MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 27, 2023

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL

FROM: CASEY ANGRES, CHIEF OF DIVISION COMPLIANCE Casey Angres
Casey Angres (Jul 13, 2023 14:33 PDT)

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 600 – KATIE BECKETT ELIGIBILITY OPTION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Operations Manual (MOM) Chapter 600 – Katie Beckett (KB) Eligibility Option are being proposed.

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.

Entities Financially Affected: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective July 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 08/23 MOM 600 – Katie Beckett Eligibility Option	MTL 18/16, 21/12, 05/14, 11/17 MOM 600 – Katie Beckett Eligibility Option

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
600	**Introduction**	The third paragraph has been removed as it was redundant.
601	**Authority**	Word "statutory" has been removed from the title. Revised first two sections for clarity. Added 42 CFR 435.540 Requirements for Medicaid related disability decisions. Added CFR 435.911 Determination of Eligibility.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
602	**Definitions**	Definitions under this section were moved to the Addendum.
603.1	**Eligibility Criteria**	Word "General" removed from the title for clarity. Introductory paragraph revised to indicate that applicants/participants must meet and maintain eligibility. Bullet C revised to indicate that "or other medical professional as approved by the SSA" must sign a statement indicating that it is safe for the child to receive care at home. Bullet D revised to indicate that the individual must meet LOC criteria. Bullet E revised for clarity to indicate that financial eligibility is determined by Division of Welfare and Supportive Services (DWSS).
603.1A	**Coverage and Limitations**	This is a new section created to detail the general Coverage and Limitations of the KB Option including: DWSS evaluated parental income. Child must have a disability as determined by Division of Health Care Financing and Policy (DHCFP) Physicians Consultant. Third Party Liability (TPL). The cost to receive in home services must not be higher than institutional cost.
603.1B	**Provider Responsibilities**	A new section was created to include that providers are responsible for confirming the recipients Medicaid eligibility each month prior to rendering services.
603.1C	**Parental Responsibilities**	A new section was created to define Parental Responsibilities within the KB program.
603.2	**Administrative Case Management**	This section was re-titled from Eligibility Determination to Administrative Case Management (supplants 603.4).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Eligibility Determination was re-titled Disability Determination and moved to 603.5 for continuity. This new section provides information that care coordination is a component of DHCFP Health Care Coordinators (HCC) which assist the recipient to remain in the home.
603.2A	**Coverage and Limitations**	A new section was created to detail DHCFP HCC responsibilities.
603.2B	**Provider Responsibilities**	A new section was created to detail necessary qualifications for DHCFP HCC.
603.3	**Intake Procedures**	This section was re-titled from Coverage and Limitations to Intake Procedures. This section was added for continuity and to detail the responsibilities of the HCC and parents during the application process and intake.
603.4	**Level of Care (LOC)**	Section was re-titled from Care Coordination to LOC. Care Coordination was moved to 603.2 and re-titled Administrative Case Management for consistency. This section was renumbered, and language was clarified. Bullet B was added to indicate areas support is needed in that go beyond those required for children the same age. Removed "Each Pediatric Specialty Care I or II child's LOC must be reevaluated every six months" from bullet F. Bullet G was re-worded for clarity.
603.5	**Disability Determination**	This section was transferred from Chapter 1000 – Disability Determination where applicable for KB.
603.6	**Katie Beckett Premium**	This section was re-titled from LOC to KB Premium. LOC section moved to 603.4 for consistency. This section was created to give some details on the new KB premium payment methodology.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.7	**Cost Effectiveness**	This section was re-titled from Rate Methodology and Cost Effectiveness to Cost Effectiveness. Section re-worded for clarity and consistency. This section includes a change in processes to include claims reports will be generated on an annual basis at the time of re-determination instead of every quarter. Change from "If recipients exceed the maximum allowable amount for two consecutive quarters" to "If recipients incurred costs exceed the maximum allowable for two consecutive years the recipient may be terminated from the KB Eligibility Option".
603.8	**Authorization Process**	This section re-numbered from 603.9 to 603.8 for consistency.
604	**Hearing Request Due to Adverse Actions**	This section was re-titled from Hearings to Hearing Requests Due to Adverse Actions and provides information on the Fair Hearing process.
604.1	**Denial of Disability Application**	A new section was added to provide information on reasons for denial of application.
604.2	**Termination of Katie Beckett Eligibility Option**	This section was re-numbered from 603.8 to 604.2 for consistency. Section re-numbered. Bullet E changed to indicate failure to keep costs at or below the maximum allowable amount for 2 consecutive years. Bullets F-I added for additional reasons for termination. Sentence added to indicate Division of Health Care Financing and Policy (DHCFP) Long Term Supportive Services (LTSS) Unit or District Office will send Notice of Decision (NOD) letting the recipient know they have been terminated.
605	**Appeals and Hearings**	This section was re-titled from References and Cross References to Appeals and Hearings and renumbered.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The section provides information on where recipients can learn about the process.
606	**References and Cross References**	This section was renumbered and serves as a reference to the Medicaid Services Manual (MSM) Chapters.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID OPERATIONS MANUAL
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KATIE BECKETT ELIGIBILITY OPTION

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 due to 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 Nevada Medicaid Katie Beckett Eligibility Option, the 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 the child was in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution.

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.

601 AUTHORITY

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

Statutes and Regulations

- Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248).
- Section 1902(e)(3) of the Social Security Act allows states to provide Medicaid assistance to children living at home if it is less expensive than providing similar care in an institution.
- 42 CFR 435.225
- 42 CFR 435.540 Requirements for Medicaid related disability decisions
- 42 CFR 435.911 Determination of Eligibility
- 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).

602 DEFINITIONS

See Addendum for Definitions

603 POLICY

603.1 ELIGIBILITY CRITERIA

Applicants or participants must meet and maintain all eligibility criteria to remain on Medicaid under the Katie Beckett Eligibility Option. The Division of Welfare and Supportive Services (DWSS) and Division of Health Care Financing and Policy (DHCFP) collaboratively determine eligibility as follows:

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) for placement in a hospital, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).

C. A physician or other medical professionals as approved by the SSA, must sign a statement indicating that it is safe and appropriate for the child to receive care in the home.

D. Must meet LOC eligibility criteria as assessed by DHCFP Health Care Coordinators (HCC).

E. Financial eligibility is determined by DWSS.

603.1A COVERAGE AND LIMITATIONS

1. DWSS evaluates parental income and resources to establish Katie Beckett (KB) premium. DHCFP invoices and collects KB premium.

2. The child must have a disability as determined by the DHCFP Physicians Consultant based on the Social Security Disability Standards.

3. Third Party Liability (TPL)

   a. Refer to Medicaid Services Manual (MSM) Chapter 100.

   b. 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.

4. The cost to receive services in the home must not be higher than institutional cost.

603.1B PROVIDER RESPONSIBILITIES

Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering Medicaid services.

603.1C PARENTAL RESPONIBILITIES

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.

603.2 ADMINISTRATIVE CASE MANAGEMENT

Care Coordination is a component of the case management services provided by DHCFP HCCs which assist the recipient to remain in the home.

603.2A COVERAGE AND LIMITATIONS

Care Coordination includes; but not limited to:

1. Facilitate access to medical, social, educational, and other needed services regardless of the funding source.

2. Monitor annual costs incurred and discuss with family during the yearly home visit to ensure that expenditures do not exceed the allowable cost limits and assist the family in prioritizing services.

3. 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.

    a. Coordinate with the DWSS caseworker to change eligibility category;

    b. Refer to Medicaid Waiver programs as appropriate; and

    c. Refer to community resources.

4. Maintain regular contact with parent or guardian by phone, email, mail, 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.

5. Conduct in-home visits (virtual or in-person) 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.

603.2B PROVIDER RESPONSIBILITIES

DHCFP HCCs must currently be licensed as a Social Worker or licensed professionals by the State of Nevada, or licensure as a Registered Nurse (RN) by the Nevada State Board of Nursing.

603.3 INTAKE PROCEDURES

The parent or legal guardian must cooperate with program processes which includes responding to the DHCFP HCC and requests for information within appropriate time frames.

Initial and/or Annual Home Visit (HV) process:

A. Upon receipt of referral, HCC will send HV letter with intake packet.

B. HCC will call within 10 business days from date on the HV letter to schedule child's initial or annual HV.

C. Parents will provide all required documents within 30 days of requested date including but not limited to:

1. Physician Statement (see section 603.5 for details of SSA acceptable medical professionals).

2. Home Visit Questionnaire.

3. Consent for Release of Information (ROI).

4. Medical Records from all providers.

5. School records including Teacher Questionnaire, Individualized Education Program (IEP) and Psychoeducational testing.

D. Required Contacts with HCC staff.

1. Contacts required by phone, email, or mail. Once contact is initiated by DHCFP, response is required within 30 days.

2. If program requirements are not met, after third attempt, DWSS will be notified of non-cooperation and the case will be closed.

603.4 LEVEL OF CARE (LOC)

A. 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.

B. Children must have intensive support needs in areas of behavioral skills, general skill training, personal care, medical interventions, etc., beyond those required for children the same age.

C. NF or ICF/ID LOC is 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.

D. 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.

E. 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.

F. 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.

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

G. For Individuals with Intellectual Disabilities, Aging and Disability (ADSD) or DHCFP determines the ICF/IID LOC.

603.5 DISABILITY DETERMINATION

DHCFP Physician Consultant reviews the application and determines eligibility based on the most recent Disability Guidelines under Social Security.

Applicants or participants must meet and maintain the disability eligibility criteria as defined in the most recently published electronic version of Disability Evaluation under Social Security (U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), SSA Publication No. 64-039, ICN No. 468600).

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 year or up to a maximum of 7 years, from the initial disability determination date. Diary dates are determined by the physician consultant based on Medicaid Improvement Possible (MIP), Medical Improvement Expected (MIE), or Medical Improvement Not Expected (MINE).

Acceptable Medical Sources (Physician Statement).

Documentation of the existence of an individuals' impairment must come from medical professionals as defined in the Disability Evaluation Under Social Security.

"Acceptable medical sources" per SSA are:

A. Licensed physicians (medical or osteopathic doctors), Advances Practice Nurse (APRN), or Physician Assistant (PA/PA-C);

B. Licensed or certified psychologists including school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school

psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;

C. Licensed Optometrists for purposes of establishing visual disorders only (except in the U.S. Virgin Islands, licensed Optometrist, for measurement of visual acuity and visual fields only);

D. Licensed Podiatrists, for purposes of establishing impairments of the foot, or foot and ankle, depending on whether the state in which the podiatrist practices permits practice of Podiatry on the foot only, or the foot and ankle;

E. Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the state professional licensing agency or be fully certified by the state education agency in the state in which he or she practices or holds a Certificate of Clinical Competence from the American Speech-Language Hearing Association.

Copies of medical evidence from hospitals, clinics, or other health facilities where an individual has been treated are also requested. All medical reports received are considered during the disability determination.

Information from other sources is also considered in assessing the extent to which a person's impairment(s) affects his or her ability to function. Other sources include publish and private social welfare agencies, non-medical sources such as teachers, day care providers, social workers, employers, and practitioners such as naturopaths, chiropractors, audiologists, occupational or physical therapists, and/or speech and language pathologists.

603.6 KATIE BECKETT PREMIUM

All families in the Katie Beckett Program are responsible for a KB premium that is billed monthly. The premium will be based on the Payment Agreement Guide (NMO) which is updated annually (April 1st) to reflect current Federal Poverty Level income ranges. The premium may be paid monthly, quarterly, or annually. Parents/guardian will still be responsible for any premium payment agreement once you sign, even if the Katie Beckett coverage is voluntarily ended, services are not used, the recipient ages out of the program or the recipient moves out of the State of Nevada. Katie Beckett premium payments are non-refundable. Failure to pay the premiums shall result in termination of eligibility from the Katie Beckett Program.

603.7 COST EFFECTIVENESS

DHCFP must assure Centers for Medicare and Medicaid Services (CMS) that the costs incurred by Medicaid for each child does not exceed the 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. Institutional care costs are an adjusted figure to what is normally covered in an inclusive rate for an appropriate LOC for a facility, for e.g., room and board daily nursing care, and general supplies (see MCM Chapter 503.16 for a full list of exclusions).

KB eligibility option allows for Medicaid providers to deliver services/supports, and assurance of the cost effectiveness of these services.

A. DHCFP uses the average daily NF, ICF/IID, or PSC I/II rates to determine the allowable costs for recipients who meet their assigned level of care.

B. Annual claims reports will be evaluated at the time of redetermination. The report shows the total Medicaid expenditure amount incurred during the past year.

C. If the adjusted incurred amount exceeds the maximum allowable amount, the HCC will contact the recipient's parent or legal guardian to review the cost to determine if there has been a significant change in condition of recipient. If there is no significant change, discuss how to mitigate the additional costs incurred.

D. An exception to this requirement occurs when a participant is re-evaluated by 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.

F. If the recipient's incurred costs exceed the maximum allowable amount for two consecutive years, the recipient may 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.

603.8 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.

604 HEARING REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of an applicant/ recipient's request for services or a recipient's eligibility determination. The DHCFP must grant the opportunity for a hearing to an applicant/recipient/designated representative/Legally Responsible Individual (LRI) in the event an adverse is taken by DHCFP. Refer to MSM Chapter 3100 for information regarding Hearing Procedures.

604.1 DENIAL OF DISABILITY APPLICATION

An application for disability may be denied if the applicant:

A. Does not meet the disability criteria as determined by DHCFP Physician Consultant;

B. Does not meet the level of care criteria for Katie Beckett Eligibility Option;

C. Has withdrawn their request for disability determination;

D. Has failed to cooperate during the application process and/or in the submission of required documents;

E. DHCFP has lost contact with the parent(s) or LRI.

F. The DHCFP LTSS Unit or District Offices will send a Notice of Decision (NOD) to the parent(s) or legal guardian(s) letting them know that the application has been denied and the reason for denial.

604.2 TERMINATION OF KATIE BECKETT ELIGIBILITY OPTION

Reason to terminate a recipient from Katie Beckett Eligibility Option

A. The parent or legal guardian has requested that the recipient be terminated from the Katie Beckett Eligibility Option.

B. The DHCFP HCC has not received requested information within requested timeframe.

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 two consecutive years.

F. Does not maintain other health coverage if it is available to the recipient, parent, and/or legal guardian.

G. Has failed to cooperate during the annual redetermination process and/or in the submission of required documents.

H. Loss of contact.

I. Failure to pay KB premium.

The DHCFP LTSS Unit or District Offices will send a NOD to the parent(s) or legal guardian(s) letting them know that recipient has been terminated and the reason for the termination.

605 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 Hearings for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipients Rights Form.

606 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