124.000 Beneficiary Aid Categories 1-1-16

The following is the full list of beneficiary aid categories. Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

FR full range

LB limited benefits

AC additional cost sharing

MNLB medically needy limited benefits

MP/MF market place/medically frail

Category	Description	Code
01 ARKIDS B	ARKids CHIP Separate Child Health Program	LB, AC
06	New Adult Group	MP/MF
09 SSI	Program of All-Inclusive Care for the Elderly (PACE)	FR
10 N WD NewCo	Working Disabled – New Cost Sharing (N)	FR, AC
10 R WD RegCo	Working Disabled – Regular Medicaid Cost Sharing I	FR, AC
11 AABD	AABD	FR
13 SSI	SSI	FR
14 SSI	SSI	FR
15	Program of All-Inclusive Care for the Elderly (PACE)	FR
16 AA-EC	AA-EC	MNLB
17 AA-SD	Aid to the Aged Medically Needy Spend Down	MNLB
18 QMB-AA	Aid to the Aged-Qualified Medicare Beneficiary (QMB)	LB
18 S AR Seniors	ARSeniors	FR
20 AFDC-GRANT	Parent Caretaker Relative	FR
25 TM	Transitional Medicaid	FR
26 AFDC-EC	AFDC Medically Needy Exceptional Category	MNLB
27 AFDC-SD	AFDC Medically Needy Spend Down	MNLB
31 AAAB	Aid to the Blind	FR
33 SSI	SSI Blind Individual	FR
34 SSI	SSI Blind Spouse	FR
35 SSI	SSI Blind Child	FR
36 AB-EC	Aid to the Blind-Medically Needy Exceptional Category	MNLB
37 AB-SD	Aid to the Blind-Medically Needy Spend Down	MNLB
38 QMB-AB	Aid to the Blind-Qualified Medicare Beneficiary (QMB)	LB

Category	Description	Code
41 AABD	Aid to the Disabled	FR
43 SSI	SSI Disabled Individual	FR
44 SSI	SSI Disabled Spouse	FR
45 SSI	SSI Disabled Child	FR
46 AD-EC	Aid to the Disabled-Medically Needy Exceptional Category	MNLB
47 AD-SD	Aid to the Disabled-Medically Needy Spend Down	MNLB
48 QMB- AD	Aid to the Disabled-Qualified Medicare Beneficiary (QMB)	LB
49 TEFRA	TEFRA Waiver for Disabled Child	AC
51 U-18	Under Age 18 No Grant	FR
52 ARKIDS A	Newborn	FR
56 U-18 EC	Under Age 18 Medically Needy Exceptional Category	MNLB
57 U-18 SD	Under Age 18 Medically Needy Spend Down	MNLB
58 QI-1	Qualifying Individual-1 (Medicaid pays only the Medicare premium.)	LB
61 PW-PL	Women's Health Waiver - Pregnant Women, Infants & Children Poverty Level (SOBRA). A 100 series suffix (the last 3 digits of the ID number) is a pregnant woman; a 200 series suffix is an ARKids-First-A child.	LB (for the pregnant woman only) FR (for SOBRA children)
61 PW "Unborn Child"	Pregnant Women PW Unborn CH-no Ster cov – Does not cover sterilization or any other family planning services.	LB (for the pregnant woman only)
63 ARKIDS A	SOBRA Newborn	FR
65 PW-NG	Pregnant Women No Grant	FR
66 PW-EC	Pregnant Women Medically Needy Exceptional Category	MNLB
67 PW-SD	Pregnant Women Medically Needy Spend Down	MNLB
76 UP-EC	Unemployed Parent Medically Needy Exceptional Category	MNLB
77 UP-SD	Unemployed Parent Medically Needy Spend Down	MNLB
80 RRP-GR	Refugee Resettlement Grant	FR
81 RRP-NG	Refugee Resettlement No Grant	FR
86 RRP-EC	Refugee Resettlement Medically Needy Exceptional Category	MNLB
87 RRP-SD	Refugee Resettlement Medically Needy Spend Down	MNLB

Category	Description	Code
88 SLI-QMB	Specified Low Income Qualified Medicare Beneficiary (SMB) (Medicaid pays only the Medicare premium.)	LB
91 FC	Foster Care	FR
92 IVE-FC	IV-E Foster Care	FR
93	Former Foster Care	FR
96 FC-EC	Foster Care Medically Needy Exceptional Category	MNLB
97 FC-SD	Foster Care Medically Needy Spend Down	MNLB

124.100 Beneficiary Aid Categories with Limited Benefits 4-1-06

Most Medicaid categories provide the full range of Medicaid services as specified in the Arkansas Medicaid State Plan. However, certain categories offer a limited benefit package. These categories are discussed below.

124.110 ARKids First-B 1-1-16

Act 407 of 1997 established the ARKids First Program. The ARKids First-B Program incorporates uninsured children into the health care system. ARKids First-B benefits are comparable to the Arkansas state employees and teachers insurance program.

Refer to the ARKids First-B provider manual for the scope of each service covered under the ARKids First-B Program.

124.120 Medically Needy 1-1-16

The medically needy categories help provide medical care for those individuals who are medically eligible for benefits, but while their income and/or resources exceed the Medicaid limits for other types of assistance, the income is insufficient to pay for all or part of necessary medical care.

Medically needy beneficiaries are covered for the full range of Medicaid benefits with the exception of long term care services (which includes ICF/IID) and personal care services.

For more information regarding the medically needy program, providers may access the Medicaid website at **www.medicaid.state.ar.us/**.

124.130 Pregnant Women, Infants & Children 9-15-09

The infants and children in the SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986) aid category receive the full range of Medicaid benefits; however, the SOBRA pregnant women (PW-PL) receive only services related to the pregnancy and services that if not provided to PW-PLs could complicate the pregnancy.

There are two groups of pregnant women, PW-PL and PW-Unborn CH. Both groups receive the same services during pregnancy. Generally, beneficiaries who are eligible for PW-PL are covered for postpartum follow-up services and family planning services. It is important to note that their PW-PL eligibility ends on the last day of the month in which the 60th postpartum day occurs. PW-Unborn Child group (covered through the State Child Health Insurance program, which is authorized by Section 4901 of the Balanced Budget Act of 1997) does not cover sterilization or any other family planning services. Therefore, providers must verify eligibility to determine if the pregnant women is PW-PL or PW “Unborn

Child” (when providers check eligibility, the system will reflect: “PW Unborn CH-no Ster cov” for the Unborn Child group).

A pregnant woman whose unborn child will be a US citizen (PW-Unborn Child) receives the same pregnancy services as those in the PW-PL category; however, after delivery, no family planning services (including sterilization) are covered.

124.140 Reserved 9-1-15

124.150 Qualified Medicare Beneficiaries (QMB) 1-1-16

The Qualified Medicare Beneficiary (QMB) group was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits from Medicaid or drugs not covered under Medicare Part D. If a person is eligible for QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Medicaid pays the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services. Only individuals considered to be Medicare/Medicaid dually eligible qualify for coverage of Medicaid services that Medicare does not cover.

To be eligible for QMB, individuals must be age 65 or older, blind or an individual with a disability and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal but may not exceed 100% of the Federal Poverty Level (FPL). Countable resources may be equal to but not exceed twice the current Supplemental Security Income (SSI) resource limitations.

Generally, individuals may not be certified in a QMB category and in another Medicaid category simultaneously. However, some QMBs may simultaneously receive assistance in the medically needy categories, SOBRA pregnant women (61 and 62). QMB generally do not have Medicaid coverage for any service that is not covered under Medicare; with the exception of the above listed categories and individuals dually eligible.

Individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the electronic eligibility display to verify the QMB category of service. The category of service for a QMB will reflect QMB-AA, QMB-AB or QMB-AD. The system will display the current eligibility.

Most providers are not federally mandated to accept Medicare assignment (See Section 142.700). However, if a physician (by Medicare’s definition) or non-physician provider desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept Medicare assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. When a provider accepts Medicare according to Section 142.200 D, the beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount. Medicaid will pay a QMB’s or Medicare/Medicaid dual eligible’s Medicare cost sharing (less any applicable Medicaid cost sharing) for Medicare covered services.

Interested individuals may be directed to apply for the QMB program at their local Department of Human Services (DHS) county office.

124.160 Qualifying Individuals-1 (QI-1) 7-15-12

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) aid category. Individuals eligible as QI-1 are not eligible for Medicaid benefits. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-1 do not receive a Medicaid card. Additionally, unlike QMBs and

SMBs, they may not be certified in another Medicaid category for simultaneous periods. Individuals who meet the eligibly requirements for both QI-1 and medically needy spend down must choose which coverage they want for a particular period of time.

Eligibility for the QI-1 program is similar to that of the QMB program. The individuals must be age 65 or older, blind or an individual with a disability and entitled to receive Medicare payment Medicare Part A hospital insurance and Medicare Part B medical insurance. Countable income must be at least 120% but less than 135% of the current Federal Poverty Level.

Countable resources may equal but not exceed twice the current SSI resource limitations.

124.170 Specified Low-Income Medicare Beneficiaries (SMB) 7-15-12

The Specified Low-Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990.

Individuals eligible as specified low-income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid benefits. They are eligible only for Medicaid payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. SMB individuals do not receive a Medicaid card.

Eligibility criteria for the SMB program are similar to those for QMB program. The individuals must be aged 65 or older, blind or an individual with disabilities and entitled to receive Medicare Part A hospital insurance and Medicare Part B insurance. Their countable income must be greater than, but not equal to, 100% of the current Federal Poverty Level and less than, but not equal to, 120% of the current Federal Poverty Level.

The resource limit may be equal to but not exceed twice the current SSI resource limitations.

Interested individuals may apply for SMB eligibility at their local Department of Human Services (DHS) county office.

124.180 Reserved 9-1-15

124.190 Reserved 9-1-15

124.200 Beneficiary Aid Categories with Additional Cost Sharing 6-1-08

Certain programs require additional cost sharing for Medicaid services. These programs are discussed in Sections 124.210 through 124.230.

124.210 ARKids First-B 6-1-08

Covered services provided to ARKids First-B participants are (with only a few exceptions) within the same scope of services provided to other Arkansas Medicaid beneficiaries, but may be subject to cost sharing requirements. See Section II of the ARKids First-B provider manual for a list of services that require cost sharing and the amount of participant liability for each service.

124.220 TEFRA 4-1-06

Eligibility category 49 contains children under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended by the Omnibus Budget Reduction Act. Children in category 49 receive the full range of Medicaid services. However, there are cost sharing requirements. Some parents are required to pay monthly premiums according to the chart below.

TEFRA Cost Share Schedule

Family Income		Monthly Premiums		
From	To	%	From	To
$0	$25,000	0.00%	$0	$0
$25,001	$50,000	1.00%	$21	$42
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$94	$125
$100,001	$125,000	1.75%	$146	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$365	$417
$200,001	And above	2.75%	$458	$458

The maximum premium is $5,500 per year ($458 per month) for income levels of $200,001 and above.

The premiums listed above represent family responsibility. They will not increase if a family has more than one TEFRA eligible child.

124.230 Working Disabled 1-1-16

The Working Disabled category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages 16 through 64, with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

There are two levels of cost sharing in this aid category, depending on the individual's income:

A. Regular Medicaid cost sharing.

Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."

B. New cost sharing requirements.

Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as "WD NewCo".

The cost sharing amounts for the "WD NewCo" eligibles are listed in the chart below:

Program Services	New Co-Payment*
ARChoices Waiver Services	None
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit

Program Services	New Co-Payment*
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Child Health Management Services	$10 per day
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
Developmental Disability Treatment Center Services	$10 per day
Diapers, Underpads and Incontinence Supplies	None
Domiciliary Care	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital's Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day

Program Services	New Co-Payment*
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

* **Exception:** Cost sharing for nursing facility services is in the form of “patient liability” which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD beneficiaries (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

** **Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech Therapy Program for individuals ages 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.