EXHIBIT I

DEPARTMENT OF HUMAN SERVICES, COUNTY OPERATIONS

SUBJECT: Medical Services Policy Manual Section: B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610 and Appendix F

DESCRIPTION: This revises Medical Services policy to comply with the Arkansas Works Waiver by adding a work requirement to the Arkansas Works Program and decreasing the eligibility income limit for the program to 95% of the federal poverty level.

PUBLIC COMMENT: A public hearing was held on September 27, 2017. The public comment period expired on October 13, 2017. The Department received the following comments:

Commenters: Kevin De Liban, Staff Attorney and Lee Richardson, Executive Director Legal Aid of Arkansas, Inc.

We write to comment on the proposed revisions to Medical Services Policy Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610, and Appendix F, issued by the Division of Medical Services on September 14, 2017 (the "proposed Medicaid policy revisions"). The public comment period for these revisions is already under way and is set to close shortly.

Premature Promulgation

As you know, "participation in Medicaid is voluntary, but if states choose to participate, they must comply with the requirements outlined in the Medicaid statute." *Ark. Med. Soc., Inc. v. Reynolds*, 6 F.3d 519, 522 (8th Cir. 1993); *see also* 42 U.S.C. § 1396a(a). Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services ("DHHS") to waive some federal requirements under certain conditions. 42 U.S.C. § 1315(a). Any requirements not explicitly waived by the Secretary remain in full force and effect. *See* Letter to Cindy Gillespie, Dir., Ark. Dep't of Human Servs. from DHHS, *Arkansas Works Section 1115 Demonstration* 3 (Dec. 8, 2016). Moreover, any changes to the existing waiver must occur only with federal permission. *See id.* at 8 ("The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan and/or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.").

The Division submitted proposed amendments to the State's existing Section 1115 project to DHHS on June 30, 2017, among other things seeking to impose work requirements and change income eligibility requirements for many Medicaid enrollees. As of the date of this letter, DHHS has not granted Arkansas the waivers needed to make these changes. As a result, the Division's promulgation of Medicaid policy revisions is "beyond the agency's . . . legal power or authority." *McLane S., Inc. v. Ark. Tobacco Control Bd.*, 375 S.W.3d 628, 644 (Ark. 2013); *see Ark. State Bd. of Election Comm'rs v.*

EXHIBIT I

Pulaski Cty. Election Comm'n, 437 S.W.3d 80, 89 (Ark. 2014) ("[T]he law is elementary that an agency has no right to promulgate a rule or regulation contrary to a statute.").

Further, even if DHHS were to approve the proposed amendments to Arkansas Works, it may deny or require revisions to specific proposals. In 2015, for example, DHHS generally approved Indiana's application for a new Section 1115 demonstration project but rejected its proposed work requirement.[1] At this time, of course, there is no way for the public to know whether DHHS will reject aspects of the proposal or demand further revisions.

Nevertheless, in its notice of rulemaking, the Division requires that any comments concerning the proposed Medicaid policy revisions be submitted by October 13, 2017. In so doing, the Division is forcing the public to comment on significant state Medicaid policy changes that may or may not be approved—and that may or may not undergo substantial revisions before implementation. By mandating public comment before federal approval, the Division has violated the Arkansas Administrative Procedure Act's ("APA") requirement that a state agency "[a]fford all interested persons *reasonable opportunity* to submit written data, views, or arguments, orally or in writing," before adopting or amending a rule. Ark. Code Ann. § 25-15-204(a)(2)(A) (emphasis added). The APA's "notice and comment procedure assures that the public and the persons being regulated are given an opportunity to participate, provide information and suggest alternatives, so that the agency is educated about the impact of a proposed rule and can make a fair and mature decision." *Wagnon v. State Health Servs. Agency*, 40 S.W.3d 849, 852-53 (Ark. App. Ct. 2001). Here, however, the public is being deprived of the meaningful opportunity to participate in the notice and comment process because they lack critical information about whether and how the proposed rules will comply with the federal Medicaid requirements should the State's request ultimately be approved.

In light of the deficiencies identified above, we respectfully request that the Division rescind its notice of rulemaking and proposed Medicaid policy revisions until DHHS acts on the proposed amendments to the State's Section 1115 demonstration project. Additionally, we respectfully request that were the Division to seek to make regulatory changes after DHHS has taken final action to approve the proposed amendments in whole or in part, the Division initiate a new 30-day notice and comment period pursuant to § 25-15-204(a) of the Arkansas APA. We believe that failure to take these steps would render the final rules invalid and unlawful. Republication of the proposed regulations as requested above will allow Arkansans to participate more fully and knowingly in their State government.

---

[1] 1 See Press release: CMS and Indiana Agree on Medicaid Expansion (Jan. 27, 2015), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html.

EXHIBIT I

Comments on the Substance of the Proposed Policy Changes

Legal Aid of Arkansas previously submitted comments concerning the proposed changes to Arkansas Works contained in the waiver application to the Centers for Medicare and Medicaid Services, particularly the reduction of the eligibility cap to 100% FPL and the imposition of work requirements. Legal Aid of Arkansas explained the ways these changes would negatively impact our client communities and we incorporate those comments by reference and attachment. Turning to the present promulgation, the proposed policies operationalize the reduced eligibility cap and work requirements in ways that are likely to further harm clients by frustrating enrollment, encouraging churning, and violating due process principals.

A. The proposed polices impose significant administrative burdens on beneficiaries and the agency.

Each exemption from the work requirement requires verification at a differing interval, whether two months, six months, or a change in circumstances. Meanwhile, for individuals who are not exempt, verification of compliance with work requirements must happen monthly.

This imposes a new regulatory entanglement on a program that already features challenging eligibility income, resource, and categorical restrictions. In addition to the myriad requirements already managed, beneficiaries and agency staff must know whether or not an individual qualifies for an exemption to the work requirement, how long any exemption lasts, how to continue an exemption, how to comply if no exemption exists, and how to prove compliance. Meanwhile, agency workers and the administrative appeal process will have to compare each month of a beneficiary's entitlement year to the work requirements to determine if an individual is eligible for that month or not. The eligibility backlog, which persisted for over two years and required CMS intervention, demonstrates that the agency is not administratively equipped to handle a more complicated eligibility or renewal process with sufficient timeliness or accuracy. As a result, beneficiaries may experience inappropriate terminations, bars to re-enrollment, and discouragement from future enrollment. The additional administrative complexity is likely to result in complication for providers of Qualified Health Plans, who must now manage increasingly complex periods of beneficiary ineligibility and re-eligibility. Meanwhile, the interruptions in coverage are likely to cause beneficiaries to go without medical care and to be liable for costs of medical care incurred during periods of ineligibility, some of which may be erroneous.

At the same time, the agency's proposed policies do not adequately address the process to determine the eligibility for different Medicaid groups once Arkansas Works eligibility is terminated. The policy manual states in Section I-610 that, "[w]hen possible, eligibility in another group should be determined at the time ineligibility for the current group is established." Here, the agency underestimates its obligations. In fact, the agency must consider all bases of eligibility prior to making a determination of ineligibility. 42 C.F.R. § 435.916(f). Presumably, both the work requirements and reduced eligibility cap will result in significant numbers of terminations from Arkansas Works. In the proposed

policy manual, the agency has provided no proof that it has any process in place to evaluate terminated beneficiaries for other categories of eligibility.

In addition to being administratively complex, the verification procedures for the new policies run counter to established Medicaid law meant to minimize the administrative burden on applicants and beneficiaries. *See, e.g.*, 42 U.S.C. § 18083(b)(1)(A); 42 C.F.R. § 435.1200(b)(3)(i) (the agency must "minimize burden on individuals seeking to obtain or renew eligibility"); 42 C.F.R. § 435.916(c) (requiring that the agency accept beneficiary reports of change of circumstances "through any of the modes for submission of applications described in § 435.907(a) of this part"). Simply, DHS will be requiring beneficiaries to submit information that it should not request in ways that are unlawful and overly restrictive.

B. Electronic compliance requirements are unlawful and will further burden program beneficiaries who do not have ready access to or literacy with required technologies.

One element of the proposed policy changes likely to prove problematic for Arkansas Works beneficiaries is the reliance on an electronic compliance mechanism, apparently to the exclusion of more traditional forms of communication with the agency. As mentioned just above, federal regulations do not support the restrictions on the means that beneficiaries use to communicate relevant information. Despite the federal regulations, the agency proposes an electronic verification system, captured in essence by the following provisions:

> **B-270**: "Arkansas Works recipients subject to the work requirement must have a valid e-mail address in order to report work activities, exemptions, or changes on the Arkansas Works portal."
>
> **G-190**: "All other exemptions will be reported and validated by the individual through an online portal. Clients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will be revalidated."
>
> **G-190**: "Demonstration of an exemption or work activity must be done electronically, except when information regarding a work activity or exemption is provided on an application."

The waiver application itself does not specify that electronic compliance operates to the exclusion of traditional forms of client interaction with DHS around public benefit programs. Imposing electronic-only verification requirements is likely to disadvantage significant numbers of beneficiaries.

Arkansas, a predominantly rural state, is especially likely to face problems caused by electronic verification requirements. Recent studies from the Pew Research Center substantiate the "digital divide" in which rural residents have less access to connective technologies than their suburban and urban counterparts.[2] Rural residents own significantly fewer smartphones, tablets, and laptops, meaning that they may lack the

2 http://www.pewresearch.org/fact-tank/2017/05/19/digital-gap-between-rural-and-nonrural-america-persists/

devices needed to submit the information DHS is requesting. Moreover, rural residents use the internet less frequently. Roughly 4 in 10 rural adults do not use the internet every day. 1 in 5 rural adults never goes online. And, rural residents less frequently have broadband in their own homes. Even those rural Arkansans who do have access to broadband are likely to connect at much slower speeds than elsewhere.[3]

The Pew Research Center study further shows that the gravity of the digital divide is magnified by socioeconomic status.[4]4 The people who qualify for Arkansas Works have less access to connective technologies than their better-off rural neighbors. Independent of the rural-urban digital divide, there is a gap in technological readiness based strictly on income.[5] Those who qualify financially for Arkansas Works are more likely to be "digitally unprepared" than better-off individuals. Similarly, internet usage and ownership of connective devices is lower among individuals with disabilities than those without a disability.[6] Many Arkansas Works beneficiaries are likely to thus be disadvantaged.

In summary, there are systemic societal issues regarding connective technologies that argue against DHS's proposed requirement for beneficiaries to electronically verify compliance with work requirements.

These societal issues are accompanied by many administrative challenges for operating and maintaining an electronic compliance system that strictly demands that beneficiaries provide proof of compliance by the 5th of the following month. The portals require a log-in. What is to happen if the log-in or password is lost? What happens if the portal website is down for maintenance or for unplanned reasons? What is DHS's plan to provide technical support to users in a timely way that allows them to readily meet the strict timelines for demonstrating compliance? How user-friendly and simple will the portal be? Will the portal be designed to be used on a smartphone screen or on bigger screens such as laptops? Will the portal require comparatively fast internet speeds in order to connect? With reduced funding for navigators, where can beneficiaries go to get help to demonstrate compliance? Will DHS field offices have staff trained on the system and readily available at all times to help beneficiaries? Will DHS field offices have laptops or tablets that the public can use to demonstrate compliance?

Will all the information be provided be safely maintained? Recently, over 20,000 Medicaid beneficiaries had personal information stolen from DHS. What steps has the agency taken to prevent something similar from re-occurring?

---

[3] https://www.brookings.edu/blog/the-avenue/2017/02/13/in-infrastructure-plan-a-big-opening-for-rural-broadband/

[4] http://www.pewresearch.org/fact-tank/2017/03/22/digital-divide-persists-even-as-lower-income-americans-make-gains-in-techadoption/

[5] http://www.pewinternet.org/2016/09/20/appendix-detail-on-digital-readiness-and-other-metrics-across-groups/

[6] http://www.pewresearch.org/fact-tank/2017/04/07/disabled-americans-are-less-likely-to-use-technology/

EXHIBIT I

Will compliance require beneficiaries to upload actual documents? If so, how does DHS plan to accommodate the extra layer of challenges caused by needing to convert physical documents to digital form and then upload them? How to ensure that documents submitted are connected to the appropriate file? Is mere attestation of compliance enough? Will beneficiaries receive any sort of proof of receipt from the system once the information has been provided?

How will the notice contemplated in Section G-190 be transmitted ("[c]lients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will be revalidated")? How far in advance of the expiration of the exemption is the notice to be transmitted? What guarantees are there that DHS will structure the notices in a way that will not be filtered automatically to spam folders? Will a beneficiary's non-receipt of the electronic notice offer the possibility of a retroactive exemption period?

Apart from all these unanswered questions regarding the operation of the electronic system, the departure from the traditional practices of verification does not seem sensible. Many beneficiaries have used nonelectronic forms of communication, such as office visits, regular mail, or, occasionally, fax to communicate with DHS as needed. What harm is there in allowing verification to happen through these traditional means while adding the electronic verification system as an alternative? Relatedly, electronic-only verification could discriminate against individuals with disabilities who require alternative means to verify compliance, as not all disabilities, as that term is defined in relevant federal law, would necessarily qualify an individual for an alternative category of Medicaid or for an exemption from the work requirements.

To the extent that DHS is convinced that the electronic application systems inaugurated under Medicaid Expansion and the Affordable Care Act adequately prepare Arkansas Works beneficiaries for electronic verification, the agency should remember that not all applicants enrolled electronically. For those who did, the agency should remember that a significant number of beneficiaries received enrollment assistance from navigator and similar programs, most of which no longer operate. And, even those who did so unassisted were completing a one-time application, which involves different circumstances and substantially less burden than an ongoing obligation to provide electronic verification.

C. The definitions of the exemptions and work activities are not sufficiently clear to ensure consistent application.

Consistent application of any exemptions and work activities are necessary to the functioning of any modified Arkansas Works program, but the definitions of various exemptions and activities are problematically vague.

A beneficiary "living in home with a dependent minor" is exempt. The meaning of "dependent minor" is unclear. Does it include grandchildren or nieces or nephews who may be living in a kinship arrangement with a non-parent family member? Does it include separated parents who have joint custody of children?

Another exemption is providing to beneficiaries "caring for [an] incapacitated person." Who is an "incapacitated person" for these purposes? Must it be someone who is legally determined to lack capacity? What if person being cared for has profound physical disabilities requiring care but is mentally competent?

There is an exemption for someone "experiencing a short-term incapacitation." How is the "short-term incapacitation" to be established? Notably, this language differs from the exemption listed in the waiver application to CMS, which provided an exemption not only for short-term incapacitation, but also for individuals "medically certified as physically or mentally unfit for employment."[7] Does the proposed policy manual's definition of "short-term incapacitation" include the provision for people "unfit for employment?" If not, are people who are "medically certified as physically or mentally unfit for employment" entitled to an exemption, and what form must certification take?

Similarly, "volunteering" is a work activity. Other than a reference to an "agency name, address, and phone number" under Section G-190, there is no information about what qualifies. Will work voluntarily performed at a church qualify? How about a neighborhood clean-up session? What must an individual do to establish that she has volunteered?

Moreover, all exemptions and work activities require an "electronic demonstration of compliance." Is the "demonstration of compliance" an attestation by the beneficiary that she has met the given exemption or activity? Must documents be furnished? What kinds of documents?
As it stands, the definitions of the proposed exemptions and work activities do not provide adequate guidance to the public. These definitions of the exemptions and work activities should be changed and made sufficiently specific to allow beneficiaries, DHS workers, and hearing officers to decide if a particularly category is met.

D. The proposed policies violate due process.
The onerous verification requirements are themselves riddled with due process concerns.

Section G-190 requires that beneficiaries report hours, exemptions, or work activity by the 5th of the following month. There are no apparently no exceptions: "Recipients cannot provide electronic demonstration of compliance retroactively after the 5th of the following month. For example, a recipient cannot provide electronic demonstration of compliance on April 7th for meeting the work requirement in March." The reason for non-report does not apparently matter to the agency, even if technical problems on its end were the cause.

---

[7] Centers for Medicare and Medicaid Services Expenditure Authority Number 11-W-00287/6, as promulgated by DHS on or around 5/19/17, Page 23 of 43.

Then, "[i]f the recipient does not report by the deadline, a notice will be sent informing the recipient that a month of non-compliance has accrued." The proposed policy offers no details on this notice. What information will the notice contain? Will it be sent by mail or only electronically? Can the determination of non-compliance be appealed?

Furthermore, "[i]f the recipient accrues a second month of non-compliance, a notice will be sent informing the recipient of the second month of non-compliance and that their case will be closed at the end of the third month of non-compliance." Also, the policy states, "This notice will serve as the notice of adverse action." That policy is unlawful. A notice of adverse action with expiring appeal rights cannot be validly issued prior to an actual agency decision to terminate. See, e.g., 42 C.F.R. §§ 431.206(c), 431.201, 431.210. Of course, here, the agency cannot decide to terminate an individual after only two months of noncompliance. Moreover, even were the agency aware of a third month of non-compliance, the agency cannot accurately state that a case will be closed until the agency has evaluated a beneficiary's eligibility under other Medicaid categories, as required by 42 C.F.R. § 435.916(f).

The statement in the proposed policy's following statement betrays a troubling understanding of due process, declaring, "If the recipient satisfactorily complies with reporting work activities by the 5th of the month following the third month of non-compliance, their case will be reinstated." This is tautological, as complying with the work activities would mean that the third month is not one of non-compliance. Moreover, a case cannot be "reinstated" if it was never terminated in the first place. And, of course, a case cannot be terminated until after the third month of non-compliance. In addition, the beneficiary would be entitled to continuing benefits pending the outcome of any appeal. 42 C.F.R. § 431.230.

The requirements of due process are more stringent considering what is at stake. As Section F-200 provides, "Those Adult Expansion Group recipients who lose coverage for non-compliance with the work requirement but meet an exemption later in the calendar year will not be allowed to regain coverage in Arkansas Works until the following year." If an individual who later would be eligible on the basis of an exemption is denied due to three prior months of non-compliance, the process used to determine those three prior months must be flawless. Moreover, there are legitimate fairness concerns about excluding an individual who meets conditions of eligibility due to a change in circumstances, which could, for example, include becoming a custodial parent or having to suddenly start caring for an incapacitated family member.

Conclusion

The agency has prematurely promulgated proposed policies before receiving CMS approval of the waiver application. Thus, the promulgation is beyond the agency's authority and unlawful. Meanwhile, the substance of the proposed policies to implement work requirements and reduced eligibility caps are fraught with legal and administrative problems and are likely to harm Legal Aid of Arkansas's client communities and cause administrative dysfunction to DHS.

EXHIBIT I

RESPONSE:
The Department is in receipt of your public comment dated October 13, 2017 in reference to proposed revisions to Medical Services Policy Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610, and Appendix F. We also received a second copy of your organization's comments dated June 18, 2017 in reference to "Comments on Arkansas 1115 Waiver Demonstration." Unfortunately, the public comment period for that rule has ended.

We thank you for your continued interest in this program and appreciate the time and effort that went into your letter concerning the proposed revisions to the Medicaid Services Policy Manual. The Department encourages stakeholder engagement and involvement when development programmatic changes. We will take your comments under advisement.

The agency states that the instant rules will require CMS approval; that approval is pending as of October 19, 2017. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The agency anticipates a savings for the current fiscal year of $4,759,286 ($285,557 in general revenue and $4,435,729 in federal funds) and $59,913,838 in the next fiscal year ($3,936,310 in general revenue and $55,977,527 in federal funds).

LEGAL AUTHORIZATION: The proposed rule change revises Medical Services policy to comply with the Arkansas Works Waiver.

The proposed amendments to existing rules are authorized by Act 6 of the first Extraordinary Session of the 91st General Assembly [Arkansas Code Annotated § 23-61-1003 (10)] and Arkansas Works Section 1115 Demonstration #11-W-00287/6.

The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12).

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Arkansas Department of Human Services

DIVISION County Operations

DIVISION DIRECTOR Mary Franklin

CONTACT PERSON Larry Crutchfield

ADDRESS PO Box 1437, Slot S332, Little Rock AR 72203

PHONE NO. 501-682-8257 **FAX NO.** 501-682-1597 **E-MAIL** larry.crutchfield@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Dave Mills

PRESENTER E-MAIL dave.mills@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.

B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.

C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.

D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Medical Services Policy Manual Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610 and Appendix F

2. What is the subject of the proposed rule? The proposed rule change revises Medical Services policy to comply with the Arkansas Works Waiver by adding a work requirement to the Arkansas Works Program and decreasing the eligibility income limit for the program to 95% of the Federal Poverty Level.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

   If yes, please provide the federal rule, regulation, and/or statute citation. Act 6 of the first Extraordinary Session of the 91st General Assembly and Arkansas Works Section 1115 Demonstration #11-W-00287/6

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?

   Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? ______________________

When does the emergency rule expire? ______________________

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
   If yes, please provide a brief summary explaining the regulation. _____

   Does this repeal an existing rule? Yes ☐ No ☒
   If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

   Is this an amendment to an existing rule? Yes ☒ No ☐
   If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Act 6 of the first Extraordinary Session of the 91st General Assembly and Arkansas Works Section 1115 Demonstration #11-W-00287/6 Arkansas Code § 25-19-201(12)

7. What is the purpose of this proposed rule? Why is it necessary? The proposed rule change revises Medical Services policy to comply with the Arkansas Works Waiver.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
   http://humanservices.arkansas.gov/Pages/LegalNotices.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
   If yes, please complete the following:

   Date: September 27, 2017
   Time: 6-7 PM
   Place: Central Arkansas Main Library – Darragh Center Auditorium

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
    October 13, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
    January 1, 2018

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of

the publication of said notice. See attached

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). See attached

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. _____

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT David McMahon

TELEPHONE 501-396-6421 **FAX** 501-682-8367 **EMAIL:** david.mcmahon@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Medical Services Policy Manual Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610 and Appendix F

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	(285,557)	General Revenue	(3,936,310)
Federal Funds	(4,473,729)	Federal Funds	(55,977,527)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	(4,759,286)	Total	(59,913,838)

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year	**Next Fiscal Year**
$ 4,759,286	$ 59,913,838

These reductions would be the loss of premium payments to the Qualified Health Plan providers for the estimated beneficiaries that would fail to meet the work requirement.

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

Current Fiscal Year	**Next Fiscal Year**
$ (285,557)	$ (3,936,310)

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

Yes ☐ No ☒

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

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

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

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

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

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
   (a) the rule is achieving the statutory objectives;
   (b) the benefits of the rule continue to justify its costs; and
   (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary of Changes

Arkansas Works Program

Sections B-270; E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610 and Appendix F

B-270 – Revised to reflect the change in the income limit for the Adult Expansion Group, add the work requirement eligibility criteria and an email address requirement.

E-110, E-268 and E-269 – These sections of policy have been changed to reflect the new federal poverty level (FPL) 95% income criteria for the Adult Expansion Group.

F-200 – This is a new section of policy to add the work requirement for the Adult Expansion Group.

F-201- This is a new section of policy to describe the work requirement phase in process.

G-190 – This is a new section of policy to add how to verify work activities.

I-600 and I-610 – These sections of policy state how the client can report a change and what changes should be reported.

Appendix F- Changed the percentage for the Adult Expansion Group to 95% and 100%.

B-270 Adult Expansion Group (Arkansas Works Program)

MS Manual 01/01/17

The Health Care Independence Program was amended to become the Arkansas Works Program starting January 1, 2017. Throughout this policy manual the Arkansas Works Program will be referred to as the Adult Expansion Group.

This group consists of adults who are 19 through 64 years of age with household income equal to or below 95% (100% with 5% disregard applied) of the applicable federal poverty level (MS E-110) and are not eligible in either the Parents/Caretaker Relatives group (MS B-230) or Former Foster Care group (MS B-260). Adults who are blind or who have a disability may be covered in this group unless they are determined eligible for coverage in another group on the basis of the need for long term care services (facility or waiver) or other disability related services.

A woman who is pregnant at the time of application cannot be included in this group until after the postpartum period. She must be enrolled in one of the pregnant women groups or in the parents/caretaker relatives group if eligible. However, a woman who becomes pregnant after enrolling in this adult group may remain in the adult group throughout her pregnancy.

Individuals eligible in this group will participate in the Arkansas Works Program authorized by the Arkansas Works Act of 2016 and its amendment in 2017. The Arkansas Works Program provides Medicaid funding in the form of premium assistance to enable individuals to enroll in private health insurance plans.

EXCEPTION: Individuals eligible for the Adult Expansion Group, who have health care needs that make coverage through the Health Insurance Marketplace impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private Qualified Health Plan (QHP) but will remain in Medicaid (Re. MS A-100).

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

PROPOSED

B-270 Adult Expansion Group (Arkansas Works Program)

Unless exempt, all Arkansas Works enrollees between the ages of 19 through 49 will be required to comply with the work requirement for the Arkansas Works Program (Re. MS F-200 and F-201). All Arkansas Works Program recipients will be referred to the Arkansas Division of Workforce Services for free job assistance services to assist them in complying with the Work Requirement.

NOTE: Arkansas Works recipients subject to the work requirement must have a valid email address in order to report work activities, exemptions or changes on the Arkansas Works portal.

PROPOSED

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual 01/01/18

Below are the income and resource limits for all Medicaid groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

Category	Income Limit	Resource Limit
ARKids A	142% of FPL *	No Resource Test
ARKids B	211% of FPL *	No Resource Test
Newborns	No Income Test Eligibility is based on mother's Medicaid eligibility at child's birth	No Resource Test
Pregnant Women: Full Medicaid Pregnant Woman Limited Medicaid Pregnant Woman Unborn Child	 1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5. 209% of FPL * 209% of FPL *	 No Resource Test
Parents and Caretaker Relatives	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Adult Expansion Group	95% of FPL *	No Resource Test
Medically Needy: Exceptional (EC) Spend Down (SD)	 EC – may not exceed the monthly income limit SD – may exceed the quarterly income limit See MS O-710 for the monthly and	 1 person: $2,000 2 person: $3,000 3 person: $3,100

	quarterly income limit	
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ARChoices, Assisted Living and PACE	3 times the SSI Payment Standard Appendix S	Individual $2000 Couple $3000
Medicare Savings: ARSeniors QMB SMB QI-1 QDWI	 Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	ARSeniors, QMB, SMB & QI-1: Individual $7,390 Couple $11,090 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	Unearned income may not exceed SSI individual benefit plus $20	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability (COBRA and OBRA '87)	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA '90)	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000
***May be eligible for an additional 5% disregard, MS E-268**.		

PROPOSED

E-268 The 5% Gross Income Disregard

MS Manual 01/01/18

Each individual will be allowed a general gross income disregard in the amount of 5% of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category that has the highest income level in which an individual could be eligible. For example, if an individual is not income eligible in the lowest income level group (e.g., Parents/Caretaker Relatives), the five (5%) disregard will be applied to the higher income group (e.g., Adult Expansion Group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the 5% disregard effectively raises the income limits for the applicable eligibility group by five (5) percentage points. For example, the income limit for the Adult Expansion Group is 95% (MS E-110). To apply the 5% disregard, add 5 to 95 to raise the income limit to 100% of FPL. The eligibility groups with dollar amounts for income limits are not the highest income limit groups for the individuals that fall into them. Therefore, the 5% disregard will never be applied to the dollar amount income limits.

Application of the 5% Disregard in the ARKids First groups

The 5% disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child and therefore, the 5% disregard can be allowed.

The 5% disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children and therefore, the 5% disregard is applied only if needed to achieve ARKids B eligibility.

Refer to MS F-180 for exceptions to health insurance coverage for ARKids B eligibles.

E-269 Who Is Eligible-Example Scenario

MS Manual 01/01/18

E-268 The 5% Gross Income Disregard

Continuing the example of Bertha, Audrey and Chloe to show whose income will be counted and who is eligible for Medicaid.

Bertha and Audrey's household are the same which includes Bertha, Audrey & Chloe.

- Bertha earns $8,000.00 per month, which equals $96,000 annually.
- Audrey earns $314.22 per month, which equals $3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income does not count. Bertha's income is counted.
- Bertha's household size is 3.
- Compare the $8,000.00 monthly income to the 95% + 5% = 100% standard for a household size of 3, $1,701.67.
- Bertha and Audrey are not eligible for Medicaid; therefore, the agency will electronically transfer their account to the FFM for possible eligibility for Advanced Premium Tax Credits and cost sharing reductions.

Chloe's household includes Chloe and her mother, Audrey.

- Audrey earns $314.22 per month, which equals $3,770.64 annually.
- Audrey's income will be counted because neither her mother, nor father is included in this household. Chloe's child support income is disregarded.
- Chloe's household size is 2.
- Compare the $314.22 monthly income to the ARKids A standard of 142% for 2, $1,835.35. **Note:** The 5% disregard was not needed for ARKids A eligibility and therefore was not applied.
- Chloe is eligible for ARKids A.

PROPOSED

F-200 Work Requirement for the Adult Expansion Group

MS Manual 01/01/18

The Arkansas Works Program requires certain recipients of the Adult Expansion Group to meet the requirement of working 80 hours or more per month. Unless exempt, Adult Expansion Group recipients are ineligible to receive Medicaid benefits if, during any 3 months of the calendar year, they failed to meet the work requirement. Adult Expansion Group recipients will fall in one of four categories for the work requirement:

1. Enrollees age 50 or older – Work requirement does not apply for this age group;

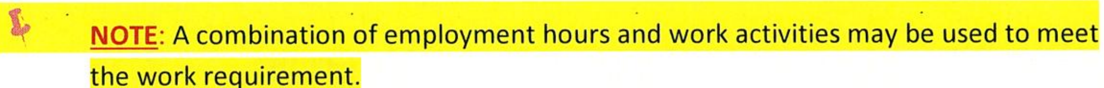
2. Enrollees age 19-49 that are employed at least 80 hours per month – Complying with the work requirement;

3. Enrollees age 19-49 that are not employed at least 80 hours per month but meet an exemption to the work requirement. Exemptions are:

    a. Currently receiving an exemption to the SNAP Requirement to Work;
    b. Receiving TEA Cash assistance;
    c. Receiving unemployment benefits;
    d. Has been determined medically frail;
    e. Caring for an incapacitated person;
    f. Living in home with a dependent minor;
    g. Being pregnant;
    h. Experiencing a short-term incapacitation;
    i. Participating in an alcohol or drug treatment program;
    j. Enrolled in full-time education, job training or vocational training; or
    k. Membership in a recognized American Indian/Alaska Native tribe.

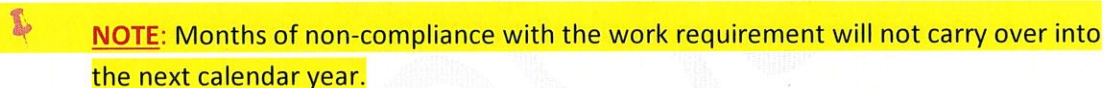
4. Enrollees age 19-49 that are not employed at least 80 hours per month but participate in any one or a combination of work activities for at least 80 hours per month to meet the work requirement. (See MS G-190) Work activities include:

    a. Currently meeting SNAP Requirement to Work;
    b. Enrolled in education (less than full time);
    c. Participating in job training (less than full time);
    d. Participating in vocational training (less than full time);
    e. Participating in a health education class;
    f. Volunteering; or
    g. Conducting an independent job search and/or participating in job search training.



NOTE: A combination of employment hours and work activities may be used to meet the work requirement.

Enrollees age 19-49 that are not employed at least 80 hours per month and do not meet an exemption or comply with work activities will lose Medicaid coverage for the remainder of the year after 3 consecutive or non-consecutive months of non-compliance with the work requirement within the calendar year. Those Adult Expansion Group recipients who lose coverage for non-compliance with the work requirement but meet an exemption later in the calendar year will not be allowed to regain coverage in Arkansas Works until the following calendar year. However, those Adult Expansion Group recipients who have lost coverage for non-compliance and turn 50 years old within the same calendar year will be allowed to apply to regain coverage the month the recipient's turns 50. Those individuals who have lost Arkansas Works coverage due to non-compliance may be determined eligible for coverage in other Medicaid categories during the period of Arkansas Works ineligibility.



NOTE: Months of non-compliance with the work requirement will not carry over into the next calendar year.

F-201 Work Requirement Participants

MS Manual 01/01/18

When the Adult Expansion Group work requirement starts on January 1, 2018, the requirement will apply to all new Adult Expansion Group recipients who are age 30 to 49. Those Adult Expansion Group recipients age 30 to 49 who were enrolled in the Adult Expansion Group prior to January 1, 2018 will be phased in from January to June 2018. In 2019, the work requirement will apply to all Adult Expansion Group recipients age 19-49.

Those Adult Expansion Group recipients who turn 30 in 2018 will be subject to the work requirement the month after their 30th birthday.

G-190 Verification of the Adult Expansion Group Work Requirement

G-190 Verification of the Adult Expansion Group Work Requirement

MS Manual 01/01/18

Those Individuals in the Adult Expansion Group that must meet the work requirement can do so by:

1. being employed at least 80 hours per month; or
2. qualifying for an exemption to the work requirement; or,
3. completing a combination of sufficient work and work activities.

Employment: In order to meet the Adult Expansion Group work requirement, the recipient must be employed at least 80 hours per month. This employment information will be verified by using the individual's reported income at application/renewal/change report to determine if the individual's reported earnings are equal to 20 hours weekly times the current minimum wage. For 2017, these numbers are 20 X $8.50=$170; $170 x 4.334=$736.78 monthly. If the individual's reported income is at or above this amount, the individual will be considered to be meeting the work requirement.

Exemptions: Exemptions are determined at application/renewal/change report. Initial exemptions will be determined at application based on information the applicant provides in the application. All other exemptions will be reported and validated by the individual through an online portal. Clients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will be revalidated. If it is determined that a recipient no longer meets the exemption, the individual must complete a combination of sufficient work and work activities in order to meet the work requirement.

The following table lists exemptions and their validation schedule.

Criteria:	Validation Approach:
Currently receiving a SNAP Requirement To Work exemption	Validated against state data every 30 days.
Receiving TEA Cash Assistance	Validated against state data every 30 days.
Caring for Incapacitated Person	Electronic demonstration of compliance required every two months and at renewal.
Short-term Incapacitation	Electronic demonstration of compliance required every two months and at renewal.
Participation in alcohol or drug treatment program	Electronic demonstration of compliance required every two months and at renewal.

G-190 Verification of the Adult Expansion Group Work Requirement

Receiving Unemployment Benefits	Electronic demonstration of compliance required every 6 months and at renewal.
Full-time Education, Job Training, or Vocational Training	Electronic demonstration of compliance required every 6 months and at renewal.
Pregnancy	Electronic demonstration of compliance valid until end of post-partum period.
Living in home with dependent minor	Electronic demonstration of compliance valid until change of circumstance.
Medically Frail	Electronic demonstration of compliance valid until change of circumstance.
American Indian/Alaska Native	Electronic demonstration of compliance valid until change of circumstance.

Work Activities: Work activities can be performed alone or in combination to comply with the Work Requirement. Total monthly Work Activity hours must equal 80 at a minimum. A combination of employment hours and work activities may be used to meet the work requirement. If the individual uses a combination of sufficient employment hours and work activities to meet the required 80 hours, monthly demonstration of compliance is required for each.

The following table lists approved work activities and their validation schedule.

Criteria:	**Validation Approach:**
Currently meeting SNAP work requirement	Electronic demonstration of compliance required monthly.
Employed	Electronic demonstration of compliance required monthly.
Education (less than full time)	Electronic demonstration of compliance required monthly.
Job Training (less than full time)	Electronic demonstration of compliance required monthly.
Vocational training less than full time	Electronic demonstration of compliance required monthly.
Volunteer	Electronic demonstration of compliance required monthly including agency name, address, and phone number.
Independent Job Search/Job Search Training	Electronic demonstration of compliance required monthly. Must be less than 50% of the required 80 hours.
Health Education Class	Electronic demonstration of compliance required monthly. Cannot account for more than 20 hours per year.

Recipients who are required to report employment hours, exemptions, or work activity, must report no later than the 5th of each month for the previous month's work activities or

exemptions. If the recipient does not report by the deadline, a notice will be sent informing the recipient that a month of non-compliance has accrued. If the recipient accrues a second month of non-compliance, a notice will be sent informing the recipient of the second month of non-compliance and that their case will be closed at the end of the third month of non-compliance. This notice will serve as the notice of adverse action. If the recipient satisfactorily complies with reporting work activities by the 5th of the month following the third month of non-compliance, their case will be reinstated.

- Recipients cannot provide electronic demonstration of compliance retroactively after the 5th of the following month. For example, a recipient cannot provide electronic demonstration of compliance on April 7th for meeting the work requirement in March.
- Recipients cannot provide electronic demonstration of compliance proactively for future months. For example, a recipient cannot provide electronic demonstration of compliance on April 25 for meeting the work requirement in May.
- Demonstration of an exemption or work activity must be done electronically, except when information regarding a work activity or exemption is provided on an application.

PROPOSED

I-600 Changes

MS Manual 01/01/18

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

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

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

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

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

When a change is reported by the client, the caseworker will:

- Review the information.

PROPOSED

- 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 01/01/18

Loss of eligibility occurs when the eligible individual:

- Moves from Arkansas,
- Requests closure,
- Dies,
- Is found to be over the income limit,
- Is found to be over the resource limit if applicable,
- Reaches the age limit for the eligibility,
- Leaves the nursing facility, or
- Has three (3) months of non-compliance with the Adult Expansion Group work requirement within a calendar year.

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

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

PROPOSED

Monthly Levels (2017 through 2018)

01/01/2018

Families and Individuals Medicaid Categories

Family Size	Adult Expansion Group 95%	Adult Expansion Group 100%	ARKids A 142%	ARKids A with 5% Disregard 147%	ARKids B 211%	ARKids B with 5% Disregard 216%	Full Pregnant Women & Parents/ Caretaker Relatives	Transitional Medicaid 185%	Limited PW/Unborn Child 209%	Limited PW/Unborn Child with 5% Disregard 214%
1	954.75	1005.00	1427.10	1477.35	2120.55	2170.80	124.00	1859.25	2100.45	2150.70
2	1285.66	1353.33	1921.73	1989.40	2855.53	2923.19	220.00	2503.66	2828.46	2896.13
3	1616.59	1701.67	2416.37	2501.45	3590.52	3675.61	276.00	3148.09	3556.49	3641.57
4	1947.50	2050.00	2911.00	3013.50	4325.50	4428.00	334.00	3792.50	4284.50	4387.00
5	2278.41	2398.33	3405.63	3525.55	5060.48	5180.39	388.00	4436.91	5012.51	5132.43
6	2609.34	2746.67	3900.27	4037.60	5795.47	5932.81	448.00	5081.34	5740.54	5877.87
7	2940.25	3095.00	4394.90	4549.65	6530.45	6685.20	505.00	5725.75	6468.55	6623.30
8	3271.16	3443.33	4889.53	5061.70	7265.43	7437.59	561.00	6370.16	7196.56	7368.73
9	3602.09	3791.67	5384.17	5573.75	8000.42	8190.01	618.00	7014.59	7924.59	8114.17
10	3933.00	4140.00	5878.80	6085.80	8735.40	8942.40	618.00	7659.00	8652.60	8859.60
Each additional member add:	330.91	348.33	494.63	512.05	734.98	752.39	9 and greater 618.00	644.41	728.01	745.43

AABD Medicaid Categories

	ARSeniors Equal to or Below 80%	QMB Equal To or Below 100%	SMB Between 100% & 120%	QI-1 At least 120% but Less Than 135%	QDWI Equal To or Below 200%
Individual	804.00	1005.00	1206.00	1356.75	2010.00
Couple	1082.66	1353.33	1624.00	1827.00	2706.66

B-270 Adult Expansion Group (Arkansas Works Program)

MS Manual 01/01/17

The Health Care Independence Program ~~has been~~ amended to become the Arkansas Works Program starting January 1, 2017. Throughout this policy manual the Arkansas Works Program will be referred to as the Adult Expansion Group.

This group consists of adults who are 19 through 64 years of age with household income below ~~133% (138%~~ with 5% disregard applied) of the applicable federal poverty level (MS E-110) and are not eligible in either the Parents/Caretaker Relatives group (MS B-230) or Former Foster Care group (MS B-260). Adults who are blind or who have a disability may be covered in this group unless they are determined eligible for coverage in another group on the basis of the need for long term care services (facility or waiver) or other disability related services.

A woman who is pregnant at the time of application cannot be included in this group until after the postpartum period. She must be enrolled in one of the pregnant women groups or in the parents/caretaker relatives group if eligible. However, a woman who becomes pregnant after enrolling in this adult group may remain in the adult group throughout her pregnancy.

Individuals eligible in this group will participate in the Arkansas Works Program authorized by Arkansas Works Act of 2016. The Arkansas Works Program provides Medicaid funding in the form of premium assistance to enable individuals to enroll in either private health insurance plans ~~or employer sponsored insurance (ESI)~~.

EXCEPTION: Individuals eligible for the Adult Expansion Group, who have health care needs that make coverage through the Health Insurance Marketplace impractical, overly complex, or would undermine continuity or effectiveness of care, will not enroll in a private QHP but will remain in Medicaid (Re. MS A-100). ~~Those individuals eligible for ESI who meet this criteria will have a choice to select either traditional Medicaid or the Employer Sponsored Insurance benefit package.~~

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

B-200 Families and Individuals Group (MAGI)

B-270 Adult Expansion Group (Arkansas Works Program)

~~An individual who is twenty-one (21) years of age or older and working must enroll in employer health insurance coverage if the employer has elected to participate in the Arkansas Works Program. An individual determined eligible for ESI must enroll in ESI coverage within 30 days of receiving the enrollment notice.~~

All Arkansas Works Program recipients will be referred to the Arkansas Division of Workforce Services for free job assistance services.

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual 01/01/187

Below are the income and resource limits for all Medicaid groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

Category	Income Limit	Resource Limit
ARKids A	142% of FPL *	No Resource Test
ARKids B	211% of FPL *	No Resource Test
Newborns	No Income Test Eligibility is based on mother's Medicaid eligibility at child's birth	No Resource Test
Pregnant Women: Full Medicaid Pregnant Woman Limited Medicaid Pregnant Woman Unborn Child	 1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5. 209% of FPL * 209% of FPL *	 No Resource Test
Parents and Caretaker Relatives	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Adult Expansion Group	9510033% of FPL *	No Resource Test
Medically Needy: Exceptional (EC) Spend Down (SD)	 EC – may not exceed the monthly income limit SD – may exceed the quarterly income limit See MS O-710 for the monthly and	 1 person: $2,000 2 person: $3,000 3 person: $3,100

	quarterly income limit	
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ~~ElderChoices~~ARChoices, Assisted Living, AAPD and PACE	3 times the SSI Payment Standard Appendix S	Individual $2000 Couple $3000
Medicare Savings: ARSeniors QMB SMB QI-1 QDWI	 Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	 ARSeniors, QMB, SMB & QI-1: Individual $7,390 Couple $11,090 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	Unearned income may not exceed SSI individual benefit plus $20	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability (COBRA and OBRA '87)	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA '90)	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000
***May be eligible for an additional 5% disregard, MS E-268.**		

E-268 The 5% Gross Income Disregard

MS Manual 01/01/18~~7~~

Each individual will be allowed a general gross income disregard in the amount of 5% of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category that has the highest income level in which an individual could be eligible. For example, if an individual is not income eligible in the lowest income level group (e.g., Parent/Caretaker Relative), the five (5%) disregard will be applied to the higher income group (e.g., Adult Expansion Group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the 5% disregard effectively raises the income limits for the applicable eligibility group by five (5) percentage points. For example, the income limit for the Adult Expansion Group is ~~133~~95% (MS E-110). To apply the 5% disregard, add 5 to ~~133~~ 95 to raise the income limit to ~~138~~100% of FPL. The eligibility groups with dollar amounts for income limits are not the highest income limit groups for the individuals that fall into them. Therefore, the 5% disregard will never be applied to the dollar amount income limits.

Application of the 5% Disregard in the ARKids First groups

The 5% disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child and therefore, the 5% disregard can be allowed.

The 5% disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children and therefore, the 5% disregard is applied only if needed to achieve ARKids B eligibility.

Refer to MS F-180 for exceptions to health insurance coverage for ARKids B eligibles.

E-269 Who Is Eligible-Example Scenario

MS Manual 01/01/18~~4~~

Continuing the example of Bertha, Audrey and Chloe to show whose income will be counted and who is eligible for Medicaid.

Bertha and Audrey's household are the same which includes Bertha, Audrey & Chloe.

- Bertha earns $8,000.00 per month, which equals $96,000 annually.
- Audrey earns $314.22 per month, which equals $3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income does not count. Bertha's income is counted.
- Bertha's household size is 3.
- Compare the $8,000.00 monthly income to the ~~133~~95% + 5% = ~~138~~100% standard for a household size of 3, $1~~2~~,701.67. ~~616.59245.95~~.
- Bertha and Audrey are not eligible for Medicaid; therefore, the agency will electronically transfer their account to the FFM for possible eligibility for Advanced Premium Tax Credits and cost sharing reductions.

Chloe's household includes Chloe and her mother, Audrey.

- Audrey earns $314.22 per month, which equals $3,770.64 annually.
- Audrey's income will be counted because neither her mother, nor father is included in this household. Chloe's child support income is disregarded.
- Chloe's household size is 2.
- Compare the $314.22 monthly income to the ARKids A standard of 142% for 2, $1,835.35. **Note:** The 5% disregard was not needed for ARKids A eligibility and therefore was not applied.
- Chloe is eligible for ARKids A.

-I-600 Changes

MS Manual 03/04/15

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, ~~or~~
- By mail, or ~~.~~
- Through the citizen portal.

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

- A change in income that causes ineligibility or causes a change in vendor payment,
- Changes in household members,
- Death,
- End of pregnancy,
- Admission to or discharge from an institution, including a nursing facility,
- Approval or discontinued disability,
- Resource changes, including the receipt of a lump sum payment or settlement,
- Shelter and expense changes for Long Term Care Individuals who have a Community Spouse, ~~or~~
- Medical Cost for Long Term Care individuals, or
- Changes -in work requirement exemptions or activities.~~hours worked~~
- ~~Change in job training activities~~
- ~~.~~

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

When a change is reported by the client, the caseworker will:

- Review the information.
- Verify through electronic sources, if applicable. Request additional verification if required.
- Enter the changed information to the system so that eligibility can be redetermined.
- Ensure appropriate notice is sent to the individual if a change in eligibility results.

NOTE: A new application is not required to add a member, but the caseworker will need to obtain tax filing status of the added member.

I-610 Loss of Eligibility

MS Manual 01/01/17

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, ~~or~~
- Leaves the nursing facility, or
- Has three (3) months of work requirements non-compliance within a 12 calendar month period .

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

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

Monthly Levels (April 1, 2017 through March 31, 2018)

04/01/2017

Families and Individuals Medicaid Categories

Family Size	Adult Expansion Group 10033%	Adult Expansion Group with 5% Disregard 138%	ARKids A 142%	ARKids A with 5% Disregard 147%	ARKids B 211%	ARKids B with 5% Disregard 216%	Full Pregnant Women & Parents/ Caretaker Relatives	Transitional Medicaid 185%	Limited PW/Unborn Child 209%	Limited PW/Unborn Child with 5% Disregard 214%
1	1005336.65	1386.90	1427.10	1477.35	2120.55	2170.80	124.00	1859.25	2100.45	2150.70
2	1353.33799.93	1867.60	1921.73	1989.40	2855.53	2923.19	220.00	2503.66	2828.46	2896.13
3	1701.672263.22	2348.30	2416.37	2501.45	3590.52	3675.61	276.00	3148.09	3556.49	3641.57
4	2050.00726.50	2829.00	2911.00	3013.50	4325.50	4428.00	334.00	3792.50	4284.50	4387.00
5	2398.333189.78	3309.70	3405.63	34525.55	5060.48	5180.39	388.00	4436.91	5012.51	5132.43
6	2746.673653.07	3790.40	3900.27	4037.60	5795.47	5932.81	448.00	5081.34	5740.54	5877.87
7	3095.004116.35	4271.10	4394.90	4549.65	6530.45	6685.20	505.00	5725.75	6468.55	6623.30
8	3443.334579.63	4751.80	4889.53	5061.70	7265.43	7437.59	561.00	6370.16	7196.56	7368.73
9	3791.675042.92	5232.50	5384.17	5573.75	8000.42	8190.01	618.00	7014.59	7924.59	8114.17
10	4140.005506.20	5713.20	5878.80	6085.80	8735.40	8942.40	618.00	7659.00	8652.60	8859.60
Each addl member add:	348.33463.28	480.70	494.63	512.05	734.98	752.39	9 and greater 618.00	644.41	728.01	745.43

AABD Medicaid Categories

	ARSeniors Equal to or Below 80%	QMB Equal To or Below 100%	SMB Between 100% & 120%	QI-1 At least 120% but Less Than 135%	QDWI Equal To or Below 200%
Individual	804.00	1005.00	1206.00	1356.75	2010.00
Couple	1082.66	1353.33	1624.00	1827.00	2706.66