A-210 Retroactive Eligibility

MS Manual ~~05/01/18~~01/01/22

Refer to Health Care Procedures Manual for more information.

The State is required to provide retroactive eligibility for up to three (3) full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period; and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during the retroactive period. Retroactive eligibility is separate and apart from current eligibility, ~~i.e.~~that is, applicants not eligible for the current period may be eligible for the retroactive period. Retroactive eligibility determinations are required for all categories, except ALF, ARChoices, Autism, DDS Waiver, QMB, and PACE.

NOTE: Retroactive coverage for Newborns will not be given prior to the date of birth.

NOTE: Beginning May 1, 2018, Adult Expansion Group recipients may be eligible for retroactive coverage thirty (30) days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

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

EXAMPLE: James is approved for coverage in the Adult Expansion Group with an application date of December 31. He asks for retroactive coverage for a doctor bill with a service date of December 1. His regular coverage will begin December 1. As the thirtieth~~30th~~ day is included in his regular coverage period, no coverage will be given for the previous month.

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

For cases in which an applicant has not resided in Arkansas for three (3) full months prior to the date of application, the retroactive period begins with the date the individual established residency in Arkansas. The "previous state" is responsible for the retroactive period prior to the time the applicant established residency in Arkansas. The ~~caseworker~~eligibility worker is

~~A-300 Identification Cards~~

~~A-330 Adult Expansion Group Identification Card~~A-300

responsible for providing the "previous state" with information necessary to determine eligibility for its portion of the retroactive period.

Services for the retroactive period are subject to the same restrictions as services for the current period (~~i.e.~~that includes, without limitation: utilization review, benefit limitations, medical necessity~~, etc.~~). Prior authorization cannot be a condition of payment for services received during the retroactive period. However, such services are subject to the same Utilization Review standards as all other services financed under the State's ~~Medicaid~~ Health Care (Medicaid) program. The State is not required nor obligated to pay for services which have been retroactively determined by Utilization Review to be unnecessary.

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

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

B-100 Eligibility Groups

MS Manual ~~01/01/14~~ 01/01/2022

A ~~Medicaid~~ Health Care eligibility group defines the eligibility requirements an individual must meet to be eligible for ~~Medicaid~~ Arkansas Health Care coverage. The eligibility group also defines the benefit package or array of services the individuals in that group will receive.

Effective January 1, 2014, each of Arkansas' ~~Medicaid~~ Health Care groups fall under one (1) of the following general groupings:

- Families and Individuals;
- Aid to the Aged, Blind, and Disabled;
- Foster Care & Adoption Assistance; or
- Emergency Services for Aliens.

Within these general groupings are more specific groups defined by specific individual characteristics, such as age~~, and/or~~ or services needed~~,~~ (for example,~~such as~~ Long Term Services and Supports). In addition, some groups are assigned two (2) or more categories of coverage due to differing benefit packages or federal funding match rates. These are described in more detail in the following sections.

B-200 Families and Individuals Group (MAGI)

MS Manual ~~01/01/17~~ 01/01/2022

Most individuals under ~~age~~ sixty-five (65) years of age will fall into the Families and Individuals general eligibility grouping. Most of the specific groups under this general grouping use the Modified Adjusted Gross Income ~~or~~ (MAGI) methodologies to determine financial eligibility for individuals. (See MS E-200 for specific policy regarding the MAGI methodology.) Therefore, this group is commonly called the "MAGI" group. Generally speaking, the MAGI groups cover children and non-SSI adults under ~~age~~ sixty-five (65) years of age who are not in need of specialized services or benefits related to a disability or blindness or who are not in need of ~~l~~Long ~~t~~Term ~~c~~Care S~~s~~upport or ~~s~~Services (See MS E-220). A non-SSI individual with a disability or blindness who is not eligible for or covered by Medicare may be covered in the Adult Expansion Group if otherwise eligible.

NOTE: Two groups (Newborns and Former Foster Care Adults) ~~which~~ that are described below do not have a financial test and therefore, the MAGI methodology is not used. However, since these two (2) groups cover non-aged, blind, or disabled adults or children, they are included in the general grouping of Families and Individuals.

Individuals in all groups must meet the General Eligibility Requirements as outlined in MS D-100-540.

The sections that follow describe each of the specific Families and Individuals (MAGI) eligibility groups.

B-210 ARKids First

MS Manual ~~07/08/16~~ 01/01/2022

The ARKids First group provides health insurance coverage for Arkansas children from birth to ~~age~~ nineteen (19) years of age. There are two (2) categories of coverage in the ARKids First group – ARKids A and ARKids B. Along with the age requirement of being under the ~~age of~~ nineteen (19) years of age, relationship or ~~and/or~~ living with a specified relative must be established for eligibility in these categories. (See MS F-110).

ARKids A provides coverage to children under ~~age~~ nineteen (19) years of age with family income under one hundred and forty two percent (142%) of the Federal Poverty Level for the applicable household size (See MS E-110). ARKids A provides the full range of ~~Medicaid~~ Health Care services. This is a mandatory eligibility group authorized and funded by Title XIX of the Social Security Act (~~Medicaid~~ Health Care).

~~B-200 Families and Individuals Group (MAGI)~~

B-2~~7~~00 ~~Adult Expansion Group (Arkansas Works Program)~~Families

ARKids B provides coverage to otherwise uninsured children under ~~age~~ nineteen (19) years of age with family income equal to or over one hundred and forty two percent (142%) but under two hundred and eleven percent (211%) of the FPL for the household size (See MS E-110). ARKids B provides a more limited range of services with limited co-pays for some services. (See Appendix G) ARKids B was authorized by Arkansas Act 407 of 1997 (the ARKids First Program Act) and was implemented as a Section 1115 ~~Medicaid~~ Health Care expansion program effective September 1, 1997. The program is currently funded by the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

Because ARKids A and ARKids B have different benefit packages and have different federal funding match rates, it is necessary to designate separate categories of coverage for them.

Please see PUB-040, Arkansas ~~Medicaid~~ Health Care, ARKids First & You for a summary of the benefit packages which highlights the differences in the two (2) packages.

B-220 Newborns

MS Manual ~~08/15/14~~01/01/2022

This group consists of newborns up to ~~age~~ one (1) year of age whose mothers were ~~Medicaid~~Health Care eligible at the time of their births. Newborns in this group are guaranteed ~~Medicaid~~ Health Care coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of ~~Medicaid~~ Health Care services.

Although this group is considered part of the ARKids First group, Newborns also have a separate category of coverage to ensure no change in household circumstances affects their one-year of guaranteed coverage. At ~~age~~ one (1) year of age, eligibility for ARKids First (A or B) is determined as for any other child (See MS I-230).

Newborns born to pregnant women approved under the Unborn child category (See MS B-250) are also eligible for the Newborn category.

B-230 Parent~~s~~/Caretaker Relatives

MS Manual ~~08/15/14~~01/01/2022

This group consists of adults who have related minor children living in the home for whom the adult exercises care and responsibility (MS F-110) and whose household income is below the income limit for this group (See MS E-110).

Both natural or adoptive parents may be living in the home with the child. There is no "deprivation of parental care or support" requirement for the parents to be included in this group.

~~B-200 Families and Individuals Group (MAGI)~~

B-2~~7~~00 ~~Adult Expansion Group (Arkansas Works Program)~~Families

If an adult meets the criteria for this group, ~~he or she~~ they must be assigned to this group even if eligibility exists in another MAGI eligibility group. Therefore, eligibility for this group is determined first before moving to other categories that may have higher income limits.

NOTE: Only adults are included in this group. Children will not be placed in this group. Their coverage will be in the appropriate ARKids program or some other type of ~~Medicaid~~ Health Care such as TEFRA, or a private insurance plan.

Adults covered in the group receive the full range of ~~Medicaid~~ Health Care benefits.

B-240 Pregnant Women

MS Manual ~~08/15/14~~01/01/2022

This group consists of women ~~age~~ nineteen (19) years of age and above who are pregnant at the time of application and are not eligible in either the Parent/Caretaker Relative (MS B-230) or Former Foster Care (MS B-260) group. A pregnant woman can apply for retroactive Pregnant Women ~~Medicaid~~ Health Care up to three (3) months after birth of the baby.

There are two (2) categories of coverage within the Pregnant Woman group.

- Those with household income at or below the income limit for Low-Income Pregnant Woman Coverage (MS E-110) receive the full range of ~~Medicaid~~ Health Care services; and~~.~~
- Those with income above that limit but under the limit for High-Income Pregnant Woman Coverage (MS E-110) are provided services related to prenatal, delivery and postpartum care, and to other conditions that may complicate pregnancy.

Both levels provide postpartum coverage through the end of the month in which the ~~60th~~ sixtieth day from the date of delivery falls.

B-250 Unborn Child (Pregnant Woman)

MS Manual ~~01/01/18~~01/01/2022

This group consists of non-citizen pregnant women who do not meet the alienage requirements for ~~Medicaid~~ Health Care and whose household income is at or below two hundred and nine percent (209%) of the federal poverty level for the appropriate household size. This includes pregnant women who are either of the following:

- Lawfully admitted aliens who do not yet meet the ~~5 year~~five-year residency requirements or one (1) of the conditions listed in MS D-224~~.~~; or~~.~~
- Undocumented aliens.

~~B-200 Families and Individuals Group (MAGI)~~

B-2~~7~~00 ~~Adult Expansion Group (Arkansas Works Program)~~Families

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~~ sixtieth day from the date of delivery falls.

B-260 Former Foster Care Adults

MS Manual ~~06/08/16~~ 01/01/2022

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

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

B-270 Adult Expansion Group (~~Arkansas Works Program~~ARHOME)

MS Manual ~~05/01/18~~01/01/2022

~~The Health Care Independence Program was amended to become t~~The Arkansas Works Program was amended to become ARHOME starting January 1, 20~~17~~22. Throughout this policy manual the ~~Arkansas Works Program~~ARHOME Program will be referred to as the Adult Expansion Group.

This group consists of adults who are nineteen (19) through sixty-four (64) years of age with household income equal to or below one hundred and thirty three percent (133%) (one hundred and thirty-eight percent (138%) with five percent (5%) disregard applied) of the applicable federal poverty level (MS E-110) and are not eligible in either the Parent~~s~~/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 T~~t~~erm C~~c~~are S~~s~~ervices (facility or waiver) or other disability related services.

~~B-200 Families and Individuals Group (MAGI)~~

B-2~~7~~00 ~~Adult Expansion Group (Arkansas Works Program)~~Families

A woman who is pregnant at the time of application cannot be included in this group until after the postpartum period. She must be enrolled in one (1) of the pregnant women groups or in the

~~p~~Parent~~s~~/Caretaker R~~r~~elatives 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~~ARHOME Program provides ~~Medicaid~~ Health Care funding in the form of premium assistance to enable individuals to enroll in private health insurance plans.

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

NOTE: If an individual in this group has a child(ren) under ~~age~~ eighteen (18) years of age living in the home, the child(ren) must be covered in~~Medicaid~~ Health Care 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-200-201). 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.~~

Individuals eligible in the Adult Expansion Group will be enrolled in a Qualified Health Plan (QHP); unless they fall under one (1) of the coverages types listed below:

~~**NOTE:** Individuals that are moving to a QHP will be enrolled in Medicaid under the Alternative Benefit Plan (ABP) for an interim period until the QHP plan is selected or the individual is auto assigned into a QHP.~~

Medically Frail: Individuals identified as disabled or blind will be enrolled in ~~Medicaid~~Health Care under the Alternative ~~b~~Benefit Plan (ABP).

American Indian (AI)/Alaskan Native (AN): Individuals identified as an American Indian

~~B-200 Families and Individuals Group (MAGI)~~

B-2~~7~~00 ~~Adult Expansion Group (Arkansas Works Program)~~Families

or Alaskan Native will not be enrolled into a QHP but will be covered under ABP in ~~Medicaid~~Health Care. -Individuals in this group may opt into a QHP if that is the preferred coverage.

Enrollment in a PASSE is mandatory for the adult expansion group (ARHOME) that have been identified as in need of Tier 2 or Tier 3 behavioral health services through the Independent Assessment (IA) system (Re. Independent Assessment).

NOTE: Individuals ~~that~~who are moving to a QHP will be enrolled in Health Care under the Alternative Benefit Plan (ABP) for an interim period until the QHP plan is selected or the individual is auto assigned into a QHP.

B-310 Long Term Services and Supports

MS Manual ~~07/01/20~~ 01/01/2022

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

B-311 Nursing Facility

MS Manual ~~07/01/20~~ 01/01/2022

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

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

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

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

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

B-312 ~~Assisted Living Facilities~~ Living Choices

MS Manual ~~07/01/20~~01/01/2022

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

($3000).

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

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

B-313 ARChoices in Homecare

Refer to Health Care Procedures Manual for more information.

MS Manual ~~07/01/20~~ 01/01/2022

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

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

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

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

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

~~Services available through this program include:~~

- ~~Attendant care~~
- ~~Home Delivered meals~~
- ~~Personal Emergency Response System~~
- ~~Adult Day Health~~
- ~~Prevocational Services for persons with physical disabilities~~
- ~~Respite Care~~
- ~~Adult Day Services~~
- ~~Environmental Adaptations/Adaptions Equipment~~

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

B-315 TEFRA

B-324 Qualifying Individuals 1 (QI-1)

MS Manual ~~07/01/20~~ 01/01/2022

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

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

B-316 Autism Waiver

MS Manual ~~07/01/20~~ 01/01/2022

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

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

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

B-320 Medicare Savings Programs (MSP)

MS Manual ~~07/01/20~~ 01/01/2022

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

B-321 ARSeniors

MS Manual ~~07/01/20~~ 01/01/2022

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

B-322 Medicare Savings Programs - Comparison Chart

Refer to Health Care Procedures manual for more information.

MS Manual ~~07/01/20~~ 01/01/2022

B-330 Workers with Disabilities

MS Manual ~~07/01/20~~ 01/01/2022

This group consists of individuals who:

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

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

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

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

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

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

B-341 Supplemental Security Income (SSI) Cash Eligibles

MS Manual ~~07/01/20~~ 01/01/2022

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

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

MS Manual ~~07/01/20~~ 01/01/2022

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

B-346 Disabled Adult Children (DAC)

MS Manual ~~07/01/20~~ 01/01/2022

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

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

B-300044 ~~Widows and Widowers with Disabilities (OBRA 87)~~Aid to

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

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

~~B-400 Foster Care Health~~

B-400 Foster Health Care

MS Manual ~~??/??/??~~01/01/2022

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

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

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

B-500 Emergency ~~Medicaid~~ Health Care Services for Aliens

Refer to Health Care Procedures Manual for more information.

MS Manual ~~05/01/18~~ 01/01/2022

This group consists of:

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

~~Medicaid~~ Health Care benefits are available to pay for the cost of emergency services for aliens who do not meet the ~~Medicaid~~ Health Care citizenship or alien status requirements or Social Security Number requirements. However, they must meet the financial and categorical eligibility requirements and state residency requirements for the category in which they apply, such as Parent Caretaker Relative, Medically Needy, Adult Expansion, ARKids A or B.

NOTE: Emergency ~~Medicaid~~ Health Care applicants, if eligible in the Adult Expansion Group, may be approved for retroactive coverage thirty (30) days prior to the date of application. Retroactive coverage for the Adult Expansion Group is date specific.

~~**EXAMPLE:** James applies for Emergency Medicaid coverage on October 20 and requests coverage for September 15 through September 17. He is not eligible for retroactive coverage because his bill is for September 15 through 17 which is more than 30 days prior to the application date. Retroactive coverage cannot begin prior to September 20.~~

~~**EXAMPLE:** James applies for Emergency Medicaid coverage on October 30 and is found to be medically eligible for the Adult Expansion Group on October 1 through October 2. He asks for retroactive coverage for a medical bill with a service date of October 1. He is eligible for retroactive coverage because his bill for October 1 is within the 30 days prior to the application date.~~

To be eligible for emergency ~~Medicaid~~ Health Care, the applicant must have, or must have had within the last three (3) months, an emergency medical condition. For the exception, see NOTE above. Labor and delivery is considered an emergency medical condition.

Emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of such severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in at least one of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily function; or
- Serious dysfunction of any bodily part or organ.

To qualify as an emergency, the medical condition must be acute. It must have a sudden onset,

a sharp rise and last a short time. If the individual's condition is chronic (ongoing), ~~such as~~including without limitation, cancer, AIDS, and end-stage renal disease~~, etc.~~, it is not considered acute and does not meet the definition of an emergency. If the chronic condition worsens, it is still not acute and does not qualify for emergency services. Federal policy specifically identifies care and services related to an organ transplant procedure as **not** qualifying under emergency services.

~~B-600 Medically Needy (Exceptional and Spend Down)~~

B-500 Emergency Health Care Services for Aliens

Before eligibility can be determined, the existence of an emergency medical condition must be verified by a physician's statement that the alien met the conditions shown above. A physician's statement that the individual will die without medical treatment does not in and of itself, constitute an emergency. The eligibility determination must include a determination of whether the condition is acute or chronic. Verification that medical expenses were incurred for treatment of the condition must also be presented.

Payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services existed. The date the alien first sought treatment is considered the first day of the emergency, regardless of the length of time the condition exists. The period of eligibility will be a fixed retroactive period, with the ~~Medicaid~~ Health Care begin, and end dates entered in the system.

F-110 Age and Relationship

MS Manual 07/01/2001/01/2022

Most Medicaid Health Care eligibility groups have an age range in which the individual must fall in order to become eligible for coverage in that particular group. ARKids A and ARKids B also require a relationship and living with a specified relative requirement. In order toTo be eligible for ARKids A or B, a child must be living with a relative who is within the following degrees of relationship tothe child:

1. A blood or adoptive relative who is within the fifth degree of kinship. Such relatives bydegree of kinship are as follows:

   1st First degree – Parent;

   2nd Second degree – Grandparent, sibling;

   3rd Third degree – Great-grandparent, uncle, aunt, nephew, niece;

   4th Fourth degree – Great-great grandparent, great-uncle, great-aunt, first cousin; and

   5th Fifth degree – Great-great-great grandparent, great-great uncle, great-great aunt, first cousin once removed (i.e.,that being, the children of one's first cousin).

   NOTE: Half-relationships will be considered the same as full relationships.

2. Stepfather, stepmother, stepbrother, stepsister.
3. Spouses of any persons named in the above groups. Such relatives may be consideredwithin the scope of this provision though the marriage is terminated by death or divorce.

Relationship and living with the specified relative apply, unless the individual has been removedfrom the custody of his or her their parents or other relative by court order, has been court ordered to an institution, has been emancipated, has reached age eighteen (18) years of age, or legal custody has been given to someone else. (For ARKids, See MS C-115, E-240 for procedures on who can apply in these situations.)

The particular age requirements for each eligibility group are listed in MS Section B.

F-120 Blindness and Disability

MS Manual ~~07/01/20~~01/01/2022 42 U.S. Code § 1382c.

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

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

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

1. Has lasted or is expected to last for a continuous period of at least ~~twelfth~~twelve (12) months (thirty (30) days for the AFDC related categories, such as categories AFDC Medically Needy) or
2. Is expected to result in death.

Blindness and Disability must be established by one (1) of the following means:

1. Receipt of SSI (AB or AD)~~,~~ or receipt of a letter of entitlement to SSI with begin date ofentitlement, if the individual has not received the first SSI payment.
2. Receipt of Social Security or Railroad Retirement (RR) based on disability~~,~~ or receipt of a letter of entitlement to Social Security or Railroad Retirement based on disability, showing a begin date of entitlement, if the individual has not received the first SSA or RRpayment.
3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefitcontinuation, when an individual has requested continuation within ten (10) days of SSA determination that a physical or intellectual disability has ceased, has not existed, or isno longer disabling.
4. Non-receipt of SSI cash benefits for reasons other than disability, but verification of anestablished disability that is current and continuing (~~e.g.~~for example, TEFRA child).
5. Receipt of the DCO-0109, Report of Medical Review Team decision, when blindness ordisability has been determined by the Medical Review Team.

Disability will either be established by Social Security Administration (SSA), Railroad Retirement(RR), or the Medical Review Team (MRT). The following disability guidelines will apply to all ~~Medicaid~~ Health Care applicants where disability is an eligibility factor and disability has not been determined. A disability decision made by SSA on a specific disability is controlling for that disability until the decision is changed by SSA. When DCO makes a disability determination, a later contrary SSA determination will supersede the state determination. If SSA has made a decision that a person does not have a disability, that decision is binding on DCO for one (1) year with exceptions noted in MS F-122.

F-121 Social Security Administration

MS Manual ~~07/01/20~~01/01/2022

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSAdeterminations must be presented to SSA for reconsideration within sixty (60) days of the

SSA denial notice. If the decision has not been appealed within sixty (60) days, the individual may still request a reopening of the decision within one (1) year.

Therefore, the Aagency must refer to SSA all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled" for reconsideration or reopening ofa determination, except in cases specified in MS F-122. When the conditions in MS F-122 are met, counties will be required to make an eligibility determination for MedicaidHealth Care.

Counties may also refer to SSA, for SSI application, those individuals whose income and resources are below SSI limits, because it would be to their advantage to receive both cashassistance and MedicaidHealth Care.

F-122 Medical Review Team (MRT)

MS Manual 07/01/2001/01/2022

When an individual applies for Medicaid Health Care and meets one (1) or more of the conditions below, required forms along with any medical records provided will be submitted to MRT, provided itappears that the other eligibility factors are met. Refer to Appendix I for required forms.

MRT will determine disability if any one (1) of the following conditions exists:

1. The individual has NOT applied for Social Security Disability or SSI or RailroadRetirement (RR).
2. The individual has been found NOT eligible for Social Security Disability or SSI forreasons other than disability (e.g.for example, income).
3. The individual has applied for Social Security Disability or SSI, and SSA has NOT made adetermination.

   EXCEPTION: Individuals applying for ARChoices, Assisted LivingLiving Choices, or PACE, who require adetermination of physical disability, will be referred to MRT even if receiving Social Security Disability IF SSA does not verify a primary type of disability that is physical.

   Refer to MS B-312, B-313, and B-318.
4. The individual alleges a NEW disabling condition which is different from (or in additionto) the condition considered by SSA in its previous determinations.
5. More than twelve (12) months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA madethe decision is worse or has changed, and he or she has not reapplied.
6. Less than twelve (12) months have elapsed since the most recent Social Security Disability or SSI denial, and the individual alleges that the condition upon which SSA

made the decision has changed or deteriorated, ~~AND~~and

a. ~~He or she has~~They have asked SSA for a reconsideration or reopening of its previous determination and SSA has refused to consider the new allegations; or

~~7. OR~~

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

Individuals who do not meet a criterion specified above will be denied without further development.

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

F-123 Dual Applications

MS Manual ~~07/01/20~~01/01/2022

When an individual applies for both ~~Medicaid~~ Health Care and Social Security Disability or SSI, and the application with SSA is still pending, if the individual appears to meet all other eligibility requirements a MRT determination of disability will be initiated. The agency will have ninety (90) daysfrom the date of the ~~Medicaid~~ Health Care application to make this determination.

If application for Social Security Disability is approved first, the ~~Medicaid~~ Health Care application may be approved (if all other requirements have been met.) If application for SSI is approved first, the ~~Medicaid~~ Health Care application will be denied except for ARChoices, ~~Assisted Living~~Living Choices, Autism, DDS, NursingFacility (NF) and PACE which may be approved. If SSA determines the applicant is NOT disabled,the ~~Medicaid~~ Health Care application will be denied.

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

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

F-125 MRT Decision

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

F-130 Child Support Enforcement Services

MS Manual ~~07/01/20~~01/01/2022

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

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

1. Referrals

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

   Act 1091 of 1995 amended by Act 1296 of 1997 requires that both parents sign an

affidavit acknowledging paternity or obtain a court order before the father's name willbe added to the birth certificate.

NOTE: If the father's name is included on the birth certificate of a child born ~~4/10/95~~April 10, 1995, or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parentsare in the home, there is no need to make a referral in these instances.

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

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

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

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

2. Good Cause

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

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

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

toplace the child for adoption.

3. Refusal to Cooperate-Sanction

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

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

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

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

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

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

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

   Blind - Central visual acuity of 20/200 or less in the better eye (with correction) or alimited visual field of twenty degrees (20°) ~~degrees~~ or less in the better eye (MS F-120); or

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

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

F-151 Functional Need

MS Manual ~~07/01/20~~01/01/2022

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

Functional need decisions for:

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

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

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

Redetermination of Functional Need

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

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

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

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

F-152 DCO Institutional Status

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

440.

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

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

F-155 Functional Need Criteria

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

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

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

ARChoices, ~~Assisted Living~~Living Choices, and PACE

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

DDS

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

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

F-160 Primary Care Physician Requirements

MS Manual ~~07/01/20~~01/01/2022

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

F-161 Primary Care Physician Managed Care Program

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

F-171 Determining Monthly Premiums

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

Compare the adjusted income to Chart 1 in Appendix P ~~(2018)~~. The income isabove the limit for a family size of five. Go to Chart 2. The premium range forthe adjusted income is from fifty-two dollars ($52.00) to seventy-eight dollars ($78.00).

EXAMPLE 2: Same family with less income reported.

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

Comparing income in Chart 1 in Appendix P, the annual income is belowthe limit for a family size of five (5). Therefore, no premium is required.

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

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

See Appendix P for the amount of premiums to be paid. The maximum annual premium amountto be paid by any family is five thousand five hundred dollars ($5,500). Families having more than one (1) child receiving TEFRA Waiver benefits will pay only one premium for all covered children. There will be no increase in premium amount for additional Waiver children.

F-180 Other Health Insurance Coverage

MS Manual ~~07/01/20~~01/01/2022

For most eligibility groups, an individual may be covered by other health insurance without affecting ~~his or her~~their eligibility for Health Care~~Medicaid~~. There are two (2) exceptions to this which are describedbelow.

Adult Expansion Group

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

ARKids B

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

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

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

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

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

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

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

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

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

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

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

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

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

MS Manual ~~07/01/20~~01/01/2022

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

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

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

~~F-100 Non-Financial Eligibility Requirements~~

F-10093 Non-Financial Eligibility Requirements

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

F-191 Medicare Part A Entitlement

MS Manual ~~07/01/20~~01/01/2022

Medicare Part A beneficiaries include the following groups:

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

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

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

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

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

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

~~F-100 Non-Financial Eligibility Requirements~~

F-10093 Non-Financial Eligibility Requirements

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

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

Individuals Entitled to Part A Without Payment of Part A Premium

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

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

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

1. SSI Recipients

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

2. Non-SSI Individuals Receiving Part B Medicare

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

3. Individuals Not Receiving Part A or Part B Medicare

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

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

MS Manual ~~07/01/20~~01/01/2022

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

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

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

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

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

F-2001 ~~Maternal Life360 HOME~~Community Bridge Organizations (CBOs) for the Adult Expansion Group (ARHOME)

F-2001 ~~Maternal Life360 HOME~~Community Bridge Organizations (CBOs) for the Adult Expansion Group (ARHOME)

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G-100 Verification Standards

MS Manual ~~01/01/14~~01/01/2022

Arkansas Act 1265 requires that the agency conduct electronic data matches first through the Federal sources and then through State sources if unable to obtain the required verification needed to determine eligibility for ~~Medicaid~~ Health Care through the Federal source. However, additional verification sources may be used if there is a discrepancy between the information provided by the individual and the electronic data source or the information can't be verified through the data matches.

G-111 Eligibility Factors That Require Verification

MS Manual ~~07/06/15~~01/01/2022

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

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

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

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

G-113 Verification Sources

MS Manual ~~11/18/15~~01/01/2022

The primary source of verification is through electronic sources such as the Federal Data Services Hub (FDSH) and the Arkansas verification database, ARFinds. The FDSH is only available to the Family and Individuals Group.

The FDSH is a verification source that enables immediate access to multiple data bases via a single electronic transaction. Information provided by the individual will be verified through the federal data services by the following federal agencies:

- Social Security Administration (SSA) – Citizenship;
- Internal Revenue Service (IRS) – Income (Most recent Federal tax return information); and
- Department of Homeland Security ~~(DHS)~~ – Immigration status.
- ~~TALX (The Work Number) – Employment and income data from the employer.~~

The Arkansas verification database~~, ARFinds,~~ is a multiple source database directly integrated with the eligibility system. Information provided ~~by ARFinds~~ includes:

- SOLQi - Inquiry of SSA information;
- WESD (Workforce and Employment Security Data) – Wage history and unemployment insurance benefits;
- OCSE (Office of Child Support Enforcement) – Child support;
- Vital Records – Births, deaths, marriages, and divorces; and
- DMV (Department of Motor Vehicles).

Other sources of verification include:

- Paper Documentation provided by the individual;
  - ✓ Check Stubs

- ✓ Employer Statements
- ✓ Bank Statements
- ✓ Collateral Statements
- ✓ Legal Documents (for example, guardianship court order~~, etc.~~)

- SNAP – verified information in the individual's SNAP record; and~~.~~
- TEA – verified information in the individual's TEA case record.

G-114 Reasonable Opportunity for Providing Verification

MS Manual ~~01/01/14~~01/01/2022

Verification must first occur through electronic sources. If unable to obtain verification though electronic sources, verification will be required from the client and a ten (10) day notice will be sent requesting the required verification. Additional time to provide the verification will be allowed if requested. Information that is not necessary to determine eligibility will not be requested.

G-115 Self Declaration

MS Manual ~~01/30/15~~01/01/2022

For the Medicare Savings Program (MSP), self-declaration will be accepted for all eligibility requirements with the exception of alien status of non-citizens. Alien status must always be verified. If the declared income and resources are within the allowable amounts for the program, the client's declaration will be accepted. The ~~caseworker~~eligibility worker, will however, view SOLQi on all applicants to confirm the accuracy of the gross benefits, Medicare claim number, and Medicare Part-A entitlement. If the applicant declares resources, the value of which would make ~~him/her~~them ineligible, and the ~~caseworker~~ eligibility worker cannot determine if the resource is countable (such as a life insurance policy or burial plan), the ~~caseworker~~ eligibility worker should then contact the applicant to determine if the resource is countable. The client's statement of the type of resource and the resource value will be accepted and documented. If it cannot be determined through contact with the client that the resource is countable, the client must be given the opportunity to provide a copy of the resource document.

G-120 Verifying the Social Security Number

MS Manual ~~01/01/14~~??/??/??01/01/2022

The SSN will be verified via the Federal Data Services Hub (FDSH) or through the SSN enumeration process for all individuals that have been entered into the eligibility system. If all match data agrees with SSA records, the system will be updated to reflect that the SSN has been verified.

If a mismatch occurs, an SSN mismatch report will be generated ~~to the county office~~ and the procedures in Appendix C will be followed to resolve the mismatch.

G-130 Verifying Citizenship

MS Manual ~~01/01/14~~01/01/2022

Federal Law and Regulations require that citizenship must be verified for all ~~Medicaid~~ Health Care recipients declaring to be citizens or nationals of the United States.

Exceptions to the verification requirement

Citizenship verification is not required for the following:

- Individuals entitled to or enrolled in Medicare;

- Individuals in receipt of SSI payments;
- Individuals receiving SSDI benefits based on disability;
- Children who are in foster care; or
- Children who are recipients of foster care maintenance or adoption assistance payments under Title IV-E.

G-131 Methods of Citizenship Verification

MS Manual ~~07/06/15~~??/??/??01/01/2022

~~Families and Individuals Group~~

Verification of citizenship will occur through the Federal Data Services Hub (FDSH) or SVES. If citizenship cannot be validated through the FDSH, the agency will conduct an electronic data match directly with Social Security Administration (SSA) or by obtaining acceptable documentation from the individual.

NOTE~~NOTE~~: ~~-~~Citizenship verified through the FDSH or SVES also verifies identity.

G-132 Reasonable Opportunity for Verifying Citizenship

MS Manual ~~07/14/17~~01/01/2022

When citizenship cannot be verified through an electronic source or SVES, the agency will provide the applicant a "~~90~~ninety (90)-day reasonable opportunity period" to provide the necessary documents to verify citizenship. (Refer to Appendix C).

NOTE~~NOTE~~: ~~-~~This reasonable opportunity period will be provided for all ~~Medicaid~~ Health Care eligibility categories

Situations that may trigger the reasonable opportunity period:

- The individual is unable to provide a SSN, needed for electronic verification with SSA;
- Either the federal data services hub or SSA or Department of Homeland Security~~HS~~ databases are temporarily down for maintenance or otherwise unavailable, thereby delaying electronic verification;
- There is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship which the agency must attempt to resolve, including by identifying typographical or clerical errors; or
- Electronic verification is unsuccessful, even after agency efforts to resolve any inconsistencies, and additional information, including documentation is needed.

A notice will be sent to the applicant advising that verification of citizenship must be provided within ninety (90) days. The due date must be included on the notice. The reasonable opportunity begins on the date the notice is received by the individual. The date the notice is received is considered to be five (5) days from the date on the notice (day one (1)is the date of the notice). Eligibility for ~~Medicaid~~ Health Care will begin on the same date the reasonable opportunity period begins.

NOTE:~~-~~ If the individual clearly shows that the notice was not received on the ~~5th~~ fifth (5th) day, the ninety (90) days will start from the date the notice was actually received.

If the needed verification for an individual is not provided within the reasonable opportunity period, then benefits for that individual will be terminated. Timely and adequate notice must be provided. Other eligible members for whom citizenship is verified will remain eligible.

When the recipient tries in good faith to present satisfactory documentation, but is unable to obtain the necessary documents and needs assistance (~~e.g.~~for example, homeless, mentally impaired, or physically incapacitated)~~,~~ and lacks someone who can act on their behalf, the ~~caseworker~~ eligibility worker should assist the recipient with obtaining the documentation of U.S. citizenship.

G-134 Subsequent Citizenship Verification

MS Manual ~~01/01/14~~01/01/2022

Once an individual's citizenship is documented and recorded, any subsequent changes in eligibility should not require repeating the documentation of citizenship. If an individual's ~~Medicaid~~ Health Care case is closed and he later reapplies, the worker will not need to request additional verification as long as proper documentation has been retained in the case file or narrated properly in the electronic record. However, if one (1) of the two (2) exceptions below occurs, the individual's citizenship must be verified again.

1. If later evidence raises a question of a person's citizenship or identity; or~~,~~

2. If there is a gap of more than five (5) years since the ~~Medicaid~~ Health Care case was closed and the verification had been previously destroyed.

G-140 Alien Status Verification Requirements

MS Manual ~~07/14/17??/??/??~~01/01/2022

~~For the Families and Individuals group, verification will first occur through the FDSH. For other groups, a~~Alien status will be verified through SAVE (Systematic Alien Verification for Entitlement). If verification cannot be completed through ~~these~~ this process~~es~~, refer to MS Appendix C. When immigration status cannot be verified through SAVE, the agency will provide the applicant a "~~ninety (90)~~ninety (90) day reasonable opportunity period" to provide the necessary documents to verify immigration status.

In order to obtain verification from SAVE, the alien must provide the following information regarding alien status:

- Biographic information (first name, last name and date of birth)~~;~~ and ~~a~~

- Numeric identifier (alien number; form I-94, Arrival/Departure Record, number; Student and Exchange Visitor Information System (SEVIS) ID number; or unexpired foreign passport number).

If the alien does not have the required information, refer ~~him/her~~them to the ~~United States~~ Department of Homeland Security ~~(USDHS)~~ to obtain proof of status. Provide the individual with a ~~ninety (90) day~~ninety (90)-day written notice requesting the information and extend notice if additional time is needed. ~~The USDHS National Customer Service Center phone number is 1-800-375-5283. The customer service center will answer all questions and schedule appointments for the USDHS field offices. The USDHS field office addresses and the Arkansas counties serviced by each office are listed below:~~

~~The Fort Smith field office is located at 4624 Kelley Highway, Fort Smith, AR 72904. This office services the following counties in Arkansas:~~

~~Ashley~~	~~Baxter~~	~~Benton~~	~~Boone~~
~~Bradley~~	~~Calhoun~~	~~Carroll~~	~~Clark~~
~~Columbia~~	~~Crawford~~	~~Franklin~~	~~Garland~~
~~Hempstead~~	~~Hot Spring~~	~~Howard~~	~~Johnson~~
~~Lafayette~~	~~Little River~~	~~Logan~~	~~Madison~~
~~Marion~~	~~Miller~~	~~Montgomery~~	~~Nevada~~
~~Newton~~	~~Ouachita~~	~~Pike~~	~~Polk~~
~~Scott~~	~~Searcy~~	~~Sebastian~~	~~Sevier~~
~~Union~~	~~Washington~~		

~~The Memphis Field Office is located at 842 Virginia Run Cove, Memphis, TN 38122. This office services the following counties in Arkansas:~~

~~Arkansas~~	~~Chicot~~	~~Clay~~	~~Cleburne~~
~~Cleveland~~	~~Conway~~	~~Craighead~~	~~Crittenden~~
~~Cross~~	~~Dallas~~	~~Desha~~	~~Drew~~
~~Faulkner~~	~~Fulton~~	~~Grant~~	~~Greene~~
~~Independence~~	~~Izard~~	~~Jackson~~	~~Jefferson~~
~~Lawrence~~	~~Lee~~	~~Lincoln~~	~~Lonoke~~
~~Mississippi~~	~~Monroe~~	~~Perry~~	~~Phillips~~
~~Poinsett~~	~~Pope~~	~~Prairie~~	~~Pulaski~~
~~Randolph~~	~~Saint Francis~~	~~Saline~~	~~Sharp~~
~~Stone~~	~~Van Buren~~	~~White~~	~~Woodruff~~
~~Yell~~			

If all other eligibility requirements are met, the ~~Medicaid~~ Health Care begin date will be the first ~~(1st)~~ day of the month of application.

If the individual does not provide necessary information of alien status for the person requesting ~~Medicaid~~ Health Care coverage, the individual will be eligible for emergency services only following the ~~ninety (90) day~~ninety (90)-day reasonable opportunity period.

G-141 Reasonable Opportunity for Verifying Alien Status

MS Manual 01/01/2022~~07/14/17~~

When alien status cannot be verified through an electronic source, Systematic Alien Verification for Entitlement (SAVE) or initial documentation provided by the individual, the agency will provide the applicant a " ninety (90) day reasonable opportunity period" to provide the necessary documents to verify alien status. (Refer to Appendix C).

NOTE: -This reasonable opportunity period will be provided for all ~~Medicaid~~ Health Care eligibility categories

A notice will be sent to the applicant advising that verification of alien status must be provided within ninety (90) days. The due date must be included on the notice. The reasonable opportunity begins on the date the notice is received by the individual. The date the notice is received is considered to be five (5) days from the date on the notice (day one (1) is the date of the notice).

The ~~Medicaid~~ Health Care begin date will be the first (1st) day of the month of application if all other eligibility requirements are met.

NOTE:- If the individual clearly shows that the notice was not received on the fifth (5th) day, the ninety (90) days will start from the date the notice was actually received.

If the needed verification for an individual is not provided within the reasonable opportunity period, then benefits for that individual will be terminated. Timely and adequate notice must be provided. Other eligible members for whom alien status is verified will remain eligible.

When the recipient tries in good faith to present satisfactory documentation, but is unable to obtain the necessary documents and needs assistance (~~e.g.~~for example, homeless, mentally impaired, or physically incapacitated)~~,~~ and lacks someone who can act on their behalf, the ~~caseworker~~ eligibility worker should assist the recipient with obtaining the documentation of alien status.

G-150 Income Verification

MS Manual ~~11/18/15~~01/01/2022

Income verification for MAGI groups will occur in the following manner:

If a MAGI household attests to income over the MAGI income limit the system will accept the self-attestation and find the household ineligible due to income. The household will receive the appropriate notice and be referred to the Federally Facilitated Health Insurance Marketplace (FFM).

If the MAGI household has income (attested or previously verified) under the MAGI limit, the system will determine if a member of the MAGI household is on an open SNAP or TEA benefit case. If one MAGI household member is found on an open SNAP or TEA Cash case, the MAGI household income is considered verified.

If a member in the MAGI household is not found on an open SNAP or TEA Cash case, the system will continue the reasonable compatibility process and check available electronic data sources.

If the household attests to income under the MAGI limit (to include zero income) and the electronic data sources return no record of income or income less than the MAGI limit, the system will consider the MAGI household to meet reasonable compatibility and no further income verification is needed.

If the electronic data sources return an amount over the MAGI limit, the system will trigger a pending verification notice to the household for income verification.

For all other eligibility groups, sources for verification of income are ~~ARFinds interfaces from the~~electronic verification, data matches ~~eligibility system,~~ verified information from the SNAP record and documentation provided by the individual. If the income reported by the applicant exceeds the income limit, it is not necessary to check the verification sources. The applicant's statement of income may be accepted without further verification.

G-151 Reasonable Compatibility Standards for Electronic Data Sources

MS Manual ~~01/30/15~~01/01/2022

Income is considered verified when the income reported by the individual is reasonably compatible with the income verified by the electronic data source.

Reasonable compatibility is met when the amount reported by the individual and the amount obtained through the electronic process are:

1. Both are equal to or below the income limit;

2. Both are greater than the income limit; or

3. If one (1) is above and one (1) is below the income limit but the difference between the two amounts is within ten percent (10%) ~~percent~~ of the one hundred percent (100%) ~~percent~~ Federal Poverty Level (FPL) for the appropriate household size.

The only time reasonable compatibility must be established is when the applicant's reported income is below the income limit and the verification source is above the income limit. See examples below.

EXAMPLE: The applicant reports a household size of one and a monthly income of nine hundred dollars ($900) per month. The FDSH provides data that the applicant has an income of nine hundred seventy-five dollars ($975) per month. The one hundred percent (100%) ~~percent~~ Federal Poverty Level (FPL) for a household of one 91) is nine hundred fifty-seven dollars and fifty cents ($957.50) per month. A ten percent (10%) ~~percent~~ Reasonable Compatibility Standard would equal an amount of ninety-six dollars ($96) (957.50 X 10% = 95.75 rounded up to ~~$~~ninety-six (96)). The reported and verified amounts are within ninety-six dollars ($96) of each other ($975.00 [verified amount] - $900 [reported amount] = $75.00) and therefore meet the reasonable compatibility standard. No additional verification is required.

EXAMPLE: The applicant reports a household size of three and a monthly income of one thousand six hundred dollars ($1,600) per month. The FDSH provides data that the applicant has an income of one thousand eight hundred dollars ($1,800) per month. The one hundred percent (100%) ~~percent~~ Federal Poverty Level (FPL) for a

household of three (3) is one thousand six hundred twenty-seven dollars and fifty cents ($1,627.50) per month. A ten percent (10%) Reasonable Compatibility Standard would equal an amount of one hundred sixty three dollars ($163) (1627.50 X 10% = 162.75 rounded up to ~~$~~one hundred sixty-three (163)). The reported and verified amounts are not within one hundred sixty-three dollars ($163) of each other ($1,800 [verified amount] - $1,600 [reported amount] = $200) and therefore do not meet the reasonable compatibility standard. In this example, the client would need to provide proof of the reported income amount.

G-152 Reasonable Compatibility of Income Does Not Exist

MS Manual ~~01/01/14~~01/01/2022

If there is a discrepancy between the information provided and the electronic data, the individual must resolve the discrepancy by submitting verification of the income. For earnings, this can be verified with check stubs, pay slips, or a collateral contact with the employer.

Sufficient verification must be obtained so that the actual income of the employee can be determined. The ~~caseworker~~ eligibility worker should not automatically assume that one (1) check stub accurately reflects earnings for an entire month. Verification of payment for the last thirty (30) days will be required if available.

EXCEPTION: For cases in which the individual has recently started employment and thirty (30) days of verification is not available, the ~~caseworker~~ eligibility worker will compute the income from the best information available. Verification of all, if any, paychecks already received by the individual or an employer's statement of anticipated earnings (for example, hourly wage or number of hours expected to work per week) should be obtained~~. and/or an employer's statement of anticipated earnings (e.g., hourly wage, number of hours expected to work/week, etc.).~~

Verification of earnings from self-employment will be from the Federal Income Tax Return, purchase, sales, and account books or by any other source ~~which~~ that establishes the source and amount of income. As soon as an individual is known to be engaged in a farming business or other self-employment enterprise, ~~he~~ they will be advised of the necessity of keeping accurate records so that ~~his~~ their income can be determined.

Verification of in-kind earned income (~~e.g.,~~including without limitation, free rent~~,~~ and groceries~~, etc.~~) will be obtained from the employer. The verification must include the value of the in-kind benefit (~~e.g.,~~including without limitation, the rent amount the client would otherwise pay~~,~~ and the cost of groceries provided~~, etc.~~) and how often it is provided (~~e.g.,~~for example, monthly or~~,~~

weekly~~, etc.~~). If the amount fluctuates from week to week or month to month, verification of the in-kind earned income paid during the last two (2) months should be obtained.

Verification of unearned income is normally obtained from documentary evidence from the source (~~e.g.,~~ for example, an award letter). However, another source may be used if it clearly establishes the source and amount of income.

G-160 Age/Date of Birth

MS Manual ~~01/30/15~~01/01/2022

Age and date of birth will be verified via the Federal Data Services Hub or other electronic sources. If there is a mismatch, a task will be generated and the ~~caseworker~~ eligibility worker will manually verify age and date of birth through birth certificate or other legal documents.

G-181 Verification of Resources using the Asset Verification System

MS Manual ~~01/01/16~~07/01/2021~~01~~01/01/2022

AABD applicant's and recipient's liquid resources will be verified using the Asset Verification System (AVS). Liquid resources include but are not limited to: checking and savings accounts, Certificates of Deposit, and bonds. The Asset Verification System will verify resource information for those categories with a resource limit. These categories include:

- ~~Long Term Care Aged, Blind Long Term Care, Long Term Care Disabled~~Nursing Facility;
- ARChoices in Homecare;
- ~~Assisted Living~~ Living Choices~~(Living Choices)~~;
- Program of All-Inclusive Care for the Elderly (PACE);
- Medically Needy Exceptional Category Aged, Medically Needy Exceptional Category Blind, and Medically Needy Exceptional Category Disabled;
- Medically Needy Spend Down Aged, Medically Needy Spend Down Blind, and Medically Needy Spend Down Disabled;
- Qualified Medicare Beneficiary (QMB); ~~Aged, QMB Blind, and QMB Disabled~~
- ARSeniors;
- Qualified Individual (QI-1);
- Specified Medicare Beneficiary (SMB);
- Disregard COLA Increase, Disregard (1984) Widow/Widower, Disregard SSA Disabled Widow/Widower, Disabled Widow/Widower Surviving Spouse, and Disabled Adult Child (DAC);~~.~~

- Qualified Disabled and Working Individuals (QDWI); and
- TEFRA and Autism.

EXCEPTION: -AVS will not provide verification for SSI Categories.

~~AVS will be used at initial application and at re-evaluation. When a new AABD application is registered a request for resource verification will be sent to the Asset Verification System. If the application is for ARChoices and has a "Waiver App Received not Reg" characteristic selected, a request for resource verification will be sent to AVS. The registration or the waiver characteristic selection will initiate the request to AVS at initial application. The generation of a re-evaluation task will initiate the request for resource verification to AVS at re-evaluation. AVS will provide verification of the balance of accounts as of the first of the month of application and first of the month balances for the 3 months prior to application. At re-evaluation AVS will provide account balances for the first of the month the re-evaluation task is created and the first of the month balances for the 3 months prior to the creation date of the task.~~

~~**NOTE:** If an application is denied or withdrawn, a request for asset verification will be resubmitted when another application is entered into the system regardless of the time of the initial request.~~

The information provided by AVS is a tool to help locate any liquid resources that the household may have or has had in the three (3) months prior to application or re-evaluation. The information that is returned by AVS will be used to verify the liquid resources that the household may possess.

The balances that will be received will show the balance of the account as of the first (1st) ~~1st first~~ of the month. The AVS information received will be used as actual verification of liquid resources for the household.

NOTE: While the AVS information is "known to the Agency", it is not considered verified information upon receipt for some benefit programs.

If the information that is returned from AVS causes ineligibility for the client, a ~~10~~ ten (10)- day advance notice will be sent to the household allowing an opportunity for them to rebut the information that was provided by AVS. This will allow the household time to explain if there is a valid reason that the resources should not be included in the eligibility determination.

Any information that is received from AVS after the eligibility determination for an application or after the processing of a re-evaluation has been completed ~~will be handled at the next re-evaluation~~is known to the ~~A~~agency and will require appropriate case action.

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:

- **being employed at least 80 hours per month; or**
- **qualifying for an exemption to the work and community engagement requirement; or**
- **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: 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: 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: 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-employedand 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.~~

~~Rec ipients 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.~~

State of Arkansas *As Engrossed: S3/8/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 410

By: Senator Irvin
By: Representative M. Gray

For An Act To Be Entitled

AN ACT TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; TO PROMOTE ECONOMIC AND PERSONAL HEALTH, PERSONAL INDEPENDENCE, AND OPPORTUNITY FOR ARKANSANS THROUGH PROGRAM PLANNING AND INITIATIVES; TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; AND TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 61, Subchapter 10 is amended to read as follows:

Subchapter 10 — ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021

23-61-1001. Title.

This subchapter shall be known and may be cited as the "~~Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021".

23-61-1002. Legislative intent.

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

~~(1) Empowers individuals to improve their economic security and achieve self-reliance;~~

~~(2) Builds on private insurance market competition and value-based insurance purchasing models;~~

~~(3) Strengthens the ability of employers to recruit and retain productive employees; and~~

~~(4)~~(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for ~~entitlement spending~~ providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

23-61-1003. Definitions.

As used in this subchapter:

~~(1) "Cost-effective" means that the cost of covering employees who are:~~

~~(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or~~

~~(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;~~

(1) "Acute care hospital" means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) "Birthing hospital" means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) "Community bridge organization" means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting

their long-term goals to achieve independence, including economic independence;

~~(2)~~(4) "Cost sharing" means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) "Critical access hospital" means an acute care hospital that is:

(A) Designated by the Centers for Medicare and Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) "Economic independence initiative" means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

~~(3)~~(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

~~(4)~~(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

~~(5)~~(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on ~~January 1, 2016~~ January 1, 2021;

~~(6)~~(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in

Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

~~(7)~~(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; ~~or~~

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

~~(8)~~(14) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer ~~through~~ that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on ~~January 1, 2016~~ January 1, 2021;

(15) "Member" means a program participant who is enrolled in an individual qualified health insurance plan;

~~(9)~~(16) "Premium" means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health

insurance benefits;

~~(10)~~(17) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined ~~to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:~~ by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

~~(i) An individual who is medically frail; or~~

~~(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and~~

~~(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.~~

~~(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016~~

(18) "Risk-based provider organization" means the same as defined in § 20-77-2703; and

(19) "Small rural hospital" means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

23-61-1004. Administration ~~of Arkansas Works Program~~.

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other ~~necessary~~ state agencies, as necessary, shall:

(A) Provide ~~health insurance or medical assistance~~ healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program by:~~;~~

~~(C)~~(i) ~~Submit and apply~~ Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare and Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

~~(D)~~(E) Offer ~~incentive benefits~~ incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

~~(E)~~(F) Seek a waiver to ~~eliminate~~ reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

(b) ~~Health insurance benefits~~ Healthcare coverage under this subchapter shall be provided through enrollment in:

(1) ~~Individual premium assistance for enrollment of Arkansas Works Program participants in~~ An individual qualified health insurance ~~plans~~ plan through a health insurer; ~~and~~

(2) ~~Supplemental benefits to incentivize personal responsibility~~ A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) Fee-for-service Medicaid program.

(c) ~~The~~ Annually, the Department of Human Services~~, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.~~ shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of *understanding.*

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and

(3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

~~(d)(1)~~(f)(1) ~~If the~~ ~~Within thirty (30) days of a reduction in~~ federal medical assistance percentages ~~as described in this section~~ for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare and Medicaid Services a plan within thirty (30) days of the reduction to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of ~~a~~ the reduction ~~in any of the following federal medical assistance percentages:~~

~~(A) Ninety-five percent (95%) in the year 2017;~~

~~(B) Ninety-four percent (94%) in the year 2018;~~

~~(C) Ninety-three percent (93%) in the year 2019; and~~

~~(D) Ninety percent (90%) in the year 2020 or any year after the year 2020~~.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

~~(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.~~

~~(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.~~

~~(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:~~

~~(A) Eligibility and enrollment;~~

~~(B) Utilization;~~

~~(C) Premium and cost-sharing reduction costs;~~

~~(D) Health insurer participation and competition;~~

~~(E) Avoided uncompensated care; and~~

~~(F) Participation in job training and job search programs.~~

~~(2)(A)~~(g)(1) A health insurer ~~who~~ that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the ~~State Insurance Department~~ Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

~~(B)~~(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

23-61-1005. Requirements for eligible individuals.

~~(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:~~

~~(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and~~

~~(B) The first year of, and thereafter annually:~~

~~(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or~~

~~(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.~~

~~(2) Failure to meet the requirement in subdivision (a)(1) of~~

~~this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:~~

~~(A) Incentivize and increase work and work training opportunities; and~~

~~(B) Participate in job training and job search programs.~~

~~(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.~~

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual's individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through fee-for-service Medicaid.

(B) An eligible individual who is enrolled in the fee-for-service Medicaid program is exempt from the requirements of subsection (a) of this section.

~~(c)~~(d) An eligible individual shall receive notice that:

(1) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity

for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice; ~~and~~

(3) ~~The Arkansas Works Program is not an entitlement program~~ Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

23-61-1006. Requirements for program participants.

~~(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).~~

~~(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.~~

~~(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:~~

~~(A) The accrual of a debt to the State of Arkansas; and~~

~~(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.~~

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or

more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

23-61-1007. Insurance standards for individual qualified health insurance plans.

(a) Insurance coverage for a ~~program participant~~ member enrolled in an

individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on ~~January 1, 2016~~ January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) ~~The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a program participant enrolled in an individual qualified health insurance plan~~ As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) ~~All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace~~ All health benefit plans purchased by the Department of Human Services shall:

(1)~~(A) Offer individual qualified health insurance plans conforming~~ Conform to the requirements of this section and applicable insurance rules~~.~~;

~~(B)~~(2) Be certified by the State Insurance Department; ~~The individual qualified health insurance plans shall be approved by the State Insurance Department; and~~

~~(2)~~(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on ~~January 1, 2016~~ January 1, 2021, or rebate the difference to the Department of Human Services for ~~program participants~~ members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established

by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Service and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

~~(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.~~

~~(e)~~(d) A health insurer offering individual qualified health insurance plans for ~~program participants~~ members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including ~~program participants~~ members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement programs as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before ~~January 1, 2017~~ January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

~~23-61-1008. [Expired.]~~

23-61-1009. Sunset.

This subchapter shall expire on ~~December 31, 2021~~ December 31, 2026.

23-61-1010. Community bridge organizations.

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the

Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs *local qualified staff* to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through

telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel.

(a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.

(b) The advisory panel shall be composed of the following members:

(1) The following members of the General Assembly:

(A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;

(B) The Chair of the House Committee on Public Health, Welfare, and Labor;

(C) The Chair of the Senate Committee on Education;

(D) The Chair of the House Committee on Education;

(E) The Chair of the Senate Committee on Insurance and Commerce;

(F) The Chair of the House Committee on Insurance and Commerce;

(G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;

(H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;

(I) An at-large member of the Senate appointed by the minority leader of the Senate; and

(J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;

(2) The Secretary of the Department of Human Services;

(3) The Arkansas Surgeon General;

(4) The Insurance Commissioner;

(5) The heads of the following executive branch agencies or their designees;

(A) Department of Health;

(B) Department of Education;

(C) Department of Corrections;

(D) Department of Commerce; and

(E) Department of Finance and Administration;

(6) The Director of the Arkansas Minority Health Commission; and

(7)(A) Three (3) community members who represent health, *business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the* health and welfare of Arkansans, appointed as follows;

(i) One (1) member shall be appointed by and serve at the will of the Governor;

(ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and

(iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.

(B) Members serving under subdivision (b)(6)(A) of this section may receive mileage reimbursement.

(c)(1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the co-chairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.

(2) The legislative member who serves as the co-chair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality

performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating Individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the

Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

20-61-1012. Rules.

The Department of Human Services shall adopt rules necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-984(b)(2)(D), concerning the Division of Workforce Services Special Fund, is amended to read as follows:

(D) The ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor; and

SECTION 3. Arkansas Code § 19-5-1146 is amended to read as follows:

19-5-1146. ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "~~Arkansas Works Program~~ Arkansas Health and Opportunity for

Me Program Trust Fund".

(b) The fund shall consist of:

(1) Moneys saved and accrued under the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation:

(A) Increases in premium tax collections; and

(B) Other spending reductions resulting from the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; and

(2) Other revenues and funds authorized by law.

(c) The Department of Human Services shall use the fund to pay for future obligations under the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program created by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

SECTION 4. Arkansas Code § 23-61-803(h), concerning the creation of the Arkansas Health Insurance Marketplace, is amended to read as follows:

(h) The State Insurance Department and any eligible entity under subdivision ~~(e)(1)~~ (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program established by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

SECTION 5. Arkansas Code § 23-79-1601(2)(A), concerning the definition of "health benefit plan" regarding coverage provided through telemedicine, is amended to read as follows:

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 6. Arkansas Code § 23-79-1801(1)(A), concerning the definition of "health benefit plan" regarding coverage for newborn screening for spinal muscular atrophy, is amended to read as follows:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 7. Arkansas Code § 26-57-604(a)(1)(B)(ii), concerning the remittance of the insurance premium tax, is amended to read as follows:

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

SECTION 8. Arkansas Code § 26-57-610(b)(2), concerning the disposition of the insurance premium tax, is amended to read as follows:

(2) The taxes based on premiums collected under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B) Transferred to the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund and used as required by the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund;

SECTION 9. EFFECTIVE DATE.

This act is effective on and after January 1, 2022.

/s/Irvin

APPROVED: 4/1/21