Summary of Changes
Sections A-180, C-120, C-130, C-150, E-265 and E-270

A-180, C-120, C-130 and C-150 – These sections of policy are being revised to change which entity will process applications received through the FFM. Applications received through the FFM will be processed by DHS.

E-265 – Removed the NOTE which referenced E-270.

E-270 – Removed this section of policy because projected income will no longer be used to determine Medicaid eligibility.

A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 02/01/18

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

The term "Insurance affordability program" includes the Medicaid program, premium tax credits including advance payment of the credit, and cost-sharing reductions. Only individuals who are determined ineligible for an appropriate Medicaid coverage group are potentially eligible for the premium tax credit and cost-sharing reductions. The upper income limit for any amount of premium assistance is 400% of the federal poverty level for the individual's household size.

When an individual applies for an insurance affordability program through the FFM and appears to be Medicaid eligible, the FFM will send a file to DHS and DHS will process it. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. DHS will notify the individual of the next steps to complete the enrollment process. See MS C-150.

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

Since Medicaid is one of the insurance affordability programs under the Affordable Care Act, an individual may apply directly to DHS for Medicaid eligibility. To coordinate and streamline the application process for the insurance affordability programs, DHS uses the same Single Streamlined Application used by the FFM. Although DHS will not make a determination of

eligibility for the premium tax credit or cost-sharing reductions for individuals determined Medicaid ineligible, DHS will send the individual's electronic account to the FFM which will include the needed application data for the FFM to make those determinations.

In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

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A-180 Medicaid/Health Insurance Marketplace Interactions

MS Manual 02~~1~~/01/18~~7~~

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) allow individuals under the age of 65 to obtain affordable health insurance coverage through a Health Insurance Marketplace established in each state. A Health Insurance Marketplace is an online marketplace where individuals can shop for a health insurance plan that is both affordable and meets the individual's specific health care needs. In addition, an individual can apply through the Health Insurance Marketplace for assistance in meeting the cost of health insurance through an insurance affordability program. In Arkansas, the Health Insurance Marketplace is a State Partnership with the Federal government and is referred to as the Federally Facilitated Health Insurance Marketplace (FFM).

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When an individual applies for an insurance affordability program through the FFM and appears to be Medicaid eligible, the FFM will send a file to DHS and DHS will process it. If found eligible, t~~T~~he applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. ~~Medicaid eligibility will first be determined for all household members applying for coverage. If eligible, the FFM will notify the individual of the Medicaid eligibility and send the individual's electronic account to the State Medicaid agency (DHS) for enrollment in the applicable Medicaid eligibility group. If all members of the individual's household are Medicaid eligible, no further action to select or enroll in a Qualified Health Plan (QHP) is required of the individual, with the exception of individuals eligible for the Adult Expansion Group. Upon receipt of the Adult Expansion Group individual's electronic account from the FFM,~~ DHS will notify the individual of the next steps to complete the enrollment process. See MS C-150.

For any individual determined ineligible for Medicaid, the FFM will then continue to determine eligibility for the premium tax credit and cost-sharing reductions. Once eligibility and the amount of the tax credit and cost-sharing reduction is determined, the individual will be given insurance plan options from which to select the plan that best suits the individual and family. Enrollment in the selected plan will then occur through the FFM.

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In addition to the interactions resulting from the application process, the Affordable Care Act mandates that the Medicaid agency and the FFM coordinate enrollment activities for the individual when changes occur that result in either Medicaid ineligibility or eligibility. For example, the parent in a family who was Medicaid eligible starts a new job which results in the loss of Medicaid eligibility. In this situation, DHS will send the electronic account to the FFM and notify the individual to go to the FFM to have eligibility for the premium tax credit and cost-sharing made and then select and enroll in a Qualified Health Plan (QHP). The loss of Medicaid eligibility triggers a 60 day Special Enrollment Period at the FFM.

C-120 Submitting an Application

MS Manual 02/01/18

An application may be completed and submitted electronically via Access Arkansas or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.

NOTE: See Appendix I for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to DHS and DHS will process it. If the applicant is found to be eligible for Medicaid, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to

the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

C-130 Tracking Applications Upon Receipt

MS Manual 02/01/18

PROPOSED

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM), that appear to be eligible for Medicaid, will be sent to DHS for processing. If found eligible, the applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS.

he denial.

C-150 Enrollment

MS Manual 02/01/18

Each individual approved for Medicaid by DHS will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Adult Expansion Group requires that once eligibility is determined, the applicant will receive a letter explaining which coverage is suitable for their need. The Division of Medical Services will

issue an eligibility approval notice for the Adult Expansion Group which will provide instructions regarding the next steps needed to complete the enrollment process.

C-120 Submitting an Application

MS Manual 021/01/184

An application may be completed and submitted electronically via Access Arkansas or through the Federally Facilitated Health Insurance Marketplace (FFM). An application may also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, email, telephone or in person to a designated DHS Agency.

NOTE: See Appendix I for a listing of which application forms are needed to apply for a specific coverage category.

An application may be submitted by the individual, the individual's spouse or Authorized Representative, emancipated minor or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor.

Although an application will be accepted and processed with only the minimal information listed below, the applicant should complete as much information as possible in order to avoid delays in determining eligibility and processing the application.

An application must include at a minimum the following information:

1. Applicant's name,
2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic or electronic).

When an individual applies for health insurance coverage through the FFM, the FFM will send a file to DHS and DHS will process it. If the applicant is found to be eligible for Medicaid, t~~T~~he applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. ~~a Medicaid eligibility determination will be made by the FFM. If the applicant is determined to be eligible for Medicaid, the FFM will notify DHS of eligibility. At that time, the system will automatically enroll the applicant in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS in this situation.~~

PROPOSED

C-125 Date of Application

MS Manual 01/01/14

The date of application is the date the application is received by DHS or, if submitted through the FFM, the date the application was received by the FFM. The date of application is critical to the eligibility determination process as it is used to determine the earliest date Medicaid coverage can begin if the applicant is determined eligible. The date of application is the date the application is electronically or telephonically signed by the applicant.

The date of application for non-online applications is the date the application is received and date stamped by the agency.

C-130 Tracking Applications Upon Receipt

MS Manual 02~~1~~/01/184

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. See MS C-135 for timeliness requirements. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application.

Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, email or in person must be entered into the system and registered by agency staff no later than the close of business of the first workday following receipt of the application.

Applications submitted through the Federally Facilitated Health Insurance Marketplace (FFM), that appear to be eligible for Medicaid, will be sent to DHS for processing. If found eligible, t~~T~~he applicant will be approved in the appropriate category based on the eligibility determination. The applicant will not be required to submit a separate Medicaid application to DHS. ~~tracked and monitored by the FFM. DHS will not receive these applications for processing. Therefore, applications submitted through the FFM will not be registered as an application in the DHS system. However, when an applicant is determined eligible for Medicaid benefits by the FFM, the applicant's electronic account with all appropriate data will be transmitted to the DHS system which will accept all data and enroll the individual in Medicaid.~~

PROPOSED

C-150 Enrollment

MS Manual 021/01/187

Each individual approved for Medicaid by DHS ~~or the FFM~~ will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card will be issued to each eligible individual if the person does not already have an existing card. The enrollment process for the Adult Expansion Group requires that once eligibility is determined, the applicant will receive a letter explaining which coverage is suitable for their need. The Division of Medical Services will issue an eligibility approval notice for the Adult Expansion Group which will provide instructions regarding the next steps needed to complete the enrollment process.

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

MS Manual 02/01/18

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.

NOTE: Income received in a month for which retroactive eligibility is being determined will be considered for the retroactive month even if it is not considered for current or future months.

Once the household members' current income has been established and verified using the 10% reasonable compatibility standard as appropriate (See MS G-151-152), the monthly amount used to determine eligibility will be calculated. Depending on how the current income was established (e.g., tax return income via the Federal Data Services Hub, State Quarterly Wage Data, checkstubs, SOLQ, etc.,), the "verified" income amount may have to be reduced or increased to reflect a monthly amount. For example, if the most recent tax return reflects the income still currently available to the individual, then the annual income from the tax return is divided by 12 to arrive at a monthly amount. If the current income was established through the most recent weekly check stubs, the average weekly amount is multiplied by 4.334 to arrive at a monthly amount. Unless the verified amount is already a monthly amount, for example Social Security benefits, then some conversion to a monthly amount is required. The calculation will be documented in the individual's case file.

The chart below shows how income amounts larger or smaller than monthly amounts can be converted to a monthly amount.

Income Amount is	Convert to Monthly
Annual	Divide by 12

Quarterly	Divide by 3
Weekly	Multiply by 4.334
Bi-weekly	Multiply by 2.167
Semi-Monthly	Multiply by 2
Monthly	No conversion needed
More Often than Weekly	Total all Income Paid/Received in the Month

There may be situations in which an alternative method must be used to arrive at current monthly income. For example, if annual income included a lump sum payment that will not be paid again, then the lump sum payment will be excluded from the rest of the annual income before the conversion to monthly income is made. Self-employment income may also require an alternative method. See MS E-266 for a more detailed discussion on self-employment income.

Example Scenario: Bertha's and Audrey's current monthly income is determined as follows. Since Chloe's income is not considered in any of the three households, there is no need to determine her current income.

Bertha

Bertha works full time as the vice president of The High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub ($96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income ($8000).

Audrey

Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns $7.25 per hour. Her current monthly income is determined as follows:
$7.25 x 10 = $72.50
$72.50 x 4.334 = $314.22 ($314.22 x 12 = $3,770.64 annual)

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

MS Manual 021/01/184

PROPOSED

Current gross monthly income will be used in determining financial eligibility for Medicaid. Current monthly income is the income the individual is expected to have in the month(s) for which eligibility is being determined.

~~**NOTE:** There is an exception to using current monthly income in which projected annual income will be used. This is discussed further in MS E-270.~~

Gross income is the amount paid to the individual before any withholding taxes or other deductions are taken from the income. Income that may have been received in the prior tax year or even the prior month but that is not currently being received or expected to be received in the current or future months will not be counted. If a continuing source of income has increased or decreased since the last tax return or from other information available to the agency, then the current income will be determined and used for eligibility purposes.

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~~**E-270 When Projected Annual Income is Used for Medicaid Eligibility**~~
~~MS Manual 01/01/14~~

E-270 When Projected Annual Income is Used for Medicaid Eligibility

~~When the agency determines an individual is Medicaid ineligible based on current monthly income, the individual's information is electronically sent to the FFM. If the FFM determines the individual is Medicaid eligible because his or her projected annual income is less than 100% of the FPL, the FFM will transfer the individual's account information back to DHS. The agency will then enroll the individual in Medicaid for the remainder of the current calendar year based on the projected annual income.~~

~~**Example:** Jane Doe has recently obtained a higher paying job. Her household size is 2 and her new monthly income is $1,939.00. She submits a DCO-152 Application for healthcare coverage through DHS who determines she is ineligible for Medicaid based on her current monthly income. Her information is sent to the FFM where her eligibility for the ATPC is determined. ATPC eligibility is based on the individual's projected annual income. The FFM determines her projected annual income for the current calendar year to be $14,400. The FFM determines she is ineligible for the ATPC because her annual income for the current year is below the 100% FPL. Therefore, the FFM sends the information back to DHS as Medicaid eligible. The agency will enroll her in Medicaid for the remainder of the current calendar year based on her projected annual income as determined by the FFM.~~