EXHIBIT E

DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS

SUBJECT: Medical Services Policy Section A-116, H-110, H-400, H-600 and H-700

DESCRIPTION:

Statement of Necessity

The Medical Services Policy has been updated to reflect new rules concerning Miller Income Trusts, patient liability and an estate recovery process change. The changes are implemented pursuant to Act 570 addressing estate recovery along with an update consistent with Act 530.

Miller Income Trust rule changes are that a client's income will no longer be required to be transferred, but instead only the amount necessary to make the client income eligible. Policy is also updated to allow for court-ordered child support and court-ordered spousal support as allowable deductions for patient liability in the Long-Term Services and Supports categories. Policy is updated to reflect that estate recovery can no longer be made from assets that are transferred by beneficiary deed. Finally, consisted with Act 530, DCO deleted the rule that a failure to pay a premium for three (3) consecutive months will result in a debt to the State of Arkansas.

The proposed rule:
- Aligns language to correspond with the implementation of the new ARIES system;
- Further defines what income must be included in a trust;
- Includes mandatory expenses as allowable deductions;
- Clarifies that only income above the eligibility cutoff must be placed in a trust;
- Removes property transferred by beneficiary deed from estate recovery; and
- Updates the rule consistent with Act 530.

Rule Summary

The following are the changes to Policy A:

A-116 Premiums for the Adult Expansion Group
Removed the sentence "Failure to pay the premium for three (3) consecutive months will result in a debt to the State of Arkansas."

The following are the proposed changes to Policy H:
1. H-100 Long-Term Services and Supports
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
2. H-111 Requirements for an Income Trust
    a. Updated, rule change: not all income must go to trust;
    b. Updated, rule change: court-ordered child support and court-ordered spousal support are an allowable deduction;

    c. Updated, rule change: not all income must go to trust—only the amount that would make the client ineligible;
    d. Verbiage and processes changed due to new system;
    e. Business processes removed to be added to business process manual; and
    f. Formatting adjusted.
3. H-112 Income Trust Application Process
    a. Business processes removed; and
    b. Formatting adjusted.
4. H-113 Post Eligibility Procedures
    a. Verbiage and processes changed due to new system;
    b. Business processes removed to be added to business process manual; and
    c. Formatting adjusted.
5. H-114 Changes to an Income Trust
    a. Verbiage and processes changed due to new system; and
    b. Formatting adjusted.
6. H-115 Reevaluations with an Income Trust
    a. Updated, rule change: not all income must go to trust—only the amount that would make the client ineligible;
    b. Verbiage and processes changed due to new system; and
    c. Formatting adjusted.
7. H-116 Termination of an Income Trust
    a. Verbiage and processes changed due to new system;
    b. Business processes removed to be added to business process manual; and
    c. Formatting adjusted.
8. H-400 Post-Eligibility
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
9. H-402 Consideration of Income
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
10. H-403 Rebutting Consideration of Income
    a. Verbiage and processes changed due to new system; and
    b. Formatting adjusted.
11. H-410 Factors Used to Determine the Cost of Care
    a. Updated, rule change: court-ordered child support and court-ordered spousal support are an allowable deduction;
    b. Updated to reflect process changes; and
    c. Formatting adjusted.
12. H-412 Contribution to the Cost of Care for Assisted Living Facilities
    a. Updated, rule change: mandatory expenses are an allowable deduction; and
    b. Formatting adjusted.
13. H-413 Contribution to the Cost of Care for PACE
    a. Updated, rule change: mandatory expenses are an allowable deduction; and
    b. Formatting adjusted.
14. H-416 Verification or Refusal of Contributions
    a. Updated to reflect process changes; and

b. Formatting adjusted.

15. H-430 Earnings of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facility Residents
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
16. H-440 Effective Eligibility Dates for Nursing Homes
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
17. H-450 Approval of an Applicant Who is in a Medicare Bed
    a. Formatting adjusted.
    b. Changed “Medicaid” to “Health Care.”
18. H-481 Case Adjustments for Lump Sum Payments in Prior Months
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
    c. Changed “Medicaid” to “Health Care.”
19. H-490 Absences from Long-Term Care Facilities
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
20. H-493 Operations Plan - Relocation of Recipients
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
21. H-600 Estate Recovery
    a. Updated, rule change: estate recovery can no longer be made from assets transferred by beneficiary deed; and
    b. Formatting adjusted.
22. H-630 Recovery Procedures
    a. Updated, rule change: estate recovery can no longer be made from assets transferred by beneficiary deed; and
    b. Formatting adjusted.
23. H-640 Application for a Hardship Waiver
    a. Formatting adjusted.
    b. Changed “Medicaid” to “Health Care.”
24. H-700 Undue Hardship Waiver
    a. Formatting adjusted.
25. H-710 Hardship Waiver for Home Equity
    a. Language and processes updated; and
    b. Formatting adjusted.
26. H-720 Hardship Waiver for Transfer of Resources/Income
    a. Language and processes updated; and
    b. Formatting adjusted.
27. H-730 Hardship Waiver for Estate Recovery
    a. Language and processes updated; and
    b. Formatting adjusted.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on April 9, 2022. The agency indicated that it received no public comments.

The proposed effective date is August 29, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $7,947,327 for the current fiscal year ($2,255,451 in general revenue and $5,691,875 in federal funds) and $9,356,792 for the next fiscal year ($2,655,458 in general revenue and $6,701,335 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $2,255,451 for the current fiscal year and $2,655,458 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

This rule change allows Long Term Services and Supports (LTSS) applicants/recipients the added deductions of court-ordered child support and spousal support in their patient liability budget. Also, there is an adjustment to Miller Income Trust requirements. Individuals no longer have to place all income into a Miller Income Trust, only the amount that causes the individual to be ineligible must be transferred. In addition, this rule change prohibits estate recovery from assets that are transferred by beneficiary deed.

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

This rule is required due to an agreement between DHS and the legislature concerning the patient liability update and the Miller Income Trust update. Legislation was proposed but was pulled due to the agreement. Act 570 addresses the change to the estate recovery process.

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

This rule change is a result of legislation that was proposed for the Miller Income Trust and Act 570 for the estate recovery change.

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

There are no less costly alternatives.

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

N/A

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

The existing rule did not allow a deduction in the patient liability budget for court-ordered child support and spousal support and does not allow for partial income to be placed in a Miller Income Trust. Changes to the estate recovery process for beneficiary deeds is mandated by Act 570. These changes will have a positive impact on LTSS applicants and recipients.

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

The agency will develop a plan to review the impact of this rule within a designated time frame to ensure that there is still a positive impact to the LTSS applicants/recipients.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). This rule implements Acts 530 and 570 of 2021.

Act 530, sponsored by Senator Missy Irvin, amended Title 23 of the Arkansas Code to ensure the stability of the insurance market in Arkansas and created the Arkansas Health and Opportunity for Me Act of 2021 and the Arkansas Health and Opportunity for Me

Program. The Department of Human Services shall adopt rules necessary to implement the Health and Opportunity for Me Act. Act 530, § 1, *codified at* Ark. Code Ann. § 23-61-1012.

Act 570, sponsored by Representative John Maddox, amended the law concerning beneficiary deeds and prohibited the recovery of benefits against an interest acquired from a deceased recipient by a grantee of a beneficiary deed in certain circumstances.

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

DEPARTMENT/AGENCY Department of Human Services
DIVISION County Operations
DIVISION DIRECTOR Mary Franklin
CONTACT PERSON Mac Golden
ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437
PHONE NO. 501-320-6383 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Mary Franklin
PRESENTER E-MAIL Mary.Franklin@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Medical Services Policy Section A-116, H-100, H-400, H-600 and H-700

2. What is the subject of the proposed rule? See Attached.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule? _____
   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?
   Yes ☐ No ☐

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

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

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

See attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? See Attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

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

Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
April 9, 2022

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
August 29th, 2022

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

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

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

NOTICE OF RULE MAKING

The Director of the Division of County Operations of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 25-10-129 and 20-77-107.

Effective July 1, 2022:

The Director of the Division of County Operations (DCO) amends the Medical Services Policy Sections A and H to incorporate the legislative changes made by Acts 530 and 570 of the 93rd General Assembly regular session as well as make technical and grammatical changes. In accordance with Act 570, DCO changes the rule to reflect that estate recovery can no longer be made from assets transferred by a beneficiary deed. Due to the implementation of a new system, verbiage and processes are changed with some business processes removed. DCO amends the Medical Services Policy to clarify what income must be included in a trust and that mandatory expenses are an allowable deduction. The change removes the requirement that all income must be placed in a trust and replaces it with the requirement that only the amount of income making the client ineligible must be transferred. DCO adds child support and spousal support as income exceptions when the agency calculates income. Correspondingly, and consistent with Act 530, DCO deleted the rule that a failure to pay a premium for three (3) consecutive months will result in a debt to the State of Arkansas.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than April 09, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502035775

Mary Franklin, Director
Division of County Operations

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION County Operations

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** Jason.Callan@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Medical Services Policy Section A-116, H-100, H-400, H-600 and H-700

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds		Cash Funds	

Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$	Total	$

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$2,255,451	General Revenue	$2,655,458
Federal Funds	$5,691,875	Federal Funds	$6,701,335
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$7,947,327	Total	$ 9,356,792

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

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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

Current Fiscal Year
$ 2,255,451

Next Fiscal Year
$ 2,655,458

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

Yes ☒ No ☐

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

(1) a statement of the rule's basis and purpose;
This rule change allows Long Term Services and Supports (LTSS) applicants/recipients the added deductions of court ordered child support and spousal support in their patient liability budget. Also, there is an adjustment to Miller Income Trust requirements. Individuals no longer have to place all income into a Miller Income Trust, only the amount that causes the individual to be ineligible must be transferred. In addition, this rule change prohibits estate recovery from assets that are transferred by beneficiary deed.

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

This rule is required due to an agreement between DHS and the legislature concerning the patient liability update and the Miller Income Trust update. Legislation was proposed but pulled due to the agreement. Act 570 addresses the change to the estate recovery process.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This rule change is a result of legislation that was proposed for the Miller Income Trust and Act 570 for the estate recovery change.

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

There are no less costly alternatives.

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

N/A

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

The existing rule did not allow a deduction in the patient liability budget for court ordered child support and spousal support and does not allow for partial income to be placed in a Miller Income Trust. Changes to the estate recovery process for beneficiary deeds is mandated by Act 570. These changes will have a positive impact on LTSS applicants and recipients.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency will develop a plan to review the impact of this rule within a designated time frame to ensure that there is still a positive impact to the LTSS applicant/recipient.

Medical Services Policy Section A-116 and Section H

Why is this change necessary? Please provide the circumstances that necessitate the change.

The Medical Services Policy has been updated to reflect new rules concerning Miller Income Trusts, patient liability and an estate recovery process change. The changes that are implemented pursuant to ACT 570 addressing estate recovery, and an update consistent with Act 530.

Miller Income Trust rule changes are that a client's income will no longer be required to be transferred, but instead only the amount necessary to make the client income eligible. Policy is also updated to allow for court ordered child support and court ordered spousal support as allowable deductions for patient liability in the Long-Term Services and Supports categories. Policy is updated to reflect that estate recovery can no longer be made from assets that are transferred by beneficiary deed. Finally, consistent with Act 530, DCO deleted the rule that a failure to pay a premium for three (3) consecutive months will result in a debt to the State of Arkansas.

The proposed rule:

- Aligns language to correspond with the implementation of the new ARIES system;
- Further defines what income must be included in a trust;
- Includes mandatory expenses as allowable deductions;
- Clarifies that only income above the eligibility cutoff must be placed in a trust;
- Removes property transferred by beneficiary deed from estate recovery; and
- Updates the rule consistent with Act 530.

What is the change?

The following are the changes to Policy A :

1. A-116 Premiums for the Adult Expansion Group
   a. Removed the sentence " Failure to pay the premium for three (3) consecutive months will result in a debt to the State of Arkansas.

The following are the proposed changes to Policy H:

1. H-100 Long-Term Services and Supports
   a. Spelling and grammar corrected; and
   b. Formatting adjusted.
2. H-111 Requirements for an Income Trust
   a. Updated, rule change: not all income must go to trust;
   b. Updated, rule change: court-ordered child support and court-ordered spousal support are an allowable deduction;
   c. Updated, rule change: not all income must go to trust—only the amount that would make the client ineligible;
   d. Verbiage and processes changed due to new system;
   e. Business processes removed to be added to business process manual; and

f. Formatting adjusted.

3. H-112 Income Trust Application Process
    a. Business processes removed; and
    b. Formatting adjusted.
4. H-113 Post Eligibility Procedures
    a. Verbiage and processes changed due to new system;
    b. Business processes removed to be added to business process manual; and
    c. Formatting adjusted.
5. H-114 Changes to an Income Trust
    a. Verbiage and processes changed due to new system; and
    b. Formatting adjusted.
6. H-115 Reevaluations with an Income Trust
    a. Updated, rule change: not all income must go to trust—only the amount that would make the client ineligible;
    b. Verbiage and processes changed due to new system; and
    c. Formatting adjusted.
7. H-116 Termination of an Income Trust
    a. Verbiage and processes changed due to new system;
    b. Business processes removed to be added to business process manual; and
    c. Formatting adjusted.
8. H-400 Post-Eligibility
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
9. H-402 Consideration of Income
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
10. H-403 Rebutting Consideration of Income
    a. Verbiage and processes changed due to new system; and
    b. Formatting adjusted.
11. H-410 Factors Used to Determine the Cost of Care
    a. Updated, rule change: court-ordered child support and court-ordered spousal support are an allowable deduction;
    b. Updated to reflect process changes; and
    c. Formatting adjusted.
12. H-412 Contribution to the Cost of Care for Assisted Living Facilities
    a. Updated, rule change: mandatory expenses are an allowable deduction; and
    b. Formatting adjusted.
13. H-413 Contribution to the Cost of Care for PACE
    a. Updated, rule change: mandatory expenses are an allowable deduction; and
    b. Formatting adjusted.
14. H-416 Verification or Refusal of Contributions
    a. Updated to reflect process changes; and
    b. Formatting adjusted.
15. H-430 Earnings of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facility Residents
    a. Spelling and grammar corrected; and

b. Formatting adjusted.

16. H-440 Effective Eligibility Dates for Nursing Homes
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
17. H-450 Approval of an Applicant Who is in a Medicare Bed
    a. Formatting adjusted.
    b. Changed "Medicaid" to "Health Care".
18. H-481 Case Adjustments for Lump Sum Payments in Prior Months
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
    c. Changed "Medicaid" to "Health Care".
19. H-490 Absences from Long-Term Care Facilities
    a. Spelling and grammar corrected; and
    b. Formatting adjusted.
20. H-493 Operations Plan - Relocation of Recipients
    a. Spelling and grammar corrected; and
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21. H-600 Estate Recovery
    a. Updated, rule change: estate recovery can no longer be made from assets transferred by beneficiary deed; and
    b. Formatting adjusted.
22. H-630 Recovery Procedures
    a. Updated, rule change: estate recovery can no longer be made from assets transferred by beneficiary deed; and
    b. Formatting adjusted.
23. H-640 Application for a Hardship Waiver
    a. Formatting adjusted.
    b. Changed "Medicaid" to "Health Care".
24. H-700 Undue Hardship Waiver
    a. Formatting adjusted.
25. H-710 Hardship Waiver for Home Equity
    a. Language and processes updated; and
    b. Formatting adjusted.
26. H-720 Hardship Waiver for Transfer of Resources/Income
    a. Language and processes updated; and
    b. Formatting adjusted.
27. H-730 Hardship Waiver for Estate Recovery
    a. Language and processes updated; and
    b. Formatting adjusted.

A-116 Premiums For The Adult Expansion Group

MS Manual 0~~1~~8/~~01~~29/~~17~~22

A program participant who has income of at least 100% of the federal poverty level will pay a premium of no more than 2% of their income to a health insurance carrier.

Individuals who are medically frail and receiving traditional Medicaid will not be required to pay a premium.

~~Failure to pay the premium for three (3) consecutive months will result in a debt to the State of Arkansas.~~

A-116 Premiums For The Adult Expansion Group

MS Manual 08/29/22

A program participant who has income of at least 100% of the federal poverty level will pay a premium of no more than 2% of their income to a health insurance carrier.

Individuals who are medically frail and receiving traditional Medicaid will not be required to pay a premium.

H-100 Long-Term Services and Supports

MS Manual ~~07~~08/~~13~~29/~~15~~2022

The policies located in Section H of this manual describe programs and procedures that are unique to the Long-Term Services and Supports eligibility groups. These sections include:

1. Income Trusts~~,~~ (MS H-110-116);
2. Spousal Impoverishment Rules~~,~~ (MS H-200);
3. Transfer of Resources~~,~~ (MS H-300); ~~and~~
4. Post-Eligibility rules~~.~~ (MS H-400);
5. Long-Term Care Insurance Partnership Program (MS H-500);
6. Estate Recovery (MS H-600); and
7. Undue Hardship Waiver (MS H-700).

H-110 Income Trusts

MS Manual ~~01~~08/~~01~~29/~~14~~22

An individual with income in excess of the income limit may establish an income trust for the purpose of becoming ~~Medicaid~~Health Care eligible. This type of trust is commonly referred to as a Miller Income Trust.

H-111 Requirements for an Income Trust

MS Manual ~~07~~08/~~13~~29/~~15~~2022

A~~n~~ Miller Income Trust must meet the following conditions:

1. Terms and Other Conditions

   The trust must be irrevocable. It can be terminated or amended only by mutual agreement between the Department of Human Services (DHS) and the trustee.

   The trust may be used to establish ~~Medicaid~~Health Care eligibility for individuals determined tobe medically in need of care in a nursing facility or assisted living facility or PACE.

The trust must have been created either by the individual or by the individual's child, spouse, sibling, attorney-in-fact or Power of Attorney, guardian, or representative payee as determined by the Social Security Administration. Establishment of a Miller Income Trust by these individuals previously listed will be considered as valid for the purposes of Health Care eligibility.

The trust must have been established on or after August 11, 1993.

The trust can only be funded from Social Security, pension, and all other income payable to an individual, including income earned by the trust account. If assets other than income, such as real or personal property, are placed in the trust, the individual cannot be eligible for facility services under the income trust provisions.

The trust must contain a provision that all assets remaining in the trust at the individual's death will be transferred to DHS up to an amount equal to medical payments made by DHS on behalf of the individual subsequent to establishment of the trust.

2. Consideration of Income

An individual with gross monthly countable income~~,~~ (excluding VA A&A and CME/UME)~~,~~ ~~which~~ that exceeds the federal cap of three (3) times the SSI payment for an individual living in ~~his~~their own home~~,~~ may establish eligibility through an income trust.

Individuals are not required to place all their income into a Miller Income Trust to be eligible for Health Care. ~~-~~Any income, other than VA A&A and CME/UME, that exceeds the income limit must be placed in the trust.
~~All of an individual's income must be placed in the trust, except VA A&A and/or CME/UME.~~

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes but will be countable toward patient liability. Patient liability is calculated from all gross income, regardless of whether or not it is placed in the trust.

~~Income which is received directly by an individual must be transferred to the trust immediately upon receipt.~~

~~H-100 Long Term Services and Supports~~

The income (other than income accumulated by the trust) must be income payable to the individual, and the income must first be received by the individual before being placed in the trust. If the individual assigns the right to receive any or all of the income to the trust, the income assigned is no longer considered income to the individual under SSI rules. Such an assignment will be considered a disqualifying transfer. However, for purposes of this section, if an individual authorizes the income to be paid into the trust by direct deposit from the payor, the direct deposit will not be considered an assignment (disqualifying transfer).

Income in excess of the income limit that is received directly by an individual must be transferred to the trust immediately upon receipt. Any income that is not transferred into a Miller Income Trust in the month it is received will be counted when determining eligibility.

If in any month the individual's income that exceeds the income limit is not placed in the trust, the individual is not eligible for ~~Medicaid~~Health Care benefits or vendor payment in that month.

The income must be placed into and maintained in a single trust account.

If an individual receives income on an irregular basis~~,~~ (such as royalty or farm rental income~~,~~ or lump sum payments such as SSA retroactive benefits), the income must beplaced into the trust when it is received.

If an individual receives income paid jointly to ~~him~~ themselves and another person(s), the facility resident's share of the income must be separated from the ~~other owner(s) share(s)~~shares owned by the other ~~s~~person(s)~~,~~ before depositing ~~his~~ the facility resident's~~their~~ share in the trust account. No income belonging to any other individual may be placed in the income trust of a ~~Medicaid~~Health Care recipient.

3. Fees and Other Disbursements

When no relatives are available to serve as the trustee, a commercial institution such as a bank can be named as trustee. Commercially reasonable administrative fees that are charged by the commercial institution may be allowed as trustee fees. The fee will be considered commercially reasonable if the fee is consistent with administrative fees charged to other customers for similar services. Trustee fees will not be allowed except

in these instances. The bank service charges for maintaining the bank account are allowable fees.

4. Trustee Responsibilities

A trustee may serve without bond or supervision of any court.

Prior to a distribution from the trust, the trustee must notify the ~~caseworker~~eligibility worker ~~which~~ that must be made from the trust before these disbursements can be made. The advance notice must be made no later than the month ~~which~~ that precedes the month in which the disbursements will be made.

After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Notice of Action with the post-eligibility budget completed ~~Post Eligibility Income Worksheet, DCO-712, completed~~ by the ~~case worker in charge of the case~~ system. (See MS H-410.)

Any disbursements made that are not for the benefit of the recipient, the community spouse, or other dependents~~,~~ as specified ~~on the DCO-712~~on the Notice of Action and in the electronic record~~,~~ will be considered a transferof resources, and a penalty period may be applied.

Payments must be made from the trust each month only in the amounts specified ~~on the DCO-712~~ on the Notice of Action and in the electronic record. The payments must be made directly to the designated recipient, i.e., tothe recipient or responsible person for the personal needs allowance (PNA); to the community spouse ~~and/~~or dependent(s), or both, for their allowances; to the recipient or responsible party for the recipient's non-covered medical expenses; to the recipient of court-ordered child support or court-ordered spousal support~~,~~ or both; and to the facility for the patient's share of cost.

While an individual is receiving ~~Medicaid~~Health Care benefits in a facility, no disbursements otherthan those specified ~~on the DCO-712~~ on the Notice of Action and in the electronic record may be made.

The trust records shall be open to inspection and for copying by DHS, and periodic reporting may be required at the discretion of DHS.

If the trustee becomes aware of any change in circumstances ~~which~~ that will affect the recipient's eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the ~~caseworker~~eligibility worker of such changes. Changes to bereported include without limitation income changes, increase or decrease of cost of non-covered medical expenses, recipient ~~dies~~ death or ~~leaves~~departure from the facility, community spouse enter~~ings~~ a facility, etc.

The trustee must notify the ~~caseworker~~eligibility worker if in any month the funds are not disbursed according to the ~~DCO-712~~ Notice of Action or if the balance in the trust account exceeds the maximum allowed as specified in MS H-113, Post-Eligibility Procedures, so that the worker can adjust the facility payment(s) for the month(s) in which the vendor payment is affected.

H-112 Income Trust Application Process

Refer to Health Care Procedures Manual for more information.

MS Manual ~~07~~08/~~13~~29/~~15~~2022

~~The process of applying for a consists of the following steps:~~

~~Request for Eligibility Determination~~

Individuals with income above the federal cap who inquire regarding ~~Medicaid~~Health Care eligibilityin a facility or for the Waiver program will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re. MS E- 500) if requested. Individuals with excess resources **cannot** establish eligibility through an income trust.

NOTE: If an individual receives income from a LTC insurance policy that puts ~~him/her~~them over the income limit, an income trust is not required unless the other countable income~~,~~ (without counting the LTC insurance payments)~~,~~ puts ~~him/her~~them over the incomelimit.

~~1. Application for Benefits~~

~~At application for facility care or the Waiver program, the applicant, representative, guardian or other person responsible for the application, must inform the caseworker~~eligibility worker ~~of~~the ~~existence of an income trust, or that such a trust is to be established, and must provide the caseworker with a copy of the trust document.~~

~~An application will not be held longer than 45 days to permit the finalization of an income trust. If all eligibility requirements have been met with the exception of income in excess of the federal cap and the trust has not been finalized within 45 days since the date of application, the application will be denied and the individual or responsible party will be informed that reapplication may be made when the trust agreement is finalized.~~

~~2. Review for Validity~~

~~3.~~

~~As soon as possible after receiving the trust document, the caseworker~~eligibility worker ~~must submit it through eDoctus to obtain an opinion that the trust document meets the requirements of a valid income trust in Arkansas. Refer to MS E-501.~~

H-113 Post-Eligibility Procedures

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

1. Post-Eligibility Consideration of Income

   The total net countable income of an individual will be included in the post-eligibility consideration. Net income will be calculated, as for all other ~~Medicaid~~Health Care eligible individuals, in the post-eligibility process.

   ~~For example, an individual has $2500 net countable monthly income. For post-eligibility purposes, the calculations will begin with $2500. The PNA, income trust fees, spousal/dependent allowances (if applicable, but not in amounts greater than the maximum allowed on the DCO-712), and non-covered medical expenses of the recipient will be deducted. The balance remaining must then be applied to the individual's cost of care in the facility.~~

   ~~The caseworker will be responsible for providing the trustee and the recipient or his/her representative with a copy of the DCO-712 at initial certification and each time it is necessary to make a revision in the post-eligibility budget due to income changes or other changes such as those made on the DCO-712mandated by the spousal laws.~~

2. Begin Date of Eligibility

   Eligibility for facility care or Waiver services shall not begin prior to the month in which the trust is established. A trust is considered established when the completed documentis signed by the applicant and the trustee. ~~The first possible beginning date of eligibility will be the first day of the month in which an approved trust was signed, provided that the individual's income has been placed in the trust account (bank account) that month,that no unauthorized funds have been disbursed during the month, and that the individual is otherwise eligible. If funds that are not or will not be allowed by the DCO-712 have been disbursed from the trust during or after the month in which the trust is established, eligibility cannot begin until the first of the month in which all disbursements are correctly made.~~

   It must be verified prior to beginning eligibility that the individual's income ~~which~~ that exceeds the program income limit has been placed in the trust.

~~H-100 Long Term Services and Supports~~

3. Trust Balance Exceeds Divisor

There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits ~~which~~ that represent income for the following month and any spousal, ~~/~~ dependent, ~~/~~ or non-covered medical expenses amounts specified on the ~~DCO-712~~ Notice of Action and in the electronic record ~~which~~ that were not disbursed for the month) exceeds the amount of the current divisor used for transfer of resources (Appendix R), the individual will not be eligible again for facility care payment until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident. ~~During any such month(s) of ineligibility the spousal, dependent, and non-covered medical allowances may be paid according to the DCO-712, and Medicaid~~Health Care ~~benefits other than the facility vendor payment will be continued~~.

NOTE: This only applies to facility payments.

~~EXAMPLE: In October 2014, a caseworker~~eligibility worker ~~learns that an income trust had a $7,208 balance at the end of the preceding month which included a $1,200 SSA check deposited the last day of September, representing payment for October. The trustee failed to make any disbursements for September, including $40 PNA, $600 to the community spouse and $200 for non-covered medical expenses. When the October SSA check and the non-payments for September are subtracted from $7,208 ($7,208 - $1,200 - $40 - $600 - $200 = $5,168), the remainder is greater than the current divisor. Therefore, the individual is not eligible for vendor payment in September and the vendor payment will be stopped for that month.~~

~~For any such month(s) of ineligibility, the caseworker~~eligibility worker ~~will send a DCO-707, Notice of Adverse Action, to the recipient or representative, and a copy of the notice to the trustee~~.

H-114 Changes to an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 0~~7~~08/~~13~~29/~~15~~2022

1. Medicare and Other Third-Party Payments

   If in any month or part of a month a patient is in a Medicare bed or has other third party coverage which lessens or eliminates the obligation of the trustee to pay the facility for the patient's share of cost as computed on the ~~DCO-712~~ in the electronic record, the funds ~~which~~ that would have been paid to the facility in that month shall remain in the trust and may not be disbursed for reasons other than for the recipient's medical care for which there is no other third party liability.

   ~~If a trustee has paid the patient's share of vendor payment at the first of a month and later is reimbursed the funds from the facility due to payments from other third party coverage, the reimbursement must be returned immediately to the trust. If the facility does not make the refund to the trustee, i.e., places the payment(s) in the patient's facility account, the funds placed in the account will be countable toward the $2000 resource limit.~~

2. ~~Client~~ Individual Leaves Facility

   If an individual leaves a facility for a therapeutic home visit ~~(~~up to fourteen (14) days~~)~~ or for a hospital visit ~~(~~up to five (5) days~~)~~, ~~Medicaid~~Health Care benefits and vendor payment will continue, andthe trustee will make disbursements in that month as specified on the ~~DCO-712~~Notice of Action and in the electronic record.

   ~~If an individual has not returned to the facility after 14 days on a home visit or after 5 days of hospitalization, Medicaid will no longer pay the vendor payment, and the individual will be responsible for arrangements with the facility. Medicaid benefits other than the vendor payment may continue unless a formal notice of discharge is sent to the DHS County Office via DCO-702 and the recipient has not entered, nor is it anticipated that he will enter another facility. During any such period of extended home visit or hospitalization when Medicaid is not paying the facility vendor payment, the trustee may continue to disburse the spousal/dependent/non-covered medical expenses as specified on the DCO-712, and may disburse funds from the trust for medical expenses of the recipient which are not specified on the DCO-712 and not covered by Medicaid or other insurance.~~

   ~~The caseworker must determine the residence of a recipient when receiving a DCO-702, Notice of Discharge from a facility, because facilities may erroneously send discharge notices when an individual has been hospitalized for more than 5 days. A facility may also correctly send notice of discharge when an individual has been transferred directly from one facility to another, from a hospital to a second facility, or from a therapeutic home visit to a second facility. In any of the above situations, the case should not be~~

~~closed and Medicaid benefits should not be terminated.~~

If an individual improves to the extent that ~~he or she is~~ they are able to return home and ~~is~~ are deemed unlikely to need continuing care in a facility according to written medical statement, the ~~Medicaid~~Health Care case must be closed. However, the trust must be maintained according to the terms of the trust, i.e., the individual's income must continue to go intothe trust; no other individual's income may be put into the trust, etc. Disbursements may be made only for medical care, food, clothing, transportation, and shelter for the individual.

3. Changes in Community Spouse or Dependent Status

If a community spouse or dependent who has been receiving a monthly income allowance from the facility resident enters a facility, has an income change, divorces therecipient, or dies, the ~~caseworker~~ eligibility worker in charge of the case must be notified within ten (10) days by the recipient, representative, trustee, or other responsible party. No additional disbursements for the spouse or dependent can be made until the ~~caseworker~~eligibility worker has revised the ~~DCO-712~~post-eligibility budget and provided the trustee with a copy of the Notice of Action.

H-115 ~~Reevaluations with an Income Trust~~Renewals with an Income Trust

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

In addition to the required verification of other eligibility factors at annual ~~reevaluation~~renewal, the ~~caseworker~~eligibility worker will verify that the ~~individual's~~ amount required to make the client income eligible, ~~income~~ has been placed in the trust and disbursements made as required since the last ~~reevaluation~~renewal. This may be done by viewing bank statements or other trustee records that may be available.

H-116 Termination of an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

~~Within 10 days of receiving a notification of the death of an individual certified under the income trust provision, the caseworker will:~~

- ~~Send a Notice of Action to inform the trustee: That if disbursements as specified on the most recent DCO-712 were not made for the month in which death occurred, these disbursements may be made. After these disbursements have been made, no other disbursements may be made from the account until~~

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~~H-100 Long Term Services and Supports~~

~~the trustee has received instructions from the DHS Third Party Liability Unit section regarding termination of the trust (Form DCO-733).~~

- ~~Complete Form DCO-734, Report of Case Closure Due to Death, and send the form to:~~

~~Arkansas Department of Human Services~~
~~Division of Medical Services~~
~~Third Party Liability~~
~~PO Box 1437 Slot- S-296~~
~~Little Rock, AR 72203-1437~~

~~The Third Party Liability Unit will use the information provided in the DCO-734 to complete and mail the trustee the DCO-733 with instructions regarding termination of the trust.~~

Since income trusts are irrevocable, ~~income trusts~~they cannot be terminated while the individual isstill alive, except when:

- ~~OPLS~~Office of Chief Council (OCC) determines an error was made in the establishment of the trust;~~, or~~
- The individual has repaid ~~Medicaid~~Health Care all payments made since the establishment of theincome trust;~~, or~~
- Individual is moving out of state and will be establishing an income trust in the other state;~~,~~ or
- Other extraordinary circumstance.

~~In all cases, OPLS must authorize the termination of the income trust.~~

H-100 Long-Term Services and Supports

MS Manual 08/29/2022

The policies located in Section H of this manual describe programs and procedures that are unique to the Long Term Services and Supports eligibility groups. These sections include:

1. Income Trusts (MS H-110-116);
2. Spousal Impoverishment Rules (MS H-200);
3. Transfer of Resources (MS H-300);
4. Post-Eligibility rules (MS H-400);
5. Long-Term Care Insurance Partnership Program (MS H-500);
6. Estate Recovery (MS H-600); and
7. Undue Hardship Waiver (MS H-700).

H-110 Income Trusts

MS Manual 08/29/2022

An individual with income in excess of the income limit may establish an income trust for the purpose of becoming Health Care eligible. This type of trust is commonly referred to as a Miller Income Trust.

H-111 Requirements for an Income Trust

MS Manual 08/29/2022

A Miller Income Trust must meet the following conditions:

1. Terms and Other Conditions

   The trust must be irrevocable. It can be terminated or amended only by mutual agreement between the Department of Human Services (DHS) and the trustee.

   The trust may be used to establish Health Care eligibility for individuals determined to be medically in need of care in a nursing facility or assisted living facility or PACE.

   The trust must have been created either by the individual or by the individual's child, spouse, sibling, attorney-in-fact or Power of Attorney, guardian, or representative payee as determined by the Social Security Administration. Establishment of a Miller Income Trust by these individuals previously listed will be considered as valid for the purposes of Health Care eligibility.

   The trust must have been established on or after August 11, 1993.

The trust can only be funded from Social Security, pension, and all other income payable to an individual, including income earned by the trust account. If assets other than income, such as real or personal property, are placed in the trust, the individual cannot be eligible for facility services under the income trust provisions.

The trust must contain a provision that all assets remaining in the trust at the individual's death will be transferred to DHS up to an amount equal to medical payments made by DHS on behalf of the individual subsequent to establishment of the trust.

2. Consideration of Income

An individual with gross monthly countable income (excluding VA A&A and CME/UME) that exceeds the federal cap of three (3) times the SSI payment for an individual living in their own home, may establish eligibility through an income trust.

Individuals are not required to place all their income into a Miller Income Trust to be eligible for Health Care. Any income other than VA A&A and CME/UME that exceeds the income limit must be placed into the trust.

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes but will be countable toward patient liability. Patient liability is calculated from all gross income regardless of whether or not it is placed in the trust.

The income (other than income accumulated by the trust) must be income payable to the individual, and the income must first be received by the individual before being placed in the trust. If the individual assigns the right to receive any or all of the income to the trust, the income assigned is no longer considered income to the individual under SSI rules. Such an assignment will be considered a disqualifying transfer. However, for purposes of this section, if an individual authorizes the income to be paid into the trust by direct deposit from the payor, the direct deposit will not be considered an assignment (disqualifying transfer).

Income in excess of the income limit that is received directly by an individual must be transferred to the trust immediately upon receipt. Any income that is not transferred into a Miller Income Trust in the month it is received will be counted when determining eligibility.

If in any month the individual's income that exceeds the income limit is not placed in the trust, the individual is not eligible for Health Care benefits or vendor payment in that month.

The income must be placed into and maintained in a single trust account.

If an individual receives income on an irregular basis (such as royalty or farm rental income or lump sum payments such as SSA retroactive benefits) the income must be placed into the trust when it is received.

If an individual receives income paid jointly to themselves and another person(s), the facility resident's share of the income must be separated from the shares owned by the other person(s) before depositing the facility resident's share in the trust account. No income belonging to any other individual may be placed in the income trust of a Health Care recipient.

3. Fees and Other Disbursements

When no relatives are available to serve as the trustee, a commercial institution such as a bank can be named as trustee. Commercially reasonable administrative fees that are charged by the commercial institution may be allowed as trustee fees. The fee will be considered commercially reasonable if the fee is consistent with administrative fees charged to other customers for similar services. Trustee fees will not be allowed except in these instances. The bank service charges for maintaining the bank account are allowable fees.

4. Trustee Responsibilities

A trustee may serve without bond or supervision of any court.

Prior to a distribution from the trust, the trustee must notify the eligibility worker responsible for the case of any fees, income taxes, or other payments that must be made from the trust before these disbursements can be made. The advance notice must be made no later than the month that precedes the month in which the disbursements will be made.

After certification of the case, no disbursements of any kind can be made by the trustee until the trustee has been provided a current Notice of Action with the post-eligibility budget completed by the system. (See MS H-410.)

Any disbursements made that are not for the benefit of the recipient, the community spouse, or other dependents as specified on the Notice of Action and in the electronic record will be considered a transfer of resources, and a penalty period may be applied.

Payments must be made from the trust each month only in the amounts specified on the Notice of Action and in the electronic record. The payments must be made directly to the designated recipient, i.e., to the recipient or responsible person for the personal needs allowance (PNA); to the community spouse or dependent(s) for their allowances; to the recipient or responsible party for the recipient's non-covered medical expenses; to the recipient of court-ordered child support or court-ordered spousal support or both; and to the facility for the patient's share of cost.

While an individual is receiving Health Care benefits in a facility, no disbursements other than those specified on the Notice of Action and in the electronic record may be made.

The trust records shall be open to inspection and for copying by DHS, and periodic reporting may be required at the discretion of DHS.

If the trustee becomes aware of any change in circumstances that will affect the recipient's eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the eligibility worker of such changes. Changes to be reported include without limitation income changes, increase or decrease of cost of non-covered medical expenses, recipient death or departure from the facility, community spouse entering a facility, etc.

The trustee must notify the eligibility worker if in any month the funds are not disbursed according to the Notice of Action or if the balance in the trust account exceeds the maximum allowed as specified in MS H-113, Post-Eligibility Procedures, so that the worker can adjust the facility payment(s) for the month(s) in which the vendor payment is affected.

H-112 Income Trust Application Process

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

Individuals with income above the federal cap who inquire regarding Health Care eligibility in a facility or for the Waiver program will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re. MS E- 500) if requested. Individuals with excess resources **cannot** establish eligibility through an income trust.

NOTE: If an individual receives income from a LTC insurance policy that puts them over the income limit, an income trust is not required unless the other countable income, without counting the LTC insurance payments, puts them over the income limit.

H-113 Post-Eligibility Procedures

MS Manual 08/29/2022

1. Post-Eligibility Consideration of Income

   The total net countable income of an individual will be included in the post-eligibility consideration. Net income will be calculated as for all other Health Care eligible individuals in the post-eligibility process.

2. Begin Date of Eligibility

   Eligibility for facility care or Waiver services shall not begin prior to the month in which the trust is established. A trust is considered established when the completed document is signed by the applicant and the trustee.

   It must be verified prior to beginning eligibility that the individual's income that exceeds the program income limit has been placed in the trust.

3. Trust Balance Exceeds Divisor

   There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits that represent income for the following month and any spousal, dependent, or non-covered medical expenses amounts specified on the Notice of Action and in the electronic record that were not disbursed for the month) exceeds the amount of the current divisor used for transfer of resources (Appendix R), the individual will not be eligible again for facility care payment until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident.

   NOTE: This only applies to facility payments.

H-114 Changes to an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

1. Medicare and Other Third Party Payments

   If in any month or part of a month a patient is in a Medicare bed or has other third party coverage which lessens or eliminates the obligation of the trustee to pay the facility for the patient's share of cost as computed in the electronic record, the funds that would have been paid to the facility in that month shall remain in the trust and may not be disbursed for reasons other than for the recipient's medical care for which there is no other third party liability.

2. Individual Leaves Facility

   If an individual leaves a facility for a therapeutic home visit up to fourteen (14) days or for a hospital visit up to five (5) days, Health Care benefits and vendor payment will continue, and the trustee will make disbursements in that month as specified on the Notice of Action and in the electronic record.

   If an individual improves to the extent that they are able to return home and are deemed unlikely to need continuing care in a facility according to written medical statement, the Health Care case must be closed. However, the trust must be maintained according to the terms of the trust, i.e., the individual's income must continue to go into the trust; no other individual's income may be put into the trust, etc. Disbursements may be made only for medical care, food, clothing, transportation, and shelter for the individual.

3. Changes in Community Spouse or Dependent Status

   If a community spouse or dependent who has been receiving a monthly income allowance from the facility resident enters a facility, has an income change, divorces the recipient, or dies, the eligibility worker in charge of the case must be notified within ten (10) days by the recipient, representative, trustee, or other responsible party. No additional disbursements for the spouse or dependent can be made until the eligibility worker has revised the post-eligibility budget and provided the trustee with a copy of the Notice of Action.

H-115 Renewals with an Income Trust

MS Manual 08/29/2022

In addition to the required verification of other eligibility factors at annual renewal, the eligibility worker will verify that the amount required to make the client income-eligible has been placed in the trust and disbursements made as required since the last renewal. This may be done by viewing bank statements or other trustee records that may be available.

H-116 Termination of an Income Trust

Refer to Health Care Procedures Manual for more information.

MS Manual 08/29/2022

Since income trusts are irrevocable, they cannot be terminated while the individual is still alive, except when:

- Office of Chief Council (OCC) determines an error was made in the establishment of the trust;

- The individual has repaid Health Care all payments made since the establishment of the income trust;
- Individual is moving out of state and will be establishing an income trust in the other state; or
- Other extraordinary circumstance.

H-400 Post-Eligibility

MS Manual 0708/0129/20022

The eligibility groups Nursing Facility, Assisted Living Facility, PACE recipients in a nursing facility, and PACE recipients in the community who have met income eligibility by establishing an irrevocable Miller Income Trust, all require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

H-402 Consideration of Income

MS Manual 078/0129/20022

After the IS has been determined to be resource eligible for Long-Term Services and Supports (LTSS), income of the IS and CS will be considered as follows:

1. Income Not From A Trust:

   a. Income received solely in the name of either spouse will be considered income only to that spouse. Refer to MS E-432 #5 for "Veteran's Benefits" exceptions.

   b. If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS.

   c. If payment of income is made in the names of the IS and/or the CS or both and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and no such interest is specified, one half (1/2) of the joint interest will be considered available to each spouse.

2. Income From A Trust:

   Income from a trust will be considered available to each spouse as provided by the trust. or, if In the absence of a specific provision in the trust, the income will be considered available to each spouse as according to the rules in 1. a-c above or as directed by the Office of Chief Counsel (OCC) opinion. If the IS or CS established the trust, refer to MS H-304 for consideration of income from the trust.

3. Income Through Property With No Instrument Establishing Ownership:

When income is from property ~~which~~ that has no instrument establishing ownership (for example, ~~i.e. unprobated or,~~ income-producing heir's property), ~~one~~ half of the income will be considered to be available to the IS and ~~one~~ half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 0~~7~~8/~~01~~29/~~202~~2022

The eligibility worker will advise the applicant or representative of the income that will be considered in the gross income test of the institutionalized spouse (IS).

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. To successfully rebut the presumption of full or partial ownership, the IS or the representative ~~he/she~~ must provide the following within thirty (30) days of the date on the ~~DHS-0712, Post Eligibility Income Worksheet~~Notice of Action:

1. A written, signed statement by the IS ~~giving his/her allegation regarding~~alleging ownership, the reason for the applicant's receipt of the income, or for ~~his/her~~their name appearing as an owner on the payment of the income;
2. Corroborating signed statements from the other owner(s);
3. A change in the instrument of ownership removing the IS's name from the instrument or a change ~~which~~ that redirects the income to the actual owner(s); and

~~4.~~ Copies of the original and revised documents reflecting the change.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the income.

If the individual elects not to rebut the consideration of ownership interest, the eligibility worker will obtain a written statement from the individual ~~which~~ that documents ~~his/her~~their election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the income produced from the presumed ownership interest will be used in ~~his/her~~the individual's eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined, and the findings will be documented in the case record. The income from the actual ownership interest (~~i.e.,~~that is, the interest determined by the rebuttal) will be used in the eligibility determination.

When the individual has successfully rebutted ownership of all or a portion of the income, income payments will be considered available to the IS in proportion to ~~his/her~~their interest (if any).

NOTE: This section does not apply to federal, state, or other entitlements, pensions, or retirement benefits.

H-410 Factors Used to Determine the Cost of Care

MS Manual 0~~7~~8/~~01~~29/2022~~02~~

Nursing facility recipients are required to contribute all of their monthly income, minus certain approved deductions, to the cost of their facility care. ~~Medicaid~~Health Care pays the balance of the monthlycharges due, based on a per diem rate according to the individual's Level of Care.

NOTE: ARChoices and DDS Waiver recipients do not contribute to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living andPACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the applicant~~/~~ or recipient, their spouse, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed in the eligibility system and a Notice of Action will be sent~~on form DHS-0712, Post-Eligibility Income Worksheet,~~ for the appropriate time period.

Steps for determining the amount of income to be applied to the cost of care are shown below:

1. **Total Earned and Unearned Income**

   Total all income of the recipient by type and amount with the following exceptions:

   - For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget.
   - VA Aid and Attendance payments and VA CME/UME will not be counted as income.
   - Mandatory deductions and work-related expenses will be deducted from gross earnings.
   - Court-ordered child support and court-ordered spousal support will be deducted from earned or unearned income.
   - An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in ~~10~~ten-bed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and State Human Development Centers. Refer to MS H-430.
   - LTC insurance payments, whether paid to the facility or directly to the recipient, are not considered in the eligibility process but are counted toward cost of care.

2. **Income Trust Fees (if applicable)**

   Deduct the applicable income trust fees. Refer to MS H-111 #3.

- The monthly service charge for maintaining the trust bank account; and
- Commercially reasonable administrative fees charged by the commercial institution serving as trustee.

3. Personal Needs Allowance

Deduct the personal needs allowance (PNA).

- Subtract a forty-dollar ($40) ~~$40~~ PNA for most facility residents.

NOTE: Facility residents whose only income is SSI will be allowed to keep thirty dollars ($30) ~~$30~~ as their PNA. The PNA of an SSI recipient who also has other income is forty dollars ($40)~~$40~~. Refer to MS H-420.

Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to ninety dollars ($90)~~$90~~ will be given the full ninety dollars ($90) ~~$90~~ as a personal needs allowance. An additional forty dollars ($40) ~~$40~~ will not be given. A ninety dollars ($90)~~$90~~ PNA will not be given to any individual whose VA pension has not been reduced to ninety dollars ($90)~~$90~~ by the Veterans Administration (VA). If VA later reduces the pension to ninety dollars ($90)~~$90~~, an income adjustment will be made. Individuals should contact the Veterans Administration if they believe they are entitled to a ninety-dollar ~~($90)~~ reduced pension.

- For residents of ICF/IIDs and State Human Development Centers with earned income, forty dollars ($40) ~~$40~~ may be given as a PNA in addition to a disregard of earned income up to the current SSI SPA.
- For nursing facility residents with earned income, forty dollars ($40) ~~$40~~ may be given as a PNA in addition to a disregard of up to one-hundred dollars ($100) ~~$100~~ of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. Refer to MS H-430.

4. Community Spouse Monthly Income Allowance (CSMIA)

- A community spouse (CS) may be entitled to a portion of the Institutionalized Spouse's (IS) income. The total amount of the IS's income, to which the CS is entitled, is the **CSMIA**. It is calculated by adding the Minimum Monthly Maintenance Needs Allowance (**CSMNA**) and the Excess Shelter Allowance and subtracting the community spouse's own income. The CSMNA is capped at a Maximum Monthly Maintenance Needs Allowance amount. The excess shelter allowance, CSMNA, and Maximum Monthly Maintenance Needs Allowance change annually. They are set by the federal government and are based on the Consumer Price Index.
- Shelter costs may include rent or mortgage (including principal and interest), prorated taxes and insurance (including personal property taxes and insurance on household contents if paid yearly), condominium or cooperative fee (including maintenance charges), and the standard utility allowance.

  Shelter costs must be verified. Utilities need not be verified.

NOTE: The standard utility allowance is not allowed if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (~~e.g.~~for example, water), the full utility allowance may be used.

- The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income, ~~;~~ meaning~~i.e.~~, the actual contributions will be deducted instead of the computed CSMIA. Refer to MS H-416.

- An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA. Refer to MS H-208.

- If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will not be subject to the limit on the CSMNA.

5. Family Member Allowance (FMA) When There is a Spouse in the Home

- A dependent family member may be entitled to an allowance. See MS Glossary for definition of dependent family member.

- The FMA is computed for each dependent family member by deducting the family member's income from the **CSMNA** and by dividing the result by three (3).

- The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income (~~i.e.~~that is, the actual contribution) will be deducted instead of the computed FMA. Refer to MS H-415.

NOTE: A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether to accept a CSMIA or FMA. The result of accepting an allowance may be reduction or termination of SSI benefits and ~~Medicaid~~Health Care. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

6. Protected Maintenance Allowance for Dependent Children When There is No Spouse in the Home

- In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.

- Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under eighteen (18) years of age~~the age of 18~~, the combined income of the children must be less than the Medically Needy Income Level (MNIL) for the appropriate number of children in the

household to qualify for protected maintenance. Refer to MS O-710 for MNILs.

- In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance.

7. Non-covered Medical Expenses 42 CFR § 435.725; Arkansas Act 892

Non-covered medical expenses of all facility recipients ~~which~~ that are not subject to payment bya third party will be deducted. Per **42 CFR § 435.725**, this includes incurred expenses for medical or remedial care that are not subject to payment by a third party, including~~—~~:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under ~~State~~ state law but not coveredunder the ~~S~~state's ~~Medicaid~~Health Care plan, subject to reasonable limits the agency may establish on amounts of these expenses.

Reasonable limits on amounts for necessary medical, or remedial care, not covered under~~Medicaid~~Health Care:

- The non-covered expenses must be incurred no earlier than the three-month period preceding the month of application.
- The non-covered expenses must be prescribed by a Medical professional (~~e.g.,~~for example: a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic or ~~/~~elective procedures (~~e.g.,~~for example.: face lifts or liposuction) will not be allowed except when prescribed by a medical professional.The expense amount is the least of the fee recognized by ~~Medicaid~~Health Care, Medicare, or theaverage cost allowed by a commercial health insurance plan in Arkansas.
- Expenses incurred as a result of the imposition of a transfer of assets penalty are not allowed.
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or ~~Medicaid~~Health Care, due to the service being medically unnecessary, arenot allowed.
- Deduction is not allowed for procedures allowed by ~~Medicaid~~Health Care when prior authorizationis denied due to the service being medically unnecessary.
- Expenses when a third party (including ~~Medicaid~~Health Care) is liable for the expenses, even ifprovided by an out-of-network provider, are not allowed.
- General health insurance premiums paid by someone other than the recipient (excluding the community spouse) who is not a financially responsible relative and repayment is not expected to be paid back to the third party by the recipient, are not allowed.

The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future. Only the non-covered medical expenses for the facility recipient may be deducted.

When there is a contract, between an applicant and a medical provider, and regular payments on a medical bill are being made, the monthly payment will be deducted as a non-coverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

Deduction of medical expenses is not allowed for nursing facility and ICF/IID residents for items and services included in the state's Reimbursement Cost Manual as allowable cost items (items the facility will provide). Examples of these include wheelchairs, canes, crutches, walkers, ambulance services or enrollment fees for ambulance services (unless there is not a ~~Medicaid~~Health Care enrolled ambulance provider in the area), other transportation services, over-the-counter pain killers, antacids, laxatives, cough syrups, suppositories, anti-diarrhea medication, diapers, band-aids, bandages, peroxide, antiseptics, ~~etc~~. Facilities are required to provide these items and services at no additional charge to the recipient.

An income offset for the purchase of eyeglasses, contact lenses, hearing aids, prostheses, and dentures can be made only if the following procedure is followed:

- The items must be prescribed by a physician or other licensed medical practitioner.
- The items must be a part of the recipient's plan of care. It must be determined by
  - the facility interdisciplinary team that the recipient's quality of life will be enhancedand that ~~he or she is~~ they are able to utilize the item(s).
- The request must be approved by the facility's Quality Assessment and Assurance
  - Committee.
- The cost of the item(s) must be determined.
- The recipient or authorized representative must provide the eligibility worker with verification of the above. The recipient or authorized representative must not makethe purchase or pay the medical bill until the eligibility worker has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include without limitation: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the ~~Medicaid~~Health Care formulary; and physician, hospital, and dental charges~~; etc~~. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility worker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, including proof of the cost. A copy of thehealth insurance bill can be used for proof of health insurance premiums, deductibles, andcoinsurance.

Medicare premiums deducted from SSA payments prior to buy-in are not allowed, as

they will be reimbursed. The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

NOTE: There is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the ~~Medicaid~~Health Care formulary. ~~Medicaid~~Health Care facility recipients who are not certified for vendor payment are limited to three (3) prescriptions per month. Nursing facility hospice recipientsare eligible for three (3) prescriptions drugs per month, with the option of receiving up to six (6) prescriptions with prior authorization.

Medical expenses can be of three types:

a. Monthly - Expenses ~~incurred regularly~~regularly incurred each month, such as the Medicare Part D enhanced plan portion of premiums above the benchmark;

b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums; or

c. One-time - Expenses incurred such as hearing aids.

If the eligibility worker is unable to determine within a fair degree of certainty what the non-covered medical expenses will be, then no medical expenses will be deducted from the income.

8. Net Income

After deduction of any applicable excluded earnings, income trust fees, personal needs allowance, maintenance allowances, court-ordered child support, court-ordered spousal support, and non-covered medical expenses, the net amount remaining will be the amount the individual is expected to apply to the cost of care.

If all of the IS's gross income is depleted at any step in the computation, the amount applied to the vendor payment (cost of care) will be zero dollars ($0). ~~$0.~~

After the ~~DHS-0712~~post-eligibility budget is completed, a copy of the information will be provided to each spouse. If the budget ~~form~~ is completed prior to application, at the request of either spouse, the ~~DHS-0712~~information will only be provided to the spouse making the request.

H-412 Contribution to the Cost of Care for Assisted Living Facilities

MS Manual 0~~7~~8/~~01~~29/2~~0~~2

Assisted Living Facility (ALF) Waiver recipients are allowed to keep a flat ninety and eight hundredths of a percent (90.8%) ~~90.8%~~ rounded up of the SSI/SPA for room and board. This will allow the individual to purchase food from the facility, or elsewhere, if they prefer. In addition to the charge for room and board, a monthly personal allowance will be deducted. The personal allowance will be based on (nine percent) 9%-of the SSI/SPA and rounded up. Both will increase

each January with the SSA/SSI Cost of Living Increases. See Appendix S for current amounts.

The following expenses are to be deducted from the cost of care for the ALF recipient in the following order:

~~1.~~ Room and board payment

a. NOTE: If the individual is receiving assistance through HUD, the deduction can only befor the amount the individual is actually paying.

2. Personal needs allowance (PNA)

~~2.~~3. Court-ordered child support and court-ordered spousal support.

~~3.~~4. Monthly medical insurance premiums

~~4.~~5. Non-covered medical expenses including over-the-counter medications and medical supplies

~~5.~~6. Spousal support payments for the community spouse and Family Member Allowance(MS H-410 #4-6)

~~6.~~7. Applicable income trust fees (MS H-111 #3)

~~7.~~8. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician

The ALF recipient's income, minus room and board, personal allowance, and certain other expenses, will be contributed to their cost of care each month.

H-413 Contribution to the Cost of Care for PACE

MS Manual 0~~7~~8/~~01~~29/2022~~02~~

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long-Term Services and Supports (LTSS) nursing facility ~~Medicaid~~Health Care. Refer to MS H-410.

For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust. For income trust guidelines, refer to MS H-110.

The eligibility worker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The patient liability amount will be calculated ~~using the form DHS-0712~~in the electronic record. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current nursing facility PNA, any applicable community spouse allowances ~~and/or~~, family allowances, court-ordered child support, court-ordered spousal support, and excess medical expenses will be deducted from the PACE participant's monthly income. Refer to MS H-410.

For individuals in the community who are eligible through establishing an income trust, income in excess of the current LTSS ~~Medicaid~~Health Care limit will also be paid to the PACE provider.

A personal needs allowance equal to the current LTSS/PACE limit of three (3) times the current SSI standard payment amount (SPA), plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-416 Verification or Refusal of Contributions

MS Manual 0~~7~~8/~~01~~29/2022~~02~~

Prior to certification of the Institutionalized Spouse (IS), the IS or representative must ~~complete and sign the statement on the reverse of the DHS-0712 to~~ indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) and the Family Member Allowance (FMA) specified on the ~~DHS-0712~~Notice of Action~~,~~ during the period of institutionalization.

~~If the DHS-0712 is not completed and signed~~Otherwise, **no** allowances for the CS or other family memberswill be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS ~~should~~ may decline the income~~by completing the appropriate section on the DHS-0712.~~.

H-430 Earnings of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facility Residents

MS Manual ~~07/01/20~~08/29/22

Residents of ICF/IID facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI standard payment amount (SPA) in addition to the forty dollars ($40)~~$40~~ personal needs allowance.

Nursing facility residents with earnings may be given a disregard of up to one-hundred ($100) of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Division of Provider Services and Quality Assurance (DPSQA) Office of Long~~-~~Term~~-~~Care (OLTC) should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/IID residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Ten~~-~~Bed ICF/IID Facilities and State Human Development Centers

   Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (~~e.g.,~~ for example, federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS H-410 for consideration of earnings at certification.

2. Fluctuating Earnings

If the earnings of ICF/IID facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

The facility administrator will report to the eligibility worker any month in which a resident's earnings exceed the SSI SPA.

If earnings consistently stay above the SSI SPA, they may be averaged (MS E-415), provided the facility administrator will agree to report to the eligibility worker:

- Every six (6) months when earnings are fairly stable, or H-400 Post-Eligibility; or
- more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than fifteen dollars ($15) ~~$15~~ above the computed average.

H-440 Effective Eligibility Dates for Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services

MS Manual 0~~7~~8/~~01~~29/202~~0~~2

The effective date of eligibility of an applicant for nursing home and ICF/IID depends on three (3) factors:

1. Date of Entry – The individual's date of entry into a participating facility is indicated on the DCO-0702, Notice of Admission, Discharge or Transfer From a Facility, which is completed by the facility and forwarded to both the DPSQA Office of Long-Term Care and the County Office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity – Medical necessity is determined by the DPSQA Office of Long-Term Care. The medical necessity decision is transmitted to the County Office and the facility by the DHS-0704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-0704 is received by the County Office on an applicant ~~which~~ that classifies ~~him/her~~them for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for ~~Medicaid~~Health Care was made. However, if the patient is in an ICF/IID facility or was subject to Pre-Admission Screening and Annual Resident Review (PASARR), medical necessity begins on the DHS-0704 decision date, for ICF/IID or PASARR- date for PASARR residents, and ~~Medicaid~~Health Care and vendor payment cannot begin prior to this date.

~~1.~~3. Date of Categorical Eligibility – Categorical eligibility for facility care and services under the

AABD criteria can be established to begin three (3) months prior to the date of application, provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three ~~(3)~~ -month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, ~~however,~~ the begin date for ~~Medicaid~~Health Care and vendor payment cannot be prior to the decision date on the DHS-0704 for ICF/IID applicants or PASARR date for individuals subject to PASARR. Authorization of services cannot be made until all three (3) factors have been met.

H-450 Approval of an Applicant Who is in a Medicare Bed

MS Manual 0~~7~~8/~~01~~29/202~~0~~2

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and ~~Medicaid~~ Health Carecoinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by ~~Medicaid~~ Health Care until the case is opened.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third-party resource to be applied to the cost of care in a facility.

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the eligibility worker of the change in status. On the day following termination of Medicare benefits, the eligibility worker may authorize facility services to be effective on that date, provided the individual continues to meet all Long- Term Services and Supports (LTSS) requirements.

H-481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual 0~~7~~8/~~01~~29/202~~0~~2

When a eligibility worker learns that a recipient, who does not have an Income Trust, received a lump sum benefit in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed, and a new application will be required.

Overpayment reports for Long-Term Services and Supports (LTSS) and other ~~Medicaid~~Health Care categories will be submitted to recover any ~~Medicaid~~Health Care payments made during the month of ineligibility.

Refer to MS Section M. If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

H-490 Absences from ~~Long Term~~Long-Term Care Facilities

MS Manual 0~~7~~8/~~01~~29/202~~0~~2

All facilities are required to report to the County Office certain recipient absences from the

facility. Absences will be reported for death, discharge, and transfer. Overnight home visits and hospitalizations will not be reported. Admissions to the Arkansas State Hospital (Little Rock) will be reported as discharges.

Death or Discharge

Upon notification from the facility reporting the death or discharge of a recipient, the County Office will initiate action to close the recipient's case. Advance notice is not required for closure due to death.

Home Visits

A recipient receiving ~~long-term~~Long-Term care services has the right to make overnight home visitswhenever ~~he~~they desire~~s~~, provided the~~y~~ visits are consistent with ~~his~~ the recipient's required level of care and ~~his~~their attending physician's orders. This includes authorized home visits during the thirty (30) days in which institutional status is achieved.

The DPSQA Office of Long-Term Care is responsible for monitoring recipient home visits and their consistency with the patient's required level of care. For example, a skilled care patient who makes overnight home visits might require reclassification action by Long-Term Care.

Facility services may continue during a recipient's absence due to therapeutic home visit without regard to the cumulative number of days absent during a calendar year. However, a fourteen (14) consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than fourteen (14)~~14~~ days will not be reported by facilities to the County Office. The date left counts as the first day of absence. When there is an indication that the recipient is expectedto return to the facility within fourteen (14)~~14~~ days, the County Office will take no action.

For home visits~~, which~~ that exceed fourteen (14) ~~14~~ consecutive days, facilities will report the date left and a discharge on the ~~15~~fifteenth consecutive day of absence. When there is no indication that the recipient is expected to return to the facility within fourteen (14) days, the County Office will initiate action to close the case.

- Cases suspended or closed can be reinstated without new application if the recipient returns to the facility within ninety (90) days of the date left on home visit.
- If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.
- If the individual does not reenter the facility within ninety (90) days, a new application will be required to reopen the case

H-493 Operations Plan - Relocation of Recipients

MS Manual 0~~7~~8/~~01~~29/202~~0~~2

The Division of Provider Services and Quality Assurance (DPSQA) Office of Long-Term Care

(OLTC) will initiate all relocation actions of ~~A~~agency recipients in facilities ~~which~~ that are closed for anyreason other than a disaster. Such reasons include decertification by the federal government orthe DPSQA, loss of licenses, voluntary withdrawal from the ~~Medicaid~~Health Care Program, or cancellation ofagreement by the DPSQA. Since federal regulations require all program recipients to be relocated within thirty (30) days of the termination date, it is essential that specific procedures be established to ensure that recipients are relocated with maximum safety and well-being.

Authority to initiate, direct, and monitor all relocation actions is delegated to the AssistantDirector of the Office of Long-Term Care, by the Director of the DPSQA.

H-400 Post-Eligibility

MS Manual 08/29/2022

The eligibility groups Nursing Facility, Assisted Living Facility, PACE recipients in a nursing facility, and PACE recipients in the community who have met income eligibility by establishing a Miller Income Trust all require certain procedures to complete the determination of eligibility. These eligibility procedures are explained in the following sections.

H-402 Consideration of Income

MS Manual 08/29/2022

After the IS has been determined to be resource eligible for Long-Term Services and Supports (LTSS), income of the IS and CS will be considered as follows:

1. Income Not From A Trust

    - Income received solely in the name of either spouse will be considered income only to that spouse. Refer to MS E-432 #5 for "Veteran's Benefits" exceptions.

    - If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS.

    - If payment of income is made in the names of the IS or the CS or both and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and no such interest is specified, one half (1/2) of the joint interest will be considered available to each spouse.

2. Income From A Trust

   Income from a trust will be considered available to each spouse as provided by the trust. In the absence of a specific provision in the trust, the income will be considered available to each spouse as according to the rules in 1. a-c above or as directed by the Office of Chief Counsel (OCC) opinion. If the IS or CS established the trust, refer to MS H-304 for consideration of income from the trust.

3. Income Through Property With No Instrument Establishing Ownership

   When income is from property that has no instrument establishing ownership (for example, income-producing heir's property), half of the income will be considered to be available to the IS and half to the CS.

H-403 Rebutting Consideration of Income

MS Manual 08/29/2022

The eligibility worker will advise the applicant or representative of the income that will be considered in the gross income test of the institutionalized spouse (IS).

If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS H-402, the IS or the representative will be given the opportunity to rebut the presumption of ownership. To successfully rebut the presumption of full or partial ownership, the IS or the representative must provide the following within thirty (30) days of the date on the Notice of Action:

1. A written, signed statement by the IS alleging ownership, the reason for the applicant's receipt of the income, or for their name appearing as an owner on the payment of the income;
2. Corroborating signed statements from the other owner(s);
3. A change in the instrument of ownership removing the IS's name from the instrument or a change that redirects the income to the actual owner(s); and
4. Copies of the original and revised documents reflecting the change.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the income.

If the individual elects not to rebut the consideration of ownership interest, the eligibility worker will obtain a written statement from the individual that documents their election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the income produced from the presumed ownership interest will be used in the individual's eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined and the findings will be documented in the case record. The income from the actual ownership interest (that is, the interest determined by the rebuttal) will be used in the eligibility determination.

When the individual has successfully rebutted ownership of all or a portion of the income, income payments will be considered available to the IS in proportion to their interest (if any).

NOTE: This section does not apply to federal, state, or other entitlements, pensions, or retirement benefits.

H-410 Factors Used to Determine Cost of Care

MS Manual 08/29/2022

Nursing facility recipients are required to contribute all of their monthly income, minus certain approved deductions, to the cost of their facility care. Health Care pays the balance of the monthly charges due based on a per diem rate according to the individual's Level of Care.

NOTE: ARChoices and DDS Waiver recipients do not contribute to the cost of their care. For the contribution to the cost of care guidelines for Assisted Living and PACE recipients, refer to MS H-412 and MS H-413.

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the applicant or recipient, their spouse, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed in the eligibility system and a Notice of Action will be sent for the appropriate time period.

Steps for determining the amount of income to be applied to the cost of care are shown below:

1. Total Earned and Unearned Income

   Total all income of the recipient by type and amount with the following exceptions:

   - For State Human Development Centers and Arkansas Health Center residents, interest income is not counted in the monthly budget.
   - VA Aid and Attendance payments and VA CME/UME will not be counted as income.
   - Mandatory deductions and work-related expenses will be deducted from gross earnings.

- Court-ordered child support and court-ordered spousal support will be deducted from earned or unearned income.
- An additional amount of up to the current SSI/SPA will be deducted from the earnings of residents in ten-bed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and State Human Development Centers. Refer to MS H-430.
- LTC insurance payments, whether paid to the facility or directly to the recipient, are not considered in the eligibility process but are counted toward cost of care.

2. Income Trust Fees (if applicable)

   Deduct the applicable income trust fees. Refer to MS H-111 #3.

   - The monthly service charge for maintaining the trust bank account and
   - Commercially reasonable administrative fees charged by the commercial institution serving as trustee

3. Personal Needs Allowance

   Deduct the personal needs allowance (PNA).

   - Subtract a forty-dollar ($40) PNA for most facility residents.

     NOTE: Facility residents whose only income is SSI will be allowed to keep thirty dollars ($30) as their PNA. The PNA of an SSI recipient who also has other income is forty dollars ($40). Refer to MS H-420.

   - Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to $90 will be given the full ninety dollars ($90) as a personal needs allowance. An additional forty dollars ($40) will not be given. A ninety dollar ($90) PNA will not be given to any individual whose VA pension has not been reduced to ninety dollars ($90) by the Veterans Administration (VA). If VA later reduces the pension to ninety dollars ($90), an income adjustment will be made. Individuals should contact the Veterans Administration if they believe they are entitled to a ninety-dollar ($90) reduced pension.
   - For residents of ICF/IIDs and State Human Development Centers with earned income, forty dollars ($40) may be given as a PNA in addition to a disregard of earned income up to the current SSI SPA.
   - For nursing facility residents with earned income, forty dollars ($40) may be given as a PNA in addition to a disregard of up to one-hundred dollars ($100) of

their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. Refer to MS H-430.

4. Community Spouse Monthly Income Allowance (CSMIA)

- A community spouse (CS) may be entitled to a portion of the Institutionalized Spouse's (IS) income. The total amount of the IS's income to which the CS is entitled is the CSMIA. It is calculated by adding the Minimum Monthly Maintenance Needs Allowance (CSMNA) and the Excess Shelter Allowance and subtracting the community spouse's own income. The CSMNA is capped at a Maximum Monthly Maintenance Needs Allowance amount. The excess shelter allowance, CSMNA, and Maximum Monthly Maintenance Needs Allowance change annually. They are set by the federal government and are based on the Consumer Price Index.
- Shelter costs may include rent or mortgage (including principal and interest), prorated taxes and insurance (including personal property taxes and insurance on household contents if paid yearly), condominium or cooperative fee (including maintenance charges), and the standard utility allowance.
- Shelter costs must be verified. Utilities need not be verified.

  NOTE: The standard utility allowance is not allowed if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (for example, water), the full utility allowance may be used.

- The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income, meaning, the actual contributions will be deducted instead of the computed CSMIA. Refer to MS H-416.
- An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA. Refer to MS H-208.
- If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will not be subject to the limit on the CSMNA.

5. Family Member Allowance (FMA) When There is a Spouse in the Home

- A dependent family member may be entitled to an allowance. See MS Glossary for definition of dependent family member.

- The FMA is computed for each dependent family member by deducting the family member's income from the CSMNA and by dividing the result by three (3).

- The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income (that is, the actual contribution) will be deducted instead of the computed FMA. Refer to MS H-415.

  NOTE: A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether to accept a CSMIA or FMA. The result of accepting an allowance may be reduction or termination of SSI benefits and Health Care. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

6. Protected Maintenance Allowance for Dependent Children When There is No Spouse in the Home

   - In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home when there is no spouse in the home.

   - Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent children under eighteen (18) years of age the combined income of the children must be less than the Medically Needy Income Level (MNIL) for the appropriate number of children in the household to qualify for protected maintenance. Refer to MS O-710 for MNILs.

   - In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance.

7. Non-covered Medical Expenses

Non-covered medical expenses of all facility recipients that are not subject to payment by a third party will be deducted. Per 42 CFR § 435.725, this includes incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

- Medicare and other health insurance premiums, deductibles, or coinsurance charges and
- Necessary medical or remedial care recognized under state law but not covered under the state's Health Care plan, subject to reasonable limits the agency may establish on amounts of these expenses

Reasonable limits on amounts for necessary medical or remedial care not covered under Health Care:

- The non-covered expenses must be incurred no earlier than the three-month period preceding the month of application.
- The non-covered expenses must be prescribed by a Medical professional (for example, a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic or elective procedures (for example, face lifts or liposuction) will not be allowed except when prescribed by a medical professional.
- The expense amount is the least of the fee recognized by Health Care, Medicare, or the average cost allowed by a commercial health insurance plan in Arkansas.
- Expenses incurred as a result of the imposition of a transfer of assets penalty are not allowed.
- Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Health Care, due to the service being medically unnecessary, are not allowed.
- Deduction is not allowed for procedures allowed by Health Care when prior authorization is denied due to the service being medically unnecessary.
- Expenses when a third party (including Health Care) is liable for the expenses, even if provided by an out-of-network provider, are not allowed.

- General health insurance premiums paid by someone other than the recipient (excluding the community spouse) who is not a financially responsible relative and repayment is not expected to be paid back to the third party by the recipient, are not allowed.

The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future. Only the non-covered medical expenses for the facility recipient may be deducted.

When there is a contract between an applicant and a medical provider and regular payments on a medical bill are being made, the monthly payment will be deducted as a noncoverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

Deduction of medical expenses is not allowed for nursing facility and ICF/IID residents for items and services included in the state's Reimbursement Cost Manual as allowable cost items (items the facility will provide). Examples of these include wheelchairs, canes, crutches, walkers, ambulance services or enrollment fees for ambulance services (unless there is not a Health Care enrolled ambulance provider in the area), other transportation services, over-the-counter pain killers, antacids, laxatives, cough syrups, suppositories, anti- diarrhea medication, diapers, band-aids, bandages, peroxide, antiseptics. Facilities are required to provide these items and services at no additional charge to the recipient.

An income offset for the purchase of eyeglasses, contact lenses, hearing aids, prostheses, and dentures can be made only if the following procedure is followed:

- The items must be prescribed by a physician or other licensed medical practitioner.
- The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that they are able to utilize the item(s).
- The request must be approved by the facility's Quality Assessment and Assurance Committee.
- The cost of the item(s) must be determined.

- The recipient or authorized representative must provide the eligibility worker with verification of the above. The recipient or authorized representative must not make the purchase or pay the medical bill until the eligibility worker has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include without limitation: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Health Care formulary; and physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the eligibility worker with proof that the item or items were prescribed by a physician or other licensed medical practitioner, including proof of the cost. A copy of the health insurance bill can be used for proof of health insurance premiums, deductibles, and coinsurance.

Medicare premiums deducted from SSA payments prior to buy-in are not allowed as they will be reimbursed. The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

NOTE: There is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the Health Care formulary. Health Care facility recipients who are not certified for vendor payment are limited to three (3) prescriptions per month. Nursing facility hospice recipients are eligible for three (3) prescriptions drugs per month, with the option of receiving up to six (6) prescriptions with prior authorization.

Medical expenses can be of three types:

- Monthly - Expenses regularly incurred each month such as the Medicare Part D enhanced plan portion of premiums above the benchmark;
- Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly insurance premiums; or
- One-time - Expenses incurred such as hearing aids.

If the eligibility worker is unable to determine within a fair degree of certainty what the non- covered medical expenses will be, then no medical expenses will be deducted from the income.

8. Net Income

   After deduction of any applicable excluded earnings, income trust fees, personal needs allowance, maintenance allowances, court-ordered child support, court-ordered spousal support, and non-covered medical expenses, the net amount remaining will be the amount the individual is expected to apply to the cost of care.

   If all of the IS's gross income is depleted at any step in the computation, the amount applied to the vendor payment (cost of care) will be zero dollars ($0).

   After the post-eligibility budget is completed, a copy of the information will be provided to each spouse. If the budget is completed prior to application, at the request of either spouse, the information will only be provided to the spouse making the request.

H-412 Contribution to the Cost of Care for Assisted Living Facilities

MS Manual 08/29/2022

Assisted Living Facility (ALF) Waiver recipients are allowed to keep a flat ninety and eight hundredths of a percent (90.8%) rounded up of the SSI/SPA for room and board. This will allow the individual to purchase food from the facility, or elsewhere, if they prefer. In addition to the charge for room and board, a monthly personal allowance will be deducted. The personal allowance will be based on (nine percent) 9% of the SSI/SPA and rounded up. Both will increase each January with the SSA/SSI Cost of Living Increases. See Appendix S for current amounts.

The following expenses are to be deducted from the cost of care for the ALF recipient in the following order:

1. Room and board payment

   NOTE: If the individual is receiving assistance through HUD, the deduction can only be for the amount the individual is actually paying.

2. Personal needs allowance (PNA)
3. Court-ordered child support and court-ordered spousal support
4. Monthly medical insurance premiums
5. Non-covered medical expenses including over-the-counter medications and medical supplies
6. Spousal support payments for the community spouse and Family Member Allowance (MS H-410 #4-6)
7. Applicable income trust fees (MS H-111 #3)

8. Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician

   The ALF recipient's income, minus room and board, personal allowance, and certain other expenses, will be contributed to their cost of care each month.

H-413 Contribution to the Cost of Care for PACE

MS Manual 08/29/2022

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long-Term Services and Supports (LTSS) nursing facility Health Care. Refer to MS H-410.

For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust. For income trust guidelines, refer to MS H-110.

The eligibility worker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The patient liability amount will be calculated in the electronic record. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current nursing facility PNA, any applicable community spouse allowances, family allowances, court-ordered child support, court-ordered spousal support, and excess medical expenses will be deducted from the PACE participant's monthly income. Refer to MS H-410.

For individuals in the community who are eligible through establishing an income trust, income in excess of the current LTSS Health Care limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTSS/PACE limit of three (3) times the current SSI standard payment amount (SPA), plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

H-416 Verification or Refusal of Contributions

MS Manual 08/29/2022

Prior to certification of the Institutionalized Spouse (IS), the IS or representative must indicate that the IS plans to contribute the Community Spouse Monthly Income Allowance (CSMIA) and

the Family Member Allowance (FMA) specified on the Notice of Action during the period of institutionalization.

Otherwise, no allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS may decline the income.

H-430 Earnings of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facility Residents

MS Manual 08/29/2022

Residents of ICF/IID facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI standard payment amount (SPA) in addition to the forty dollars ($40)personal needs allowance.

Nursing facility residents with earnings may be given a disregard of up to one-hundred ($100) of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Division of Provider Services and Quality Assurance (DPSQA) Office of Long-Term Care (OLTC) should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/IID residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Ten-Bed ICF/IID Facilities and State Human Development Centers

   Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (for example, federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS H-410 for consideration of earnings at certification.

2. Fluctuating Earnings

   If the earnings of ICF/IID facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

   The facility administrator will report to the eligibility worker any month in which a resident's earnings exceed the SSI SPA.

   If earnings consistently stay above the SSI SPA, they may be averaged (MS E-415), provided the facility administrator will agree to report to the eligibility worker:

   - every six (6) months when earnings are fairly stable; or
   - more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than fifteen dollars ($15) above the computed average.

H-440 Effective Eligibility Dates for Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services

MS Manual 08/29/2022

The effective date of eligibility of an applicant for nursing home and ICF/IID depends on three (3) factors:

1. Date of Entry

   The individual's date of entry into a participating facility is indicated on the DCO-0702, Notice of Admission, Discharge or Transfer From a Facility, which is completed by the facility and forwarded to both the DPSQA Office of Long-Term Care and the County Office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity

   Medical necessity is determined by the DPSQA Office of Long-Term Care. The medical necessity decision is transmitted to the County Office and the facility by the DHS-0704, Evaluation of Medical Need Criteria, which classifies the patient for a specific level of care. If a DHS-0704 is received by the County Office on an applicant that classifies them for a specific level of care, medical necessity exists to the date of the individual's entry or to the date of application if the patient was accepted as private pay only until the application for Health Care was made. However, if the patient is in an ICF/IID facility or was subject to Pre-Admission Screening and Annual Resident Review (PASARR), medical necessity begins on the DHS-0704 decision date for ICF/IID or PASARR date for PASARR residents, and Health Care and vendor payment cannot begin prior to this date.

3. Date of Categorical Eligibility

   Categorical eligibility for facility care and services under the AABD criteria can be established to begin three (3) months prior to the date of application provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI or Foster Care, the date to begin vendor payment is not governed by the three-month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, the begin date for Health Care and vendor payment cannot be prior to the decision date on the DHS-0704 for ICF/IID applicants or PASARR date for individuals subject to PASARR.

4. Authorization of services cannot be made until all three (3) factors have been met.

H-450 Approval of an Applicant Who is in a Medicare Bed

MS Manual 08/29/2022

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Health Care coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner and timeframe as applications for non-Medicare approved admissions, except that nursing home services will not be authorized until Medicare benefits have been exhausted. Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Health Care until the case is opened.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third-party resource to be applied to the cost of care in a facility.

If at some point, the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the eligibility worker of the change in status. On the day following termination of Medicare benefits, the eligibility worker may authorize facility services to be effective on that date, provided the individual continues to meet all Long-Term Services and Supports (LTSS) requirements.

H-481 Case Adjustments for Lump Sum Payments in Prior Months

MS Manual 08/29/2022

When a eligibility worker learns that a recipient, who does not have an Income Trust, received a lump sum benefit in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the

receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed, and a new application will be required.

Overpayment reports for Long-Term Services and Supports (LTSS) and other Health Care categories will be submitted to recover any Health Care payments made during the month of ineligibility.

Refer to MS Section M. If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

H-490 Absences from Long-Term Care Facilities

MS Manual 08/29/2022

All facilities are required to report to the County Office certain recipient absences from the facility. Absences will be reported for death, discharge, and transfer. Overnight home visits and hospitalizations will not be reported. Admissions to the Arkansas State Hospital (Little Rock) will be reported as discharges.

Death or Discharge

Upon notification from the facility reporting the death or discharge of a recipient, the County Office will initiate action to close the recipient's case. Advance notice is not required for closure due to death.

Home Visits

A recipient receiving Long-Term care services has the right to make overnight home visits whenever they desire, provided the visits are consistent with the recipient's required level of care and their attending physician's orders. This includes authorized home visits during the thirty (30) days in which institutional status is achieved.

The DPSQA Office of Long-Term Care is responsible for monitoring recipient home visits and their consistency with the patient's required level of care. For example, a skilled care patient who makes overnight home visits might require reclassification action by Long-Term Care.

Facility services may continue during a recipient's absence due to therapeutic home visit without regard to the cumulative number of days absent during a calendar year. However, a fourteen (14) consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than fourteen (14) days will not be reported by facilities to the County Office. The date left counts as the first day of absence. When there is an indication that the recipient is expected to return to the facility within fourteen (14) days, the County Office will take no action.

For home visits that exceed fourteen (14) consecutive days facilities will report the date left and a discharge on the fifteenth consecutive day of absence. When there is no indication that the recipient is expected to return to the facility within fourteen (14) days, the County Office will initiate action to close the case.

- Cases suspended or closed can be reinstated without new application if the recipient returns to the facility within nintety (90) days of the date left on home visit.
- If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.
- If the individual does not reenter the facility within ninety (90) days, a new application will be required to reopen the case.

H-493 Operations Plan – Relocation of Recipients

MS Manual 08/29/2022

The Division of Provider Services and Quality Assurance (DPSQA) Office of Long-Term Care (OLTC) will initiate all relocation actions of Agency recipients in facilities that are closed for any reason other than a disaster. Such reasons include decertification by the federal government or the DPSQA, loss of licenses, voluntary withdrawal from the Health Care Program, or cancellation of agreement by the DPSQA. Since federal regulations require all program recipients to be relocated within thirty (30) days of the termination date, it is essential that specific procedures be established to ensure that recipients are relocated with maximum safety and well-being.

Authority to initiate, direct and monitor all relocation actions is delegated to the Assistant Director of the Office of Long-Term Care, by the Director of the DPSQA.

H-600 Estate Recovery

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

The Omnibus Budget Reconciliation Act of 1993 and Arkansas Act 415 of 1993 mandate recovery of medical payments correctly made from ~~8/13/93~~ August 13, 1993, and later from the estates of:

- Individuals of any age who were considered to be permanently institutionalized, who received medical services in a nursing or ICF/IID facility, and who were required to pay all but a minimal amount of income for their care, and ~~for~~
- Individuals fifty-five (55) years of age ~~age 55~~ and older who received medical services in a nursing or ICF/IID facility or in a home and community based waiver program, whether or not they were considered to be permanently institutionalized.

Estate recovery will not be made from the estate of deceased individuals when:

- There is a surviving spouse, dependent children under twenty-one (21) years of age ~~21~~, or children ~~that~~ who are blind or have a disability (as determined by SSA disability guidelines),
- Recovery will create an undue hardship for other surviving family members, or
- Recovery is not cost effective.

Estate recovery will not be made from resources ~~which~~ that were protected as a result of the individual having a Qualified Long-Term Care Insurance Partnership Policy. The maximum amount protected at estate recovery will be the amount protected when eligibility was established. If any of the protected resources have been spent or given away, only the amount remaining will be protected at estate recovery.

Estate recovery will not be made from interests acquired through grant of a beneficiary deed~~,~~ per Act 570 of 2021 when:

- The beneficiary deed was properly excuted and recorded~~;~~ and
- Documentation has been provided to the entity seeking recovery.

H-630 Recovery Procedures

MS Manual ~~07/13/2015~~08/29/2022

State law requires in most cases that the appointed personal representative of the estate of a deceased person shall promptly mail to the creditors of an estate, including the Department of Human Services (DHS), a copy of the notice of their appointment ~~which~~ that has been published in the newspaper. The published notice is to include the requirement that all claims against the

estate be submitted within six (6) months of the date of publication of the first notice. A copy of the petition for probate of a will or administration of an estate and the decedent's Social Security number ~~shall be~~will be attached to the notice forwarded to DHS.

After receiving notice of the opening of an estate or filing of an "Affidavit for the Collection of a Small Estate", the TPL Unit will check the MMIS System to determine if the decedent received ~~Medicaid~~Health Care benefits in a nursing facility, ICF/IID facility, or under a home and community based waiver program.

Property interest established by a properly excuted and recorded beneficiary deed are not subject to estate recovery~~ per H-600~~.

TPL will not pursue recovery if:

1. There is a surviving spouse;
2. There are surviving minor children;
3. There are surviving children of any age who are blind or permanently and totally disabled as defined in **42 U.S.C. §§ 1381 et seq**;
4. In cases of a home, there is a son or daughter currently lawfully residing in the home ~~and was residing in the recipient's home~~where they have been residing for at least two (2) years immediately before the recipient's admission to the medical institution, and who establishes to the satisfaction of the ~~S~~state that ~~he or she~~they provided care to the recipient ~~which~~ that permitted the recipient to reside in the home rather than in an institution;
5. In cases of a home, there is a sibling currently lawfully residing in the home, and the sibling was residing in the home at least one (1) year immediately before the date of the recipient's admission to the medical institution; or,
6. The recovery is not cost effective.

For factors one (1) through five (5) of the above-listed (MS H-630), recovery is not waived. Instead, it may be postponed until the individuals identified in those factors die or move from the home.

If benefits were paid for services in a nursing facility, ICF/IID facility, or home and under a home and community based waiver program, TPL will mail to the personal representative or the

distributee of a small estate a Notice of Estate Recovery (DHS-20), advising of the intent to recover ~~Medicaid~~Health Care payments and of the procedures for requesting a hardship waiver.

A payment profile for the decedent will be ordered from the Division of Medical Services (DMS). When the payment profile is received, a claim against the estate will be prepared for the signature of the Director of DMS. The claim will be filed with the appropriate Probate Clerk and a copy mailed to the personal representative, attorney for the estate, or distributee of the estate.

If no benefits were paid, no further action will be taken.

H-640 Application for a Hardship Waiver

MS Manual 0~~1~~8/~~01~~29/~~14~~22

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within 30 days after receiving notice from DHS of intent to recover ~~Medicaid~~ Health Care payments and the procedures for requesting a hardship waiver (DHS- 20). Refer to MS H-730 for procedures.

H-600 Estate Recovery

MS Manual 08/29/2022

The Omnibus Budget Reconciliation Act of 1993 and Arkansas Act 415 of 1993 mandate recovery of medical payments correctly made from August 13, 1993 and later from the estates of:

- Individuals of any age who were considered to be permanently institutionalized, who received medical services in a nursing or ICF/IID facility, and who were required to pay all but a minimal amount of income for their care, and
- Individuals fifty-five (55) years of age and older who received medical services in a nursing or ICF/IID facility or in a home and community based waiver program, whether or not they were considered to be permanently institutionalized.

Estate recovery will not be made from the estate of deceased individuals when:

- There is a surviving spouse, dependent children under twenty-one (21) years of age, or children who are blind or have a disability (as determined by SSA disability guidelines),
- Recovery will create an undue hardship for other surviving family members, or
- Recovery is not cost effective.

Estate recovery will not be made from resources that were protected as a result of the individual having a Qualified Long Term Care Insurance Partnership Policy. The maximum amount protected at estate recovery will be the amount protected when eligibility was established. If any of the protected resources have been spent or given away, only the amount remaining will be protected at estate recovery.

Estate recovery will not be made from interests acquired through grant of a beneficiary deed, per Arkansas Act 570 of 2021 when:

- The beneficiary deed was properly excuted and recorded; and
- Documentation has been provided to the entity seeking recovery.

H-630 Recovery Procedures

MS Manual 08/29/2022

State law requires in most cases that the appointed personal representative of the estate of a deceased person shall promptly mail to the creditors of an estate, including the Department of Human Services (DHS), a copy of the notice of their appointment that has been published in the newspaper. The published notice is to include the requirement that all claims against the estate

be submitted within six (6) months of the date of publication of the first notice. A copy of the petition for probate of a will or administration of an estate and the decedent's Social Security number will be attached to the notice forwarded to DHS.

After receiving notice of the opening of an estate or filing of an "Affidavit for the Collection of a Small Estate", the TPL Unit will check the MMIS System to determine if the decedent received Health Care benefits in a nursing facility, ICF/IID facility, or under a home and community based waiver program.

Property interest established by a properly excuted and recorded beneficiary deed are not subject to estate recovery.

TPL will not pursue recovery if:

1. There is a surviving spouse;
2. There are surviving minor children;
3. There are surviving children of any age who are blind or permanently and totally disabled as defined in 42 U.S.C. §§ 1381 et seq;
4. In cases of a home, there is a son or daughter currently lawfully residing in the home where they have been residing for at least two (2) years immediately before the recipient's admission to the medical institution, and who establishes to the satisfaction of the State that they provided care to the recipient that permitted the recipient to reside in the home rather than in an institution;
5. In cases of a home, there is a sibling currently lawfully residing in the home, and the sibling was residing in the home at least one (1) year immediately before the date of the recipient's admission to the medical institution; or,
6. The recovery is not cost effective.

For factors one (1) through five (5) of the above-listed (MS H-630), recovery is not waived. Instead, it may be postponed until the individuals identified in those factors die or move from the home.

If benefits were paid for services in a nursing facility, ICF/IID facility, or home and under a home and community based waiver program, TPL will mail to the personal representative or the distributee of a small estate a Notice of Estate Recovery (DHS-20), advising of the intent to recover Health Care payments and of the procedures for requesting a hardship waiver.

A payment profile for the decedent will be ordered from the Division of Medical Services (DMS). When the payment profile is received, a claim against the estate will be prepared for the

signature of the Director of DMS. The claim will be filed with the appropriate Probate Clerk and a copy mailed to the personal representative, attorney for the estate, or distributee of the estate.

If no benefits were paid, no further action will be taken.

H-640 Application for a Hardship Waiver

MS Manual 08/29/22

The personal representative or distributee of an estate may apply for a hardship waiver at the time notice of the estate is given to DHS, or within 30 days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver (DHS- 20). Refer to MS H-730 for procedures.

H-700 Undue Hardship Waiver

MS Manual 0~~1~~8/~~01~~29/~~14~~2022

An individual may request an Undue Hardship Waiver:

1. When denied eligibility due to excess home equity~~;~~,
2. When denied nursing facility vendor payment due to a transfer of resources/income for less than fair market value~~;~~, or
3. After receiving notice from the Department of Human Services (DHS) of intent to recover ~~Medicaid~~Health Care payments through the Estate Recovery process.

The individual or a~~A~~uthorized r~~R~~epresentative will need to provide the ~~caseworker~~eligibility worker verification to support the allegation of hardship.

H-710 Hardship Waiver for Home Equity

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (Re. MS E-517) An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home.

The ~~caseworker~~eligibility worker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the ~~Division of Aging and Adult Services~~ Division of County Operations LTSS ~~Support~~ Unit. A decision on the hardship waiver will be made by the Division of County Operations (DCO) Hardship Waiver Committee. The ~~caseworker~~eligibility worker will send the committee decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, ~~he/she~~they may appeal the decision within thirty (30) days~~'~~ of receipt of the notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

MS Manual 0~~7~~8/~~13~~29/~~15~~2022

Once the ~~caseworker~~eligibility worker has determined that this transfer does not meet an exception found at MS H-309~~,~~ and it has~~'s~~ been determined that the resource~~/~~ or income was not transferred exclusively for some other purpose through a rebuttal found at MS H-312-313, a hardship waiver may be pursued. An individual who is denied Waiver services or nursing facility vendor payment due to a transfer of resources or ~~/~~income for less than fair market value may request an Undue Hardship Waiver.

No penalty period for uncompensated transfer will be imposed upon an institutionalized or Waiver individual to the extent that it is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

1. Counting uncompensated value would make an individual ineligible;
2. Lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;
3. The individual's total resources are not great enough to pay for facility care for one (1) month; and
4. The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions ~~merely~~ would merely cause the individual inconvenience or would restrict their~~his~~ lifestyle without putting ~~him~~ them at risk of serious deprivation.

The individual or the individual's authorized representative may apply for an undue hardship waiver. In addition, a representative from the facility in which an individual is residing may apply for an undue hardship waiver on behalf of the client with either the consent of the client or ~~his/her~~thier personal representative. To ensure consistency with decisions regarding what constitutes a hardship, the ~~caseworker~~eligibility worker will route all applications for an undue hardship waiver to the ~~Division of Aging and Adult Services~~Division of County Operations LTSS ~~Support~~ Unit.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. The ~~caseworker~~eligibility worker will send the committee's decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the ~~DHS~~ committee's decision, ~~he/she~~ they may appeal the decision within thirty (30) days~~'~~ of receipt of the notice about the ~~DHS~~ decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 0~~7~~8/~~13~~29/~~15~~22

The personal representative or distributee of an estate may apply for a hardship waiver at the time that notice of the estate is given to DHS~~,~~ or within thirty (30) days after receiving notice from DHS of intent to recover ~~Medicaid~~Health Care payments and the procedures for requesting a hardship waiver (DHS-20). To apply for a waiver, the representative or distributee must mail a statement setting forth the facts ~~which~~ that constitute the undue hardship to:

Third Party Liability Unit
Attention: Decedents' Estates
P. O. Box 1437, Slot S296
Little Rock, AR 72203-1437

The statement must set forth the facts ~~which~~ that constitute the undue hardship. Tax returns, income statements, or other documents ~~which~~ that support the position that estate recovery would work an undue hardship on the survivors must be submitted. The Third Party Liability Unit will send the hardship request and supporting documents to the ~~Division of Aging and Adult Services LTSS Support Unit, Central Office~~DCO Hardship Waiver Committee. In determining the existence of an undue hardship, the Central Office Hardship Waiver Committee will consider factors including but not limited to the following:

1. The estate asset that is subject to recovery is the sole- income--producing asset of ~~beneficiaries~~ a beneficiary of the estate;

2. Without receipt of the proceeds of the estate, a beneficiary would become eligible for federal or state benefits;

3. Allowing a beneficiary to receive the inheritance from the estate would enable a beneficiary to discontinue eligibility for federal or state benefits;

4. The estate asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of ~~homes~~ a home in the county where the homestead is located, as of the date of the decedent's death; and

5. Other compelling circumstances.

A determination that hardship does not exist will be made if the individual created the hardship through estate planning in which assets were divested in order to avoid estate recovery.

A decision on the hardship waiver will be made by the ~~DHS Central Office~~DCO Hardship Waiver Committee.

The ~~DHS~~ committee's decision and information about the right to appeal the decision will be sent by certified mail, return receipt requested, to the person who applied for the waiver. If the person who applied for the waiver disagrees with the ~~DHS~~ committee's decision, ~~he/she~~ they may appeal the decision within thirty (30) days~~'~~ of receipt of the notice about the ~~DHS~~ decision (MS J-100).

If recovery is not made due to the determination of hardship, DHS may decide to recover at a later time if the conditions which caused the original hardship cease to exist.

H-700 Undue Hardship Waiver

MS Manual 08/29/2022

An individual may request an Undue Hardship Waiver:

1. When denied eligibility due to excess home equity;
2. When denied nursing facility vendor payment due to a transfer of resources/income for less than fair market value; or
3. After receiving notice from the Department of Human Services (DHS) of intent to recover Health Care payments through the Estate Recovery process.

The individual or authorized representative will need to provide the eligibility worker verification to support the allegation of hardship.

H-710 Hardship Waiver for Home Equity

MS Manual 08/29/2022

An individual who is denied eligibility due to excess home equity may request an Undue Hardship Waiver. (Re. MS E-517) An example of a situation in which an undue hardship may exist is if the individual makes an allegation that the home equity should not be counted because of a legal impediment to selling or transferring the home.

The eligibility worker will submit all Home Equity Undue Hardship Waiver requests and supporting documentation to the Division of County Operations LTSS Unit. A decision on the hardship waiver will be made by the Division of County Operations (DCO) Hardship Waiver Committee. The eligibility worker will send the committee decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the DHS decision, they may appeal the decision within thirty (30) days of receipt of the notice about the DHS decision (MS J-100).

H-720 Hardship Waiver for Transfer of Resources/Income

MS Manual 08/29/2022

Once the eligibility worker has determined that this transfer does not meet an exception found at MS H-309 and it has been determined that the resource or income was not transferred exclusively for some other purpose through a rebuttal found at MS H-312-313, a hardship waiver may be pursued. An individual who is denied Waiver services or nursing facility vendor payment due to a transfer of resources or income for less than fair market value may request an Undue Hardship Waiver.

No penalty period for uncompensated transfer will be imposed upon an institutionalized or Waiver individual to the extent that it is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

1. Counting uncompensated value would make an individual ineligible;
2. Lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;
3. The individual's total resources are not great enough to pay for facility care for one (1) month; and
4. The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions would merely cause the individual inconvenience or would restrict their lifestyle without putting them at risk of serious deprivation.

The individual or the individual's authorized representative may apply for an undue hardship waiver. In addition, a representative from the facility in which an individual is residing may apply for an undue hardship waiver on behalf of the client with either the consent of the client or their personal representative. To ensure consistency with decisions regarding what constitutes a hardship, the eligibility worker will route all applications for an undue hardship waiver to the Division of County Operations LTSS Unit.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee. The eligibility worker will send the committee's decision and information about the right to appeal the decision to the person who applied for the waiver. If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty (30) days of receipt of the notice about the decision (MS J-100).

H-730 Hardship Waiver for Estate Recovery

MS Manual 08/29/2022

The personal representative or distributee of an estate may apply for a hardship waiver at the time that notice of the estate is given to DHS or within thirty (30) days after receiving notice from DHS of intent to recover Health Care payments and the procedures for requesting a hardship waiver (DHS-20). To apply for a waiver, the representative or distributee must mail a statement setting forth the facts that constitute the undue hardship to:

Third Party Liability Unit
Attention: Decedents' Estates
P. O. Box 1437, Slot S296
Little Rock, AR 72203-1437

The statement must set forth the facts that constitute the undue hardship. Tax returns, income statements or other documents that support the position that estate recovery would work an undue hardship on the survivors must be submitted. The Third Party Liability Unit will send the hardship request and supporting documents to the DCO Hardship Waiver Committee. In determining the existence of an undue hardship, the DCO Hardship Waiver Committee will consider factors including, but not limited to the following:

1. The estate asset that is subject to recovery is the sole-income producing asset of a beneficiary of the estate;

2. Without receipt of the proceeds of the estate, a beneficiary would become eligible for federal or state benefits;

3. Allowing a beneficiary to receive the inheritance from the estate would enable a beneficiary to discontinue eligibility for federal or state benefits;

4. The estate asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of a home in the county where the homestead is located, as of the date of the decedent's death; and

5. Other compelling circumstances.

A determination that hardship does not exist will be made if the individual created the hardship through estate planning in which assets were divested in order to avoid estate recovery.

A decision on the hardship waiver will be made by the DCO Hardship Waiver Committee.

The committee's decision and information about the right to appeal the decision will be sent by certified mail, return receipt requested, to the person who applied for the waiver. If the person who applied for the waiver disagrees with the committee's decision, they may appeal the decision within thirty (30) days of receipt of the notice about the decision (MS J-100).

If recovery is not made due to the determination of hardship, DHS may decide to recover at a later time if the conditions which caused the original hardship cease to exist.

Stricken language would be deleted from and underlined language would be added to present law.
Act 570 of the Regular Session

State of Arkansas *As Engrossed: H3/11/21*
93rd General Assembly **A Bill**
Regular Session, 2021 HOUSE BILL 1162

By: Representative Maddox
By: Senator B. Ballinger

For An Act To Be Entitled

AN ACT TO AMEND THE LAW CONCERNING BENEFICIARY DEEDS; TO PROHIBIT THE RECOVERY OF BENEFITS AGAINST AN INTEREST ACQUIRED FROM A DECEASED RECIPIENT BY A GRANTEE OF A BENEFICIARY DEED IN CERTAIN CIRCUMSTANCES; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE LAW CONCERNING BENEFICIARY DEEDS; AND TO PROHIBIT THE RECOVERY OF BENEFITS AGAINST AN INTEREST ACQUIRED FROM A DECEASED RECIPIENT BY A GRANTEE OF A BENEFICIARY DEED IN CERTAIN CIRCUMSTANCES.

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

SECTION 1. Arkansas Code § 18-12-608(a)(1)(B), concerning the terms of beneficiary deeds, is amended to read as follows:

(B)(i) A beneficiary deed transfers the interest to the designated grantee effective upon the death of the owner, subject to~~:~~

~~(a) All~~ all conveyances, assignments, contracts, leases, mortgages, deeds of trust, liens, security pledges, oil, gas, or mineral leases, and other encumbrances made by the owner or to which the real property was subject at the time of the owner's death, whether or not the conveyance or encumbrance was created before or after the execution of the beneficiary deed~~; and~~

~~(b) A claim for reimbursement of federal or state benefits by the Department of Human Services from the estate of the grantor or the interest acquired by a grantee of the beneficiary deed under § 20-76-436.~~

(ii) No legal or equitable interest shall vest in the grantee until the death of the owner prior to revocation of the beneficiary deed.

SECTION 2. Arkansas Code § 20-76-436 is amended to read as follows:

20-76-436. Recovery of benefits from recipients' estates.

(a)(1) Federal or state benefits in cash or in kind, including, but not limited to, Medicaid, Aid to Families with Dependent Children [abolished], Transitional Employment Assistance Program, Temporary Assistance for Needy Families, and food stamps distributed or paid by the Department of Human Services as well as charges levied by the department for services rendered shall upon the death of the recipient constitute a debt to be paid.

(2)~~(A)~~ The department may make a claim against the estate of a deceased recipient ~~or the interest acquired from the deceased recipient by a grantee of a beneficiary deed under § 18-12-608~~ for the amount of any benefits distributed or paid or charges levied by the department.

~~(B) If a grantee of a beneficiary deed under § 18-12-608 makes a written request for a release or disclaimer of the department's interest in the real property described in the beneficiary deed, the department within thirty (30) calendar days of the request shall either:~~

~~(i) Make a claim against the interest acquired from the deceased recipient by a grantee of the beneficiary deed; or~~

~~(ii) Provide the requested disclaimer and a release suitable for recording in the real estate records of the county where the real property is located.~~

(b)(1) The department shall not seek recovery against the estate of a deceased recipient ~~or the interest acquired from the deceased recipient by a grantee of a beneficiary deed under § 18-12-608~~ for the amount of any benefits distributed or paid or charges levied if the recovery is not cost effective or if the recovery ~~works~~ causes an undue hardship on the heirs or devisees of the decedent's estate ~~or the grantee of a beneficiary deed under § 18-12-608~~.

(2) In determining the existence of an undue hardship, the department shall consider factors including~~, but not limited to,~~ without limitation the following:

(A) The asset subject to recovery is the sole income-producing asset of ~~the beneficiaries~~ a beneficiary of the estate ~~or the grantee of a beneficiary deed under § 18-12-608~~;

(B) Without receipt of the ~~beneficiary deed or~~ proceeds of the estate, a ~~grantee or~~ beneficiary would become eligible for federal or state benefits;

(C) Allowing ~~a grantee of a beneficiary deed under § 18-12-608 to receive the interest under the beneficiary deed or a~~ the beneficiary to receive the inheritance from the estate would enable the ~~grantee or~~ beneficiary to discontinue eligibility for federal or state benefits;

(D) The asset subject to recovery is a home with a value of fifty percent (50%) or less of the average price of ~~homes~~ a home in the county where the homestead is located, as of the date of the deceased recipient's death; or

(E) There are other compelling circumstances.

(c) To the extent that there is ~~any~~ a conflict between the ~~preceding~~ criteria listed in subsection (b) of this section and the standards that may be specified by the United States Secretary of Health and Human Services, the federal standards shall prevail.

(d) Applicants for federal or state benefits shall be notified in writing in prominent type on the application form that the department may make a claim against their estate ~~or the interest acquired from the applicant by a grantee of a beneficiary deed under § 18-12-608~~.

/s/Maddox

APPROVED: 4/5/21

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