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305.01 Introduction

(Eff. 02/01/06)

Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248) provides states with the option to make Medicaid benefits available to certain disabled children who would otherwise require institutional care to attain eligibility and who would not ordinarily be eligible for Supplemental Security Income (SSI) because their parent’s income and/or resources exceed the limit.

These children are generally called Katie Beckett or TEFRA children. This is an eligibility option, not a waiver category. South Carolina began covering these children effective January 1, 1995. DHHS Form Letter 3292 provides an overview of the TEFRA program and the application process for individuals applying and considering applying for this category.

305.02 Processing and Maintaining TEFRA Cases

(Rev. 10/01/10)

Applications for TEFRA may be received at any local Medicaid Eligibility Office. The Division of Central Eligibility Processing is responsible for processing and maintaining all of these cases.

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| Procedure Applications taken or received in a local Medicaid eligibility office should be forwarded to the Division of Central Eligibility Processing:  Mailing Address Division of Central Eligibility Processing  PO Box 100101  Columbia, SC 29202-3101  Courier Address Division of Central Eligibility Processing  1801 Main St  Columbia, SC 29202 |

305.03 Non-Financial Criteria

(Rev. 02/01/20)

An individual must meet the following non-financial requirements referenced in MPPM Chapter 102.

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/SSN MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

For applications filed on or after January 1, 2018, children who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. Unless the child attains satisfactory immigration status, eligibility must be terminated once the child turns age 19.

In order for the applicant to be approved correctly, the eligibility specialist must submit a Medicaid Policy ticket in Service Manager. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
  + DHSID evidence must added for application processed in Cúram,
  + Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

305.04 Categorical Criteria

(Eff. 02/01/06)

Applicants/Beneficiaries must meet certain categorical eligibility requirements.

305.04.01 Age

(Rev. 11/01/20)

To become eligible and remain eligible as a TEFRA child, the applicant/ beneficiary must be under age 19. Accept the applicant’s allegation of age, unless the information is questionable, and then it must be verified. When a child reaches age 19, eligibility for continuing benefits under another Medicaid category must be determined using appropriate criteria (Refer to MPPM 101.08.06.)

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| **Note:** If the child is age 18, the eligibility worker should refer him/her to the Social Security Administration (SSA) to apply for SSI benefits. However, this is not an eligibility requirement. |

305.04.02 Disability

(Eff. 02/01/06)

An applicant/beneficiary must meet the SSI disability definition of disability. Refer to MPPM 102.06.02, 102.06.02A, 102.06.02B, and 102.06.02C.

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| **Note:** The applicant/beneficiary must sign a [DHHS Form 921](http://medsweb.scdhhs.gov/EligibilityForms/FM%20921.pdf), Authorization to Disclose Health Information, for the number of providers listed on the [DHHS Form 3218-D ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203218-D%20ME.pdf), Child Under Age 19 Disability Report. In addition, the applicant/beneficiary must sign and date, five (5) blank “Authorization to Disclose Health Information” forms. The DHHS Form 921 must be signed and dated by the applicant/beneficiary. For applicants/beneficiaries under age 12, an individual with legal authority to act on behalf of the applicant/beneficiary must sign and date the release. When the applicant/beneficiary is a child age 12 or older (still considered a minor) who is capable of assisting with the application process, both the child and his parent (or individual legally authorized to act on his behalf) must sign and date the DHHS Form 921. |

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305.04.03 Level of Care Determination

(Rev. 11/01/20)

Individuals requesting coverage under the TEFRA group must be certified to be in need of institutional care under one of the following levels:

* Intermediate care,
* Intermediate care for the Intellectually Disabled (ICF-ID),
* Skilled care, or
* A level of care provided in a hospital.

A TEFRA application must be screened for each of the levels of care before the case can be denied for not meeting level of care. The TEFRA coordinator will request a level of care determination be completed.

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| Procedure A copy of the level of care notification must be on file before authorization of TEFRA eligibility.  **Process for requesting a Level of Care**   1. The TEFRA Coordinator must:  * Complete a [DHHS Form 1231 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201231%20ME.pdf), Request for Assessment for Level of Care. Include the following, if available: * A copy of the DHHS Form 3218-D ME, Disability Report, Child Under Age 19, * Copies of any medical records sent by the parent(s) * Submit the information to the Community Long Term Care (CLTC) Area Office  1. Community Long Term Care (CLTC)  * Complete a determination Nursing Home Level of Care (Skilled or Intermediate) * If the NH level of care is met, CLTC sends certification letter to the TEFRA coordinator * If the NH level of care is not met, CLTC informs the TEFRA coordinator; the TEFRA coordinator forwards all information to the Department of Disabilities and Special Needs (DDSN) for a determination of ICF-ID level of care.  1. Department of Disabilities and Special Needs  * Makes an ICF-ID level of care determination * If the ICF-ID level of care is met, DDSN sends the level of care approval to the TEFRA coordinator * If the ICF-ID level of care is not met, DDSN sends the level of care denial and the complete level of care record to the TEFRA coordinator, the TEFRA coordinator forwards all information to the CLTC for a determination of Hospital level of care.  1. Community Long Term Care  * Determines if a hospital level of care is met * If hospital level of care is met, CLTC sends a certification to the TEFRA coordinator. * If hospital level of care is not met, CLTC sends a denial letter to the TEFRA coordinator verifying the following:   + All level of care have been evaluated, and   + The child does not meet any level of care.  1. If the applicant/authorized representative feels that DHHS has made an error in processing the case, the authorized representative may ask for a fair hearing before the South Carolina Department of Health and Human Services (refer to MPPM 101.12.11.)   At annual review of Medicaid eligibility, the eligibility worker must check the level of care determine if it has expired. If the level of care has expired, a referral for a level of care must be completed and sent to the agency that last established the beneficiary’s level of care using the procedure listed below.  When the eligibility worker is completing a continuing disability review (CDR), a referral for a level of care must be completed and sent to the agency that last established the beneficiary’s level of care using the procedure listed below. If it is determined the beneficiary no longer meets level of care as originally determined, the review must screened for the remaining the levels of care before the case can be closed for not meeting level of care. |

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| **Procedure**   * If DDSN initially determined the level of care, complete the following: * Send a letter to notify the family that a level of care review will be done along with the following: * DDSN Permission to Evaluate TEFRA Applicant form, * Allow the beneficiary at least fifteen (15) days to return the information * Once the information has been returned, send the paperwork to the local Disabilities and Special Needs Board. * If CLTC initially determined the level of care, complete the following:   + Complete a DHHS Form 1231 ME and forward to the local CLTC office. |

305.04.04 Living Arrangements

(Eff. 03/01/23)

A TEFRA eligible child cannot reside in an institution. The case record must contain medical certification that **in home care** is appropriate.

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| **Acceptable Verification**  **For applications with a Level of Care determination made on or after March 1, 2023**  One of the following methods may be used to certify that in home care is appropriate for the child:   * The agency determining the Level of Care will provide certification that in home care is appropriate for the child. The certifying statement will be documented on the Level of Care. If necessary, the agency may consult the child’s physician to make the determination. * The DHHS Form 3291 as shown below in **“For applications with a Level of Care made before March 1, 2023”**   **For applications with a Level of Care determination made before March 1, 2023**   * [DHHS Form 3291 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203291%20ME.pdf), TEFRA In-Home Care Certification, must be completed by a physician; or * A physician’s written statement that “it is appropriate to care for the child at home” and filed in the case record. * A child may receive waiver services under TEFRA. |

305.05 Cost Effectiveness

(Eff. 02/01/06)

The TEFRA category of assistance is available only to children who would ordinarily require care in a medical institution, but who are appropriately maintained and served in the home setting.

The cost of caring for the child in the community is expected to be less that the estimated cost of providing care in a medical institution. Federal statute requires that the state provide assurances of that. This is accomplished as follows:

* At initial application, it is “assumed” that the estimated cost of caring for the child at home will not exceed the estimated cost of institutional care.
* State DHHS evaluates cost effectiveness:
  + At the end of the first year, or
  + At their discretion.
* State DHHS notifies the TEFRA coordinator if the home care is not cost effective.

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| **Note:** State DHHS will notify the TEFRA coordinator in writing of any decisions affecting the child’s status. If it is determined that care of the child in the home is not cost effective, the TEFRA coordinator will initiate closure of the TEFRA case and determine if eligibility can be established under another payment category. |

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305.06 Financial Eligibility

(Eff. 02/01/06)

To qualify for Medicaid under the TEFRA program, the child must meet established income and resource guidelines.

305.06.01 Income

(Eff. 02/01/06)

Income is the receipt of any assets, payments, or property in a specified period, which the beneficiary may use to meet his basic needs for food or shelter. Such use may be through sale or conversion. Do not count any payments made to the child that do not meet the statutory definition of income.

* Countable income must be equal to or less than the Medicaid Cap (3 times the SSI Federal Benefit Rate) Refer to MPPM 103.07.
* Only the child’s income is considered; parent’s income is not counted
* Count gross income amounts. No deductions apply.

Refer to MPPM Chapter 301 for specific income policy.

305.06.02 Resources

(Eff. 02/01/06)

Resources are generally defined as those assets, including both real and personal property, which an individual or couple owns and can apply, either directly or by sale or conversion, to meet the basic needs of food and shelter.

* The countable resource limit is $2000.
* Only the child’s resources are considered; parent’s resources are not counted.
* Transfer of assets:
  + There is no penalty for transfers of assets for less than fair market value,
  + However, if waivered services are requested, transfer policy does apply.

Countable resources are those remaining after all exclusions have been applied. In determining “countable resources,” apply the same disregards used in determining eligibility for an individual applying for institutional care.

Refer to MPPM Chapter 302 for specific resource policy.

305.07 Denial of Application

(Eff. 04/01/07)

The level of care and the disability determination must be completed before an application can be denied. If an application is denied, all of the reasons for the denial must be included in the notice with a citation of the appropriate MPPM section supporting the denial.

305.08 Continued Financial Eligibility

(Rev. 04/01/07)

A re-determination of financial eligibility must be completed every twelve (12) months. TEFRA cases should be partially reviewed/rebudgeted if changes occur during the 12-month period between re-determinations.

305.09 Right to Appeal

(Rev. 11/01/20)

Any action or decision that affects an applicant’s/beneficiary’s eligibility for Medicaid may be appealed. Refer to MPPM 101.12.11.

305.10 Case Examples

(Rev. 10/01/13)

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| **Example #1**  Chelsea Johnson is 10-years old. She has been a disabled child due to congenital birth defects. Her SSI will be terminated due to her parent’s excess income. They apply for TEFRA. Chelsea has no income. She does have a bank account with a balance of $1200.  **Processing Steps**   * Disability is already established as SSI terminated due to financial reasons. * The TEFRA coordinator:   + Sends a level of care request (DHHS Form 1231 ME) to Community Long Term Care (CLTC)   + Requests the parents to provide:     - Bank statement to verify balance for child’s bank account     - Physician’s statement verifying the appropriateness of in home care, or a completed DHHS Form 3291 ME   + Check IEVS     - Should verify SSI termination     - Check for other verified or lead information regarding income and resources. * Verifications received   + Certification of Intermediate Level of Care from CLTC   + DHHS Form 3291 ME completed and signed by physician certifying in home care is appropriate   + Current bank statement verifying a balance of $1211.00 in a saving account accruing an average quarterly interest of $2.26 * Budgeting – Use the Automated Budget Workbook   + Income – $0 (interest is excluded as income)   + Resources – $1211 |
| **Example #2**  Jamey Haney is 7-years old and has Down Syndrome. He lives with his mother, Debbie. Debbie has an annual salary of $35,000. Jamey’s father, John D Haney, passed away in January, and in March, Jamey began to receive $825 a month survivor’s benefits from Social Security. Jamey has a savings account with $1500. A TEFRA application was filed on June 1 requesting retroactive coverage for March, April, and May.  **Processing Steps**   * On June 2, the TEFRA coordinator:   + Pends case in MEDS   + Sends a DHHS Form 1231 checklist to Ms. Haney requesting the following by June 12:     - DHHS Form 3218-D ME packet completed and releases signed     - Bank statements for March, April, May, and current month for Jamey’s saving account     - Verification of Social Security benefits or claim number     - Have Jamey’s physician complete the DHHS Form 3291 ME, or provide a written statement indicating in home care is appropriate.   + Third Party Information     - Data Matching (no hits)     - DHHS Form 1255 ME to check father’s probate records. * On June 10:   + Ms. Haney returns the Disability packet, the bank statements, a DHHS Form 3291 ME, and the SSA claim number.   + The TEFRA coordinator:     - Makes two copies of the disability packet       * Retains one copy for the Case File       * Sends original disability packet to the Disability Determination Unit at State DHHS     - Sends a DHHS Form 1231 ME, attaching the second copy of the disability packet, to CLTC requesting a level of care determination. * CLTC determines Jamey does not meet an Intermediate or Skilled Level of Care * The TEFRA coordinator send the DHHS Form 1231 with the copy of the disability packet to DDSN requesting a determination for level of care * DDSN determines Jamey meets the ICF-ID Level of Care, and sends a level of care approval to the TEFRA coordinator. * The TEFRA coordinator rechecks IEVS, and verifies the SSA amount * Other verifications received:   + ICF-ID Level of Care certification from DDSN   + Disability allowance (received in October) with an onset date of March 1   + DHHS Form 1255 ME from the probate court verifying Ms. Haney was the sole beneficiary of her husband’s will * Budgeting – use DHHS Form 1296-A ME or the Automated Budgeting Workbook:   + Income:     - $825 SSA income for each month     - $825 < Medicaid Cap, therefore income test passed   + Resources     - A Separate determination is made for each month       * March $1236 < $2000       * April $1355 < $2000       * May $1500 < $2000       * June $1586 < $2000 * All eligibility criteria are met, and the Medicaid is approved effective March. |