

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. _____

Medical Services Policy MS 31100 - Tuberculosis Medicaid and DCO-133, Tuberculosis (TB) Medicaid Application for Assistance		Date
Intended Effective Date	Legal Notice Published	_____
<input type="checkbox"/> Emergency	Final Date for Public Comment	_____
<input type="checkbox"/> 10 Days After Filing	Filed With Legislative Council	_____
<input checked="" type="checkbox"/> Other	Reviewed by Legislative Council	_____
December 1, 2002	Adopted by State Agency	December 1, 2002

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, DCO
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?**
MS 31100 - Tuberculosis Medicaid and DCO-133, Tuberculosis (TB) Medicaid Application for Assistance.
- 2. **What is the subject of the proposed rule?**
Extending Medicaid eligibility to low-income individuals infected or suspected of being infected with tuberculosis.
- 3. **Is this rule required to comply with federal statute or regulations? Yes___No_X**
If yes, please provide the federal regulation and/or statute citation.
- 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 X No ___** If yes, please provide a brief summary explaining the regulation.

The new rule will add limited Medicaid coverage for individuals with gross income at or below 200% of the Federal Poverty Level, who are or are suspected to be infected with tuberculosis. These individuals will receive only TB related services.

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 ___ No X **If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.**

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 20-15-20 et. Seq., Arkansas Act 416 of 1977, and Section 7 of Arkansas Act 280 of 1939.

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

The purpose of the new rule is to add limited Medicaid coverage for individuals with gross income at or below 200% of the Federal Poverty Level, who are or are suspected to be infected with tuberculosis. These individuals will receive only TB related services and only in the following service areas: prescribed drugs; physician services and outpatient hospital; laboratory and X-ray; and clinic services. It is necessary due to the emerging recurrence of tuberculosis in Arkansas.

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?**

December 1, 2002.

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.**

Unknown at this time.

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. 682-8257 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: Medical Services Policy MS 31100 - Tuberculosis Medicaid and DCO-133, Tuberculosis (TB) Medicaid Application for Assistance

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

Current Fiscal Year

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other _____
Savings Total _____

General Revenue
Federal Funds
Cash Funds
Special Revenue
Other
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?
5. What is the total estimated cost by fiscal year to the agency to implement this regulation?

Current Fiscal Year

Nest Fiscal Year

July 28, 1995

NOTICE OF RULE MAKING

Pursuant to Arkansas Code Annotated 20-76-201 et Seq., Medicaid coverage is being extended effective December 1, 2002 to individuals with gross income at or below 200% FPL, who are infected with or suspected to be infected with tuberculosis.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-332, Little Rock, AR 72203, Attention: Office of Program Planning & Development. All comments must be submitted in writing to the address indicated above no later than 30 days from

_____.

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: _____

31100 **Tuberculosis Medicaid**

12-01-02

Because of the emerging recurrence of tuberculosis (TB) in this country, Congress included provisions in its 1993 legislation that gives states the option of extending Medicaid eligibility to low-income individuals infected or suspected of being infected with TB. Arkansas elected to implement this program effective December 1, 2002, by expanding the Tuberculosis Program currently operated by the Arkansas Department of Health (ADH). Applications for TB Medicaid will be taken at the local Health Department and sent to the DHS Central Office for processing.

31105 **Scope of Services**

12-01-02

Individuals in the TB category will not be eligible for full Medicaid services. Eligible individuals will receive only TB related services. Only the following services, when related to the treatment of TB-infection, will be covered:

1. Prescribed drugs;
2. Physicians' services and outpatient hospital services;
3. Laboratory and X-ray services (including services to confirm the presence of infection); and
4. Clinic services, including Rural Health Clinics and Federally Qualified Health Center services.

Medicaid age limits for Services, Medicaid benefit rates and Medicaid benefit limitations apply to covered services.

Individuals in the TB category are not required to select a Primary Care Physician (PCP) since this is a limited services category.

31110 **Eligibility Requirements**

12-01-02

To qualify for this new category, an individual must meet the following eligibility requirements:

1. The individual must have a positive TB infection diagnosis as confirmed by certain tests or a suspicion of TB infection in his or her diagnosis. These individuals include:
 - (a) Any individual with a positive tuberculin skin test using the Mantoux method and who receives treatment for latent TB infection or active tuberculosis;
 - (b) Any individual with a negative tuberculin skin test but whose sputum culture or culture from another tissue sample is positive for the tuberculin organism;
 - (c) Any individual who never received a tuberculin skin test but whose sputum culture or culture from another tissue sample is positive for the tuberculin organism;
 - (d) Any individual whose TB skin test is negative and whose sputum or other tissue culture for tuberculosis is not or cannot be obtained, but who, in the physician's judgment, requires and is given TB-related drug or surgical therapy or both; or
 - (e) Any symptomatic individual with a negative TB skin test who is being treated with a TB drug regimen while awaiting the TB culture results because the physician suspects

the individual may have active TB, and whose cultures turn out to be negative for TB, causing the TB drug regimen to be discontinued.

2. The individual's income must be at or below 200% of the federal poverty level for the one member unit size (See Appendix F for current amounts). Each adult applicant will be considered as a single individual and income of a spouse will be disregarded. The individual's gross income, without deductions, will be compared to 200% of the federal poverty level. If an application is made for TB Medicaid for a child, and the child is not eligible in any other Medicaid or ARKids category, then the parent(s)' income will be deemed according to MS 2111.

Income will be self-declared with no verification required. Once certified, future income changes will be disregarded.

3. The individual must not be eligible in another Medicaid category.
4. The individual must be an Arkansas resident per the residency requirements at MS 2220-2220.
5. The individual must be a U. S. Citizen or qualified alien per MS 3310 #3, 3324 and 31115.
6. The individual must declare a Social Security number or apply for one if one has not been issued or if one has been issued, but the number is not known per MS 1390.
7. The individual must assign rights to Medical Support/Third Party Liability (TPL) according to MS 1350. TPL information will be obtained by ADH, and will be submitted to DHS with a completed DMS-662.

31115 **Citizenship or Alien Status**

12-01-02

The usual rules that govern citizenship and alienage apply to TB Medicaid. To be eligible, an individual must either be a citizen or a qualified alien (MS 3310 #3 and 3324.) If the applicant is not a U. S. Citizen, ADH will request documentation of alien status, and provide to DHS with the application. DHS will make the determination of whether the applicant is a qualified alien.

31120 **Resources**

12-01-02

There is no resource test for TB Medicaid.

31125 **Application Process**

12-01-02

Applications will be taken at the local Arkansas Department of Health office. Preliminary eligibility will be determined by ADH. If the applicant appears eligible, the ADH worker will forward the TB Medicaid application (DCO-133) along with any supporting documentation (e.g.,

documentation of alien status, DMS-662, etc.) to the DHS Central Eligibility Unit for the final determination and entry to the system.

ADH will indicate on the DCO-133 if the TB-infection is active or latent (i.e., a positive tuberculin test without evidence of active TB). The applications indicating latent infection will be certified for fixed eligibility for one year from the Medicaid begin date. Applications indicating active infection will be certified ongoing. Retroactive Medicaid for up to three months can be authorized, but the Medicaid begin date cannot be prior to December 1, 2002.

Physicians should refer possible TB-infected patients to the ADH local unit to apply for TB Medicaid.

ADH should refer individuals under the age of 19 to the local DHS county office for possible ARKids eligibility.

Applications for TB Medicaid will not be taken at the local DHS county office. Individuals inquiring at DHS about TB Medicaid should be referred to ADH to make an application. TB patients who apply for full Medicaid services at the DHS office and are found ineligible should be referred to ADH for TB Medicaid.

31130 **Continuing Eligibility** **12-01-02**

Applications indicating Latent TB-infection will be certified in fixed eligibility for one year. Active TB-infected and suspected TB-infected cases will be approved for continuous eligibility, and will not be reevaluated on an annual basis, but will continue until ADH notifies DHS that the individual is determined not to be TB-infected. In the suspected TB-infected cases ADH will notify DHS if the individual is determined to not be TB-infected and the case will be closed. Changes in income will not affect eligibility. Treatment for TB can be from four to twenty-four months, with follow-up treatment for two to three years.

31135 **Case Closures** **12-01-02**

Cases will be closed when ADH notifies DHS that:

1. The suspected TB-infected individual is determined not to be TB-infected.
2. The active TB-infected individual is no longer infected.
3. The individual dies.
4. The individual is no longer an Arkansas resident.

DHS will send a 10-day advance notice of closure via the DCO-700 or DCO-55, unless advance notice is not required (Re. MS 3633).

TUBERCULOSIS (TB) MEDICAID

Application For Assistance

Social Security Number	Last Name			First Name	MI	
Birth Date	Race	Sex	County	E-mail Address		
Street Address				City	State	Zip Code
Mailing Address (if different)				City	State	Zip Code
Home or contact telephone	Work telephone			May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fax number	
Are you a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide documentation of your alien status						
What is your gross monthly income? Don't include income of your spouse or other family members. \$ _____						

Read carefully before you sign this application

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize the Department of Human Services (DHS) and the Arkansas Department of Health (ADH) to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Employment Security Division, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility.
- I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify ADH if I cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.
- I authorize and release to DHS and ADH all medical information or other information needed for quality assurance purposes.

Assignment of Medical Support. I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature of Applicant

Date

FOR USE BY ADH PERSONNEL ONLY

✓ Eligibility Checklist

- Individual is infected with Tuberculosis. TB infection is:
 SUSPECTED **ACTIVE** **LATENT**
- Has health insurance coverage. Please find attached a DMS-662.
- United States Citizen
 Not a United States Citizen. Documentation of Alien Status is attached.
- Social Security Number is on the front of the application.
- Applicant is an Arkansas resident.
- Monthly gross income is at or below \$1476.66 (200% of Federal Poverty Level through 3/31/03).

Medicaid Begin Date: _____

Signature of ADH Official _____ Date _____ Telephone Number _____

E-Mail Address: _____

Local ADH Address: _____

FOR DHS USE ONLY

R E G	REGISTER #	APP DATE	COUNTY	CAT	WORKER #	KEY DATE	OP INT
	D E N	WORKER #	DENIAL DATE	REASON	CAT	CN	KEY DATE

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of County Operations

PERSON COMPLETING THIS STATEMENT Linda Greer

TELEPHONE NO. 682-8257 **FAX NO.** 682-1597 **EMAIL:** linda.greer@mail.state.ar.us

To comply with Act 1104 of 1995, 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 MS 31100 - Tuberculosis Medicaid and DCO-133, Tuberculosis (TB) Medicaid Application for Assistance.

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

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. Please indicate if the cost provided is the cost of the program. NOT APPLICABLE**

Current Fiscal Year

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Total _____

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation? Identify the party subject to the proposed regulation, and explain how they are affected.**

Current Fiscal Year

Next Fiscal Year

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

Current Fiscal Year

Next Fiscal Year

\$183,198.00 Federal
63,433.00 State
\$246,631.00 Total

\$314,071.00 Federal
108,750.00 State
\$422,821.00 Total

