HI - Submission Package - HI2020MS0003O - (HI-21-0004) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	HI2020MS0003O	**Submission Type**	Official
Program Name	N/A	**State**	HI
SPA ID	HI-21-0004	**Region**	San Francisco, CA
Version Number	4	**Package Status**	Approved
Submitted By	Jodeen Wai	**Submission Date**	2/10/2021
Package Disposition		**Approval Date**	5/10/2021 4:31 PM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii
Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID HI-21-0004

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	1/1/2021	HI-20-0001
Ticket to Work Basic	1/1/2021	NEW

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

We are submitting State Plan Amendment TN: No 21-0004 for your review and approval.

The proposed amendment to the Medicaid State Plan creates a new eligibility group. This group, also identified under the "Ticket to Work and Work Incentives Improvement Act" authority, allows individuals with a disability at least 19 years of age but less than 65 years of age whose income is below 138% of the Federal Poverty Level and applicable Household size a resource standard equal to three (3) times the SSI resource limit adjusted annually by the increase in the consumer price index to qualify and or keep their Medicaid coverage.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$237200
Second	2022	$320700

Federal Statute / Regulation Citation

1902(a)(10)(A)(ii)(XV) of the Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
21-0004 CMS 179- signed	2/16/2021 4:05 PM EST	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [x] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [ ] Mandatory Eligibility Groups
  - [x] Optional Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Optional Eligibility Groups	◯	APPROVED

  - [ ] Non-Financial Eligibility
  - [ ] Eligibility and Enrollment Processes
- [ ] Benefits and Payments

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- [x] Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
Honolulu Star-Advertiser	12/30/2020	Oahu
Hawaii Tribune Herald	12/30/2020	East side of Hawaii Island
The Garden Island	12/30/2020	Kauai
The Maui News	12/30/2020	Maui, Molokai, Lanai
West Hawaii Today	12/30/2020	West side of Hawaii Island

- [ ] Publication in state's administrative record, in accordance with the administrative procedures requirements
- [ ] Email to Electronic Mailing List or Similar Mechanism
- [ ] Website Notice
- [ ] Public Hearing or Meeting
- [ ] Other method

Upload copies of public notices and other documents used

Name	Date Created	
21-0004 Public Notice posted 12.30.20 Eff. 12.31.20	2/10/2021 8:08 PM EST	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery

☐ Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

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SPA ID HI-21-0004
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Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date N/A
Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[x] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
12/9/2020	via email

[ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
20-0006 Tribal Letter emeje12.08.20(2) (part 1) - signed	2/10/2021 8:34 PM EST	
20-0006 Tribal Letter emeje12.08.20(2) (part 2) - signed	2/10/2021 8:34 PM EST	
State Plan Amendment updates to KeOlaMamo (IHS)12.24.20	2/10/2021 8:39 PM EST	

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID HI2020MS0003O
SPA ID HI-21-0004
Submission Type Official
Initial Submission Date 2/10/2021
Approval Date 5/10/2021
Effective Date 1/1/2021
Superseded SPA ID HI-20-0001
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		x			CONVERTED
Reasonable Classifications of Individuals under Age 21		x			NEW
Children with Non-IV-E Adoption Assistance		x			CONVERTED
Independent Foster Care Adolescents					NEW
Optional Targeted Low Income Children		x			CONVERTED
Individuals above 133% FPL under Age 65					NEW
Individuals Needing Treatment for Breast or Cervical Cancer		x			NEW
Individuals Eligible for Family Planning Services					NEW
Individuals with Tuberculosis					NEW
Individuals Electing COBRA Continuation Coverage					NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		x			NEW
Individuals Eligible for Cash Except for Institutionalization		x			NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		x			NEW
Optional State Supplement Beneficiaries		x			APPROVED
Individuals in Institutions Eligible under a Special Income Level					NEW
PACE Participants					NEW
Individuals Receiving Hospice		x			NEW
Children under Age 19 with a Disability					NEW
Age and Disability-Related Poverty Level		x			NEW
Work Incentives					NEW
Ticket to Work Basic		x	x		APPROVED
Ticket to Work Medical Improvements					NEW
Family Opportunity Act Children with a Disability					NEW
Individuals Receiving State Plan Home and Community-Based Services					NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers					NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	HI-20-0001		
	System-Derived		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		x	☐	◯	NEW
Medically Needy Children under Age 18		x	☐	◯	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		x	☐	◯	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		x	☐	◯	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	◯	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		x	☐	◯	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	HI-20-0001		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Individuals between ages 16 and 64 with a disability, who have earned income.

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW User-Entered		

The state covers the optional Ticket to Work basic eligibility group in accordance with the following provisions:

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are at least age 16 but less than 65 years of age.

2. Have earned income.

3. But for earned income, meet the SSI definition of disability.

4. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources.

- (•) Yes
- ( ) No

Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ( ) Yes
- (•) No

3. Less restrictive methodologies are used in calculating countable resources.

- (•) Yes
- ( ) No

The less restrictive resource methodologies are:

[x] The state uses a less restrictive methodology with respect to the treatment of motor vehicles.

[x] The value of a countable motor vehicle is totally disregarded, without limits or conditions.

- ( ) One motor vehicle
- (•) More than one motor vehicle

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

C. Income Standard Used

The income standard for this group is:

- ○ 1. No income standard
- ◉ 2. A percentage of the federal poverty level:

FPL 138.00%

- ○ 3. A percentage of the SSI Federal Benefit Rate:
- ○ 4. A dollar amount
- ○ 5. Other

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

D. Resource Standard Used

The resource standard for this group is:

- ○ 1. No resource standard
- ○ 2. SSI resource standard
- ◉ 4. A dollar amount higher than the SSI resource standard

Single Individual	$7970.00
Couple	$11960.00

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
Submission Type	Official	**Initial Submission Date**	2/10/2021
Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | HI2020MS0003O | HI-21-0004

Package Header

Package ID	HI2020MS0003O	**SPA ID**	HI-21-0004
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Approval Date	5/10/2021	**Effective Date**	1/1/2021
Superseded SPA ID	NEW		
	User-Entered		

F. Additional Information (optional)

The countable net income limit is at or below 138% of the FPL for a household of applicable size.

The resource standards for a single individual and couple identified in Section D. Resource Standard Used are the resource standards for the Medicare Part D full low-income subsidy (LIS) program for 2021. The resource standards for single individuals and couples for Hawaii's Ticket to Work – Basic eligibility group will adjust each subsequent year in accordance with adjustments to the full LIS resource standards, so that the resource standards for the Ticket to Work – Basic eligibility group will match the full LIS resource standards.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Table of Contents

State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 22-0008

This file contains the following documents in the order listed:

HI - Submission Package - HI2022MS0002O - (HI-22-0008) - Eligibility

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th St., Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

August 16, 2022

Dr. Judy Mohr Peterson
Division Administrator
Med-QUEST Division (MQD)
Office of the Director, Department of Human Services
PO Box 339
Honolulu, HI 96809-0339

Re: Approval of State Plan Amendment HI-22-0008

Dear Dr. Judy Mohr Peterson,

On June 29, 2022, the Centers for Medicare and Medicaid Services (CMS) received Hawaii State Plan Amendment (SPA) HI-22-0008 to implement Section 9812 of the American Rescue Plan Act of 2021 (PL 117-2), expanding the postpartum care coverage period from 60 days to 12 months.

We approve Hawaii State Plan Amendment (SPA) HI-22-0008 with an effective date(s) of April 01, 2022.

If you have any questions regarding this amendment, please contact Brian Zolynas at brian.zolynas@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

HI - Submission Package - HI2022MS0002O - (HI-22-0008) - Eligibility

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0002O | HI-22-0008

CMS-10434 OMB 0938-1188

Package Header

Package ID HI2022MS0002O

SPA ID HI-22-0008

Submission Type Official

Initial Submission Date 6/29/2022

Approval Date 8/16/2022

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii

Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0002O | HI-22-0008

Package Header

Package ID HI2022MS0002O

SPA ID HI-22-0008

Submission Type Official

Initial Submission Date 6/29/2022

Approval Date 8/16/2022

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID HI-22-0008

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage	4/1/2022	NEW

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0002O | HI-22-0008

Package Header

Package ID HI2022MS0002O
SPA ID HI-22-0008
Submission Type Official
Initial Submission Date 6/29/2022
Approval Date 8/16/2022
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Hawaii is electing to provide continuous eligibility for an individual's 12-month postpartum period under provisions of the American Rescue Plan Act of 2021.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$1724233
Second	2023	$3448465

Federal Statute / Regulation Citation

American Rescue Plan Act Section 9812

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
CMS 179 SPA 22-0008.signedje06.29.22	6/28/2022 8:58 PM EDT	
SPA 22-0008 Medicaid-Funding-Questionsenje05.18.22	6/28/2022 8:58 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0002O | HI-22-0008

Package Header

Package ID HI2022MS0002O

SPA ID HI-22-0008

Submission Type Official

Initial Submission Date 6/29/2022

Approval Date 8/16/2022

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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HI - Submission Package - HI2022MS0002O - (HI-22-0008) - Eligibility

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0002O | HI-22-0008

CMS-10434 OMB 0938-1188

Package Header

Package ID	HI2022MS0002O	**SPA ID**	HI-22-0008
Submission Type	Official	**Initial Submission Date**	6/29/2022
Approval Date	8/16/2022	**Effective Date**	4/1/2022
Superseded SPA ID	NEW		
	User-Entered		

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

- (•) Yes
- ( ) No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.
3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

    a. The individual requests voluntary termination of eligibility;

    b. The individual ceases to be a resident of the state;

    c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or

    d. The individual dies.

C. Additional Information (optional)

This view was generated on 8/16/2022 11:17 AM EDT

HI - Submission Package - HI2023MS0001O - (HI-23-0001) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	HI2023MS0001O	**Submission Type**	Official
Program Name	N/A	**State**	HI
SPA ID	HI-23-0001	**Region**	San Francisco, CA
Version Number	1	**Package Status**	Approved
Submitted By	Jodeen Wai	**Submission Date**	3/3/2023
Package Disposition		**Approval Date**	4/13/2023 11:40 AM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID HI2023MS0001O
SPA ID HI-23-0001
Submission Type Official
Initial Submission Date 3/3/2023
Approval Date 4/13/2023
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii
Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID HI2023MS0001O
SPA ID HI-23-0001
Submission Type Official
Initial Submission Date 3/3/2023
Approval Date 4/13/2023
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID HI-23-0001

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	1/1/2023	HI-22-0001
Optional State Supplement Beneficiaries	1/1/2023	HI-22-0001

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID HI2023MS0001O
SPA ID HI-23-0001
Submission Type Official
Initial Submission Date 3/3/2023
Approval Date 4/13/2023
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

We are submitting State Plan Amendment TN No. 23-0001 for your review and approval.

Effective January 1, 2023, Supplemental Security income (SSI) beneficiaries received an 8.7% Cost of Living Adjustment increase from the Social Security Administration. This amendment is required to increase the monthly income standards for Domiciliary Care Type I from $1,492.90 to $1,565.90 and for Domiciliary Care Type II from $1,600.90 to $1,673.90.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2023	$0
Second	2024	$0

Federal Statute / Regulation Citation

42 C.F.R. 435.234 and 42 C.F.R. 435.1006

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
23-0001 CMS 179je03.03.23 signed	3/3/2023 2:11 PM EST	
23-0001 Medicaid Funding Questionsenje02.01.23	3/3/2023 2:11 PM EST	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID HI2023MS0001O
Submission Type Official
Approval Date 4/13/2023
Superseded SPA ID N/A
SPA ID HI-23-0001
Initial Submission Date 3/3/2023
Effective Date N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [ ] Mandatory Eligibility Groups
  - [ ] Optional Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Optional Eligibility Groups		APPROVED

  - [ ] Non-Financial Eligibility
  - [ ] Eligibility and Enrollment Processes
- [ ] Benefits and Payments

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
Approval Date	4/13/2023	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID HI2023MS0001O
SPA ID HI-23-0001
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Approval Date 4/13/2023
Effective Date N/A
Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (●) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (●) Yes
- ( ) No

- [ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- [ ] All Indian Health Programs
- [ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
2/10/2023	Signed letter for tribal consultation was sent via email on February 10, 2023.

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
SPA 23-0001 Tribal Consultationje02.09.23 - signed	3/3/2023 2:18 PM EST	PDF

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
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Superseded SPA ID	HI-22-0001		
	User-Entered		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	CONVERTED
Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	NEW
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	APPROVED
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	NEW
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	☐	○	NEW
Ticket to Work Basic		☐	☐	○	APPROVED
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
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Superseded SPA ID	HI-22-0001		
	User-Entered		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
Approval Date	4/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	HI-22-0001		
	User-Entered		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Individuals who receive an optional state supplementary payment.

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
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Superseded SPA ID	HI-22-0001		
	User-Entered		

The state covers the Optional State Supplement Beneficiaries eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Receive an optional state supplement that meets the conditions described in sections C and D.

2. Except for income, would be eligible for:

- ○ a. SSI
- ◉ b. The mandatory eligibility group for 209(b) states

3. Do not have gross income exceeding 300% of the SSI Federal Benefit Rate (FBR).

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
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Superseded SPA ID	HI-22-0001		
	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ○ Yes
- ◉ No

2. The state covers the following classifications:

- ☐ a. All individuals age 65 or older.
- ☐ b. All individuals who have blindness.
- ☐ c. All individuals who have a disability.
- ☐ d. Individuals in domiciliary facilities or other group living arrangements who are age 65 or older.
- ☐ e. Individuals in domiciliary facilities or other group living arrangements who have blindness.
- ☐ f. Individuals in domiciliary facilities or other group living arrangements who have a disability.
- ☐ g. Individuals receiving a federally-administered optional state supplement that meets the conditions specified in sections C. and D.
- ☐ h. Individuals in additional classifications specified by the Secretary.
- ☐ i. Reasonable groups of individuals receiving a state-administered optional state supplement that meets the conditions specified in sections C. and D.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
Approval Date	4/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	HI-22-0001		
	User-Entered		

C. Optional State Supplement Program

1. The optional state supplement program is administered:

- (•) a. Solely by the federal government. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments.
- ( ) b. By a combination of federal and state administration. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments for some classifications of individuals, while state supplementary payments for other classifications of individuals are administered by the state.
- ( ) c. Solely by the state.

2. Payments under the optional state supplement program are:

a. Based on need and paid in cash on a regular basis;

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and

c. Available to all individuals in each population selected in section B.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
Approval Date	4/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	HI-22-0001		
	User-Entered		

D. Income Standard of Optional State Supplement Program

1. The income standard for the optional state supplement:

a. Varies by political subdivision.

- ○ Yes
- ◉ No

b. Varies by payment classification.

- ◉ Yes
- ○ No

The payment classifications used are:

- ☐ i. All individuals age 65 or older, regardless of living arrangement.
- ☐ ii. All individuals who have blindness, regardless of living arrangement.
- ☐ iii. All individuals who have a disability, regardless of living arrangement.
- ☐ iv. Independent living.
- ☐ v. Living in household of another.
- ☐ vi. Independent living and receiving non-medical care outside the home.
- ☐ vii. Living in household of another and receiving non-medical care outside the home.
- ☐ viii. Living in a domiciliary facility or other group living arrangement.

Income Standard

Individual	Couple
$1565.90	$1565.90

- ☐ ix. Other payment classification.

Name of Classification	Description:
DOMICILIARY CARE LEVEL I:	Maximum of five (5) residents A residential facility that provides twenty-four hour living accommodations including care and services for up to five residents. The care and services for Domiciliary Care Level I are the same Domiciliary Care level II.

Individual	Couple
$1565.90	$1565.90

Name of Classification	Description:
DOMICILIARY CARE LEVEL II:	Six (6) or more residents A residential facility that provides twenty-four hour living accommodations,

		including care and services, for 6 or more residents. The care and services for Domiciliary Care Level II are the same Domiciliary Care level I.
	Individual	**Couple**
	$1673.90	$1673.90

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0001O | HI-23-0001

Package Header

Package ID	HI2023MS0001O	**SPA ID**	HI-23-0001
Submission Type	Official	**Initial Submission Date**	3/3/2023
Approval Date	4/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	HI-22-0001		
	User-Entered		

E. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 5/5/2023 4:18 PM EDT

HI - Submission Package - HI2022MS0003O - (HI-23-0004) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	HI2022MS0003O	**Submission Type**	Official
Program Name	N/A	**State**	HI
SPA ID	HI-23-0004	**Region**	San Francisco, CA
Version Number	3	**Package Status**	Approved
Submitted By	Jodeen Wai	**Submission Date**	3/14/2023
Package Disposition		**Approval Date**	3/1/2024 1:36 PM EST

RAI

CMS is issuing this Request for Additional Information (RAI) pursuant to Section 1915(f) of the Social Security Act (added by P.L. 97-35). This request has the effect of stopping the 90-day time period for CMS to act on the material. A new 90 day time frame will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action.

In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Submission Package HI2022MS0003O
Authority Eligibility
State HI
Agency Name Med-QUEST Division (MQD)
Submission Date Mar 14, 2023

All Questions

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
1	Former Foster Care Children	Please confirm that the state is implementing the requirements of section 1002(a) of the SUPPORT Act to 1) eliminate the requirement that an individual not be eligible for another mandatory eligibility group (other than the adult group) to be eligible for the former foster care children (FFCC) eligibility group; 2) cover under the FFCC eligibility group individuals who aged out of foster care in a state other than the state where they currently live and are seeking Medicaid coverage, as long as they otherwise meet the eligibility requirements for this group; and 3) apply the above FFCC eligibility group policy changes exclusively to individuals who turned age 18 on or after January 1, 2023.	Section 1002(a) of the SUPPORT Act; section 1902(a)(10)(A)(i)(IX) of the Social Security Act	The changes that Hawaii made are on the Medicaid Application (DHS 1100). In the online application, for the question related to receiving foster care, we removed "in Hawaii" from the question. Applicants can select this status regardless of the state they were in foster care and aged out. We made the same change to the paper application. Hawaii provided a training to all MQD staff members on 09/25/23 for them to complete. We provided a copy of the training separately to CMS.
2	Former Foster Care Children	Please describe any changes to state IT systems and eligibility and enrollment processes the state is making to implement the SUPPORT Act eligibility requirements described in the FFCC eligibility group SPA. What is the status of the changes? What training is the state providing to Medicaid agency personnel on the FFCC eligibility group changes?	Section 1002(a) of the SUPPORT Act; section 1902(a)(10)(A)(i)(IX) of the Social Security Act	Please see Hawaii Response to Question ID 1.
3	Former Foster Care Children	Please describe how the changes to systems and to the state's processes will ensure that the required policy changes for the FFCC group will apply only to individuals who turned age 18 on or after January 1, 2023.	Section 1002(a) of the SUPPORT Act; section 1902(a)(10)(A)(i)(IX) of the Social Security Act	Hawaii received approval of a section 1902(e)(14)(A) waiver authority on December 20, 2023, to enable the state to extend eligibility in the FFCC group to youth formerly in foster care from any state, without regard to when the individual turned age 18. This means that a person

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
				who aged out of foster care in another state and who turned age 18 before January 1, 2023, can be eligible for the FFCC group. This 1902(e)(14)(A) authority covers initial eligibility determinations and renewals conducted in the period from January 1, 2023, until Hawaii has approval of a section 1115 demonstration for youth formerly in foster care from another state, which is expected on August 1, 2024. Once the 1115 demonstration is in place, the state will have more permanent authority to cover out-of-state youth formerly in foster care who are not eligible for the state plan because they turned age 18 before January 1, 2023. The result will be that any person in our state under age 26 who aged out of foster care in any state will be considered for FFCC coverage in Hawaii. We will be able to determine whether applicants and beneficiaries are eligible in the state plan or in the demonstration by looking at their birthday to determine when they turned age 18.
4	Former Foster Care Children	What communication or outreach activities does the state have planned to inform beneficiaries and youth formerly in foster care generally of the changes to the FFCC group and the importance of maintaining Medicaid eligibility?	Section 1002(a) of the SUPPORT Act; section 1902(a)(10)(A)(i)(IX) of the Social Security Act	Hawaii will continue to work with Outreach Branch Staff and Community Stake holders of these changes as well as add this information to our Medicaid website to inform community of this change.
5	Former Foster Care Children	As we discussed on our March 23 call, the optional check boxes at sections B.2. and C.2. in the Former Foster Care Children RU are completely at state option, depending on state policy preference. The state has selected options only in section C. We believe it may be operationally simpler for the state to select the same options in sections B. and C. Please review your selections and make any needed updates. We can discuss the details of the optional policies with you if helpful.	Section 1002(a) of the SUPPORT Act; section 1902(a)(10)(A)(i)(IX) of the Social Security Act	Hawaii will make changes to reviewable unit. Thank you CMS for additional clarification. Hawaii will remove initial selection of C.2.a. and C.2.c.

1 – 5 of 5

Submission Package was updated by the State in accordance with the response above

Yes

○ No

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID HI2022MS0003O
SPA ID HI-23-0004
Submission Type Official
Initial Submission Date 3/14/2023
Approval Date 03/01/2024
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii
Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

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Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID HI-23-0004

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Mandatory Eligibility Groups	1/1/2023	HI-19-0001
Former Foster Care Children	1/1/2023	HI-13-0007-MM1

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

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Submission Type Official
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Approval Date 03/01/2024
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The Centers for Medicare & Medicaid Services (CMS) alerted states of changes to the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act"), enacted on October 24, 2018. Section 1002(a) requires states to cover individuals eligible under the Former Foster Care Children (FFCC) group who aged out of foster care from another state other than the state they currently live, effective January 1, 2023. Hawaii is submitted this state plan amendment to come into compliance with this regulation

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2023	$0
Second	2024	$0

Federal Statute / Regulation Citation

Section 10002(a) of the SUPPORT Act, 1902(a)(10)(A)(i)(IX)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
SPA 23-0004 CMS 179 - signed	3/14/2023 2:29 PM EDT	
SPA 23-0004 medicaid-funding-questionsenje	3/14/2023 2:29 PM EDT	
SPA 23-0004 Letter to CMS - signed	3/14/2023 2:29 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

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Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [x] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [x] Mandatory Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Mandatory Eligibility Groups		APPROVED

  - [ ] Optional Eligibility Groups
  - [ ] Non-Financial Eligibility
  - [ ] Eligibility and Enrollment Processes
- [ ] Benefits and Payments

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID	HI2022MS0003O	**SPA ID**	HI-23-0004
Submission Type	Official	**Initial Submission Date**	3/14/2023
Approval Date	03/01/2024	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID HI2022MS0003O
SPA ID HI-23-0004
Submission Type Official
Initial Submission Date 3/14/2023
Approval Date 03/01/2024
Effective Date N/A
Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (●) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (●) Yes
- ( ) No

- [ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- [ ] All Indian Health Programs
- [ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
2/22/2023	A signed letter was sent via email February 22, 2023.

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
SPA 23-0004 Tribal Consultationje02.21.23 - signed	3/14/2023 2:15 PM EDT	

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID HI2022MS0003O
SPA ID HI-23-0004
Submission Type Official
Initial Submission Date 3/14/2023
Approval Date 03/01/2024
Effective Date 1/1/2023
Superseded SPA ID HI-19-0001
System-Derived

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☐	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☐	☐	○	CONVERTED
Pregnant Women		☐	☐	●	CONVERTED
Deemed Newborns		☐	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☐	☐	○	NEW
Former Foster Care Children		☐	☐	○	APPROVED
Transitional Medical Assistance		☐	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals in 209(b) States Who Are Age 65 or Older or Who have Blindness or a Disability		☐	☐	○	APPROVED
Closed Eligibility Groups		☐	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☐	☐	○	NEW
Working Individuals under 1619(b)		☐	☐	○	NEW
Qualified Medicare Beneficiaries		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Qualified Disabled and Working Individuals					NEW
Specified Low Income Medicare Beneficiaries					NEW
Qualifying Individuals					NEW

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID	HI2022MS0003O	**SPA ID**	HI-23-0004
Submission Type	Official	**Initial Submission Date**	3/14/2023
Approval Date	03/01/2024	**Effective Date**	1/1/2023
Superseded SPA ID	HI-19-0001		
	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☐	☐	○	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	HI2022MS0003O	**SPA ID**	HI-23-0004
Submission Type	Official	**Initial Submission Date**	3/14/2023
Approval Date	03/01/2024	**Effective Date**	1/1/2023
Superseded SPA ID	HI-13-0007-MM1		
	User-Entered		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | HI2022MS0003O | HI-23-0004

Package Header

Package ID	HI2022MS0003O	**SPA ID**	HI-23-0004
Submission Type	Official	**Initial Submission Date**	3/14/2023
Approval Date	03/01/2024	**Effective Date**	1/1/2023
Superseded SPA ID	HI-13-0007-MM1		
	User-Entered		

D. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 3/4/2024 1:18 PM EST

HI - Submission Package - HI2023MS0004O - (HI-23-0010) - Eligibility

VIEW PRINT PREVIEW

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Children

MEDICAID | Medicaid State Plan | Eligibility | HI2023MS0004O | HI-23-0010

Spell Check Instructions | Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	HI2023MS0004O	**SPA ID**	HI-23-0010
Submission Type	Official	**Initial Submission Date**	9/28/2023
Approval Date	12/14/2023	**Effective Date**	7/1/2023
Superseded SPA ID	NEW		
	User-Entered		

View Implementation Guide

VIEW ALL RESPONSES

The state provides continuous eligibility for children in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Hospitalized Children

Collapse

The state provides Medicaid to a child eligible for and enrolled under the Infants and Children under Age 19 (42 CFR 435.118) eligibility group until the end of an inpatient stay for which inpatient services are covered, if the child:

1. Was receiving inpatient services covered by Medicaid on the date the child becomes ineligible under the eligibility group based on the child's age; and

2. Would remain eligible but for attaining such age.

B. Options for Continuous Eligibility for Children

Collapse

The state provides continuous eligibility to children.

- (•) Yes
- ( ) No

1. Continuous eligibility is provided to all children of the following age:

- (•) a. Under age 19
- ( ) b. Under other age

2. The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends the last day of the earlier of the following periods:

a. The month that the child's age exceeds the age limit to which this provision applies

b. The end of the continuous eligibility period, which is:

- (•) i. 12 months
- ( ) ii. Another period of continuous eligibility, not to exceed 12 months

3. Continuous eligibility is provided to children eligible under all mandatory and optional eligibility groups (excluding Medically Needy) who would otherwise lose eligibility because of any change in circumstances, unless:

a. The child dies;

b. The child or the child's representative voluntarily requests a termination of the child's eligibility;

c. The child ceases to be a resident of the state;

d. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

e. The child attains the maximum age specified in B.

C. Additional Information (optional)

Collapse

HI - Submission Package - HI2024MS0001O - (HI-24-0001) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	HI2024MS0001O	**Submission Type**	Official
Program Name	N/A	**State**	HI
SPA ID	HI-24-0001	**Region**	San Francisco, CA
Version Number	1	**Package Status**	Approved
Submitted By	Jodeen Wai	**Submission Date**	3/12/2024
Package Disposition		**Approval Date**	4/15/2024 4:42 PM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii
Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
Submission Type Official
Approval Date 04/15/2024
Superseded SPA ID N/A
SPA ID HI-24-0001
Initial Submission Date 3/12/2024
Effective Date N/A

SPA ID and Effective Date

SPA ID HI-24-0001

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	1/1/2024	HI-23-0001
Optional State Supplement Beneficiaries	1/1/2024	HI-23-0001

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Effective January 1, 2024, Supplemental Security Income (SSI) beneficiaries received an 3.2% Cost of Living Adjustment increase from the Social Security Administration. This Amendment is required to increase the monthly income standards for Domiciliary Care Type I from $1565.90 to $1594.90 and for Domiciliary Care Type II from $1673.90 to $1702.90.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	$0
Second	2025	$0

Federal Statute / Regulation Citation

42 CFR 435.1006

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
SPA 24-0001 CMS 179	3/12/2024 1:56 PM EDT	
SPA 24-0001 Medicaid Funding Questions	3/12/2024 1:56 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [x] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [ ] Mandatory Eligibility Groups
  - [x] Optional Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Optional Eligibility Groups		APPROVED

  - [ ] Non-Financial Eligibility
  - [ ] Eligibility and Enrollment Processes
- [ ] Benefits and Payments

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	N/A
Superseded SPA ID	N/A		

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date 1/1/2024
Superseded SPA ID HI-23-0001
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	CONVERTED
Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	●	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	NEW
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	APPROVED
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	NEW
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	☐	○	NEW
Ticket to Work Basic		☐	☐	○	APPROVED
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date 1/1/2024
Superseded SPA ID HI-23-0001
System-Derived

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	1/1/2024
Superseded SPA ID	HI-23-0001		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Individuals who receive an optional state supplementary payment.

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	1/1/2024
Superseded SPA ID	HI-23-0001		
	System-Derived		

The state covers the Optional State Supplement Beneficiaries eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Receive an optional state supplement that meets the conditions described in sections C and D.

2. Except for income, would be eligible for:

- ○ a. SSI
- ◉ b. The mandatory eligibility group for 209(b) states

3. Do not have gross income exceeding 300% of the SSI Federal Benefit Rate (FBR).

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
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Superseded SPA ID	HI-23-0001		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ○ Yes
- ◉ No

2. The state covers the following classifications:

- ☐ a. All individuals age 65 or older.
- ☐ b. All individuals who have blindness.
- ☐ c. All individuals who have a disability.
- ☐ d. Individuals in domiciliary facilities or other group living arrangements who are age 65 or older.
- ☐ e. Individuals in domiciliary facilities or other group living arrangements who have blindness.
- ☐ f. Individuals in domiciliary facilities or other group living arrangements who have a disability.
- ☐ g. Individuals receiving a federally-administered optional state supplement that meets the conditions specified in sections C. and D.
- ☐ h. Individuals in additional classifications specified by the Secretary.
- ☐ i. Reasonable groups of individuals receiving a state-administered optional state supplement that meets the conditions specified in sections C. and D.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	1/1/2024
Superseded SPA ID	HI-23-0001		
	System-Derived		

C. Optional State Supplement Program

1. The optional state supplement program is administered:

- (•) a. Solely by the federal government. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments.
- ( ) b. By a combination of federal and state administration. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments for some classifications of individuals, while state supplementary payments for other classifications of individuals are administered by the state.
- ( ) c. Solely by the state.

2. Payments under the optional state supplement program are:

a. Based on need and paid in cash on a regular basis;

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and

c. Available to all individuals in each population selected in section B.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID HI2024MS0001O
SPA ID HI-24-0001
Submission Type Official
Initial Submission Date 3/12/2024
Approval Date 04/15/2024
Effective Date 1/1/2024
Superseded SPA ID HI-23-0001
System-Derived

D. Income Standard of Optional State Supplement Program

1. The income standard for the optional state supplement:

a. Varies by political subdivision.

- ○ Yes
- ◉ No

b. Varies by payment classification.

- ◉ Yes
- ○ No

The payment classifications used are:

- ☐ i. All individuals age 65 or older, regardless of living arrangement.
- ☐ ii. All individuals who have blindness, regardless of living arrangement.
- ☐ iii. All individuals who have a disability, regardless of living arrangement.
- ☐ iv. Independent living.
- ☐ v. Living in household of another.
- ☐ vi. Independent living and receiving non-medical care outside the home.
- ☐ vii. Living in household of another and receiving non-medical care outside the home.
- ☐ viii. Living in a domiciliary facility or other group living arrangement.

Income Standard

Individual	Couple
$1594.90	$1594.90

- ☐ ix. Other payment classification.

Name of Classification	Description:
DOMICILIARY CARE LEVEL I:	Maximum of five (5) residents A residential facility that provides twenty-four hour living accommodations including care and services for up to five residents. The care and services for Domiciliary Care Level I are the same Domiciliary Care level II.

Individual	Couple
$1594.90	$1594.90

Name of Classification	Description:
DOMICILIARY CARE LEVEL II:	Six (6) or more residents A residential facility that provides twenty-four hour living accommodations,

including care and services, for 6 or more residents. The care and services for Domiciliary Care Level II are the same Domiciliary Care level I.

Individual	Couple
$1702.90	$1702.90

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0001O | HI-24-0001

Package Header

Package ID	HI2024MS0001O	**SPA ID**	HI-24-0001
Submission Type	Official	**Initial Submission Date**	3/12/2024
Approval Date	04/15/2024	**Effective Date**	1/1/2024
Superseded SPA ID	HI-23-0001		
	System-Derived		

E. Additional Information (optional)

This view was generated on 4/22/2024 3:11 PM EDT

HI - Submission Package - HI2024MS0003O - (HI-24-0013) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	HI2024MS0003O	**Submission Type**	Official
Program Name	N/A	**State**	HI
SPA ID	HI-24-0013	**Region**	San Francisco, CA
Version Number	2	**Package Status**	Approved
Submitted By	Jodeen Wai	**Submission Date**	9/25/2024
Package Disposition		**Approval Date**	11/15/2024 10:46 AM EST

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
Submission Type Official
Initial Submission Date 9/25/2024
Approval Date 11/15/2024
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Hawaii
Medicaid Agency Name: Med-QUEST Division (MQD)

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
Submission Type Official
Initial Submission Date 9/25/2024
Approval Date 11/15/2024
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID HI-24-0013

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	10/1/2024	HI-24-0001
Optional State Supplement Beneficiaries	10/1/2024	HI-24-0001

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
Submission Type Official
Initial Submission Date 9/25/2024
Approval Date 11/15/2024
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Increases the state supplemental payment ceilings for type I adult residential care homes, licensed developmental disabilities domiciliary homes, community case foster family homes, certified adult foster homes, and type II adult residential care homes. Effective 10/01/24.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	$0
Second	2025	$0

Federal Statute / Regulation Citation

42 CFR 435.234 and 42 CFR 435.1006

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
SPA 24-0013 Medicaid Funding Questions - signed	9/25/2024 2:50 PM EDT	
SPA 24-0013 CMS 179 - signed	9/25/2024 2:50 PM EDT	
2303136-1Signed Memo to Gov related to CMS 179	9/25/2024 2:50 PM EDT	
SPA 24-0013 Letter to CMS - signed	9/25/2024 2:51 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
Submission Type Official
Initial Submission Date 9/25/2024
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Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Hawaii allows for Medicaid Director to review and authorize under current Governor.

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [ ] Mandatory Eligibility Groups
  - [ ] Optional Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Optional Eligibility Groups		APPROVED

  - [ ] Non-Financial Eligibility
  - [ ] Eligibility and Enrollment Processes
- [ ] Benefits and Payments

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID	HI2024MS0003O	**SPA ID**	HI-24-0013
Submission Type	Official	**Initial Submission Date**	9/25/2024
Approval Date	11/15/2024	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID	HI2024MS0003O	**SPA ID**	HI-24-0013
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Superseded SPA ID	N/A		

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
Submission Type Official
Initial Submission Date 9/25/2024
Approval Date 11/15/2024
Effective Date 10/1/2024
Superseded SPA ID HI-24-0001
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	CONVERTED
Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	●	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	NEW
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	APPROVED
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	NEW
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	☐	○	NEW
Ticket to Work Basic		☐	☐	○	APPROVED
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Package Header

Package ID HI2024MS0003O
SPA ID HI-24-0013
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Effective Date 10/1/2024
Superseded SPA ID HI-24-0001
System-Derived

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

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	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

Individuals who receive an optional state supplementary payment.

Package Header

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The state covers the Optional State Supplement Beneficiaries eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Receive an optional state supplement that meets the conditions described in sections C and D.

2. Except for income, would be eligible for:

- ○ a. SSI
- ◉ b. The mandatory eligibility group for 209(b) states

3. Do not have gross income exceeding 300% of the SSI Federal Benefit Rate (FBR).

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

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Superseded SPA ID	HI-24-0001		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ○ Yes
- ◉ No

2. The state covers the following classifications:

- ☐ a. All individuals age 65 or older.
- ☐ b. All individuals who have blindness.
- ☐ c. All individuals who have a disability.
- ☐ d. Individuals in domiciliary facilities or other group living arrangements who are age 65 or older.
- ☐ e. Individuals in domiciliary facilities or other group living arrangements who have blindness.
- ☐ f. Individuals in domiciliary facilities or other group living arrangements who have a disability.
- ☐ g. Individuals receiving a federally-administered optional state supplement that meets the conditions specified in sections C. and D.
- ☐ h. Individuals in additional classifications specified by the Secretary.
- ☐ i. Reasonable groups of individuals receiving a state-administered optional state supplement that meets the conditions specified in sections C. and D.

Optional State Supplement Beneficiaries

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Package Header

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Superseded SPA ID	HI-24-0001		
	System-Derived		

C. Optional State Supplement Program

1. The optional state supplement program is administered:

- (•) a. Solely by the federal government. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments.
- ( ) b. By a combination of federal and state administration. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments for some classifications of individuals, while state supplementary payments for other classifications of individuals are administered by the state.
- ( ) c. Solely by the state.

2. Payments under the optional state supplement program are:

a. Based on need and paid in cash on a regular basis;

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and

c. Available to all individuals in each population selected in section B.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | HI2024MS0003O | HI-24-0013

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Superseded SPA ID	HI-24-0001		
	System-Derived		

D. Income Standard of Optional State Supplement Program

1. The income standard for the optional state supplement:

a. Varies by political subdivision.

- ○ Yes
- ◉ No

b. Varies by payment classification.

- ◉ Yes
- ○ No

The payment classifications used are:

- ☐ i. All individuals age 65 or older, regardless of living arrangement.
- ☐ ii. All individuals who have blindness, regardless of living arrangement.
- ☐ iii. All individuals who have a disability, regardless of living arrangement.
- ☐ iv. Independent living.
- ☐ v. Living in household of another.
- ☐ vi. Independent living and receiving non-medical care outside the home.
- ☐ vii. Living in household of another and receiving non-medical care outside the home.
- ☐ viii. Living in a domiciliary facility or other group living arrangement.

Income Standard

Individual	Couple
$1727.00	$1727.00

- ☐ ix. Other payment classification.

Name of Classification	Description:
DOMICILIARY CARE LEVEL I:	Maximum of five (5) residents A residential facility that provides twenty-four hour living accommodations including care and services for up to five residents. The care and services for Domiciliary Care Level I are the same Domiciliary Care level II.

Individual	Couple
$1727.00	$1727.00

Name of Classification	Description:
DOMICILIARY CARE LEVEL II:	Six (6) or more residents A residential facility that provides twenty-four hour living accommodations,

including care and services, for 6 or more residents. The care and services for Domiciliary Care Level II are the same Domiciliary Care level I.

Individual	Couple
$1835.00	$1835.00

Optional State Supplement Beneficiaries

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E. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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