of Developmental Disabilities Services (DDS). -DDS waiver services are provided to individuals who meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care. -The income cannot exceed three (3) times the current SSI payment standard SSI/SPA. However, individuals with income over the limit may be eligible if they have established an income trust. Refer to MS H-110. -If the waiver applicant is living in the home of his/her parents, the parental income and resources will be disregarded. -Any contributions made to the applicant by the parents will be counted as unearned income. -In-Kind Support and Maintenance will not be considered as income. -Resources cannot exceed \$2000. -A period of ineligibility will be imposed for uncompensated transfers.

B-318 PACE-Program of All Inclusive Care for the Elderly

MS Manual 06/01/1607/01/20

This group consists of individuals 55 years of age or older who need nursing facility care to live as independently as possible. -PACE is a comprehensive health and social services program that provides and coordinates primary, preventive, acute and long term care services. -Individuals

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-320 Medicare Savings Programs (MSP)

under age 65 must establish physical disability through SSI/SSA, ~~or~~ 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 times the current SSI payment standard SSI-SPA. However, individuals with income over the limit may be eligible if they have established an income trust. (Re-fer 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. For a list of these counties, see refer to Appendix K.

B-320 Medicare Savings Programs (MSP)

MS Manual 01/01/1407/01/20

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

B-321 ARSeniors

MS Manual 08/15/1407/01/20

This group consists of individuals aged 65 or over whose income is equal to or below 80% of the Federal Poverty Levels (FPL). -Recipients do not have to be entitled to Medicare (e.g. Qualified Aliens who have not worked

enough quarters to qualify for Medicare can still be eligible for ARSeniors). -If the individual is entitled to Medicare he/she must receive Medicare. If the individual chooses not to enroll in Medicare (if eligible), he or she is not eligible for the ARSeniors program. -ARSeniors provides full Medicaid coverage. -See Refer to MS F-190.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-322 Qualified Medicare Beneficiaries (QMB)

B-322 Qualified Medicare Beneficiaries (QMB)

MS Manual 08/15/1407/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to or conditionally eligible for Medicare Part A. -The income limit is 100% of the Federal Poverty Levels (FPL) FPL. -QMB pays the Medicare premium, deductibles, and coinsurances. -See Refer to MS F-190.

B-323 Specified Low-Income Medicare Beneficiaries (SMB)

MS Manual 08/15/1407/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to (actually receiving) Medicare Part A. -The income limit is between 100% and 120% of the Federal Poverty Levels (FPL) FPL. -SMB pays only the Medicare Part B premium. -See Refer to MS F-190.

B-324 Qualifying Individuals 1 (QI-1)

MS Manual 08/15/1407/01/20

This group consists of individuals who are aged, blind, or have a disability and entitled to (actually receiving) Medicare Part A. These individuals would be eligible for SMB except their income exceeds the SMB level. -QI-1's must have income of at least 120% but less than 135% of the Federal Poverty Levels (FPL) FPL. -QI-1 pays only the Medicare Part B premium. -See Refer to MS F-190.

B-325 Qualified Disabled and Working Individuals (QDWI)

MS Manual 10/09/1507/01/20

This group consists of individuals who are blind or have a disability and who lost Medicare Part A entitlement solely due to the individual's earnings that reached or exceeded the Substantial Gainful Activity (SGA) amount. -Individuals who are 65 years of age or older will not qualify as a QDWI. -The -QDWI income limit is 200% of the Federal Poverty Levels (FPL) FPL. -QDWI's are eligible only for payment of their Medicare Part A-Hospital Insurance premium. -See Refer to MS F-190.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-326 Medicare Savings Programs - Comparison Chart

B-326 Medicare Savings Programs - Comparison Chart

MS Manual 01/01/1907/01/20

The following comparison chart provides a brief overview of the five categories including the coverage provided and eligibility requirements.

	AR Seniors	QMB	SMB	QI-1	QDWI
Benefits <u>MS A-100</u>	Full Range of Medicaid Benefits	Pays Medicare Premium(s), deductible and coinsurance	Pays Part B Premium	Pays Part B Premium	Pays Part A Premium
Categorical <u>MS F-110 thru 120</u>	Aged Only	Aged, Blind, or Disabled	Aged, Blind, or Disabled	Aged, Blind, or Disabled	Blind or Disabled
Income Limits <u>MS E-110; Appendix F</u>	Equal to or below 80% of FPL	100% of the Federal Poverty Level (FPL)	Between 100% and 120% of FPL	At least 120% but less than 135% of FPL	200% of FPL
Resource Limits <u>MS E-110</u>	Individual \$7,730.00 Couple \$11,600.00 <u>Refer to Appendix Z Updated Annually</u>				Individual \$4000 Couple \$6000
Medicare Requirements <u>MS F-190</u>	Must receive Medicare if entitled to Medicare	Entitled to to (actually receiving) or conditionally eligible for Medicare Part A	Entitled to (actually receiving) Medicare Part A		Lost Medicare Part A & SSA-DIB benefits due to SGA Entitled to reenroll in Medicare Part A

B-330 Workers with Disabilities

MS Manual 01/01/1607/01/20

This group consists of individuals who are:

- Have a disability
- Are working at the time of application;
- Are employed in any ongoing work activity for which income is received and reported to the IRS. (Refer to Glossary for definition of working.)
- Are at least 16 years of age, but less than 65 years of age; and who,
- except-Except for earned income, would be income eligible to receive Supplemental Security Income (SSI).

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

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

~~The intent of this group is to allow SSI eligibles to go to work or increase their earnings without losing their eligibility for Medicaid. Refer to Glossary for definition of working.~~

~~Individuals who lose SSI and SSI related Medicaid due to earnings, are potentially eligible for Medicaid under the Workers with Disabilities policy. However, there is no requirement that an individual must have at one time been an SSI recipient to be eligible for Medicaid under this category. However, if an individual was not an SSI or SSA disability recipient, a disability determination must be made by the DHS Medical Review Team (MRT) 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 \$20 general exclusion) must be under the SSI payment amount for one person to qualify for this group. Refer to Appendix S for SGA and SSI payment amount.

Recipients will be able to access services through ARChoices ~~waiver~~ 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 ~~case eligibility worker~~ that if they accept services from ARChoices ~~waiver~~ Waiver providers while their applications are pending and are subsequently denied for ARChoices ~~waiver~~ Waiver, they will be responsible for paying the provider.

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

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

MS Manual 08/15/1407/03/20

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/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 01/01/1407/01/20

~~The~~ 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 Medicaid benefits and services.

MEDICAL SERVICES POLICY MANUAL, SECTION B MARKUP

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

B-341 Supplemental Security Income (SSI) Cash Eligibles

MARK-UP

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-205 Pregnant Woman (PW) Period of Eligibility

C-200 Alternative Application Processes

MS Manual 01/01/1607/01/20

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

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

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

C-205 Pregnant Woman (PW) Period of Eligibility

MS Manual 10/30/1507/01/20

An individual found eligible may receive PW Medicaid coverage only- during the period of pregnancy and through the end of the month in which the 60th day postpartum falls. Postpartum coverage will be provided to women who are Medicaid certified at the time of delivery and to women who have a Medicaid application pending at the time of birth and are later found eligible for PW coverage.

An individual who applies for Pregnant Woman – Full or Medically Needy Medicaid after termination of a pregnancy may be given benefits to the end of the birth month, if eligible, but may not be given postpartum coverage. A pregnant woman who applies after the birth of the child and is found eligible in the birth month for Limited PW or Unborn Child will be given full postpartum coverage.

If the pregnant woman has medical bills in the 3-three months prior to the date of application, retroactive eligibility will be determined. There must have been medical bills incurred to give retroactive coverage. ~~The medical bills must be verified, and must be for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage. If retroactive coverage is not given, the record should be clearly documented to~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-210 Newborn Referral Process

show that coverage was

If a PW applicant is not income eligible in the month of application or the month in which the 45th day falls, but is income and otherwise eligible in one of the retroactive months, the application will be approved beginning in the earliest month of retroactive eligibility. Eligibility will then continue through the end of the month in which the 60th day postpartum falls, if the applicant is eligible for the postpartum coverage, with disregard of any income changes which occurred after the beginning month of eligibility.

There will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period, even if the applicant is not eligible in the month of application or in the month when the 45th day of the application falls. (Refer to MS 1-610).

C-210 Newborn Referral Process

MS Manual 08/01/1507/01/20

Hospital and physician providers use the DCO-0645, Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage, to refer children who are born to and will reside with their Medicaid eligible mothers following discharge from the hospital. The referring provider is requested to complete the DCO-0645 and send it to the DHS County Office of the mother's residence within five (5) days of the child's birth, when possible. The DCO-645 will serve as verification of the birth date of the child, as well as, documentation of relationship and citizenship.



NOTE: ~~The In the following situations, coverage for the infant should be made on a DCO-0152, Application for Health Coverage, or online at access.arkansas.gov; will be used to refer those infants who will be living with someone else other than the biological mother following discharge from the hospital.~~

- ~~• If the mother of the child is not Medicaid eligible and has not made application for Medicaid to cover her pregnancy, or~~
- ~~• If the mother of the child is approved under the Unborn eChild category (refer to MS B-220), or~~
- ~~• If the infant will be living with someone else other than the biological mother following discharge from the hospital.~~

Upon receipt of the DCO-645, the worker will check the system to determine if the birth mother has any type of Medicaid coverage in the system. If the mother has been determined Medicaid

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-211 Newborn Referral Disposal Process

eligible in any category, the DCO-645 will be processed as a change. If there is no record of the mother having any type of Medicaid coverage or if the newborn infant will be residing with someone other than the mother, the prospective caretaker should apply for coverage for the child on a DCO-152 or online at access.arkansas.gov.

C-211 Newborn Referral Disposal Process

MS Manual 08/01/1507/01/20

Once a newborn is eligible, the newborn will remain eligible until the last day of the month of the child's first birthday regardless of whether the mother continues to be eligible.

The only exceptions to a full year of coverage are:

- The newborn coverage may be terminated only if the child no longer resides in the State of Arkansas.
- Death of the child during the 12-month coverage period.

If the mother was a certified Medicaid eligible recipient or was later determined Medicaid eligible for the birth month in any category, Medicaid coverage of the child will be provided as follows:

Secure information necessary to open a Newborn Medicaid case.

The system will place the child in the newborn eligibility group with the DOB as the Medicaid begin date.

DCO-700S or system-generated notice will be sent to the person with whom the child will be residing. The person will be either the biological mother listed under Part II B of the DCO-645 or someone other than the biological mother if the DCO-152 is used. The notice will advise the caretaker of the Newborn approval (or denial, if applicable) and advise the caretaker to report all address changes for the family, and that application may be made for the newborn in another Medicaid eligibility group when the newborn's eligibility has expired under newborn coverage.

C-220 Autism Waiver Application Process

MS Manual 04/01/1807/01/20

1915 (c) of the Social

Security Act

The Autism Waiver program is operated by Partners for Inclusive Communities (Partners), a contracted entity under the administrative authority of the Division of Medical Services. The

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-220 Autism Waiver Application Process

Autism Waiver brochure and the telephone number for Partners the contracted entity is are available at local DHS County offices. Interested individuals should contact Partners for more information or to start the application process.

To apply for services, the child must be between eighteen ~~(18)~~ months and five 5 years old. A child five 5-years and one 1-day old is over the age limit for application. If approved, coverage will be for a minimum of two 2-years and a maximum of three 3-years. The three 3-year coverage period starts on the first (1st) date of a billable service by a provider. If coverage has not ended prior to the child's eighth ~~(8th)~~ birthday, coverage will end the day before the child's eighth (8th) birthday.

The following describes the Autism application process:

If a parent or guardian inquires at the county office about the Autism Waiver, county office personnel will:

1. Provide the Autism Waiver brochure.
2. Inform the inquirer that he or she must contact Partners at the phone number listed on the brochure for more information or to start the application process.
3. If the child doesn't have a pending Medicaid application or an open Medicaid case, explain Medicaid/ARKids requirements and assist the parent or guardian if he or she wishes to apply for Medicaid or ARKids.

When the parent or guardian contacts Partners, Partners will:

1. Explain the program and program requirements.
2. Screen the applicant to determine if he or she meets the program criteria.
3. Send the following forms to the parent or guardian, if the child meets the therapeutic requirements:
 - a. DCO 9700, TEFRA and Autism Waiver Application;
 - b. If a disability determination is needed, a DCO 108C, Social Report for Children;
 - c. DCO 106, Disability Worksheet; and
 - d. DHS-4000, Authorization to Disclose Health Information.
4. Advise the parent or guardian to return completed forms to Partners.

Upon receipt of the application and documentation, Partners will:

1. Review the application and documentation to determine if the application should be denied based on Partners' autism diagnosis assessment.
2. Send the application and documentation to the Area TEFRA Processing Unit (ATPU).

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-230 TEFRA Application Process

3. Complete form DHS-703, Evaluation of Medical Need Criteria if the applicant meets Partners medical criteria and forward it to the Office of Long Term Care (OLTC). OLTC will document the level of care determination on the DHS-704 and return the form to Partners. Partners will forward the completed DHS-704 to the appropriate ATPU.
4. Send notification of ineligibility denial to ATPU via the DHS-3330 if the applicant does not meet medical criteria.

ATPU will:

1. Register all applications received from Partners in the Autism Waiver Service Program.
2. Deny application and send the applicant's parent or guardian a system generated notice of denial, if the applicant is determined not to be eligible based on Partner's medical criteria.
3. Determine financial eligibility, if the child meets the autism criteria.
4. Forward medical records (Forms DCO-106, DCO-108C and DHS-4000) to MRT while determining financial eligibility, if a disability determination is required.
5. Determine financial eligibility and if found not eligible:
 - a. Deny the application.
 - b. Send the parent or guardian a system generated notice of denial and a DHS-3330 to Partners.
 - c. Notify MRT to stop the disability determination if the determination has not been received.
6. Approved the application, if the applicant is medically and financially eligible:
 - a. The Medicaid begin date will be the date the application is approved.
 - b. Send the parent or guardian a system generated notice of approval and a DHS-3330 to Partners.

C-230 TEFRA Application Process

MS Manual 02/05/1607/01/20

P.L. 97-

248

TEFRA applications (DCO-9700) will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers. Information will be available through the Division of Developmental Disabilities (DDS) Services Coordinators and Providers. Information will also be available on the DHS/DMS website.

To complete the eligibility determination, the following steps must be completed:

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-231 TEFRA Re-Application When Case Closed Due to Non-Payment of Premiums

- The application must be made by an adult responsible for the care of the child.
- A DMS 2602, Physician's Assessment of Eligibility, must be completed by the child's physician to determine Medical Necessity and Appropriateness of Care.

If disability has not previously been established by the Social Security Administration, a Medical Review Team (MRT) disability review must be completed. The application will be made by the adult responsible for the care of the child and will be processed in the child's county of residence.

TEFRA Waiver applicants should be screened for ARKids eligibility. The ARKids program should be explained to the parents so they can make an informed choice between ARKids and TEFRA. ARKids can generally be approved much more quickly than TEFRA as no disability or medical necessity determination is required.

The DMS-2602, Physician's Assessment of Eligibility, will be given to the individual to must be completed by the child's physician. If disability is to be established by the DHS Medical Review Team (MRT), forms DCO-106, DCO-0107, DCO-0108C, and DHS-4000(s), if needed, will also be completed. The TEFRA Waiver Brochure, RUB-405, should also be given additional information to the applicant explaining on the medical determination process and the premium process. (Refer to Appendix I, for other forms to be completed during the application process.)

C-231 TEFRA Re-Application When Case Closed Due to Non-Payment of Premiums

MS Manual 01/01/1407/01/20

When the TEFRA case is closed due to non-payment of premiums, a new application must be made before eligibility can resume. Eligibility will be redetermined at the time the new application is made.

If the case has been closed less than 12 months because of failure to pay premiums, the past due premiums must be paid in full before the child can be re-approved for TEFRA Waiver services.

If a case is closed 12 months or more due to failure to pay premiums, payment of the past due premiums will not be required to reopen the case.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-232 TEFRA Eligibility Determination

C-232 TEFRA Eligibility Determination

MS Manual 05/12/1707/01/20

With the exception of the Appropriateness of Care requirement, eligibility will be determined by the ~~caseworker~~ eligibility worker in the same manner as ~~Long~~ Long-Term Services and Supports (LTSS) cases.

A child who would not be eligible or potentially eligible for Medicaid in an institution cannot be considered for TEFRA. If the child's countable income is less than the current ~~LTC~~ LTSS income limit (refer to Appendix S) and the child's countable resources are less than \$2,000.00 ~~the current resource limit~~, he/she will meet the TEFRA income and resource requirements. Parental income and resources will be disregarded when determining eligibility. However, parental income will be considered when calculating the monthly premium amount. Refer to MS F-170 through MS F-173.

C-233 TEFRA Disability Determination

MS Manual 01/01/1407/01/20

To qualify for TEFRA, a child must be considered an individual with a disability according to the SSI regulations that govern children with disabilities. Disability for a child will either be established by the Social Security Administration (SSA) or the DHS Medical Review Team (MRT). If a child received SSI within one year prior to making TEFRA Waiver application, but was terminated for reasons other than lack of disability, (e.g. parental income or resources), documentation will be obtained for the case record. A disability decision made by SSA on a specific disability is controlling for that disability, until the decision is changed by SSA. The child will be considered an individual with a disability based on the previous SSA disability determination. {Refer to MS F 120-128129.}

C-234 Determining Appropriateness of Care for TEFRA

MS Manual 05/12/1707/01/20

When the completed DMS-2602 is returned to the county office by the child's physician, the DMS-2602 and DCO-2603 and any medical records that have been submitted will be sent to:

DMS
Attention: TEFRA Committee
P.O. Box 1437, Slot S-406
Little Rock, AR 72203

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-235 Disposition of TEFRA Application

Based on information provided on the DMS 2602, Physician's Assessment of Eligibility, and any medical records submitted, the TEFRA Committee will determine medical necessity and if the applicant meets the Appropriateness of Care criteria. If the applicant is having difficulty obtaining the Physician's Assessment of Eligibility, the County Office should provide assistance to obtain the required form.

~~If this criteria is met, and if the referral is otherwise appropriate, the TEFRA Committee will complete Sections III and IV of the DCO-2603. The TEFRA Committee will determine Medical Necessity and will be responsible for returning the DHS-704, DMS-2602 and DCO-2603 to the county office for final approval or denial, pending MRT decision if applicable. The TEFRA Committee is coordinated by the Office of Long Term Care.~~

NOTE: An application will not be denied solely for failure of the physician to complete and return the DMS-2602 until an effort has been made to assist the client in obtaining the completed DMS-2602. The caseworker will remind the applicant of the necessity of the form and of his/her responsibility for obtaining the form. Assistance will be given whenever possible.

C-235 Disposition of TEFRA Application

MS Manual 05/12/1707/01/20

~~The DCO-2603, Summary of Case Eligibility/TEFRA will be reviewed for documentation that each eligibility requirement has been met. If at any point in the eligibility determination the child fails to meet eligibility requirements, the application will be denied.~~

The begin date for TEFRA Waiver eligibility will be the date of application, unless retroactive coverage is needed. If needed, the eligibility begin date can be as early as three months prior to the date of application, provided all eligibility requirements are met.

A child cannot be approved for retroactive coverage before the onset of his/her disability as he/she would not meet the TEFRA disability or medical necessity requirements prior to the onset of disability. A child who had been residing in an institution would not be eligible for any retroactive coverage while still residing in the institution as TEFRA Waiver coverage is for non-institutionalized children only. For any retroactive coverage needed, it can be assumed that medical necessity and appropriateness of care have been met unless there is evidence to the contrary.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-240 ARChoices Waiver Application Process

C-240 ARChoices Waiver Application Process

MS Manual 01/01/1607/01/20

A potential Waiver client will make application (DCO-777/DHS-0777) at the DHS county office County Office in his/her county of residence for a financial eligibility determination. Refer to Appendix I for other forms to be completed during the application process. Separate applications will be registered when both individuals of a couple apply.

If an applicants should be advised that if they accept services from an ARChoices providers while their applications are is pending, they he/she will be responsible for paying the provider if the application is subsequently denied.

~~1. NOTE: If the applicant's income is under the SSI/SPA, he/she may be referred to SSA to make a SSI application. However, ARChoices eligibility is not contingent upon SSI eligibility, and the eligibility determination will not be delayed pending a SSI determination.~~

To qualify for the ARChoices waiver, the individuals aged 21-64 must be determined to have a physical disability through either the Social Security Administration (SSA), the DHS Medical Review Team (MRT), or Railroad Retirement Board (RR) or SSA. The individual may have a mental disability, but if so, it must be in addition to a physical disability to qualify for ARChoices. Individuals requiring services in ARChoices must be classified as requiring an Intermediate Level of Care. Individuals classified as Skilled Level of Care are not eligible for the ARChoices Program. (Refer to MS F-155.)

To determine if the disability for SSA is physical, the caseworker will fax the request for verification to the local Social Security office that serves their county. The memo request must include the name and SSN of the ARChoices applicant, the county office address, telephone number, fax number, contact person and the request for verification of type of disability. If the individual is not receiving SSI or the SSA disability is based solely on mental disability, an MRT decision will be needed. When referring a case to MRT, it is important to make it clear that it is an ARChoices case so MRT will know that a physical disability determination is needed. The caseworker should write on the top of the Social Report "ARChoices".

To determine if the disability for RR is physical, contact the RR Board at 1-877-772-5772 or

1200 Cherry Brook Drive

Suite 500

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-241 ARChoices Waiver Assessment Process

Little Rock, AR 72211-4122.

C-241 ARChoices Waiver Assessment Process

MS Manual 01/01/1622/22/22

All applicants will be referred to the DHS RN by DHS-3330 for coordination of the medical assessment.

within 2 days of the initial interview. If a physical disability determination is required for an ARChoices applicant, the referral will be made on the date the disability determination is received by the agency. The Office of Long Term Care will determine if the applicant meets the Intermediate Level of Care requirements.

The assessment results will be routed by the DAAS Central Office staff to the DHS RN and to the county office via Form DHS-704, Decision for Nursing Home/Waiver Placement.

If an individual meets the Intermediate Level of Care requirements, and if the individual is otherwise eligible, DAAS will work with the client, family, or other caregiver to ensure that the client receives services necessary to meet his/her needs according to the written Plan of Care. (Refer to MS C-247)

The DHS RN is required to make 3 attempts to contact the applicant through telephone contacts and home visits within an established timeframe of receiving the referral from the caseworker. The procedures below describe what happens when the RN fails to make contact:

1. If the DHS RN cannot contact the applicant after several attempts, a DHS-3330 will be sent to the caseworker informing him/her of the failed attempts.

The caseworker will then send a DCO-700, Notice of Action, to the applicant and a copy to the DHS RN advising that the application will be denied if the applicant does not make contact with the RN within 10 days. The caseworker will provide the name and telephone number of the RN on the notice.

2. After 10 days, the caseworker will check with the DHS RN to see if the applicant made contact. If not, the application will be denied using reason "Other". The caseworker will send a manual notice of action to the client explaining the reason of the denial and document all information in the narrative.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-241 ARChoices Waiver Assessment Process

On pending applications, the caseworker will:

1. Check the Long Term Care Unit (LTCU) Screen within 30 days of application to determine if the assessment has been completed.
2. Contact the DHS RN if the LTCU Screen does not indicate the assessment has been completed.
3. Hold the application pending receipt of the DHS-704 if the DHS-703, DHS Evaluation of Medical Need Criteria has been completed by the DHS RN.

If notified that the application will be denied due to lack of medical information, it is ultimately the responsibility of the applicant to provide the required information.

If the caseworker learns the medical assessment has not been completed by the DHS RN, the caseworker will:

1. Send a DHS-3330 to the DHS RN and indicate "Second Request" for medical assessment, and
2. Fax a copy of the DHS-3330 to DAAS, 501-682-8155, ATTN: HCBS Nurse Manager.

On the 35th day, the caseworker will again contact the DHS RN. If the medical assessment has not been completed, the caseworker will contact his/her Program Eligibility Analyst. When possible, DAAS will take the necessary action to complete the medical assessment prior to the 35th day.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-242 ARChoices Waiver Applications from Nursing Facility Residents

When a DHS RN receives a referral on a nursing facility resident who elects ARChoices:

1. The DHS RN will contact the individual to proceed with the assessment process to develop a Plan of Care.
2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care with the preceding 6 months. The necessity of completing a new assessment will be left to the professional judgment of the DHS RN.
3. If 6 months or more have elapsed since the last determination of Level of Care, or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to the Office of Long Term Care.

C-242 ARChoices Waiver Applications from Nursing Facility Residents

MS Manual 01/01/16??/??/??

Both Medicaid certified if the county is contacted regarding the ARChoices Waiver for a Medicaid certified nursing facility residents who wish to apply for the ARChoices Waiver and who are is classified Intermediate Level of Care, the will be referred to the DHS RN for coordination of the County will send a DHS 3330 to the DHS RN who will initiate an assessment, and Non-Medicaid nursing facility residents who wish to apply for the ARChoices Waiver will also be referred to the DHS RN for coordination of the assessment, as outlined below.

When the RN proceeds with the assessment process:

1. A DHS 3330 will be sent to the county office, along with page 2 of the Plan of Care showing the recipient's election of Waiver services with signature.
2. The signed election of Waiver services will serve as the application for Waiver services.
3. It is not necessary to complete a DCO 777 or DCO 7781 unless it is time for the annual renewal of the LTC case.
4. The ARChoices Waiver application must be registered.

NOTE: When accepting Page 2 of the Plan of Care as described in this section, the Plan of Care must include the client's signature, the election of community services and the date. The date must be later than the date of nursing home admission. The DHS RN's

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-243 Residents of Residential Care Facilities Applying for ARChoices Waiver

~~signature is not required on the Plan of Care when used for this purpose. The name of the DHS RN will be included on the DHS 3330.~~

~~If an ARChoices Waiver application is received from a non-Medicaid eligible nursing facility resident:~~

- ~~1. The application must be registered.~~
- ~~2. The application will not be routinely denied because the individual is institutionalized.~~
- ~~3. The caseworker will send a DCO 3330 to the DHS RN who will initiate an assessment as described in MS C-241.~~

C-243 Residents of Residential Care Facilities Applying for ARChoices Waiver

MS Manual 01/01/1407/01/20

~~If an individual living in a residential care facility (RCF) applies for Waiver services and has no plans to move out of the RCF, the caseworker will explain to the applicant that, according to current LTC LTSS and RCF policy, he or she does not meet the required Level of Care to receive Waiver services, and the application will be denied.~~

~~When the applicant gives a date that he or she plans to move out of the RCF and the relocation date is within the next 45 days, the application will be taken and the targeted relocation date will be documented. The caseworker will include the date that the applicant plans to move out of the RCF on the DHS 3330 that will be sent to the DHS RN. The normal application process at MS C-240 will then be followed. Eligibility for a Waiver program cannot begin until the individual has moved out of the RCF and all other eligibility criteria have been met.~~

~~At the end of the 45 day period, if the applicant has not relocated, the caseworker will send a 10 day notice advising that the application for Waiver services will be denied if the relocation does not occur within the next 10 days.~~

C-244 ARChoices Waiver Eligibility Determination

MS Manual 01/01/1607/01/20

~~Eligibility determinations for ARChoices Waiver cases will be conducted in the same manner as for AABD long term care Long Term Services and Supports (LTSS) nursing facility cases.~~

~~Refer to the Business Process Manual.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-245 Approval/Denial for New ARChoices Waiver Applicants

The SSI related income and resource criteria located in section MS Section E will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

When determining an applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income will be compared to the current LTC limit. Only the income of the applicant will be considered for eligibility.

In determining resource eligibility, the current LTCLTSS resource limits will apply.

- A single applicant's resources will be compared to the one-person limit.
- When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit.
- If only one individual of a couple applies for ARChoices, the rules for spousal resources at MS H-200 will apply.

C-245 Approval/Denial for New ARChoices Waiver Applicants

MS Manual 01/01/1607/01/20

The policy and procedures outlined in MS C 246-249 that determine the Waiver eligibility date will apply to applicants entering Waiver programs from both the community and from institutions.

If there is a closed case number on file for the client, this number will be used to open the ARChoices Waiver case.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of an eligible individual will be entered in the appropriate fields in the system. The total gross income will also be entered as Protected Maintenance, since Waiver recipients will not contribute to the cost of services.

The county office will notify DAAS of certifications and denials via the DHS 3330 on the date the action is taken. The DHS 3330 may be mailed, emailed, or faxed to the DHS RN or placed in a designated location at the DHS county office for the DHS RN to collect.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-245 Approval/Denial for New ARChoices Waiver Applicants

Denial reasons include, but are not limited to:

1. ~~Failure to meet the nursing home admission criteria.~~
2. ~~Withdrawal of the application by the applicant.~~
3. ~~Ineligibility based on income or resources.~~
4. ~~Death of the applicant when no Waiver services were provided.~~

If the caseworker denies the application for any reason, the DHS RN will be notified via a DHS-3330 and the RN will notify providers of service via the AAS-9511.

When denying an ARChoices application because the applicant refuses to receive at least one service, is not in need of a service or the service is not available in their area, denial code "Other" will be used. A manual notice will be sent, notifying the applicant of the denial.

If the ARChoices Waiver application is denied for any reason, and Waiver services were provided during the period of ineligibility, any charges incurred will be the financial responsibility of the applicant.

If the ARChoices application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section. If the individual wins the appeal and has no unpaid ARChoices charges, Medicaid coverage will begin the date the appeal is won. However, the Waiver portion of the case will not be opened until the date the caseworker completes the case. If the individual has unpaid ARChoices Waiver charges, and services were authorized by the DHS RN, eligibility for both Medicaid and Waiver services will begin the date service began. However, under no circumstances will Waiver eligibility begin prior to the date of application on the DCO-777 or before the Provisional Plan of Care is signed by the DHS RN and the applicant.

When the Office of Appeals and Hearings reverses an Agency decision that an individual did not meet medical necessity requirements, a new DHS-704 will not be issued. The final Agency decision will contain the determination of the Intermediate Level of Care. The Medicaid Begin Date will be the date of the hearing officer's decision and the Eligibility Start Date on the Waiver portion of the case will be the same as the Keying Date. As no Level of Care Review Date will be given, the caseworker will enter a date 12 months after the date of the hearing officer's decision.

NOTE: If Waiver services were provided and the applicant dies prior to approval of the application, Waiver eligibility will begin the date services began and end the date of death if all other eligibility requirements are met.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-246 Effective Date of Eligibility for ARChoices Waiver

C-246 Effective Date of Eligibility for ARChoices Waiver

MS Manual 01/01/1607/01/20

After all eligibility criteria have been established, the effective date of ARChoices Waiver Medicaid eligibility will be the date of approval into the system.

~~The effective date of eligibility cannot be prior to the date of approval of the case. (MS A 200)~~



~~NOTE: The ARChoices eligibility date will not be established prior to the date the of approval is entered into the system unless an earlier date is provided by DHS RN based on the Provisional Service Plan of Care (see C-247 and C-248) on the DHS 3330. The Waiver eligibility date will not be established retroactively by the caseworker. If no date is given by the DHS RN, the Waiver eligibility date will be the date the approval is entered into the system.~~

C-247 Provisional and Comprehensive Service Plan of Care for ARChoices Waiver

MS Manual 01/01/1607/01/20

~~A Provisional Service Plan of Care is developed when, based on the assessment, the individual has met functional/medical criteria, but financial eligibility has not yet been determined. The client and the provider assume the responsibility of liability should the client not meet all criteria for eligibility and services to begin.~~

~~The Provisional Plan of Care will include all Plan of Care information with the exception of the Medicaid number and Comprehensive Plan of Care expiration date. The Provisional Plan of Care will expire 60 days from the date the Plan of Care is signed by the DHS RN and the applicant.~~

~~A signed copy of the Provisional Plan of Care will be mailed to each provider included on the Plan of Care. The provider will begin services within an established timeframe and notify the DHS RN via the AAS 9510 that services have started. The DHS RN will track the start of care dates. If at least one Waiver service begins within 30 days of the development of the Provisional Plan of Care and the applicant is otherwise eligible, the Waiver eligibility date will be established retroactively effective the day the Provisional Plan of Care was signed by the DHS RN and the applicant. If no Waiver services begin within 30 days of the development of the Provisional Plan of Care, the effective date of service will be the date the approval is keyed into the system or the day a Waiver service started as verified by the DHS RN.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-248 Optional Participation for ARChoices Waiver

If an application is denied, a new Provisional Plan of Care must be developed when a subsequent application is made. Regardless of the reason for the denial and regardless of when a new Waiver application is made, a Provisional Plan of Care will only be utilized on a current Waiver application.

Prior to the Provisional Plan of Care expiration date, the DHS RN will mail the Comprehensive Plan of Care to the client and all providers included in the Plan of Care. If the Medicaid application has been approved, the Comprehensive Plan of Care will include the Medicaid recipient's ID number, diagnosis, Waiver eligibility date and the Comprehensive Plan of Care expiration date. The new Plan of Care expiration date will be 365 days from the date the DHS RN and the applicant signed the Plan of Care. Once the application is either approved or denied, a Plan of Care including the Medicaid ID number or an AAS-9511 giving the date of denial will be sent to the providers.

C-248 Optional Participation for ARChoices Waiver

MS Manual 01/01/1607/01/20

Refer to the Business Process Manual.

Neither Waiver providers nor Waiver applicants are required to begin or receive services prior to the establishment of Medicaid eligibility. Participation is offered by the DHS RN at the time of assessment. If services are started based on the receipt of a Provisional Service Plan of Care, it is the responsibility of each provider to explain the process and the financial liability to the applicant and/or family members prior to beginning services. -The decision to begin services prior to eligibility must be a joint decision between the provider and the applicant.

Note: The provider is required to notify the DHS RN via the AAS-9510 regardless of the participation decision. The information reported by the provider on the AAS-9510 will document which services are being delayed and which services are beginning based on the provisional Plan of Care.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-249 ARChoices Waiver Approvals for Medicaid Recipients Who Leave LTCa Nursing Facility

C-249 ARChoices Waiver Approvals for Medicaid Recipients Who Leave LTCa Nursing Facility

MS Manual 01/01/1607/01/20

The ARChoices case may be certified when the county is notified by the nursing facility that the recipient has left the facility if all the following conditions are met:

1. The county has received a DHS-3330 and Plan of Care signed by the recipient or if a Money Follow the Person (MFP) (MS-1540-541) participant, Form DCO-777 may be provided.
2. The system shows an Intermediate Level of Care.
3. The Level of Care was entered into the system in the previous 6 months.
4. There is a future Level of Care review date or no review date is required.

If the Intermediate Level of Care was entered by the county more than 6 months previously, or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DHS-704 verifying Intermediate Level of Care status.

To certify the ARChoices Waiver case, close the LTC vendor portion of the case but do NOT close Medicaid. Two (2) days after closure of the vendor portion of the case, the Waiver portion of the case may be opened. The vendor effective date is the day after leaving the nursing home.

To clear the pending application screen when approving Non-SSI recipients, counties will submit an email to DCO SYSTEM SUPPORT requesting the register number to be cleared. If the recipient is a MFP participant, the email should include this information:

For SSI recipients, the register number will be cleared by keying the approval reason in the system.

When opening a case in which the Intermediate Level of Care was entered less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ARChoices Waiver eligibility. The Level of Care Review Date will be 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC case, use that Level of Care Review Date when opening the Waiver case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ARChoices eligibility.

Counties will review the records of recipients who leave facilities for the ARChoices Waiver. If it is time for the annual reevaluation, a reevaluation will be done prior to Waiver certification.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-250 Assisted Living Facility (ALF) Application Process

No Waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a Provisional Service Plan of Care is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest Waiver eligibility date will be the day the applicant was discharged home.

C-250 Assisted Living Facility (ALF) Application Process

MS Manual 01/01/1407/01/20

Applications for ALF Waiver will be made on the LTC Long-Term Services and Supports Application for Assistance, DCO-777-DHS-0777 in the county DHS office County Office where the facility is located. Applications can be made by the applicant, designated representative, next of kin, or person acting responsibly for the individual.

~~If application is made in the applicant's home county before he/she enters the facility and the applicant enters a facility in another county, the application will be denied in the system. A notice will not be system generated for this denial. A DCO-700 will be completed and mailed by the caseworker, advising the client or representative that the application has been sent to the appropriate county. All documents will be scanned into the electronic case file and then transferred to the county County Office where the facility is located. The transferring county will send an email and task to the County Administrator and Program Eligibility Coordinator in the receiving county when the transfer in ANSWER is complete. A new application will not be needed by the receiving county County Office and the original date of application will be entered when the application is reregistered.~~

~~If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.~~

~~If application is made before the applicant enters a facility, The applicant he/she will have 30 days from the date of approval to move into a Medicaid approved Assisted Living Facility. If the individual has not moved into the ALF within the 30-30-day time period, the application will be denied.~~

C-251 Registering the ALF Application

MS Manual ??/??/??01/13/15

Applications will be registered as Assisted Living or SSI Assisted Living (SSI recipient). ALF Waiver recipients having SSI will retain their SSI Aged Individual, SSI Blind Individual or SSI Disabled

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-252 ALF Applications from Nursing Facilities or, ARChoices Waiver Recipients

~~individual case numbers. Separate applications will be registered when both members of a couple apply.~~

C-252 ALF Applications from Nursing Facilities or, ARChoices Waiver Recipients

MS Manual 01/01/1607/01/20

Medicaid certified nursing facility residents who are classified Intermediate Level of Care and ARChoices Waiver recipients who wish to apply for ALF will be referred to the DHS RN for coordination of a new medical assessment, if deemed necessary. Once functional need is established, the DHS RN will develop a person-centered Service Plan.

Refer to the Business Process Manual.

~~If the county is contacted regarding an ALF application for a Medicaid-certified nursing facility resident who is classified Intermediate Level of Care, or an ARChoices Waiver recipient, the caseworker will notify the DHS RN via the DHS 3330. The DHS RN will visit the client on site to begin the assessment process to develop a Plan of Care. The county will be notified of the recipient's election of ALF Waiver services. The signed election of ALF Waiver services will serve as the application for ALF and a new DCO 777 or DCO 7781 need not be completed by the applicant, unless it is time for the annual reevaluation of the LTC or Waiver case.~~

~~If a non-Medicaid eligible nursing facility resident wishes to apply for ALF Waiver, the DCODHS-0777, Application for Assistance, must be completed and registeredsubmitted. The caseworker will notify the DHS RN, who will initiate the assessment process.~~

C-253 ALF Assessment Process

MS Manual 01/01/1622/22/22

~~All applicants will be referred to the DHS RN by DHS 3330 for coordination of the functional need assessment within 2 two days of the date of application or the date the physical disability verification is received if a disability determination is required.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-254 ALF Eligibility Determination

C-254 ALF Eligibility Determination

MS Manual 01/13/1507/01/20

Eligibility determination for ALF Waiver cases will be conducted in the same manner as for Long Term Services and Supports (AABD-LTSS) nursing facility Long Term Care cases.

Refer to the Business Process Manual.

The SSI related income and resource criteria located in MS E-400-530 will be followed. SSI exclusions are not allowed from gross income in determining eligibility.

In determining an ALF applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income compared in his/her budget to the current LTC-LTSS limit. (Refer to: Appendix S). For an applicant with an ineligible spouse, only the income of the applicant will be considered for eligibility. An individual with income over the current LTSS income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust. Refer to MS H-110-116. When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment (Re: MS H-200) regarding income will be applied. Refer to MS H-200. An individual with income over the current LTC income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust (Re: MS H-110-116).

In determining resource eligibility, the current LTC-LTSS resource limits will apply.

- A single applicant's resources will be compared to the one-person limit.
- When there is a married couple and both apply, their combined resources will be compared to the couple's resource limit at application.
- When there is a married couple and only one member of the couple applies, the rules for spousal impoverishment (Re: MS H-200) regarding resources will be applied.

For information regarding contribution to the cost of care, refer to MS H-412.

C-255 ALF Approvals/Denial for New ALF Applicants (Non-LTC Nursing Facility)

MS Manual 01/01/1407/01/20

After all eligibility criteria have been established, the effective date of ALF Waiver eligibility is established by the DHS RN based on the latter of the date of application, date of admission to the assisted living facility, or the date the person-centered Service Plan of Care is signed by the

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-256 ALF Approvals for Medicaid Recipients Who Leave LTC a Nursing Facility or ARChoices Waiver

DHS RN and the applicant. -The DHS RN will provide the Waiver eligibility date to the county County Office via the DHS 3330.

~~Eligibility will not be established prior to the development of the Assisted Living Plan of Care by the DHS RN. Applicants who desire Medicaid coverage for the time before admission to the ALF or before the Plan of Care is signed, must be determined in another category. The same application can be used but a separate application must be registered to determine coverage prior to eligibility for Assisted Living Facility Medicaid.~~

~~When certifying an eligible couple, each will be entered into the system using separate case numbers.~~

~~The gross income of the elf financial or non-financial criteria isare not met, the application will be denied. If the application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section. ible individual will be entered in the appropriate fields in the system. The cost of room and board, as well as, the spousal support amount, health insurance premium amount, bank service charges for the income trust account, and other deductions, if applicable, will be entered as Protected Maintenance. The personal allowance will be shown in the PA field.~~

C-256 ALF Approvals for Medicaid Recipients Who Leave LTC a Nursing Facility or ARChoices Waiver

MS Manual 01/01/1607/01/20

~~If the county County Office receives notice that the Nursing nursing Facility facility or ARChoices Waiver recipient has elected to enter an Assisted Living Facility (ALF), the LTSS Eligibility Specialist eligibility worker will send a DHS 3330 to notify the DAAS DHS RN of the election to transition. The DAAS DHS RN will complete a new assessment in order to determine the individual's tier level. The ALF Waiver case can be approved once verification of an Intermediate Level of Care and the ALF waiver begin date from the DHS RN is received from the DAAS DHS RN and a new DHS 0704 is received.~~

To certify the ALF Waiver case, close the LTC vendor payment or Waiver portion of the case, but do NOT close Medicaid. Two days after the LTC vendor, ARChoices portion of the case is closed; the ALF Waiver portion of the case may be opened. The vendor effective date is the day after leaving the nursing home or ARChoices case closure.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-260 Program of All Inclusive Care for the Elderly (PACE) Application Process

When opening a case in which the Intermediate Level of Care was entered on the LTC vendor portion of the system less than six months previously and there is no Level of Care Review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility with a Level of Care Review Date 12 months from the original Level of Care Decision Date.

If there is a future Level of Care Review Date when closing the LTC or Waiver case, use that Level of Care Review Date when opening the ALF case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility. Caseworkers should review the records of recipients who leave LTC facilities or other Waiver programs for the ALF Waiver program. If it is time for the annual reevaluation, the reevaluation should be done prior to ALF certification.

NOTE: If a LTC case was closed then reopened for ALF services and a retroactive adjustment must be made to the LTC case, send a memorandum to the Office of Long Term Care, MMIS Unit, Slot S406, P.O. Box 1437, Little Rock, 72203. The memorandum must include the name, case number, month(s) of retroactive changes(s), and the new net income amount(s).

As the providers are different for each Waiver program, the caseworker must notify the DHS RN any time that a Waiver recipient changes from one Waiver program to another, or when the case is closed or transferred.

C-260 Program of All Inclusive Care for the Elderly (PACE) Application Process

MS Manual 06/01/1607/01/20

Prospective PACE recipients can apply for PACE services through their local DHS county offices County Offices. Applicants may apply by referral from the PACE provider, by referral from the DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective recipient must meet the medical and financial eligibility criteria outlined in MS E-400 and F-155 and reside in a PACE service area. Refer to Appendix K for PACE providers and the zip codes they serve.

Applicants residing in a PACE service area will be referred to the DHS RN for coordination of the medical assessment.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-260 Program of All Inclusive Care for the Elderly (PACE) Application Process

The DCO eligibility worker will approve or deny the application based on financial and non-financial eligibility requirements. The final determination of eligibility will be communicated to the PACE provider by the DHS RN.

When the initial application is made at the local DHS county office, the caseworker will begin the application process.

The caseworker will determine if the applicant resides in the service area approved for the PACE organization to which the applicant is seeking enrollment. See MS Appendix K. Application for PACE will be made on the DCO 777, LTC Application for Assistance. A DCO 727, Disposal of Assets Disclosure, must be completed for individuals entering a LTC facility. The DCO 710 and DCO 713 will be completed for individuals with ineligible spouses. The DCO 712 will be used only when the individual enters a nursing facility or when an Income Trust is established.

After verifying the applicant resides in the PACE service area, the caseworker will send a DHS-3330, Alternative Community Services Waiver Communications Form, to the DHS RN to request completion of a medical assessment. Because PACE eligibility may not begin until the medical assessment has been completed, it is very important to make the referral to the DHS RN as quickly as possible. Unless there are extenuating circumstances that cannot be avoided, the county office will send the DHS 3330 referring the applicant for medical assessment to the DHS RN within 2 days of registering the PACE application.

NOTE: A new application is not required when a PACE recipient moves from one PACE service area to another. As long as the PACE recipient signs an enrollment agreement with the new PACE provider before the first of the following month and there is not lapse in coverage, making the address change in the system is all that is required.

The financial eligibility process will continue and may be made before or after the medical determination.

If the prospective PACE recipient makes the initial inquiry with the PACE provider, the provider will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

If the initial inquiry for PACE is made with the DHS RN, the RN will instruct the recipient to make application at the local DHS county office for determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for medical assessment.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-261 PACE Assessment Process for Nursing Facility Residents, ARChoices, or Assisted Living Facility Participants

The DHS RN will complete the in-home medical assessment of the applicant after receiving the DHS-3330. The DHS RN will also verify that the applicant resides in the service area approved for the PACE organization. The DHS RN will then submit the DHS-3330 to the county office indicating that the assessment has been completed.

The DHS RN will submit the DHS-703 to the Office of Long Term Care (OLTC). OLTC will send a DHS-704, Decision for Nursing Home/PACE Placement, to DAAS if all necessary information is available. DAAS will then send a copy of the DHS-704 to the DHS RN and the county office.

The DCO caseworker eligibility worker will make the final decision to approve or deny the application when based on the financial and non-financial eligibility requirements determination is made.

C-261 PACE Assessment Process for Nursing Facility Residents, ARChoices, or Assisted Living Facility Participants

MS Manual 01/01/1607/01/20

42 CFR

§ 460

Nursing facility residents, ARChoices Waiver recipients, or Assisted Living Facility (ALF) participants who wish to apply for PACE will be referred to the DHS RN for coordination of a medical assessment.

When a DHS RN receives a referral on a nursing facility resident or an active ARChoices or Assisted Living Waiver participant who elects the PACE program:

1. The DHS RN will contact the individual to proceed with the assessment process.
2. An assessment may not be necessary if the individual was classified as Intermediate Level of Care within the preceding 6 months. The necessity of completing a new

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-262 Approval/Denial for PACE Applicantstion Approval

assessment will be left to the professional judgment of the DHS RN based on the medical condition and circumstances of the applicant.

3. If 6 months or more have elapsed since the last determination of Level of Care or if the DHS RN deems a new assessment to be appropriate, a new assessment will be submitted to Utilization Review.

C-262 Approval/Denial for PACE Applicantstion Approval

MS Manual 01/01/1407/01/20

If the application is approved, the caseworker will notify the applicant by system notice. The caseworker will notify the DHS RN on the DHS 3330 of the PACE eligibility date. A participant's enrollment in the PACE program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement; but it may not be prior to the date of application at the county office, County Office or prior to the date the medical assessment was completed by the DHS RN.

If financial or non-financial criteria are not met, the application will be denied. If the application is denied, the client has the right to appeal by filing for a Fair Hearing. Refer to the MS L-100 section.

The county worker will establish the PACE eligibility date based on the information provided to them by the DHS RN via the DHS 3330. The DHS 3330 must include the date the medical assessment was completed or the county worker will not be able to process the approval. The PACE eligibility date will be established and keyed as the first day of the calendar month following the date of the medical assessment, as indicated on the DHS 3330 from the DHS RN. Once the approval is keyed, the county worker will notify the DHS RN via a DHS 3330, giving the effective date of approval and the Medicaid ID number. The participant will not receive a Medicaid card as benefits will be received through the PACE provider. A PACE applicant may complete an enrollment application prior to the final medical and financial eligibility determination. However, the capitation payments will only be paid if the enrollee is found to be medically and financially eligible for PACE. An ineligible applicant will be responsible for paying any charges for PACE services he or she has received.

A capitated monthly payment will be generated to the PACE organization based on data received from the ANSWER system that indicates the number of individuals having the PACE aid category. There are four different payment rates based on rate category:

Pre-65 Medicaid-Only Individuals under age 65 having Medicaid only

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-263 Approvals for Waiver Recipients to PACE and PACE Participants to Waiver

~~Pre-65 Dual Eligible Individuals under age 65 having both Medicare and Medicaid~~

~~Post-65 Individuals over age 65~~

~~QMB Only Individuals eligible for QMB but not currently eligible for PACE Medicaid~~

~~The caseworker will key the PACE approval to the ANSWER system. PACE providers will have service areas based on the client's Zip Code. ANSWER will assign the PACE provider to the eligible recipient. The PACE provider information will include a start date, stop date, provider number add date and last change date. The caseworker as well as the DHS RN will assess each individual and determine whether the individual's place of residence and zip code fall within the service area of the PACE organization prior to eligibility determination and keying to ANSWER.~~

~~Refer to MS C-263 for procedures for approving Waiver recipients to PACE and PACE participants to a Waiver group.~~

C-263 Approvals for Waiver Recipients to PACE and PACE Participants to Waiver

MS Manual 01/01/1607/01/20

~~When the caseworker determines that a Waiver recipient is was found to be medically and financially eligible for PACE, the Waiver case will cannot be closed in ANSWER until the day before the PACE eligibility is started as the participant's enrollment in the PACE program is effective on the first day of the calendar month. Refer to (MS C-262.)~~

~~When a PACE participant applies for a Waiver category, the approval for the Waiver category cannot be submitted until two days after the closure.~~

EXAMPLE 1: ~~Jane Hathaway is an ARChoices recipient who applied for PACE on 5/29. The DHS RN completed the DHS 3330 providing the PACE eligibility date as 6/15. The caseworker determined Ms. Hathaway to be medically and financially eligible for ARChoices. The caseworker closes the ARChoices case effective 6/30 as PACE eligibility cannot begin until 7/01. Approval for PACE cannot be submitted in ANSWER until two days after the closure of the ARChoices case in order to prevent billing errors.~~

EXAMPLE 2: ~~Jack Jones is a dissatisfied PACE participant and wishes to disenroll from PACE. He applied for ARChoices on 6/15. The caseworker established that Mr. Jones is medically and financially eligible for ARChoices on 7/3. The caseworker submits in ANSWER closure of the PACE case on 7/3. The effective date to begin his~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-264 PACE Enrollment

~~ARChoices will be 7/4 in order for Mr. Jones not to lose any Medicaid coverage. However, approval for ARChoices must be submitted in ANSWER two days after the PACE closure to prevent billing errors.~~

C-264 PACE Enrollment

MS Manual 01/01/1407/01/20

Participant enrollment into the PACE Program is voluntary. ~~The Division of Aging and Adult Services (DAAS) Aging, Adult and Behavioral Health Services (DAABHS)~~ must assess the potential enrollee and concur that the client meets the requirements for nursing facility care prior to enrollment. ~~The DHS-RN must certify that an assessment has been completed.~~

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and that enrollment requires the completion of an intensive assessment that includes a minimum of one home visit and one visit by the potential PACE enrollee to the PACE center.

C-265 PACE Disenrollment

MS Manual 01/01/1407/01/20

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

1. ~~The participant's failure to pay if he/she has a payment responsibility.~~
2. ~~The participant's disruptive or threatening behavior.~~
3. ~~The participant moving out of the PACE service delivery area.~~
4. ~~The participant no longer meeting the nursing facility Level of Care requirement.~~
5. ~~The participant's death.~~
6. ~~The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.~~ ~~or~~
7. A PACE program agreement is not renewed.

~~To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Division of Aging and Adult Services with the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS-RN will review the request and corresponding documentation and will~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-266 PACE Provider Post-Enrollment Assessments

~~make a recommendation to the DHS RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS RN Supervisor, in consultation with PACE Program Management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS RN.~~

The PACE Organization may appeal an adverse decision to the DAAS Division of Aging, Adult and Behavioral Health Services (DAABHS).

C-266 PACE Provider Post-Enrollment Assessments

MS Manual 01/01/14 07/01/20

Upon enrollment, it is required that each PACE provider have an interdisciplinary team in place that is responsible for the overall assessment of care needs and subsequent management, supervision and provision of care for PACE participants. ~~The team's membership consists of a primary care physician (PCP), registered nurse, social worker, physical therapist, occupational therapist, recreational therapist/activity coordinator, dietician, PACE center supervisor, home care coordinator, personal care attendant/aid, and a transportation staff/driver.~~

The interdisciplinary team is responsible for the assessment, treatment planning and care delivery of the PACE participant. PACE regulations establish the following assessment requirements:

1. An initial in-person assessment must be completed by the Primary Care Physician, RN, Social Worker, Physical Therapist and/or Occupational Therapist, Dietician, and the Home Care Liaison.
2. At least semi-annually, an in-person assessment and treatment plan must be completed by the Primary Care Physician, RN, Social Worker, and Recreational Therapist/Activity Coordinator.
3. An annual in-person assessment and treatment plan must be completed by the Physical Therapist and/or Occupational Therapist, Dietician and Home Care Liaison Coordinator.

PACE organizations will consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. ~~The consolidated plan will then be discussed and finalized with the PACE participant and his or her significant others. Reassessments and Treatment Plan changes will be completed when the health or psycho-social situation of the client changes.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-270 Division of Developmental Disabilities Services (DDS) Waiver Application Process

C-270 Division of Developmental Disabilities Services (DDS) Waiver Application Process

MS Manual 01/13/1507/01/20

The DDS eligibility worker will obtain a completed DHS-0777DCO-777 from each applicant or the parent/guardian/representative of the applicant ~~UNLESS-unless~~ the applicant is a current Medicaid recipient residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), a ICF/IID and Nursing nursing Home facility, ~~OR-or~~ opened in a TEFRA case. Please ~~Refer to Appendix I~~ for the required forms to be completed during the application process.

~~For current Medicaid recipients, who are residing in ICF/IID and Nursing nursing Home facilities, refer to procedures in MS C-273.~~

Refer to the Business Process Manual.

~~When a TEFRA recipient completes ACS 102, Freedom of Choice form, requesting DDS waiver services, an additional application is not required as eligibility for Medicaid has been established. Please refer to Appendix I for the required application forms. For further guidance on approving the DDS waiver and closing the TEFRA case, refer to (MS C-272).~~

~~For other Medicaid categories (e.g. ARKids, etc.) form DCO-777 will be completed along with all the required forms necessary to process the application for DDS Waiver services.~~

~~Upon receipt of completed applications, the DDS Waiver Application Unit (WAU) will register in the appropriate category and determine eligibility.~~

~~**EXCEPTION:** Applications by SSI recipients need not be registered.~~

A-DDS

~~Medicaid Eligibility eligibility worker will have 45 days in which to process an application, or 90 days if a disability determination is needed. It will be the responsibility of the DDS Medicaid Eligibility eligibility worker to verify and document each eligibility requirement.~~

~~Please ~~Refer to MS A-200 and MS A-212~~ for information regarding the Medicaid coverage period and retroactive eligibility.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-271 Approving the DDS Application

~~1. **NOTE:** If a Waiver applicant (or recipient) requests an Administrative Hearing at any time, the DDS Medicaid eEligibility worker will be responsible for preparing the Medicaid file, the county statement and will attend the hearing. MS L 100-173.~~

C-271 Approving the DDS Application

~~MS Manual 01/13/15??/??/??~~

~~When submitting approval for the Waiver Program the caseworker will register the application in ANSWER. If there is an existing case, the caseworker will be required to use the closed budget.~~

~~When the Budget Unit characteristic of Waiver Nursing Home is selected, the ANSWER interface screen will display the number "2999" in the WVNO field to identify clients who have been moved from an ICF/IID facility to enter the Waiver Program. **The ICF/IID case must be closed before the Waiver case is opened, (ICF/IID case must be closed and allowed to edit over 72 hours before the Waiver case is opened). Waiver certification cannot be made on the same day of the ICF/IID closure.**~~

~~When the Budget Unit characteristic of Waiver Community on the WAIV ANSWER interface screen shows the number "2900" on WVNO field, this identifies the client who has been living in the community prior to acceptance in the Waiver Program.~~

~~On the WAIV ANSWER interface screen the DDS Waiver recipient's total gross income will be displayed.~~

~~If an applicant is currently open in a Medically Needy case all eligibility factors including disability, if not previously established will be determined prior to Waiver certification. The Medically Needy case will be closed or the individual dropped from the case prior to approval for the Waiver services.~~

~~If an individual found eligible for the Waiver program is currently certified in a Medically Needy Spend Down case, a Waiver certification will not be made until the Spend Down case has expired.~~

~~An open TEFRA child found eligible for the Waiver program will be certified in the appropriate category after closure of the TEFRA case.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-272 DDS Waiver Applicants Currently Residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ICF/IID Facilities

C-272 DDS Waiver Applicants Currently Residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ICF/IID Facilities

MS Manual 01/13/1507/01/20

Eligibility determinations may be made for applicants who request Waiver services and who are currently residing in an ICF/IID facility, when there is a plan to move them to a community setting. The approval request from DDS Waiver Unit is included in the file. The Waiver Services and Medicaid Income Eligibility files are separate.

If an eligibility determination is made before an applicant is discharged from the ICF/IID facility, the Waiver case cannot be opened before the individual leaves the facility.

For Medicaid eligible DDS Waiver applicants currently residing in ICF/IID Facilities, the following actions must be completed:

Upon notification that an individual in an ICF/IID facility is requesting DDS Waiver services, DDS staff (Intake Unit or HDC Admission Coordinator), will meet with the individual's guardian/legal representative and complete ACS-102, Freedom of Choice form. Along with the ACS-102, the DDS Staff will gather the following documentation to complete the Waiver packet:

DHS-400 Release of information

Current intellectual and adaptive assessments with scoring, written report and credentialed signature within Waiver prescribed timeframes

DHS-703-Physician's diagnosis (current within 1 year)

Completed Areas of Need form

Current Social History

If the individual and/or his guardian are ready to select a provider, a provider choice form will be completed. DDS staff will also obtain a copy of the DHS-704 (Eligibility) form from the individual's file at the facility.

If the individual has not chosen a provider, the Waiver Unit Program Manager will assign a DDS Waiver Specialist to meet with the individual and/or his guardian to provide assistance in choosing a provider from the available choices.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-272 DDS Waiver Applicants Currently Residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ICF/IID Facilities

Form ACS-102 and the DHS-704 will be submitted by the DDS staff to the DDS Waiver Application Unit (WAU) along with notification of the request for waiver services for further processing and distribution.

The WAU will send the ACS-102 and DHS-704 to the DDS Medicaid Income Eligibility Unit (MIEU) for Waiver eligibility determination.

Once a determination of eligibility has been made, the DDS MIEU will email form DCO-3330 to the WAU advising eligibility status under the waiver category.

Once a choice of provider has been selected, plan of care submitted and approved, and discharge date (determined by the ICF staff in cooperation with the receiving waiver provider) scheduled, the Waiver Application Unit will submit a copy of the DHS-702 to the DDS MIEU requesting the Medicaid case to be approved in waiver category upon date of discharge.

The Medicaid Income Eligibility Unit will forward a copy of the DHS-702 in email to the DCO Medicaid caseworker of the applicant (copying County Supervisor and County Administrator) and request he/she close the applicant on the WNIU interface screen.

Allow up to 72 hours edit; open on the WAIV interface screen, submit the DHS-3330 to the Waiver Application Unit verifying waiver approval and start date as well as send a DHS-700 or system generated approval notice to the individual or guardian/legal representative advising of approval.

For individuals in a nursing facility, the following procedures will be followed:

The DDS Intake Specialist and/or Admission Coordinator will notify and submit the waiver packet to the DDS WAU.

The individuals discharging from a nursing facility, the DDS Psychological Examiners will review current and past (if applicable) psychological evaluations to establish the ICF/IID level of care requirement is met.

The Psychological Examiner will complete the DHS-704 on eligible/ineligible individuals and submit to WAU.

Once the ICF/IID Level of Care has been determined, the WAU will then disperse ACS-102 and DHS-704 to the MIEU for eligibility determination.

WAU will submit DHS-702 verifying discharge date and request approval in DDS Waiver group.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-280 SSA Referral Processes for Specific AABD Groups

If an eligibility determination is made before an applicant is discharged from the ICF/IID facility, the Waiver case cannot be opened before the individual leaves the facility. The 45 (or 90) day time frame for processing applications must be followed.

To certify the DDS waiver case, close the LTC vendor portion of the case, but do NOT close Medicaid. ~~72 hours after closure of the vendor portion of the case, the Waiver portion of the case may be opened.~~

When the client has left the facility, DCO caseworker will close the ICF/IID case in ANSWER with a Nursing Home STOP DATE effective the date the individual left the facility. A MED-END date should not be entered in ANSWER. After 72 hours if an individual who left an ICF/IID facility is to live in a community setting, the DDS worker will key the Waiver certification in ANSWER. The WAIVER START DATE cannot overlap, so it will be the day after the client left the ICF/IID facility. The address will be changed in ANSWER. It is not necessary to rekey or change the MED-BEGIN DATE; the original date shown on the screen will remain.

C-280 SSA Referral Processes for Specific AABD Groups

MS Manual 01/13/1507/01/20

The Social Security Administration has several referral processes that are used to notify DCO when Medicaid may be extended when individuals lose their SSI eligibility. SSA will determine which individuals are potentially eligible based on their disability and marital status and will refer those individuals to DCO for eligibility determinations under the provisions described in the sections below.

C-281 Eligible Due to Disregard of Social Security COLA Increases (Pickle)

MS Manual 01/13/1507/01/20

The Social Security Administration notifies the Division of County Operations (DCO) of individuals losing SSI eligibility due to COLA increases. These individuals will receive a notice regarding this change and will be given an opportunity to provide information to establish that they remain Medicaid eligible. Refer to MS B-342 for eligibility requirements.

~~The following procedures will be completed to insure that closed SSI recipients will continue to receive Medicaid.~~

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-282 Identification of Stragglers

Central Office Procedure:

Converted Cases

From a special lead file provided by the Social Security Administration, Baltimore, the Central Office will identify individuals losing SSI eligibility due to COLA increases. These individuals will be converted to the AABD No grant category at the end of each calendar year, with a reevaluation due the following year in January.

At the time Central Office converts the individuals entitled to No grant categories, they will produce a listing of the converted individuals by county entitled "SSI COLA Cases Converted to No Grant Categories". This report will run in December of each year and will be located in Web Reports in the Share Site. The County Office will take appropriate steps if needed.

County Office Responsibilities

Converted Cases

Upon receipt of the county listing of individuals converted to AABD No grant due to loss of their SSI eligibility, the county office will review each individual on the list which identifies them by name, category, case number, and by the indicator (COLA 20, enter year converted) to identify their status as a former SSI case converted to AABD No grant under provisions of the Pickle Amendment.

Each January the county office will mail form DCO-111, Notice of Conversion, to all individuals on the most recent "SSI COLA Cases Converted ..." listing to advise them of their current Medicaid eligibility status.

During the three month period, January through March each year, the county office will conduct renewals on all converted No grant cases on the county listing. The purpose of these reviews will be to build an electronic case record, to establish a new renewal date and to determine whether any individuals have been converted to AABD No grant in error.

C-282 Identification of Stragglers

MS Manual 01/13/1507/01/20

The Social Security Administration will notify Central Office of any individuals who qualify for continued Medicaid coverage under the Pickle Amendment who were not identified on the lead file transmitted from Baltimore.

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-283 Disabled Adult Children (DAC)

~~As these individuals are identified to the Central Office, a listing will be on the NAS box/DCO Web Reports.~~

~~Upon receipt of the listing from the Report, the County Office will contact the identified individuals, advise them of their potential Medicaid eligibility, and arrange for an application interview. Application will be made taken on form the DCO-0095, Application for Medicaid Assistance.~~

~~, and registered in ANSWER in the appropriate AABD budget unit on the Budget Unit Tab.~~

C-283 Disabled Adult Children (DAC)

MS Manual 01/13/1507/01/20

The Social Security Administration will notify the Agency of DAC cases, through SDX, and County Offices will receive printouts entitled "SSI Recipients Terminated Due to DAC Increases" through system generation. Within 5 working days from receipt of the printouts, the County Office will notify the listed individuals that application will be needed to determine continuing benefits. Application will be made on the DCO-0095, Application for Medicaid Assistance and registered in the appropriate category. Refer to MS B-346 for eligibility requirements.

C-284 Disabled Widows, Widowers, and Disabled Surviving Divorced Spouses

MS Manual 01/13/1507/01/20

The Social Security Administration will determine which individuals are potentially eligible, based on their disability and marital status, and will refer those individuals to DCO for eligibility determinations under these provisions. Application will be made on the DCO-0095, Application for Medicaid Assistance. Refer to MS B-345 for eligibility requirements and registered in the appropriate category.

C-285 Individuals Who Have Remarried

MS Manual 01/01/1407/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-200 Alternative Application Processes

C-286 COLA (Pickle), Disabled Adult Child (DAC), and Widows/Widowers Referral Letter

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

C-286 COLA (Pickle), Disabled Adult Child (DAC), and Widows/Widowers Referral Letter

MS Manual 01/01/1407/01/20

The Social Security Administration mails a referral letter directly to the DCO Medicaid Eligibility Unit when an individual may be a candidate for preservation of Medicaid eligibility under the provision of COLA, DAC, or Widow/Widowers benefits.

- ~~The referral letter contains the pertinent demographic and Medicaid benefit group information. The Medicaid Eligibility Unit then routes the referral letter to the DHS County Office of residence of the claimant and a caseworker will determine eligibility in the appropriate category.~~

E-400 Determining Financial Eligibility for AABD Groups

E-405 Income

E-400 Determining Financial Eligibility for AABD Groups

MS Manual 01/01/1607/01/20

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

E-405 Income

MS Manual 01/01/1407/01/20

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

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

E-410 Income Evaluation

MS Manual 10/26/1507/01/20

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

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

Non-monthly income receipts will be treated as follows:

E-400 Determining Financial Eligibility for AABD Groups

E-410 Income Evaluation

1. Regularly Received Non-monthly Monthly Income - When income that will affect eligibility is regularly received by the individual in an established amount and at a set time, the ~~caseworker/eligibility worker will begin processing case~~ will be adjusted in the month prior to the receipt of the income after an advance. ~~The caseworker/eligibility worker will notify (via the DCO-707/DHS-0707) the recipient or person acting on his behalf of case adjustment at least ten days prior to the month in which the income is to be received.~~ notice. If the increased income will result in only one month of ineligibility, the case may be reinstated effective the first day of the month following the month of ineligibility without taking a new application. Advance notice to the client will state that the case is being suspended for a month and that it will be reinstated the following month without action from the client, provided the client is still resource eligible. To adjust the case for a month of ineligibility, refer to the ANSWER Desk Guide found on SHARE.

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

~~If the Anticipated anticipated income changes that will not result in case closure, may be entered on the WNHU interface no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the caseworker/eligibility worker. The recipient or representative should will be notified of the increased vendor payment responsibility by DCO-707/DHS-0707 at least ten-10 days prior to input of the change.~~

2. Irregularly Received Non-Monthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ~~ten-10 day advance notice of intended action will be given before effecting any case closures or income adjustments resulting in changes in vendor payment are completed.~~ All income adjustments or closures will be made effective the first day of the month in which the income is received. The recipient or person acting on his/her behalf must be fully advised by ~~DCO-707/DHS-0707~~ of the amount of his/her vendor payment responsibility in these cases. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken.

As with regularly received non-monthly income, if benefits will be terminated for only one month for receipt of irregular non-monthly income, a new application will not be

E-400 Determining Financial Eligibility for AABD Groups

E-410 Income Evaluation

~~required and the customer will be so advised.~~ Closures of two or more months will require a new application.

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

When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. ~~(Refer to MS H 481 for procedures).~~

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three if paid monthly) will be used to determine the countable monthly amount. ~~If small interest/dividend amounts paid monthly or quarterly which fluctuate slightly, counties may be averaged and use the averaged amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change.~~ Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

~~The caseworker/eligibility worker will provide the individual (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility~~

E-400 Determining Financial Eligibility for AABD Groups

E-415 Determination and Verification of Earnings from Employment

~~and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the \$40 monthly allowance for personal needs is considered, the recipient will not receive the full \$40 monthly allowance unless he/she withdraws the interest/dividends as paid.~~

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

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

E-415 Determination and Verification of Earnings from Employment

MS Manual 01/01/1407/01/20

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly. ~~In cases where 5 pay periods during the month of application result in ineligibility, the application will not be denied (if otherwise eligible) but will be considered for eligibility in the following month when there will be only 4 pay periods. In ongoing cases where earnings are biweekly, the cases will be flagged to make income adjustments on WNHU during the months when 5 paychecks are to be received.~~

If the earnings fluctuate, ~~the caseworker will determine, by averaging or other means will be used to determine,~~ an amount which fairly reflects the monthly income actually currently available to the applicant ~~on a monthly basis. The case narrative will clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the actual, current income available to the applicant.~~

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the

E-400 Determining Financial Eligibility for AABD Groups

E-421 Determining Amount of Net Earnings from Self-Employment

employee can be determined. ~~The caseworker/eligibility worker will not automatically assume that one check stub accurately reflects earnings for an entire month. The latest month's verification will be required. If a person is paid weekly, then the latest 4 (or 5) consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest two check stubs will be required, and if paid monthly, then the latest check stub will be required. If the customer/individual does not have the required verification, then verification from the employer will be required.~~

EXCEPTION: ~~For cases in which the applicant/recipient has just begun employment and a month's verification is not available, the caseworker/eligibility worker will compute the income from the best information available. In this instance, the case will be flagged for a redetermination of earnings in the following month using full verification procedures.~~

E-421 Determining Amount of Net Earnings from Self-Employment

MS Manual 01/01/1407/01/20

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

1. ~~When the individual has been carrying on the same trade or business for some time, net earnings from self employment have been fairly constant from year to year, and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months would be substantially different from what it has been in the past, the estimate of earnings for the current taxable year should be the same as the net profit last year. Monthly income should be determined as one-twelfth of the net profit as shown on the tax return for the preceding year.~~
2. ~~When the individual is engaged in the same business that he/she had the preceding taxable year and anticipates no change or can give no reason why the net earnings for current and future months would be substantially different from what it has been in the past, determine the ratio between his net profit and gross receipts for the last year (e.g. net profit of \$1,200 for \$6,000 gross income, or 20%). Determine from his/her records the actual gross receipts for the current taxable year and project for the remainder of the year (e.g. \$4,000 in current year's receipts for the first 6 months gives an assumed gross of \$8,000 for the entire year). Apply the previously determined gross-net ratio (e.g. 20% of \$8,000 is \$1,600) and the~~

E-400 Determining Financial Eligibility for AABD Groups

E-421 Determining Amount of Net Earnings from Self-Employment

~~resulting estimated net profit would be allocated equally into each month of the taxable year. This method would not be suitable for a business which is seasonal or has income peaks at certain times of the year.~~

- ~~3. Have the self-employed individual supply a profit and loss statement or other business records for the taxable year to date so that a net profit can be projected for the year and allocated monthly.~~
- ~~4. Use the individual's best estimate based on his/her business records.~~
- ~~5. Consideration may be given to the individual's explanation as to why he/she believes his/her estimated net earnings for the current year will be substantially different from the information on tax returns for past years or business records for past periods. Some examples of satisfactory explanations include business loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic event which can be documented. Obtain documentation for the records (newspaper accounts, police reports, medical reports, etc.). With documentation, a lower estimate may be accepted.~~

~~After the estimated net income from self employment has been determined, explain to the individual how it has been determined and the effect it has on eligibility. Advise t~~The individual~~that he/she may appeal if he/she disputes the estimates, or that he/she may request a change or reapply if new evidence becomes available.~~

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

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

~~When one of the alternate methods under items 3, 4 or 5 has been used to determine net earnings, advise the individual that he/she should maintain monthly records of ongoing receipts and expenditures until the federal tax return is available so that substantial variations of income can be identified and reported immediately to avoid erroneous eligibility.~~

E-427 Development of Living Expenses

MS Manual 01/01/1407/01/20

When development of living expenses is required due to unstated income, ~~explain to the individual what information will be needed to develop living expenses and why it is needed. it is necessary to~~ Consider consider the living expenses of every member of the self-employed individual's household, ~~and explain that all expenses must be considered. It is essential that a complete disclosure of the following be obtained.:~~

The following guide should be used in developing living expenses:

- ~~1. Prepare on a separate narrative sheet(s) a topical breakdown of pertinent monthly living expenses such as:~~
 1. Shelter or Living Quarters Cost (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.).
 2. Clothing and Upkeep.
 3. Medical Expense Not Reimbursed by Insurance (doctor bills, dentist bills, drugs, health insurance premiums, etc.).
 4. Transportation (car loan payments, insurance premiums, gasoline, tires, oil, mass transportation fares, etc.).
 5. Food, Meals and Household Supplies (groceries, cleaning supplies, restaurant meals, etc.).
 6. Credit Purchases and Loans (furniture bill payments, finance company payments, etc.).
 7. Other (life insurance premiums, legal services, traffic fines, cigarettes, alcoholic beverages, etc.).
- ~~2. The reported living expenses will be considered as expenses in the actual time periods in which the expenses were paid by members of the household. Take into account the tendency to overlook expenses. Avoid averaging expenses between different months unless the monthly living expense total would be distorted if they were not averaged. If averaging is used, give an explanation of the reason on the narrative sheet.~~
- ~~3. Add the following statement to the narrative sheet(s) of living expenses: "I agree that this is a fair statement of monthly household living expenses".~~
- ~~4. Obtain the signature of the self-employed individual. If the self-employed individual does not provide the information, obtain the signature of the individual who does, and explain why the self-employed individual cannot or will not sign the statement.~~

E-428 Determination of Unstated Income

MS Manual 10/26/1507/01/20

The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

Determination of Unstated Income:

Reported income—Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. The amount of reported income for a month is determined by adding to the allocated monthly portion of net income from self-employment, the amount of other monthly income for the self-employed individual and any other individual who is an applicant or whose income is being deemed to the applicant, or who is an ineligible child taken into account because of deeming of income.

Reported income is the aggregate of unearned and earned income of the following people living together as one household:

1. Applicant(s)
2. Individual(s) whose income is deemed to the applicant; and
3. Ineligible children, if any, who would be taken into account considered in computing the amount of deemed income where there is a deeming situation.

1. Computation of Unstated Income:

- a. Applicant is self-employed—When an applicant or both applicants in a household (in the case of a couple) are self-employed, the computation of unstated unearned income, if any, requires that the amount of reported monthly income be subtracted from the amount of monthly living expenses, and the result, if greater than zero, be added to the amount of total unearned income of the applicant(s). Such income would be treated as other unearned income in the application.

EXAMPLE: The applicant reports earned income consisting of \$100 per month net earnings from self-employment. The spouse, also an applicant, reports a pension of \$100 per month. Living expenses are developed and total \$400 per month. The total family income of \$200 is subtracted from the \$400 monthly living expenses, leaving \$200 that will be counted as unstated unearned income for the couple to be divided as \$100.00 for each member of the couple.

- b. Individual whose income is deemed is self-employed—When the self-employed individual(s) in a household with an applicant is an ineligible spouse or parent,

E-400 Determining Financial Eligibility for AABD Groups

E-430 Sources of Unearned Income

~~the computation of unstated unearned income (reported income subtracted from living expenses) increases the amount of unearned income of the self-employed individual. The effect of the unstated unearned income on the applicant depends on the deeming computation. Refer to MS A-214 for SSI Retroactive Medicaid determinations.~~

~~Providing an Opportunity to Explain~~—When unstated unearned income is determined, ~~discuss the matter with the individual and provide the individual with~~ will have an opportunity to explain how living expenses are met. If the stated living expenses include obligations which do not represent actual expenditures (because bills are not being paid), ~~adjust the amount of living expenses after obtaining a second (will be adjusted) statement of living expenses.~~ If there are loans which account for the money used to pay living expenses, ~~the individual should provide obtain a statement of specifics of the loan(s) and verification of verify the loan transaction(s).~~ Verified proceeds from loans received and used for living expenses can be subtracted from the amount of unstated unearned income left after subtracting reported income from living expenses. The use of resources may also be used to explain how living expenses are met.

~~Notice of Determination~~—When unstated unearned income is counted, ~~the individual will receive explain on the~~ notice of decision (DCO 707DHS-0707) that an inclusion of unstated income was made based on a comparison of living expenses with reported income because of excess living expenses.

E-430 Sources of Unearned Income

MS Manual 01/01/1607/01/20

The following are possible sources of unearned income:

1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, ~~and Veterans Benefits (exclude V.A. Aide and Attendance and CME/UME payments. Re. MS E-451).~~ Civil Service, military Military allotments Allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, ~~and Black Lung benefits, and Veterans Benefits. (Exclude V.A. Aide and Attendance and Continuing or Unusual Medical Expense reimbursements (CME/UME) payments. Refer to MS E-451. Count gross income when determining eligibility.)~~

NOTE: If state and federal taxes are withheld, count the gross income when determining eligibility for nursing facility and ICF/IID cases. -Consider the net income in the post eligibility determination of the vendor payment.

E-400 Determining Financial Eligibility for AABD Groups**E-432 Types of Unearned Income**

NOTE: Payments from Long Term Care insurance policies, whether paid to the client or paid directly to the facility, are not counted as income in determining eligibility, but are included with net income for post eligibility determination of the liability amount for vendor payment. If the client has a Miller Income Trust, LTC insurance payments do not have to be placed into the trust account. Payments received in subsequent months will be handled in a similar fashion as reimbursements and the budget will be adjusted for the month the payment is intended to cover. LTC insurance payments that pay the same amount each month should be included in the budget. Per diem payments may be estimated for a period not to exceed six months if they meet the criteria at MS H 415.

2. Payments received for the rental of rooms, apartments, dwelling units, buildings, or land. If paid regularly, taxes, insurance, interest on loans, and the expense of upkeep may be deducted.

NOTE: In Waiver and TEFRA cases, the deductions are not given for eligibility determinations. In Long Term Services and Supports (LTSS) cases where there is a patient liability nursing facility, ALF, ARChoices (Adult Family Homes)PACE, and ICF/IID cases, the deductions are not given in the initial OR post eligibility determinations, and neither for home nor for non-home rental properties.

3. Interest, dividends, and income from capital investments, insurance policies, etc.
4. Royalty income from oil, gas or other mineral leases.
5. Regular payments from estates, trust funds (Re-MS E-522 #13), or other personal property which cannot be converted into cash because of legal provisions.
6. Child support payments.
7. Regular contributions from organizations, churches, friends, relatives, or social agencies.
8. Income or support and maintenance received in-kind.

Refer to the Business Process Manual.

E-432 Types of Unearned Income

MS Manual 01/01/1607/01/20

1. Social Security Benefits

Social Security benefits are paid, according to Social Security rules, to upon retirement, disability, or death of a covered wage earner. Retirement benefits are payable at age 62.

E-400 Determining Financial Eligibility for AABD Groups

E-432 Types of Unearned Income

~~Social Security disability benefits are payable at any age. At their spouse or widow/er, and/or their is eligible at age 60, disabled widows/ers at age 50. A spouse, widow/er is eligible at any age if there are minor children of the wage earner living in their home. Children are covered until age 18, or until age 19, if attending school, and an individual may receive a child benefit at any age if incapacitated prior to age 2122. All unmarried children of a wage earner are covered, even though the wage earner and the mother of the children were later separated or divorced. Illegitimate children may be covered if the wage earner can be established as the parent.~~

Social Security benefits will be verified by SOLQ, SSA 1610, or by award letters.

2. Reduction of SSA Benefits

The withholding from Title II benefits by SSA for the recovery of SSI or SSA overpayments is mandatory. ~~The money withheld will not be considered as available income for the institutionalized or HCBS individual's contribution toward the cost of care in Long Term Services and Supports (LTSS) cases where there is a patient liability.~~

3. Railroad Retirement Benefits

Railroad Retirement Benefits are paid to individuals and spouses covered under the Railroad Retirement Act. An individual may receive both Railroad Retirement and Social Security, if covered under both programs, and the spouse of a Railroad Retirement beneficiary may receive a spouse's benefit while drawing Social Security.

~~Information on Railroad Retirement Benefits may be secured from:~~

U.S. Railroad Retirement Board
1200 Cherry Brook Drive, Suite 500
Little Rock, AR 72211-4122

4. Military Allowances or Allotments

~~If the applicant has a son, daughter, or spouse in the Armed Services, the Service Representative will explore the possibility of obtaining an allotment.~~

~~The address of the Army Finance Center is:~~

Army Finance Support Agency
Indianapolis, Indiana 46492

E-400 Determining Financial Eligibility for AABD Groups

E-432 Types of Unearned Income

The address of the Navy Finance Center is:

**Navy Finance Center
Federal Office Building
Cleveland, Ohio 44199**

The address of the Air Force Finance Center is:

**Air Force Finance Center
3800 York Street
Denver, Colorado 80205**

5. Veterans Benefits

If the applicant is a veteran, or the spouse, widow/er, child, or other dependent of a veteran, full exploration will be made of potential eligibility for Veterans Benefits. Only the portion of the VA Benefit attributable to the veteran/surviving spouse will be counted as his/her income. The dependent's portion of the VA Benefit will be counted as income to the dependent(s). It will be necessary to determine the portion of the VA Benefit that is attributable to the applicant/recipient. Veterans, widows/ers and other surviving dependents eligible for higher benefit payments under the Veteran's Pension

E-400 Determining Financial Eligibility for AABD Groups

E-432 Types of Unearned Income

Improvement Act must agree to apply for and accept those benefits. Information on Veterans' Benefits should be requested on Form DCO 0052 from:

VA Regional Office

Building 65, Fort Roots

North Little Rock, Arkansas 72205

The caseworker/eligibility worker will not attempt to represent veterans or dependents in filing claims. Such persons should be referred to Service Officers of the local American Legion Post, County Offices, Veterans Administration Contact Offices, or:

Veterans' Service Office

American Legion Arkansas Department

1415 West 7th St.

Little Rock, Arkansas 72201

6. Civil Service Benefits

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

Information on Civil Service Benefits may be secured from:

**U.S. Office of Personnel Management
Retirement Operations Center
Boyers, PA 16017**

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

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

In-Kind Support and Maintenance

When an individual receives an item of food and/or shelter outright, or when someone else pays for (or makes a payment on) food and/or shelter for the individual, the individual receives in-kind support and maintenance (ISM). Generally, ISM is counted when the individual has use of the food and/or shelter item. Mortgage payments made

E-400 Determining Financial Eligibility for AABD Groups

E-432 Types of Unearned Income

by a third party on the home where the individual resides will be considered ISM; or an individual living rent free (or making only token payments) in the home of another is considered to be receiving ISM.

Other In-Kind Income

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

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

For example, car payments for an individual are not other in-kind income, even though the equity value increases; but the equity value may be counted as a resource. Premium payments made for an individual on health insurance, life insurance, credit life, or credit disability insurance are not counted as other in-kind income (There is no equity value increase in these examples). However, the cash surrender value of a life insurance policy may be counted as a resource. (Refer to MS E-523 -#2).

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

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

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

The value of other in-kind income is determined by its current market value. The value of in-kind support and maintenance is determined by presumed value. The presumed

value of in-kind support and maintenance is based on one third of SSI standard payment amount plus \$20.00.

~~Please refer to~~ Refer to Appendix S for presumed values of in-kind support and maintenance.

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

To rebut the presumed value:

- a. ~~The actual cash value of the in-kind support and/or maintenance must be established. For example, if the individual is receiving free room and board, living in the household of another, determine the actual cost necessary to maintain the household. Include mortgage payments, utilities, real estate taxes, insurance, and food for all members. Expenses should be verified by receipts. Determine the individual's pro rata share by dividing the actual monthly cost by the number of individuals living in the household. This will be the actual cost figure. If the individual purchases his own food, do not include this cost in determining the monthly household expenses.~~

~~If the individual lives rent free in the home of another or makes only token payments for rent compared to the value received, establish the rental value of the home. This can be established by securing a statement from the owner or through obtaining a verbal estimate from a rental agency. The payment made by the individual in return for in-kind support and maintenance is deducted as stated under step 2.~~

~~If a third party makes payments on behalf of the individual for basic needs items such as rent, consider the actual amount paid as the cash value.~~

- b. ~~Any cash contributed by the individual(s) in return for in-kind support and/or maintenance received is subtracted directly from the established cash value (never the presumed value).~~
- c. ~~If the net amount derived is lower than the presumed value, the presumption is rebutted, and the net figure would be considered as unearned income.~~
- d. ~~If the actual net cash value of in-kind support and maintenance exceeds the presumed value, the presumed value is counted as unearned income.~~

E-400 Determining Financial Eligibility for AABD Groups

E-432 Types of Unearned Income

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

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

- a. ~~In-Kind~~ kind payments made in lieu of cash wages are not considered as in-kind support and maintenance except when paid to agricultural or domestic employees.
 - b. ~~a.~~ In-kind payments made in lieu of cash wages to other types of employees are considered to be earned income instead of in-kind support and maintenance. The value of support and maintenance provided in a nonmedical nonprofit retirement home or similar facility which does not receive full payment from the individual or which receives subsidy payments from a nonprofit organization is not considered as in-kind income of the individual.
 - e. ~~b.~~ The value of support and maintenance in such facilities is considered as in-kind support and maintenance for individuals who have acquired rights to life care in the facility by turning over all of their assets to the home or through membership in a fraternal group or union.
- The value of support and maintenance provided in public or private non-profit institutions for educational or vocational training is considered as income of the individual.
- d. ~~c.~~ Support and maintenance provided during a medical confinement and paid to a medical provider by a third party is excluded from income for eligibility determinations. This could be in a hospital or facility.

Third party payments made directly to a facility as payment for items covered by the facility vendor payment will be considered as income in the computation of the patient's share of the vendor payment. If third party payments are made to cover special charges or additional services and items not covered by the LTSS program, they will not be considered as income.

- e. ~~d.~~ The value of support and maintenance provided by a private for profit nonmedical retirement home or similar facility which does not receive third

E-400 Determining Financial Eligibility for AABD Groups

E-433 Determining Financial Eligibility for the SSI/COLA Groups

party payments on behalf of an individual is not considered as income of the individual.

The value of support and maintenance in such facilities is considered if third party payments are being made on behalf of the individual.

- e. Occasional in-kind items of little value (not exceeding \$20.00 in a month) are excluded when they are received irregularly or infrequently.

E-433 Determining Financial Eligibility for the SSI/COLA Groups

MS Manual 10/26/1507/01/20

In determining income eligibility, the SSI related income criteria in the MS E-400-451 section will be used to determine eligibility for the following groups:

PICKLE

All SSA COLA increases received since loss of SSI benefits will be disregarded, including the initial SSA COLA increase which resulted in loss of SSI. (Other types of SSA benefit increases and other changes in income and resources will not be disregarded.) The \$20 general exclusion and other SSI exclusions (Re. MS E-450) will also be deducted from current income.

If an ineligible spouse or other family member (e.g. parent of a child with a disability) has income that must be deemed to the applicant, their COLA increases since the applicant lost SSI will also be disregarded. For deeming procedures, refer to MS E-440-451 section.

After all COLA disregards and SSI exclusions have been deducted from current income, the net countable income will be compared to the current SSI SPA standard payment amount (SPA). Refer to Appendix S. If the individual's income is under the SPA, he/she is eligible for continuing Medicaid benefits.

If the individual has an ineligible spouse, countable income will be determined according to MS E-440-451, allowing COLA disregards, and the net income compared to the couple's SPA.

If eligibility is to be determined for both members of a married couple, total their current income, subtract their combined COLA disregards, a \$20 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's SSI SPA to determine Medicaid eligibility.

Widows and Widowers with Disabilities (COBRA 1985)

E-400 Determining Financial Eligibility for AABD Groups

E-433 Determining Financial Eligibility for the SSI/COLA Groups

The individual's total amount of SSA income will be entered in the eligibility system on the individual's income tab along with an adjustment for any disregarded amount. Include the total of the SSA 1984 Reduction Factor increase, which is received from SSA and all COLA's received since January 1984 will be disregarded from current SSA income. The \$20 general exclusion and other SSI exclusions (Re. MS E-450) will also be deducted from current income. The \$20 general exclusion and any other applicable SSI exclusions will automatically be deducted in the budget summary. Only those individuals with net income under the SSI SPA will be eligible. If there is an ineligible spouse, deem according to MS E-440-451, and compare the resulting income to the couple's SSI/SPA. -Refer to Appendix S.

Widows and Widowers with a Disability (OBRA 1987)

Income eligibility determination will be made by disregarding ALL current SSA income, regardless of type of benefit, when the benefit began, or amount of benefit will be disregarded. Any other income (Railroad Retirement (RR), VA, private pension, etc.) will be considered in the budget. After the \$20 and other applicable SSI Exclusions (Re. MS E-450) are deducted from income, the resulting net income will be compared to the current SSI/SPA. (Refer to Appendix S). If the income is under the current SSI/SPA, the individual will be eligible for Medicaid. If there is an ineligible spouse, deem according to MS E-440-451, and compare the resulting income to the couple's SSI/SPA. -Refer to Appendix S.

Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 1990)

In determining income eligibility, all SSA income currently received by the widow/er with a disability or surviving divorced spouse with a disability will be disregarded. All other types of countable income will be counted in the budget, as required by the MS E-400 section. The SSI exclusions will be allowed. After all exclusions and disregards from gross income have been made, the net income will be compared to the current SSI/SPA level. (Refer to Appendix S). If net income is at or below the individual SSI/SPA, the individual will be eligible.

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

In the event SSA refers both members of a married couple for eligibility determination, the SSA income of both individuals will be disregarded, along with the SSI exclusions, before comparing

E-400 Determining Financial Eligibility for AABD Groups

E-435 Medicare Savings Income Calculation

their net income to the SSI/SPA for a couple in the eligibility determination. The couple's resource limit will apply.

Disabled Adult Child (DAC)

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

Examples:

- ~~If applicant previously had \$446 SSI and was awarded \$466 DAC, count "00" income;~~
- ~~If applicant had \$400 DAC, \$66 SSI and was awarded \$66 DAC increase, count \$400 DAC;~~
- ~~If applicant had \$300 DAC, \$100 VA, \$66 SSI and was awarded \$66 DAC increase, count \$300 DAC and \$100 VA.~~

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

E-435 Medicare Savings Income Calculation

MS Manual 05/05/1607/01/20

The Medicare Savings Program (MSP) recipient's monthly countable income must meet the appropriate Federal Poverty Level (FPL) for the specific category. -Refer to Appendix F for the MSP FPLs. -Countable income is determined according to LTC-LTSS guidelines. -For LTSS LTC guidelines, refer to sections MS E-405-451, MS H-421 and MS H-430. -Self-declaration will be accepted. -Refer to MS G-115. SSI exclusions (MS E-450) will be deducted from current income to determine income eligibility.

~~After all SSI exclusions (MS E-450) have been deducted from current income, the net countable income will be compared to the current ARSeniors income level for Aged individuals. If the individual's income is at or below the ARSeniors income level, he/she is eligible for Medicaid benefits as an ARSeniors recipient.~~

~~If the individual is not aged, or if the aged individual's income is above the ARSeniors level, income should be compared to QMB limits, and then to the SMB and QI-1 limits if necessary. If the individual has an ineligible spouse, countable income will be determined according to MS E-440-445, and the net income will be compared to the couple's ARSeniors, QMB, SMB or QI-1 income level.~~

E-400 Determining Financial Eligibility for AABD Groups

E-440 Deeming Procedures

If eligibility is to be determined for both members of a married couple, total their current income. Subtract the \$20.00 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's ARSeniors, QMB, SMB or QI-1 income level to determine eligibility.

However, the caseworker/eligibility worker will be responsible for viewing the State Online Query (SOLO) before certification of the case. In-Kind Support and Maintenance will be considered in ARSeniors, QMB, SMB, and QI-1 determinations. For a couple, total monthly countable income will be compared to the couple's standard in each case. If only one spouse is eligible, the procedures for deeming of income at MS E-440-445 will apply.

Individuals applying for only Medicare Savings coverage will not be required to apply for SSI if their income is less than the SSI/SPA. Refer to Appendix S. If an individual does not wish to be referred to SSA and does not want to be certified for full Medicaid benefits in another Medicaid category, he/she may be certified for Medicare Savings coverage only.

E-440 Deeming Procedures

MS Manual 01/01/1607/01/20

For the Medically Needy, Medicare Savings Program, and SSI/COLA groups (except DAC), when the eligible applicant resides with his or her ineligible spouse or ineligible parents, deeming of income from the ineligible spouse or parent(s) is required. Deeming is the process of considering another person's income to be available for meeting an applicant's or recipient's basic needs of food and shelter.

For the Nursing Facility, ARChoices, Assisted Living Facility, PACE, TEFRA, Autism, and DDS categories, deeming is not required.

- **NOTE:** For deeming procedures for an alien sponsor, refer to MS E-300 and E-445. For deeming procedures for the Medically Needy, refer to MS O-531 through MS O-535.

E-441 Deeming of Income from Ineligible Spouse

MS Manual 10/26/1507/01/20

Consider a couple to be married if they are:

1. Legally married under State law, or

E-400 Determining Financial Eligibility for AABD Groups

E-441 Deeming of Income from Ineligible Spouse

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

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

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

Deeming of Income from Ineligible Spouse:

1. Determine the applicant's countable income allowing the SSI exclusions at MS E-450. If countable income is equal to or exceeds the individual SSI Standard Payment Amount (SPA) for the SSI/COLA groups or Medicare Savings Program (MSP) Standard for the MSP groups, the applicant is ineligible. If countable income is less than the individual SPA or MSP Standard, complete spreadsheet in ANSWER using #2-#6c below to determine ~~deemed income will be deemed~~ from the ineligible spouse.

NOTE: For spouse-to-spouse deeming to apply, the applicant or recipient must be eligible based on his or her own income.

- 1.2. Determine the total income of the ineligible spouse by types, earned and unearned less any excluded from deeming. (Refer to MS E-446 to determine income excluded from deeming).
- 2.3. From the ineligible spouse's income, ~~a deduct~~ a living allowance (refer to Appendix S) is deducted for each ineligible child (refer to Glossary) in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). Income of the child is used to reduce this allowance unless it is excluded as student earned income; ~~refer~~ Refer to MS E-446 #10. ~~to determine whether any of the student earned income is used to reduce the living allowance.~~ The living allowance is deducted from the unearned income first and any unused balance is then deducted from earned income. Total the remaining income.
- 3.4. If the ineligible spouse's remaining income is equal to or less than his living allowance, there is no income to be deemed. The applicant is income eligible.

E-400 Determining Financial Eligibility for AABD Groups

E-441 Deeming of Income from Ineligible Spouse

~~4.5.~~ If the ineligible spouse's remaining income exceeds his living allowance, ~~total~~ the remaining income by type will be totaled with the applicant's gross earned and unearned income amounts.

~~5.6.~~ Treat the two totals of income, earned and unearned, as you would for an eligible couple. The SSI exclusions at MS E-450 are deducted and the remaining earned and unearned income totaled to arrive at countable income.

- ~~a.~~ From the unearned income, the \$20/mo. general exclusion is automatically deducted when the budget is submitted. Carry over any unused balance of the exclusion and deduct from earned income.
- ~~b.~~ From earned income deduct the \$65/mo. work expense allowance plus one-half (1/2) the remaining balance;
- ~~c.~~ Total the remaining earned and unearned income to arrive at countable income.

~~7.~~ Compare the countable income after deeming to the appropriate SSI SPA or MSP Standard for a couple. If the countable income is less than the couple's SPA or MSP Standard, the applicant is eligible. If the countable income is equal to or greater than the couple's SPA or MSP Standard, the applicant is ineligible.

~~●~~ Note: The following example reflects January 1, 2013–December 31, 2013 amounts.

EXAMPLE: Deeming of Income from an Ineligible Spouse

An applicant has gross earned income of \$585/mo. and unearned income of \$390/mo. His ineligible spouse has gross earned income of \$370/mo. and unearned income of \$380/mo. His ineligible child has no income. Deemed income is determined as follows:

- ~~1.~~ From the applicant's earned income deduct the work expense allowance, \$65 plus one-half (1/2) the remaining balance (i.e. $\$585 - \$65 = \$520$ divided by 2 = \$260).
- ~~2.~~ From the applicant's unearned income deduct the general exclusion (i.e. $\$390 - \$20 = \$370$). Add the earned and unearned income amounts ($\$260 + \$370 = \$630$).

Since the applicant's total countable income is less than the individual SPA (i.e. \$630 as compared to \$710) complete #3–#6C.

- ~~3.~~ The ineligible spouse has total income of \$370 earned income and \$380 unearned income.

E-400 Determining Financial Eligibility for AABD Groups

E-442 Deeming of Income from Ineligible Parent(s) to Child

4. ~~From the ineligible spouse's unearned income deduct the living allowance for the ineligible child (i.e., $\$380 - \$356 = \$24$). Add this amount to the ineligible spouse's earned income ($\$370$ earned income + $\$24 = \394).~~
5. ~~The ineligible spouse's remaining income is not less than or equal to her living allowance (i.e., $\$394$ as compared to $\$356$);~~
6. ~~Total the ineligible spouse's remaining income (after deeming) with the applicant's gross earned and unearned income (i.e., $\$370 + \$585 = \$955$ (earned), and $\$24 + \$390 = \$414$ (unearned));~~
 - a. ~~From the couple's total unearned income deduct the general exclusion (i.e., $\$414 - \$20 = \$394$);~~
 - b. ~~From the couple's total earned income deduct the \$65 work expense allowance plus one half (1/2) the remaining balance (i.e., $\$955 - \$65 = \$890$ divided by 2 = $\$445$);~~
 - c. ~~Add the remaining unearned and earned income to arrive at countable income (i.e., $\$394 + \$445 = \$839$; and~~
7. ~~The countable income after deeming is less than the couple SPA (i.e., $\$839$ as compared to $\$1,066$); therefore, the applicant is eligible.~~

E-442 Deeming of Income from Ineligible Parent(s) to Child

MS Manual 10/26/1507/01/20

For purposes of deeming, a stepparent's needs and income will be disregarded.

1. Determine the gross monthly income of the ineligible parents(s) by type, earned and unearned less income excluded from deeming. -Refer to MS E-446 to determine income excluded from deeming.
2. From the ineligible parent(s)'s income, deduct a living allowance for each ineligible child in the home (i.e., those not receiving TEA cash or SSI as a blind child or child with a disability). -Any income of the child is used to reduce this allowance unless it is excluded as student earned income. -Refer to MS E-446 #10 to determine whether any of the student earned income is used to reduce the living allowance. The living allowance is deducted from unearned income first. -Any unused balance is then deducted from earned income.

E-400 Determining Financial Eligibility for AABD Groups

E-442 Deeming of Income from Ineligible Parent(s) to Child

3. After deduction of living allowance(s) from income, deduct SSI exclusions. (MS E-450).

4. Total remaining earned and unearned income and deduct a living allowance for the ineligible parent(s) equal to the SSI standard payment amount (SPA). (Appendix S).

3.5. Any remaining income (if any) is deemed to the child as unearned income. It is subject to the SSI exclusions at MS E-450. the next step in the deeming determination from ineligible parent(s) will be as follows:

- a. From unearned income, deduct the \$20/mo. general exclusion (carry over any unused balance of the exclusion and deduct from earnings);
- b. From earned income, deduct the \$65/mo. work expense allowance plus one-half (1/2) the remaining balance;
- c. Total remaining earned and unearned income;
- d. From total remaining income, deduct a living allowance for the ineligible parent(s) equal to the SSI standard payment amount (SPA.)
- e. Remaining income (if any) is deemed to the child as unearned income. It is subject to the \$20/mo. general exclusion in the child's countable income determination.

6. If parental income is deemed to more than one eligible child, prorate the deemed income equally to each child.

Examples: Deeming of income from parent(s) to a child. (Examples reflect 1/1/13 - 12/31/13 figures).

EXAMPLE 1: A child has gross unearned income of \$35/mo. His ineligible parents have gross earned and unearned income of \$900/mo. and \$223/mo., respectively. There is one ineligible child.

Deemed income is determined as follows:

1. The ineligible parents have gross monthly earned and unearned income of \$900 and \$223, respectively. Proceed to #2.
2. From the ineligible parents' unearned income, deduct the living allowance for the ineligible child (i.e. $\$223 - \$356 = \$ -133$). The remaining income is $\{\$900 - 133 = \767 , step 3 will be completed.
3. From remaining income;

E-400 Determining Financial Eligibility for AABD Groups

E-442 Deeming of Income from Ineligible Parent(s) to Child

- a. ~~Deduct the \$20 general exclusion (i.e., $\$767 - \$20 = \$747$)~~
- b. ~~Deduct \$65 and $\frac{1}{2}$ the remainder (i.e., $\$747 - \$65 = \$682$ divided by 2 = $\$341$)~~
- c. ~~Deduct the ineligible parents' living allowance to equal to the couple's SSI Standard Payment Amount (i.e., $\$341 - \$1,066 = 0$);~~
- d. ~~\$0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.~~

EXAMPLE 2: ~~A child has gross unearned income of \$130/mo. His ineligible parents have gross unearned income of \$800/mo. There is one ineligible child.~~

Deemed income is determined as follows:

- 1. ~~The ineligible parents have gross monthly unearned income of \$800. Proceed to #2.~~
- 2. ~~From the ineligible parents income, deduct the living allowance for the ineligible child (i.e., $\$800 - \$356 = \$444$). Since remaining income is unearned only, step 3 will be completed.~~
- 3. ~~From remaining income;~~
 - a. ~~Deduct the general exclusion (i.e., $\$444 - 20 = \424);~~
 - b. ~~Deduct the ineligible parents' living allowance (i.e., $\$424 - 1066 = 0$);~~
 - c. ~~\$0.00 is deemed to the child as unearned income. This amount will be added to the child's own income for his/her eligibility determination.~~

EXAMPLE 3: ~~A child has gross unearned income of \$35/mo. His ineligible parents have gross earned and unearned income of \$685/mo. and \$300/mo., respectively. There are no ineligible children.~~

Deemed income is determined as follows:

- 1. ~~The ineligible parents have gross monthly earned and unearned income of \$685 and \$300, respectively. Proceed to #2.~~
- 2. ~~Calculate as follows:~~
 - a. ~~From unearned income deduct the general exclusion (i.e., $\$300 - \$20 = \$280$).~~
 - b. ~~From earned income, deduct the work expense allowance plus one half ($\frac{1}{2}$) the remaining balance (i.e., $\$685 - \$65 = \$620$ divided by 2 = $\$310$).~~
 - c. ~~Total remaining earned and unearned income (i.e., $\$310 + \$280 = \$590$).~~

E-400 Determining Financial Eligibility for AABD Groups

E-443 Deeming of Income From a Parent Who Would Be Eligible Except for Excess Deemed Income to an Eligible Child

- d. ~~From the total remaining income deduct the ineligible parents' living allowance (i.e. \$590 - 1066 = 0).~~
- e. ~~\$0.00 is deemed to the child as unearned income. This amount would be added to the child's own income for his eligibility determination.~~

E-443 Deeming of Income From a Parent Who Would Be Eligible Except for Excess Deemed Income to an Eligible Child

MS Manual 01/01/1407/01/20

When there is a blind child or child with a disability living in the home with his or her parents and one parent is categorically eligible, the income of the ineligible parent is deemed first to the categorically eligible spouse and then to the eligible child. For this condition to apply, there must be acceptable evidence provided that proves that one parent would qualify as aged, blind or as an individual with a disability except for income. The deemed income to a blind or disabled child under these circumstances is determined as follows:

1. Complete steps 2 through 7 of ~~Spouse-spouse-to-to-Spouse-spouse~~ deeming as indicated at MS E-441. - Deeming of Income from the Ineligible Spouse.
2. If the couple's income determined under ~~Spouse-spouse-to-spouse to Spouse~~ deeming is equal to or less than the couple's SSI standard payment amount (SPA), there is no income deemed to the child.
3. If the couple's income exceeds the couple's SPA, all of the countable income above the SPA is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally among each child. The amount deemed to the child as unearned income is subject to the \$SSI exclusions ~~20 per month~~ general exclusion in his/her eligibility determination. (Refer to MS A-214).

E-444 Deeming of Income to an Eligible Child from Parent/Parents Who Would Be Eligible Except for Excess Income

MS Manual 01/01/1407/01/20

When there is a blind child or child with a disability living in the home with his or her parent(s) who would be eligible except for excess income, only the income above the parents' SSI standard payment amount (/SPA) is deemed to the child. -For this condition to apply, there must be acceptable evidence provided that proves that the parent/parents would qualify as aged,

E-400 Determining Financial Eligibility for AABD Groups

E-445 Exceptions to Deeming for Alien's Sponsor

blind, or as an individual with a disability except for income. -Deemed income is determined as follows:

1. Determine the parent/parents' countable income as if no children were involved. -Allow the SSI exclusions listed at MS E-450.
2. If the countable income is equal to or less than the SPA, there is no income to deem to the child. If the countable income is greater than the SPA, the amount above the SPA is available for deeming to the child.
3. Reduce the excess income amount by a living allowance for each ineligible child in the home (i.e., those not blind or determined to have a disability). If this reduces excess income to zero, there is no income to deem to the eligible child. If not proceed to #4.
4. If excess income remains after deduction of living allowances, it is deemed to the child as unearned income. If more than one eligible child is in the home, divide the income equally to each child. The amount deemed to the child as unearned income is subject to the SSI exclusions \$20.00 per month general exclusion in his/her eligibility determination. {Re-fer to MS A-214}.

E-445 Exceptions to Deeming for Alien's Sponsor

MS Manual 01/01/1807/01/20

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

- Aliens who do not have sponsors.
- Aliens who have been battered or subject to extreme cruelty in the United States, and their children or parents who have been battered or subject to extreme cruelty. The abuse may be perpetrated by a U.S. citizen or lawful permanent residence spouse, parent, or their family members living in the same household in the U.S.- This exception applies for 12 months from the date of determination that the alien has been battered. {Re-fer to MS D-223}.
- Aliens who are indigent.- An alien with a sponsor who signed form I-864, Affidavit of Support and the alien is unable to obtain food and shelter. -If the alien lives with the sponsor, it will be assumed that the sponsor is providing food and shelter and the indigence exception will not be granted, and deeming will apply. -If the alien is living apart from the sponsor, consider the alien unable to obtain food and shelter if:

MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

E-400 Determining Financial Eligibility for AABD Groups

E 446 Items (Income) Not Included in Deeming

- a. The income the alien receives is less than the income limit for the category of Medicaid for which the individual would be eligible.
- b. The resources available to the alien are under the resource limit for the Medicaid category for which the alien would be eligible.
- Aliens who can attain citizenship.
- Aliens qualifying for Emergency Medicaid services only. (Refer to MS B-500).
- Pregnant women and children who meet one of the conditions in MS D-224.

E 446 Items (Income) Not Included in Deeming

MS Manual 01/01/1407/01/20

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

1. Assistance or Income based on need: Includes payments by any Federal Agency, State or political subdivision of SSI payments and any income which was taken into account considered in determining such assistance.
 - a. Exclusion applies to V.A. Pension but not to V.A. Compensation.
 - a.b. Also includes TEA payments and income which was taken into account considered in determining assistance (including all income of a step-parent in cases which involve a step-parent).
2. Portions of Grants, Scholarships or Fellowships used to pay tuition and fees at an educational institution or the cost of Vocational Technical training which is preparatory for employment.
3. Foster Care Payments received for an ineligible child.
4. SNAP and Department of Agriculture donated foods.
5. Home produce grown for personal consumption.
6. Refund of income taxes, real property taxes, or taxes on food purchased by the family.
7. Income used to comply with terms of court-ordered support and Title IV-D support payments.

E-400 Determining Financial Eligibility for AABD Groups

E-447 Deeming from a Non-Qualified Alien Spouse

8. The value of In-Kind Support and Maintenance provided to ineligible members of the household.
9. Income excluded by other Federal Statute.
10. Earned income of an ineligible child who is a student unless the child makes such income available (contributes) to the family. This income would not be used to offset the living allowance which is deducted from parental income in the deeming process. If a contribution is being made by the student, consider only the amount contributed as available income.
11. Income necessary for a plan to achieve self-support (i.e., Approved Plan through Rehabilitation Services).

E-447 Deeming from a Non-Qualified Alien Spouse

MS Manual 10/26/1507/01/20

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

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

E-450 Supplemental Security Income Exclusions

MS Manual 10/26/1507/01/20

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

1. Refunds on real property taxes, food taxes or income taxes.
2. Assistance based on need (State Supplementation of SSI, Interim General Assistance).
3. The tuition and fees portion of grants, scholarships, and fellowships.

MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

E-400 Determining Financial Eligibility for AABD Groups

E-450 Supplemental Security Income Exclusions

4. Home produce for personal consumption.
5. Irregular income or infrequent income which:
 - a. Cannot be predicted with any regularity.
 - b. Is received less than twice per year, ~~and~~
 - c. Does not exceed \$10 per month earned income or \$20 per month unearned income.
 - d. Income exceeding these amounts is considered in full.
6. The full amount of foster care payments made to an adult individual or eligible spouse.
7. One third of child support payments as income to a child.
8. The Student Earned Income Exclusion for a working student under the age of 22 who is enrolled in an educational institution attending a course of study preparatory for gainful work. This exclusion will be adjusted annually based on increases in the cost of living index. There may be years when no increases result from the calculation. ~~Please refer~~ Refer to Appendix S for current amount.
9. \$20 monthly may be excluded from any income not based on need (Per individual or per each couple determination), but
 - a. Is not allowed from VA pension or payments made by Bureau of Indian Affairs, ~~and~~
 - b. Is always applied to unearned income first, the balance, if any, is then applied to earned income.
10. \$65 plus 1/2 of the remainder of monthly earned income.
11. Income to cover work expenses for the blind (FICA, federal withholding, state income tax, transportation, lunches, expenses for a seeing eye dog, etc.).
12. Income to fulfill a self-support plan for blind or disabled recipients. (Approved plan through Rehabilitation Services).
13. Home Energy Assistance and Support and Maintenance Assistance provided by private non-profit organization, state or federal government body, a supplier of home heating oil or gas, or a municipal utility providing home energy.

MEDICAL SERVICES POLICY MANUAL, SECTION E MARKUP

E-400 Determining Financial Eligibility for AABD Groups

E-451 Assets Disregarded as Income

14. Support and Maintenance and other assistance received as a result of a presidentially declared disaster.

15. Agent Orange Settlement Payments (also excluded from resources).

Exceptions: The above SSI exclusions do not apply to LTSS categories including Nursing Facility, Home and Community Based Services Waiver (HCBW/HCBS) Waivers, and PACE. These exclusions also do not apply to Autism and TEFRA cases because the income limit for these categories are at the Federal maximum of three times the SSI payment limit for an individual in his own home.

E-451 Assets Disregarded as Income

MS Manual 10/26/1507/01/20

The following assets are disregarded as income in their entirety for all AABD categories, including Long-Term TSS Services and Supports (LTSS) categories (i.e. Nursing Facility, Home and Community-Community-Based Waivers, and PACE), also TEFRA and Autism:

1. Credit disability insurance payments made on home or automobile loans.
2. Personal services performed for the individual (mowing grass, house cleaning, etc.).
3. Funds received from any source for the repair or replacement of lost, damaged or stolen goods (Refer to MS E-530 #4 for resource consideration).
4. The sale of a resource (proceeds continue to be a resource) does not constitute income, but does represent a change in form of a resource.
5. Benefits received under other federal programs (Disaster Relief Program, Child Nutrition Act, etc.).
6. Dividends from insurance policies are not counted as income in determining eligibility, but are counted in determining net income for LTC-LTSS patient liability.
7. VA Aid and Attendance payments in the full amount (i.e., not reduced to \$90) are excluded in making initial eligibility determinations, and are also excluded as income to be applied to the vendor payment in a nursing or ICF/IID facility.
8. VA pension benefits reduced to \$90 monthly and paid to single veterans with no dependents, or surviving spouses of veterans with no dependents, who are certified Medicaid eligibles in Medicaid facilities.

The \$90 payment is considered Aid and Attendance for eligibility purposes, and the full \$90 is allowed as a personal needs allowance in facility cases. Individuals receiving VA

compensation are not subject to the \$90 reduction and they will not be given a \$90 Personal Needs Allowance (PNA).

9. VA reimbursements for continuing medical expenses (CME) resulting in an increased monthly pension or for unusual medical expenses (UME) resulting in lump sum payments. These payments are not income in the initial eligibility determination and individuals are not required to apply these payments toward the vendor payment.
10. Any payments, including gifts and inheritances, made to an applicant/recipient due to the death of another person may be excluded from unearned income to the extent that the payments are spent on the deceased person's last illness and burial. If an applicant/recipient is unable to make payment of last expenses in the month that the funds are received, the funds will not be considered a countable resource until after one calendar month following the month of receipt (e.g., Funds received on July 15th may be excluded during July and August. If not spent, the funds will be a countable resource September 1st.) Any interest accruing to the unspent funds is countable unearned income in the month accrued.
11. Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) states that payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are not considered income in determining Medicaid eligibility. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also, payments made pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made are not income in determining Medicaid eligibility.

NOTE: Any interest earned by these funds is countable unearned income in the month in which it is added to the account.

12. Federal tax refunds and advance payments.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-120 Blindness and Disability

F-120 Blindness and Disability

MS Manual 01/30/1507/01/20

42 U.S. Code § 1382c.

Some eligibility groups require an individual to be either blind or have a disability. -The particular blindness and disability requirement for each eligibility group is listed in Appendix J.

Blindness is defined as having central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye.

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

1. Has lasted or is expected to last for a continuous period of at least 12 months ~~((thirty days for the AFDC related categories, such as categories AFDC-EC (26), AFDC-SD Medically Needy) (27)), or~~
2. Is expected to result in death.

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

1. Receipt of SSI (AB or AD), or receipt of a letter of entitlement to SSI with begin date of entitlement, if the individual has not received the first SSI payment;
2. Receipt of Social Security or Railroad Retirement (RR) based on disability, or receipt of a letter of entitlement to Social Security or Railroad Retirement based on disability, showing a begin date of entitlement, if the individual has not received the first SSA or RR payment;
3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefit continuation, when an individual has requested continuation within ~~10~~ ten days of SSA

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-122 Medical Review Team (MRT)

determination that a physical or intellectual disability has ceased, has not existed, or is no longer disabling;

4. Nonreceipt of SSI cash benefits for reasons other than disability, but verification of an established disability that is current and continuing; (e.g. TEFRA child); ~~or~~
5. Receipt of the DCO-Q109, Report of Medical Review Team decision, when blindness or disability has been determined by the Medical Review Team.

The type of documentation used will be indexed in the recipient's electronic record.

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

F-122 Medical Review Team (MRT)

MS Manual 01/01/1607/01/20

When an individual applies for Medicaid and meets one or more of the conditions below, the DCO-106, Disability Worksheet, required forms along with any medical records provided DCO-107, Confidential Report of Medical Examination of Patient, and/or DHS 4000, Authorization to Disclose Health Information and DCO-108, Medical Review Team Social Report (DCO-108C is used for children), along with copies of the Social Security Disability or SSI denial letter (if applicable and available) will be submitted to MRT (Re. MS F-124), provided it appears that the other eligibility factors are met. Refer to Appendix I for required forms.

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

1. The individual has NOT applied for Social Security Disability or SSI or Railroad Retirement (RR).

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- 1-2. The individual has been found NOT eligible for Social Security Disability or SSI for reasons other than disability (e.g., income);

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-123 Dual Applications

3. The individual has applied for Social Security Disability or SSI, and SSA has NOT made a determination.

EXCEPTION: Individuals applying for ARChoices, Assisted Living, 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.

- 2.4. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations.

- 3.5. More than 12 months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA made the decision is worse or has changed, and he or she has not reapplied.

- 4.6. Less than 12 months have elapsed since the most recent Social Security Disability or SSI denial, and the individual alleges that the condition upon which SSA made the decision has changed or deteriorated, AND:

- a. He or she has asked SSA for a reconsideration or reopening of its previous determination and SSA has refused to consider the new allegations,

OR

- b. The individual no longer meets the non-disability Social Security Disability or SSI requirements (e.g., income).

Individuals who do not meet a criterion specified above will be denied without further development. The DCO-106 will be used to document the individual's statements/allegations regarding his disability status.



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

F-123 Dual Applications

MS Manual 01/01/1607/01/20

When an individual applies for both Medicaid and Social Security Disability or SSI, and the application with SSA is still pending, if the individual appears to meet all other eligibility requirements the county should initiate a MRT determination of disability will be initiated. if the

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-123 Dual Applications

~~individual appears to meet all other eligibility requirements. The agency will have 90 days from the date of the Medicaid application to make this determination.~~

~~While an MRT decision is pending, the caseworker should check the Social Security Disability or SSI status of the applicant 30 days after the Medicaid application has been made, and again at certification, if found eligible by MRT. If MRT finds that the individual meets the disability requirements and SSA has not yet made a decision, the caseworker may approve the case for Medicaid. To verify that no SSA decision has been made, SOLQ screens will be checked, if appropriate, and the individual or authorized representative will be contacted by mail or telephone prior to approval.~~

~~Additional case action is indicated as follows:~~

~~If application for Social Security Disability is approved first, the Medicaid application may be approved (if all other requirements have been met).~~

- ~~• Notify MRT~~
- ~~• Approve Medicaid application (if all other requirements have been met).~~

~~If application for SSI is approved first, the Medicaid application will be denied except for ARChoices, Assisted Living, Autism, DDS, Nursing Facility (NF) and PACE which may be approved.~~

- ~~• Notify MRT~~
- ~~• Deny Medicaid application, except for ARChoices, Assisted Living, Autism, DDS, Nursing Facility (NF) and PACE which may be approved on WNHU/WAIV if all other requirements have been met.~~

~~If SSA determines the applicant is NOT disabled, the Medicaid application will be denied.~~

~~Notify MRT~~

~~Deny Medicaid Application~~

~~If the caseworker approves a case the Medicaid application is approved based on a Medical Review Team (MRT) disability decision and later learns the individual has been denied by SSA, the Medicaid case will be closed after appropriate notice, unless the recipient appeals the closure. If the appeal is made within the 10-day time frame, the Medicaid case will remain open~~

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-124 Procedures for Verification of Blindness and Disability by MRT

pending the outcome of the DHS appeals process. In no case will the Medicaid case remain open pending the outcome of the SSA appeals process if the recipient has appealed the SSA decision.

If an approved Medicaid recipient is approved for SSI, the system will automatically convert the Medicaid case to an SSI category and no further action will be required of DCO except to notify MRT that no future reexamination is required, if appropriate.

If the caseworker denies an Medicaid application is denied based on a MRT decision and later learns that SSA has approved the disability, when the applicant notifies DCO, the original application will be re-registrinstated regardless of the time frame, as Medicaid claims will be paid if the provider files claims timely, Medicaid claims will be paid. Refer to MS A-190. The application will be processed the application with the original application date provided all other eligibility criteria were met for this time period.

~~F-124 Procedures for Verification of Blindness and Disability by MRT~~

~~MS Manual 01/30/15??/??/??~~

The following procedures will be followed for verification of blindness or disability through the Medical Review Team:

1. For Blindness:

- a. The caseworker will give the applicant or his representative a DCO-701, Report on Eye Examination, for completion by the ophthalmologist or optometrist who is to conduct the eye examination. In addition, a Business Reply Mail envelope will be provided for return of the DCO-701 after completion.
- b. Upon receipt of the completed DCO-701, the caseworker will check it to assure that all items of identifying information are completed. If necessary, the caseworker will complete the name, address, race, sex, and date of birth blanks on the form before forwarding to MRT. In addition to checking the DCO-701 for completeness, the caseworker will complete the DCO-108 or DCO-108C and attach it to the DCO-701 and forward it to MRT. A notation of the date that the forms are forwarded to MRT will be made in the electronic record.

2. For Disability:

- a. Determine if the individual is engaged in a substantial gainful activity (SGA), following the guidelines at MS F-128.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-124 Procedures for Verification of Blindness and Disability by MRT

If the individual is found to be engaged in SGA, deny the application, using action reason "denied due to employment". Do not send the application to MRT.

- b. If the applicant has been a patient in a private or state hospital, a VA hospital, or the University of Arkansas for Medical Sciences within the past year (the past five years for the Arkansas State Hospital), complete form DHS-4000. The Medical Review Team will request medical information from these institutions. A separate form DHS-4000 must be completed for each institution.
- c. If the applicant has not been hospitalized within the past year and does not regularly see a physician, form DCO-107 must be completed. If the applicant has been hospitalized within the past year, form DCO-107 may also be completed if the applicant chooses to supply medical information in addition to that which can be obtained from the institution by form DHS-4000. If an applicant goes to a physician regularly, in lieu of another physical examination, form DHS-4000 may be used to obtain copies of the records from the physician (no DCO-107 needed).

The caseworker will complete Part 1 of Form DCO-107 when the form is needed. The applicant must sign and date the form in Part 2. The form will then be given to the applicant to take to the medical practitioner of his or her choice. A Business Reply Mail envelope will be provided with the DCO-107. The medical practitioner will complete Part 3 of the form and return the form to the county office.

If an applicant states he or she does not have the funds for payment of a physician's examination, the applicant should be informed that MRT can arrange and pay for an examination. If the applicant wishes MRT to do this, the caseworker should report this on the DCO-108 or DCO-108C.

- d. Complete Forms DCO-106 and DCO-108 or DCO-180C. These must be completed for all cases submitted to the Medical Review Team.
- e. Submit the following completed items to the Medical Review Team:
 - i. DCO-108 or DCO-108C,
 - ii. DCO-106,

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-125 MRT Decision

iii. ~~DCO-107,~~

iv. ~~DCO-4000, and~~

v. ~~Any other medical information which the applicant wishes to provide or which is available in the individual's electronic record.~~

F-125 MRT Decision

MS Manual ~~01/30/15~~ 07/01/20

The Medical Review Team (MRT) will report the decision regarding physical or mental incapacity to the ~~county~~ County office ~~Office~~ on Form DCO-0109.

If an adverse action is taken on an individual's case, MRT will send a ~~DCO-700 notice~~ to the individual listing the specific medical records that were used in making the determination and the criteria that was not met.

If MRT finds that the medical information is not adequate to make a decision, further medical/psychiatric/psychological examinations may be recommended by MRT at the expense of the Agency.

Arrangements for such evaluations will be made by MRT only. When medical and social evidence has been resubmitted on questioned cases, the Medical Review Team will make a decision as to disability and notify the ~~county~~ County office ~~Office~~ on Form 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-126 Reapplication that Requires a Disability Determination

MS Manual ~~01/01/14~~ 07/01/20

If a reapplication is filed and the case has been closed within the past five years for reasons other than disability and the last Medical Review Team Report (MRT) ~~DCO-109~~ stated, "Reexamination not necessary" or the date for reexamination has not yet been reached, new medical and social information will not be submitted to MRT. If the case has been closed for more than five years, new medical and social information must be submitted. ~~in all cases of reapplication, a DCO-106 will be completed to determine the applicant's SSA disability status.~~

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-127 MRT-Reexamination of Disability

F-127 MRT-Reexamination of Disability

MS Manual 01/01/1407/01/20

Reexamination of disability will be required by MRT when:

1. Medical and social information indicates that an individual may recover in a year or more and/or be rehabilitated to the point where he could meet substantial gainful employment.
2. The ~~county office~~ County Office requests reexamination at any time for the aforementioned reasons.
3. Reexamination is indicated on the Medical Review Team Report ~~DCO-0109~~.

F-128 Substantial Gainful Activity (SGA)

MS Manual 10/21/1607/01/20

Substantial gainful activity (SGA) is defined as the performance of significant physical and/or mental work activities for pay or profit, or work activities generally performed for pay or profit.

Countable monthly earnings are obtained by deducting any employer subsidy and any impairment related work expense (not payroll deductions) from the gross income (gross income includes payment in-kind for the performance of work in lieu of cash). Then, if earnings are irregular, they will be averaged over the period of months being considered to obtain countable monthly earnings.

Employer subsidy is the payment of wages that is more than the value of the actual services performed.

If the work is sheltered or if there is marked discrepancy between the amount of pay and the value of services, there exists the strong possibility of a subsidy that requires development of specific evidence.

Sheltered Employment is work performed by individuals with disabilities in a protected environment under an institutional program; nonsheltered employment is any work performed by individuals in an unprotected environment.

Impairment Related Work Expenses are items or services needed in order to maintain employment, such as attendant services, prostheses, or other devices. Drugs and medical

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-128 Substantial Gainful Activity (SGA)

services are not deductible unless it can be shown they are necessary to control the disability to enable the individual to work. Deductible expenses must be paid for by the individual, and individual and cannot be reimbursable from any source. Legitimate expenses may include installation, repair, or maintenance. The payments may be deducted in one month or prorated over 12 months.

The expenses must be considered "reasonable," i.e., not more than Medicare would allow or than would ordinarily be charged in the individual's community. The following SGA Earnings Guidelines provide the basis for evaluating whether an individual is engaged in SGA:

Countable Earnings of Less Than \$300 Per Month—When average countable monthly earnings are less than \$300 per month, an assumption may be made that the work is not SGA. This assumption may be made for both sheltered and nonsheltered employment; specific evidence does not need to be developed for either sheltered or nonsheltered employment.

Countable Earnings of \$300 to \$1130 Per Month—When average countable monthly earnings from nonsheltered employment fall within the \$300 to \$1130 per month range, an assumption may be made that the work is not SGA unless:

The work is comparable to that of unimpaired individuals engaged in similar occupations as their means of livelihood; or

The work, although significantly less than that done by unimpaired individuals, is reasonably worth over \$1130 per month according to pay scales in the community.

When "a." or "b." occurs in a nonsheltered employment situation (or if gross earnings include a subsidy), current medical and social information will be submitted to MRT.

When average countable monthly earnings from sheltered employment fall within the \$300 to \$1130 per month range, the work is not ordinarily SGA. However, if earnings include a subsidy, current medical and social information will be submitted to MRT.

Countable Earnings of More Than \$1130 Per Month—When average countable monthly earnings are more than \$1130 per month, an assumption may be made that the work is SGA unless impairment causes the individual to quit work or reduce employment within a short time (6 months or less) under circumstances that would justify the employment being termed an unsuccessful work attempt. Specific evidence must be developed for both sheltered and nonsheltered employment.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-129 Request for MRT Disability Determinations

When there is no subsidy involved in gross pay and when there is no marked discrepancy between the amount of pay and the value of the services, an assumption will be made that pay from employment is fully earned. Action will be taken to deny the application or close the case as the individual does not meet the criteria for disability (Re. MS F-120). Advance notice will be given on the DCO-700.

Refer to MS Appendix S for the current SGA amount for disability and blindness.

~~1. NOTE: If an applicant with a disability reports earnings of more than \$1130 per month, the caseworker may deny the application due to employment without making a referral to MRT unless application is for Workers with Disabilities. If an applicant who is blind reports earnings of more than \$1820 per month, the caseworker may deny the application due to employment without making a referral to MRT.~~

F-129 Request for MRT Disability Determinations

MS Manual 10/21/16??/??/??

The caseworker will scan all forms requesting a MRT disability determination into Docushare according to the instructions below:

- ~~1. The forms will be scanned individually under the appropriate index selection.~~
- ~~2. After the information is scanned, the caseworker will send an email to the MRT unit notifying them that the MRT packet is scanned into Docushare and ready to be reviewed.~~
- ~~3. MRT will then print the appropriate MRT forms from Docushare and will prepare the MRT packet for review.~~
- ~~4. After the MRT decision has been made, MRT will upload the DCO-109 to Docushare and send an email to the individuals listed on the original request to inform them that the MRT decision is available.~~

Outstationed workers that do not have the ability to scan into Docushare will:

- ~~1. Scan and email the complete packet to the MRT distribution list.~~
- ~~2. MRT will print and scan the request packet into Docushare.~~

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-130 Child Support Enforcement Services

3. ~~After the MRT decision has been made, MRT will upload the DCO-109 to DocuShare and send an email to the individuals listed on the original request to inform them that the MRT decision is available.~~

F-130 Child Support Enforcement Services

MS Manual 01/30/1507/01/20

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Medicaid recipients ~~only persons/families~~ 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 Medicaid ~~only~~ applicants/recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Medicaid-~~only families~~ 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, or caretaker relative is receiving Medicaid 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 will be added to the birth certificate.



NOTE: If the father's name is included on the birth certificate of a child born 4/10/95 or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

EXCEPTION: ~~Individuals-Recipients~~ in the Limited Medicaid Pregnant Woman eligibility group will not be required to cooperate with the OCSE on Medicaid certified children

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-130 Child Support Enforcement Services

until after their postpartum period has ended and the ~~woman~~ recipient enters another group where cooperation with OCSE is required.



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

- ~~parent~~ Parent(s), guardian, or caretaker relative is ~~not~~ receiving Medicaid but the children are receiving Medicaid or
- ~~when the p~~ Parent, guardian, or caretaker relative is the only one receiving Medicaid and the children are not receiving Medicaid or
- ~~the p~~ Parent(s), guardian, or caretaker relative is receiving Medicaid in an exempt category (i.e., Limited Medicaid Pregnant Women).

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

When a referral for Newborn Coverage is received by the county, the caseworker will determine if there is an absent parent and obtain enough information to complete the referral in the system. Approval of the newborn in the 20-day period allowed for approval will not be delayed due to lack of absent parent information or due to non-cooperation by the newborn's mother.

If a child is removed from the custody of his or her parent(s) by court order (fault is assigned to the parent(s) due to abuse or neglect), refer the parent(s) to the Office of Child Support Enforcement (OCSE). If the child is voluntarily placed in the facility (even if later a court order is established for the state to assume custody), or removed by court order with no fault assigned to parent(s) (e.g., the child is abusive), only refer a parent if they were absent from the home at the time of placement. Custodial parents (parents present in the home at the time of placement) will only be referred to OCSE if the child was court-ordered and the court assigns fault to the parent(s).

Absent parents of all foster children will be referred to OCSE by the Division of Children and Family Services worker.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-130 Child Support Enforcement Services

2. Good Cause guidelines

The caseworker will explain the Assignment of Medical Support found on the Medicaid application and will explain the OCSE requirements if an in office interview is conducted. The Absent Parent Information will be added to the system for each Medicaid eligible child who has an absent parent or when legal paternity must be established. Upon receipt of the referral, OCSE will initiate steps to contact the custodial and noncustodial parents.

An individual applicant/recipient may have good cause not to cooperate in the state's State's efforts to collect child and/or Medical support. The applicant/recipient individual may be excused from cooperating if he or she believes that cooperation would not be in the best interest of the child, and if the applicant/recipient individual can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant/recipient individual has good cause for refusing to cooperate:

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

For Non-MAGI categories, Aa DCO 0090, Notice Concerning Good Cause for Refusal to Cooperate, will be completed at for each in office application interview. If Good good Cause cause is claimed, the DCO 0105, Claim of Good Cause for Refusing to Cooperate in Child Support Enforcement Activities, will be completed and the system will be updated.

For MAGI categories, requests for verification of Good Cause will be system generated.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-140 Medical Care Requirements

~~When Medicaid eligibility has ended, OCSE will notify the custodial parent or caretaker relative that support services will continue. The custodial parent or caretaker relative must advise OCSE in writing if they do not want these services to continue.~~

3. Refusal to Cooperate-Sanction

~~The County Office will be notified via an electronic interface when an individual fails to cooperate with the OCSE in establishing paternity and medical support. A task is assigned in the system for the caseworker to review and apply the sanction, if appropriate. A 10-day notice is not required. An adequate notice will be sent. If the custodial parent goes into the OCSE office after the sanction has been applied with all the information requested, OCSE will send a form FIN 39, Notice of Cooperation, to the county office requesting to lift the sanction. Cooperation in establishing child support payments is not a requirement for Medicaid-only cases.~~

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

~~The needs of an adult relative who refuses to cooperate with OCSE will continue to be included in the need standard along with the child, but Medicaid for this individual will end after the appropriate notice period has expired. The status of the individual will be Active and the Medicaid coverage would have an end date. It is not necessary to obtain a protective payee for the child when the adult relative has refused to cooperate.~~

~~As the needs of an adult relative are never included in the need standard with an eligible child in Aid to the Blind or Disabled Medicaid categories, the failure of an adult relative to cooperate with OCSE will have no effect on the child's Medicaid eligibility.~~

F-140 Medical Care Requirements

MS Manual 05/12/17-07/01/20

For facility care, the individual must meet the categorical eligibility and medical necessity requirements. -Refer to MS F-150 and F-151.

For Home and Community-Community-Based Waivers, Autism, DDS and PACE, the individual must meet the medical necessity, appropriateness of care, and cost effectiveness requirements. -Refer to MS F-151, MS F-152, MS F-153, and MS F-154.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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

For TEFRA, the individual must meet the medical necessity and appropriateness of care requirements. -Refer to MS F-151 and MS F-153.

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

MS Manual 01/30/1507/01/20

Current recipients of SSI and Foster Care (Category 91 or 92), for whom the Agency has legal responsibility, automatically meet the categorical eligibility requirement.

However, if, during the processing of an LTSS application, any question regarding the categorical eligibility of these individuals should arise, the question will be resolved with either Agency or SSA personnel before proceeding further with the application. The question and resolution should be documented in the electronic record.

If the eligibility of an SSI recipient is questionable, a statement will be obtained from SSA (preferably written) to document its awareness and treatment of the eligibility factor. If there appears to be a policy conflict between DCO and SSA, the DCO Medicaid Eligibility Unit (MEU) will be contacted by email to clear the discrepancy. Refer to Manual Transmittals for email addresses for the MEU.

Categorical eligibility for individuals other than SSI or Foster Care (Category 91 or 92) will be determined according to SSI-related AABD facility eligibility criteria as follows:

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

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

EXAMPLE: An individual enters a facility anytime on July 18th. - The 30-day count begins at 12:01 a.m. of the morning of July 18th and ends at midnight of August 16th.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-151 Functional Need

2. Categorical Relatedness - In order to meet the requirement of categorical relatedness, the individual must meet one of the following:

Aged - Age 65 or older (Re-MS F-110); or

Blind - Central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye (Re-MS F-120); or

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

- Has lasted or is expected to last for a continuous period of at least 12 months; or
- Is expected to result in death (Re-Refer to MS F-120 and MS F-124.).

F-151 Functional Need

MS Manual 01/01/1607/01/20

Before nursing facility, waiver services or PACE can be authorized, it must be determined that the patient's condition warrants facility care or waiver services. - Functional need decisions are made based on the information submitted on the DHSDHS-0703. - The decision will be reported to the County Office on the DHSDCO-0704.

Functional need decisions for:

- Nursing facility applicants and recipients are made by the Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC);
- Assisted Living, ARChoices Waivers- and PACE applicants and recipients are made by the Division of Aging, and Adult, and Behavioral Health Services (DAABHS);
- DDS waiver applicants and recipients are made by the Division of Developmental Disabilities Services;
- TEFRA applicants and recipients are made by the TEFRA Committee; and
- Autism applicants and recipients are made by 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 nursing facility. Persons requiring pre-admission evaluations for mental retardation or mental illness

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-151 Functional Need

shall not be eligible for Medicaid reimbursement of nursing facility services prior to the date that a determination is made (the PASARR effective date on the DHSDCO-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 services prior to the decision date on the DHSDCO-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 those admitted for convalescent care.

~~When the need for continued stay in a facility has been determined to be functionally necessary, a new review date is assigned and the approval/patient classification is valid through that date. The county office/County Office will not receive notice of change in classification, unless a change in functional need will require case closure, or transfer to another facility. The change in classification (if any), the decision date, and the new review date will be system entered by OLTC.~~

~~When the county office/County Office is notified by DCO-702 from a facility that an individual has entered another facility prior to the scheduled review date, the county office/County Office will complete a blank DCO-0704 (Re-) to advise the receiving facility of the scheduled review date, if any, and the current level of care.~~

~~When OLTC finds that reclassification of a recipient is warranted, the reclassification information will be provided to the facility and to the case/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 the county office/County Office by sending the DHSDCO-0704.—If it is a PASARR determination, OLTC will notify the recipient or his or her legal guardian by letter.

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

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-152 DCO Institutional Status

~~The county office~~County Office will:

- ~~1. Provide advance notice of discontinuance of services to the recipient or legal guardian and next of kin (when possible), giving the nature and effective date of the proposed action.~~
- ~~2. Close the LTC case.~~

F-152 DCO Institutional Status

MS Manual ~~01/30/15~~07/01/20

Evidence of institutional status includes any written document, record, etc. from a hospital and/or nursing facility which verifies that the individual was in the hospital and/or nursing facility for 30 consecutive calendar days. ~~(Re-Refer to MS F-150).~~

When an individual cannot meet the institutional status requirement, the application will be denied, unless the individual dies before meeting the ~~30 day~~30-day requirement. In that case, certification may be made for the actual days spent in the facility.

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

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



NOTE: The institutional status requirement does not apply to individuals who were certified for SSI or Foster Care ~~(Category 91 or 92)~~ in the month of facility entry.

Individuals who become ineligible for SSI or Foster Care ~~(Category 91 or 92)~~ following the month of nursing facility entry, will have their categorical eligibility determined according to SSI-related

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-154 Cost Effectiveness

AABD facility eligibility criteria, with the exception of the institutional status requirement.—Refer to MS F-150.

F-154 Cost Effectiveness

MS Manual 05/12/17 07/01/20

The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution.

For ARChoices, PACE, and Assisted Living, this determination will be made by DAAS the Division of Aging, Adult, and Behavioral Health Services (DAABHS).— If at any time DAABHS determines that cost effectiveness is not met, the case eligibility worker will be notified by DHS-3330 and the case will be closed after the appropriate notice is sent to the individual.

For DDS, the Division of Developmental Disabilities Services is responsible for monitoring cost effectiveness.

For Autism and TEFRA, the Division of Medical Services is responsible for monitoring cost effectiveness.

F-155 Functional Need Criteria

MS Manual 01/01/16 07/01/20

Individuals requiring services in ARChoices or ALF must be classified as requiring an Intermediate (I-A, II-B, III-C) Level of Care as determined by the DPSQA Office of Long Term Care (OLTC). Individuals classified as Skilled Care patients are not eligible for ARChoices or ALF.

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

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

If an individual has a serious mental illness or has mental retardation, the individual will not be eligible.—However, the diagnosis of severe mental illness or mental retardation will not bar

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-155 Functional Need Criteria

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 Facility for Individuals with Intellectual Disabilities (ICF/IID) ~~ICF/IID~~ level of care.

ARChoices, Assisted Living, and PACE

To be determined an individual with a functional disability, a licensed medical professional must determine an individual must meets at least one of the following three criteria, as determined by a licensed medical professional established by the Division of Aging, Adult and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care.

1. ~~The individual is unable to perform either of the following:~~
 - a. ~~At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person;~~
 - b. ~~At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or~~
2. ~~Medical assessment results in a score of three or more on Cognitive Performance Scale;~~
~~or~~
3. ~~Medical assessment results in Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.~~

DDS

To be determined an individual with a developmental disability, DDS will administer a comprehensive Diagnosis and Evaluation. – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) eligibility is

DDS determines ICF/IID eligibility based on a schedule according to the individual's age;

1. ~~For individuals aged 0-5, both IQ and Adaptive Functioning Level will be tested every year;~~

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-156 Incapacitation

- ~~2. For minors age 5-21 or 18 years with certificate of high school completion, current IQ and adaptive functioning will be tested within 3 years of the date of referral; and~~
- ~~3. For adults age 22 and older, the IQ score obtained at age 22 years or over and an adaptive behavior assessment current within 5 years from date of referral will be used.~~

DDS will develop an individualized plan of care which will be reviewed within six (6) months of the initial assessment and, again, prior to 12 months from admission to the program.

Thereafter, DDS Plan of Care reviews will be completed annually.

F-156 Incapacitation

MS Manual ~~01/30/15~~ 07/01/20

A person is presumed to possess legal capacity unless declared incapacitated by a probate court.

Arkansas Statutes define a person as "incapacitated" when by reason of minority or of impairment due to a disability such as mental illness, mental deficiency, physical illness, chronic use of drugs, or chronic intoxication, he is lacking sufficient understanding or capacity to make or communicate decisions to meet the essential requirements for his health or safety or to manage his estate.

Whenever a person is incapable of caring for himself or his property, a need for a guardian is indicated. A guardian of the estate may be appointed if the person is incapable of managing property, money or his legal affairs. Guardianship of the person is indicated if the person is incapable of taking care of his person.

Normally, the question of incapacitation will not be considered in an eligibility determination. If a person has been adjudicated incapacitated and has had a guardian appointed for him, it will be necessary for the guardian to make application for benefits since the individual does not have that legal power.

If a person's incapacitation has not been determined, it will not be considered in an eligibility determination as long as the person is able to make his wants or application known. If a person has excess resources and a claim is made that his resources are not available due to incapacitation, it will be the responsibility of the person alleging the incapacitation to furnish proof of the incapacitation and to find a person able and willing to serve as guardian of the person and/or estate. The person alleging the incapacitation will be required to provide a medical affidavit attesting to the incapacitation of the individual.

Advance Notice

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-156 Incapacitation

When the medical statement has been obtained, the ~~county office~~ County Office will inform the person alleged to be incapacitated and the person who has made the allegation that:

1. A period of 120 days will be allowed to find a person who will serve as guardian, to present the guardianship request to probate court, and to finalize the guardianship proceedings;
2. The resources in question will be excluded for 120 days or until the first day of the month following the month in which the court order establishing guardianship is filed, whichever occurs earlier;
3. A copy of the court order establishing guardianship must be given the ~~county office~~ County Office within ten days of filing the order; and that
4. Any LTC-Long-Term Services and Supports (LTSS) payments made on behalf of the person alleged to be incapacitated during the exclusion period will be subject to recovery in accordance with overpayment policy if the probate court fails to find the individual incapacitated or if the person alleging incapacitation fails to initiate and finalize action for the appointment of a guardian within the allotted time.

If the guardianship has not been finalized within 120 days and if the parties involved maintain that diligent and good faith efforts have been taken to obtain the guardianship, the ~~county office~~ County Office will submit the case record to the Office of Policy and Legal Services Chief Counsel (OPLSOCC) along with all related documents and a cover memorandum summarizing the facts and requesting a review to determine if an extension of time is warranted.

If the written opinion obtained from ~~OCC~~ OPLS states that circumstances justify an extension of the ~~120 day~~ 120-day period and specifies the duration of time for the extension, the extension will be granted.

If no time extension is found justifiable, the county will proceed as instructed below.

Case Closures

Case closures, when applicable, will be made on the first day of the month following the month in which:

1. The court order establishing guardianship is filed and reported; or

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-161 Primary Care Physician Managed Care Program

2. The allotted 120 days has ended (when OCC OPLS did not grant an extension or when no guardianship action was initiated), ~~or~~
3. The time extension granted by OCC OPLS has expired and guardianship has not been finalized.

Advance notice of closure is not required.

Overpayments

If LTC LTSS services have been paid, an overpayment will be written when:

1. The individual was not found to be incapacitated by the court;
2. The person making the allegation failed to initiate action and to establish guardianship within the allotted time, or to finalize guardianship within the OCC OPLS extension of time, or OCC OPLS did not find an extension of the 120 days was warranted.

No overpayments will be written when the court has found that the individual is incapacitated. A copy of the court order will be obtained by the ~~county office~~ County Office for the case record, and the guardian will be responsible for petitioning the court to dispose of excess resources. A redetermination of LTSS LTC eligibility will not be made until disposition of the excess resources has been made.

F-161 Primary Care Physician Managed Care Program

MS Manual 01/30/1507/01/20

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

Each Medicaid recipient must choose a ~~primary~~ Primary care ~~Care physician~~ Physician (PCP) except those who:

- Have Medicare as their primary insurance;
- Are in nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) ~~ICF/IID facilities~~;
- Are Medically Needy Spend Down only;
- Have retroactive eligibility only; or

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-162 Recipient Responsibilities

- Are temporarily absent from the ~~state~~State.

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

F-162 Recipient Responsibilities

MS Manual 01/01/1407/01/20

A Primary Care Physician (PCP) ~~PCP~~ must be chosen for each family member who is a recipient. Each member may have a different physician.

The Medicaid recipient can choose a PCP:

- ~~By calling the ConnectCare help line at 1-800-275-1131 (TDD: 1-800-285-1131),~~
- ~~By visiting the website at,~~
- ~~At the doctor's office, or~~
- ~~At the local DHS County Office.~~

The recipient must choose a physician who provides services in the recipient's county of residence, in a county which adjoins the county of residence, or in a county which adjoins the adjoining county. A recipient who lives in a county which borders another state may choose a physician in the bordering state.

If a recipient chooses to see a health care provider other than the primary care physician, or other than a provider to whom the primary care physician has made a referral, the recipient will be responsible for payment for any services received.

F-163 County Office Responsibilities

MS Manual 01/30/15??/??/??

The caseworker will provide and review Form DCO-2613, Notice to Medicaid Applicants/Beneficiaries, with the applicant if in the office. If requested by the applicant, the caseworker will assist in completing Form DMS-2609 or DCO-2609 County, Primary Care

MEDICAL SERVICES POLICY MANUAL, SECTION F

Error! No text of specified style in document.

F-164 Changes in Primary Care Physicians

Physician Selection and Change Form, for each non-excluded family member. First, second, and third choice of physicians should be listed for each family member.

When a PCP is selected by the individual, the county staff uses the web-based program at or a telephonic voice response system at 1-800-805-1512 to enroll the individual. If the individual's first choice has a full caseload, the worker will try the second choice and if necessary, the third choice. If all physicians selected by the individual have a full caseload, a notice will be mailed to the individual to select three more physicians. A new DCO-2609 must be completed.

NOTE: Counties may use either Form DMS-2609 or DCO-2609 County. However, if an individual requests a form for enrollment at a physician's office, a DMS-2609 will be provided. The DCO-2609 County is for county use only.

Form DCO-2609 will be scanned into the electronic record and the original will be mailed or given to the individual, if requested.

Each County Office will maintain a current listing of all participating physicians in the geographical area. All individuals will be given access to the listing when making physician selections. Counties will receive updates to the listings on a monthly basis.

F-164 Changes in Primary Care Physicians

MS Manual 01/01/2007/01/20

A change in a recipient's primary Primary care-Care P physician can be made in the following circumstances:

1. A physician moves from the county, closes his office, or withdraws from the program.
2. A recipient moves from the county.
3. A recipient finds his relationship with the physician unacceptable.

If there is an allegation of substandard care, the recipient may report it to the Utilization Review Section, Division of Medical Services (501-682-8340). In this situation, no change in physician will be made until the County Office is authorized to do so by the Utilization Review Section.

4. A physician finds his relationship with the recipient unacceptable; the recipient is abusive to the physician; or the recipient fails to comply with medical instructions.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-170 TEFRA Premium

A recipient, including a SSI recipient, can change his/her primary care physician by:

- Calling the ConnectCare help line at 1-800-275-1131, (TDD: 1-800-285-1131),
- Visiting the website at, or
- Contacting the local DHS County Office.

F-170 TEFRA Premium

MS Manual 01/01/1407/01/20

TEFRA households with annual income after allowable expenses above 150% of the Federal Poverty Level for their household size will be required to pay monthly premiums as described in the sections below.

F-171 Determining Monthly Premiums

MS Manual 01/30/1507/01/20

The amount of the premium will be determined based on the custodial parent(s) total gross income as reported on the applicable Federal Income Tax Return (e.g., line 22 ~~six~~ of the 2011 ~~2018~~ version of form 1040 or line 15 of the 1040A) less the following deductions:

- Six hundred dollars (\$600) per child, biological or adopted including the waiver child, who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents.
- Excess medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parents (e.g., line 4 ~~four~~ on the 2011-2018 version of Schedule A).

EXAMPLE 1: Family consists of ~~five~~ people, mom, dad, waiver-TEFRA child, and ~~2~~ two minor siblings, living in the home. Total income on last year's Federal Income Tax Return showed \$65,417.48. Excess medical and dental on Schedule A showed \$9,463.25. All children in the home were included on the return.

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

Compare the adjusted income to Chart 1 in Appendix P (2018). The income is above the limit for a family size of ~~five~~. Go to Chart 2. The premium range for the adjusted income is from \$52.00 to \$78.00.

EXAMPLE 2: Same family with less income reported.

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

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-173 Payment of Premiums

Comparing income in Chart 1 in Appendix P (20132018), the annual income is below the limit for a family size of five\$41,355.~. Therefore, no premium is required.

If the custodial parent alleges that household income has decreased significantly since filing the Federal Income Tax Return, additional verification can be submitted to determine current income.

NOTE:— A stepparent living in the home will be considered a custodial parent and his or her income will be included when determining the premium amount.

See Appendix P for the amount of premiums to be paid. The maximum annual premium amount to be paid by any family is \$5,500. Families having more than one child receiving TEFRA Waiver benefits will pay only one premium for all covered children. There will be no increase in premium amount for additional Waiver children.

F-173 Payment of Premiums

MS Manual 01/01/14??/??/??

Payments must be made through monthly bank drafts or quarterly payments in advance. For new recipients, premiums will be applied beginning with the month after the month of approval.

The TEFRA Premium Unit will collect the TEFRA/Medicaid premium payments and send the premium invoice to TEFRA households. When a TEFRA case is approved, the TEFRA Premium Unit will send a TEFRA Premium Payment Selection Form to the recipient giving the option of authorizing an automatic bank draft or making quarterly payments in advance. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check. The check must be sent in with the Payment Selection Form. The draft or quarterly payment will begin with the third month after the month of approval.

For those individuals who choose to pay through monthly bank drafts, the TEFRA Premium Unit will draft the account for the third month after approval and the following months. Each draft will be made on the first day of the covered month. The TEFRA Premium Unit will send monthly invoices that the bank account has been drafted.

For those who choose quarterly payments, the individual must initially pay for the month after the month of approval and the following month in advance by check, after which the TEFRA

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-180 Other Health Insurance Coverage

Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter.

If eligibility ends during the quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the family will be reimbursed for the partial month.

Failure to provide the Payment Selection Form or make the two month two month initial payment will cause the child to be ineligible, and the case will be closed after proper advance notice. For ongoing cases, if the premium is not paid for three months, advance notice will be sent and the case will be closed. The TEFRA Premium Unit will notify the county office County Office if the Payment Selection Form is not received.

Monthly aged reports will be sent to each county showing the cases with overdue premiums and the number of monthly payments in arrears. The caseworker eligibility worker will send a 10 day advance notice to each case showing three months of non payment, advising that the case will be closed if payment is not made. At the end of the notice period, if payment of the premiums has not been made, the case will be closed. (Refer to C 231 for re application when TEFRA case is closed due to non payment of premiums.)

F-180 Other Health Insurance Coverage

MS Manual 09/01/1807/01/20

For most eligibility groups, an individual may be covered by other health insurance without affecting his or her eligibility for Medicaid. There are two exceptions to this which are described below.

Adult Expansion Group

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

ARKids B

Children who have health insurance or who have been covered by health insurance other than Medicaid in the 90 days preceding the date of application will not be eligible for ARKids B unless one of the following conditions is met:

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-180 Other Health Insurance Coverage

- a. The premium paid by the family for coverage of the child under the group health plan exceeded five percent of household income.



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

- b. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the 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 9.5 percent of the household income.
- d. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.
- e. A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).
- f. The child has special health care needs. Special health care needs are defined as the health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.
- g. The child lost coverage due to the death or divorce of a parent.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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

h.g. Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out of state and covers the child on his or her HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the caseworker eligibility worker based on information provided by the applicant.

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

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

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

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

MS Manual 01/01/1407/01/20

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

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

- ARSeniors – Individuals do not have to be entitled to Medicare (e.g., Qualified Aliens who have not worked enough quarters to Qualify for Medicare can still be eligible for ARSeniors). – However, individuals who are entitled to Medicare and choose not to enroll in Medicare are not eligible for the ARSeniors program.
- QMB – Individuals must be entitled to or conditionally eligible for Medicare Part A.
- Specified Low-Income Medicare Beneficiaries (SMB) SMB – Individuals must be entitled to Medicare Part A.
- Qualifying Individuals 1 (QI-1) QI-1 – Individuals must be entitled to Medicare Part A.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-191 Medicare Part A Entitlement

- Qualified Disabled and Working Individuals (QDWI) ~~QDWI~~ -- Individuals who lost Medicare Part A & SSA Disability Insurance Benefits (DIB) benefits due to Substantial Gainful Activity (SGA) ~~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 01/30/1507/01/20

Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who are:
 - a. Entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries, ~~or~~
 - b. Not entitled to monthly Social Security or Railroad Retirement benefits, but meet the requirements of a special transitional provision (some individuals who are not eligible for regular SSA or Railroad Retirement benefits still qualify for Part A hospital insurance); ~~or~~
 - c. Not entitled to monthly Social Security benefits and not a qualified Railroad Retirement beneficiary, but enrolled and paying a monthly premium. To be eligible under this provision, an individual must be age 65 or older, a U.S. resident, and a U.S. citizen or an alien lawfully admitted for permanent residence who has resided continuously in the U.S. for five years, and enrolled for Part B medical insurance or has filed a Part B enrollment request which will entitle the individual to Part B; ~~or~~
 - d. Conditionally eligible except that they are not receiving Part A Medicare because they cannot afford to pay the premium for Part A.
2. Persons under age 65 who are entitled to or deemed entitled to Social Security disability benefits for 24 months (included are workers with disabilities, widow(er)s with disabilities, surviving divorced spouses with disabilities, and individuals entitled to childhood disability benefits) beginning with the 25th month of entitlement to such benefits, and certain individuals entitled to Railroad Retirement benefits due to a disability.
3. Persons of any age who have end-stage renal disease (ESRD) who require a kidney transplant or a regular course of dialysis and who are Social Security or Railroad

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-191 Medicare Part A Entitlement

Retirement recipients, or the spouse or a child of an SSA recipient when the spouse or child has ESRD.

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

For QMB, SMB₂ and QI-1, if an individual is receiving Part A Medicare but not receiving Part B Medicare, the application will be approved, if eligible.—Being enrolled in Part B Medicare is not an eligibility requirement.—After the approval and the individual's name appears on the buy-in rolls, the Centers for Medicare and Medicaid Services (CMS) will receive notice that the individual is eligible and entitled to Part B Medicare.—The individual will not be assessed a late filing penalty.

Individuals Entitled to Part A Without Payment of Part A Premium

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-192 Medicare Entitlement Requirements for Qualified Disabled and Working Individuals (QDWI)QDWI

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 the DHS Central Office for accretion to the system and, thus, for QMB benefits, including payment of Part A Premium. If a County Office has an inquiry or application for QMB benefits from an individual receiving SSI, the individual should be informed that he/she is eligible for QMB benefits, and that the benefits will begin as soon as the automated system accretes him/her for these benefits. A QMB application from an SSI recipient will be denied by the County.

2. Non-SSI Individuals Receiving Part B Medicare

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

3. Individuals Not Receiving Part A or Part B Medicare

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

F-192 Medicare Entitlement Requirements for Qualified Disabled and Working Individuals (QDWI)QDWI

MS Manual 01/01/1407/01/20

The following requirements must be met by an individual to qualify for benefits as a QDWI:

1. Lost Medicare Part A and SSA-Disability Insurance Benefits (SSA-DIB) due to Substantial Gainful Activity (SGA) — The individual must have previously received and lost entitlement to SSA-DIB and Medicare Part A solely due to earnings that exceed the SGA amount, as determined by the Social Security Administration. If the individual's loss of

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-193 Initial Enrollment Period and General Enrollment Period for Medicare Part A

SSA-DIB and Medicare Part A was for another reason (e.g., no longer has a disability), the individual will not qualify as a QDWI.

2. Entitled to Reenroll in Medicare Part A—The individual must be entitled to reenroll for Medicare Part A and must reapply for coverage with the Social Security Administration prior to QDWI certification.

The following information must be verified:

- a) Individual's blindness or disability is continuing,
- b) Individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA,
- c) Individual has reenrolled for Medicare Part A,
- d) Effective date of Medicare Part A coverage.

The individual will be asked to provide any notices received from SSA or to obtain the needed information directly from SSA. The County Office can also access the information through SOLQ if needed.

F-193 Initial Enrollment Period and General Enrollment Period for Medicare Part A

MS Manual 01/01/1407/01/20

A Qualified Disabled and Working Individuals (QDWI) QDWI applicant must reenroll for Medicare Part A, if he/she has 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) SGA, advising them to contact the SSA office. Once reapplication has been made for Medicare Part A, SSA will refer potentially eligible individuals to the County Office to make a QDWI application.

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

The Individual Enrollment Period begins with the month in which the individual receives notice from SSA that his/her entitlement to Disability and Medicare will end solely due to SGA. The enrollment period ends 7-seven months later.

MEDICAL SERVICES POLICY MANUAL, SECTION F

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F-193 Initial Enrollment Period and General Enrollment Period
for Medicare Part A

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

MARK-UP

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

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

H-400 Post Eligibility

MS Manual 07/13/15 07/01/20

The eligibility groups Nursing Facility, Assisted Living Facility, PACE recipients in a nursing facility, and PACE recipients in the community who have met income eligibility by establishing an irrevocable income trust and individuals receiving waiver services in an Adult Family Home require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

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

MS Manual 01/01/14 07/01/0

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

H-402 Consideration of Income

MS Manual 07/13/15 07/01/20

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

1. Income Not From A Trust

- a. Income received solely in the name of either spouse will be considered income only to that spouse. Refer to MS E-432#5 for "Veteran's Benefits" exceptions.
- b. If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS.
- c. If payment of income is made in the names of the IS and/or the CS and another person, the income will be considered available to each spouse in proportion to

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-403 Rebutting Consideration of Income

each spouse's interest. If payment is made with respect to both spouses, and no such interest is specified, one half of the joint interest will be considered available to each spouse.

2. Income From A Trust

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

3. Income Through Property With No Instrument Establishing Ownership

When income is from property which has no instrument establishing ownership— (i.e. unprobated, income-producing heir property), one half of the income will be considered to be available to the IS and one-half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 01/01/14 07/01/20

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

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. ~~In order to~~To successfully rebut the presumption of full or partial ownership, he/she must provide the following within 30 days of the date on the DHSDCO-0712, Post Eligibility Income Worksheet:

1. A written, signed statement by the IS giving his/her allegation regarding ownership, the reason for the applicant's receipt of the income or for his/her name appearing as an owner on the payment of the income;
2. Corroborating, signed statements from the other owner(s);
3. A change in the instrument of ownership removing the IS's name from the instrument or a change which redirects the income to the actual owner(s); and

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

4. Copies of the original and revised documents reflecting the change in 3.

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

If the individual elects not to rebut the consideration of ownership interest, obtain a written statement from the individual which documents his/her election.

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

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

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

NOTE: This section does not apply to federal, state or other entitlements, pensions or retirement benefits. For example, ownership of a \$600 Social Security income entitlement for an IS cannot be rebutted.

H-410 Factors Used to Determine the Cost of Care

MS Manual 01/01/1607/01/20

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

NOTE: ARChoices (except those who participate in the Adult Family Home service) and DDS Waiver recipients do not make a contribution to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living, ARChoices Adult Family Home and PACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the applicant/recipient, their spouse, IS, CS, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed on form DHSDCO-0712, Post Eligibility Income Worksheet, for the appropriate time period.

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

1. Total Earned and Unearned Income

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

- ◆ For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget.
- ◆ VA Aid and Attendance payments and VA CME/UME will not be counted as income.
- ◆ Mandatory deductions and work related expenses will be deducted from gross earnings.
- ◆ An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in 10-bed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ICF/IID facilities and State Human Development Centers. Refer to MS H-430.
- ◆ LTC insurance payments, whether paid to the facility or directly to the recipient, are not considered in the eligibility process, but are counted toward cost of care.

2. Income Trust Fees (if applicable).

Deduct the applicable income trust fees. Refer to MS H-111 #3.

- ~~◆ Any applicable income trust fees.~~
- ◆ The monthly service charge for maintaining the trust bank account and
- ◆ Commercially reasonable administrative fees charged by the commercial institution serving as trustee fees may be deducted in cases certified November 1, 1995 and later. Refer to MS H 100.

3. Personal Needs Allowance.

Deduct the personal needs allowance (PNA).

- ◆ Subtract a \$40 PNA for most facility residents.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

NOTE: Facility residents whose only income is SSI will be allowed to keep \$30 as their PNA. -The PNA of a SSI recipient who also has other income is ~~\$40.00~~. Refer to MS H-420.

- ◆ Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to \$90 will be given the full \$90 as a personal needs allowance. -An additional \$40 will not be given. -A \$90 PNA will not be given to any individual whose VA pension has not been reduced to \$90 by the Veterans Administration (VA). -If VA later reduces the pension to \$90, an income adjustment will be made.

It will not be the responsibility of the caseworker to attempt to identify individuals who may be eligible for a \$90 PNA or to allow a \$90 PNA when the VA benefits have not been reduced to \$90. If a single veteran or surviving spouse of a veteran with no dependents is receiving VA pension and the benefits have not been reduced to \$90 at certification, only a \$40 PNA will be given. The case will be adjusted when the caseworker learns that the pension has been reduced to \$90.

Individuals ~~may be instructed to~~ should contact the Veterans Administration if they believe they are entitled to a \$90 reduced pension.

- ◆ For residents of ICF/IIDs and State Human Development Centers with earned income, \$40 may be given as a PNA in addition to a disregard of earned income up to the current SSI/SPA.
- ◆ For nursing facility residents with earned income, \$40 may be given as a PNA in addition to a disregard of up to \$100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. Refer to MS H-430.

4. ~~If the individual has no spouse or dependents or noncovered medical expenses, the PNA will be the only allowance given to arrive at net income. If the individual has dependent children, but no spouse, refer to # 6 below. If the individual has a spouse or spouse and other dependents living in the community, refer to # 5 below.~~

5.4. The Community Spouse Monthly Income Allowance (CSMIA), which is determined by:

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

- ◆ A community spouse (CS) may be entitled to a portion of the Institutionalized Spouse's (IS) income. The total amount of the IS's income to which the CS is entitled is the **CSMIA**. It is calculated by adding the Minimum Monthly Maintenance Needs Allowance (**CSMNA**) and the Excess Shelter Allowance and subtracting the community spouse's own income. The CSMNA is capped at a Maximum Monthly Maintenance Needs Allowance amount. The excess shelter allowance, CSMNA, and Maximum Monthly Maintenance Needs Allowance change annually. They are set by the federal government and are based on the Consumer Price Index.
- ◆ Computing the Excess Shelter Allowance in Section 5a of the DCO-712. Total shelter costs may include:
 - ◆ Rent or mortgage (including principal and interest);
 - ◆ Prorated taxes and insurance (including personal property taxes and insurance on household contents if paid yearly);
 - ◆ Condominium or cooperative fee, (including maintenance charges); and
 - ◆ The standard utility allowance.

Shelter costs must be verified. Utilities need not be verified.

— **NOTE:** Do not add the standard utility allowance is not allowed in computation if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (Ex. e.g. water), the full utility allowance may be used.

Computing the Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) by adding the amount shown in 5b of the DCO-712 to the Excess Shelter Allowance. The total CSMNA amount may not exceed the maximum indicated on the DCO-712 (the maximum will be adjusted annually according to the Consumer Price Index).

Computing the Community Spouse Monthly Income Allowance (CSMIA) by subtracting the CS's gross income from the CSMNA (VA A&A and CME/UME are not countable income to the CS).

- ◆ The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA. Refer to {Re-MS H-416}.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

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

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

- ◆ ~~for each~~ dependent family member may be entitled to an allowance. See MS Glossary for definition of dependent family member.
- ◆ ~~The FMA is computed for each dependent family member by deducting the family member's income from the CSMNA amount shown in Section 6 of the DCO-712 and by dividing the result by 3~~three.
- ◆ ~~The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income (i.e., the actual contribution) will be deducted instead of the computed FMA. Refer to (Re: MS H-415).~~

NOTE: A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether or not to accept a CSMIA or FMA. ~~It should be explained to the CS that~~ The result of accepting an allowance may be reduction or termination of SSI benefits and Medicaid. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

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

- ◆ In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.
- ◆ Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under the age of 18, the combined income of the children must be less than the Medically Needy Income Level (MNIL) for the appropriate number of children in the household to qualify for protected maintenance. (See Refer to MS O-710 for MNILs.)
- ◆ In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance. Actual amounts allowed for protected maintenance are determined as follows:
- ◆ Determine the children's maintenance level using the appropriate MNIL for the children.
- ◆ Total any income that the children may have. If the total gross income equals or is greater than the maintenance level in the step above, no protected maintenance from the institutionalized individual's income will be allowed. If the children's income total is less than the maintenance level, their total gross income will be subtracted from the maintenance level to arrive at the amount that will be given from the individual's income for protected maintenance.
- ◆ EXAMPLE: Two dependent children each have \$75 monthly income, for a total of \$150. The \$150 income will be subtracted from the 2 person MNIL of \$216.66, leaving \$66.66. \$66.66 of the institutionalized individual's income will be given to the children as protected maintenance.
- ◆ If there are no noncovered medical expenses, the net income after deducting the protected maintenance for the child(ren) will be applied to the cost of facility care. If there are noncovered medical expenses, proceed to # 7 below.

7. Non-covered medical Medical expenses Expenses Arkansas Act 892

42 CFR § 435.725;

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

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

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

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

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

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

repayment is not expected to be paid back to the third party by the recipient, are not allowed.



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

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

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

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

- 1) The items must be prescribed by a physician or other licensed medical practitioner.
- 2) The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that he or she is able to utilize the item(s).
- 3) The request must be approved by the facility's Quality Assessment and Assurance Committee.
- 4) The cost of the item(s) must be determined.
- 5) The recipient or authorized representative must provide the eligibility caseworker with verification of the above. The recipient or authorized representative must not

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-410 Factors Used to Determine the Cost of Care

make the purchase or pay the medical bill until the eligibility caseworker has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Medicaid formulary; physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility caseworker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, including proof of the cost. A copy of the health insurance bill can be used for proof of health insurance premiums, deductibles, and coinsurance.

~~Deduction from income for cosmetic and elective procedures (e.g., face lifts or liposuction) will not be allowed from the income of a facility recipient. Other expenses not allowed are the premiums for insurance, which pays cash to a recipient when medical expenses have been incurred and Medicare premiums deducted from SSA payments prior to buy-in are not allowed as they will be reimbursed.~~ The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

NOTE: ~~As of January 1, 1990,~~ There is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the Medicaid formulary. Medicaid facility recipients who are not certified for vendor payment are ~~limited to three prescriptions per month.~~ Nursing facility LTC hospice recipients are eligible for three (3) prescriptions drugs per month, with the option of receiving up to six (6) prescriptions with prior authorization.

Medical expenses can be of three types:

- a. Monthly - Expenses incurred regularly each month such as the Medicare Part D enhanced plan portion of premiums above the benchmark ~~doctor visits and medical supplies;~~
- b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums ~~doctor visits;~~
- c. ~~One-time~~ - Expenses incurred such as hearing aids ~~hospital bills.~~

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-412 Contribution to the Cost of Care for Assisted Living Facilities and ARChoices: Adult Family Home

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

7.8. Net Income

~~After deduction of The total of any applicable excluded earnings, income trust fees (when applicable), personal needs allowance, maintenance allowances, and non-covered medical expenses (if any), will be entered in the system as Protected Maintenance. The net amount remaining will be the amount the individual is expected to apply to the cost of care. The actual vendor payment will be determined by the eligibility system based on the net income entered by the caseworker.~~

~~For active cases where the VA pension has been reduced by VA to \$90, \$90 will be entered as VA pension. \$50 plus any additional amounts considered as non-covered medical expense will be populated by the system from previously entered information. The system will automatically exclude the \$40 RNA resulting in the full \$90 being given to the recipient.~~

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

~~After the DHSDCO-0712 is completed, a copy will be provided to each spouse. If the form is completed prior to application, at the request of either spouse, the DCODHS-0712 will only be provided to the spouse making the request.~~

H-412 Contribution to the Cost of Care for Assisted Living Facilities and ARChoices: Adult Family Home

MS Manual 01/01/1607/01/20

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

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

1. Room and board payment.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-412 Contribution to the Cost of Care for Assisted Living Facilities and ARChoices: Adult Family Home



NOTE: If the individual is receiving assistance through HUD, the deduction can only be for the amount the individual is actually paying.

2. Personal needs allowance (PNA);
3. Monthly medical insurance premiums;
4. Non-covered medical expenses including over the counter medications and medical supplies;
5. Spousal support payments for the community spouse and Family Member Allowance. Refer to (MS H-410 #4-6);
6. Applicable income trust fees ~~Bank service charges on the Income Trust account.~~ (Refer to MS H-111 #3-);
7. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician.

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

Computing the recipient's cost of care for ARChoices: Adult Family Home

A spreadsheet "ARChoices Liability Worksheet" was developed which can be accessed in the system to determine the patient liability for ARChoices: Adult Family Home. This spreadsheet was developed only to assist the caseworker to compute the patient liability. This does not require the applicant/recipient's signature and should not be given to the applicant/recipient.

The following provides the procedures in completing the task of computing the recipient's cost of care:

- The DAAS RN will send the caseworker a DHS 3330 requesting patient liability to be calculated for a potential recipient of the Adult Family Home service.
- The caseworker will compute the patient liability using the current income by accessing the spreadsheet. If additional information is required from the applicant/recipient, the caseworker will send a DHS 3330 informing the DAAS RN of this action.
- The caseworker will send a 10-day notice via the DHS-707 when additional information is needed to determine the patient liability. The DHS-707 will explain what information is needed to determine the patient's liability for the Adult Family Home service. If not

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-413 Contribution to the Cost of Care for PACE

~~received by the 10th day, then the patient liability will be computed without allowing these expenses and narrated in the system.~~

- ~~• The caseworker will send the DHS 3330 providing the liability amount under "other". If this amount was computed without allowing any expenses as the caseworker had not received a response from the applicant/recipient, this must also be noted on the DHS-3330.~~
- ~~• The caseworker will send a DHS 707 to the applicant/recipient providing the patient liability amount which is the applicant/recipient's contribution of care.~~
- ~~• DAAS will key the patient liability amount to the Recipient Waiver screen which provides this amount to MMIS and will notify the Adult Family HoWillie.A.Rogers@dhs.arkansas.govme provider.~~

~~Any action taken on an active ARChoices case record that changes the amount of patient liability must be reported to the DAAS RN the same day as the new liability amount and the effective date of the change.~~

H-413 Contribution to the Cost of Care for PACE

MS Manual 07/13/1507/01/20

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

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

The eligibility caseworker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. -The patient liability amount will be calculated using the form DHS-ODCO-712. -The PACE provider will collect and retain the patient liability. -For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current nursing facility LTC-PNA, any applicable community spouse allowances and/or family allowances, and excess medical expenses will be deducted from the PACE participant's monthly income. -Refer to MS H-410.

For individuals in the community who are eligible through establishing an income trust, income in excess of the current LTSS LTC-Medicaid limit will also be paid to the PACE provider. A personal needs allowance- equal to the current LTSS LTC/PACE limit of three times the current

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-415 Option to Estimate Net Income

SSI/SPA standard payment amount (SPA), plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-415 Option to Estimate Net Income

MS Manual 01/01/1407/01/20

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

H-416 Verification or Refusal of Contributions

MS Manual 07/13/1507/01/20

Prior to certification of the Institutionalized Spouse (IS) ~~IS~~, the IS or representative must complete and sign the statement on the reverse of the DHS-ODCO-712 to indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) ~~CSMIA~~ and the Family Member Allowance (FMA) ~~FMA specified on the front of the DHS-ODCO-712~~, during the period of institutionalization.

If the DHS-ODCO-712 is not completed and signed, ~~no~~ allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income by completing the appropriate section on the DHS-ODCO-712.

1 ~~Note: Use the DCO-712 for the current year for which eligibility is being determined.~~

H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients

MS Manual 07/13/1507/01/20

As of 7/1/88, ~~those~~ SSI recipients entering a medical or nursing facility will be allowed to retain their full SSI benefits if:

- a. ~~they who~~ have a home to maintain; and

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

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

- b. ~~they have obtained~~ who obtain a medical statement for SSA to document that the medical confinement will not exceed ~~3~~ three calendar months after the month of entry to the facility

~~will be allowed to retain their full SSI benefits for a period up to 3 full months. No extension beyond the~~ three months will be allowed.

~~When aware of the extension of SSI benefits for facility applicants/recipients, the caseworker will totally disregard the SSI benefits for determination of facility eligibility and vendor payment. If the applicant/recipient has income from any other source (e.g. VA, SSA, RR Retirement, etc.), that income will be included in the facility budget.~~

~~For applicants receiving the full SSI benefit (who have no other income), only a \$30 personal needs allowance will be entered into the system and the remaining SSI income will be disregarded.~~

~~When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered on the income tab. The \$40 personal needs allowance will be deducted from the countable income and the remaining income will be shown as NH Net Income (patient liability).~~

~~If the SSI recipient's stay in the facility actually exceeds three months, no adjustment in the budget will be required, as it remains correct.~~

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

MS Manual 01/01/14 07/01/20

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

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

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

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

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

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

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

~~Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different ways that the contributions may be considered. The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given. Any questions that the ineligible spouse/parent(s) has regarding the effects of a specific action will be answered.~~

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

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

MS Manual 07/13/1507/01/20

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

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

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

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

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

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

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

2. Fluctuating Earnings

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

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

If earnings consistently stay above the SSI SPA, they may be averaged (MS E-415), provided the facility administrator will agree to report to the eligibility caseworker:

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

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

MS Manual 07/13/15 07/01/20

The effective date of eligibility of an applicant for nursing home and ICF/IID LTC and services in an ICF-MR depends on three factors:

1. Date of Entry – The individual's date of entry into a participating facility is indicated on the DCO-0702, Notice of Admission, Discharge or Transfer From a Facility, which is completed by the facility and forwarded to both the DPSQA Office of Long Term Care

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

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

and the ~~county~~ County office ~~Office~~ for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity -- Medical necessity is determined by the DPSQA Office of Long Term Care. The medical necessity decision is transmitted to the County Office ~~county office~~ and the facility by the DHS-0704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-0704 is received by the ~~county~~ County office ~~Office~~ on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/IID facility or was subject to Pre-Admission Screening and Annual Resident Review (PASARR) PASARR, medical necessity begins on the DHS-0704 decision date for ICF/IID or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.
3. Date of Categorical Eligibility -- Categorical eligibility for facility care and services under the AABD criteria can be established to begin three months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, however, the begin date for Medicaid and vendor payment cannot be prior to the decision date on the DHS-0704 for ICF/IID applicants or PASARR PASARR date for individuals subject to PASARR.

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

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

MS Manual ~~01/01/14~~ 07/01/20

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Medicaid coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized ~~on the WNHU interface in ANSWER~~ until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-460 When a Nursing Facility LTC Recipient Transitions to a Medicare Bed

individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened on the WASM interface in ANSWER. Therefore, Medicaid for Medicare eligible individuals will be authorized on the WASM interface in ANSWER so that all other Medicaid covered services may be paid. The caseworker will use the characteristic code of "entered LTC as Medicare" on the Budget Unit characteristic tab when approving Medicaid only.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third-party resource to be applied to the cost of care in a facility.

When Medicare approves an individual for skilled nursing care, the facility should notify the caseworker of the Medicare admission via the DCO-702. Refer to MS H-460.

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the eligibility caseworker of the change in status via the DCO-702. On the day following termination of Medicare benefits, the eligibility caseworker may authorize facility services on the WNHU interface in ANSWER to be effective on that date, provided the individual continues to meet all Long-Term Services and Supports (LTSS) LTC requirements.

H-460 When a Nursing Facility LTC Recipient Transitions to a Medicare Bed

MS Manual 07/13/15

When an individual transitions from a Medicaid bed to a Medicare bed, the nursing facility will send the county office a DCO-702, Notice of Admission, Discharge or Transfer from a Facility, with the date of the transition.

The caseworker will close the vendor payment in ANSWER by entering a vendor end date on the budget summary tab. The Medicaid portion will remain open. A notice will be sent via the DHS-707 to the recipient or authorized representative stating that the bank account or patient fund account at the facility will accumulate additional income due to the vendor payment being suspended and this could result in excess resources. A copy of the notice will be provided to the facility.

If the caseworker receives notification from the facility via a DCO-702 stating that the recipient has moved back to a Medicaid bed, a resource assessment must be done prior to reopening the

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-470 Quality Assurance Control Errors

~~vendor portion of the case. Business processes have been moved to the Business Process Manual.~~

H-470 Quality Assurance Control Errors

MS Manual 01/01/1407/01/20

The amount computed as net income to be applied to the vendor payment will be subject to Quality Assurance ~~Control~~ error.

If a contribution or medical expense is deducted from gross income and the Institutionalized Spouse (IS) is not actually meeting the contribution or expense, this will be an understated liability and a dollar error.

If the contribution (or full contribution) or medical expense is not being deducted from the income, and the IS has agreed to pay the contribution, or has incurred a medical expense, this will be an overstated liability but no dollar error.

H-480 Acquisition of Additional Income and Resources

MS Manual 07/13/1507/01/20

The acquisition of additional income and resources by a recipient will be verified in the same manner used for determination of initial eligibility. ~~Necessary income adjustments or closures will be entered in the eligibility system.~~ Advance notice will be given when required for terminations of assistance or increased vendor payment liability.

Refer to: MS E-500 thru E-530 and MS Section H for specific information regarding resource evaluations, changes, etc.; MS E-400 thru MS E-451 for specific information regarding income treatment; and MS H-410 for specific information regarding the net income determination or when there is a Community Spouse (CS).

H- 481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual 07/13/1507/01/20

When a eligibility caseworker learns that a recipient, who does not have an Income Trust, received a lump sum benefit in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed and a new application will be required.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-490 Absences from Long Term Care Facilities

EXAMPLE: — The caseworker learns in March 2013 that the recipient received a lump sum payment in January 2013 which caused ineligibility due to excess income but, in February 2013, the recipient's income and resources were below the limits again. The case will not be closed and a new application will not be required because the recipient regained eligibility the month following receipt of the lump sum.

Case adjustments in this situation will be made as follows:

Case Adjustment for LTC Ineligibility Period — To adjust the case for the month of ineligibility, an entry should be made on the WNIU interface for the month of ineligibility. The caseworker should key the start date as the first day of the month the client was income ineligible, and the stop date as the last day of the month the client was ineligible. The income amount keyed should be the total income received in the month or one dollar more than the maximum skilled care rate whichever is greater.

No System Case Adjustment is needed for Medicaid categories other than LTC.

Overpayments — Overpayment reports for Long Term Services and Supports (LTSS) LTC and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility. Refer to (Re: MS Section M). If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

When the caseworker has advance knowledge of lump sum payments (e.g., land rent paid annually) that will result in one month of ineligibility, procedures at MS E-410 #1 will be followed, advance notice given, and the case adjusted at the appropriate time.

H-490 Absences from Long Term Care Facilities

MS Manual 07/13/1507/01/20

All facilities are required to report to the County Office county office certain recipient absences from the facility on Form DCO-702. Absences will be reported for death, discharge, and transfer. Overnight home visits and hospitalizations will not be reported. - Admissions to the Arkansas State Hospital (Little Rock) will be reported as discharges. Refer to (Re: MS H-491).

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-490 Absences from Long Term Care Facilities

Death or Discharge

Upon ~~notification receipt of Form DCO-702 from the facility reporting the death or discharge of a recipient, the County Office~~ county office will initiate action to close the recipient's case.

Advance notice is not required for closure due to death. ~~The county office will:~~

~~Complete form DHS-707 to notify the recipient or his next of kin of the case closure or intended case closure and reason for action;~~

~~End facility services on WNHU and close case on WASM (SSI cases will be closed when notification is received from Customer Assistance that case should be closed);~~

~~Provide assistance to the next of kin in securing a deceased recipient's personal allowance funds and property (if assistance is requested);~~

~~Complete a DCO-734, Report of Case Closure Due To Death, for Estate Recovery purposes, and send to the Third Party Liability section.~~

Home Visits

A recipient receiving long term care services has the right to make overnight home visits whenever he desires, provided they are consistent with his required level of care and his attending physician's orders. This includes authorized home visits during the 30 days in which institutional status is achieved.

The DPSQA Office of Long Term Care is responsible for monitoring recipient home visits and their consistency with the patient's required level of care. For example, a skilled care patient who makes overnight home visits might require reclassification action by Long Term Care.

Facility Long Term Care services may continue during a recipient's absence due to therapeutic home visit without regard to the cumulative number of days absent during a calendar year. However, a 14 consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than 14 days will not be reported by facilities to the County Office ~~county office~~. The date left counts as the first day of absence. When there is an indication that the recipient is expected to return to the facility within 14 days, the County Office ~~county office~~ will take no action.

For home visits, which exceed 14 consecutive days, facilities will report the date left and a discharge on the 15th consecutive day of absence ~~on the DCO-702~~. When there is no indication

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-491 Procedure for Reactivating a Suspended Case

that the recipient is expected to return to the facility within 14 days of the date left, the County Office ~~county office~~ will initiate action to close the case, as described below:

Facility Care

~~Complete Form DHS-707 to provide advance notice of Medicaid closure.~~

~~Complete WNHU entry to show the End Date effective the 15th day of absence and to close on WASM for termination of Medicaid.~~

SSI Recipients

~~Advance notice by DHS-707 is not required since their Medicaid status is based on receipt of SSI rather than LTC assistance.~~

~~Key the End Date effective the 15th day of absence for WNHU entry. SSI cases will not be keyed for closure on WASM.~~

- ◆ ~~Cases suspended or closed using this procedure can be reinstated without new application if the recipient returns to the facility within 90 days of the date left on home visit. Refer to (Re: MS H-491).~~
- ◆ ~~If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.~~
- ◆ ~~If the individual does not reenter the facility within 90 days, the case record will be placed in closed files. A new application will be required to reopen the case.~~

H-491 Procedure for Reactivating a Suspended Case

MS Manual ~~??/??/??~~01/01/17

Business processes have been moved to the Business Process Manual. When a recipient returns from an extended home visit, the facility will notify the county office of his return on Form DCO-702. To reactivate the suspended or closed case, the County Office will:

1. Facility Care

~~Verify institutional status.~~

~~Complete reevaluation, if due.~~

~~Verify current income.~~

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-491 Procedure for Reactivating a Suspended Case

~~Verify patient classification, the level of care decision date, and a future level of care review date, if applicable, by requesting DHS-704 from OLTC, if a current DHS-704 is not on file.~~

~~Reopen Medicaid on WASM and reopen facility services on WNHU with the Nursing Facility (NF) county, NF number, patient classification, level of care decision date, level of care review date, if applicable, NF eligibility start date, NF net income, income start date, and any budget changes entered.~~

~~2. SSI Recipients~~

~~Complete reevaluation, if due.~~

~~b. Verify current income.~~

~~Verify patient classification, level of care decision date and a future level of care review date, if applicable, by requesting DHS-704 from OLTC if a current DHS-704 is not on file.~~

~~Reopen facility services on WNHU with the NF County, NF Number, patient classification, level of care decision date, level of care review date, if applicable, NF eligibility start date, NF net income, income start date and any budget changes entered. Update WNHU prior to WASM.~~

Hospitalization

~~Hospitalizations will not be reported to the county office (Exception: Arkansas State Hospital admissions) by the facility, but will be reported to the claims processing agency for payment adjustments.~~

~~If a recipient dies during hospitalization, is discharged to his home or elsewhere from the hospital, or reenters another facility following hospitalization, the facility will report to the county on form DCO-702 for appropriate county office action (Re: MS H-490).~~

~~Any terminations due to death or discharge will be made effective the date of death or discharge. The number of hospital days for which the facility will be reimbursed is a determination of the claims processing agent. In all instances of termination following hospitalization, the End Date in ANSWER should coincide with the date of death or discharge shown on the DCO-702.~~

~~if the county office is notified of a transfer from the hospital to another facility, the county office will not end services.~~

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-491 Procedure for Reactivating a Suspended Case

Hospitalization at the Arkansas State Hospital (Little Rock)

All admissions to the Arkansas State Hospital (Little Rock) will be reported as a discharge by the facility on the DCO 702 to the county office.

In all cases of reported recipient absence to the State Hospital, facility services will be discontinued effective the date the recipient left the facility and will remain suspended until the recipient returns to the facility.

Cases of recipients who are absent to the State Hospital will be suspended and be maintained in the county of last facility residence for up to 60 days. For those recipients who return to the facility within 60 days, facility services will be restarted effective the date of reentry. Cases of recipients who do not return to the facility within 60 days will be either closed or transferred to the county of domiciliary residence.

Even though nursing home services may not continue, recipients under age 21 and recipients age 65 or over may qualify for continued Medicaid assistance while at the State Hospital under the same eligibility criteria used for Long Term Care Services eligibility. Adult Expansion Group recipients aged 19 through age 64 will qualify for continued Medicaid while at the State Hospital.

Procedures for suspending cases of recipients who have been admitted to the State Hospital are contained in the following paragraphs.

Procedures for Suspension of Cases Arkansas State Hospital

The procedure used to suspend a case during a recipient's absence to the State Hospital depends on the recipient's aid category and whether continued Medicaid assistance is authorized. Two procedures are employed to account for differences between ages.

Medicaid recipients under age 21 or age 65 or over are eligible for continued Medicaid assistance while receiving inpatient psychiatric care at the State Hospital. In order to continue Medicaid assistance to these individuals without a disruption of eligibility, the county office will:

End nursing home services on WNHU effective the date the recipient left the facility.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-491 Procedure for Reactivating a Suspended Case

Notify the State Hospital by interagency memorandum of the recipient's continued Medicaid eligibility including the recipient's name, his ten-digit Medicaid ID #, his aid category, his residence county, D.O.B., SSN, Medicare Claim # and/or other health insurer, facility left, and date he left the facility. Address correspondence to:

Director

Social Work Dept.

AR State Hospital

4313 W. Markham

Little Rock, AR 72201

Maintain the case record in the county of last facility residence until notice is received from the State Hospital by DHS-3300 of readmission to long term care or of other action, or until 60 days of continuous hospitalization.

For recipients who return to long term care prior to 60 days continuous hospitalization, reinstate LTC services with the eligibility start date as the date of readmission. The level of care, level of care decision date, and level of care review date, if applicable, as shown on WNHU will be entered, along with current net income, NH county, and NH number. If the level of care review date has passed, a new DHS-704 is required. If the patient is readmitted to a facility other than the one left, the address will be changed on WASM, and the case record transferred on WNHU to the county where the facility is located (Re. MS H 492). (Addresses will not be changed for SSI recipients).

Case records of recipients who remain at the State Hospital for more than 60 days will be transferred to Pulaski South or Craighead County, and the recipient's address will be changed on WASM to that of the appropriate State Hospital. A new DHS-704 will be required before Long Term Care Services can be reinstated when the recipient has been hospitalized for more than 60 days and subsequently reenters long term care.

If a recipient is discharged from a State Hospital and does not return to long term care or becomes ineligible for assistance for any other reason, the county office will initiate action to terminate assistance. Advance notice will be given on form DHS-707 where required.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-492 Transfer

SSI recipients are included in this section because the Agency cannot terminate their Medicaid status. If termination of Medicaid is required, it will be received from SSA through the State Data Exchange (SDX).

Adult Expansion Group recipients age 19 through 64 will be eligible for continued Medicaid assistance while in the State Hospital.

H-492 Transfer

MS Manual 22/22/2207/13/15

Business processes have been moved to the Business Process Manual.

Upon receipt of a DCO-702 from a facility indicating a transfer of a patient from one facility to another, the caseworker will:

1. Complete the address change, NH number and NH county code (if different) in the eligibility system. See note below for SSI address changes. Do not enter NH Eligibility Start or End Dates on WNHU with a transfer action.
2. Complete Sections I, II (Date to be Reviewed, only), and III of a blank DHS-704, mail the original to the receiving facility and file a copy in the case record.

A patient may not be transferred from one facility to another within a chain of facilities without approval of the patient (or his responsible relative or guardian where necessary) and the approval of the Office of Long Term Care.

NOTE: For transfer of SSI cases from one facility to another, no address change will be entered on WASM, but the NH number and NH county code (if different) will be entered on WNHU.

Resident of Human Development Center

When transfer from an Arkansas Human Development Center to a nursing facility is required, the following procedures apply:

1. The Center Administrator or designee should contact the county office to request assistance in locating a facility if necessary.
2. If a facility has already been selected by the center, the name of the resident, the name of a family member or responsible person, the name and address of the facility, and the effective date of transfer will be given to the county office on form DCO-702.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-493 Operations Plan - Relocation of Recipients

3. Upon receipt of the DCO 702 indicating transfer, change the address, the NH number and NH county (if different) in the eligibility system. Do not enter NH Eligibility Start or Stop Dates on WNHU with a transfer action.
4. The county office will complete Sections I, II (Date to be Reviewed, only when applicable) and III of a blank DHS-704, mail the original to the receiving facility and file a copy in the case record.

NOTE: OLTC has policy and procedures for allowing HDC patients to recuperate at the Conway HDC in certain instances when medically prescribed. The practice does not require transfer of the case record, as the recuperation period is for a limited number of days.

H-493 Operations Plan - Relocation of Recipients

MS Manual 01/01/1607/01/20

The Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) will initiate all relocation actions. This Plan describes procedures for relocation of Agency recipients in facilities which are closed for any reason other than a disaster. Such reasons include: decertification by the federal government or the Division of Medical Services DPSQA, loss of licenses, voluntary withdrawal from the Medicaid Program, or cancellation of agreement by the Division of Provider Services and Quality Assurance (DPSQA) Division of Medical Services. Since federal regulations require all program recipients to be relocated within 30 days of the termination date, it is essential that specific procedures be established to insure ensure that recipients are relocated with maximum safety and well-being.

The Office of Long Term Care of the Division of Medical Services will initiate all relocation actions. OLTC Personnel will provide written notification to the facility, DAAS Assistant Director, county office, data processing, accounting section, and the claims processing agent advising of the 30 day advance notice, the date relocation of recipients will begin, and the final date for vendor payment. A representative of OLTC will make personal contact with facility personnel to explain the Agency purpose and to arrange for necessary relocation action. Health personnel (nurses and physicians) assigned to the Office of Long Term Care will be responsible for evaluating the physical condition of all recipients to insure they are physically capable of being relocated without serious consequences to their health condition.

Authority to initiate, direct and monitor all relocation actions is delegated to the Assistant Director of the Office of Long Term Care, by the Director of the Director of the Division of Medical Services DPSQA.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-494 Relocation Procedures

H-494 Relocation Procedures

MS Manual ~~??/??/??~~01/01/16

The following procedures are applicable to designated elements of the Agency. It is essential that all personnel involved in the relocation of recipients observe these procedures and insure that maximum effort is directed toward the orderly and safe relocation of all recipients. Patient safety and well-being will be of primary concern at all times.

Business processes have been moved to the Business Process Manual.

1. Office of Long Term Care

The Office of Long Term Care will initiate non-disaster relocation actions as follows:

Notify the facility, DAAS Assistant Director, and county office of agreement cancellation.

Allow 30 days for the orderly relocation of all recipients.

Identify and maintain a list of facilities, by classification, with vacancies.

Provide vacancy data to the appropriate county office.

Make personal contact with the facility administrator/owner(s), and attending physicians to explain the purpose and actions involved in relocation of recipients.

Alert the Division of Aging and Adult Services that their assistance may be needed.

Provide Agency representatives to assist with inventory of personal effects and allowance and to instruct the facility to transfer these items with the recipient.

Provide medical personnel (nurses and physicians, if required) to evaluate the physical status of each recipient to insure the individual's safety during the relocation.

Coordinate with receiving facilities to insure they are prepared to accept incoming recipients.

Provide maximum assistance to county offices to insure all relocation actions are accomplished in an orderly and timely manner.

Provide weekly status reports to the Director, Division of Medical Services, and to the DAAS Assistant Director.

Coordinate with the county office, data-processing section, accounting section, and claims processing agent to insure that case records, payments and Medicaid cards are transferred in conjunction with recipients.

2. County Office

Upon receipt of written notification that an agreement will be cancelled and relocation action will be implemented, the county office will:

Give priority attention to all relocation actions.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-494 Relocation Procedures

Identify all recipients in the facility.

Provide the Office of Long Term Care with a list of applicants who reside in the facility but who are not yet certified.

Provide casework services to recipients and families. This will include:

Interviewing recipients and families to explain the reason for relocation, obtain a preference for a new facility or area of the state and match the preference facility or area against vacancy lists.

Contacting the new facility and setting a date for receiving recipients. Request the new facility to provide transportation, if available. If not, request local Area Agency on Aging to provide transportation. If unsuccessful in either case, request transportation assistance from the Central Office, Office of Long Term Care.

Insuring that ambulance service is provided when indicated by OLTC.

Insure that the sending facility submits a discharge on form DCO-702 for each recipient.

Enter the new county code for each transferred recipient in ANSWER. (Re: MS-H-492).

Submit a report of completed action to the Assistant Director, Office of Long Term Care.

If relocation is declined, insure that the recipient, a family member, or responsible person, specifies in writing that he does not desire relocation to another facility.

Use form DHS-707 to advise all recipients, family, or responsible person(s) declining relocation to another facility that long term care payment will be discontinued.

After advance notice period, take immediate action to close those cases of clients who decline relocation, and submit appropriate documents to the terminal operator and recipients.

Contact all recipients who are out of the facility because of hospitalization or home leave to ascertain their relocation preferences. Contact the attending physician for hospitalized recipients and obtain his approval for discussing relocation actions prior to talking with the recipient. If the attending physician recommends against discussing this action until a later time, follow-up actions will be insured at a later date. Request the hospital to give notice prior to discharging the recipient or when the recipient expires.

Priority will be given to hospitalized recipients for relocation in the local area.

The Facility

The facility will be requested to provide maximum assistance to include the following:

Provide full cooperation with all Agency personnel.

Make available all records to Agency personnel.

Transfer personal belongings and allowances with each recipient.

Medical Services Policy Manual, Section H **MARKUP**

H-400 Post Eligibility

H-494 Relocation Procedures

~~Provide the receiving facilities a copy of the most recent DHS-704, and a discharge plan for each recipient.~~

~~Insure maximum assistance is provided in all relocation actions.~~

~~Insure that all Agency recipients are identified and relocated in an orderly and timely manner.~~

~~Submit a DCO-702 for each recipient to the county office and Office of Long Term Care, Central Office.~~

MARK-UP

Medical Services Policy Manual, Section H MARKUP

H-400 Post Eligibility

Within seven (7) days after the last recipient has been relocated, submit a final adjustment form to show all recipients (relocated, deceased, hospitalized, or on home leave during the 30-day relocation period). Business Process Manual References:

~~Within seven (7) days after the last recipient has been relocated, submit a final adjustment form to show all recipients (relocated, deceased, hospitalized, or on home leave during the 30-day relocation period). Business Process Manual References:~~

~~H-403 Rebutting Consideration of Income~~

~~H-410 Factors Used to Determine the Cost of Care~~

~~H-415 Option to Estimate Net Income~~

~~H-416 Verification or Refusal of Contributions~~

~~H-420 Treatment of Extended SSI Benefits for Institutionalized Recipients~~

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

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

~~H-460 When a Nursing Facility Recipient Transitions to a Medicare Bed~~

~~H-480 Acquisition of Additional Income and Resources~~

~~H-481 Case Adjustments for Lump Sum Payments in Prior Months~~

~~H-490 Absences from Long Term Care Facilities~~

~~H-491 Procedure for Reactivating a Suspended Case~~

~~H-492 Transfer Procedures~~

~~H-493 Operations Plan - Relocation of Recipients~~

~~H-494 Relocation Procedures~~

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

APR 10 2020

I-300 AABD Eligibility Groups Renewal Process

BUREAU OF
LEGISLATIVE RESEARCH

I-310 Eligibility Worker Caseworker Responsibilities

I-300 AABD Eligibility Groups Renewal Process

MS Manual 01/01/1407/01/20

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

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

See Appendix Q for the specific renewal form that is used for each of the AABD groups.

~~I-310 Eligibility Worker Caseworker Responsibilities~~

~~MS Manual 01/01/14??/??/??~~

~~The caseworker is responsible for the following actions to complete an AABD renewal:~~

- ~~1. Ensure that the completed renewal form and any verification provided by the individual are scanned into the system upon receipt.~~
- ~~2. Review the information provided and request any necessary verification to validate the information.~~
- ~~3. Redetermine the individual's eligibility based on the information received from the individual and enter any new or changed information to the system.~~
- ~~4. Update the system to reflect continued eligibility, level of service, vendor payment, etc. or to end the individual's eligibility if no longer eligible.~~
- ~~5. Generate the appropriate notice to advise the individual of continued eligibility or of ineligibility.~~

I-320 Alternate Renewal Processes

MS Manual 03/04/1507/01/20

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

- ElderChoices/~~AAPD Waiver~~ARChoices;
- Assisted Living Facilities;
- PACE;
- DDS Waiver;

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

I-300 AABD Eligibility Groups Renewal Process

I-321 ElderChoices/AAPD ARChoices Waiver

- TEFRA;
- Autism and
- Medicare Savings Program.

The following sections describe their renewal processes.

I-321 ElderChoices/AAPD ARChoices Waiver

MS Manual 01/01/1407/01/20

~~ElderChoices and AAPD ARChoices Waiver renewals will be conducted annually by the Long Term Care Unit (LTCU) Services and Supports Unit (LTSSU). Refer to Appendix O for the list of required forms to be used in the renewal process. Form DCO-7781, LTC Medicaid Annual Renewal, will be completed. After eligibility has been re-determined, the review date will be entered in the system.~~

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

~~Reassessment of medical necessity will be completed by the DHS RN. The Office of Long Term Care will review the assessment and assign the Level of Care.~~

I-322 Assisted Living Facility

MS Manual 01/01/1407/01/20

~~Assisted Living Facility Waiver renewals will be conducted annually by the County Office Long Term Services and Supports Unit. Refer to Appendix O for the list of required forms to be used in the renewal process. After eligibility has been re-determined, the review date will be keyed to the system.~~

~~Reassessment of medical necessity will also be completed annually by DAAS. The DHS RN will coordinate an annual reassessment of medical necessity.~~

I-323 PACE

MS Manual 01/01/1407/01/20

~~Both financial and medical eligibility will be re-determined annually. Medical eligibility will be re-determined by the DHS RN. Financial eligibility will be conducted at each annual renewal by the county County office Office Long Term Services and Supports Unit. Form DCO-7781 and all other forms required at initial application will be completed. Refer to Appendix O for the list of required forms to be used in the renewal process.~~

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

I-300 AABD Eligibility Groups Renewal Process

I-324 Division of Developmental Services

~~DAAS will complete an annual Level of Care assessment on all PACE participants using the same assessment instruments and review and approval processes as the initial assessment. DAAS The~~
The DHS RN will coordinate an annual reassessment on all PACE participants. The Division of Aging, Adult and Behavioral Health Services (DAABHS) may "deem eligible" those individuals who are determined to no longer meet the nursing facility Level of Care requirement, but who would reasonably be expected to meet nursing facility Level of Care within the next six months in the absence of continued coverage under PACE.

I-324 Division of Developmental Services

MS Manual ~~03/04/15~~07/01/20

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

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

I-325 TEFRA

MS Manual ~~07/01/18~~07/01/20

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

I-300 AABD Eligibility Groups Renewal Process

I-326 Autism

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

EXAMPLE: A child received SSI for ~~six~~6 months in 2013~~8~~ and then ~~lost~~ SSI due to increased parental income. The parent applies for TEFRA in September 2018~~3~~ and the case is certified in November 2018~~3~~ based on the previous SSI disability determination. The child has not received SSI benefits since certified. At the annual renewal in 2019~~4~~, a MRT disability determination is required.

A review by MRT is also necessary if the eligibility caseworker becomes aware of significant improvement and/or employment at or near the SGA level. ~~(Re- Refer to MS F-124).~~

~~All forms completed for the initial application, including the DMS-2602 and DCO-2603, must be completed at renewal. Refer to Appendix O for a list of required renewal forms. In addition, the premium amount will be redetermined at renewal. If the premium changes, the parent will be notified of the new amount by the TEFRA Premium Unit.~~

I-326 Autism

MS Manual 03/04/1507/01/20

Autism Waiver cases will be renewed every 12 months by the Area TEFRA Processing Unit (ATPU). ATPU will mail the parent or guardian a DCO-7779, Annual Renewal Notice, to ~~redetermine eligibility. Refer to Appendix O for a list of required renewal forms.~~

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

~~If the renewal form is not returned, a DCO-700, Notice of Action, will be sent advising that the DCO-7779 must be received within 10 days or the case will be closed after the notice expires.~~

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

I-300 AABD Eligibility Groups Renewal Process

I-327 Medicare Savings Program (MSP)

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

I-327 Medicare Savings Program (MSP)

MS Manual 03/04/1507/01/20

ARSeniors, QMB, SMB, and QI-1 reevaluations will be conducted on an annual basis. ~~Form DCO-811, SNAP/MSP Annual Review, will be used to complete the reevaluation. For MSP recipients with or without a SNAP case that has been certified for 24 months or 36 months, form DCO-811 will be system generated in the 11th month following the last review (6th work day from the end of the month). The recipient must complete all appropriate sections of the form and return the completed form to the address listed on the DCO-811 by the 10th of the following month. The information on the DCO-811 will be used to determine continued eligibility for both SNAP and MSP. If the recipient has both a SNAP and a MSP case, both reviews must be completed at the same time. If the spouse has a MSP case, his/her case must be reviewed at the same time as the casehead. If an individual is in the household who is not the spouse of the SNAP or MSP casehead, his/her MSP review will be completed as appropriate, based on the date of the last case review. Self-declaration will be accepted. An interview is not required for these households. Form DCO-662 should be completed (for ARSeniors and QMB only) when there has been a change in insurance coverage. The caseworker will mail the DCO-662 to the recipient to gather information on the reported change and to request a copy of the new insurance card. If additional information is needed, a DCO-103, Request for Information, will be sent to the client.~~

Refer to Appendix O for a list of required renewal forms.

~~If the DCO-811 is not returned by the due date, form DCO-93, Notice of Action, will be issued to the recipient advising that his/her case will be closed. This notice is specific to MSP and SNAP 24/36 annual reviews. The notice will explain why the case is being closed and provide instructions on how to prevent the case closure. If the DCO-811 is not returned by the date specified on the form DCO-93, the caseworker will close the case.~~

~~If the SNAP case is closed and the continued eligibility for MSP can be established, the MSP review will be completed. If the MSP case is closed for failure to provide information and the requested information is returned within 30 days after closure, the MSP case will be reinstated and eligibility determined.~~

A MSP Medicare Savings Program Annual Review review can be completed via the telephone and will not require a returned, signed DCO-0811, Annual Review.

MEDICAL SERVICES POLICY MANUAL, SECTION I MARKUP

1-300 AABD Eligibility Groups Renewal Process

The telephone review may be completed at anytime during the review process to obtain information needed to complete the review. The call can be initiated either by the worker or the client.

MARK-UP

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-510 ARKids A & B

I-500 Categorical Changes

MS Manual 01/01/1407/01/20

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

I-510 ARKids A & B

MS Manual 01/01/1407/01/20

If information is provided that would cause the ARKids A recipient to be ineligible for ARKids A or B, an advance notice will be sent, and the case closed after expiration of the notice. If the information provided will cause ineligibility for ARKids A and the recipient is determined to be eligible for ARKids B, the case will be certified in ARKids B and the recipient notified of the case change.

I-520 Adult Expansion Group

MS Manual 04/03/1707/01/20

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

I-530 Medicare Savings Programs

MS Manual 01/01/1407/01/20

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

~~County Offices need not take any action on these cases (for QMB eligibility or coverage) unless Medicaid eligibility in the other category ends.~~ When Medicaid eligibility in a category other than a Medicare Savings category ends for an individual who is still entitled to Medicare Part A, eligibility for Medicare Savings will be determined based on information available to the County Office ~~county office~~. A new application will not be obtained from the individual. ARSeniors, QMB, Specified Low Income Medicare Beneficiaries (SMB) ~~SMB~~, or Qualifying Individuals-1 (QI-1)

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-531 Medicare Savings Programs-COLA Increases

Q1 eligibility should be determined and the case certified (if eligible) in the month that the non-QMB related case was closed. If eligible, coverage will begin on the first of the month following certification. When certifying the Medicare Savings case, re-key the original renewal date in the computer system.

EXAMPLE: A nursing facility recipient loses Medicaid eligibility upon returning home from a nursing facility. He is entitled to Medicare Part A and appears to be income and resource eligible for QMB coverage. The county will determine QMB eligibility based on available information. If eligible, the individual's coverage will begin the month following certification as a QMB. A new application will not be obtained from the individual.

NOTE: When an individual previously closed in another category is reopened as a Medicare Savings category, the closed case number will be used as the Medicare Savings category case number.

I-531 Medicare Savings Programs-COLA Increases

MS Manual 01/01/1407/01/20

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

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

If the individual or couple is ineligible due to the COLA increase, an advance notice of closure DCO-700 will be sent, as advance notice of closure and the case will be closed when the period notice expires. The January SSA COLA Cost of Living Adjustment will also be disregarded in determining initial eligibility for Medicare Savings applicants for the period of January 1st through March 31st of each year. Eligibility must then be redetermined for April 1st and beyond using the new Medicare Savings income limits and the increased SSA amount which includes the January SSA COLA amounts.

Refer to the Business Process Manual.

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-532 Simultaneous Coverage In Other Categories

I-532 Simultaneous Coverage In Other Categories

MS Manual 03/04/1507/01/20

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

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

~~EXAMPLE: An individual eligible for both an Aid to the Disabled and a Disabled QMB category will be certified in the Aid to the Disabled category, but will receive full QMB benefits. An individual may be approved for a spend down and a QMB for simultaneous periods.~~

~~EXAMPLE: An individual applies for QMB coverage and for other Medicaid categories on March 1, and has sufficient non-coverable medical bills for a spend down period of March, April, and May. QMB coverage is approved on March 30. QMB coverage will begin April 1. For any concurrent months of QMB and spend down eligibility, Medicare premiums may not be considered as a non-coverable medical expense.~~

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

I-540 Alternating TEFRA and SSI Eligibility

MS Manual 01/01/1407/01/20

Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. In these instances, the ~~eligibility case worker~~ worker must redetermine TEFRA eligibility for each month in which the child is not SSI eligible. Children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months. If fluctuating parental income causes a child's SSI eligibility

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-541 Autism

status to change from ~~month-month-to-to-month~~ and less than 10 months have passed since the last full TEFRA Waiver certification or renewal, only a new DCO-9700 (TEFRA and Autism Application for Assistance) and a redetermination of income and resource eligibility are

required to reopen the TEFRA Waiver case. Redetermination of other eligibility factors will not be required.

I-541 Autism

MS Manual ~~04/01/18~~07/01/20

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

I-550 Money Follows the Person (MFP)

MS Manual ~~01/01/16~~07/01/20

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

The Division of Aging, ~~and Adult and Behavioral Health Services (DAABHSDAAS)~~ has administrative responsibility for the MFP program to provide each participant placement through the existing Medicaid Waiver (ARChoices, Assisted Living, DDS) which best suits the participant's desires and needs. ~~DAABHS DAAS~~ will contact individuals designated as potential transitions or who expressed a desire to live in the community. To be eligible to participate, the individual must have resided in an institution (nursing home or ICF/IID) for a period of not less than 90 consecutive days and have received Medicaid for inpatient services for at least ~~one~~1 day.

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

MS Manual ~~01/01/16~~07/01/20

For MFP, a Division of Aging, Adult and Behavioral Health Services (DAABHS) ~~DAABHS-DAAS~~ Transition Coordinator will be responsible with assisting the individual who is interested in transitioning from facility care to a home and community-based waiver. This includes assisting

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-560 ANSWER Procedures for ARChoices Recipients Turning Age 65

the individual with applying for the appropriate program, accessing services, and preparation for being discharged from the nursing facility.

The Transition Coordinator will assist the client with completing and submitting form DHS-DCO-0777, Long-Term Services and Supports Long Term Care Application for Assistance. The caseworker will receive the application from the Transition Coordinator indicating this is a MFP application and the type of waiver requested. In situations in which a DHS RN has already been involved with a patient, the caseworker may receive a DHS-3330 and Page 2 of the Plan of Care signed by the applicant which is also sufficient. If the DHS-3330 and Page 2 of Plan of Care are received, procedures in MS-C-250 will be followed.

Upon receipt of the DCO-777 application in the County Office, the caseworker will send a DHS-3330 to the DHS RN will be notified to assess-coordinate an assessment of medical necessity and develop a service plan of care. The caseworker will write MFP in the right hand corner of the DHS-3330 prior to submitting to the DHS RN. This will make the DHS-3330 easily identified by the DHS RN that this is a MFP application. The caseworker will also inform the DHS RN which waiver category is being applied.

The DHS RN will proceed with the assessment process. The DHS RN will use the DCO-704 for medical eligibility determination if signed within the past 6 months. If the Intermediate Level of Care was entered by the county more than 6 months previously or if the Level of Care Review Date has expired, the Waiver case may not be certified until the county receives a new DCO-704 verifying Intermediate Level of Care status. The DHS RN will follow procedures outlined in MS-C-241.

Refer to MS-C-242 for procedures to approve an ARChoices Waiver application and closure of the nursing facility case.

Refer to MS-C-256 for procedures to approve an Assisted Living waiver application and to close the nursing facility case.

I-560 ANSWER Procedures for ARChoices Recipients Turning Age 65

MS Manual 22/22/2201/01/16

No action will be required when an ARChoices recipient who is in the ANSWER category ARChoices/AAPD turns age 65 as there is no difference in the services received through the ARChoices program. Additionally, a new assessment is not required. Behind the scenes, the

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

I-570 Workers with Disabilities Eligible to Receive ARChoices Services

~~ACES system will convert the individual automatically from category 41 to category 11, or an SSI person from a category 43 to category 13. At the next reevaluation, the LTSS Eligibility Specialist will process in ANSWER the budget unit change from ARChoices/AAPD to ARChoices/ElderChoices.~~

I-570 Workers with Disabilities Eligible to Receive ARChoices Services

MS Manual 01/01/1607/01/20

The ARChoices Waiver has been amended to include the Workers with Disabilities category as a group that is eligible for services within the ~~w~~Waiver. In order to be eligible for the ARChoices Waiver services and the Workers with Disabilities category, applicants must meet both the functional need criteria of the ARChoices Waiver program (MS F-155) and the financial criteria of the Workers with Disabilities category (MS B-330).

Referral for Assessment

When an applicant or recipient of the Workers with Disabilities category applies for the services available within the ARChoices category, the DHS RN will be notified to coordinate an assessment of medical necessity (functional need) and develop a service plan of care ~~county worker will complete a DHS 3130 within 2 days of the office interview for referral to the DHS RN for coordination of the medical assessment.~~ For a recipient of the Workers with Disabilities category, completion of a new application is not necessary unless it is time for the annual reevaluation of the Workers with Disabilities category. The assessment process in MS C-241 will be followed. ~~The application, reevaluation, or the request for ARChoices services on an active Workers with Disabilities case will be pended until receipt of the DHS 704 from the Home and Community Waiver Unit.~~

County Office Eligibility Determination

~~The case eligibility worker will determine if the applicant meets the eligibility requirements of the Workers with Disabilities category. Refer to (MS B-330 and E-110).~~

For Workers with Disabilities/ARChoices cases, disability will be determined using the Workers with Disabilities criterion which allows an individual to earn over the Substantial Gainful Activity (SGA) level SGA at the time of application. MS F-120 provides guidance on when to refer to MRT for a disability decision. A referral to MRT is not necessary for an applicant who received SSI or SSA disability within the last year and lost entitlement solely due to employment or when an applicant is still considered as an active SSI or SSA disability recipient whose cash benefits were suspended due to earnings. However, to be eligible for ARChoices ~~w~~Waiver, the disability must

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-500 Categorical Changes

be determined as physical. ~~The county worker must contact the local SSA office requesting verification of physical disability. If unable to verify if a physical disability exists through SSA, then a MRT determination is required.~~

The applicant or recipient may be eligible for retroactive eligibility, if needed, for the Workers with Disabilities category (MS A-200). However, the individual will not be eligible for the ARChoices Waiver until the day of the month in which the Waiver eligibility is finalized by the eligibility caseworker (MS A-200) and approval submitted to the system unless a retroactive eligibility date is established by the DHS RN. Refer to MS C-247.

ARChoices Transition to the Workers with Disabilities Category

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

~~ARChoices recipients who have earnings that cause ineligibility for ARChoices should be reviewed before closing to see if they would meet the financial criteria of the Workers with Disabilities category. Once the case eligibility worker determines eligibility for the Workers with Disabilities category, the ARChoices category will be closed, and the Workers with Disabilities category will be approved effective with the day after closure. The ARChoices case will then be reopened manually by DCO System Support.~~

NOTE: — An ARChoices applicant or recipient may still be eligible for ARChoices when employed as long as his/her total income (earned + unearned) does not exceed the waiver income limit. Also, an individual can remain categorically eligible for the ARChoices waiver when SSI eligible but no longer in payment status. Social Security Disability rules allow beneficiaries to earn over SGA during their Trial Work Periods and Extended Periods of Eligibility. ~~The county worker is not required to verify or request verification. In this case, verification of income and resources is not required-;~~ however, The DHS-704 is required to meet the medical necessity must be met as well as verification that a physical disability exists.

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-610 Loss of Eligibility

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I-600 Changes

MS Manual 05/01/1807/01/20

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

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

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

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-610 Loss of Eligibility

~~When a change is reported by the client, the caseworker will:~~

- ~~• Review the information.~~
- ~~• Verify through electronic sources, if applicable. Request additional verification if required.~~
- ~~• Enter the changed information to the system so that eligibility can be redetermined.~~

~~Ensure appropriate notice is sent to the individual if a change in eligibility results.~~

~~**NOTE:** A new application is not required to add a member, but the caseworker will need to obtain tax filing status of the added member.~~

I-610 Loss of Eligibility

MS Manual 05/01/1807/01/20

Loss of eligibility occurs when the eligible individual:

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

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

EXCEPTION: Once eligibility is established for a pregnant woman (PW) in any Medicaid category, there will be "No Look Back" at later income increases throughout the pregnancy and the

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-620 Alternative Change/Closure Processes

postpartum period. The PW will remain Medicaid eligible through the end of the postpartum period regardless of increases in income. Refer to MS C-205 and MS I-690.

I-620 Alternative Change/Closure Processes

MS Manual 01/01/16~~07~~01/20

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

- ARChoices in Homecare Waiver;
- Assisted Living Facility; (Living Choices) Waiver
- Division of Developmental Disability Services Waiver;
- TEFRA;
- Autism;
- SSI Related Groups ~~and~~
- Pregnant Women.

I-630 ARChoices Waiver

MS Manual 01/01/16~~07~~01/20

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

If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) ~~DAAS~~ or Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) ~~OLTC~~ determines that cost effectiveness is not met, that the client no longer meets the requirements for Intermediate Level of Care, or that the client is no longer receiving Waiver services, the County Office ~~county office~~ will be notified by DHS-3330 or DHS-704, and the Waiver case will be closed. If the Waiver case is closed for any reason, the case eligibility worker will determine if the client is eligible for any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ARChoices Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month (e.g., land rent paid annually), procedures at MS E-410 will be followed, advance notice given, and the case adjusted ~~on the system at the~~

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-631 ARChoices Waiver Temporary Absences from the Home

appropriate time. In both instances, a DHS-3330 and a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

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

1. ~~The case is being reopened within 2 months of the closure date.~~
2. ~~The DHS-704 was signed within 6 months prior to the new application date.~~
3. ~~The DHS RN was notified by a DHS-3330 of the closure within 3 days of the action taken.~~
4. ~~The DHS RN was notified by a DHS-3330 of the reopening within 3 days of the action taken.~~

If all of the conditions above are not met, a new DHS-704 will be needed to reopen the ARChoices case. When closing an ARChoices case because a recipient refuses to receive at least one service, closure code "Refused Other Procedural Requirement" will be used. A manual notice will be sent to the recipient notifying him or her of the closure. If the client does not refuse services but the DHS RN determines that the recipient is no longer in need of services or that services are no longer available in the recipient's area, closure code "Other Non-Needs Related" will be used. A manual notice will be sent notifying the recipient of the closure.

A Waiver client may appeal an adverse decision made on his/her case as outlined in MS L 100-173 of the Medical Services Policy manual. If the client chooses, the ARChoices Waiver case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the service provider. Because it is the responsibility of the DHS RN to coordinate services in the client's home, he/she must be aware of planned adverse action and the request for an appeal. Therefore, when a Notice of Adverse Action is mailed to an ARChoices Waiver client, a copy will be emailed to the DHS RN the same day. Also, when the caseworker learns that request for an appeal has been submitted on a Waiver case, the caseworker will notify the DHS RN via DHS-3330 immediately. If the county office at any time finds the recipient ineligible for the Waiver program, the DHS RN will be notified immediately by DHS-3330 and the Waiver case will be closed.

I-631 ARChoices Waiver Temporary Absences from the Home

MS Manual 01/01/1607/01/20

Once an ARChoices Waiver application has been approved, Waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the County Officecounty

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-631 ARChoices Waiver Temporary Absences from the Home

office will be notified immediately by the DHS RN when Waiver services are discontinued and action will be initiated by the County Office ~~county office~~ to close the Waiver case.

1. Institutionalization

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

a) Hospitalization

~~When a Waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does not return home within 30 days from the date of entry. If after 30 days the recipient has not returned home, the DHS RN will notify the County Office~~ county office ~~via Form DHS-3330 and action will be initiated by the County Office~~ county office ~~to close the Waiver case. For ARChoices services to resume after discharge from the hospital and after the Waiver case has been closed, the individual must make a new application.~~

b) Nursing Facility Admission

~~When a Waiver recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the Waiver client returns home within 30 days, a new medical assessment and DHS-704 will not be required. A new DCO-777 or DCO-7781 application will not be required unless it is time for the annual renewal. It is not necessary to register a new application in this situation.~~

~~If the individual requests payment for the temporary stay in the nursing facility, a signed application DCO-777 or DCO-7781 must be obtained and registered, along with a new medical the assessment and DHS-704. If it is time for the annual renewal, the renewal must be completed prior to certifying the vendor payment. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ARChoices Waiver recipients are considered to be "institutionalized" for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30-day institutionalization requirement.~~

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-640 Assisted Living Facility (ALF)

If the individual does not return home, i.e., stays in the facility and requests ~~Nursing-nursing Facility~~ facility vendor payment, the Medicaid case may be left open while processing the ~~registered LTC-nursing facility~~ application. ~~If found eligible for vendor payment, the case will be closed with a Waiver Stop Date using the date of entry into the nursing facility.~~ Vendor payments will also be authorized beginning the date of entry.

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

2. Absence from the Home - Non-Institutionalization

When a Waiver recipient is absent from the home for reasons other than institutionalization, the ~~County Office~~ county office will not be notified unless the recipient does not return home within 30 days. If after 30 days the recipient has not returned home and the providers can no longer deliver services as prescribed by the ~~Service Plan of Care~~ (e.g., the recipient has left the state and the return date is unknown), the DHS RN will notify the ~~County Office~~ county office via DHS-3330 and action will be taken by the ~~eligibility~~ case worker to close the Waiver case.

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

I-640 Assisted Living Facility (ALF)

MS Manual 01/01/1407/01/20

ALF Waiver recipients will be advised to report any changes in income or resources to the ~~county-DHS County Office~~ office. If at any time the Division of Aging, Adult and Behavioral Health Services (DAABHS) DAAS or the Office of Long Term Care DMS determines that cost effectiveness is not met or that the client no longer meets the requirements for an Intermediate Level of Care, the ~~County Office~~ county office will be notified and the ALF case will be closed. If the case is closed for any reason, the ~~eligibility~~ case worker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-641 Temporary Absences from the Assisted Living Facility

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the County has advance knowledge of ineligibility in a future month, procedures at ~~{MS E-410}~~ will be followed, advance notice given, and the case adjusted ~~on the system~~ at the appropriate time. ~~In both instances, a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.~~

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen. ~~If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if all of the following conditions are met:~~

- ~~1. The case is being reopened within 2 months of the closure date.~~
- ~~2. The DHS-704 was signed within six months prior to the new application date.~~
- ~~3. The DHS RN was notified of the closure within 3 days of the action.~~
- ~~4. The DHS RN was notified of the reopening within 3 days of the action taken.~~

~~If all of the conditions above are not met, a new DHS-704 will be required to reopen the ALF Waiver case.~~

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in MS Section L. If the client chooses, the ALF case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client and the facility. ~~When the caseworker learns that request for an appeal has been submitted on an ALF case, the caseworker will notify the DHS RN immediately.~~

~~If at any time the county office finds the recipient ineligible for the ALF program, the DHS RN will be notified immediately and the county office caseworker will begin the process of closing the case.~~

I-641 Temporary Absences from the Assisted Living Facility

MS Manual 01/01/1407/01/20

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

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-641 Temporary Absences from the Assisted Living Facility

1. Hospitalization

~~When an ALF recipient enters a hospital, the county office will not be notified and no action will be necessary unless the recipient does not return to the ALF within 30 days. If the recipient does not return from the hospital within 30 days, dies during hospitalization, or is discharged to his home or elsewhere from the hospital, the ALF facility will report to the county~~ County and on Form DCO-702 and the caseworker will initiate case closure will be initiated. If the recipient reenters another facility after discharge from the hospital or if the individual is reassessed and no longer meets the Intermediate Level of Care, the facility will also report to the eCounty on Form DCO-702 and the eligibility caseworker will take appropriate action.

2. Nursing Facility Admission

When an ALF recipient enters a nursing facility and it is anticipated that the stay will be less than 30 days, ~~the case will remain open if the client does not request vendor payment for the temporary stay. If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 application must be obtained and registered and a new along with a new medical assessment DHS-704 obtained.~~ If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ALF recipients are considered institutionalized for Medicaid purposes and the Waiver eligibility prior to the facility stay may be applied toward the 30 day institutionalization requirement.

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

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

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

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

I-650 DDS Waiver

I-650 DDS Waiver

MS Manual 01/01/1407/01/20

Recipients will be required to report changes to the DDS Medicaid Eligibility worker within 10 days. The DDS Medicaid Eligibility worker will promptly redetermine eligibility when information is received about changes in a recipient's circumstances. When a change occurs that results in ineligibility, a 10 day advance notice will be given unless advance notice is not required. ~~(Re-Refer to MS J-130). Notice is made to the individual/legal representative with copy to the DDS applicable area manager and authorized case management and direct service providers.~~

Eligibility will end at the end of the ~~ten~~ 10-day advance notice period, unless the recipient or his/her legal representative requests a hearing, or unless whatever was causing the intent to close is resolved prior to the end of the 10 days.

~~If the County Office is notified at any time by DDS that the client is no longer eligible for DDS Waiver Services, the County Office will determine if the client is eligible for any other Medicaid category.~~

I-660 TEFRA

MS Manual 01/01/1407/01/20

When a change occurs that affects eligibility, the caseworker will notify the TEFRA Committee advising when the closure will be made. The applicant will be sent a 10-day advance notice using form DCO-700, unless advance notice is not required. ~~(Re- Refer to MS J-130.) A copy of the DCO-700, a memorandum or an email will be sent to the TEFRA Committee to inform of the closure.~~

I-670 Autism

MS Manual 03/04/1507/01/20

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

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

MS Manual 03/04/1507/01/20

MEDICAL SERVICES POLICY MANUAL, SECTION I **MARKUP**

I-600 Changes

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

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

In determining Qualified Medicare Beneficiaries (QMB) ~~QMB~~ eligibility, all SSA income will be counted in the budget. ~~The QMB income and resource calculations and documentation will be entered into the electronic case file. It will not be necessary to obtain a new application unless it is time to make the annual reevaluation of the disability case.~~

If an individual is found QMB eligible, the existing disability case will be closed.

The individual should be notified in advance ~~by DCO-700~~ of closure of the disability case because of Part A Medicare eligibility or entitlement, but that the case will be reopened as a QMB with benefits limited to payment of Medicare premiums, deductibles and coinsurance.

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

MS Manual 01/01/1707/01/20

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

~~In these cases, if the pregnant woman's original coverage is:~~

~~Parent Caretaker Relative (PCR); the category will be switched to Full Pregnant Women (FPW). The income used for the PCR category will be used for the FPW category.~~

~~Adult Expansion Group; the category will be switched to FPW or Limited Pregnant Women (LPW) based on the income used to determine eligibility for the Adult Expansion Group.~~

~~ARKids A; the category will be switched to ARKids B.~~

~~ARKids B; the category will remain ARKids B. If the woman is pregnant when the ARKids B 12 months of continuous coverage ends or she turns age 19, eligibility will be determined in the appropriate Pregnant Women category.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

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

TN No. _____ Approval Date _____ Effective Date _____

Supersedes TN No. _____

State of Arkansas
91st General Assembly
Regular Session, 2017

A Bill

HOUSE BILL 2177

By: Representative McCollum

For An Act To Be Entitled

AN ACT TO CLARIFY THE PROPER ADMINISTRATION BY THE
DEPARTMENT OF HUMAN SERVICES OF THE FEDERAL
REGULATIONS PERTAINING TO POST-ELIGIBILITY TREATMENT
OF INCOME OF INSTITUTIONALIZED INDIVIDUALS OF LONG-
TERM CARE MEDICAID; AND FOR OTHER PURPOSES.

Subtitle

TO CLARIFY THE PROPER ADMINISTRATION BY
THE DEPARTMENT OF HUMAN SERVICES OF THE
FEDERAL REGULATIONS PERTAINING TO POST-
ELIGIBILITY TREATMENT OF INCOME OF
INSTITUTIONALIZED INDIVIDUALS OF LONG-
TERM CARE MEDICAID.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-77-127, concerning eligibility for long-term care, is amended to add an additional subsection to read as follows:

(c)(1)(A) Under 42 C.F.R. § 435.725, certain amounts of income may be deducted from income to:

(i) Calculate the amount certain institutionalized recipients of long-term care Medicaid must contribute to the cost of their care; and

(ii) Determine the amount by which the Medicaid payment to the institution is to be reduced.

(B) The federal regulations also provide for deduction amounts for incurred expenses for "necessary medical or remedial care



1 recognized under State law but not covered under the State's Medicaid plan,
2 subject to reasonable limits the agency may establish on amounts of these
3 expenses", which are commonly referred to as "Medicaid income offsets".

4 (2) The Department of Human Services shall clarify the proper
5 administration of 42 C.F.R. § 435.725, as it existed on January 1, 2017, by
6 creating and promulgating rules that:

7 (A) Identify and define the types of expenses that are
8 not covered by the Medicaid State Plan that are potentially eligible for
9 Medicaid income offset;

10 (B) Identify the types of expenses that are not eligible
11 for Medicaid income offset;

12 (C) Define a process for determining whether the medical
13 or remedial service is medically appropriate and necessary and not covered
14 under the Medicaid State Plan; and

15 (D) Set reasonable limits on the amounts allowed for
16 eligible Medicaid income offsets.

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19 **APPROVED: 04/04/2017**
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