

State of Hawaii  
Department of Human Services  
MED-QUEST DIVISION

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**MEDICAID STATE PLAN**

**SPA MEMO NO.:** 24-01

**DATE:** 04/24/24

**ORIGINATOR:** POLICY AND PROGRAM DEVELOPMENT OFFICE

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**TO:** Custodian of Med-QUEST Division Medicaid State Plan

**FROM:** Judy Mohr Peterson, PhD   
Med-QUEST Division Administrator

**SUBJECT:** APPROVAL OF AMENDMENT UNDER THE MEDICAID STATE PLAN

**EXPLANATION:**

The State of Hawaii received approval from the Centers for Medicare & Medicaid Services for State Plan Amendment (SPA) Number 24-0001 "Yearly Optional State Supplementary Payment" on April 15, 2024.

Effective January 1, 2024, Supplemental Security Income (SSI) beneficiaries received a 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.

**FILING INSTRUCTIONS:**

Review and file the amended Medicaid State Plan pages in your Medicaid State Plan Manual as follows:

**Supplement 6 to Attachment 2.6-A and Reviewable Unit "Optional State Supplement Beneficiaries"**

Remove OLD Supplement 6 to Attachment 2.6-A and replace with amended Reviewable Unit "Optional State Supplement Beneficiaries".

Please keep approved SPA 24-0001 package and supporting documentation for your records.

The Med-QUEST Division amendment described above has been incorporated into the electronic version of the Medicaid State Plan located at the Department of Human Services website link for public transparency below:

<http://humanservices.hawaii.gov/reports/hawaii-medicaid-state-plan/>

## Attachments

C: Attorney General's Office  
Audit, Quality Control & Research Office/Quality Control Staff  
Clinical Standards Office  
Department of Health/Child & Adolescent Mental Health Division  
Department of Health/State Planning Council Developmental Disabilities  
Department of Health/Developmental Disabilities Division  
Department of Human Services /Adult Protective and Community Services Branch  
Department of Human Services/Policy and Program Development Office  
Eligibility System Project (KOLEA)  
Finance Office  
Hawaii Document Center/HI State Library  
Hawaii Legislative Reference Bureau Library  
Health Care Services Branch  
Legal Aid Society of Hawaii

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

- [Summary](#)
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- [Approval Letter](#)
- [News](#)
- [Related Actions](#)

CMS-10434 OMB 0938-1188

## Package Information

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

# Submission - Summary

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

## Package Header

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

## State Information

<b>State/Territory Name:</b>	Hawaii	<b>Medicaid Agency Name:</b>	Med-QUEST Division (MQD)
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## Submission Component

- ☒ State Plan Amendment
- ☒ Medicaid
- ☐ CHIP

Submission - Summary

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

Package Header

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Approval Date	04/15/2024	Effective Date	N/A
Superseded SPA ID	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

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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	
<a href="#">SPA 24-0001 CMS 179</a>	3/12/2024 1:56 PM EDT	
<a href="#">SPA 24-0001 Medicaid Funding Questions</a>	3/12/2024 1:56 PM EDT	

Submission - Summary

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

Package Header

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Superseded SPA ID	N/A		

Governor's Office Review

<div><div><input type="radio"/> No comment</div><div><input type="radio"/> Comments received</div><div><input type="radio"/> No response within 45 days</div><div><input checked="" type="radio"/> Other</div></div>	<div><div>Describe</div><div>Hawaii allows for Medicaid Director to review and authorize under current Governor.</div></div>
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# Submission - Medicaid State Plan

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

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 Source Type Submission Package
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

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<b>Superseded SPA ID</b>	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

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<b>Superseded SPA ID</b>	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

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### Package Header

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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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Reasonable Classifications of Individuals under Age 21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children with Non-IV-E Adoption Assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Independent Foster Care Adolescents		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Optional Targeted Low Income Children		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Individuals above 133% FPL under Age 65		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Family Planning Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals with Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Electing COBRA Continuation Coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Optional State Supplement Beneficiaries		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	APPROVED
Individuals in Institutions Eligible under a Special Income Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
PACE Participants		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Hospice		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children under Age 19 with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Age and Disability-Related Poverty Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Work Incentives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Ticket to Work Basic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	APPROVED
Ticket to Work Medical Improvements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Family Opportunity Act Children with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Optional Eligibility Groups

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

Package Header

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	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Children under Age 18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Parents and Other Caretaker Relatives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Optional Eligibility Groups

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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 | HI2024MS0001O | HI-24-0001

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

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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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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

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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
\$15	\$15
94.9	94.9
0	0

- ☐ 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**

\$1702.90

**Couple**

\$1702.90

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.

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