

ARKANSAS REGISTER

Transmittal Sheet



Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office
Use Only:

Effective Date _____

Code
Number _____

Name of Agency _____ Arkansas Department of Human Services _____

Department _____ Division of County Operations _____

Contact Person _____ Linda Greer _____ Phone _____ 682-8257 _____

Statutory Authority for Promulgating Rules _____ AR Code Annotated 20-76-201 et. Seq. & AR Code Annotated 20-15-20 et. Seq. _____

Medical Services Policy MS 23000 and DCO-912, ARxSeniors Waiver Program; End of Qualified Individuals 2 (QI-2) Program; and Increase in Income Limit for ARSeniors Medicaid to 80% FPL.

Date

Intended Effective Date _____ Legal Notice Published Nov. 8-14, 2002 _____

Emergency _____ Final Date for Public Comment Dec. 7, 2002 _____

10 Days After Filing _____ Filed With Legislative Council _____

Other _____ Reviewed by Legislative Council _____

January 1, 2003 _____ Adopted by State Agency _____ January 1, 2003 _____

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with Act 434 of 1967 As Amended.

Signature

Director, Division of County Operations

Title

Date

**QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS
WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE**

DEPARTMENT/AGENCY Department of Human Services
DIVISION of County Operations
DIVISION DIRECTOR Joni Jones, Director
CONTACT PERSON Linda Greer, Acting Assistant Director, OPPD

ADDRESS P. O. Box 1437, Slot S-332, Little Rock, AR 72203
PHONE NO. 682- 8257 FAX NO. 682-1597

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 attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

- 1. **What is the short title of this rule?**
Medical Service Policy MS 23000 and DCO-912.

- 2. **What is the subject of the proposed rule?**
 - a. The proposed rule provides limited prescription drug coverage to Aged QMB (Category 18) recipients with income at or below 90%, but more than 80% of the Federal Poverty Level. If approved by CMS, this waiver will provide up to 2 prescription drugs per month for each covered individual.
 - b. The rule ends the QI-2 Program 12-31-02 due to its sunset provision in federal law and removes references to the QI-2 Program from policy.
 - c. The rule increases the income limit of the ARSeniors Program from 75% to 80% of the Federal Poverty Level.
 - d. The rule adds the ARxSeniors Selection Form, DCO-912.

- 3. **Is this rule required to comply with federal statute or regulations? Yes No X -Items a, c & d**
If yes, please provide the federal regulation and/or statute citation.
Yes for end of QI-2 only. Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33).

- 4. **Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes No X**

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 regular provisions of the Administrative

Procedure Act? Yes_ No

5. Is this a new rule? Yes ___ No X

Does this repeal an existing rule? Yes ___ No X

If yes, please provide a copy of the repealed rule.

Is this an amendment to an existing rule? Yes X No ___ If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

Mark-up attached.

6. What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

AR Code Annotated 20-76-201 et. Seq., AR Code Annotated 20-15-201 et. Seq., & Act 1658 of 2001. Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33).

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

To add the ARxSeniors Waiver program and ARxSeniors Selection Form to provide limited prescription drug coverage for low income aged QMB (Category 18) recipients; to end the Qualified Individuals 2 (QI-2) Program; to increase the income limit for ARSeniors Medicaid from 75% to 80% of the Federal Poverty Level.

8. Will a public hearing be held on this proposed rule?

Yes ___ No X If yes, please give the date, time, and place of the public hearing?

9. When does the public comment period expire?

10. What is the proposed effective date of this proposed rule?

January 1, 2003

11. Do you expect this rule to be controversial? Yes

No X If yes, please explain.

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

None known.

PLEASE ANSWER ALL QUESTIONS COMPLETELY

July 28, 1995

DEPARTMENT Department of Human Services
DIVISION Division of County Operations
PERSON COMPLETING THIS STATEMENT Linda Greer
TELEPHONE NO. 682-8250 FAX NO. 682-1597

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE: Policy MS 23000, ARxSeniors Waiver and End of QI-2 Program.

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

ARxSeniors - Refer to DMS promulgation of ARxSenior Waiver

QI-2 - The end of the QI-2 Program does not have a financial impact on state general revenue as the Program was 100% federally funded.

ARSeniors - Refer to Arkansas State Plan Transmittal 2002 -23, Official Notice DMS-2002 W-7 for Increase in income limit.

2. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

Not Applicable

3. If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.

2002 Fiscal Year

2003 Fiscal Year

General Revenue _____

General Revenue _____

Federal Funds _____

Federal Funds _____

Cash Funds _____

Cash Funds

Special Revenue _____

Special Revenue _____

Other _____

Other

Savings Total _____

Savings Total

4. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?

2002 Fiscal Year

2003 Fiscal Year

5. What is the total estimated cost by fiscal year to the agency to implement this regulation?

2002 Fiscal Year

2003 Fiscal Year

July 28, 1995

NOTICE OF RULE MAKING

Pursuant to Arkansas Code 20-76-201 et Seq., and Act 1658 of 2001, and pending federal waiver approval, effective January 1, 2003, limited prescription drug coverage is being extended to Aged QMB (Category 18) recipients with income at or below 90%, but over 80% of the Federal Poverty Level in the ARxSeniors Waiver Program. Effective December 31, 2002, the Qualified Individuals 2, (QI-2) Program will end pursuant to P.L.105-33. Effective January 1, 2003, the income limit for ARSeniors Medicaid will increase from 75% to 80% of the Federal Poverty Level.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-333, Little Rock, AR 72203. All comments must be submitted in writing to the above address no later than _____.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

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 age, religion, disability, political affiliation, veteran status, age, race, color or national origin.

Joni Jones,
Director, Division of County Operations

Date: _____

23000 Medicare Savings Programs 01-01-03

Since 1988, several laws have been passed requiring states to provide savings to certain Medicare recipients through the state's Medicaid program. The categories enacted are Qualified Medicare Beneficiaries (QMB) including ARSeniors and ARxSeniors for certain Aged QMBs, Specified Low-Income Medicare Beneficiaries (SMB), Qualifying Individuals - 1 (QI-1), and Qualified Disabled and Working Individuals (QDWI). These categories provide Medicare savings by paying the Medicare premium(s) or a portion of the Medicare premium and possibly the Medicare deductibles and coinsurance. Except for ARSeniors, these categories do not pay for the full range of Medicaid services.

23010 Medicare Savings Programs - Comparison Chart 01-01-03

The comparison chart on the next page provides a brief overview of the six categories including the coverage provided and eligibility requirements.

23100 History of ARSeniors, ARxSeniors, QMB, SMB, QI-1

01-01-03

1. ARSeniors: Initiated Act 1 of 2000 authorizes expanded services to lower income Aged QMB (Category 18) recipients. Funding for this program is provided from the Tobacco Settlement funds. This coverage group is called ARSeniors and provides the full range of Medicaid services to individuals receiving Aged QMB whose income is equal to or less than 80% of the Federal Poverty Level (FPL). The ARSeniors program was implemented effective November 1, 2002.
2. ARxSeniors: Act 1658 of 2001 authorizes the Arkansas Department of Human Services to initiate a waiver to provide two prescription drugs with cost-sharing to low-income Aged QMB recipients. These individuals also receive the benefits provided under the QMB category. ARxSeniors is for Aged QMB recipients who are above the ARSeniors income level of 80% FPL, but equal to or below 90% FPL. The ARxSeniors program was implemented effective January 1, 2003.
3. QMB: Section 301 of Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, requires Medicaid buy-in of Medicare premiums and coverage of deductibles and coinsurance for Qualified Medicare Beneficiaries (QMBs) with income at or below 100% of the FPL and resources at or below twice the SSI limit.
4. SMB: On January 1, 1993, Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) mandated that State Medicaid Agencies pay the Medicare Part B premium for Specified Low Income Medicare Beneficiaries (SMBs) for individuals with income between 100% and 110% of the Federal Poverty Level. These limits became effective in 1994. Beginning in 1995, the SMB income limit increased to between 100% and 120% of the Federal Poverty Level.
5. QI-1: Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33) created the Qualifying Individuals-1 group (QI-1). QI-1s are individuals who would be eligible for SMB except that their incomes exceed the SMB level. QI-1s must have income of at least 120% but less than 135% of the Federal Poverty Level.
6. QI-2: Section 4732 of the Balanced Budget Act of 1997 (Public Law 105-33) also created the Qualifying Individuals-2 group (QI-2) with a sunset date of December 31, 2002. QI-2s must have income of at least 135% but less than 175% of the Federal Poverty Level. The QI-2 program ended December 31, 2002, as it was not re-authorized by Congress.

23105 Scope of Services

01-0-03

ARSeniors for Aged QMBs provides full Medicaid coverage. It is the only coverage group in the Medicare Savings categories that provides the full range of Medicaid benefits. If applicants for ARSeniors Medicaid are eligible in the month of application, they can also receive retroactive coverage for the three months prior to application, if otherwise eligible. However, retroactive benefits cannot begin prior to November 1, 2002.

ARxSeniors for Aged QMBs provides two prescription drugs with cost-sharing in addition to regular QMB benefits. The co-payment for the two prescription drugs will be \$10.00 for generic and \$20.00 for name brand drugs. In addition to the co-payment, there will be an enrollment fee of \$25.00 per state fiscal year (SFY). The enrollment fee will be paid at a rate of \$5.00 per prescription in addition to the recipient co-payment. The enrollment fee amount will be deducted electronically from the price of the prescription and collected by the pharmacy provider at the time of purchase until the recipient is credited with the full amount of \$25.00 during the SFY.

QMB pays all Medicare premiums, deductibles, and coinsurance. There is no retroactive coverage for QMBs. Coverage of Medicare premiums, deductibles, and coinsurance will begin on the first of the month following the month of approval in the QMB category.

SMBs are eligible for the payment of Medicare Part B premiums only. No other Medicare cost sharing charges will be covered. SMBs, are, however, eligible for retroactive benefits for up to 3 calendar months prior to application, if the individual meets all SMB eligibility requirements in the retroactive period. Coverage must begin on the first day of the month. Individuals who qualify for SMB will not receive a Medicaid card

QI-1s are eligible for payment of their Medicare Part B premiums only. QI-1s are eligible for retroactive benefits for up to 3 calendar months prior to application if the individual meets all eligibility requirements. Coverage must begin on the first day of the month. However, retroactive coverage cannot begin before January 1 in the current calendar year. QI-1s will not receive a Medicaid card.

23110 Eligibility Requirements

01-01-03

ARSeniors, ARxSeniors, QMBs, SMBs and QI-1s must all meet the same basic eligibility requirements. Self-declaration will be accepted for all eligibility requirements with the exception of alien status of non-citizens. Eligibility requirements are as follows:

1. Categorical Relatedness: the individual must be aged, blind or disabled as specified in MS 3321 - 3323. The individual must be aged to qualify for ARSeniors and ARxSeniors.
2. Medicare Part A Entitlement or Conditional Eligibility: QMBs and ARxSeniors must be entitled to or conditionally eligible for hospital benefits under Medicare Part A (Re. MS 23125). SMBs and QI-1s must be entitled to Part A. Entitled means that the individual has applied for, is eligible for, and is enrolled in Medicare Part A. Conditionally eligible means that an individual can be enrolled (entitled) for Part A Medicare only on the condition that he/she is eligible for QMB, and thus eligible for the state Medicaid agency to pay the Part A premium as part of the QMB benefits. ARSeniors recipients do not have to be entitled to Medicare. (e.g. Qualified Aliens who have not worked enough quarters to qualify for Medicare can still be eligible for ARSeniors.) However, individuals who are entitled to Medicare and choose not to enroll in Medicare are not eligible for the ARSeniors program.

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3. Citizenship or Alien Status: the individual must meet the citizenship/alien status requirement as specified in MS 3324.
 4. Enumeration: the individual must meet the Social Security Enumeration requirement as specified in MS 1358.
 5. Residency: the individual must be an Arkansas resident as specified at MS 2200.
 6. Resources: ARSeniors, ARxSeniors, QMBs, SMBs or QI-1s can have resources equal to but not exceeding twice the current SSI limitations (Re. MS 3310, #5). The current Medicare Savings resource standards are as follows:

Individual	\$4,000
Couple	\$6,000

Countable resources are determined according to LTC guidelines (Re. MS 3330-3337). Caseworkers will determine resource eligibility based on what is self-declared on the application.

7. Income: The Medicare Savings Programs recipient's monthly countable income must meet the appropriate Federal Poverty Level for the specific category. (Re: FPL Chart at Appendix F):
 - ◆ ARSeniors - equal to or less than 80%
 - ◆ ARxSeniors – greater than 80% but equal to or less than 90%
 - ◆ QMB - equal to or less than 100%
 - ◆ SMB - between 100% to 120%
 - ◆ QI-1 - at least 120% but less than 135%

Countable income is determined according to LTC guidelines (Re. MS 3340 -3348). Self-declaration will be accepted. However, the caseworker will be responsible for requesting a SSA Query before certification. In-Kind Support and Maintenance is considered in ARSeniors, ARxSeniors, QMB, SMB and QI-1 determinations. For a couple, total monthly countable income will be compared to the couple's standard in each case. If only one spouse is eligible, the procedures for deeming of income at MS 2111-2111.5 will apply.

Individuals applying for Medicare Savings coverage only will not be required to apply for SSI if their income is less than the SSI/SPA (Re: SSI Chart at Appendix S). If an individual does not wish to be referred to SSA and does not want to be certified for full Medicaid benefits in another Medicaid category, he/she may be certified for Medicare Savings coverage only.

8. Mandatory Assignment of Rights to Medical Support/Third Party Liability: Re. MS 1350. (Applies only to QMB, ARSeniors and ARxSeniors).

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9. CSE Referrals for Minors With Absent Parents: Required only if the child is on QMB and a parent is receiving Medicaid in a category other than Pregnant Women or Family Planning. Otherwise, referral is strictly voluntary. A QMB child is eligible for free services through OCSE.

23115 **Self Declaration**

11-01-02

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

23120 **Simultaneous Coverage in Other Categories**

01-01-03

Individuals who apply for ARxSeniors, QMB or SMB coverage and have medical expenses in prior months may be considered in other Medicaid categories (including spend-down categories) for the retroactive coverage.

Except for Medicaid Spend-downs, an individual may not be certified in a QMB or SMB category and in another Medicaid category for simultaneous periods. If an individual is eligible in a category other than QMB, he will be eligible for and receive the QMB benefits along with other Medicaid benefits (Re MS 23150). If an individual could be eligible in either a QMB category or a non-QMB category, the individual should be approved in the non-QMB category.

Example: An individual eligible for both an Aid to the Disabled and a Disabled QMB category will be certified in the Aid to the Disabled category, but will receive full QMB benefits. An individual may be approved for a spend-down and a QMB for simultaneous periods.

Example: An individual applies for QMB coverage and for other Medicaid categories on March 1, and has sufficient non-coverable medical bills for a spend-down period of March, April, and May. QMB coverage is approved on March 30. QMB coverage will begin April 1. For any concurrent months of QMB and spend-down eligibility, Medicare premiums may not be considered as a non-coverable medical expense.

Unlike QMBs and SMBs, QI-1s may not be certified in any other Medicaid category for simultaneous periods. An individual who is eligible for QI-1 and a spend-down will have to choose which coverage is wanted for a particular period of time.

23125 **Medicare Part A Entitlement**

01-01-03

ARSeniors do not have to be eligible for Medicare entitlement. QMBs and ARxSeniors must be entitled to or conditionally eligible for hospital insurance benefits under Medicare Part A. SMBs and QI-1s must be entitled to (receiving) Medicare Part A. Medicare Part A beneficiaries include the following groups:

1. Persons age 65 or older who meet one of the following criteria:
 - a. entitled to monthly Social Security benefits on the basis of covered work under the Social Security Act; or qualified Railroad Retirement beneficiaries; or
 - b. not entitled to monthly Social Security or Railroad Retirement benefits, but meet the requirements of a special transitional provision (some individuals who are not eligible for regular SSA or Railroad Retirement benefits still qualify for Part A hospital insurance); or
 - c. not entitled to monthly Social Security benefits and not a qualified Railroad Retirement beneficiary, but enrolled and paying a monthly premium (to be eligible under this provision, an individual must be age 65 or older, a U.S. resident, and a U.S. citizen or an alien lawfully admitted for permanent residence who has resided continuously in the U.S. for 5 years, and enrolled for Part B medical insurance or has filed a Part B enrollment request which will entitle the individual to Part B).

Individuals who are conditionally eligible fall into this group, except that they are not receiving Part A Medicare because they cannot afford to pay the premium for Part A.

2. Persons under age 65 who are entitled to or deemed entitled to Social Security disability benefits for 24 months (included are disabled workers, disabled widow(er)s, disabled surviving divorced wives, and individuals entitled to childhood disability benefits) beginning with the 25th month of entitlement to such benefits, and certain individuals entitled to Railroad Retirement benefits due to a disability.
3. Persons of any age who have end-stage renal disease (ESRD) which requires kidney transplant or a regular course of dialysis and who are Social Security or Railroad Retirement recipients, or the spouse or a child of an SSA recipient when the spouse or child has ESRD.

Entitlement to Part B Medical Insurance only does not constitute eligibility for QMB, SMB or QI-1. An individual must also be entitled to Part A for SMB or QI-1 and entitled to or conditionally eligible for Part A to be eligible for QMB.

Individuals Entitled to Part A Without Payment of Part A Premium

A person entitled to Social Security retirement benefits or a qualified Railroad Retirement

beneficiary is automatically eligible for hospital insurance beginning with the first day of the month of attainment of age 65, but the individual must apply with SSA in order to be enrolled in Part A Medicare.

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

Individuals Who Would Be Entitled to Part A if They Could Pay Part A Premiums (Conditional Eligibles – applies to QMBs and ARxSeniors only)

1. SSI Recipients - Ordinarily, the Social Security Administration will refer these individuals directly to the DHS Central Office for accretion to the system and, thus, for QMB benefits, including payment of Part A Premium. If a County Office has an inquiry or application for QMB benefits from an individual receiving SSI, the individual should be informed that he/she is eligible for QMB benefits, and that the benefits will begin as soon as the automated system accretes him/her for these benefits. A QMB application from an SSI recipient should be denied by the County.

2. Non-SSI Individuals Receiving Part B Medicare

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

3. Individuals Not Receiving Part A or Part B Medicare

An individual not receiving Part A or Part B Medicare must first go to SSA to apply for Medicare benefits. If SSA determines an individual will meet the Medicare requirements the individual may be referred to DHS for a QMB eligibility determination. Proof of Part B entitlement must be established before an application can be processed. If the individual is not entitled to Part B, the application will be denied. If the client does not provide proof of entitlement (Medicare card, SSA award letter, etc.) the caseworker will submit a Query to SSA, or contact SSA for verification of entitlement.

Application will be made on the DCO-808 or DCO-777 by the applicant, an authorized representative, or a person acting responsibly on his or her behalf.

After completion, the application will be mailed or taken to the local DHS County office for processing. The applicant will not be required to visit the local DHS county office for an interview.

23130 Application Process 01-01-03

Only one application will be required when both members of a couple apply.

Forms to be completed at application are the application form DCO-808 or DCO-777, DCO-86 and DCO-662 (ARSeniors, ARxSeniors and QMB only).

Applications will be registered on the computer system.

23135 Time Limit on Processing Applications 11-01-02

The caseworker will process the application by approval, denial, or withdrawal within 45 days. Applications requiring an MRT decision (e.g., when a Medicare Part A beneficiary under age 65 is receiving Railroad Retirement benefits based on a disability) should be completed within 90 days.

23140 Determining Eligibility 01-01-03

After all SSI exclusions have been deducted from current income, the net countable income will be compared to the current ARSeniors income level for Aged individuals. If the individual's income is at or below the ARSeniors income level, he/she is eligible for Medicaid benefits as an ARSeniors recipient. If income exceeds the ARSeniors income level, income will be compared to the ARxSeniors income level. If the individual is at or below the ARxSeniors income level, he/she is eligible for ARxSeniors benefits.

If the individual is not aged, or if the aged individual's income is above the ARxSeniors level, income should be compared to QMB limits, and then to the SMB and QI-1 limits if necessary. If the individual has an ineligible spouse, countable income will be determined according to MS 2111.1, and the net income will be compared to the couple's ARSeniors, ARxSeniors, QMB, SMB or QI-1 income level.

If eligibility is to be determined for both members of a married couple, total their current income, subtract the \$20.00 exclusion per couple and other applicable SSI exclusions to arrive at their countable income. This income will be compared to the couple's ARSeniors, ARxSeniors, QMB, SMB or QI-1 income level to determine eligibility.

23141 ARxSeniors Coverage Choice 01-01-03

Individuals eligible for ARxSenior benefits will not automatically be approved in the ARxSeniors category following QMB approval. The individual will be given the opportunity to

choose or reject the prescription drug benefits provided by ARxSeniors. Having coverage for the two prescription drugs may cause the individual to be ineligible for some of the prescription drug assistance programs offered by various pharmaceutical companies. If the individual rejects the ARxSeniors coverage, he/she will still be eligible for the basic QMB coverage.

When the case is approved for QMB, the DCO-912, ARxSeniors Selection Form, will be sent to the client asking him/her to choose either ARxSenior or regular QMB coverage. The selection notice will explain the possible consequence of choosing ARxSeniors. The client must return the form indicating his/her choice on the check-off box before receiving the extended ARxSenior benefit. If the form is not returned, the individual will continue to receive QMB coverage only.

23145

Disposition

01-01-03

1. Approval - If all eligibility requirements are met, the application may be approved. The caseworker will complete the following tasks:
 - a. Enter approval data on the system.
 - b. The Medicaid begin date entered will be the 1st day of the month following the month of approval for ARxSeniors and QMB. For ARSeniors, coverage can begin three months from the date of application. SMB and QI-1 coverage can begin on the first day of the month, three months prior to the application month if the individual is eligible for retroactive coverage. For QI-1, retroactive coverage can not begin before January 1 in the current calendar year.
 - c. A unit size of one (1) will be entered for an individual applicant. For a couple, whether both members apply or not, a unit size of two (2) will be entered.
 - d. The current income will be entered in the system. The total SSI exclusions will also be entered and the current FPL amount for the appropriate category will be used.
 - e. Notify client of approval by form DCO-700 or by system generated notice, DCO-55.
 - f. If ARxSeniors eligible, send form DCO-912 to explain the ARxSeniors choice.
2. Denial – If the applicant does not meet all the eligibility requirements, the application will be denied. The caseworker will complete the following tasks:
 - a. Record pertinent information in narrative to document the denial decision.
 - b. Complete denial data on application and enter denial data into computer system.
 - c. Notify applicant of denial by DCO-700 or by system generated notice, DCO-55.
3. Withdrawal – If the applicant wishes to withdraw the application, a signed statement must be obtained from the applicant stating that he or she wishes to withdraw the application. The caseworker will then proceed with the steps for denying the application.

23150 Medicaid Category Changes

01-01-03

Persons who are Medicaid eligible in a category that provides full Medicaid coverage and who are entitled to Medicare Part A will receive the same Medicare cost-sharing coverage as QMBs in addition to their other Medicaid benefits. County offices need not take any action on these cases (for QMB eligibility or coverage) unless Medicaid eligibility in the other category ends.

When Medicaid eligibility in a category other than a Medicare Savings category ends for an individual who is still entitled to Medicare Part A, eligibility for Medicare Savings will be determined based on information available to the county office. A new application will not be obtained from the individual. ARSeniors, ARxSeniors, QMB, SMB, or QI-1 eligibility should be determined and the case certified (if eligible) in the month that the non-QMB related case was closed. If eligible, coverage will begin on the first of the month following certification. When certifying the Medicare Savings case, re-key the original reevaluation date in the computer system.

Examples:

1) A LTC recipient loses Medicaid eligibility upon returning home from a LTCF. He is entitled to Medicare Part A and appears to be income and resource eligible for QMB coverage. The county will determine QMB eligibility based on available information. If eligible, the individual's coverage will begin the month following certification as a QMB. A new application will not be obtained from the individual.

2) An AA-MN-SD ends, and a subsequent SD cannot be done because the individual has inherited \$3000 which is above the MN resource allowance. The individual can be found eligible for QMB benefits, however. NOTE: When an individual previously closed in another category is reopened as a Medicare Savings category, the closed case number will be used as the Medicare Savings category case number.

23155 Temporary Disregard of SSA Cost of Living Adjustment (COLA)

01-01-03

When the annual SSA COLA increases are received in January each year by Medicare Savings recipients, counties will disregard the COLA increases until the new Federal Poverty Limits are issued in that year, even if the SSA COLA increase puts the individual or couple over the current allowable income limits.

When the new Medicare Savings income eligibility limits, based on revised poverty levels, are received, counties will compare the individual's or couple's current countable income (including the January COLA increases) with the revised Medicare Savings income levels to determine if eligibility will continue for April 1st and beyond.

If the individual or couple is ineligible due to the COLA increase, a DCO-700 or DCO-55 will be sent as advance notice of closure, and the case will be closed when the period expires.

The January SSA Cost of Living Adjustment will also be disregarded in determining initial eligibility for Medicare Savings applicants for the period of January 1st through March 31st of

each year. Eligibility must then be redetermined for April 1st and beyond, using the new Medicare Savings income limits and the increased SSA amount which includes the January SSA COLA amounts.

23160 Reevaluation

01-01-03

ARSeniors, ARxSeniors, QMB, SMB and QI-1 reevaluations will be conducted on an annual basis. At reevaluation, all eligibility factors will be redetermined (Re. MS 23110). Self-declaration will be accepted. The recipient will not be required to attend an interview. Completion of the application form DCO-808 or DCO-777, DCO-662 (for ARSeniors, ARxSeniors and QMB only), and DCO-75 is necessary at each reevaluation.

23165 Change/Closure

01-01-03

When a change occurs that affects eligibility, a ten day advance notice of closure, via Form DCO-700 or DCO-55, will be given, unless advance notice is not required (Re. MS 3633). The caseworker will enter data into the computer system to end Medicare Savings eligibility effective the date the notice expires.

At reevaluation or other times when the case is updated, the caseworker should be aware of the Aged QMB recipient's net countable income, noting whether the income is above or below 80% and 90%. When an ARSenior recipient's net countable income increases to over 80% or an ARxSeniors income increases to over 90%, but he/she remains QMB eligible, ARSeniors or ARxSeniors benefits respectively will end the day the new income is keyed to the system. A 10-day advance notice will be sent to the recipient explaining the reduction in benefits, and the change will not be keyed until after the notice period has ended. If an individual has a reduction in income that causes him/her to be eligible in a coverage group with increased benefits, a notice should be sent explaining the new benefits. If the reduction in benefits causes the individual to be eligible for ARxSeniors, the DCO-912 must be sent explaining the choice for ARxSeniors or regular QMB benefits.

23500 Qualified Disabled and Working Individuals

02-01-01

Section 6408 of the Omnibus Budget Reconciliation Act of 1989 requires State Medicaid Agencies to pay the Hospital Insurance - Medicare Part A - premium for certain individuals who lost Medicare Part A entitlement solely due to the individual's earnings that reach or exceed the Substantial Gainful Activity (SGA) amount.

These provisions were effective July 1, 1990

23505 Extent of Services

02-01-01

Qualified Disabled and Working Individuals (QDWI's) are not eligible for Medicaid services. QDWI's are eligible only for payment of their Hospital Insurance - Medicare Part A - premium. These individuals will not receive a Medicaid card.

23510 Application Process

02-01-01

Application for QDWI will be made by the individual requesting assistance, or his/her authorized representative, at the DHS County Office located in the individual's county of residence.

Forms to be completed at application are the DCO-777, and DCO-86.

Applications will be registered on the computer system.

A separate application will be taken and registered in the appropriate category for each individual when both members of a married couple apply.

The Caseworker will have a maximum of 45 days to dispose of the application by either approval, denial, or withdrawal.

23515 Eligibility Requirements

02-01-01

The following requirements must be met by an individual to qualify for benefits as a QDWI:

1. Categorical Relatedness - It must be verified that the individual continues to be disabled or blind. This determination will be made by the Social Security Administration. Individuals who are 65 years of age or older will not qualify as a QDWI.
2. Lost Medicare Part A and SSA-DIB due to Substantial Gainful Activity (SGA) The individual must have previously received and lost entitlement to SSA-DIB and Medicare Part A solely due to earnings that exceed the SGA amount, as determined by the Social Security Administration. If the individual's loss of SSA-DIB and Medicare Part A was for another reason (e.g., no longer disabled), the individual will not qualify as a QDWI

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3. Entitled to Reenroll in Medicare Part A - The individual must be entitled to reenroll for Medicare Part A and must reapply for coverage with the Social Security Administration prior to QDWI certification.

Verification that the individual's blindness or disability is continuing; that the individual's entitlement to SSA-DIB and Medicare Part A was lost solely due to SGA; that the individual has reenrolled for Medicare Part A; and the effective date of Medicare Part A coverage will be made by requesting the individual to provide any notices received from SSA. If the individual does not have the necessary verification, he/she will be instructed to obtain the needed verification from SSA. The County Office will contact SSA if the individual cannot obtain the necessary verification.

4. Income - Countable income cannot exceed 200% of the Federal Poverty Level (Re: FPL Chart at Appendix F). Income will be determined according to LTC guidelines (Re. MS 3340-3348).

5. Resources - Countable resources cannot exceed twice the SSI resource limit. The QDWI resource standards are:

Individual	\$4,000
Couple	\$6,000

Resources will be determined according to LTC guidelines (RE. MS 3330-3337). There will be no penalty imposed for transfer of resources.

6. Social Security Enumeration - the individual must meet the Social Security Enumeration requirements specified in MS 1358.
7. Citizenship or Alien Status - the individual must meet the citizenship/alien status requirement specified in MS 3324.
8. Residency - the individual must be an Arkansas resident (Re. MS 2200).
9. Mandatory Assignment of Rights to Medical Support/Third Party Liability (Re. MS 1350).
10. Not Otherwise Eligible for Medicaid - the individual is not eligible as a QDWI if eligibility can be established in any other Medicaid category. Note: The individual should be eligible for full Medicaid benefits which includes Part A buy in under the Working Disabled category (Re: MS 28000).

Each eligibility factor will be verified by the Caseworker and documented in the case narrative.

23520 Income Determination

02-01-01

The income of an ineligible spouse will be deemed to the QDWI applicant (Re. MS 2111-2111.5) and the net income compared to the couple's QDWI limit.

The income of an eligible couple will be totaled, and SSI exclusions will be given (only one \$20 exclusion). The net income for the couple will be compared to the couple's QDWI income limit.

The income of QDWI's may vary monthly due to their income from employment. MS 3343 will be utilized in the determination and verification of earnings from employment.

23525 Initial Enrollment Period (IEP) and General Enrollment Period for Medicare Part A **02-01-01**

A QDWI applicant must reenroll for Medicare Part A, if he/she has not previously reenrolled prior to making application.

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

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

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

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

23530 Disposition of Application **02-01-01**

Approval:

If all eligibility factors have been met, and the case is approved, the Caseworker will perform the following tasks:

- a. The individual will be certified in fixed eligibility.
- b. There is no system generated notice for QDWI approvals.
- c. A "9" must be entered in the Lock-in Indicator Field on ACES to identify QDWI recipients. ANSWER is programmed to automatically enter the "9" for the QDWI category
- d. The Medicaid Begin Date will be based on the date of the application and the date on which all eligibility factors are met, including the effective month of Medicare Part A. QDWI eligibility can be effective up to the first day of the 3 month period prior to the date of application, if all eligibility factors were met during that 3 month period.

For example, an individual applies for QDWI benefits on September 1 and the effective month of Medicare Part A is August. This individual's QDWI benefits could begin August 1. If, however, the individual has not reenrolled for Medicare Part A prior to making application, and his Medicare Part A entitlement will not be effective until October 1, QDWI benefits cannot be effective prior to October 1.

- e. The Medicaid End Date must be one day PRIOR to the Medicaid Begin Date. For example, if an individual is approved for QDWI benefits effective 09/01/00, the Medicaid End Date entered will be 08/31/00. This will be done to prevent the system from generating a Medicaid card. Since the individual is not eligible for Medicaid, he/she is not entitled to a Medicaid card.
- f. Notify client of the approval of the payment of his/her Medicare Part A premium by DCO-700.

Send a memorandum to Employment and Income Support Section, P.O. Box 1437, Slot 1223, Little Rock, AR 72203, requesting activation of the Part A buy-in.

Denial and Withdrawal:

When denying the application, the Caseworker will:

- a. Record pertinent information in the case narrative.
- b. Complete the denial data on the system.
- c. Notify applicant of denial by Form DCO-700.

For withdrawals only, a signed written statement must be obtained from the applicant stating that he/she wishes to withdraw the application.

23535 Reevaluations/Changes/Closures

02-01-01

QDWI reevaluations will be conducted annually. Since the cases are certified in closed status, DCO-75's will not be generated to the counties to inform them of reevaluations that are due. The Caseworker will manually issue DCO-75's to notify individuals of appointment dates.

The counties will receive a report monthly to identify active QDWI's. The report will list the Case Number, Case Name, Last Action Date and an Overdue column. An asterisk will be in the Overdue column for an individual if more than 12 months have lapsed since the last Action Date.

All eligibility factors will be redetermined. Completion of Form DCO-777 is necessary at each reevaluation. If the individual continues to be eligible, the Caseworker will send a memorandum to the Central Office-Employment and Income Support Section, P. O. Box 1437, Slot 1223, Little Rock, AR 72203, to request that the reevaluation date be updated. The case will remain in closed status.

When a change occurs that makes an individual ineligible for QDWI, the Caseworker will send a memorandum to the Central Office-Employment and Income Support Section, P. O. Box 1437, Slot 1223, Little Rock, AR 72203, to inactivate the case and stop payment of the Medicare Part A premium for the individual. A 10 day notice of closure will be issued by the county, unless advance notice is not required (Re. MS 3633).