

MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER

May 24, 2017

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 600 – KATIE BECKETT ELIGIBILITY OPTION

BACKGROUND AND EXPLANATION

A revision to Medicaid Operations Manual (MOM) Chapter 600 – Katie Beckett Eligibility Option is being proposed to add language to address a decrease in the participant’s level of care (LOC). If during a re-evaluation the participant’s LOC is decreased, the maximum allowable costs will be decreased accordingly.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective May 25, 2017.

<u>MATERIAL TRANSMITTED</u>	<u>MATERIAL SUPERSEDED</u>
MTL 11/17 MOM 600 – KATIE BECKETT ELIGIBILITY OPTION	MTL 21/12, 05/14, 18/16 MOM 600 – KATIE BECKETT ELIGIBILITY OPTION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.7(e)	Rate Methodology and Cost Effectiveness	Language added as follows: If during a re-evaluation the participant’s LOC is decreased, the maximum allowable costs will be decreased accordingly.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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600 INTRODUCTION

Under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), States are allowed the option to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of the parents' income or resources.

Section 134 is also known as the "Katie Beckett" Option in reference to the child whose disability prompted this change. Under the Katie Beckett Eligibility Option Medicaid eligibility category, a State is allowed to waive the deeming of parental income and resources for a disabled child under 19 years of age who would be eligible for Medicaid if he or she were in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution.

The child must require a Level of Care (LOC) that would make him or her eligible for placement in a hospital, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID). A physician must sign a statement indicating that it is appropriate for the child to receive services in the home. These eligibility criteria are redetermined on an annual basis or in the case of a Pediatric Specialty Care level, every six months.

For children who become eligible for Medicaid under the Katie Beckett Eligibility Option, Medicaid covers medically necessary services as defined by the Medicaid State Plan. Waiver services are not available to children enrolled in the Katie Beckett Eligibility Option.

There is a monetary limit to the Medicaid medical coverage costs. The cost of the child's care in the home must be no greater than the amount Medicaid would pay if the child was institutionalized.

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601 STATUTORY AUTHORITY

Federal regulations governing the administration of the Katie Beckett Eligibility Option are referenced in the following locations:

- a. Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248). This Section of the Act focuses on Medicaid coverage of home care for certain disabled children
- b. Section 1902(e)(3) of the Social Security Act. Section 134 of TEFRA amends Section 1902 (e)(3) of the Social Security Act by adding the following option for each state: any individual who is 18 years of age or younger and qualified as a disabled individual under Section 1614(a); determination by the State that the individual requires a Level of Care (LOC) provided in a hospital, Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); is appropriate to provide such care for the individual outside such an institution; the estimated amount, which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and if the individual were in a medical institution, would be eligible to have a Supplemental Security Income (SSI) or State supplemental payment made with respect to the individual under Title XVI, shall be deemed, for purposes of this title only, to be an individual with respect to whom a Supplemental Security Income payment, or State supplemental payment respectively, is being paid under Title XVI.
- c. Title 42 of the Code of Federal Regulations (CFR), Section 435.225 (42 CFR 435.225) relates to individuals under age 19 who would be eligible for Medicaid if they were in a medical institution. The Code states that the agency may provide Medicaid to children 18 years of age or younger who qualify under Section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution; if the agency elects the option provided by paragraph (a) of this Section, it must determine, in each case, that the following conditions are met:
 1. The child requires the LOC provided in the hospital, SNF or ICF;
 2. It is appropriate to provide the LOC outside such an institution; and
 3. The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.
 4. The agency must specify in its State Plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

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State Plan Supplement 3 to Attachment 2.2-A: Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home (Katie Beckett Eligibility Option).

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602 DEFINITIONS

ABLE

An able parent and/or legal guardian of a minor child, is a Legally Responsible Individual (LRI) who has the option to be present in the home during the time of carrying out necessary maintenance, health/medical care, education, supervision, support services and/or the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as needed.

ACTIVITIES of DAILY LIVING (ADLs)

ADLs are self care activities routinely preformed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility continence and eating.

For the purpose of evaluation, the ADLs are defined as:

- Bathing/Dressing/Grooming: Includes bathing (washing oneself in a bathtub or shower, or by sponge bath. It also includes the individual’s ability to get into and out of the shower or tub), dressing and undressing and personal hygiene.
- Toileting: Includes getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene. Also includes the routine maintenance of incontinence.
- Transferring: Includes moving into or out of a chair, bed or wheelchair.
- Mobility: Includes walking and getting around with the use of assistive devices or with assistance.
- Eating: Putting food into the body from a cup, plate, feeding tube or intravenously. Does not include the preparation of food which is an IADL.

AGE APPROPRIATE

A developmental concept whereby certain activities may be deemed appropriate or inappropriate to the child’s “stage” or level of development (developmental milestones).

CAPABLE

A capable parent and/or legal guardian of a minor child, is an LRI who is physically and cognitively capable of carrying out necessary maintenance, health/medical care, education, supervision, support services and/or the provision of needed ADLs and IADLs.

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CARE COORDINATION

A formal process that ensures ongoing coordination of efforts on behalf of Medicaid-eligible recipients who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitating communication and enrollment between the recipient and providers and providing for continuity of care by creating linkages to and monitoring transitions between intensities of services. Care coordination is a required component of case management services and is not a separate reimbursable service.

COST EFFECTIVENESS

The method by which the Division of Health Care Financing and Policy (DHCFP) monitors and tracks reimbursement for medical services to ensure that the established Level of Care (LOC) cost limitations are not exceeded.

DEVELOPMENTAL MILESTONE

A functional ability that is achieved by most children at a certain age. Developmental milestones can include physical, social, emotional, cognitive and communication skills.

DIAGNOSIS

The determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical and developmental examination and laboratory tests.

DIARY or DIARY DATE

Specific to the Katie Beckett Eligibility Option, the diary date drives the physician consultant's disability reevaluation date. The disability reevaluation date can be established for one, two or three years from the initial disability determination date. Diary dates are determined by the physician consultant based on Medical Improvement Possible (MIP), Medical Improvement Expected (MIE) or Medical Improvement Not Expected (MINE).

DISABILITY DETERMINATION

The DHCFP's physician consultant and professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies based on Social Security Disability Standards. Those standards outlined by Social Security Disability are:

- a. The child/participant must have a physical or mental condition(s) that seriously limits his or her life activities; and

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- b. The condition(s) must have lasted, or be expected to last, at least one year or the condition is expected to be terminal.

ELIGIBILITY

References a person's status to receive Medicaid program benefits. Eligibility is determined by the Division of Welfare and Supportive Services (DWSS) based upon specific criteria for the Katie Beckett Eligibility Option.

FUNCTIONAL ABILITY

Functional ability is defined as a measurement of the ability to perform ADLs and IADLs progressing from dependence to independence. This includes, but may not be limited to: dressing, bathing, grooming, mobility, eating, meal preparation, shopping, cleaning, effective speech or communication and adequate functioning of the respiratory system for ventilation and gas exchange to supply the individual's usual activity level, and performing cognitive tasks such as problem solving, processing information and learning. For the Katie Beckett Eligibility Option, the age and developmental stage of the child is taken into account when assessing functional ability.

FUNCTIONAL IMPAIRMENT

Functional impairment is a temporary or permanent disability (resulting from an injury or sudden trauma, aging, disease or congenital condition) which limits a person's ability to perform one or more ADLs or IADLs, including but not limited to: dressing, bathing, grooming, mobility, eating, meal preparation, shopping, cleaning, effective speech or communication, adequate function of the respiratory system for ventilation and gas exchange to supply the individual's usual activity level and performing cognitive tasks such as problem solving, processing information and learning.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/ID)

An institution (or distinct part of an institution) which is primarily used for the diagnosis, treatment or habilitation of persons with intellectual disabilities or related conditions. In a protected residential setting, an ICF/ID facility provides ongoing evaluation, planning, 24-hour supervision, coordination and integration for health and habilitative services to help individuals function if or when they are able to return home.

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INTERMEDIATE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Health and habilitative services provided to individuals with intellectual disabilities or related conditions. The services are certified as needed and provided in a licensed inpatient facility.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians and parents of minor recipients, including: stepparents, foster parents and adoptive parents.

LEVEL OF CARE (LOC) ASSESSMENT

A screening assessment to determine if an applicant's or participant's condition requires the level of services provided in a hospital, Nursing Facility (NF) or ICF/ID.

NOTICE OF DECISION (NOD)

The method by which the DWSS or the DHCFP advises the participant of his or her Medicaid eligibility status.

PARENT

- a. natural, adoptive or foster parent of a child (unless a foster parent is prohibited by State Law from serving as a parent);
- b. a guardian, but not the State if a child is a ward of the State;
- c. an individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives; or
- d. an individual who is legally responsible for the child's welfare

PARENTAL RESPONSIBILITY

An able or capable parent and/or legal guardian of a minor child, has a duty/obligation to provide the necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provision of ADLs and IADLs.

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PARENTAL FINANCIAL RESPONSIBILITY (PFR)

The cost-sharing portion that enables a child to receive Medicaid coverage under the Katie Beckett Eligibility Option. PFR is based on evaluation of parental income and resources by the DWSS with the PFR amount determined based upon a sliding fee schedule.

PERIODIC

Intervals established for screening by medical, dental and other health care providers to detect disease or disability that meet reasonable standards of medical practice. The procedures performed and their frequency depend upon the child's age and health history.

SCREENING

A methodical examination performed to determine a child's health status and to make appropriate diagnosis and treatment referrals.

SKILLED NURSING (SN)

SN means the assessments, judgments, interventions and evaluations of intervention, which require the training and experience of a licensed nurse. SN care includes, but is not limited to:

- a. performing assessments to determine the basis for action or the need for action;
- b. monitoring fluid and electrolyte balance;
- c. suctioning of the airway;
- d. central venous catheter care;
- e. mechanical ventilation, and
- f. tracheotomy care.

TREATMENT

One or more medically necessary services or care options provided to prevent, correct or improve disease or abnormalities detected by screening and diagnostic procedures.

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603 POLICY

603.1 GENERAL ELIGIBILITY CRITERIA

Eligibility for Nevada Medicaid under Katie Beckett Eligibility Option allows the State to waive the deeming of parental income and resources for children who meet all of the following conditions:

- a. The child must be under 19 years of age and determined to be disabled based upon Social Security Disability Standards.
- b. The child must require a Level of Care (LOC) that would make him or her eligible for placement in a hospital, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).
- c. A physician must sign a statement indicating that it is safe and appropriate for the child to receive care in the home.
- d. Expenditures must not exceed the amount that the Division of Health Care Financing and Policy (DHCFP) would pay for Medicaid services if the child was institutionalized.
- e. As an individual, the child's income and or resources do not exceed the limits established by the Division of Welfare and Supportive Services (DWSS). Income and resource limits can be obtained from the DWSS, as DWSS determines financial eligibility.

603.2 ELIGIBILITY DETERMINATION

Applicants or participants must meet and maintain all eligibility criteria to remain on Medicaid under the Katie Beckett Eligibility Option. Eligibility determination is made on an annual basis by the combined efforts of the DWSS, the DHCFP and the Aging and Disability Services Division (ADSD) when indicated.

- a. The DWSS processes applications to determine Medicaid eligibility.
 - 1. Parental income and resources are waived when determining the child's eligibility.
 - 2. The DWSS evaluates parental income and resources to establish the dollar amount of the Parental Financial Responsibility (PFR), if any.
 - 3. Collection of the PFR is the responsibility of the DWSS.
- b. The DHCFP staff in the District Offices facilitate the processing of Katie Beckett Eligibility Option applications for Medicaid eligibility. Upon receipt of applicant information from the DWSS, the DHCFP District Office staff:

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1. Complete a face-to-face interview and conduct a formal assessment of the child in the home setting to determine if an LOC exists.
 2. Facilitate the collection of medical records to forward to the DHCFP's Physician Consultant and review team at the DHCFP Central Office for disability determination and redeterminations.
 3. If a child does not meet a NF LOC, but medical records provide information indicating there is either an intellectual disability or related condition diagnosis, the parent(s) or guardian(s) is referred to ADSD for further assessment.
- c. The ADSD staff are responsible for the evaluation and determination of an ICF/ID LOC for intellectual disabilities or related conditions.
1. The DHCFP requires that the individual determining an ICF/ID LOC must be at least a Developmental Specialist III (DSIII) or a Qualified Intellectual Disability Professional (QIDP).
- d. Third Party Liability (TPL)
1. Refer to Medicaid Services Manual (MSM) Chapter 100.
 2. Participants eligible for Medicaid through the Katie Beckett Eligibility Option are required to pursue and/or maintain other health coverage if it is available to the recipient, parent, and/or legal guardian.

603.3 COVERAGE AND LIMITATIONS

Parental Responsibility

An able and/or capable parent or Legally Responsible Individual (LRI) of a minor child has a duty/obligation to provide the necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes but not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of a family.

603.4 CARE COORDINATION

Care Coordination is a component of the services provided by the DHCFP Health Care Coordinators which assists the participant to remain in his or her home. The role of the DHCFP Health Care Coordinator is to:

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- a. facilitate access to medical, social, educational and other needed services regardless of the funding source.
- b. monitor quarterly calendar costs incurred to ensure that expenditures are not exceeded for the allowable cost limits and assist the family in prioritizing services.
- c. prepare parent or guardian for transition to other services when Medicaid eligibility is no longer met under the Katie Beckett Eligibility Option (i.e. SSI eligibility, age 19) and or assist with any ongoing or unmet needs.
 1. Coordinate with the DWSS caseworker to change eligibility category;
 2. Refer to Medicaid Waiver programs as appropriate; and
 3. Refer to community resources.
- d. make at least quarterly contact with parent or guardian by phone, letter or in person to ensure that all necessary services are accessed and identify any significant change in the child's condition or unmet needs, making referrals as necessary.
- e. conduct in-home visits with the child and parent or guardian for determination of a LOC, making appropriate referrals as necessary. The number of visits per year is driven by the LOC, but home visits are conducted at least annually.

603.5 PROGRAM COOPERATION

The parent or legal guardian must cooperate with program processes which includes responding within 30 days to communications from the DHCFP Health Care Coordinator and requests for information.

603.6 LEVEL OF CARE (LOC)

LOC assessments must be age appropriate and take into consideration the diagnoses, developmental milestones and functional abilities of the child. ADLs may be looked at as tasks but must be developmentally appropriate in relationship to the child's age and that a child should be able to perform independently.

An NF or ICF/ID LOC is assigned for a one-year period of time after the initial assessment and evaluation. There is a home visit conducted at least annually to reassess the LOC.

NF Pediatric Specialty Care I and Pediatric Specialty Care II LOC's are assigned for a six-month period, and a reassessment of the LOC occurs every six months. Service levels determine the monthly cost allowance available for services and supplies for the child.

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- a. Nursing Facility Standard is appropriate when the child’s diagnoses result in functional impairments that indicate a need for skilled nursing care or comprehensive habilitation as evidenced by the following:
1. The child’s diagnoses require specialized professional training and monitoring beyond those normally expected of parents.
 2. The child requires skilled observation and assessment several times daily due to significant health needs.
 3. The child has unstable health, functional limitations, complicating conditions, cognitive or behavioral conditions or is medically fragile such that there is a need for active care management.
 4. The child’s impairment substantially interferes with the ability to engage in everyday activities and perform age appropriate activities of daily living at home and in the community, including but not limited to bathing, dressing, toileting, feeding and walking/mobility.
 5. The child’s daily routine is substantially altered by the need to complete these specialized, complex and time consuming treatments and medical interventions or self-care activities.
 6. The child needs complex care management and/or hands on care that substantially exceeds age appropriate assistance.
 7. The child needs restorative and rehabilitative or other special treatment.
- b. Nursing Facility Pediatric Specialty Care I and Pediatric Specialty Care II is limited to participants from birth to 19 years of age, who are medically fragile and require specialized, intensive, licensed skilled nursing care beyond the scope of services than what is generally provided to the majority of NF participants.

To qualify for this LOC, a participant must be receiving highly skilled services which require special training and oversight. Pediatric Specialty Care rates are approved for a maximum of six months at a time. Each Pediatric Specialty Care I or II child’s LOC must be reevaluated every six months.

For a detailed description of Pediatric Specialty Care I and II, refer to MSM 500 – Nursing Facilities.

- c. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID). ADSD determines the ICF/ID LOC.

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603.7 RATE METHODOLOGY AND COST EFFECTIVENESS

- a. The DHCFP Reimbursement Analysis & Payment Unit uses the average daily NF rates to determine the allowable costs for recipients who meet a NF level of care.
- b. The rates for the ICF/ID facilities are averaged. This amount is then used to determine the allowable costs for recipients who meet an ICF/ID level of care.
- c. At the end of each calendar quarter, a list of approved Katie Beckett Eligibility Option cases is generated by the DHCFP staff. The list shows the total Medicaid expenditure amount incurred for that quarter for each eligible child under the Katie Beckett Eligibility Option.

The purpose is to ensure that the costs incurred by Medicaid for each child does not exceed the projected costs of institutional care. There are services and supplies that are not included in the Facility Rate and are excluded from the child’s Institutional LOC overall costs.

If the adjusted incurred amount exceeds the maximum allowable amount, the Health Care Coordinator at the appropriate DHCFP office is notified. The DHCFP Health Care Coordinator will contact the participant’s parent or legal guardian and advise him/her:

- 1. of the requirement to keep costs at or below the maximum allowable amount; and
- 2. that failure to keep costs at or below the maximum allowable amount for a second consecutive quarter will result in termination of Medicaid eligibility under the Katie Beckett Eligibility Option.

If the participant’s incurred costs exceed the maximum allowable amount for two consecutive quarters, he/she will be terminated from the Katie Beckett Eligibility Option and consequently from Medicaid services, effective the first day of the month following the date of determination of non-compliance with program requirements.

- d. An exception to this requirement occurs when a participant is re-evaluated by the DHCFP and determined to require a higher LOC (thereby increasing the maximum allowable amount).
- e. **If during a re-evaluation the participant’s LOC is decreased, the maximum allowable costs will be decreased accordingly.**

603.8 TERMINATION FROM THE KATIE BECKETT ELIGIBILITY OPTION

Reasons to terminate a recipient from the Katie Beckett Eligibility Option:

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- a. The parent or legal guardian has requested that the recipient be terminated from the Katie Beckett Eligibility Option.
- b. The DHCFP Health Care Coordinator has not received requested information, or has lost contact with the parent or legal guardian.
- c. The recipient has moved out of state.
- d. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, ICF/ID, RTC or incarcerated).
- e. Failure to keep costs at or below the maximum allowable amount for a second consecutive quarter will result in termination of Medicaid eligibility under the Katie Beckett Eligibility Option.

603.9 AUTHORIZATION PROCESS

Medicaid eligibility does not guarantee payment for services. Some services covered by Nevada Medicaid must be authorized based on medical necessity, and/or specific program policy and limitations. Out of state medical care may be authorized per MSM Chapter 101.1. Services are authorized by the Quality Improvement Organization (QIO)-like vendor.

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604 HEARINGS

Refer to Medicaid Services Manual (MSM) Chapter 3100 for information regarding Hearing Procedures.

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605 REFERENCES AND CROSS REFERENCES

Please consult chapters of the Medicaid Services Manual (MSM) which may correlate with this chapter.

Chapter 100	Medicaid Program
Chapter 200	Hospital Services
Chapter 300	Radiology Services
Chapter 400	Mental Health and Alcohol/Substance Abuse Services
Chapter 500	Nursing Facilities
Chapter 600	Physician Services
Chapter 700	Rates and Cost Containment
Chapter 800	Laboratory Services
Chapter 900	Private Duty Nursing
Chapter 1000	Dental Services
Chapter 1100	Ocular Services
Chapter 1200	Prescribed Drugs
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1400	Home Health Agency
Chapter 1500	Healthy Kids Program (EPSDT)
Chapter 1600	Intermediate Care for Individuals with Intellectual Disabilities
Chapter 1700	Therapy
Chapter 1900	Transportation Services
Chapter 2800	School Based Child Health Services
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Chapter 3500	Personal Care Services (PCS) Program
Chapter 3600	Managed Care Organization