210-RICR-50-10-03

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 10 – HOME AND COMMUNITY-BASED LTSS

PART 3 – Eligibility Pathways: Katie Beckett Program

3.1 Overview

A. In 1982, Congress created a new Medicaid State Plan option under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), also referred to as the Katie Beckett (KB) provision, which enables otherwise ineligible children who have severe disabling impairments and/or complex health needs to obtain the services they need at home rather than in an institutional-setting in certain circumstances.

B. The scope of services KB-eligible children receive are also generally available under the Medicaid State Plan for Medicaid Affordable Care Coverage (MACC) group children with special needs eligible on the basis of the MAGI standard. Accordingly, all children are evaluated for MAGI-based eligibility first using the 261 percent of the Federal Poverty Level (FPL) standard. The KB provision applies to children who are not eligible for Medicaid through this pathway and, in doing so, assures some of Rhode Island's most vulnerable children will have access to critical home-based services which are not covered by most commercial and other third-party insurers.

3.2 Scope and Authority

Under the terms of the KB Medicaid State Plan option, a child must meet general and financial requirements as well as clinical criteria related to disability and the need for an institutional level of care. Prior to authorization of services, the State must also apply a federally required cost-effectiveness test to determine whether home-based services are as effective at meeting a child's needs at an equal or lower cost than care provided in an institutional setting.

3.3 Special Conditions

A. To qualify for Medicaid LTSS through the KB provision, a child must meet the general Medicaid requirements pertaining to residency, citizenship and immigration status. In addition, a child must be under nineteen (19) years of age and the following conditions must be met:

1. Financial Eligibility – Children seeking coverage for an institutional level of care at home who do not meet the eligibility criteria for MACC using the MAGI standard are subject to a financial eligibility review of income and resources using the SSI method for Community Medicaid, as set forth in Part 40-00-3 of this Title with the following exception --

   a. Parental assets unavailable. When seeking Medicaid LTSS under the KB provision, the assets --income and resources – of the parent(s) or legal guardian(s) are deemed to be unavailable to the child applying for coverage. Accordingly, the financial eligibility determination is based on the child's income and resources. The standards that apply are the federal benefit rate relative to income and up to the medically needy limit of $4,000 in resources. This is the SSI method of treatment of income and resources that applies when a child with special needs is seeking coverage in an institutional setting.

   b. Excluded expenses. In the calculation of countable income, any payments for in-home supportive services provided to the child which are covered by Medicaid or other federal, state or local government programs are excluded.

2. Clinical Eligibility – Upon application for coverage under the KB provision, a determination of clinical eligibility is made. There are two reviews included in this determination:

   a. Disability review. The disability status of the child is reviewed using the applicable SSI criteria. Information provided by a child's primary health care practitioner and ancillary providers is used as the basis for this review. Appropriate consents and authorizations must be provided by the applicant's parents/guardian to ensure full access to health care records and evaluations required for the disability review.

   b. Level of need. After the disability determination, the child's need for an institutional level of care using needs-based criteria related to functional and health status is considered.

c. Clinical determination. Based on the disability and level of care reviews, a determination is made on whether the child has disabling impairments and/or complex health needs that:

(1) Require the level of care typically provided in an institution; and

(2) The required services can be safely provided in the community.

3. The standards and criteria used to make the disability and level of care determinations are available on paper by contacting the Katie Beckett Unit at 401-462-0247 and on the EOHHS website at: http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/PeoplewithSpecialNeedsandDisabilities/Children/KatieBeckettEligibility.aspx

a. A child must meet federal criteria for childhood disability. Under Title XVI of the Social Security Act, a child under age 19 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that cause(s) marked and severe functional limitations, and that has lasted or can be expected to last for a continuous period of not less than 12 months, or can be expected to result in death. (A complete description of the Social Security Administration requirements can be found in *Disability Evaluation Under Social Security* - also known as the Blue Book).

b. As provided in 42 C.F.R. § 435.225 (b)(1), a child must require the level of care provided in a hospital (or psychiatric hospital), intermediate care facility for the intellectually disabled (ICF/ID), or nursing facility. Without appropriate interventions and supports (both at home and in the community), the child would either reside in an institution or be at immediate risk for institutional placement.

B. Cost Effectiveness Test – Both the decision on disability and level of care must be determined prior to the institutional versus home care cost-effectiveness comparison. Thus, the final step in determining eligibility under the KB provision is a comparison of the costs of providing the care a child needs at home versus in a health care institutional setting. If the costs of care at home are found to be higher, coverage under the KB provision must be denied.

1. Basis of comparison. The gross average monthly cost for providing care in the applicable health care institution - Nursing Facility, Intermediate Care Facility – Intellectual Disabilities (ICF-ID), or Hospital - as dictated by the

child's needs is compared to the total gross monthly cost for allowed homecare services.

2. Institutional costs. This amount is determined on an annual basis and is set forth in the Medicaid Code of Administrative Rules, "Waiver Programs and Provisions" (Section 0396) by institution.

3. Allowed home care cost. The gross monthly costs for the following are included in this calculation:

    a. Certified home health agency services, including skilled nursing; physical speech; occupational therapy; and home health aide services; and

    b. Purchase or rental of durable medical equipment;

    c. Home based therapeutic services; and

    d. Minor assistive devices, minor home modifications, and other special equipment.

4. These costs are only taken into consideration if they are not covered or reimbursed by a third-party including, but not limited to, private commercial insurance and other publicly financed programs administered by a government agency or body, such as a school district.

5. Determination of cost-effectiveness. Upon taking these costs into consideration, cost-effectiveness is determined as follows:

    a. KB Eligibility approved. If the total estimated cost of care in the home is less than the total estimated cost of care in the appropriate institution, home care is considered to be cost-effective, this special condition is met and a child who is otherwise eligible under the KB provision qualifies for the full scope of Medicaid benefits.

    b. KB Eligibility denied. If the total estimated cost of services required to meet a child's needs at home exceeds the cost of institutional care, the child is ineligible under the KB provision, even if the child meets all other eligibility requirements.

6. Eligibility determinations for Medicaid / KB. Determinations for KB must take no longer than ninety (90) days from the date the completed application is received. The application remains open after that period if the Medicaid agency or its eligibility designee (DHS) or agents (application entities) are responsible for delays in the determination.

3.4 Continuing Eligibility

The financial eligibility of KB eligible children is renewed on an annual basis and when there are changes in state residence, the income and/or resources available to the child, living arrangements – that is, from home into an alternative health care setting -- or access to or coverage by a third-party payer. Clinical eligibility is also reviewed annually or when there is a change in health or functional status, unless it is determined that the frequency of reviews must be altered due to the unique needs/circumstances of the child.

3.5 Authorization and Delivery of Services

Upon determining a child is eligible for Medicaid under the KB provision, the necessary home-based services are authorized. Children without third-party coverage are enrolled in a RIte Care Plan in accordance with the provisions in the Medicaid Code of Administrative Rules, "RIte Care" and "Enrollment" (Sections 1309 and 1311). Children with alternative forms of coverage are provided services on a fee-for-service basis.

210-RICR-50-10-3

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 10 - HOME & COMMUNITY BASED LTSS

PART 3 - Katie Beckett Program (210-RICR-50-10-03)

Type of Filing: Adoption
Effective Date: 12/07/2017

Editorial Note: This Part was filed with the Department of State prior to the launch of the Rhode Island Code of Regulations. As a result, this digital copy is presented solely as a reference tool. To obtain a certified copy of this Part, contact the Administrative Records Office at (401) 222-2473.