Summary of Changes

Arkansas Works Program

Medical Services Policy Manual

Sections A-100, A-110, A-330, A-340, B-270, D-500, E-110, E-268, E-269, F-200, F-201, G-190, Appendix X, Appendix Y

This proposed rule change revises Medical Services policy to comply with the Arkansas Works Waiver by increasing the eligibility income limit for the program to 138% of the Federal Poverty Level, to remove references to Employer Sponsored Insurance, and to add extenuating circumstances as good cause exemptions for the work requirement.

Section A-100, A-330, A-340, D-500, and Appendix X have been revised to remove references to Employer Sponsored Insurance.

Section A-110 has been revised to clarify the income limit is up to and including 100% of the FPL for cost sharing.

Section B-270 has been revised to reflect the 133% income limit for the Arkansas Works Program.

Sections E-110, E-268 and E-269 have been revised to reflect the 133% income limit for the Arkansas Works Program.

Section F-200 has been updated to add language expanding what qualifies as a short-term incapacitation. Examples were added to clarify how work activity hours can be calculated manually. Also, language was added to direct questions on how to compute work activity hours to the newly created Appendix Y.

Section F-201 has been revised to identify good cause exemptions for months of non-compliance with the work requirement for the Arkansas Works Program.

Section G-190 has been revised to remove the requirement that SNAP recipients electronically report their compliance with the SNAP requirement to work. That information will now be validated against state data daily through an electronic match.

Appendix X has been updated to remove language referencing Employer Sponsored Insurance (ESI).

Appendix Y has been created to provide a chart to display how to manually compute work activity hours due to system malfunction.

A-100 General Program Information

MS Manual 05/01/18

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

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

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

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

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

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

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

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

A-105 Nondiscrimination

MS Manual 08/15/14

No person will be prevented from participating, denied benefits, or subjected to discrimination on the basis of race, color, national origin, age, religion, disability, sex, veteran status, or political affiliation. The Agency will be in compliance with the provisions of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations issued by the Department of Health and Human Services.

The Agency has the responsibility for informing applicants and recipients that assistance is provided on a nondiscriminatory basis and that they may file a complaint with the Agency or federal government if it is thought that discrimination has occurred on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual 05/01/18

The types of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Medicaid recipients are responsible for paying a coinsurance amount equal to 10% of the per diem charge for the first Medicaid covered day per inpatient hospital admission. Medicaid recipients are also responsible for paying a copayment amount per prescription based on a graduated payment scale, not to exceed $3.00 per prescription.

The coinsurance and copayment policy does not apply to the following recipients and/or services:

1. Individuals under the age of 18 receiving coverage through ARKids A or Newborn
2. Pregnant women
3. Individuals residing in a nursing or ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities) facility who are approved for vendor payment
4. Emergency services
5. Health Maintenance Organization (HMO) enrollees
6. Services provided to individuals receiving hospice care
7. Adult Expansion Group enrollees with household income up to and including 100% of the FPL for their household size are not required to pay co-pays or other cost-sharing.

A-115 Cost Sharing for Workers with Disabilities

MS Manual 08/15/14

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

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

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

A-330 Adult Expansion Group Identification Cards

MS Manual 05/01/18

For those individuals who are enrolled in a Qualified Health Plan through auto assignment or by their own selection, an identification card will be mailed directly to the individual by the insurance carrier. For those individuals who are enrolled in Medicaid through the Adult Expansion Group (MS-C-150), a Medicaid card will be mailed within 5 business days of the individual being found eligible for traditional Medicaid.

A-340 Reissuance of Identification Cards

MS Manual 05/01/18

Replacement cards will be authorized through the system. The procedures are the same for SSI and non-SSI recipients.

1. Review recipient's case information in the system to verify that correct information (e.g., name, date of birth, mailing address, etc.) has been updated.

2. Select the ID button on the Budget Summary and then check the "Replace" box by the member(s) who needs the replacement card and then click the Save button.

   If the recipient is SSI eligible, locate the SSI case number in the system. If there is no record of the case, or the SSI recipient is not receiving a check, refer him or her directly to the local SSA Office. If the SSI recipient has been approved for 30 days or less, inform him or her that it is too early to have received a Medicaid card. It takes Social Security 30 days or more from the date of approval to forward the eligibility date through SDX.

   If the SSI case record is located on WASM, but information on the record is incorrect (e.g., wrong address), the caseworker should contact System Support or Client Assistance for correction(s) to the case.

   NOTE: Adult Expansion Group recipients enrolled in a Qualified Health Plan will contact their insurance provider for answers to plan questions. Contact information will be printed on the insurance card and on the carrier information included with the card.

The purpose of this group is to provide pre-natal care to the unborn child who is expected to be born in the United States. As this coverage is intended to benefit unborn children who will be U.S. citizens at birth, the pregnant woman will not qualify for this coverage if she intends to leave the U.S. before the baby is born.

This group is also different from the other Pregnant Women groups in that it receives an enhanced federal match rate under the Children's Health Insurance Program (CHIP). The CHIP enhanced funding coverage is available only to pregnant women who have no other insurance that covers pregnancy related services.

The non-citizen pregnant woman will receive postpartum coverage. Postpartum coverage is through the end of the month in which the 60th day from the date of delivery falls.

B-260 Former Foster Care Adults

MS Manual 06/08/16

This group consists of adults up to age 26 who aged out of foster care in Arkansas. There is no income or resource test. Other than the general Medicaid eligibility requirements that all Medicaid eligibles must meet (MS D-100), the requirements for eligibility in this group are that the adult was in foster care in Arkansas, was enrolled in Medicaid when aging out of foster care at age 18-21 depending on the individual circumstances and is currently under age 26.

Individuals in this group receive the full range of Medicaid benefits.

B-270 Adult Expansion Group (Arkansas Works Program)

MS Manual 05/01/18

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 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 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.

Unless exempt, all Arkansas Works enrollees between the ages of 19 through 49 will be required to comply with the work and community engagement 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 and community engagement requirement.

NOTE: Individuals enrolled in the Arkansas Works Program are required to have a valid email address.

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

MS Manual 05/01/18

As a condition of eligibility for Medicaid, recipients are required to assign their rights to Medical Support/Third Party Liability payments to the Department of Human Services. This means that any funds settlements or other payments made by or on behalf of third parties should be paid directly to the Arkansas Medicaid Program. In Arkansas, Third Party Liability payments are automatically assigned by state law.

The Medical Assistance Program is required by Federal and State Regulations to utilize all Third Party sources and to seek reimbursement for services which have been paid by both a Third Party and Medicaid.

Private insurance and Medicaid are complementary. A recipient's Medicaid eligibility, except for an ARKids B recipient, is not affected by having Third Party coverage (Re. MS F-180).

When a recipient has Third Party coverage in addition to Medicaid, which can be used for medical expenses, Third Party coverage must be utilized first. Medicaid will pay up to the Medicaid allowable charge. For example: A Medicaid recipient has insurance which paid 80%, or $80 of a $100 medical bill. The Medicaid allowable charge for the bill was only $60.00. A Medicaid payment was not due since the Medicaid allowable charge was less than the insurance payment. Third Party sources whose payments Medicaid will retrieve include private health insurance, automobile liability insurance where applicable, workmen's compensation, settlements for injuries, etc.

Tri-Care is considered to be a Third Party source. Whenever a Tri-Care beneficiary is also eligible for Medicaid, Tri-Care is in every instance the primary payer. This applies to all classes of Tri-Care beneficiaries, i.e., dependents of active duty members, retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

NOTE: The Third Party Liability policy does not apply to individuals enrolled in a private Qualified Health Plan through the Adult Expansion Group, however Assignment of Rights to Medical Support does apply.

E-100 Financial Eligibility

MS Manual 10/26/15

Each individual applying for or receiving Medicaid benefits must have a financial eligibility determination made at application and, if eligible, on an on-going annual basis or when a change affecting eligibility occurs. Financial eligibility consists of an income test and if the category requires, a resource or asset test.

Most Medicaid eligibility groups have an income limit which an individual's countable income must fall under in order to be eligible for coverage in that group. Income limits and the manner in which countable income is determined vary by eligibility groups. The groups to which an income limit does not apply, and therefore no income determination is made, are the following:

- Newborns (MS B-220);
- Former Foster Care Adults (MS B-280);
- Workers with Disabilities (MS B-330).

NOTE: For the Workers with Disabilities category, before determining eligibility, the applicant must pass a pre-test screening to ensure his/her unearned income does not exceed the SSI individual benefit plus $20. If the applicant meets this criteria, all income is disregarded in the financial eligibility determination. However, both unearned and earned income will be used to determine cost sharing. See MS A-115.

A resource limit applies to most of the eligibility groups that do not use MAGI methodologies for financial eligibility. For these groups, the value of an individual's countable resources must be determined. There is no resource limit, and therefore no resource determination is made, for the following groups:

- Those using MAGI methodologies (MS E-110);
- Newborns (MS B-220);
- Former Foster Care Adults (MS B-260);
- Workers with Disabilities (MS B-330).

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

MS Manual 05/01/18

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	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
Limited Medicaid Pregnant Woman	209% of FPL *	
Unborn Child	209% of FPL *	
Parent and Caretaker Relative	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	133% 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 quarterly income limit	1 person: $2,000 2 person: $3,000 3 person: $3,100
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports:	3 times the SSI Payment Standard	Individual $2000

E-100 Financial Eligibility

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

Nursing Facility, DDS, ARChoices, Assisted Living and PACE	Appendix S	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 $7,560 Couple $11,340 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.**		

used to determine the monthly income. If the most recent tax data is not available or does not reflect current income, the individual's income will be determined by other means as determined appropriate by the caseworker, such as sales receipts, business records, etc.

Costs directly related to producing the income are subtracted from the self-employment annual gross before the monthly earnings are included in the budget. See Schedule C in Appendix Q for all allowable costs associated with self-employment income.

After allowable deductions from annual income, the remainder is then divided by 12 to determine the monthly income.

E-267 Comparing Income to Income Standard for Appropriate Household Size

MS Manual 01/01/14

After the Medicaid household composition, size and countable current income have been established, the Medicaid household's countable income will be compared to the household size income standard for the appropriate eligibility group to determine whether an individual is income eligible. Income eligibility will first be determined in the eligibility group the individual falls into with the lowest income standard, e.g., eligibility for a parent would first be determined in the Parent/Caretaker Relative group before a group with a higher income standard.

E-268 The 5% Gross Income Disregard

MS Manual 05/01/18

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 133% (MS E-110). To apply the 5% disregard, add 5% to 133% to raise the income limit to 138% 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 05/01/18

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% + 5% = 138% standard for a household size of 3, $1,345.96.
- 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, $1,948.24. **Note:** The 5% disregard was not needed for ARKids A eligibility and therefore was not applied.
- Chloe is eligible for ARKids A.

F-200 Work and Community Engagement Requirement for the Adult Expansion Group

MS Manual 05/01/18

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 and community engagement requirement. Adult Expansion Group recipients will fall in one of five categories for the work and community engagement requirement:

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

2. Enrollees age 19-49 that are employed or self-employed at least 80 hours per month on an ongoing basis – Exempt from the work and community engagement requirement;

3. Enrollees age 19-49 that are employed or self-employed on a one-time, not ongoing monthly basis - Complying with the work and community engagement requirement;

4. Enrollees age 19-49 that are not employed or self-employed at least 80 hours per month but meet an exemption to the work and community engagement 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; is medically certified as physically or mentally unfit for employment; or has an acute medical condition validated by a medical professional that would prevent complying with the requirements.
    i. Participating in an alcohol or drug treatment program; or
    j. Enrolled in full-time education, job training or vocational training;

5. Enrollees age 19-49 that are not employed or self-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 and community engagement 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.

Example 1: Mary is currently attending UALR. She is currently enrolled in 9 credit hours this semester, which means she attends school 9 hours each week. Since Mary is taking 9 credit hours, these hours can be applied towards her weekly work activity hours. For 1 credit hour of school, Mary will be able to claim 2.5 work activity hours. In Mary's case, she would accrue a total 90 hours because 9 credit hours X 4 weeks = 36 x 2.5 work activity hours = 90 monthly work activity hours. Since Mary has accrued more than 80 hours, she would be exempt.

Example 2: Abbie is currently attending Pulaski Tech part-time and is enrolled in 4 hours this semester, which means she attends class 4 hours each week. Since Abbie is taking 4 credit hours, these hours can be applied towards her work activity. For 1 credit hour of school, Abbie will be able to claim 2.5 work activity hours. In Abbie's case, she would accrue a total of 40 work activity hours because 4 credit hours x 4 weeks = 16 hours x 2.5 work activity hours = 40 monthly work activity hours. Since Abbie has accrued less than 80 hours of work activity hours, she would not be exempt.

Example 3: James is currently conducting an independent job search and has completed 4 interviews this month. For each interview (job contact) James makes, he will be able to claim 3 work activity hours. In James' case, he would accrue 12 work activity hours because 4 interviews (job contacts) X 3 hours per contact = 12 work activity hours.

Example 4: Robert is currently volunteering for 40 hours monthly at his hometown Goodwill location. For each hour Robert volunteers, he will be able to claim 1 work activity hour. In Robert's case, he would accrue 40 work activity hours because 40 reported hours x 1 hour = 40 work activity hours.

F-200 Work and Community Engagement Requirement for the Adult Expansion Group

NOTE: A combination of employment hours and work activities may be used to meet the work and community engagement requirement. See Appendix Y for a detailed chart on how to manually figure work activity hours.

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 and community engagement requirement within the calendar year. Those Adult Expansion Group recipients who lose coverage for non-compliance with the work and community engagement 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 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 and community engagement requirement will not carry over into the next calendar year.

When the Adult Expansion Group work requirement starts on June 1, 2018, the requirement will apply to all new Adult Expansion Group recipients who are age 30-49. Those Adult Expansion Group recipients age 30-49 who were enrolled in the Adult Expansion Group prior to June 1, 2018 will be phased in from June to September 2018. All other Adult Expansion Group recipients who are subject to work and community engagement requirements will be phased in at later dates after proper advance notice is provided.

Enrollees who reach the age subject to the work and community engagement requirement during a calendar year will become subject to the requirement the month after their birthday.

F-201 Good Cause Exemptions

MS Manual 05/01/18

Good cause is defined as an adequate reason for failing to take a certain action prescribed by law. Good cause will be determined if a recipient's circumstances hindered them from being able to achieve the following:

- Completing their work activities;
- Reporting their work activities; or
- Reporting their exemptions.

Recipients who demonstrate good cause for failing to meet the work and community engagement requirement or failing to report work activities will not have a month of non-compliance accrued. The circumstances constituting good cause must have occurred during the month for which the recipient is seeking a good cause exemption. The recognized good cause exemptions include, but are not limited to, the following verified circumstances:

- The recipient has a disability and was unable to meet the work and community engagement requirement for reasons related to that disability; or has an immediate family member in the home with a disability and was unable to meet the requirement for reasons related to the disability of that family member; or the recipient or an immediate family member who was living in the home with the recipient experiences hospitalization or serious illness;
- The recipient experiences the birth, or death, of a family member living in the home with the recipient;
- The recipient experiences severe inclement weather (including a natural disaster); or
- The recipient has a family emergency or other life-changing event such as divorce or domestic violence.

If a good cause exemption is granted for reporting but not for compliance with the work and community engagement requirement, the beneficiary will remain responsible for completing the required number of work activities in that month to avoid having it count as a month of noncompliance.

G-190 Verification of the Adult Expansion Group Work and Community Engagement Requirement

MS Manual 05/01 /18

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

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

Employment: Individuals who earn the equivalent of Arkansas minimum wage for at least 80 hours per month through **ongoing** employment or self-employment will be considered exempt from reporting work activities on a monthly basis. The 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 80 hours monthly times the current minimum wage.

Individuals who earn the equivalent of Arkansas minimum wage for at least 80 hours monthly, on a one-time **not ongoing** basis will be considered compliant with the work and community engagement requirement and must report their work activities on a monthly basis.

Individuals who are employed less than the equivalent of Arkansas minimum wage for at least 80 hours monthly must combine their employment or self-employment with other allowed work activities for a combined total of 80 hours monthly to be considered compliant with the work and community engagement requirement and must report their work activities on a monthly basis.

Example 1: Joe is employed by a local grocery store and earns $800 monthly on an ongoing basis. $800 monthly wages divided by $8.50 (current Arkansas minimum wage) = 94 monthly hours. Joe is exempt from reporting monthly work activities until he has a change in circumstance reducing his employment below 80 hours monthly.

Example 2: Amy was paid $680 in June by a family friend to paint their home. Amy did this as a one-time job and is not employed or self-employed on an ongoing basis. $680 one-time wages divided by $8.50 (current Arkansas minimum wage) = 80 hours. Amy is compliant with the work and community engagement requirement for the month of June and must report again in July which work activities she completes to be compliant.

Example 3: Sue works at a local restaurant as a cook and earns $400 monthly on an ongoing basis. $400 monthly wages divided by $8.50 (current Arkansas minimum wage) = 47 hours. Sue must complete 33 additional hours in an allowed work activity to be considered compliant each month.

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 need to 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 and community engagement 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 daily.
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.
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.
Employed or self-employed on an **ongoing** basis and earning the equivalent of Arkansas minimum wage for at least 80 hours per month.	Electronic demonstration of compliance valid until change of circumstance.
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.

Work Activities: Work activities can be performed alone or in combination to comply with the work and community engagement 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 and community engagement 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 Requirement to Work	Validated against state data daily.
Employed or self-employed and earning less than 80 hours monthly times the current Arkansas minimum wage on an **ongoing** basis	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.

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G-190 Verification of the Adult Expansion Group Work and Community Engagement Requirement

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 and community engagement 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 and community engagement 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.
- If the recipient provides false or incomplete information or fails to report a change, the individual will be subject to possible consequences such as repayment, disqualification, and/prosecution for fraud (MS M-210).
- Quality Assurance reviews will be conducted on a periodic basis. When a case is selected for a Quality Assurance review, additional verification may be required to be provided by the recipient.

MEDICAL SERVICES – APPENDIX X, REFERRALS FOR INDEPENDENTCHOICES

05/01/18

IndependentChoices is for individuals who:

1. Are 18 years of age or older and currently receive Medicaid in a category that covers personal care, or
2. Are in the ARChoices in Homecare waiver program; and
    a. have an assessed need for personal assistance services; and
    b. are willing to accept the responsibilities of directing their in-home services or
    c. have a representative who can direct their care for them.

IndependentChoices allows a Medicaid recipient in need of personal care or ARChoices attendant care to hire his or her own caregiver. The participant is given an allowance based on medical need to pay the caregiver. Caregivers are often friends or family members. A spouse or anyone legally responsible for the participant (e.g., a guardian) cannot be the paid caregiver.

Medicaid categories that **do not** cover personal care are:

- Medicare Savings categories (QMB, SMB, and QI-1) – **NOTE**: Individuals enrolled in ARSeniors are eligible for IndependentChoices.
- Medically Needy categories (both Exceptional and Spend Down)
- ARKids B
- Limited Pregnant Woman (A pregnant woman whose income is at or below 209% of the federal poverty level)
- Adult Expansion Group with a Qualified Health Plan (QHP).

Individuals enrolled in all other Medicaid categories including Medically Frail individuals in the Adult Expansion Group may be eligible for IndependentChoices if the other criteria are met. Individuals who are not currently on Medicaid or are in one of the above categories should not be referred to IndependentChoices. County offices should continue to refer interested individuals who are Medicaid recipients in appropriate categories to the IndependentChoices toll-free number at **1-866-710-0456**. If the individual receives ARChoices in Homecare, direct them to their DAAS RN.

County office staff who have further questions regarding eligibility for IndependentChoices may also call the above number.

Medical Services – Appendix Y, Work Activity Hours Chart

05/01/2018

Use the following chart to manually determine work activity hours:

Work Activity	Work Activity Hours
Working at a job that earns you money. Report your income each month. DHS will decide your work hours based on the Arkansas minimum wage. If you do not earn enough each month before taxes are taken out of your check, you must combine this activity with others to make the 80 hours.	• Your reported income divided by Arkansas minimum wage = work activity hours
Going to school, job training, vocational, or other educational program.	• English As a Second Language (ESL): 1 hour of instruction = 2.5 work activity hours • GED/Basic Skills/Literacy: 1 reported hour = 2 work activity hours • College/University: 1 credit hour = 2.5 work activity hours • High School: 1 hour of instruction = 2.5 work activity hours • Occupational Training: 1 hour of instruction = 2 work activity hours • Unpaid Job Training: 1 reported hour = 1 work activity hour • Vocational Training: 1 credit hour = 2.5 work activity hours
Volunteering in your community. You can find ways to volunteer at www.volunteerar.org.	• 1 reported hour = 1 work activity hour
Looking for a job on your own or going to free job search training at an Arkansas Workforce Center. You may count up to 39 total hours from these activities each month.	• Job Search: 1 reported job contact = 3 work activity hours • Job Search Training: 1 reported hour = 1 work activity hour
Going to a health education class. You may count up to 20 hours each year from this activity. Learn more about these classes at www.access.arkansas.gov. Click on the Arkansas Works button.	• 1 reported hour = 1 work activity hour