Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

A1-Designation and Authority RU PRA document

Version 1.0

08/09/2017

Document Number: 162-QSSI-MACPro-PRA-A1-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. A1- Designation and Authority Screenshots

1.1 Section A. Single State Agency and Section B. Attorney General Certification

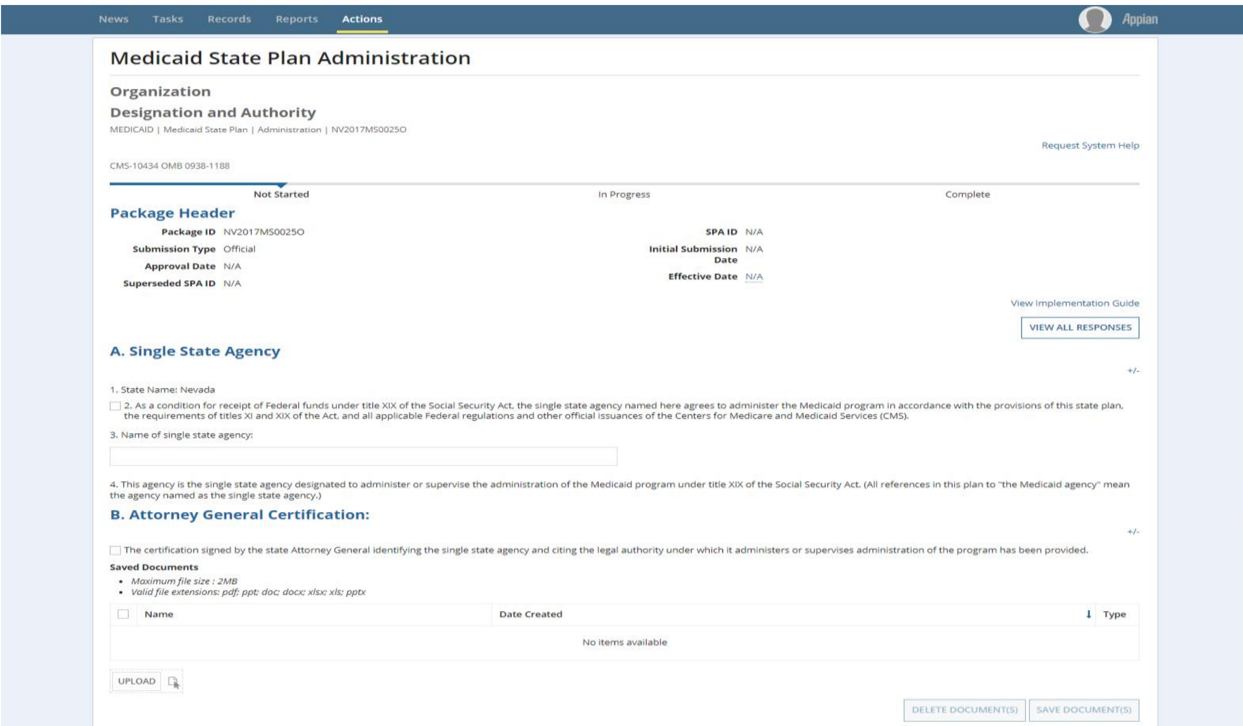
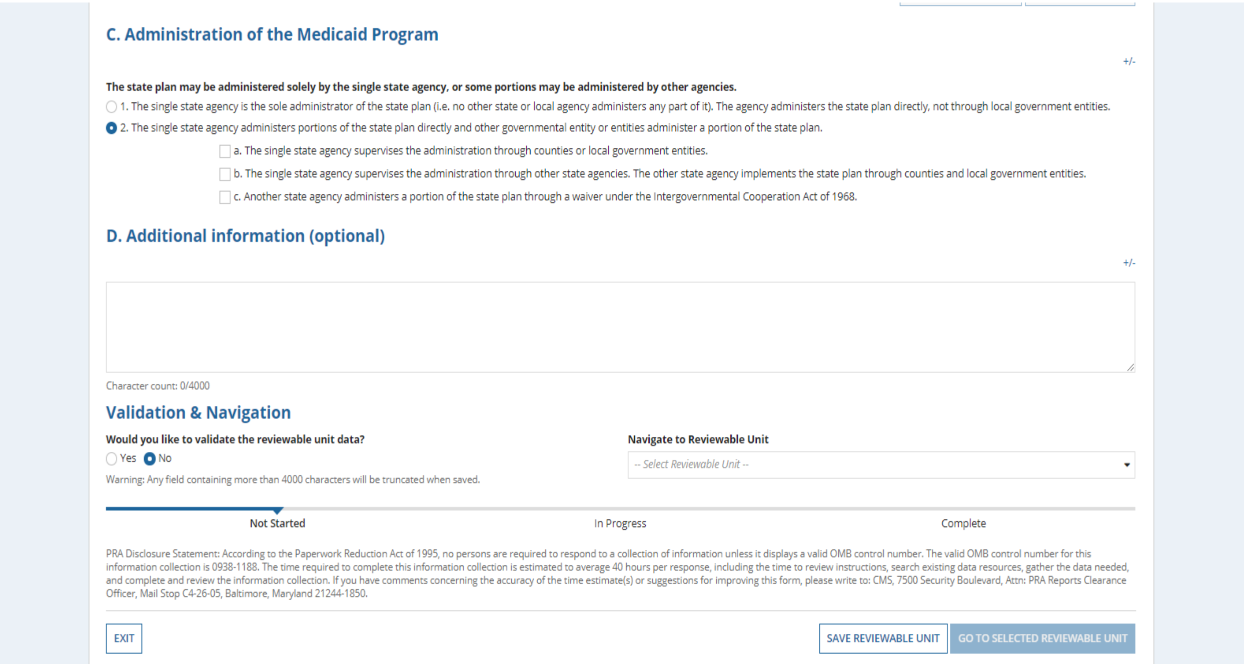


Figure 1: Section A and B

1.2 Section C. Administration of the Medicaid Program and D. Additional information (optional)


C. Administration of the Medicaid Program

+/-

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

a. The single state agency supervises the administration through counties or local government entities.

b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.

c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968.

D. Additional information (optional)

+/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

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EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 2: Section C and D

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

A2-Intergovernmental Cooperation Act Waivers RU PRA document

Version 1.0

08/11/2017

Document Number: 163-QSSI-MACPro-PRA-A2-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. A2- Intergovernmental Cooperation Act Waivers Screenshots

1.1 Section A. Intergovernmental Cooperation Act Waivers

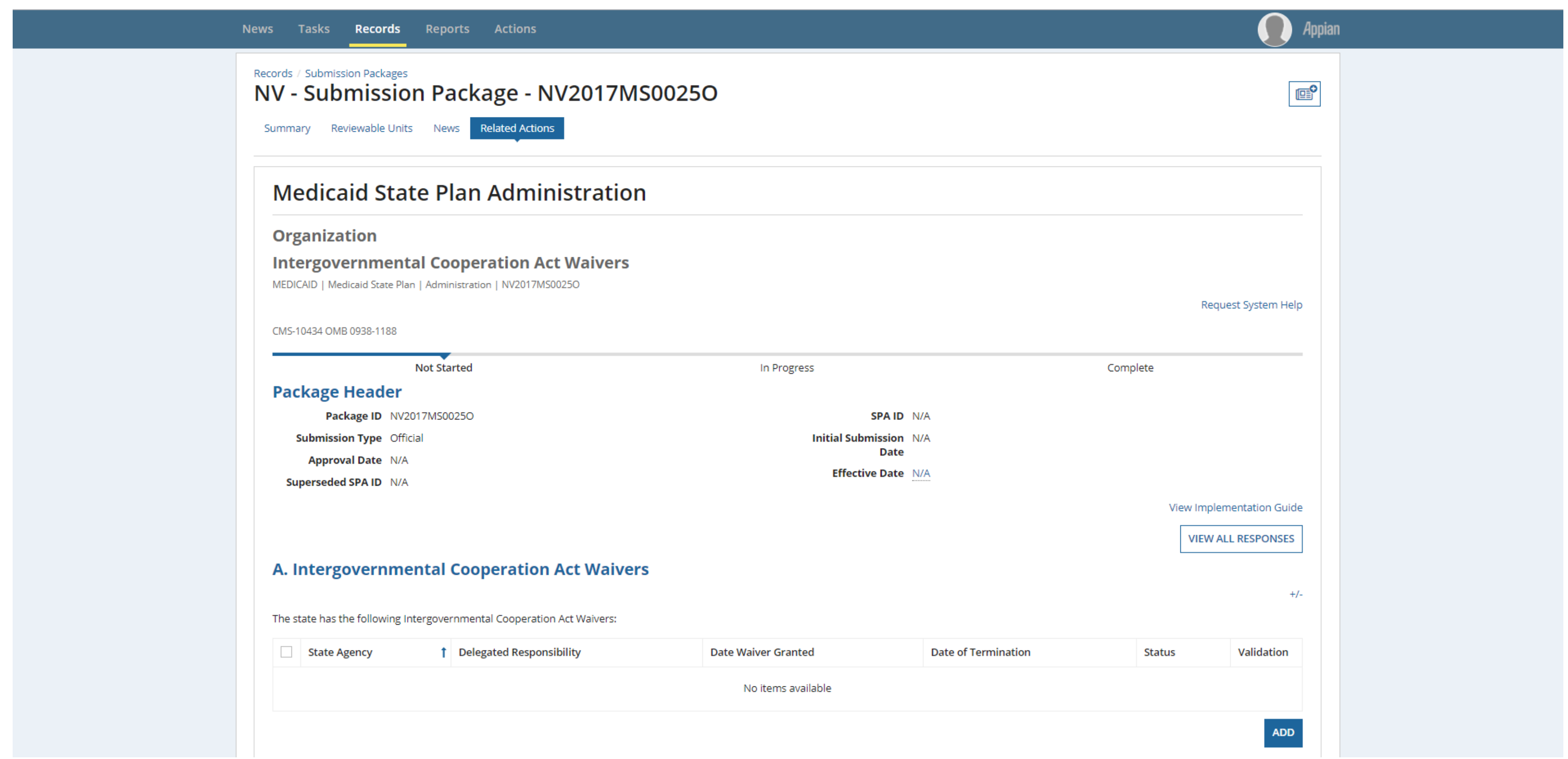

Figure 1: Section A

1.2 Add Waiver

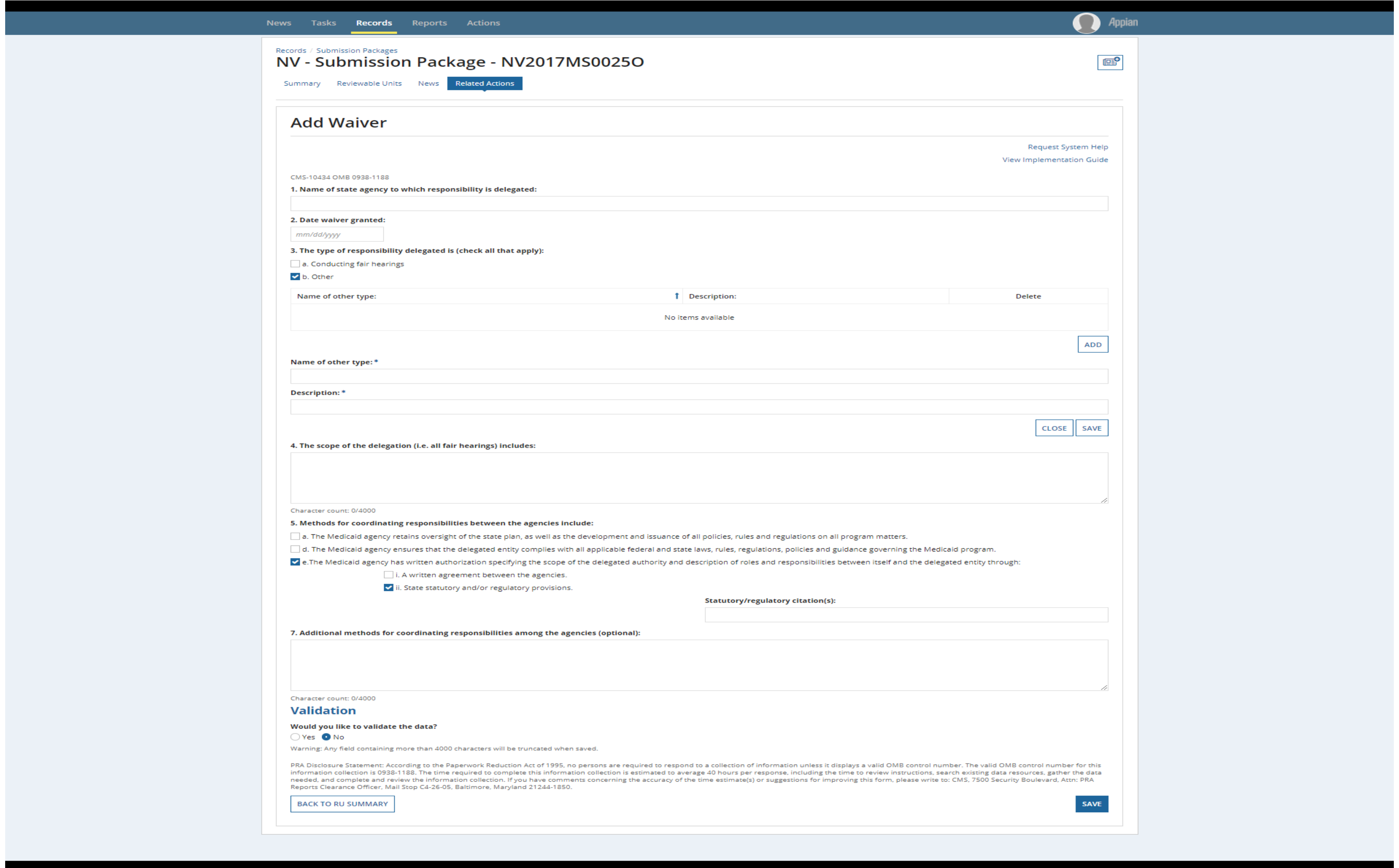

Figure 2: Add Waiver

1.3 Section B. Additional Information (optional)

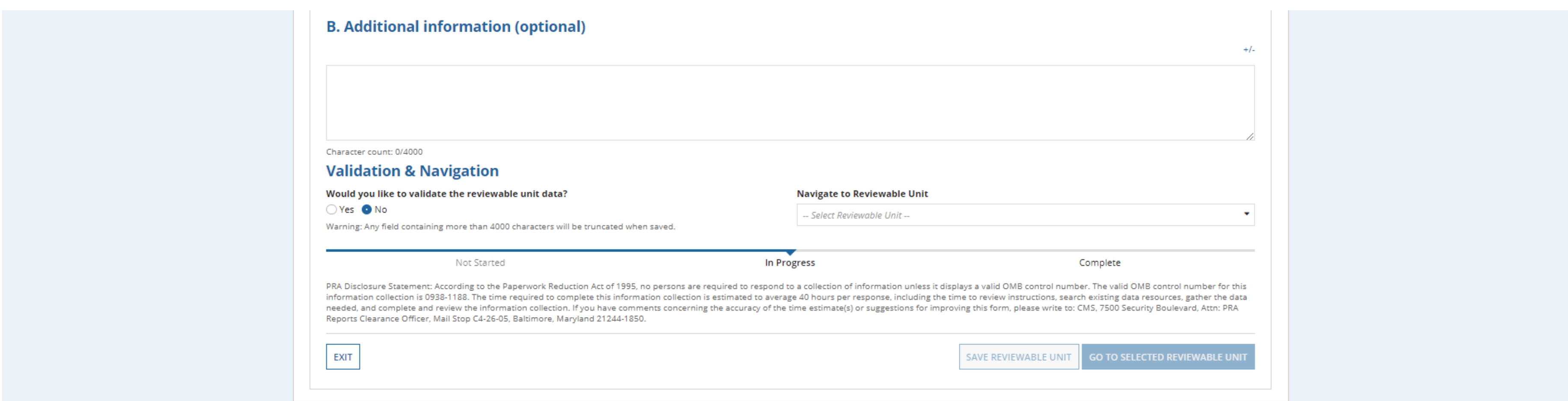

Figure 3: Section B

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

A3-Eligibility Determinations and Fair Hearings RU PRA document

Version 1.0

08/21/2017

Document Number: 235-QSSI-MACPro-PRA-A3-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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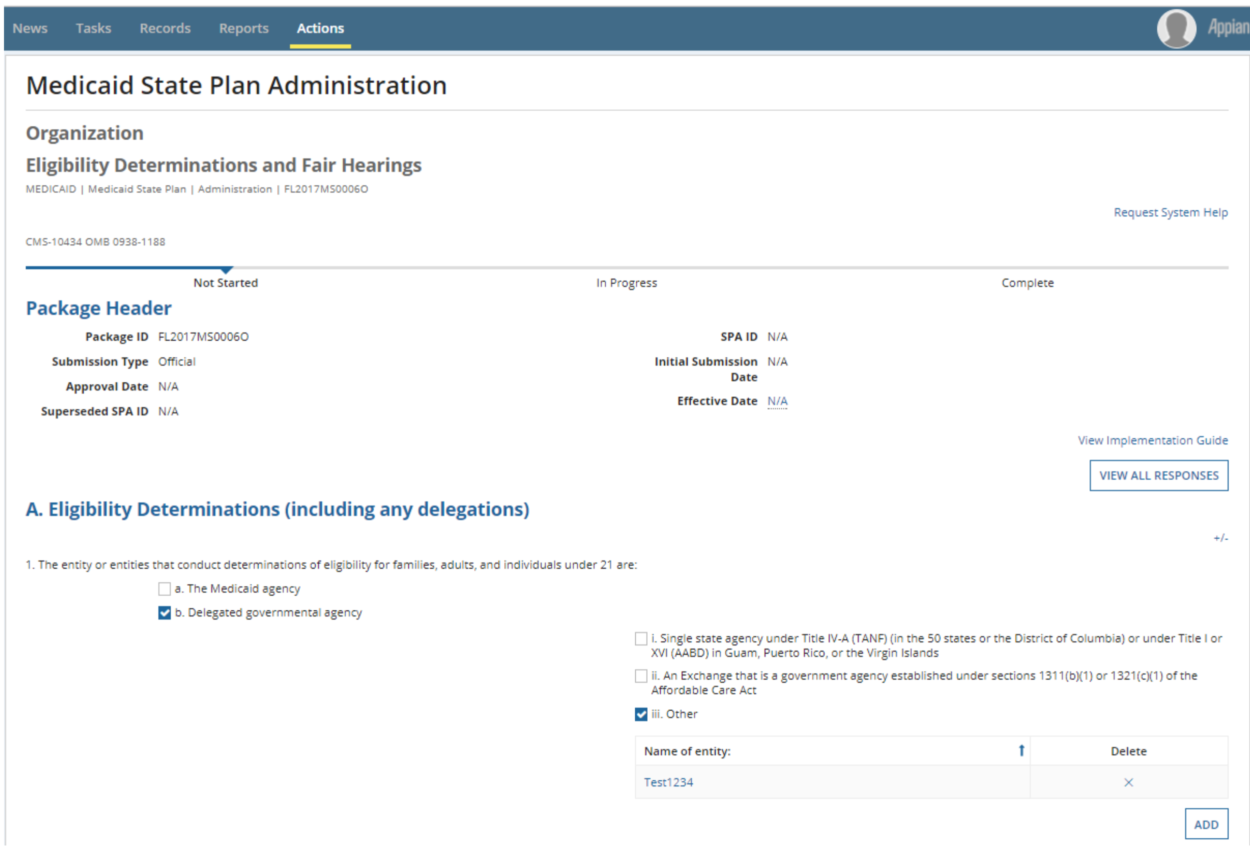
1. A3- Eligibility Determinations and Fair Hearings Screenshots

1.1 Section A. Eligibility Determinations (including any delegations)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Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | FL2017MS0006O

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CMS-10434 OMB 0938-1188

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Package Header

Package ID	FL2017MS0006O	SPA ID	N/A
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

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VIEW ALL RESPONSES

A. Eligibility Determinations (including any delegations)

+/-

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [ ] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [ ] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [x] iii. Other

Name of entity:	Delete
Test1234	×

ADD

Figure 1: Section A Screenshot 1

2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:

- [ ] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [ ] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries
  - [x] iv. Other

Name of entity:	Delete
Test5678	×

ADD

- [ ] c. Local governmental entities

3. Assurances:

- [ ] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [ ] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [ ] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [ ] d. The delegated entity is capable of performing the delegated functions.

Figure 2: Section A Screenshot 2

1.2 Section B. Fair Hearings (including any delegations)

B. Fair Hearings (including any delegations)

+/-

- [ ] The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
- [ ] The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

- [x] a. Medicaid agency
- [ ] b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.
- [ ] c. Local governmental entities
- [x] d. Delegated governmental agency
  - [x] i. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
    - (1) The Medicaid agency has established a review process whereby it reviews appeals decisions made by the Exchange or Exchange appeals entity, but only with respect to conclusions of law, including interpretations of state or federal policies.
      - (•) Yes
      - ( ) No
    - [ ] (2) The Medicaid agency only reviews appeals decisions with respect to the proper application of federal and state law, regulations and policies and that the review process is conducted by an impartial official not involved in the initial determination.
  - [x] ii. An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act
    - (1) Name of entity:
    - (2) The Medicaid agency has established a review process whereby it reviews appeals decisions made by the Exchange or Exchange appeals entity, but only with respect to conclusions of law, including interpretations of state or federal policies.
      - (•) Yes
      - ( ) No
    - [ ] (3) The Medicaid agency only reviews appeals decisions with respect to the proper application of federal and state law, regulations and policies and that the review process is conducted by an impartial official not involved in the initial determination.

2. The state must assure the following with respect to delegations of authority to conduct fair hearings regarding eligibility based on applicable modified adjusted gross income (MAGI):

- [ ] a. There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- [ ] b. When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.
- [ ] c. The Medicaid agency does not delegate authority to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.
- [ ] d. The delegated entity is capable of performing the delegated functions.

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

- [ ] All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Figure 3: Section B

1.3 Section C. Evidentiary Hearings and Section D. Additional information (optional)

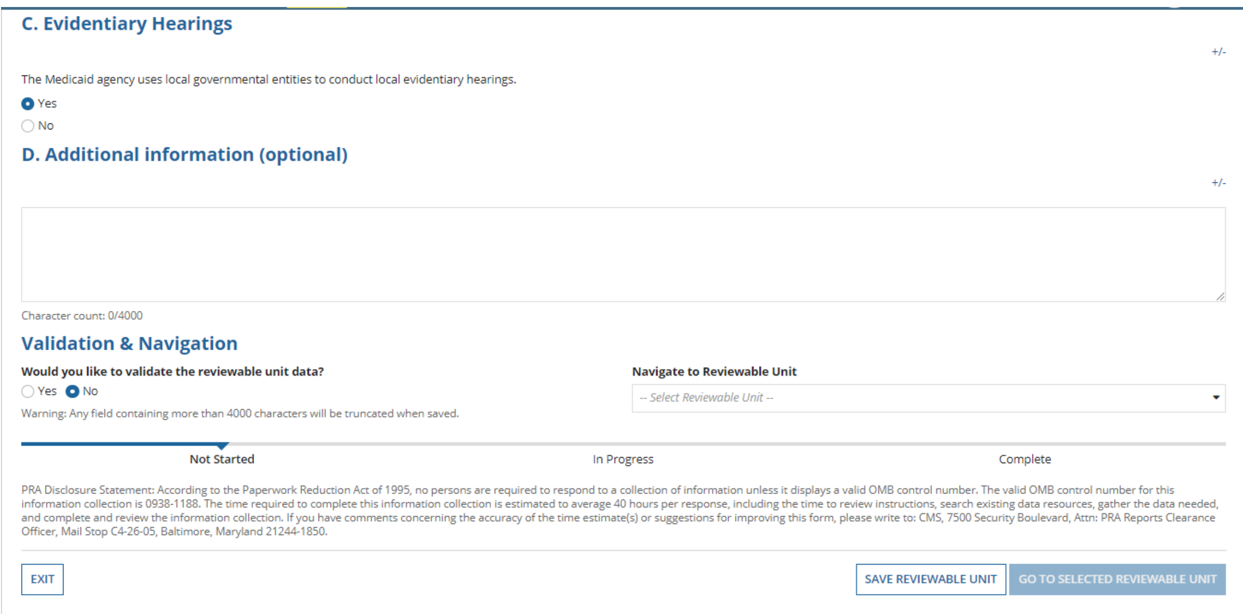

Figure 4: Section C and D

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

A4-Organization and Administration RU PRA document

Version 1.0

08/21/2017

Document Number: 242-QSSI-MACPro-PRA-A4-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. A4-Organization and Administration Screenshots

1.1 Section A. Description of the Organization and Functions of the Single State Agency

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | FL2017MS0006O

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID FL2017MS0006O
Submission Type Official
Approval Date N/A
Superseded SPA ID N/A
SPA ID N/A
Initial Submission Date N/A
Effective Date N/A

View Implementation Guide

VIEW ALL RESPONSES

A. Description of the Organization and Functions of the Single State Agency

+/-

1. The single state agency is:
- a. A stand-alone agency, separate from every other state agency
- b. Also the Title IV-A (TANF) agency
- c. Also the state health department
- d. Other:

Description:

Figure 1: Section A Screenshot 1

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

Character count: 0/4000

b. Fair Hearings (including expedited fair hearings)

Character count: 0/4000

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Character count: 0/4000

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Character count: 0/4000

e. Administration, including budget, legal counsel

Character count: 0/4000

f. Financial management, including processing of provider claims and other health care financing

Character count: 0/4000

g. Systems administration, including MMIS, eligibility systems

Character count: 0/4000

h. Other functions, e.g., TPL, utilization management (optional)

Character count: 0/4000

3. An organizational chart of the Medicaid agency has been uploaded:

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

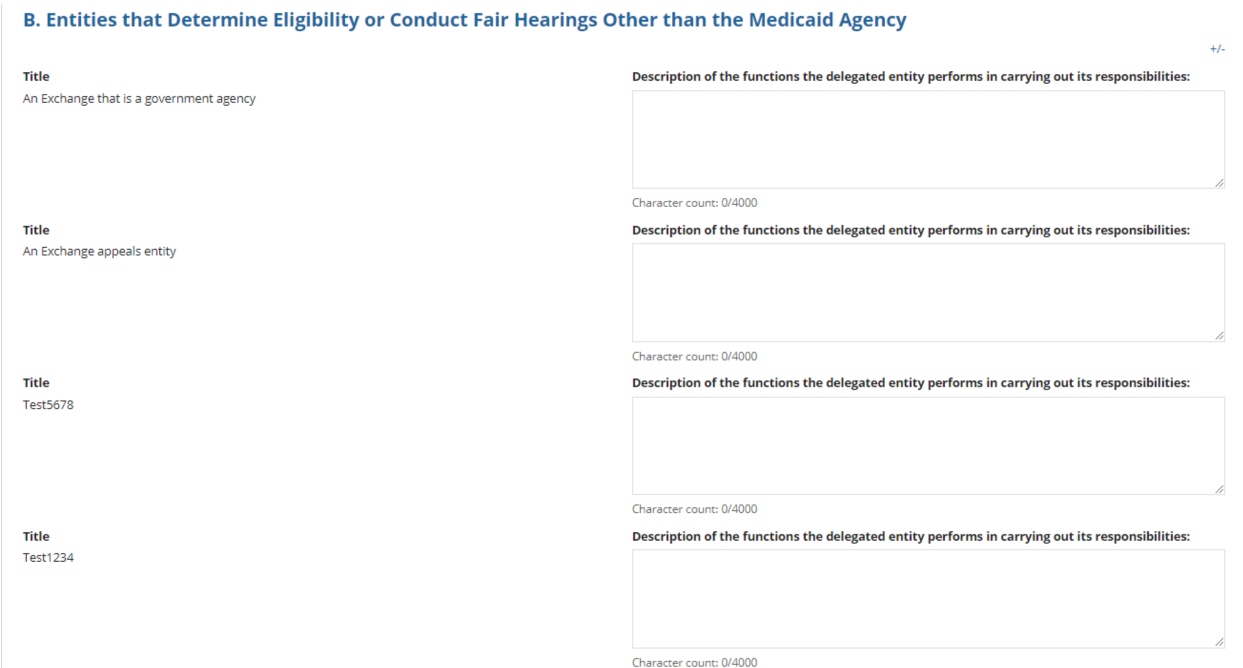
	Name	Date Created	Type
	No items available		

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 2: Section A Screenshot 2

1.2 Section B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency


B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

+/-

Title
An Exchange that is a government agency

Description of the functions the delegated entity performs in carrying out its responsibilities:

Character count: 0/4000

Title
An Exchange appeals entity

Description of the functions the delegated entity performs in carrying out its responsibilities:

Character count: 0/4000

Title
Test5678

Description of the functions the delegated entity performs in carrying out its responsibilities:

Character count: 0/4000

Title
Test1234

Description of the functions the delegated entity performs in carrying out its responsibilities:

Character count: 0/4000

Figure 3: Section B

1.3 Section C. Supervision of the Administration of the State Plan through a State Agency Other Than the Medicaid Agency and Section D. Supervision of the Administration of the State Plan through Local Government Entities

C. Supervision of the Administration of the State Plan through a State Agency Other Than the Medicaid Agency

+/-

The following state agencies administer the state plan under the supervision of the Medicaid agency:

Name of other state agency:

Description of the functions the staff of the state agency and counties or local entities perform in carrying out their responsibilities:

- [ ] Eligibility Determinations
- [ ] Fair Hearings
- [x] Other

Character count: 0/4000

Delete

+ Add State Agency

D. Supervision of the Administration of the State Plan through Local Government Entities

+/-

1. The types of the local government entities that administer the state plan under the supervision of the Medicaid agency are:

- [ ] a. Counties
- [ ] b. Parishes
- [x] c. Other

Type of local government entity:

Test1234

c. Other

2. Are all of the local government entities selected used to administer the state plan? *

- (•) Yes
- ( ) No

3. The number used to administer the state plan is: *

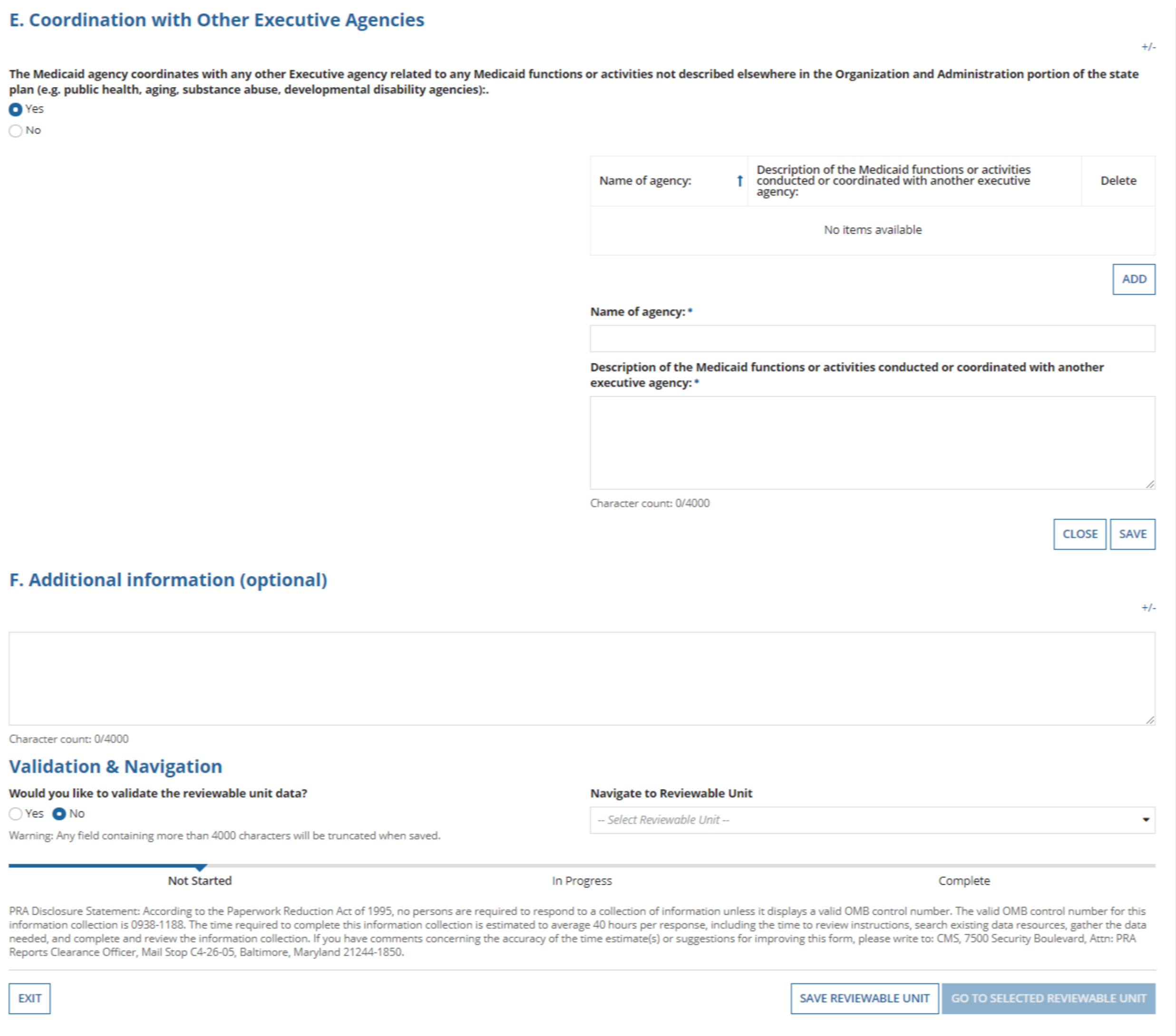
4. The functions staff perform in carrying out the entity's responsibilities are described below:

- [ ] a. Eligibility Determinations
- [ ] b. Fair Hearings
- [x] c. Other

Character count: 0/4000

Figure 4: Section C and D

1.4 Section E. Coordination with Other Executive Agencies and Section F. Additional information (optional)



E. Coordination with Other Executive Agencies

+/-

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

Yes

No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:	Delete
No items available		

ADD

Name of agency: *

Description of the Medicaid functions or activities conducted or coordinated with another executive agency: *

Character count: 0/4000

CLOSE SAVE

F. Additional information (optional)

+/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

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Figure 5: Section E and F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

A5-Single State Agency Assurances RU PRA document

Version 1.0

08/21/2017

Document Number: 240-QSSI-MACPro-PRA-A5-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.1 Section A. Assurances and Section B. Additional Information (optional) 1

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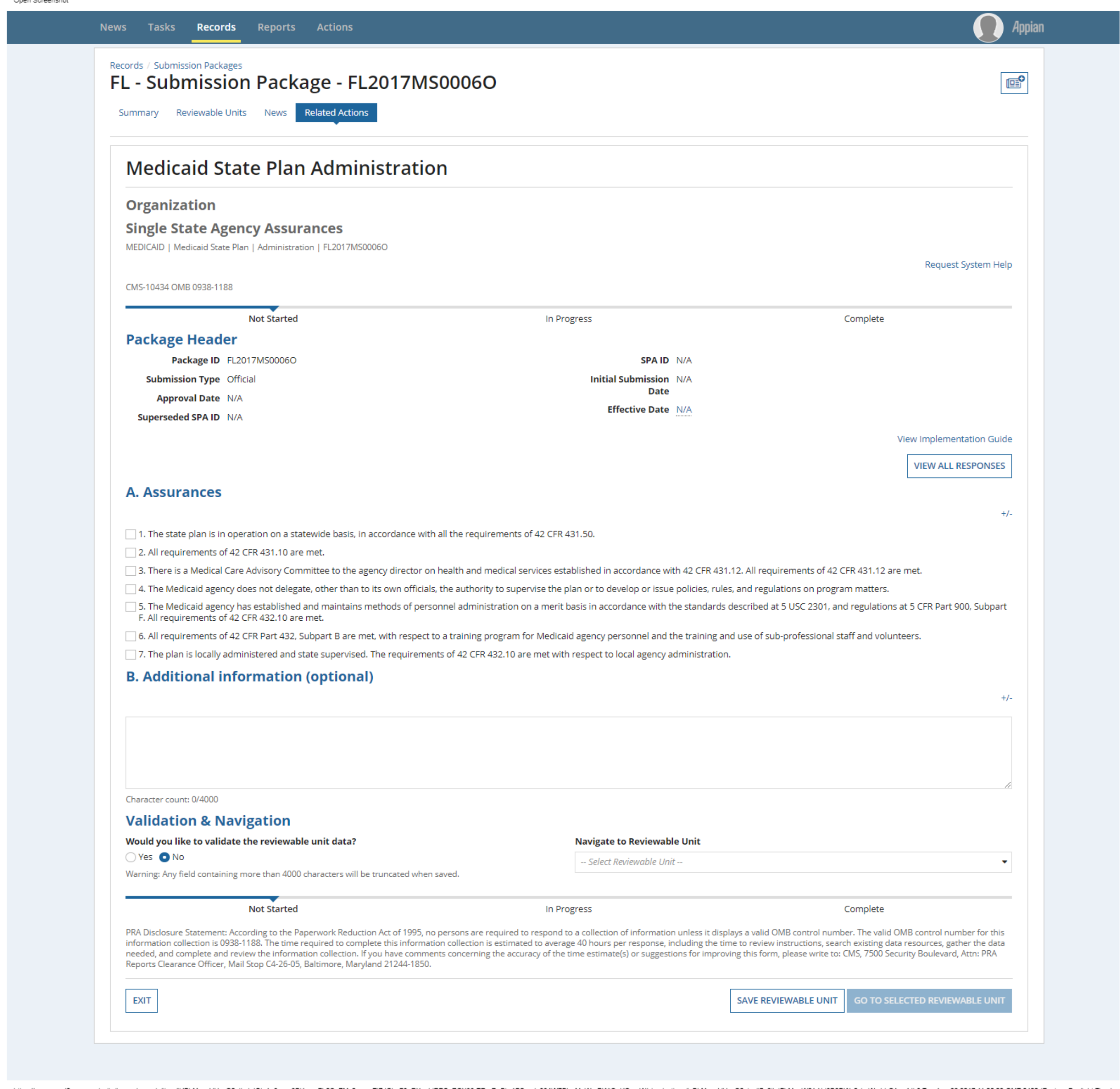
List of Tables

No table of figures entries found.

1. A5-Single State Agency Assurances Screenshots

1.1 Section A. Assurances and Section B. Additional Information (optional)

Open Screenshot



News Tasks Records Reports Actions Appian

Records / Submission Packages

FL - Submission Package - FL2017MS0006O

Summary Reviewable Units News Related Actions

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | FL2017MS0006O

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CMS-10434 OMB 0938-1188

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Package Header

Package ID	FL2017MS0006O	SPA ID	N/A
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

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VIEW ALL RESPONSES

A. Assurances

+/-

- ☐ 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- ☐ 2. All requirements of 42 CFR 431.10 are met.
- ☐ 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- ☐ 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- ☐ 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- ☐ 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.
- ☐ 7. The plan is locally administered and state supervised. The requirements of 42 CFR 432.10 are met with respect to local agency administration.

B. Additional information (optional)

+/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

○ Yes ● No

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https://macpro.../suite/tempo/records/item/... Tue Aug 22 2017 11:05:02 GMT-0400 (Eastern Daylight Time)

Figure 1: Section A and Section B

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH1 - Health Homes Intro RU PRA document

Version 1.0

08/10/2017

Document Number: 167-QSSI-MACPro-PRA-HH1-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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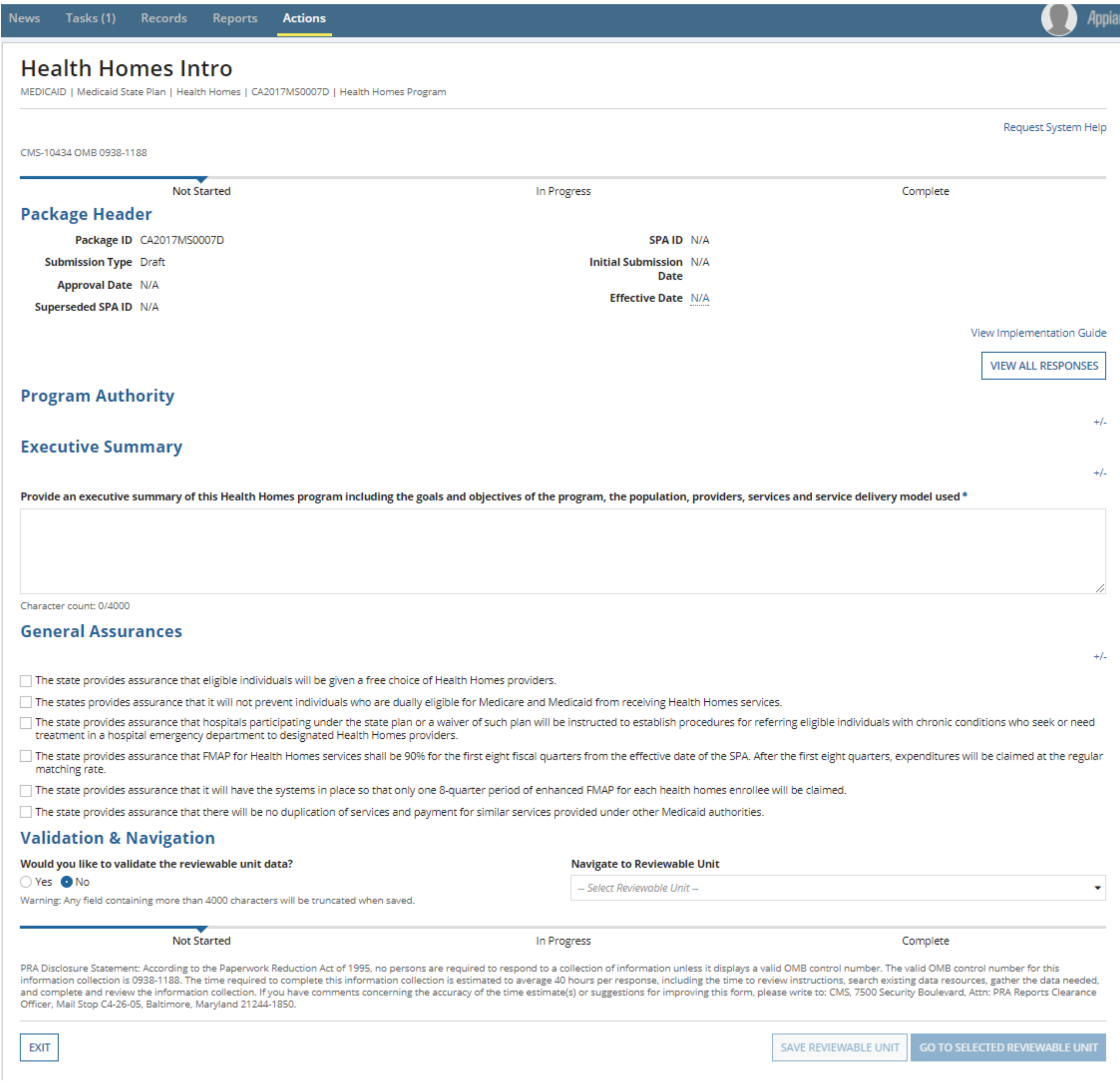
1. HH1 – Health Homes Intro Screenshots

1.1 "Executive Summary" and "General Assurances" Sections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Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | CA2017MS0007D | Health Homes Program

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CMS-10434 OMB 0938-1188

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Package ID CA2017MS0007D
Submission Type Draft
Approval Date N/A
Superseded SPA ID N/A
SPA ID N/A
Initial Submission Date N/A
Effective Date N/A

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VIEW ALL RESPONSES

Program Authority

+/-

Executive Summary

+/-

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used *

Character count: 0/4000

General Assurances

+/-

- [ ] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [ ] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [ ] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [ ] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [ ] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [ ] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Validation & Navigation

Would you like to validate the reviewable unit data?
Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit
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Figure 1: Executive Summary and General Assurances

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH2 - Population and Enrollment PRA document

Version 1.0

08/10/2017

Document Number: 168-QSSI-MACPro-PRA-HH2-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.4 “Population Criteria” Section – Path 2 2
1.5 “Population Criteria” Section – Path 3 2
1.6 “Enrollment of Participants” Section – Path 1 3
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Figure 8: Enrollment of Participants - 3 3

1. HH2 – Population and Enrollment Screenshots

1.1 "Categories of Individuals and Populations Provided Health Homes Services" Section

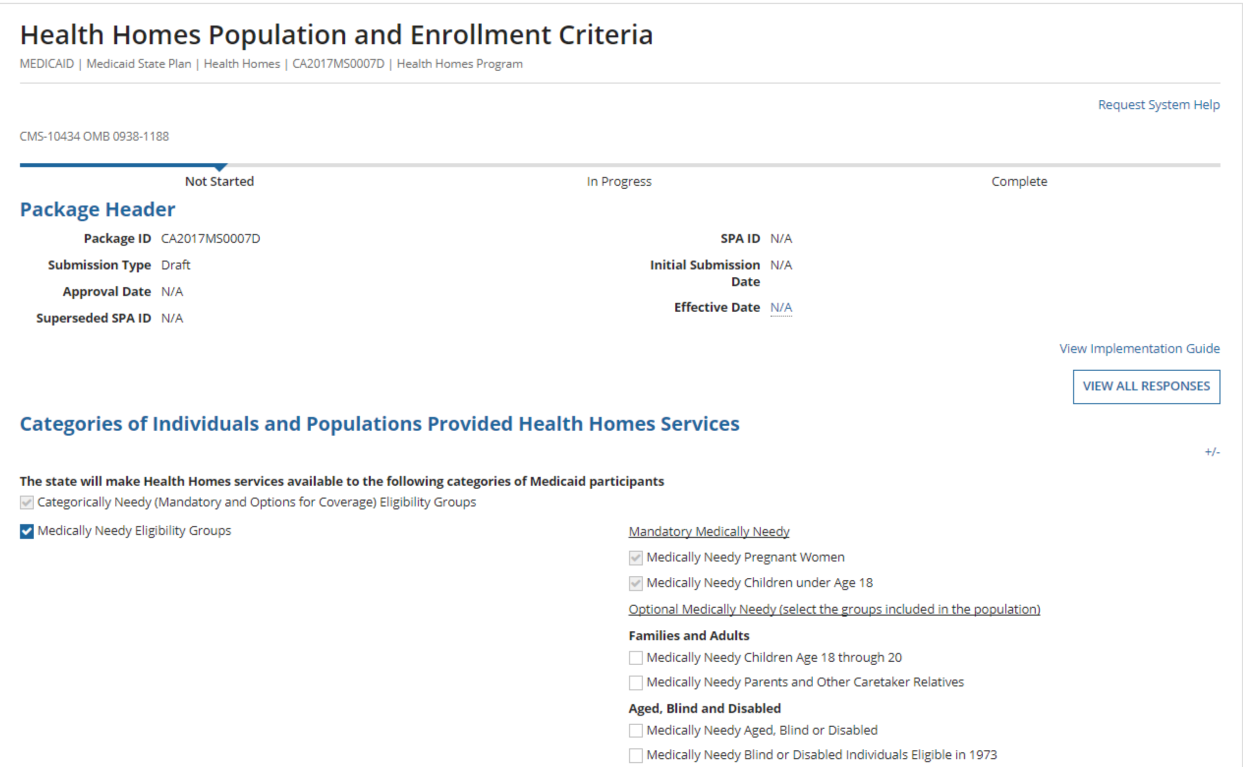


Figure 1: Categories of Individuals and Populations Provided Health Homes Services

1.2 "Population Criteria" Section

Figure 2: Population Criteria

1.3 "Population Criteria" Section – Path 1

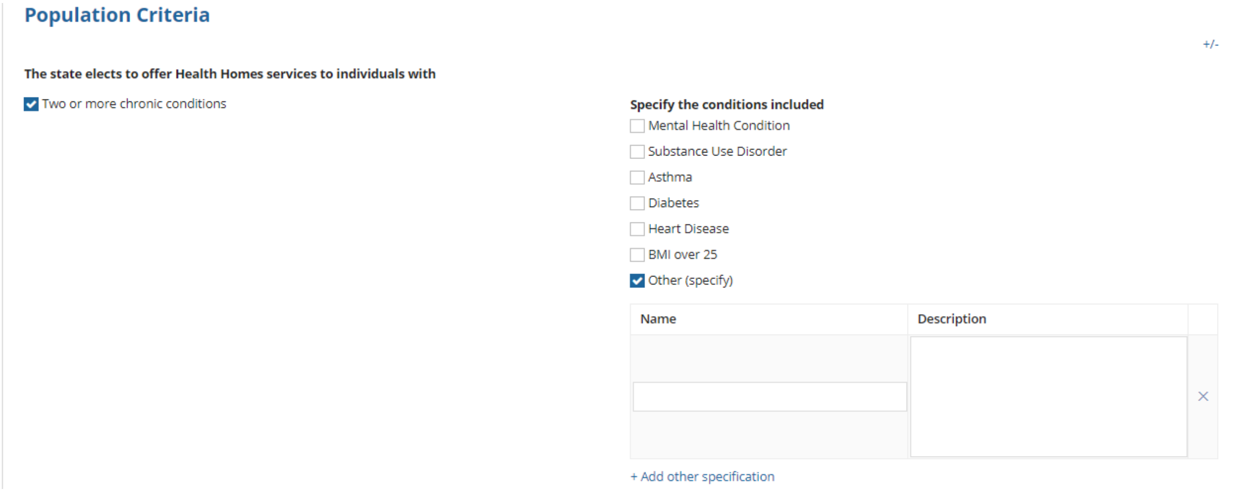


Figure 3: Population Criteria - 1

1.4 "Population Criteria" Section – Path 2

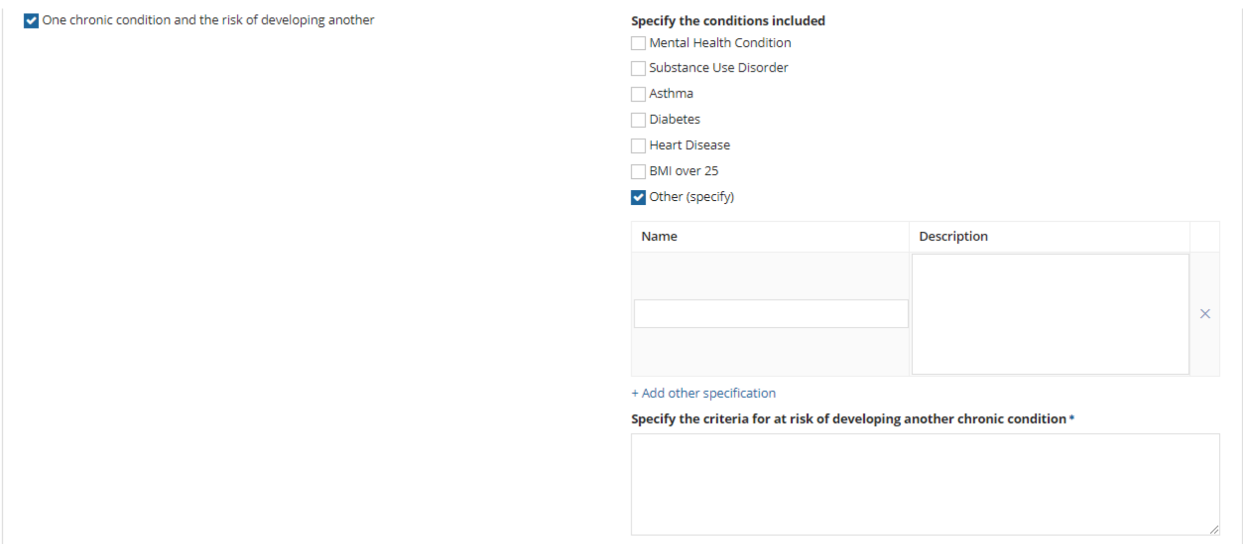


Figure 4: Population Criteria - 2

1.5 "Population Criteria" Section – Path 3

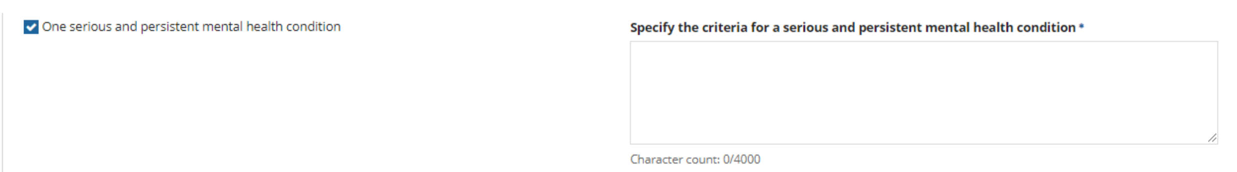
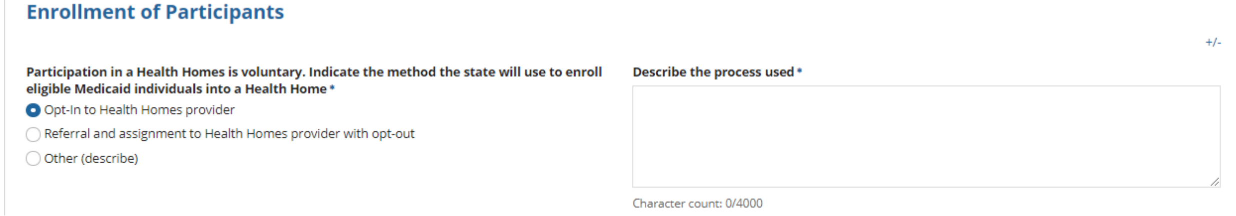


Figure 5: Population Criteria - 3

1.6 "Enrollment of Participants" Section – Path 1


Enrollment of Participants

+/-

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home *

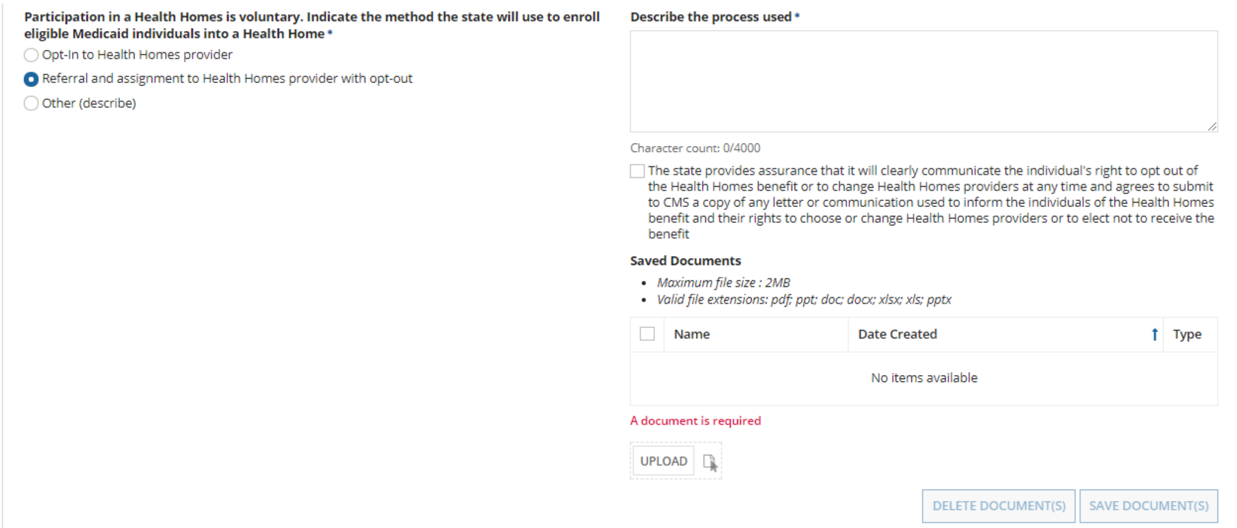
- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used *

Character count: 0/4000

Figure 6: Enrollment of Participants - 1

1.7 "Enrollment of Participants" Section – Path 2


Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home *

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used *

Character count: 0/4000

The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

	Name	Date Created	Type
No items available			

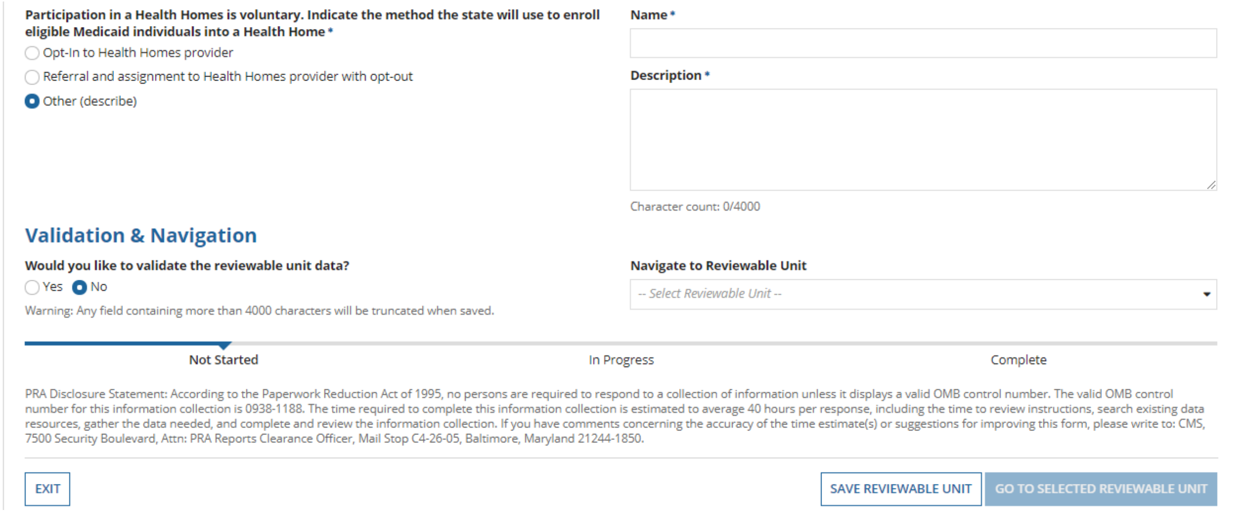
A document is required

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 7: Enrollment of Participants - 2

1.8 "Enrollment of Participants" Section – Path 3


Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home *

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Name *

Description *

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started In Progress Complete

PRA Disclosure Statement: 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 average 40 hours per response, 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.

EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 8: Enrollment of Participants - 3

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH3 – Geographic Limitations RU PRA document

Version 1.0

08/10/2017

Document Number: 172-QSSI-MACPro-PRA-HH3-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. HH3 – Geographic Limitations Screenshots

1.1 Geographic Limitations – Path 1

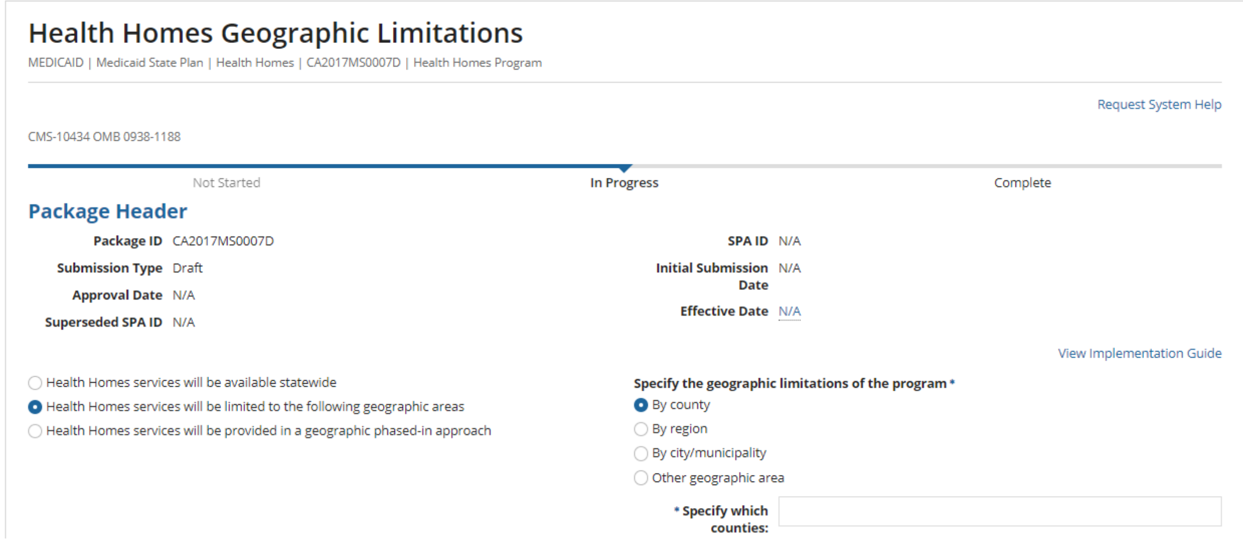

Figure 1: Geographic Limitations - 1

1.2 Geographic Limitations – Path 2

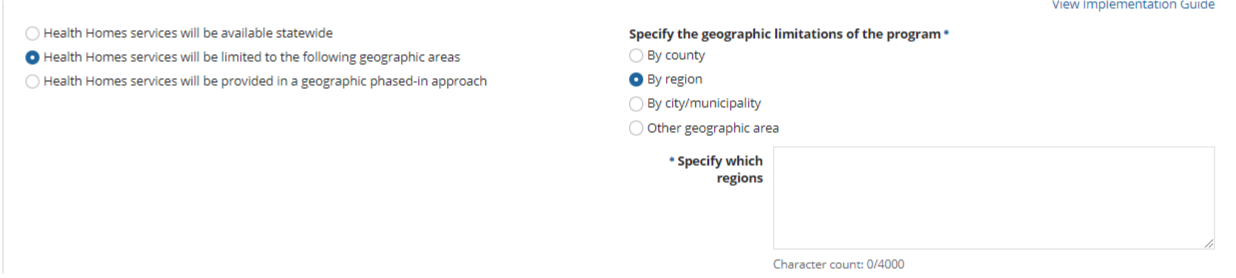

Figure 2: Geographic Limitations - 2

1.3 Geographic Limitations – Path 3

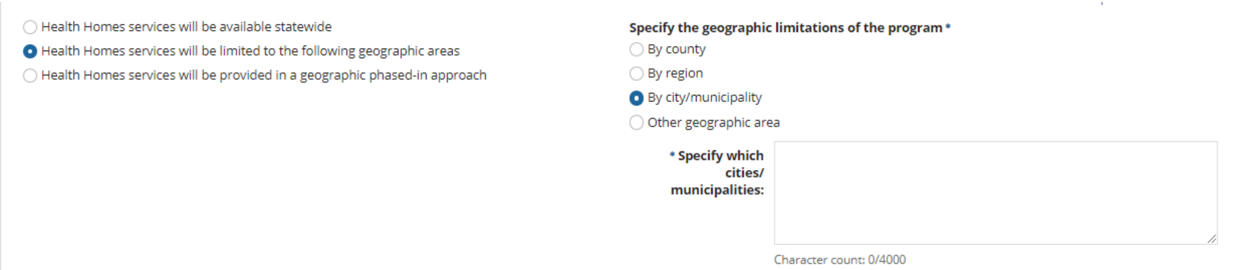

Figure 3: Geographic Limitations – 3

1.4 Geographic Limitations – Path 4

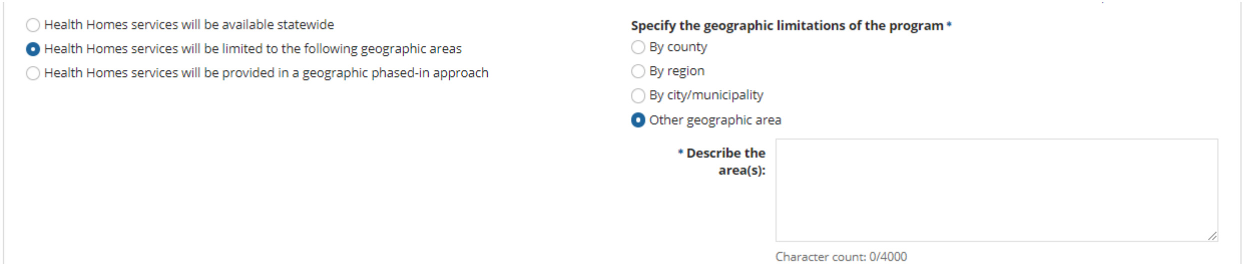

Figure 4: Geographic Limitations – 4

1.5 Geographic Limitations – Path 5

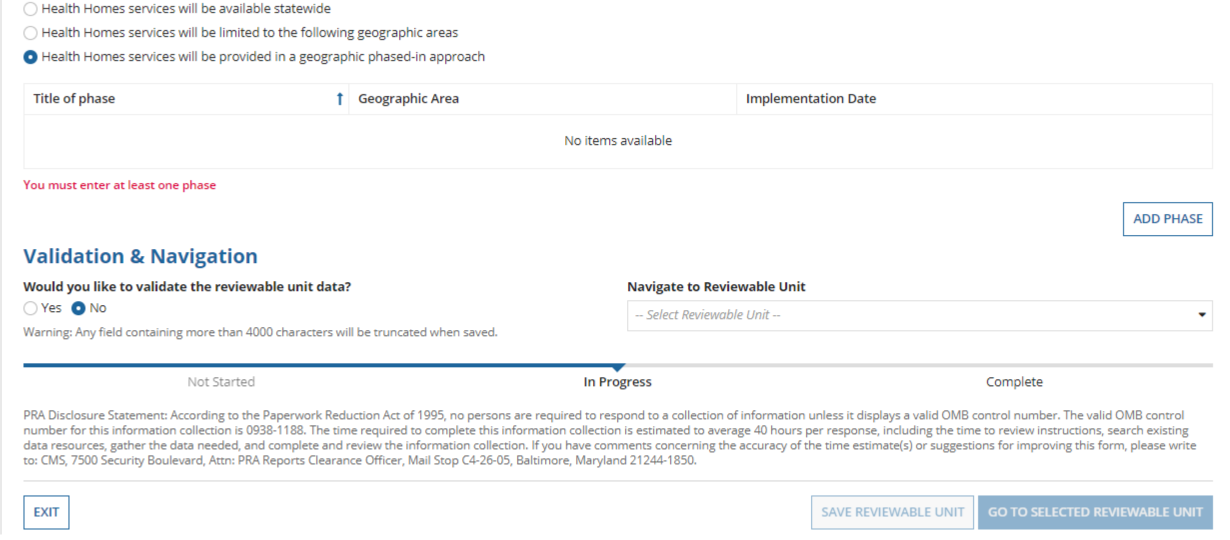

Figure 5: Geographic Limitations - 5

2. Geographic Limitations Add or Edit Phase Screenshots

2.1 Geographic Limitations - Add or Edit Phase – Path 1

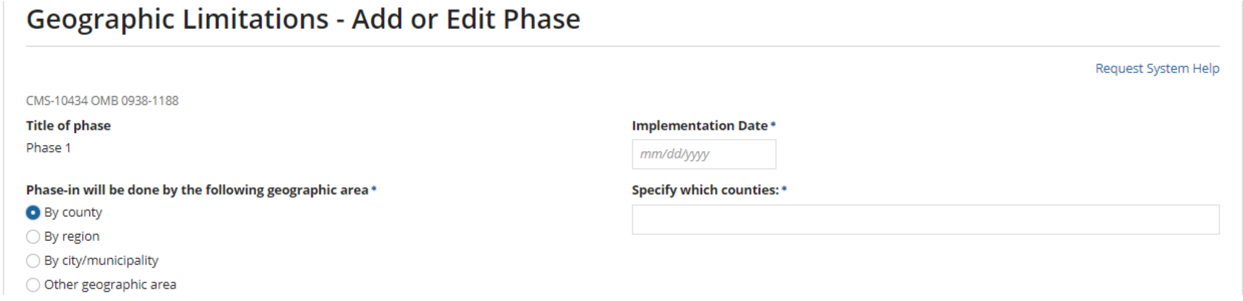

Figure 6: Geographic Limitations - Add or Edit Phase -1

2.2 Geographic Limitations - Add or Edit Phase – Path 2

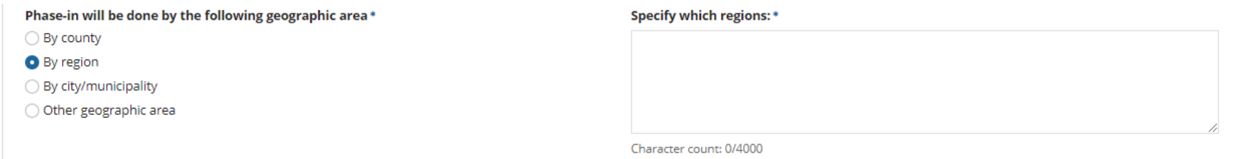

Figure 7: Geographic Limitations - Add or Edit Phase – 2

2.3 Geographic Limitations - Add or Edit Phase – Path 3

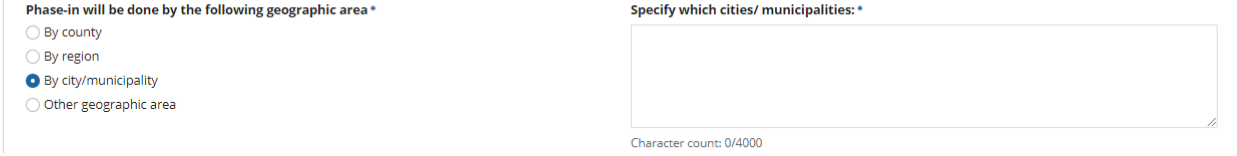

Figure 8: Geographic Limitations - Add or Edit Phase – 3

2.4 Geographic Limitations - Add or Edit Phase – Path 4

Figure 9: Geographic Limitations - Add or Edit Phase - 4

2.5 Geographic Limitations - Add or Edit Phase

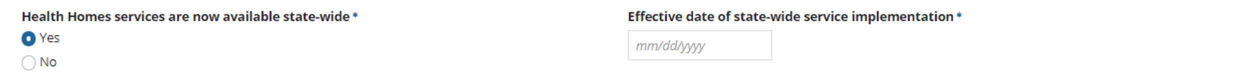

Figure 10: Geographic Limitations - Add or Edit Phase – 5

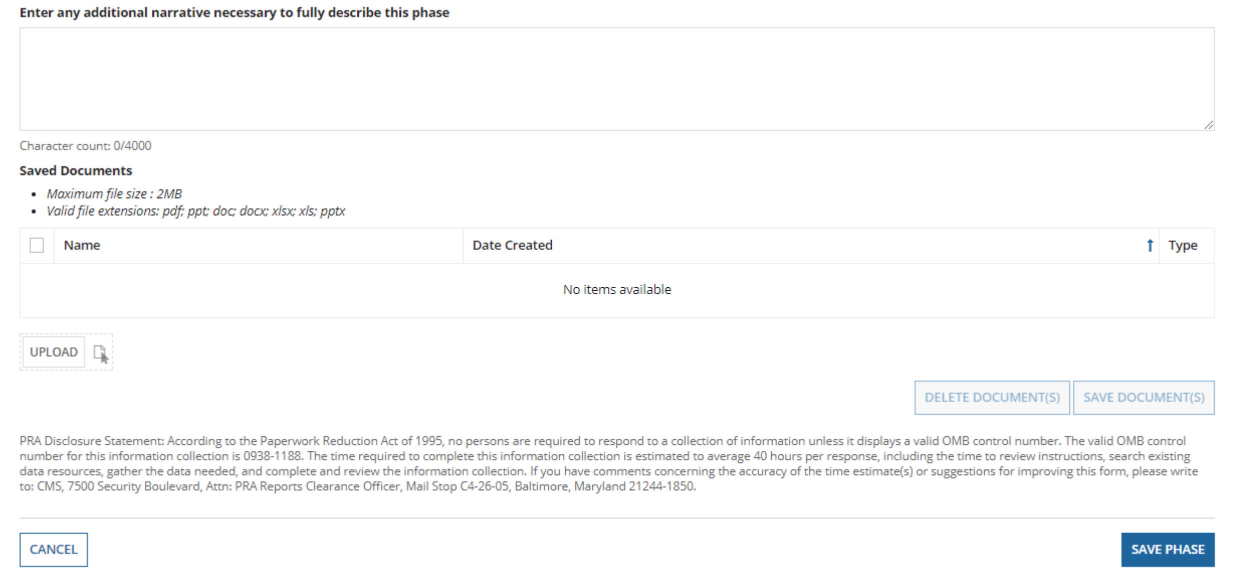

Figure 11: Geographic Limitations - Add or Edit Phase - 6

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH4 – Health Homes Services RU PRA document

Version 1.0
08/11/2017

Document Number: 165-QSSI-MACPro-PRA-HH4-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. HH4 – Health Homes Services Screenshots

1.1 “Service Definitions” Section – Comprehensive Care Management

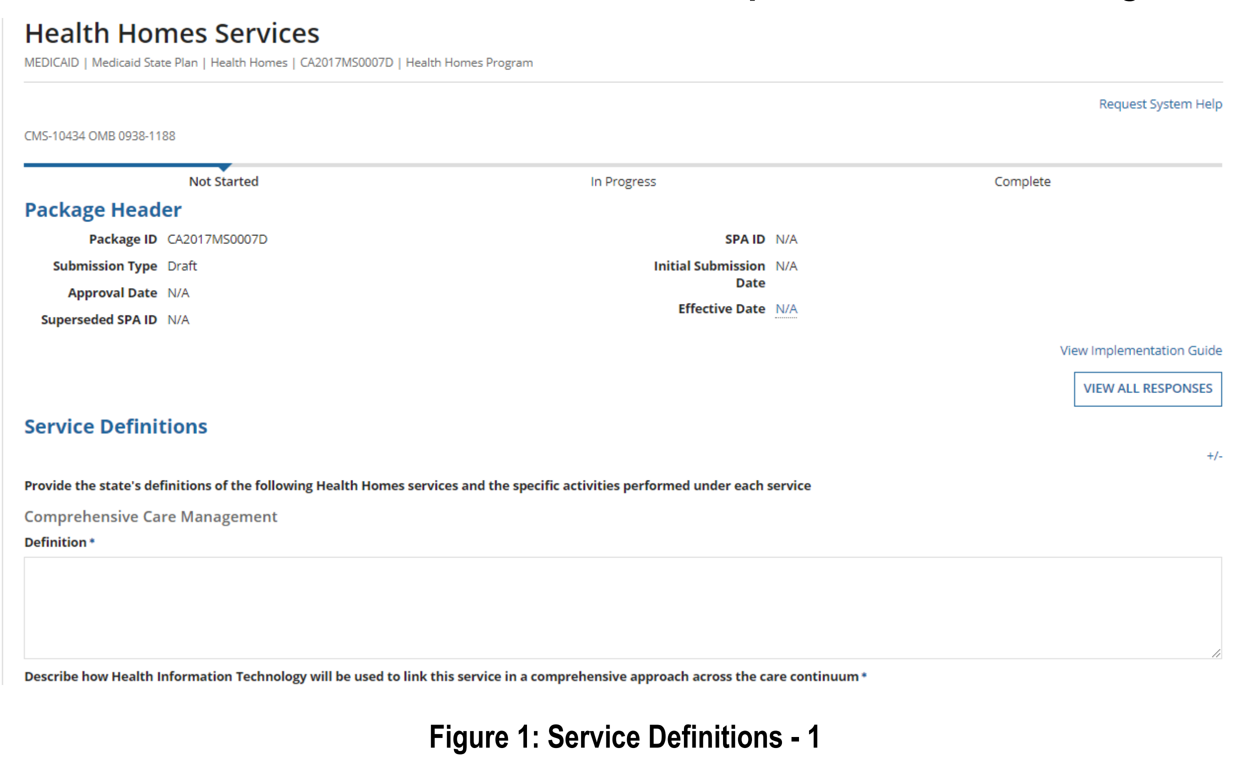


Figure 1: Service Definitions - 1

Figure 2: Service Definitions - 2

Scope of service

The service can be provided by the following provider types

Must check one or more

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Figure 3: Service Definitions - 3

Scope of service

The service can be provided by the following provider types

Must check one or more

- [x] Behavioral Health Professionals or Specialists — **Description ***

  Character count: 0/4000
- [x] Nurse Practitioner — **Description ***

  Character count: 0/4000
- [x] Nurse Care Coordinators — **Description ***

  Character count: 0/4000
- [x] Nurses — **Description ***

Figure 4: Service Definitions - 4

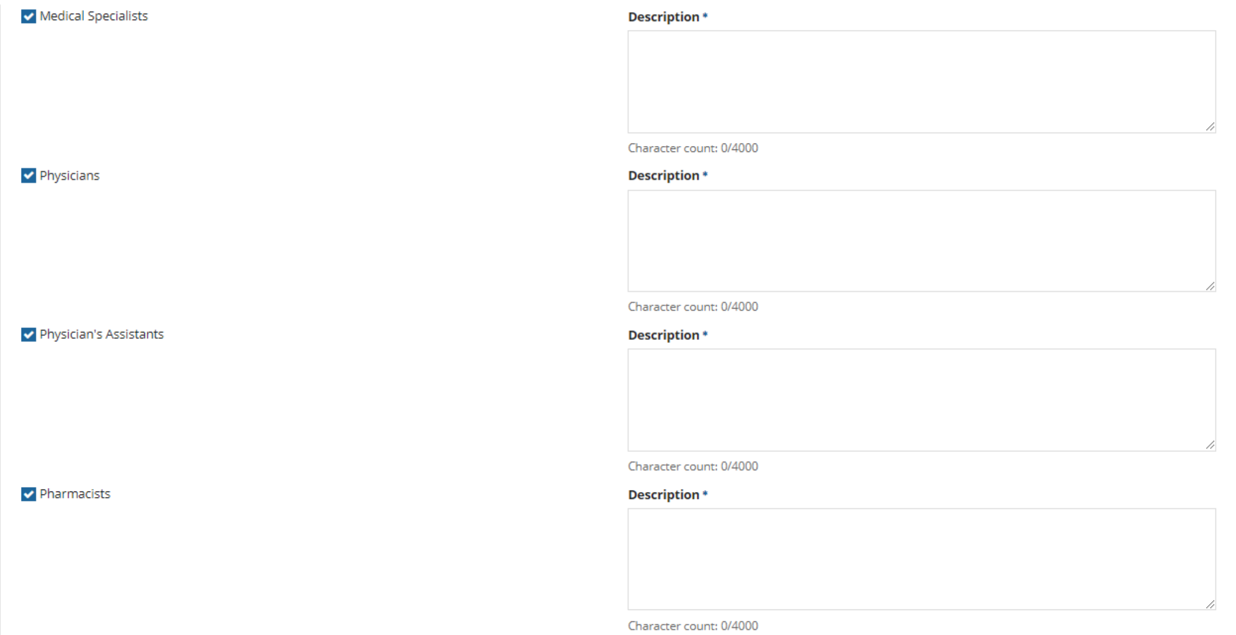


Figure 5: Service Definitions - 5

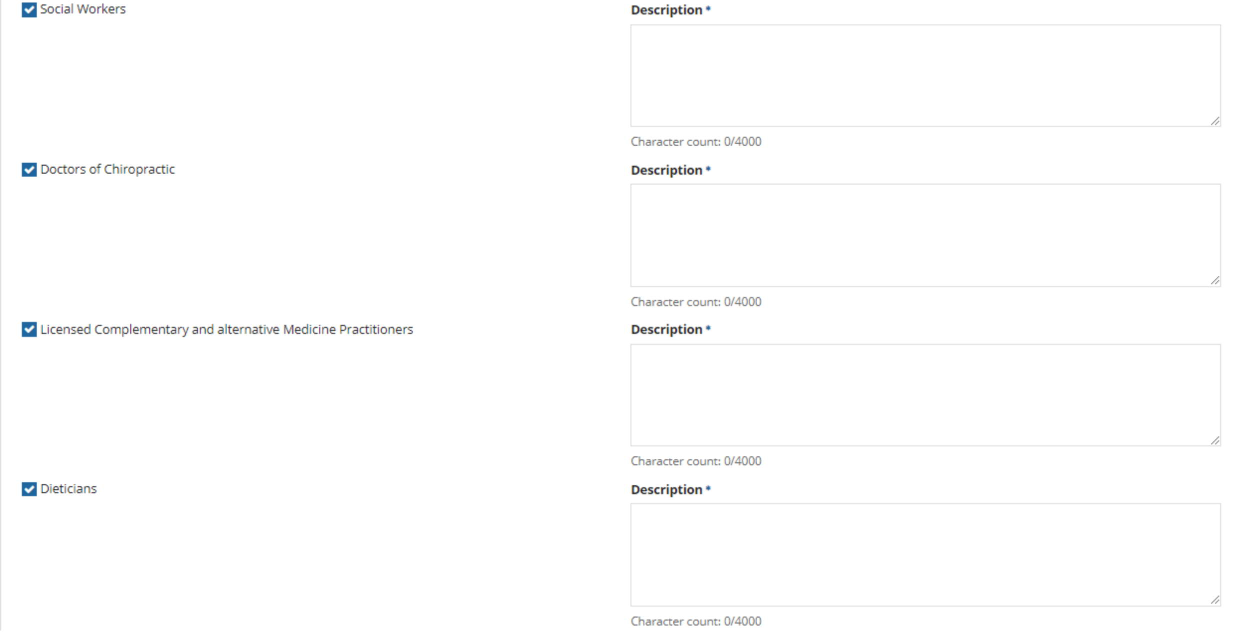


Figure 6: Service Definitions - 6

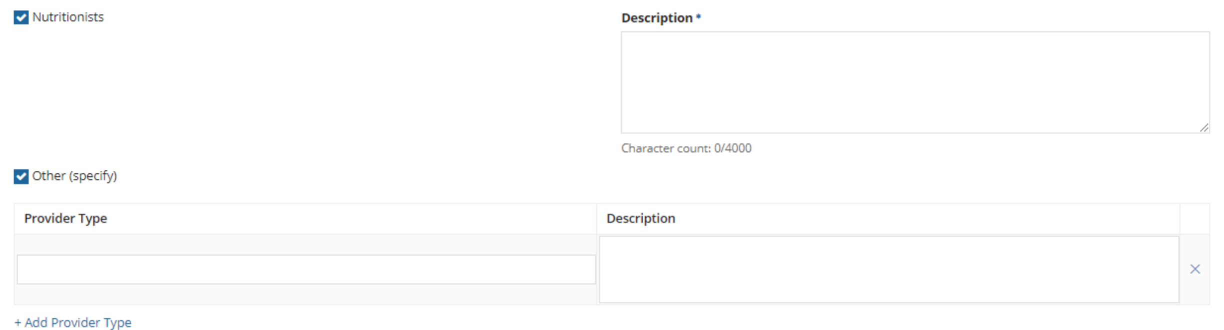


Figure 7: Service Definitions - 7

1.2 "Service Definitions" Section – Care Coordination

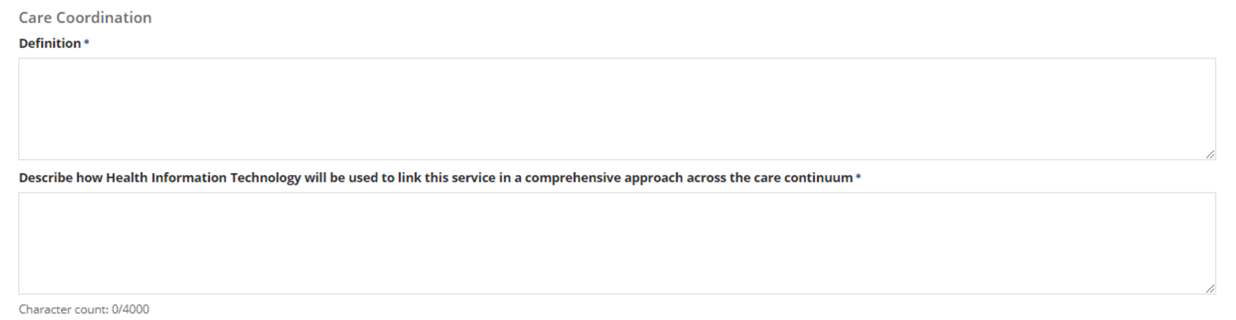


Figure 8: Service Definitions - 8

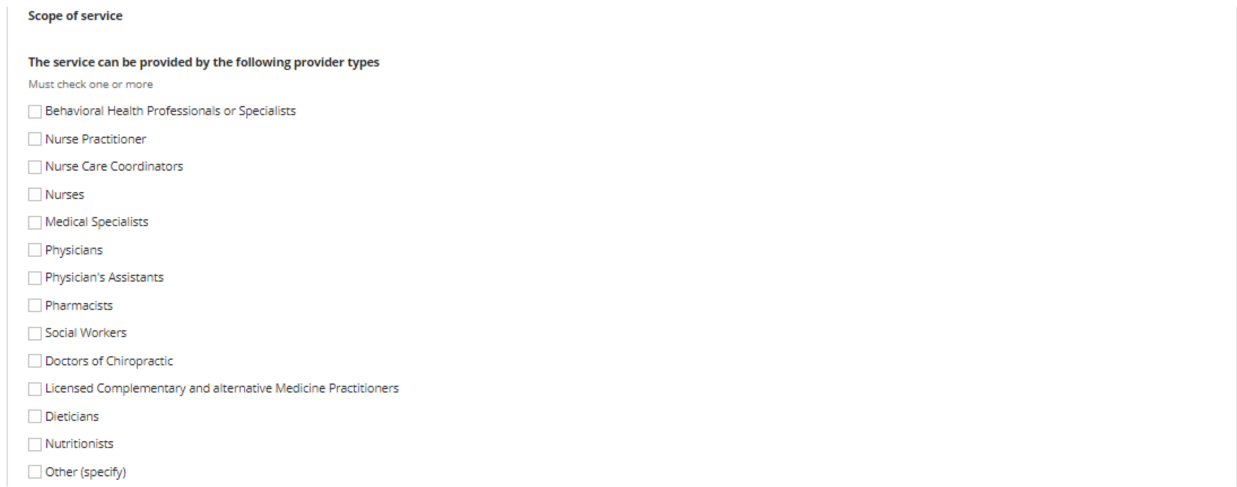
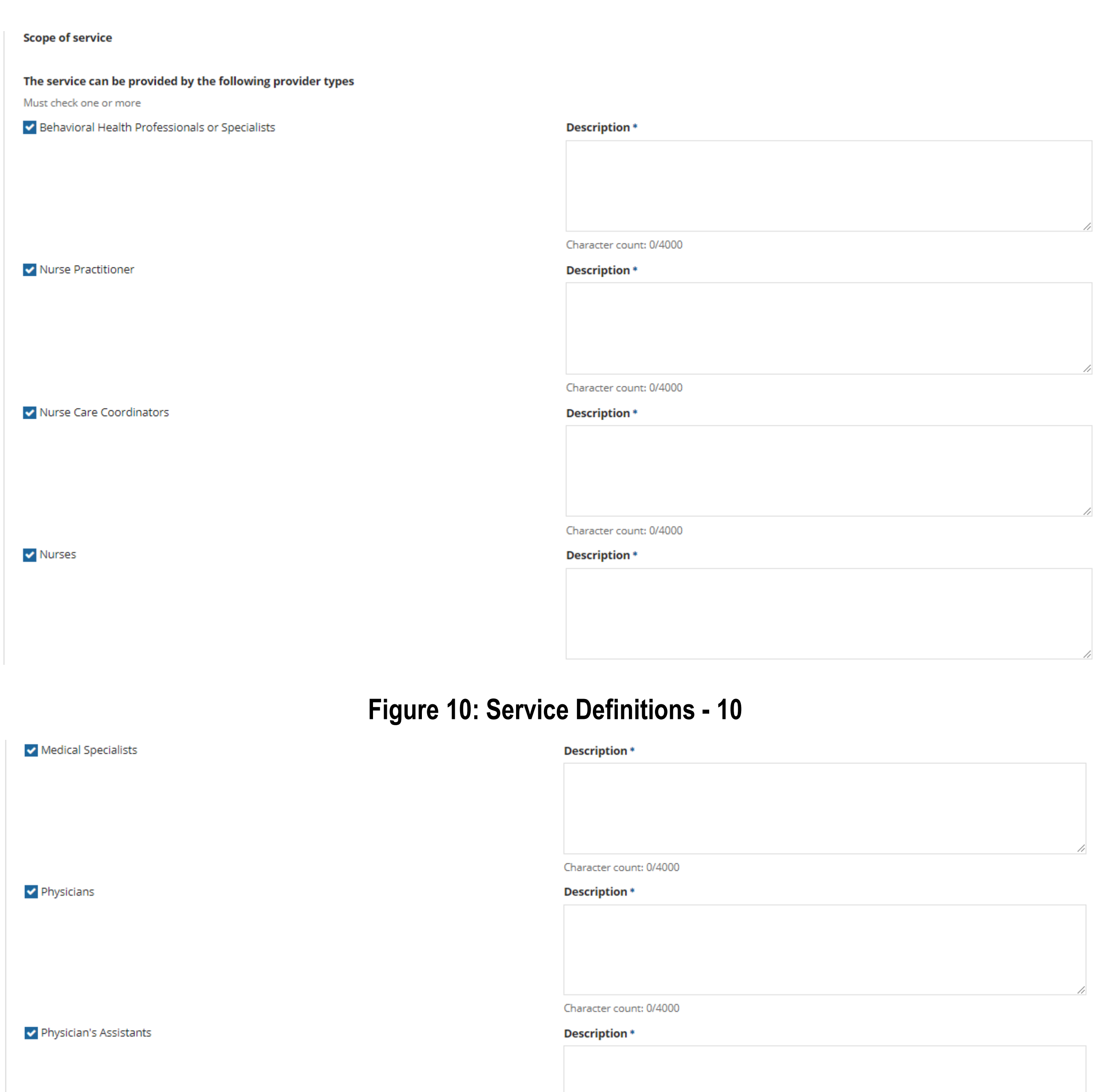


Figure 9: Service Definitions - 9



Scope of service

The service can be provided by the following provider types

Must check one or more

☑ Behavioral Health Professionals or Specialists

Description *

Character count: 0/4000

☑ Nurse Practitioner

Description *

Character count: 0/4000

☑ Nurse Care Coordinators

Description *

Character count: 0/4000

☑ Nurses

Description *

Figure 10: Service Definitions - 10

☑ Medical Specialists

Description *

Character count: 0/4000

☑ Physicians

Description *

Character count: 0/4000

☑ Physician's Assistants

Description *

Character count: 0/4000

☑ Pharmacists

Description *

Character count: 0/4000

Figure 11: Service Definitions - 11

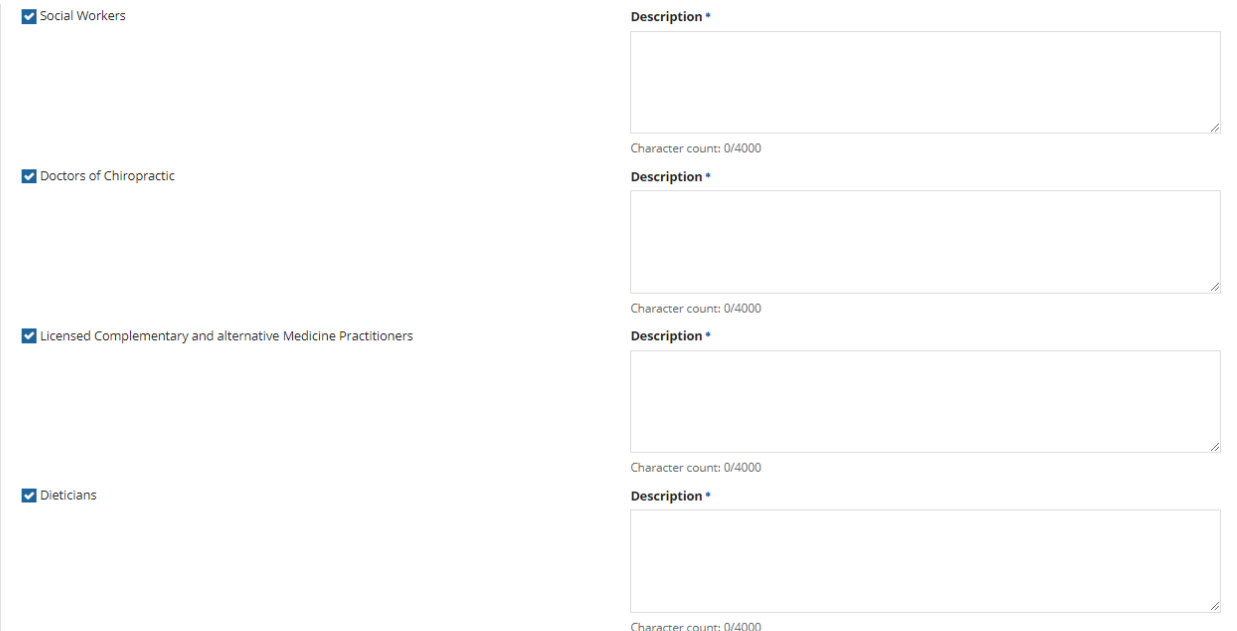


Figure 12: Service Definitions - 12

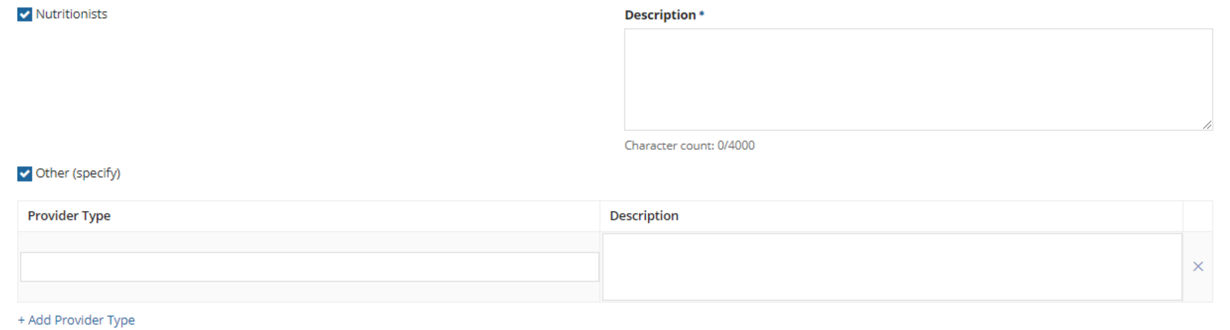


Figure 13: Service Definitions - 13

1.3 “Service Definitions” Section – Health Promotion

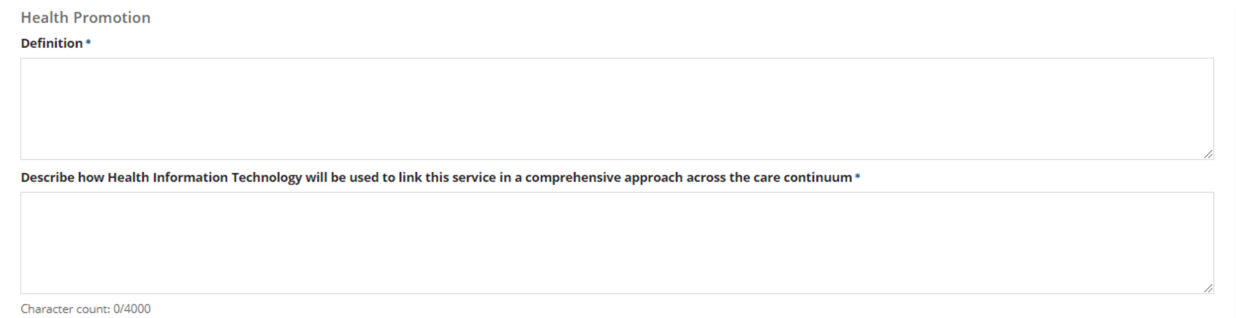


Figure 14: Service Definitions - 14

Scope of service

The service can be provided by the following provider types

Must check one or more

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Figure 15: Service Definitions - 15

Scope of service

The service can be provided by the following provider types

Must check one or more

- [x] Behavioral Health Professionals or Specialists — Description *

  Character count: 0/4000
- [x] Nurse Practitioner — Description *

  Character count: 0/4000
- [x] Nurse Care Coordinators — Description *

  Character count: 0/4000
- [x] Nurses — Description *

Figure 16: Service Definitions - 16

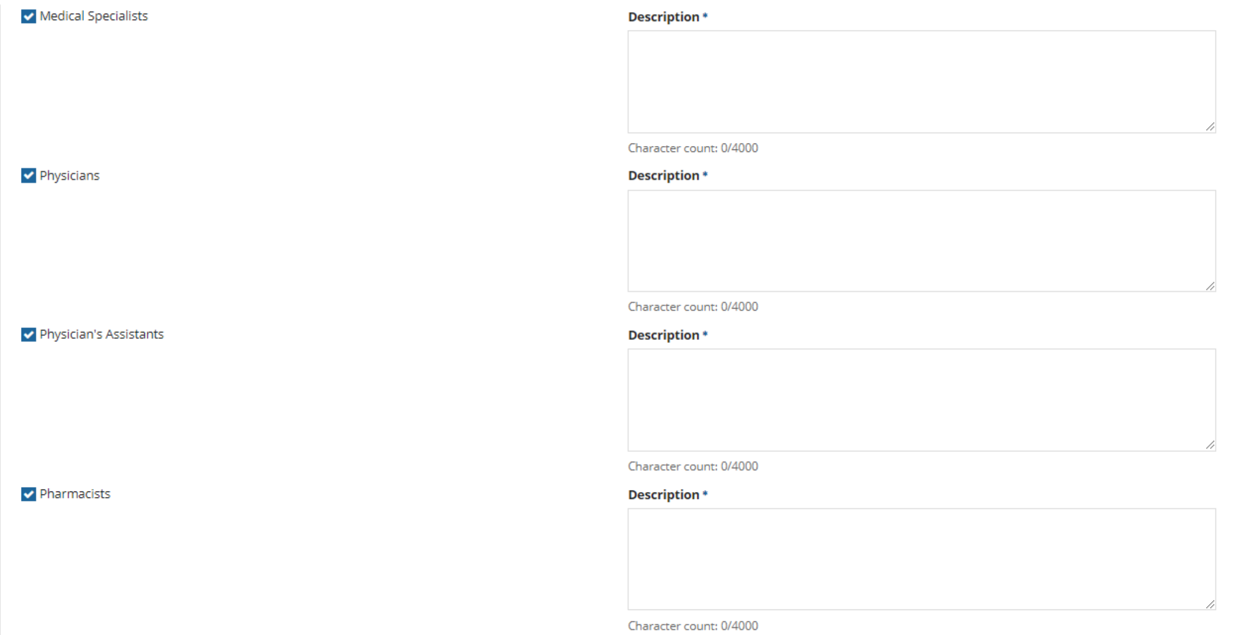


Figure 17: Service Definitions - 17

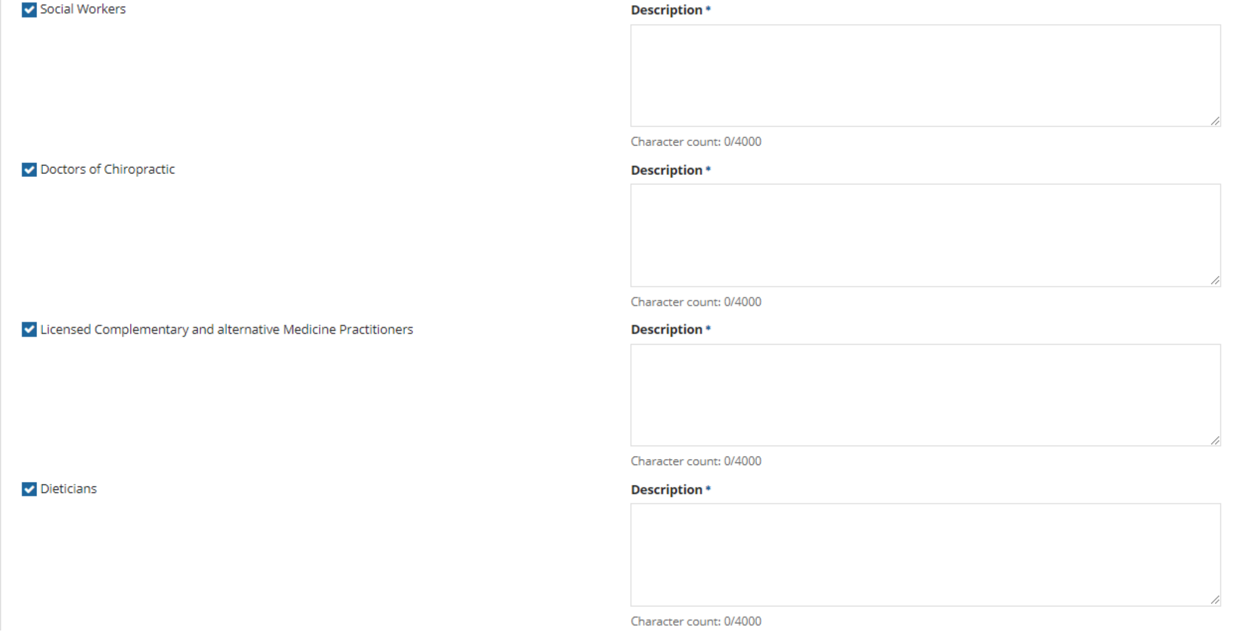


Figure 18: Service Definitions - 18

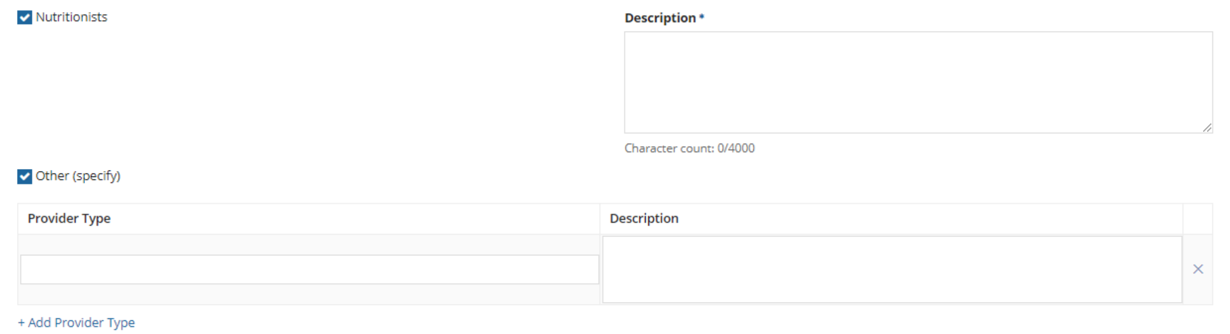


Figure 19: Service Definitions - 19

1.4 "Service Definitions" Section – Comprehensive Transitional Care from Inpatient to Other Settings

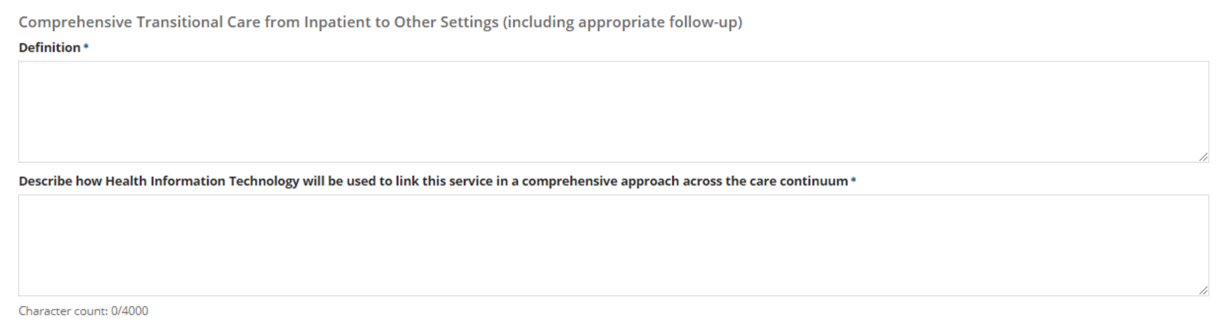


Figure 20: Service Definitions - 20

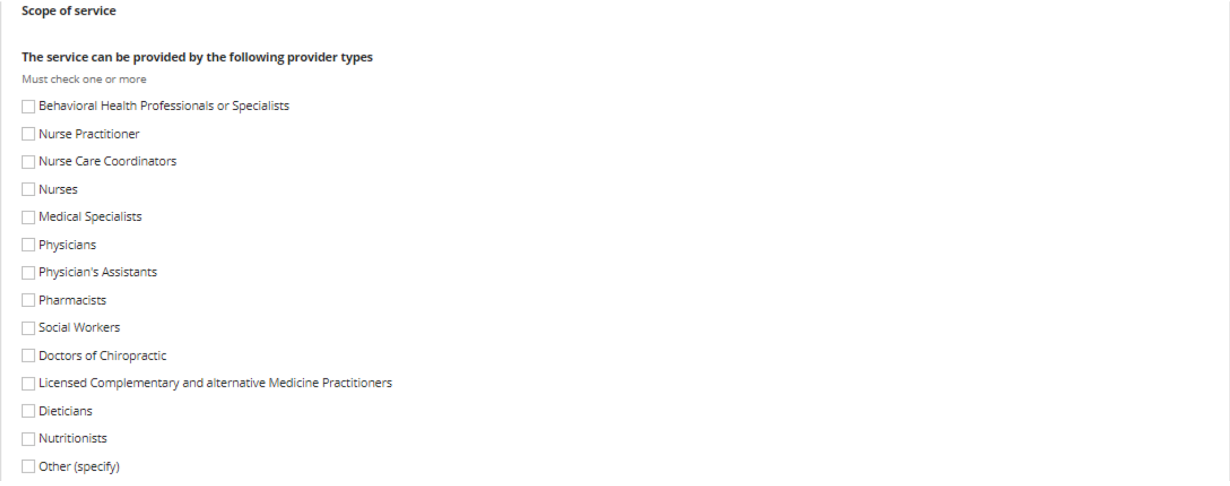


Figure 21: Service Definitions - 21

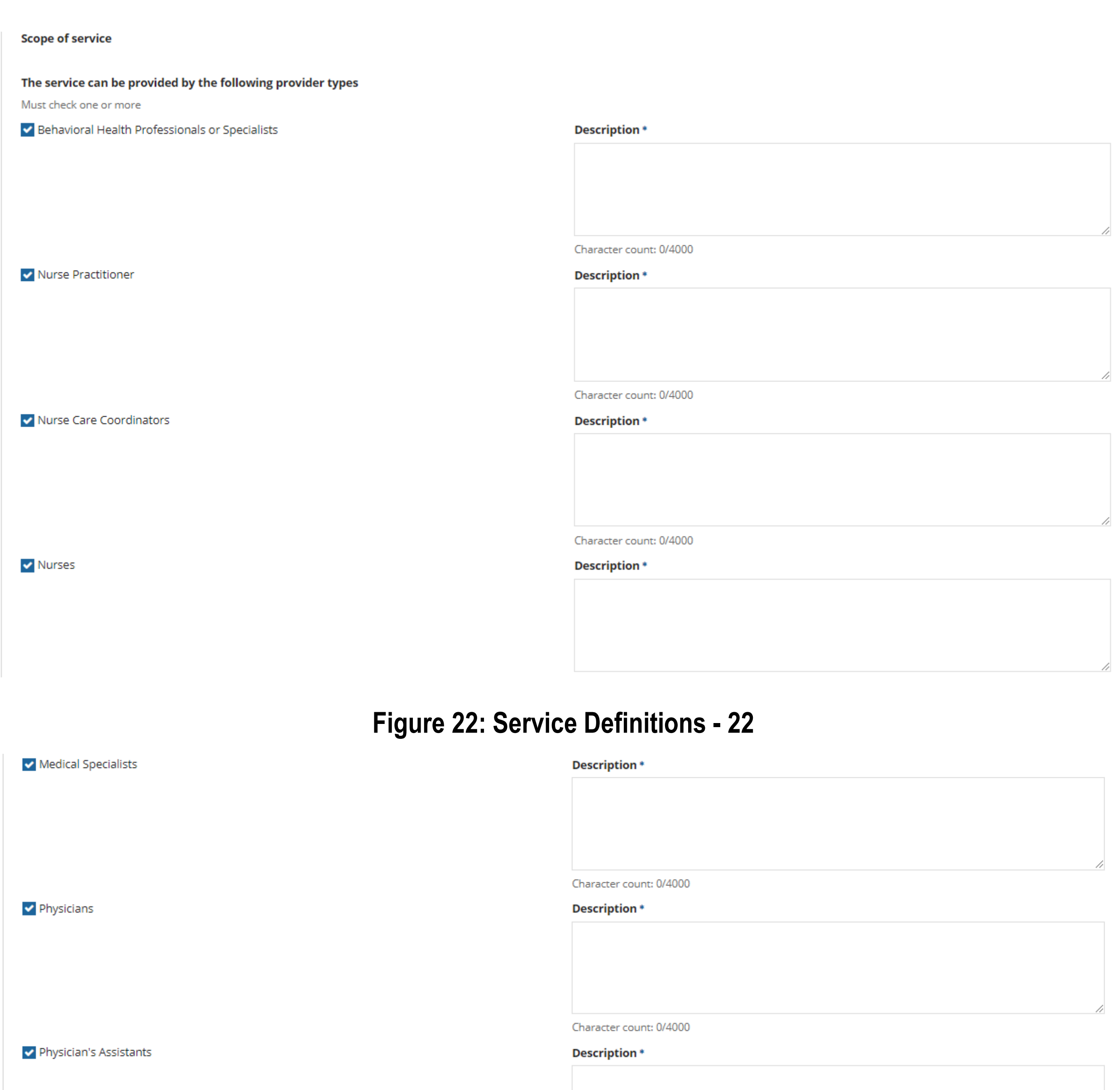


Figure 22: Service Definitions - 22

Medical Specialists

Description *

Character count: 0/4000

Physicians

Description *

Character count: 0/4000

Physician's Assistants

Description *

Character count: 0/4000

Pharmacists

Description *

Character count: 0/4000

Figure 23: Service Definitions - 23

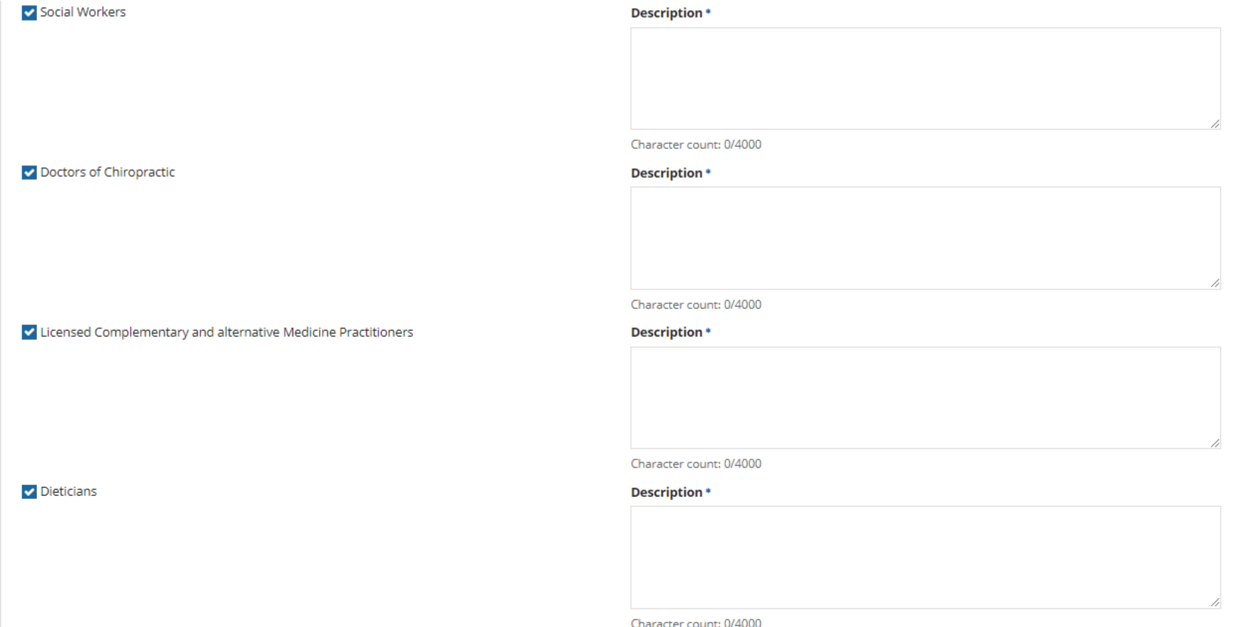


Figure 24: Service Definitions - 24

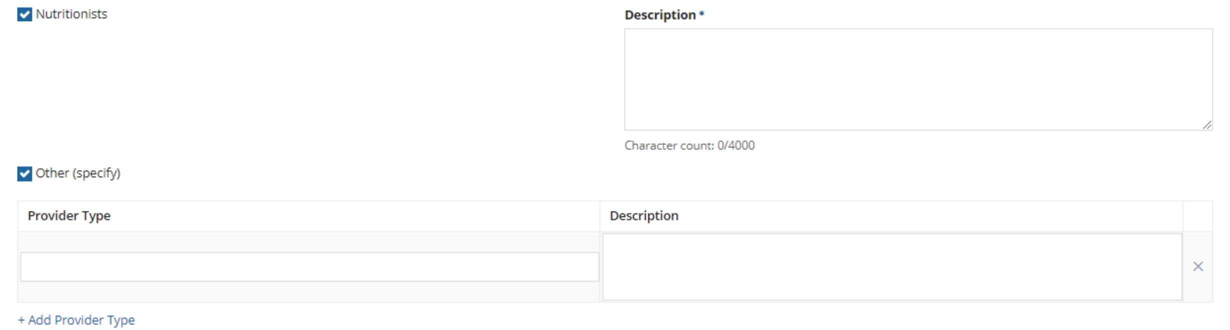


Figure 25: Service Definitions - 25

1.5 "Service Definitions" Section – Individual and Family Support

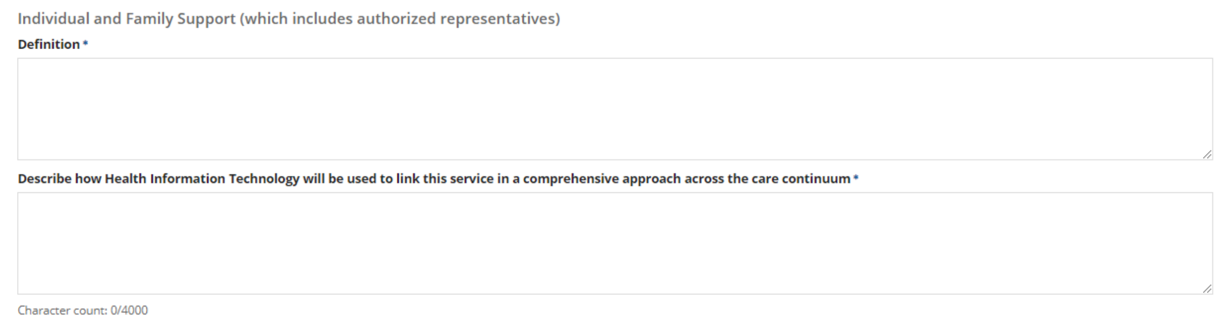


Figure 26: Service Definitions - 26

Scope of service

The service can be provided by the following provider types

Must check one or more

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Figure 27: Service Definitions - 27

Scope of service

The service can be provided by the following provider types

Must check one or more

- [x] Behavioral Health Professionals or Specialists

Description *

Character count: 0/4000

- [x] Nurse Practitioner

Description *

Character count: 0/4000

- [x] Nurse Care Coordinators

Description *

Character count: 0/4000

- [x] Nurses

Description *

Figure 28: Service Definitions - 28

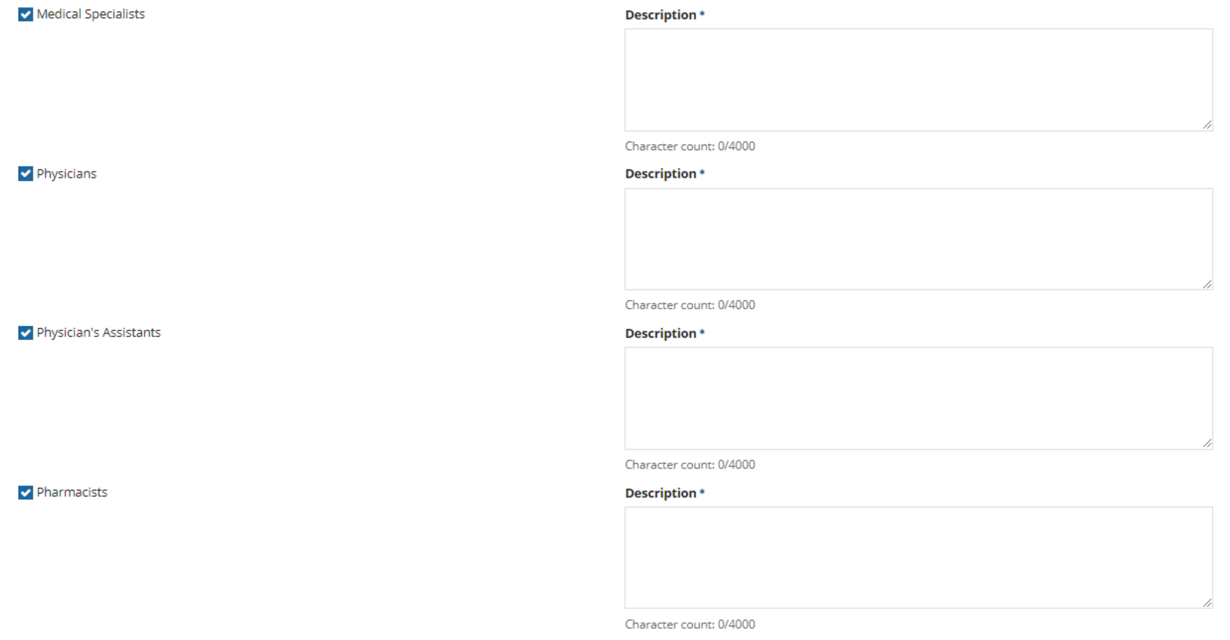


Figure 29: Service Definitions - 29

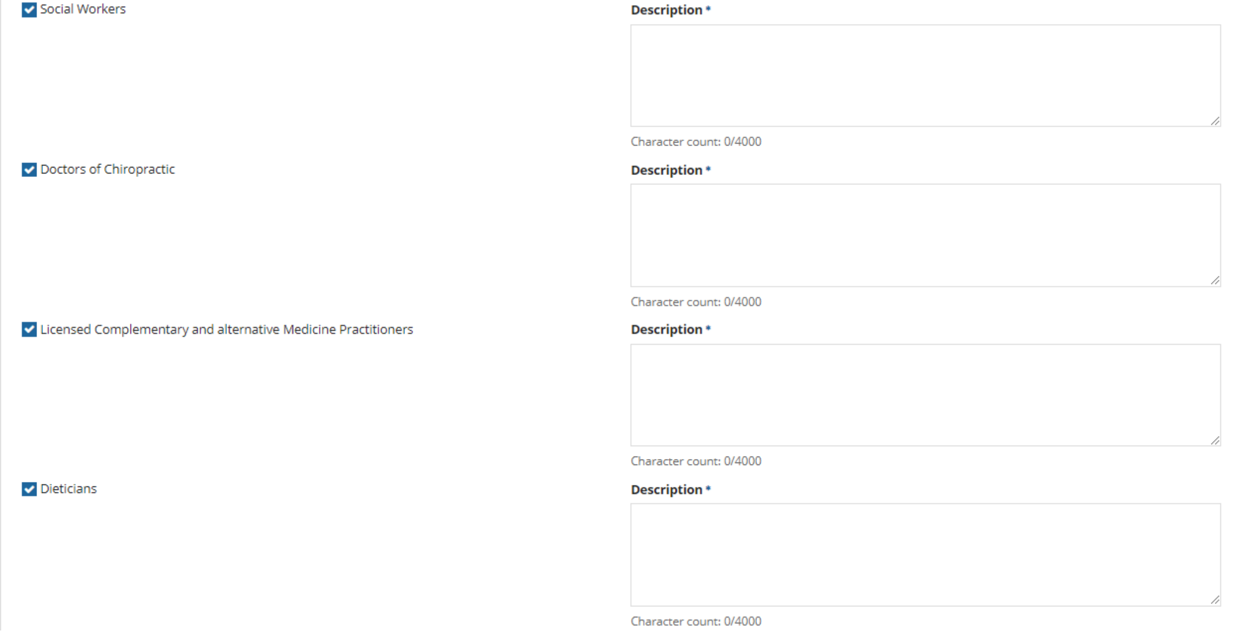


Figure 30: Service Definitions - 30

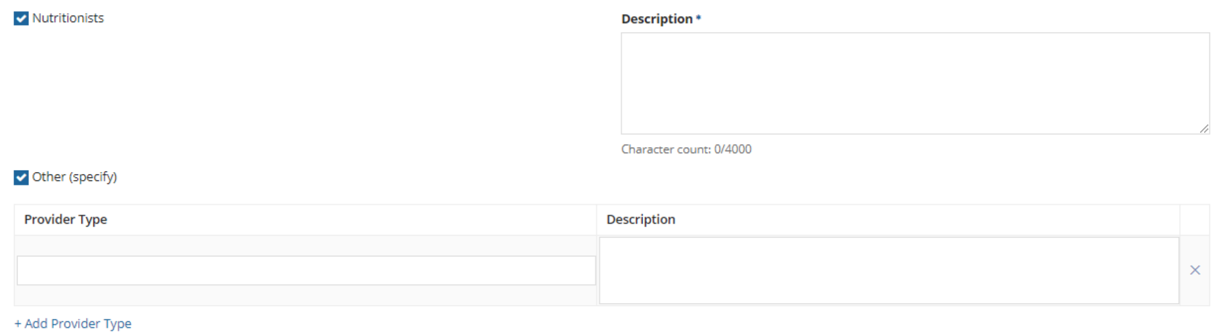


Figure 31: Service Definitions - 31

1.6 "Service Definitions" Section – Referral to Community and Social Support Services

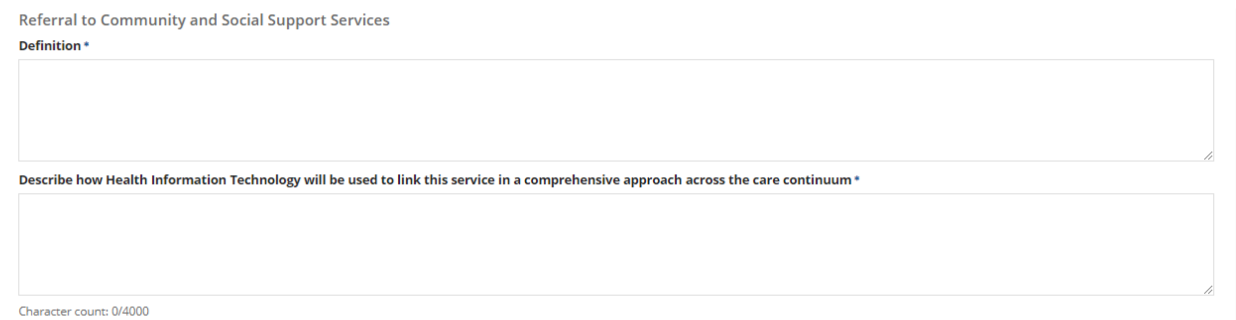


Figure 32: Service Definitions - 32

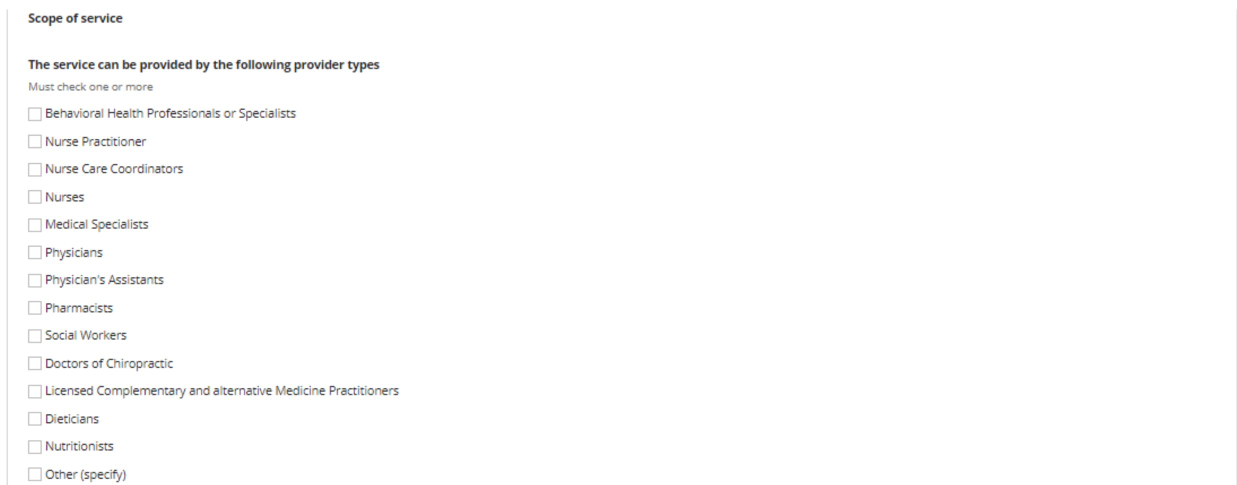


Figure 33: Service Definitions - 33

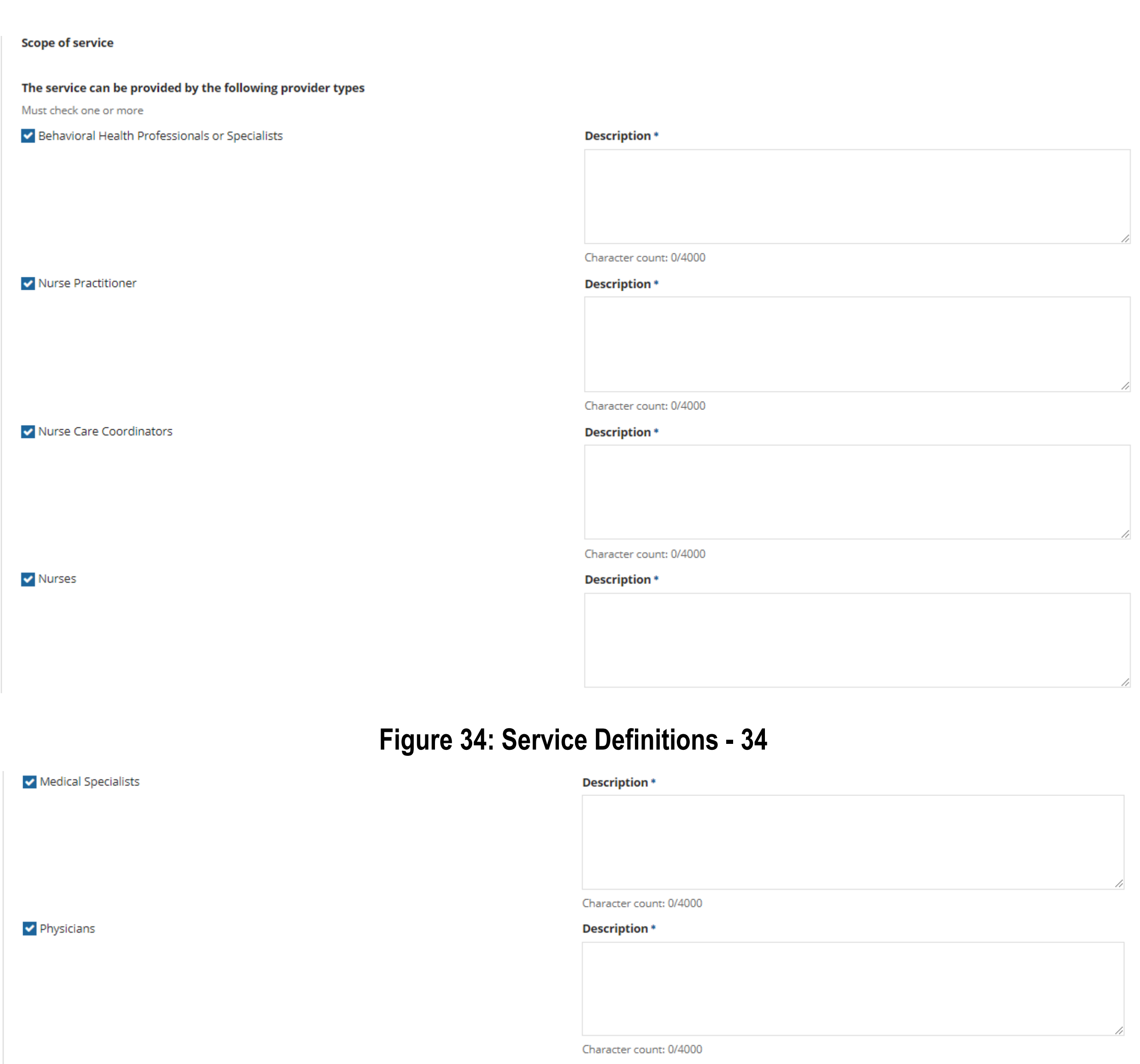


Figure 34: Service Definitions - 34

Medical Specialists

Description *

Character count: 0/4000

Physicians

Description *

Character count: 0/4000

Physician's Assistants

Description *

Character count: 0/4000

Pharmacists

Description *

Character count: 0/4000

Figure 35: Service Definitions - 35

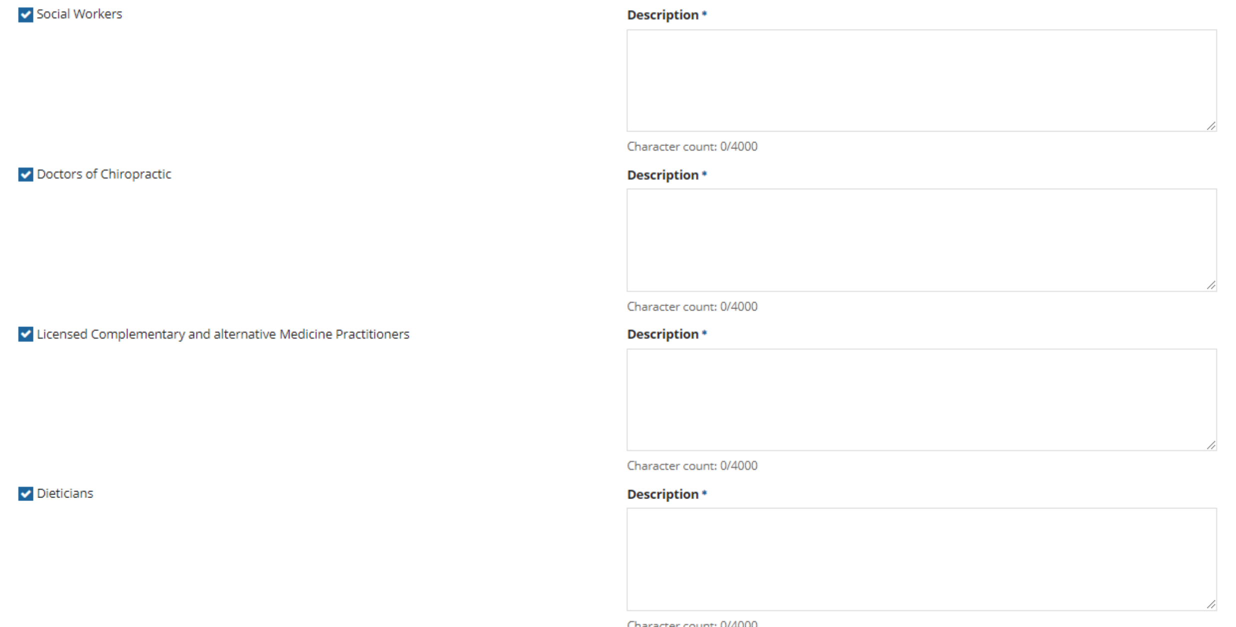


Figure 36: Service Definitions - 36

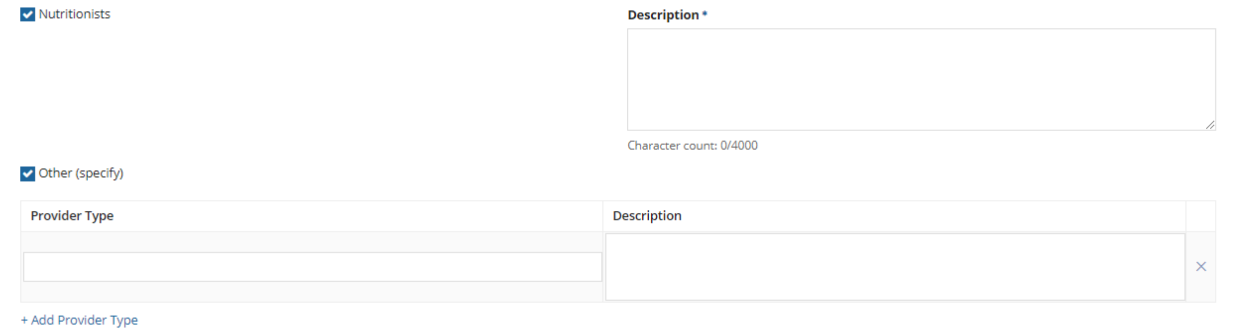


Figure 37: Service Definitions - 37

1.7 "Health Homes Patient Flow" Section

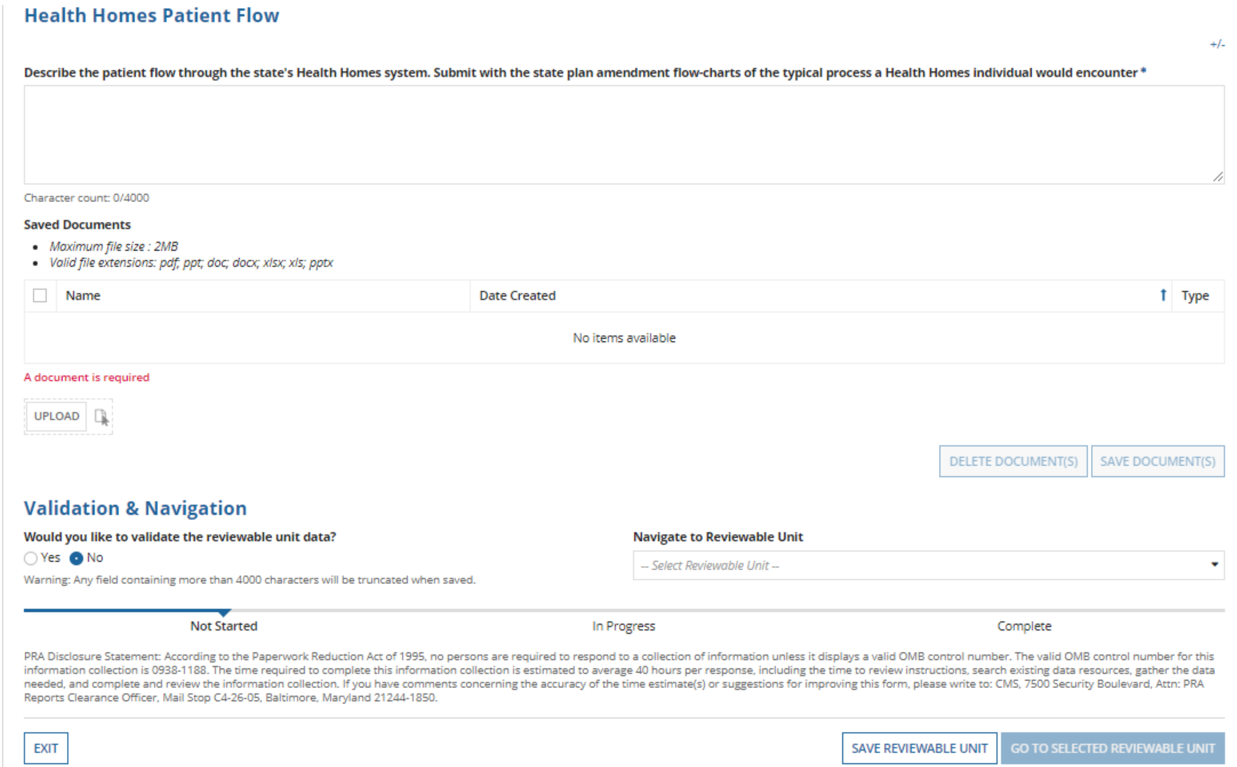


Figure 38: Health Homes Patient Flow

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH5-Health Homes Providers RU PRA document

Version 1.0

08/11/2017

Document Number: 164-QSSI_MACPro-PRA-HH5-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. HH5 – Health Homes Providers Screenshots

1.1 "Types of Health Homes Providers" Section

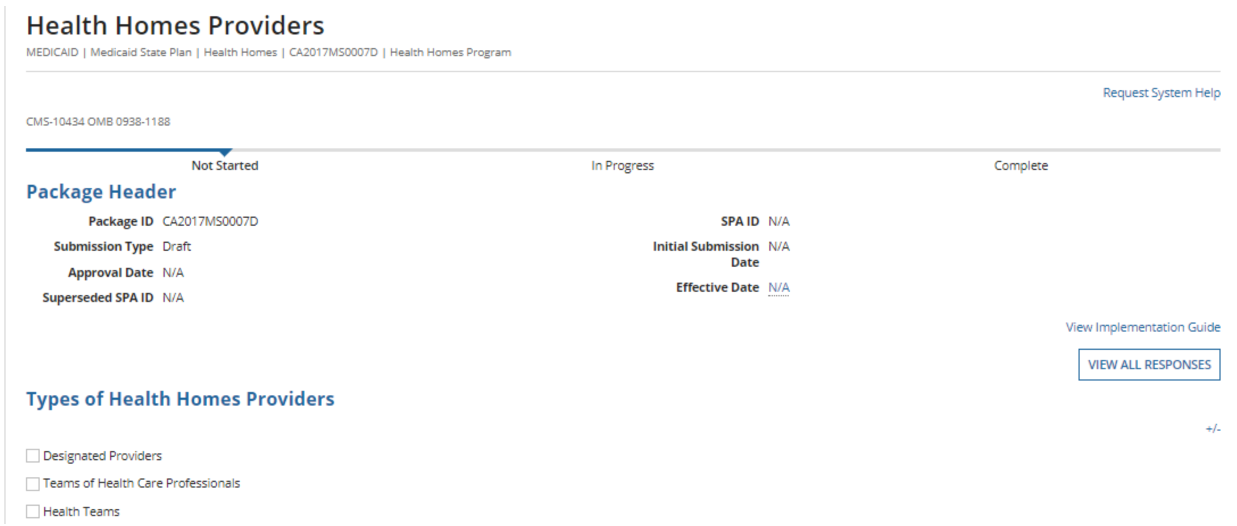


Figure 1: Types of Health Homes Providers -1

1.2 "Types of Health Homes Providers" Section – Path 1

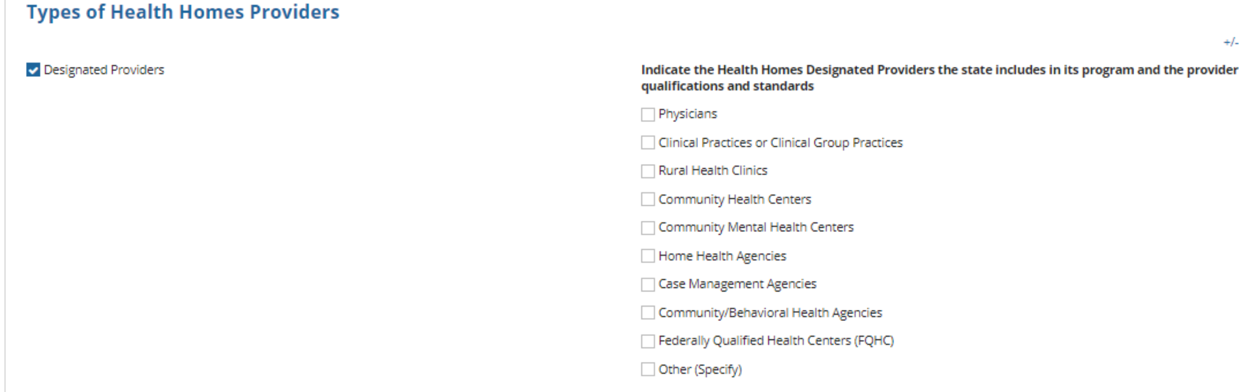


Figure 2: Types of Health Homes Providers -2

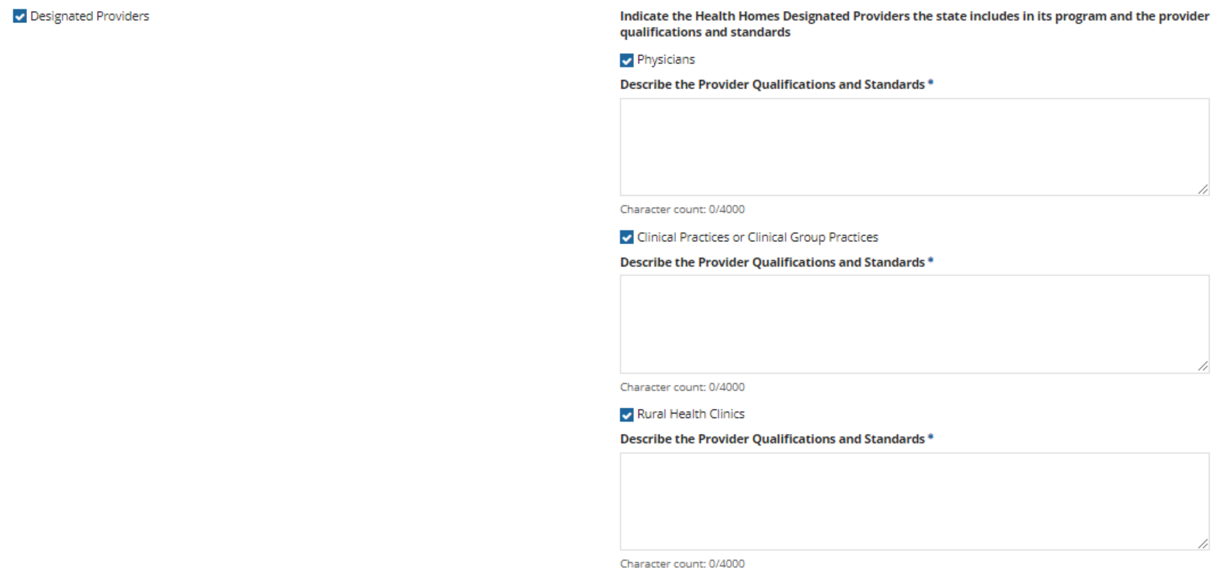


Figure 3: Types of Health Homes Providers -3

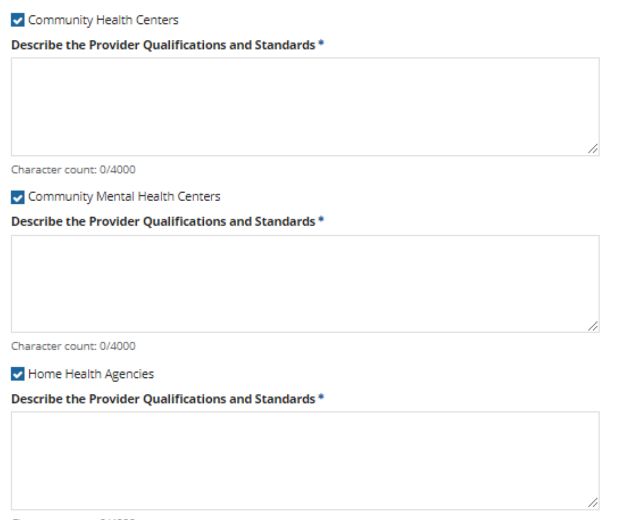


Figure 4: Types of Health Homes Providers -4

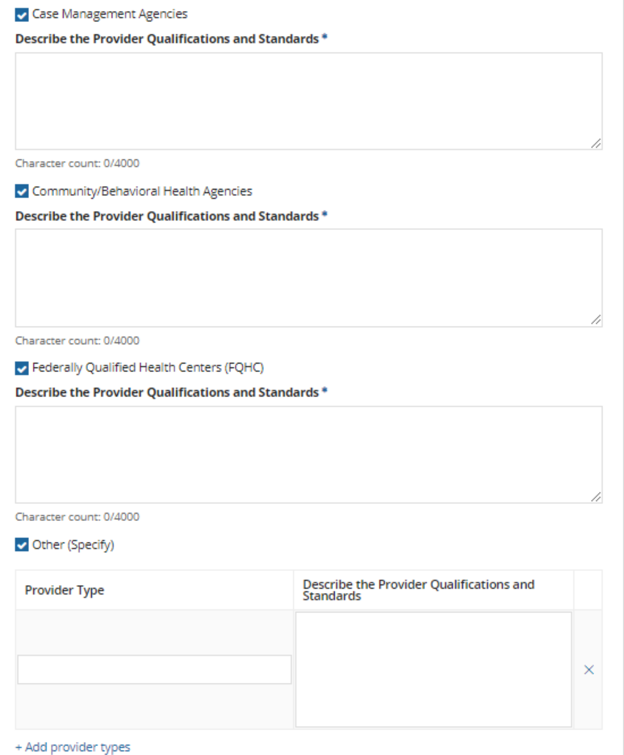


Figure 5: Types of Health Homes Providers -5

1.3 "Types of Health Homes Providers" Section – Path 2

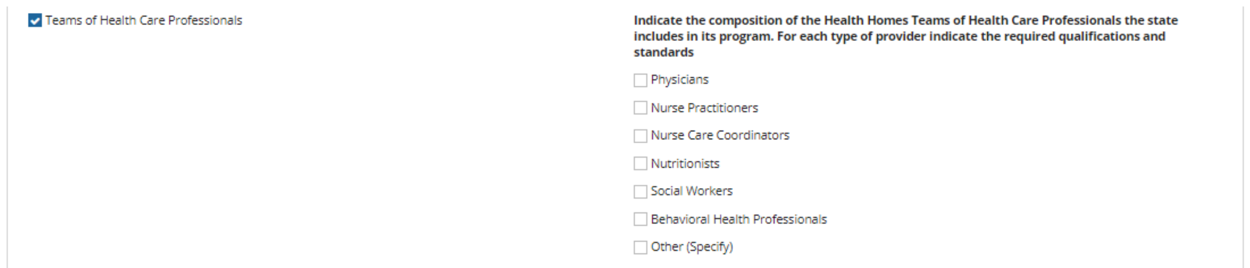
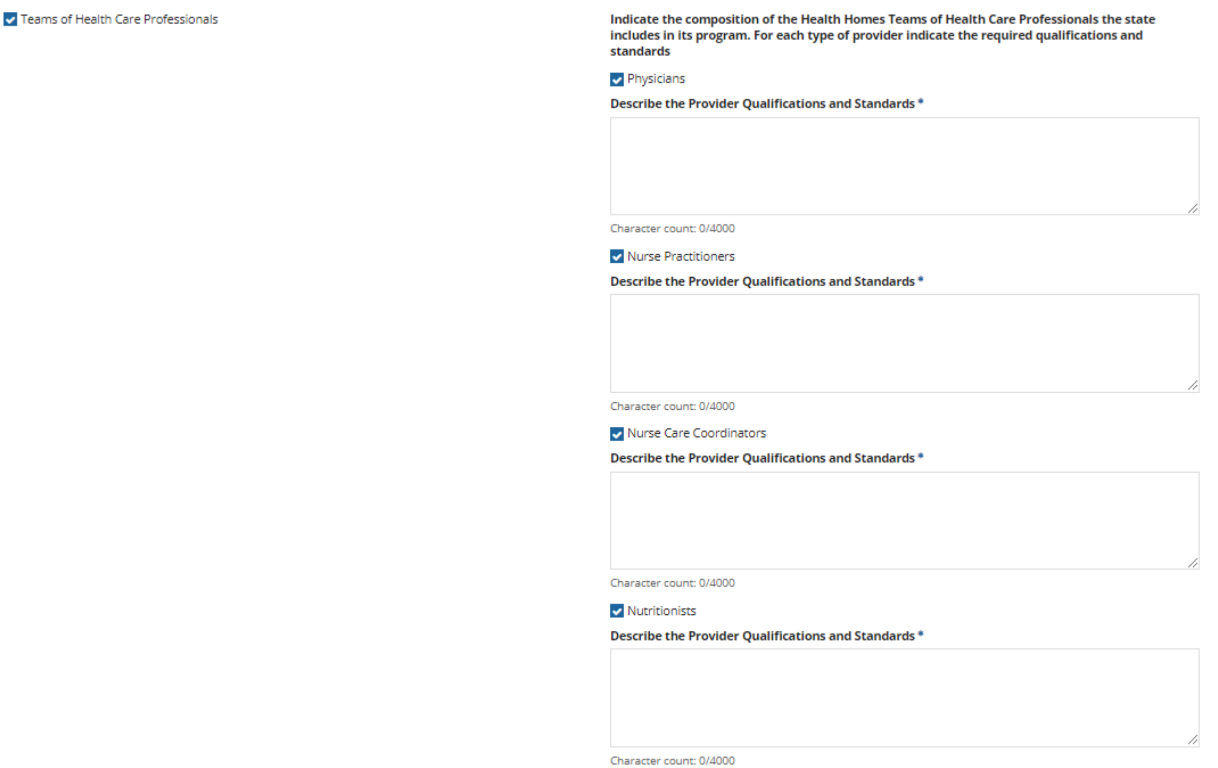


Figure 6: Types of Health Homes Providers -6


Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

Physicians

Describe the Provider Qualifications and Standards *

Character count: 0/4000

Nurse Practitioners

Describe the Provider Qualifications and Standards *

Character count: 0/4000

Nurse Care Coordinators

Describe the Provider Qualifications and Standards *

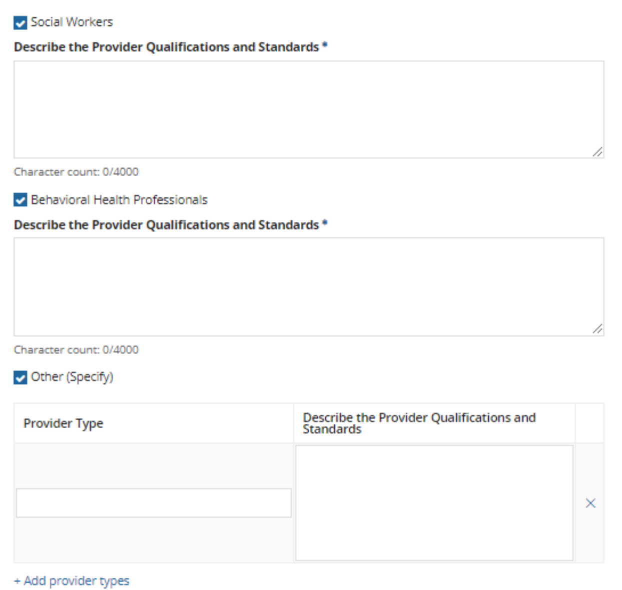
Character count: 0/4000

Nutritionists

Describe the Provider Qualifications and Standards *

Character count: 0/4000

Figure 7: Types of Health Homes Providers -7


Social Workers

Describe the Provider Qualifications and Standards *

Character count: 0/4000

Behavioral Health Professionals

Describe the Provider Qualifications and Standards *

Character count: 0/4000

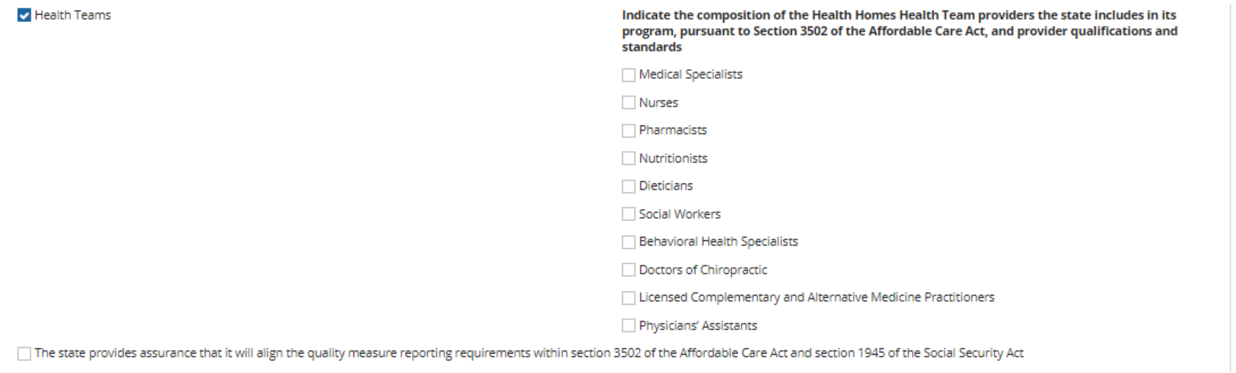
Other (Specify)

Provider Type	Describe the Provider Qualifications and Standards

+ Add provider types

Figure 8: Types of Health Homes Providers -8

1.4 "Types of Health Homes Providers" Section – Path 3



☑ Health Teams

Indicate the composition of the Health Homes Health Team providers the state includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards

☐ Medical Specialists

☐ Nurses

☐ Pharmacists

☐ Nutritionists

☐ Dieticians

☐ Social Workers

☐ Behavioral Health Specialists

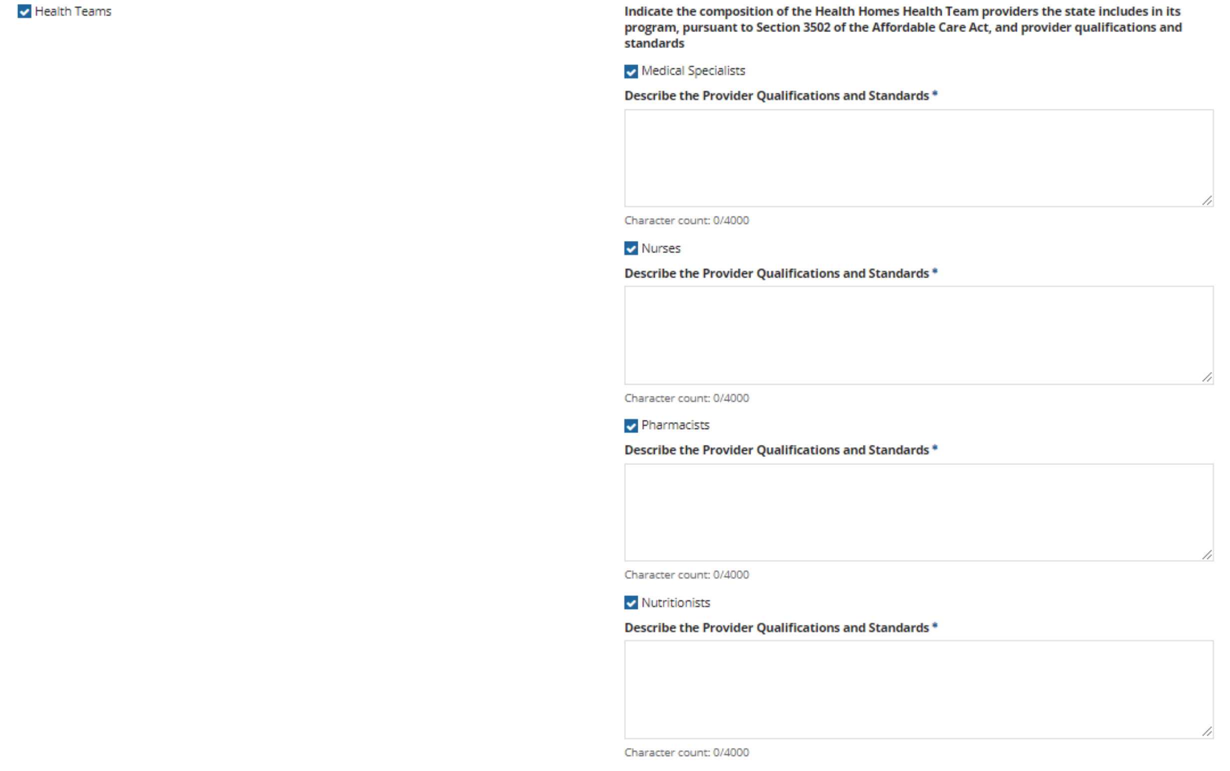
☐ Doctors of Chiropractic

☐ Licensed Complementary and Alternative Medicine Practitioners

☐ Physicians' Assistants

☐ The state provides assurance that it will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945 of the Social Security Act

Figure 9: Types of Health Homes Providers -9



☑ Health Teams

Indicate the composition of the Health Homes Health Team providers the state includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards

☑ Medical Specialists

Describe the Provider Qualifications and Standards *

Character count: 0/4000

☑ Nurses

Describe the Provider Qualifications and Standards *

Character count: 0/4000

☑ Pharmacists

Describe the Provider Qualifications and Standards *

Character count: 0/4000

☑ Nutritionists

Describe the Provider Qualifications and Standards *

Character count: 0/4000

Figure 10: Types of Health Homes Providers -10

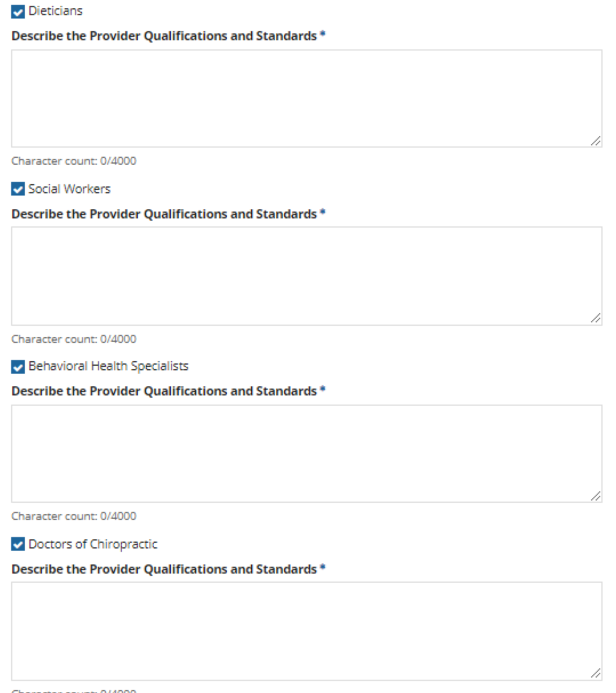


Figure 11: Types of Health Homes Providers -11

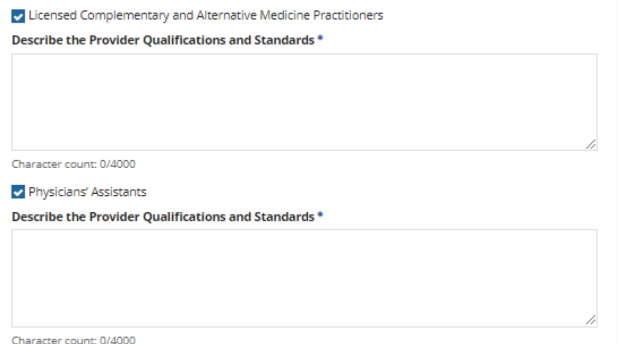
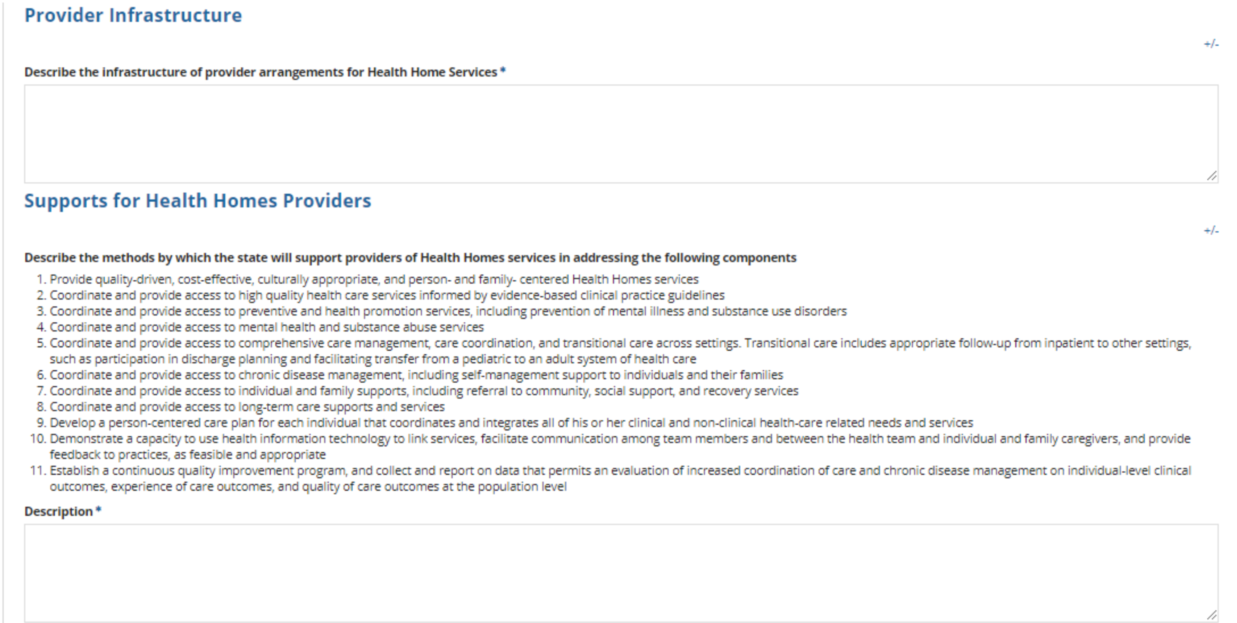


Figure 12: Types of Health Homes Providers -12

1.5 "Provider Infrastructure" and "Supports for Health Homes Providers" Sections


Provider Infrastructure

+/-

Describe the infrastructure of provider arrangements for Health Home Services *

Supports for Health Homes Providers

+/-

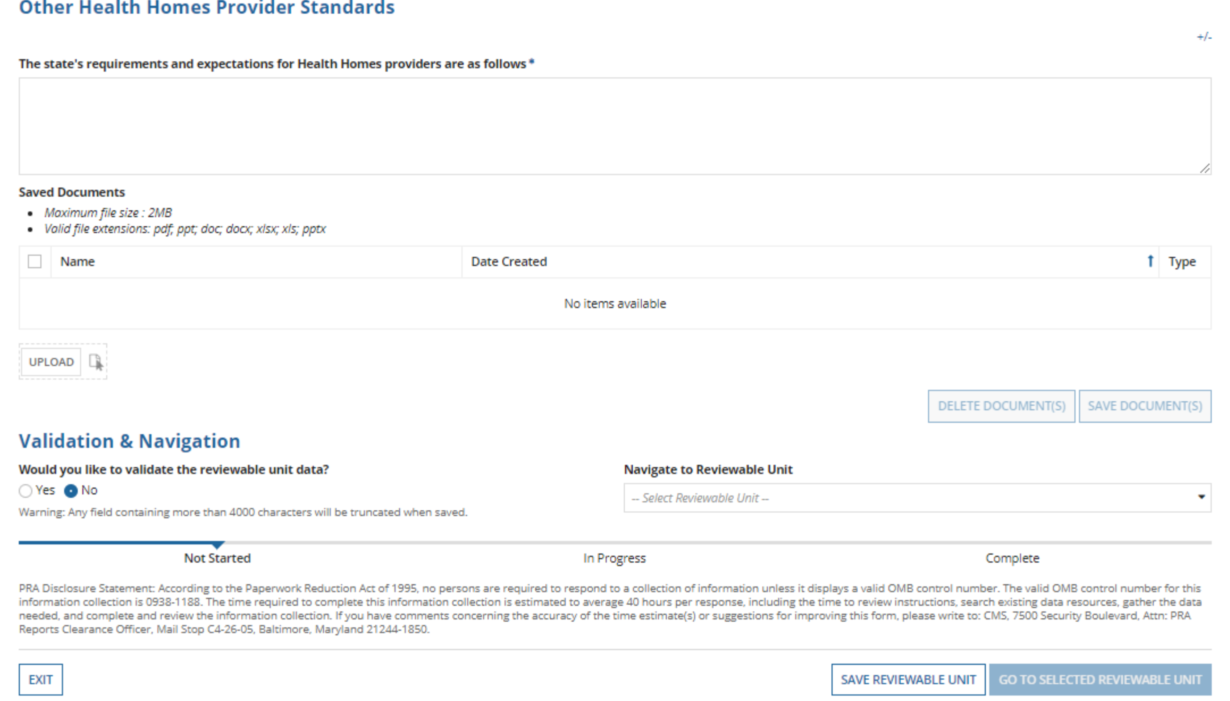
Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description *

Figure 13: Provider Infrastructure and Supports for Health Homes Providers

1.6 "Other Health Homes Provider Standards" Section


Other Health Homes Provider Standards

+/-

The state's requirements and expectations for Health Homes providers are as follows *

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

	Name	Date Created	Type
	No items available		

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

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PRA Disclosure Statement: 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 average 40 hours per response, 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.

EXIT

SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 14: Other Health Homes Provider Standards

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH6-Health Homes Delivery Systems PRA document

Version 1.0

08/16/2017

Document Number: 184-QSSI-MACPro-PRAHH6-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 9: Health Homes Service Delivery – 9.. 4
Figure 10: Health Homes Service Delivery – 10.. 5

1. HH6-Health Homes Service Delivery Systems – Screenshots

1.1 Health Homes Service Delivery Systems

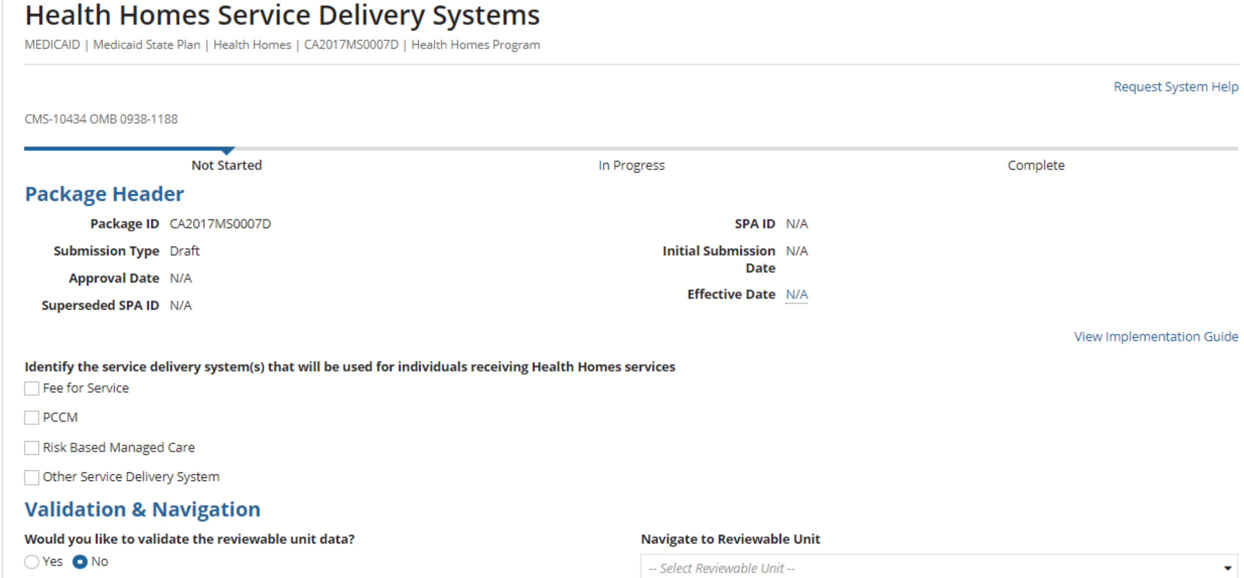


Figure 1 : Health Homes Service Delivery - 1

1.2 Health Homes Service Delivery Systems – Path 1

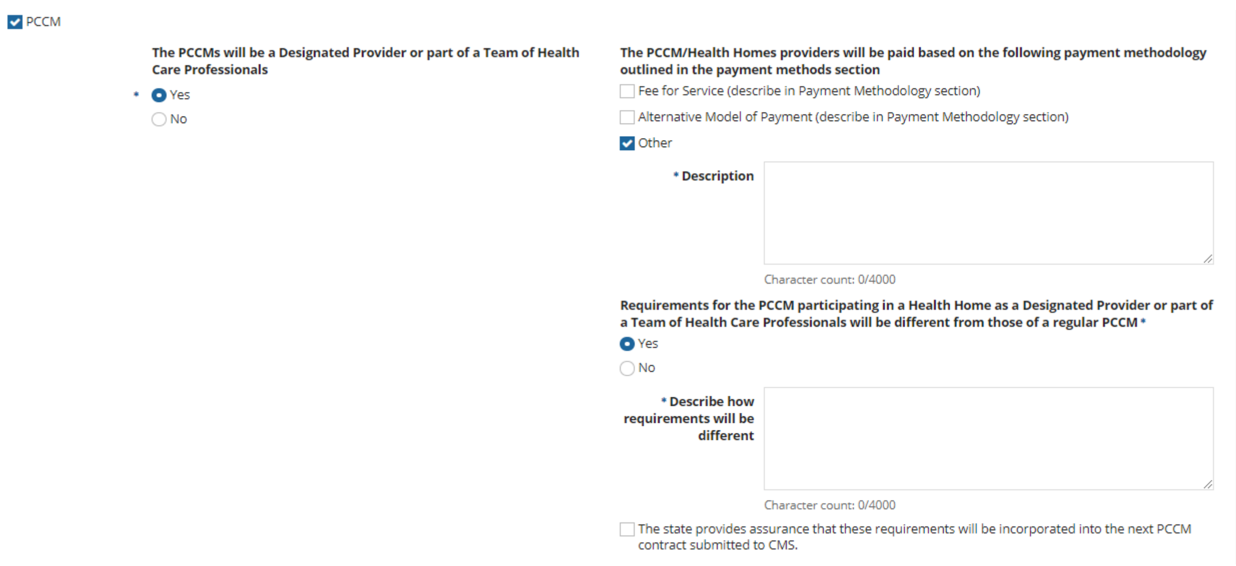
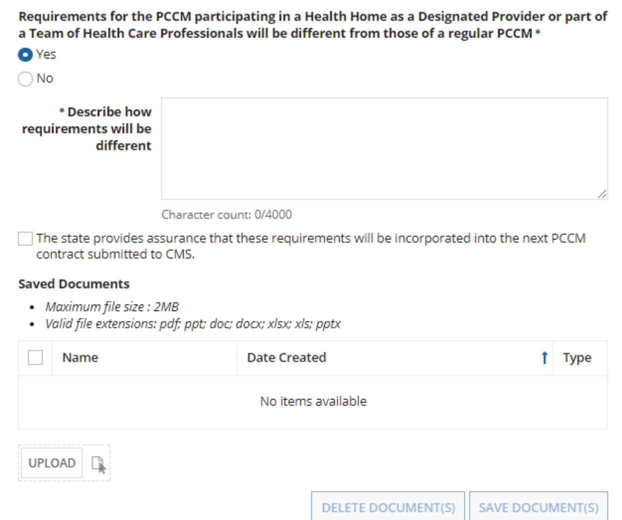


Figure 2: Health Homes Service Delivery - 2


Requirements for the PCCM participating in a Health Home as a Designated Provider or part of a Team of Health Care Professionals will be different from those of a regular PCCM *

Yes

No

* Describe how requirements will be different

Character count: 0/4000

The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

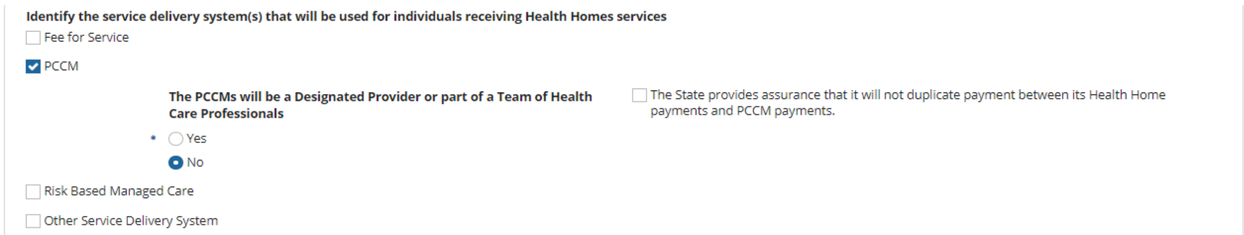
	Name	Date Created	Type
	No items available		

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 3: Health Homes Service Delivery - 3

1.3 Health Homes Service Delivery Systems – Path 2


Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

Fee for Service

PCCM

The PCCMs will be a Designated Provider or part of a Team of Health Care Professionals

* Yes

No

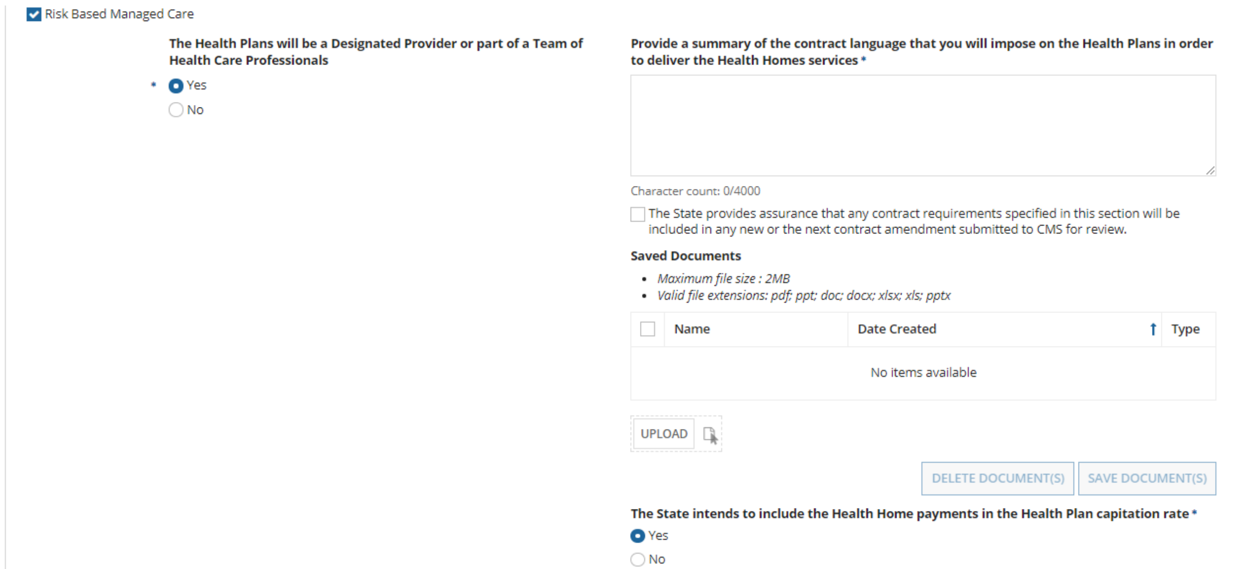
The State provides assurance that it will not duplicate payment between its Health Home payments and PCCM payments.

Risk Based Managed Care

Other Service Delivery System

Figure 4: Health Homes Service Delivery – 4

1.4 Health Homes Service Delivery Systems – Path 3



☑ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ◉ Yes
- ○ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services *

Character count: 0/4000

☐ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

☐	Name	Date Created	Type
No items available			

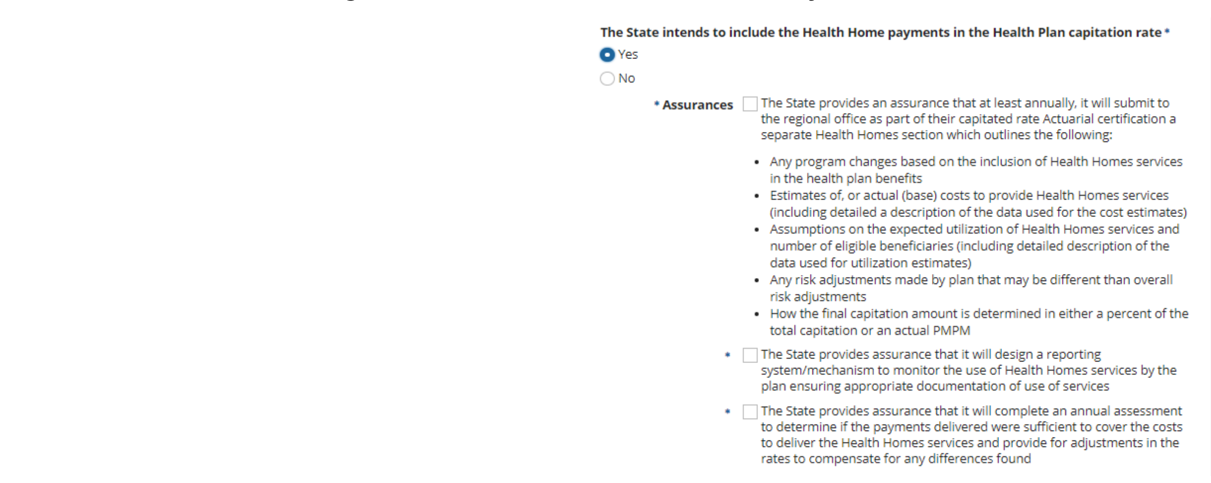
UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

The State intends to include the Health Home payments in the Health Plan capitation rate *

- ◉ Yes
- ○ No

Figure 5: Health Homes Service Delivery – 5



The State intends to include the Health Home payments in the Health Plan capitation rate *

- ◉ Yes
- ○ No

*** Assurances**

☐ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☐ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☐ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

Figure 6: Health Homes Service Delivery – 6

1.5 Health Homes Service Delivery Systems – Path 4

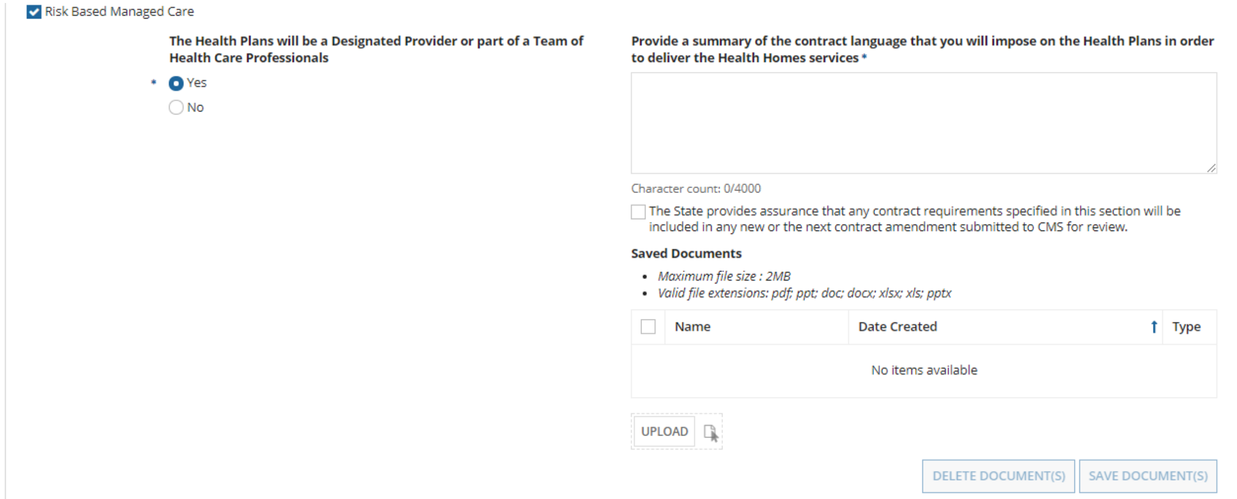


Figure 7: Health Homes Service Delivery – 7

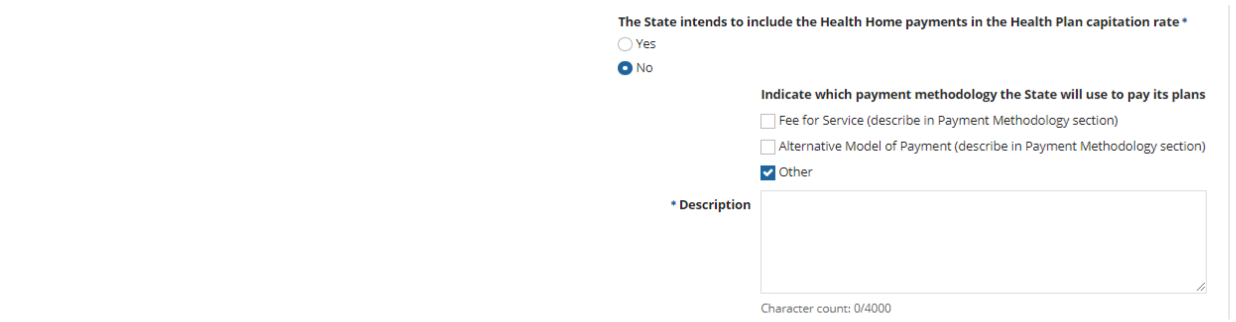


Figure 8: Health Homes Service Delivery – 8

1.6 Health Homes Service Delivery Systems – Path 5

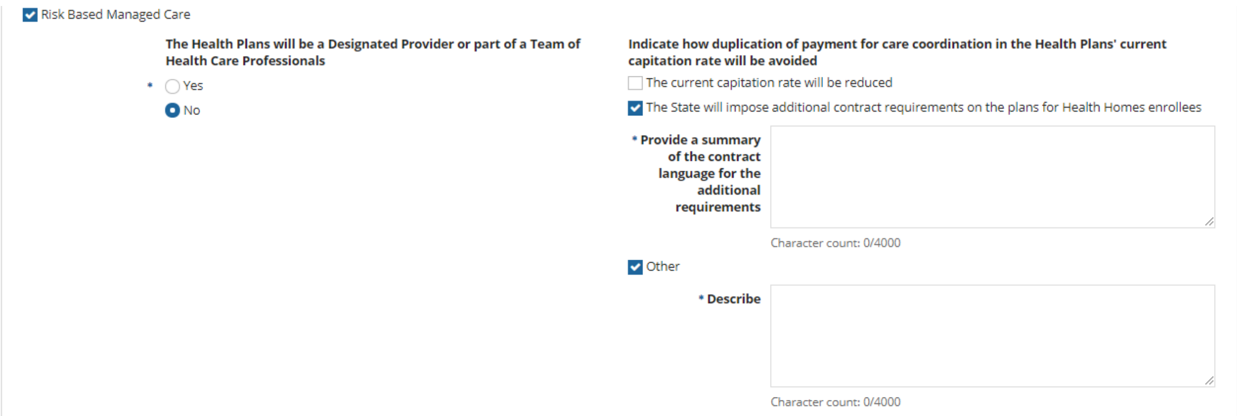


Figure 9: Health Homes Service Delivery – 9

1.7 Health Homes Service Delivery Systems – Path 6

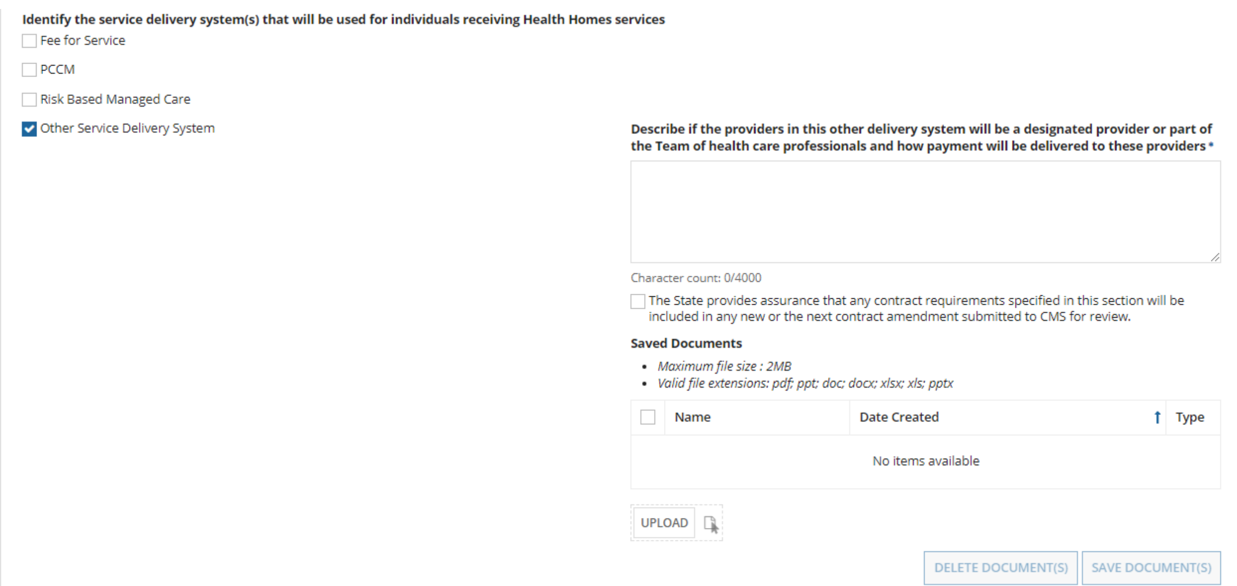


Figure 10: Health Homes Service Delivery – 10

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH7-Health Homes Payment Methodologies PRA document

Version 1.0

08/16/2017

Document Number: 185-QSSI-MACPro-PRA-HH7-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 5: Payment Methodology – 5 3

Figure 6: Assurances 3

1. HH7-Health Homes Payment Methodologies – Screenshots

1.1 "Payment Methodology" Section

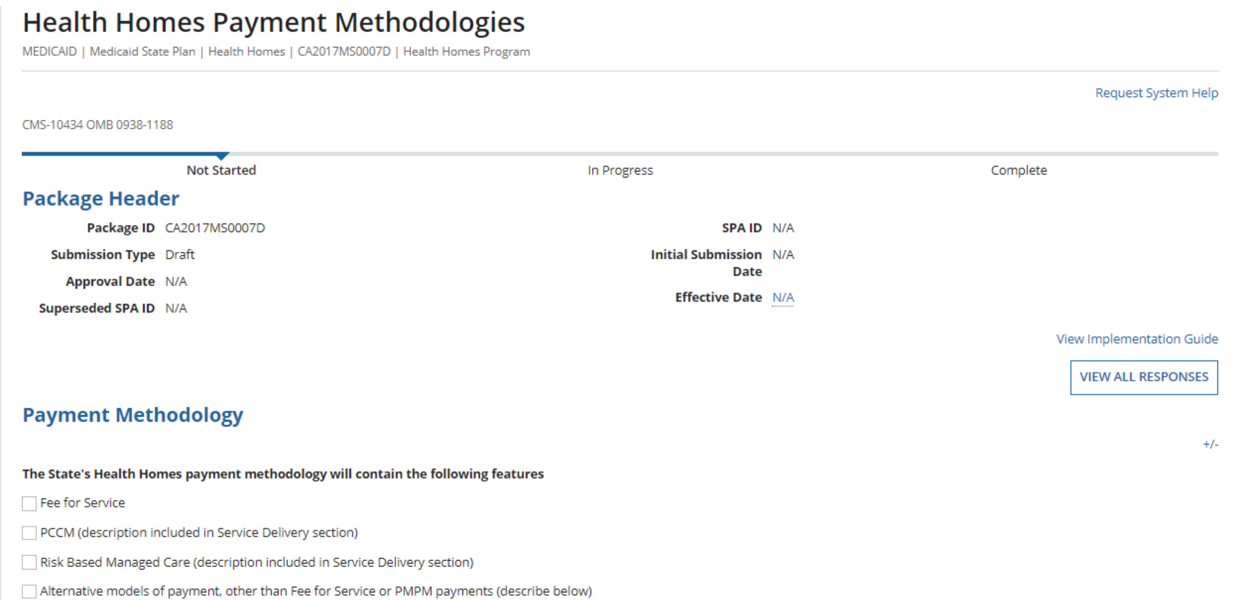

Figure 1: Payment Methodology – 1

1.2 "Payment Methodology" Section – Path 1

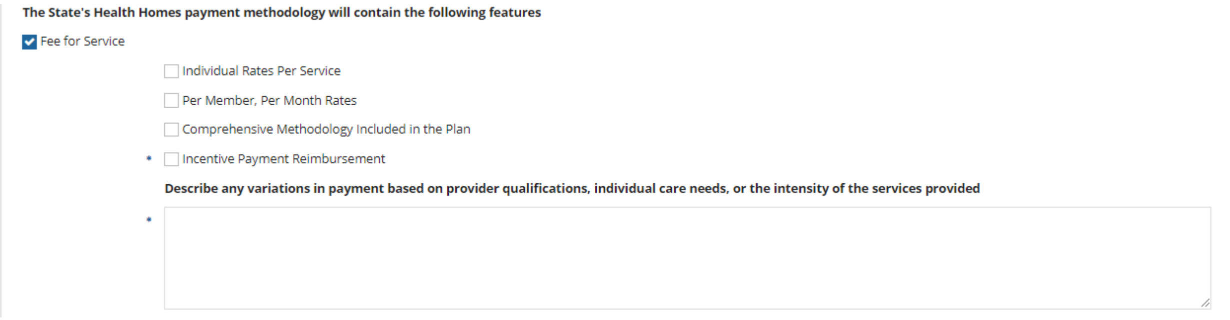

Figure 2: Payment Methodology – 2

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [x] Individual Rates Per Service
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

      Describe below
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

      Describe below

Figure 3: Payment Methodology – 3

- [x] Comprehensive Methodology Included in the Plan
  - [x] Fee for Service Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [x] Other

    Describe below
- [x] Incentive Payment Reimbursement
  - [x] Fee for Service Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [x] Other

    Describe below

Figure 4: Payment Methodology – 4

1.3 "Payment Methodology" Section – Path 2

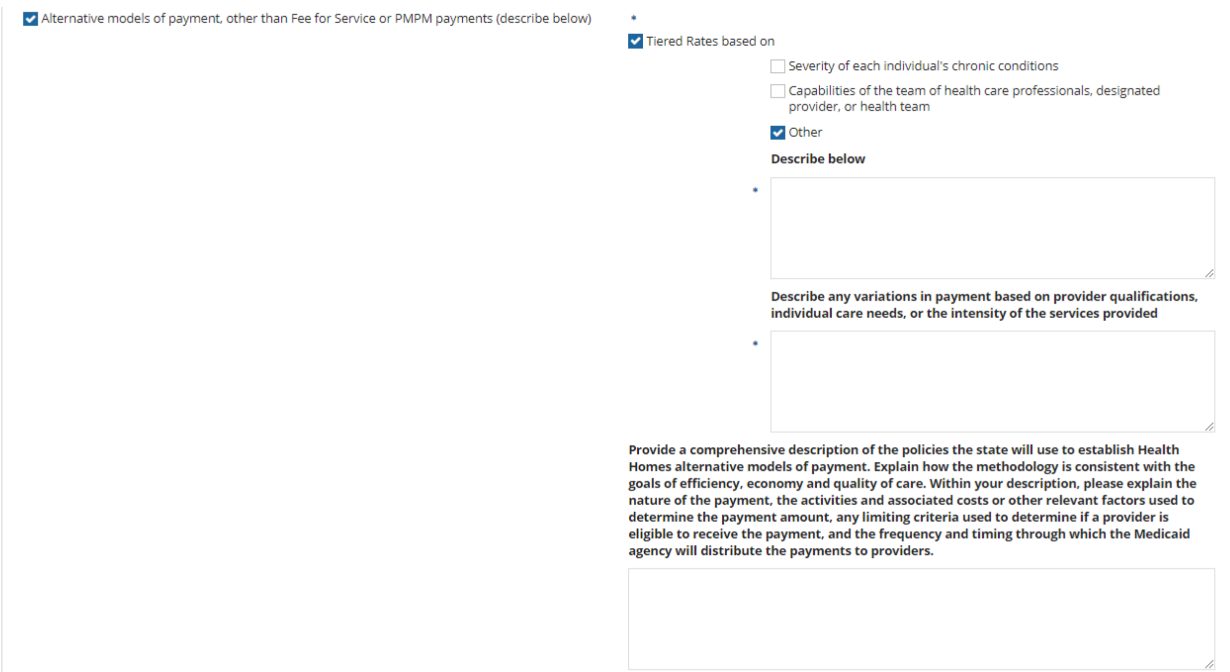

Figure 5: Payment Methodology – 5

1.4 "Assurances" Section

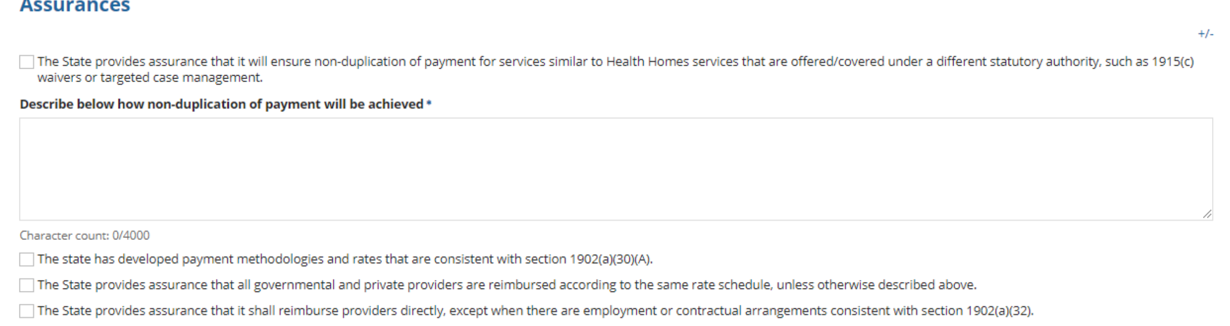

Figure 6: Assurances

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH8-Health Homes Monitoring, Quality Measurement and Evaluation PRA document

Version 1.0

08/16/2017

Document Number: 186-QSSI-MACPro-PRA-HH8-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 3: Quality Measurement and Evaluation 2

1. HH8-Health Homes Monitoring, Quality Measurement and Evaluation – Screenshots

1.1 “Monitoring” Section

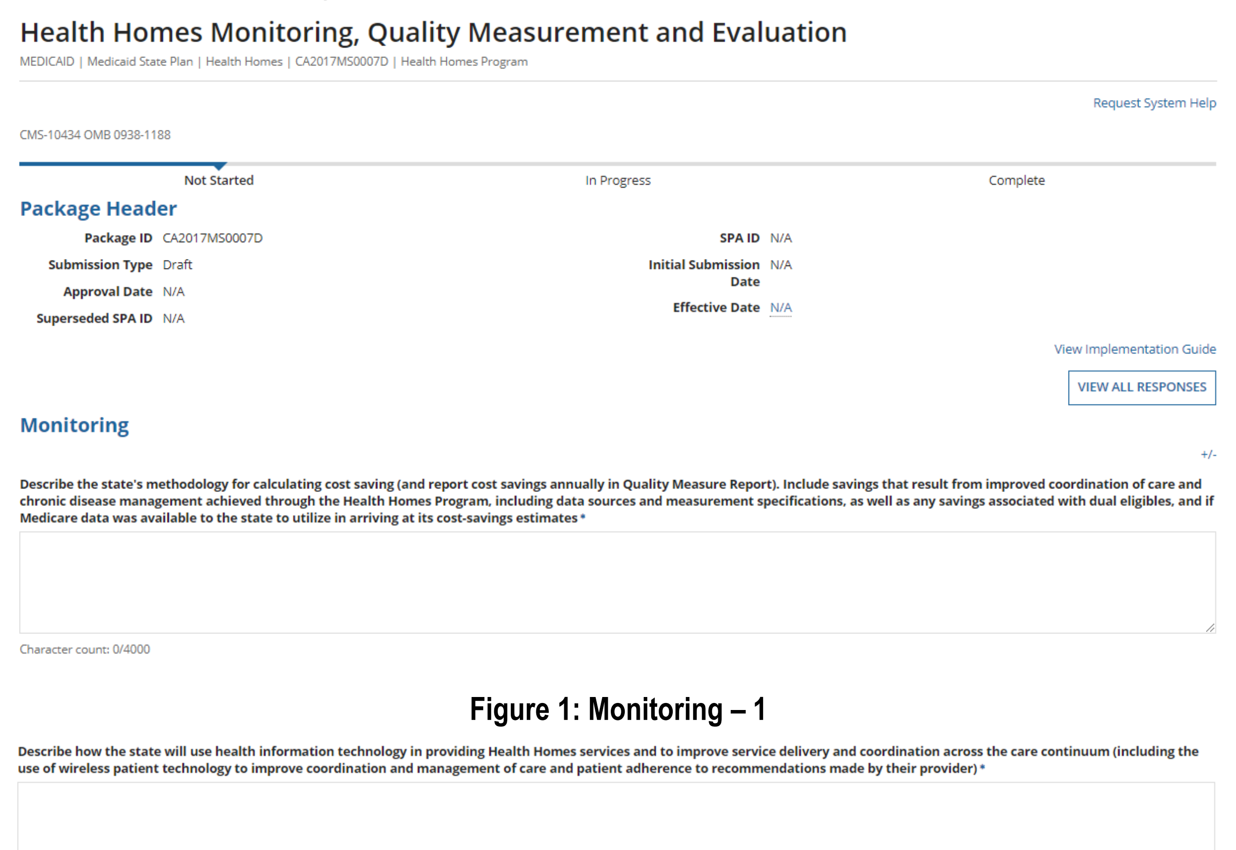
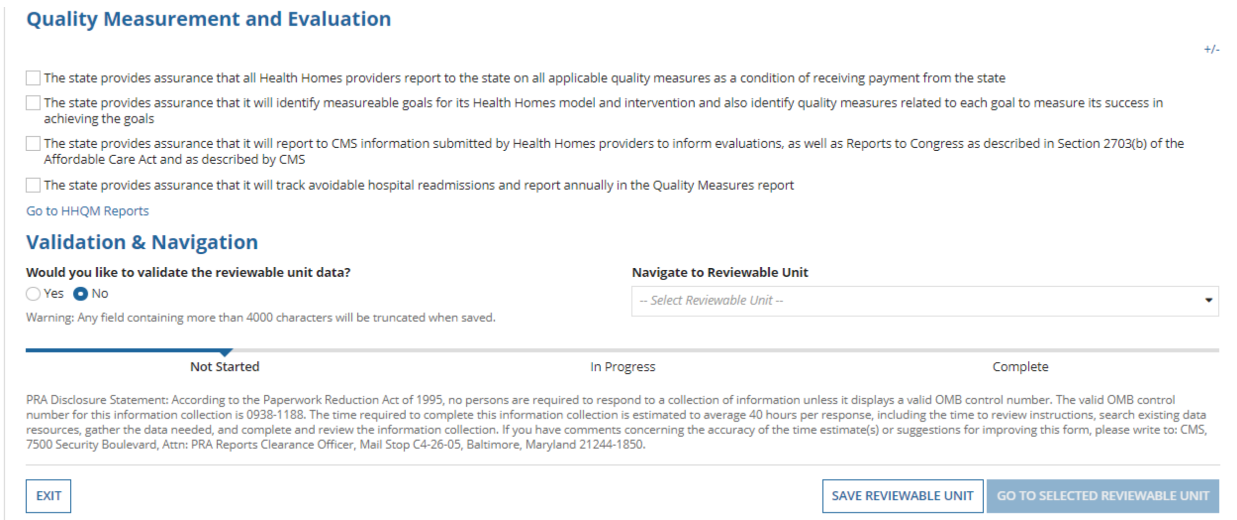


Figure 1: Monitoring – 1

Figure 2: Monitoring - 2

1.2 "Quality Measurement and Evaluation" Section



Quality Measurement and Evaluation

+/-

- [ ] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [ ] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [ ] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

Go to HHQM Reports

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started In Progress Complete

PRA Disclosure Statement: 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 average 40 hours per response, 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.

EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 3: Quality Measurement and Evaluation

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

HH9-Health Homes Program Termination PRA document

Version 1.0

08/16/2017

Document Number: 187-QSSI-MACPro-PRA-HH9-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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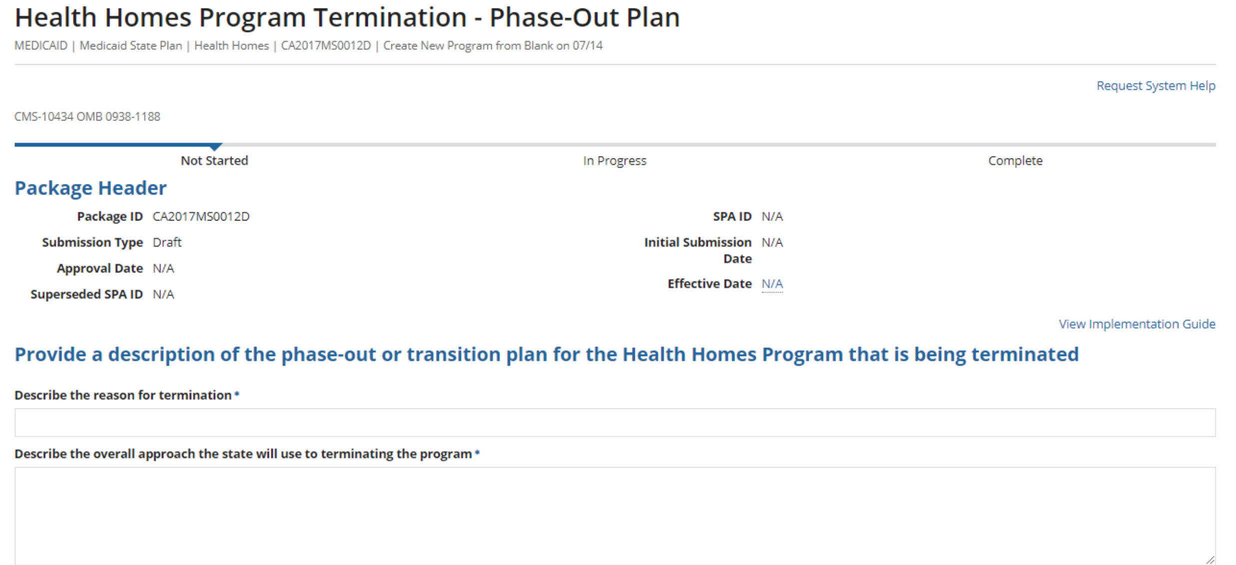
Figure 2: Health Homes Program Termination – 2 ... 1

Figure 3: Health Homes Program Termination – 3 ... 2

1. HH8-Health Homes Program Termination – Screenshots

1.1 Health Homes Program Termination



Health Homes Program Termination - Phase-Out Plan

MEDICAID | Medicaid State Plan | Health Homes | CA2017MS0012D | Create New Program from Blank on 07/14

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0012D	**SPA ID**	N/A
Submission Type	Draft	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

View Implementation Guide

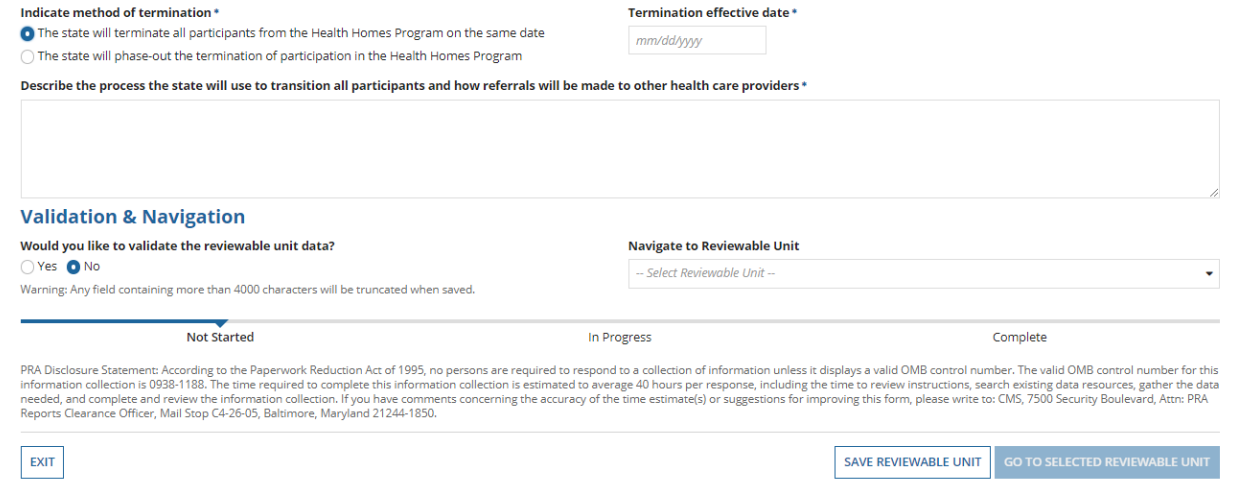
Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination *

Describe the overall approach the state will use to terminating the program *

Figure 1: Health Homes Program Termination – 1

1.2 Health Homes Program Termination – Path 1



Indicate method of termination *

- (selected) The state will terminate all participants from the Health Homes Program on the same date
- The state will phase-out the termination of participation in the Health Homes Program

Termination effective date *

mm/dd/yyyy

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers *

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No (selected)

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started In Progress Complete

PRA Disclosure Statement: 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 average 40 hours per response, 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.

EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 2: Health Homes Program Termination – 2

1.3 Health Homes Program Termination – Path 2

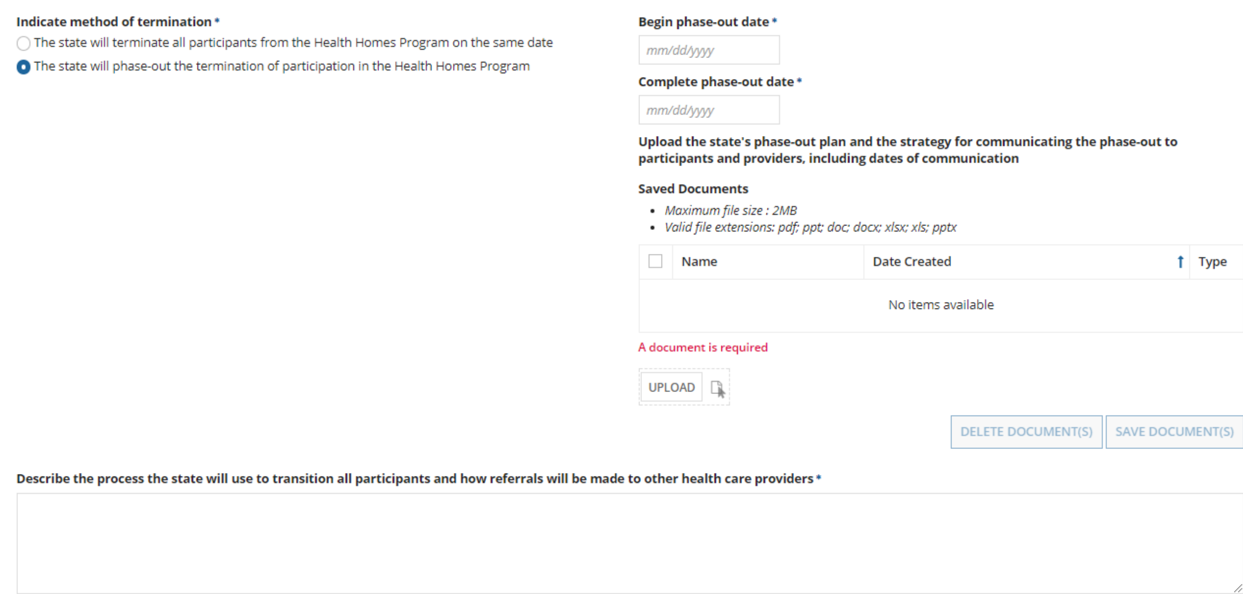


Figure 3: Health Homes Program Termination – 3

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

I1-Submission Summary PRA document

Version 1.0

08/16/2017

Document Number: 189-QSSI-MACPro-PRA-I1-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 4: Submission Summary – 4 2

Figure 5: Governor's Office Review - 1 2

Figure 6: Governor's Office Review - 2 3

1. I1-Submission Summary – Screenshots

1.1 Submission Summary

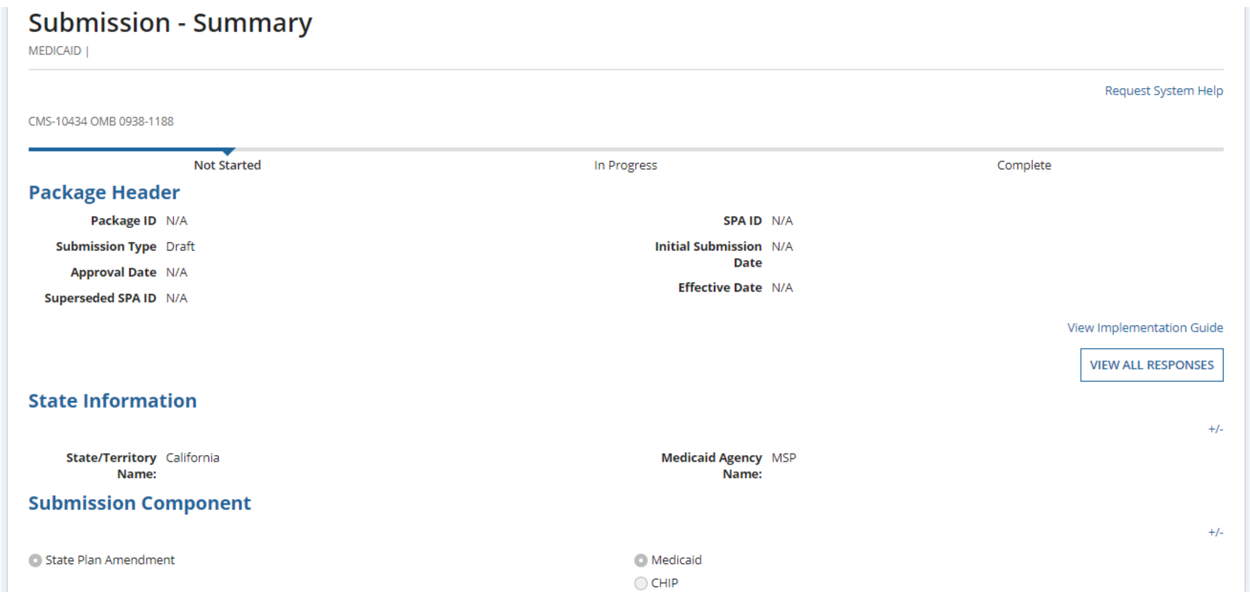

Figure 1: Submission Summary – 1

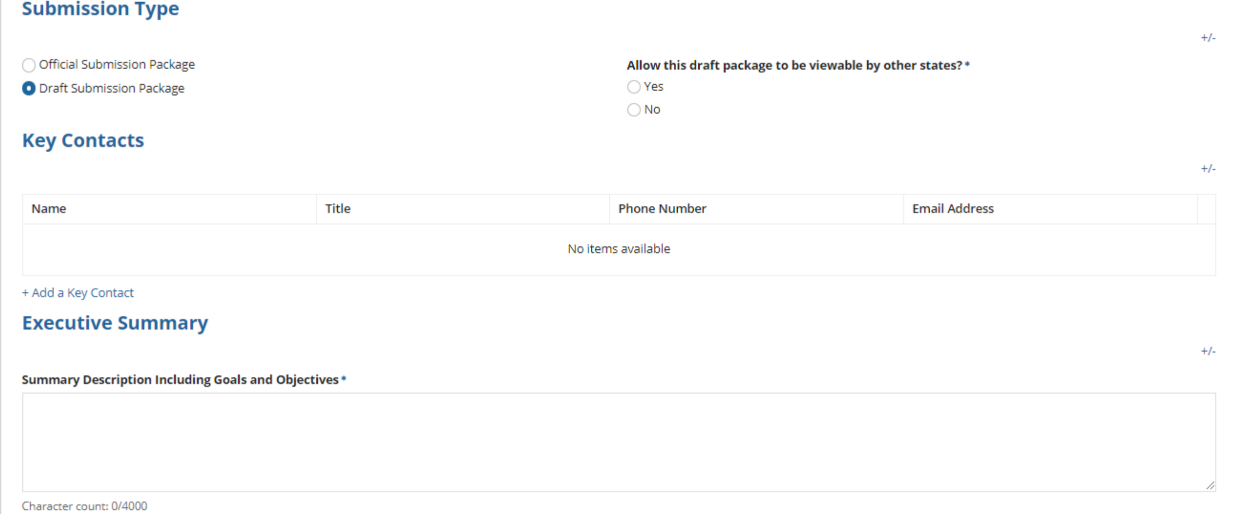

Figure 2: Submission Summary – 2

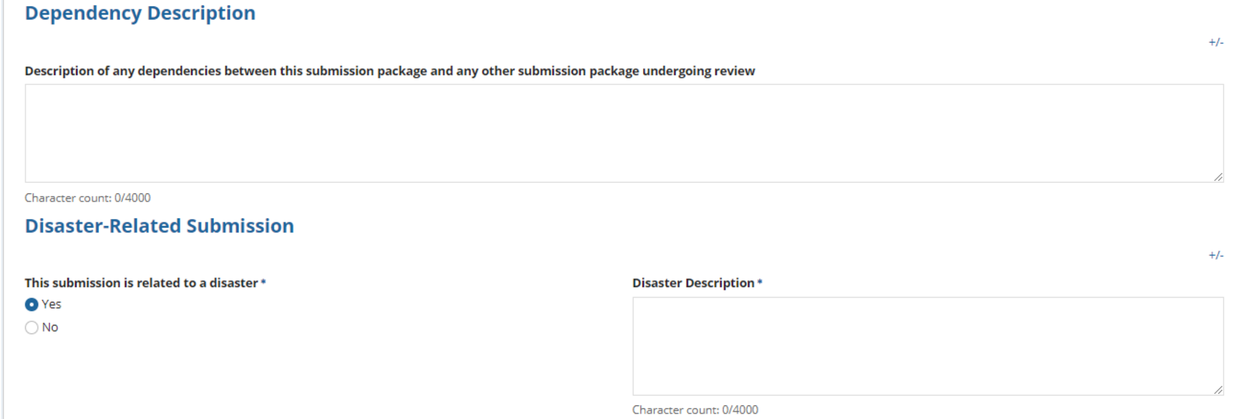

Figure 3: Submission Summary – 3

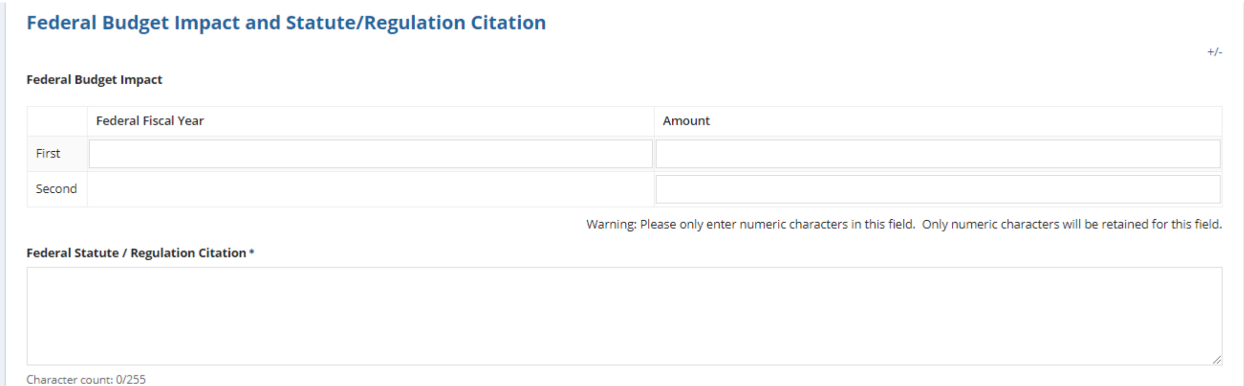

Figure 4: Submission Summary – 4

1.2 “Governor’s Office Review” Section – Path 1

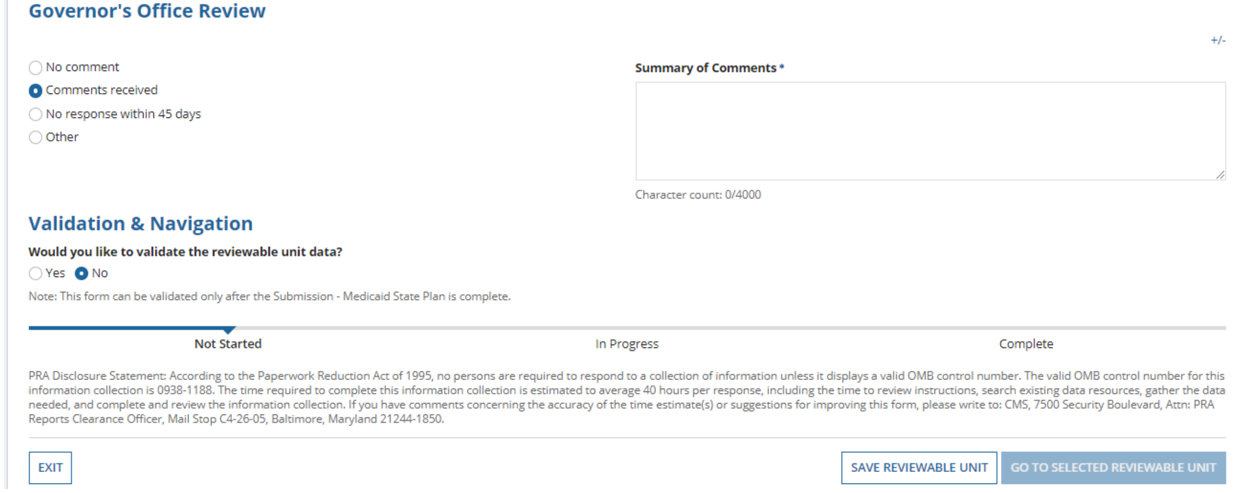

Figure 5: Governor’s Office Review - 1

1.3 "Governor's Office Review" Section – Path 2

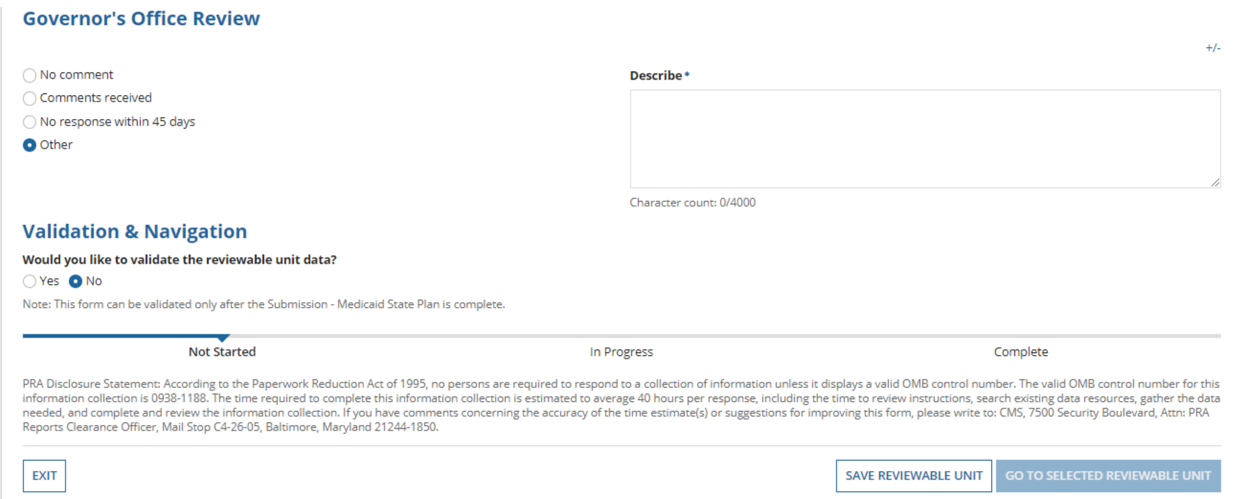

Figure 6: Governor's Office Review - 2

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

I2-Medicaid State Plan PRA document

Version 1.0

08/17/2017

Document Number: 192-QSSI-MACPro-PRA-I2-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.6 Medicaid State Plan – Benefits and Payment – Path 5 3

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Figure 4: Benefits and Payment – 1 2

Figure 5: Benefits and Payment – 2 2

Figure 6: Benefits and Payment – 3 3

Figure 7: Benefits and Payment – 4 3

Figure 8: Benefits and Payment – 5 3

1. I2-Medicaid State Plan – Screenshots

1.1 Medicaid State Plan

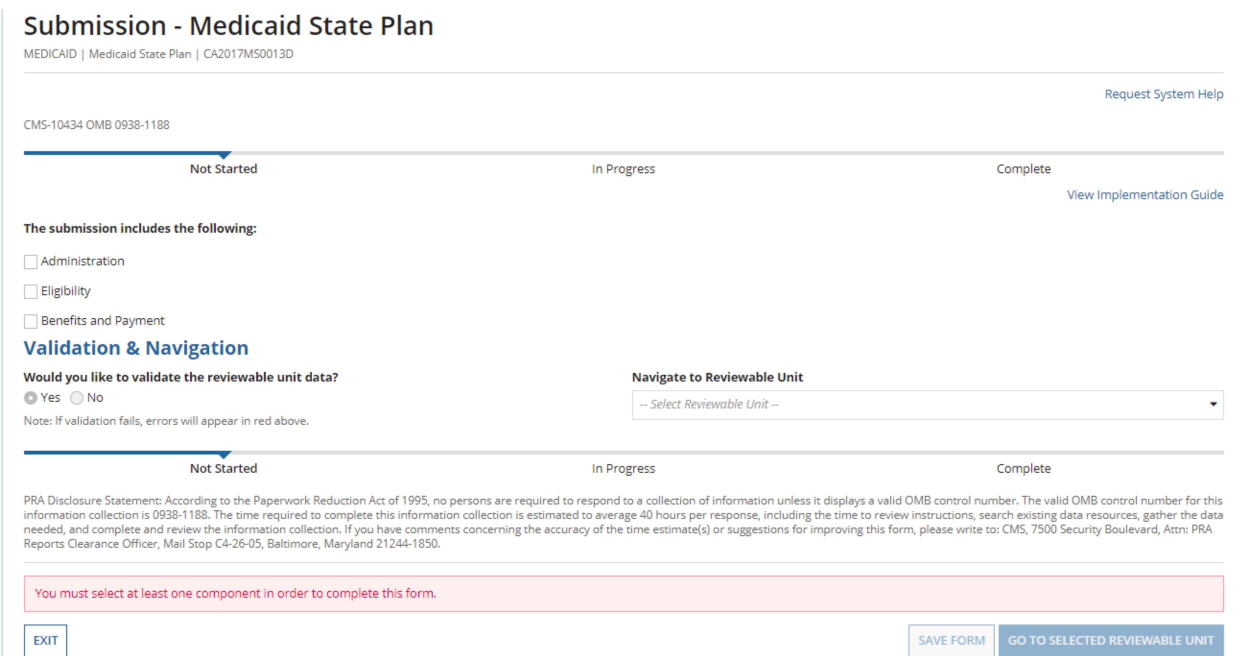

Figure 1: Medicaid State Plan – 1

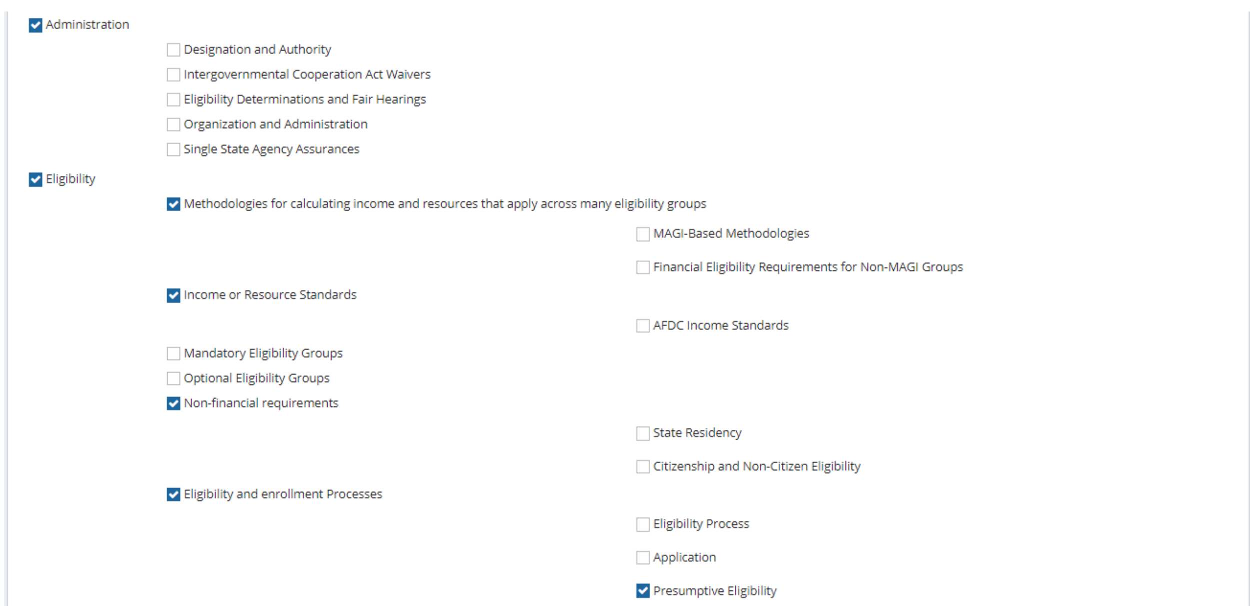

Figure 2: Medicaid State Plan – 2

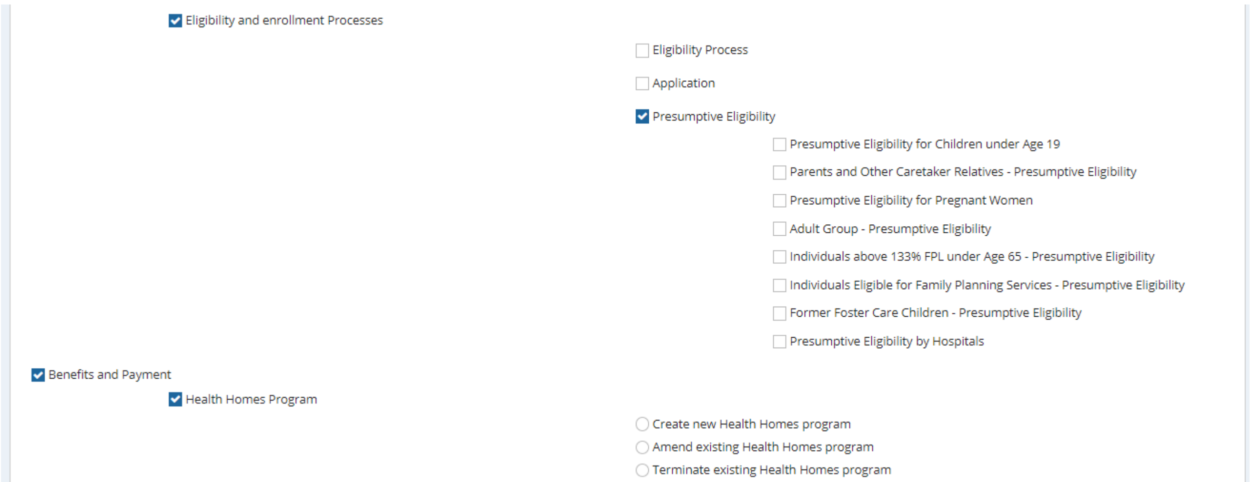

Figure 3: Medicaid State Plan – 3

1.2 Medicaid State Plan – Benefits and Payment – Path 1

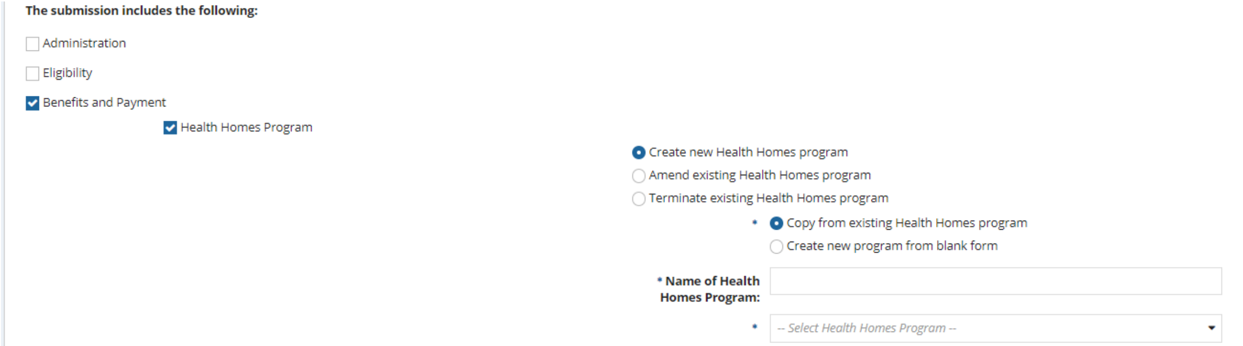

Figure 4: Benefits and Payment – 1

1.3 Medicaid State Plan – Benefits and Payment – Path 2

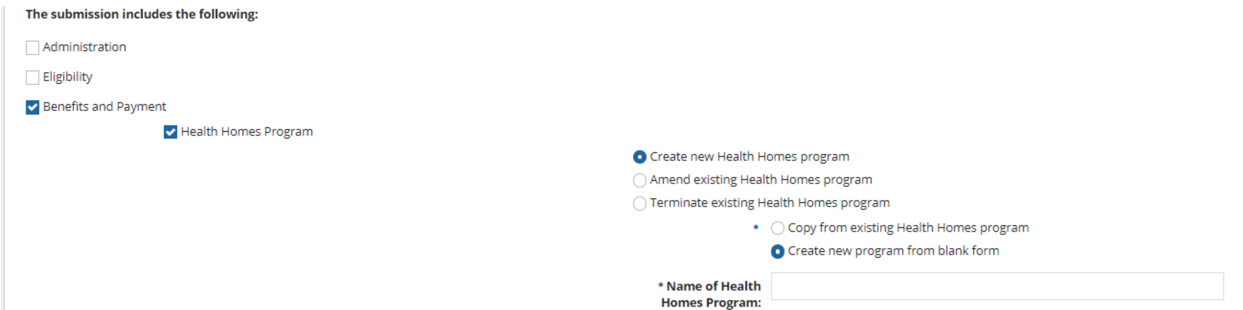

Figure 5: Benefits and Payment – 2

1.4 Medicaid State Plan – Benefits and Payment – Path 3

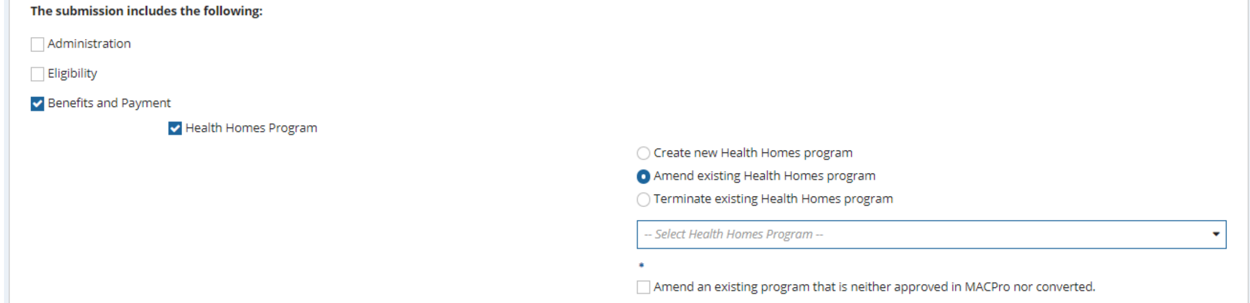

Figure 6: Benefits and Payment – 3

1.5 Medicaid State Plan – Benefits and Payment – Path 4

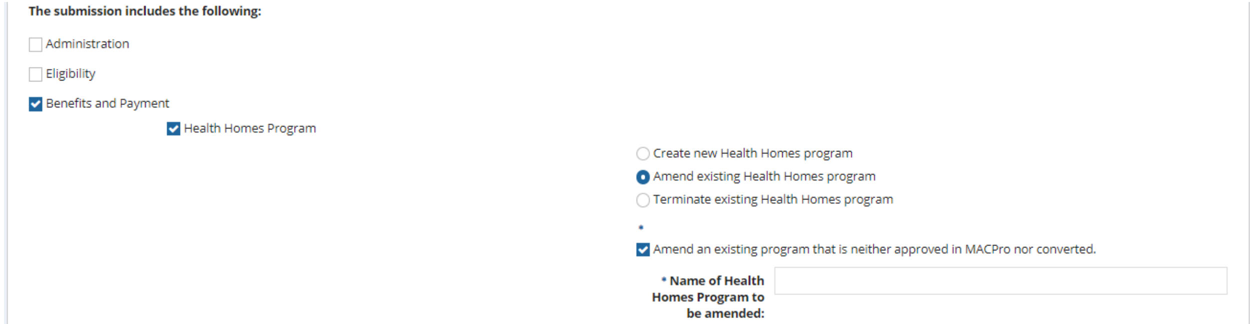

Figure 7: Benefits and Payment – 4

1.6 Medicaid State Plan – Benefits and Payment – Path 5

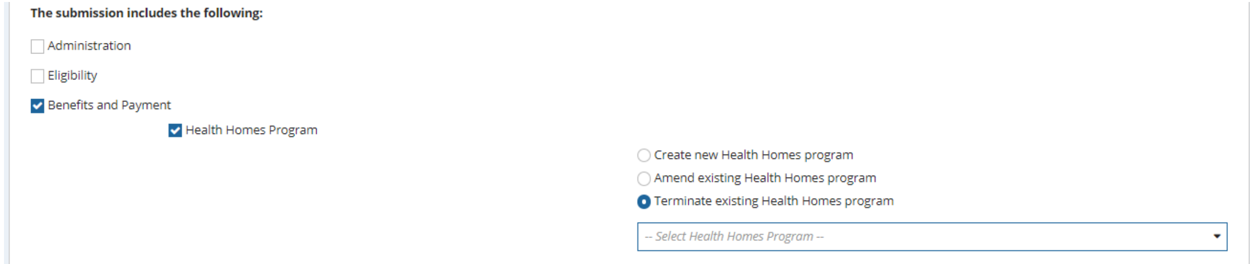

Figure 8: Benefits and Payment – 5

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

I3-Public Comment PRA document

Version 1.0

08/17/2017

Document Number: 193-QSSI-MACPro-PRA-I3-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 10: Public Comment – 10 5

Figure 11: Public Comment – 11 6

Figure 12: Public Comment – 12 6

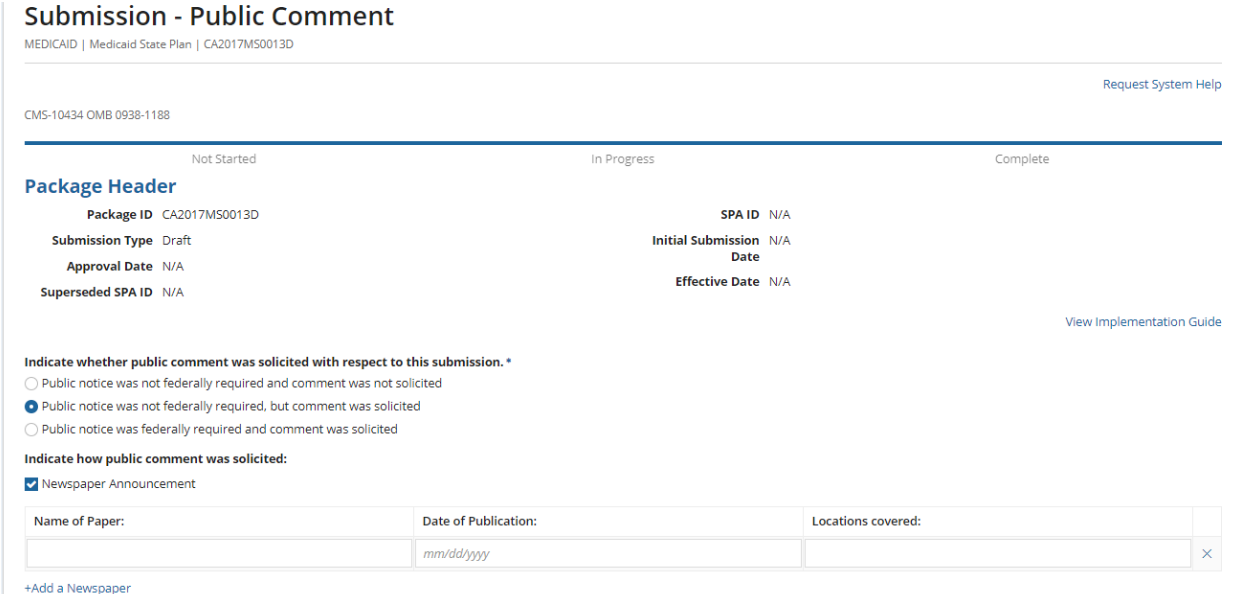
Figure 13: Public Comment – 13 7

Figure 14: Public Comment – 14 7

Figure 15: Public Comment – 15 8

1. I3-Public Comment – Screenshots

1.1 Public Comment – Path 1



Submission - Public Comment

MEDICAID | Medicaid State Plan | CA2017MS0013D

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	**SPA ID**	N/A
Submission Type	Draft	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

View Implementation Guide

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

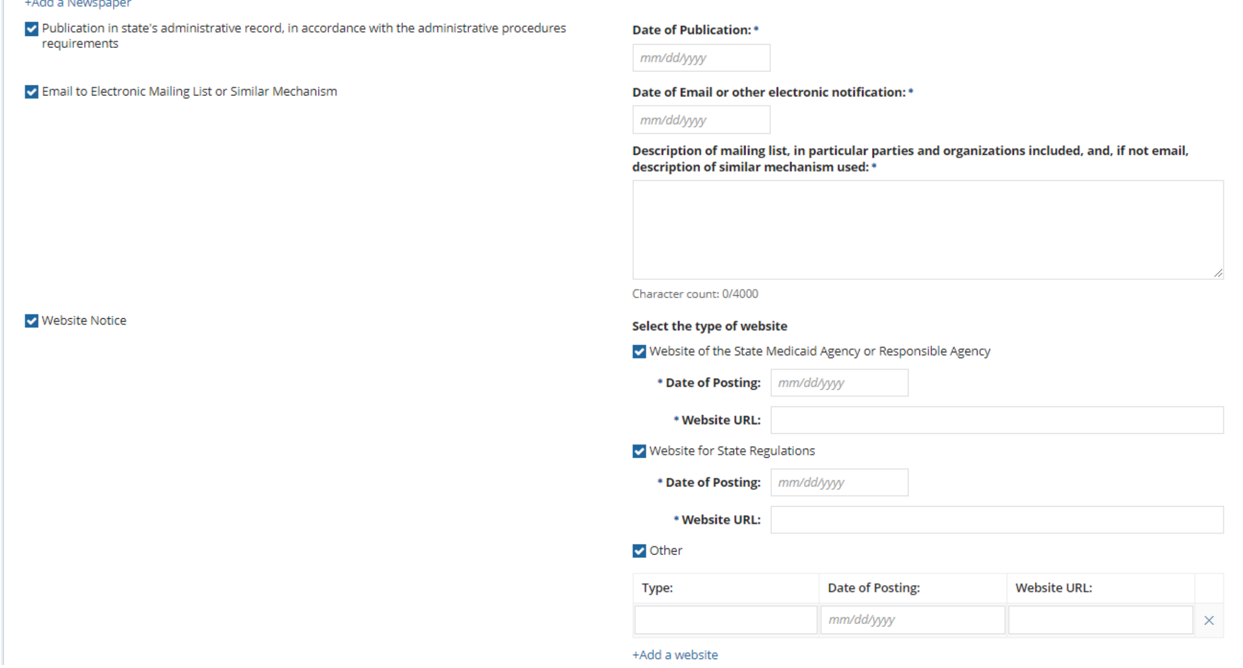
Indicate how public comment was solicited:

Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
	mm/dd/yyyy	

+Add a Newspaper

Figure 1: Public Comment – 1



+Add a Newspaper

Publication in state's administrative record, in accordance with the administrative procedures requirements

Date of Publication: *

mm/dd/yyyy

Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification: *

mm/dd/yyyy

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used: *

Character count: 0/4000

Website Notice

Select the type of website

Website of the State Medicaid Agency or Responsible Agency

* **Date of Posting:** mm/dd/yyyy

* **Website URL:**

Website for State Regulations

* **Date of Posting:** mm/dd/yyyy

* **Website URL:**

Other

Type:	Date of Posting:	Website URL:
	mm/dd/yyyy	

+Add a website

Figure 2: Public Comment – 2

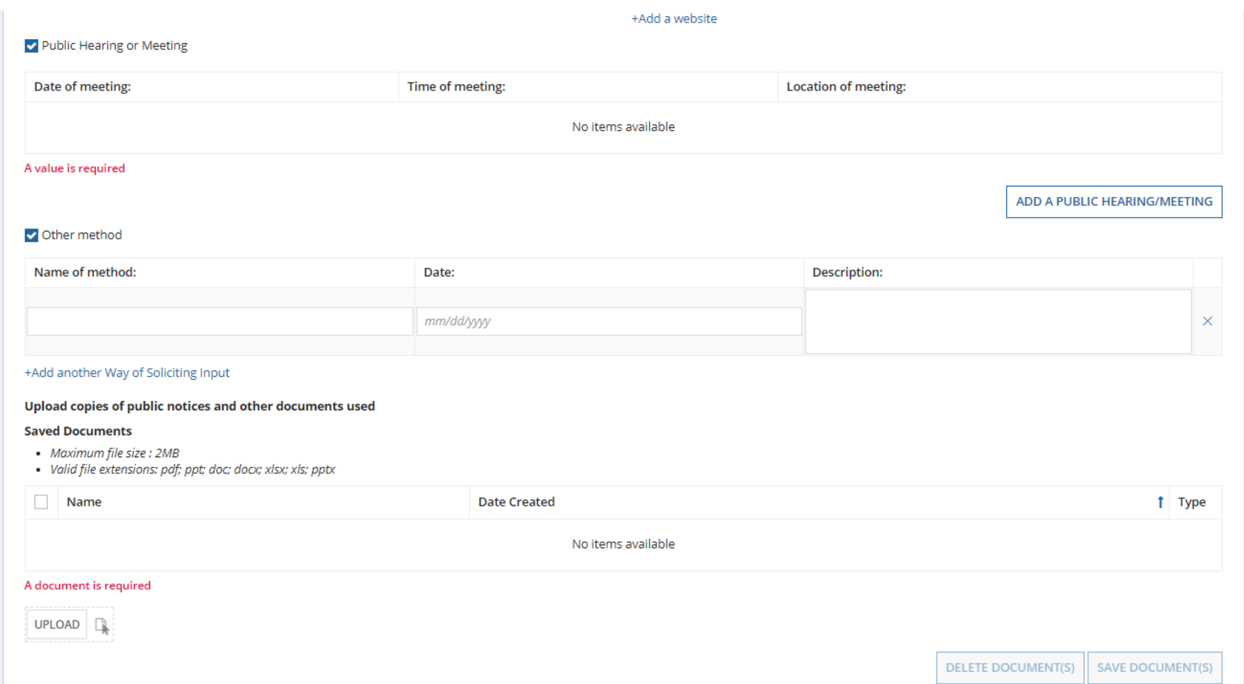


Figure 3: Public Comment – 3

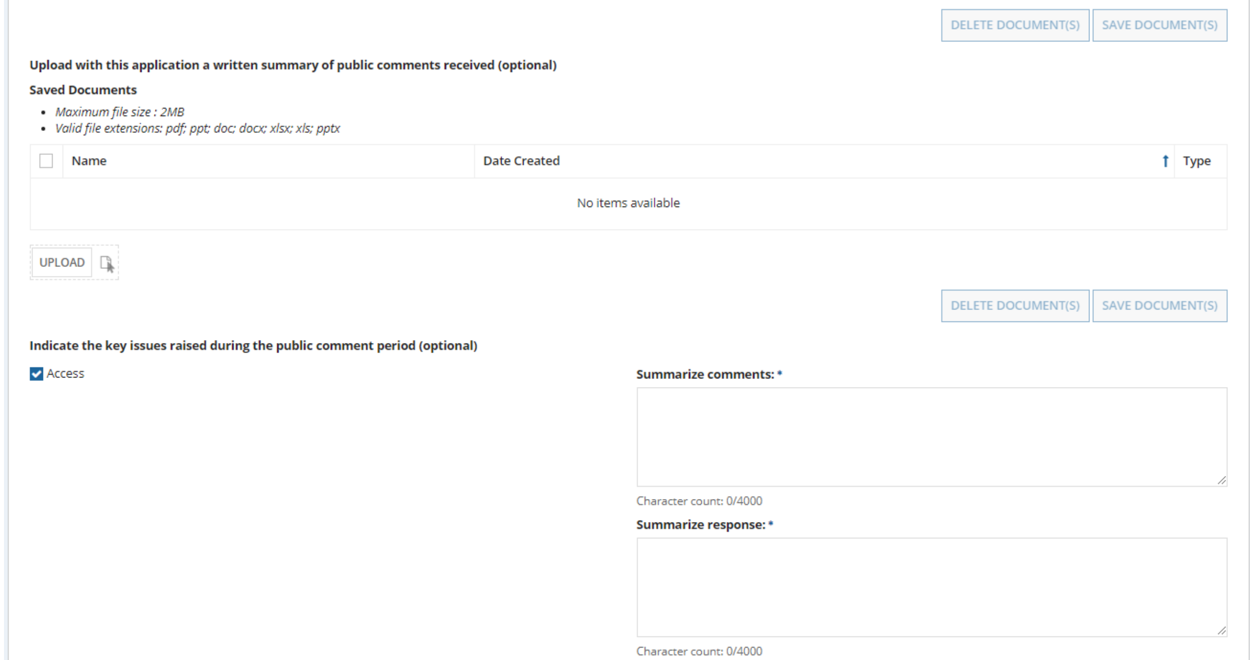


Figure 4: Public Comment – 4

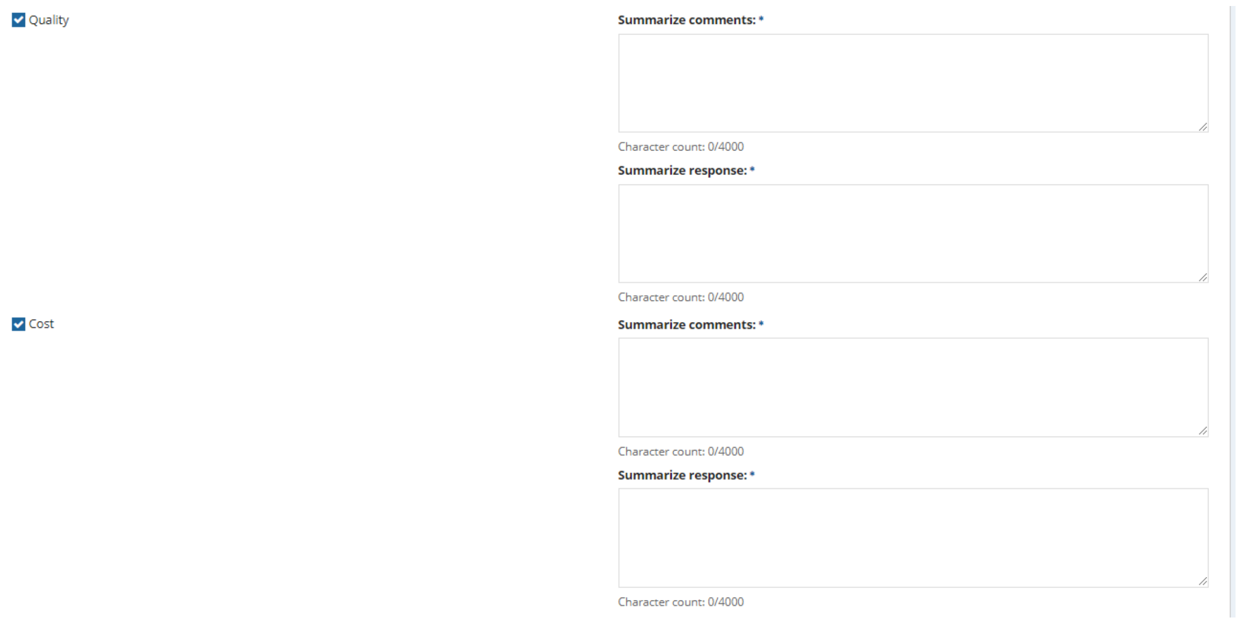


Figure 5: Public Comment – 5

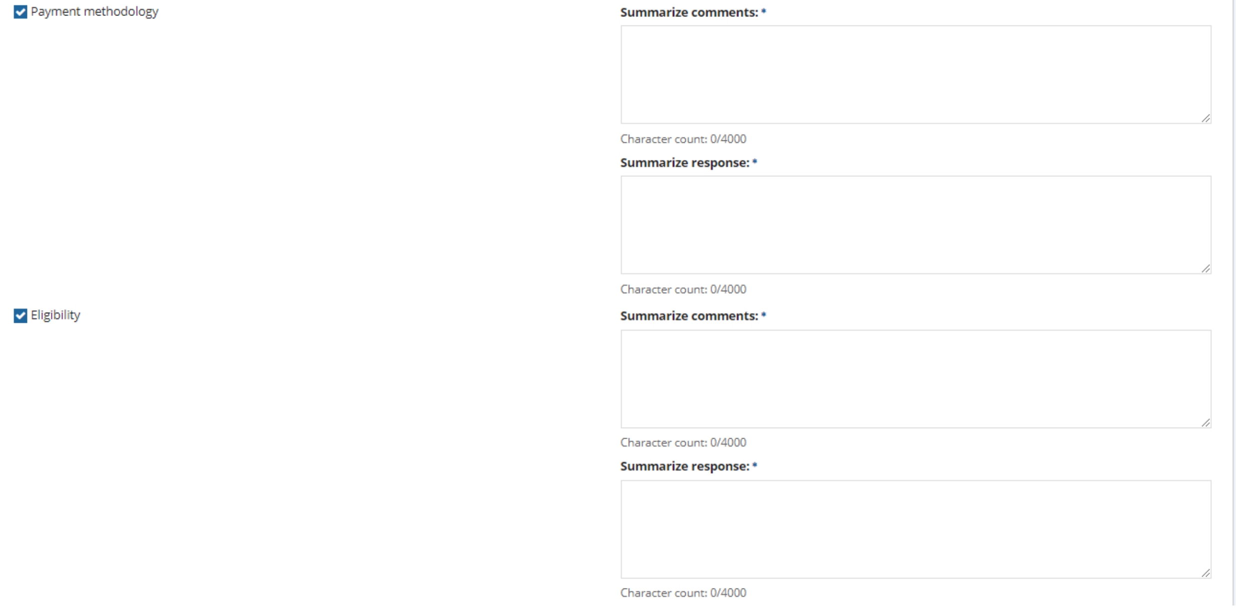


Figure 6: Public Comment – 6

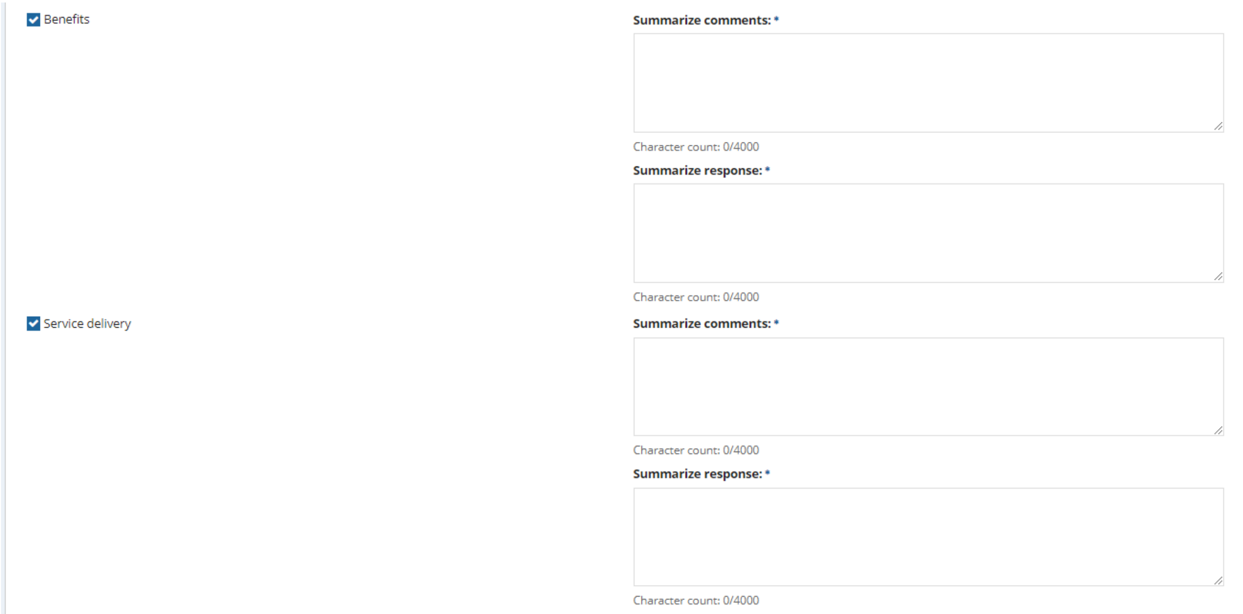


Figure 7: Public Comment – 7

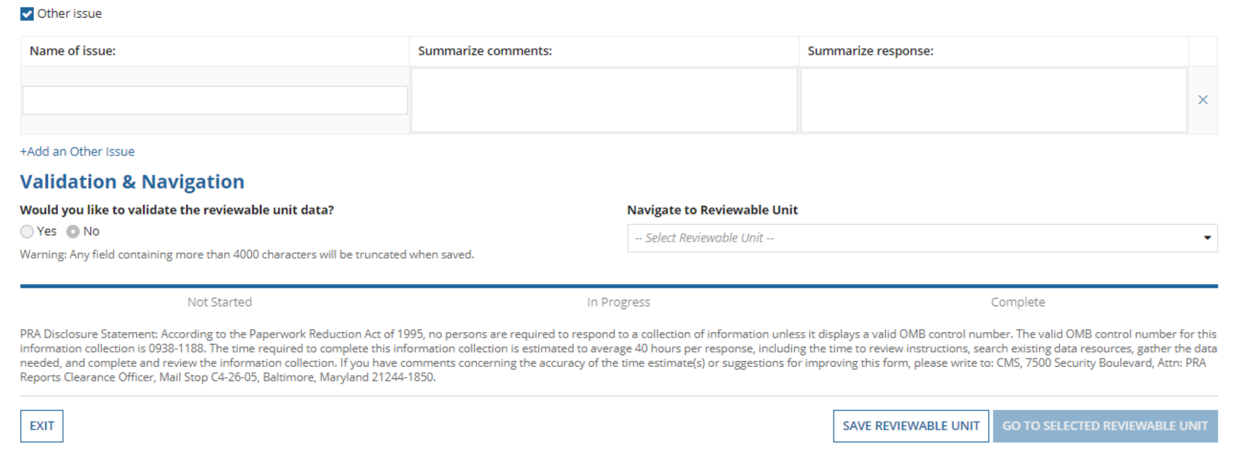


Figure 8: Public Comment – 8

1.2 Public Comment – Path 2

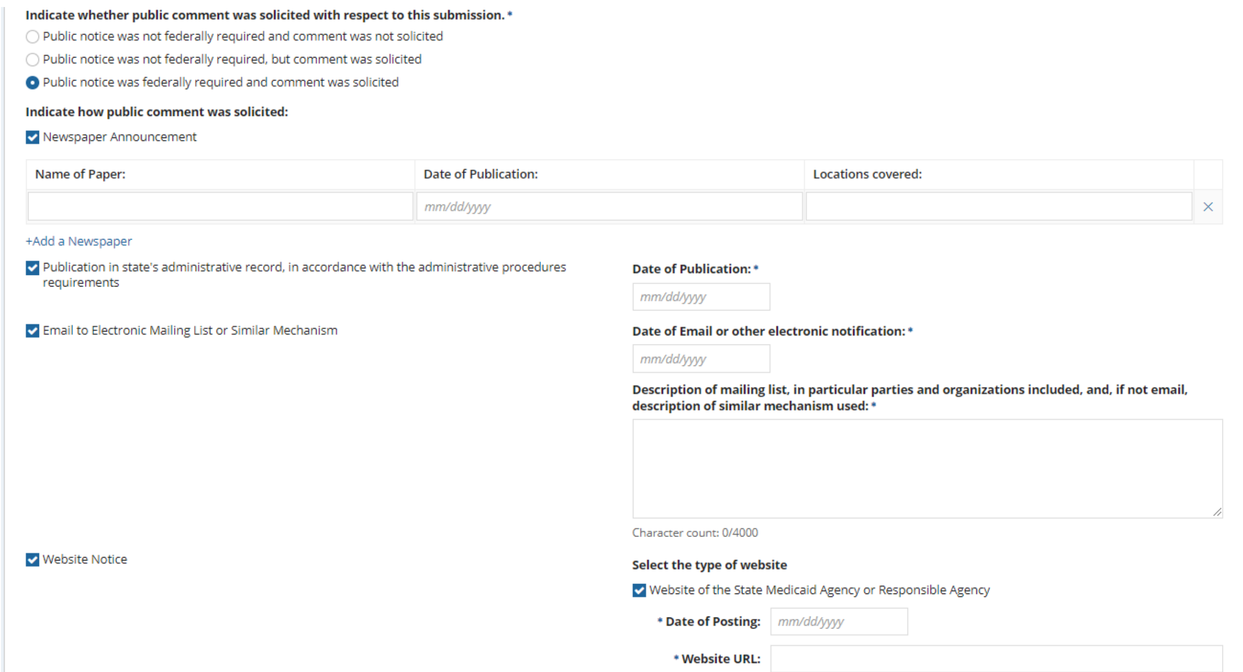


Figure 9: Public Comment – 9

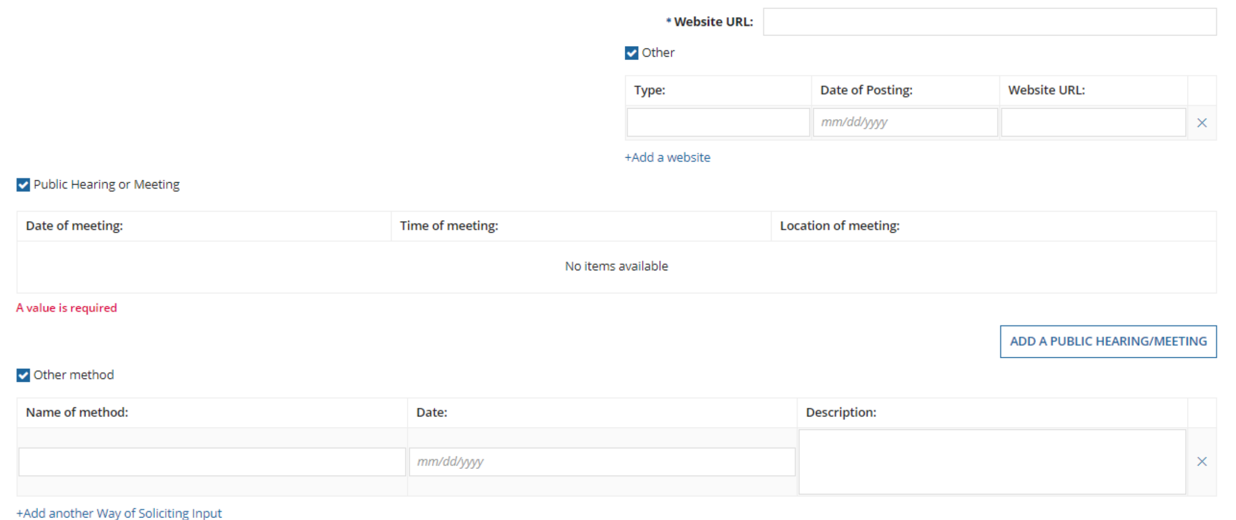


Figure 10: Public Comment – 10

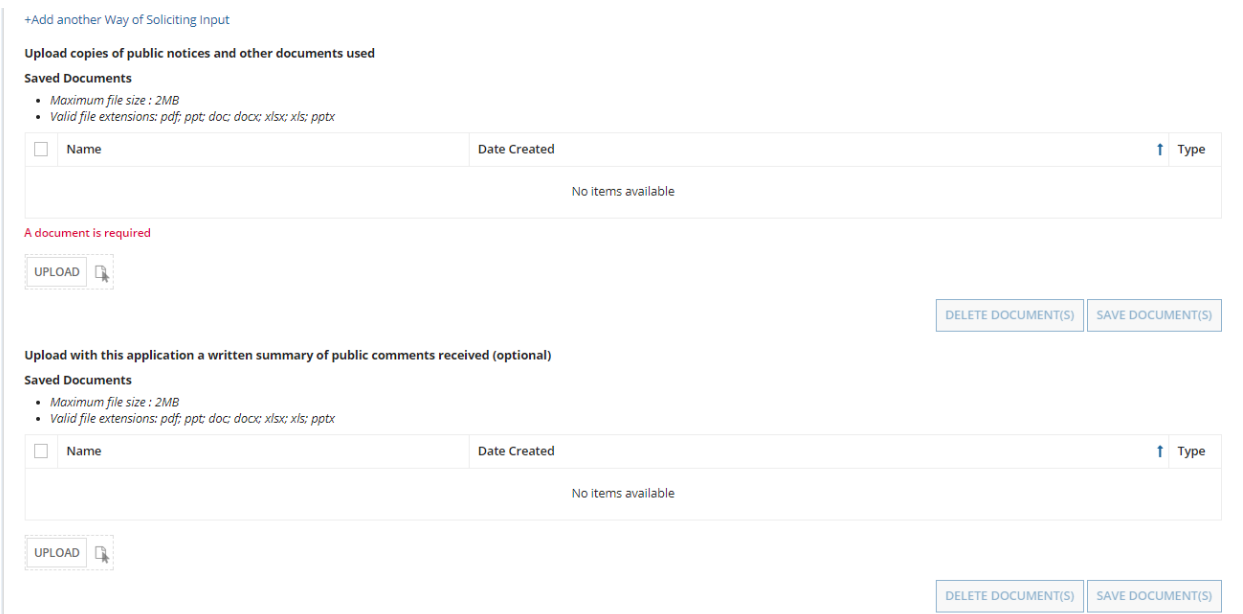


Figure 11: Public Comment – 11

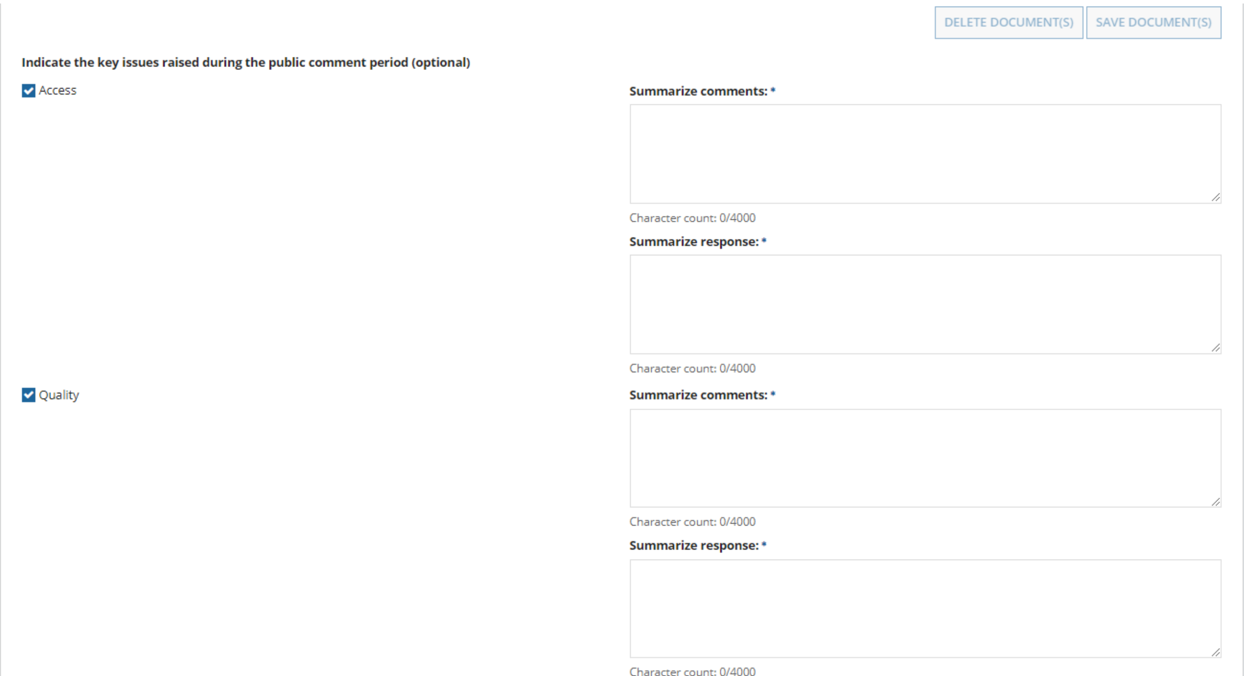


Figure 12: Public Comment – 12

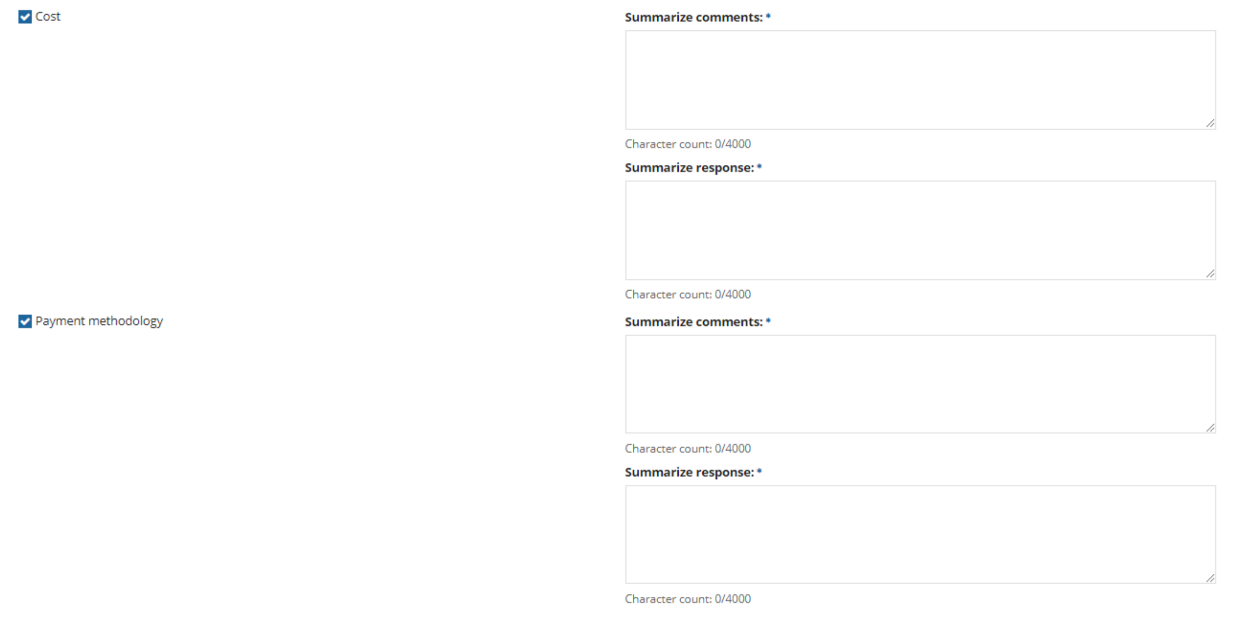


Figure 13: Public Comment – 13

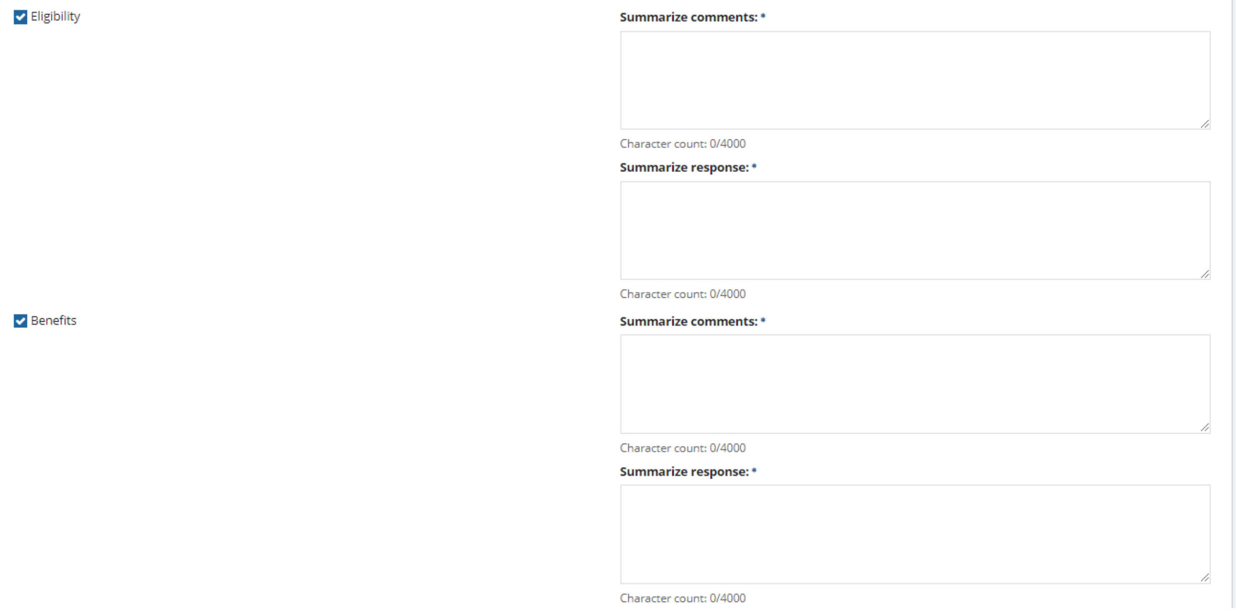


Figure 14: Public Comment – 14

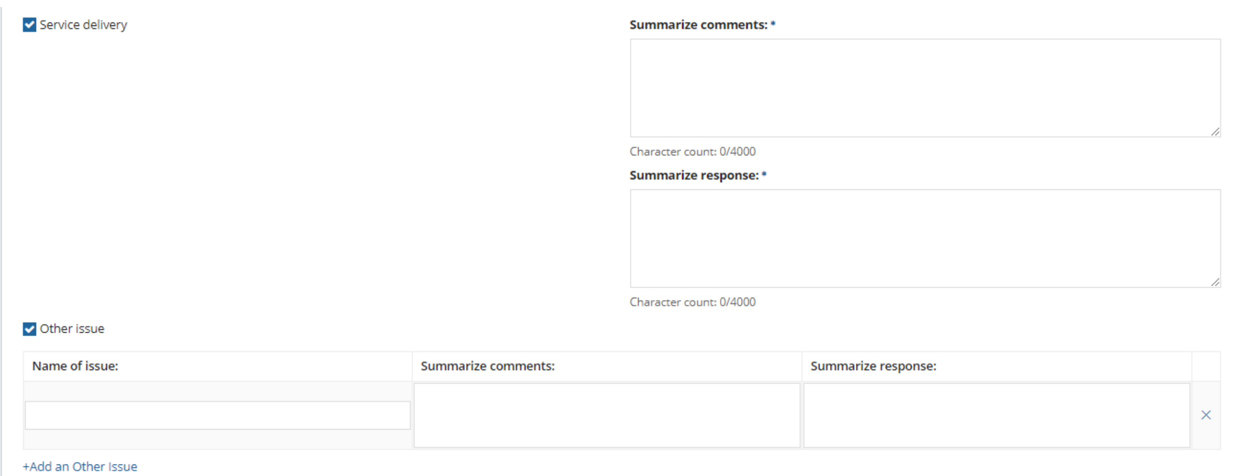


Figure 15: Public Comment – 15

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

I4-Tribal Input PRA document

Version 1.0

08/17/2017

Document Number: 194-QSSI-MACPro-PRA-I4-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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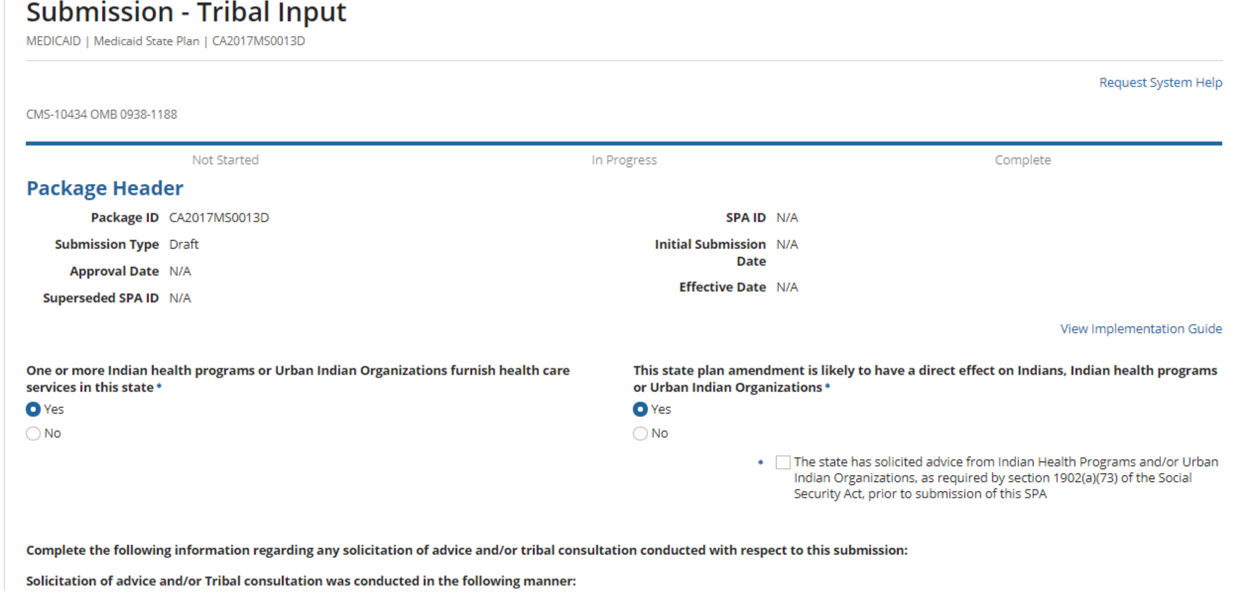
Figure 7: Tribal Input – 7 4
Figure 8: Tribal Input – 8 4
Figure 9: Tribal Input – 9 5
Figure 10: Tribal Input – 10 5
Figure 11: Tribal Input – 11 6
Figure 12: Tribal Input – 12 6
Figure 13: Tribal Input – 13 7
Figure 14: Tribal Input – 14 7

1. I4-Tribal Input – Screenshots

1.1 Tribal Input – Path 1



Submission - Tribal Input

MEDICAID | Medicaid State Plan | CA2017MS0013D

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID CA2017MS0013D

Submission Type Draft

Approval Date N/A

Superseded SPA ID N/A

SPA ID N/A

Initial Submission Date N/A

Effective Date N/A

View Implementation Guide

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 *

Yes

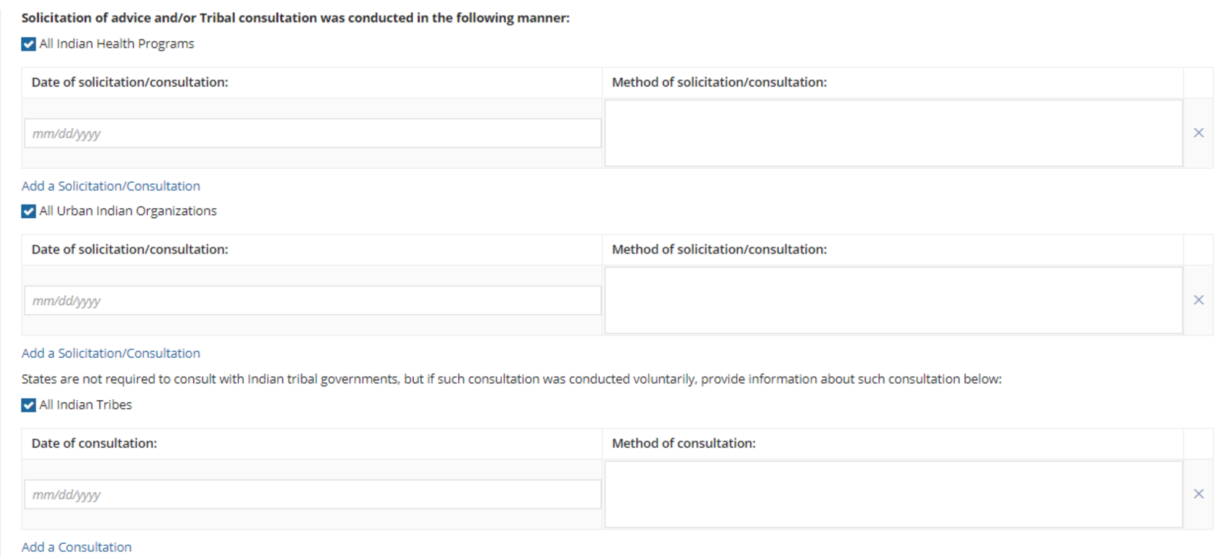
No

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, 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:

Figure 1: Tribal Input – 1



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

All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
mm/dd/yyyy	

Add a Solicitation/Consultation

All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
mm/dd/yyyy	

Add a Solicitation/Consultation

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

Date of consultation:	Method of consultation:
mm/dd/yyyy	

Add a Consultation

Figure 2: Tribal Input – 2

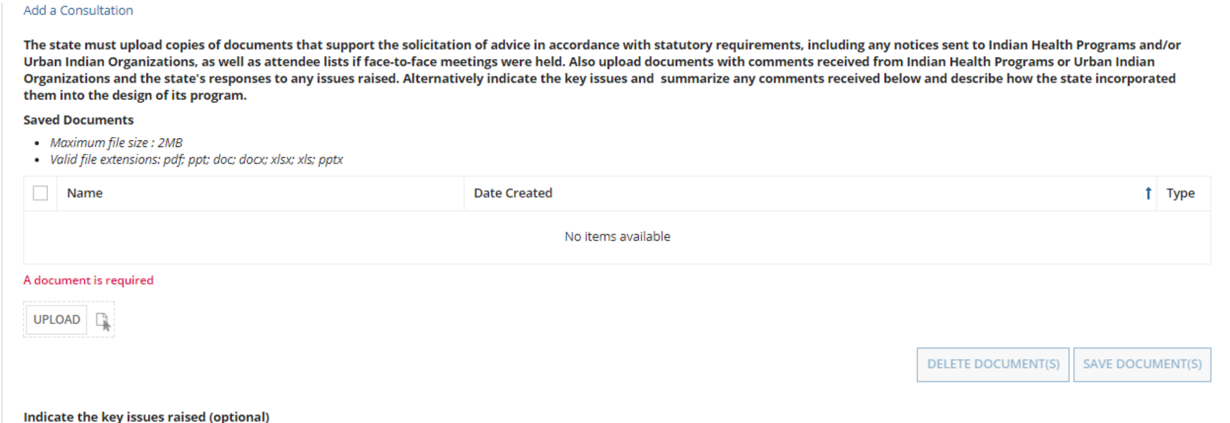


Figure 3: Tribal Input – 3

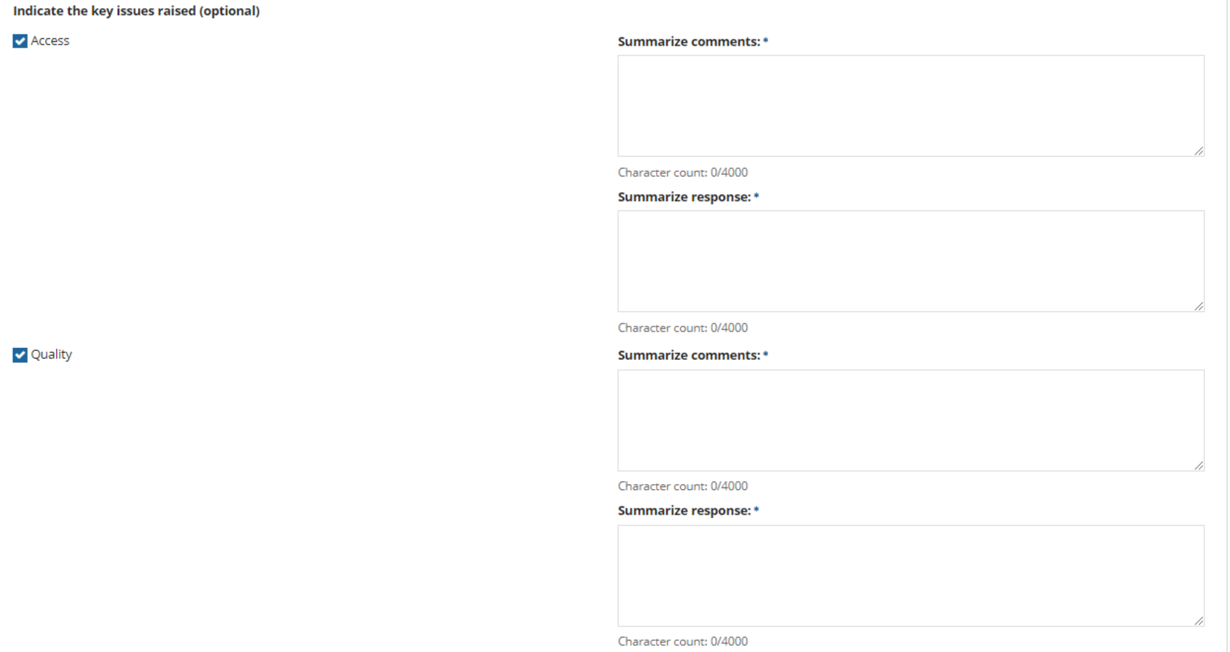


Figure 4: Tribal Input – 4

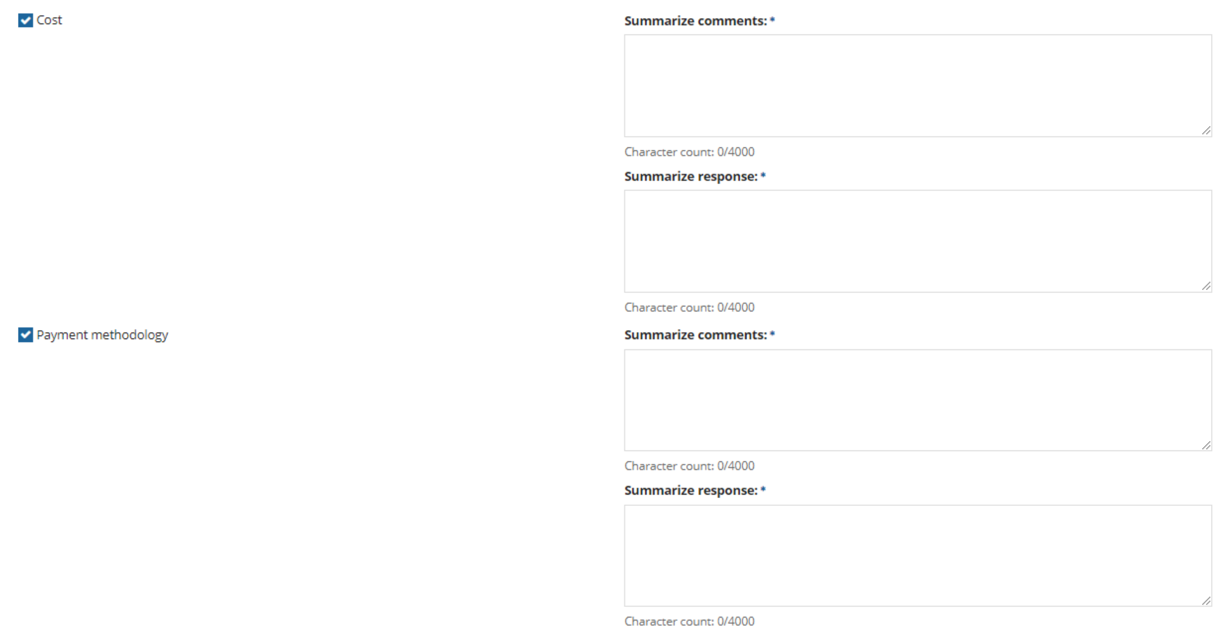


Figure 5: Tribal Input – 5

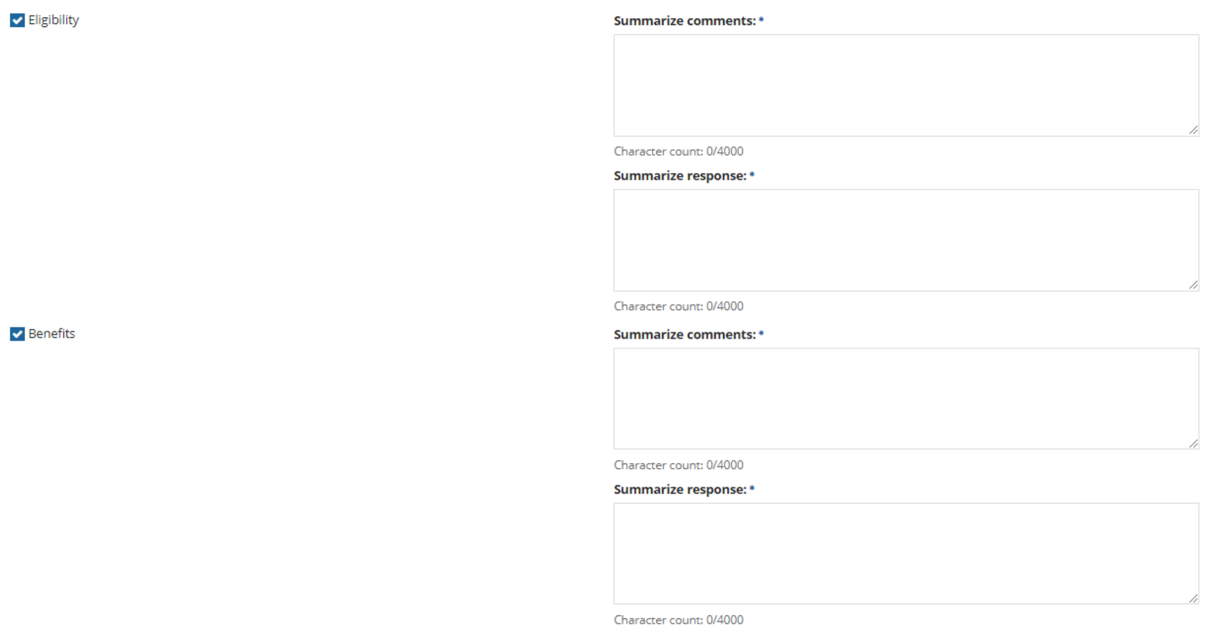
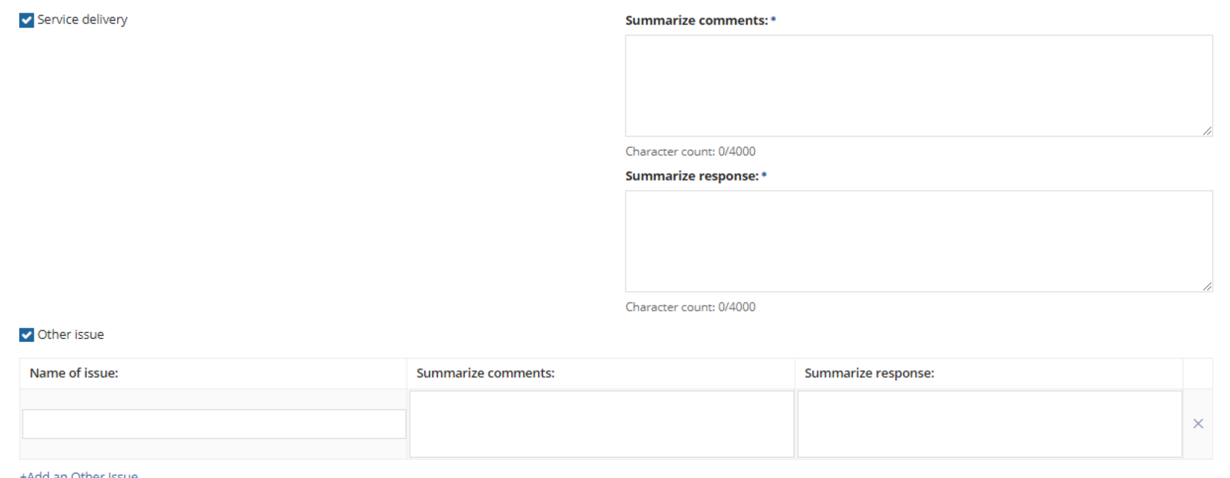


Figure 6: Tribal Input – 6


Service delivery

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

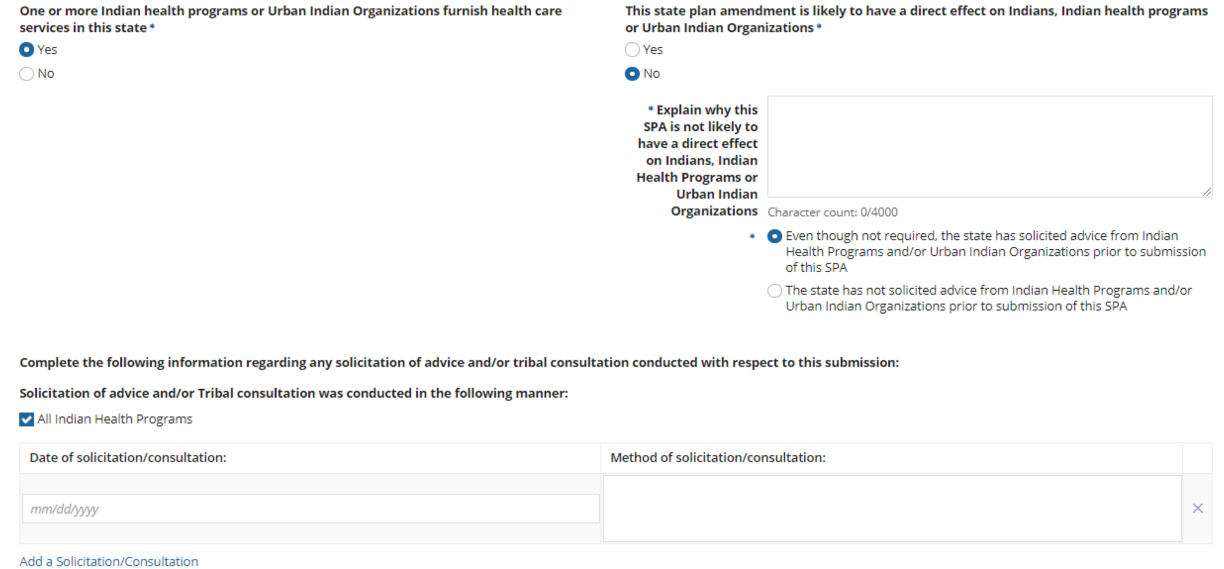
Other issue

Name of issue:	Summarize comments:	Summarize response:

+Add an Other Issue

Figure 7: Tribal Input – 7

1.2 Tribal Input – Path 2


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 *

Yes

No

* Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations

Character count: 0/4000

Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA

The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations 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

Date of solicitation/consultation:	Method of solicitation/consultation:
mm/dd/yyyy	

Add a Solicitation/Consultation

Figure 8: Tribal Input – 8

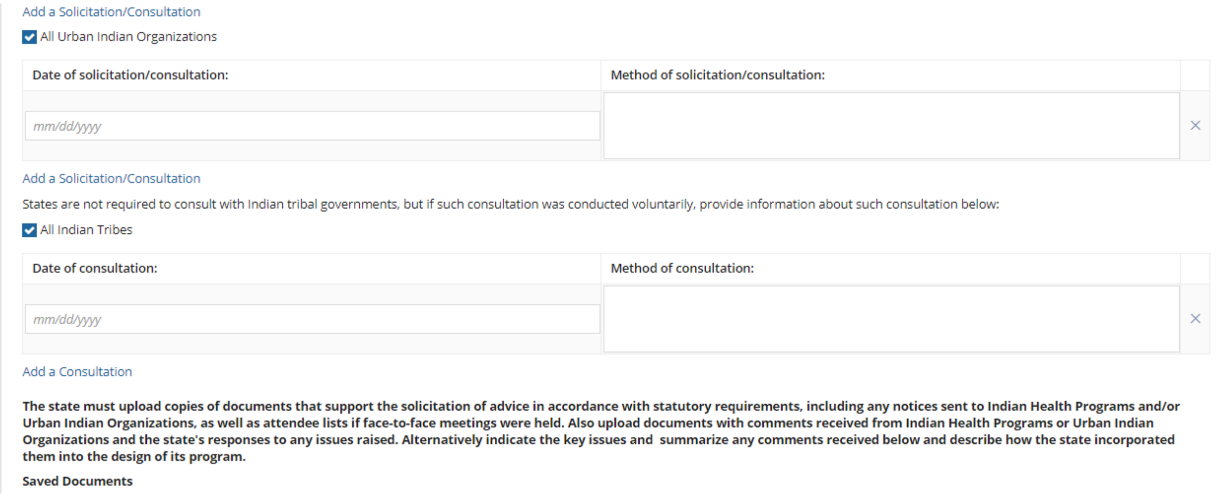


Figure 9: Tribal Input – 9

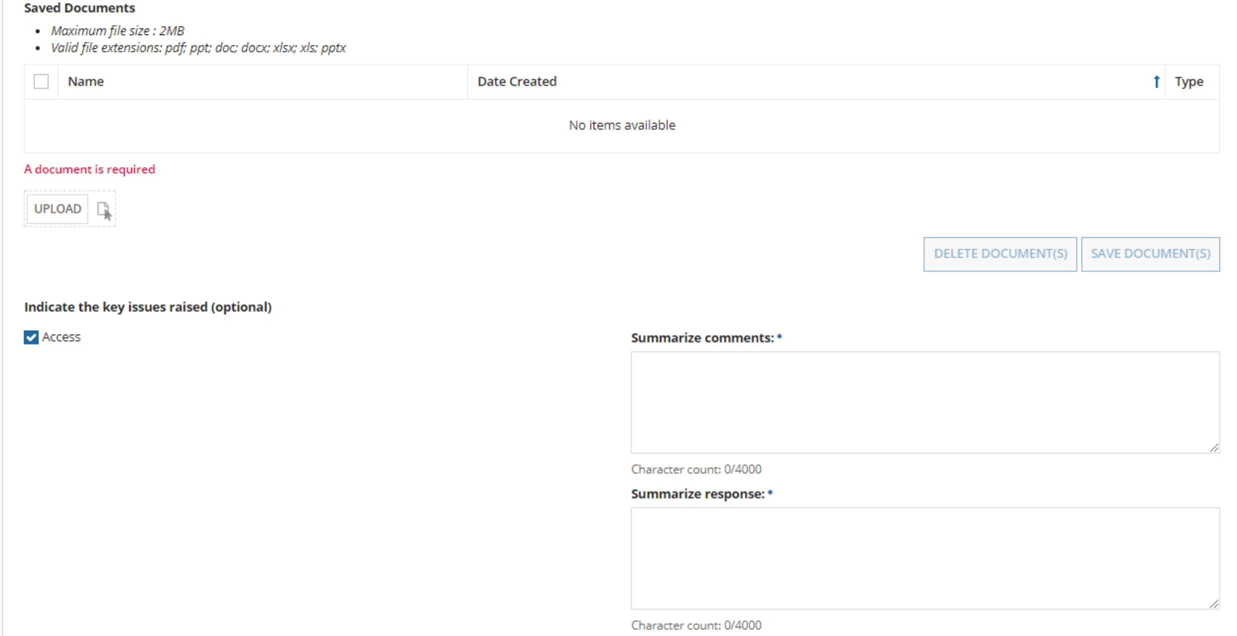


Figure 10: Tribal Input – 10

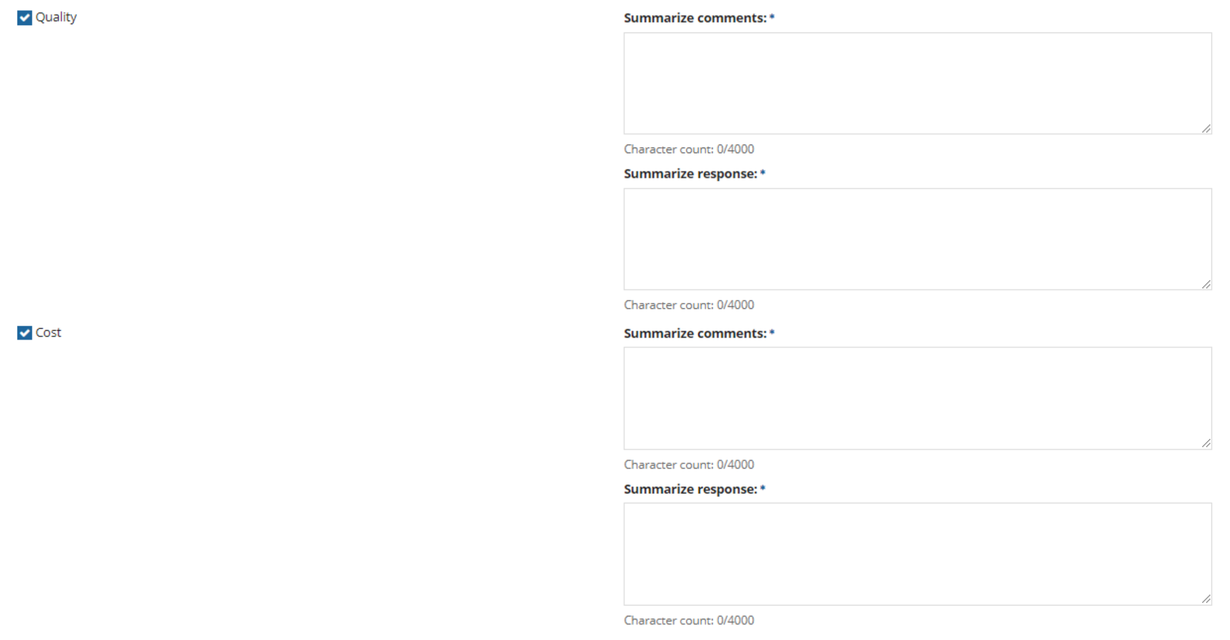


Figure 11: Tribal Input – 11

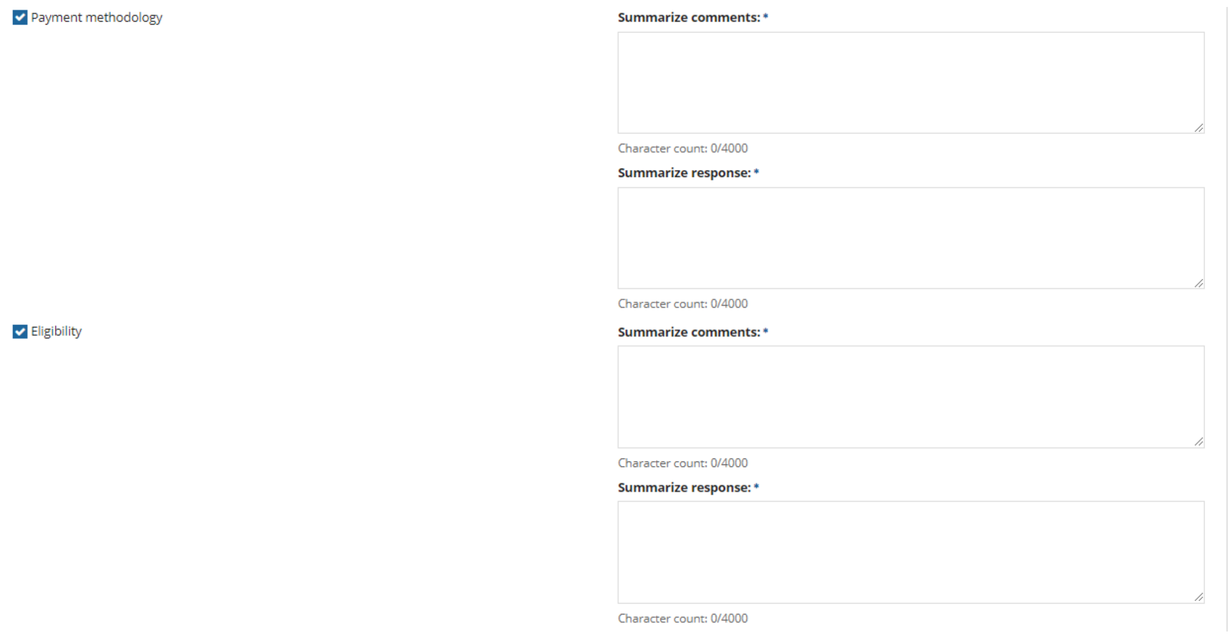


Figure 12: Tribal Input – 12

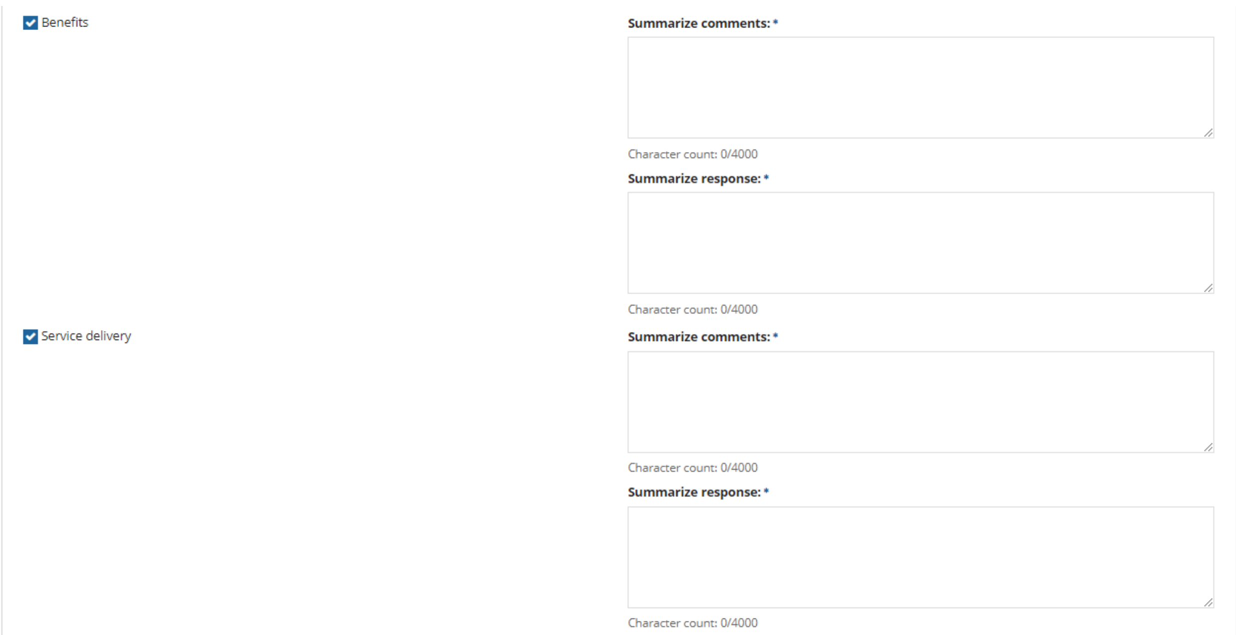


Figure 13: Tribal Input – 13

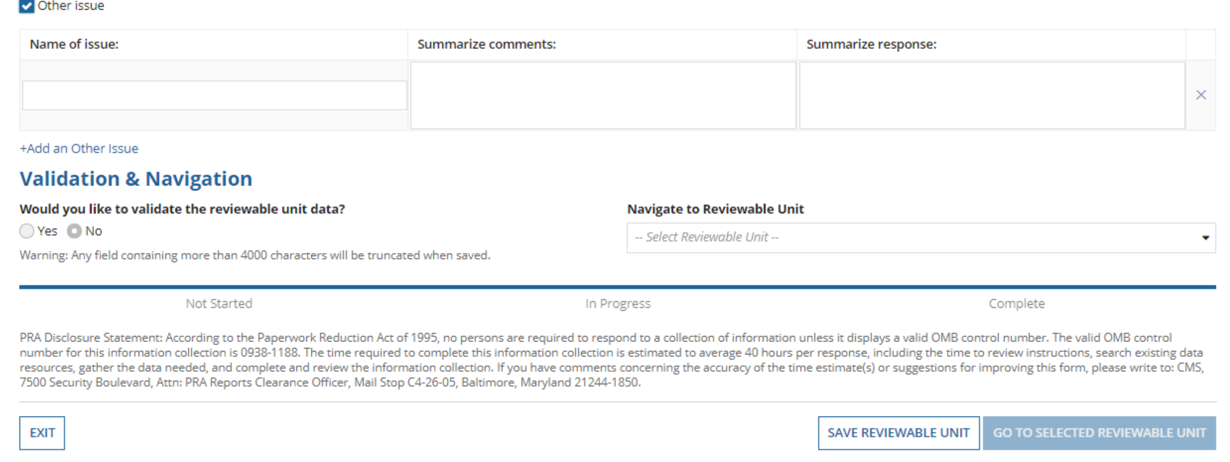


Figure 14: Tribal Input – 14

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

I5-Other Comment PRA document

Version 1.0

08/17/2017

Document Number: 195-QSSI-MACPro-PRA-I5-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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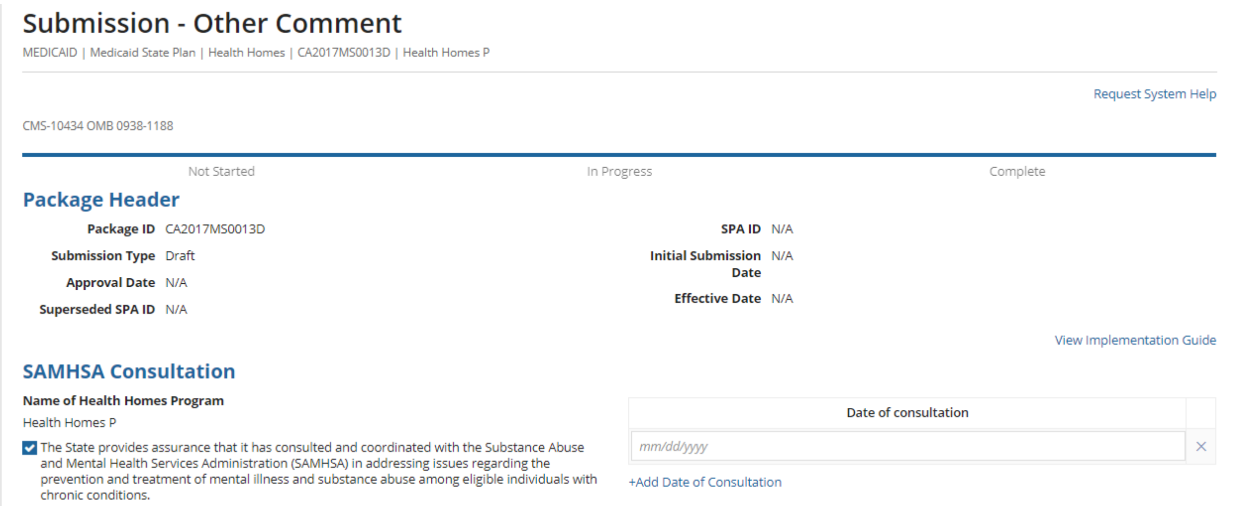

Figure 1: Other Comment

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S2 - Financial Eligibility Requirements for Non-MAGI Groups RU PRA Document

Version 1.0

08/16/2017

Document Number: 181-QSSI-MACPro-R5.1-S2-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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No table of figures entries found.

1. S2 - Financial Eligibility Requirements for Non-MAGI Groups Screenshots

1.1 Package Header and A. Financial Eligibility Methodologies

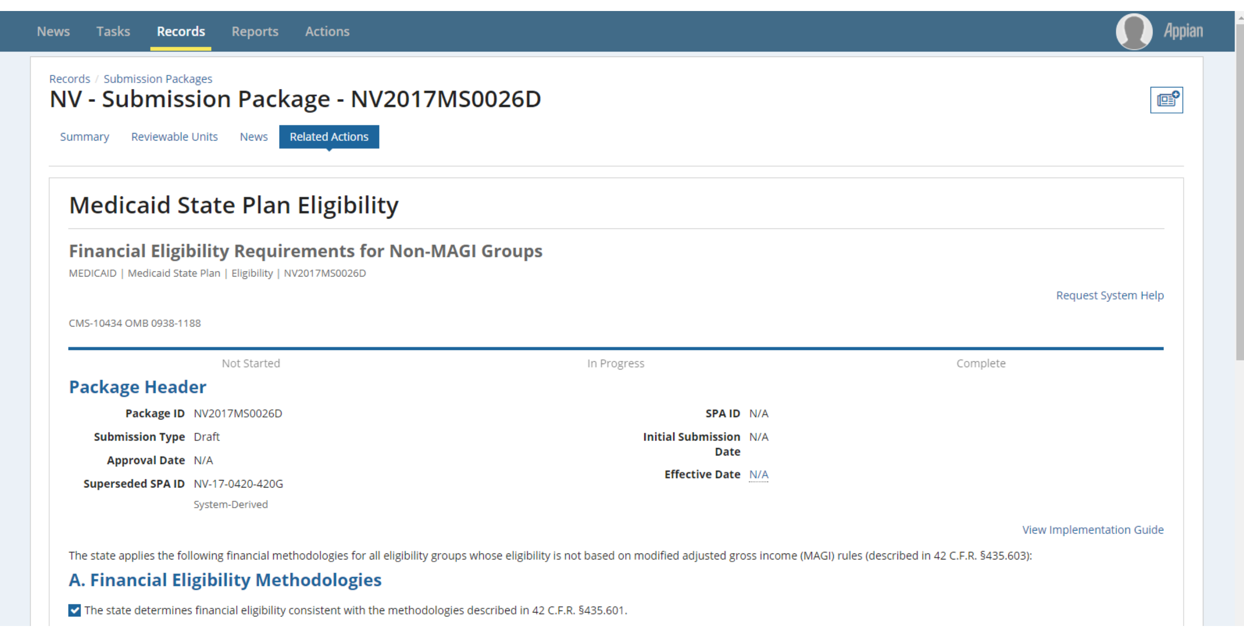
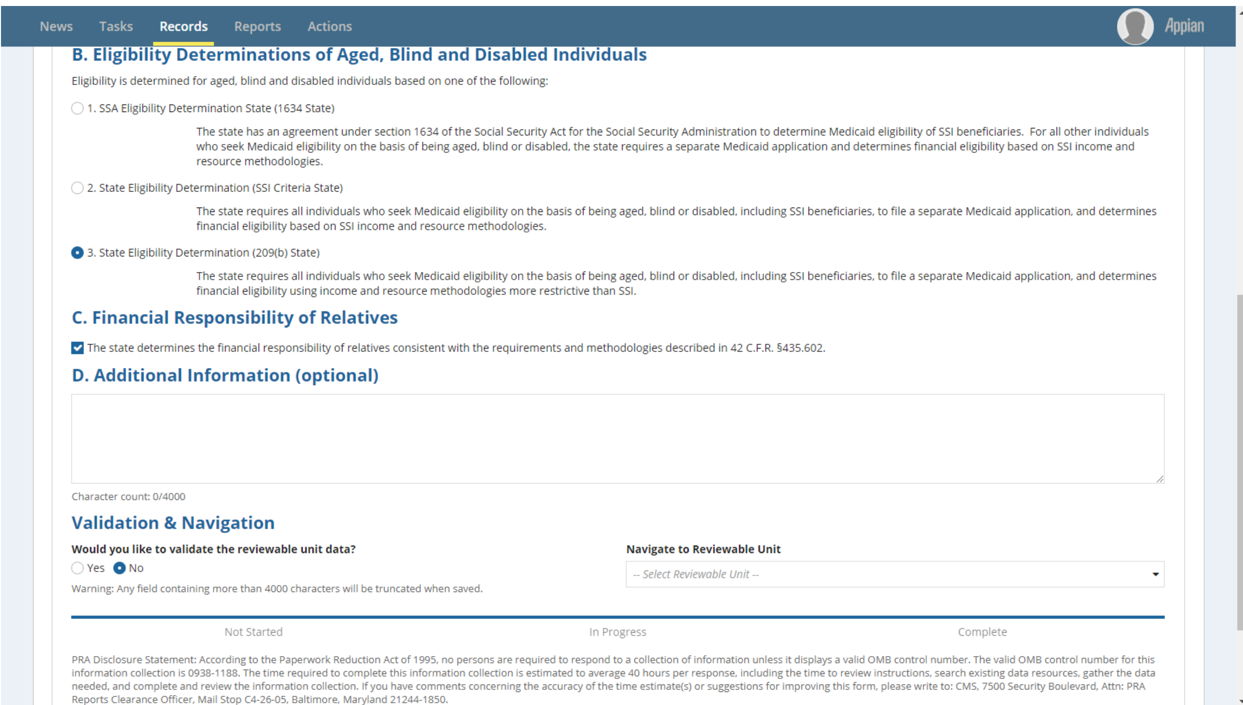


Figure 1: Package Header and Section A

1.2 B. Eligibility Determinations of Aged, Blind and Disabled Individuals, C. Financial Responsibility of Relatives and D. Additional Information (optional)



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B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

○ 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

● 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

☑ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

○ Yes ● No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started In Progress Complete

PRA Disclosure Statement: 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 average 40 hours per response, 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.

Figure 2: Section B, Section C and Section D

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S2T-Financial Eligibility Requirements for Non-MAGI Groups – Territories PRA document

Version 1.0
08/18/2017

Document Number: 214-QSSI-MACPro-PRA-S2T-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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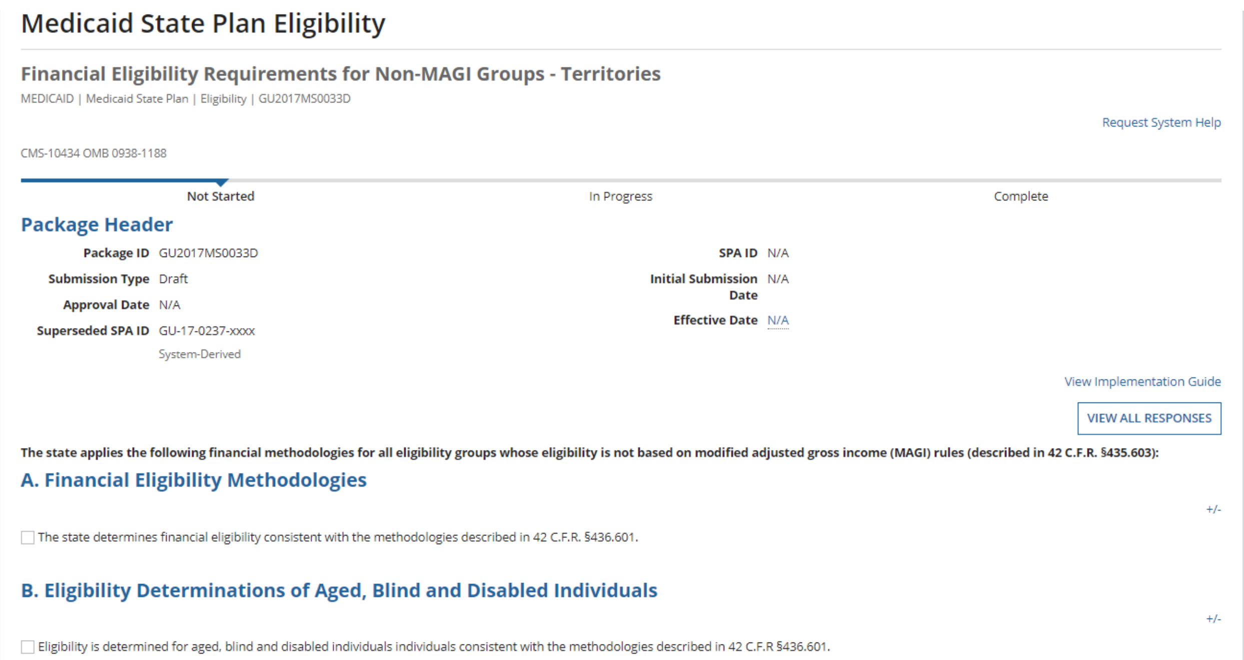
1.1 Financial Eligibility Requirements for Non-MAGI Groups – Territories


Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups - Territories

MEDICAID | Medicaid State Plan | Eligibility | GU2017MS0033D

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID GU2017MS0033D

Submission Type Draft

Approval Date N/A

Superseded SPA ID GU-17-0237-xxxx

System-Derived

SPA ID N/A

Initial Submission Date N/A

Effective Date N/A

View Implementation Guide

VIEW ALL RESPONSES

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

+/-

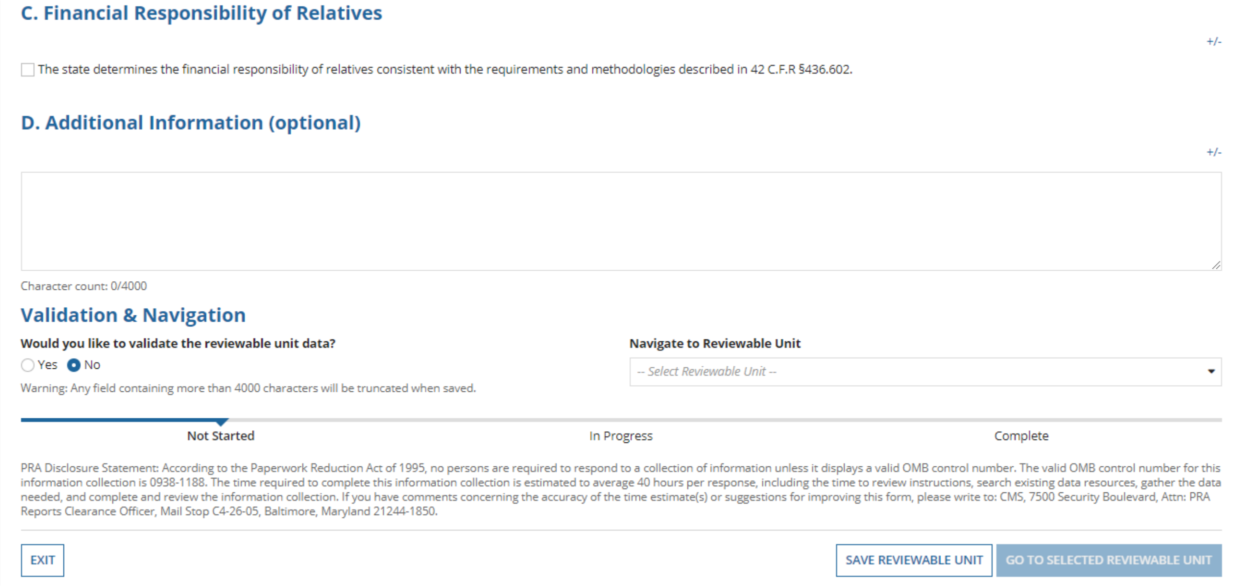
☐ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §436.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

+/-

☐ Eligibility is determined for aged, blind and disabled individuals individuals consistent with the methodologies described in 42 C.F.R §436.601.

Figure 1: Financial Eligibility Requirements for Non-MAGI Groups – Territories – 1


C. Financial Responsibility of Relatives

+/-

☐ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R §436.602.

D. Additional Information (optional)

+/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

○ Yes ● No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started In Progress Complete

PRA Disclosure Statement: 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 average 40 hours per response, 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.

EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 2: Financial Eligibility Requirements for Non-MAGI Groups – Territories – 2

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S3 - Optional Eligibility Groups RU PRA Document

Version 1.0

08/16/2017

Document Number: 178-QSSI-MACPro-R5.1-S3-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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No table of figures entries found.

1. S3 - Optional Eligibility Groups Screenshots

1.1 Package Header

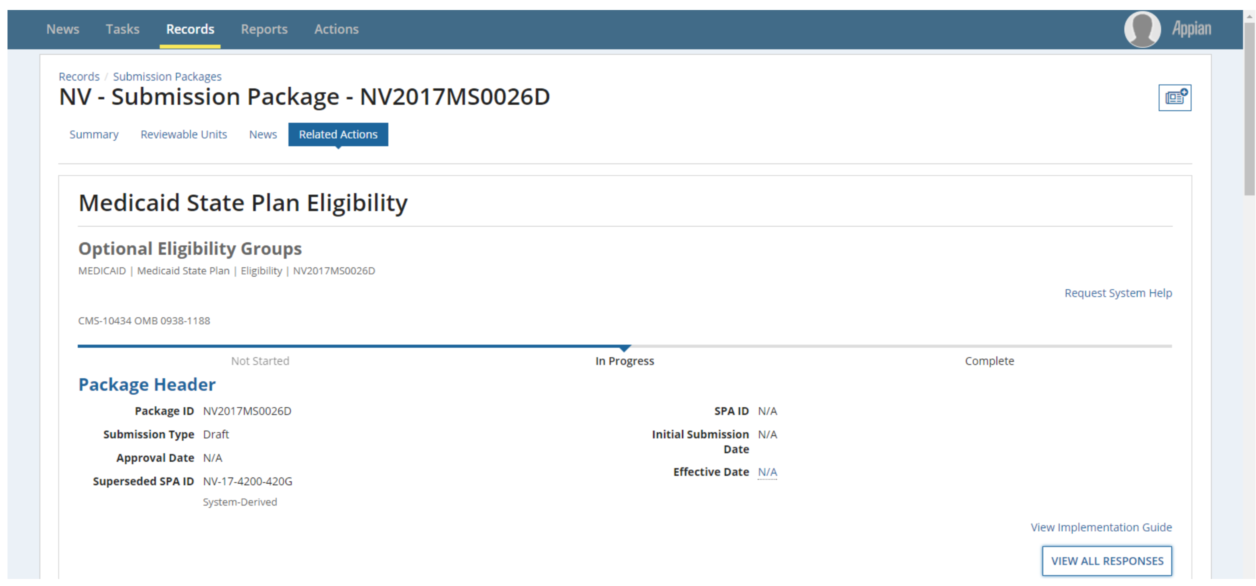
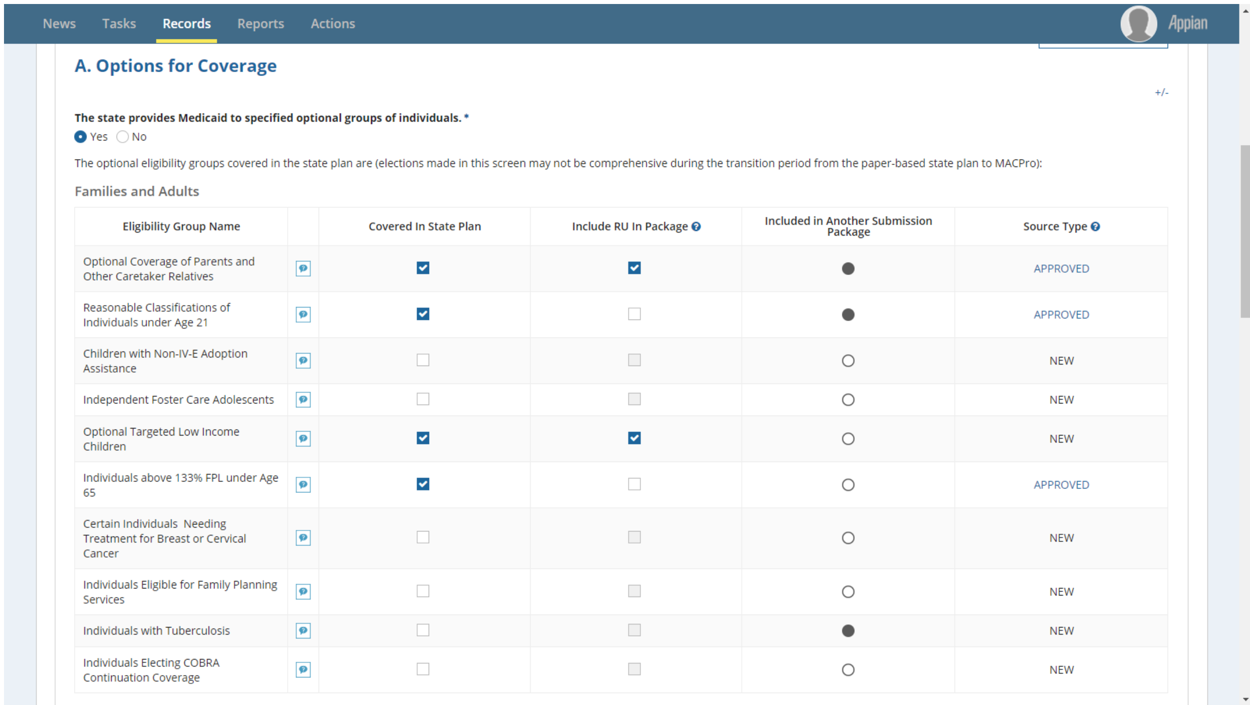


Figure 1: Package Header

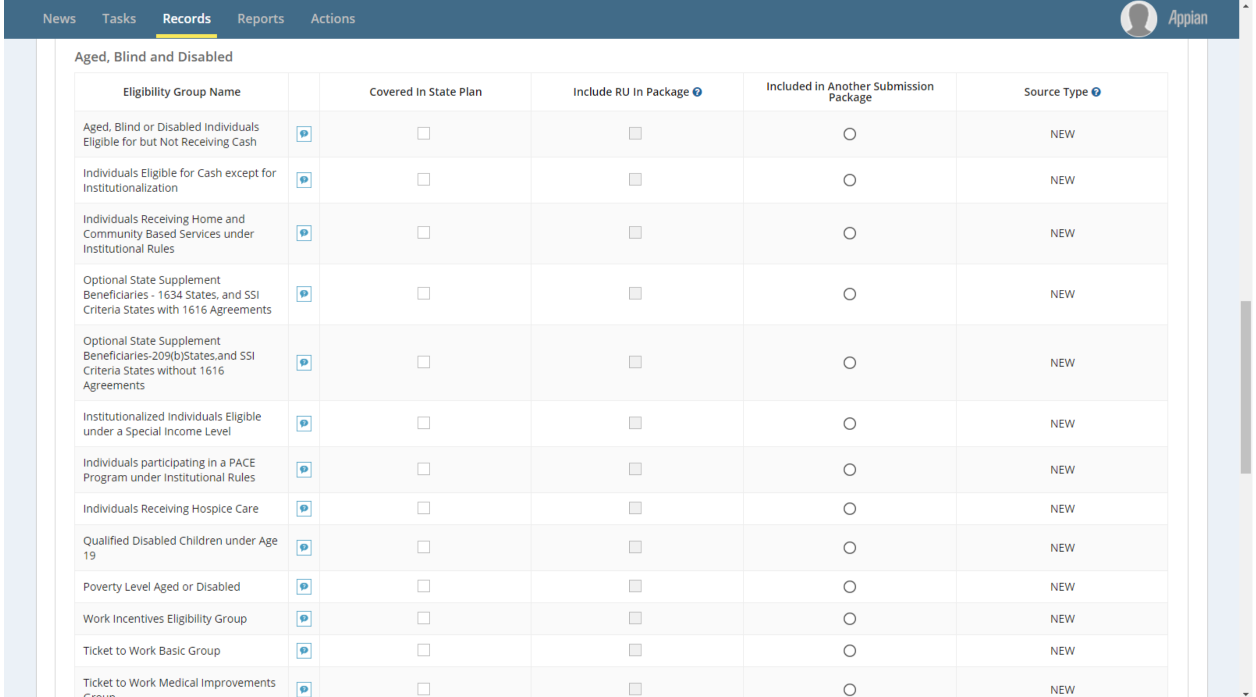
1.2 A. Options for Coverage – Part 1



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		☑	☑	●	APPROVED
Reasonable Classifications of Individuals under Age 21		☑	☐	●	APPROVED
Children with Non-IV-E Adoption Assistance		☐	☐	○	NEW
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☑	☑	○	NEW
Individuals above 133% FPL under Age 65		☑	☐	○	APPROVED
Certain 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

Figure 2: Section A-Part 1

1.3 A. Options for Coverage – Part 2



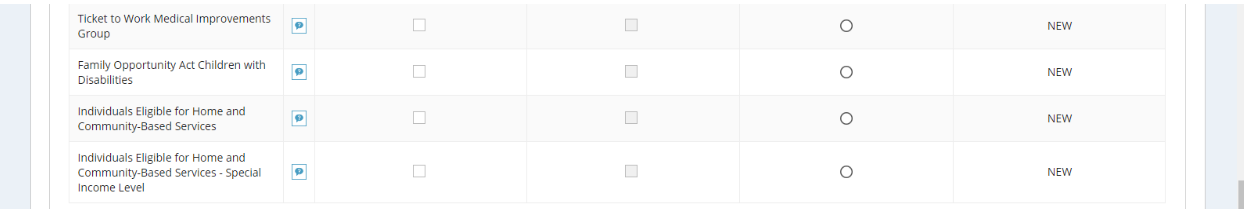
News Tasks Records Reports Actions Appian

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash					NEW
Individuals Eligible for Cash except for Institutionalization					NEW
Individuals Receiving Home and Community Based Services under Institutional Rules					NEW
Optional State Supplement Beneficiaries - 1634 States, and SSI Criteria States with 1616 Agreements					NEW
Optional State Supplement Beneficiaries-209(b)States,and SSI Criteria States without 1616 Agreements					NEW
Institutionalized Individuals Eligible under a Special Income Level					NEW
Individuals participating in a PACE Program under Institutional Rules					NEW
Individuals Receiving Hospice Care					NEW
Qualified Disabled Children under Age 19					NEW
Poverty Level Aged or Disabled					NEW
Work Incentives Eligibility Group					NEW
Ticket to Work Basic Group					NEW
Ticket to Work Medical Improvements Group					NEW

Figure 3: Section A-Part 2

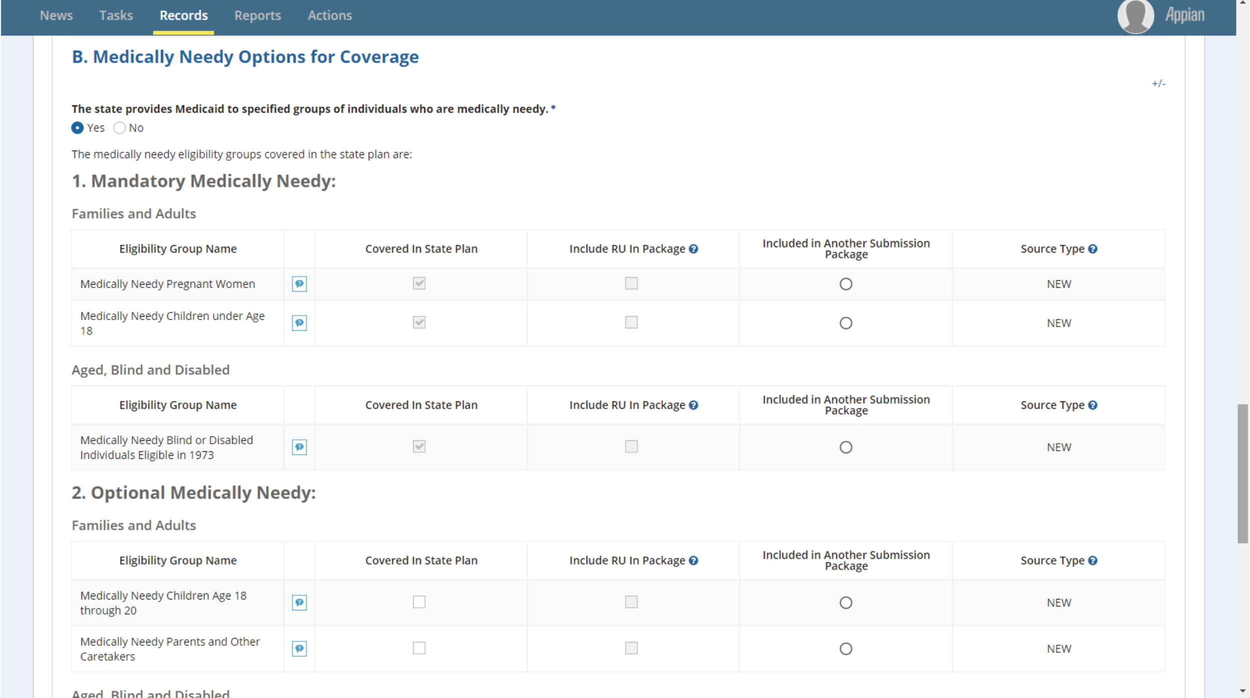
1.4 A. Options for Coverage – Part 3



Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Ticket to Work Medical Improvements Group					NEW
Family Opportunity Act Children with Disabilities					NEW
Individuals Eligible for Home and Community-Based Services					NEW
Individuals Eligible for Home and Community-Based Services - Special Income Level					NEW

Figure 4: Section A-Part 3

1.5 B. Medically Needy Options for Coverage –Part 1



News Tasks Records Reports Actions Appian

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
Medically Needy Blind or Disabled Individuals 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 Children Age 18 through 20					NEW
Medically Needy Parents and Other Caretakers					NEW

Aged, Blind and Disabled

Figure 5: Section B-Part 1

1.6 B. Medically Needy Options for Coverage-Part 2, C. Additional Information (optional) and "Eligibility Groups Deselected from Coverage"

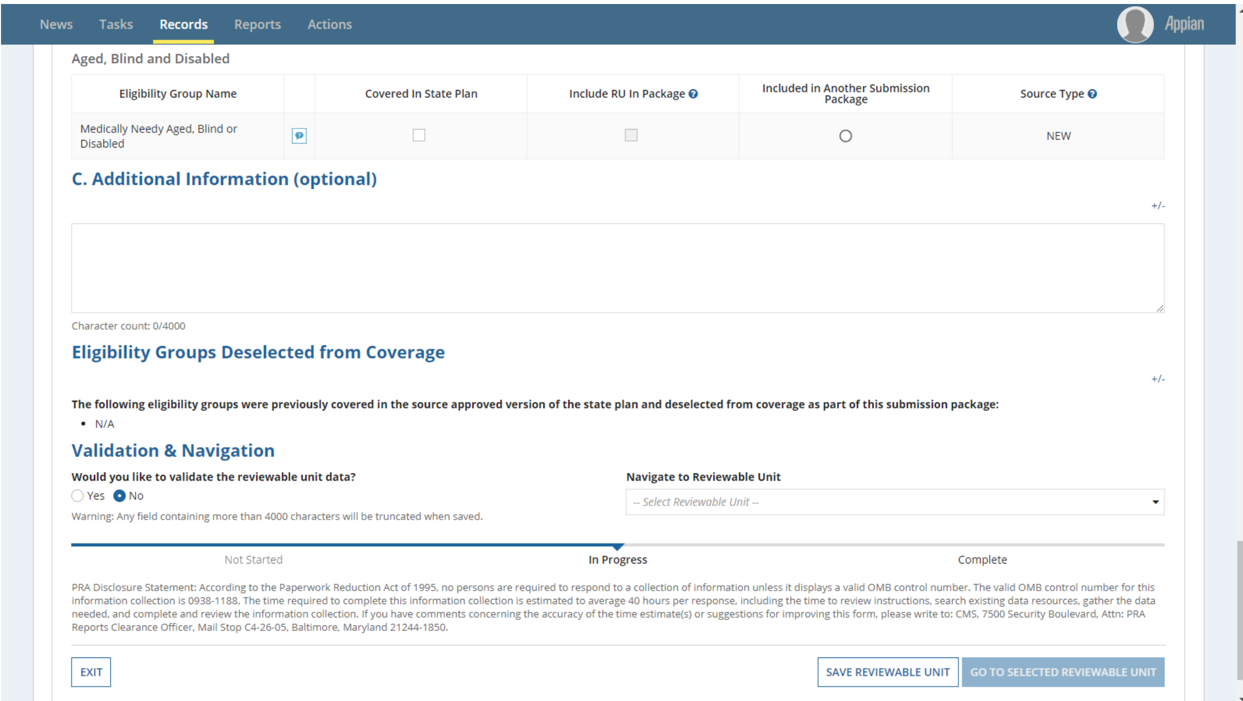


Figure 6: Section B-Part 2, Section C and Section "Eligibility Groups Deselected from Coverage"

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S3a - De-selected RU PRA Document

Version 1.0
08/16/2017

Document Number: 188-QSSI-MACPro-R5.1-S3a-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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No table of figures entries found.

1. S3a – De-selected RU Screenshots

1.1 Package Header

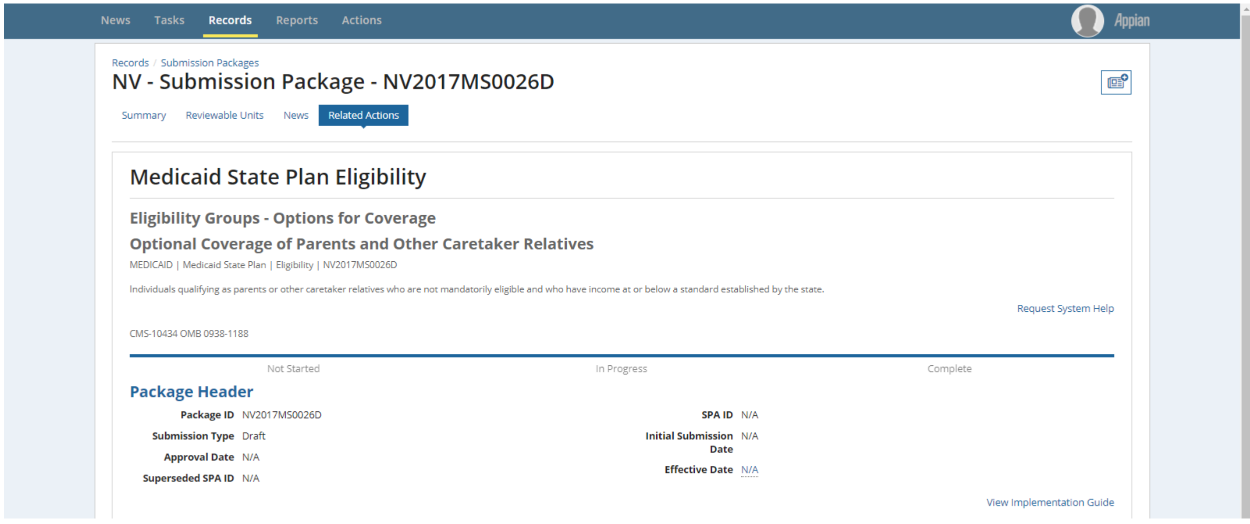

Figure 1: Package Header

1.2 Group No Longer Covered

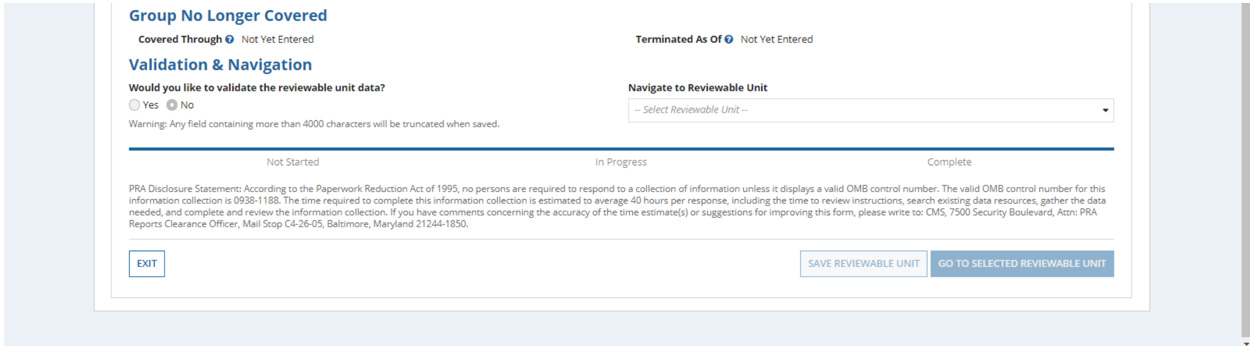

Figure 2: Group No Longer Covered

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S4 - Mandatory Eligibility Groups RU PRA Document

Version 1.0

08/16/2017

Document Number: 190-QSSI-MACPro-R5.1-S4-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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No table of figures entries found.

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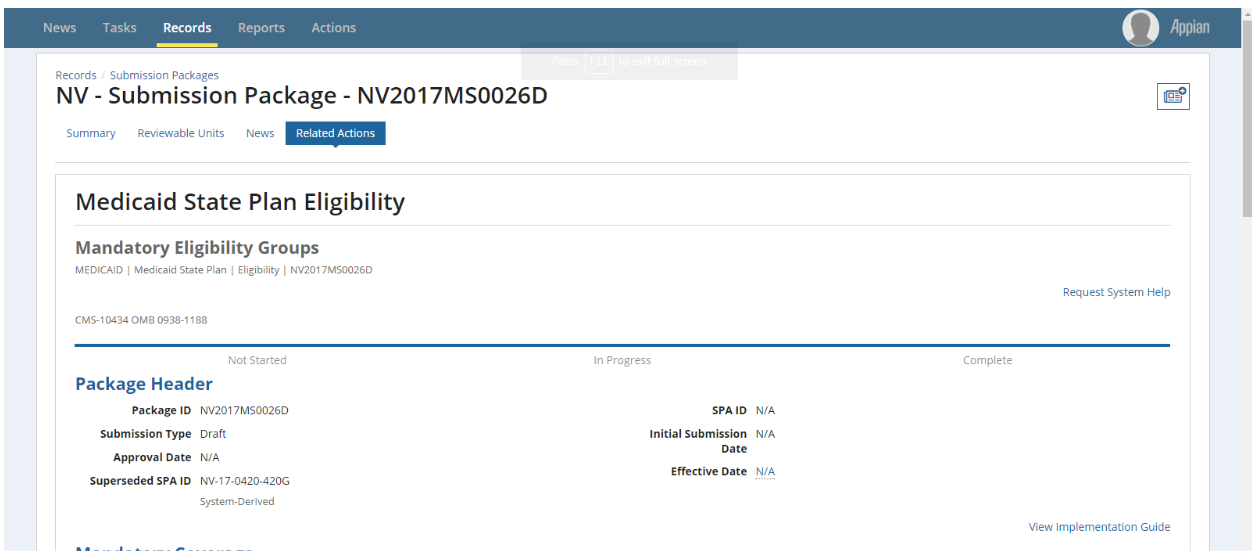
1.1 Package Header


News Tasks Records Reports Actions Appian

Records / Submission Packages

NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News Related Actions

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID NV2017MS0026D

Submission Type Draft

Approval Date N/A

Superseded SPA ID NV-17-0420-420G

System-Derived

SPA ID N/A

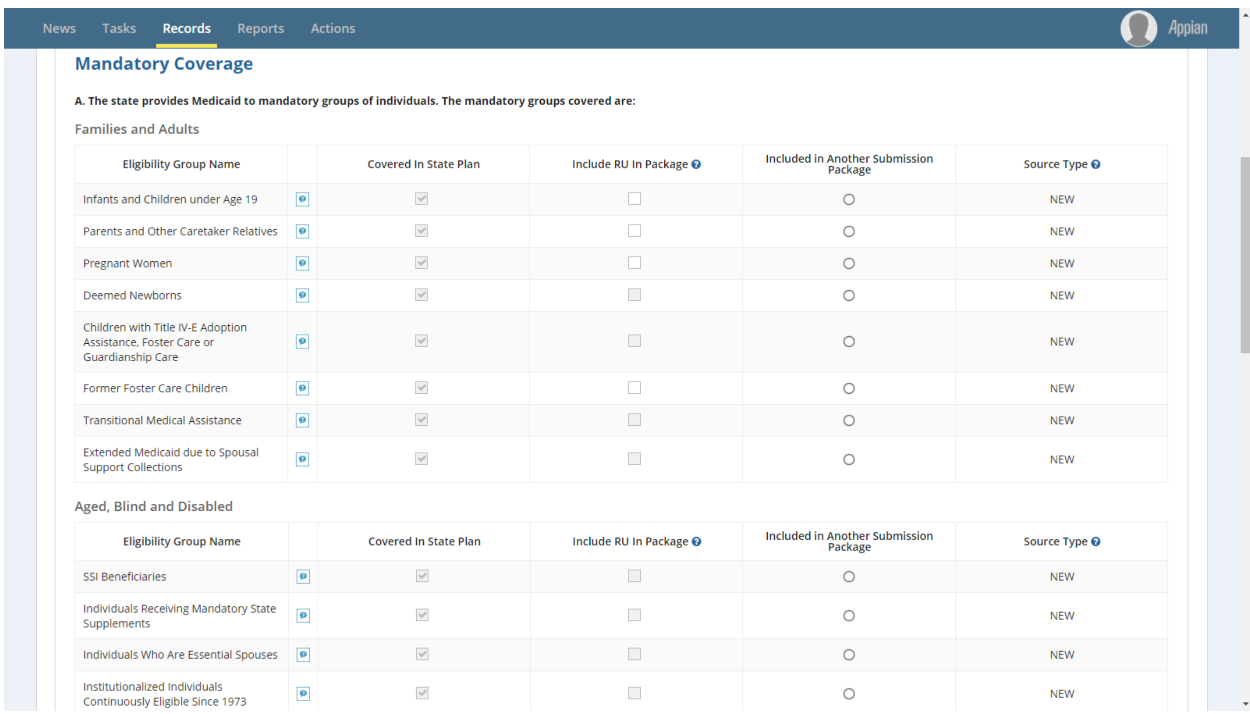
Initial Submission Date N/A

Effective Date N/A

View Implementation Guide

Figure 1: Package Header

1.2 Mandatory Coverage – Section A - Part 1


News Tasks Records Reports Actions Appian

Mandatory Coverage

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

Families and Adults

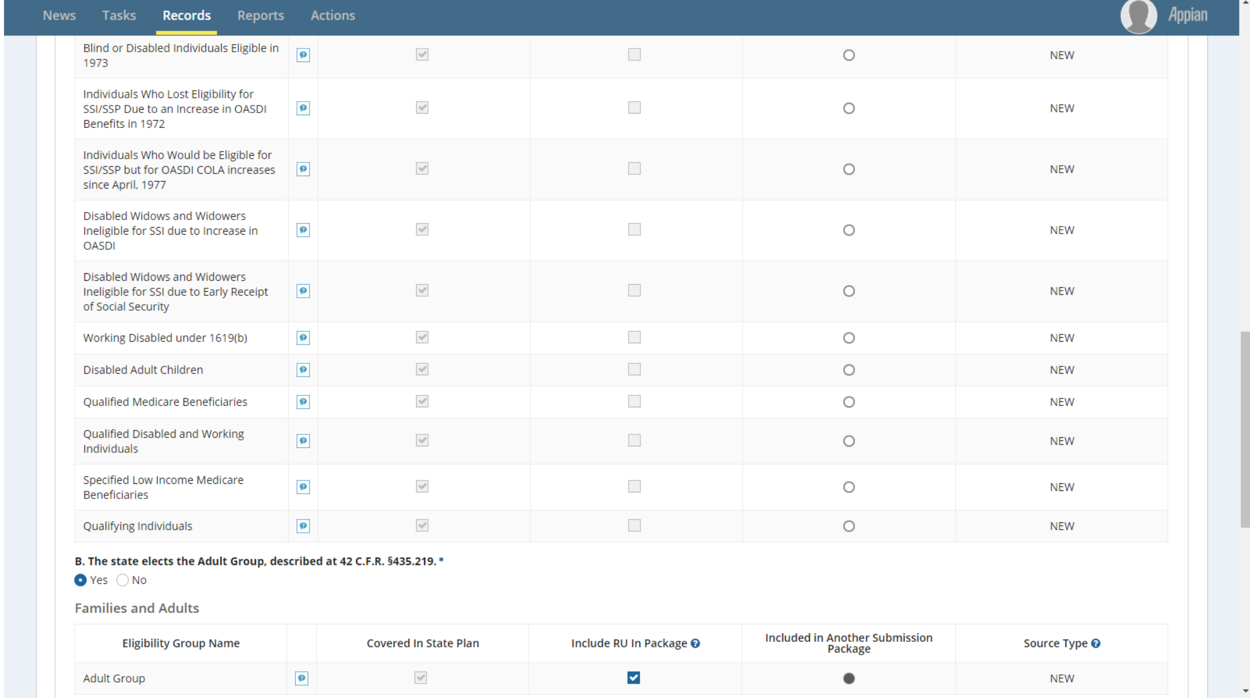
Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☑	☐	○	NEW
Parents and Other Caretaker Relatives		☑	☐	○	NEW
Pregnant Women		☑	☐	○	NEW
Deemed Newborns		☑	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☑	☐	○	NEW
Former Foster Care Children		☑	☐	○	NEW
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
SSI Beneficiaries		☑	☐	○	NEW
Individuals Receiving Mandatory State Supplements		☑	☐	○	NEW
Individuals Who Are Essential Spouses		☑	☐	○	NEW
Institutionalized Individuals Continuously Eligible Since 1973		☑	☐	○	NEW

Figure 2: Section A-Part 1

1.3 Mandatory Coverage – Section A-Part 2 and Section B



Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Blind or Disabled Individuals Eligible in 1973	☑	☐	○	NEW
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	☑	☐	○	NEW
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	☑	☐	○	NEW
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	☑	☐	○	NEW
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	☑	☐	○	NEW
Working Disabled under 1619(b)	☑	☐	○	NEW
Disabled Adult Children	☑	☐	○	NEW
Qualified Medicare Beneficiaries	☑	☐	○	NEW
Qualified Disabled and Working Individuals	☑	☐	○	NEW
Specified Low Income Medicare Beneficiaries	☑	☐	○	NEW
Qualifying Individuals	☑	☐	○	NEW

B. The state elects the Adult Group, described at 42 C.F.R. §435.219. *

◉ 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	☑	☑	●	NEW

Figure 3: Section A-Part 2 and Section B

1.4 Mandatory Coverage – Section C

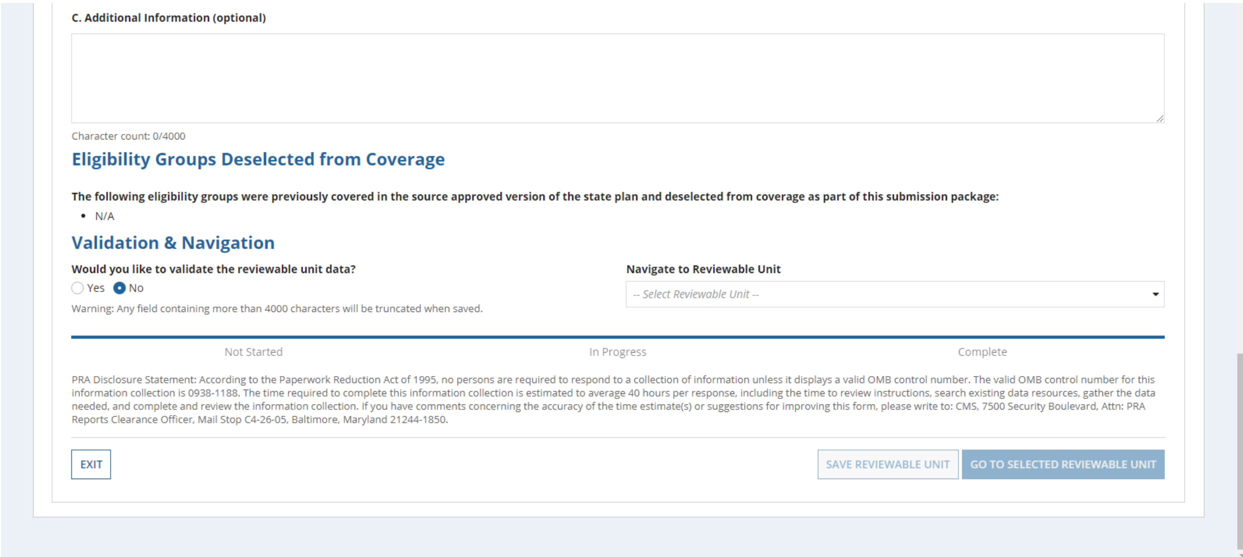


Figure 4: Section C

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S10-MAGI Based Methodologies RU PRA document

Version 1.0

08/10/2017

Document Number: 166-QSSI-MACPro-PRA-S10-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S10- MAGI Based Methodologies Screenshots

1.1 Section A. Household Composition

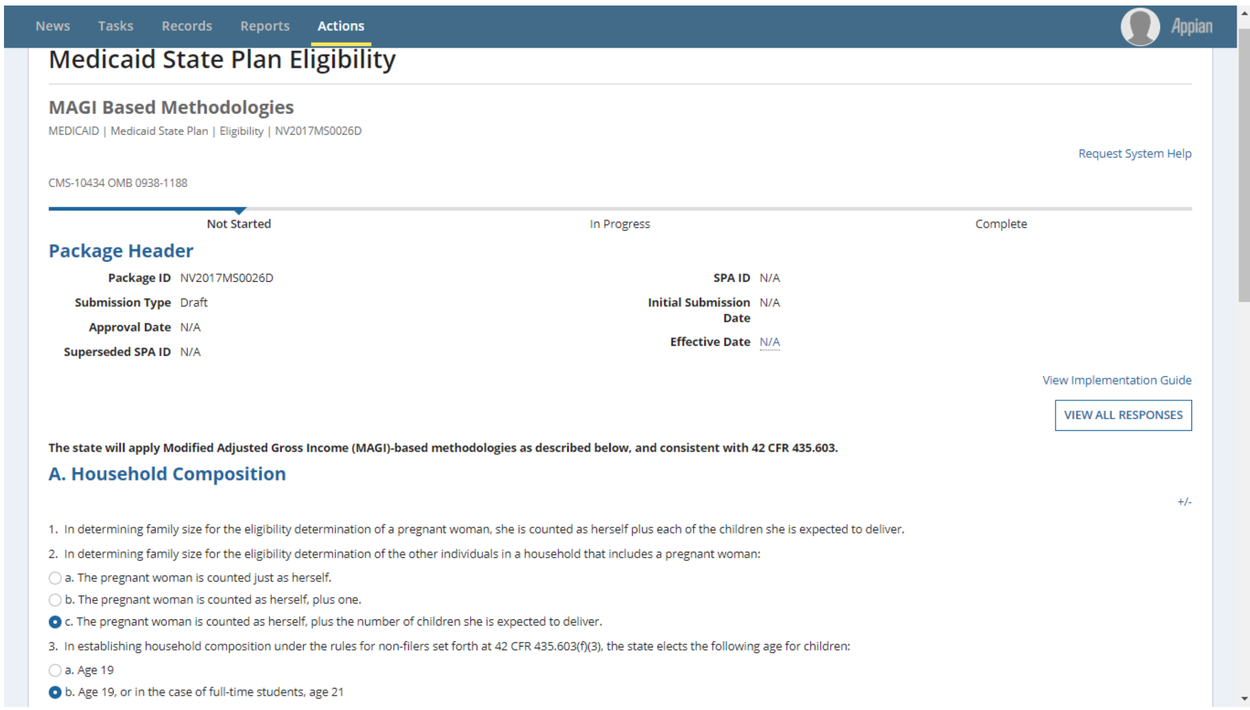
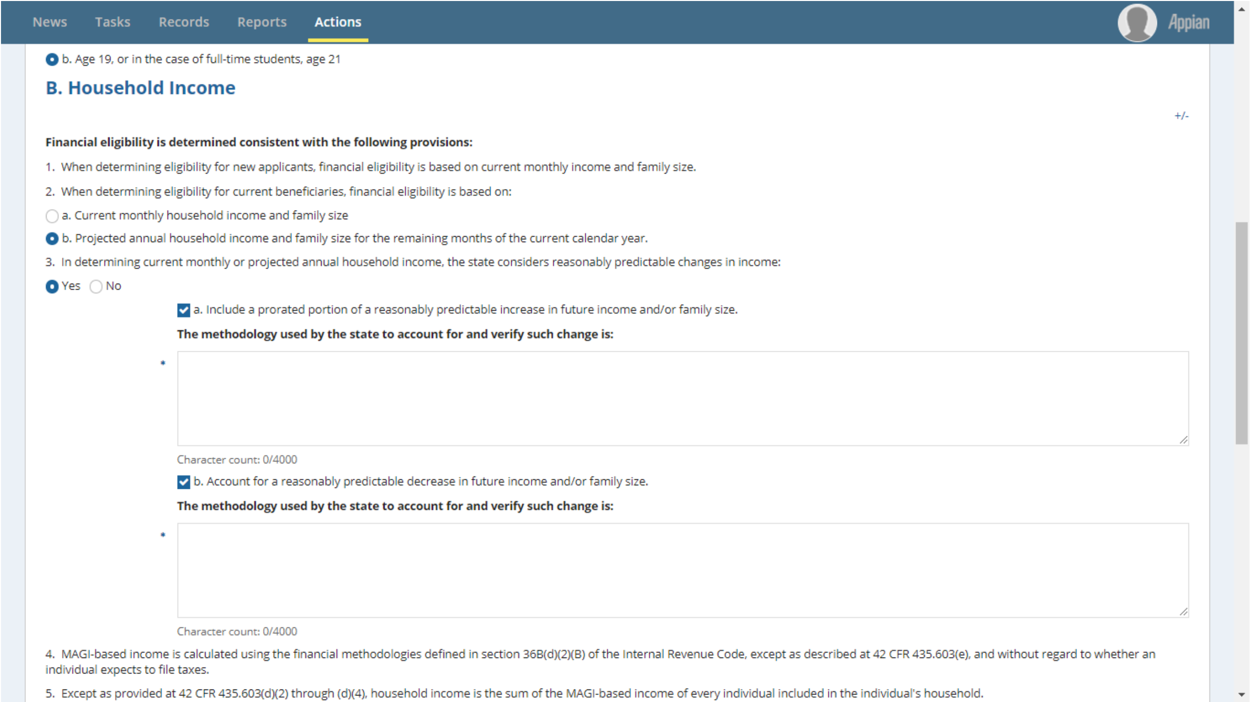


Figure 1: Section A- Household Composition

1.2 Section B. Household Income


News Tasks Records Reports Actions Appian

b. Age 19, or in the case of full-time students, age 21

B. Household Income

+/-

Financial eligibility is determined consistent with the following provisions:

1. When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.
2. When determining eligibility for current beneficiaries, financial eligibility is based on:
   - a. Current monthly household income and family size
   - b. Projected annual household income and family size for the remaining months of the current calendar year.
3. In determining current monthly or projected annual household income, the state considers reasonably predictable changes in income:
   Yes No
   - a. Include a prorated portion of a reasonably predictable increase in future income and/or family size.
     The methodology used by the state to account for and verify such change is:
     Character count: 0/4000
   - b. Account for a reasonably predictable decrease in future income and/or family size.
     The methodology used by the state to account for and verify such change is:
     Character count: 0/4000
4. MAGI-based income is calculated using the financial methodologies defined in section 36B(d)(2)(B) of the Internal Revenue Code, except as described at 42 CFR 435.603(e), and without regard to whether an individual expects to file taxes.
5. Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Figure 2: Section B

1.3 Section B. Household Income – Path 1

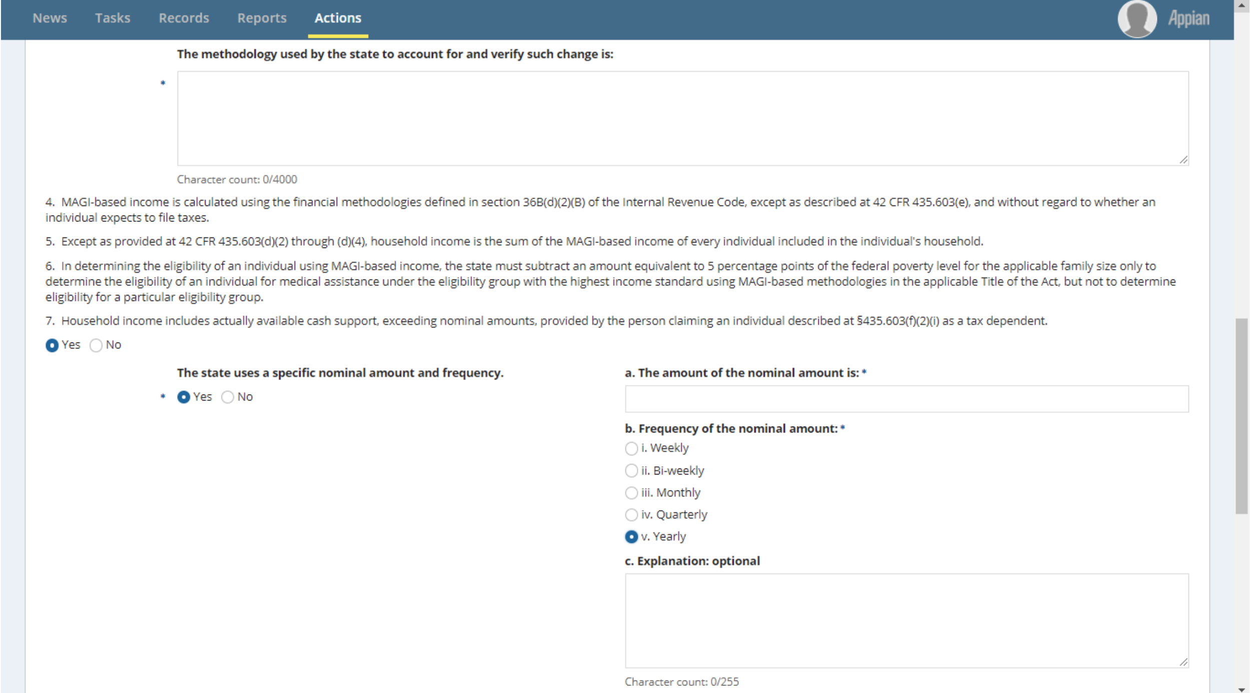


Figure 3: Section B- Path 1

1.4 Section B. Household Income – Path 2

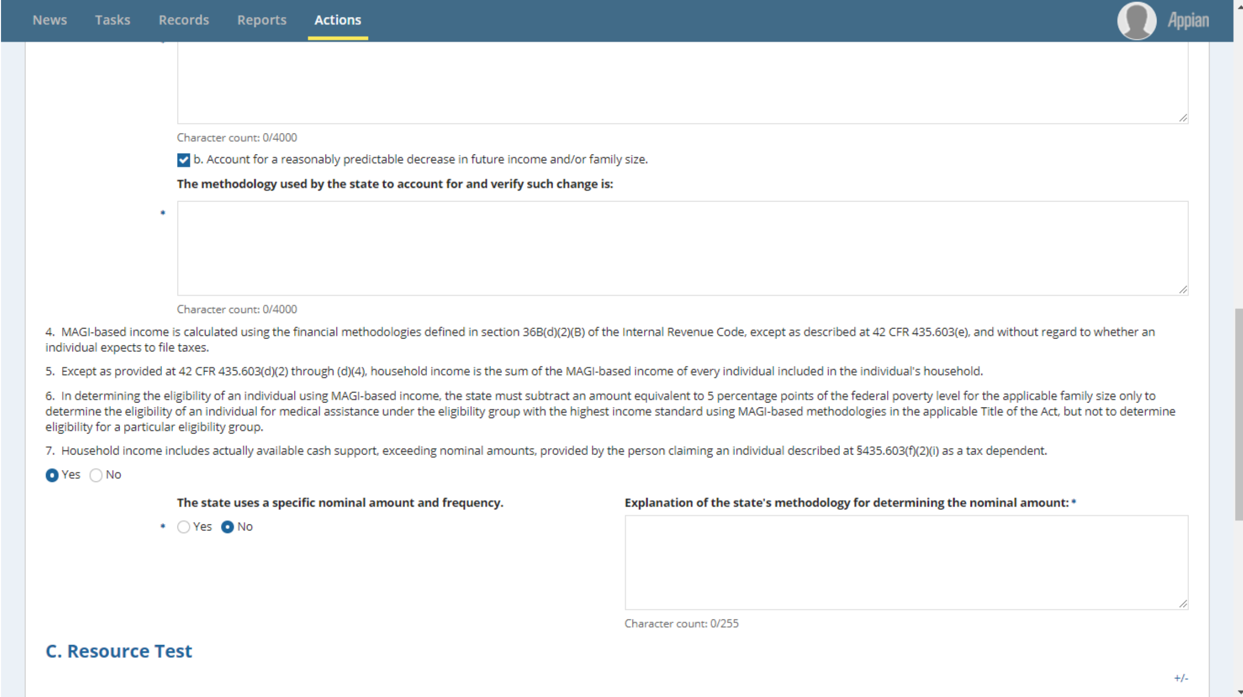


Figure 4: Section B- Path 2

1.5 Section C. Resource Test and Section D. Additional Information (optional)

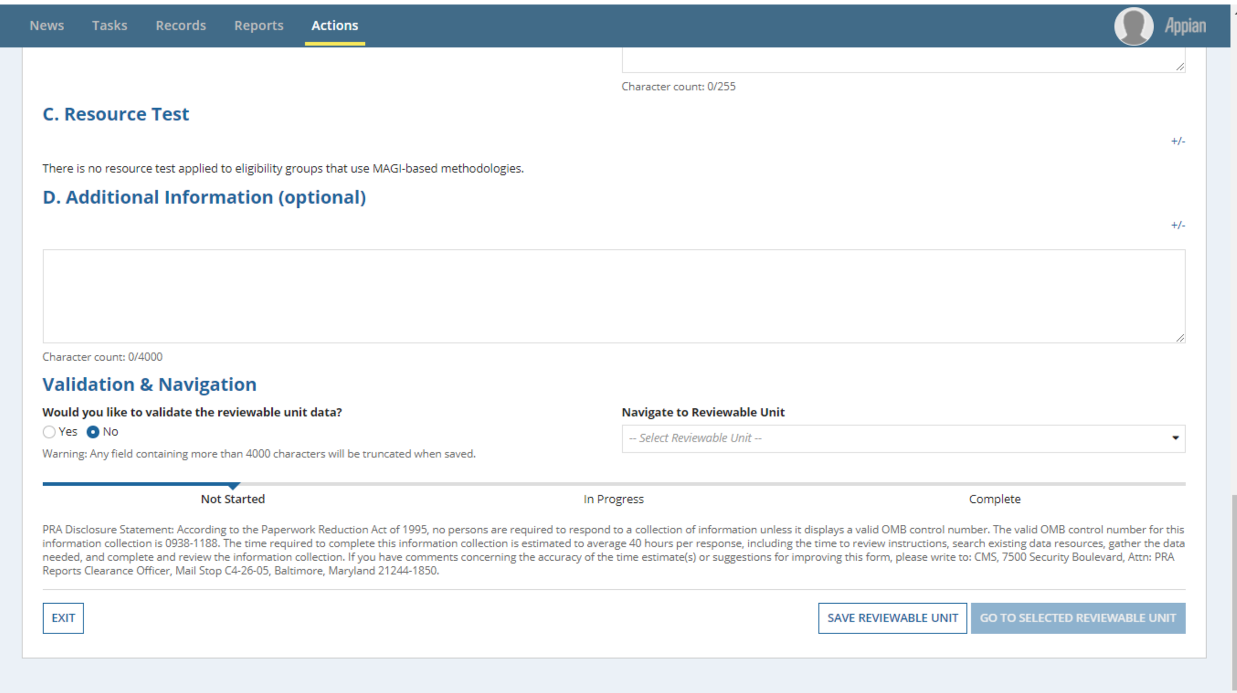


Figure 5: Section C and Section D

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S10T-MAGI Based Methodologies - Territories RU PRA document

Version 1.0

08/16/2017

Document Number: 176-QSSI-MACPro-R5.1-S10T-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 3: Section B- Options 6-8 2

Figure 4: Section C and Section D 3

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1. S10T- MAGI Based Methodologies - Territories Screenshots

1.1 Section A. Household Composition

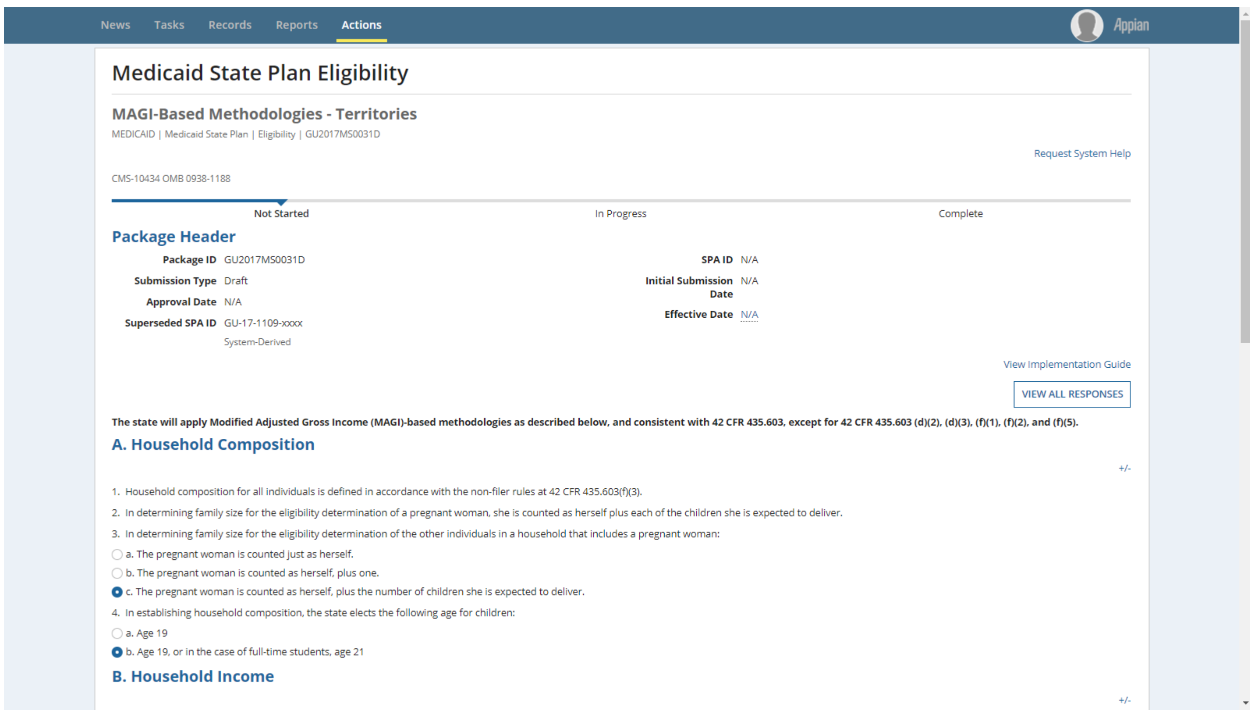
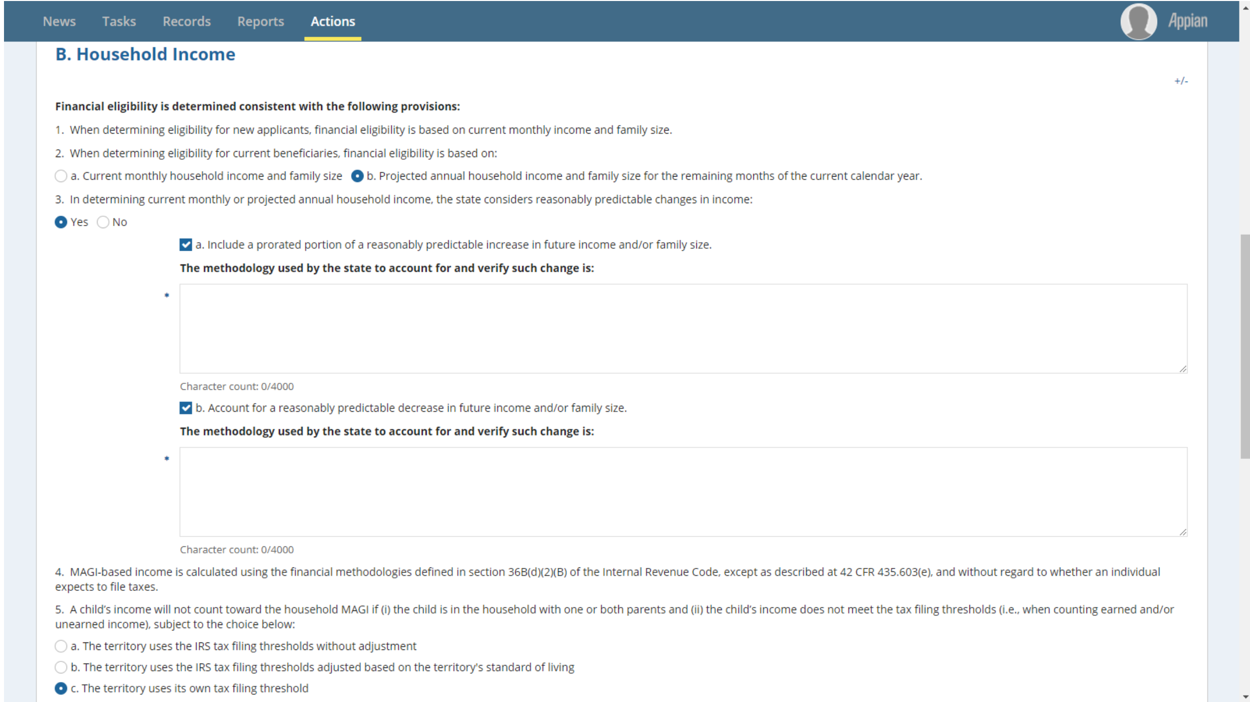


Figure 1: Section A- Household Composition

1.2 Section B. Household Income – Options 1-5


News Tasks Records Reports **Actions** Appian

B. Household Income

+/-

Financial eligibility is determined consistent with the following provisions:

1. When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.
2. When determining eligibility for current beneficiaries, financial eligibility is based on:

( ) a. Current monthly household income and family size (•) b. Projected annual household income and family size for the remaining months of the current calendar year.

3. In determining current monthly or projected annual household income, the state considers reasonably predictable changes in income:

(•) Yes ( ) No

[x] a. Include a prorated portion of a reasonably predictable increase in future income and/or family size.

The methodology used by the state to account for and verify such change is:

Character count: 0/4000

[x] b. Account for a reasonably predictable decrease in future income and/or family size.

The methodology used by the state to account for and verify such change is:

Character count: 0/4000

4. MAGI-based income is calculated using the financial methodologies defined in section 36B(d)(2)(B) of the Internal Revenue Code, except as described at 42 CFR 435.603(e), and without regard to whether an individual expects to file taxes.
5. A child's income will not count toward the household MAGI if (i) the child is in the household with one or both parents and (ii) the child's income does not meet the tax filing thresholds (i.e., when counting earned and/or unearned income), subject to the choice below:

( ) a. The territory uses the IRS tax filing thresholds without adjustment
( ) b. The territory uses the IRS tax filing thresholds adjusted based on the territory's standard of living
(•) c. The territory uses its own tax filing threshold

Figure 2: Section B-Options 1-5

1.3 Section B. Household Income – Options 6-8

6. If a child is not living with at least one parent, the child's income counts as a regular member for any household in which the child is a member, including the household in which the child is the member whose eligibility is being evaluated (i.e., a child who is living with a grandmother (caretaker relative) and siblings).
7. In determining the eligibility of an individual using MAGI-based income, the territory must subtract an amount equivalent to 5 percentage points of the poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
8. In determining the eligibility of an individual using MAGI-based income, the territory may elect to use the local poverty level in place of the Federal poverty level. See Income Standards - Territories screen for option selected.

View Approved Version of Income Standards - Poverty Level - Territories

Figure 3: Section B- Options 6-8

1.4 Section C. Resource Test and Section D. Additional Information (optional)

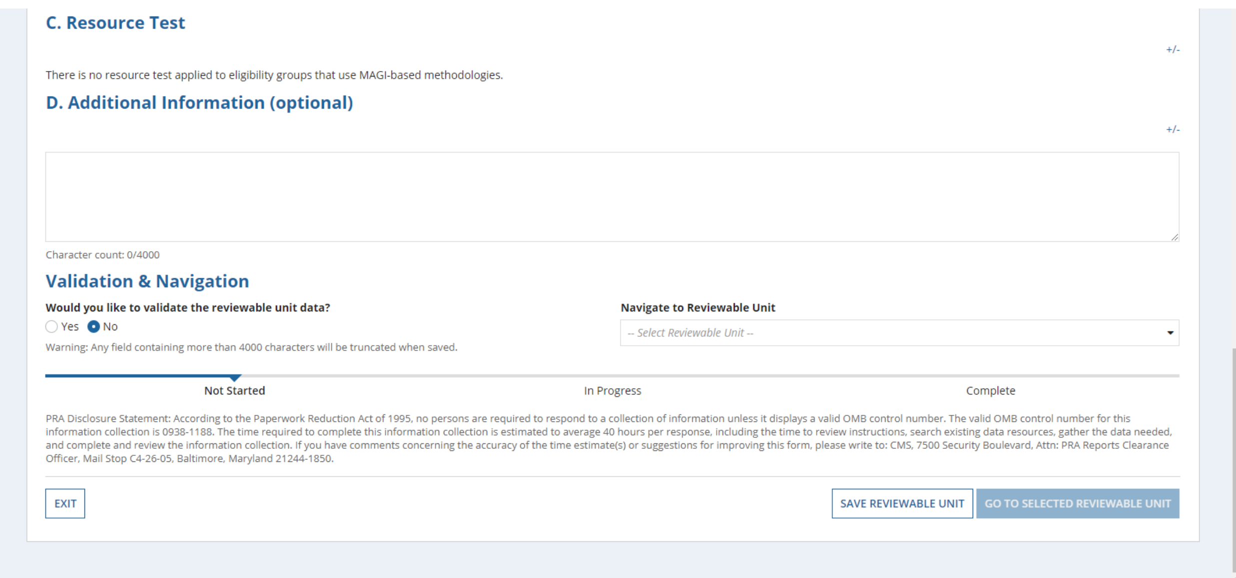


Figure 4: Section C and Section D

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S11 - Reasonable Classification of Children - All PRA Document

Version 1.0

08/21/2017

Document Number: 238-QSSI-MACPro-R5.1-S11-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.1 Reasonable Classification of Children – Limit – Screenshot 1

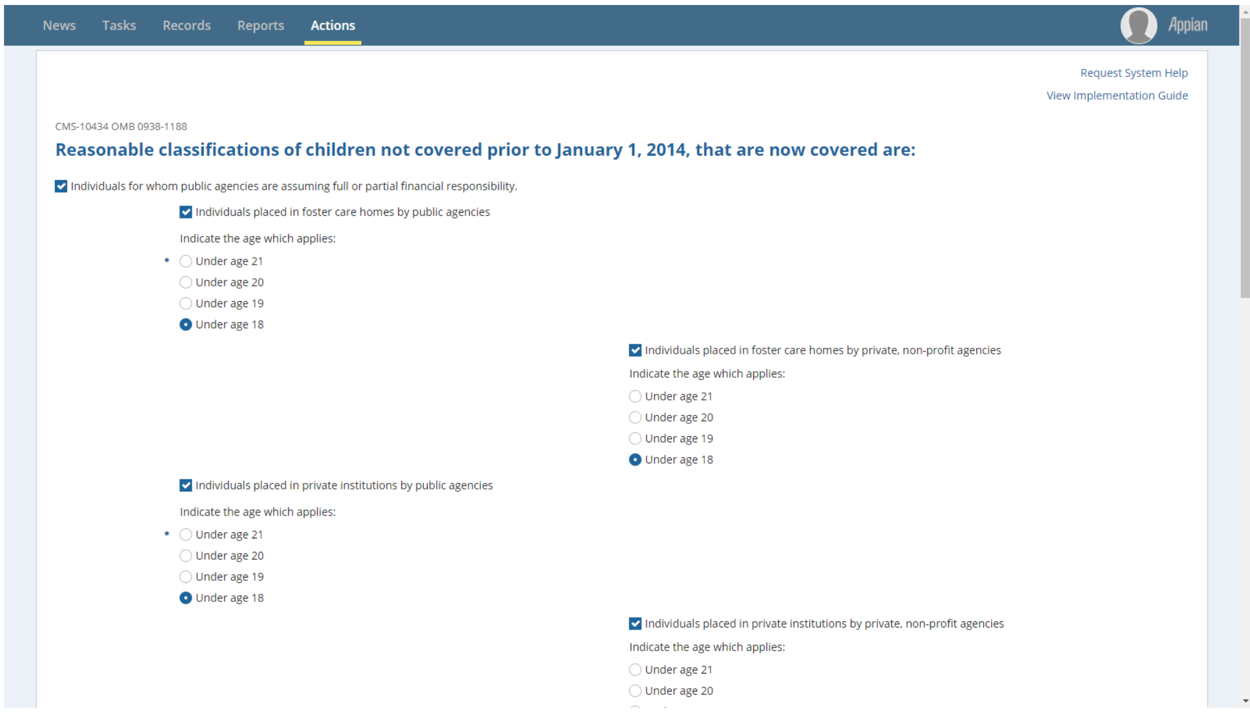

Figure 1: Reasonable Classification of Children - All– Screenshot 1

1.2 Reasonable Classification of Children - All– Screenshot 2

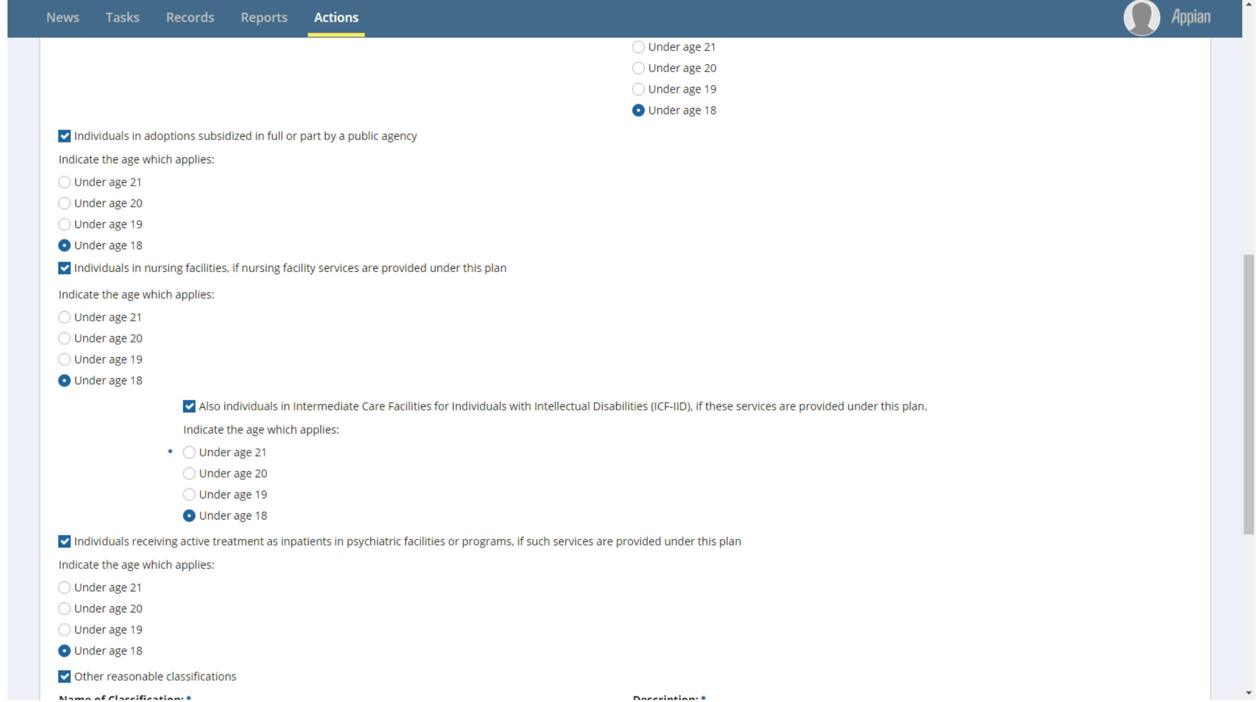

Figure 2: Reasonable Classification of Children - All– Screenshot 2

1.3 Reasonable Classification of Children - All– Screenshot 3

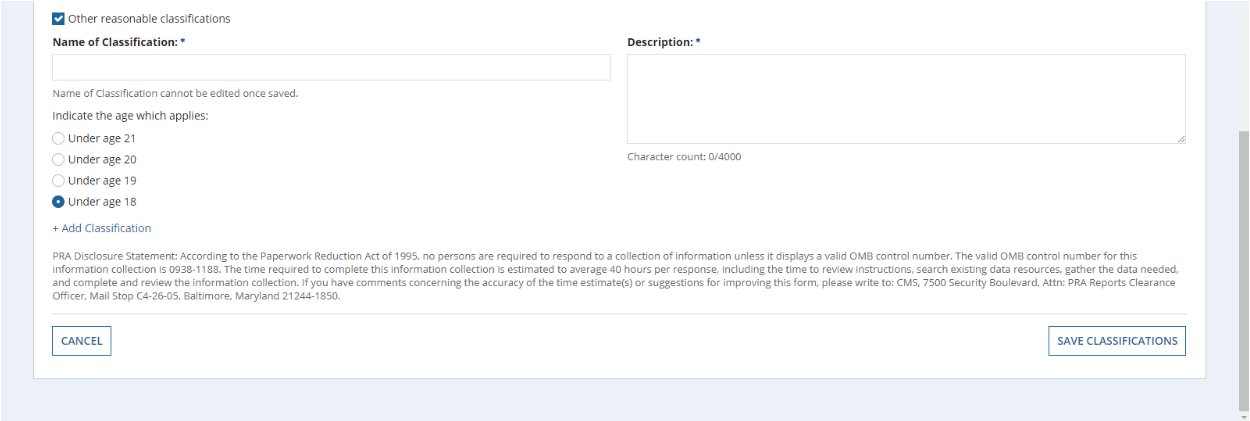

Figure 3: Reasonable Classification of Children - All– Screenshot 3

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S11a - Reasonable Classification of Children - Limit PRA Document

Version 1.0

08/21/2017

Document Number: 239-QSSI-MACPro-R5.1-S11a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S11a - Reasonable Classification of Children – Limit Screenshots

1.1 Reasonable Classification of Children – Limit – Screenshot 1

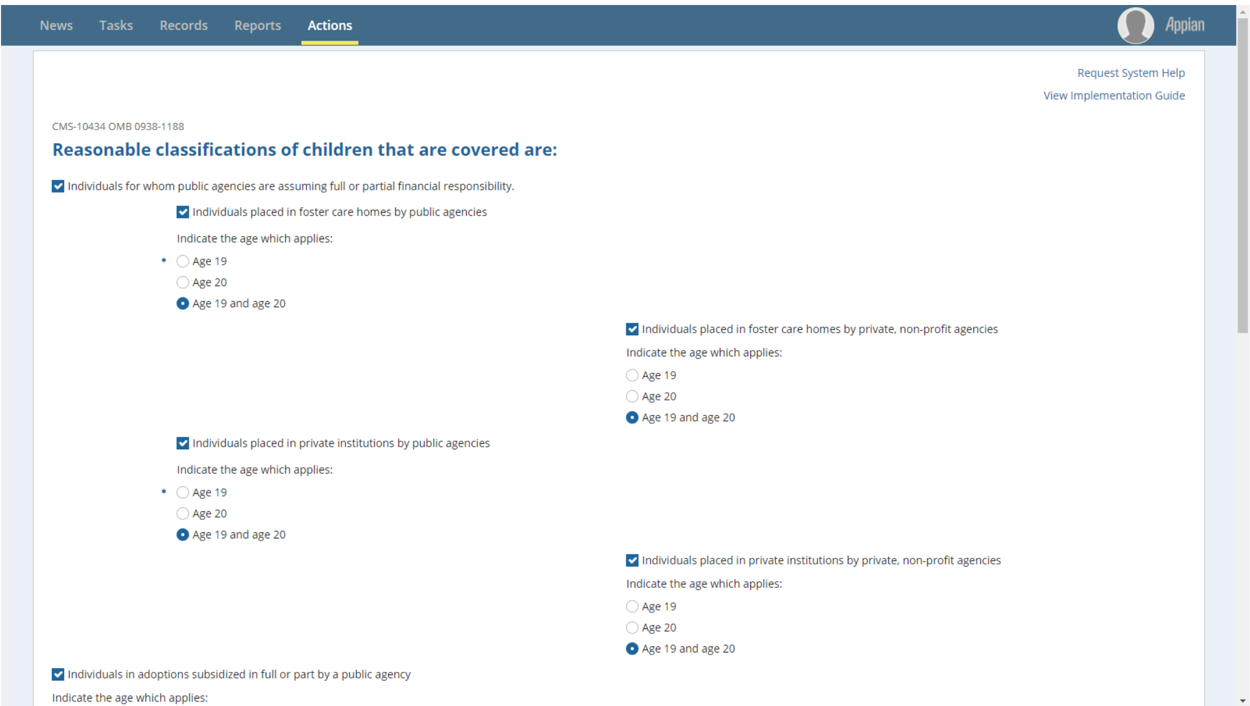
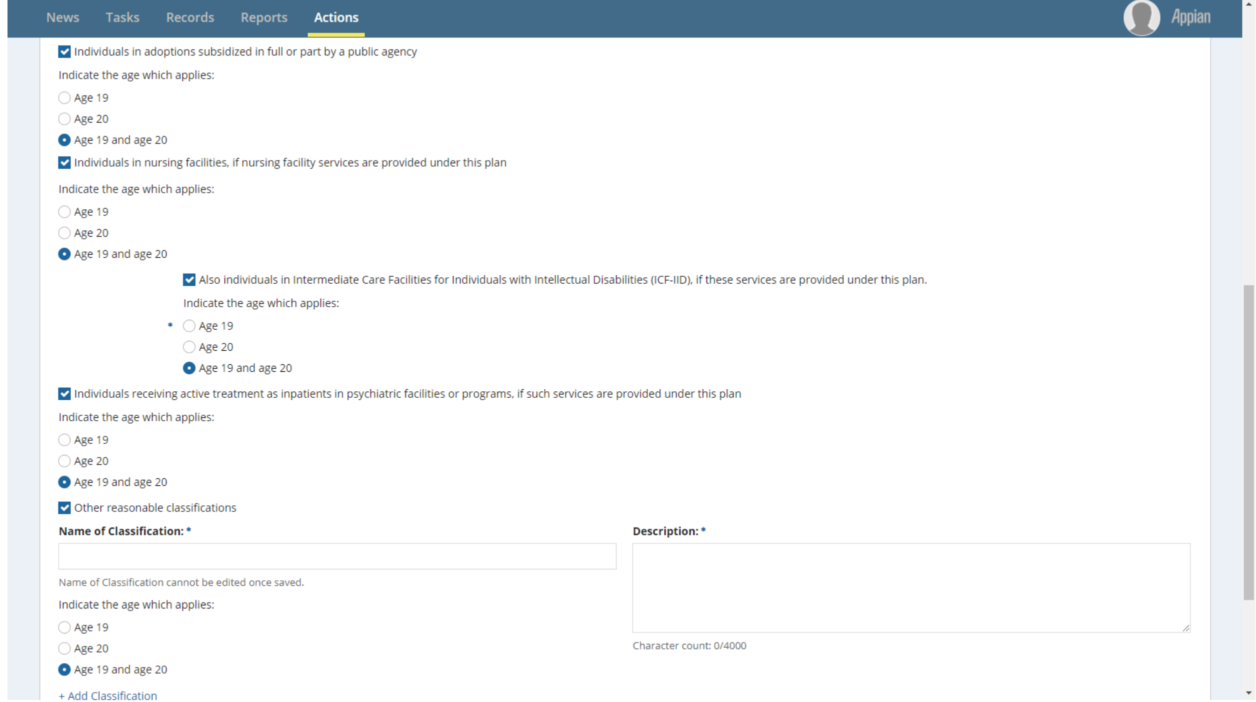


Figure 1: Reasonable Classification of Children - Limit– Screenshot 1

1.2 Reasonable Classification of Children - Limit– Screenshot 2


News Tasks Records Reports Actions Appian

- [x] Individuals in adoptions subsidized in full or part by a public agency

Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

- [x] Individuals in nursing facilities, if nursing facility services are provided under this plan

Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

- [x] Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.

Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

- [x] Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

- [x] Other reasonable classifications

Name of Classification: *

Name of Classification cannot be edited once saved.

Description: *

Character count: 0/4000

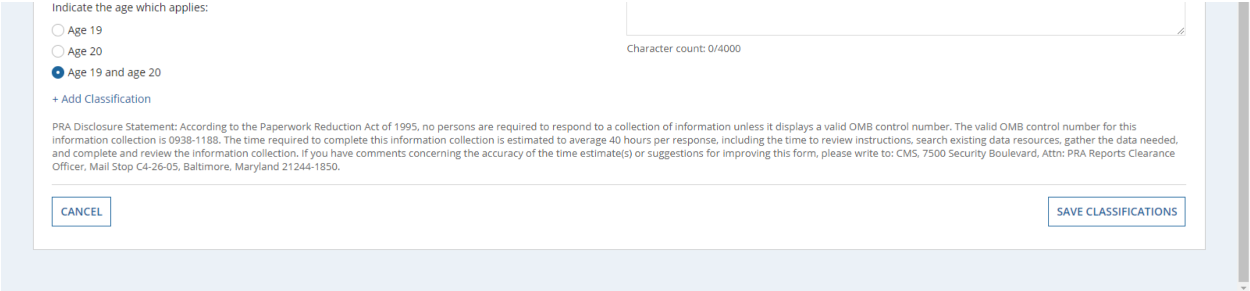
Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

+ Add Classification

Figure 2: Reasonable Classification of Children - Limit– Screenshot 2

1.3 Reasonable Classification of Children - Limit– Screenshot 3


Indicate the age which applies:

- ( ) Age 19
- ( ) Age 20
- (•) Age 19 and age 20

Character count: 0/4000

+ Add Classification

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CANCEL SAVE CLASSIFICATIONS

Figure 3: Reasonable Classification of Children - Limit– Screenshot 3

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S13a - Income Standard PRA Document

Version 1.0
08/18/2017

Document Number: 219-QSSI-MACPro-R5.1-S13a-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S13a - Income Standard Screenshots

1.1 Income Standard – Path 1

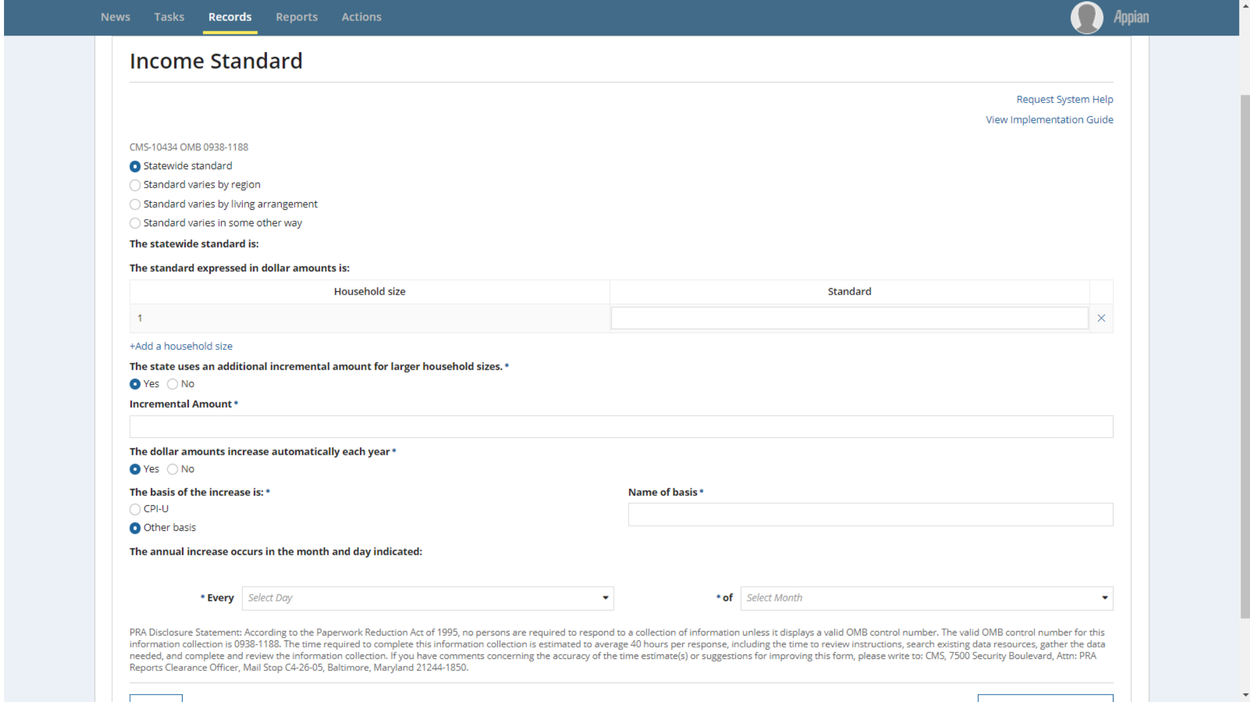

Figure 1: Income Standard – Path 1

1.2 Income Standard – Path 2

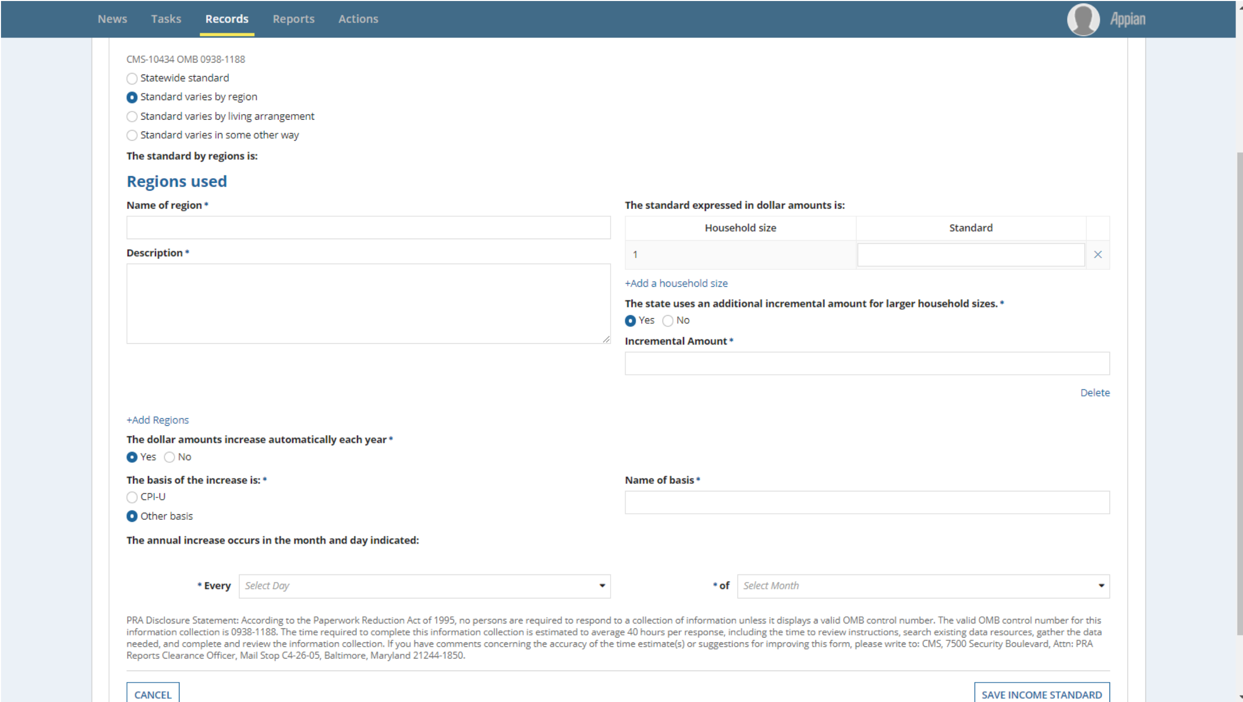

Figure 2: Income Standard – Path 2

1.3 Income Standard – Path 3

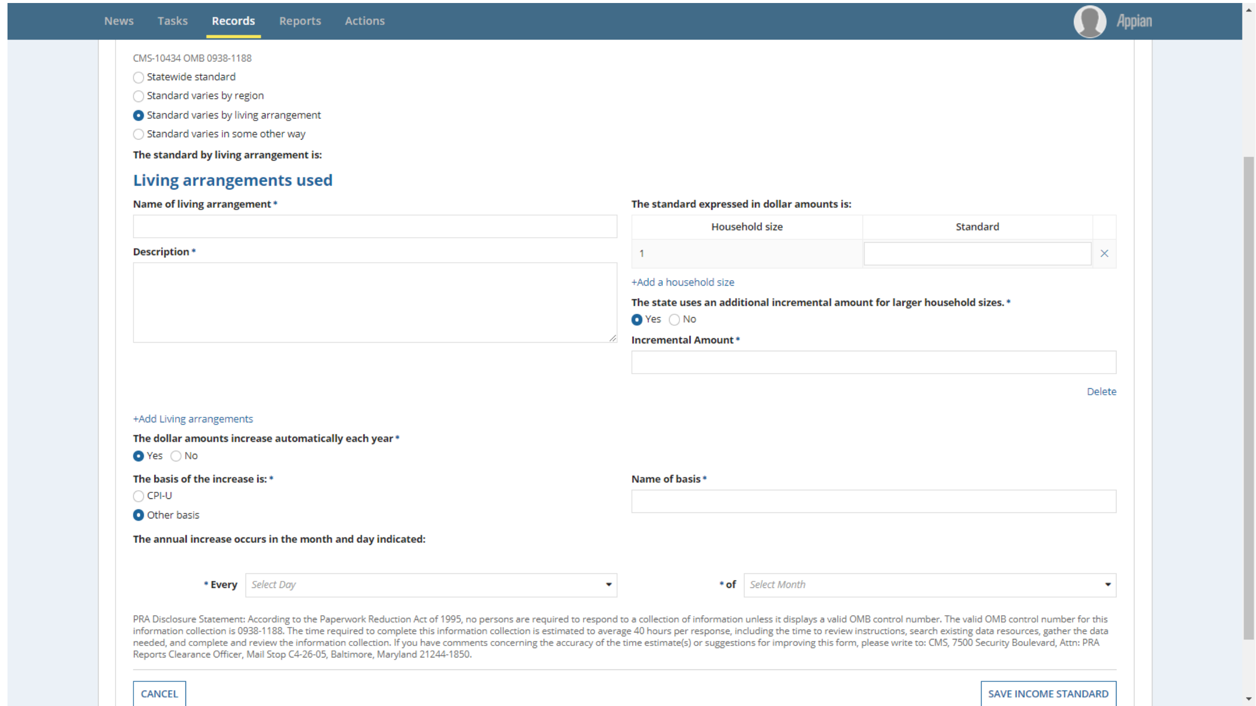

Figure 3: Income Standard – Path 3

1.4 Income Standard – Path 4

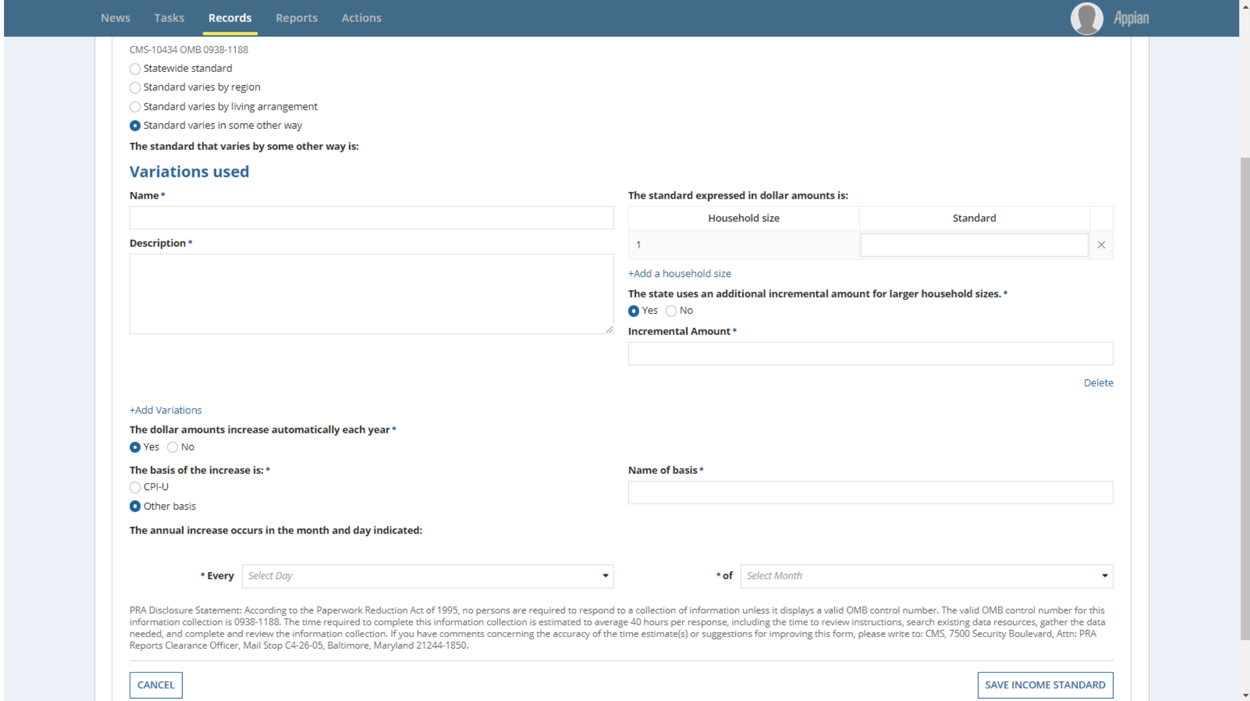

Figure 4: Income Standard – Path 4

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S14-AFDC Income Standards PRA document

Version 1.0
08/17/2017

Document Number: 205-QSSI-MACPro-PRA-S14-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S14-AFDC Income Standards – Screenshots

1.1 AFDC Income Standards

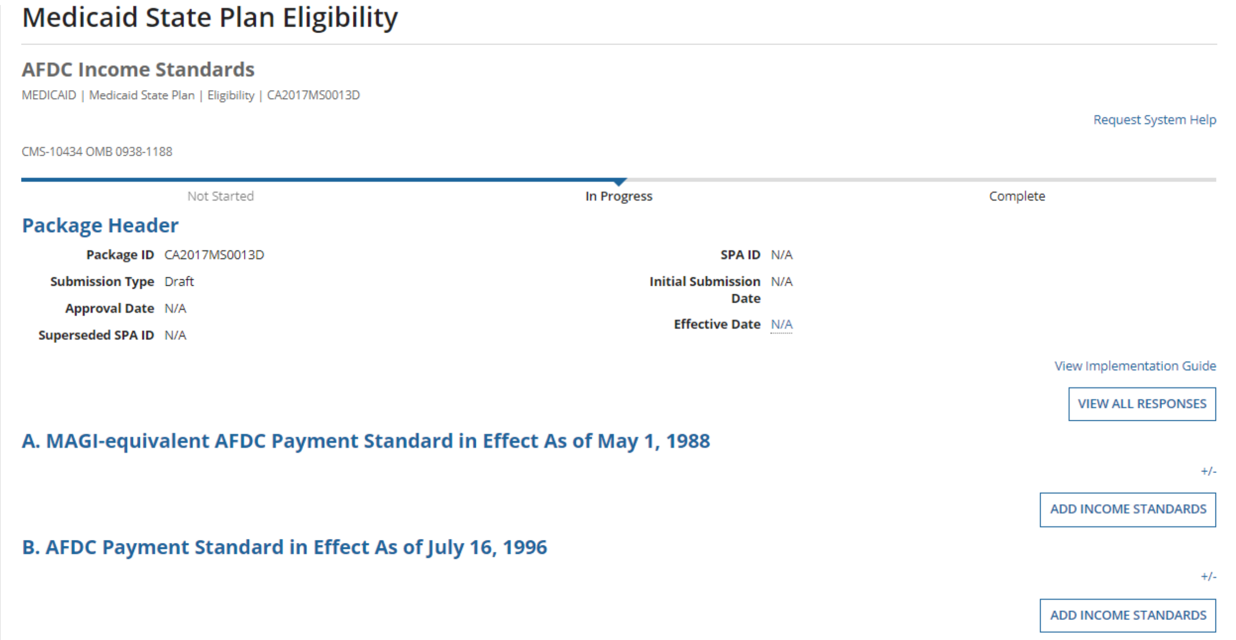

Figure 1: AFDC Income Standards - 1

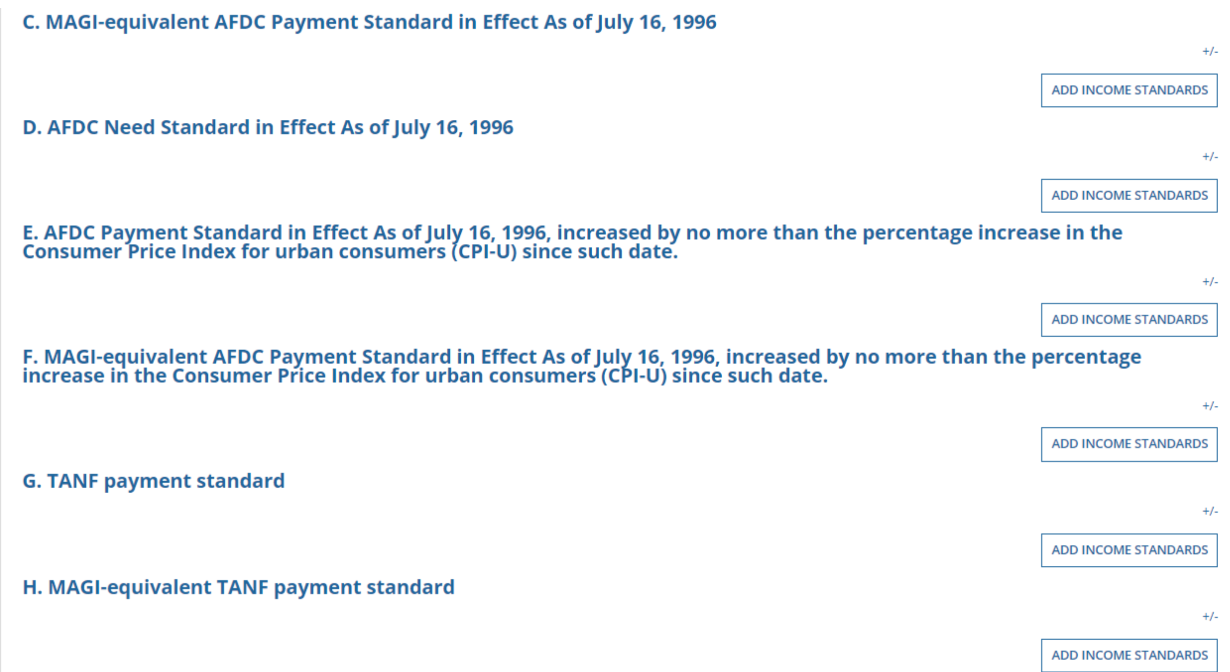

Figure 2: AFDC Income Standards – 2

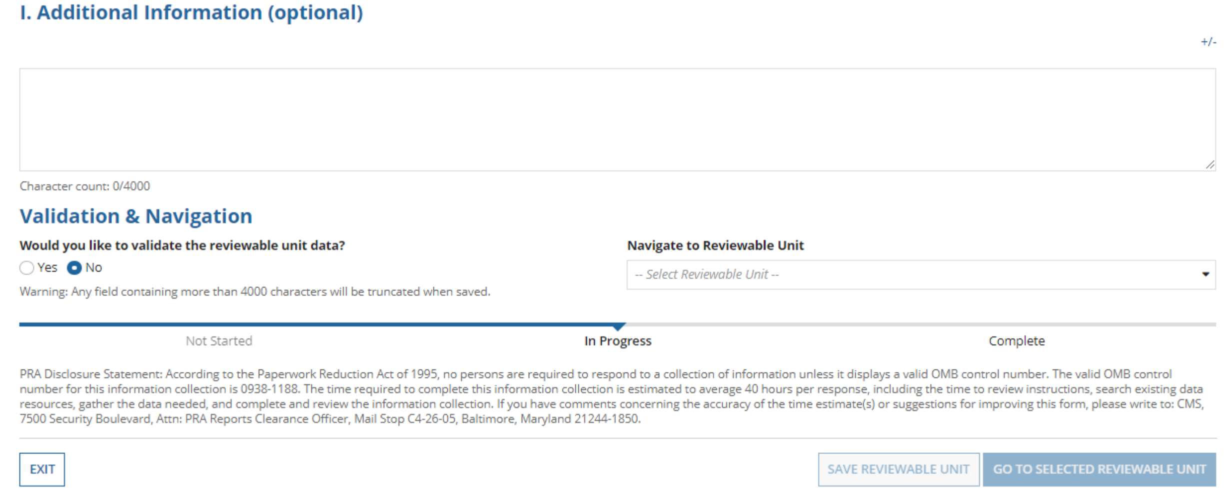

Figure 3: AFDC Income Standards – 3

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S14a-Income Standards – Poverty Level - Territories PRA document

Version 1.0

08/18/2017

Document Number: 210-QSSI-MACPro-PRA-S14a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S14a- Income Standards – Poverty Level – Territories – Screenshots

1.1 Income Standards – Poverty Level – Territories

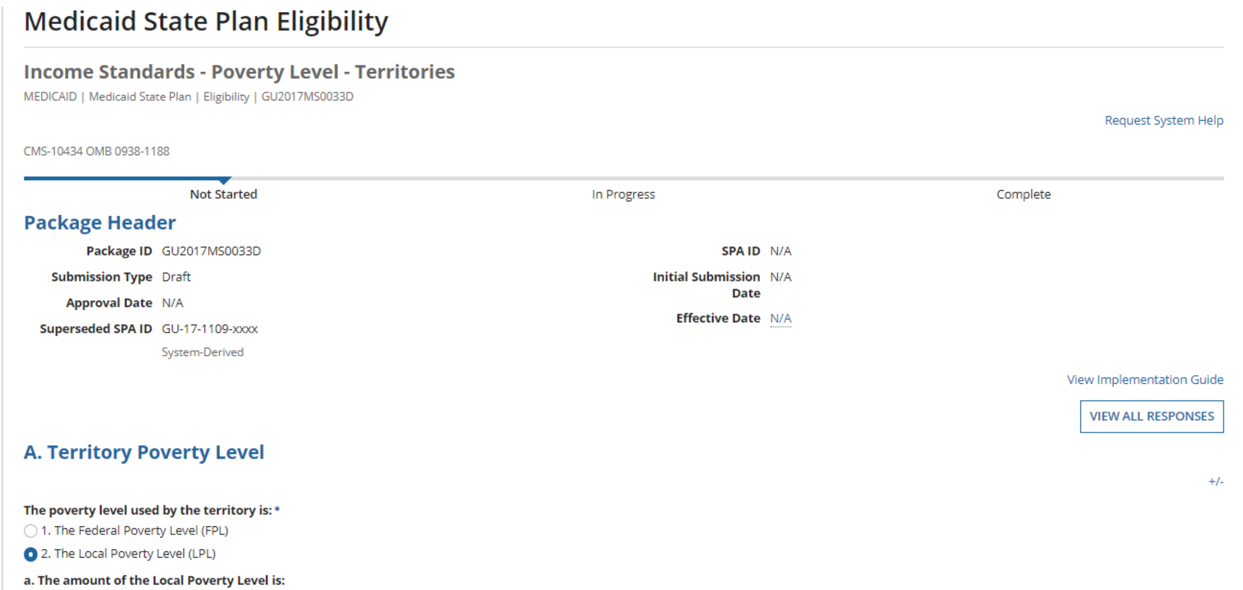

Figure 1: Income Standards – Poverty Level – Territories – 1

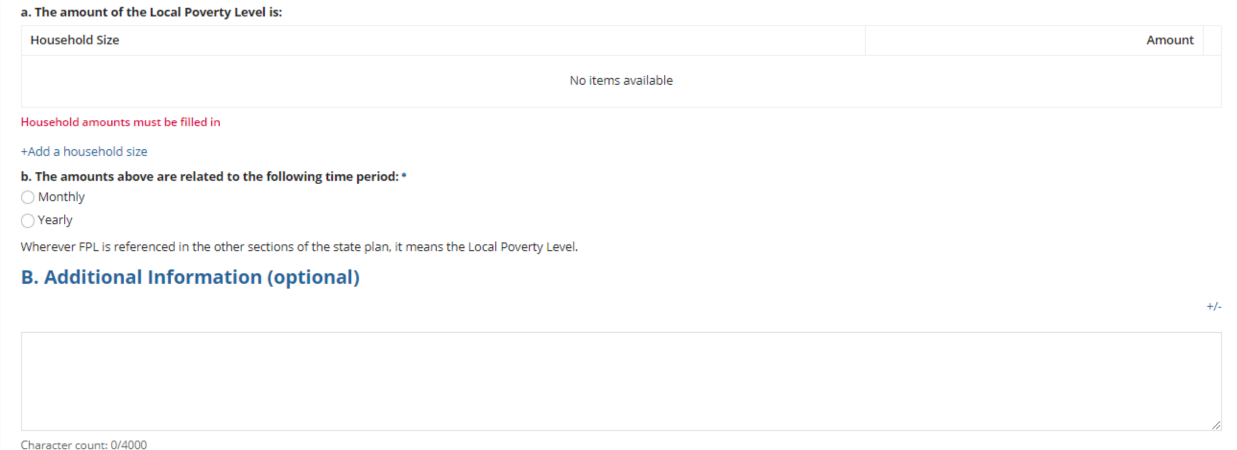

Figure 2: Income Standards – Poverty Level – Territories – 2

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S14T- Income Standards - AFDC-related – Territories PRA document

Version 1.0

08/18/2017

Document Number: 211-QSSI-MACPro-PRA-S14T-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 3: Income Standards - AFDC-related – Territories – 3 2

1. S14T- Income Standards - AFDC-related – Territories – Screenshots

1.1 Income Standards - AFDC-related – Territories

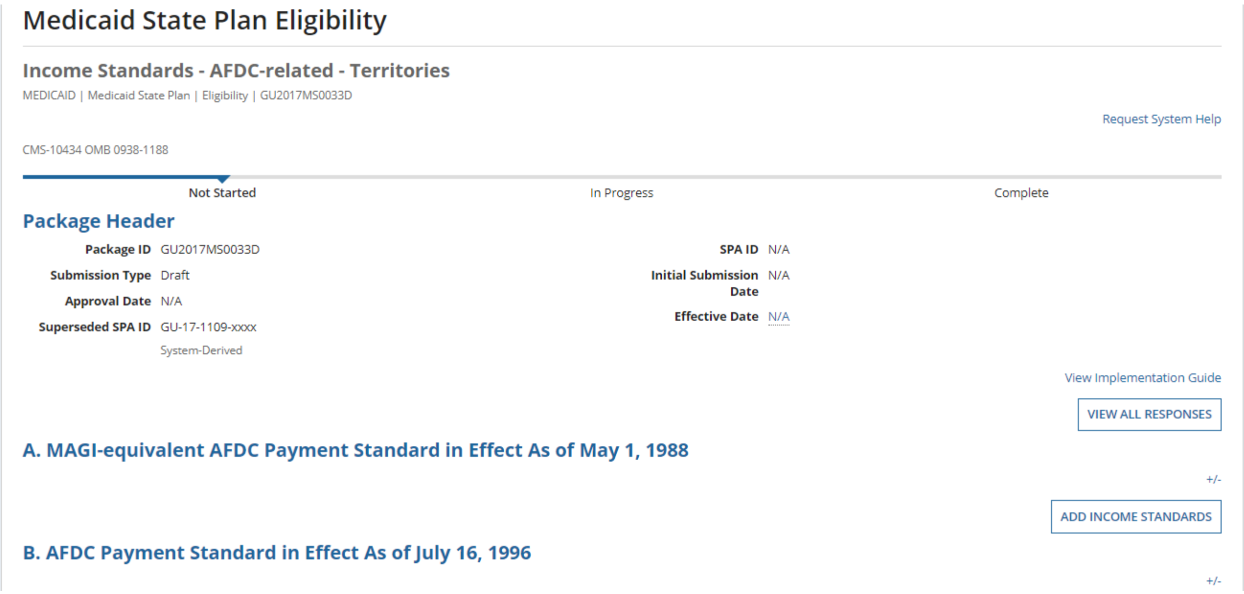

Figure 1: Income Standards - AFDC-related – Territories – 1

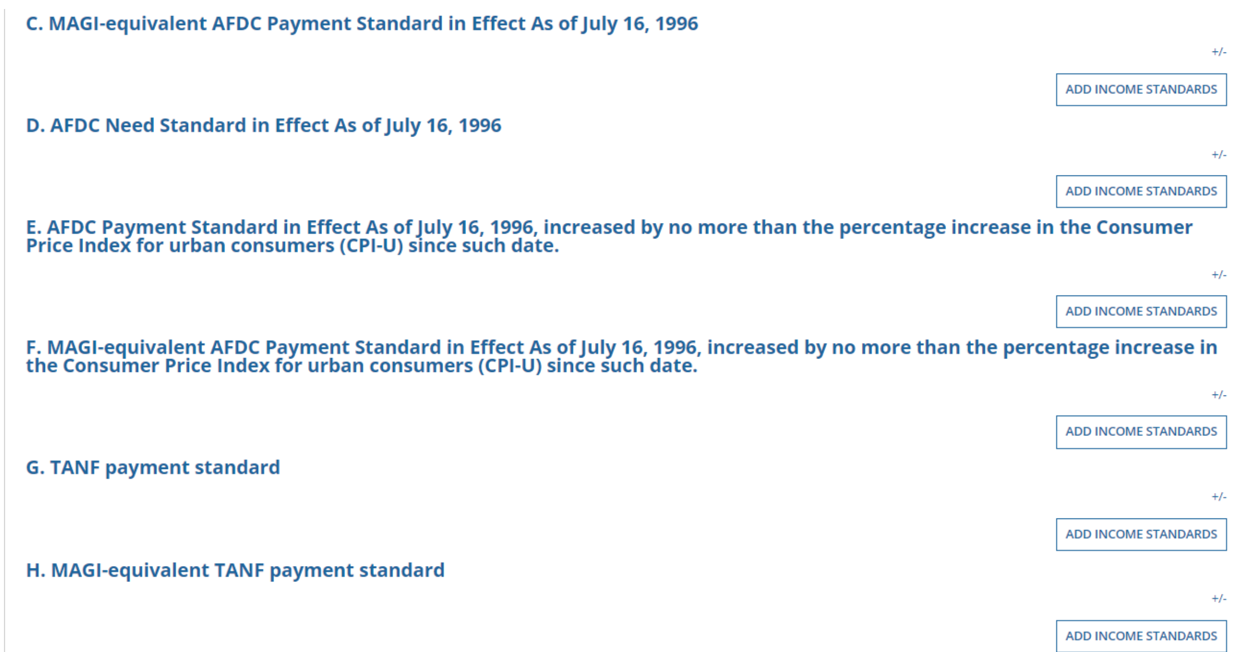

Figure 2: Income Standards - AFDC-related – Territories – 2

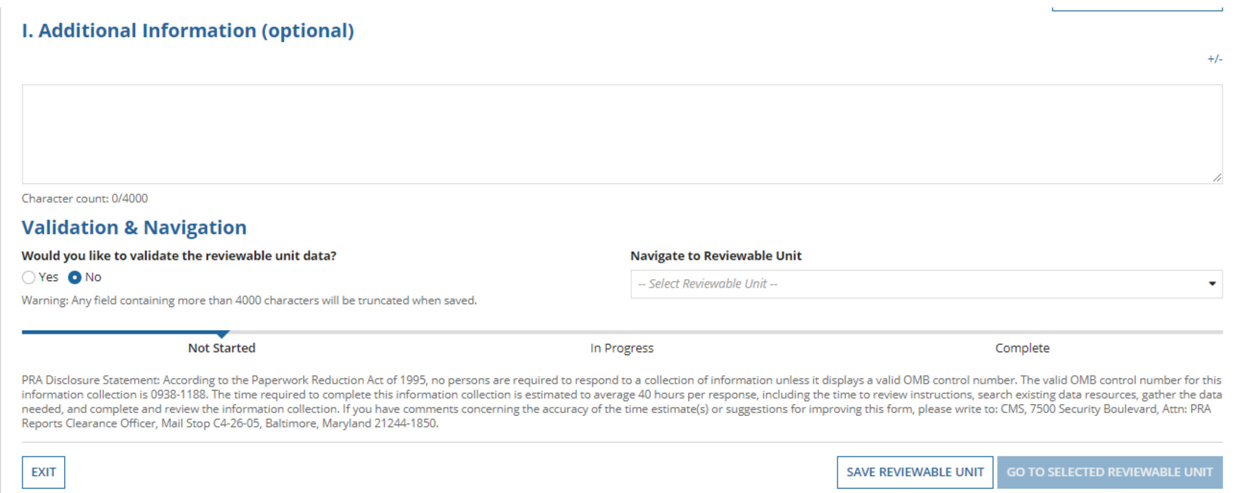

Figure 3: Income Standards - AFDC-related – Territories – 3

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S16 - Presumptive Eligibility for Children under Age 19 RU PRA Document

Version 1.0

08/16/2017

Document Number: 179-QSSI-MACPro-R5.1-S16-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S16 - Presumptive Eligibility for Children under Age 19 Screenshots

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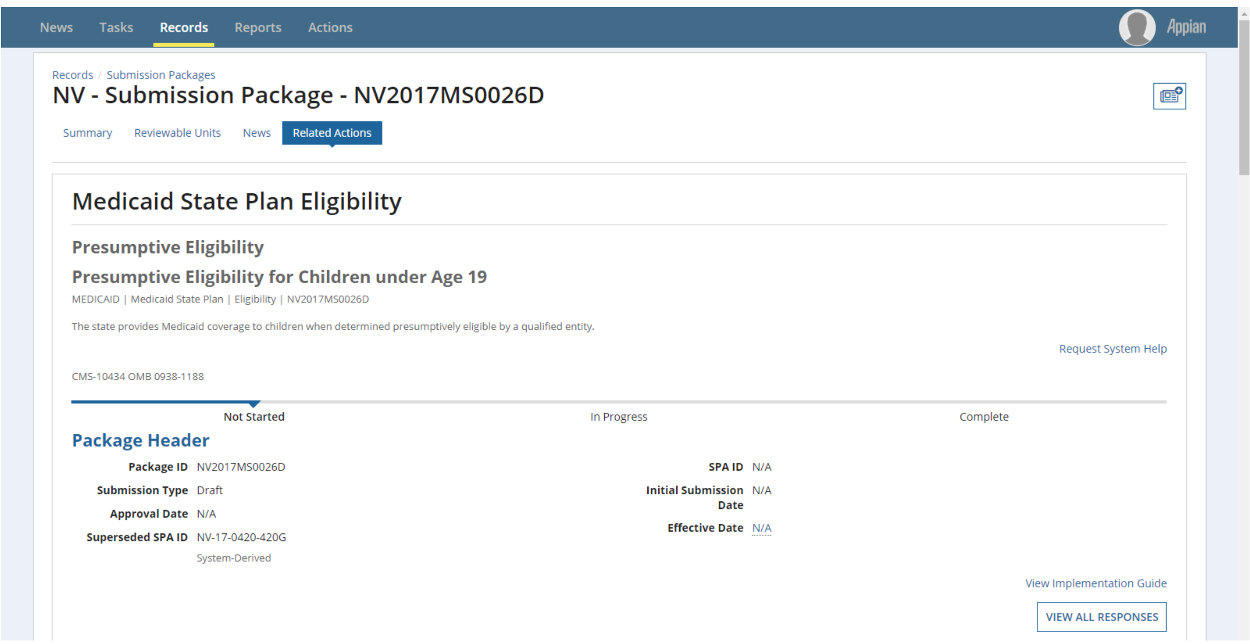

Figure 1: Package Header

1.2 A. Presumptive Eligibility Income Standard, B. Presumptive Eligibility Age Limit and C. Presumptive Eligibility Period

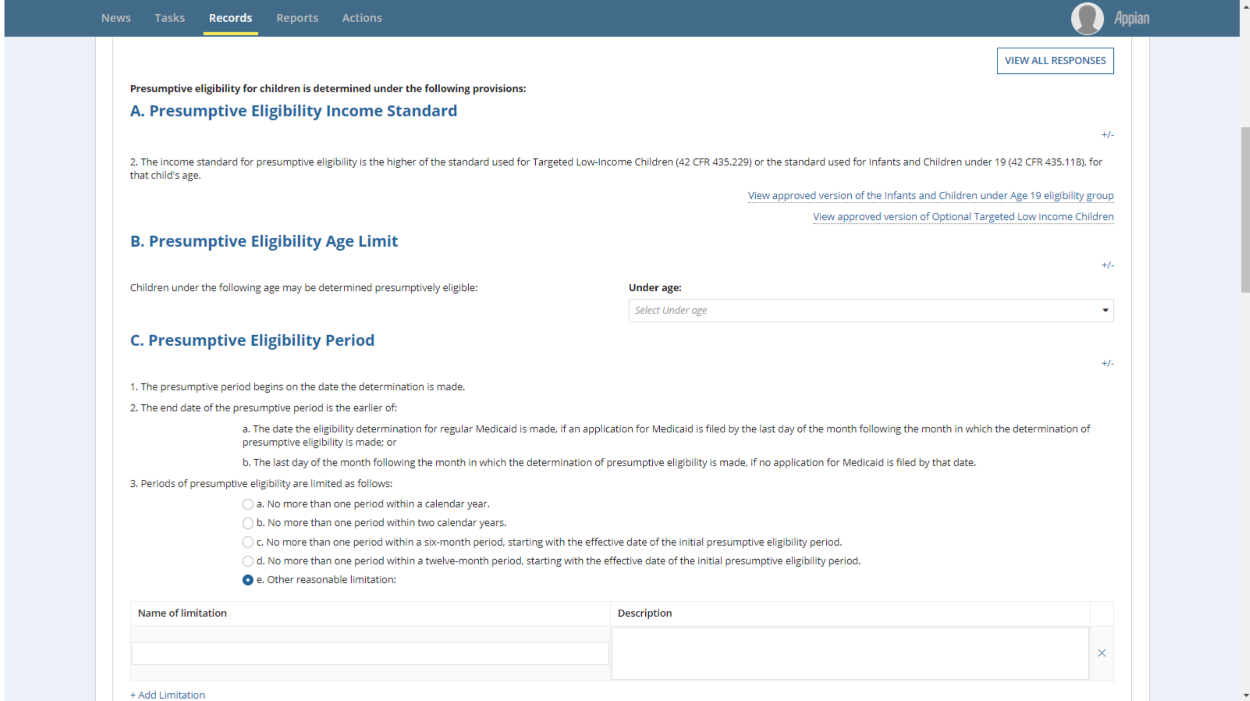

Figure 2: Section A, Section B and Section C

1.3 D. Application for Presumptive Eligibility–Part 1

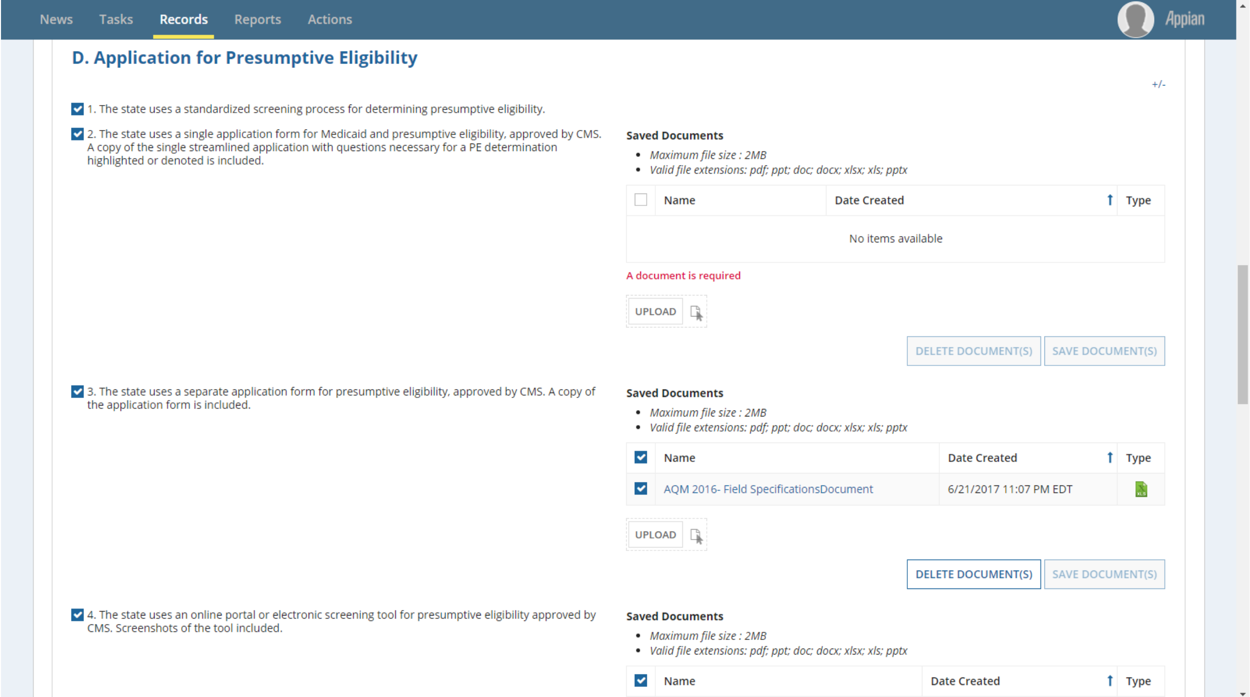

Figure 3: Section D-Part 1

1.4 D. Application for Presumptive Eligibility–Part 2 and E. Presumptive Eligibility Determination

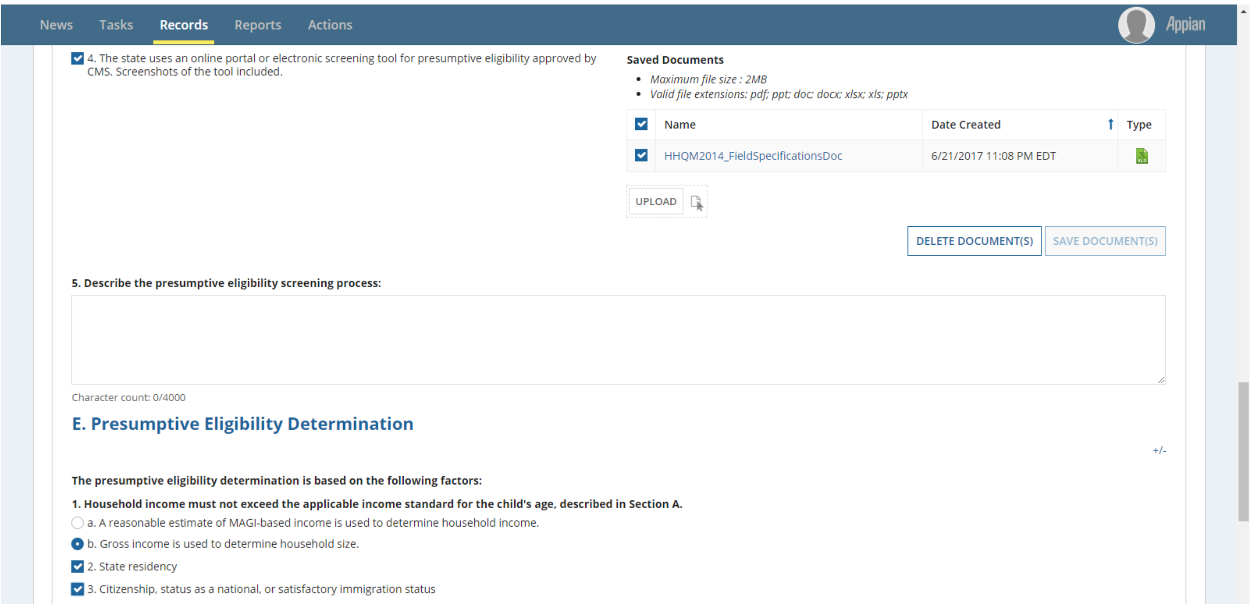

Figure 4: Section D-Part 2 and Section E

1.5 F. Qualified Entities

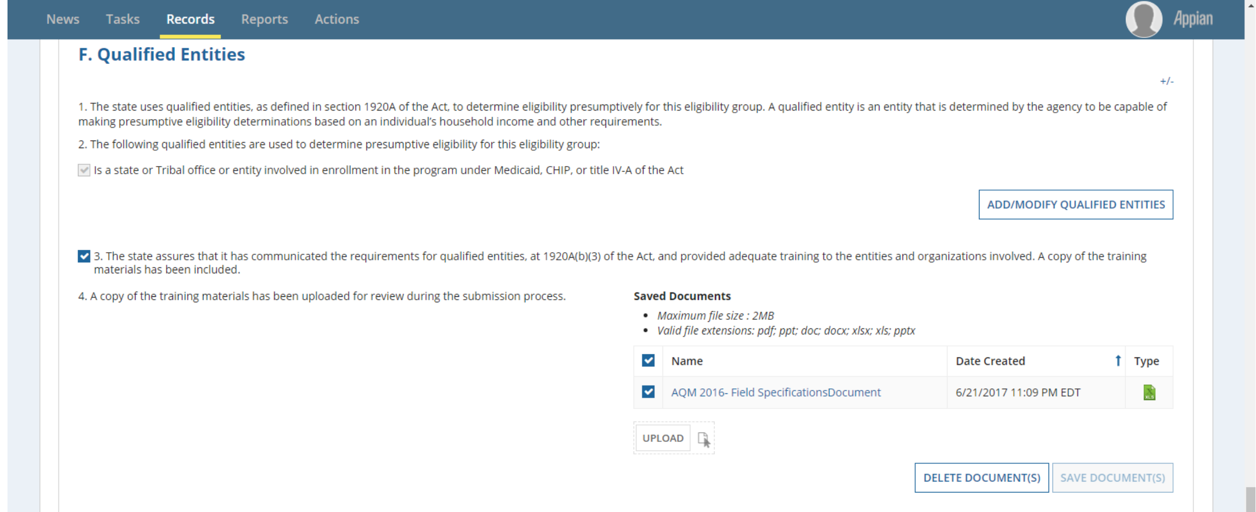

Figure 5: Section F

1.6 G. Additional Information (optional)

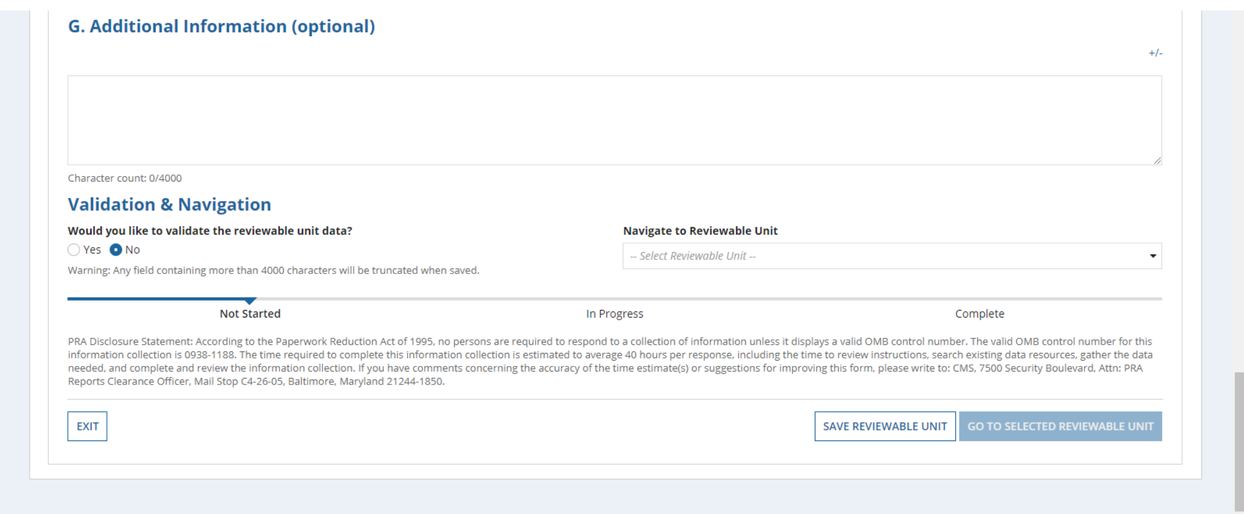

Figure 6: Section G

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S17 - Qualified Entities PRA Document

Version 1.0
08/16/2017

Document Number: 180-QSSI-MACPro-R5.1-S17-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S17 - Qualified Entities Screenshots

1.1 Qualified Entities – Part 1

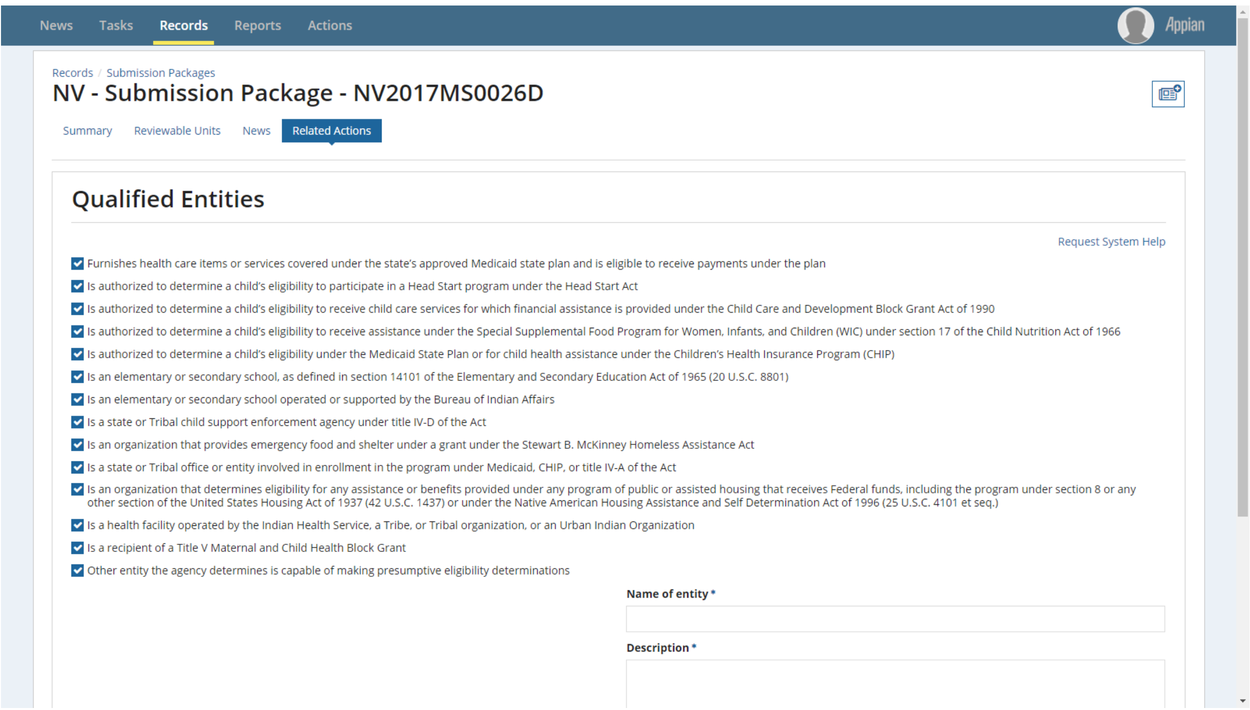

Figure 1: Qualified Entities – Part 1

1.2 Qualified Entities – Part 2

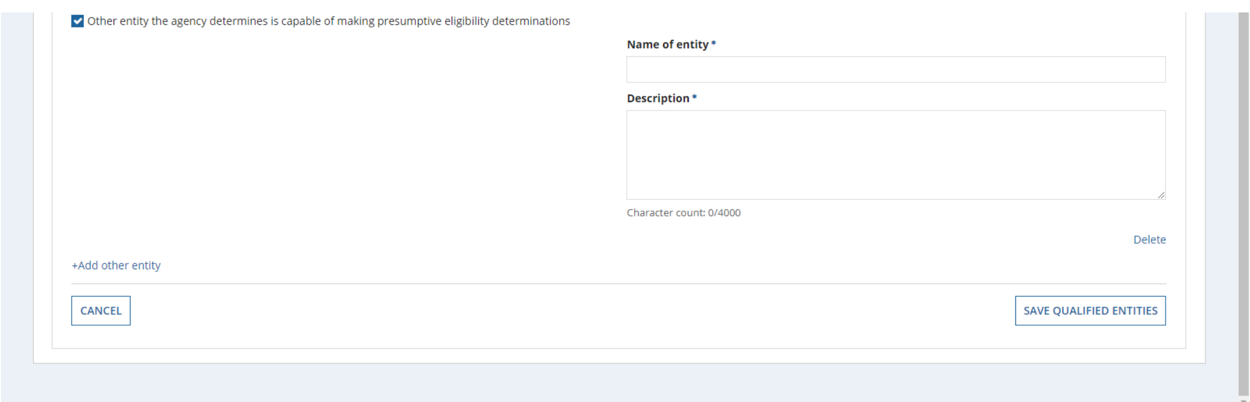

Figure 2: Qualified Entities – Part 2

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S21-Presumptive Eligibility by Hospitals PRA document

Version 1.0

08/21/2017

Document Number: 231-QSSI-MACPro-PRA-S21-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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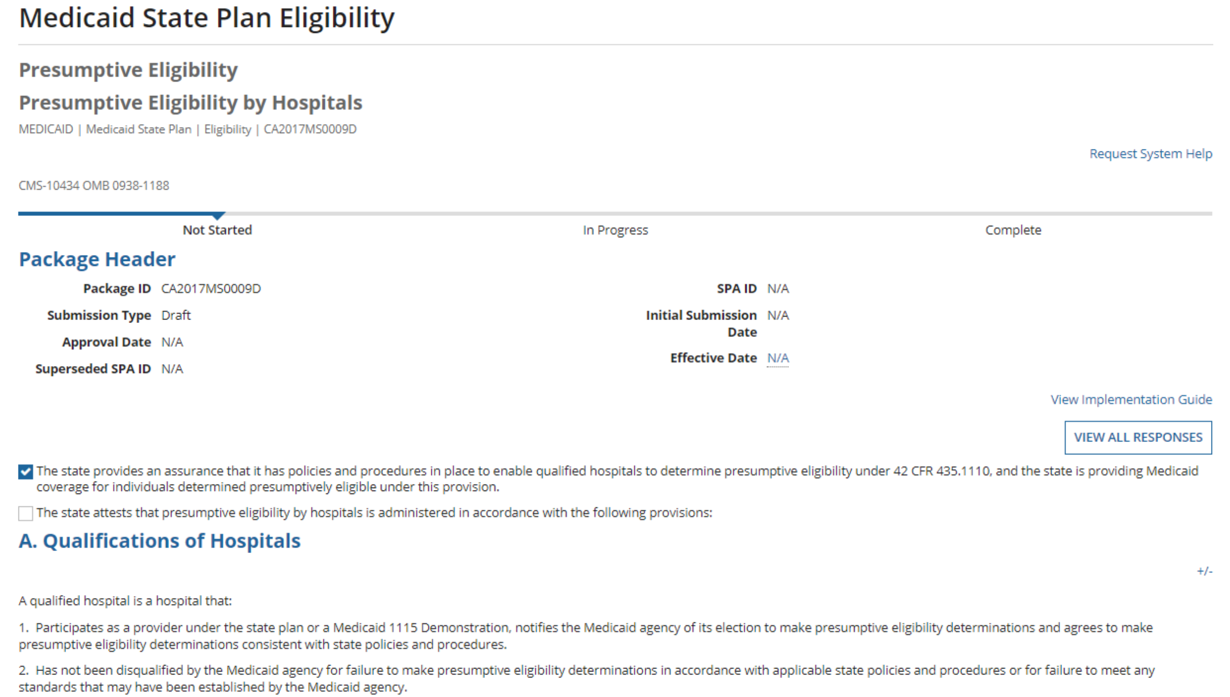
Figure 6: Presumptive Eligibility by Hospitals – 6 4

Figure 7: Presumptive Eligibility by Hospitals – 7 4

1. S21-Presumptive Eligibility by Hospitals – Screenshots

1.1 Presumptive Eligibility by Hospitals


Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D

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CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0009D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

☑ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☐ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

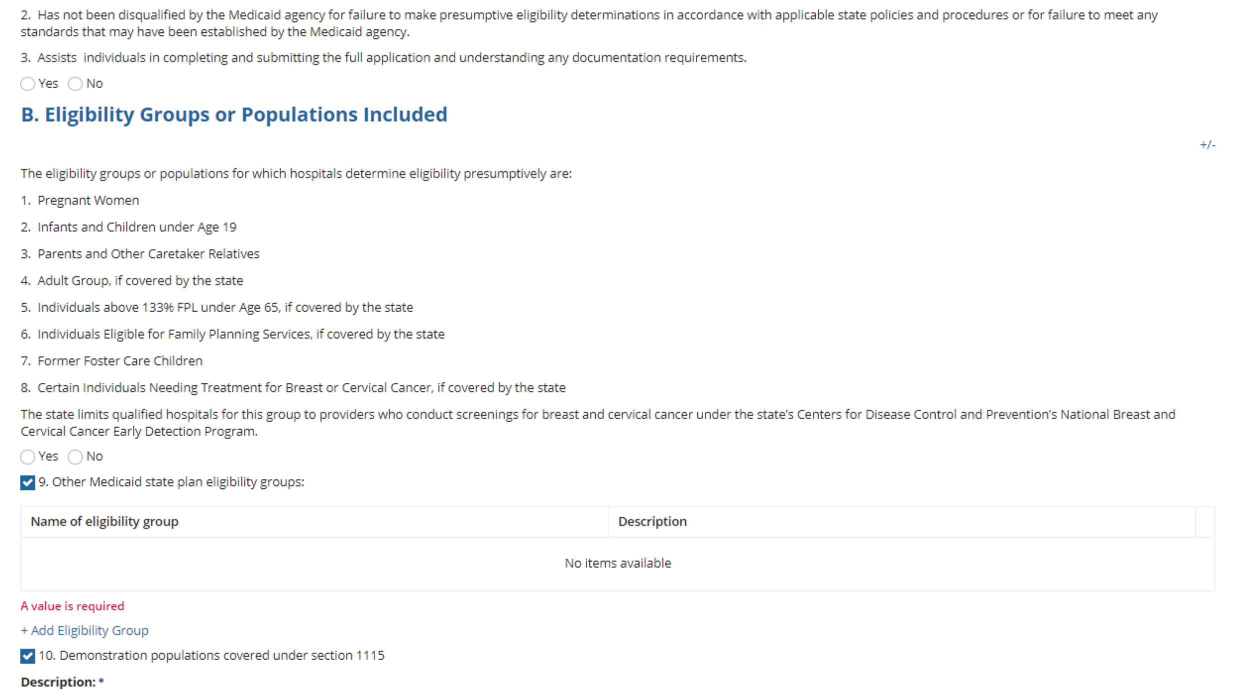
+/-

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Figure 1: Presumptive Eligibility by Hospitals – 1



2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◯ Yes ◯ No

B. Eligibility Groups or Populations Included

+/-

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

◯ Yes ◯ No

☑ 9. Other Medicaid state plan eligibility groups:

Name of eligibility group	Description
No items available	

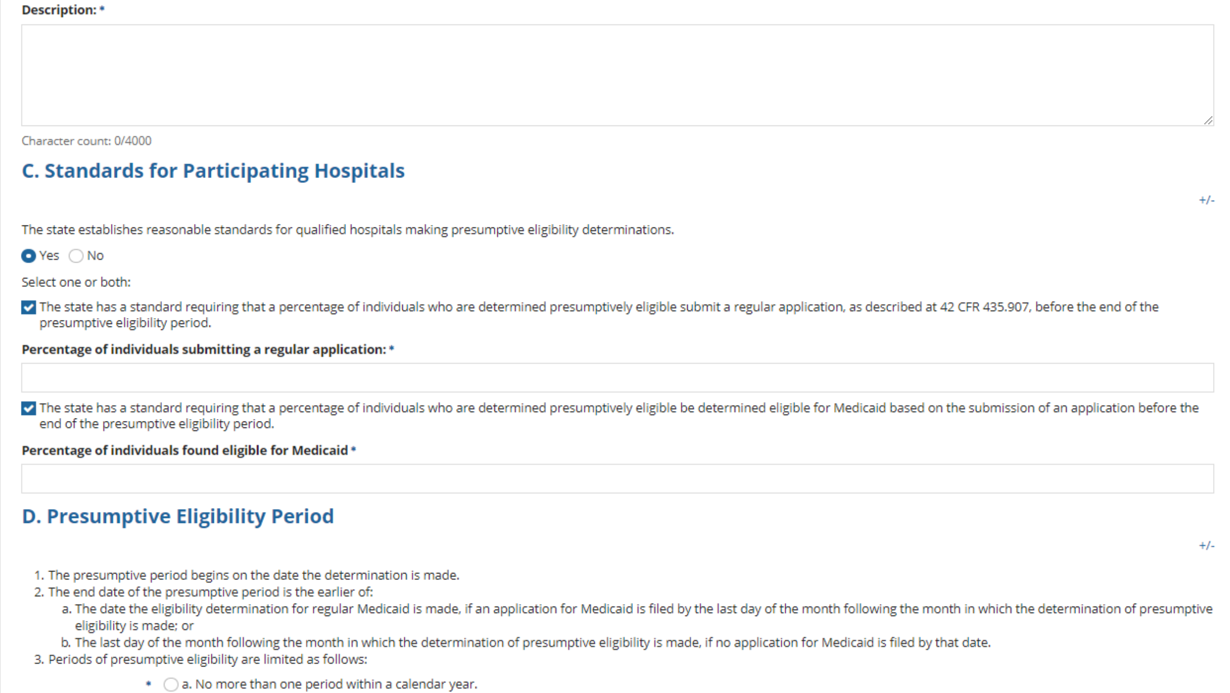
A value is required

+ Add Eligibility Group

☑ 10. Demonstration populations covered under section 1115

Description: *

Figure 2: Presumptive Eligibility by Hospitals – 2



Description: *

Character count: 0/4000

C. Standards for Participating Hospitals

+/-

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

◉ Yes ◯ No

Select one or both:

☑ The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application: *

☑ The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

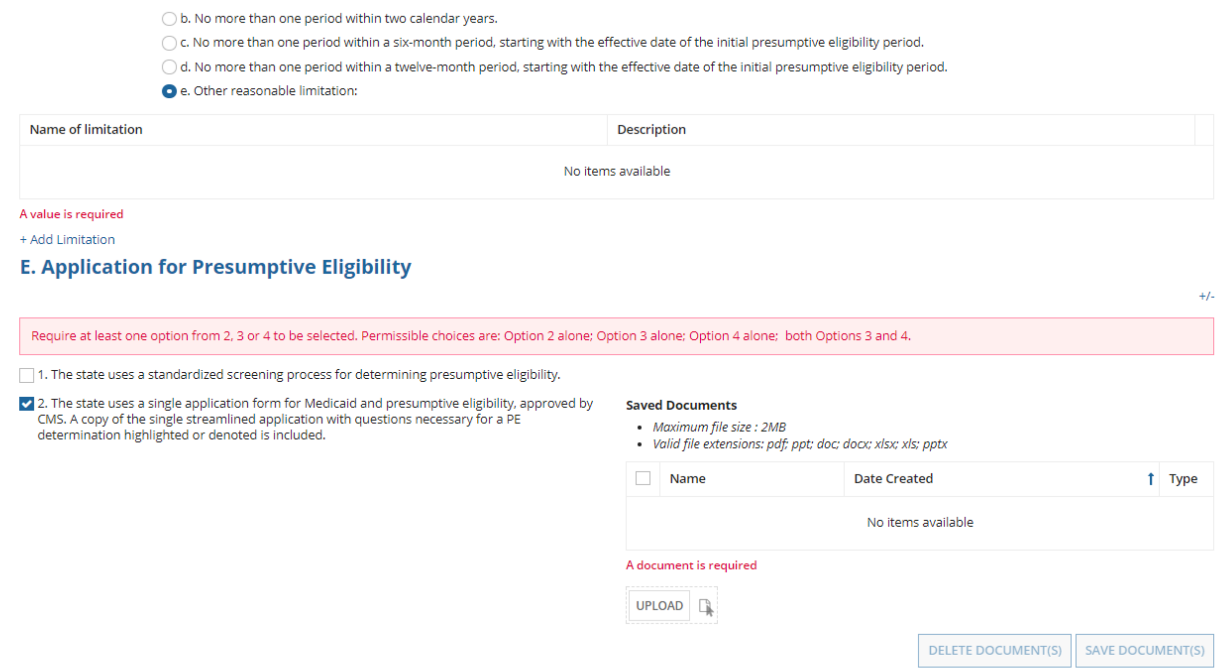
Percentage of individuals found eligible for Medicaid *

D. Presumptive Eligibility Period

+/-

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:
   - ◯ a. No more than one period within a calendar year.

Figure 3: Presumptive Eligibility by Hospitals – 3



b. No more than one period within two calendar years.
c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
e. Other reasonable limitation:

Name of limitation	Description
No items available	

A value is required
+ Add Limitation

E. Application for Presumptive Eligibility

+/-

Require at least one option from 2, 3 or 4 to be selected. Permissible choices are: Option 2 alone; Option 3 alone; Option 4 alone; both Options 3 and 4.

1. The state uses a standardized screening process for determining presumptive eligibility.

2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

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- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

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No items available			

A document is required
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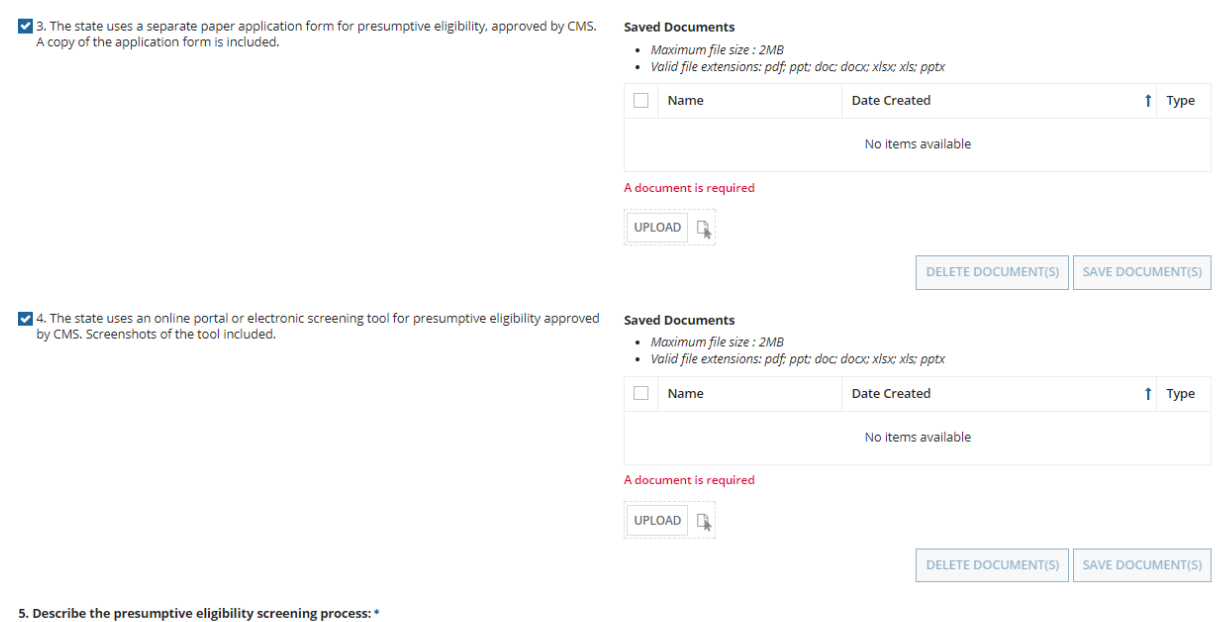
Figure 4: Presumptive Eligibility by Hospitals – 4



3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents
- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

	Name	Date Created	Type
No items available			

A document is required
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4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents
- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

	Name	Date Created	Type
No items available			

A document is required
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5. Describe the presumptive eligibility screening process: *

Figure 5: Presumptive Eligibility by Hospitals – 5

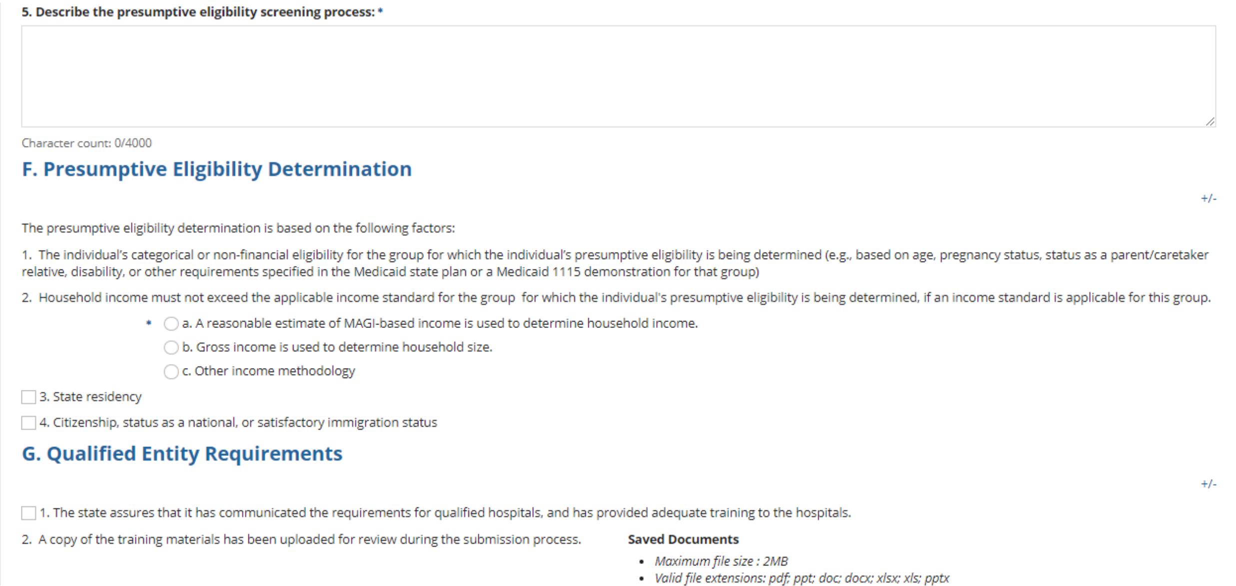

Figure 6: Presumptive Eligibility by Hospitals – 6

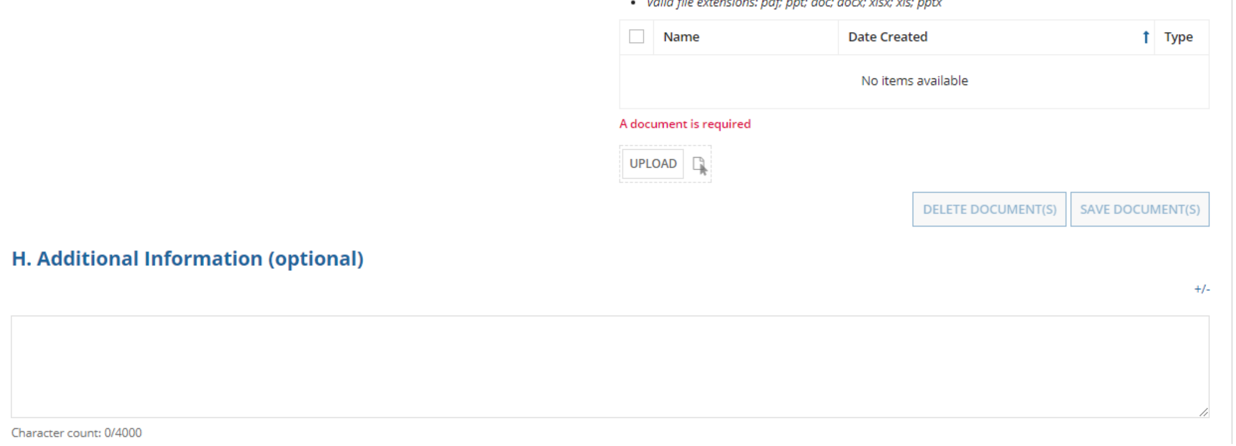

Figure 7: Presumptive Eligibility by Hospitals – 7

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S25-Parents and Other Caretaker Relatives PRA document

Version 1.0

08/18/2017

Document Number: 212-QSSI-MACPro-PRA-S25-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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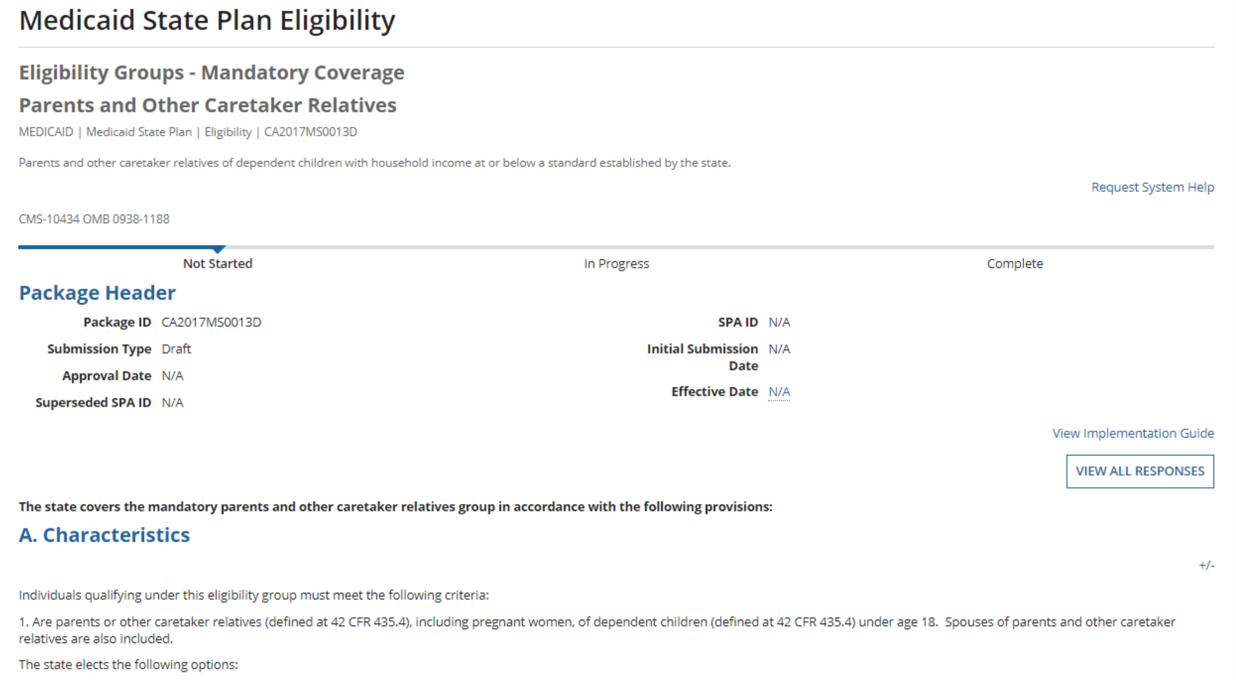
Figure 10: Additional Information 4

1. S25-Parents and Other Caretaker Relatives – Screenshots

1.1 Section A. "Characteristics"



Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

The state covers the mandatory parents and other caretaker relatives group in accordance with the following provisions:

A. Characteristics

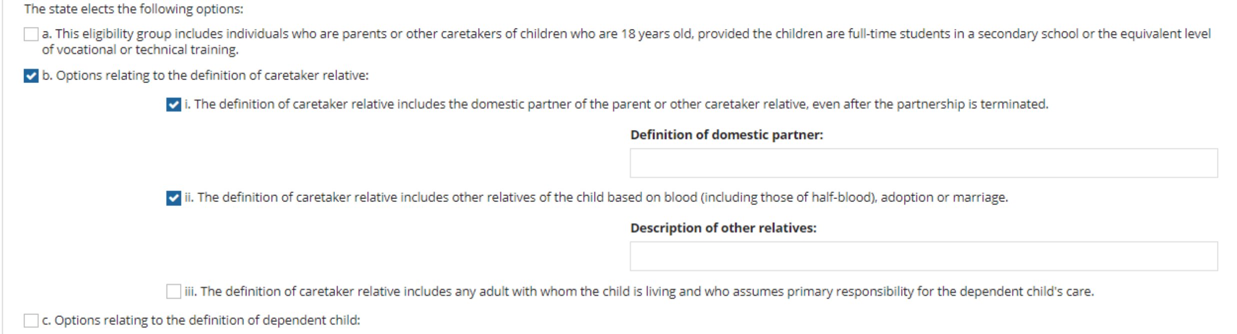
+/-

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

1. Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

Figure 1: Characteristics – 1



The state elects the following options:

☐ a. This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☑ b. Options relating to the definition of caretaker relative:

☑ i. The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☑ ii. The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

☐ iii. The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☐ c. Options relating to the definition of dependent child:

Figure 2: Characteristics – 2

1.2 Section A. "Characteristics" Option C.ii – Path 1

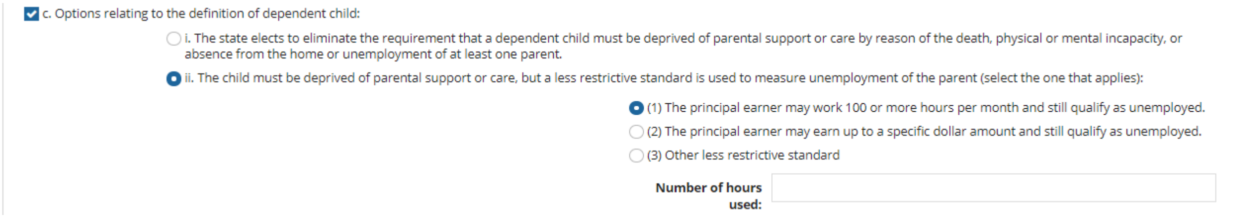


Figure 3: Characteristics Option C.ii – 1

1.3 Section A. "Characteristics" Option C.ii – Path 2

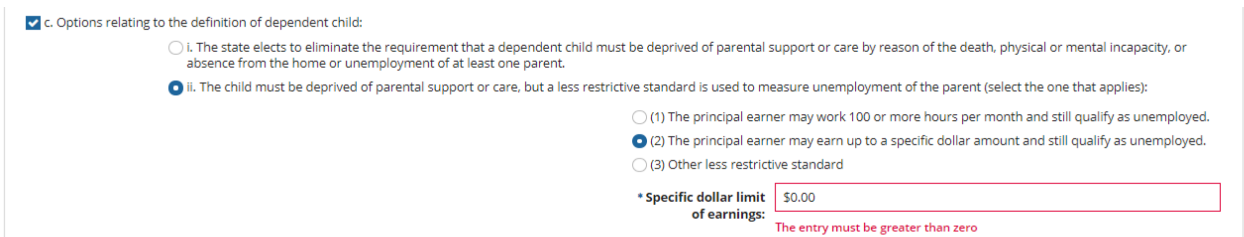


Figure 4: Characteristics Option C.ii – 2

1.4 Section A. "Characteristics" Option C.ii – Path 3

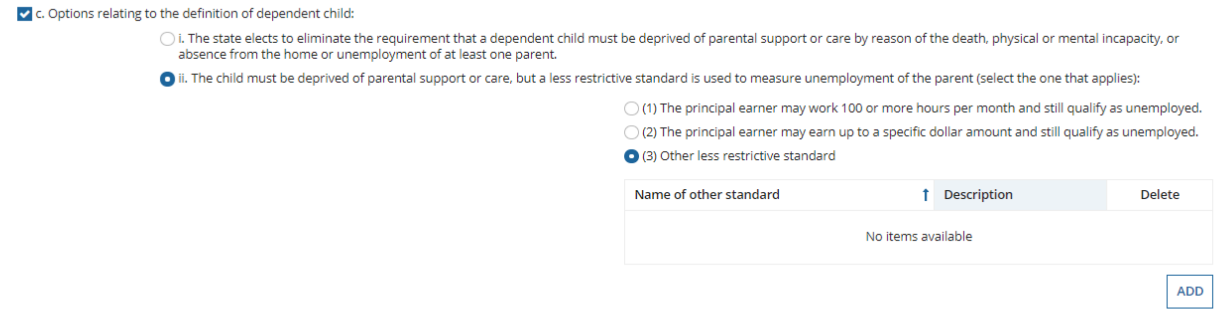


Figure 5: Characteristics Option C.ii – 3

1.5 Section C. "Income Standard Used" – Path 1

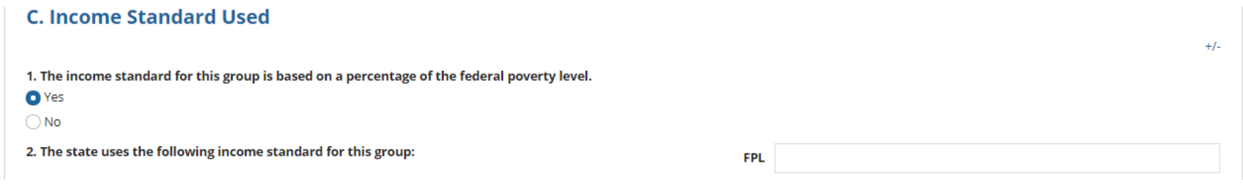
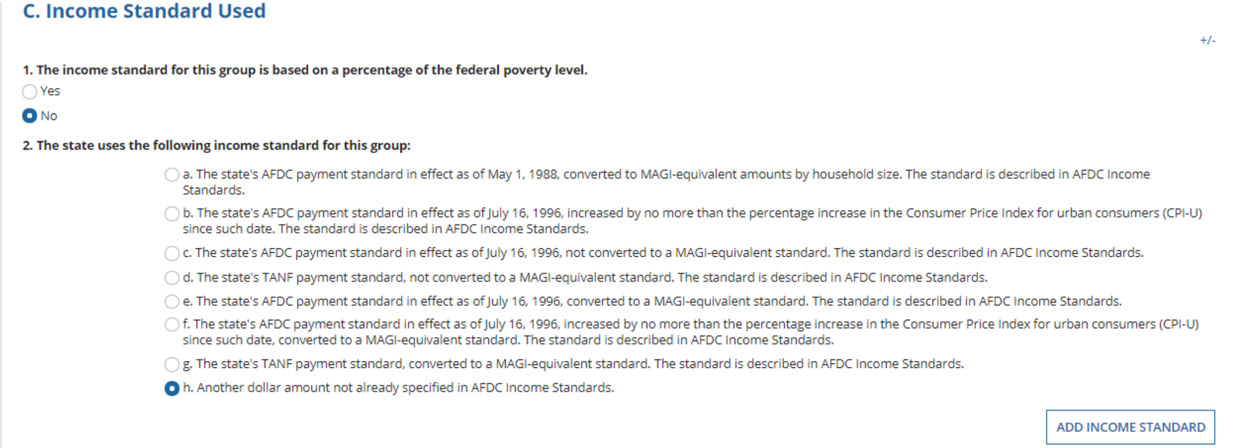


Figure 6: Income Standard Used – 1

1.6 Section C. "Income Standard Used" – Path 2



C. Income Standard Used

+/-

1. The income standard for this group is based on a percentage of the federal poverty level.

Yes

No

2. The state uses the following income standard for this group:

a. The state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

b. The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in AFDC Income Standards.

c. The state's AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

d. The state's TANF payment standard, not converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

e. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

f. The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

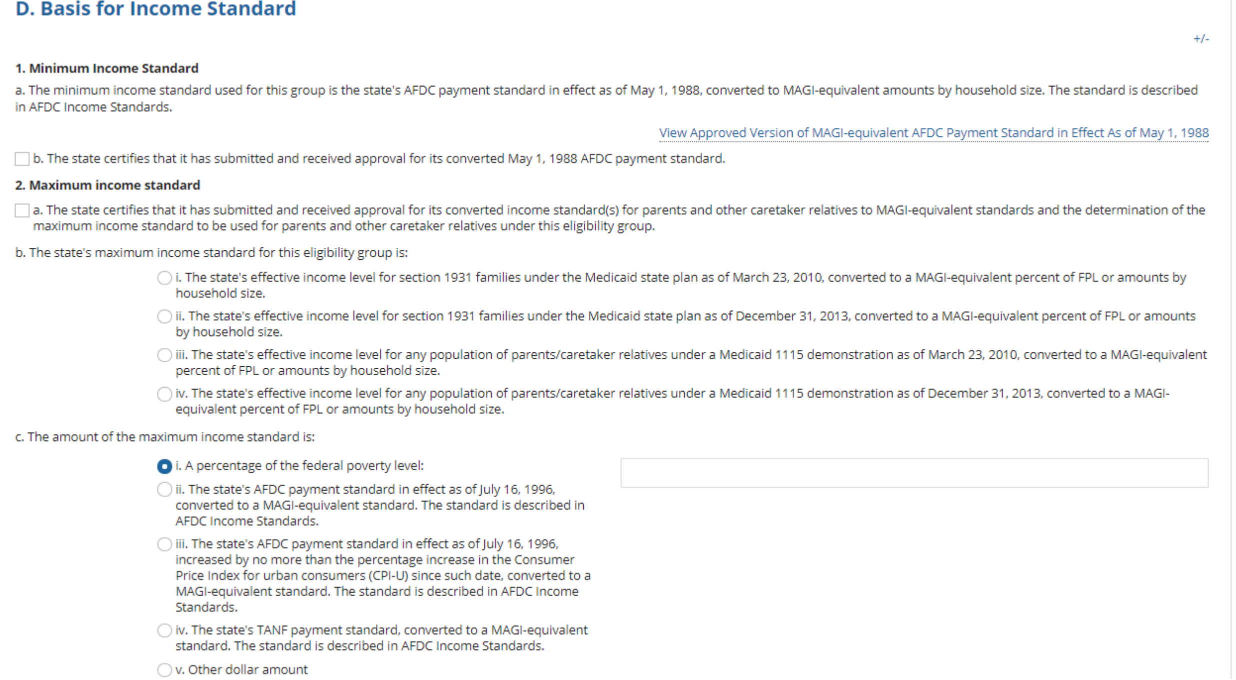
g. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

h. Another dollar amount not already specified in AFDC Income Standards.

ADD INCOME STANDARD

Figure 7: Income Standard Used – 2

1.7 Section D. "Basis for Income Standard" – Path 1



D. Basis for Income Standard

+/-

1. Minimum Income Standard

a. The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

View Approved Version of MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

b. The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

2. Maximum income standard

a. The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

i. The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

ii. The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

iii. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

iv. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

c. The amount of the maximum income standard is:

i. A percentage of the federal poverty level:

ii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

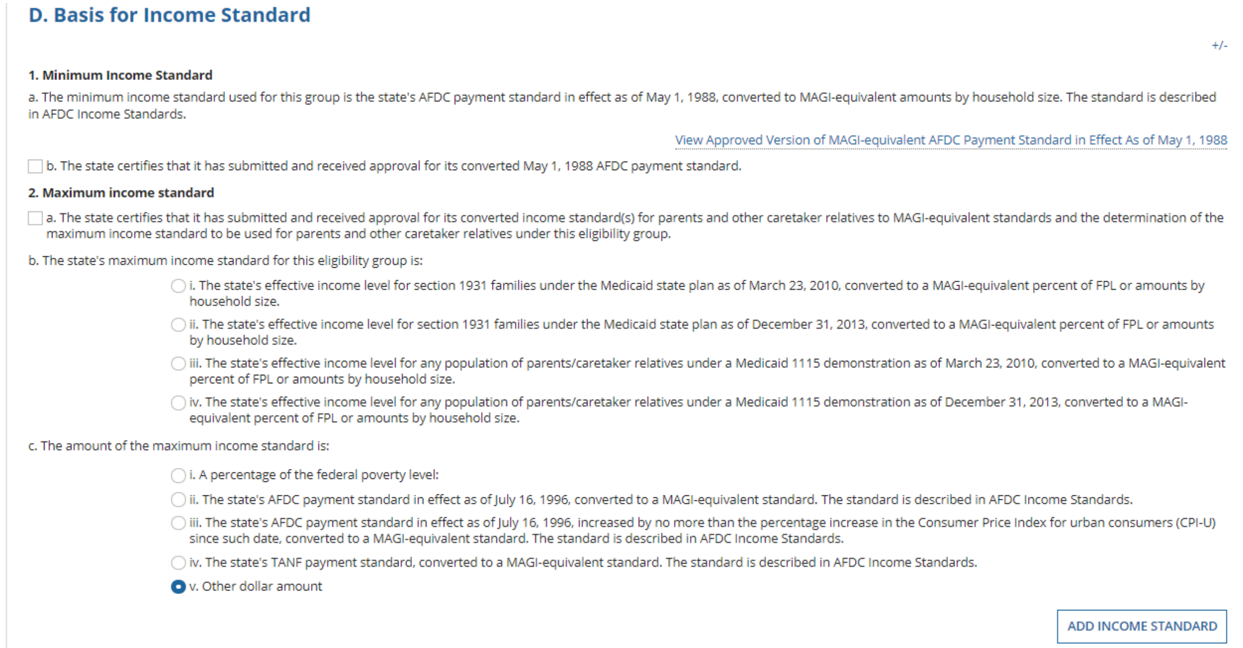
iii. The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

iv. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

v. Other dollar amount

Figure 8: Basis for Income Standard – 1

1.8 Section D. "Basis for Income Standard" – Path 2



D. Basis for Income Standard

+/-

1. Minimum Income Standard

a. The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

View Approved Version of MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

☐ b. The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

2. Maximum income standard

☐ a. The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

○ i. The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ ii. The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ iii. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ iv. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

c. The amount of the maximum income standard is:

○ i. A percentage of the federal poverty level:

○ ii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

○ iii. The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

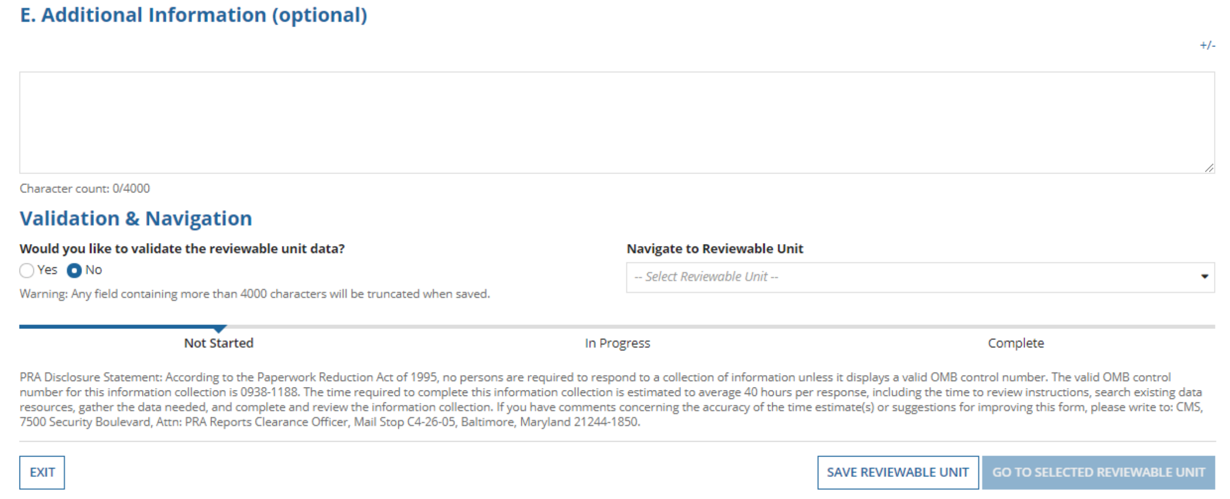
○ iv. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.

◉ v. Other dollar amount

ADD INCOME STANDARD

Figure 9: Basis for Income Standard – 2

1.9 Section E. "Additional Information"



E. Additional Information (optional)

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Figure 10: Additional Information

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S25a-Presumptive Eligibility for Parents and Other Caretaker Relatives PRA document

Version 1.0
08/17/2017

Document Number: 206-QSSI-MACPro-PRA-S25a-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 5: Parents and Other Caretaker Relatives – 5.. 3

1. S25a-Presumptive Eligibility for Parents and Other Caretaker Relatives – Screenshots

1.1 Presumptive Eligibility for Parents and Other Caretaker Relatives

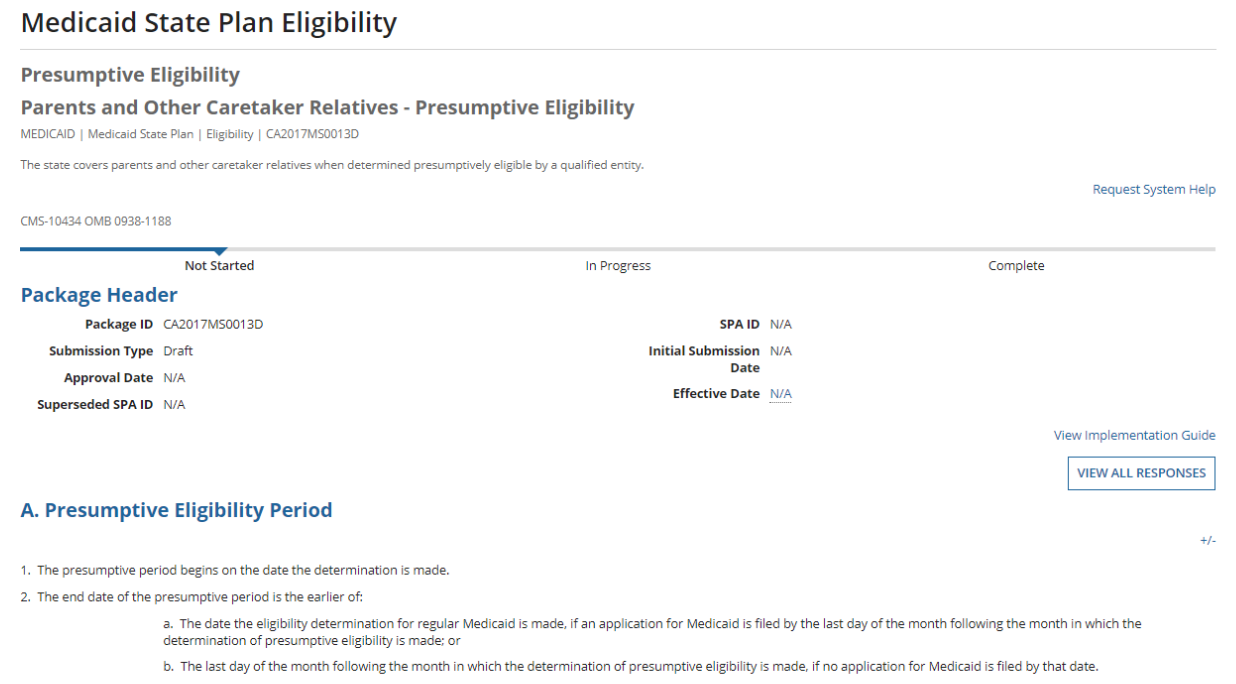
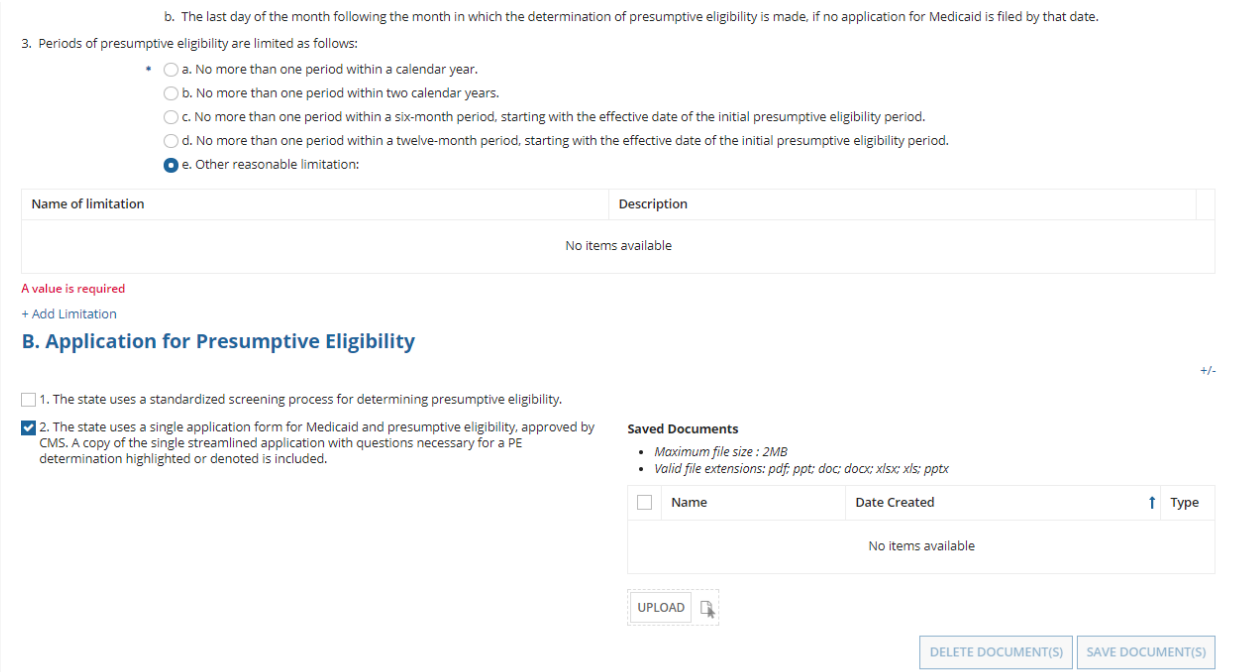


Figure 1: Presumptive Eligibility for Parents and Other Caretaker Relatives – 1



b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

- ◯ a. No more than one period within a calendar year.
- ◯ b. No more than one period within two calendar years.
- ◯ c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
- ◯ d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- ◉ e. Other reasonable limitation:

Name of limitation	Description
No items available	

A value is required

+ Add Limitation

B. Application for Presumptive Eligibility

+/-

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☑ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

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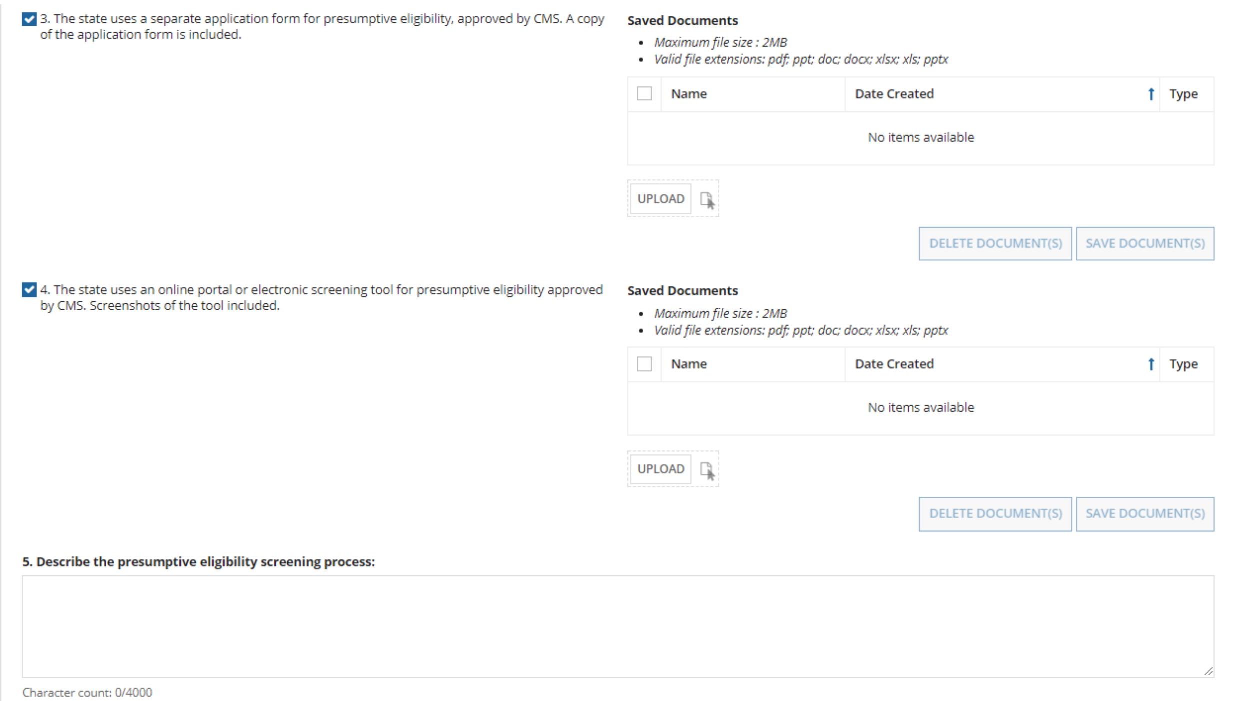
Figure 2: Presumptive Eligibility for Parents and Other Caretaker Relatives – 2



☑ 3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	Type
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☑ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	Type
No items available			

UPLOAD

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5. Describe the presumptive eligibility screening process:

Character count: 0/4000

Figure 3: Presumptive Eligibility for Parents and Other Caretaker Relatives – 3

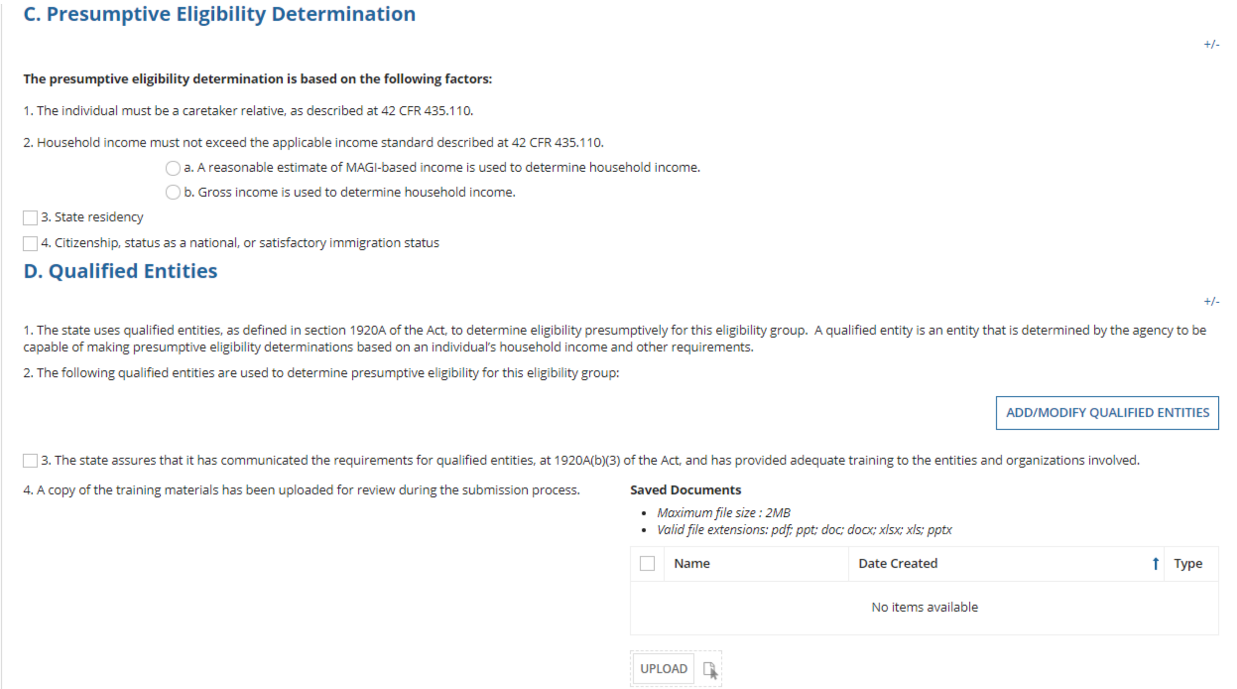

Figure 4: Presumptive Eligibility for Parents and Other Caretaker Relatives – 4

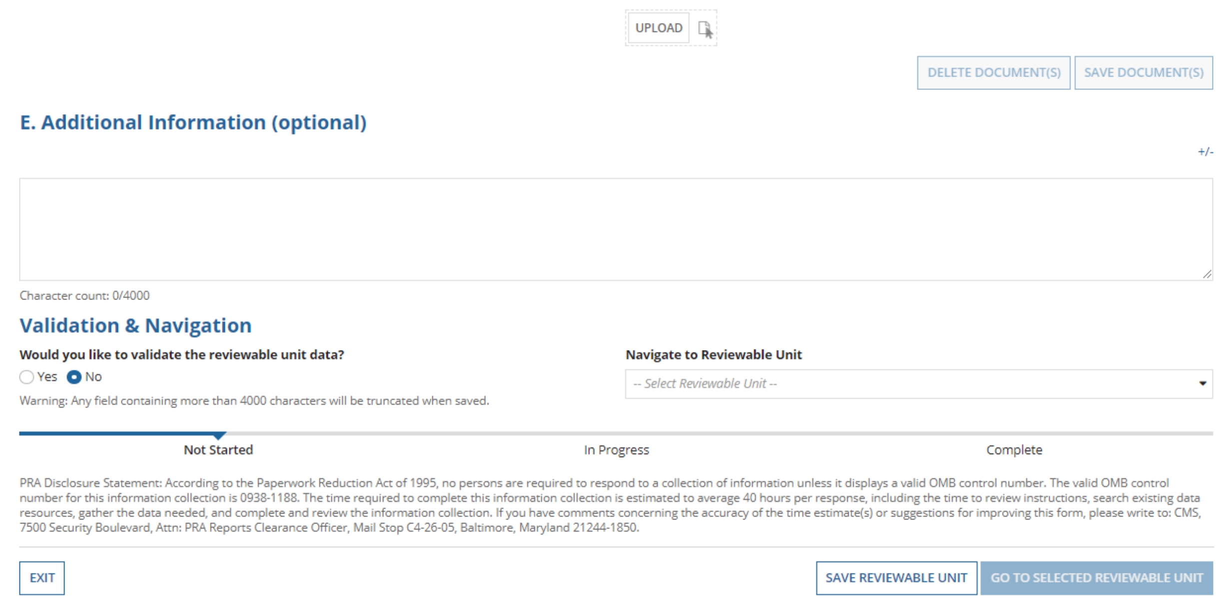

Figure 5: Parents and Other Caretaker Relatives – 5

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S28-Pregnant Women PRA document

Version 1.0

08/18/2017

Document Number: 213-QSSI-MACPro-PRA-S28-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 8: Basis for income limit for full Medicaid coverage for pregnant women – 2 4

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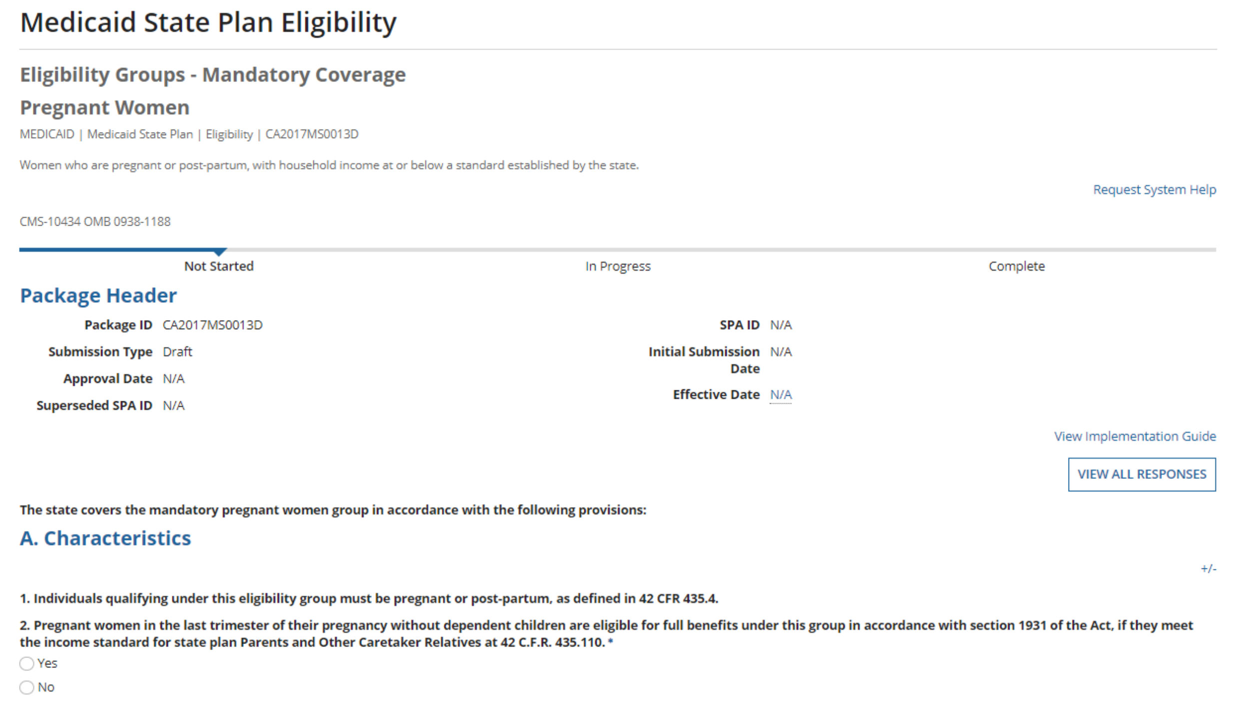
1. S28-Pregnant Women – Screenshot

1.1 Section A. "Characteristics"



Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

Women who are pregnant or post-partum, with household income at or below a standard established by the state.

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

The state covers the mandatory pregnant women group in accordance with the following provisions:

A. Characteristics

+/-

1. Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

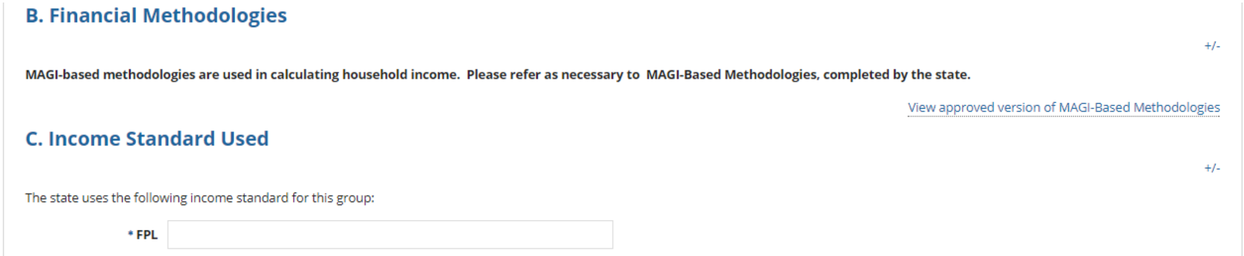
2. Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 C.F.R. 435.110. *

Yes

No

Figure 1: Characteristics

1.2 Section B. "Financial Methodologies" and Section C. "Income Standard Used"



B. Financial Methodologies

+/-

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

View approved version of MAGI-Based Methodologies

C. Income Standard Used

+/-

The state uses the following income standard for this group:

* FPL

Figure 2: Financial Methodologies and Income Standard Used

1.3 Section D. "Benefits for Pregnant Women" – Path 1

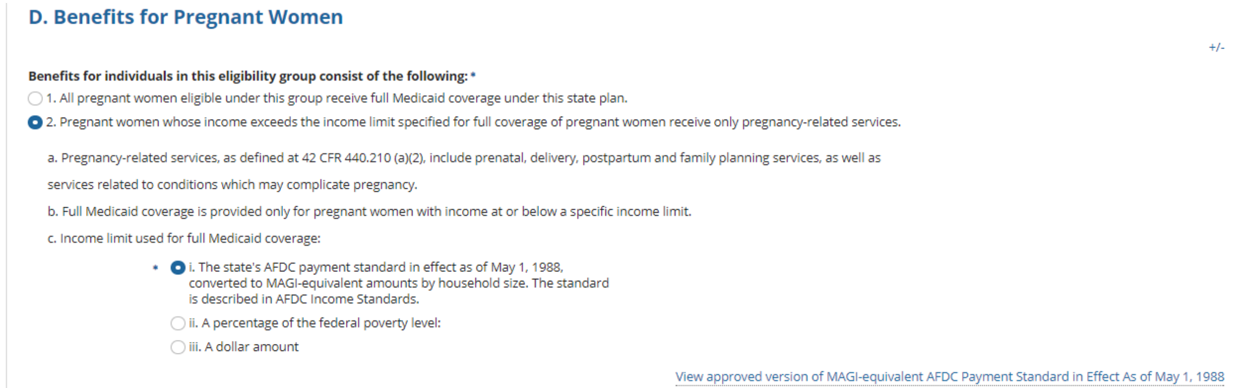


Figure 3: Benefits for Pregnant Women – 1

1.4 Section D. "Benefits for Pregnant Women" – Path 2

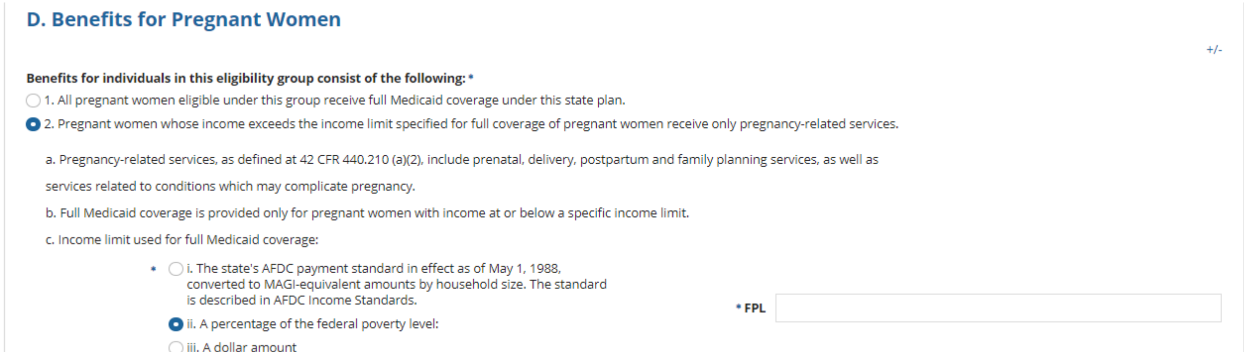


Figure 4: Benefits for Pregnant Women – 2

1.5 Section D. "Benefits for Pregnant Women" – Path 3

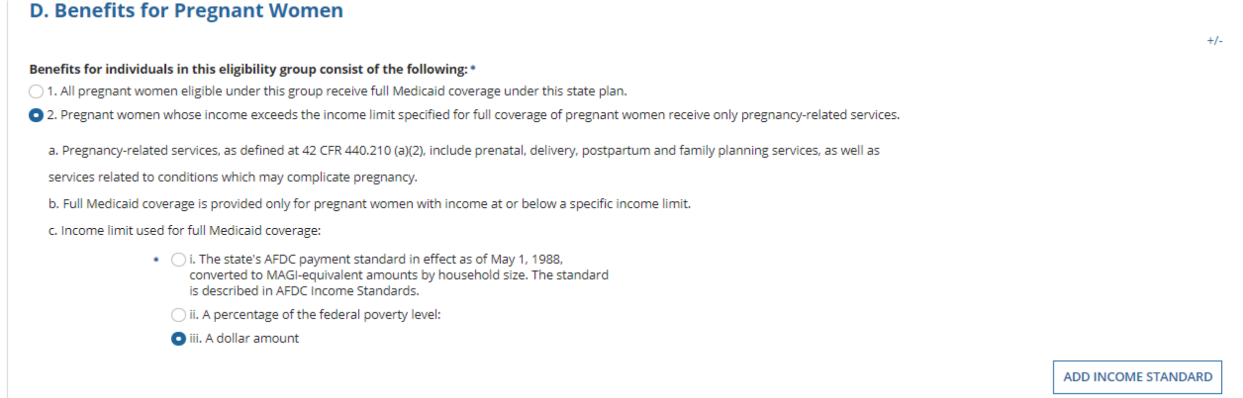
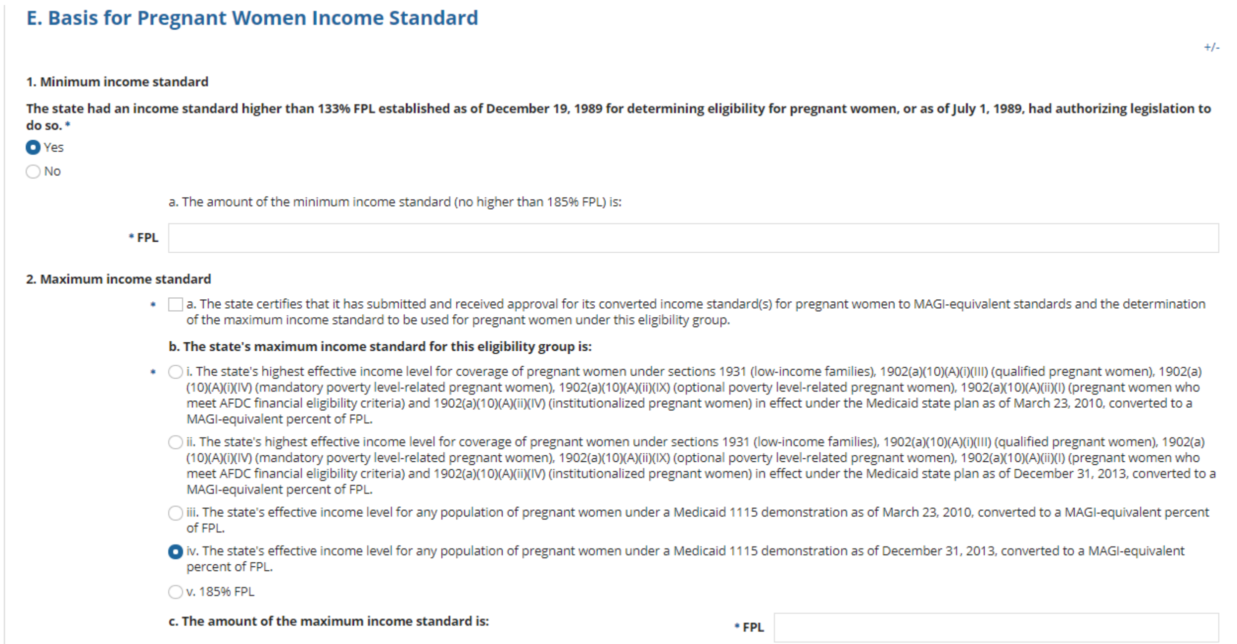


Figure 5: Benefits for Pregnant Women – 3

1.6 Section E. "Basis for Pregnant Women Income Standard"



E. Basis for Pregnant Women Income Standard

+/-

1. Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so. *

- (•) Yes
- ( ) No

a. The amount of the minimum income standard (no higher than 185% FPL) is:

* FPL

2. Maximum income standard

- [ ] a. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

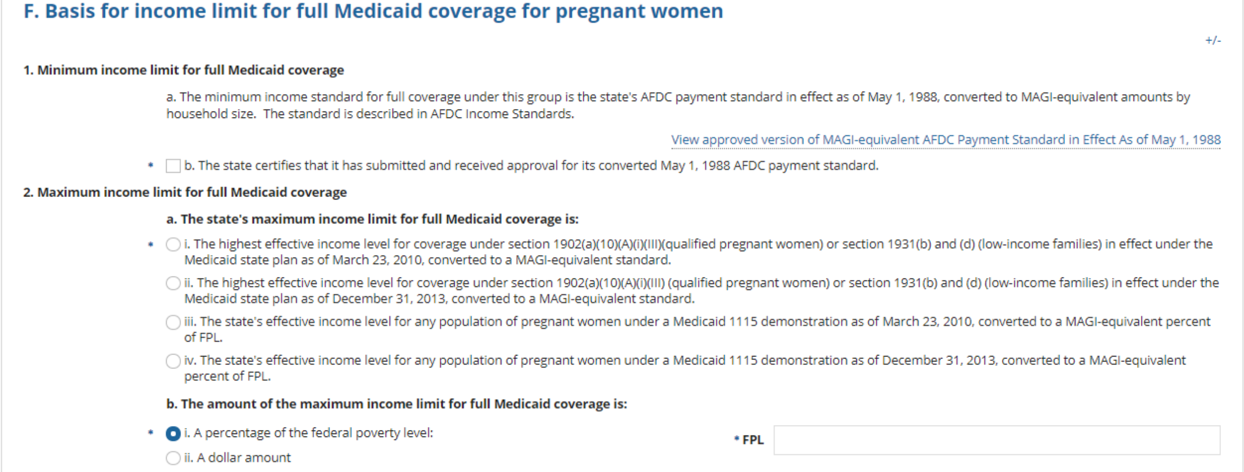
b. The state's maximum income standard for this eligibility group is:

- ( ) i. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ( ) ii. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ( ) iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- (•) iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ( ) v. 185% FPL

c. The amount of the maximum income standard is: * FPL

Figure 6: Basis for Pregnant Women Income Standard

1.7 Section F. "Basis for income limit for full Medicaid coverage for pregnant women" – Path 1



F. Basis for income limit for full Medicaid coverage for pregnant women

+/-

1. Minimum income limit for full Medicaid coverage

a. The minimum income standard for full coverage under this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

View approved version of MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

- [ ] b. The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

2. Maximum income limit for full Medicaid coverage

a. The state's maximum income limit for full Medicaid coverage is:

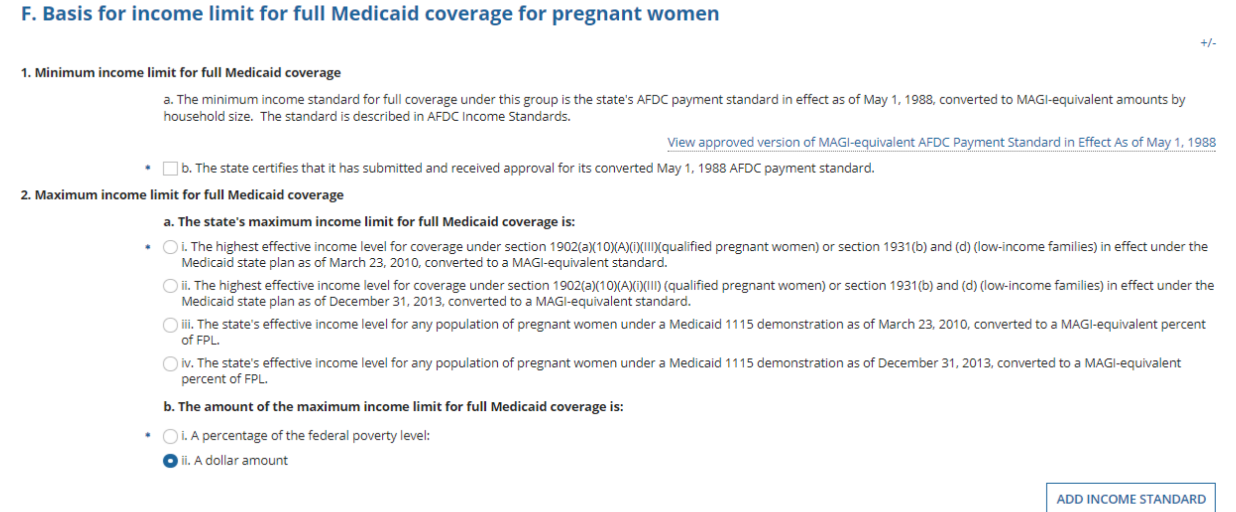
- ( ) i. The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III)(qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent standard.
- ( ) ii. The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent standard.
- ( ) iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ( ) iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

b. The amount of the maximum income limit for full Medicaid coverage is:

- (•) i. A percentage of the federal poverty level: * FPL
- ( ) ii. A dollar amount

Figure 7: Basis for income limit for full Medicaid coverage for pregnant women – 1

1.8 Section F. "Basis for income limit for full Medicaid coverage for pregnant women" – Path 2


F. Basis for income limit for full Medicaid coverage for pregnant women

+/-

1. Minimum income limit for full Medicaid coverage

a. The minimum income standard for full coverage under this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

View approved version of MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

- b. The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

2. Maximum income limit for full Medicaid coverage

a. The state's maximum income limit for full Medicaid coverage is:

- i. The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III)(qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent standard.
- ii. The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent standard.
- iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

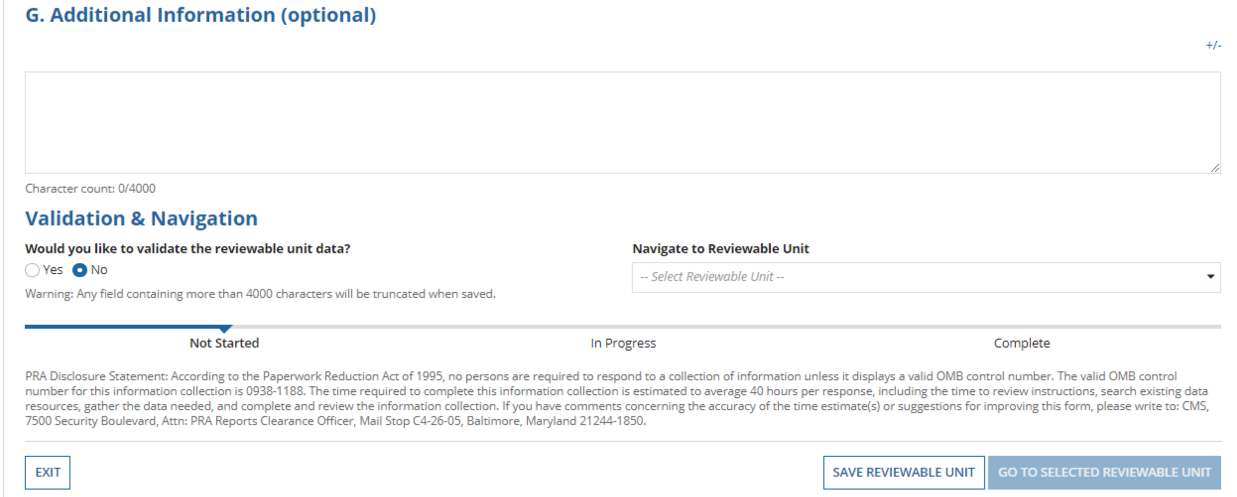
b. The amount of the maximum income limit for full Medicaid coverage is:

- i. A percentage of the federal poverty level:
- ii. A dollar amount

ADD INCOME STANDARD

Figure 8: Basis for income limit for full Medicaid coverage for pregnant women – 2

1.9 Section G. "Additional Information"


G. Additional Information (optional)

+/-

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Figure 9: Additional Information

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S28a-Presumtpive Eligibility for Pregnant Women PRA document

Version 1.0

08/17/2017

Document Number: 207-QSSI-MACPro-PRA-S28a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 3: Presumptive Eligibility for Pregnant Women – 3 2

Figure 4: Presumptive Eligibility for Pregnant Women – 4 3

1. S28a-Presumptive Eligibility for Pregnant Women – Screenshots

1.1 Presumptive Eligibility for Pregnant Women

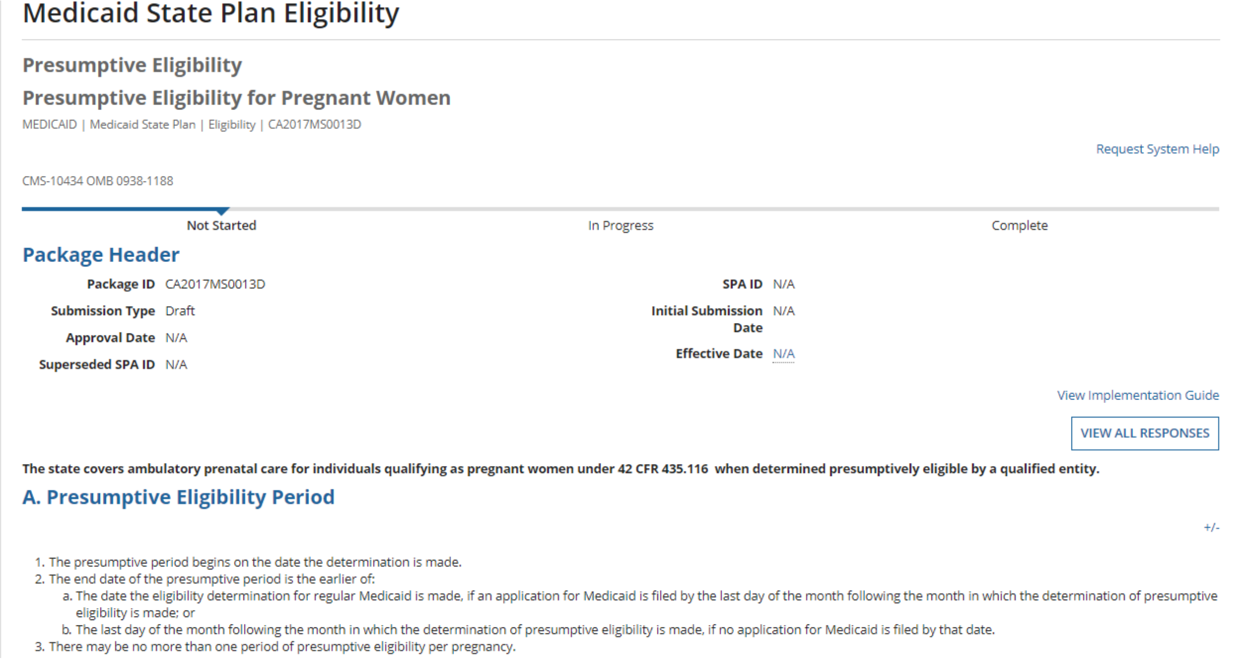
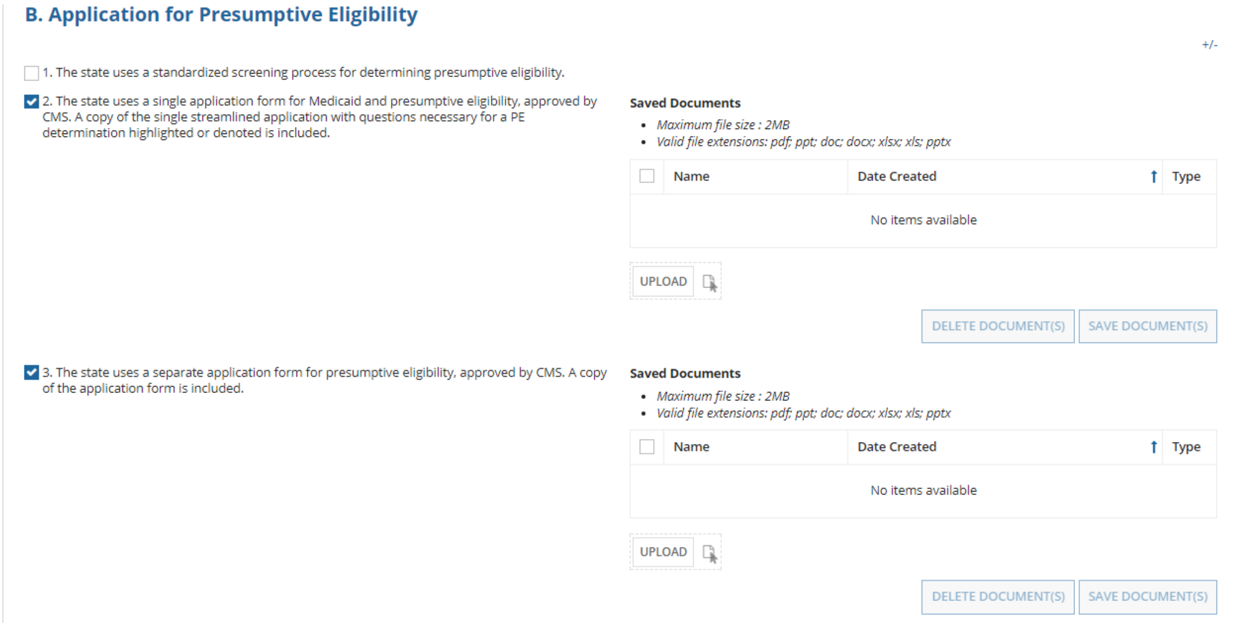


Figure 1: Presumptive Eligibility for Pregnant Women– 1



B. Application for Presumptive Eligibility

+/-

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☑ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

☐	Name	Date Created ↑	Type
		No items available	

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DELETE DOCUMENT(S) SAVE DOCUMENT(S)

☑ 3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

☐	Name	Date Created ↑	Type
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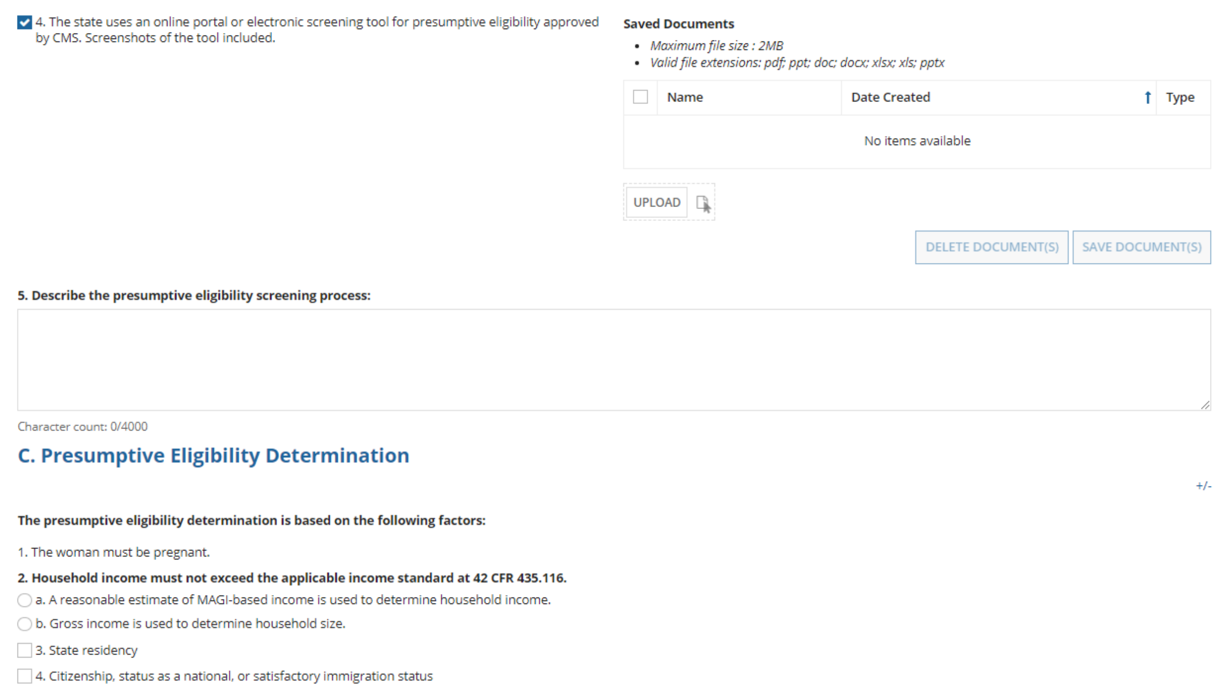
Figure 2: Presumptive Eligibility for Pregnant Women – 2



☑ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

☐	Name	Date Created ↑	Type
		No items available	

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5. Describe the presumptive eligibility screening process:

Character count: 0/4000

C. Presumptive Eligibility Determination

+/-

The presumptive eligibility determination is based on the following factors:

1. The woman must be pregnant.

2. Household income must not exceed the applicable income standard at 42 CFR 435.116.

○ a. A reasonable estimate of MAGI-based income is used to determine household income.

○ b. Gross income is used to determine household size.

☐ 3. State residency

☐ 4. Citizenship, status as a national, or satisfactory immigration status

Figure 3: Presumptive Eligibility for Pregnant Women – 3

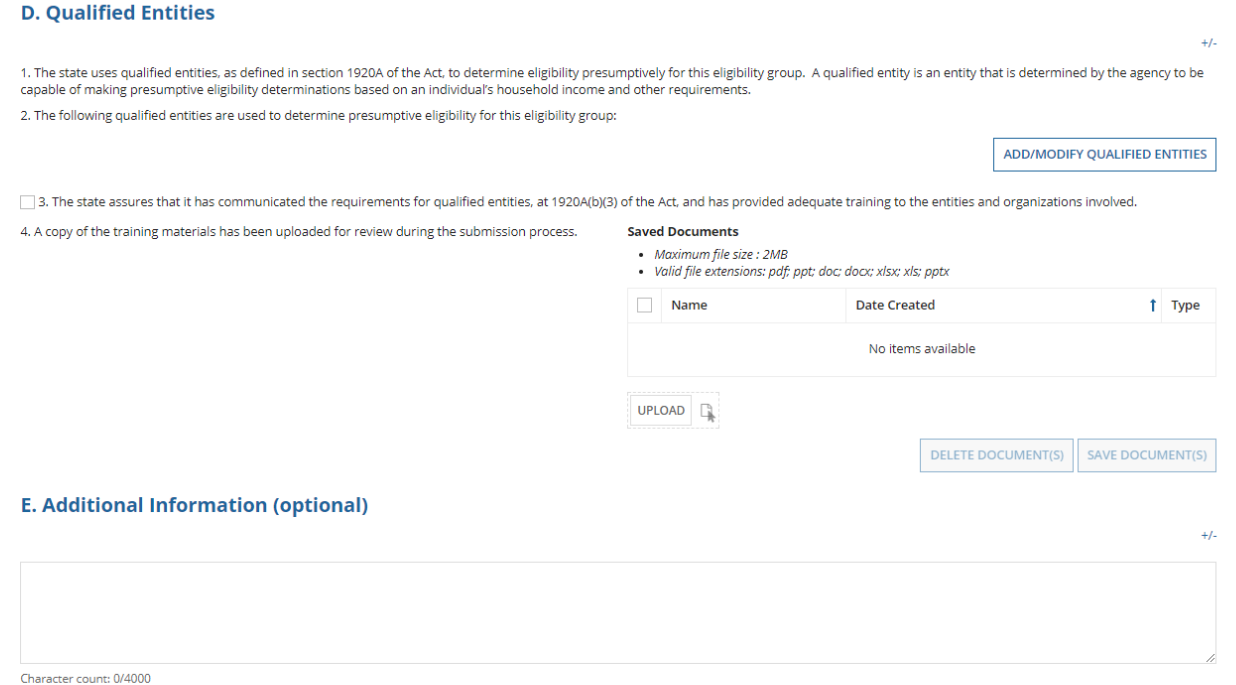

Figure 4: Presumptive Eligibility for Pregnant Women – 4

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S28T-Presumptive Eligibility for Pregnant Women PRA document

Version 1.0
08/21/2017

Document Number: 232-QSSI-MACPro-PRA-S28T-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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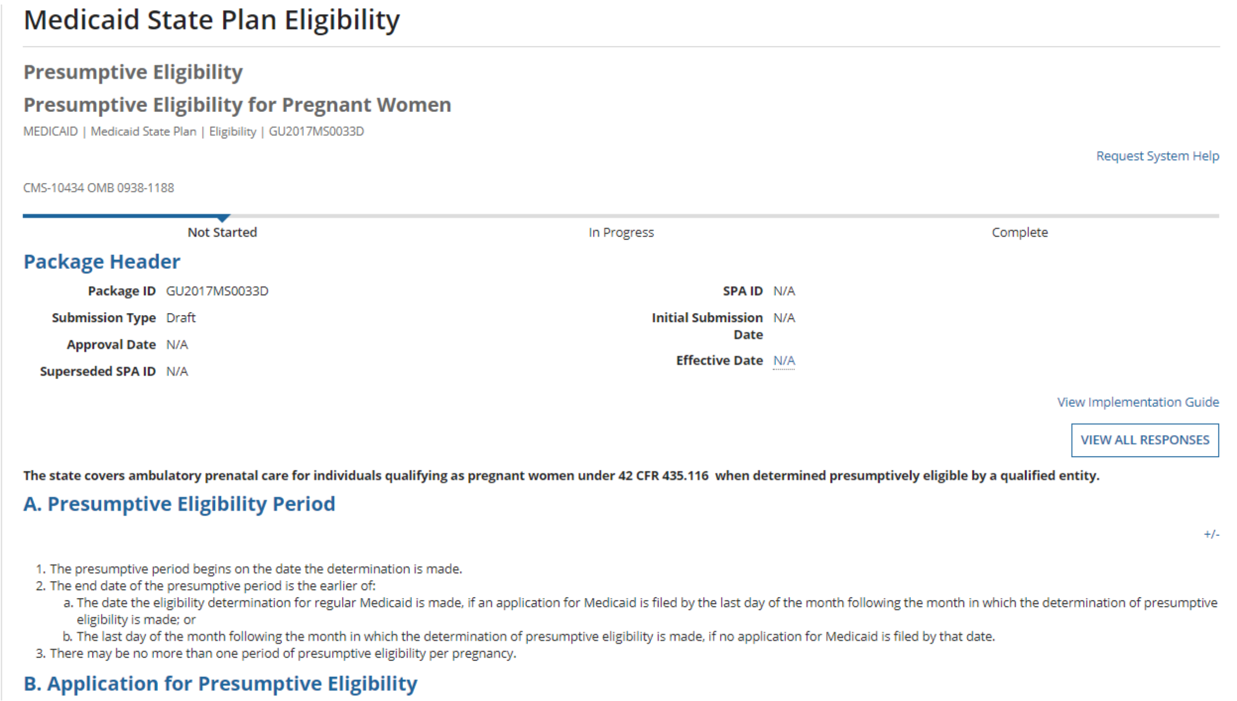
Figure 4: Presumptive Eligibility for Pregnant Women – 4 3

1. S28T-Presumptive Eligibility for Pregnant Women – Screenshots

1.1 Presumptive Eligibility for Pregnant Women


Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility for Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | GU2017MS0033D

Request System Help

CMS-10434 OMB 0938-1188

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Package Header

Package ID	GU2017MS0033D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

The state covers ambulatory prenatal care for individuals qualifying as pregnant women under 42 CFR 435.116 when determined presumptively eligible by a qualified entity.

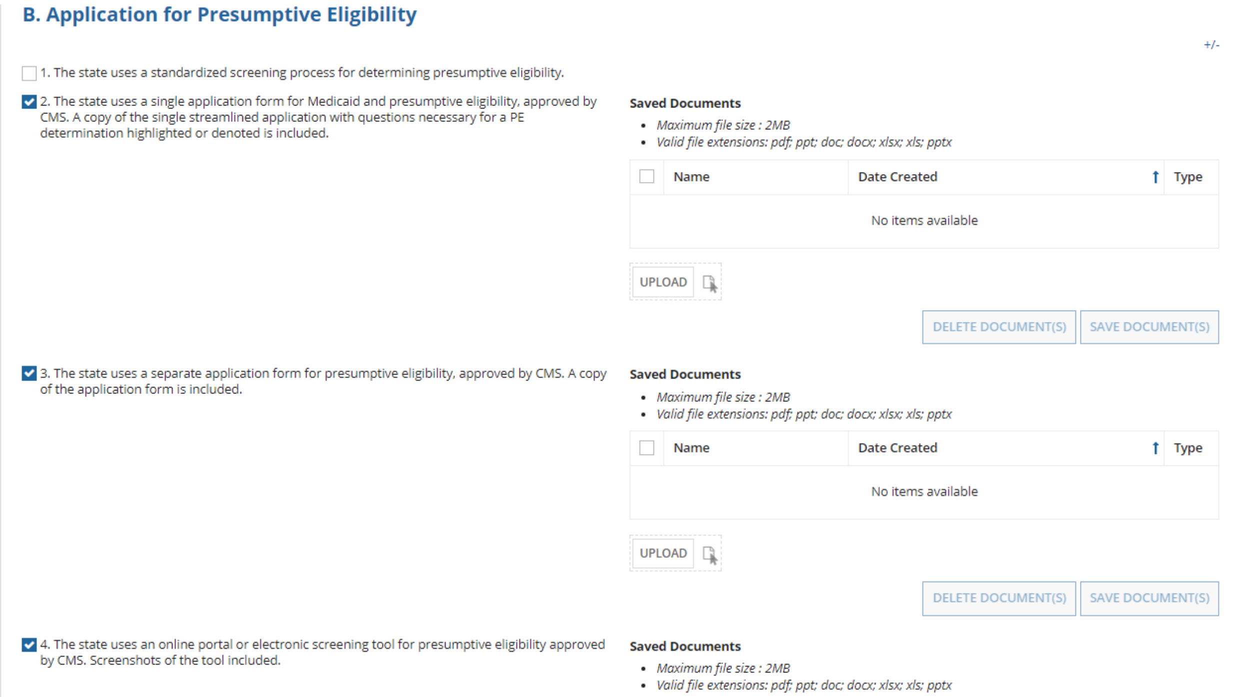
A. Presumptive Eligibility Period

+/-

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. There may be no more than one period of presumptive eligibility per pregnancy.

B. Application for Presumptive Eligibility

Figure 1: Presumptive Eligibility for Pregnant Women – 1


B. Application for Presumptive Eligibility

+/-

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☑ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	Type
No items available			

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☑ 3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	Type
No items available			

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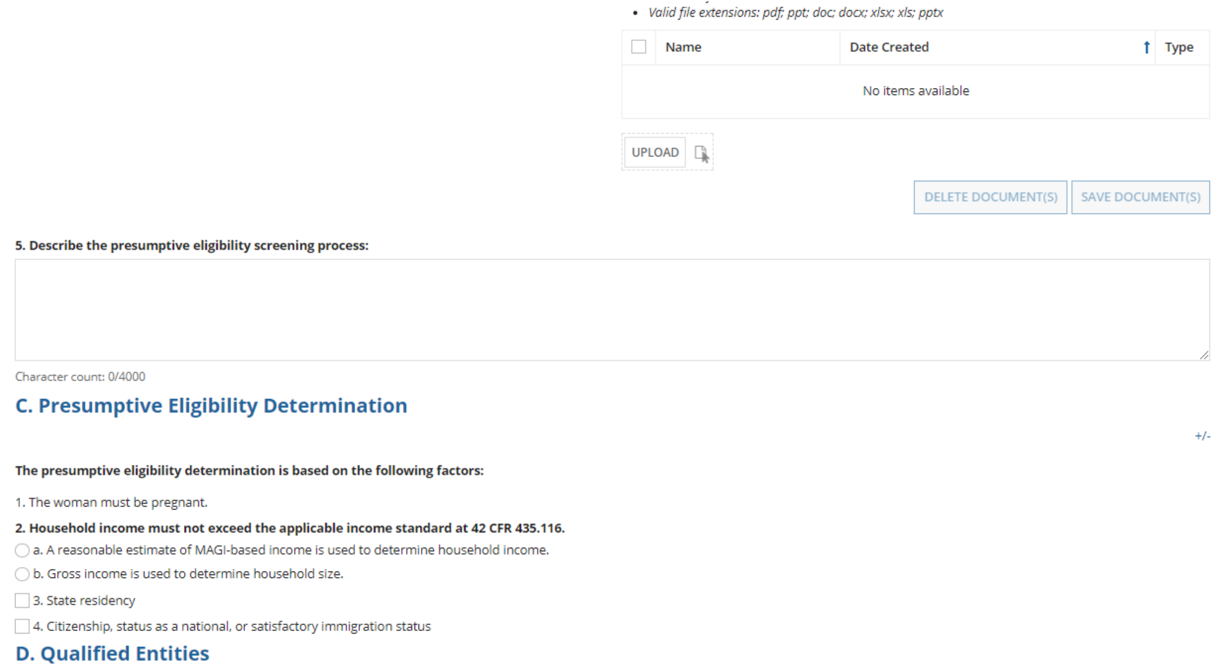
☑ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

Figure 2: Presumptive Eligibility for Pregnant Women – 2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No items available			

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5. Describe the presumptive eligibility screening process:

Character count: 0/4000

C. Presumptive Eligibility Determination

+/-

The presumptive eligibility determination is based on the following factors:

1. The woman must be pregnant.

2. Household income must not exceed the applicable income standard at 42 CFR 435.116.

○ a. A reasonable estimate of MAGI-based income is used to determine household income.

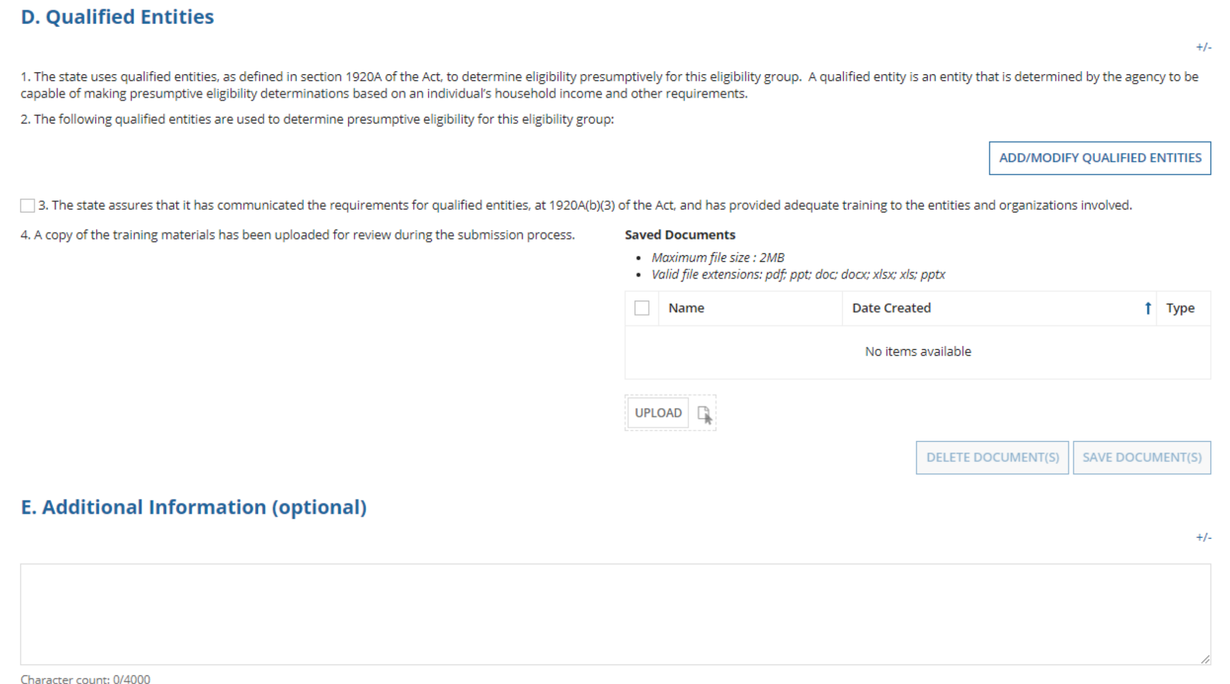
○ b. Gross income is used to determine household size.

☐ 3. State residency

☐ 4. Citizenship, status as a national, or satisfactory immigration status

D. Qualified Entities

Figure 3: Presumptive Eligibility for Pregnant Women – 3


D. Qualified Entities

+/-

1. The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group. A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.
2. The following qualified entities are used to determine presumptive eligibility for this eligibility group:

ADD/MODIFY QUALIFIED ENTITIES

3. The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved.

4. A copy of the training materials has been uploaded for review during the submission process.

Saved Documents
- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

	Name	Date Created	Type
No items available			

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E. Additional Information (optional)

+/-

Character count: 0/4000

Figure 4: Presumptive Eligibility for Pregnant Women – 4

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S30 – Infants and Children under Age 19 RU PRA Document

Version 1.0
08/18/2017

Document Number: 209-QSSI-MACPro-R5.1-S30-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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No table of figures entries found.

1. S30 - Infants and Children under Age 19 Screenshots

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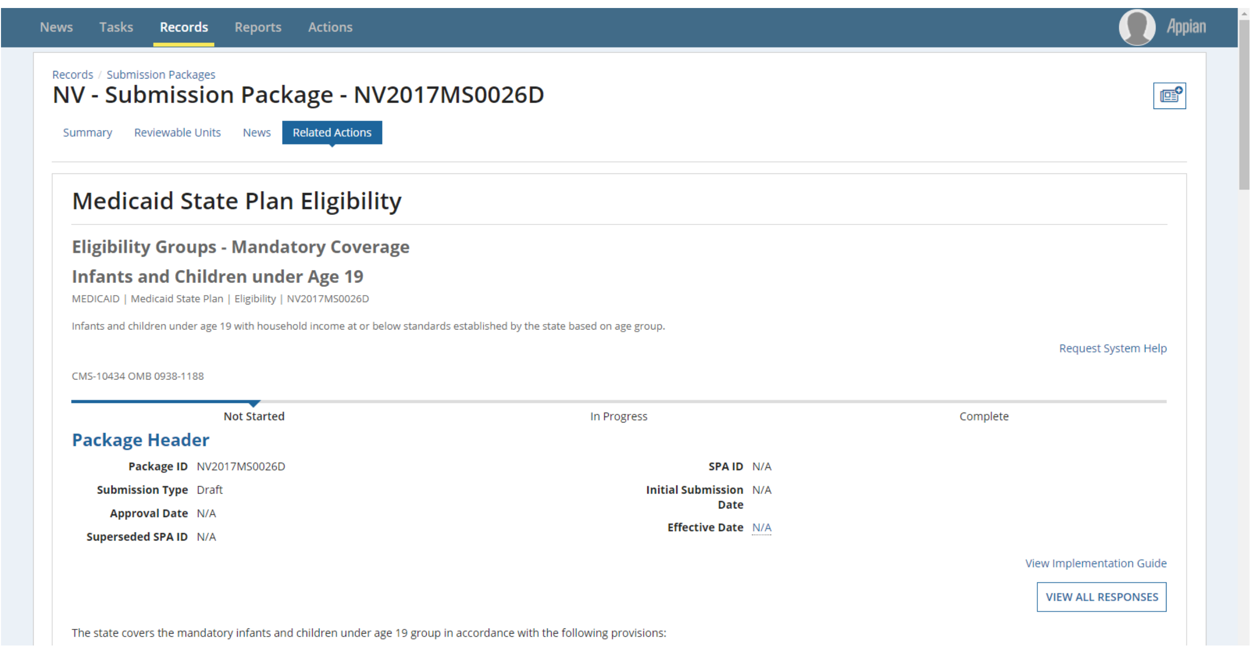


Figure 1: Package Header

1.2 A. Characteristics and B. Financial Methodologies and C. Income Standards Used

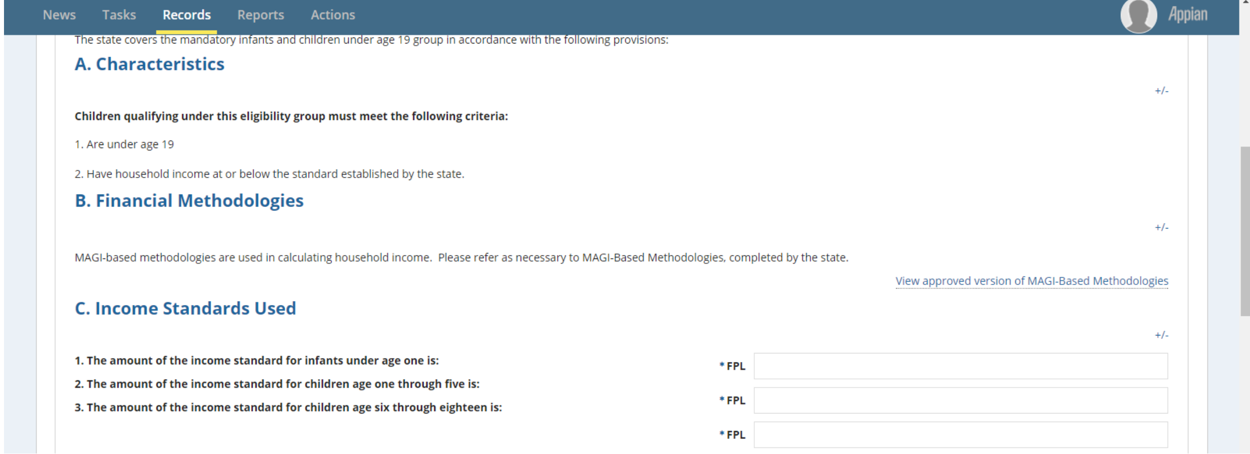


Figure 2: Section A, Section B and Section C

1.3 D. Basis for the Income Standard for Infants under Age 1 – Path 1

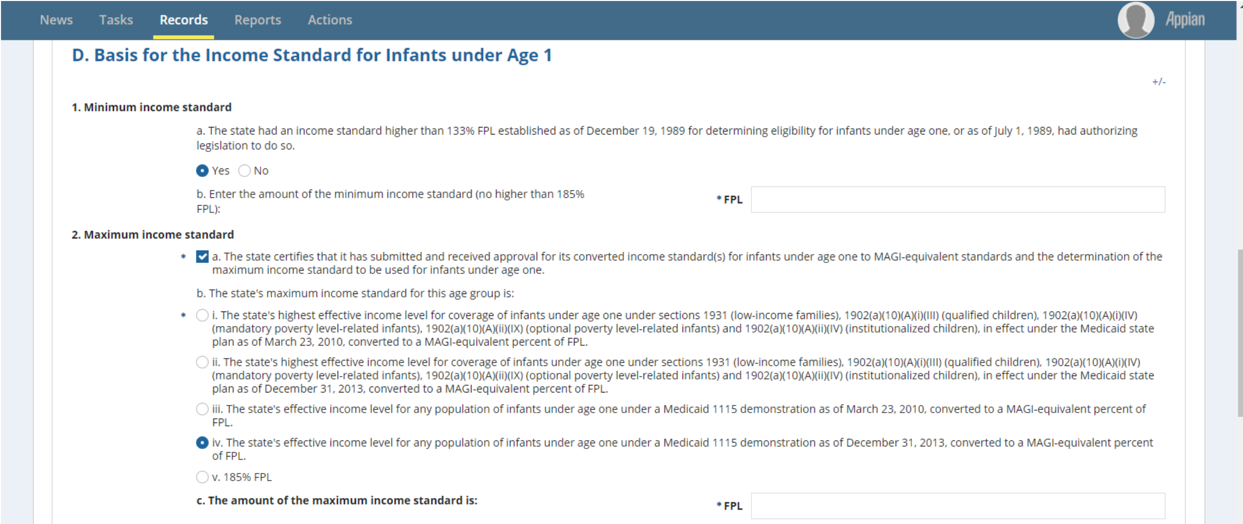


Figure 3: Section D-Path1

1.4 D. Basis for the Income Standard for Infants under Age 1 – Path 2

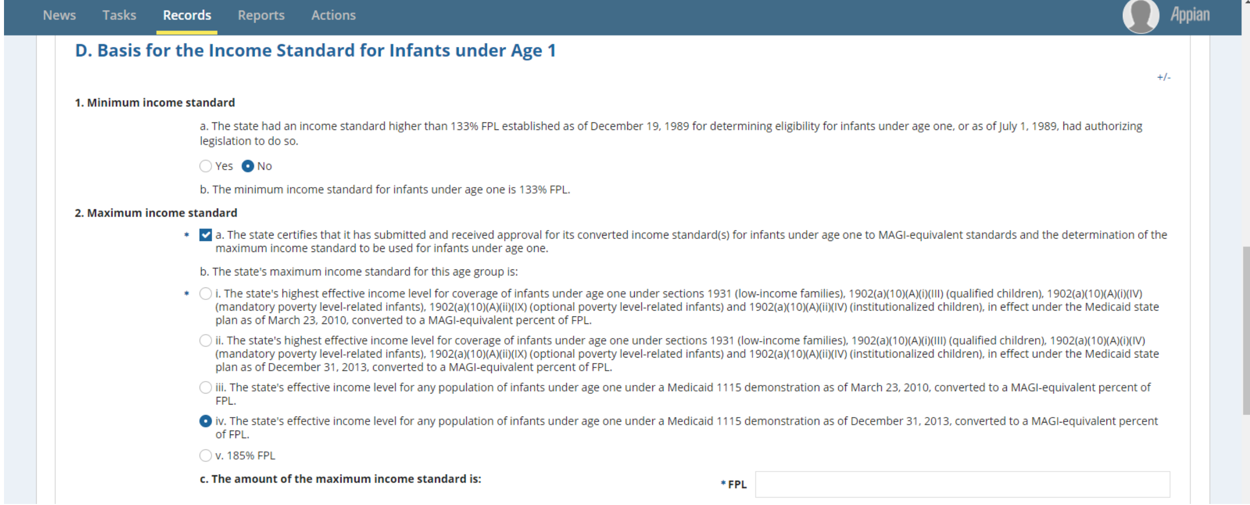
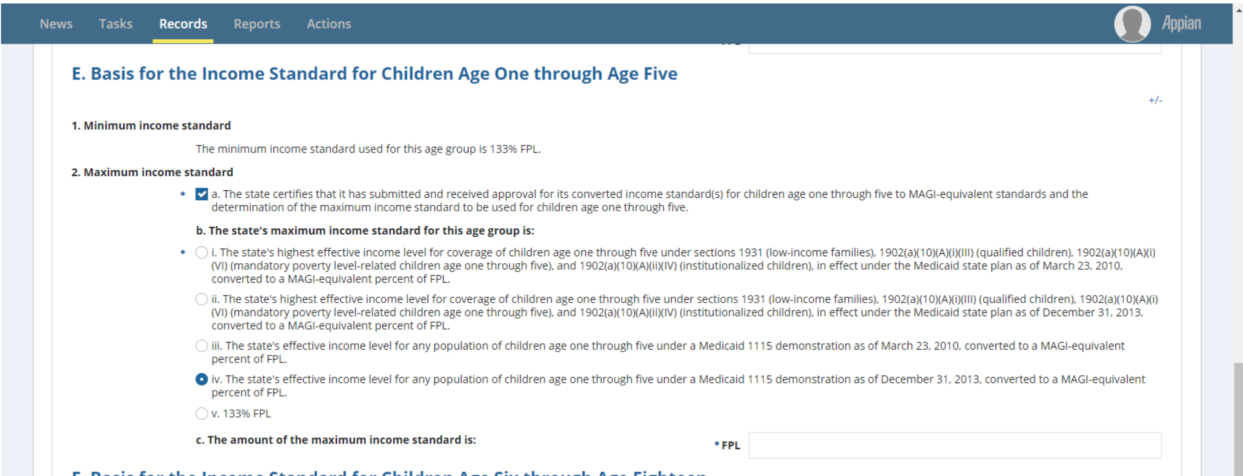


Figure 4: Section D-Path2

1.5 E. Basis for the Income Standard for Children Age One through Age Five



News Tasks Records Reports Actions Appian

E. Basis for the Income Standard for Children Age One through Age Five

+/-

1. Minimum income standard

The minimum income standard used for this age group is 133% FPL.

2. Maximum income standard

a. The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

b. The state's maximum income standard for this age group is:

i. The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

ii. The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

iii. The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

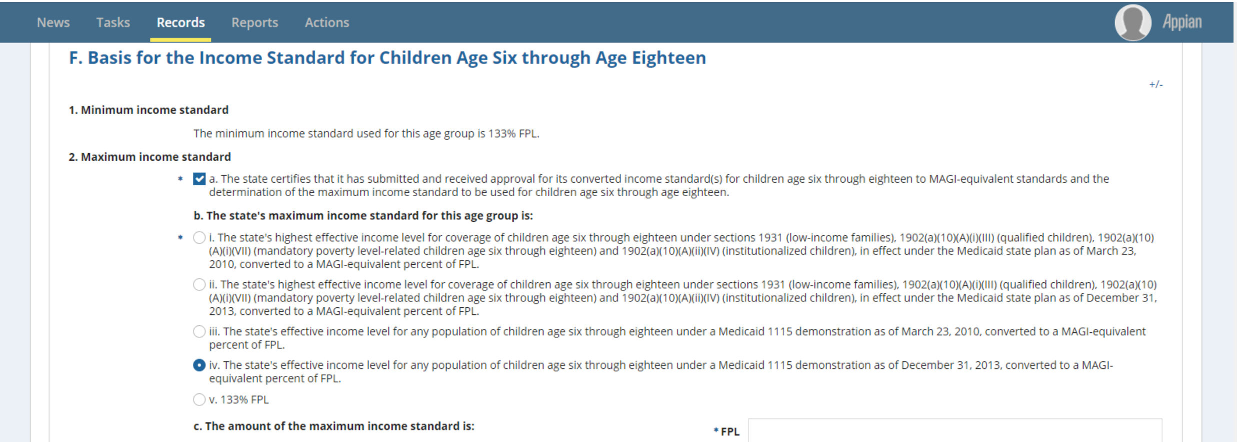
iv. The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

v. 133% FPL

c. The amount of the maximum income standard is: * FPL

Figure 5 : Section E

1.6 F. Basis for the Income Standard for Children Age Six through Age Eighteen



News Tasks Records Reports Actions Appian

F. Basis for the Income Standard for Children Age Six through Age Eighteen

+/-

1. Minimum income standard

The minimum income standard used for this age group is 133% FPL.

2. Maximum income standard

a. The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

b. The state's maximum income standard for this age group is:

i. The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

ii. The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

iii. The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

iv. The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

v. 133% FPL

c. The amount of the maximum income standard is: * FPL

Figure 6 : Section F

1.7 G. Additional Information (optional)

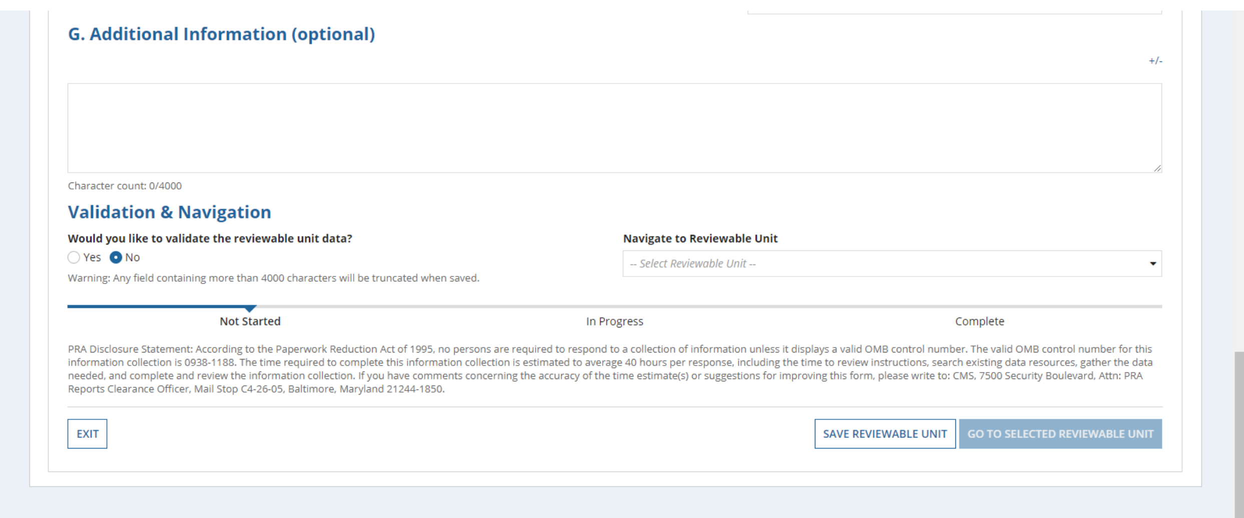


Figure 7 : Section G

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S30T - Infants and Children under Age 19 - Territories RU PRA Document

Version 1.0
08/16/2017

Document Number: 191-QSSI-MACPro-R5.1-S30T-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S30T- Infants and Children under Age 19 - Territories Screenshots

1.1 Package Header

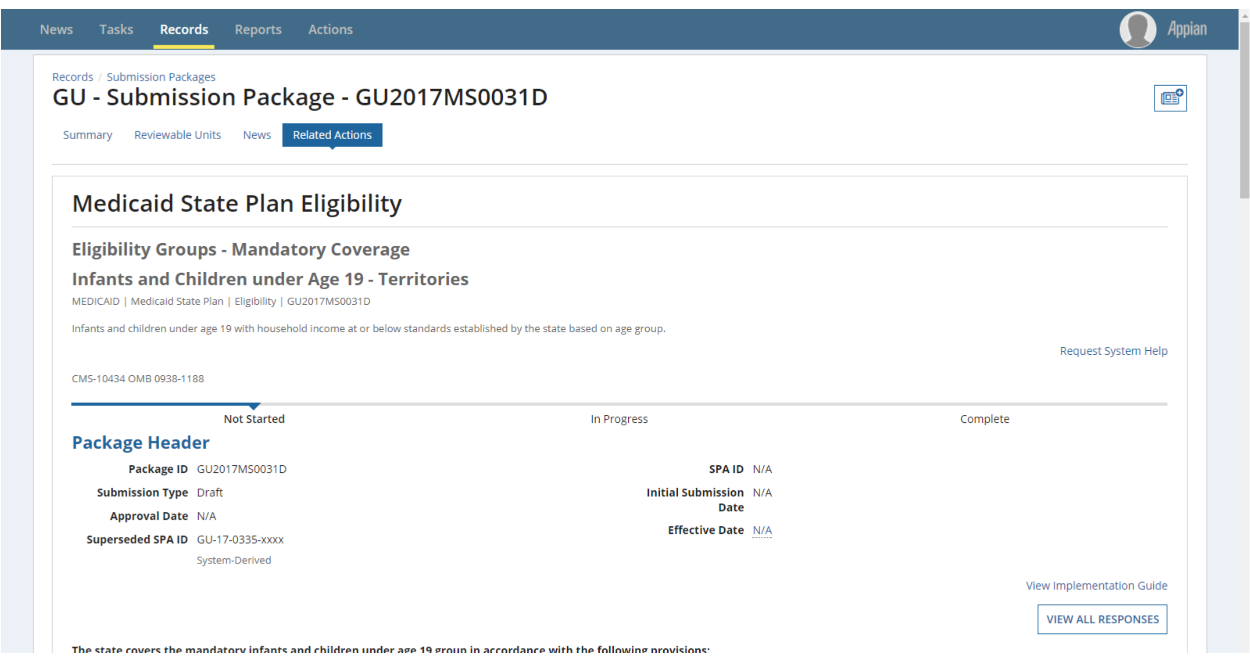


Figure 1: Package Header

1.2 A. Characteristics and B. Financial Methodologies

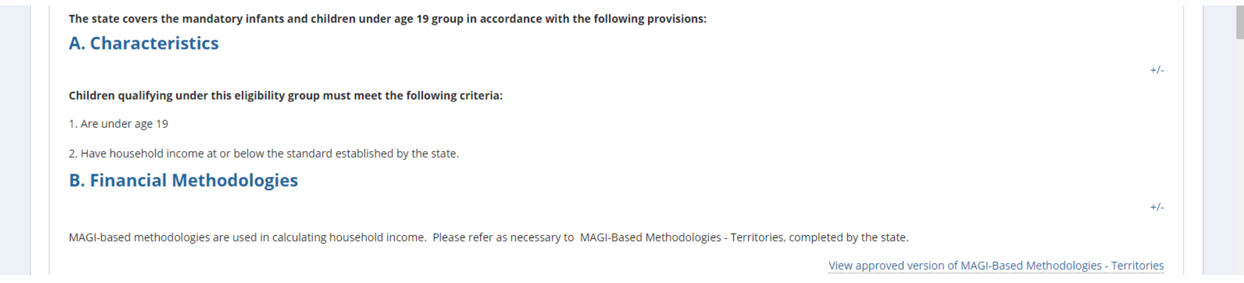


Figure 2: Section A and Section B

1.3 C. Income Standards Used and D. Basis for the Income Standard for Infants under Age 1

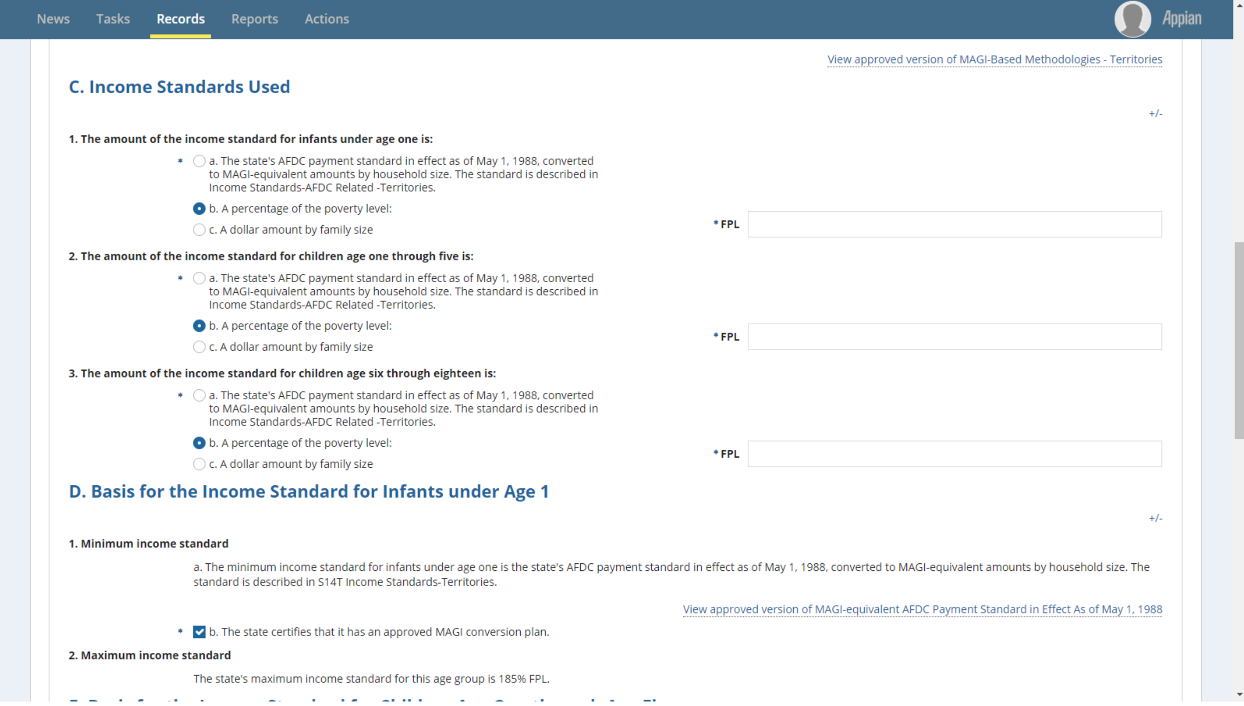
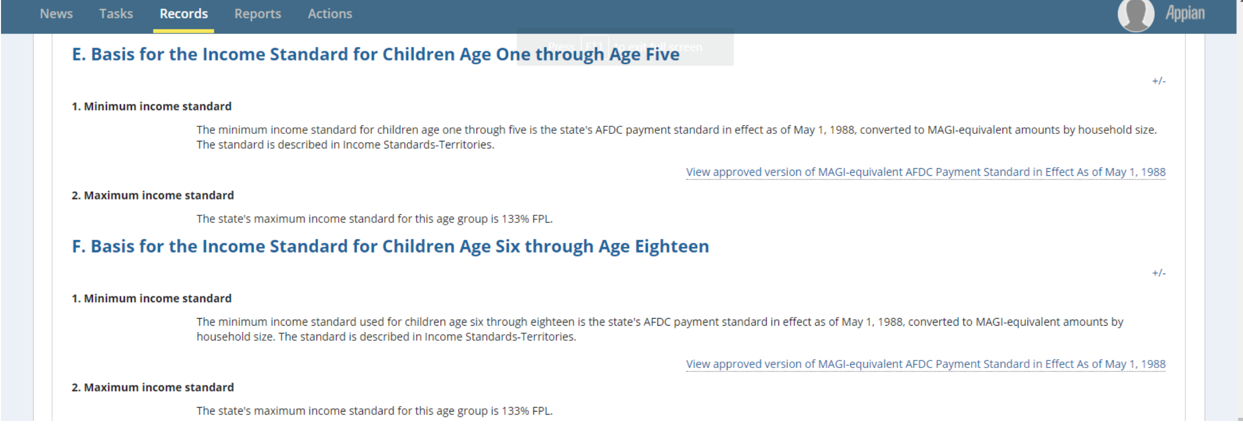


Figure 3: Section C and Section D

1.4 E. Basis for the Income Standard for Children Age One through Age Five and F. Basis for the Income Standard for Children Age Six through Age Eighteen



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1.5 G. Additional Information (optional)

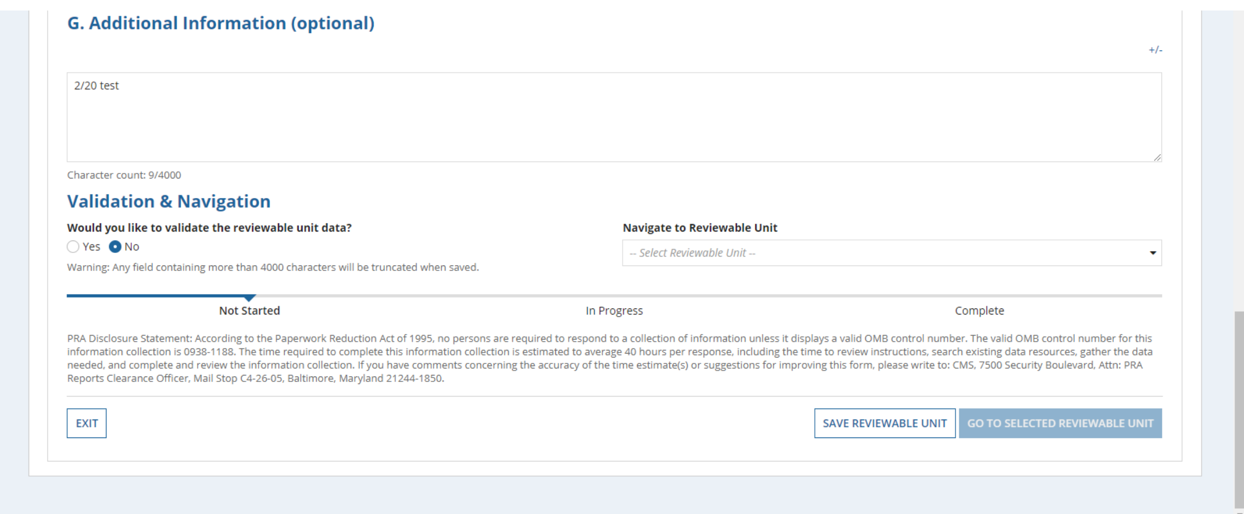

Figure 5: Section G

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S32 - Adult Group RU PRA Document

Version 1.0
08/16/2017

Document Number: 183-QSSI-MACPro-R5.1-S32-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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List of Tables

No table of figures entries found.

1. S32 - Adult Group Screenshots

1.1 Package Header

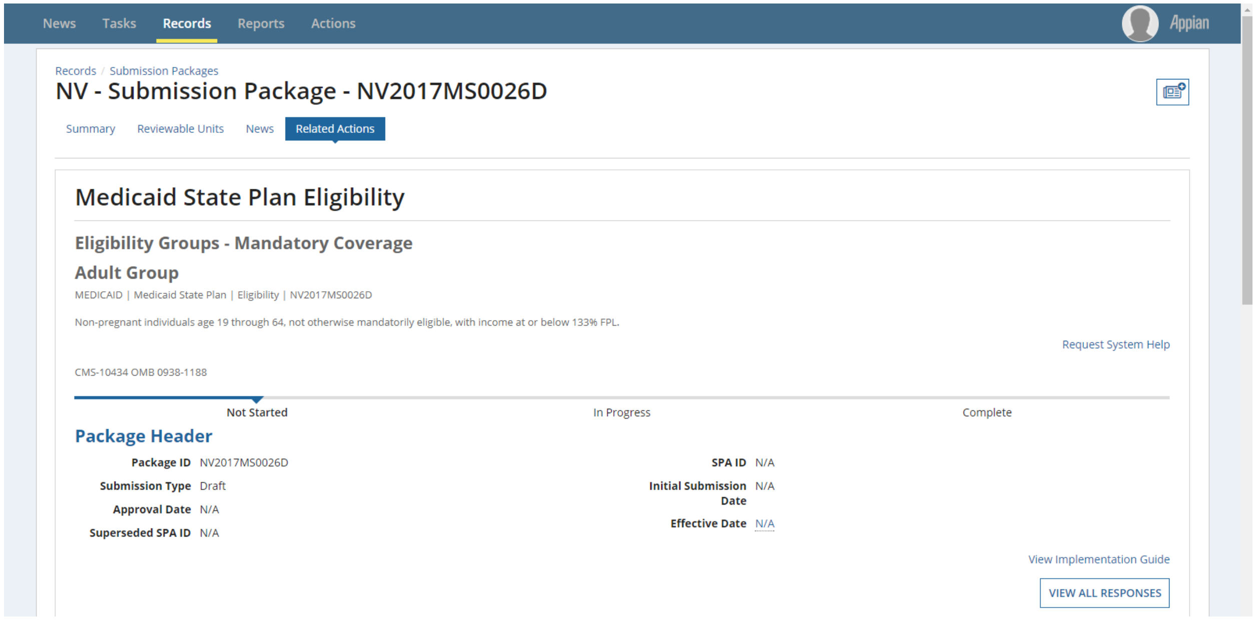

Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies, C. Income Standard Used and D. Coverage of Dependent Children

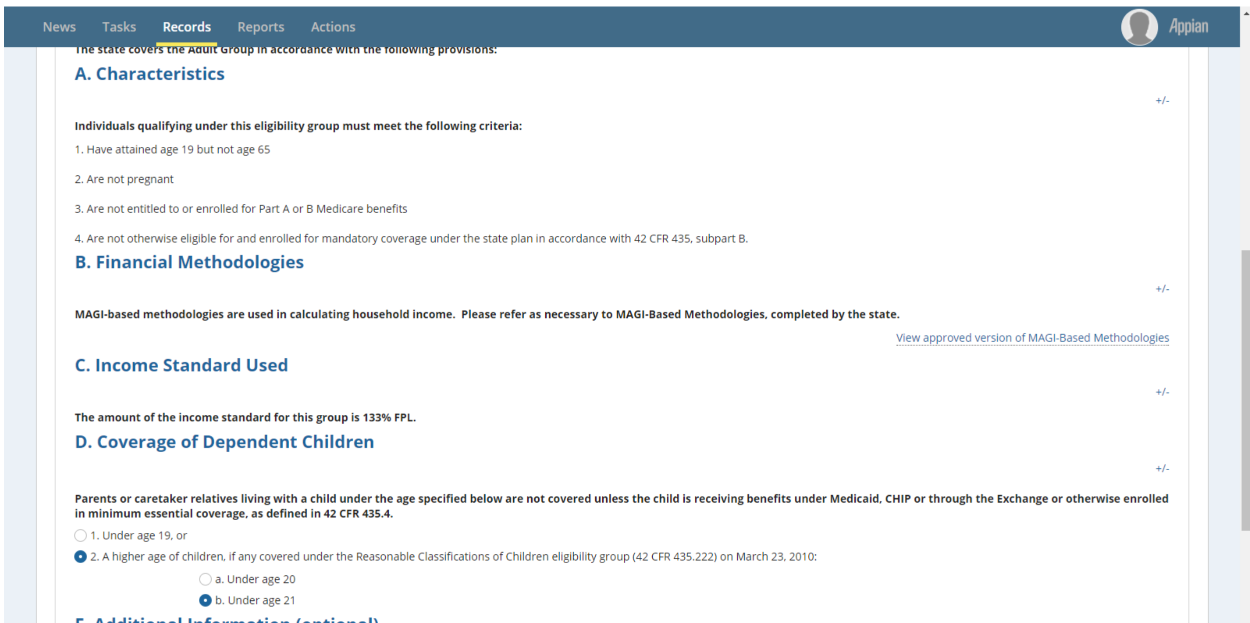

Figure 2: Section A, Section B, Section C and Section D

1.3 E. Additional Information (optional)

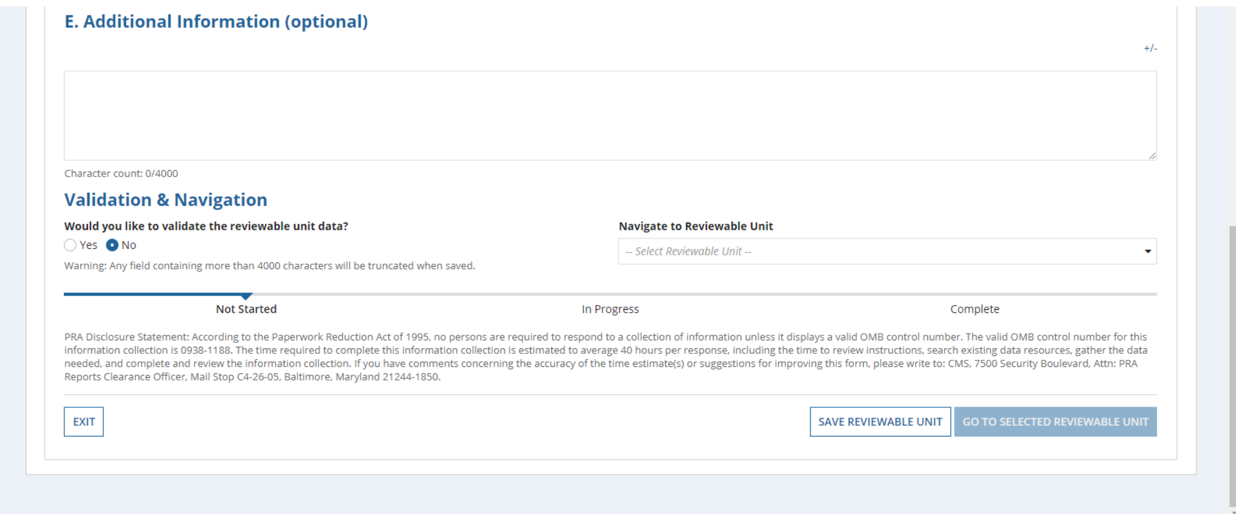

Figure 3: Section E

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S32a-Adult Group - Presumptive Eligibility PRA document

Version 1.0
08/18/2017

Document Number: 215-QSSI-MACPro-PRA-S32a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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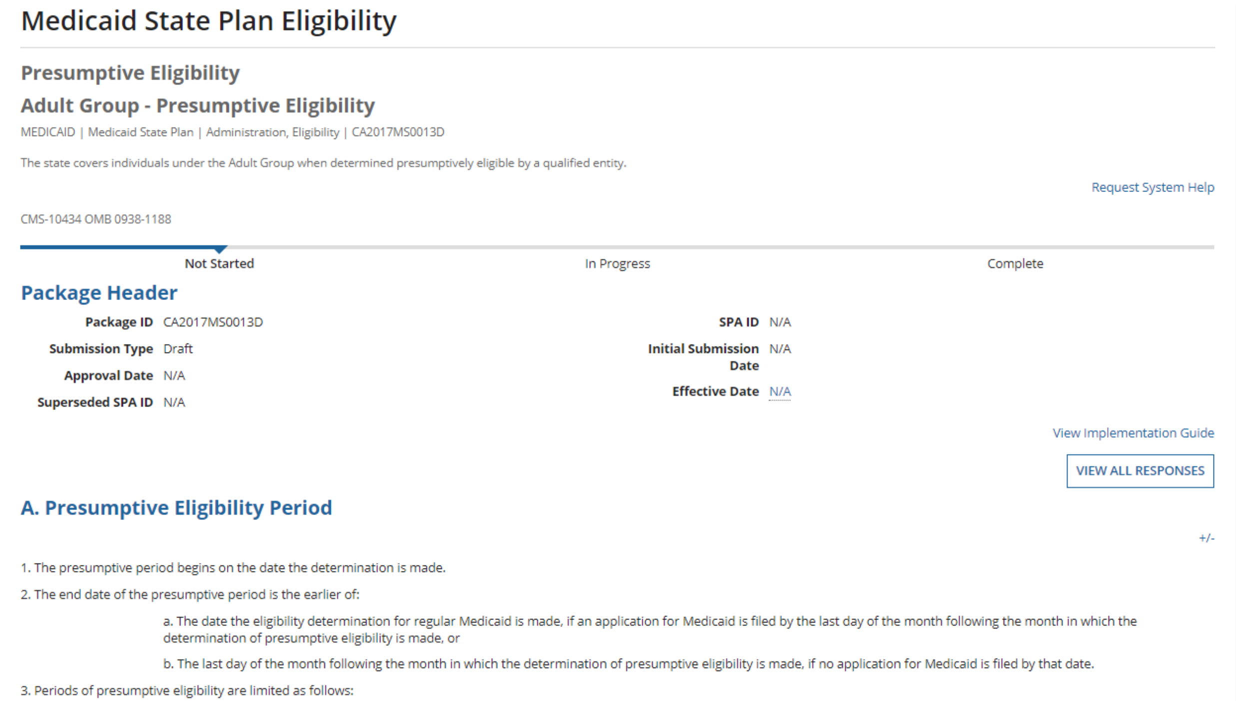
Figure 4: Adult Group - Presumptive Eligibility – 4 3

Figure 5: Adult Group - Presumptive Eligibility – 5 3

1. S32a-Adult Group - Presumptive Eligibility - Screenshots

1.1 Adult Group - Presumptive Eligibility


Medicaid State Plan Eligibility

Presumptive Eligibility

Adult Group - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Administration, Eligibility | CA2017MS0013D

The state covers individuals under the Adult Group when determined presumptively eligible by a qualified entity.

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

A. Presumptive Eligibility Period

+/-

1. The presumptive period begins on the date the determination is made.

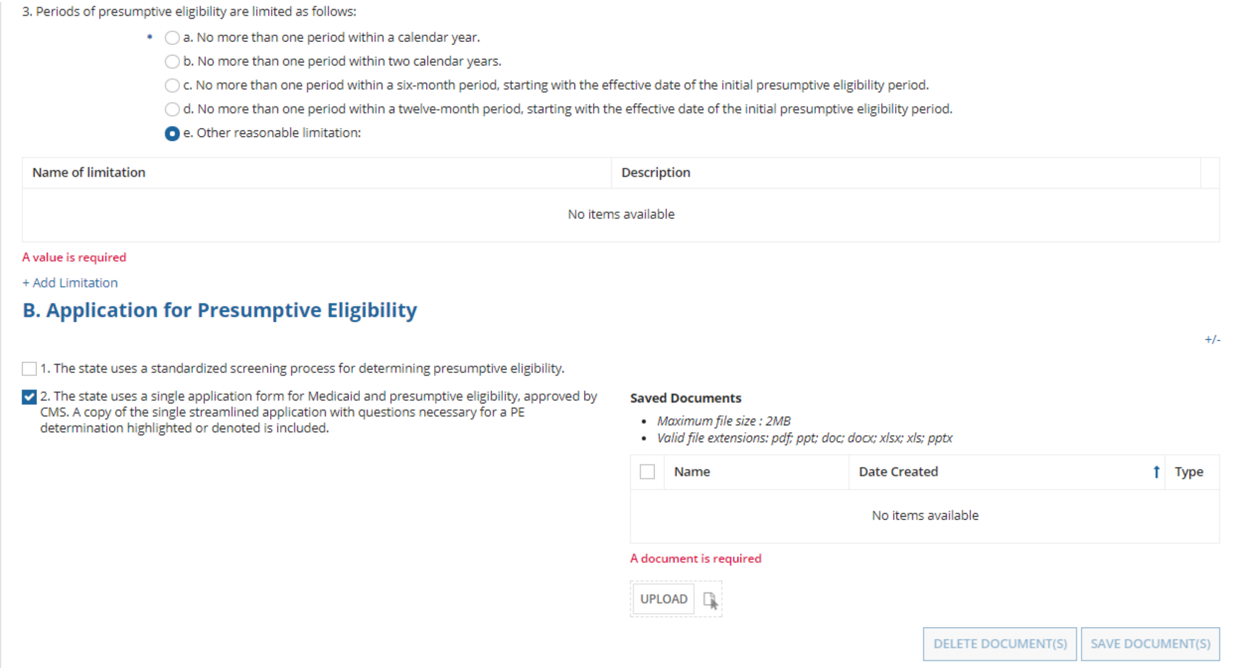
2. The end date of the presumptive period is the earlier of:

a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made, or

b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

Figure 1: Adult Group - Presumptive Eligibility – 1



3. Periods of presumptive eligibility are limited as follows:

- a. No more than one period within a calendar year.
- b. No more than one period within two calendar years.
- c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
- d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- e. Other reasonable limitation:

Name of limitation	Description
No items available	

A value is required

+ Add Limitation

B. Application for Presumptive Eligibility

+/-

1. The state uses a standardized screening process for determining presumptive eligibility.

2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

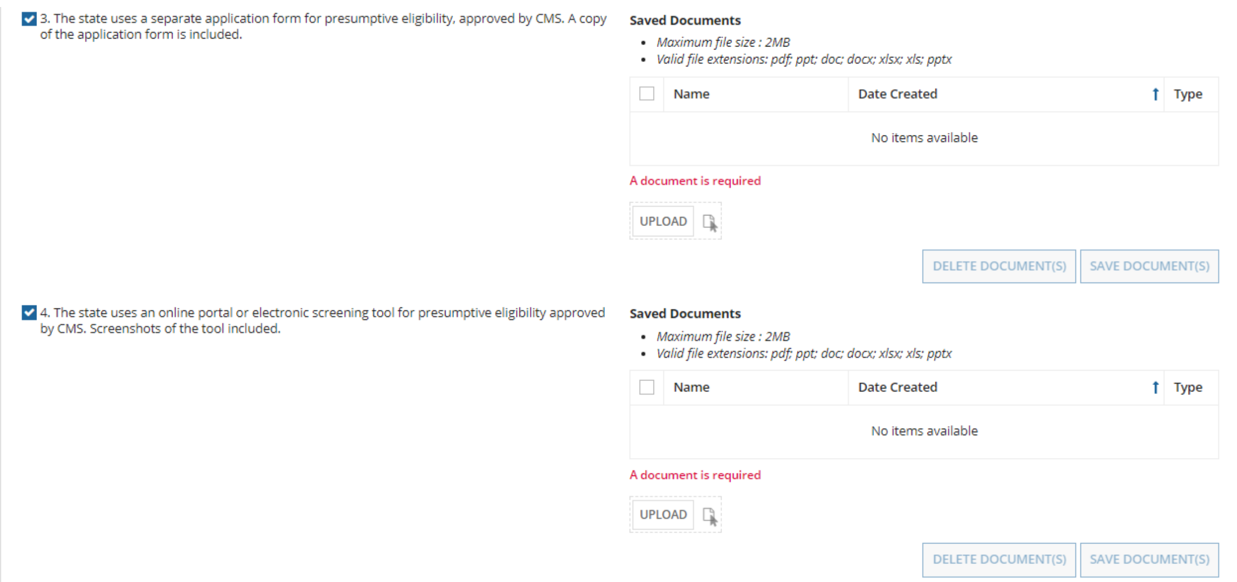
	Name	Date Created	Type
No items available			

A document is required

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 2: Adult Group - Presumptive Eligibility – 2



3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

	Name	Date Created	Type
No items available			

A document is required

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

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No items available			

A document is required

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Figure 3: Adult Group - Presumptive Eligibility – 3

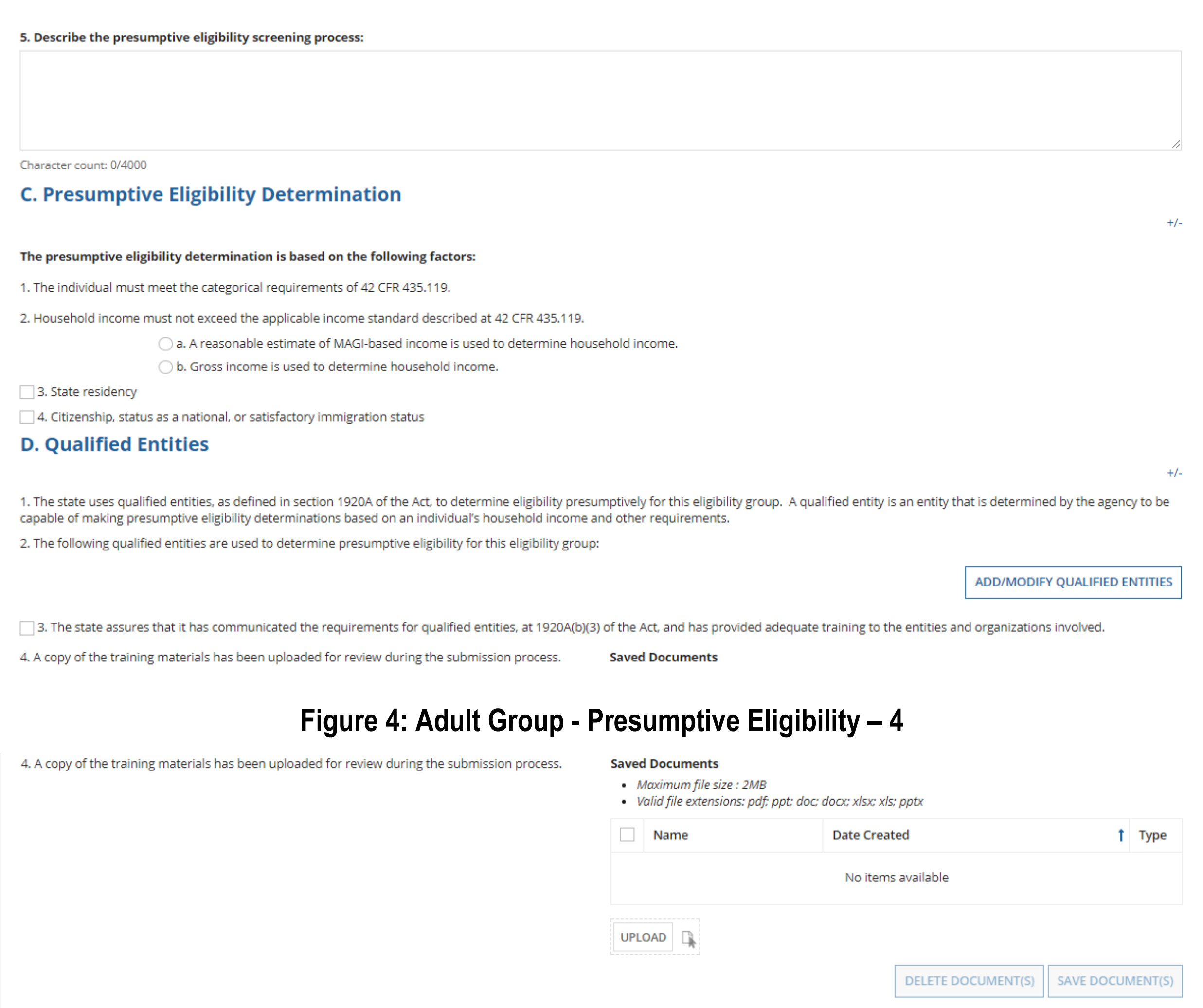

Figure 4: Adult Group - Presumptive Eligibility – 4

4. A copy of the training materials has been uploaded for review during the submission process.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

	Name	Date Created	Type
No items available			

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DELETE DOCUMENT(S) SAVE DOCUMENT(S)

E. Additional Information (optional)

+/-

Character count: 0/4000

Figure 5: Adult Group - Presumptive Eligibility – 5

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S32T-Adult Group - Presumptive Eligibility PRA document

Version 1.0

08/21/2017

Document Number: 241-QSSI-MACPro-PRA-S32T-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 5: Adult Group - Presumptive Eligibility – 5 3

1. S32T-Adult Group - Presumptive Eligibility – Screenshots

1.1 Adult Group - Presumptive Eligibility

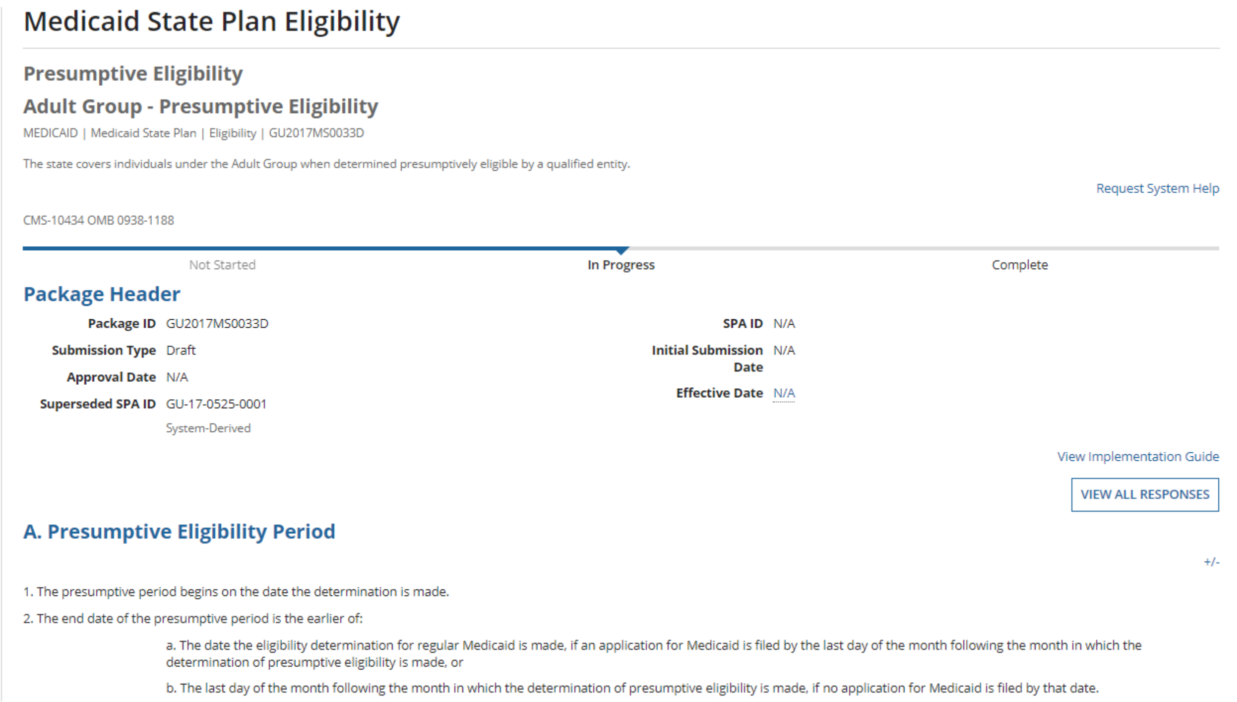
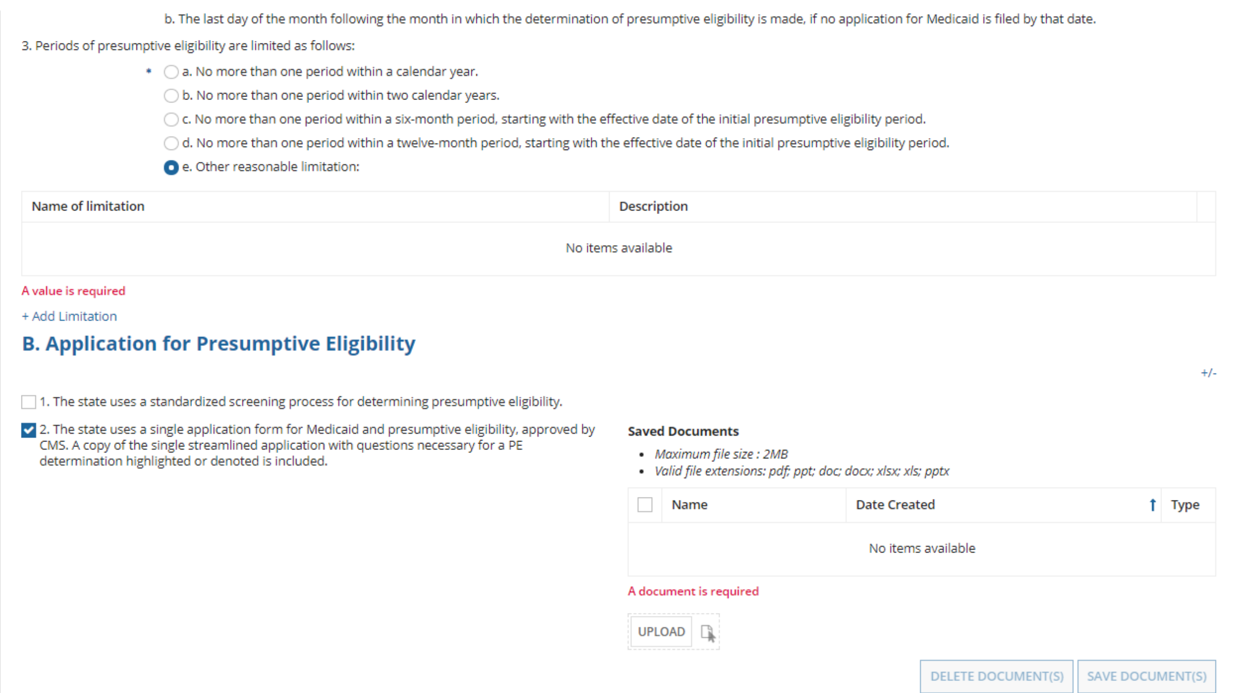


Figure 1: Adult Group - Presumptive Eligibility – 1



b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

- a. No more than one period within a calendar year.
- b. No more than one period within two calendar years.
- c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
- d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- e. Other reasonable limitation:

Name of limitation	Description
No items available	

A value is required

+ Add Limitation

B. Application for Presumptive Eligibility

+/-

1. The state uses a standardized screening process for determining presumptive eligibility.

2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

Name	Date Created	Type
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A document is required

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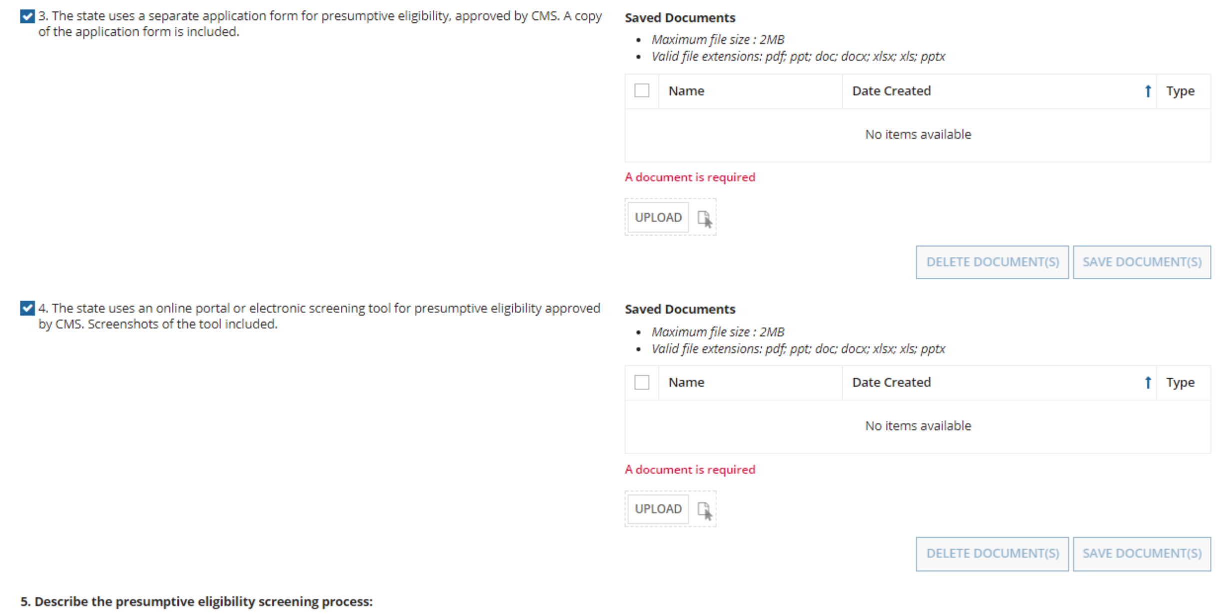
Figure 2: Adult Group - Presumptive Eligibility – 2



3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

Name	Date Created	Type
No items available		

A document is required

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DELETE DOCUMENT(S) SAVE DOCUMENT(S)

4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

Name	Date Created	Type
No items available		

A document is required

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5. Describe the presumptive eligibility screening process:

Figure 3: Adult Group - Presumptive Eligibility – 3

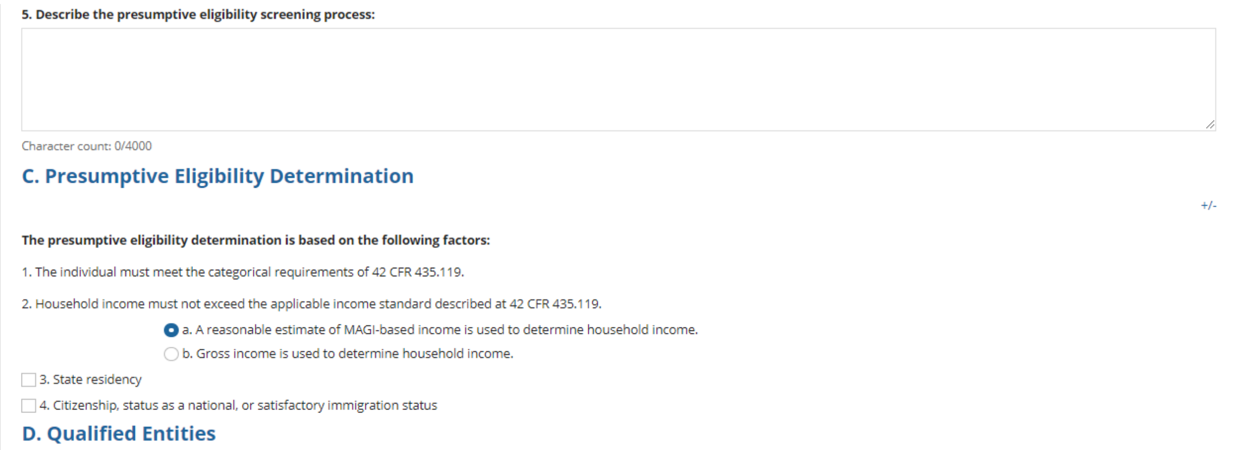

Figure 4: Adult Group - Presumptive Eligibility – 4

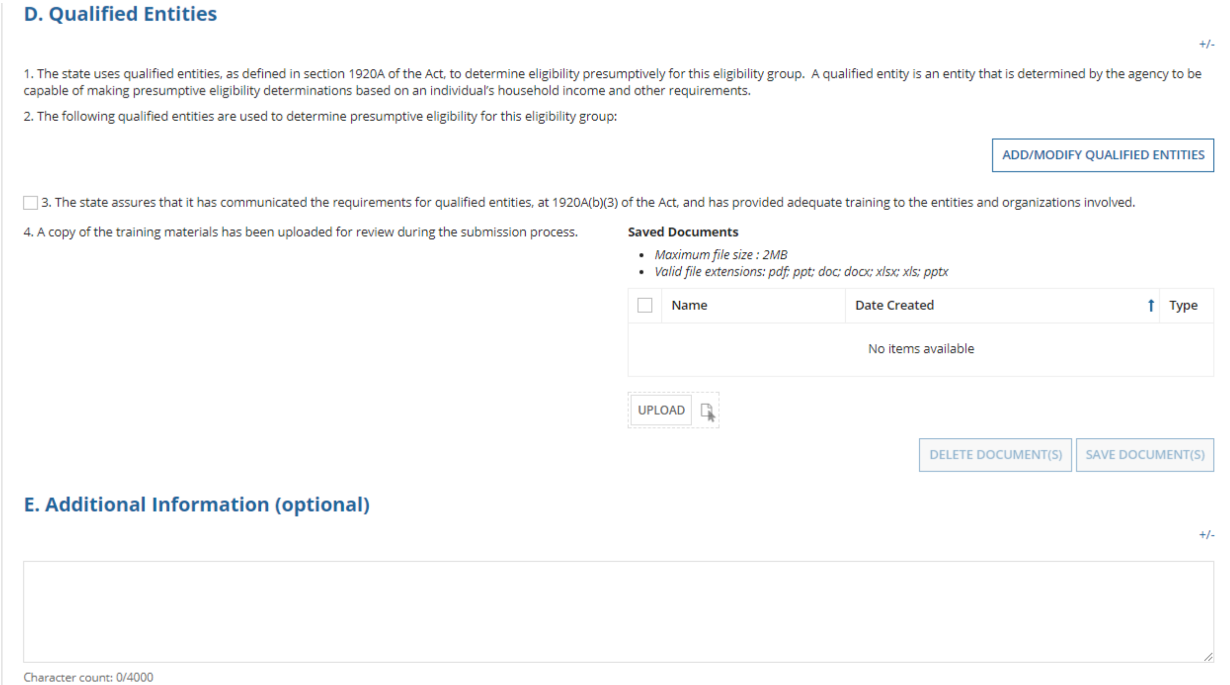

Figure 5: Adult Group - Presumptive Eligibility – 5

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S33-Former Foster Care Children PRA document

Version 1.0

08/18/2017

Document Number: 216-QSSI-MACPro-PRA-S33-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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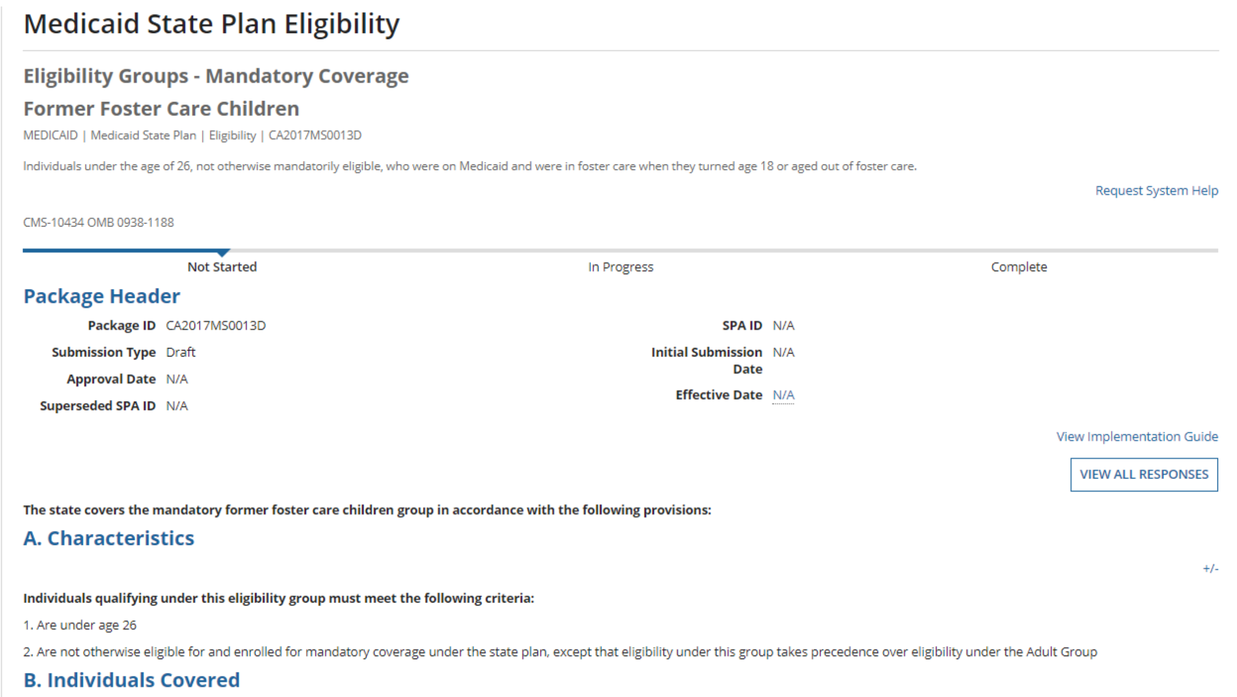
1. S33-Former Foster Care Children – Screenshots

1.1 Former Foster Care Children



Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and were in foster care when they turned age 18 or aged out of foster care.

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

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

A. Characteristics

+/-

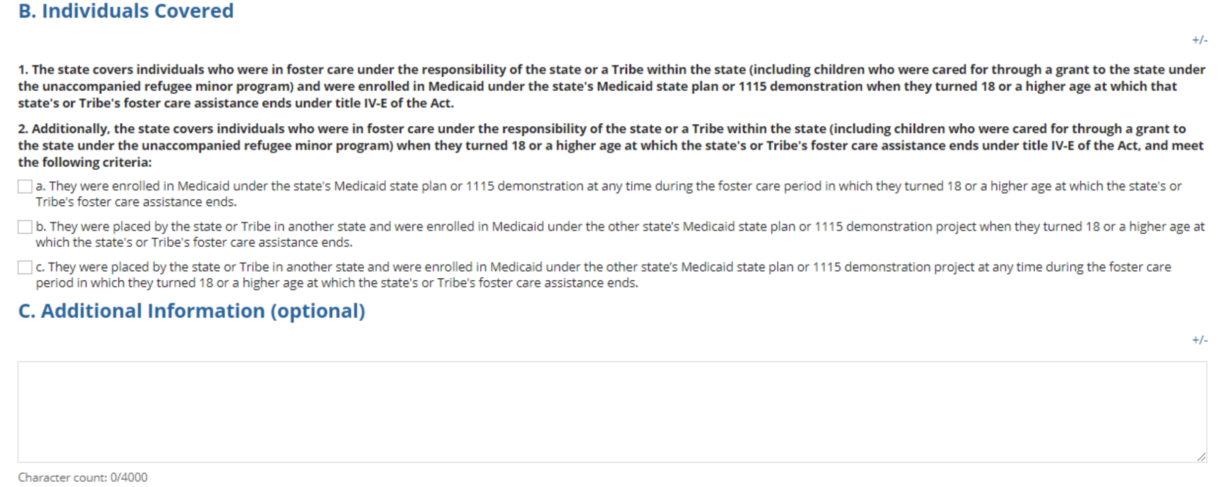
Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. 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

B. Individuals Covered

Figure 1: Former Foster Care Children – 1



B. Individuals Covered

+/-

1. The state covers 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) and were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration 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.

2. Additionally, the state covers 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. Additional Information (optional)

+/-

Character count: 0/4000

Figure 2: Former Foster Care Children – 2

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S33a-Former Foster Care Children – Presumptive Eligibility PRA document

Version 1.0

08/18/2017

Document Number: 217-QSSI-MACPro-PRA-S33a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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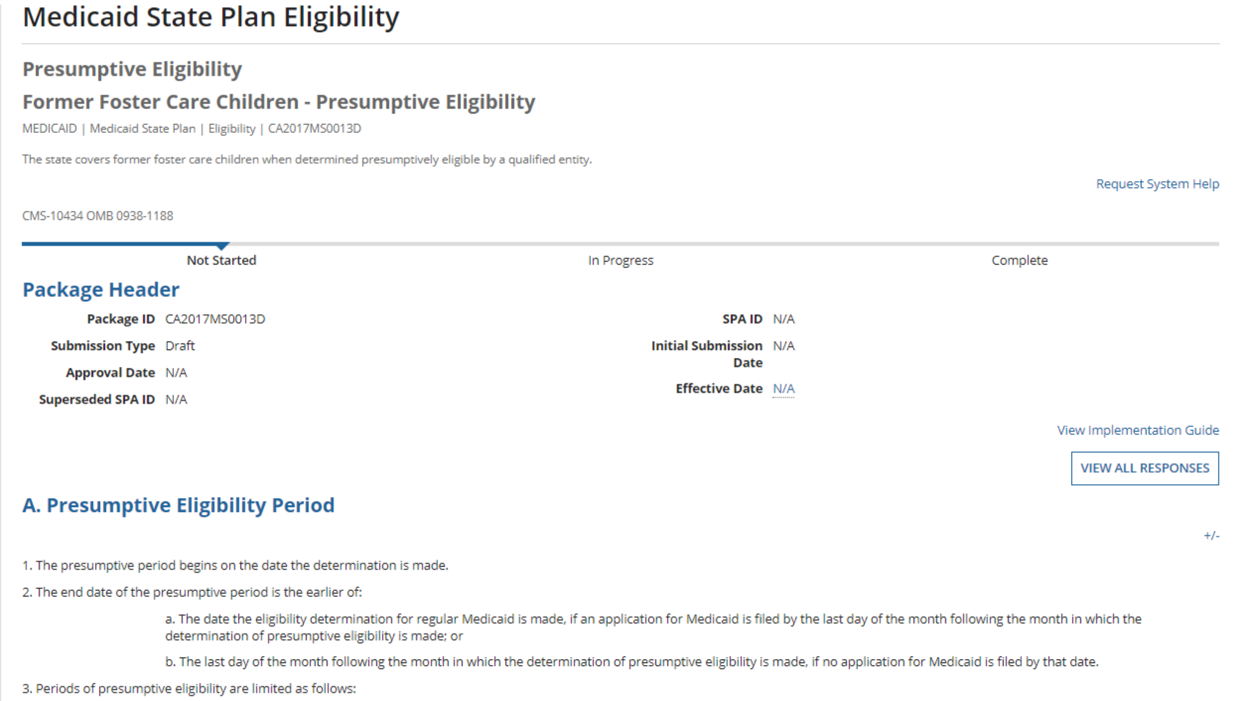
Figure 5: Former Foster Care Children – Presumptive Eligibility – 5............................... 3

1. S33a-Former Foster Care Children – Presumptive Eligibility - Screenshots

1.1 Former Foster Care Children – Presumptive Eligibility


Medicaid State Plan Eligibility

Presumptive Eligibility

Former Foster Care Children - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

The state covers former foster care children when determined presumptively eligible by a qualified entity.

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	CA2017MS0013D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

A. Presumptive Eligibility Period

+/-

1. The presumptive period begins on the date the determination is made.

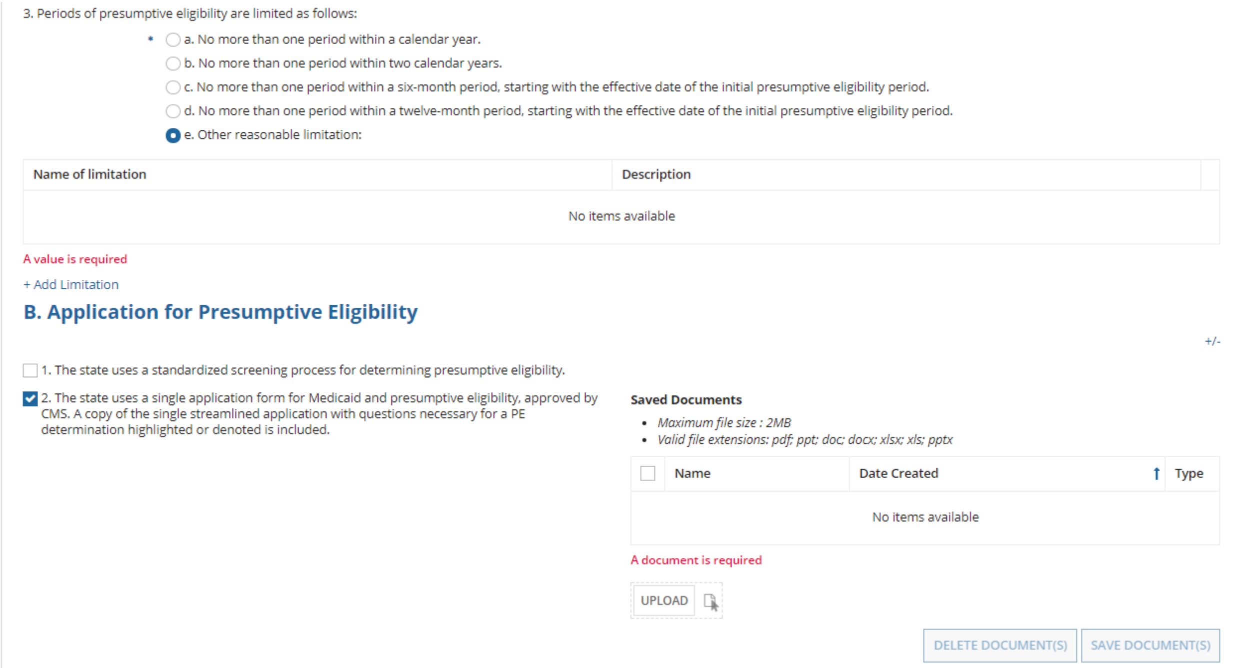
2. The end date of the presumptive period is the earlier of:

a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

Figure 1: Former Foster Care Children – Presumptive Eligibility – 1



3. Periods of presumptive eligibility are limited as follows:

- a. No more than one period within a calendar year.
- b. No more than one period within two calendar years.
- c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
- d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- e. Other reasonable limitation:

Name of limitation	Description
No items available	

A value is required

+ Add Limitation

B. Application for Presumptive Eligibility

+/-

1. The state uses a standardized screening process for determining presumptive eligibility.

2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

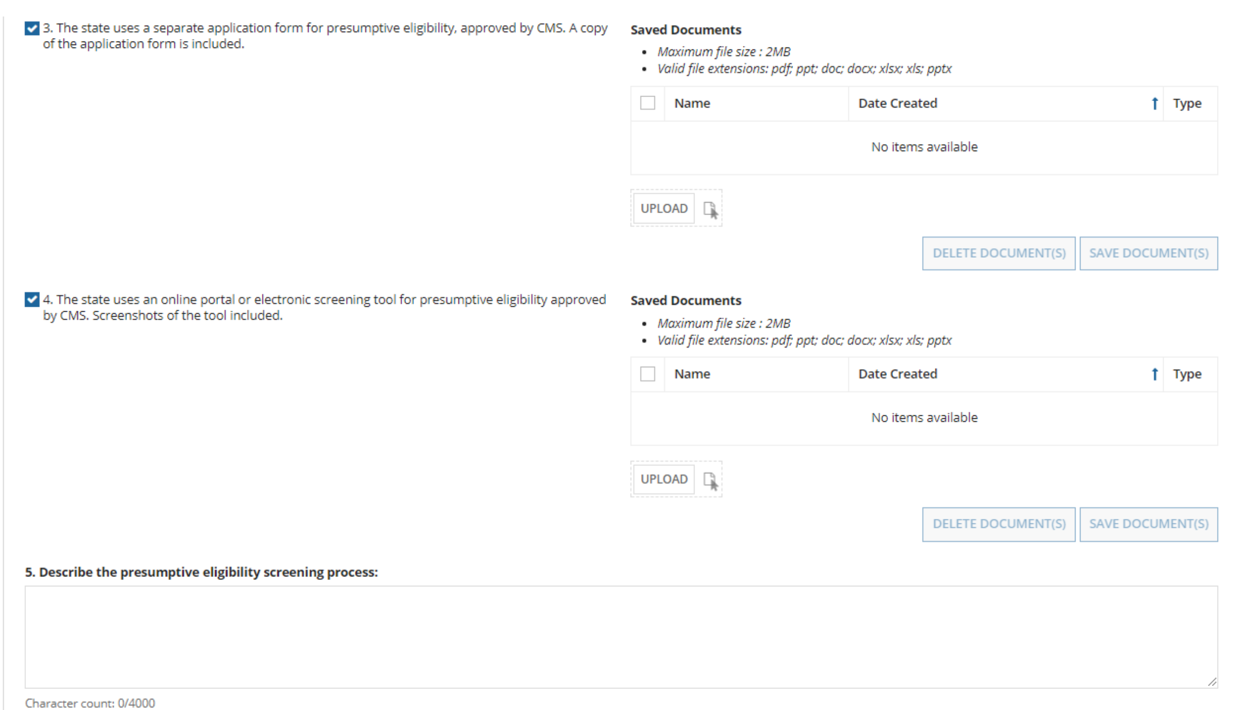
Name	Date Created	Type
No items available		

A document is required

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 2: Former Foster Care Children – Presumptive Eligibility – 2



3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

Name	Date Created	Type
No items available		

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Saved Documents

- Maximum file size : 2MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

Name	Date Created	Type
No items available		

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5. Describe the presumptive eligibility screening process:

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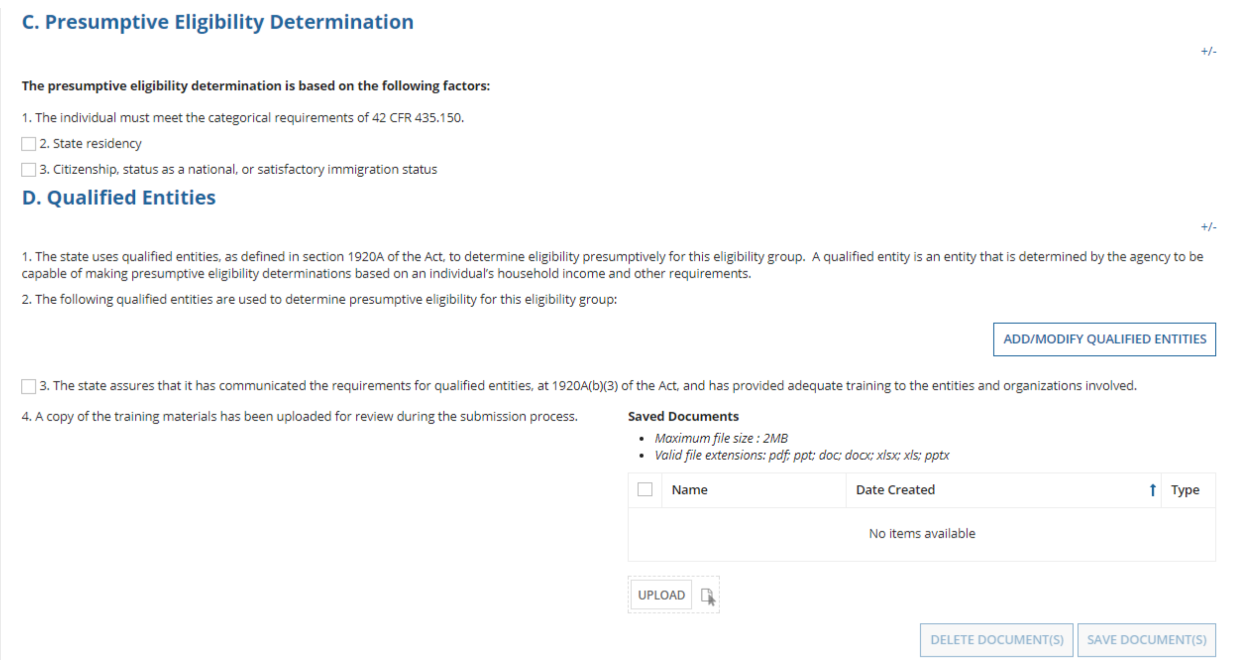
Figure 3: Former Foster Care Children – Presumptive Eligibility – 3



C. Presumptive Eligibility Determination

+/-

The presumptive eligibility determination is based on the following factors:

1. The individual must meet the categorical requirements of 42 CFR 435.150.

☐ 2. State residency

☐ 3. Citizenship, status as a national, or satisfactory immigration status

D. Qualified Entities

+/-

1. The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group. A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.

2. The following qualified entities are used to determine presumptive eligibility for this eligibility group:

ADD/MODIFY QUALIFIED ENTITIES

☐ 3. The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved.

4. A copy of the training materials has been uploaded for review during the submission process.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

☐	Name	Date Created	Type
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UPLOAD

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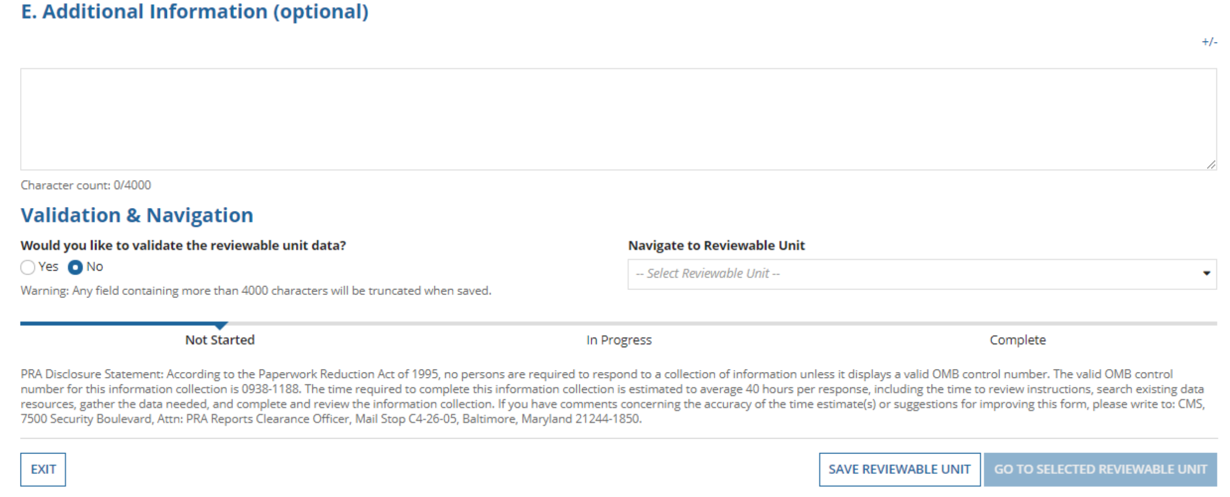
Figure 4: Former Foster Care Children – Presumptive Eligibility – 4



E. Additional Information (optional)

+/-

Character count: 0/4000

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Figure 5: Former Foster Care Children – Presumptive Eligibility – 5

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S50 – Individuals above 133% FPL under Age 65 RU PRA Document

Version 1.0

08/18/2017

Document Number: 220-QSSI-MACPro-R5.1-S50-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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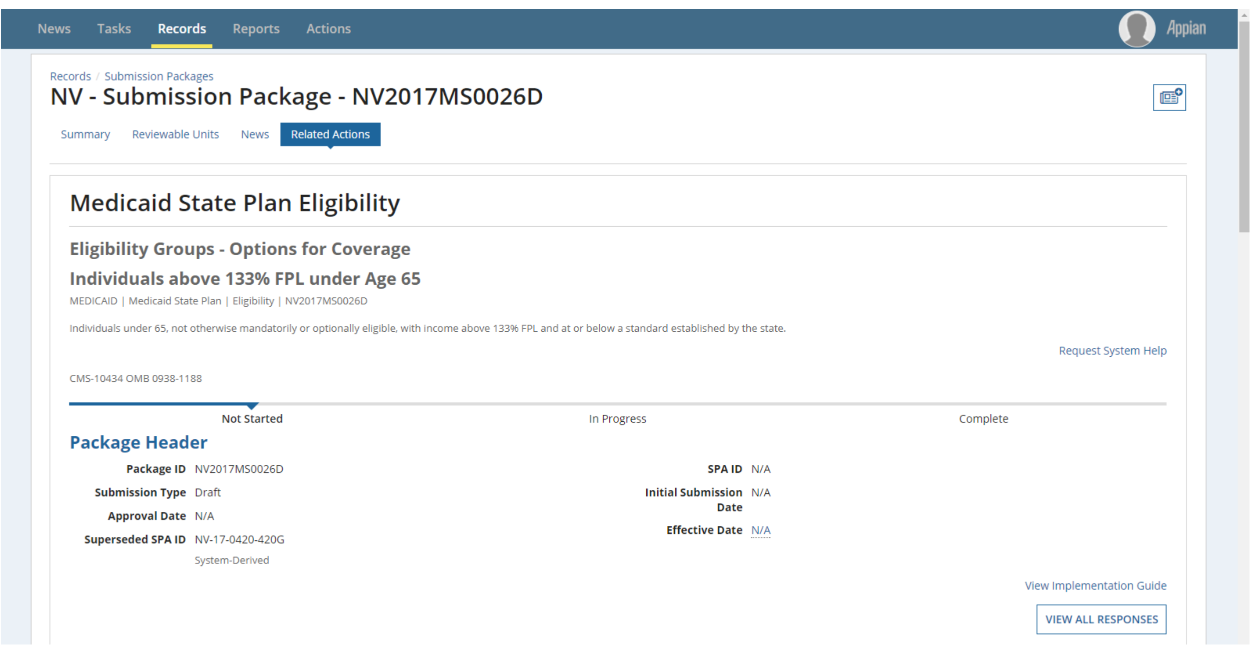

Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

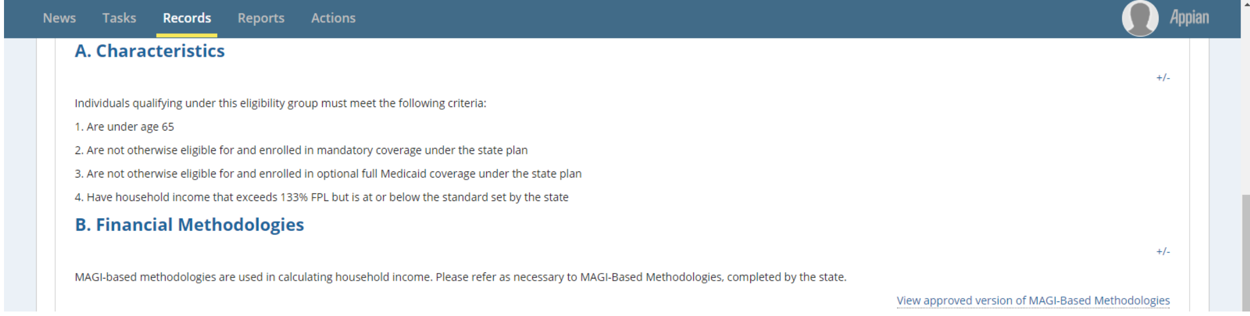

Figure 2: Section A and Section B

1.3 C. Individuals Covered

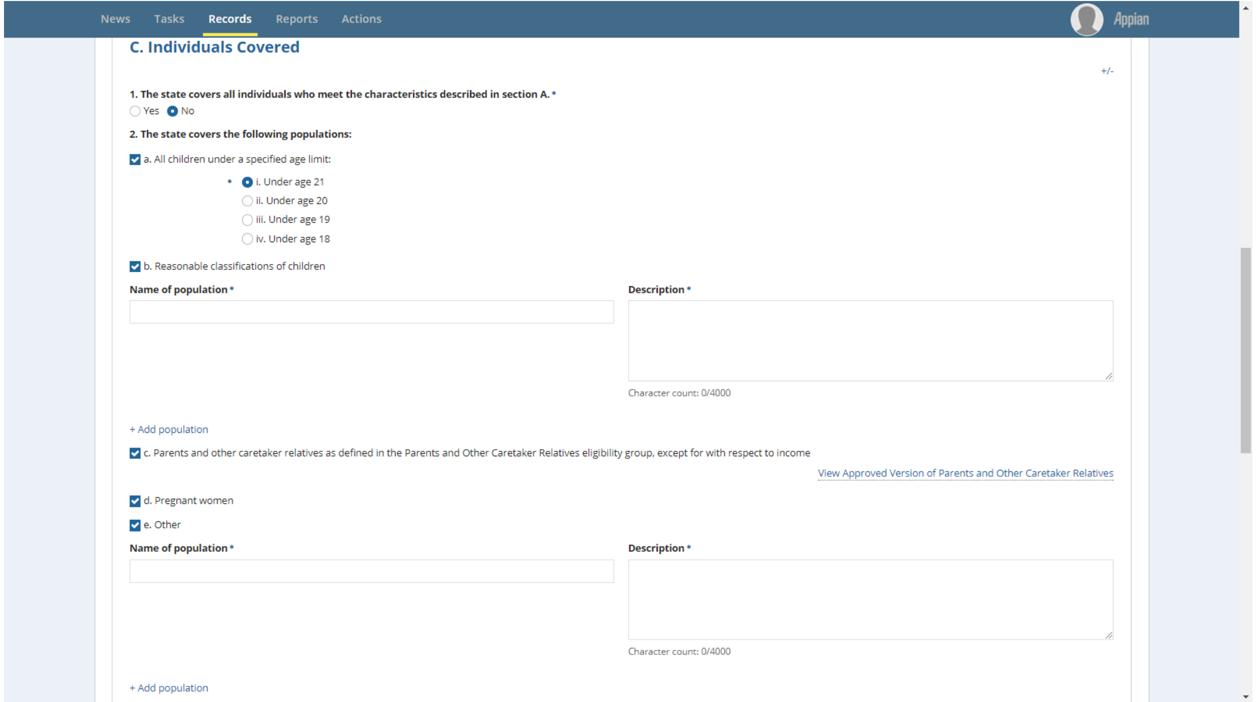

Figure 3: Section C

1.4 D. Income Standard Used – Path 1

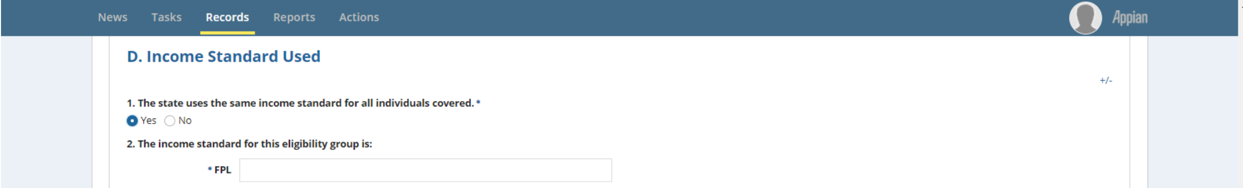

Figure 4: Section D – Path 1

1.5 D. Income Standard Used – Path 2

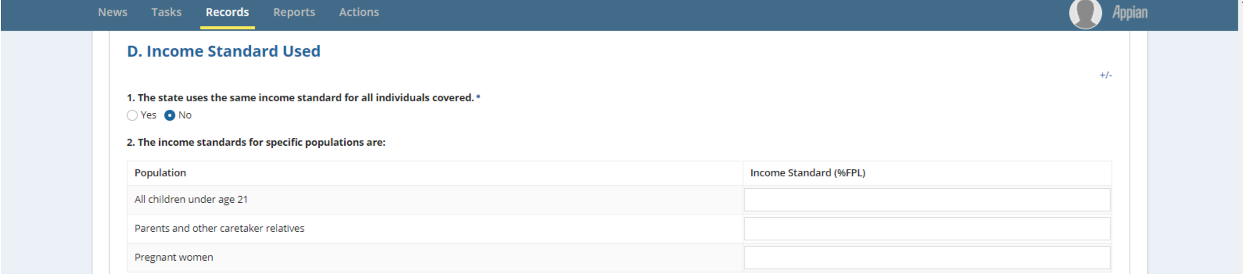

Figure 5: Section D – Path 2

1.6 D. Income Standard Used – Path 3 – Screenshot 1

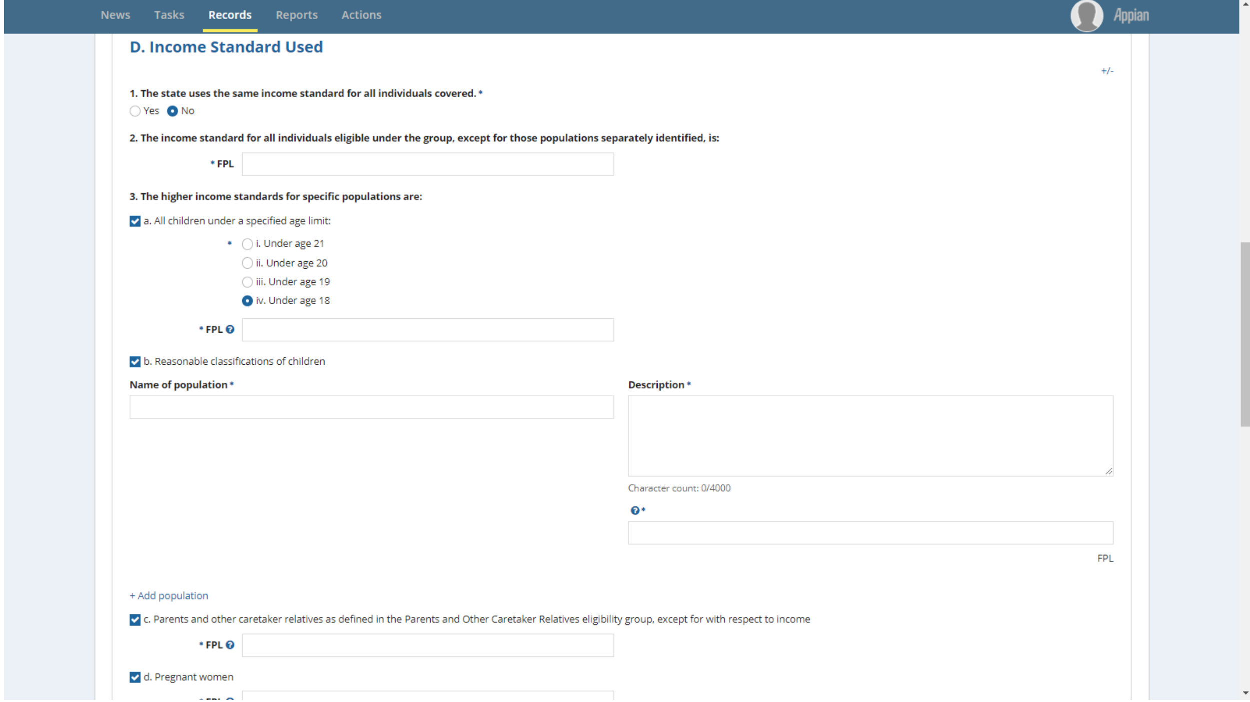

Figure 6: Section D – Path 3 – Screenshot 1

1.7 D. Income Standard Used – Path 3 – Screenshot 2

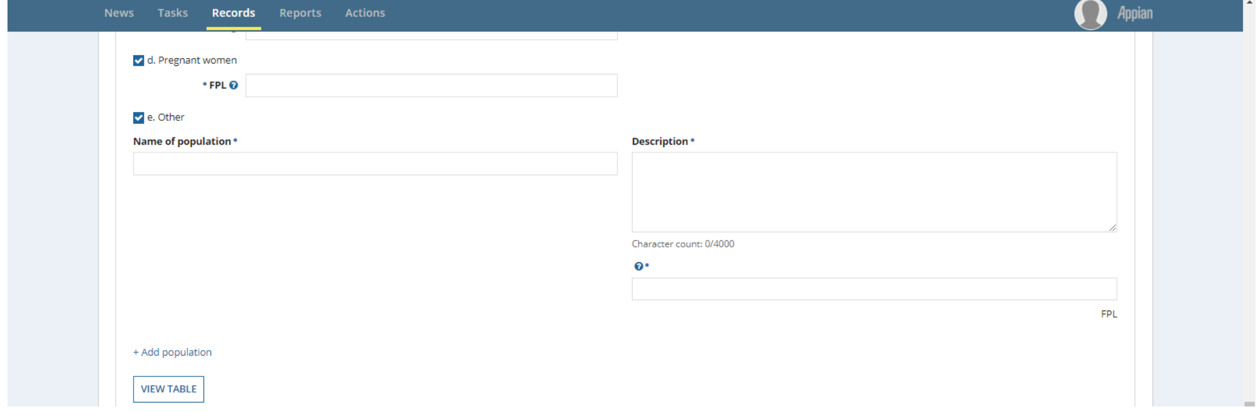

Figure 7: Section D – Path 3 – Screenshot 2

1.8 E. Coverage of Dependent Children

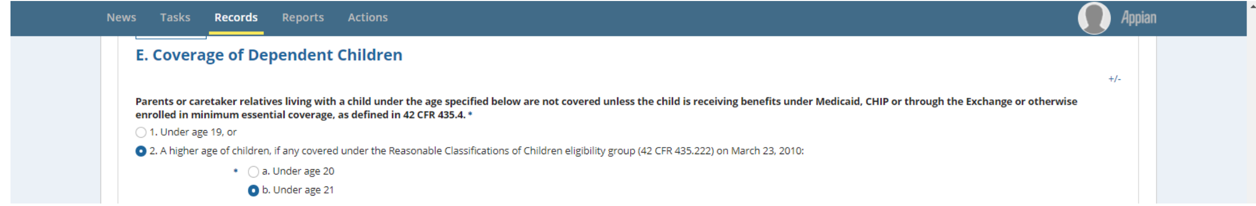

Figure 8: Section E

1.9 F. Phase-In

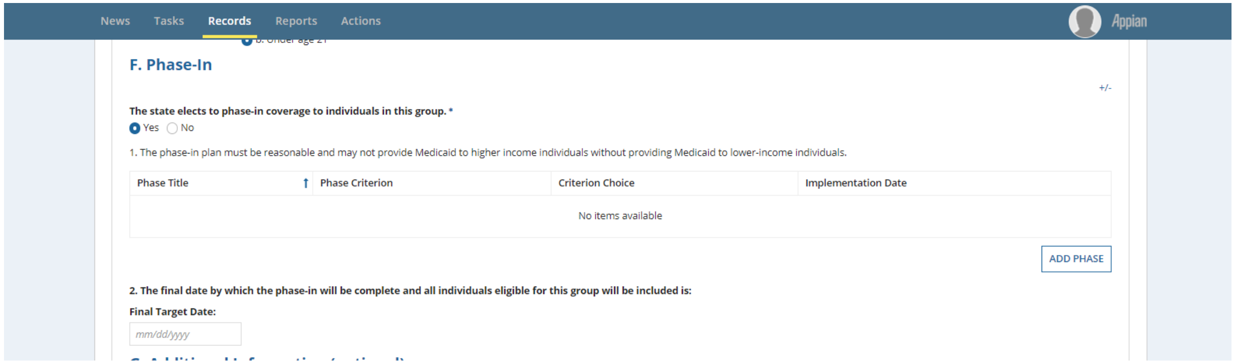

Figure 9: Section F – Phase-In

1.10 F. Phase-In – Add or Edit Phase – Path 1 – Screenshot 1

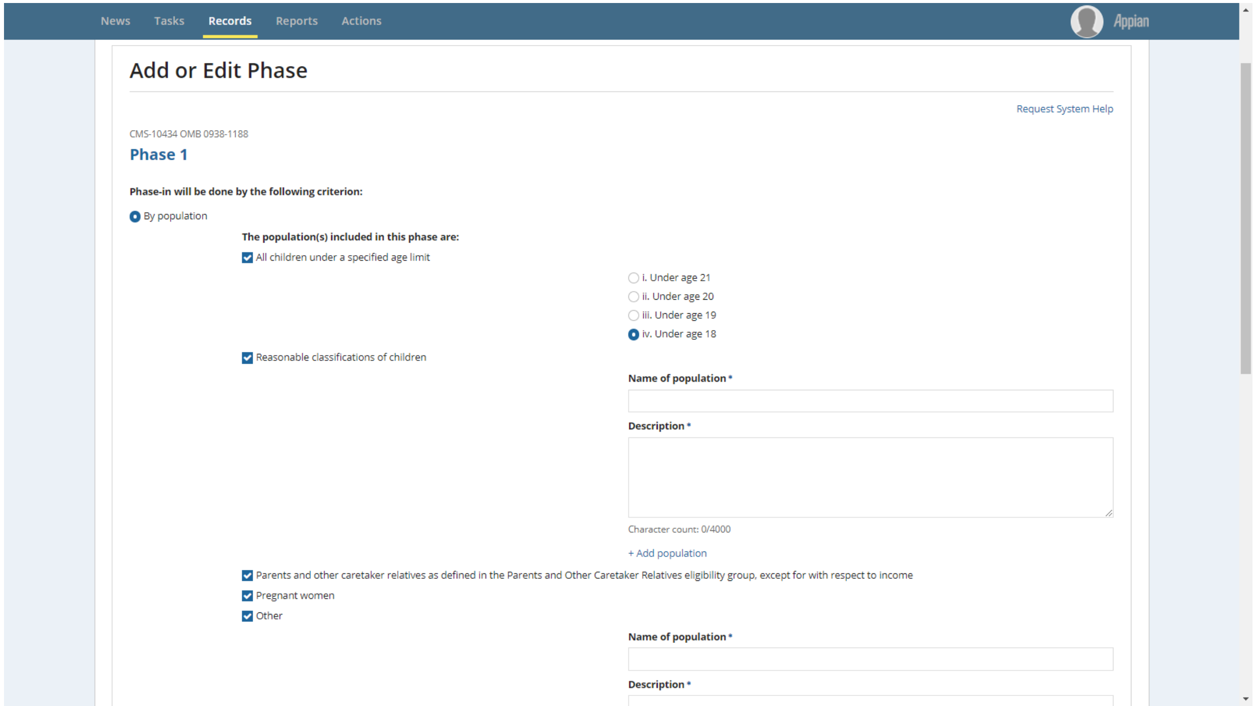

Figure 10 : Section F - Add or Edit Phase – Path 1 – Screenshot 1

1.11 F. Phase-In – Add or Edit Phase – Path 1 – Screenshot 2

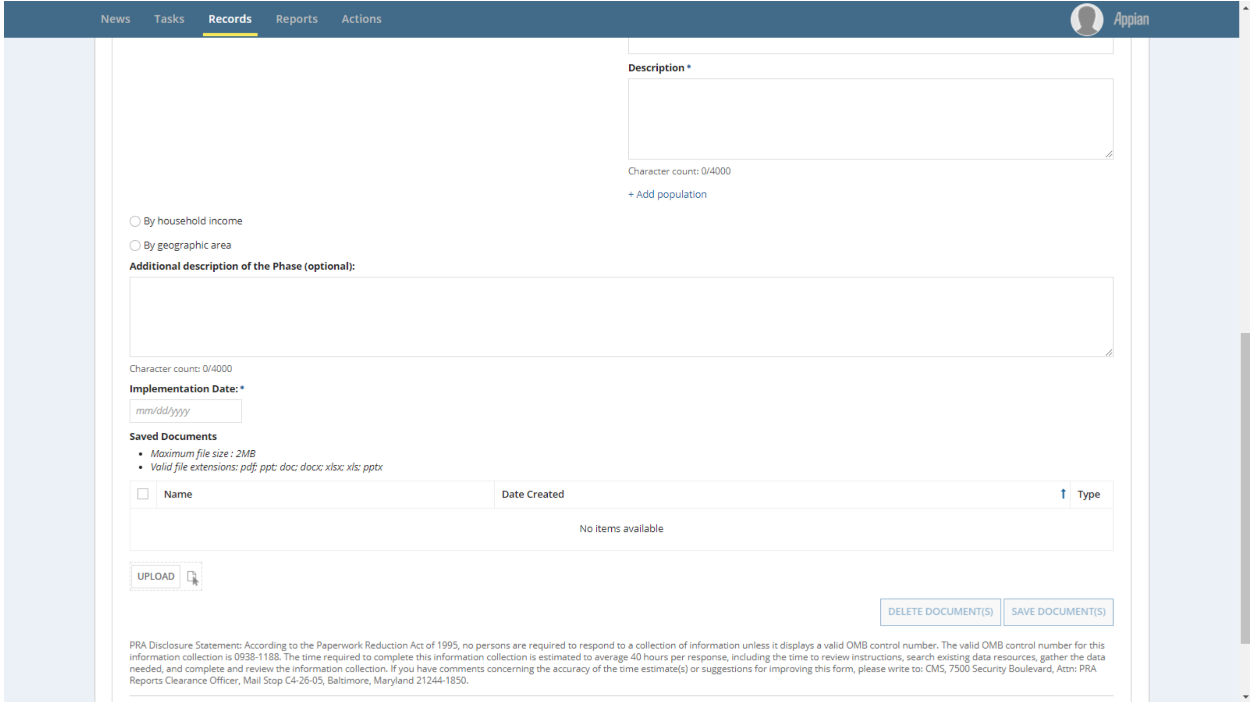

Figure 11 : Section F - Add or Edit Phase – Path 1 – Screenshot 2

1.12 F. Phase-In – Add or Edit Phase – Path 2

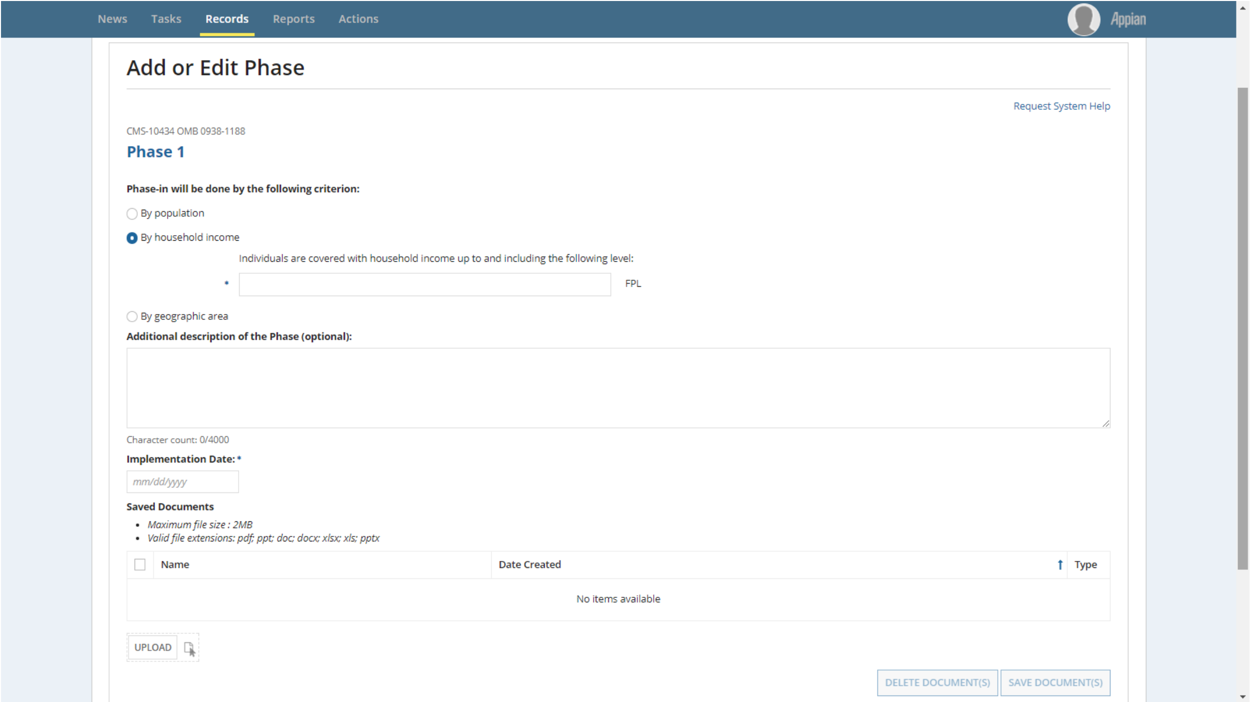

Figure 12: Section F - Add or Edit Phase – Path 2

1.13 F. Phase-In – Add or Edit Phase – Path 3

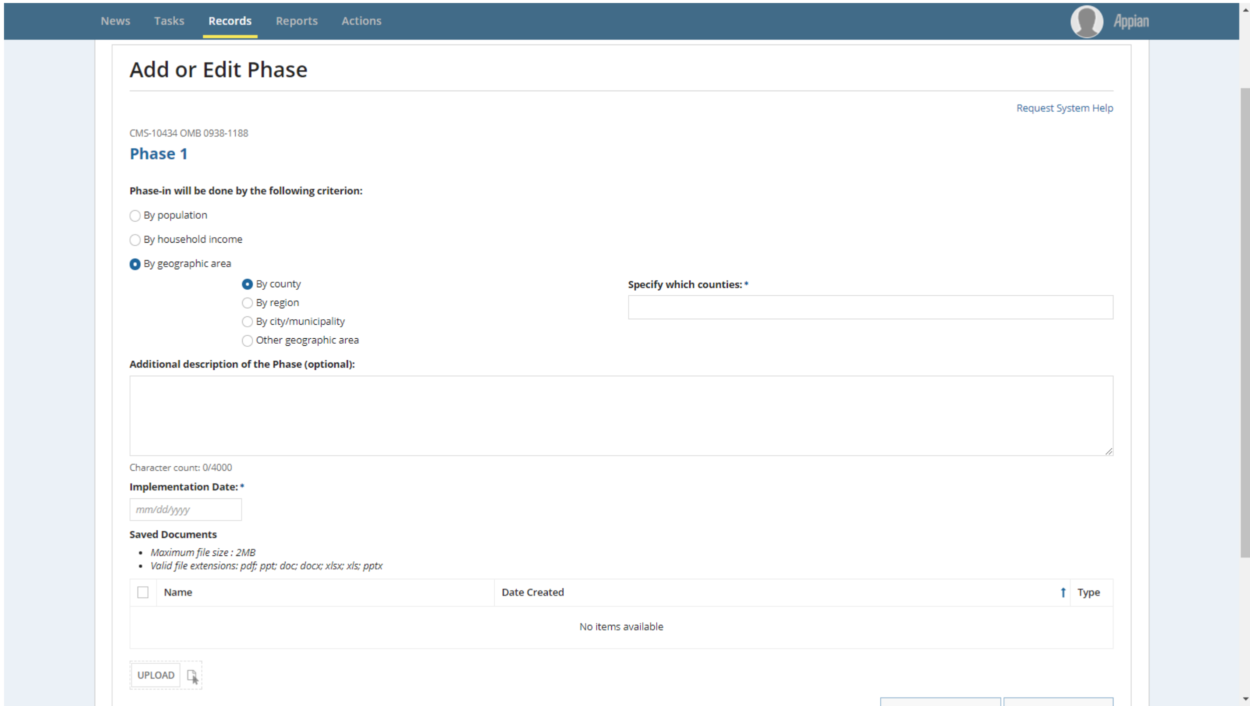

Figure 13: Section F - Add or Edit Phase – Path 3

1.14 F. Phase-In – Add or Edit Phase – Path 4

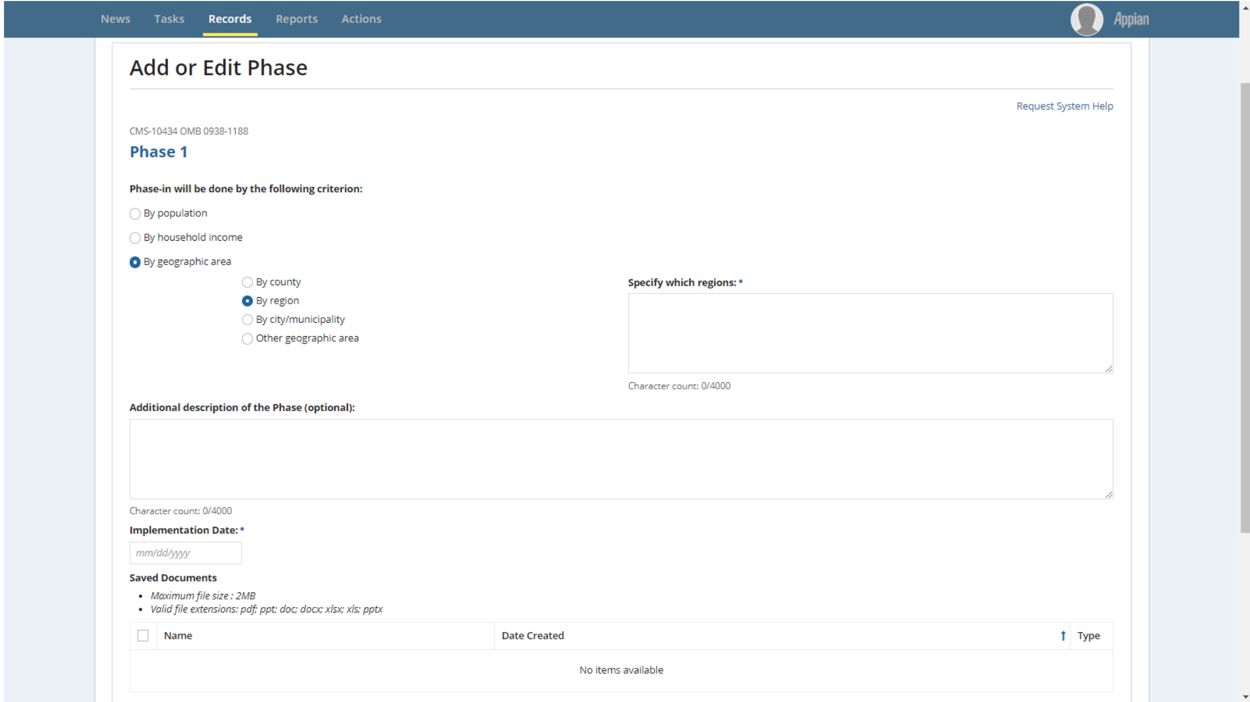

Figure 14: Section F - Add or Edit Phase – Path 4

1.15 F. Phase-In – Add or Edit Phase – Path 5

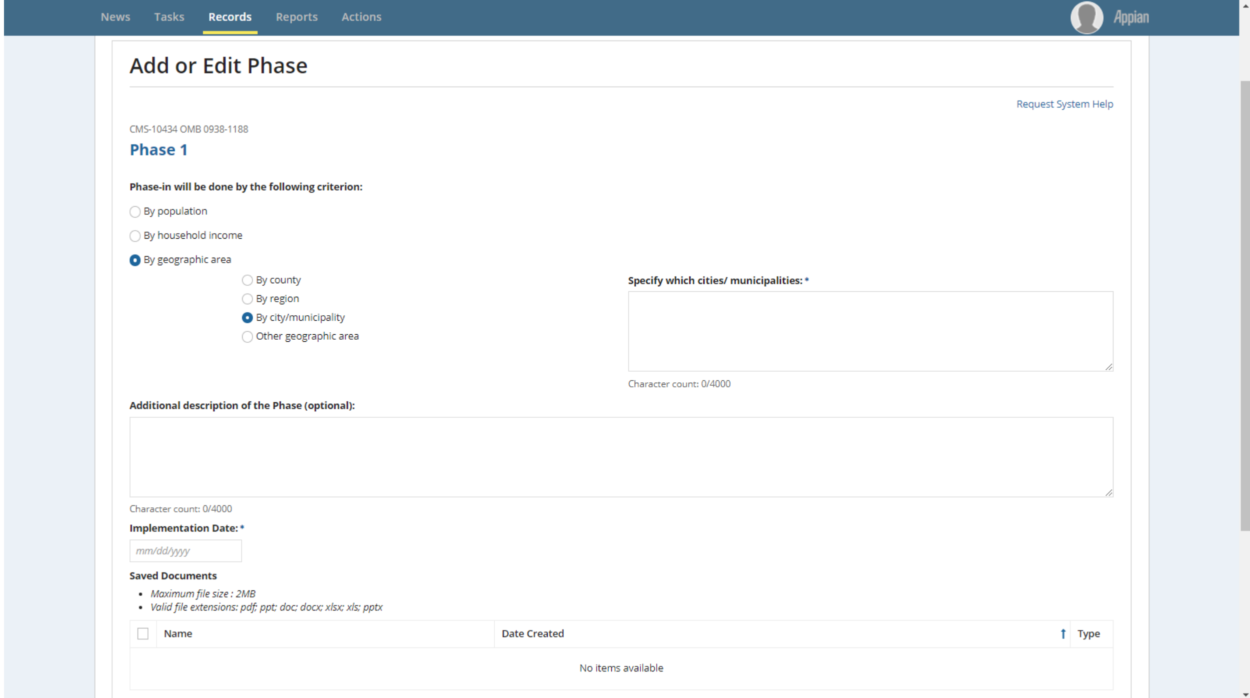

Figure 15: Section F - Add or Edit Phase – Path 5

1.16 F. Phase-In – Add or Edit Phase – Path 6

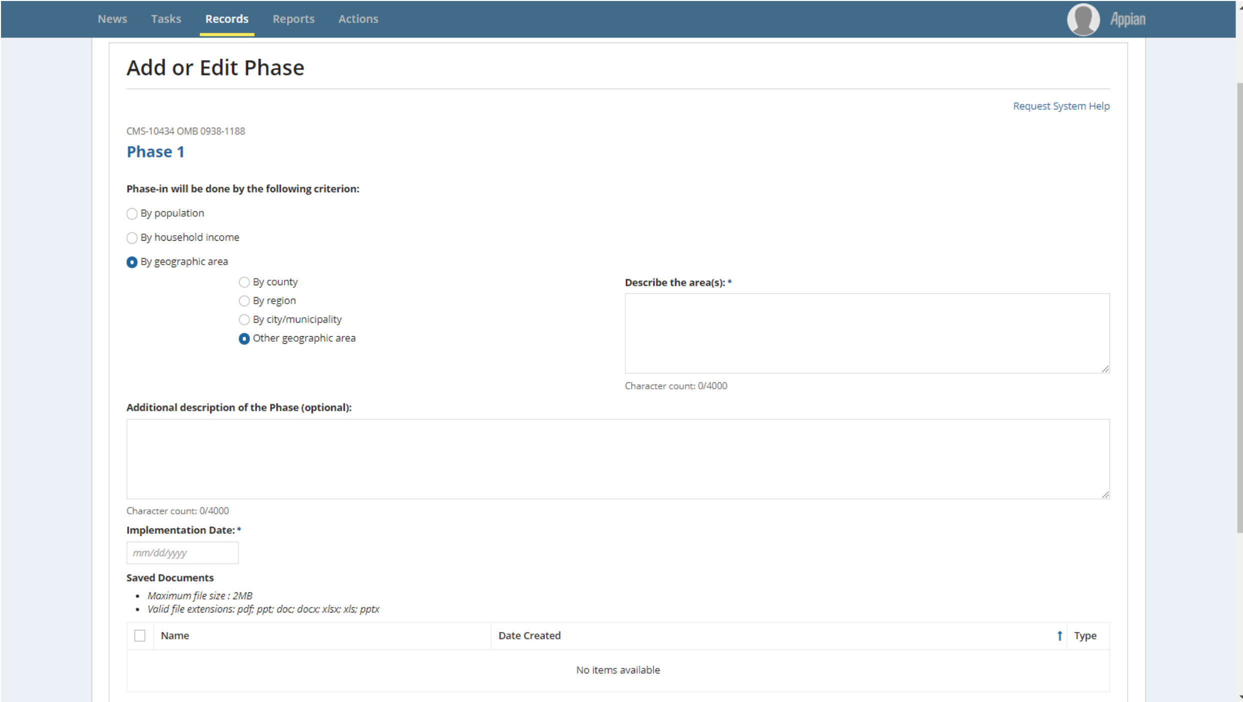

Figure 16: Section F - Add or Edit Phase – Path 6

1.17 G. Additional Information (optional)

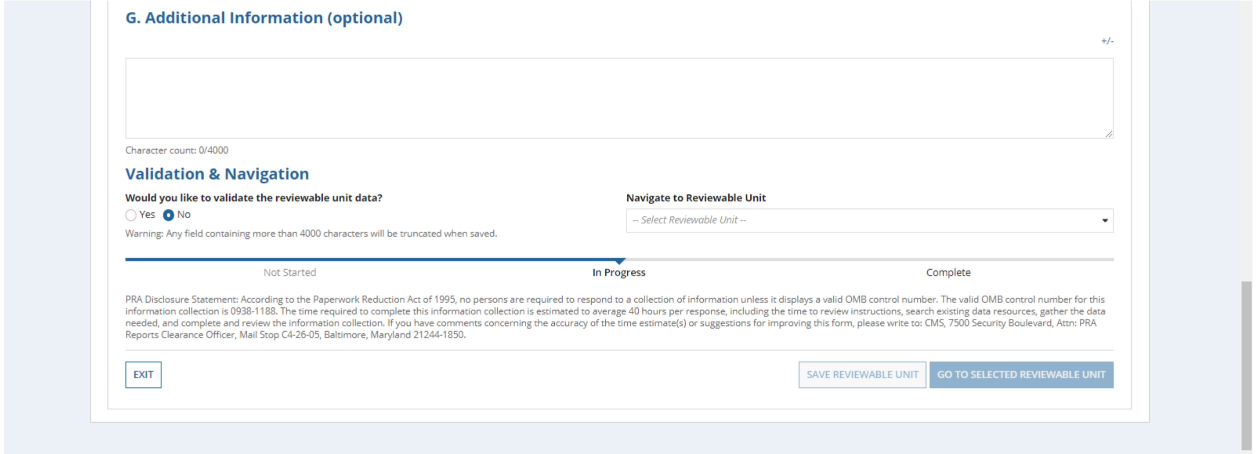

Figure 17: Section G

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S50a - Individuals above 133% FPL under Age 65 - Presumptive Eligibility RU PRA Document

Version 1.0

08/18/2017

Document Number: 221-QSSI-MACPro-R5.1-S50a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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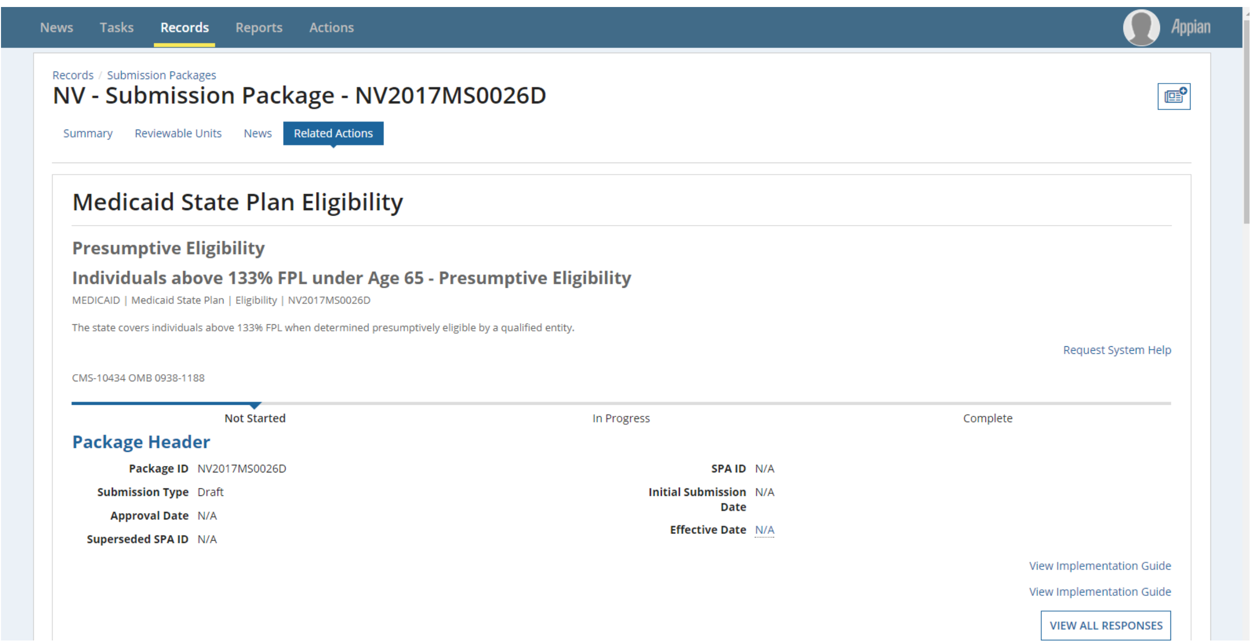

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1.2 A. Presumptive Eligibility Period and B. Application for Presumptive Eligibility

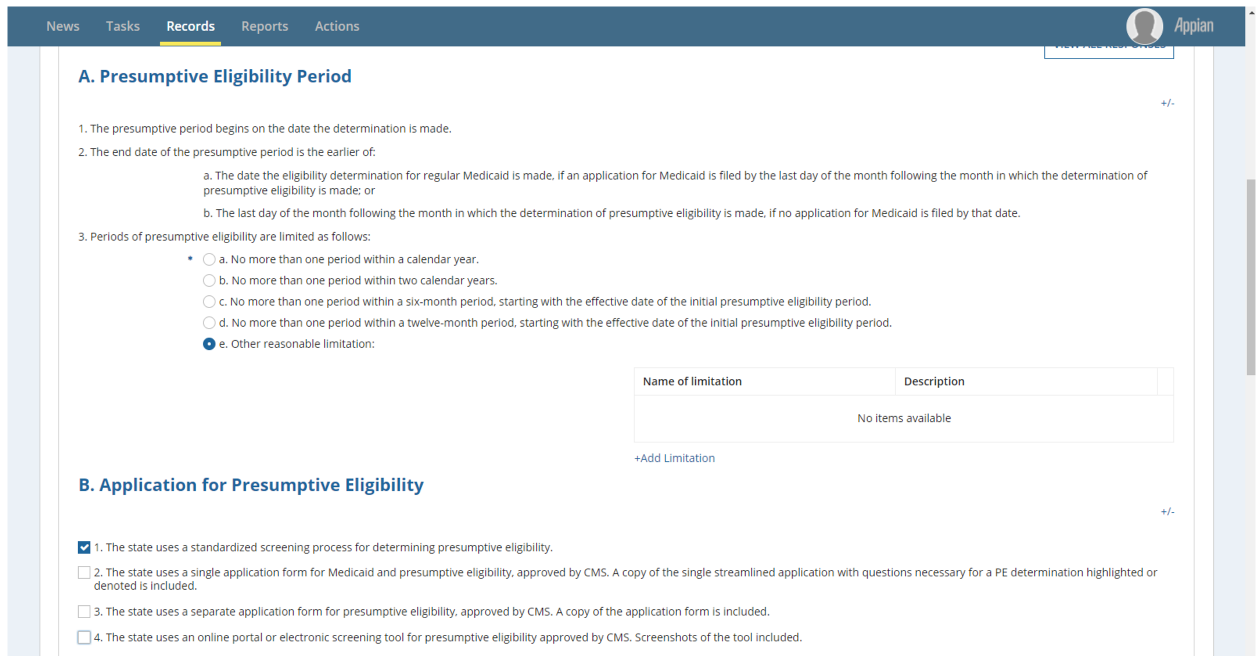

Figure 2: Section A and Section B

1.3 C. Presumptive Eligibility Determination and D. Qualified Entities

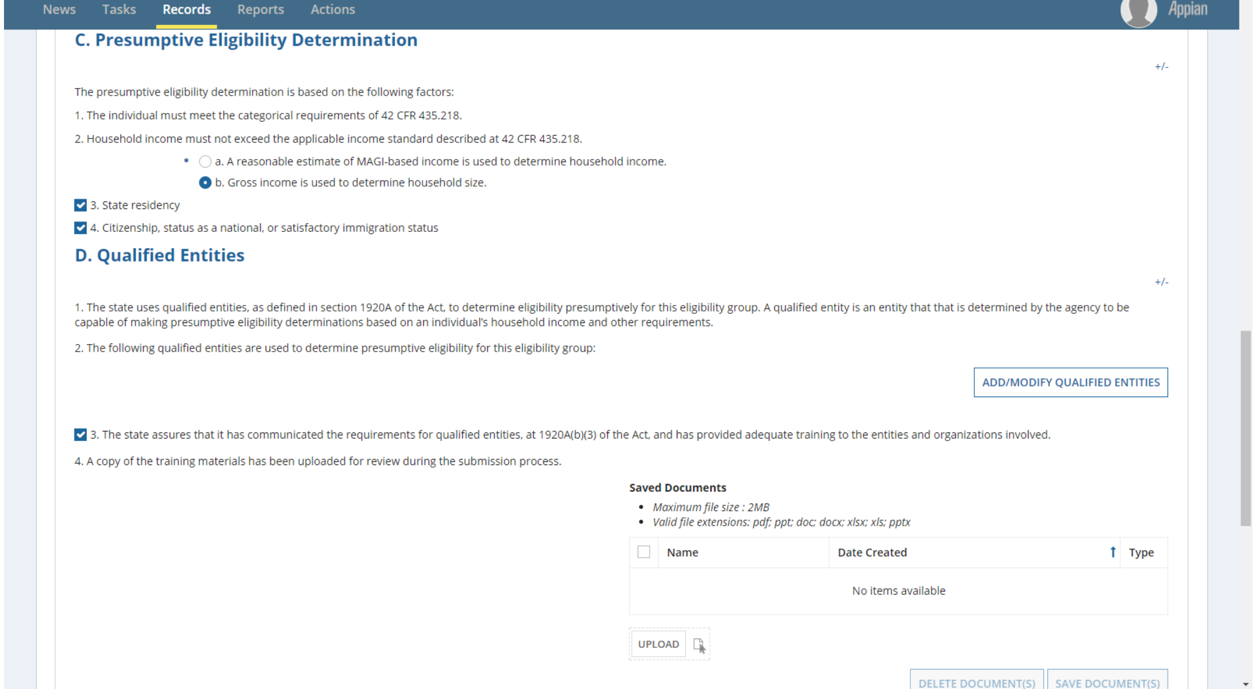

Figure 3 : Section C and Section D

1.4 E. Additional Information (optional)

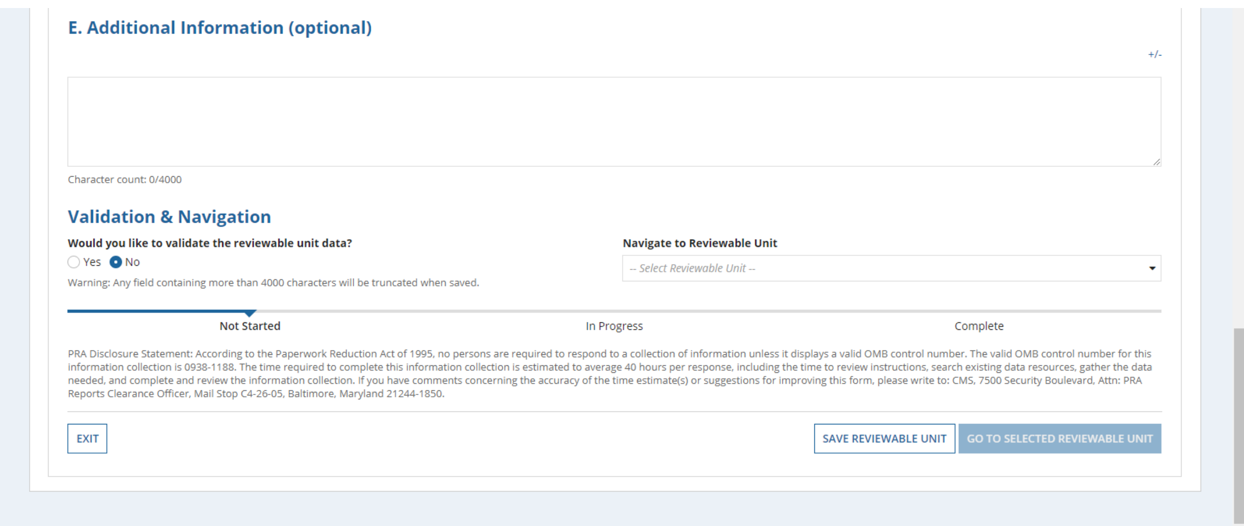

Figure 4 : Section E

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S51 - Optional Coverage of Parents and Other Caretaker Relatives RU PRA Document

Version 1.0
08/15/2017

Document Number: 171-QSSI-MACPro-R5.1-S51-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.1 Package Header

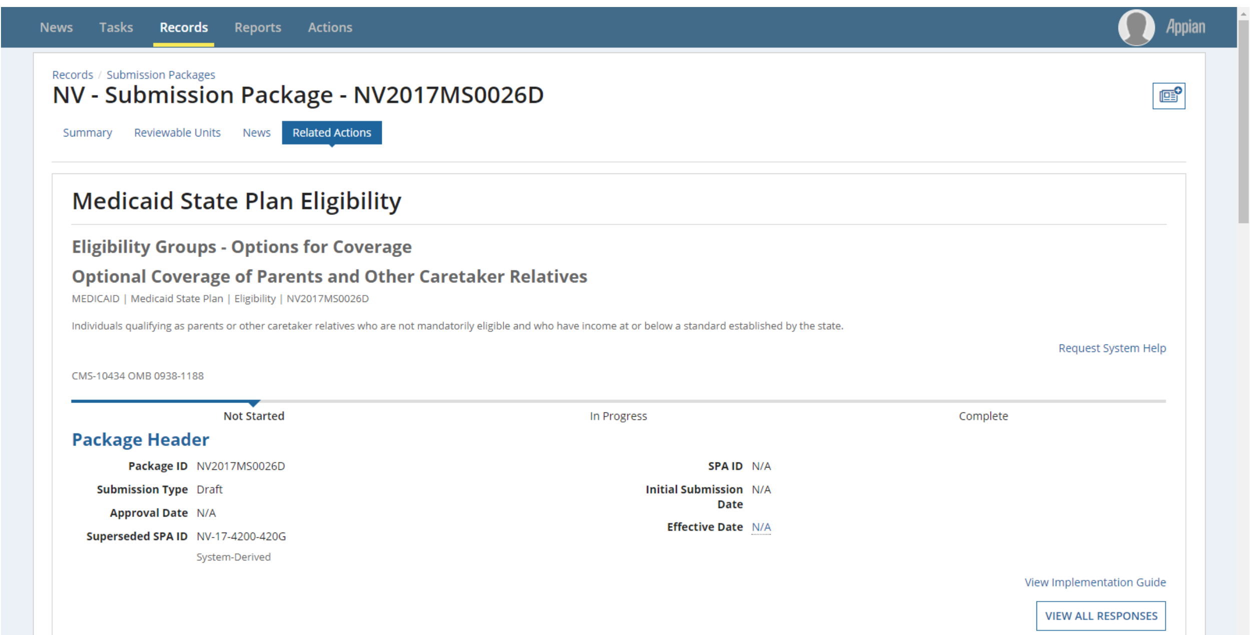


Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies, C. Coverage Prior to January 1, 2014 and D. Income Standard Used–Path 1

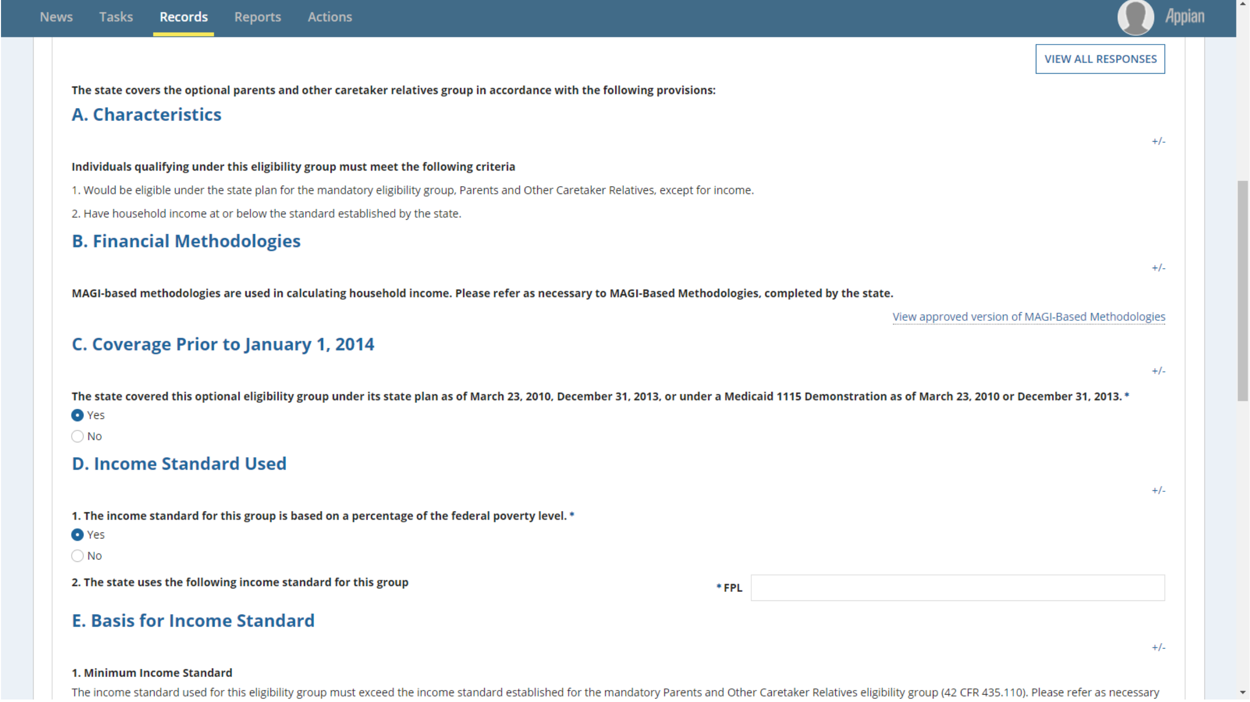


Figure 2: Section A, Section B, Section C and Section D-Path1

1.3 D. Income Standard Used – Path 2

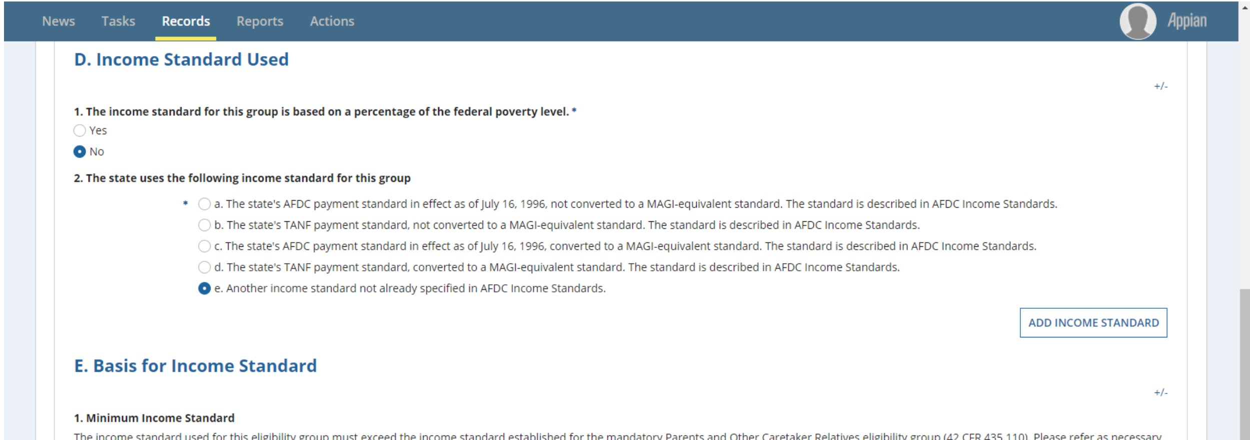
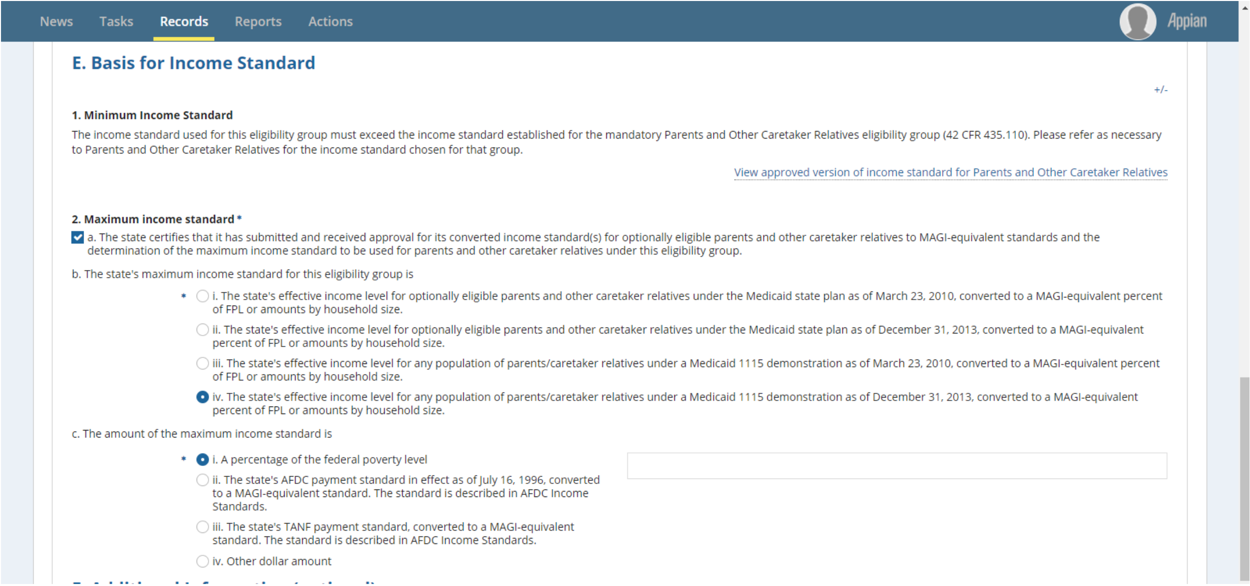


Figure 3: Section D–Path 2

1.4 E. Basis for Income Standard


News Tasks Records Reports Actions Appian

E. Basis for Income Standard

+/-

1. Minimum Income Standard

The income standard used for this eligibility group must exceed the income standard established for the mandatory Parents and Other Caretaker Relatives eligibility group (42 CFR 435.110). Please refer as necessary to Parents and Other Caretaker Relatives for the income standard chosen for that group.

View approved version of income standard for Parents and Other Caretaker Relatives

2. Maximum income standard *

a. The state certifies that it has submitted and received approval for its converted income standard(s) for optionally eligible parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

b. The state's maximum income standard for this eligibility group is

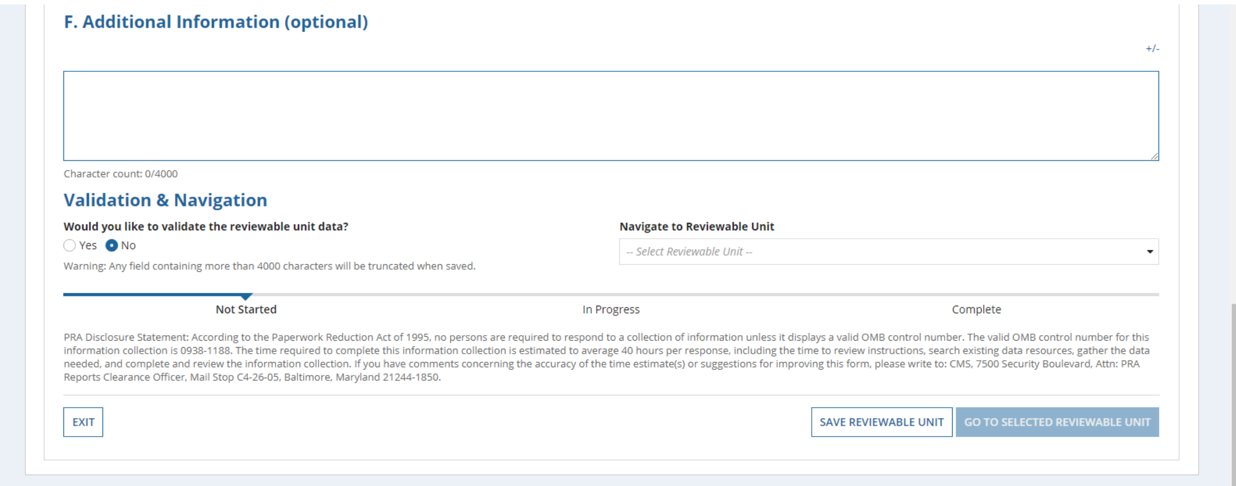
- i. The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ii. The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- iii. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- iv. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

c. The amount of the maximum income standard is

- i. A percentage of the federal poverty level
- ii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
- iii. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
- iv. Other dollar amount

Figure 4: Section E

1.5 F. Additional Information (optional)


F. Additional Information (optional)

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Validation & Navigation

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EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 5: Section F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S52 – Reasonable Classification of Individuals under Age 21 RU PRA Document

Version 1.0

08/21/2017

Document Number: 237-QSSI-MACPro-R5.1-S52-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 12 : Section D – Path 3 6

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1. S52 - Reasonable Classification of Individuals under Age 21 Screenshots

1.1 Package Header

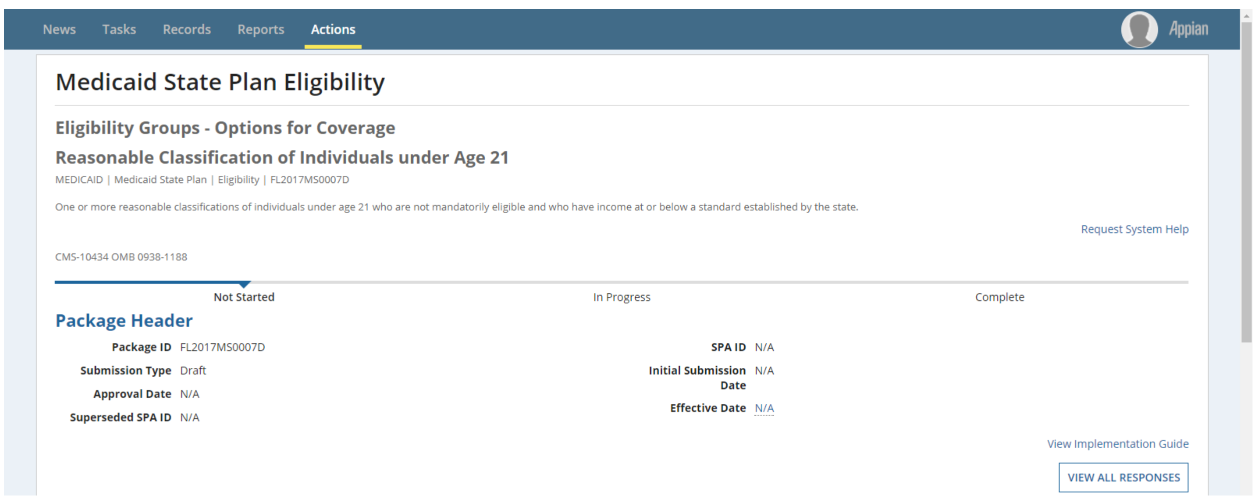


Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

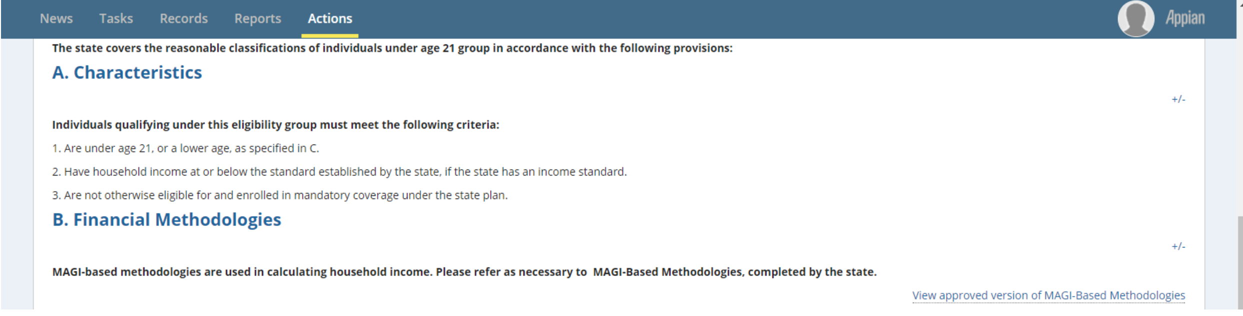


Figure 2: Section A and Section B

1.3 C. Individuals Covered – Path 1 – Screenshot 1

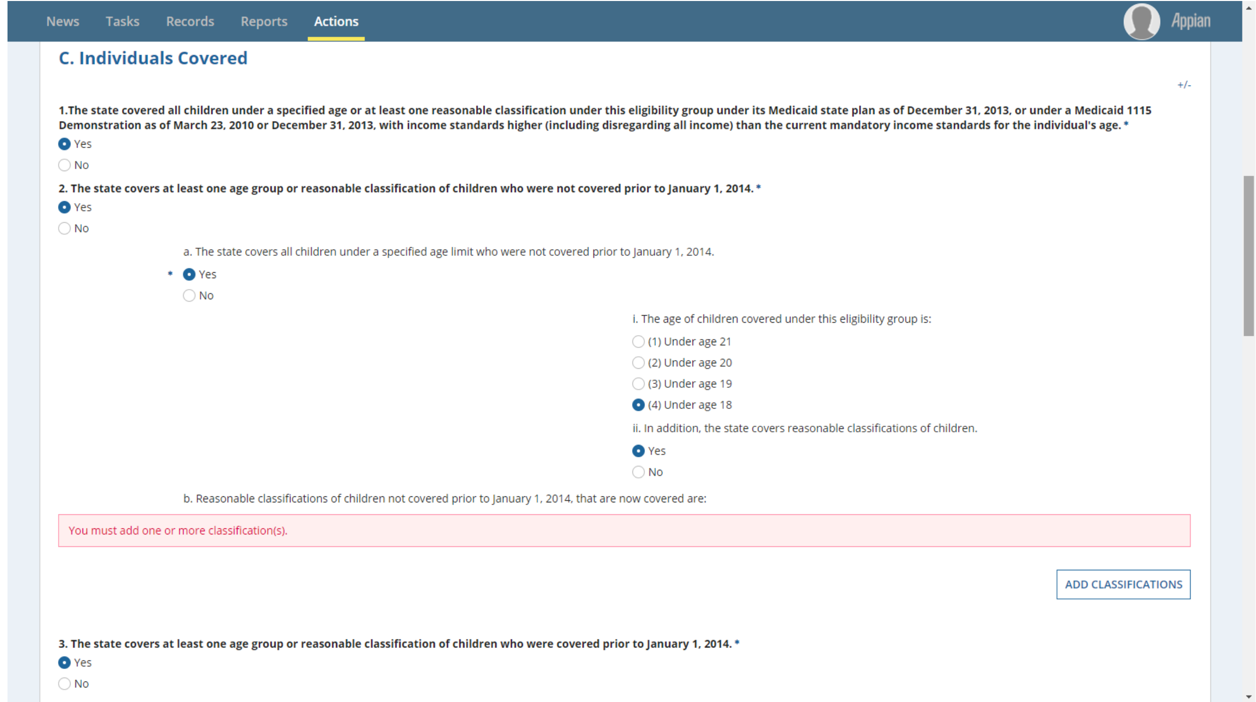


Figure 3: Section C- Path 1– Screenshot 1

1.4 C. Individuals Covered – Path 1 – Screenshot 2

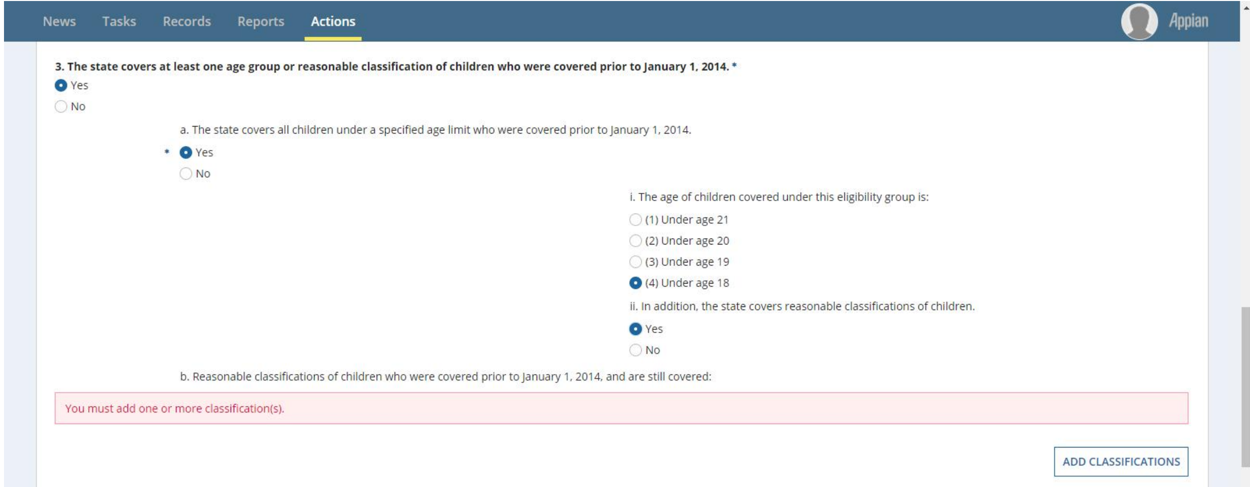


Figure 4 : Section C – Path 1 – Screenshot 2

1.5 C. Individuals Covered – Path 2

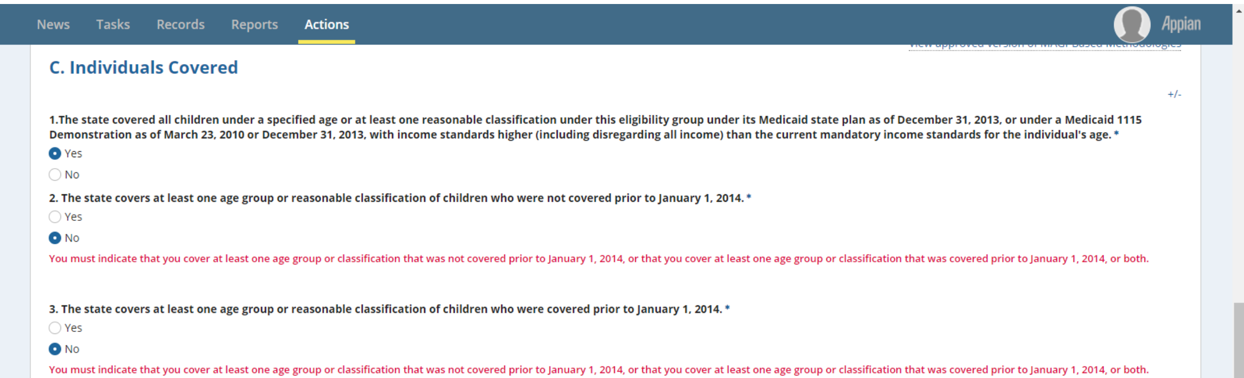


Figure 5: Section C –Path 2

1.6 C. Individuals Covered – Path 3

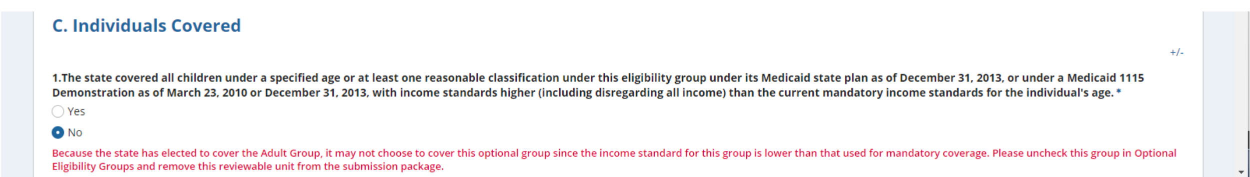


Figure 6: Section C – Path 3

1.7 C. Individuals Covered – Path 4

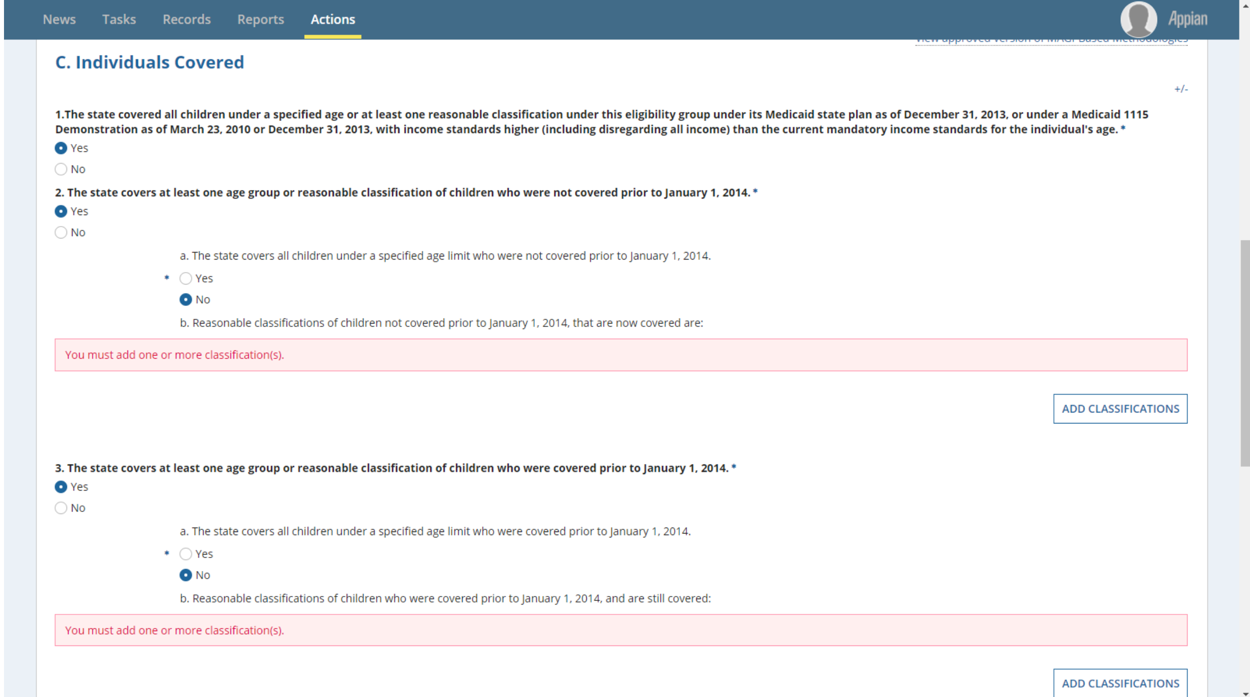


Figure 7: Section C – Path 4

1.8 C. Individuals Covered – Path 5

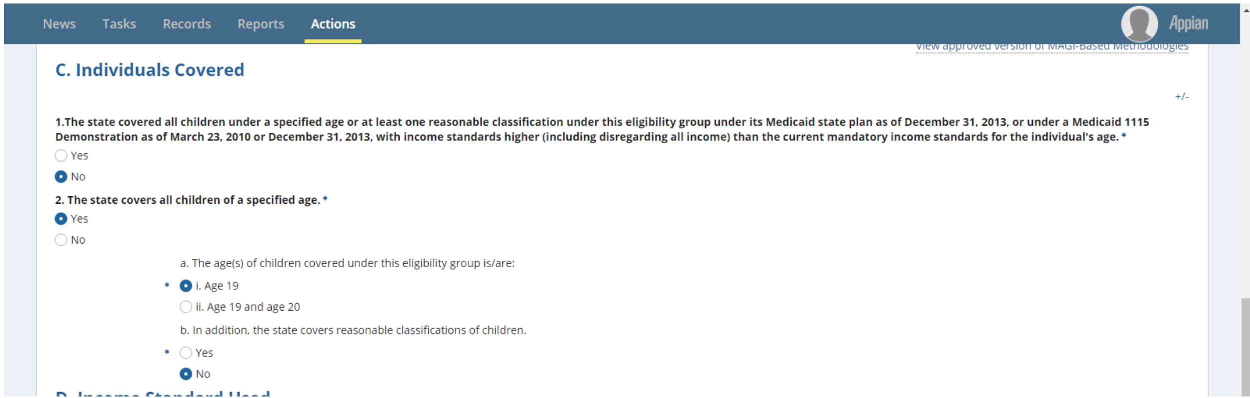


Figure 8: Section C – Path 5

1.9 C. Individuals Covered – Path 6

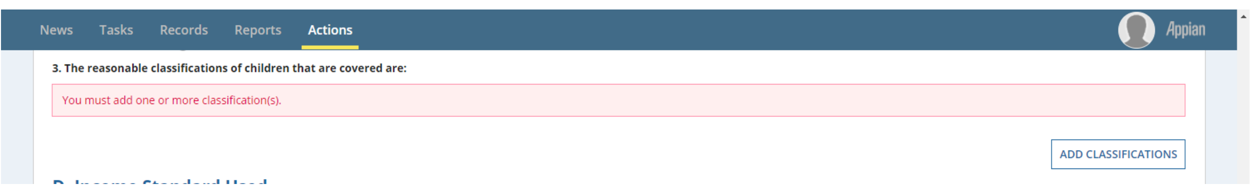
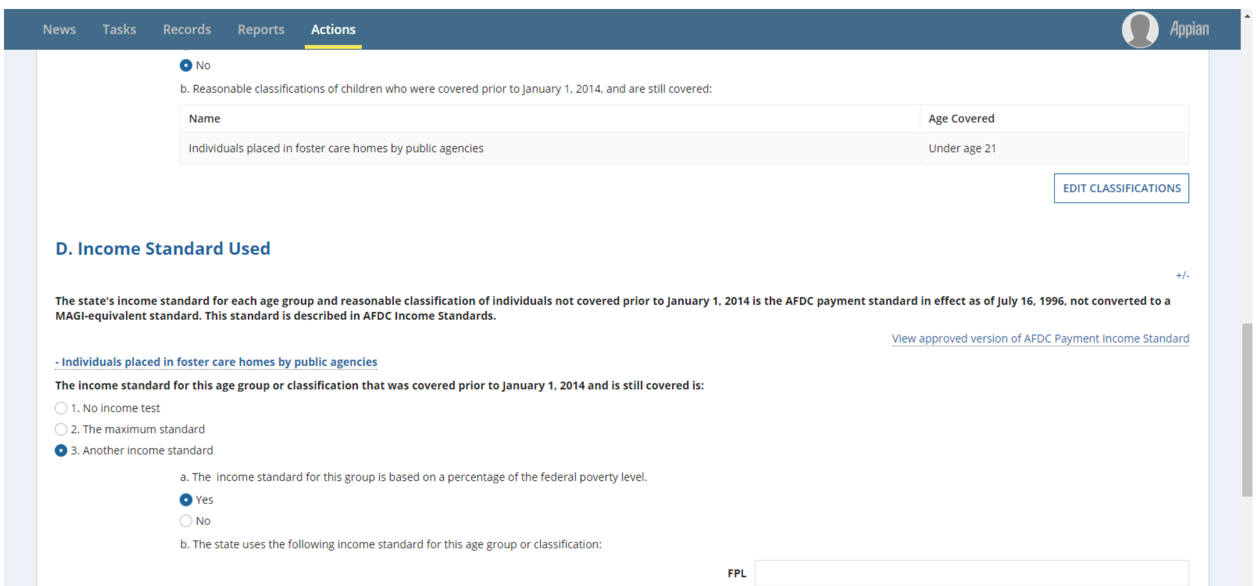


Figure 9: Section C – Path 6

1.10 D. Income Standard Used – Path 1



News Tasks Records Reports Actions Appian

No

b. Reasonable classifications of children who were covered prior to January 1, 2014, and are still covered:

Name	Age Covered
Individuals placed in foster care homes by public agencies	Under age 21

EDIT CLASSIFICATIONS

D. Income Standard Used

+/-

The state's income standard for each age group and reasonable classification of individuals not covered prior to January 1, 2014 is the AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. This standard is described in AFDC Income Standards.

View approved version of AFDC Payment Income Standard

- Individuals placed in foster care homes by public agencies

The income standard for this age group or classification that was covered prior to January 1, 2014 and is still covered is:

1. No income test
2. The maximum standard
3. Another income standard (selected)

a. The income standard for this group is based on a percentage of the federal poverty level.

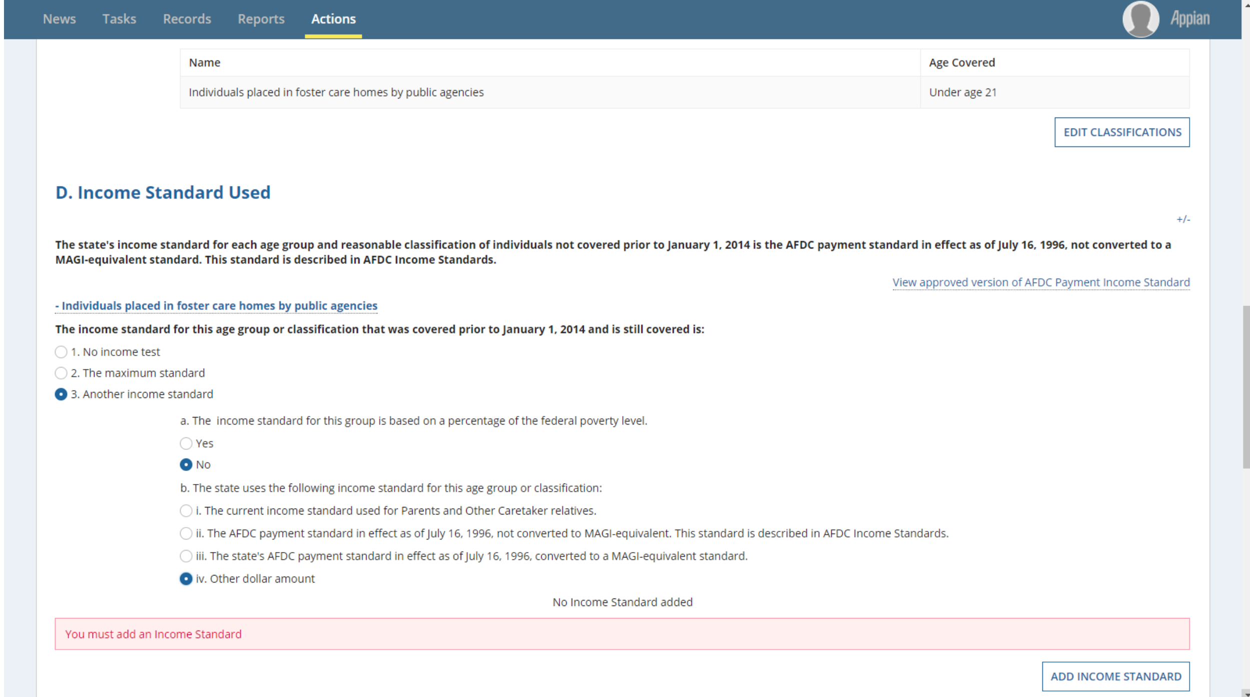
Yes (selected)
No

b. The state uses the following income standard for this age group or classification:

FPL

Figure 10: Section D – Path 1

1.11 D. Income Standard Used – Path 2



News Tasks Records Reports Actions Appian

Name	Age Covered
Individuals placed in foster care homes by public agencies	Under age 21

EDIT CLASSIFICATIONS

D. Income Standard Used

+/-

The state's income standard for each age group and reasonable classification of individuals not covered prior to January 1, 2014 is the AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. This standard is described in AFDC Income Standards.

View approved version of AFDC Payment Income Standard

- Individuals placed in foster care homes by public agencies

The income standard for this age group or classification that was covered prior to January 1, 2014 and is still covered is:

1. No income test
2. The maximum standard
3. Another income standard (selected)

a. The income standard for this group is based on a percentage of the federal poverty level.

Yes
No (selected)

b. The state uses the following income standard for this age group or classification:

i. The current income standard used for Parents and Other Caretaker relatives.
ii. The AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in AFDC Income Standards.
iii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard.
iv. Other dollar amount (selected)

No Income Standard added

You must add an Income Standard

ADD INCOME STANDARD

Figure 11: Section D – Path 2

1.12 D. Income Standard Used – Path 3

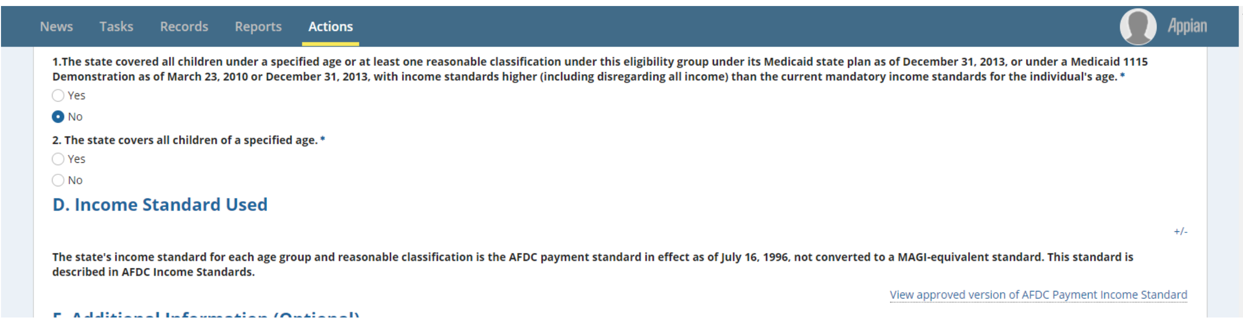


Figure 12 : Section D – Path 3

1.13 D. Income Standard Used – Path 4

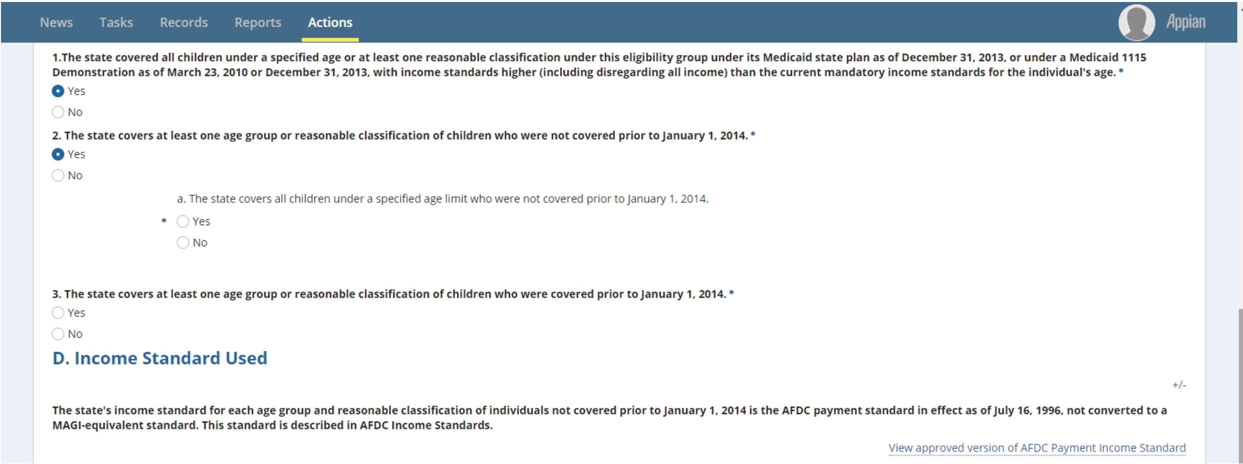


Figure 13: Section D – Path 4

1.14 E. Basis for Income Standard

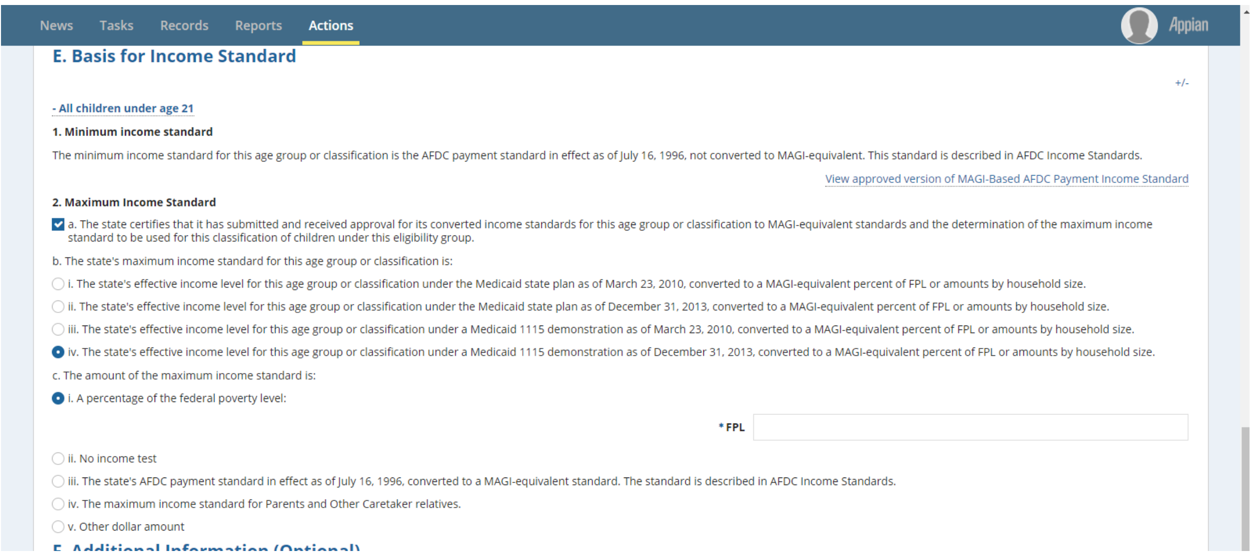


Figure 14: Section E

1.15 F. Additional Information (optional)

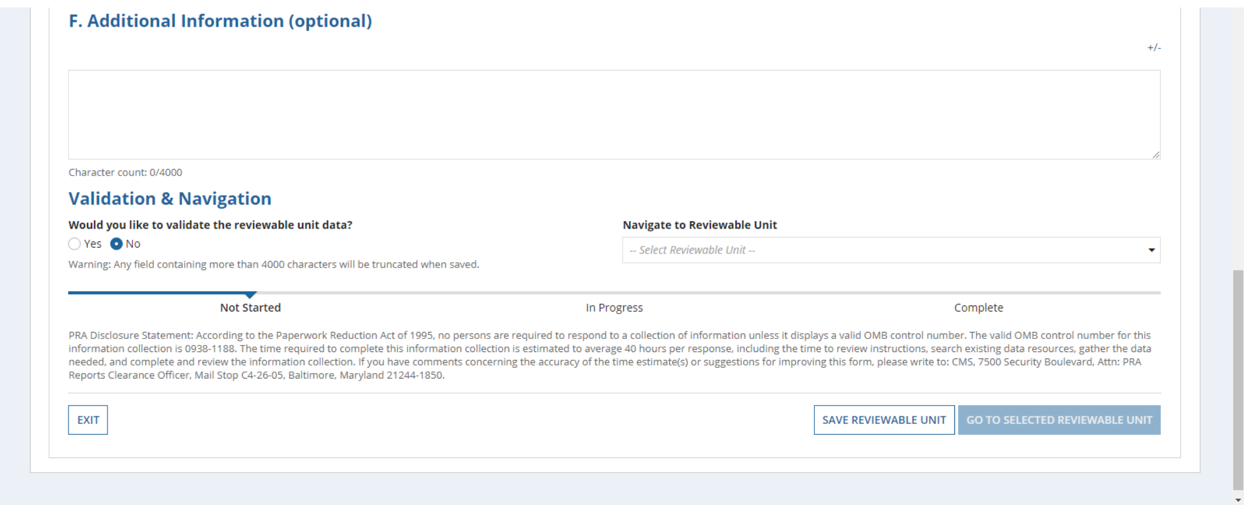


Figure 15: Section F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S53 – Children with Non IV-E Adoption Assistance RU PRA Document

Version 1.0

08/20/2017

Document Number: 236-QSSI-MACPro-R5.1-S53-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 7: Section D – Path 1 – Screenshot 2 – Path 1 4

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Figure 10: Section D – Path 3 5

Figure 11: Section E 5

Figure 12: Section F 6

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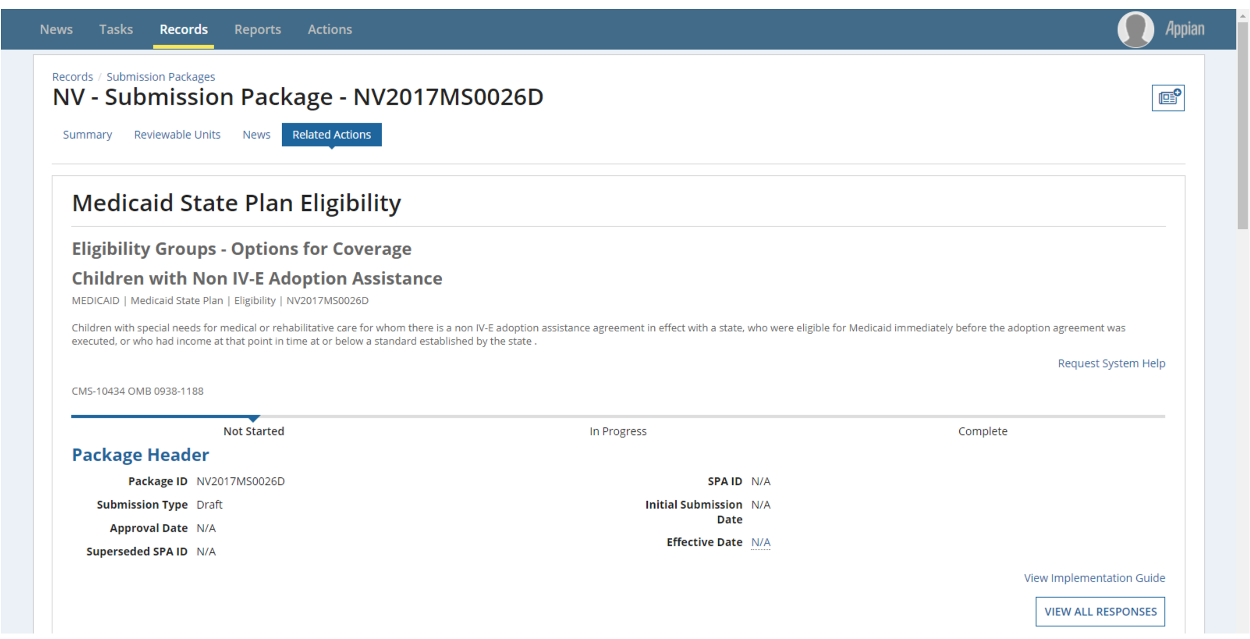

Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

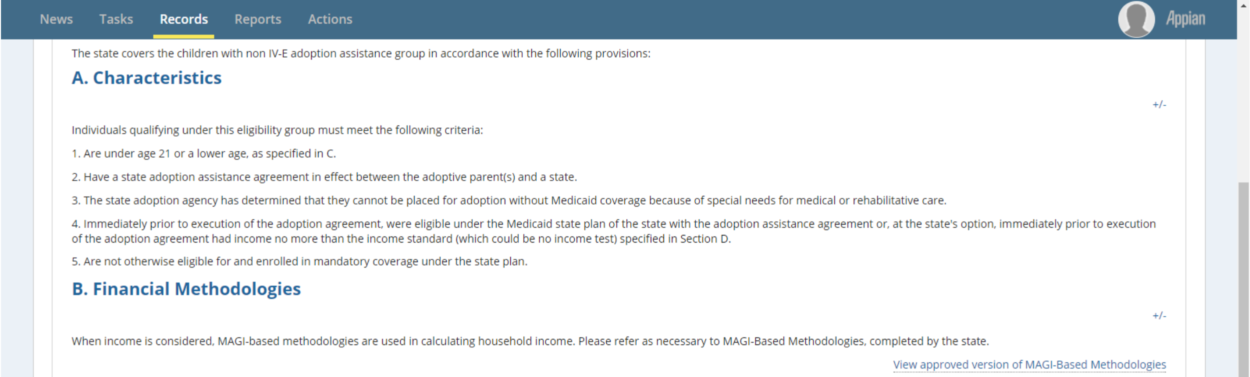

Figure 2: Section A and Section B

1.3 C. Individuals Covered – Path 1

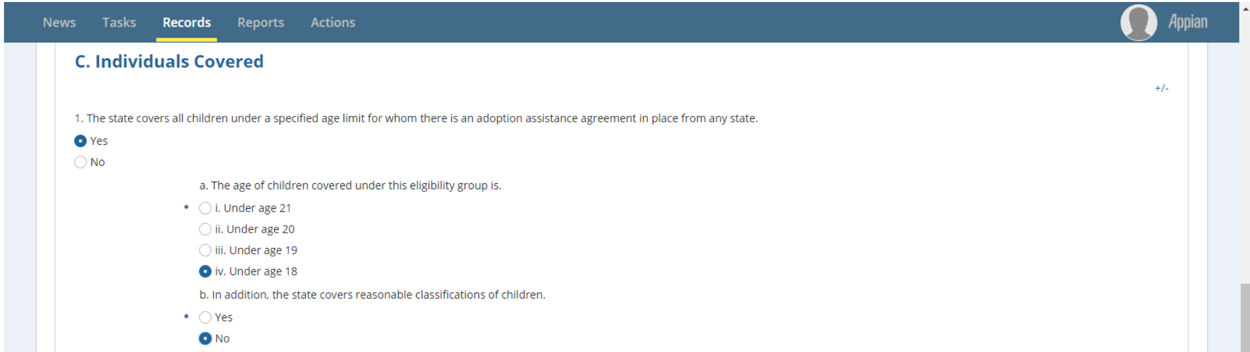

Figure 3: Section C- Path 1

1.4 C. Individuals Covered – Path 2 – Screenshot 1

Figure 4 : Section C – Path 2 – Screenshot 1

1.5 C. Individuals Covered – Path 2 – Screenshot 2

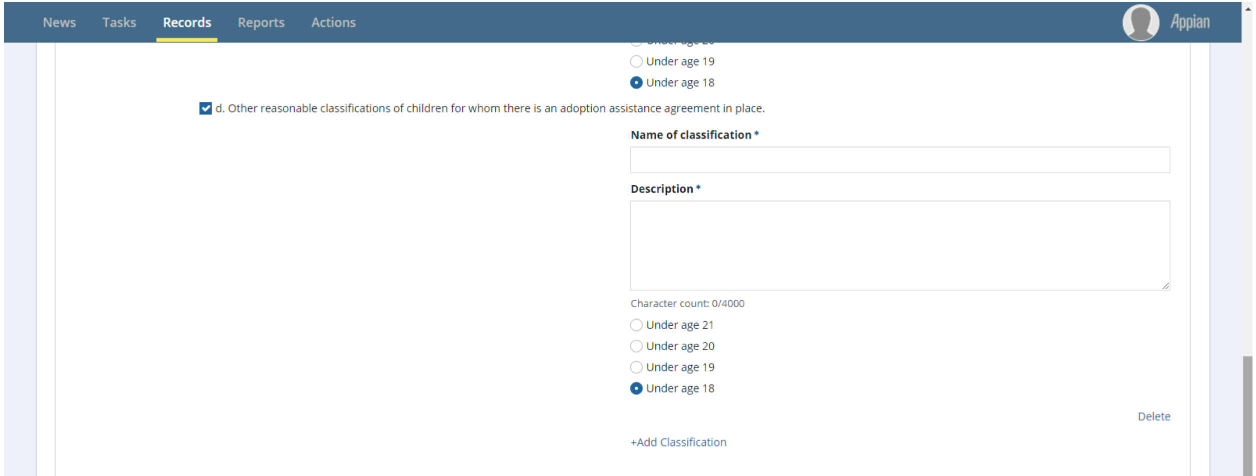

Figure 5: Section C – Path 2 – Screenshot 2

1.6 D. Income Standard Used – Path 1 – Screenshot 1

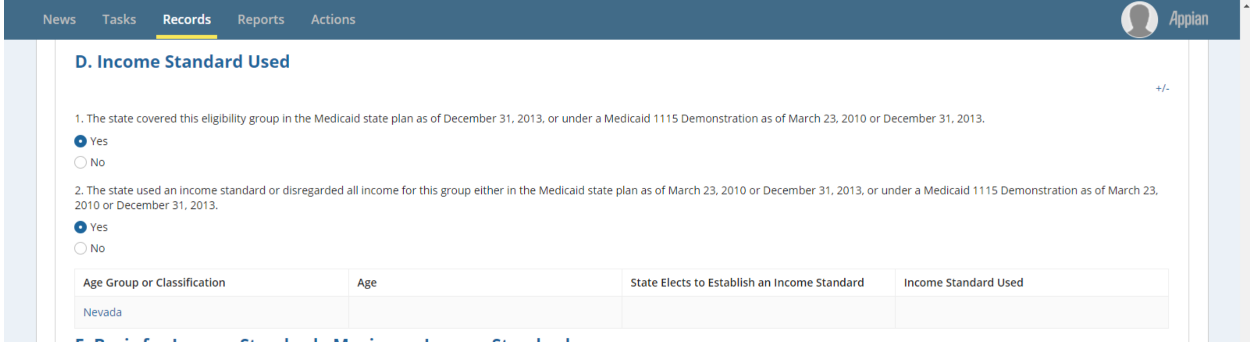

Figure 6: Section D – Path 1 – Screenshot 1

1.7 D. Income Standard Used – Path 1 – Screenshot 2 – Path 1

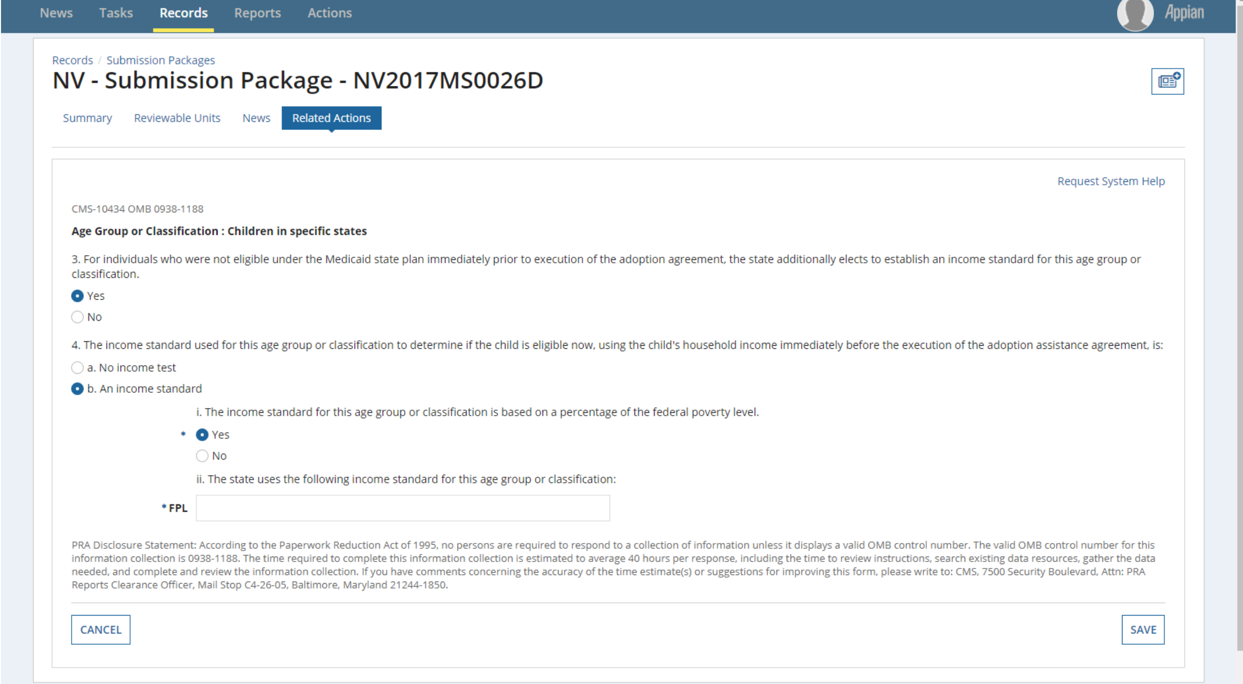

Figure 7: Section D – Path 1 – Screenshot 2 – Path 1

1.8 D. Income Standard Used – Path 1 – Screenshot 2 – Path 2

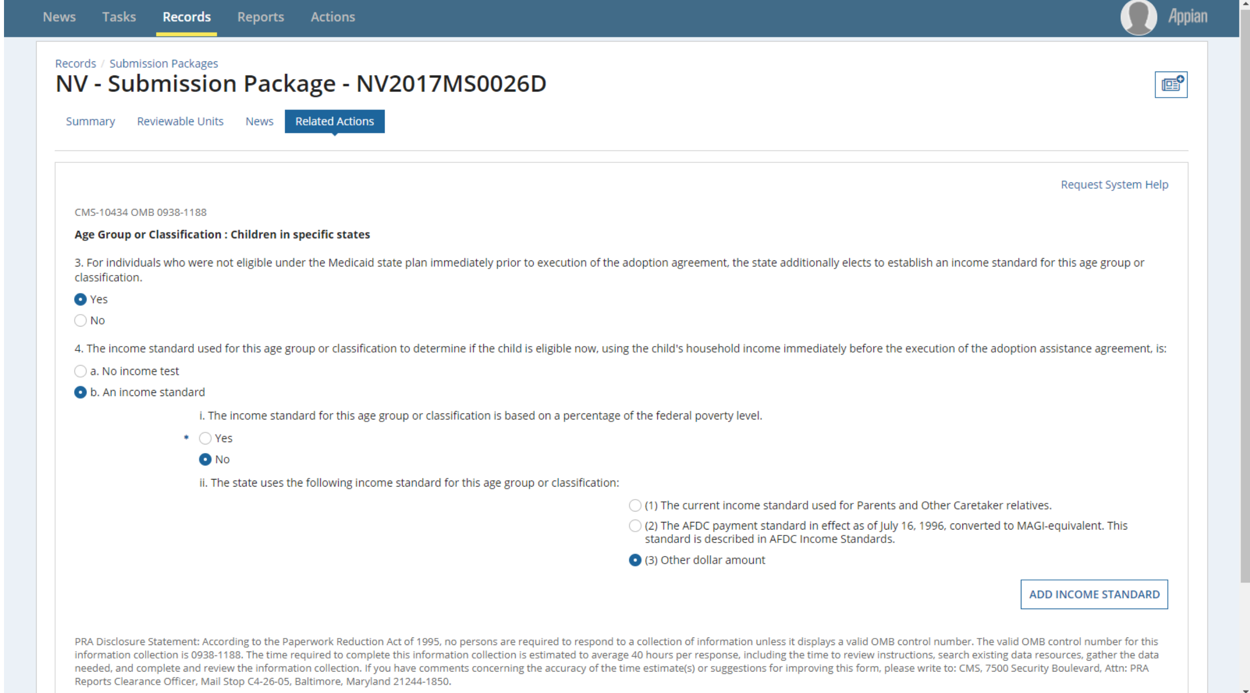

Figure 8 : Section D – Path 1 – Screenshot 2 – Path 2

1.9 D. Income Standard Used – Path 2

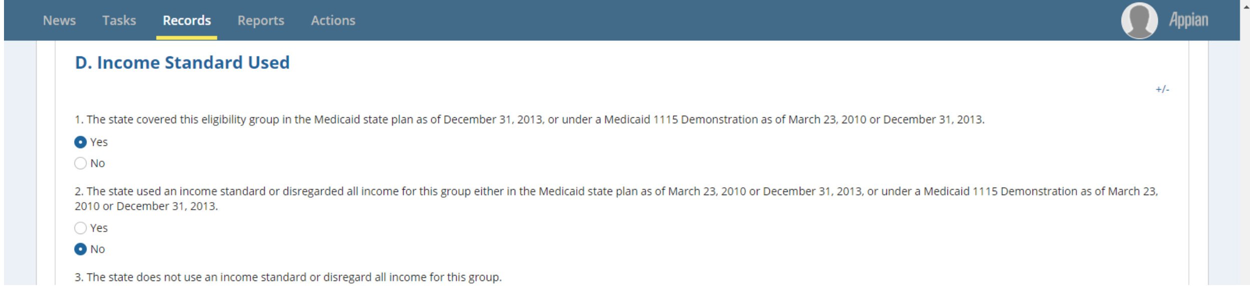

Figure 9: Section D – Path 2

1.10 Income Standard Used – Path 3

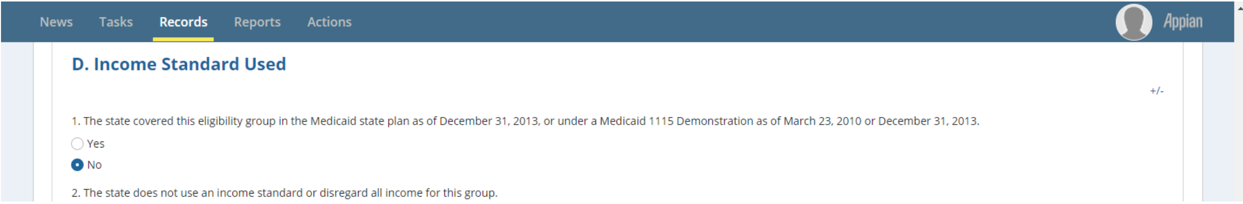

Figure 10: Section D – Path 3

1.11 E. Basis for Income Standard - Maximum Income Standard

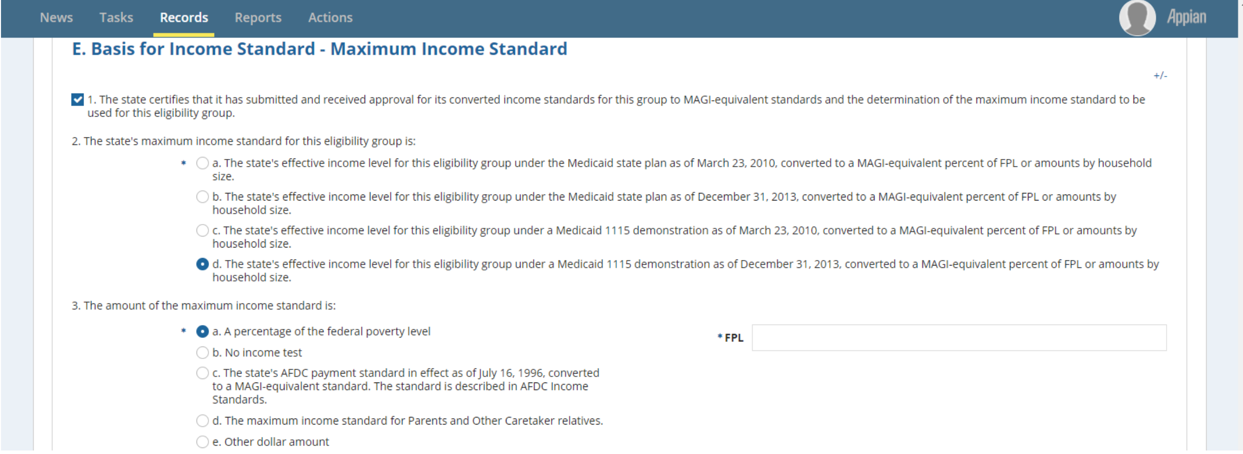

Figure 11: Section E

1.12 F. Additional Information (optional)

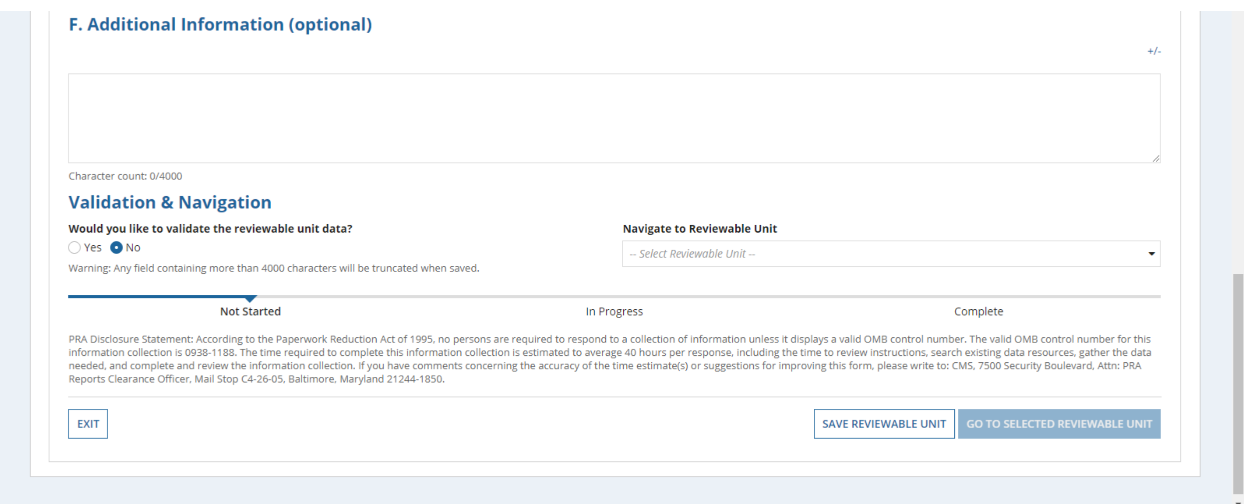

Figure 12: Section F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S54 - Optional Targeted Low Income Children RU Document

Version 1.0
08/15/2017

Document Number: 175-QSSI-MACPro-R5.1-S54-D
Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S54 - Optional Targeted Low Income Children Screenshots

1.1 Package Header

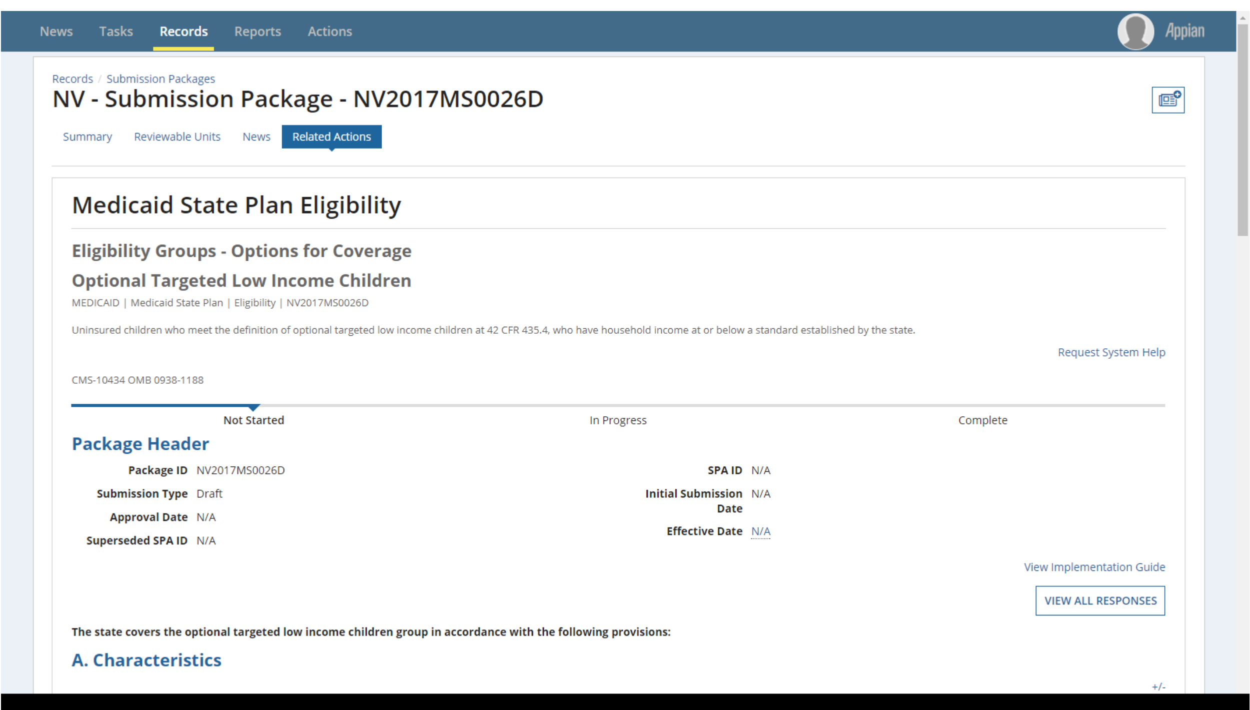

Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies and C. Individuals Covered-Path 1

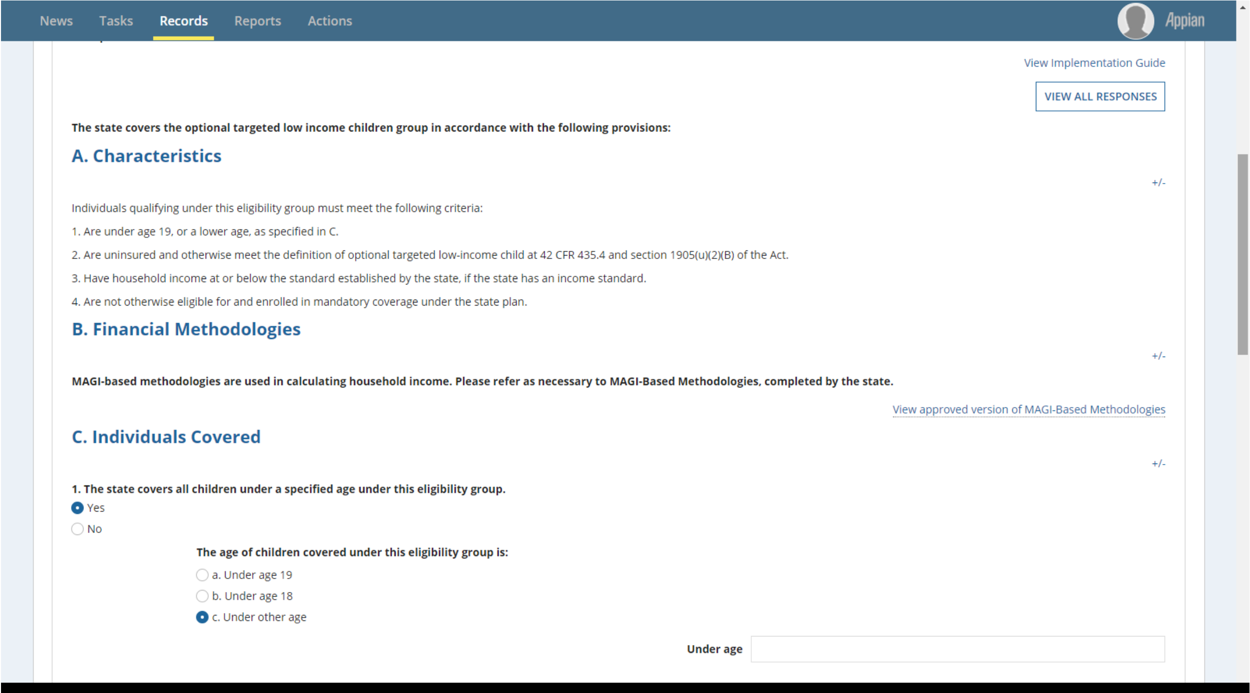

Figure 2: Section A, Section B and Section C-Path1

1.3 C. Individuals Covered-Path 2

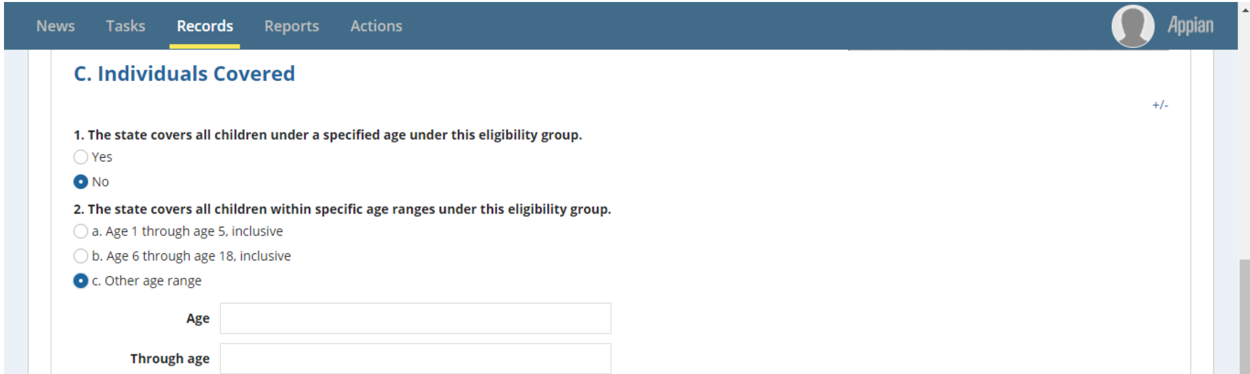

Figure 3: Section C-Path2

1.4 D. Income Standard Used

Figure 4: Section D

1.5 E. Basis for Income Standard

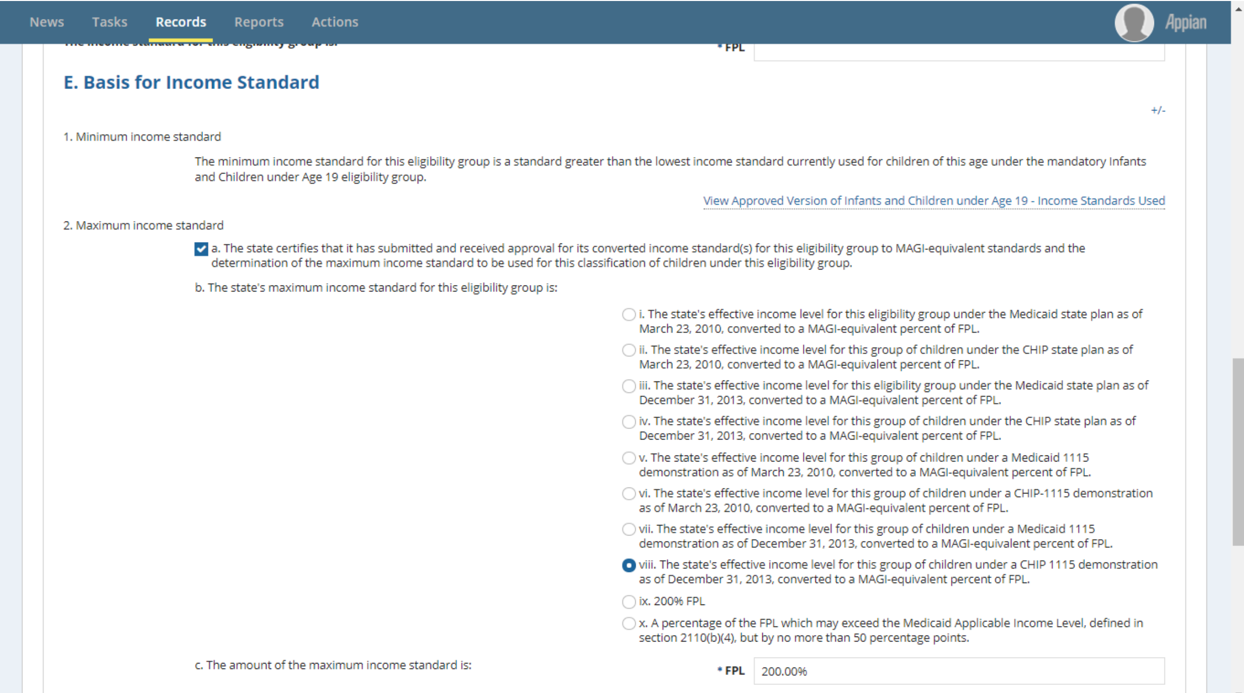

Figure 5: Section E

1.6 F. Additional Information (optional)

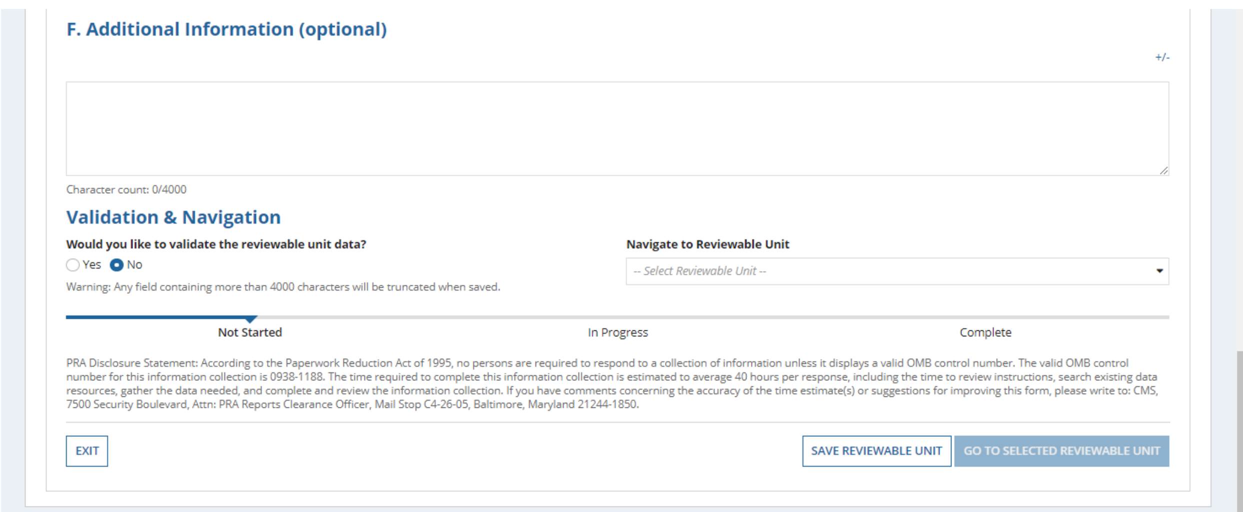

Figure 6: Section F

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S55-Individuals with Tuberculosis PRA document

Version 1.0

08/22/2017

Document Number: 243-QSSI-MACPro-PRA-S55-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.7 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 3 ... 3
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Figure 8: Section D – 4 ... 3

Figure 9: Sections E & F ... 3

1. S55-Individuals with Tuberculosis - Screenshots

1.1 Section A. "Characteristics"

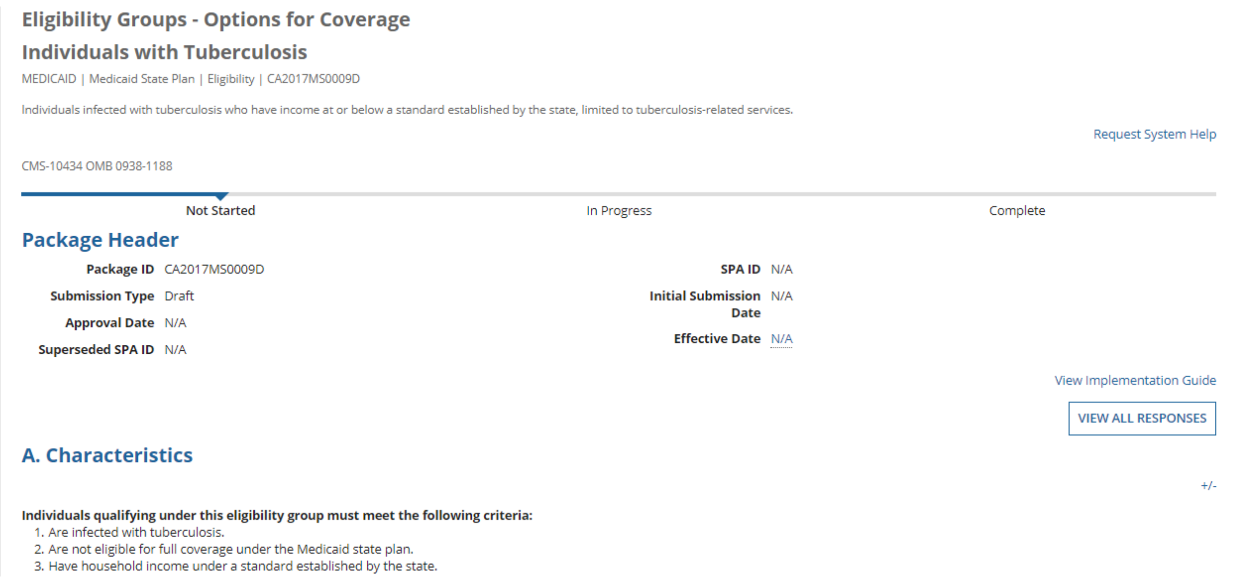


Figure 1: Section A

1.2 Section B. "Financial Methodologies"

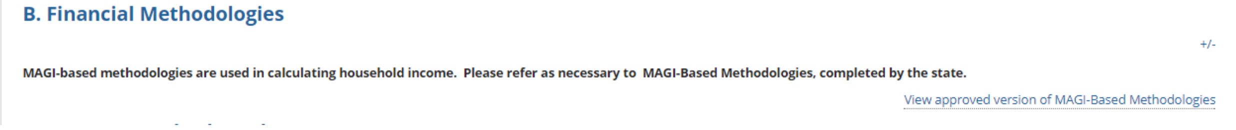


Figure 2: Section B

1.3 Section C. "Income Standard Used" – Path 1

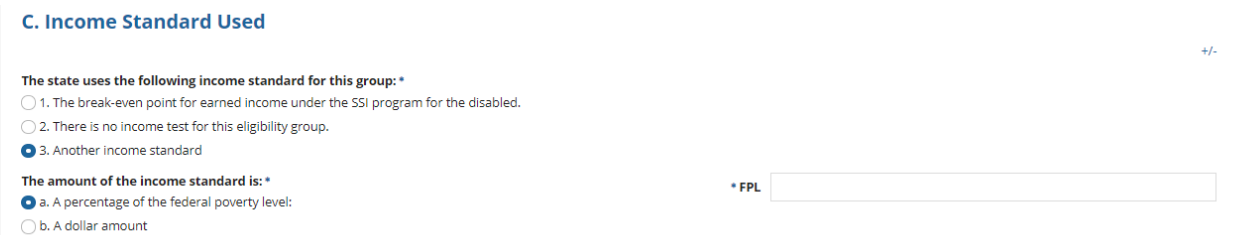
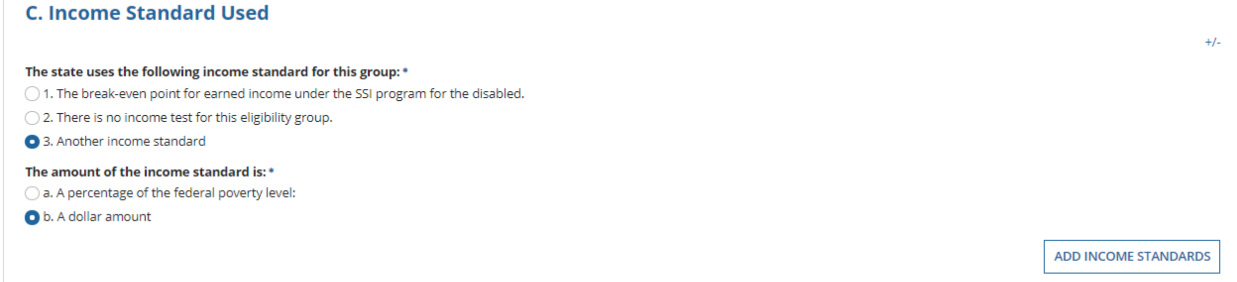


Figure 3: Section C. - 1

1.4 Section C. "Income Standard Used" – Path 2



C. Income Standard Used

+/-

The state uses the following income standard for this group: *

1. The break-even point for earned income under the SSI program for the disabled.

2. There is no income test for this eligibility group.

3. Another income standard

The amount of the income standard is: *

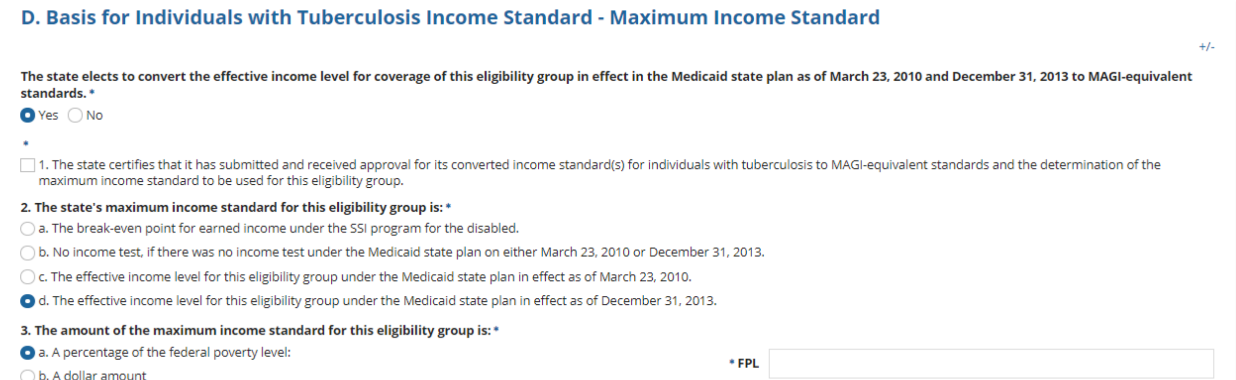
a. A percentage of the federal poverty level:

b. A dollar amount

ADD INCOME STANDARDS

Figure 4: Section C. – 2

1.5 Section D. "Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard" – Path 1



D. Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard

+/-

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards. *

Yes No

*

1. The state certifies that it has submitted and received approval for its converted income standard(s) for individuals with tuberculosis to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

2. The state's maximum income standard for this eligibility group is: *

a. The break-even point for earned income under the SSI program for the disabled.

b. No income test, if there was no income test under the Medicaid state plan on either March 23, 2010 or December 31, 2013.

c. The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010.

d. The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013.

3. The amount of the maximum income standard for this eligibility group is: *

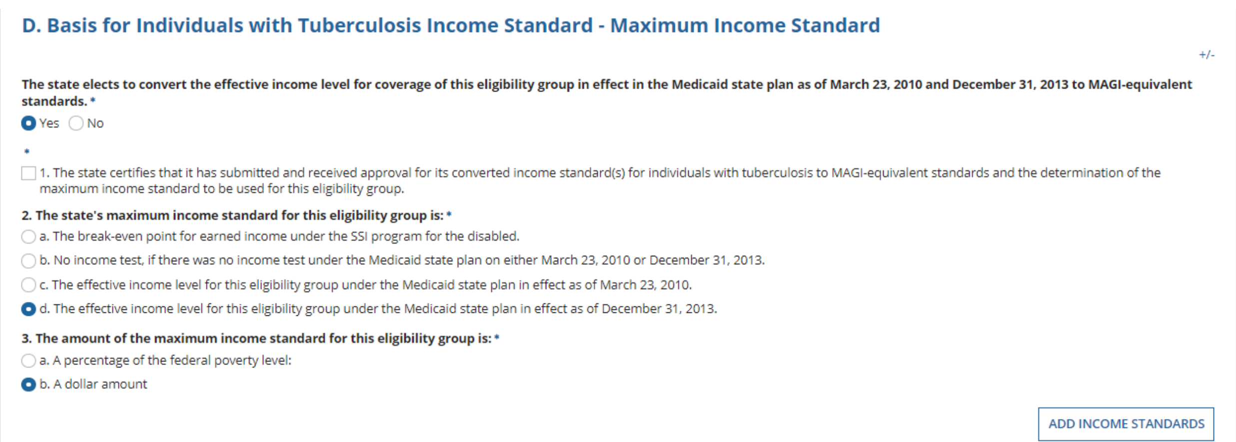
a. A percentage of the federal poverty level:

b. A dollar amount

* FPL

Figure 5: Section D – 1

1.6 Section D. "Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard" – Path 2



D. Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard

+/-

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards. *

Yes No

*

1. The state certifies that it has submitted and received approval for its converted income standard(s) for individuals with tuberculosis to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

2. The state's maximum income standard for this eligibility group is: *

a. The break-even point for earned income under the SSI program for the disabled.

b. No income test, if there was no income test under the Medicaid state plan on either March 23, 2010 or December 31, 2013.

c. The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010.

d. The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013.

3. The amount of the maximum income standard for this eligibility group is: *

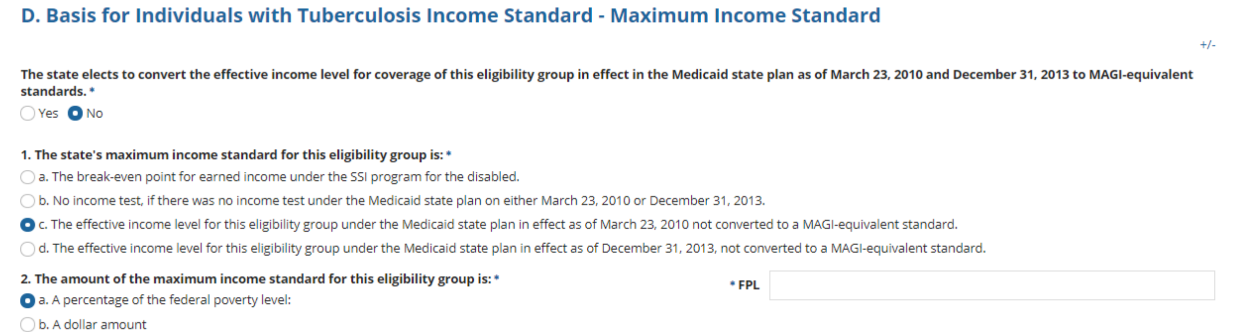
a. A percentage of the federal poverty level:

b. A dollar amount

ADD INCOME STANDARDS

Figure 6: Section D – 2

1.7 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 3


D. Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard

+/-

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards. *

Yes No

1. The state's maximum income standard for this eligibility group is: *

a. The break-even point for earned income under the SSI program for the disabled.

b. No income test, if there was no income test under the Medicaid state plan on either March 23, 2010 or December 31, 2013.

c. The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010 not converted to a MAGI-equivalent standard.

d. The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013, not converted to a MAGI-equivalent standard.

2. The amount of the maximum income standard for this eligibility group is: *

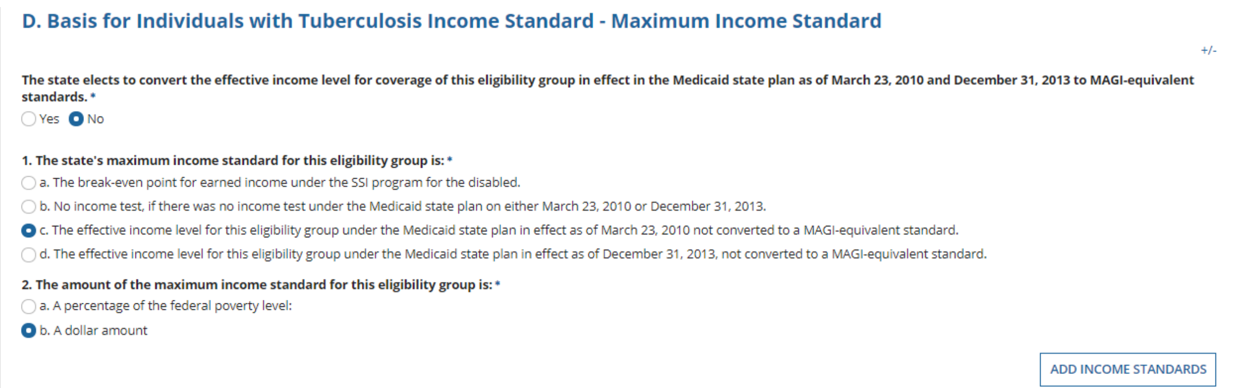
a. A percentage of the federal poverty level:

b. A dollar amount

* FPL

Figure 7: Section D – 3

1.8 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 4


D. Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard

+/-

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards. *

Yes No

1. The state's maximum income standard for this eligibility group is: *

a. The break-even point for earned income under the SSI program for the disabled.

b. No income test, if there was no income test under the Medicaid state plan on either March 23, 2010 or December 31, 2013.

c. The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010 not converted to a MAGI-equivalent standard.

d. The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013, not converted to a MAGI-equivalent standard.

2. The amount of the maximum income standard for this eligibility group is: *

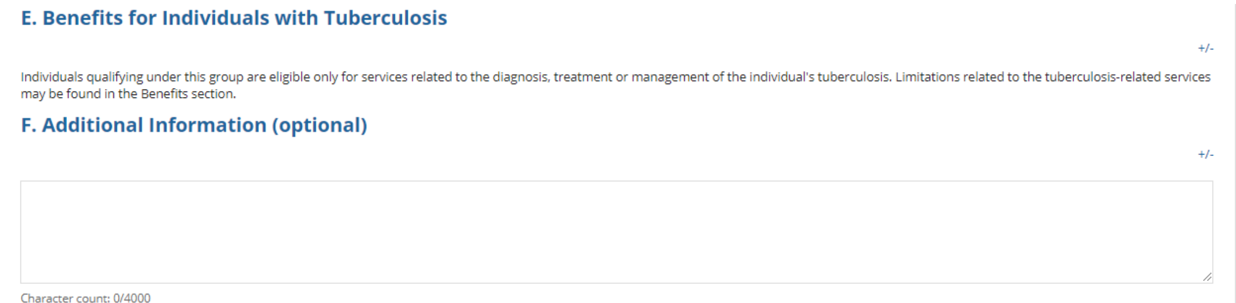
a. A percentage of the federal poverty level:

b. A dollar amount

ADD INCOME STANDARDS

Figure 8: Section D – 4

1.9 Section E. “Benefits for Individuals with Tuberculosis” and Section F. “Additional Information”


E. Benefits for Individuals with Tuberculosis

+/-

Individuals qualifying under this group are eligible only for services related to the diagnosis, treatment or management of the individual's tuberculosis. Limitations related to the tuberculosis-related services may be found in the Benefits section.

F. Additional Information (optional)

+/-

Character count: 0/4000

Figure 9: Sections E & F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S57 – Independent Foster Care Adolescents RU PRA Document

Version 1.0

08/18/2017

Document Number: 218-QSSI-MACPro-R5.1-S57-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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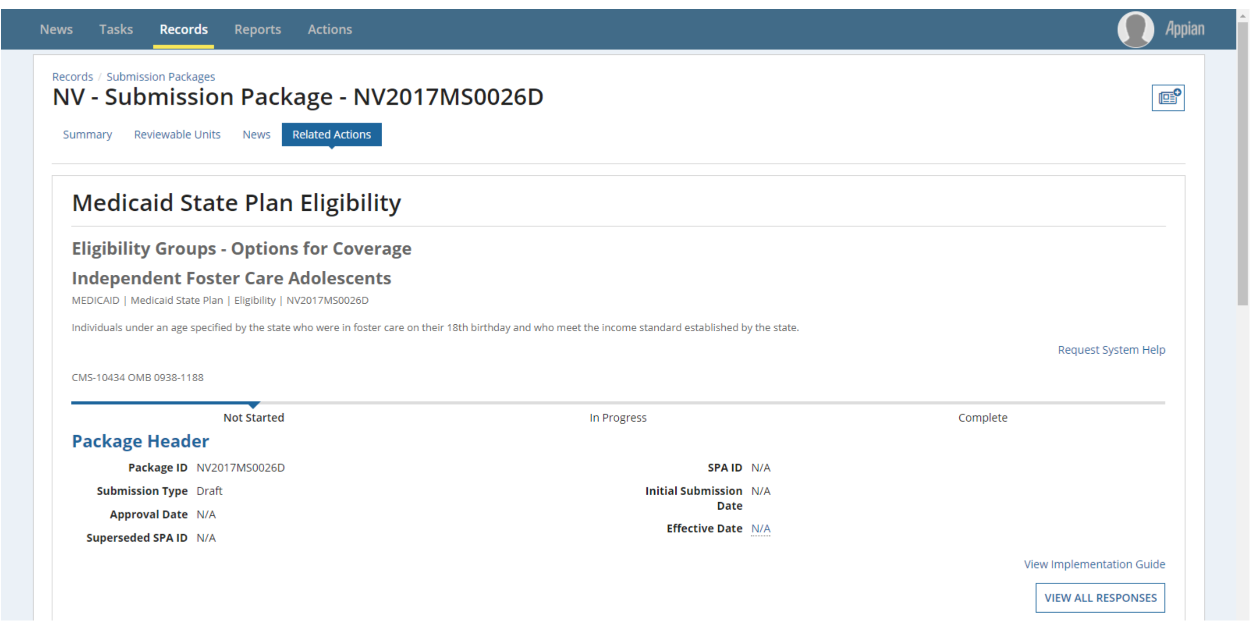

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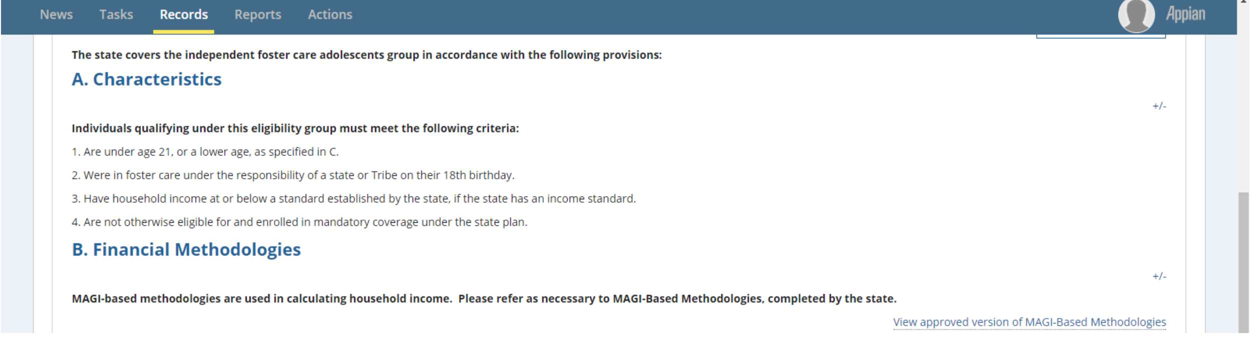

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1.3 C. Individuals Covered – Path 1 – Screenshot 1

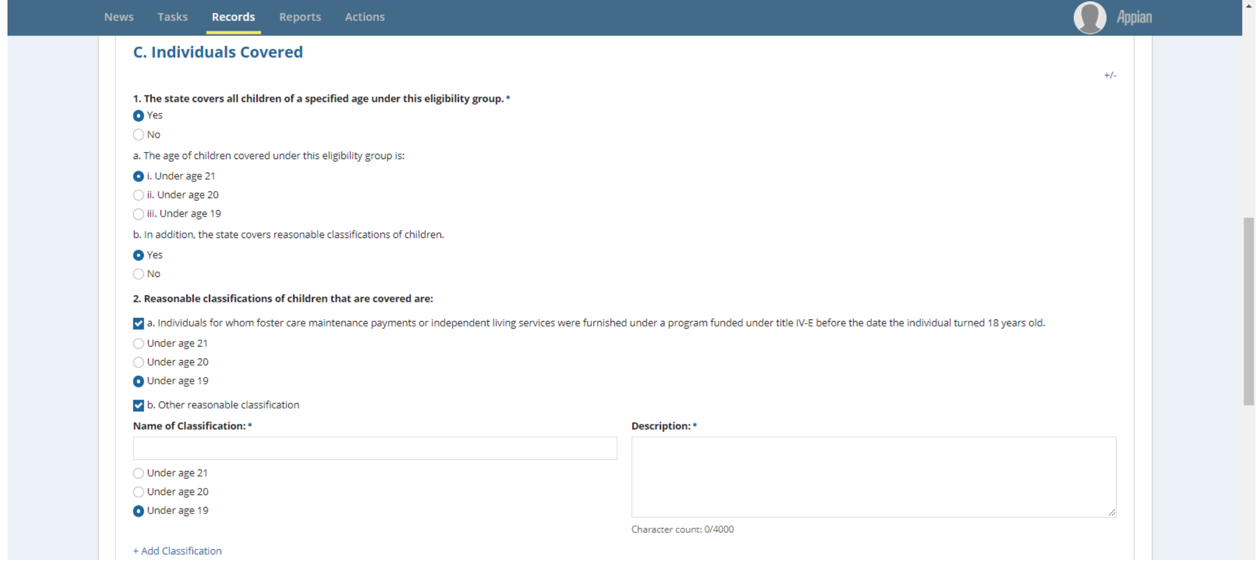
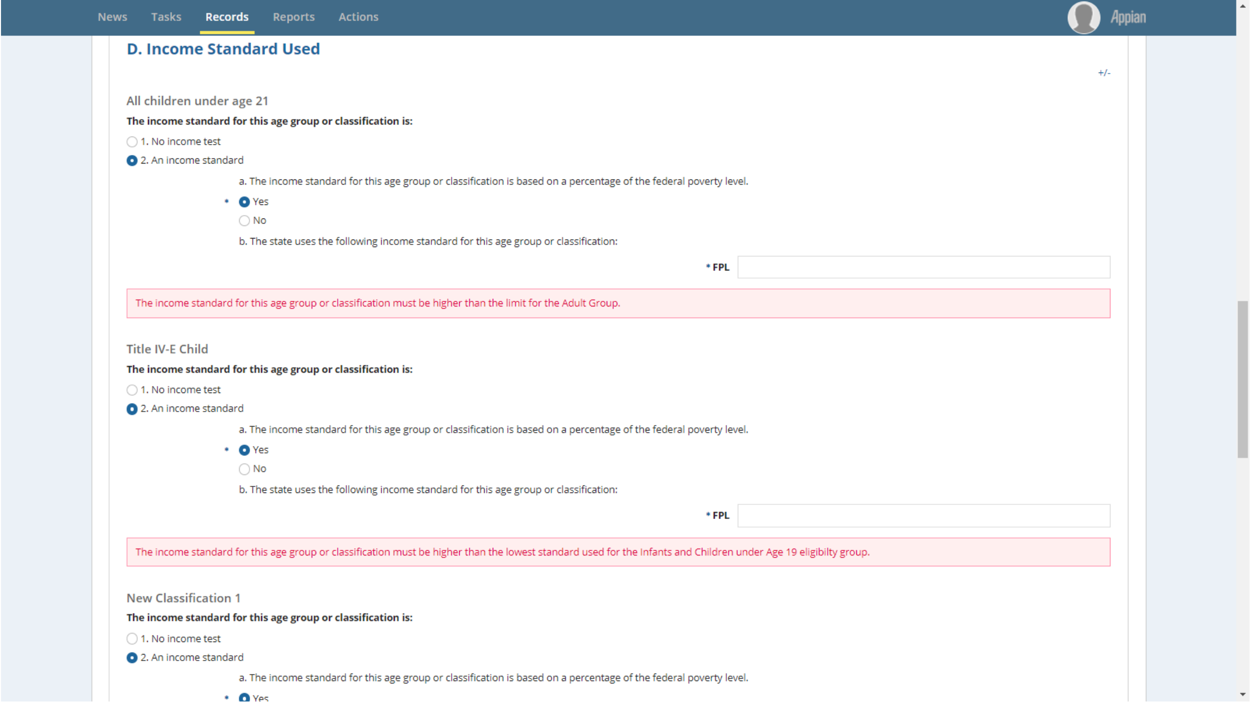


Figure 3: Section C – Path 1 – Screenshot 1

1.4 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 2 – Path 1



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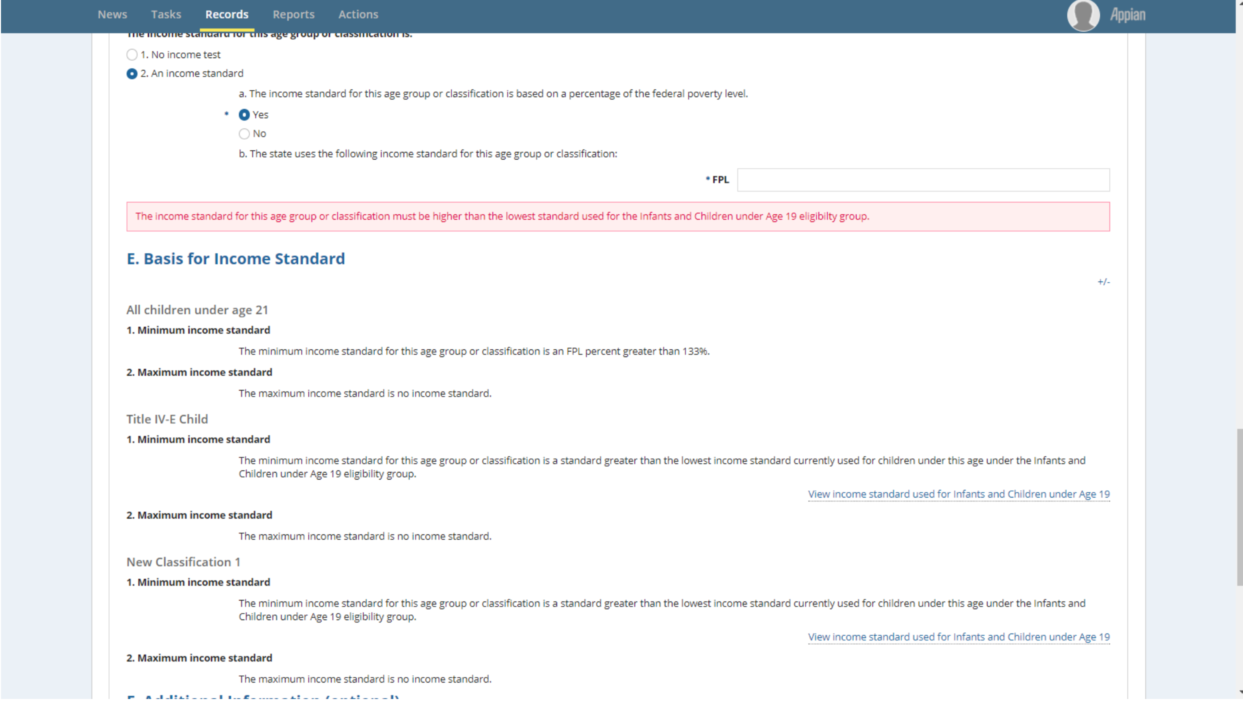
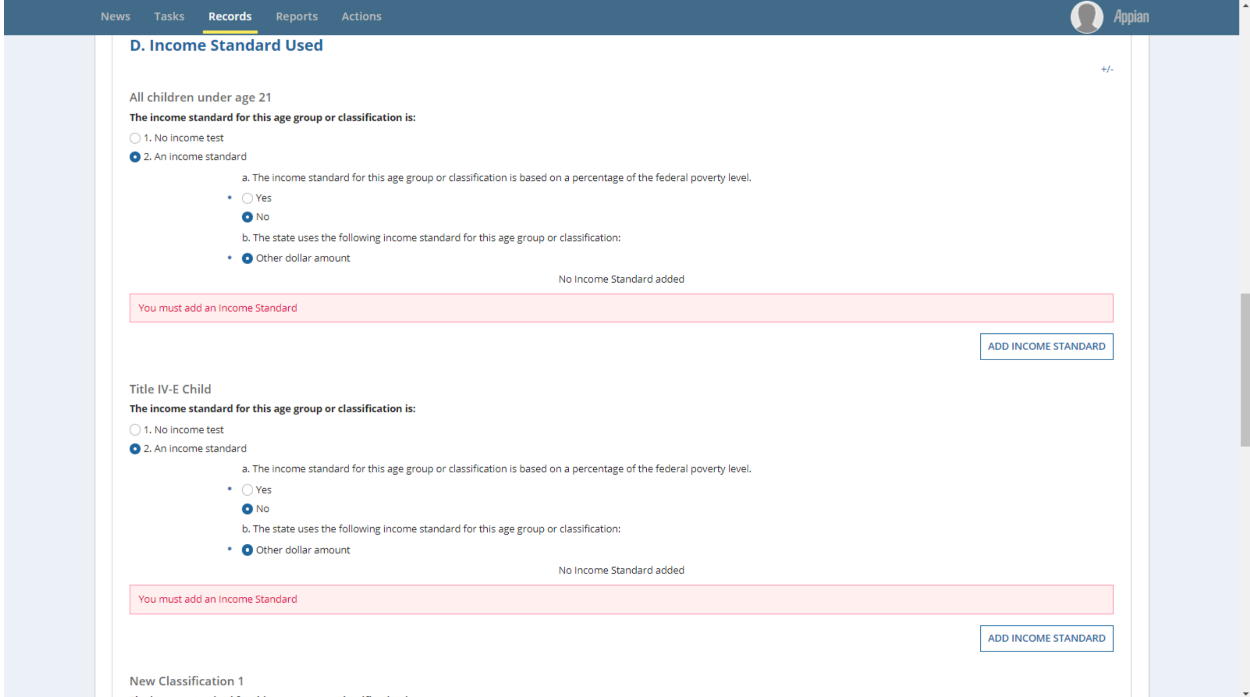


Figure 5: Section D, Section E – Path 1 – Screenshot 3

1.6 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 2 – Path 2 – Screenshot 1



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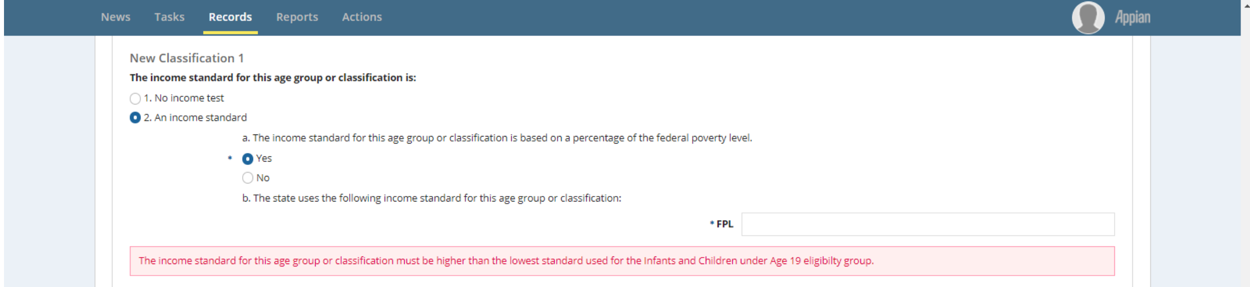

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1.8 C. Individuals Covered – Path 2 – Screenshot 1

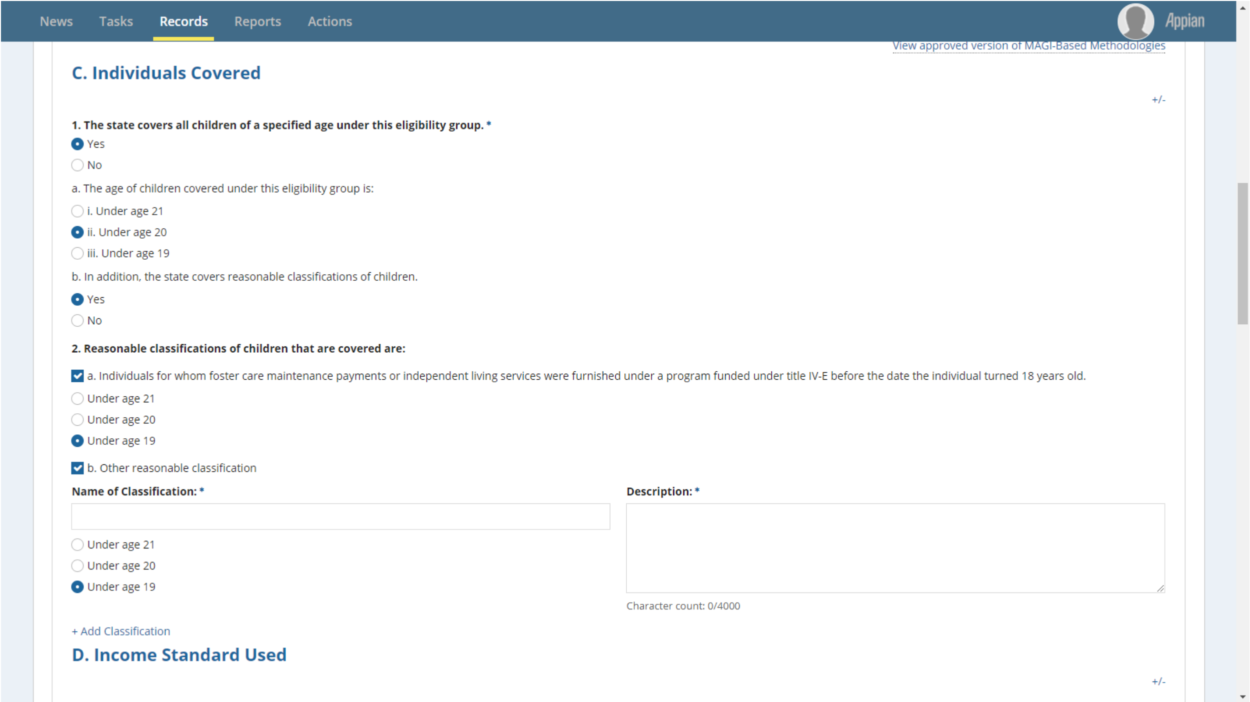


Figure 8: Section C– Path 2 – Screenshot 1

1.9 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 2 – Path 1

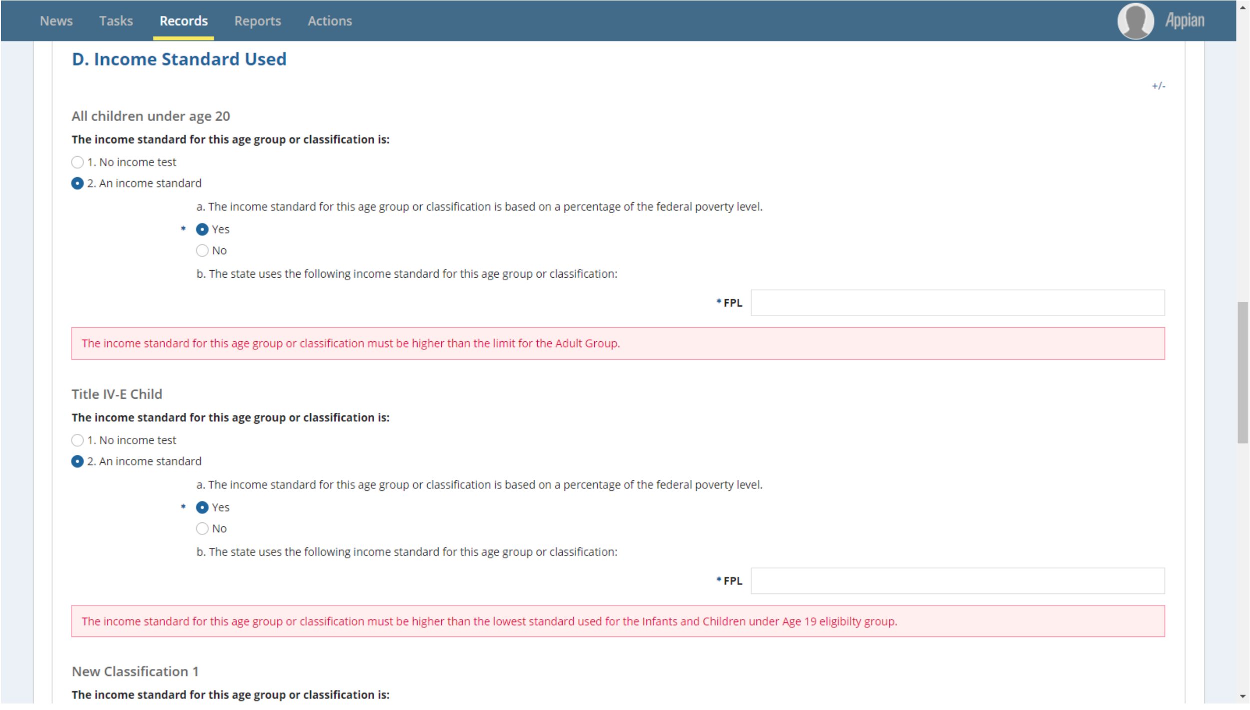


Figure 9: Section D, Section E – Path 2 – Screenshot 2 – Path 1

1.10 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 3

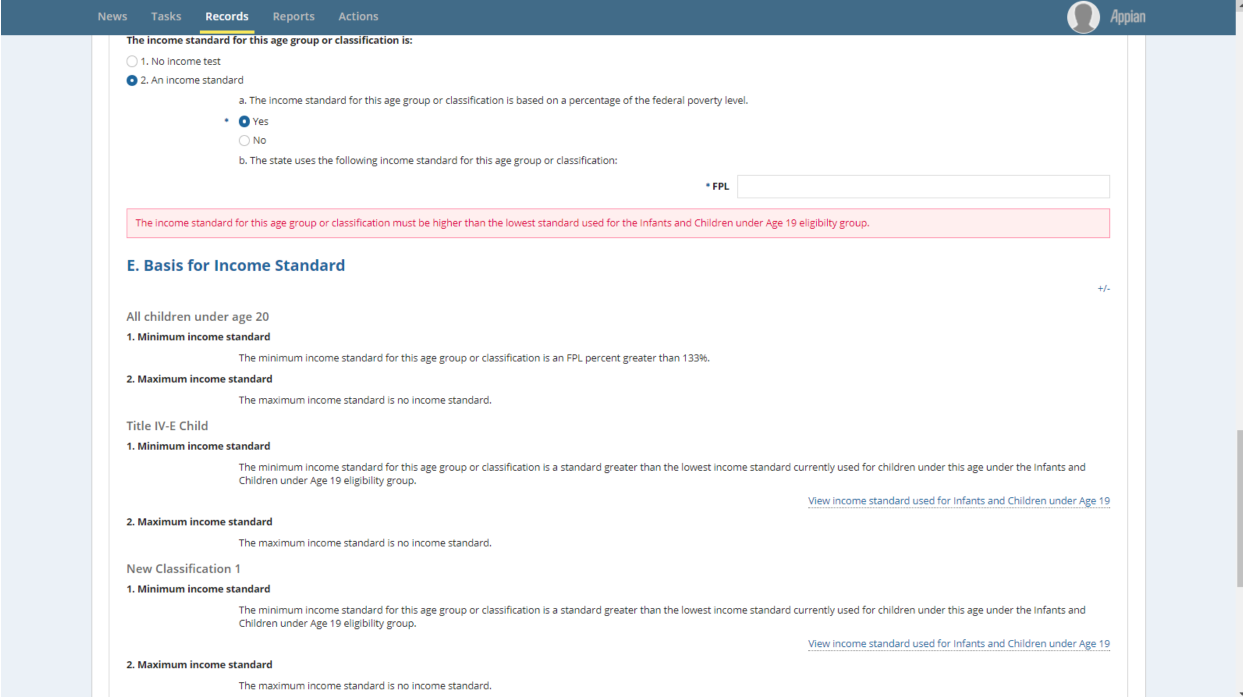
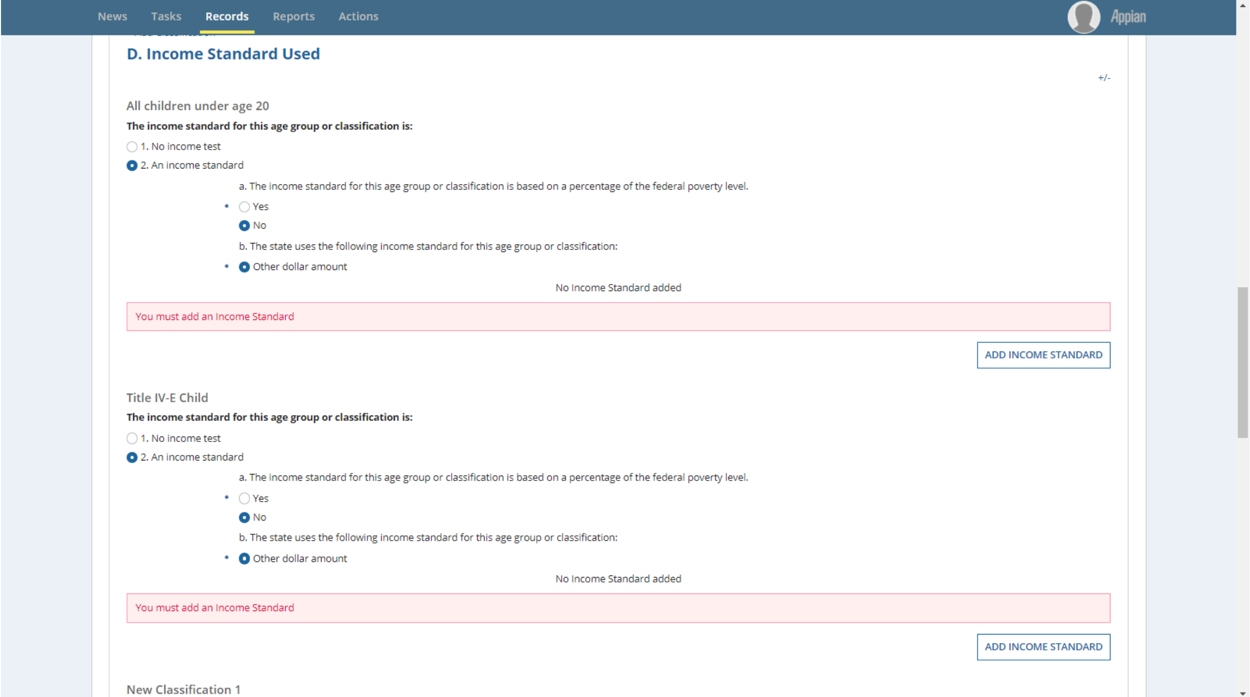


Figure 10: Section D, Section E – Path 2 – Screenshot 3

1.11 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 2 – Path 2 – Screenshot 1



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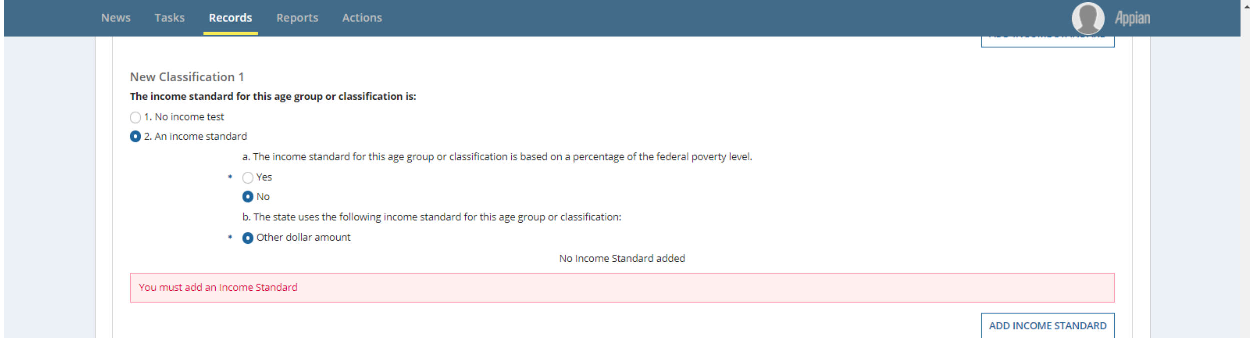


Figure 12: Section D, Section E – Path 2 – Screenshot 2 – Path 2 – Screenshot 2

1.13 C. Individuals Covered– Path 3 – Screenshot 1

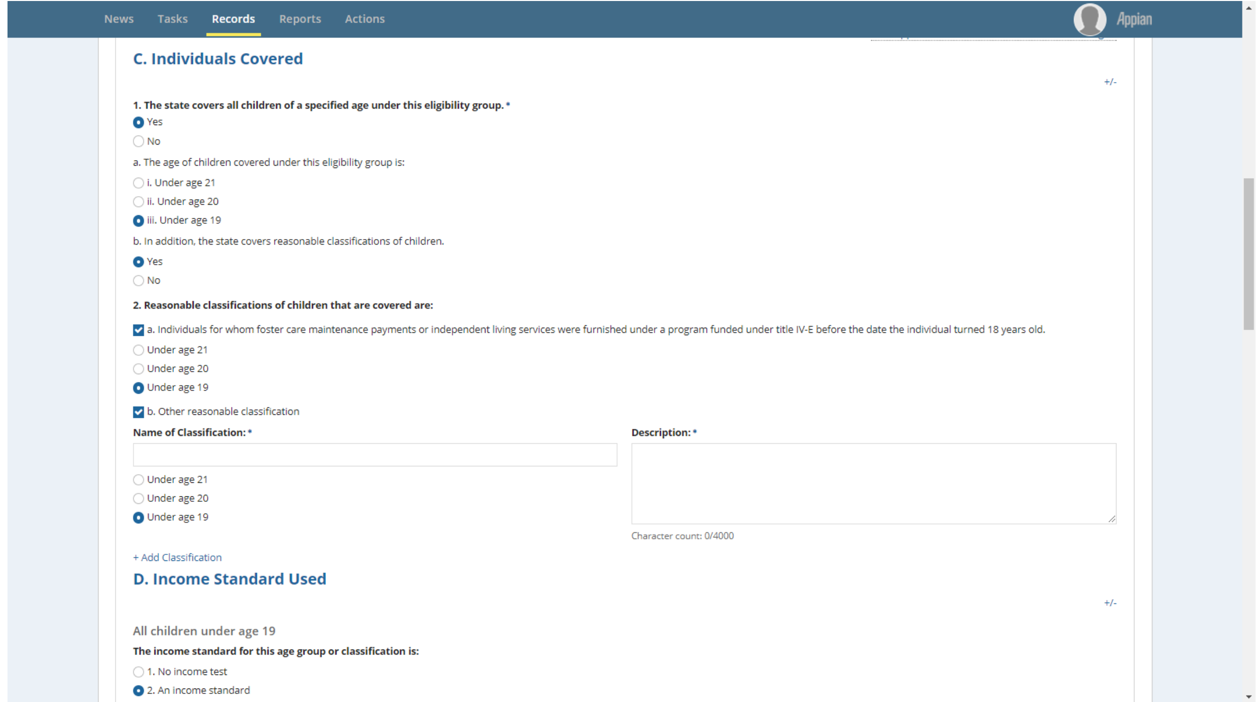


Figure 13: 1.13 Section C – Path 3 – Screenshot 1

1.14 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 1

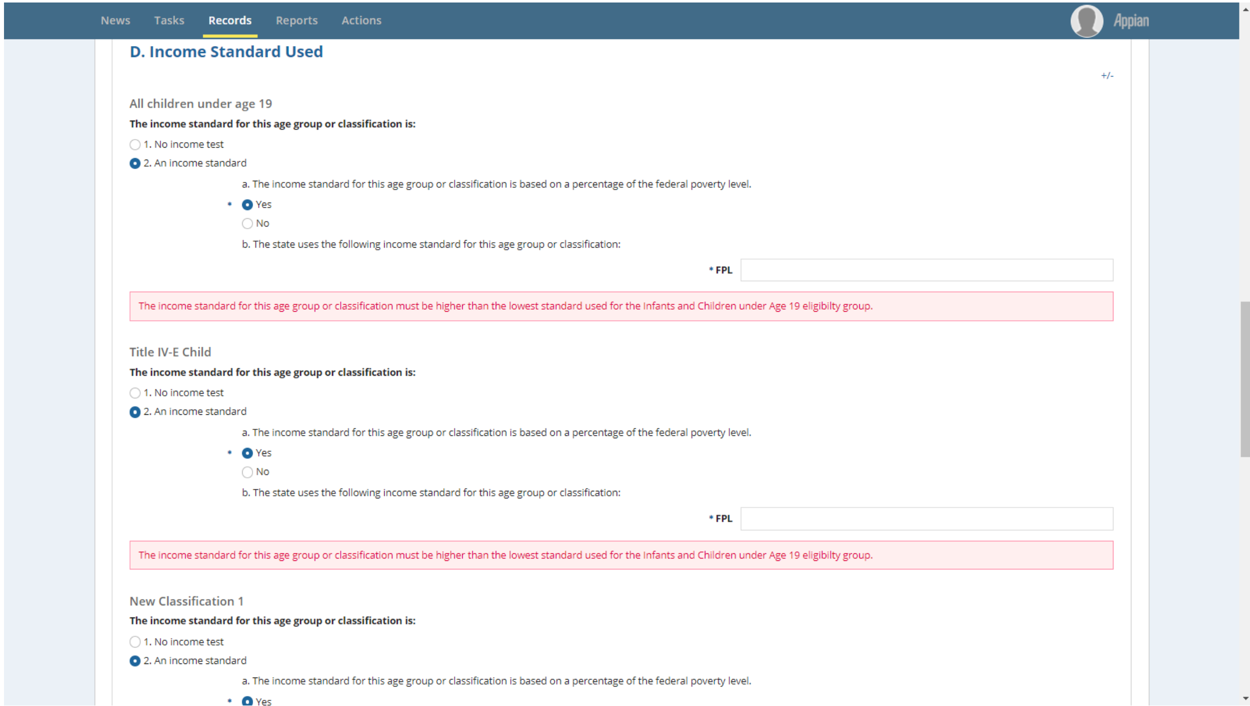
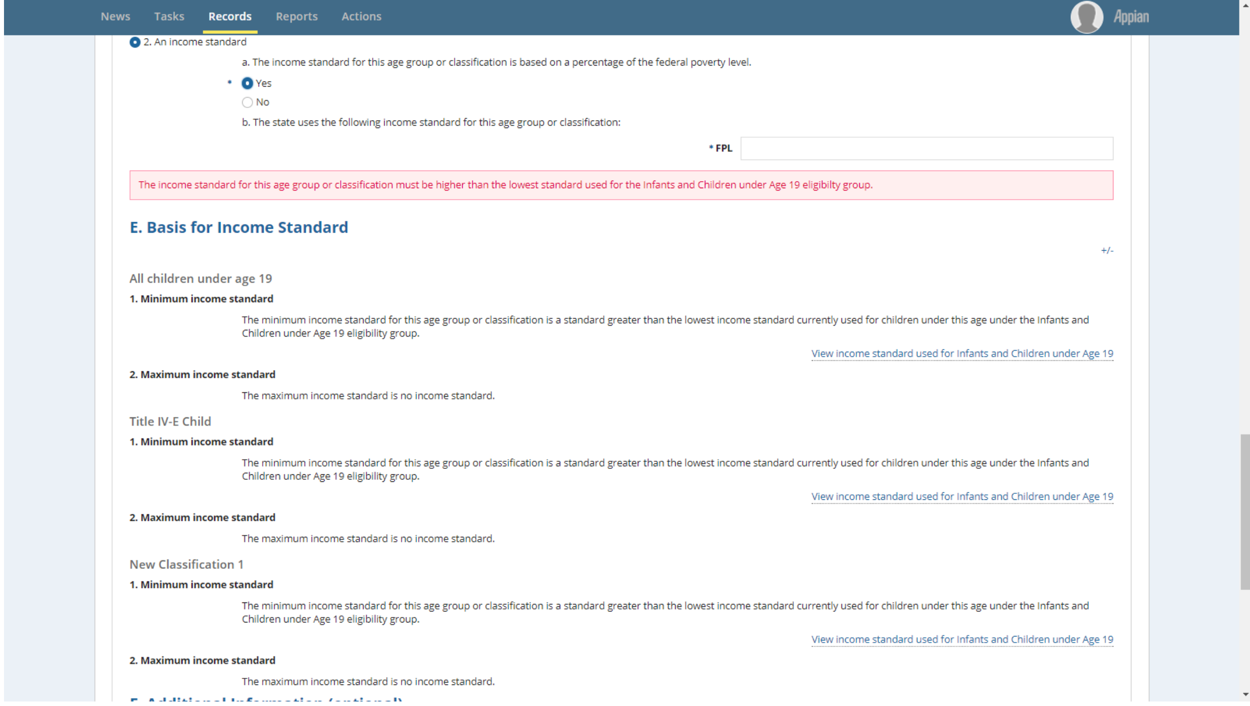


Figure 14: Section D, Section E – Path 3 – Screenshot 2 – Path 1

1.15 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 3



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1.16 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 1

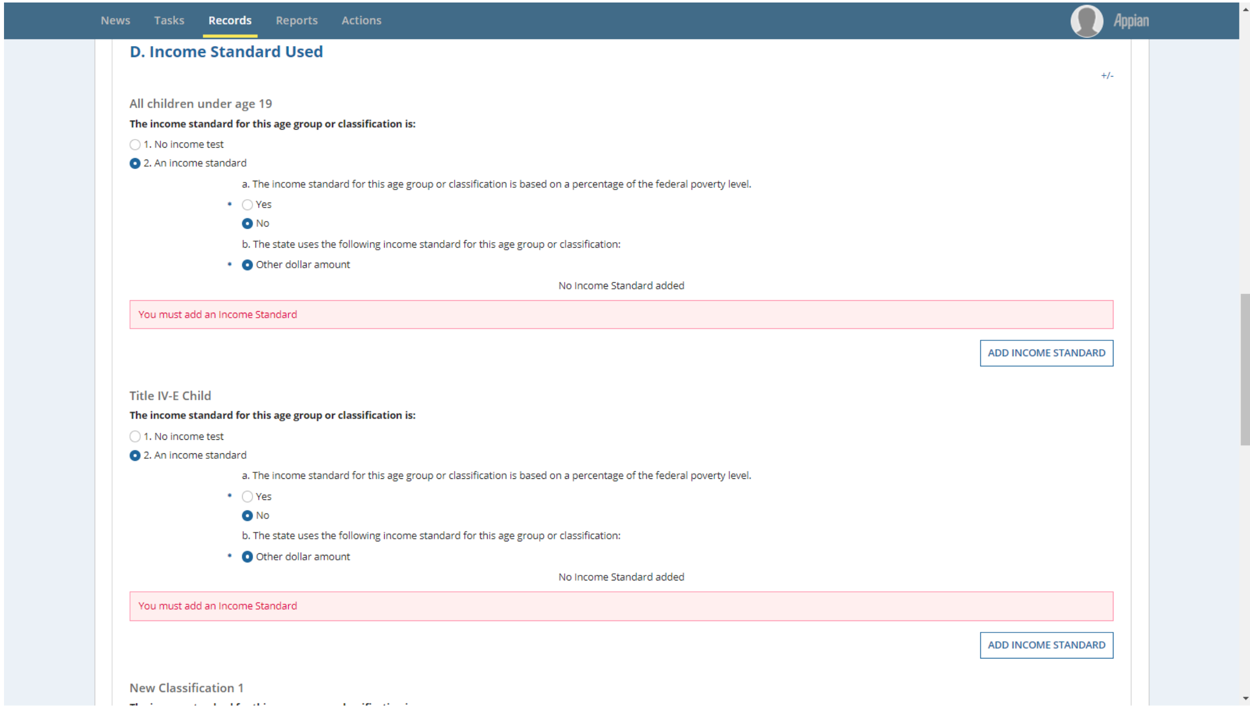

Figure 16: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 1

1.17 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 2

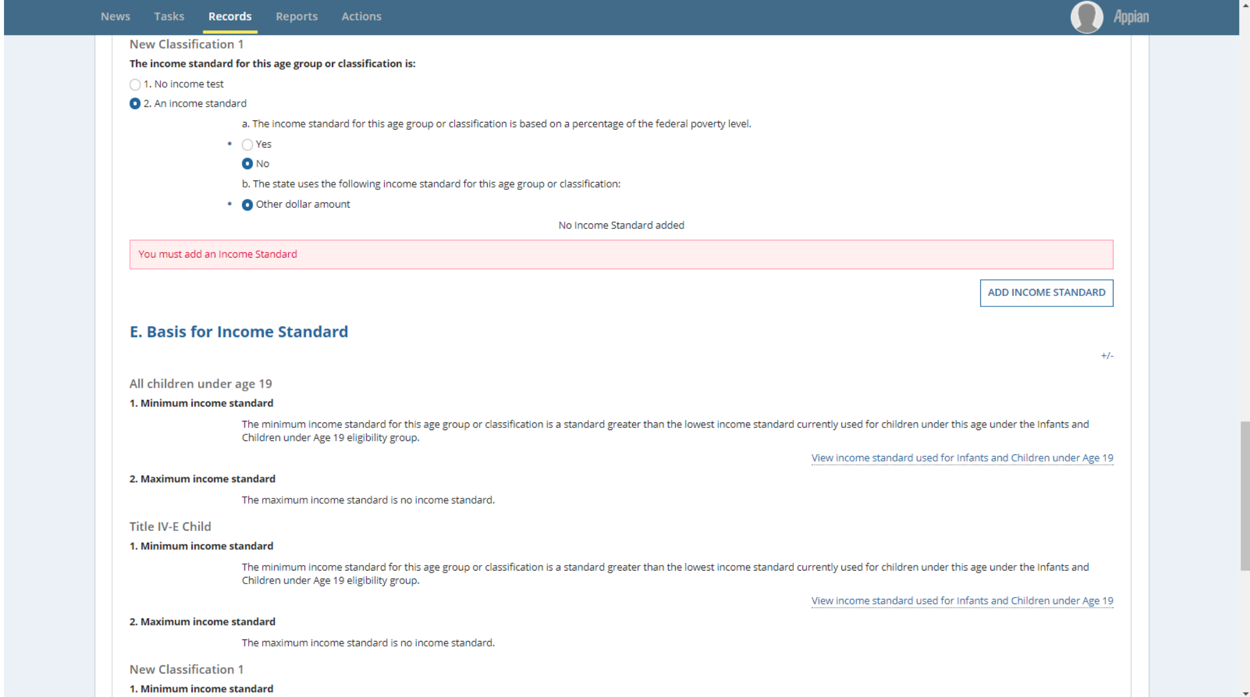

Figure 17: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 2

1.18 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 3

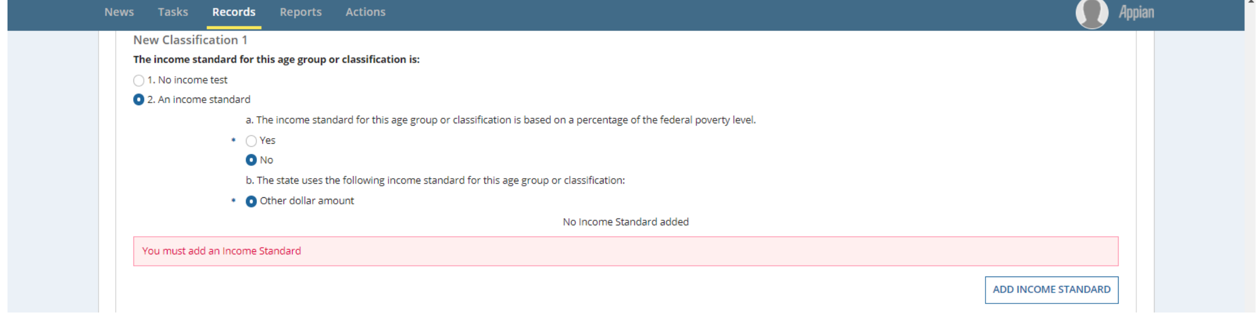

Figure 18: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 3

1.19 C. Individuals Covered– Path 4 – Screenshot 1

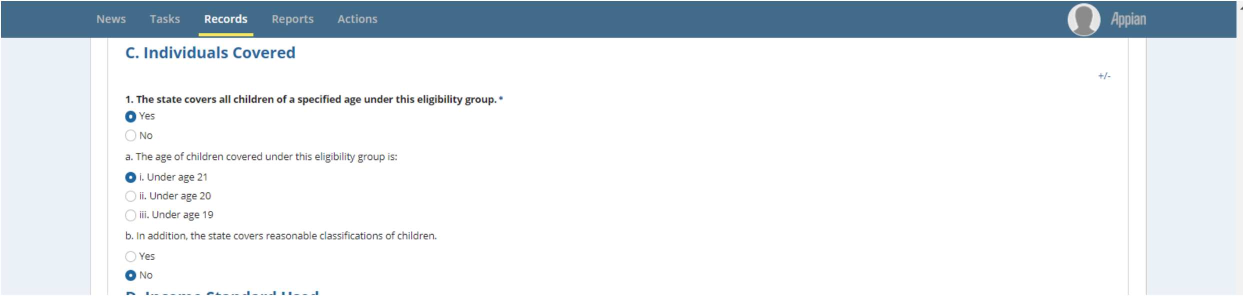

Figure 19 : Section C– Path 4 – Screenshot 1

1.20 D. Income Standard Used and E. Basis for Income Standard – Path 4 – Screenshot 2 – Path 1

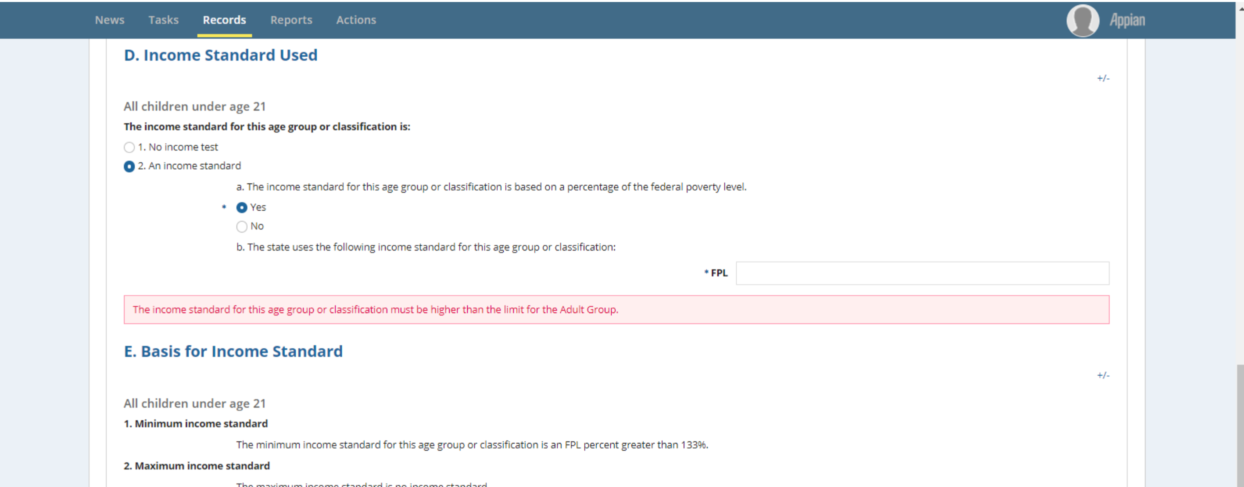

Figure 20 : Section D, Section E – Path 4 – Screenshot 2 – Path 1

1.21 D. Income Standard Used and E. Basis for Income Standard – Path 4 – Screenshot 2 – Path 2

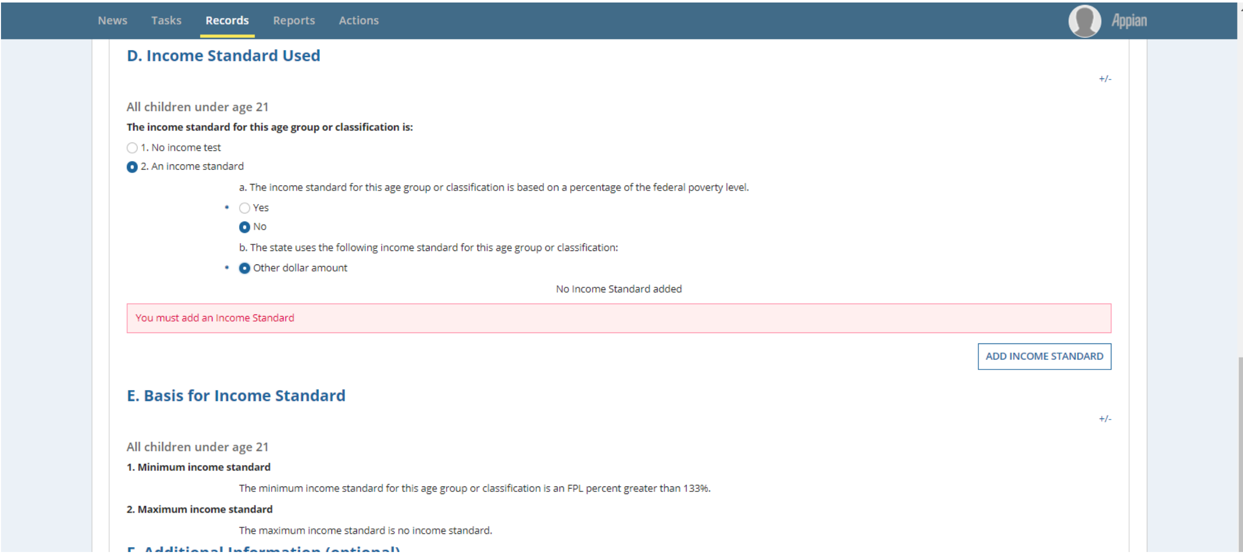

Figure 21: Section D, Section E – Path 4 – Screenshot 2 – Path 2

1.22 C. Individuals Covered– Path 5 – Screenshot 1

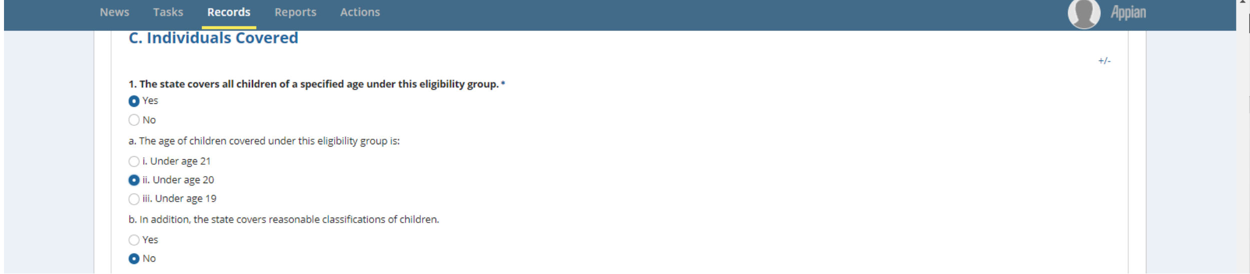

Figure 22: Section C – Path 5 – Screenshot 1

1.23 D. Income Standard Used and E. Basis for Income Standard – Path 5 – Screenshot 2 – Path 1

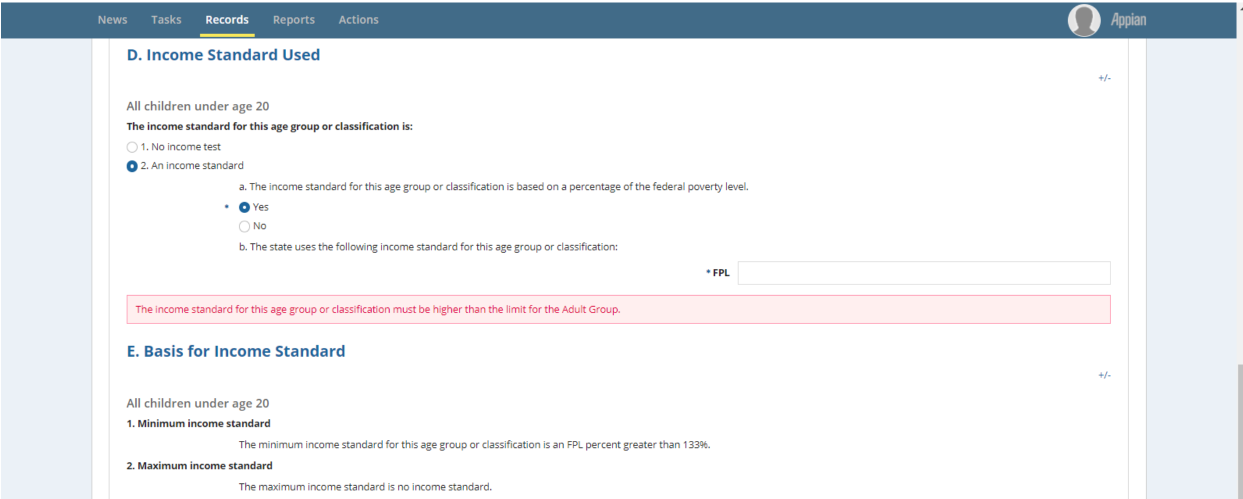

Figure 23

1.24 1.21 D. Income Standard Used and E. Basis for Income Standard – Path 5 – Screenshot 2 – Path 2

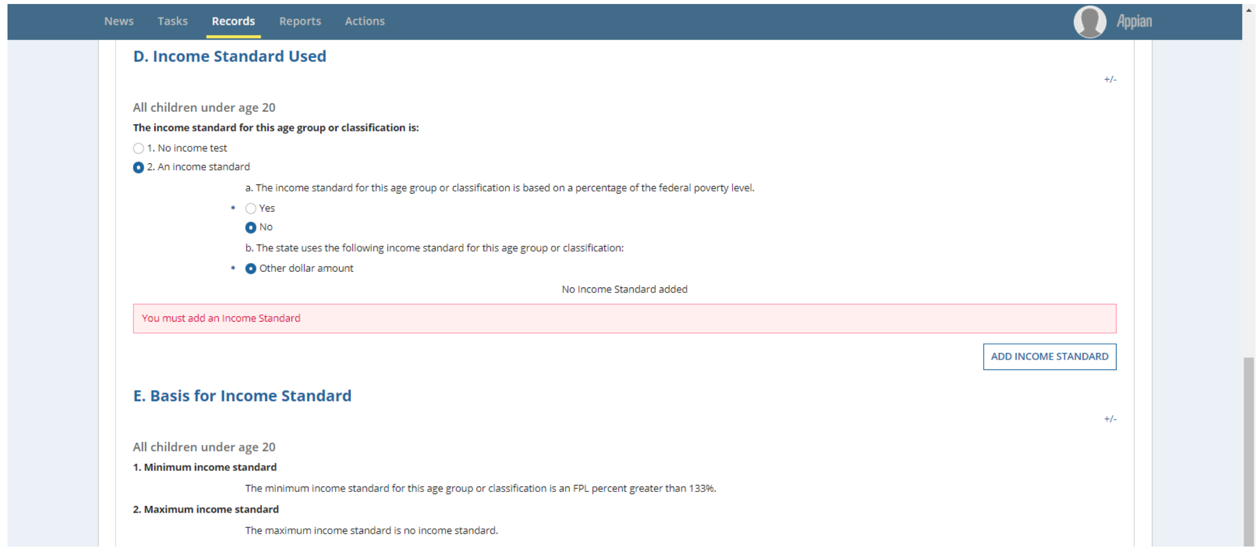

Figure 24 : Section D, Section E – Path 5 – Screenshot 2 - Path 2

1.25 C. Individuals Covered– Path 6 – Screenshot 1

Figure 25 : Section C– Path 6 – Screenshot 1

1.26 D. Income Standard Used and E. Basis for Income Standard – Path 6 – Screenshot 2 – Path 1

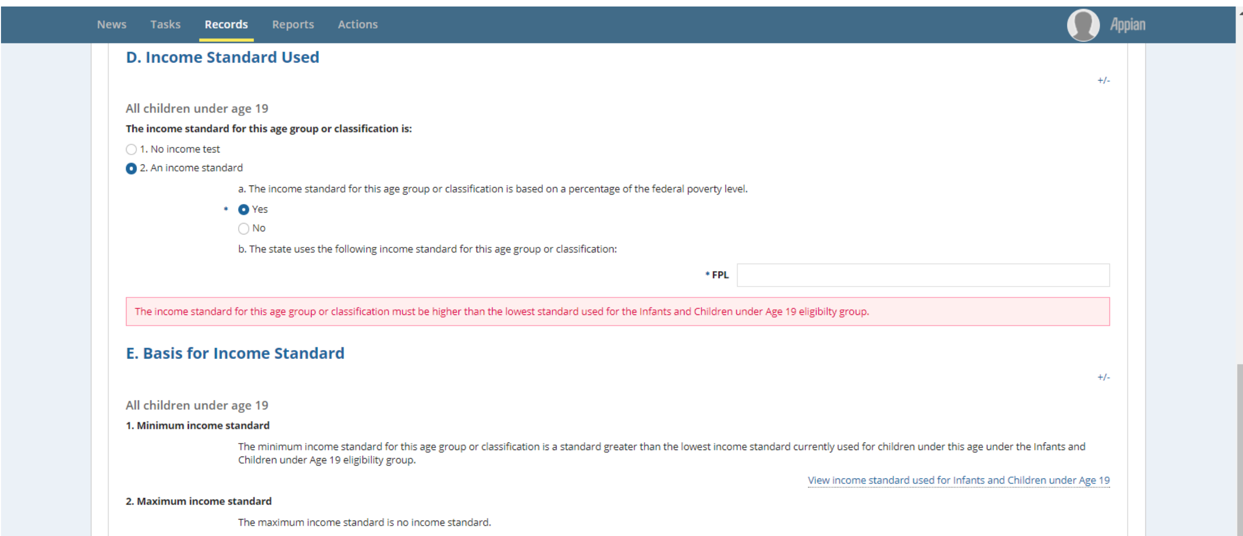

Figure 26: Section D, Section E – Path 6 – Screenshot 2 - Path 1

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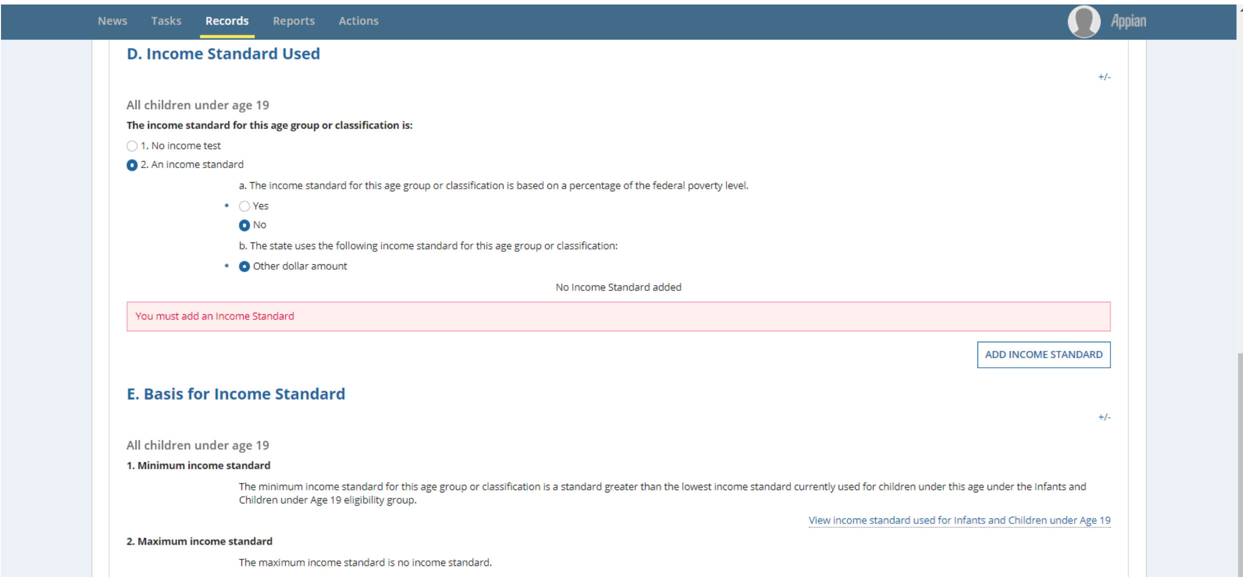

Figure 27: Section D, Section E – Path 6 – Screenshot 2 - Path 2

1.28 C. Individuals Covered– Path 7 – Screenshot 1

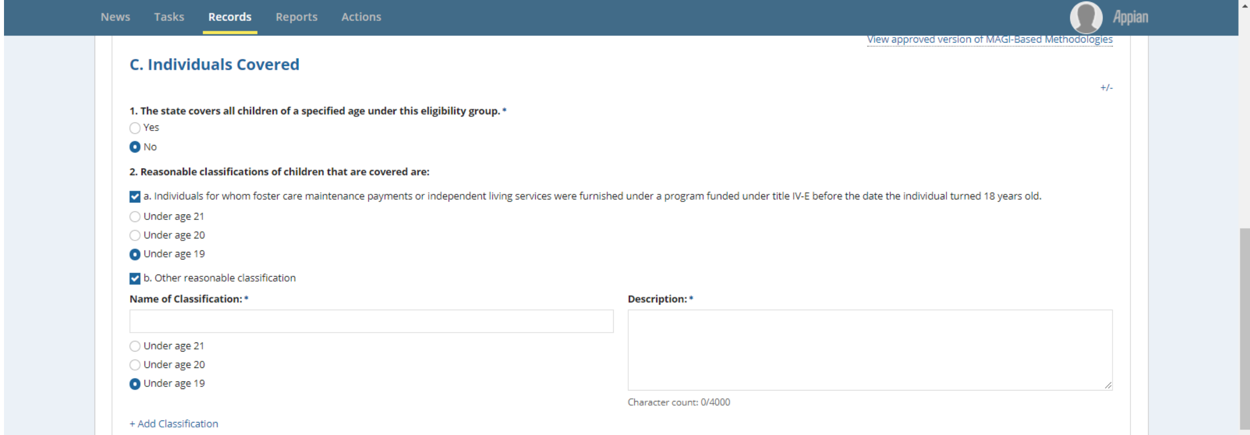

Figure 28: Section C– Path 7 – Screenshot 1

1.29 D. Income Standard Used– Path 7 – Screenshot 2 – Path 1

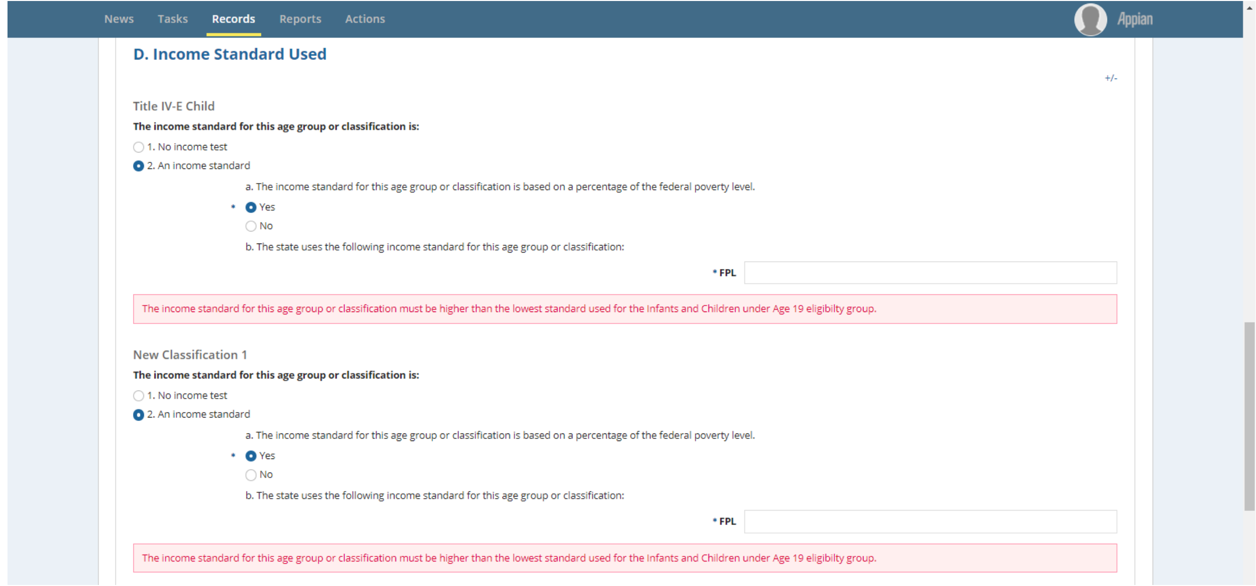

Figure 29: Section D, Section E – Path 7 – Screenshot 2 - Path 1

1.30 D. Income Standard Used – Path 7 – Screenshot 2 – Path 2

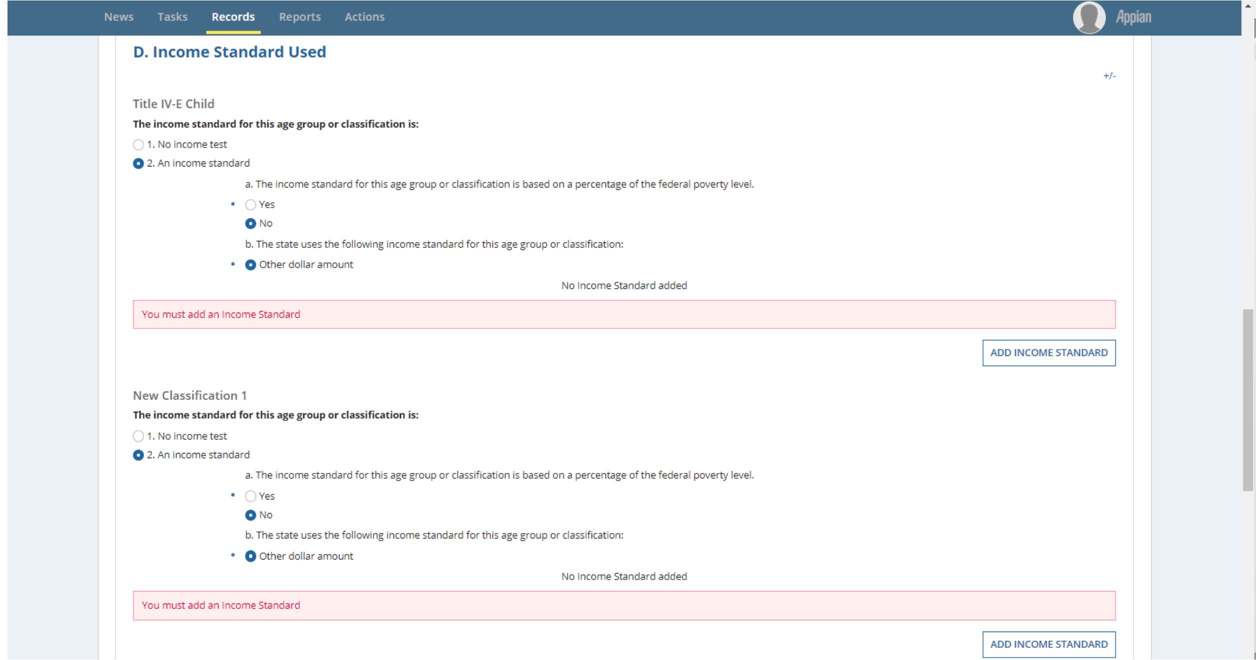

Figure 30: Section D, Section E – Path 7 – Screenshot 2 - Path 2

1.31 E. Basis for Income Standard – Path 7 – Screenshot 3

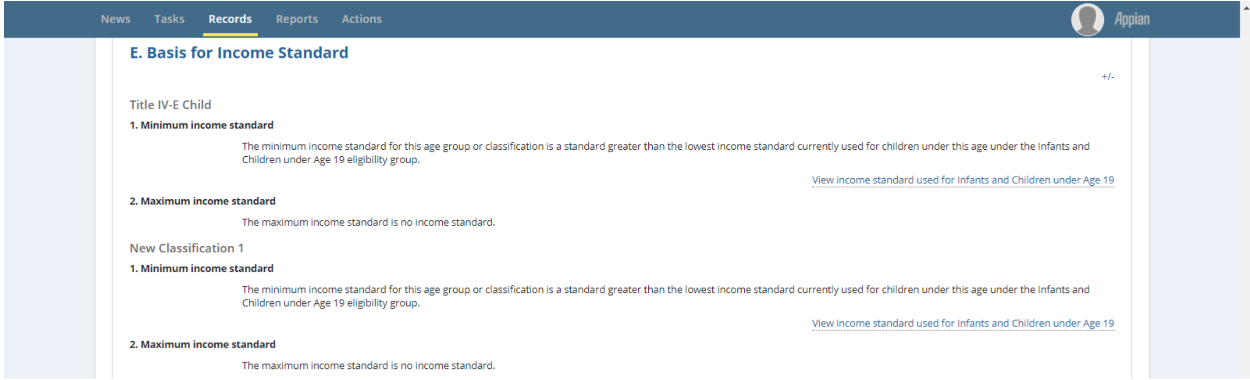

Figure 31: Section E

1.32 F. Additional Information (optional)

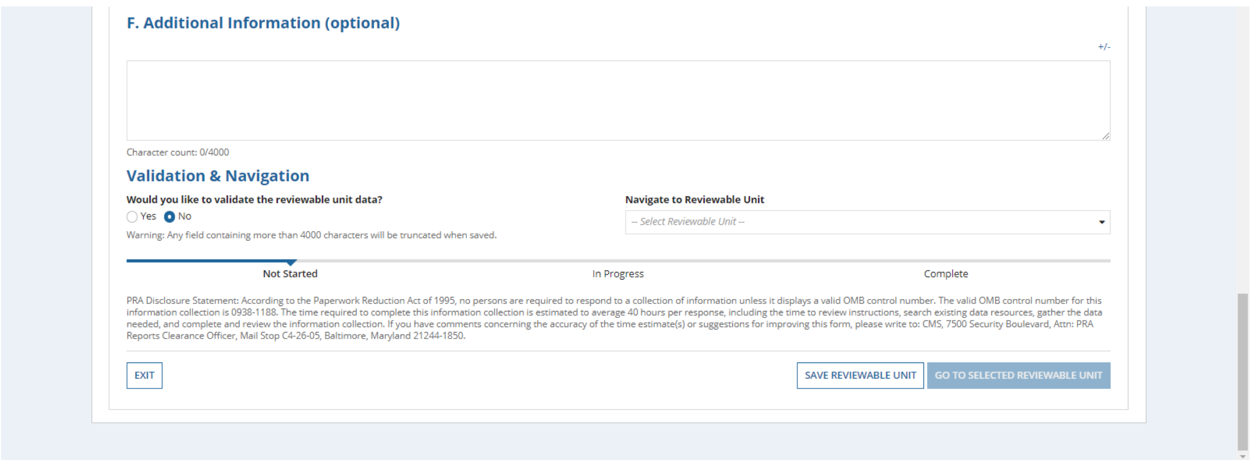

Figure 32: Section F

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S59 – Individuals Eligible for Family Planning Services RU PRA Document

Version 1.0

08/20/2017

Document Number: 228-QSSI-MACPro-R5.1-S59-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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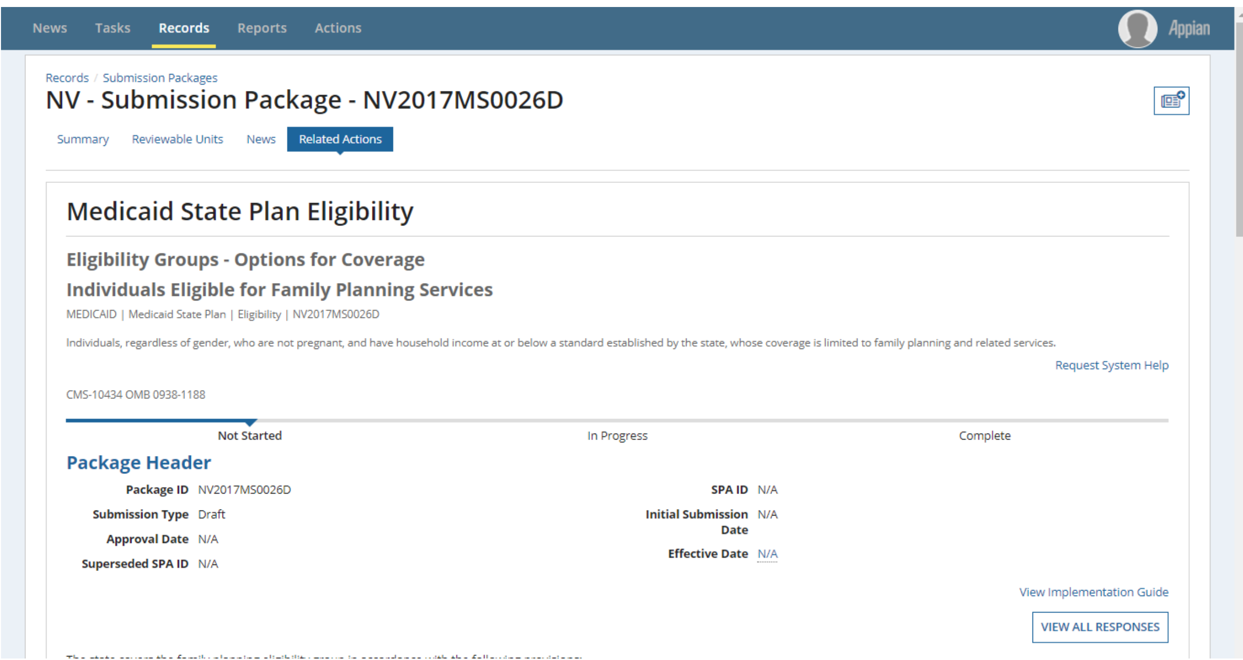


Figure 1: Package Header

1.2 A. Characteristics, B. Individuals Covered – Path 1

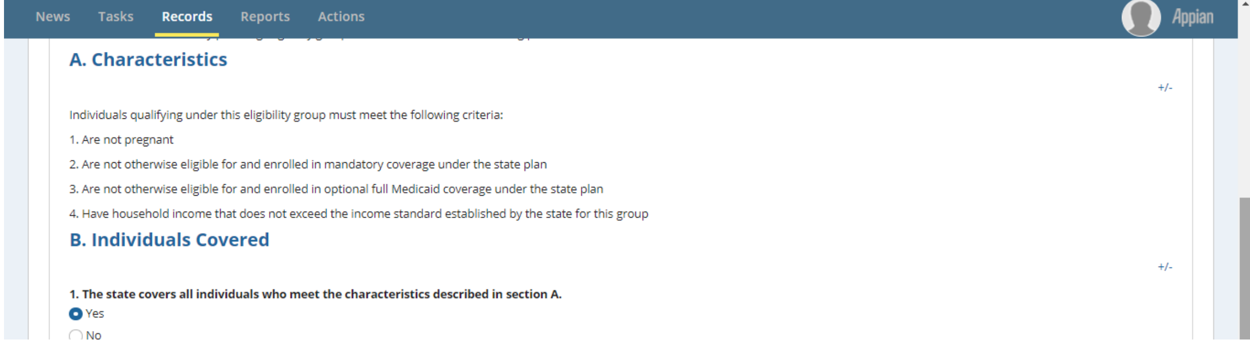


Figure 2: Section A, Section B – Path 1

1.3 B. Individuals Covered – Path 2

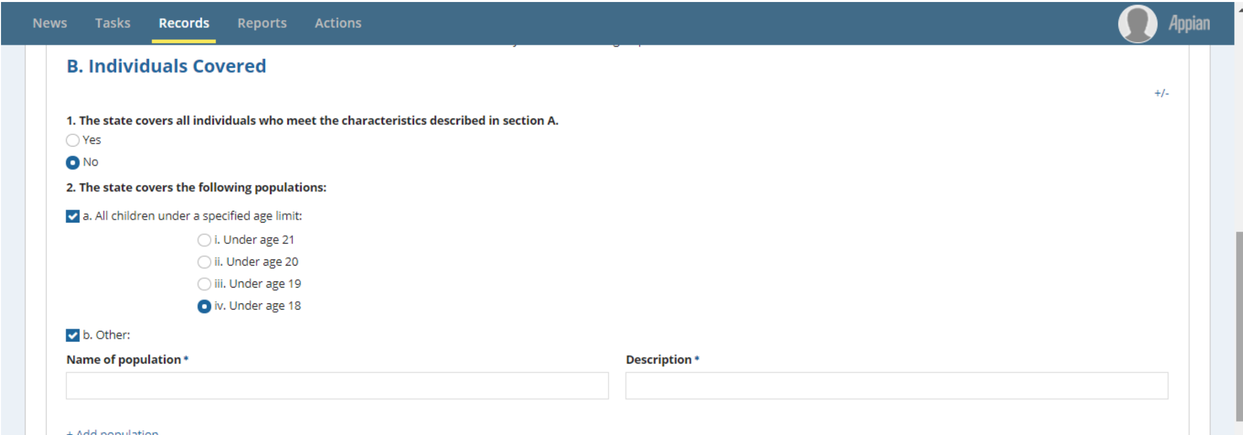


Figure 3: Section B – Path 2

1.4 C. Income Standard Used – Path 1

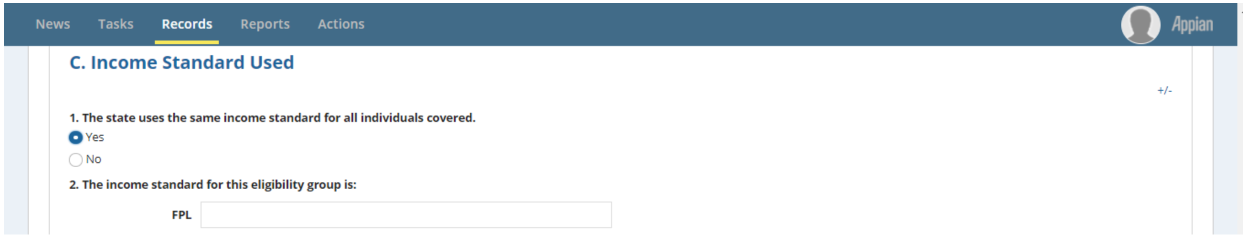


Figure 4: Section C - Path 1

1.5 C. Income Standard Used – Path 2

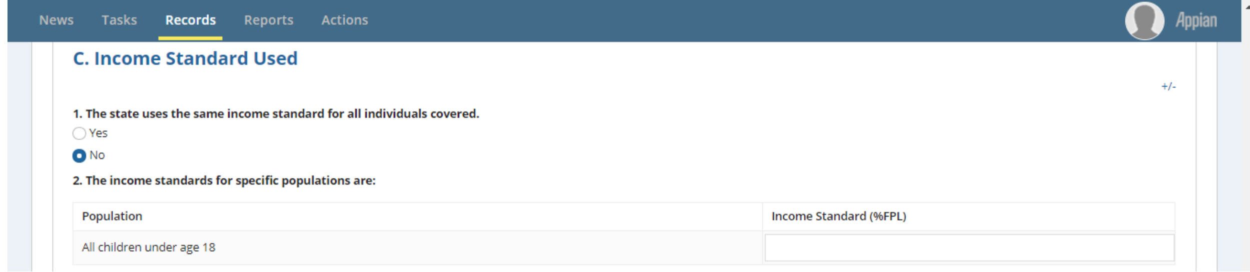
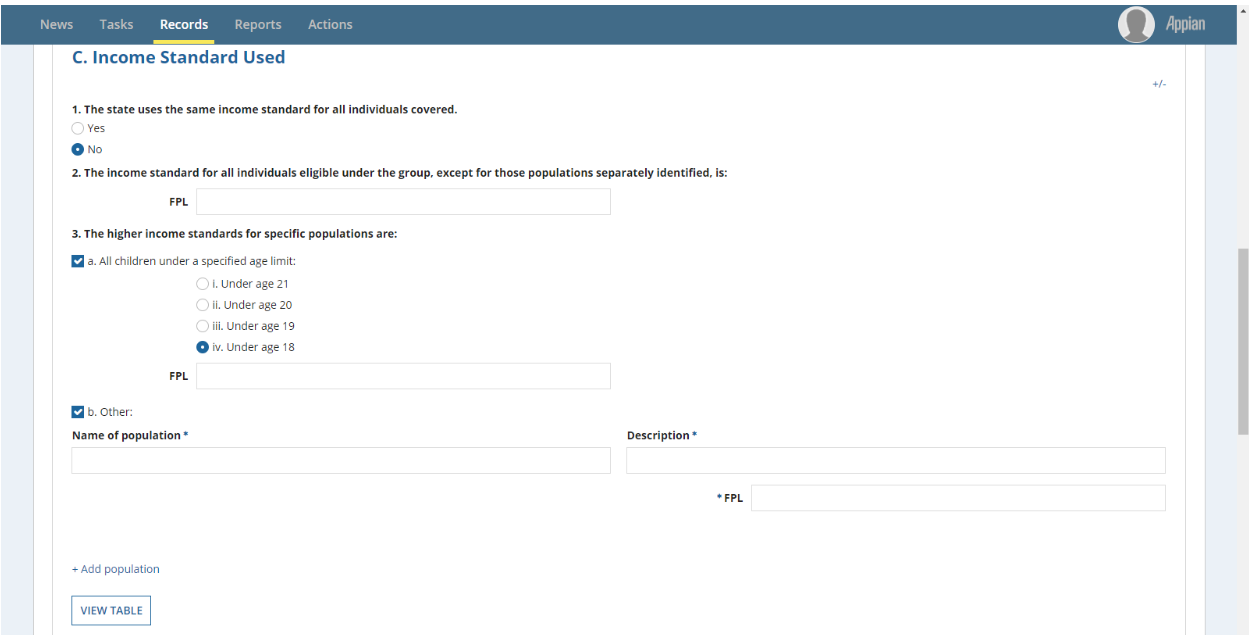


Figure 5: Section C - Path 2

1.6 C. Income Standard Used – Path 3



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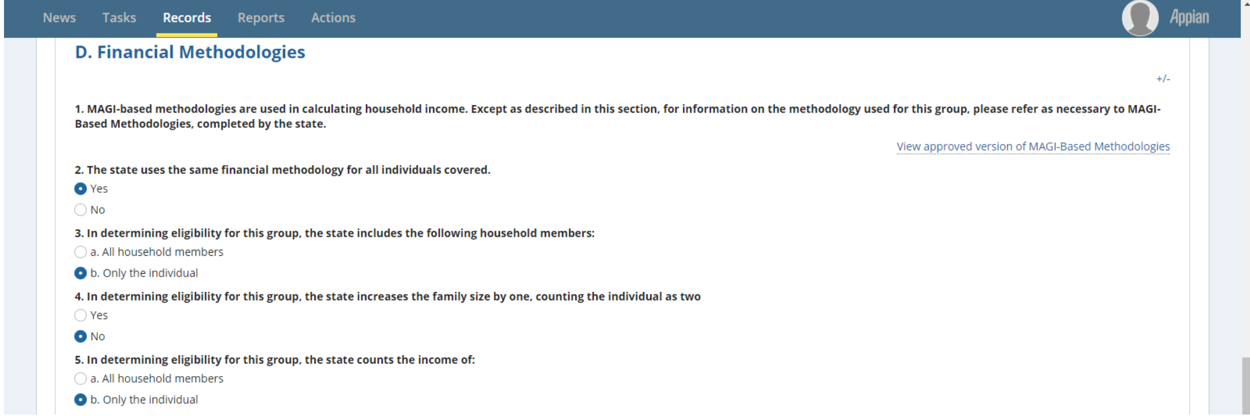
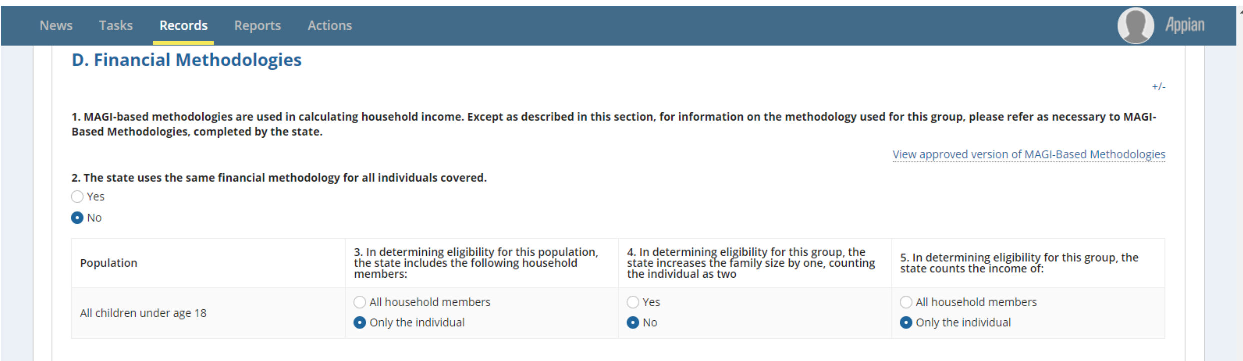


Figure 7: Section D – Path 1

1.8 D. Financial Methodologies – Path 2


News Tasks Records Reports Actions Appian

D. Financial Methodologies

+/-

1. MAGI-based methodologies are used in calculating household income. Except as described in this section, for information on the methodology used for this group, please refer as necessary to MAGI-Based Methodologies, completed by the state.

View approved version of MAGI-Based Methodologies

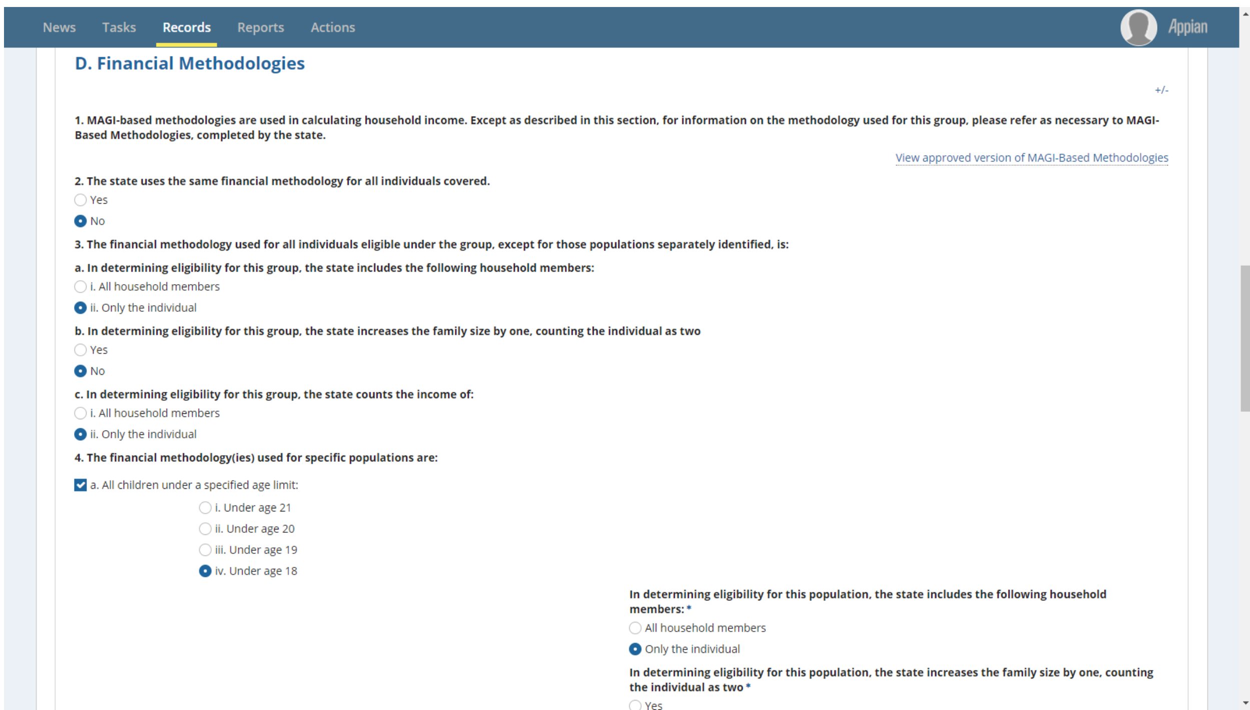
2. The state uses the same financial methodology for all individuals covered.

- Yes
- No (selected)

Population	3. In determining eligibility for this population, the state includes the following household members:	4. In determining eligibility for this group, the state increases the family size by one, counting the individual as two	5. In determining eligibility for this group, the state counts the income of:
All children under age 18	All household members Only the individual (selected)	Yes No (selected)	All household members Only the individual (selected)

Figure 8: Section D - Path 2

1.9 D. Financial Methodologies – Path 3 – Screenshot 1


News Tasks Records Reports Actions Appian

D. Financial Methodologies

+/-

1. MAGI-based methodologies are used in calculating household income. Except as described in this section, for information on the methodology used for this group, please refer as necessary to MAGI-Based Methodologies, completed by the state.

View approved version of MAGI-Based Methodologies

2. The state uses the same financial methodology for all individuals covered.

- Yes
- No (selected)

3. The financial methodology used for all individuals eligible under the group, except for those populations separately identified, is:

a. In determining eligibility for this group, the state includes the following household members:

- i. All household members
- ii. Only the individual (selected)

b. In determining eligibility for this group, the state increases the family size by one, counting the individual as two

- Yes
- No (selected)

c. In determining eligibility for this group, the state counts the income of:

- i. All household members
- ii. Only the individual (selected)

4. The financial methodology(ies) used for specific populations are:

- a. All children under a specified age limit: (checked)
  - i. Under age 21
  - ii. Under age 20
  - iii. Under age 19
  - iv. Under age 18 (selected)

In determining eligibility for this population, the state includes the following household members: *

- All household members
- Only the individual (selected)

In determining eligibility for this population, the state increases the family size by one, counting the individual as two *

- Yes

Figure 9 : Section D - Path 3 - Screenshot 1

1.10 D. Financial Methodologies – Path 3 – Screenshot 2

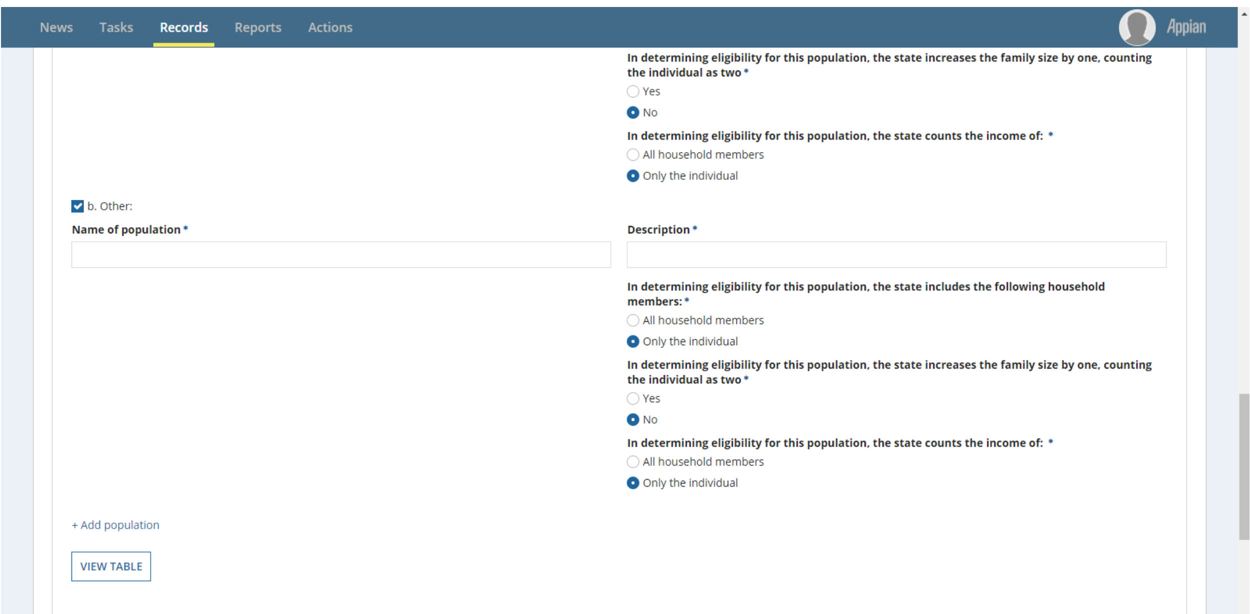


Figure 10 : Section D - Path 3 - Screenshot 2

1.11 E. Basis for Income Standard - Maximum Income Standard, F. Family Planning Benefits and G. Additional Information (optional)

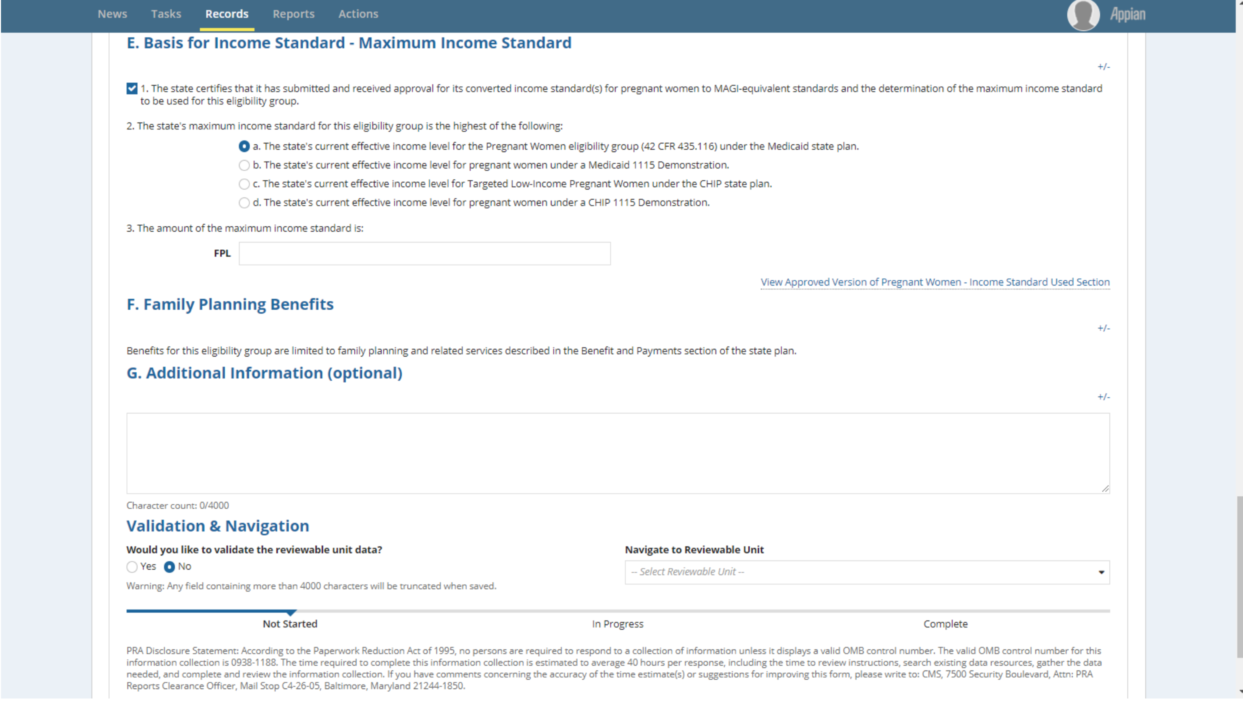


Figure 11 : Section E, Section F and Section G

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S59a - Individuals Eligible for Family Planning Services - Presumptive Eligibility RU PRA Document

Version 1.0

08/20/2017

Document Number: 229-QSSI-MACPro-R5.1-S59a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1.4 B. Application for Presumptive Eligibility – Screenshot 2 2
1.5 C. Presumptive Eligibility Determination and D. Qualified Entities 3
1.6 E. Additional Information (optional) 3

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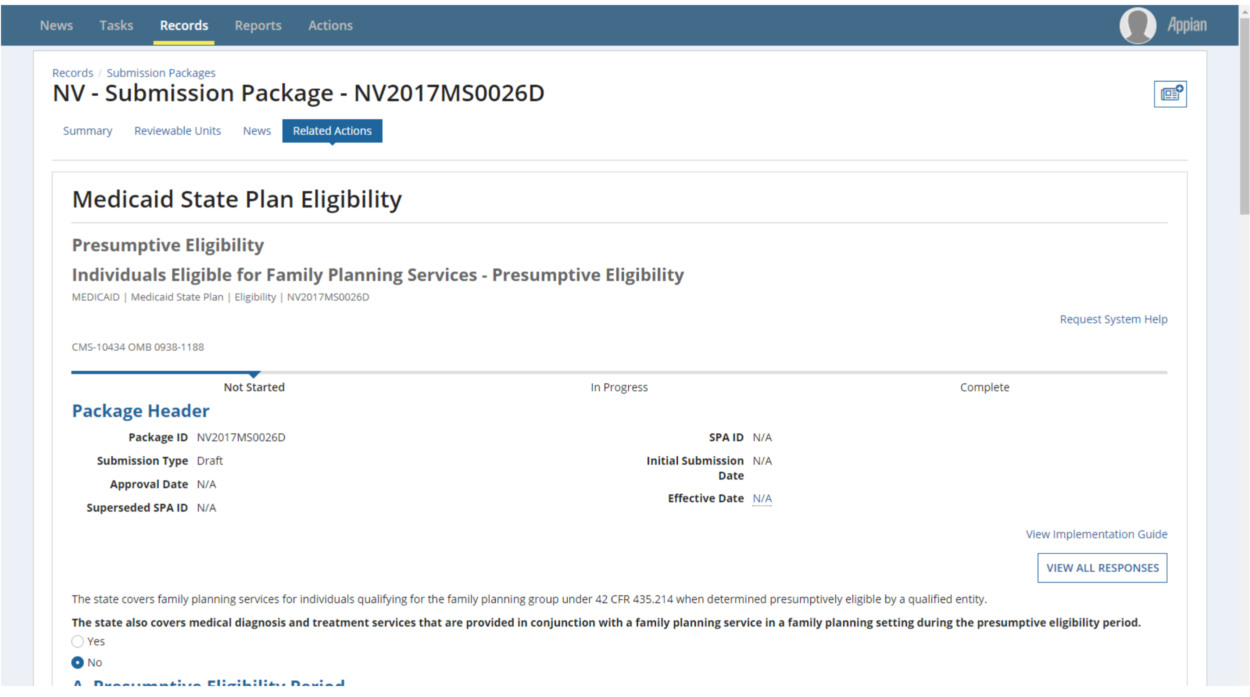
1.1 Package Header


News Tasks Records Reports Actions

Records / Submission Packages

NV - Submission Package - NV2017MS0026D

Summary | Reviewable Units | News | Related Actions

Medicaid State Plan Eligibility

Presumptive Eligibility

Individuals Eligible for Family Planning Services - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D

Request System Help

CMS-10434 OMB 0938-1188

Not Started — In Progress — Complete

Package Header

Package ID	NV2017MS0026D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

View Implementation Guide

VIEW ALL RESPONSES

The state covers family planning services for individuals qualifying for the family planning group under 42 CFR 435.214 when determined presumptively eligible by a qualified entity.

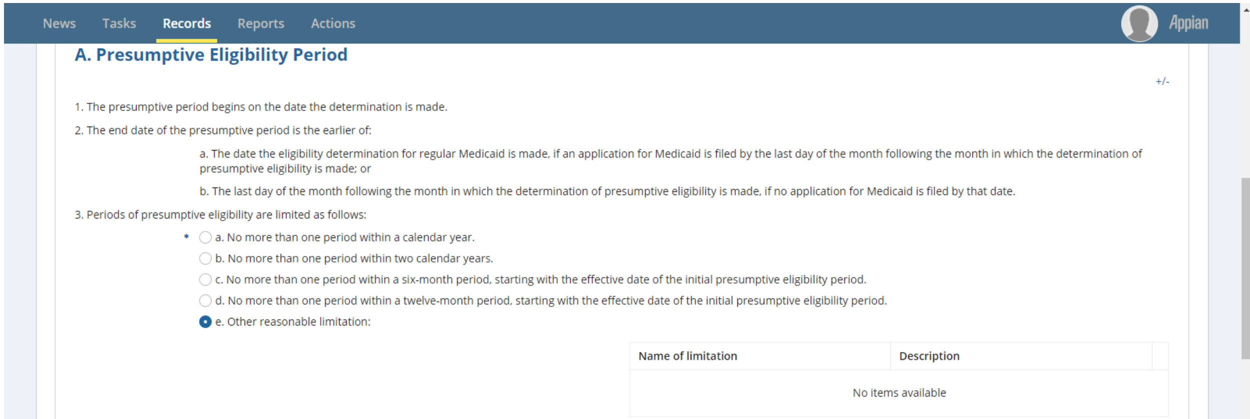
The state also covers medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting during the presumptive eligibility period.

○ Yes

● No

Figure 1: Package Header

1.2 A. Presumptive Eligibility Period


News Tasks Records Reports Actions

A. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.

2. The end date of the presumptive period is the earlier of:

a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

○ a. No more than one period within a calendar year.

○ b. No more than one period within two calendar years.

○ c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

○ d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

● e. Other reasonable limitation:

Name of limitation	Description
No items available	

Figure 2: Section A

1.3 B. Application for Presumptive Eligibility – Screenshot 1.

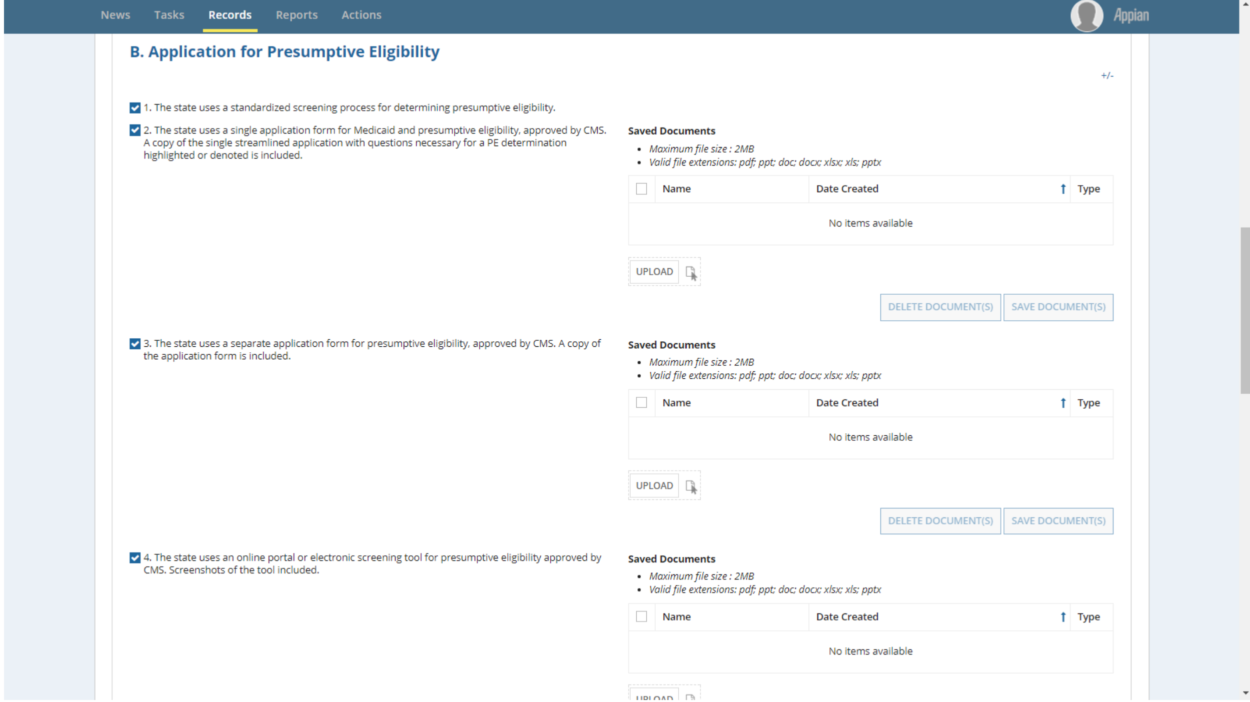


Figure 3: Section B – Screenshot 1

1.4 B. Application for Presumptive Eligibility – Screenshot 2

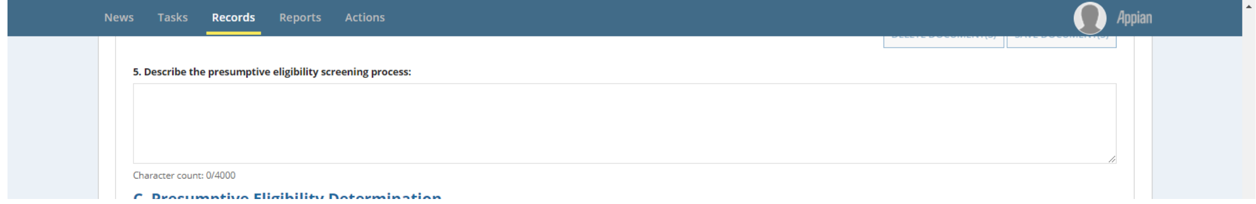


Figure 4: Section B – Screenshot 2

1.5 C. Presumptive Eligibility Determination and D. Qualified Entities

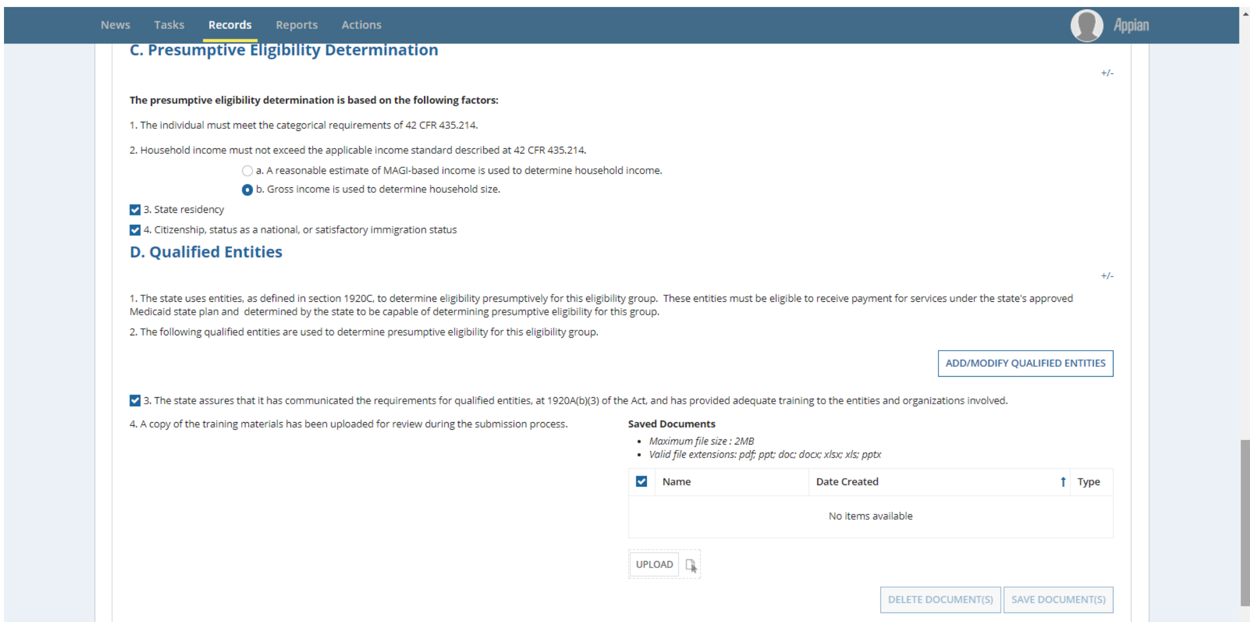


Figure 5 : Section C and Section D

1.6 E. Additional Information (optional)

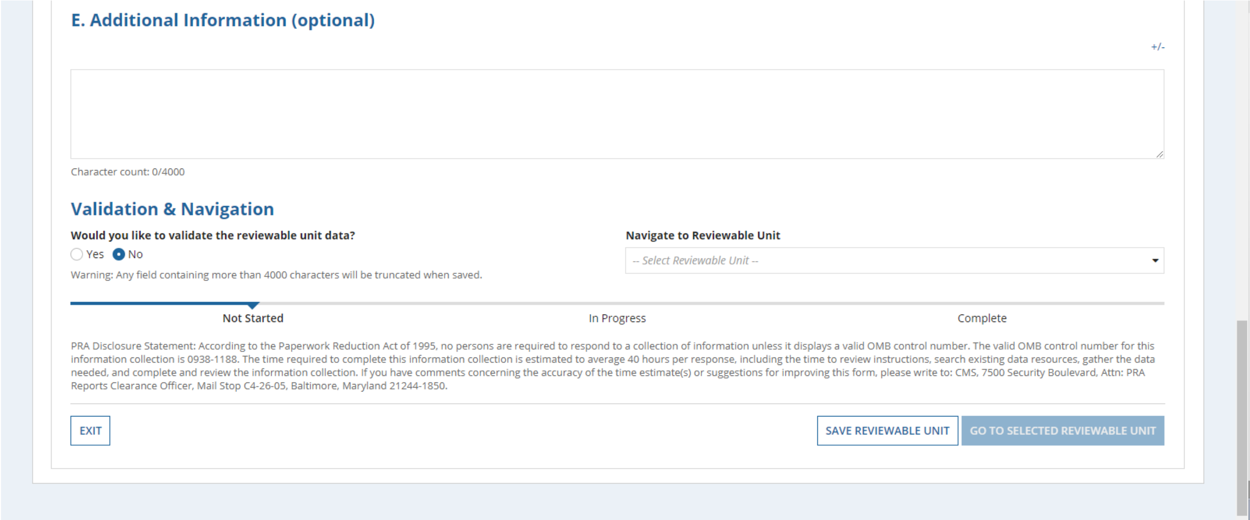


Figure 6 : Section E

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S88-State Residency PRA document

Version 1.0

08/21/2017

Document Number: 233-QSSI-MACPro-PRA-S88-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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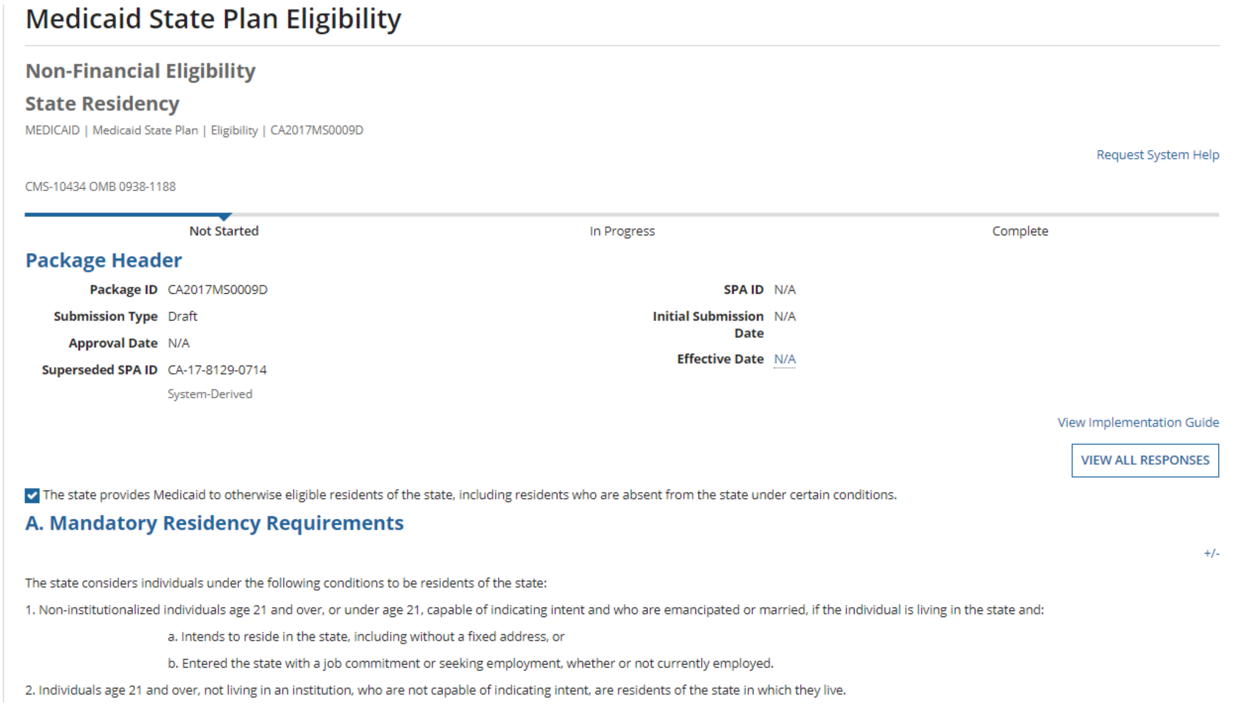
1. S88-State Residency - Screenshots

1.1 State Residency


Medicaid State Plan Eligibility

Non-Financial Eligibility
State Residency
MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D

Request System Help

CMS-10434 OMB 0938-1188

Not Started
In Progress
Complete

Package Header

Package ID	CA2017MS0009D	SPA ID	N/A
Submission Type	Draft	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	CA-17-8129-0714 System-Derived		

View Implementation Guide

VIEW ALL RESPONSES

The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A. Mandatory Residency Requirements

+/-

The state considers individuals under the following conditions to be residents of the state:

1. Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:

a. Intends to reside in the state, including without a fixed address, or

b. Entered the state with a job commitment or seeking employment, whether or not currently employed.

2. Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.

Figure 1: State Residency – 1

2. Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.

3. Non-institutionalized individuals under 21 who are not emancipated or married and who are not receiving payments under Title IV-E of the Social Security Act:

   a. Residing in the state, with or without a fixed address, or

   b. The state of residency of the parent or caretaker, in accordance with 42 CFR. 435.403(h)(1), with whom the individual resides.

4. Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 living in institutions who are not emancipated or married:

   a. Regardless of in which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or

   b. Regardless of in which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or

   c. If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.

5. Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.

6. Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.

7. Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.

8. Individuals receiving IV-E payments living in the state, or

9. Individuals who otherwise meet the requirements of 42 CFR 435.403.

B. Interstate Agreements

+/-

Individuals are considered to be residents of the state if they meet the criteria specified in an interstate agreement.

(●) Yes
( ) No

1. The state participates in the Interstate Compact on Adoption and Medical Assistance (ICAMA)

( ) Yes
( ) No

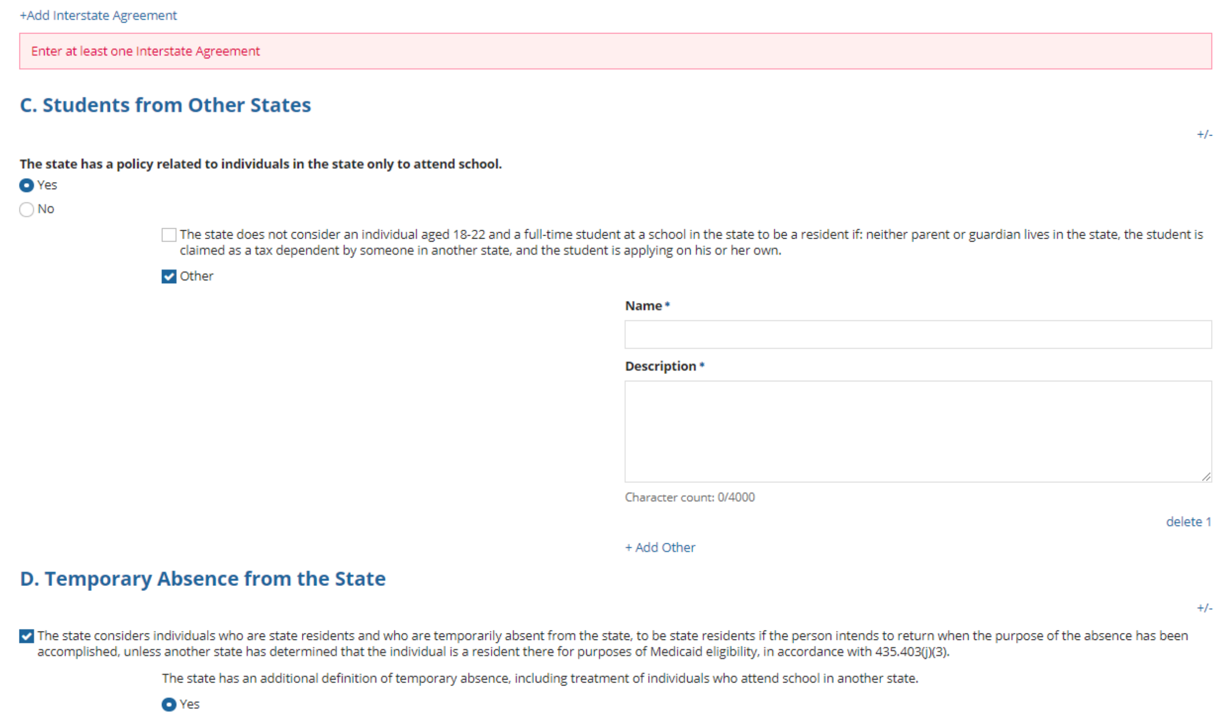
2. The state has other interstate agreements.

(●) Yes
( ) No

The state has interstate agreements with the following other states:

+Add Interstate Agreement

Figure 2: State Residency – 2



+Add Interstate Agreement

Enter at least one Interstate Agreement

C. Students from Other States

+/-

The state has a policy related to individuals in the state only to attend school.

(●) Yes
( ) No

[ ] The state does not consider an individual aged 18-22 and a full-time student at a school in the state to be a resident if: neither parent or guardian lives in the state, the student is claimed as a tax dependent by someone in another state, and the student is applying on his or her own.

[x] Other

Name *

Description *

Character count: 0/4000

delete 1

+ Add Other

D. Temporary Absence from the State

+/-

[x] The state considers individuals who are state residents and who are temporarily absent from the state, to be state residents if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the individual is a resident there for purposes of Medicaid eligibility, in accordance with 435.403(j)(3).

The state has an additional definition of temporary absence, including treatment of individuals who attend school in another state.

(●) Yes

Figure 3: State Residency – 3

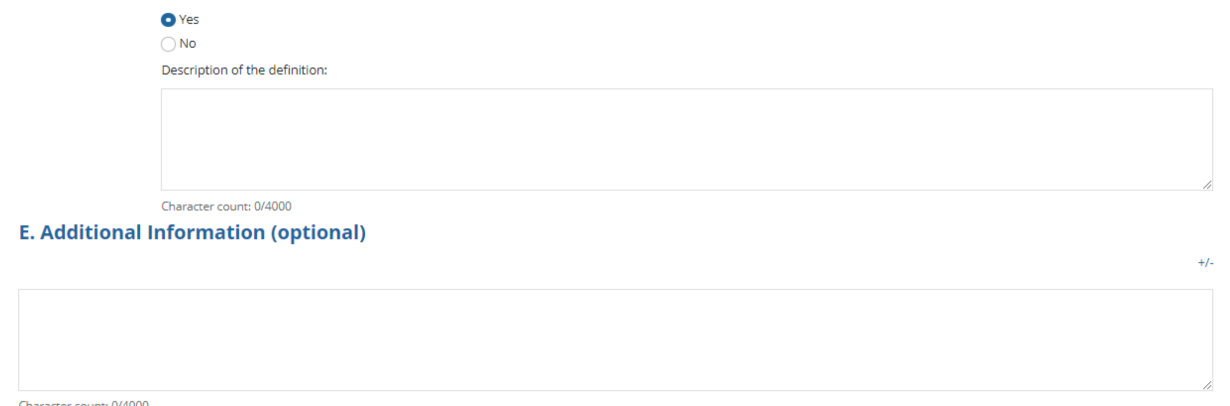


Figure 4: State Residency – 4

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S89-Citizenship and Non-Citizenship PRA document

Version 1.0
08/22/2017

Document Number: 244-QSSI-MACPro-PRA-S89-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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Figure 5: Citizenship and Non-Citizenship – 5 3

1. S89-Citizenship and Non-Citizenship – Screenshots

1.1 Citizenship and Non-Citizenship

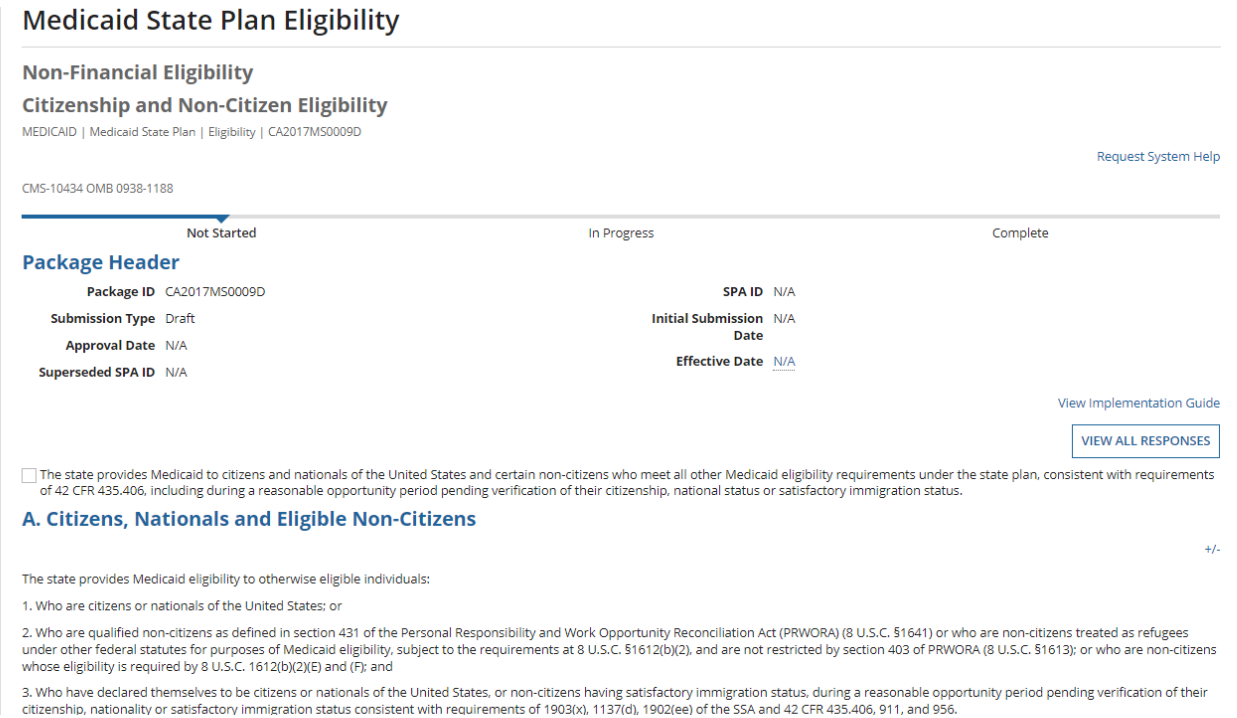


Figure 1: Citizenship and Non-Citizenship – 1

3. Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

* ◯ Yes
  ◯ No

* ☐ b. When a reasonable opportunity period is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

◯ i. The date of the application containing the declaration of citizenship or immigration status.

◯ ii. The first day of the month of application.

B. Optional Coverage of Qualified Non-Citizens

+/-

The state provides Medicaid coverage to all otherwise-eligible Qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C. §1613). *

◯ Yes
◉ No

Indicate which requirements apply:

1. The state requires Lawful Permanent Residents to have 40 qualifying work quarters under Title II of the Social Security Act. *

◯ Yes
◯ No

2. The state limits eligibility to 7 years for the following non-citizens:

a. Non-citizens admitted to the U.S. as a refugee under section 207 of the Immigration and Nationality Act (INA)

b. Non-citizens granted asylum under section 208 of the INA

c. Non-citizens whose deportation is withheld under section 243(h) or 241(b)(3) of the INA

d. Non-citizens granted status as a Cuban-Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980

e. Non-citizens admitted to the U.S. as Amerasian immigrants

f. Non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility

Figure 2: Citizenship and Non-Citizenship – 2

f. Non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility

◯ Yes
◯ No

C. Coverage of Lawfully Residing Individuals

+/-

The state elects the option to provide Medicaid coverage to otherwise eligible individuals, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

◉ Yes
◯ No

☐ 1. Pregnant women

☐ 2. Individuals under a specified age:

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she is:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii.Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

Figure 3: Citizenship and Non-Citizenship – 3

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

f. Has been granted withholding of removal under the Convention Against Torture;

g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.

☑ k. Other

Description:

Character count: 0/4000

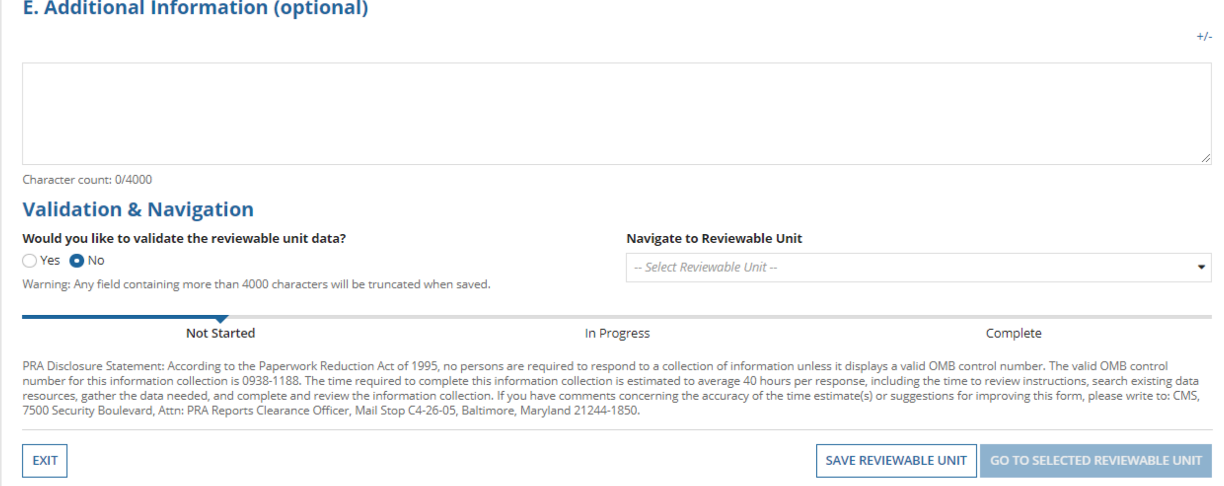
D. Emergency Coverage

+/-

☐ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the Social Security Act and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613(a)
2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

Figure 4: Citizenship and Non-Citizenship – 4



E. Additional Information (optional)

+/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

○ Yes ● No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

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EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

Figure 5: Citizenship and Non-Citizenship – 5

Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S94-Eligibility Process PRA document

Version 1.0

08/21/2017

Document Number: 234-QSSI-MACPro-PRA-S94-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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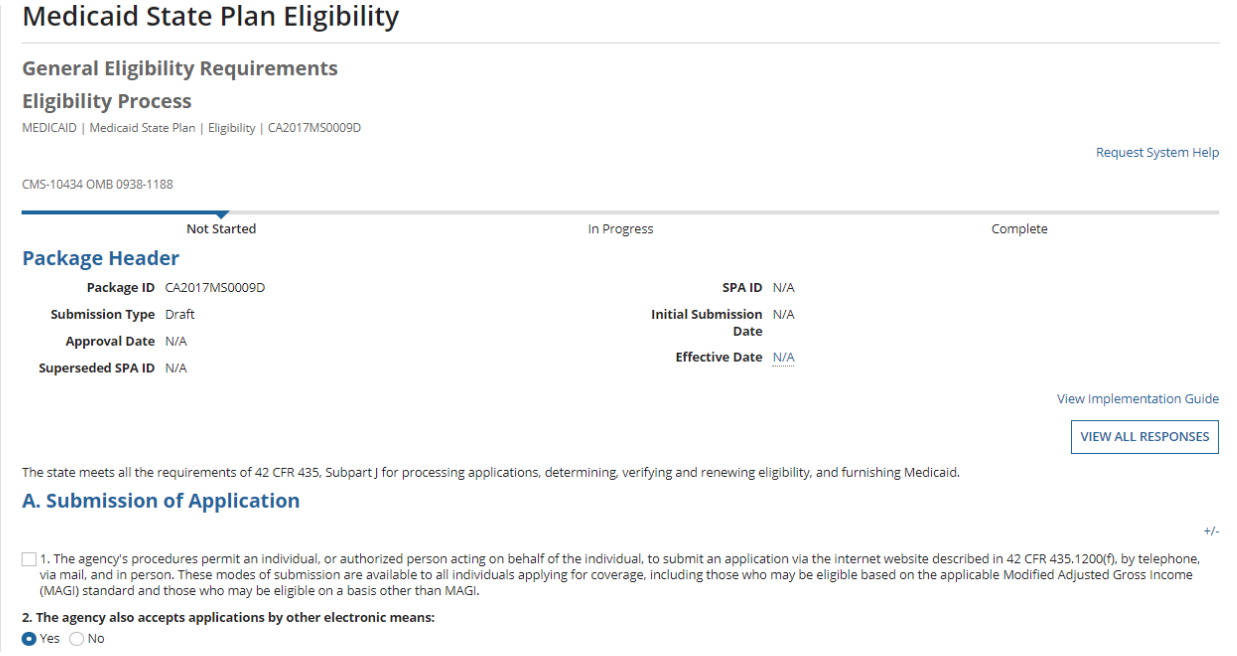
1. S94-Eligibility Process – Screenshots

1.1 Eligibility Process


Medicaid State Plan Eligibility

General Eligibility Requirements

Eligibility Process

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D

Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID CA2017MS0009D

Submission Type Draft

Approval Date N/A

Superseded SPA ID N/A

SPA ID N/A

Initial Submission Date N/A

Effective Date N/A

View Implementation Guide

VIEW ALL RESPONSES

The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining, verifying and renewing eligibility, and furnishing Medicaid.

A. Submission of Application

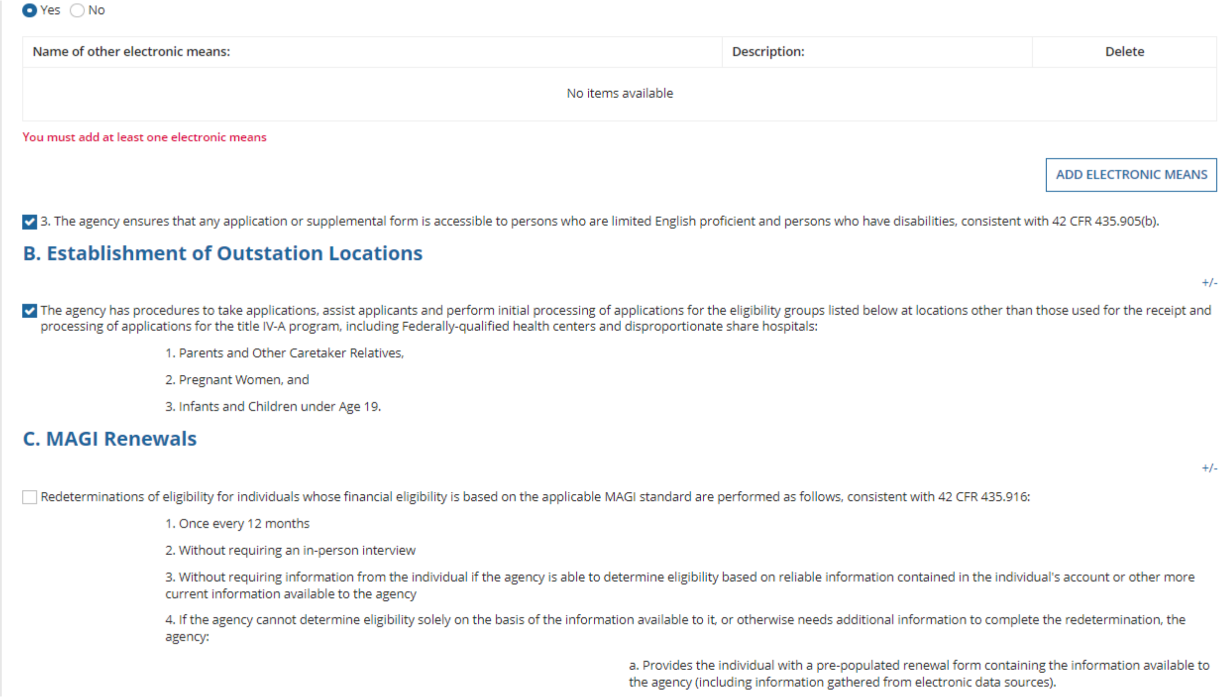
+/-

1. The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person. These modes of submission are available to all individuals applying for coverage, including those who may be eligible based on the applicable Modified Adjusted Gross Income (MAGI) standard and those who may be eligible on a basis other than MAGI.

2. The agency also accepts applications by other electronic means:

Yes No

Figure 1: Eligibility Process – 1



Yes No

Name of other electronic means:	Description:	Delete
No items available		

You must add at least one electronic means

ADD ELECTRONIC MEANS

3. The agency ensures that any application or supplemental form is accessible to persons who are limited English proficient and persons who have disabilities, consistent with 42 CFR 435.905(b).

B. Establishment of Outstation Locations

+/-

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals:

1. Parents and Other Caretaker Relatives,
2. Pregnant Women, and
3. Infants and Children under Age 19.

C. MAGI Renewals

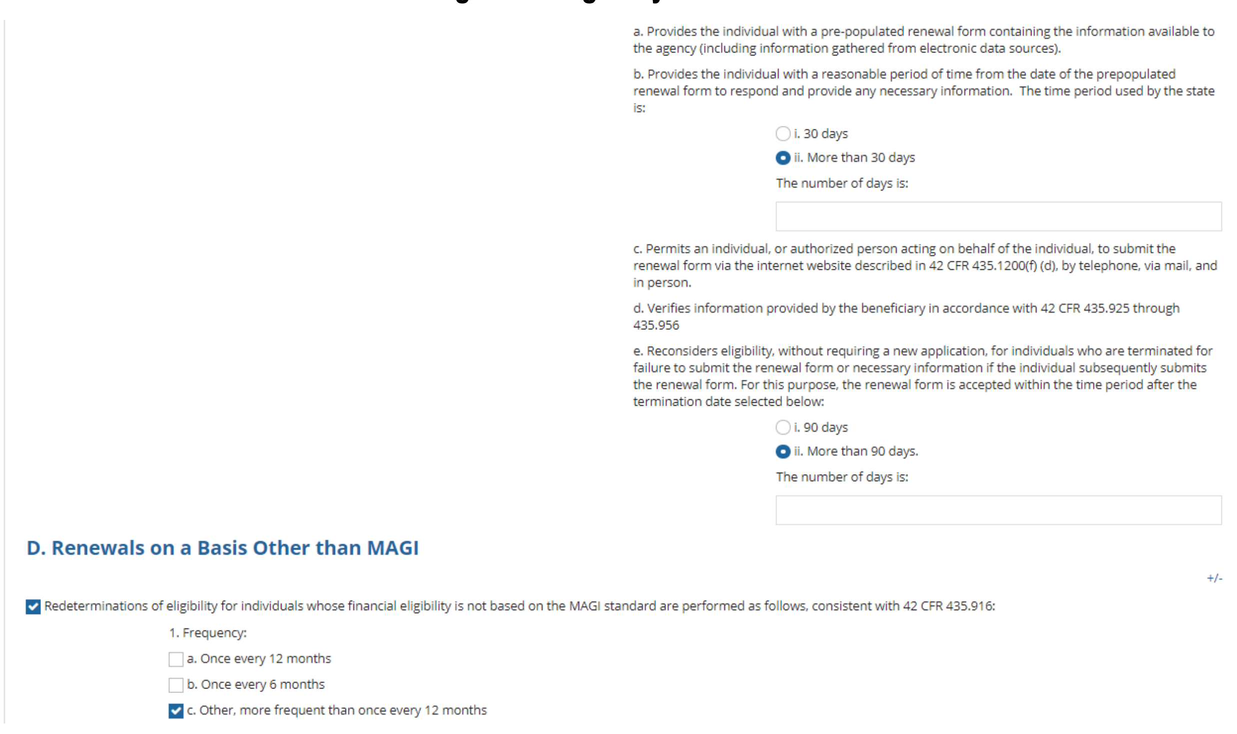
+/-

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable MAGI standard are performed as follows, consistent with 42 CFR 435.916:

1. Once every 12 months
2. Without requiring an in-person interview
3. Without requiring information from the individual if the agency is able to determine eligibility based on reliable information contained in the individual's account or other more current information available to the agency
4. If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, the agency:

a. Provides the individual with a pre-populated renewal form containing the information available to the agency (including information gathered from electronic data sources).

Figure 2: Eligibility Process – 2



a. Provides the individual with a pre-populated renewal form containing the information available to the agency (including information gathered from electronic data sources).

b. Provides the individual with a reasonable period of time from the date of the prepopulated renewal form to respond and provide any necessary information. The time period used by the state is:

i. 30 days
ii. More than 30 days

The number of days is:

c. Permits an individual, or authorized person acting on behalf of the individual, to submit the renewal form via the internet website described in 42 CFR 435.1200(f) (d), by telephone, via mail, and in person.

d. Verifies information provided by the beneficiary in accordance with 42 CFR 435.925 through 435.956

e. Reconsiders eligibility, without requiring a new application, for individuals who are terminated for failure to submit the renewal form or necessary information if the individual subsequently submits the renewal form. For this purpose, the renewal form is accepted within the time period after the termination date selected below:

i. 90 days
ii. More than 90 days.

The number of days is:

D. Renewals on a Basis Other than MAGI

+/-

Redeterminations of eligibility for individuals whose financial eligibility is not based on the MAGI standard are performed as follows, consistent with 42 CFR 435.916:

1. Frequency:

a. Once every 12 months
b. Once every 6 months
c. Other, more frequent than once every 12 months

Figure 3: Eligibility Process – 3

☑ c. Other, more frequent than once every 12 months

Frequency (once every x months):

2. Without requiring information from the individual, if the agency is able to determine eligibility based on reliable information contained in the individual's account or other more current information available to the agency.

3. If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, the agency:

☑ a. Provides the individual with a renewal form

i. The renewal form is pre-populated with information available to the agency (including information gathered from electronic data sources).

○ Yes ○ No

ii. As part of this process, the agency:

(1) Provides the individual with a reasonable period of time from the date of the prepopulated renewal form to respond and provide any necessary information. The time period used by the state is:

○ (a) 30 days

◉ (b) More than 30 days

The number of days is:

(2) Permits an individual, or authorized person acting on behalf of the individual, to submit the renewal form using the following methods:

☐ (a) Via the internet website described in 42 CFR 435.1200(f)

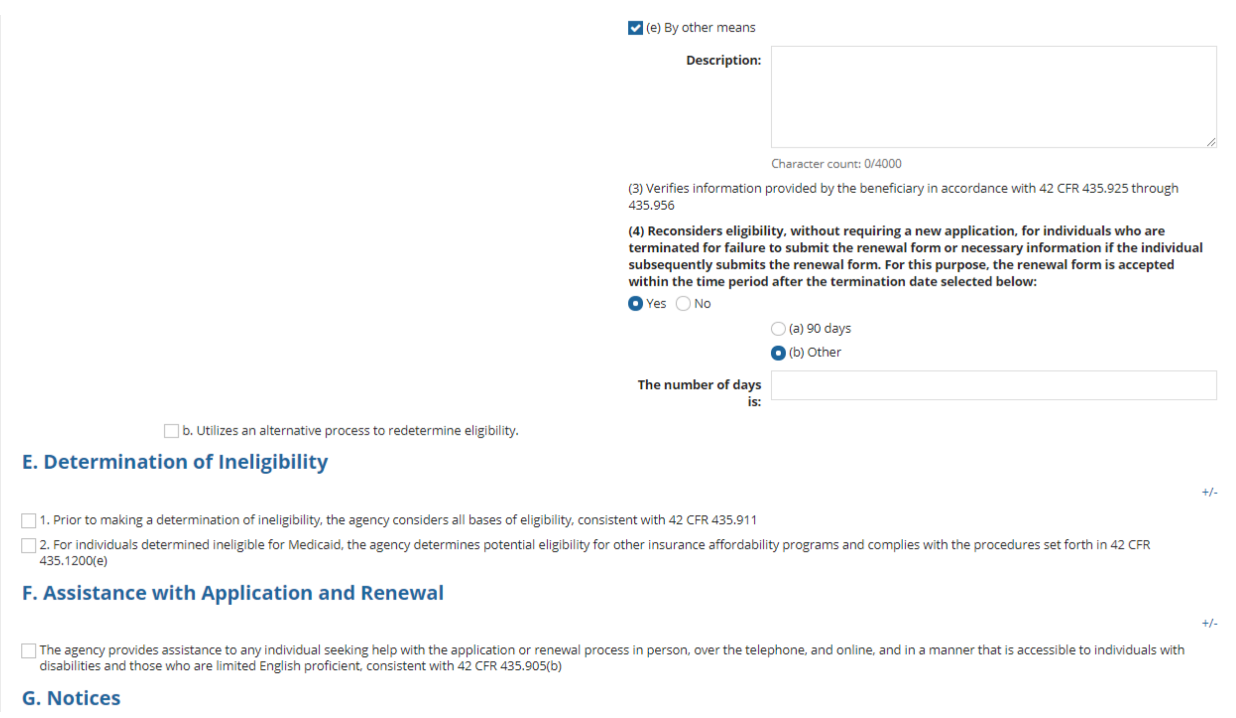
☐ (b) By telephone

☐ (c) Via mail

☐ (d) In person

☑ (e) By other means

Figure 4: Eligibility Process – 4



☑ (e) By other means

Description:

Character count: 0/4000

(3) Verifies information provided by the beneficiary in accordance with 42 CFR 435.925 through 435.956

(4) Reconsiders eligibility, without requiring a new application, for individuals who are terminated for failure to submit the renewal form or necessary information if the individual subsequently submits the renewal form. For this purpose, the renewal form is accepted within the time period after the termination date selected below:

◉ Yes ○ No

○ (a) 90 days

◉ (b) Other

The number of days is:

☐ b. Utilizes an alternative process to redetermine eligibility.

E. Determination of Ineligibility

+/-

☐ 1. Prior to making a determination of ineligibility, the agency considers all bases of eligibility, consistent with 42 CFR 435.911

☐ 2. For individuals determined ineligible for Medicaid, the agency determines potential eligibility for other insurance affordability programs and complies with the procedures set forth in 42 CFR 435.1200(e)

F. Assistance with Application and Renewal

+/-

☐ The agency provides assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with 42 CFR 435.905(b)

G. Notices

Figure 5: Eligibility Process – 5

G. Notices

+/-

☐ 1. The agency provides individuals with a choice to receive notices and information in an electronic format or by regular mail, in accordance with 42 CFR 435.918.

☐ 2. The agency provides applicants with timely and accurate notice of any approval or disapproval of Medicaid eligibility, which includes, but is not limited to: the basis and effective date of eligibility, the circumstances and procedures for reporting a change that may impact eligibility, the level of benefits and services approved, any applicable premiums or cost sharing, appeal rights, and if applicable, the amount of medical expenses which must be incurred to establish eligibility.

☐ 3. The agency makes notices, as well as cards evidencing eligibility for medical assistance, available to an individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Notices and cards are made available through the following method(s)

Character count: 0/4000

☐ 4. The agency provides beneficiaries with timely and adequate notice of proposed adverse action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid, and sends corresponding notice(s) to the individual at least 10 days prior to the action's effective date, as described in 42 CFR 431.211.

☐ 5. All notices provided by the agency are written in plain language. To ensure that notices are clear and undertstandable to consumer, the agency:

☐ a. Utilizes an in-house readability and plain language review process

☐ b. Contracts with an outside entity to complete a readability and plain language review

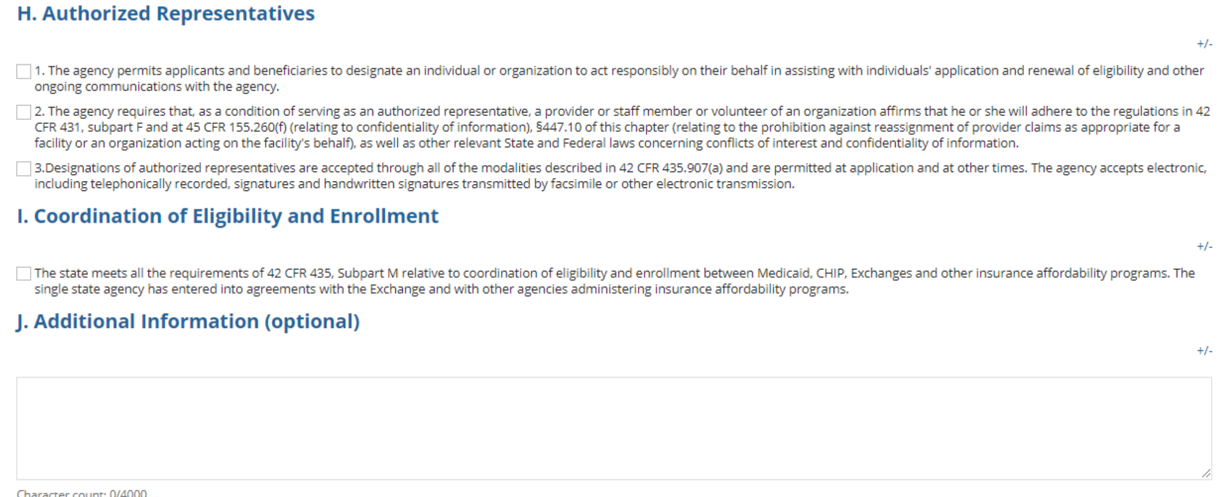
☑ c. Other

Description:

Character count: 0/4000

H. Authorized Representatives

Figure 6: Eligibility Process – 6



H. Authorized Representatives

+/-

☐ 1. The agency permits applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with individuals' application and renewal of eligibility and other ongoing communications with the agency.

☐ 2. The agency requires that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization affirms that he or she will adhere to the regulations in 42 CFR 431, subpart F and at 45 CFR 155.260(f) (relating to confidentiality of information), §447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

☐ 3.Designations of authorized representatives are accepted through all of the modalities described in 42 CFR 435.907(a) and are permitted at application and at other times. The agency accepts electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

I. Coordination of Eligibility and Enrollment

+/-

☐ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

J. Additional Information (optional)

+/-

Character count: 0/4000

Figure 7: Eligibility Process – 7

Centers for Medicare & Medicaid Services

CMS eXpedited Life Cycle (XLC)

Medicaid and CHIP Program (MACPro)

S94a-Application PRA document

Version 1.0

08/17/2017

Document Number: 208-QSSI-MACPro-PRA-S94a-D

Contract Number: HHSM-500-2007-00024I: HHSM-500-T0014

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1. S94a-Application – Screenshots

1.1 Application

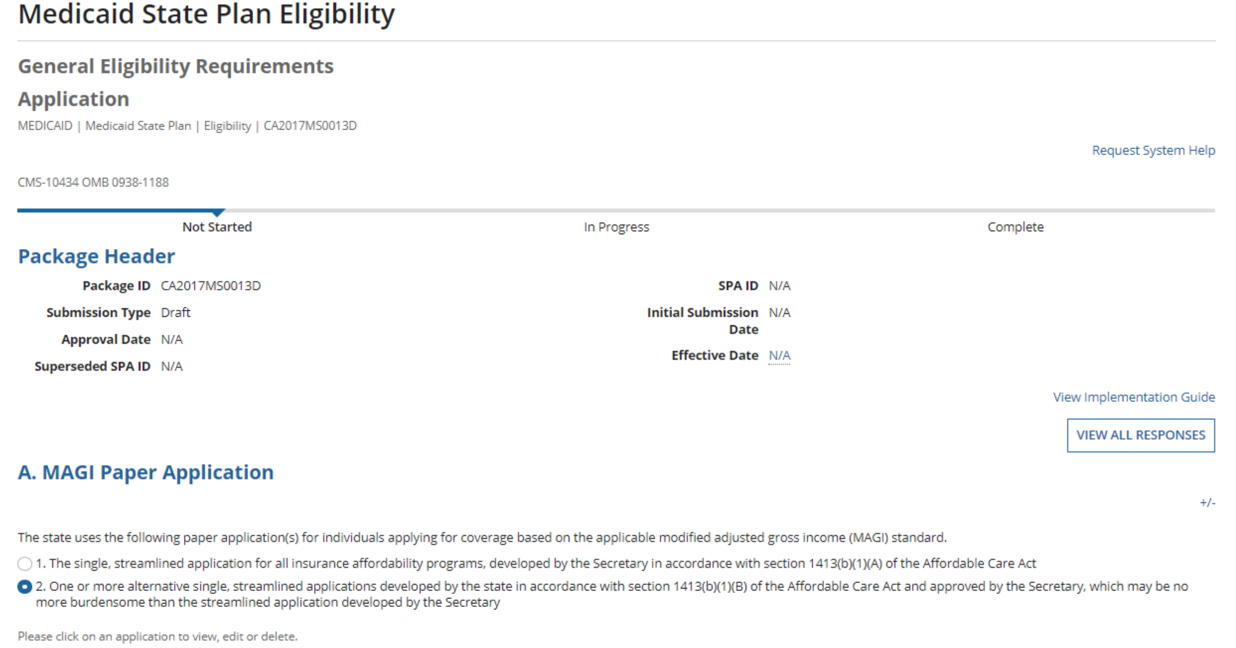


Figure 1: Application - 1

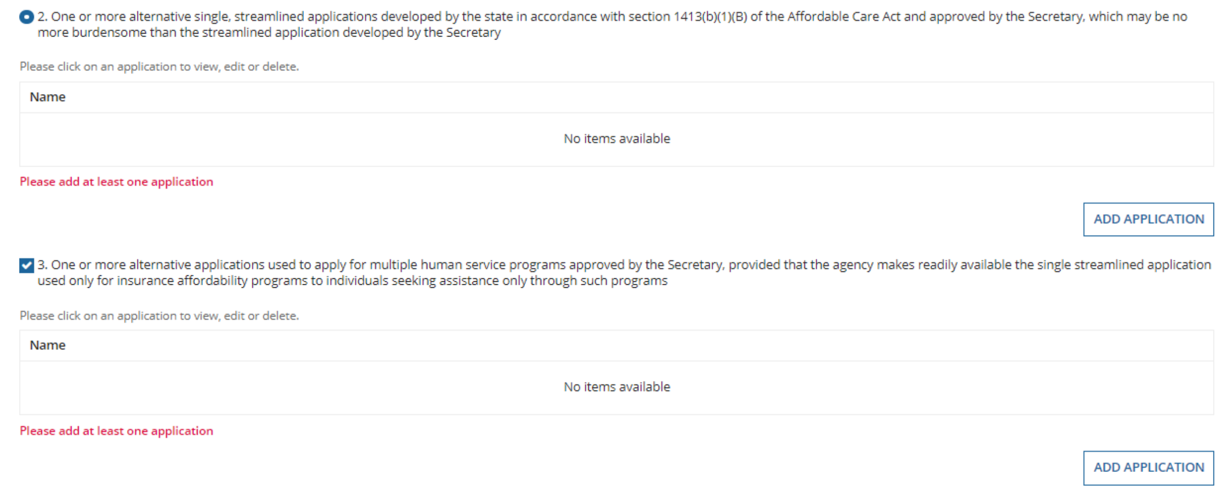


Figure 2: Application – 2

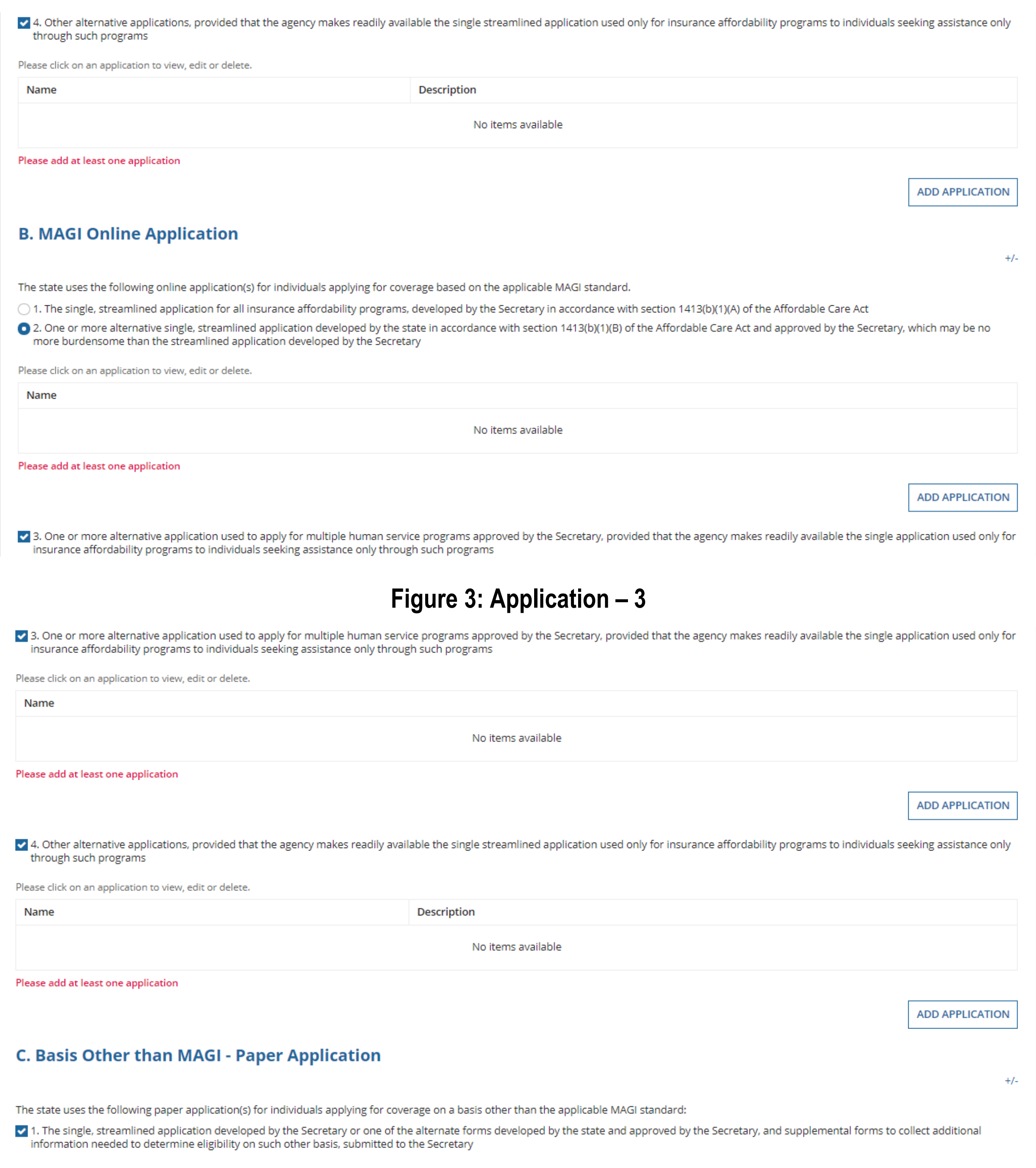
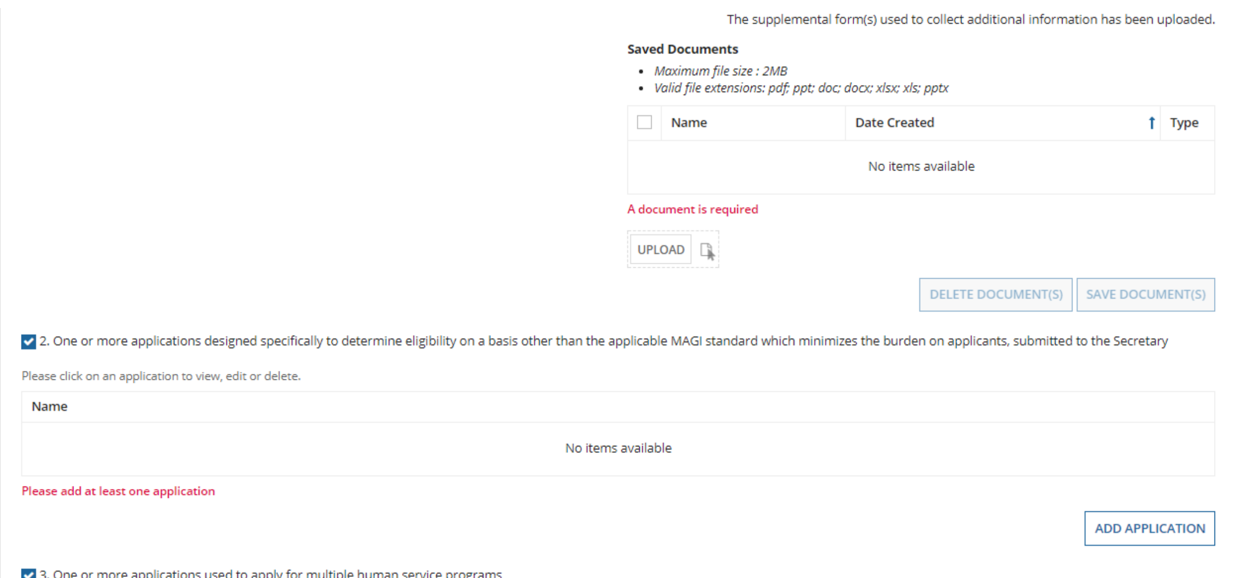


Figure 3: Application – 3

Figure 4: Application – 4



The supplemental form(s) used to collect additional information has been uploaded.

Saved Documents

- *Maximum file size : 2MB*
- *Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx*

	Name	Date Created	Type
	No items available		

A document is required

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

☑ 2. One or more applications designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary

Please click on an application to view, edit or delete.

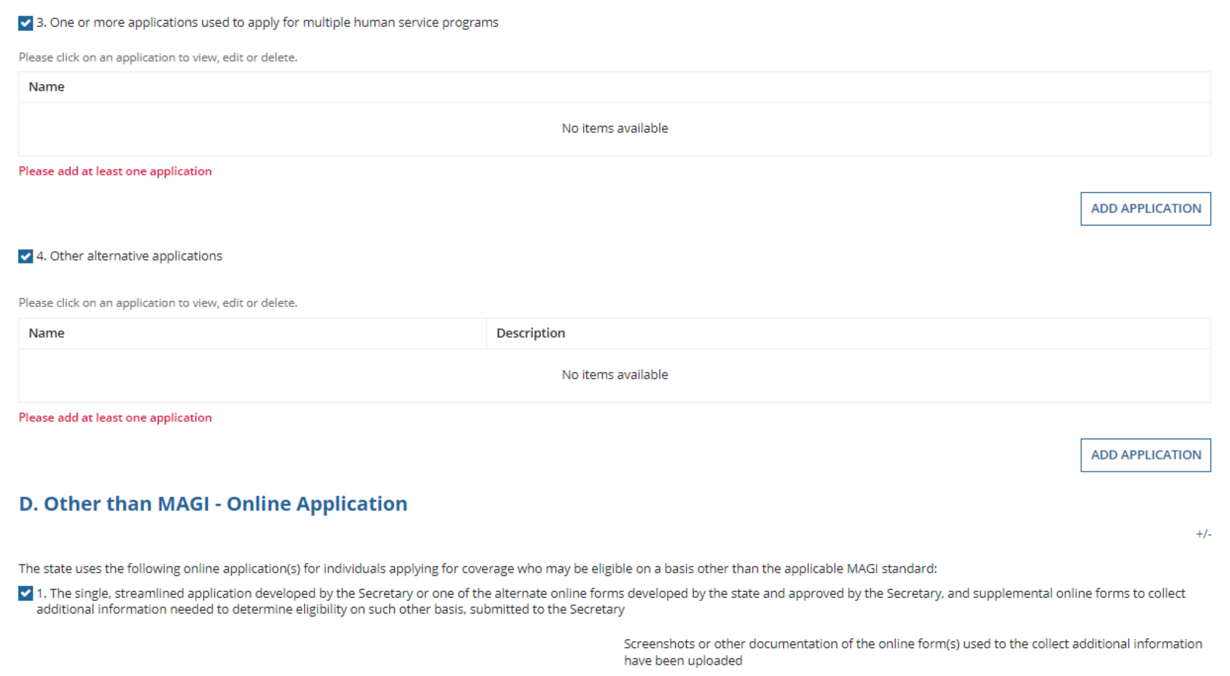
Name
No items available

Please add at least one application

ADD APPLICATION

☑ 3. One or more applications used to apply for multiple human service programs

Figure 5: Application – 5



☑ 3. One or more applications used to apply for multiple human service programs

Please click on an application to view, edit or delete.

Name
No items available

Please add at least one application

ADD APPLICATION

☑ 4. Other alternative applications

Please click on an application to view, edit or delete.

Name	Description
No items available	

Please add at least one application

ADD APPLICATION

D. Other than MAGI - Online Application

+/-

The state uses the following online application(s) for individuals applying for coverage who may be eligible on a basis other than the applicable MAGI standard:

☑ 1. The single, streamlined application developed by the Secretary or one of the alternate online forms developed by the state and approved by the Secretary, and supplemental online forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

Screenshots or other documentation of the online form(s) used to the collect additional information have been uploaded

Figure 6: Application – 6

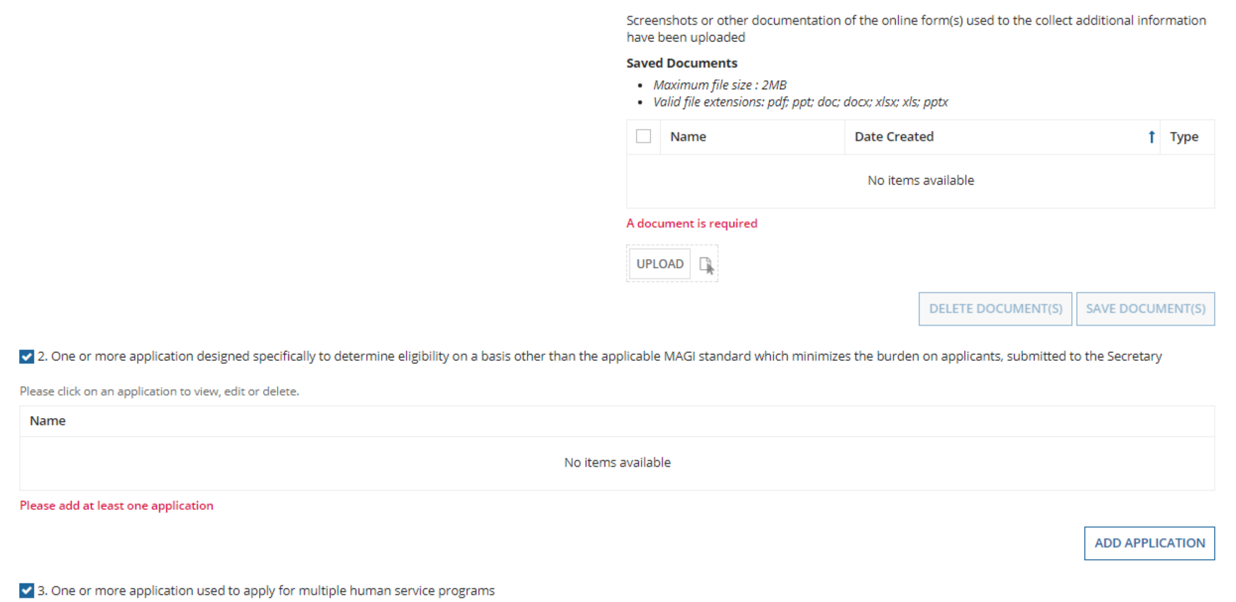


Figure 7: Application – 7

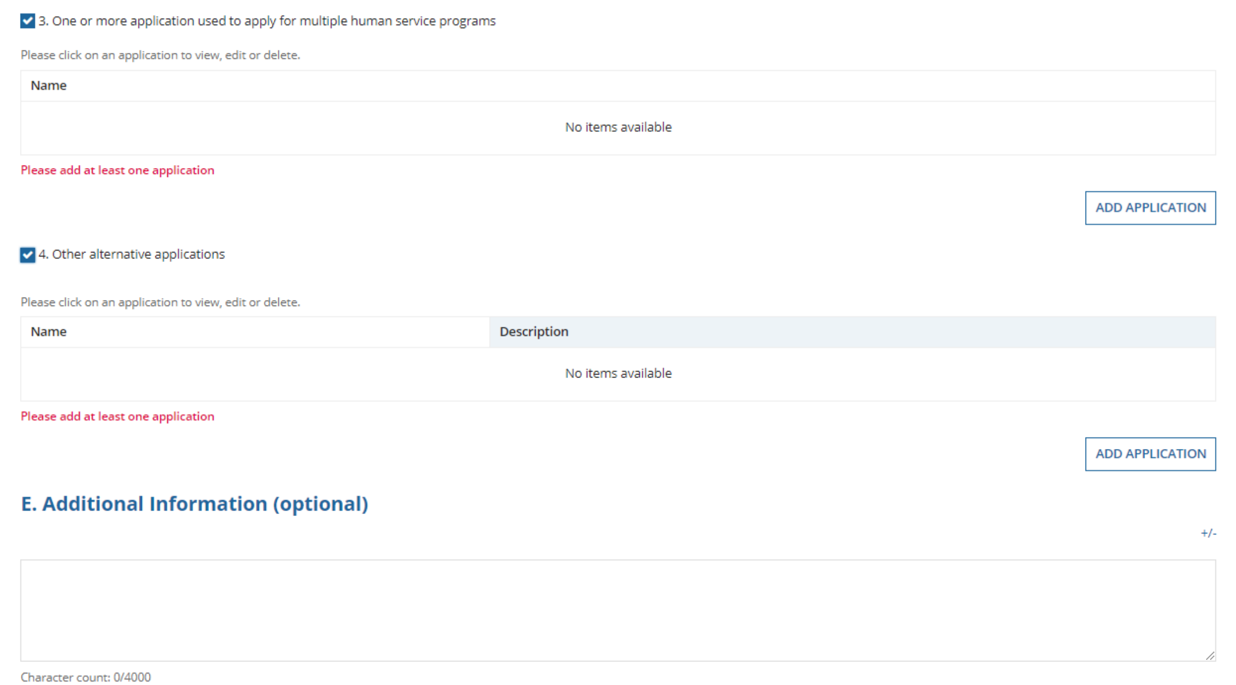


Figure 8: Application – 8