



**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

Table of Contents

- 1. **A1- Designation and Authority Screenshots** 1
 - 1.1 Section A. Single State Agency and Section B. Attorney General Certification 1
 - 1.2 Section C. Administration of the Medicaid Program and D. Additional information (optional) 2

List of Figures

- Figure 1: Section A and B 1
- Figure 2: Section C and D 2

List of Tables

No table of figures entries found.

1. A1- Designation and Authority Screenshots

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

The screenshot displays the 'Medicaid State Plan Administration' interface. At the top, there is a navigation bar with 'Actions' highlighted and a user profile for 'Applan'. Below this, the page title is 'Medicaid State Plan Administration'. The 'Organization' section shows 'Designation and Authority' for 'MEDICAD | Medicaid State Plan | Administration | NV2017MS00250'. A progress bar indicates the status is 'Not Started'. The 'Package Header' section lists: Package ID NV2017MS00250, Submission Type Official, Approval Date N/A, Superseded SPA ID N/A, SPA ID N/A, Initial Submission Date N/A, and Effective Date N/A. Section A, 'Single State Agency', includes a form for State Name (Nevada) and a checkbox for agency agreement. Section B, 'Attorney General Certification', includes a checkbox for certification and a 'Saved Documents' table with an 'UPLOAD' button and 'DELETE DOCUMENT(S)' and 'SAVE DOCUMENT(S)' buttons.

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.

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: 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

Table of Contents

- 1. **A2- Intergovernmental Cooperation Act Waivers Screenshots 1**
 - 1.1 Section A. Intergovernmental Cooperation Act Waivers 1
 - 1.2 Add Waiver..... 2
 - 1.3 Section B. Additional Information (optional) 3

List of Figures

- Figure 1: Section A..... 1
- Figure 2: Add Waiver..... 2
- Figure 3: Section B..... 3

1. A2- Intergovernmental Cooperation Act Waivers Screenshots

1.1 Section A. Intergovernmental Cooperation Act Waivers

Records / Submission Packages
NV - Submission Package - NV2017MS00250

Summary Reviewable Units News **Related Actions**

Medicaid State Plan Administration

Organization
Intergovernmental Cooperation Act Waivers
MEDICAID | Medicaid State Plan | Administration | NV2017MS00250

CMS-10434 OMB 0938-1188

Request System Help

Not Started In Progress Complete

Package Header

Package ID	NV2017MS00250	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		

View Implementation Guide
[VIEW ALL RESPONSES](#)

A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

<input type="checkbox"/>	State Agency	Delegated Responsibility	Date Waiver Granted	Date of Termination	Status	Validation
No items available						

[ADD](#)

Figure 1: Section A

1.2 Add Waiver

The screenshot shows the 'Add Waiver' form within the CMS XLC interface. The page header includes navigation tabs for 'News', 'Tasks', 'Records', 'Reports', and 'Actions', along with a user profile for 'Applan'. The main content area is titled 'NV - Submission Package - NV2017MS00250' and includes sub-tabs for 'Summary', 'Reviewable Units', 'News', and 'Related Actions'. The form itself is titled 'Add Waiver' and contains the following sections:

- 1. Name of state agency to which responsibility is delegated:** A text input field.
- 2. Date waiver granted:** A date input field with the format 'mm/dd/yyyy'.
- 3. The type of responsibility delegated is (check all that apply):**
 - a. Conducting fair hearings
 - b. Other
- Name of other type:** A table with columns for 'Name of other type', 'Description', and 'Delete'. It currently shows 'No items available'.
- Name of other type: *** A text input field.
- Description: *** A text input field.
- 4. The scope of the delegation (i.e. all fair hearings) includes:** A large text area for detailed input.
- 5. Methods for coordinating responsibilities between the agencies include:**
 - a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.
 - d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.
 - e. The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:
 - i. A written agreement between the agencies.
 - ii. State statutory and/or regulatory provisions.
- Statutory/regulatory citation(s):** A text input field.
- 7. Additional methods for coordinating responsibilities among the agencies (optional):** A large text area for detailed input.
- Validation:**
 - Would you like to validate the data?
 - Yes
 - No
 - Warning: Any field containing more than 4000 characters will be truncated when saved.
- BACK TO RU SUMMARY** and **SAVE** buttons.

Figure 2: Add Waiver



**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

Table of Contents

- 1. A3- Eligibility Determinations and Fair Hearings Screenshots..... 1**
- 1.1 Section A. Eligibility Determinations (including any delegations) – Screenshot 1 1
- 1.2 Section B. Fair Hearings (including any delegations) 2
- 1.3 Section C. Evidentiary Hearings and Section D. Additional information (optional) 3

List of Figures

- Figure 1: Section A Screenshot 1 1
- Figure 2: Section A Screenshot 2..... 2
- Figure 3: Section B..... 2
- Figure 4: Section C and D 3

List of Tables

No table of figures entries found.

1. A3- Eligibility Determinations and Fair Hearings Screenshots

1.1 Section A. Eligibility Determinations (including any delegations)

The screenshot shows the 'Medicaid State Plan Administration' interface. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions' (highlighted). A user profile icon for 'Applan' is in the top right. Below the navigation bar, the page title is 'Medicaid State Plan Administration'. Underneath, it says 'Organization: Eligibility Determinations and Fair Hearings' with a sub-link 'MEDICAID | Medicaid State Plan | Administration | FL2017MS00060' and a 'Request System Help' link. A progress indicator shows 'Not Started', 'In Progress', and 'Complete' stages. The 'Package Header' section displays fields: Package ID (FL2017MS00060), Submission Type (Official), Approval Date (N/A), Superseded SPA ID (N/A), SPA ID (N/A), Initial Submission Date (N/A), and Effective Date (N/A). There is a 'View Implementation Guide' link and a 'VIEW ALL RESPONSES' button. The main section is titled 'A. Eligibility Determinations (including any delegations)'. It contains a question: '1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:'. Below this are several radio button options: 'a. The Medicaid agency', 'b. Delegated governmental agency' (checked), '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', and 'iii. Other' (checked). At the bottom, there is a table with one row: 'Name of entity: Test1234' and a 'Delete' button with an 'x' icon. An 'ADD' button is located at the bottom right of the table area.

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
- 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
- iv. Other

Name of entity:	Delete
Test5678	X

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:

- a. Medicaid agency
- b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.
- c. Local governmental entities
- d. Delegated governmental agency

- 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.
- 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



**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

Table of Contents

- 1. A4-Organization and Administration Screenshots 1**
 - 1.1 Section A. Description of the Organization and Functions of the Single State Agency 1
 - 1.2 Section B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency 3
 - 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 4
 - 1.4 Section E. Coordination with Other Executive Agencies and Section F. Additional information (optional)..... 5

List of Figures

- Figure 1: Section A Screenshot 1 1
- Figure 2: Section A Screenshot 2..... 2
- Figure 3: Section B..... 3
- Figure 4: Section C and D 4
- Figure 5: Section E and F..... 5

List of Tables

No table of figures entries found.

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 | FL2017MS00060

[Request System Help](#)

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID FL2017MS00060

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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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; xls; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

UPLOAD 

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 2: Section A Screenshot 2

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

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

c. Other

Type of local government entity:

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

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

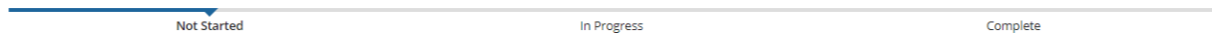
Would you like to validate the reviewable unit data?

- Yes
- No

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

Navigate to Reviewable Unit

-- Select Reviewable Unit --



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 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

Table of Contents

1. A5-Single State Agency Assurances Screenshots	1
1.1 Section A. Assurances and Section B. Additional Information (optional)	1

List of Figures

Figure 1: Section A and Section B	1
---	---

List of Tables

No table of figures entries found.



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

Table of Contents

1. HH1 – Health Homes Intro Screenshots 1
 1.1 “Executive Summary” and “General Assurances” Sections..... 1

List of Figures

Figure 1: Executive Summary and General Assurances..... 1

1. HH1 – Health Homes Intro Screenshots

1.1 “Executive Summary” and “General Assurances” Sections

News Tasks (1) Records Reports Actions
Applan

Health Homes Intro

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

[Request System Help](#)

CMS-10434 OMB 0938-1188

Not Started
In Progress
Complete

Package Header

Package ID CA2017MS0007D	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	

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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 3-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

-- 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 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

Table of Contents

- 1. HH2 – Population and Enrollment Screenshots..... 1**
- 1.1 “Categories of Individuals and Populations Provided Health Homes Services”
Section 1
- 1.2 “Population Criteria” Section 1
- 1.3 “Population Criteria” Section – Path 1 2
- 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
- 1.7 “Enrollment of Participants” Section – Path 2 3
- 1.8 “Enrollment of Participants” Section – Path 3 3

List of Figures

- Figure 1: Categories of Individuals and Populations Provided Health Homes Services .. 1
- Figure 2: Population Criteria..... 1
- Figure 3: Population Criteria - 1 2
- Figure 4: Population Criteria - 2 2
- Figure 5: Population Criteria - 3 2
- Figure 6: Enrollment of Participants - 1 3
- Figure 7: Enrollment of Participants - 2 3
- 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

Health Homes Population and Enrollment Criteria

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

[Request System Help](#)

CMS-10434 OMB 0938-1188

Not Started
In Progress
Complete

Package Header

Package ID CA2017MS0007D	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	

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VIEW ALL RESPONSES

Categories of Individuals and Populations Provided Health Homes Services

+/-

The state will make Health Homes services available to the following categories of Medicaid participants

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups
 - Mandatory Medically Needy
 - Medically Needy Pregnant Women
 - Medically Needy Children under Age 18
 - Optional Medically Needy (select the groups included in the population)
 - Families and Adults**
 - Medically Needy Children Age 18 through 20
 - Medically Needy Parents and Other Caretaker Relatives
 - Aged, Blind and Disabled**
 - Medically Needy Aged, Blind or Disabled
 - Medically Needy Blind or Disabled Individuals Eligible in 1973

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

1.2 “Population Criteria” Section

Population Criteria

+/-

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
- One chronic condition and the risk of developing another
- One serious and persistent mental health condition

Figure 2: Population Criteria

1.3 “Population Criteria” Section – Path 1

Population Criteria +/-

The state elects to offer Health Homes services to individuals with

Two or more chronic conditions

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name	Description

+ Add other specification

Figure 3: Population Criteria - 1

1.4 “Population Criteria” Section – Path 2

One chronic condition and the risk of developing another

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name	Description

+ Add other specification

Specify the criteria for at risk of developing another chronic condition *

Figure 4: Population Criteria - 2

1.5 “Population Criteria” Section – Path 3

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition *

Character count: 0/4000

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required

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

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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

Table of Contents

- 1. HH3 – Geographic Limitations Screenshots 1**
 - 1.1 Geographic Limitations – Path 1 1
 - 1.2 Geographic Limitations – Path 2 1
 - 1.3 Geographic Limitations – Path 3 2
 - 1.4 Geographic Limitations – Path 4 2
 - 1.5 Geographic Limitations – Path 5 2
- 2. Geographic Limitations Add or Edit Phase Screenshots..... 3**
 - 2.1 Geographic Limitations - Add or Edit Phase – Path 1 3
 - 2.2 Geographic Limitations - Add or Edit Phase – Path 2 3
 - 2.3 Geographic Limitations - Add or Edit Phase – Path 3 3
 - 2.4 Geographic Limitations - Add or Edit Phase – Path 4 3
 - 2.5 Geographic Limitations - Add or Edit Phase..... 4

List of Figures

- Figure 1: Geographic Limitations - 1 1
- Figure 2: Geographic Limitations - 2 1
- Figure 3: Geographic Limitations – 3..... 2
- Figure 4: Geographic Limitations – 4..... 2
- Figure 5: Geographic Limitations - 5 2
- Figure 6: Geographic Limitations - Add or Edit Phase -1 3
- Figure 7: Geographic Limitations - Add or Edit Phase – 2..... 3
- Figure 8: Geographic Limitations - Add or Edit Phase – 3..... 3
- Figure 9: Geographic Limitations - Add or Edit Phase - 4 3
- Figure 10: Geographic Limitations - Add or Edit Phase – 5..... 4
- Figure 11: Geographic Limitations - Add or Edit Phase - 6 4

1. HH3 – Geographic Limitations Screenshots

1.1 Geographic Limitations – Path 1

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

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CMS-10434 OMB 0938-1188

Not Started **In Progress** Complete

Package Header

Package ID	CA2017MS0007D	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		

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Health Homes services will be available statewide
 Health Homes services will be limited to the following geographic areas
 Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program *

By county
 By region
 By city/municipality
 Other geographic area

* Specify which counties:

Figure 1: Geographic Limitations - 1

1.2 Geographic Limitations – Path 2

[View Implementation Guide](#)

Health Homes services will be available statewide
 Health Homes services will be limited to the following geographic areas
 Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program *

By county
 By region
 By city/municipality
 Other geographic area

* Specify which regions

Character count: 0/4000

Figure 2: Geographic Limitations - 2

1.3 Geographic Limitations – Path 3

Health Homes services will be available statewide
 Health Homes services will be limited to the following geographic areas
 Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program *

By county
 By region
 By city/municipality
 Other geographic area

* Specify which cities/municipalities:

Character count: 0/4000

Figure 3: Geographic Limitations – 3

1.4 Geographic Limitations – Path 4

Health Homes services will be available statewide
 Health Homes services will be limited to the following geographic areas
 Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program *

By county
 By region
 By city/municipality
 Other geographic area

* Describe the area(s):

Character count: 0/4000

Figure 4: Geographic Limitations – 4

1.5 Geographic Limitations – Path 5

Health Homes services will be available statewide
 Health Homes services will be limited to the following geographic areas
 Health Homes services will be provided in a geographic phased-in approach

Title of phase	↑ Geographic Area	Implementation Date
No items available		

You must enter at least one phase

[ADD PHASE](#)

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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Figure 5: Geographic Limitations - 5

2. Geographic Limitations Add or Edit Phase Screenshots

2.1 Geographic Limitations - Add or Edit Phase – Path 1

Geographic Limitations - Add or Edit Phase

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CMS-10434 OMB 0938-1188

Title of phase
Phase 1

Implementation Date *

Phase-in will be done by the following geographic area *

- By county
- By region
- By city/municipality
- Other geographic area

Specify which counties: *

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

2.2 Geographic Limitations - Add or Edit Phase – Path 2

Phase-in will be done by the following geographic area *

- By county
- By region
- By city/municipality
- Other geographic area

Specify which regions: *

Character count: 0/4000

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

2.3 Geographic Limitations - Add or Edit Phase – Path 3

Phase-in will be done by the following geographic area *

- By county
- By region
- By city/municipality
- Other geographic area

Specify which cities/ municipalities: *

Character count: 0/4000

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

2.4 Geographic Limitations - Add or Edit Phase – Path 4

Phase-in will be done by the following geographic area *

- By county
- By region
- By city/municipality
- Other geographic area

Describe the area(s): *

Character count: 0/4000

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

2.5 Geographic Limitations - Add or Edit Phase

Health Homes services are now available state-wide *

Yes No

Effective date of state-wide service implementation *

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


Enter any additional narrative necessary to fully describe this phase

Character count: 0/4000

Saved Documents

- Maximum file size : 2MB
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<input type="checkbox"/>	Name	Date Created	Type
No items available			



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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

Table of Contents

- 1. HH4 – Health Homes Services Screenshots..... 1**
- 1.1 “Service Definitions” Section – Comprehensive Care Management..... 1
- 1.2 “Service Definitions” Section – Care Coordination 4
- 1.3 “Service Definitions” Section – Health Promotion..... 6
- 1.4 “Service Definitions” Section – Comprehensive Transitional Care from
 Inpatient to Other Settings..... 9
- 1.5 “Service Definitions” Section – Individual and Family Support 11
- 1.6 “Service Definitions” Section – Referral to Community and Social Support
 Services 14
- 1.7 “Health Homes Patient Flow” Section 17

List of Figures

- Figure 1: Service Definitions - 1 1
- Figure 2: Service Definitions - 2 1
- Figure 3: Service Definitions - 3 2
- Figure 4: Service Definitions - 4 2
- Figure 5: Service Definitions - 5 3
- Figure 6: Service Definitions - 6 3
- Figure 7: Service Definitions - 7 4
- Figure 8: Service Definitions - 8 4
- Figure 9: Service Definitions - 9 4
- Figure 10: Service Definitions - 10 5
- Figure 11: Service Definitions - 11 5
- Figure 12: Service Definitions - 12 6
- Figure 13: Service Definitions - 13 6
- Figure 14: Service Definitions - 14 6
- Figure 15: Service Definitions - 15 7
- Figure 16: Service Definitions - 16 7
- Figure 17: Service Definitions - 17 8

Figure 18: Service Definitions - 18	8
Figure 19: Service Definitions - 19	9
Figure 20: Service Definitions - 20	9
Figure 21: Service Definitions - 21	9
Figure 22: Service Definitions - 22	10
Figure 23: Service Definitions - 23	10
Figure 24: Service Definitions - 24	11
Figure 25: Service Definitions - 25	11
Figure 26: Service Definitions - 26	11
Figure 27: Service Definitions - 27	12
Figure 28: Service Definitions - 28	12
Figure 29: Service Definitions - 29	13
Figure 30: Service Definitions - 30	13
Figure 31: Service Definitions - 31	14
Figure 32: Service Definitions - 32	14
Figure 33: Service Definitions - 33	14
Figure 34: Service Definitions - 34	15
Figure 35: Service Definitions - 35	15
Figure 36: Service Definitions - 36	16
Figure 37: Service Definitions - 37	16
Figure 38: Health Homes Patient Flow	17

1. HH4 – Health Homes Services Screenshots

1.1 “Service Definitions” Section – Comprehensive Care Management

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

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CMS-10434 OMB 0938-1188

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Package Header

Package ID	CA2017MS0007D	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		

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Service Definitions

+/-

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Figure 1: Service Definitions - 1

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

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

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 4: Service Definitions - 4

<input checked="" type="checkbox"/> Medical Specialists	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physicians	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physician's Assistants	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Pharmacists	Description * <input type="text"/> Character count: 0/4000

Figure 5: Service Definitions - 5

<input checked="" type="checkbox"/> Social Workers	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Doctors of Chiropractic	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Licensed Complementary and alternative Medicine Practitioners	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Dieticians	Description * <input type="text"/> Character count: 0/4000

Figure 6: Service Definitions - 6

Nutritionists

Other (specify)

Description *

Character count: 0/4000

Provider Type	Description

+ Add Provider Type

Figure 7: Service Definitions - 7

1.2 “Service Definitions” Section – Care Coordination

Care Coordination

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

Figure 8: Service Definitions - 8

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 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
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 10: Service Definitions - 10

- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Figure 11: Service Definitions - 11

Social Workers

Description *

Character count: 0/4000

Doctors of Chiropractic

Description *

Character count: 0/4000

Licensed Complementary and alternative Medicine Practitioners

Description *

Character count: 0/4000

Dieticians

Description *

Character count: 0/4000

Figure 12: Service Definitions - 12

Nutritionists

Description *

Character count: 0/4000

Other (specify)

Provider Type	Description

+ Add Provider Type

Figure 13: Service Definitions - 13

1.3 “Service Definitions” Section – Health Promotion

Health Promotion

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

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

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 16: Service Definitions - 16

<input checked="" type="checkbox"/> Medical Specialists	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physicians	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physician's Assistants	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Pharmacists	Description * <input type="text"/> Character count: 0/4000

Figure 17: Service Definitions - 17

<input checked="" type="checkbox"/> Social Workers	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Doctors of Chiropractic	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Licensed Complementary and alternative Medicine Practitioners	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Dieticians	Description * <input type="text"/> Character count: 0/4000

Figure 18: Service Definitions - 18

Nutritionists

Other (specify)

Description *

Character count: 0/4000

Provider Type	Description

+ Add Provider Type

Figure 19: Service Definitions - 19

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

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

Figure 20: Service Definitions - 20

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 21: Service Definitions - 21

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

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 22: Service Definitions - 22

- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Figure 23: Service Definitions - 23

Social Workers

Description *

Character count: 0/4000

Doctors of Chiropractic

Description *

Character count: 0/4000

Licensed Complementary and alternative Medicine Practitioners

Description *

Character count: 0/4000

Dieticians

Description *

Character count: 0/4000

Figure 24: Service Definitions - 24

Nutritionists

Description *

Character count: 0/4000

Other (specify)

Provider Type	Description

+ Add Provider Type

Figure 25: Service Definitions - 25

1.5 “Service Definitions” Section – Individual and Family Support

Individual and Family Support (which includes authorized representatives)

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

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

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 28: Service Definitions - 28

<input checked="" type="checkbox"/> Medical Specialists	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physicians	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Physician's Assistants	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Pharmacists	Description * <input type="text"/> Character count: 0/4000

Figure 29: Service Definitions - 29

<input checked="" type="checkbox"/> Social Workers	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Doctors of Chiropractic	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Licensed Complementary and alternative Medicine Practitioners	Description * <input type="text"/> Character count: 0/4000
<input checked="" type="checkbox"/> Dieticians	Description * <input type="text"/> Character count: 0/4000

Figure 30: Service Definitions - 30

Nutritionists

Description *

Character count: 0/4000

Other (specify)

Provider Type	Description
<input type="text"/>	<input type="text"/>

+ Add Provider Type

Figure 31: Service Definitions - 31

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

Referral to Community and Social Support Services

Definition *

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum *

Character count: 0/4000

Figure 32: Service Definitions - 32

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 33: Service Definitions - 33

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

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Figure 34: Service Definitions - 34

- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Description *

Character count: 0/4000

Figure 35: Service Definitions - 35

Social Workers

Description *

Character count: 0/4000

Doctors of Chiropractic

Description *

Character count: 0/4000

Licensed Complementary and alternative Medicine Practitioners

Description *

Character count: 0/4000

Dieticians

Description *

Character count: 0/4000

Figure 36: Service Definitions - 36

Nutritionists

Description *

Character count: 0/4000

Other (specify)

Provider Type	Description

+ Add Provider Type

Figure 37: Service Definitions - 37

1.7 “Health Homes Patient Flow” Section

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter *

Character count: 0/4000

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required

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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EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

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

Table of Contents

1. HH5 – Health Homes Providers Screenshots	1
1.1 “Types of Health Homes Providers” Section	1
1.2 “Types of Health Homes Providers” Section – Path 1	1
1.3 “Types of Health Homes Providers” Section – Path 2	3
1.4 “Types of Health Homes Providers” Section – Path 3	5
1.5 “Provider Infrastructure” and “Supports for Health Homes Providers” Sections	7
1.6 “Other Health Homes Provider Standards” Section.....	7

List of Figures

Figure 1: Types of Health Homes Providers -1	1
Figure 2: Types of Health Homes Providers -2	1
Figure 3: Types of Health Homes Providers -3	2
Figure 4: Types of Health Homes Providers -4	2
Figure 5: Types of Health Homes Providers -5	3
Figure 6: Types of Health Homes Providers -6	3
Figure 7: Types of Health Homes Providers -7	4
Figure 8: Types of Health Homes Providers -8	4
Figure 9: Types of Health Homes Providers -9	5
Figure 10: Types of Health Homes Providers -10	5
Figure 11: Types of Health Homes Providers -11	6
Figure 12: Types of Health Homes Providers -12	6
Figure 13: Provider Infrastructure and Supports for Health Homes Providers.....	7
Figure 14: Other Health Homes Provider Standards	7

1. HH5 – Health Homes Providers Screenshots

1.1 “Types of Health Homes Providers” Section

Health Homes Providers
MEDICAID | Medicaid State Plan | Health Homes | CA2017M50007D | Health Homes Program

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CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID CA2017M50007D	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	

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Types of Health Homes Providers +/-

- Designated Providers
- Teams of Health Care Professionals
- Health Teams

Figure 1: Types of Health Homes Providers -1

1.2 “Types of Health Homes Providers” Section – Path 1

Types of Health Homes Providers +/-

- Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Figure 2: Types of Health Homes Providers -2

Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

Physicians
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Clinical Practices or Clinical Group Practices
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Rural Health Clinics
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Figure 3: Types of Health Homes Providers -3

Community Health Centers
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Community Mental Health Centers
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Home Health Agencies
Describe the Provider Qualifications and Standards *

Character count: 0/4000

Figure 4: Types of Health Homes Providers -4

Case Management Agencies
Describe the Provider Qualifications and Standards *
Character count: 0/4000

Community/Behavioral Health Agencies
Describe the Provider Qualifications and Standards *
Character count: 0/4000

Federally Qualified Health Centers (FQHC)
Describe the Provider Qualifications and Standards *
Character count: 0/4000

Other (Specify)

Provider Type	Describe the Provider Qualifications and Standards

+ Add provider types

Figure 5: Types of Health Homes Providers -5

1.3 “Types of Health Homes Providers” Section – Path 2

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
- Nurse Practitioners
- Nurse Care Coordinators
- Nutritionists
- Social Workers
- Behavioral Health Professionals
- Other (Specify)

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

This screenshot shows a vertical list of four provider types, each with a checked checkbox and a text area for qualifications. The provider types are: Dietitians, Social Workers, Behavioral Health Specialists, and Doctors of Chiropractic. Each entry includes a label, a "Describe the Provider Qualifications and Standards" prompt, a text input field, and a "Character count: 0/4000" indicator.

Figure 11: Types of Health Homes Providers -11

This screenshot shows a vertical list of two provider types, each with a checked checkbox and a text area for qualifications. The provider types are: Licensed Complementary and Alternative Medicine Practitioners and Physicians' Assistants. Each entry includes a label, a "Describe the Provider Qualifications and Standards" prompt, a text input field, and a "Character count: 0/4000" indicator.

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

<input type="checkbox"/>	Name	Date Created		Type
No items available				

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Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

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Navigate to Reviewable Unit

-- Select Reviewable Unit --

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In Progress
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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

Table of Contents

- 1. HH6-Health Homes Service Delivery Systems – Screenshots 1**
- 1.1 Health Homes Service Delivery Systems 1
- 1.2 Health Homes Service Delivery Systems – Path 1 1
- 1.3 Health Homes Service Delivery Systems – Path 2 2
- 1.4 Health Homes Service Delivery Systems – Path 3 3
- 1.5 Health Homes Service Delivery Systems – Path 4 4
- 1.6 Health Homes Service Delivery Systems – Path 5 4
- 1.7 Health Homes Service Delivery Systems – Path 6 5

List of Figures

- Figure 1 : Health Homes Service Delivery - 1 1
- Figure 2: Health Homes Service Delivery - 2 1
- Figure 3: Health Homes Service Delivery - 3 2
- Figure 4: Health Homes Service Delivery – 4 2
- Figure 5: Health Homes Service Delivery – 5 3
- Figure 6: Health Homes Service Delivery – 6 3
- Figure 7: Health Homes Service Delivery – 7 4
- Figure 8: Health Homes Service Delivery – 8 4
- 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

Health Homes Service Delivery Systems

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

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CMS-10434 OMB 0938-1188

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Complete

Package Header

Package ID CA2017MS0007D	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	

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

Fee for Service

PCCM

Risk Based Managed Care

Other Service Delivery System

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Figure 1 : Health Homes Service Delivery - 1

1.2 Health Homes Service Delivery Systems – Path 1

PCCM

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

Yes No

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section

Fee for Service (describe in Payment Methodology section)

Alternative Model of Payment (describe in Payment Methodology section)

Other

*** Description**

Character count: 0/4000

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.

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

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

Risk Based Managed Care

Other Service Delivery System

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

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			



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

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

Figure 7: Health Homes Service Delivery – 7

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

Yes
 No

Indicate which payment methodology the State will use to pay its plans

Fee for Service (describe in Payment Methodology section)
 Alternative Model of Payment (describe in Payment Methodology section)
 Other

* Description

Character count: 0/4000

Figure 8: Health Homes Service Delivery – 8

1.6 Health Homes Service Delivery Systems – Path 5

Risk Based Managed Care

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

Yes
 No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

The current capitation rate will be reduced
 The State will impose additional contract requirements on the plans for Health Homes enrollees

* Provide a summary of the contract language for the additional requirements

Character count: 0/4000

Other

* Describe

Character count: 0/4000

Figure 9: Health Homes Service Delivery – 9

1.7 Health Homes Service Delivery Systems – Path 6

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

Fee for Service

PCCM

Risk Based Managed Care

Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers *

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			




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

Table of Contents

- 1. HH7-Health Homes Payment Methodologies – Screenshots 1**
- 1.1 “Payment Methodology” Section 1
- 1.2 “Payment Methodology” Section – Path 1 1
- 1.3 “Payment Methodology” Section – Path 2 3
- 1.4 “Assurances” Section 3

List of Figures

- Figure 1: Payment Methodology – 1 1
- Figure 2: Payment Methodology – 2 1
- Figure 3: Payment Methodology – 3 2
- Figure 4: Payment Methodology – 4 2
- Figure 5: Payment Methodology – 5 3
- Figure 6: Assurances 3

1. HH7-Health Homes Payment Methodologies – Screenshots

1.1 “Payment Methodology” Section

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

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CMS-10434 OMB 0938-1188

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Package Header

Package ID	CA2017MS0007D	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		

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Payment Methodology +/-

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

- Fee for Service
- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Figure 1: Payment Methodology – 1

1.2 “Payment Methodology” Section – Path 1

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

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Comprehensive Methodology Included in the Plan
 - Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Figure 2: Payment Methodology – 2

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

- Fee for Service
 - Individual Rates Per Service
 - - 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
 - Other
 - Describe below**
 -
 - Per Member, Per Month Rates
 - - 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
 - Other
 - Describe below**
 -

Figure 3: Payment Methodology – 3

- Comprehensive Methodology Included in the Plan
 - - 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
 - Other
 - Describe below**
 -
- Incentive Payment Reimbursement
 - - 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
 - Other
 - Describe below**
 -

Figure 4: Payment Methodology – 4

1.3 “Payment Methodology” Section – Path 2

Alternative models of payment, other than Fee for Service or PMPM payments (describe below) *

Tiered Rates based on

- Severity of each individual's chronic conditions
- Capabilities of the team of health care professionals, designated provider, or health team
- Other

Describe below

•

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

•

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Figure 5: Payment Methodology – 5

1.4 “Assurances” Section

Assurances +/-

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved *

Character count: 0/4000

- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

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

Table of Contents

- 1. **HH8-Health Homes Monitoring, Quality Measurement and Evaluation – Screenshots** 1
 - 1.1 “Monitoring” Section 1
 - 1.2 “Quality Measurement and Evaluation” Section 2

List of Figures

- Figure 1: Monitoring – 1 1
- Figure 2: Monitoring - 2 1
- Figure 3: Quality Measurement and Evaluation 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 measurable 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

Navigate to Reviewable Unit

-- Select Reviewable Unit --

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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

Table of Contents

- 1. HH8-Health Homes Program Termination – Screenshots 1**
 - 1.1 Health Homes Program Termination 1
 - 1.2 Health Homes Program Termination – Path 1..... 1
 - 1.3 Health Homes Program Termination – Path 2..... 2

List of Figures

- Figure 1: Health Homes Program Termination – 1 1
- Figure 2: Health Homes Program Termination – 2..... 1
- Figure 3: Health Homes Program Termination – 3..... 2

1. HH8-Health Homes Program Termination – Screenshots

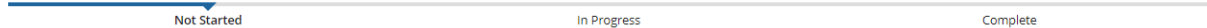
1.1 Health Homes Program Termination

Health Homes Program Termination - Phase-Out Plan

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

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CMS-10434 OMB 0938-1188



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	

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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 *

- 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 *

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

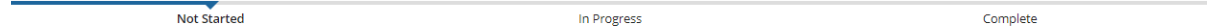
Validation & Navigation

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Figure 2: Health Homes Program Termination – 2

1.3 Health Homes Program Termination – Path 2

Indicate method of termination *

- 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

Begin phase-out date *

mm/dd/yyyy

Complete phase-out date *

mm/dd/yyyy

Upload the state's phase-out plan and the strategy for communicating the phase-out to participants and providers, including dates of communication

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required

UPLOAD 

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

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

Table of Contents

- 1. I1-Submission Summary – Screenshots..... 1**
- 1.1 Submission Summary 1
- 1.2 “Governor’s Office Review” Section – Path 1 2
- 1.3 “Governor’s Office Review” Section – Path 2 3

List of Figures

- Figure 1: Submission Summary – 1 1
- Figure 2: Submission Summary – 2 1
- Figure 3: Submission Summary – 3 2
- 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

Submission - Summary

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CMS-10434 OMB 0938-1188

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Package ID N/A	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	

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State Information

State/Territory Name: California	Medicaid Agency Name: MSP
----------------------------------	---------------------------

Submission Component

State Plan Amendment

Medicaid
 CHIP

Figure 1: Submission Summary – 1

Submission Type

Official Submission Package
 Draft Submission Package

Allow this draft package to be viewable by other states? *
 Yes
 No

Key Contacts

Name	Title	Phone Number	Email Address
No items available			

[+ Add a Key Contact](#)

Executive Summary

Summary Description Including Goals and Objectives *

Character count: 0/4000

Figure 2: Submission Summary – 2

Dependency Description +/-

Description of any dependencies between this submission package and any other submission package undergoing review

Character count: 0/4000

Disaster-Related Submission +/-

This submission is related to a disaster *

Yes
 No

Disaster Description *

Character count: 0/4000

Figure 3: Submission Summary – 3

Federal Budget Impact and Statute/Regulation Citation +/-

Federal Budget Impact

	Federal Fiscal Year	Amount
First	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Second	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

Warning: Please only enter numeric characters in this field. Only numeric characters will be retained for this field.

Federal Statute / Regulation Citation *

Character count: 0/255

Figure 4: Submission Summary – 4

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

Governor's Office Review +/-

No comment
 Comments received
 No response within 45 days
 Other

Summary of Comments *

Character count: 0/4000

Validation & Navigation

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

Note: This form can be validated only after the Submission - Medicaid State Plan is complete.

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 5: Governor’s Office Review - 1

1.3 “Governor’s Office Review” Section – Path 2

Governor's Office Review +/-

No comment
 Comments received
 No response within 45 days
 Other

Describe *

Character count: 0/4000

Validation & Navigation

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

Note: This form can be validated only after the Submission - Medicaid State Plan is complete.

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 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

Table of Contents

1.	I2-Medicaid State Plan – Screenshots.....	1
1.1	Medicaid State Plan	1
1.2	Medicaid State Plan – Benefits and Payment – Path 1	2
1.3	Medicaid State Plan – Benefits and Payment – Path 2	2
1.4	Medicaid State Plan – Benefits and Payment – Path 3	3
1.5	Medicaid State Plan – Benefits and Payment – Path 4	3
1.6	Medicaid State Plan – Benefits and Payment – Path 5	3

List of Figures

Figure 1:	Medicaid State Plan – 1	1
Figure 2:	Medicaid State Plan – 2	1
Figure 3:	Medicaid State Plan – 3	2
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

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | CA2017MS0013D [Request System Help](#)

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

[View Implementation Guide](#)

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payment

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Note: If validation fails, errors will appear in red above.

Not Started

In Progress

Complete

Navigate to Reviewable Unit

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.

You must select at least one component in order to complete this form.

EXIT

SAVE FORM

GO TO SELECTED REVIEWABLE UNIT

Figure 1: Medicaid State Plan – 1

- Administration
 - Designation and Authority
 - Intergovernmental Cooperation Act Waivers
 - Eligibility Determinations and Fair Hearings
 - Organization and Administration
 - Single State Agency Assurances
- Eligibility
 - Methodologies for calculating income and resources that apply across many eligibility groups
 - MAGI-Based Methodologies
 - Financial Eligibility Requirements for Non-MAGI Groups
 - Income or Resource Standards
 - AFDC Income Standards
 - Mandatory Eligibility Groups
 - Optional Eligibility Groups
 - Non-financial requirements
 - State Residency
 - Citizenship and Non-Citizen Eligibility
 - Eligibility and enrollment Processes
 - Eligibility Process
 - Application
 - Presumptive Eligibility

Figure 2: Medicaid State Plan – 2

Eligibility and enrollment Processes

Eligibility Process

Application

Presumptive Eligibility

- Presumptive Eligibility for Children under Age 19
- Parents and Other Caretaker Relatives - Presumptive Eligibility
- Presumptive Eligibility for Pregnant Women
- Adult Group - Presumptive Eligibility
- Individuals above 133% FPL under Age 65 - Presumptive Eligibility
- Individuals Eligible for Family Planning Services - Presumptive Eligibility
- Former Foster Care Children - Presumptive Eligibility
- Presumptive Eligibility by Hospitals

Benefits and Payment

Health Homes Program

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program

Figure 3: Medicaid State Plan – 3

1.2 Medicaid State Plan – Benefits and Payment – Path 1

The submission includes the following:

Administration

Eligibility

Benefits and Payment

Health Homes Program

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program
 - Copy from existing Health Homes program
 - Create new program from blank form

* Name of Health Homes Program:

* -- Select Health Homes Program --

Figure 4: Benefits and Payment – 1

1.3 Medicaid State Plan – Benefits and Payment – Path 2

The submission includes the following:

Administration

Eligibility

Benefits and Payment

Health Homes Program

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program
 - Copy from existing Health Homes program
 - Create new program from blank form

* Name of Health Homes Program:

Figure 5: Benefits and Payment – 2

1.4 Medicaid State Plan – Benefits and Payment – Path 3

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payment
 - Health Homes Program

Create new Health Homes program
 Amend existing Health Homes program
 Terminate existing Health Homes program

-- Select Health Homes Program --

*
 Amend an existing program that is neither approved in MACPro nor converted.

Figure 6: Benefits and Payment – 3

1.5 Medicaid State Plan – Benefits and Payment – Path 4

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payment
 - Health Homes Program

Create new Health Homes program
 Amend existing Health Homes program
 Terminate existing Health Homes program

*
 Amend an existing program that is neither approved in MACPro nor converted.

* Name of Health Homes Program to be amended:

Figure 7: Benefits and Payment – 4

1.6 Medicaid State Plan – Benefits and Payment – Path 5

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payment
 - Health Homes Program

Create new Health Homes program
 Amend existing Health Homes program
 Terminate existing Health Homes program

-- Select Health Homes Program --

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

Table of Contents

1.	I3-Public Comment – Screenshots	1
1.1	Public Comment – Path 1.....	1
1.2	Public Comment – Path 2.....	5

List of Figures

Figure 1: Public Comment – 1.....	1
Figure 2: Public Comment – 2.....	1
Figure 3: Public Comment – 3.....	2
Figure 4: Public Comment – 4.....	2
Figure 5: Public Comment – 5.....	3
Figure 6: Public Comment – 6.....	3
Figure 7: Public Comment – 7.....	4
Figure 8: Public Comment – 8.....	4
Figure 9: Public Comment – 9.....	5
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

+Add a website

Public Hearing or Meeting

Date of meeting:	Time of meeting:	Location of meeting:
No items available		

A value is required

[ADD A PUBLIC HEARING/MEETING](#)

Other method

Name of method:	Date:	Description:
	<small>mm/dd/yyyy</small>	

+Add another Way of Soliciting Input

Upload copies of public notices and other documents used

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

A document is required

[UPLOAD](#)

[DELETE DOCUMENT\(S\)](#) [SAVE DOCUMENT\(S\)](#)

Figure 3: Public Comment – 3

[DELETE DOCUMENT\(S\)](#) [SAVE DOCUMENT\(S\)](#)

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

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

[UPLOAD](#)

[DELETE DOCUMENT\(S\)](#) [SAVE DOCUMENT\(S\)](#)

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

Access

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 4: Public Comment – 4

This screenshot shows a public comment form with two categories: Quality and Cost. Each category has a 'Summarize comments' and a 'Summarize response' section, each with a text area and a character count of 0/4000.

- Quality
 - Summarize comments: *
[Text area]
Character count: 0/4000
 - Summarize response: *
[Text area]
Character count: 0/4000
- Cost
 - Summarize comments: *
[Text area]
Character count: 0/4000
 - Summarize response: *
[Text area]
Character count: 0/4000

Figure 5: Public Comment – 5

This screenshot shows a public comment form with two categories: Payment methodology and Eligibility. Each category has a 'Summarize comments' and a 'Summarize response' section, each with a text area and a character count of 0/4000.

- Payment methodology
 - Summarize comments: *
[Text area]
Character count: 0/4000
 - Summarize response: *
[Text area]
Character count: 0/4000
- Eligibility
 - Summarize comments: *
[Text area]
Character count: 0/4000
 - Summarize response: *
[Text area]
Character count: 0/4000

Figure 6: Public Comment – 6

Benefits

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Service delivery

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 7: Public Comment – 7

Other issue

Name of issue:	Summarize comments:	Summarize response:
<input type="text"/>	<input type="text"/>	<input type="text"/>

[+Add an Other Issue](#)

Validation & Navigation

Would you like to validate the reviewable unit data?

Yes No

Navigate to Reviewable Unit

-- Select Reviewable Unit --

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

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 8: Public Comment – 8

1.2 Public Comment – Path 2

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

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

Email to Electronic Mailing List or Similar Mechanism

Website Notice

Date of Publication: *
mm/dd/yyyy

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

Select the type of website

Website of the State Medicaid Agency or Responsible Agency

* Date of Posting: mm/dd/yyyy

* Website URL:

Figure 9: Public Comment – 9

* Website URL:

Other

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

+Add a website

Public Hearing or Meeting

Date of meeting:	Time of meeting:	Location of meeting:
No items available		

A value is required

[ADD A PUBLIC HEARING/MEETING](#)

Other method

Name of method:	Date:	Description:
	mm/dd/yyyy	

+Add another Way of Soliciting Input

Figure 10: Public Comment – 10

+Add another Way of Soliciting Input


Upload copies of public notices and other documents used

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

A document is required

UPLOAD 


DELETE DOCUMENT(S) SAVE DOCUMENT(S)

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

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

UPLOAD 

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 11: Public Comment – 11

DELETED DOCUMENT(S) SAVE DOCUMENT(S)

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

Access

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Quality

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 12: Public Comment – 12

This screenshot shows a public comment form with two categories: 'Cost' and 'Payment methodology'. Each category has a 'Summarize comments' and a 'Summarize response' section, each with a 4000-character limit.

- Cost:** Includes a 'Summarize comments' field (0/4000) and a 'Summarize response' field (0/4000).
- Payment methodology:** Includes a 'Summarize comments' field (0/4000) and a 'Summarize response' field (0/4000).

Figure 13: Public Comment – 13

This screenshot shows a public comment form with two categories: 'Eligibility' and 'Benefits'. Each category has a 'Summarize comments' and a 'Summarize response' section, each with a 4000-character limit.

- Eligibility:** Includes a 'Summarize comments' field (0/4000) and a 'Summarize response' field (0/4000).
- Benefits:** Includes a 'Summarize comments' field (0/4000) and a 'Summarize response' field (0/4000).

Figure 14: Public Comment – 14

Service delivery

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Other issue

Name of issue:	Summarize comments:	Summarize response:	
<input type="text"/>			×

[+Add an Other Issue](#)

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

Table of Contents

1.	I4-Tribal Input – Screenshots.....	1
1.1	Tribal Input – Path 1.....	1
1.2	Tribal Input – Path 2.....	4

List of Figures

Figure 1: Tribal Input – 1	1
Figure 2: Tribal Input – 2	1
Figure 3: Tribal Input – 3	2
Figure 4: Tribal Input – 4	2
Figure 5: Tribal Input – 5	3
Figure 6: Tribal Input – 6	3
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:
<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

[Add a Solicitation/Consultation](#)

All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

[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:
<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

[Add a Consultation](#)

Figure 2: Tribal Input – 2

Add a Consultation


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

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

A document is required



Indicate the key issues raised (optional)

Figure 3: Tribal Input – 3

Indicate the key issues raised (optional)

Access

Quality

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 4: Tribal Input – 4

Cost

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Payment methodology

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 5: Tribal Input – 5

Eligibility

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Benefits

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

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:
<div style="border: 1px solid #ccc; height: 20px; width: 100%;"></div>		

+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:
<div style="border: 1px solid #ccc; padding: 2px;">mm/dd/yyyy</div>	<div style="border: 1px solid #ccc; height: 20px; width: 100%;"></div>

Add a Solicitation/Consultation

Figure 8: Tribal Input – 8

Add a Solicitation/Consultation

All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

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:
<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

Add a Consultation

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

Saved Documents

Figure 9: Tribal Input – 9

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required

Indicate the key issues raised (optional)

Access

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 10: Tribal Input – 10

The screenshot shows a web form with two sections. The first section is titled "Quality" and has a checked checkbox. Below it is a large empty text box. To the right of this box is a "Summarize comments:" label and a "Character count: 0/4000" indicator. The second section is titled "Cost" and also has a checked checkbox. It follows the same layout with a large empty text box, a "Summarize comments:" label, and a "Character count: 0/4000" indicator. Below the "Cost" section, there is a "Summarize response:" label and another large empty text box, followed by another "Character count: 0/4000" indicator.

Figure 11: Tribal Input – 11

The screenshot shows a web form with two sections. The first section is titled "Payment methodology" and has a checked checkbox. Below it is a large empty text box. To the right of this box is a "Summarize comments:" label and a "Character count: 0/4000" indicator. The second section is titled "Eligibility" and also has a checked checkbox. It follows the same layout with a large empty text box, a "Summarize comments:" label, and a "Character count: 0/4000" indicator. Below the "Eligibility" section, there is a "Summarize response:" label and another large empty text box, followed by another "Character count: 0/4000" indicator.

Figure 12: Tribal Input – 12

Benefits

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Service delivery

Summarize comments: *

Character count: 0/4000

Summarize response: *

Character count: 0/4000

Figure 13: Tribal Input – 13

Other issue

Name of issue:	Summarize comments:	Summarize response:
<input type="text"/>	<input type="text"/>	<input type="text"/>

+Add an Other Issue

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 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 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

Table of Contents

1. I5-Other Comment – Screenshots	1
1.1 Other Comment – “SAMHSA Consultation” Section	1

List of Figures

Figure 1: Other Comment.....	1
------------------------------	---



**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

Table of Contents

- 1. **S2 - Financial Eligibility Requirements for Non-MAGI Groups Screenshots..... 1**
 - 1.1 Package Header and A. Financial Eligibility Methodologies..... 1
 - 1.2 B. Eligibility Determinations of Aged, Blind and Disabled Individuals, C. Financial Responsibility of Relatives and D. Additional Information (optional) 2

List of Figures

- Figure 1: Package Header and Section A 1
- Figure 2: Section B, Section C and Section D..... 2

List of Tables

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

The screenshot displays a web interface for Medicaid State Plan Eligibility. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The user 'Appian' is logged in. The main heading is 'NV - Submission Package - NV2017MS0026D'. Below this, there are tabs for 'Summary', 'Reviewable Units', 'News', and 'Related Actions'. The page title is 'Medicaid State Plan Eligibility' and the sub-heading is 'Financial Eligibility Requirements for Non-MAGI Groups'. A breadcrumb trail shows 'MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D'. A 'Request System Help' link is present. A progress bar shows 'Not Started', 'In Progress', and 'Complete' stages. The 'Package Header' section lists: 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), and Effective Date (N/A). A 'View Implementation Guide' link is also visible. Section A, 'Financial Eligibility Methodologies', includes a checked checkbox for 'The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.' and a note that 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).

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)

News Tasks **Records** Reports Actions Appian

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

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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

Table of Contents

- 1. **S2T-Financial Eligibility Requirements for Non-MAGI Groups – Territories – Screenshots** 1
 - 1.1 Financial Eligibility Requirements for Non-MAGI Groups – Territories 1

List of Figures

- Figure 1: Financial Eligibility Requirements for Non-MAGI Groups – Territories – 1 1
- Figure 2: Financial Eligibility Requirements for Non-MAGI Groups – Territories – 2 1

1. S2T-Financial Eligibility Requirements for Non-MAGI Groups – Territories – Screenshots

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	SPA ID N/A
Submission Type Draft	Initial Submission Date N/A
Approval Date N/A	Effective Date N/A
Superseded SPA ID GU-17-0237-xxxx <small>System-Derived</small>	

[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. 5435.603):

A. Financial Eligibility Methodologies +/-

The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. 5436.601.

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 5436.601.

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 5436.602.

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

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

Table of Contents

1.	S3 - Optional Eligibility Groups Screenshots.....	1
1.1	Package Header	1
1.2	A. Options for Coverage – Part 1	1
1.3	A. Options for Coverage – Part 2	2
1.4	A. Options for Coverage – Part 3	2
1.5	B. Medically Needy Options for Coverage –Part 1	3
1.6	B. Medically Needy Options for Coverage-Part 2, C. Additional Information (optional) and Eligibility Groups Deselected from Coverage	4

List of Figures

Figure 1: Package Header	1
Figure 2: Section A-Part 1	1
Figure 3: Section A-Part 2	2
Figure 4: Section A-Part 3	2
Figure 5: Section B-Part 1	3

List of Tables

No table of figures entries found.

1. S3 - Optional Eligibility Groups Screenshots

1.1 Package Header

Records / Submission Packages
NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Medicaid State Plan Eligibility

Optional 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 SPA ID N/A
 Submission Type Draft Initial Submission Date N/A
 Approval Date N/A Effective Date N/A
 Superseded SPA ID NV-17-4200-420G System-Derived

View Implementation Guide

VIEW ALL RESPONSES

Figure 1: Package Header

1.2 A. Options for Coverage – Part 1

News Tasks **Records** Reports Actions

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.*
 Yes No

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

Families and Adults

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

Figure 2: Section A-Part 1

1.3 A. Options for Coverage – Part 2

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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Cash except for Institutionalization		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Home and Community Based Services under Institutional Rules		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Optional State Supplement Beneficiaries - 1634 States, and SSI Criteria States with 1616 Agreements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Optional State Supplement Beneficiaries-209(b)States,and SSI Criteria States without 1616 Agreements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Institutionalized Individuals Eligible under a Special Income Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals participating in a PACE Program under Institutional Rules		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Hospice Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualified Disabled Children under Age 19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Poverty Level Aged or Disabled		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Work Incentives Eligibility Group		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Ticket to Work Basic Group		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Ticket to Work Medical Improvements Group		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Figure 3: Section A-Part 2

1.4 A. Options for Coverage – Part 3

Ticket to Work Medical Improvements Group		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Family Opportunity Act Children with Disabilities		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Home and Community-Based Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Home and Community-Based Services - Special Income Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Figure 4: Section A-Part 3

1.5 B. Medically Needy Options for Coverage –Part 1

News Tasks **Records** Reports Actions

 Applan

B. Medically Needy Options for Coverage +/-

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

Yes No

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

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Children under Age 18		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Blind or Disabled Individuals Eligible in 1973		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Children Age 18 through 20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Parents and Other Caretakers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	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”

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
Medically Needy Aged, Blind or Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

C. Additional Information (optional)

Character count: 0/4000

Eligibility Groups Deselected from Coverage

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

- N/A

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

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EXIT SAVE REVIEWABLE UNIT GO TO SELECTED REVIEWABLE UNIT

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

Table of Contents

1. S3a – De-selected RU Screenshots	1
1.1 Package Header	1
1.2 Group No Longer Covered	1

List of Figures

Figure 1: Package Header	1
Figure 2: Group No Longer Covered	1

List of Tables

No table of figures entries found.

1. S3a – De-selected RU Screenshots

1.1 Package Header

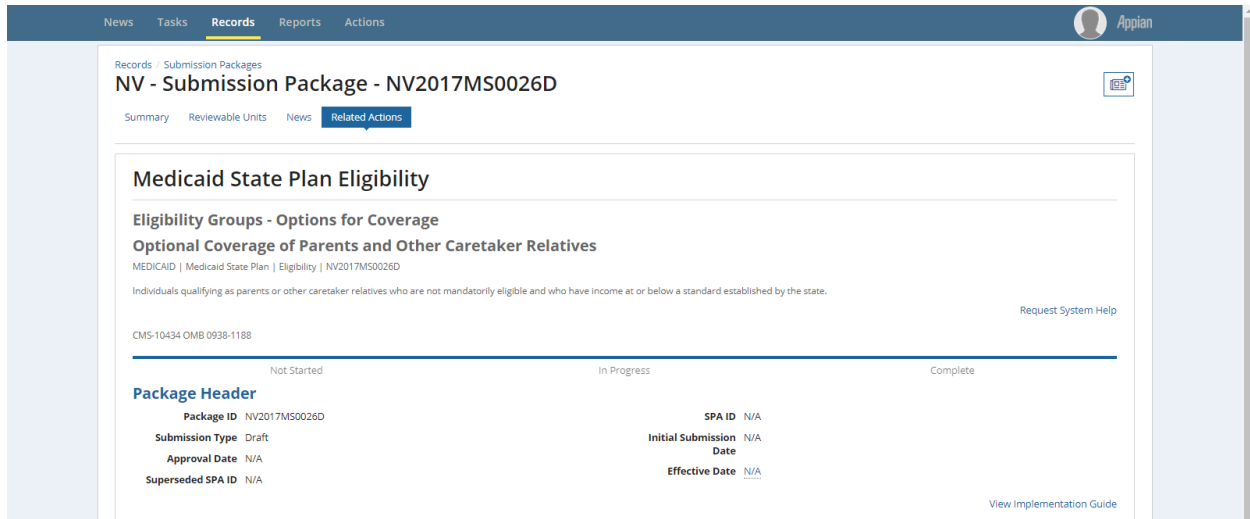


Figure 1: Package Header

1.2 Group No Longer Covered

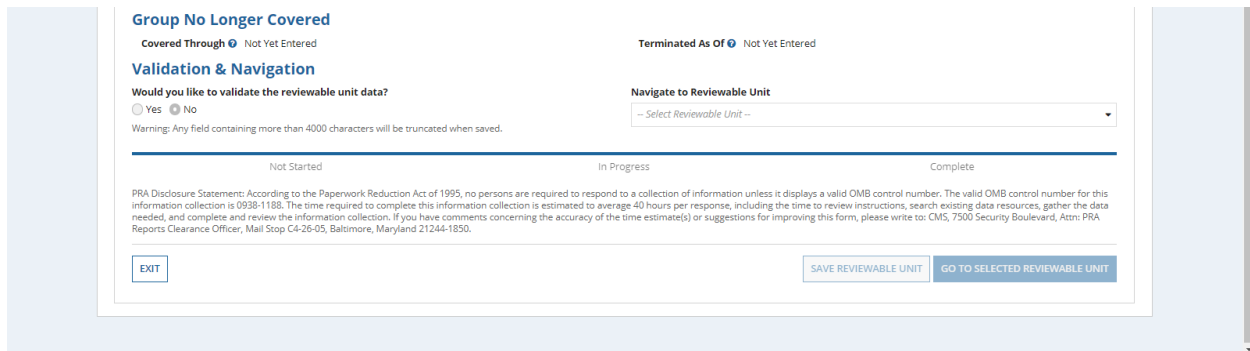


Figure 2: Group No Longer Covered



**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

Table of Contents

- 1. **S4 - Mandatory Eligibility Groups Screenshots** 1
 - 1.1 Package Header 1
 - 1.2 Mandatory Coverage – Section A - Part 1..... 1
 - 1.3 Mandatory Coverage – Section A-Part 2 and Section B 2
 - 1.4 Mandatory Coverage – Section C 2

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A-Part 1 1
- Figure 3: Section A-Part 2 and Section B..... 2
- Figure 4: Section C..... 2

List of Tables

No table of figures entries found.

1. S4 - Mandatory Eligibility Groups Screenshots

1.1 Package Header

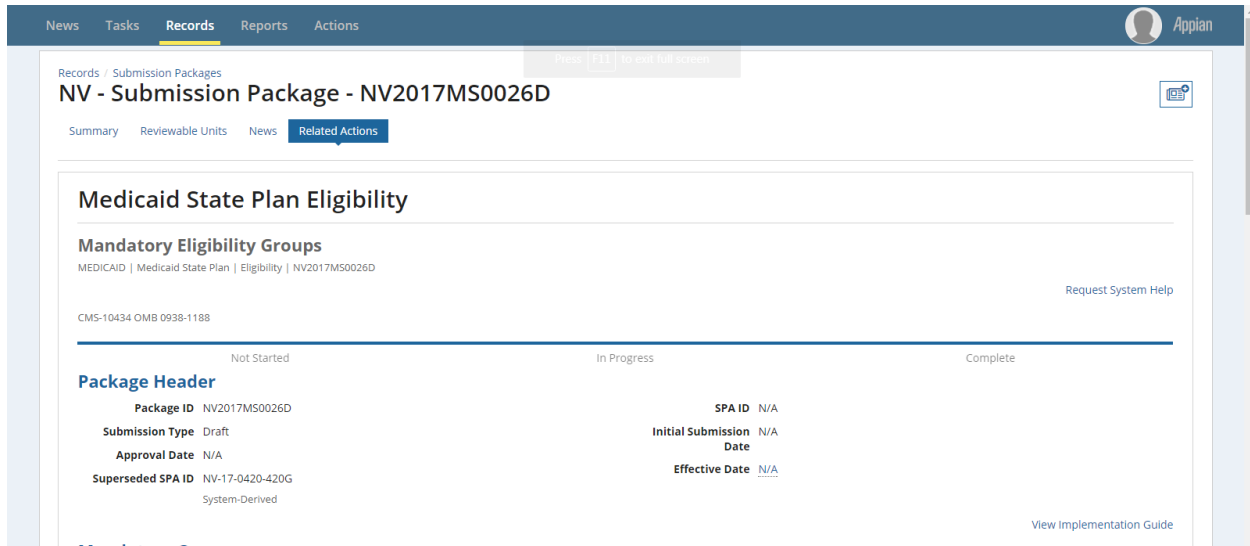


Figure 1: Package Header

1.2 Mandatory Coverage – Section A - Part 1

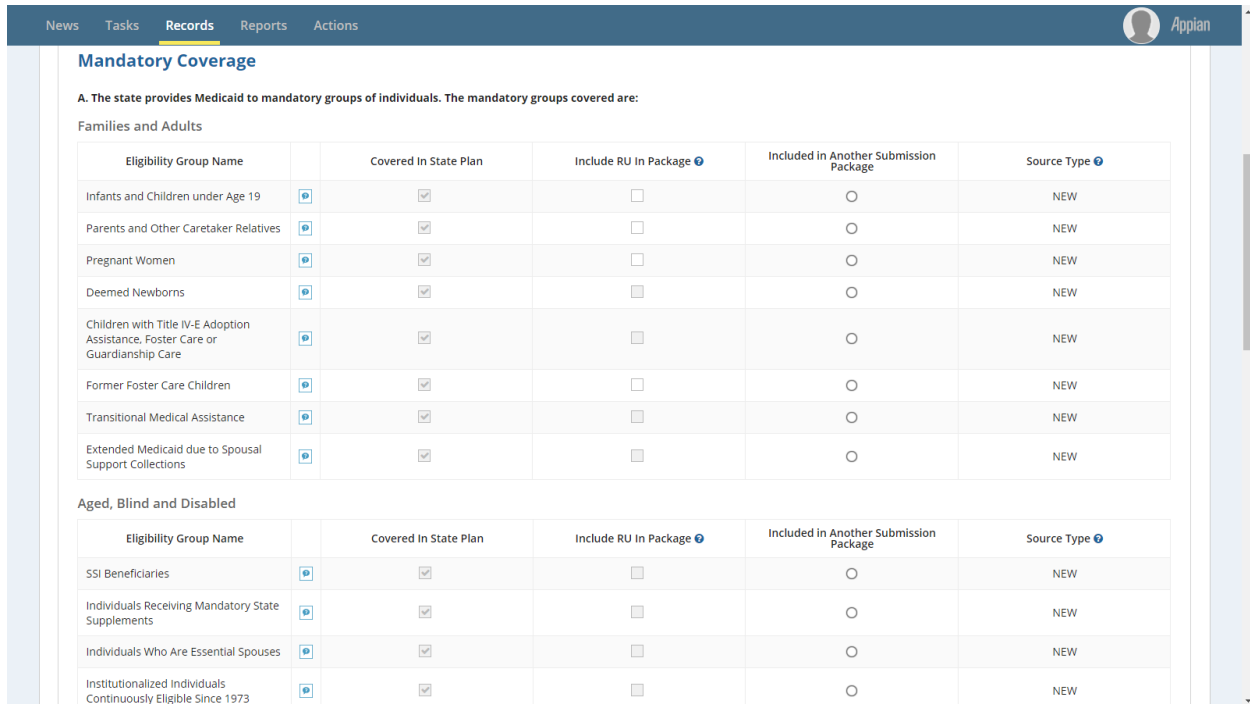


Figure 2: Section A-Part 1

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

News	Tasks	Records	Reports	Actions		
		Blind or Disabled Individuals Eligible in 1973	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increases since April, 1977	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Working Disabled under 1619(b)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Disabled Adult Children	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Qualified Medicare Beneficiaries	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Qualified Disabled and Working Individuals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Specified Low Income Medicare Beneficiaries	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		Qualifying Individuals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

B. The state elects the Adult Group, described at 42 C.F.R. §435.219. *
 Yes No

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	NEW

Figure 3: Section A-Part 2 and Section B

1.4 Mandatory Coverage – Section C

C. Additional Information (optional)

Character count: 0/4000

Eligibility Groups Deselected from Coverage

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

- N/A

Validation & Navigation

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

Navigate to Reviewable Unit
 -- Select Reviewable Unit --

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

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 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

Table of Contents

- 1. S10- MAGI Based Methodologies Screenshots..... 1**
 - 1.1 Section A. Household Composition..... 1
 - 1.2 Section B. Household Income 2
 - 1.3 Section B. Household Income – Path 1..... 3
 - 1.4 Section B. Household Income – Path 2..... 4
 - 1.5 Section C. Resource Test and Section D. Additional Information (optional) ... 5

List of Figures

- Figure 1: Section A- Household Composition..... 1
- Figure 2: Section B..... 2
- Figure 3: Section B- Path 1 3
- Figure 4: Section B- Path 2 4
- Figure 5: Section C and Section D 5

List of Tables

No table of figures entries found.

1. S10- MAGI Based Methodologies Screenshots


1.1 Section A. Household Composition

The screenshot displays a web interface for 'Medicaid State Plan Eligibility'. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The 'Actions' tab is active. A user profile icon for 'Appian' is visible in the top right corner. Below the navigation bar, the page title is 'Medicaid State Plan Eligibility'. Underneath, it says 'MAGI Based Methodologies' and provides a breadcrumb trail: 'MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D'. A 'Request System Help' link is on the right. A reference number 'CMS-10434 OMB 0938-1188' is shown. A progress bar indicates the current status is 'Not Started'. A 'Package Header' section lists details: Package ID (NV2017MS0026D), Submission Type (Draft), Approval Date (N/A), Superseded SPA ID (N/A), SPA ID (N/A), Initial Submission Date (N/A), and Effective Date (N/A). A 'View Implementation Guide' link and a 'VIEW ALL RESPONSES' button are also present. A note states: 'The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.' Section 'A. Household Composition' is expanded, showing three numbered items with radio button options:

- In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.
- In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:
 - a. The pregnant woman is counted just as herself.
 - b. The pregnant woman is counted as herself, plus one.
 - c. The pregnant woman is counted as herself, plus the number of children she is expected to deliver.
- In establishing household composition under the rules for non-filers set forth at 42 CFR 435.603(f)(3), the state elects the following age for children:
 - a. Age 19
 - b. Age 19, or in the case of full-time students, age 21

Figure 1: Section A- Household Composition

1.2 Section B. Household Income

News Tasks Records Reports **Actions** 

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:

- When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.
- 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.
- 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
- 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.
- 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

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.

6. In determining the eligibility of an individual using MAGI-based income, the state must subtract an amount equivalent to 5 percentage points of the federal 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.

7. Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes No

The state uses a specific nominal amount and frequency.

Yes No

a. The amount of the nominal amount is: *

b. Frequency of the nominal amount: *

i. Weekly

ii. Bi-weekly

iii. Monthly

iv. Quarterly


v. Yearly

c. Explanation: optional

Character count: 0/255

Figure 3: Section B- Path 1

1.4 Section B. Household Income – Path 2

News Tasks Records Reports **Actions** 

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.

6. In determining the eligibility of an individual using MAGI-based income, the state must subtract an amount equivalent to 5 percentage points of the federal 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.

7. Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

Yes No

The state uses a specific nominal amount and frequency.

• Yes No

Explanation of the state's methodology for determining the nominal amount: *

Character count: 0/255

C. Resource Test

+/-

Figure 4: Section B- Path 2

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

News Tasks Records Reports **Actions** Appian

Character count: 0/255

C. Resource Test

There is no resource test applied to eligibility groups that use MAGI-based methodologies.

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 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

Table of Contents

- 1. S10T- MAGI Based Methodologies - Territories Screenshots..... 1**
 - 1.1 Section A. Household Composition..... 1
 - 1.2 Section B. Household Income – Options 1-5..... 2
 - 1.3 Section B. Household Income – Options 6-8..... 2
 - 1.4 Section C. Resource Test and Section D. Additional Information (optional) ... 3

List of Figures

- Figure 1: Section A- Household Composition..... 1
- Figure 2: Section B-Options 1-5 2
- Figure 3: Section B- Options 6-8 2
- Figure 4: Section C and Section D 3

List of Tables

No table of figures entries found.

1. S10T- MAGI Based Methodologies - Territories Screenshots

1.1 Section A. Household Composition

The screenshot displays the 'Medicaid State Plan Eligibility' web application interface. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions' tabs, and a user profile icon for 'Applan'. The main content area is titled 'Medicaid State Plan Eligibility' and 'MAGI-Based Methodologies - Territories'. It includes a breadcrumb trail: 'MEDICAID | Medicaid State Plan | Eligibility | GU2017MS0031D'. A progress bar shows 'Not Started', 'In Progress', and 'Complete' stages. Below this is a 'Package Header' section with fields for Package ID (GU2017MS0031D), Submission Type (Draft), Approval Date (N/A), Superseded SPA ID (GU-17-1109-xxxxx, System-Derived), SPA ID (N/A), Initial Submission Date (N/A), and Effective Date (N/A). A 'VIEW ALL RESPONSES' button is visible. The main text states: 'The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603, except for 42 CFR 435.603 (d)(2), (d)(3), (f)(1), (f)(2), and (f)(5)'. Section 'A. Household Composition' is expanded, showing four numbered items with radio button options. Item 3 has three options, with option 'c' selected. Item 4 has two options, with option 'b' selected. Section 'B. Household Income' is partially visible below.

Figure 1: Section A- Household Composition

1.2 Section B. Household Income – Options 1-5

The screenshot shows a web application interface with a navigation bar at the top containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon labeled 'Appian' is in the top right. The main content area is titled 'B. Household Income' and contains the following text and options:

Financial eligibility is determined consistent with the following provisions:

- When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.
- 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.
- 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
- 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.
- 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

The screenshot shows a web application interface with a navigation bar at the top containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon labeled 'Appian' is in the top right. The main content area contains the following text and options:

- 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).
- 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.
- 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)

C. Resource Test

There is no resource test applied to eligibility groups that use MAGI-based methodologies.

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 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

Table of Contents

- 1. **S11 - Reasonable Classification Of Children – Limit Screenshots..... 1**
 - 1.1 Reasonable Classification of Children – Limit – Screenshot 1 1
 - 1.2 Reasonable Classification of Children - Limit– Screenshot 2 2
 - 1.3 Reasonable Classification of Children - Limit– Screenshot 3 2

List of Figures

- Figure 1: Reasonable Classification of Children - Limit– Screenshot 1 1
- Figure 2: Reasonable Classification of Children - Limit– Screenshot 2 2
- Figure 3: Reasonable Classification of Children - Limit– Screenshot 3 2

List of Tables

No table of figures entries found.

1. S11 - Reasonable Classification of Children – All Screenshots

1.1 Reasonable Classification of Children – Limit – Screenshot 1

News Tasks Records Reports **Actions**

Request System Help
View Implementation Guide

CMS-10434 OMB 0938-1188

Reasonable classifications of children not covered prior to January 1, 2014, that are now covered are:

- Individuals for whom public agencies are assuming full or partial financial responsibility.
 - Individuals placed in foster care homes by public agencies
Indicate the age which applies:
 - Under age 21
 - Under age 20
 - Under age 19
 - Under age 18
 - Individuals placed in private institutions by public agencies
Indicate the age which applies:
 - Under age 21
 - Under age 20
 - Under age 19
 - Under age 18
- Individuals placed in foster care homes by private, non-profit agencies
Indicate the age which applies:
 - Under age 21
 - Under age 20
 - Under age 19
 - Under age 18
- Individuals placed in private institutions by private, non-profit agencies
Indicate the age which applies:
 - Under age 21
 - Under age 20
 - Under age 19
 - Under age 18

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

1.2 Reasonable Classification of Children - All- Screenshot 2

The screenshot shows a web application interface with a top navigation bar containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is visible in the top right. The main content area contains several sections for selecting classification criteria:

- Individuals in adoptions subsidized in full or part by a public agency. Indicate the age which applies: Under age 21, Under age 20, Under age 19, Under age 18.
- Individuals in nursing facilities, if nursing facility services are provided under this plan. Indicate the age which applies: Under age 21, Under age 20, Under age 19, Under age 18.
- Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID), if these services are provided under this plan. Indicate the age which applies: Under age 21, Under age 20, Under age 19, Under age 18.
- Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan. Indicate the age which applies: Under age 21, Under age 20, Under age 19, Under age 18.
- Other reasonable classifications. Below this are fields for 'Name of Classification' and 'Description'.

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

1.3 Reasonable Classification of Children - All- Screenshot 3

This screenshot focuses on the 'Other reasonable classifications' section of the form. It includes:

- Other reasonable classifications.
- A text input field for 'Name of Classification: *' with a note: 'Name of Classification cannot be edited once saved.'
- A text area for 'Description: *' with a character count of 0/4000.
- Radio buttons for age selection: Under age 21, Under age 20, Under age 19, Under age 18.
- A '+ Add Classification' button.
- A PRA Disclosure Statement at the bottom: '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.'
- 'CANCEL' and 'SAVE CLASSIFICATIONS' buttons at the bottom.

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

Table of Contents

- 1. **S11a - Reasonable Classification of Children – Limit Screenshots 1**
 - 1.1 Reasonable Classification of Children – Limit – Screenshot 1 1
 - 1.2 Reasonable Classification of Children - Limit– Screenshot 2 2
 - 1.3 Reasonable Classification of Children - Limit– Screenshot 3 2

List of Figures

- Figure 1: Reasonable Classification of Children - Limit– Screenshot 1 1
- Figure 2: Reasonable Classification of Children - Limit– Screenshot 2 2
- Figure 3: Reasonable Classification of Children - Limit– Screenshot 3 2

List of Tables

No table of figures entries found.

1. S11a - Reasonable Classification of Children – Limit Screenshots

1.1 Reasonable Classification of Children – Limit – Screenshot 1

News Tasks Records Reports **Actions**

Request System Help
View Implementation Guide

CMS-10434 OMB 0938-1188

Reasonable classifications of children that are covered are:

- Individuals for whom public agencies are assuming full or partial financial responsibility.
 - Individuals placed in foster care homes by public agencies
Indicate the age which applies:
 - Age 19
 - Age 20
 - Age 19 and age 20
 - Individuals placed in private institutions by public agencies
Indicate the age which applies:
 - Age 19
 - Age 20
 - Age 19 and age 20
- Individuals in adoptions subsidized in full or part by a public agency
Indicate the age which applies:
- Individuals placed in foster care homes by private, non-profit agencies
Indicate the age which applies:
 - Age 19
 - Age 20
 - Age 19 and age 20
- Individuals placed in private institutions by private, non-profit agencies
Indicate the age which applies:
 - Age 19
 - Age 20
 - Age 19 and age 20

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

1.2 Reasonable Classification of Children - Limit- Screenshot 2

News Tasks Records Reports **Actions** Applan

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

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

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

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

Other reasonable classifications
Name of Classification: *

Name of Classification cannot be edited once saved.
Indicate the age which applies:
 Age 19
 Age 20
 Age 19 and age 20
[+ Add Classification](#)

Description: *

Character count: 0/4000

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
[+ Add Classification](#)

Character count: 0/4000

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 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

Table of Contents

- 1. **S13a - Income Standard Screenshots..... 1**
 - 1.1 Income Standard – Path 1..... 1
 - 1.2 Income Standard – Path 2..... 2
 - 1.3 Income Standard – Path 3..... 2
 - 1.4 Income Standard – Path 4..... 3

List of Figures

- Figure 1: Income Standard – Path 1..... 1
- Figure 2: Income Standard – Path 2..... 2
- Figure 3: Income Standard – Path 3..... 2
- Figure 4: Income Standard – Path 4..... 3

List of Tables

No table of figures entries found.

1. S13a - Income Standard Screenshots

1.1 Income Standard – Path 1

The screenshot shows a web form titled "Income Standard" with a navigation bar at the top containing "News", "Tasks", "Records", "Reports", and "Actions". A user profile icon for "Applan" is in the top right. The form content includes:

- Header: "Income Standard" with links for "Request System Help" and "View Implementation Guide".
- Form ID: "CMS-10434 OMB 0938-1188".
- Standard Selection: Radio buttons for "Statewide standard" (selected), "Standard varies by region", "Standard varies by living arrangement", and "Standard varies in some other way".
- Statewide Standard Definition: A table with columns "Household size" and "Standard". The first row shows "1" in the household size column and an empty field in the standard column.
- Additional Amount: Radio buttons for "The state uses an additional incremental amount for larger household sizes." (selected "Yes"). A text field for "Incremental Amount *".
- Automatic Increase: Radio buttons for "The dollar amounts increase automatically each year *" (selected "Yes").
- Increase Basis: Radio buttons for "The basis of the increase is: *" (selected "Other basis"). A text field for "Name of basis *".
- Annual Increase: Radio buttons for "The annual increase occurs in the month and day indicated:". Two dropdown menus for "Every" (Select Day) and "of" (Select Month).
- Footer: A small PRA Disclosure Statement.

Figure 1: Income Standard – Path 1

1.2 Income Standard – Path 2

CMS-10434 OMB 0938-1188

Statewide standard
 Standard varies by region
 Standard varies by living arrangement
 Standard varies in some other way

The standard by regions is:

Regions used

Name of region *

Description *

+Add Regions

The dollar amounts increase automatically each year *

Yes No

The basis of the increase is: *

CPI-U
 Other basis

The annual increase occurs in the month and day indicated:

* Every * of

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.

CANCEL SAVE INCOME STANDARD

Figure 2: Income Standard – Path 2

1.3 Income Standard – Path 3

CMS-10434 OMB 0938-1188

Statewide standard
 Standard varies by region
 Standard varies by living arrangement
 Standard varies in some other way

The standard by living arrangement is:

Living arrangements used

Name of living arrangement *

Description *

+Add Living arrangements

The dollar amounts increase automatically each year *

Yes No

The basis of the increase is: *

CPI-U
 Other basis

The annual increase occurs in the month and day indicated:

* Every * of

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.

CANCEL SAVE INCOME STANDARD

Figure 3: Income Standard – Path 3

1.4 Income Standard – Path 4

CMS-10434 OMB 0938-1188

Statewide standard
 Standard varies by region
 Standard varies by living arrangement
 Standard varies in some other way

The standard that varies by some other way is:

Variations used

Name *

Description *

+Add Variations

The dollar amounts increase automatically each year *
 Yes No

The basis of the increase is: *
 CPI-U
 Other basis

The annual increase occurs in the month and day indicated:

* Every * of

The standard expressed in dollar amounts is:

Household size	Standard
1	<input type="text"/>

+Add a household size

The state uses an additional incremental amount for larger household sizes. *
 Yes No

Incremental Amount *

Delete

Name of basis *

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 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

Table of Contents

1. S14-AFDC Income Standards – Screenshots	1
1.1 AFDC Income Standards	1

List of Figures

Figure 1: AFDC Income Standards - 1	1
Figure 2: AFDC Income Standards – 2	2
Figure 3: AFDC Income Standards – 3	2

1. S14-AFDC Income Standards – Screenshots

1.1 AFDC Income Standards

Medicaid State Plan Eligibility

AFDC Income Standards

MEDICAID | Medicaid State Plan | Eligibility | 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](#)

[VIEW ALL RESPONSES](#)

A. MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

+/-

[ADD INCOME STANDARDS](#)

B. AFDC Payment Standard in Effect As of July 16, 1996

+/-

[ADD INCOME STANDARDS](#)

Figure 1: AFDC Income Standards - 1

C. MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996 +/-
ADD INCOME STANDARDS

D. AFDC Need Standard in Effect As of July 16, 1996 +/-
ADD INCOME STANDARDS

E. 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. +/-
ADD INCOME STANDARDS

F. MAGI-equivalent 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. +/-
ADD INCOME STANDARDS

G. TANF payment standard +/-
ADD INCOME STANDARDS

H. MAGI-equivalent TANF payment standard +/-
ADD INCOME STANDARDS

Figure 2: AFDC Income Standards – 2

I. 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 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: 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

Table of Contents

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

List of Figures

Figure 1: Income Standards – Poverty Level – Territories – 1 1
Figure 2: Income Standards – Poverty Level – Territories – 2 1

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

1.1 Income Standards – Poverty Level – Territories

Medicaid State Plan Eligibility

Income Standards - Poverty Level - 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	SPA ID N/A
Submission Type Draft	Initial Submission Date N/A
Approval Date N/A	Effective Date N/A
Superseded SPA ID GU-17-1109-xxxx <small>System-Derived</small>	

[View Implementation Guide](#)

VIEW ALL RESPONSES

A. Territory Poverty Level +/-

The poverty level used by the territory is:*

1. The Federal Poverty Level (FPL)

2. The Local Poverty Level (LPL)

a. The amount of the Local Poverty Level is:

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

a. The amount of the Local Poverty Level is:

Household Size	Amount
No items available	

Household amounts must be filled in

[+Add a household size](#)

b. The amounts above are related to the following time period:*

Monthly

Yearly

Wherever FPL is referenced in the other sections of the state plan, it means the Local Poverty Level.

B. Additional Information (optional) +/-

Character count: 0/4000

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

Table of Contents

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

List of Figures

Figure 1: Income Standards - AFDC-related – Territories – 1	1
Figure 2: Income Standards - AFDC-related – Territories – 2	1
Figure 3: Income Standards - AFDC-related – Territories – 3	2

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

1.1 Income Standards - AFDC-related – Territories

Medicaid State Plan Eligibility

Income Standards - AFDC-related - Territories
MEDICAID | Medicaid State Plan | Eligibility | GU2017MS0033D

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CMS-10434 OMB 0938-1188

Not Started	In Progress	Complete
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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 GU-17-1109-xxxx <small>System-Derived</small>	

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A. MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

+/-

[ADD INCOME STANDARDS](#)

B. AFDC Payment Standard in Effect As of July 16, 1996

+/-

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

C. MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

+/-

[ADD INCOME STANDARDS](#)

D. AFDC Need Standard in Effect As of July 16, 1996

+/-

[ADD INCOME STANDARDS](#)

E. 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.

+/-

[ADD INCOME STANDARDS](#)

F. MAGI-equivalent 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.

+/-

[ADD INCOME STANDARDS](#)

G. TANF payment standard

+/-

[ADD INCOME STANDARDS](#)

H. MAGI-equivalent TANF payment standard

+/-

[ADD INCOME STANDARDS](#)

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

I. Additional Information (optional) +/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

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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

Table of Contents

1.	S16 - Presumptive Eligibility for Children under Age 19 Screenshots.....	1
1.1	Package Header	1
1.2	A. Presumptive Eligibility Income Standard, B. Presumptive Eligibility Age Limit and C. Presumptive Eligibility Period	2
1.3	D. Application for Presumptive Eligibility–Part 1.....	3
1.4	D. Application for Presumptive Eligibility–Part 2 and E. Presumptive Eligibility Determination.....	4
1.5	F. Qualified Entities	4
1.6	G. Additional Information (optional).....	5

List of Figures

Figure 1: Package Header	1
Figure 2: Section A, Section B and Section C.....	2
Figure 3: Section D-Part 1.....	3
Figure 4: Section D-Part 2 and Section E.....	4
Figure 5: Section F.....	4
Figure 6: Section G	5

List of Tables

No table of figures entries found.

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

1.1 Package Header

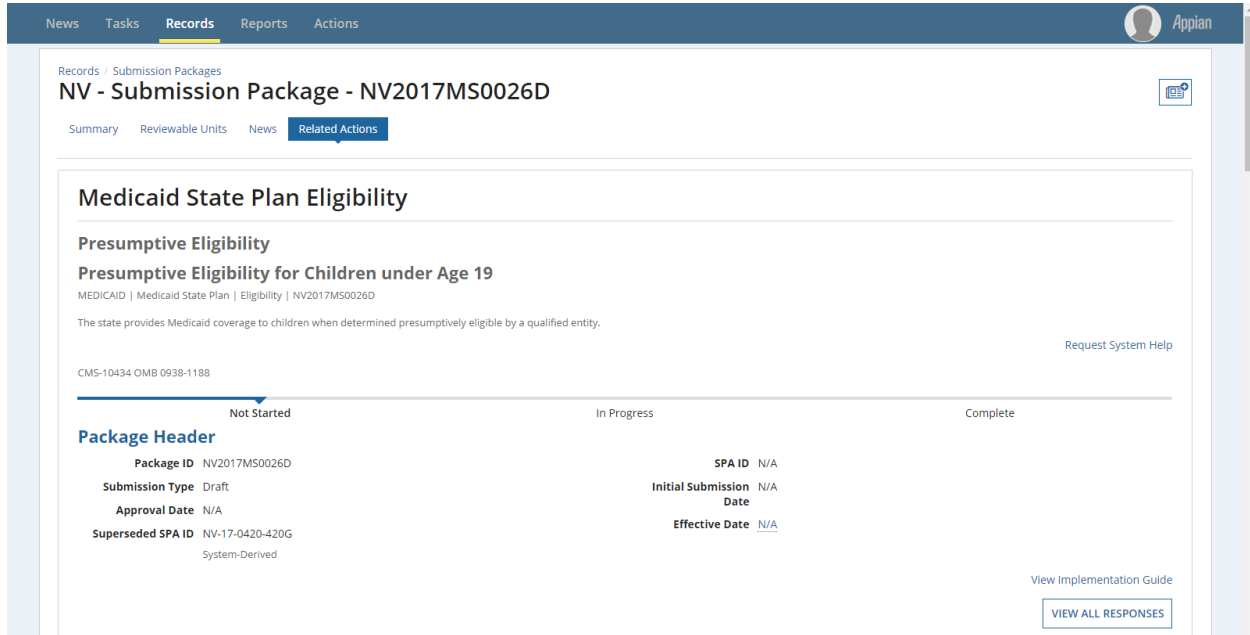


Figure 1: Package Header

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

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Presumptive eligibility for children is determined under the following provisions:

A. Presumptive Eligibility Income Standard +/-

2. The income standard for presumptive eligibility is the higher of the standard used for Targeted Low-income Children (42 CFR 435.229) or the standard used for Infants and Children under 19 (42 CFR 435.118), for that child's age.

[View approved version of the Infants and Children under Age 19 eligibility group](#)
[View approved version of Optional Targeted Low Income Children](#)

B. Presumptive Eligibility Age Limit +/-

Children under the following age may be determined presumptively eligible:

Under age:

C. 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

[+ Add Limitation](#)

Figure 2: Section A, Section B and Section C

1.3 D. Application for Presumptive Eligibility–Part 1

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D. 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.

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

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

Saved Documents

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<input checked="" type="checkbox"/>			

Figure 3: Section D-Part 1

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

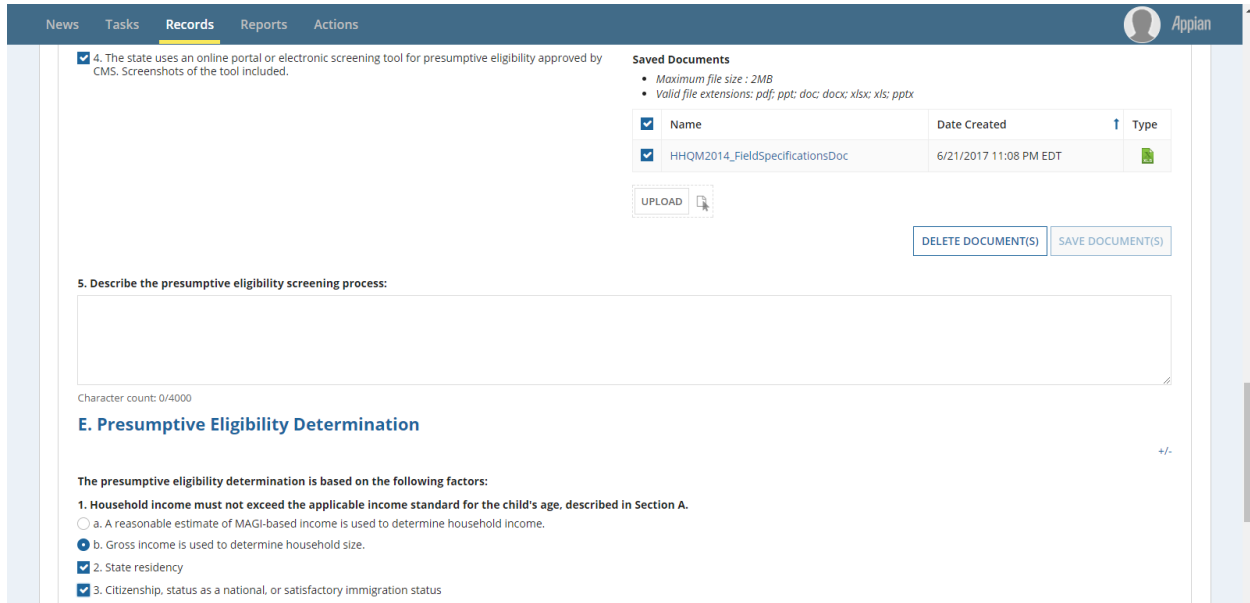


Figure 4: Section D-Part 2 and Section E

1.5 F. Qualified Entities

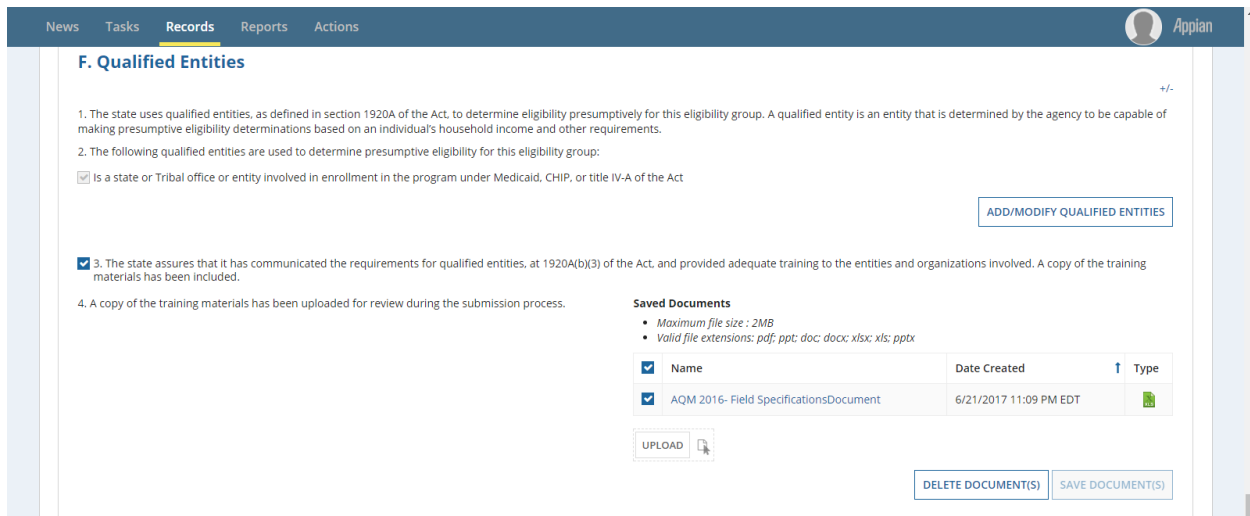


Figure 5: Section F



**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

Table of Contents

1. S17 - Qualified Entities Screenshots.....	1
1.1 Qualified Entities – Part 1.....	1
1.2 Qualified Entities – Part 2.....	1

List of Figures

Figure 1: Qualified Entities – Part 1.....	1
Figure 2: Qualified Entities – Part 2.....	1

List of Tables

No table of figures entries found.

1. S17 - Qualified Entities Screenshots

1.1 Qualified Entities – Part 1

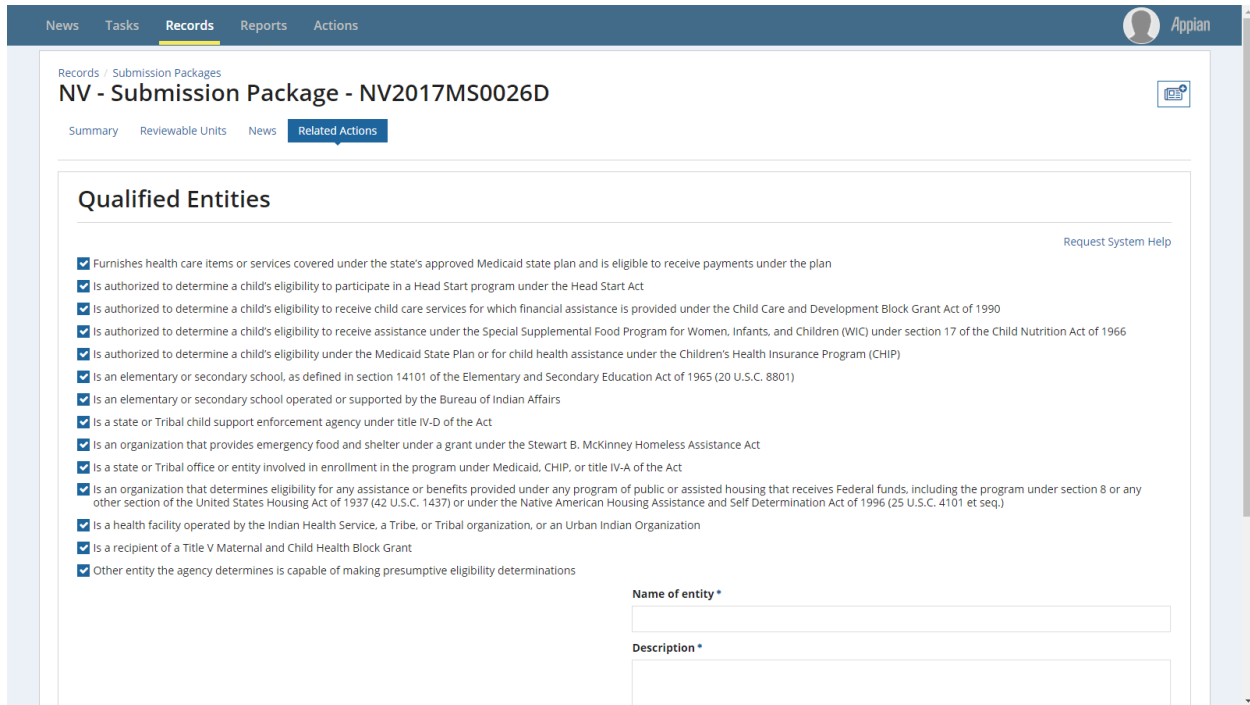


Figure 1: Qualified Entities – Part 1

1.2 Qualified Entities – Part 2

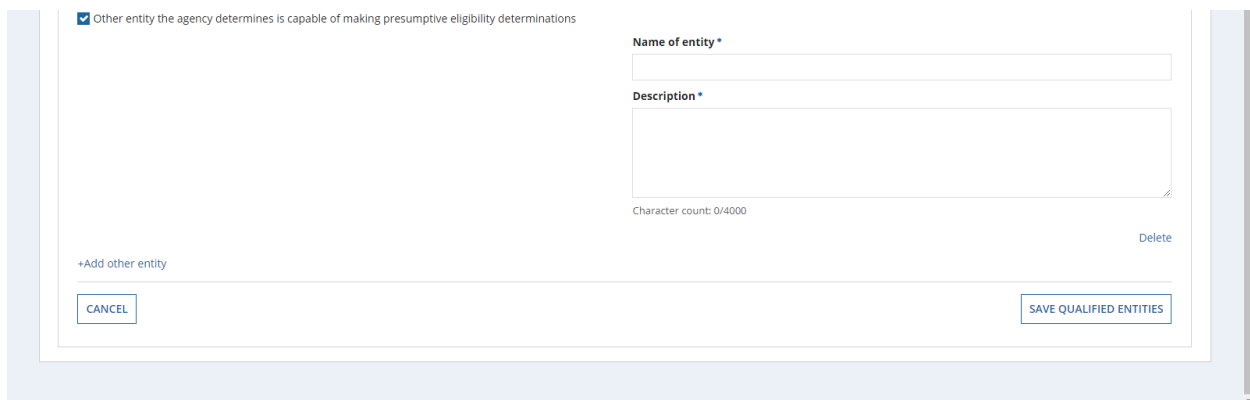


Figure 2: Qualified Entities – Part 2



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

Table of Contents

1. S21-Presumptive Eligibility by Hospitals – Screenshots 1
 1.1 Presumptive Eligibility by Hospitals..... 1

List of Figures

Figure 1: Presumptive Eligibility by Hospitals – 1 1
 Figure 2: Presumptive Eligibility by Hospitals – 2..... 2
 Figure 3: Presumptive Eligibility by Hospitals – 3..... 2
 Figure 4: Presumptive Eligibility by Hospitals – 4..... 3
 Figure 5: Presumptive Eligibility by Hospitals – 5..... 3
 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

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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

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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.

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 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

<input type="checkbox"/>	Name	Date Created	↑	Type
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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

<input type="checkbox"/>	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

5. Describe the presumptive eligibility screening process: *

Character count: 0/4000

F. Presumptive Eligibility Determination +/-

The presumptive eligibility determination is based on the following factors:

- The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)
- Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household size.
 - c. Other income methodology
- State residency
- Citizenship, status as a national, or satisfactory immigration status

G. Qualified Entity Requirements +/-

- The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.
- 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

Figure 6: Presumptive Eligibility by Hospitals – 6

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

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H. Additional Information (optional) +/-

Character count: 0/4000

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

Table of Contents

1.	S25-Parents and Other Caretaker Relatives – Screenshots.....	1
1.1	Section A. “Characteristics”	1
1.2	Section A. “Characteristics” Option C.ii – Path 1	2
1.3	Section A. “Characteristics” Option C.ii – Path 2.....	2
1.4	Section A. “Characteristics” Option C.ii – Path 3.....	2
1.5	Section C. “Income Standard Used” – Path 1	2
1.6	Section C. “Income Standard Used” – Path 2	3
1.7	Section D. “Basis for Income Standard” – Path 1	3
1.8	Section D. “Basis for Income Standard” – Path 2.....	4
1.9	Section E. “Additional Information”	4

List of Figures

Figure 1: Characteristics – 1	1
Figure 2: Characteristics – 2	1
Figure 3: Characteristics Option C.ii – 1.....	2
Figure 4: Characteristics Option C.ii – 2.....	2
Figure 5: Characteristics Option C.ii – 3.....	2
Figure 6: Income Standard Used – 1.....	2
Figure 7: Income Standard Used – 2.....	3
Figure 8: Basis for Income Standard – 1	3
Figure 9: Basis for Income Standard – 2.....	4
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 | CA2017M50013D

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

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Package Header

Package ID	CA2017M50013D	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		

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[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

c. Options relating to the definition of dependent child:

i. The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

ii. The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

(1) The principal earner may work 100 or more hours per month and still qualify as unemployed.

(2) The principal earner may earn up to a specific dollar amount and still qualify as unemployed.

(3) Other less restrictive standard

Number of hours used:

Figure 3: Characteristics Option C.ii – 1

1.3 Section A. “Characteristics” Option C.ii – Path 2

c. Options relating to the definition of dependent child:

i. The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

ii. The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

(1) The principal earner may work 100 or more hours per month and still qualify as unemployed.

(2) The principal earner may earn up to a specific dollar amount and still qualify as unemployed.

(3) Other less restrictive standard

* Specific dollar limit of earnings:

The entry must be greater than zero

Figure 4: Characteristics Option C.ii – 2

1.4 Section A. “Characteristics” Option C.ii – Path 3

c. Options relating to the definition of dependent child:

i. The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

ii. The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

(1) The principal earner may work 100 or more hours per month and still qualify as unemployed.

(2) The principal earner may earn up to a specific dollar amount and still qualify as unemployed.

(3) Other less restrictive standard

Name of other standard	Description	Delete
No items available		

Figure 5: Characteristics Option C.ii – 3

1.5 Section C. “Income Standard Used” – Path 1

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: FPL

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) +/-

Character count: 0/4000

Validation & Navigation

Would you like to validate the reviewable unit data?

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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

Table of Contents

1. S25a-Parents and Other Caretaker Relatives – Screenshots..... 1
1.1 Parents and Other Caretaker Relatives 1

List of Figures

Figure 1: Parents and Other Caretaker Relatives – 1..... 1
Figure 2: Parents and Other Caretaker Relatives – 2..... 2
Figure 3: Parents and Other Caretaker Relatives – 3..... 2
Figure 4: Parents and Other Caretaker Relatives – 4..... 3
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

Medicaid State Plan Eligibility

Presumptive Eligibility

Parents and Other Caretaker Relatives - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

The state covers parents and other caretaker relatives when determined presumptively eligible by a qualified entity.

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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

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[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.

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.

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

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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; xls; xlsx; pptx

<input type="checkbox"/>	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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

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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

C. Presumptive Eligibility Determination +/-

The presumptive eligibility determination is based on the following factors:

- The individual must be a caretaker relative, as described at 42 CFR 435.110.
- Household income must not exceed the applicable income standard described at 42 CFR 435.110.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household income.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

D. Qualified Entities +/-

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

[ADD/MODIFY QUALIFIED ENTITIES](#)
- 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.
- 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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

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

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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

Table of Contents

1.	S28-Pregnant Women – Screenshot	1
1.1	Section A. “Characteristics”	1
1.2	Section B. “Financial Methodologies” and Section C. “Income Standard Used”	1
1.3	Section D. “Benefits for Pregnant Women” – Path 1	2
1.4	Section D. “Benefits for Pregnant Women” – Path 2	2
1.5	Section D. “Benefits for Pregnant Women” – Path 3	2
1.6	Section E. “Basis for Pregnant Women Income Standard”	3
1.7	Section F. “Basis for income limit for full Medicaid coverage for pregnant women” – Path 1	3
1.8	Section F. “Basis for income limit for full Medicaid coverage for pregnant women” – Path 2	4
1.9	Section G. “Additional Information”	4

List of Figures

Figure 1: Characteristics	1
Figure 2: Financial Methodologies and Income Standard Used	1
Figure 3: Benefits for Pregnant Women – 1	2
Figure 4: Benefits for Pregnant Women – 2	2
Figure 5: Benefits for Pregnant Women – 3	2
Figure 6: Basis for Pregnant Women Income Standard	3
Figure 7: Basis for income limit for full Medicaid coverage for pregnant women – 1	3
Figure 8: Basis for income limit for full Medicaid coverage for pregnant women – 2	4
Figure 9: Additional Information	4

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.

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CMS-10434 OMB 0938-1188

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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

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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

D. Benefits for Pregnant Women

+/-

Benefits for individuals in this eligibility group consist of the following: *

- 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.
 - a. Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.
 - b. Full Medicaid coverage is provided only for pregnant women with income at or below a specific income limit.
 - c. Income limit used for full Medicaid coverage:
 - i. 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.
 - ii. A percentage of the federal poverty level:
 - iii. A dollar amount

[View approved version of MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988](#)

Figure 3: Benefits for Pregnant Women – 1

1.4 Section D. “Benefits for Pregnant Women” – Path 2

D. Benefits for Pregnant Women

+/-

Benefits for individuals in this eligibility group consist of the following: *

- 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.
 - a. Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.
 - b. Full Medicaid coverage is provided only for pregnant women with income at or below a specific income limit.
 - c. Income limit used for full Medicaid coverage:
 - i. 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.
 - ii. A percentage of the federal poverty level:

* FPL
 - iii. A dollar amount

Figure 4: Benefits for Pregnant Women – 2

1.5 Section D. “Benefits for Pregnant Women” – Path 3

D. Benefits for Pregnant Women

+/-

Benefits for individuals in this eligibility group consist of the following: *

- 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.
 - a. Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.
 - b. Full Medicaid coverage is provided only for pregnant women with income at or below a specific income limit.
 - c. Income limit used for full Medicaid coverage:
 - i. 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.
 - ii. A percentage of the federal poverty level:
 - iii. A dollar amount

ADD INCOME STANDARD

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) +/-

Character count: 0/4000

Validation & Navigation

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

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Figure 9: Additional Information



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

Medicaid and CHIP Program (MACPro)

S28a-Presumptive 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

Table of Contents

1. S28a-Presumptive Eligibility for Pregnant Women – Screenshots 1
 1.1 Presumptive Eligibility for Pregnant Women 1

List of Figures

Figure 1: Presumptive Eligibility for Pregnant Women– 1 1
Figure 2: Presumptive Eligibility for Pregnant Women – 2 2
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

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility for Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

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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](#)

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.

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

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:

- The woman must be pregnant.
- Household income must not exceed the applicable income standard at 42 CFR 435.116.**
 - A reasonable estimate of MAGI-based income is used to determine household income.
 - Gross income is used to determine household size.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

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; xls; xlsx; pptx

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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)

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

Table of Contents

1. S28T-Presumptive Eligibility for Pregnant Women – Screenshots	1
1.1 Presumptive Eligibility for Pregnant Women	1

List of Figures

Figure 1: Presumptive Eligibility for Pregnant Women – 1	1
Figure 2: Presumptive Eligibility for Pregnant Women – 2	2
Figure 3: Presumptive Eligibility for Pregnant Women – 3	2
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

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Submission Type Draft	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

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

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

UPLOAD

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

<input type="checkbox"/>	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

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

Figure 2: Presumptive Eligibility for Pregnant Women – 2

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

<input type="checkbox"/>	Name	Date Created	↑ Type
No items available			

UPLOAD

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

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:

- The woman must be pregnant.
- Household income must not exceed the applicable income standard at 42 CFR 435.116.**
 - A reasonable estimate of MAGI-based income is used to determine household income.
 - Gross income is used to determine household size.
- State residency
- 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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

[UPLOAD](#) 

[DELETE DOCUMENT\(S\)](#) [SAVE DOCUMENT\(S\)](#)

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

Table of Contents

1.	S30 - Infants and Children under Age 19 Screenshots	1
1.1	Package Header	1
1.2	A. Characteristics and B. Financial Methodologies and C. Income Standards Used.....	1
1.3	D. Basis for the Income Standard for Infants under Age 1 – Path 1	2
1.4	D. Basis for the Income Standard for Infants under Age 1 – Path 2.....	2
1.5	E. Basis for the Income Standard for Children Age One through Age Five	3
1.6	F. Basis for the Income Standard for Children Age Six through Age Eighteen	3
1.7	G. Additional Information (optional).....	4

List of Figures

Figure 1: Package Header	1
Figure 2: Section A, Section B and Section C	1
Figure 3: Section D-Path1	2
Figure 4: Section D-Path2	2
Figure 5 : Section E.....	3
Figure 6 : Section F	3
Figure 7 : Section G	4

List of Tables

No table of figures entries found.

1. S30 - Infants and Children under Age 19 Screenshots

1.1 Package Header

Records / Submission Packages
NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19
 MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D

Infants and children under age 19 with household income at or below standards established by the state based on age group.

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	

Request System Help

View Implementation Guide

[VIEW ALL RESPONSES](#)

The state covers the mandatory infants and children under age 19 group in accordance with the following provisions:

Figure 1: Package Header

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

The state covers the mandatory infants and children under age 19 group in accordance with the following provisions:

A. Characteristics

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

- Are under age 19
- Have household income at or below the standard established by the state.

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 Standards Used

- The amount of the income standard for infants under age one is: * FPL
- The amount of the income standard for children age one through five is: * FPL
- The amount of the income standard for children age six through eighteen is: * FPL

Figure 2: Section A, Section B and Section C

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

D. Basis for the Income Standard for Infants under Age 1

1. Minimum income standard

a. The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

b. Enter the amount of the minimum income standard (no higher than 185% FPL): * FPL

2. Maximum income standard

- a. The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.
- b. The state's maximum income standard for this age group is:
- i. The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(i)(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 infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(i)(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 infants under age one 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 infants under age one 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 3: Section D-Path1

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

D. Basis for the Income Standard for Infants under Age 1

1. Minimum income standard

a. The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

b. The minimum income standard for infants under age one 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 infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.
- b. The state's maximum income standard for this age group is:
- i. The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(i)(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 infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(i)(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 infants under age one 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 infants under age one 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 4: Section D-Path2

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

Figure 5 : Section E

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

Figure 6 : Section F



**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

Table of Contents

- 1. S30T- Infants and Children under Age 19 - Territories Screenshots 1**
 - 1.1 Package Header 1
 - 1.2 A. Characteristics and B. Financial Methodologies 1
 - 1.3 C. Income Standard Used and D. Basis for the Income Standard for Infants under Age 1 2
 - 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 2
 - 1.5 G. Additional Information (optional) 3

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A and Section B 1
- Figure 3: Section C and Section D 2
- Figure 4: Section E and Section F 2
- Figure 5: Section G 3

List of Tables

No table of figures entries found.

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

1.1 Package Header

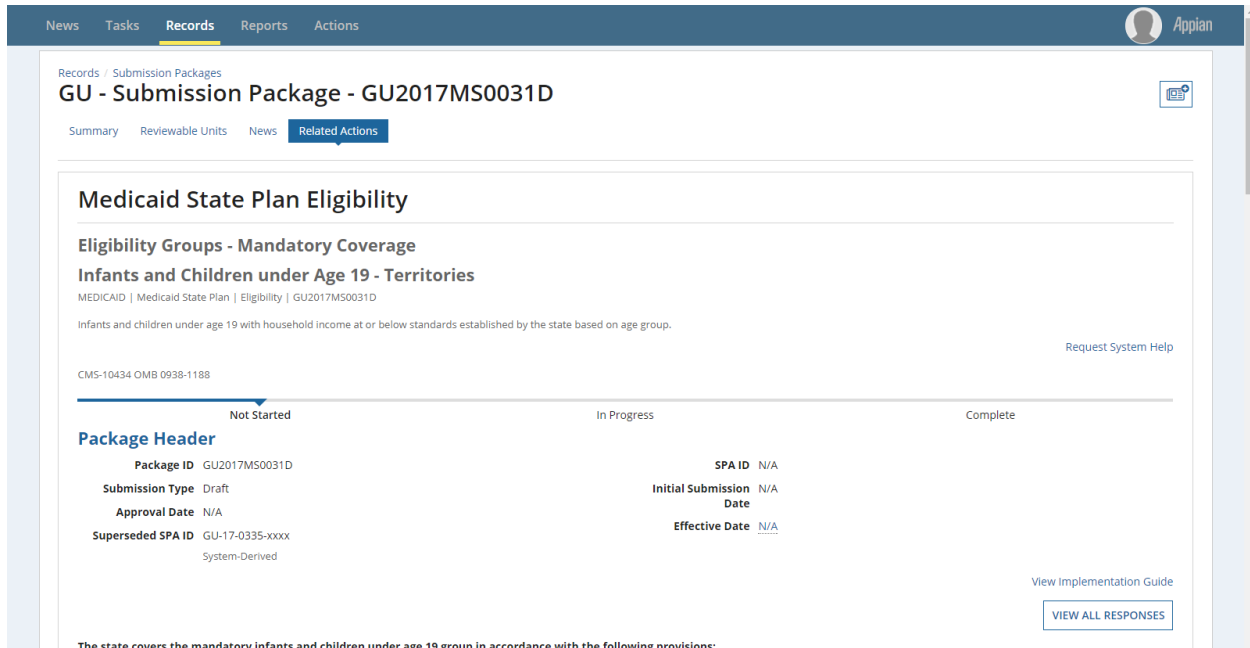


Figure 1: Package Header

1.2 A. Characteristics and B. Financial Methodologies

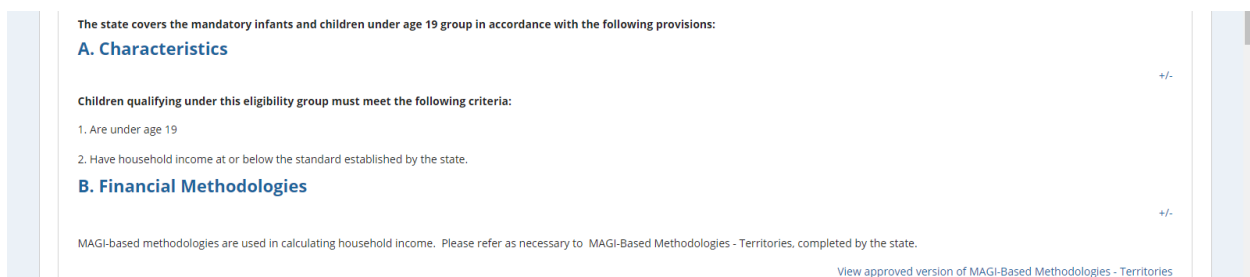


Figure 2: Section A and Section B

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

Figure 4: Section E and Section F

1.5 G. Additional Information (optional)

G. Additional Information (optional) +/-

2/20 test

Character count: 9/4000

Validation & Navigation

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

Navigate to Reviewable Unit
-- Select Reviewable Unit --

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

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.

EXITSAVE REVIEWABLE UNITGO TO SELECTED REVIEWABLE UNIT

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

Table of Contents

- 1. **S32 - Adult Group Screenshots** 1
 - 1.1 Package Header 1
 - 1.2 A. Characteristics, B. Financial Methodologies, C. Income Standard Used and D. Coverage of Dependent Children 1
 - 1.3 E. Additional Information (optional) 2

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A, Section B, Section C and Section D..... 1
- Figure 3: Section E..... 2

List of Tables

No table of figures entries found.

1. S32 - Adult Group Screenshots

1.1 Package Header

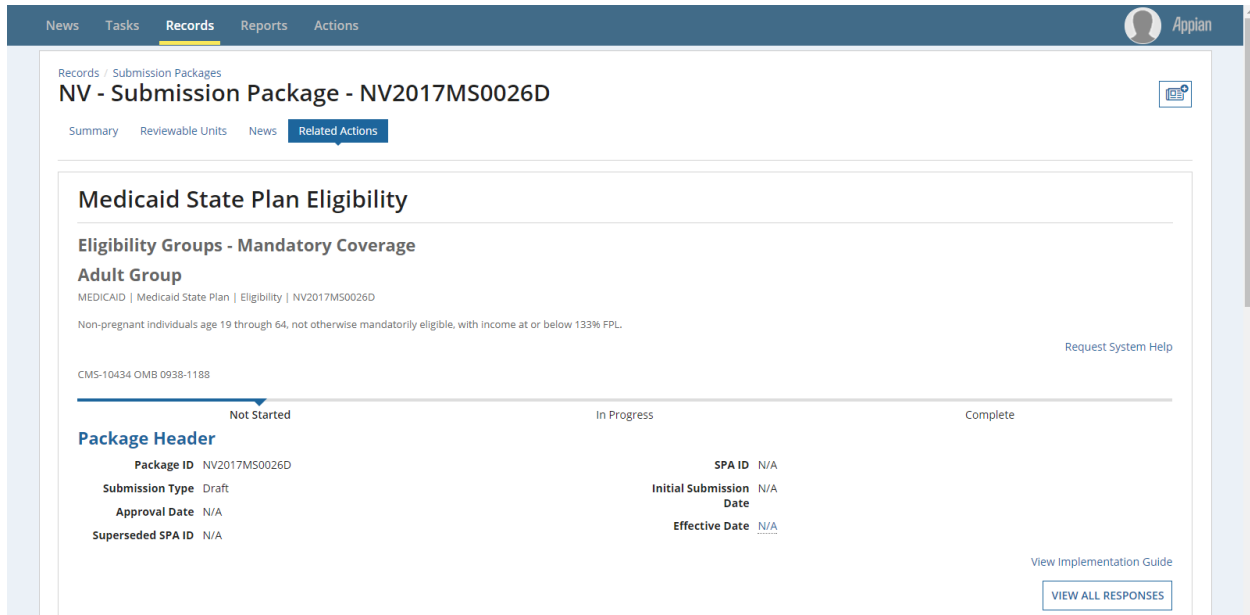


Figure 1: Package Header

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

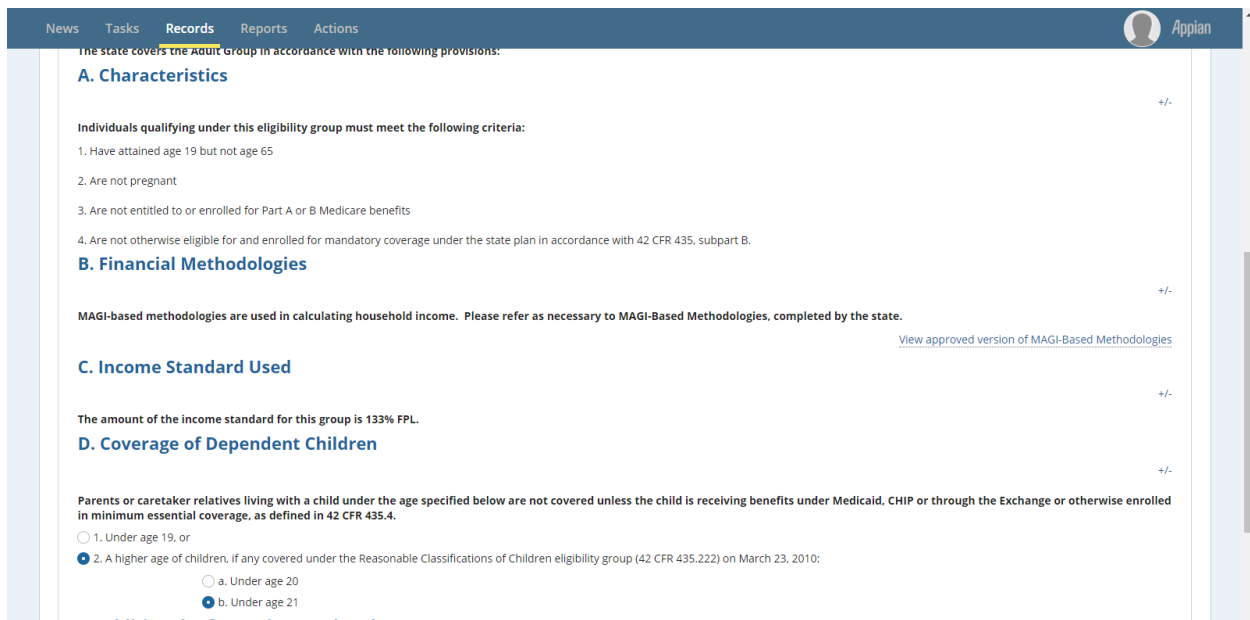


Figure 2: Section A, Section B, Section C and Section D



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

Table of Contents

1. S32a-Adult Group - Presumptive Eligibility 1
 1.1 Adult Group - Presumptive Eligibility 1

List of Figures

Figure 1: Adult Group - Presumptive Eligibility – 1 1
Figure 2: Adult Group - Presumptive Eligibility – 2 2
Figure 3: Adult Group - Presumptive Eligibility – 3 2
Figure 4: Adult Group - Presumptive Eligibility – 4 3
Figure 5: Adult Group - Presumptive Eligibility – 5 3

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

☐	Name	Date Created	↑ Type
No items available			

A document is required

UPLOAD

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Figure 3: Adult Group - Presumptive Eligibility – 3

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:

- The individual must meet the categorical requirements of 42 CFR 435.119.
- Household income must not exceed the applicable income standard described at 42 CFR 435.119.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household income.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

D. Qualified Entities

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


[ADD/MODIFY QUALIFIED ENTITIES](#)
- 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.
- A copy of the training materials has been uploaded for review during the submission process. **Saved Documents**

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

[UPLOAD](#) 

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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

Table of Contents

- 1. S32T-Adult Group - Presumptive Eligibility – Screenshots 1
 - 1.1 Adult Group - Presumptive Eligibility 1

List of Figures

- Figure 1: Adult Group - Presumptive Eligibility – 1 1
- Figure 2: Adult Group - Presumptive Eligibility – 2 2
- Figure 3: Adult Group - Presumptive Eligibility – 3 2
- Figure 4: Adult Group - Presumptive Eligibility – 4 3
- Figure 5: Adult Group - Presumptive Eligibility – 5 3

1. S32T-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 | Eligibility | GU2017MS0033D

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 GU2017MS0033D
Submission Type Draft
Approval Date N/A
Superseded SPA ID GU-17-0525-0001
 System-Derived

SPA ID N/A
Initial Submission Date N/A
Effective Date 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.

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

A document is required

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

A document is required

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

A document is required

5. Describe the presumptive eligibility screening process:

Figure 3: Adult Group - Presumptive Eligibility – 3

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:

- The individual must meet the categorical requirements of 42 CFR 435.119.
- Household income must not exceed the applicable income standard described at 42 CFR 435.119.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household income.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

D. Qualified Entities

Figure 4: Adult Group - Presumptive Eligibility – 4

D. Qualified Entities

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

[ADD/MODIFY QUALIFIED ENTITIES](#)
- 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.
- 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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

[UPLOAD](#)

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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)

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

Table of Contents

1. S33-Former Foster Care Children – Screenshots	1
1.1 Former Foster Care Children	1

List of Figures

Figure 1: Former Foster Care Children – 1	1
Figure 2: Former Foster Care Children – 2	1

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 N/A

Approval Date N/A

Date

Superseded SPA ID N/A

Effective Date 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

Table of Contents

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

List of Figures

Figure 1: Former Foster Care Children – Presumptive Eligibility – 1..... 1
Figure 2: Former Foster Care Children – Presumptive Eligibility – 2..... 2
Figure 3: Former Foster Care Children – Presumptive Eligibility – 3..... 2
Figure 4: Former Foster Care Children – Presumptive Eligibility – 4..... 3
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; xls; xlsx; pptx

<input type="checkbox"/>	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; xls; xlsx; pptx

<input type="checkbox"/>	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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	↑	Type
No items available				

UPLOAD 

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

5. Describe the presumptive eligibility screening process:

Character count: 0/4000

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



**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

Table of Contents

1. S50 - Individuals above 133% FPL under Age 65 Screenshots	1
1.1 Package Header	1
1.2 A. Characteristics, B. Financial Methodologies,	1
1.3 C. Individuals Covered	2
1.4 D. Income Standard Used – Path 1.....	2
1.5 D. Income Standard Used – Path 2.....	2
1.6 D. Income Standard Used – Path 3 – Screenshot 1.....	3
1.7 D. Income Standard Used – Path 3 – Screenshot 2.....	3
1.8 E. Coverage of Dependent Children	4
1.9 F. Phase-In.....	4
1.10 F. Phase-In – Add or Edit Phase – Path 1 – Screenshot 1	5
1.11 F. Phase-In – Add or Edit Phase – Path 1 – Screenshot 2	5
1.12 F. Phase-In – Add or Edit Phase – Path 2.....	6
1.13 F. Phase-In – Add or Edit Phase – Path 3.....	6
1.14 F. Phase-In – Add or Edit Phase – Path 4.....	7
1.15 F. Phase-In – Add or Edit Phase – Path 5.....	7
1.16 F. Phase-In – Add or Edit Phase – Path 6.....	8
1.17 G. Additional Information (optional).....	8

List of Figures

Figure 1: Package Header	1
Figure 2: Section A and Section B	1
Figure 3: Section C.....	2
Figure 4: Section D – Path 1	2
Figure 5: Section D – Path 2	2
Figure 6: Section D – Path 3 – Screenshot 1	3
Figure 7: Section D – Path 3 – Screenshot 2	3
Figure 8: Section E.....	4
Figure 9: Section F – Phase-In.....	4
Figure 10 : Section F - Add or Edit Phase – Path 1 – Screenshot 1.....	5
Figure 11 : Section F - Add or Edit Phase – Path 1 – Screenshot 2.....	5
Figure 12: Section F - Add or Edit Phase – Path 2.....	6

Figure 13: Section F - Add or Edit Phase – Path 3..... 6
Figure 14: Section F - Add or Edit Phase – Path 4..... 7
Figure 15: Section F - Add or Edit Phase – Path 5..... 7
Figure 16: Section F - Add or Edit Phase – Path 6..... 8
Figure 17: Section G 8

List of Tables

No table of figures entries found.

1. S50 - Individuals above 133% FPL under Age 65 Screenshots

1.1 Package Header

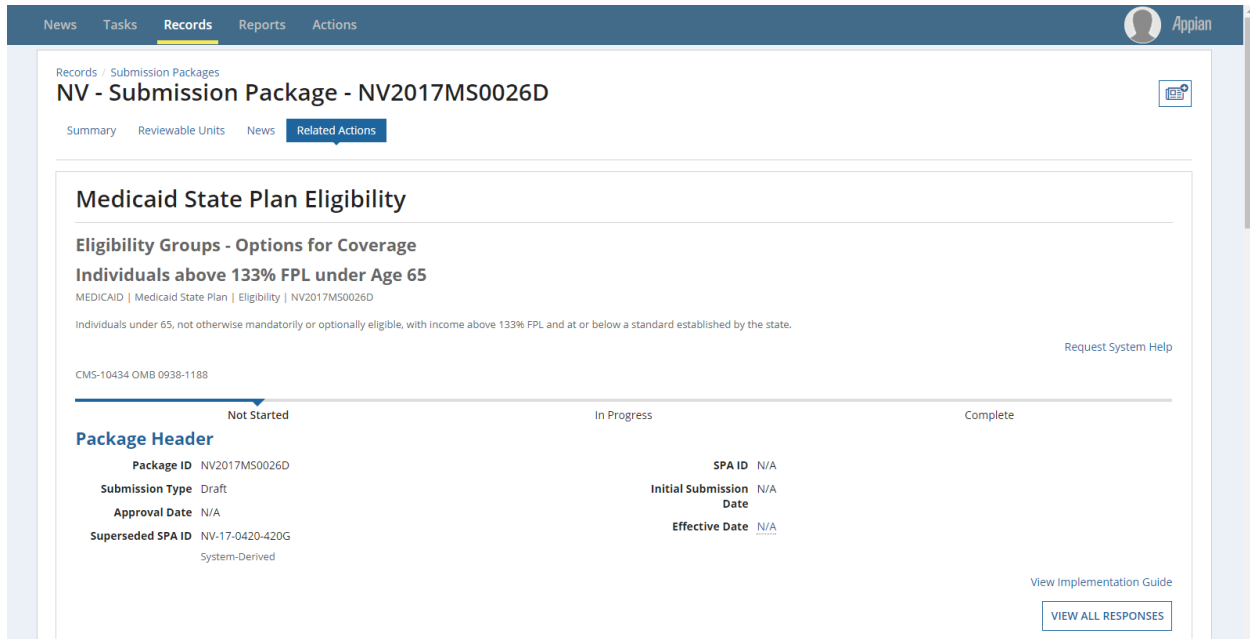


Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

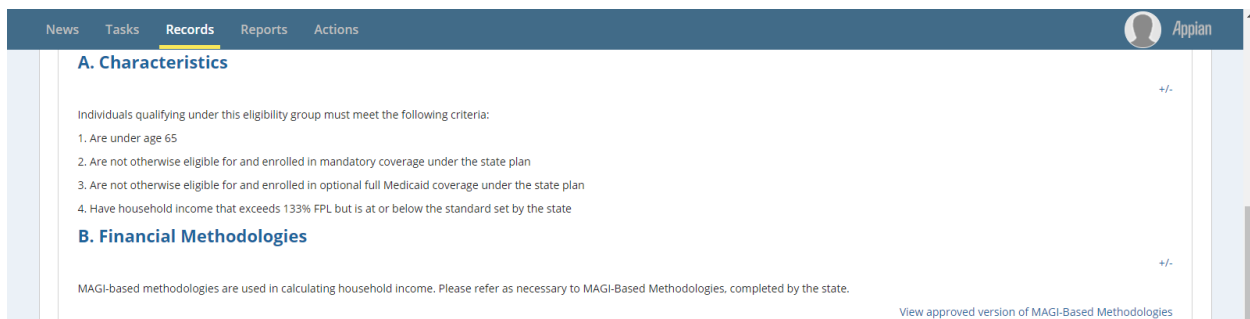


Figure 2: Section A and Section B

1.3 C. Individuals Covered

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

Population	Income Standard (%FPL)
All children under age 21	
Parents and other caretaker relatives	
Pregnant women	

Figure 5: Section D – Path 2

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

The screenshot shows a web form titled "D. Income Standard Used" with a navigation bar at the top containing "News", "Tasks", "Records", "Reports", and "Actions". A user profile icon for "Appian" is in the top right. The form content includes:

- Section 1: "The state uses the same income standard for all individuals covered.*" with radio buttons for "Yes" and "No".
- Section 2: "The income standard for all individuals eligible under the group, except for those populations separately identified, is:" followed by an "FPL" input field.
- Section 3: "The higher income standards for specific populations are:"
 - Sub-section a: "All children under a specified age limit:" with radio buttons for "Under age 21", "Under age 20", "Under age 19", and "Under age 18".
 - Sub-section b: "Reasonable classifications of children" with a "Name of population" and "Description" text area, a "Character count: 0/4000" indicator, and an "FPL" input field.
 - Sub-section c: "Parents and other caretaker relatives as defined in the Parents and Other Caretaker Relatives eligibility group, except for with respect to Income" with an "FPL" input field.
 - Sub-section d: "Pregnant women" with an "FPL" input field.

Figure 6: Section D – Path 3 – Screenshot 1

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

This screenshot shows a different view of the "D. Income Standard Used" form. It includes:

- Section d: "Pregnant women" with an "FPL" input field.
- Section e: "Other" with a "Name of population" and "Description" text area, a "Character count: 0/4000" indicator, and an "FPL" input field.
- A "+ Add population" link and a "VIEW TABLE" button at the bottom left.

Figure 7: Section D – Path 3 – Screenshot 2

1.8 E. Coverage of Dependent Children

The screenshot shows the 'E. Coverage of Dependent Children' configuration page. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The 'Records' tab is active. Below the navigation bar, the page title 'E. Coverage of Dependent Children' is displayed. The main content area contains the following text: 'Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.*'. Below this text are two radio button options: '1. Under age 19, or' and '2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:'. Option 2 is selected. Under option 2, there are two sub-options: 'a. Under age 20' and 'b. Under age 21', with 'b' selected.

Figure 8: Section E

1.9 F. Phase-In

The screenshot shows the 'F. Phase-In' configuration page. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The 'Records' tab is active. Below the navigation bar, the page title 'F. Phase-In' is displayed. The main content area contains the following text: 'The state elects to phase-in coverage to individuals in this group.*'. Below this text are two radio button options: 'Yes' and 'No', with 'Yes' selected. Below the radio buttons is a numbered list: '1. The phase-in plan must be reasonable and may not provide Medicaid to higher income individuals without providing Medicaid to lower-income individuals.'. Below this list is a table with the following columns: 'Phase Title', 'Phase Criterion', 'Criterion Choice', and 'Implementation Date'. The table is currently empty, with the text 'No items available' centered below it. To the right of the table is an 'ADD PHASE' button. Below the table is another numbered list: '2. The final date by which the phase-in will be complete and all individuals eligible for this group will be included is:'. Below this list is a 'Final Target Date:' label and a text input field with the placeholder 'mm/dd/yyyy'.

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

Table of Contents

- 1. **S50a - Individuals above 133% FPL under Age 65 - Presumptive Eligibility Screenshots** 1
 - 1.1 Package Header 1
 - 1.2 A. Presumptive Eligibility Period and B. Application for Presumptive Eligibility 2
 - 1.3 C. Presumptive Eligibility Determination and D. Qualified Entities 2
 - 1.4 E. Additional Information (optional) 3

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A and Section B 2
- Figure 3 : Section C and Section D 2
- Figure 4 : Section E 3

List of Tables

No table of figures entries found.

1. S50a - Individuals above 133% FPL under Age 65 - Presumptive Eligibility Screenshots

1.1 Package Header

News Tasks **Records** Reports Actions Applan

Records / Submission Packages
NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Medicaid State Plan Eligibility

Presumptive Eligibility

Individuals above 133% FPL under Age 65 - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D

The state covers individuals above 133% FPL 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	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		

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[VIEW ALL RESPONSES](#)

Figure 1: Package Header

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

A. Presumptive Eligibility Period

- The presumptive period begins on the date the determination is made.
- The end date of the presumptive period is the earlier of:
 - 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
 - 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.
- 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	

[+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.
3. The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.
4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Figure 2: Section A and Section B

1.3 C. Presumptive Eligibility Determination and D. Qualified Entities

C. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

- The individual must meet the categorical requirements of 42 CFR 435.218.
- Household income must not exceed the applicable income standard described at 42 CFR 435.218.
 - 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

- 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 that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.
- 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.
- 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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

[UPLOAD](#)

[DELETE DOCUMENT\(S\)](#) [SAVE DOCUMENT\(S\)](#)

Figure 3 : Section C and Section D



**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

Table of Contents

- 1. S51- Optional Coverage of Parents and Other Caretaker Relatives Screenshots 1**
- 1.1 Package Header 1
- 1.2 A. Characteristics, B. Financial Methodologies, C. Coverage Prior to January 1, 2014 and D. Income Standard Used–Path 1 2
- 1.3 D. Income Standard Used – Path 2..... 2
- 1.4 E. Basis for Income Standard..... 3
- 1.5 F. Additional Information (optional) 3

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A, Section B, Section C and Section D-Path1 2
- Figure 3: Section D–Path 2 2
- Figure 4: Section E..... 3
- Figure 5: Section F..... 3

List of Tables

No table of figures entries found.

1. S51- Optional Coverage of Parents and Other Caretaker Relatives Screenshots

1.1 Package Header

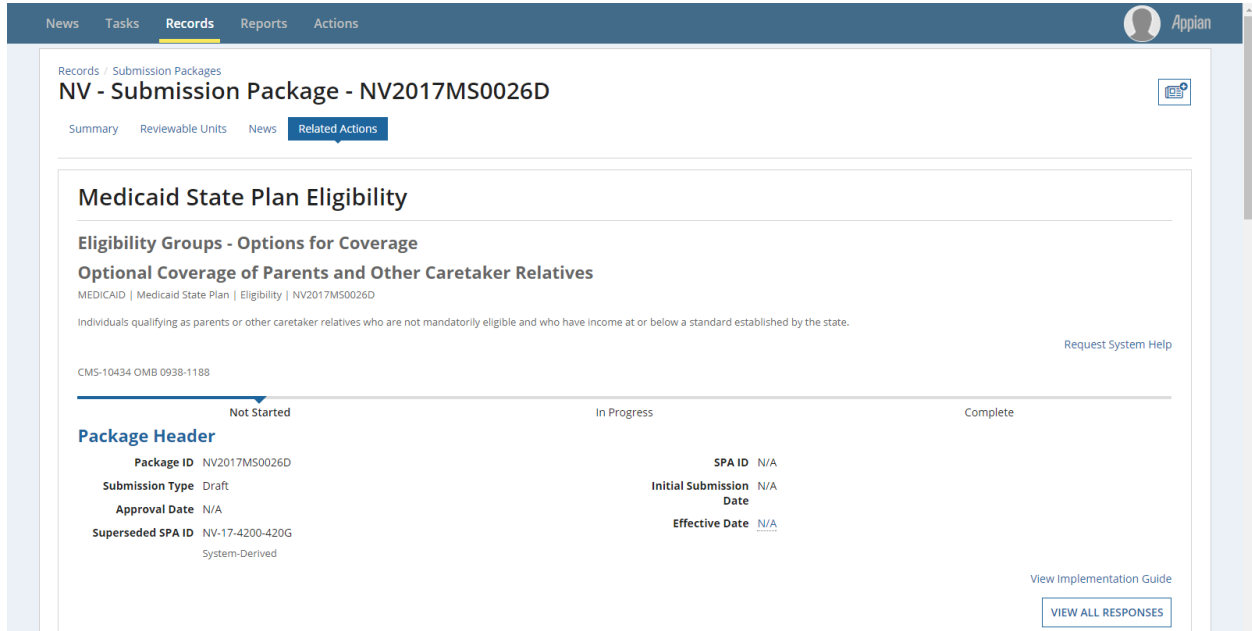


Figure 1: Package Header

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

News Tasks **Records** Reports Actions Appian

[VIEW ALL RESPONSES](#)

The state covers the optional 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. Would be eligible under the state plan for the mandatory eligibility group, Parents and Other Caretaker Relatives, except for income.
2. Have household income at or below the standard established by the state.

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. Coverage Prior to January 1, 2014 +/-

The state covered this optional eligibility group under its state plan as of March 23, 2010, December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. *

Yes
 No

D. 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 * FPL

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

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

1.3 D. Income Standard Used – Path 2

News Tasks **Records** Reports Actions Appian

D. 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 July 16, 1996, not converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
 - b. The state's TANF payment standard, not converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
 - c. 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.
 - d. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
 - e. Another income standard not already specified in AFDC Income Standards.

[ADD INCOME STANDARD](#)

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

Figure 3: Section D–Path 2

1.4 E. Basis for Income Standard

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)

Character count: 0/4000

Validation & Navigation

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

Navigate to Reviewable Unit
 -- Select Reviewable Unit --

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

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 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

Table of Contents

1. S52 - Reasonable Classification of Individuals under Age 21 Screenshots	1
1.1 Package Header	1
1.2 A. Characteristics, B. Financial Methodologies,	1
1.3 C. Individuals Covered – Path 1 – Screenshot 1	2
1.4 C. Individuals Covered – Path 1 – Screenshot 2	2
1.5 C. Individuals Covered – Path 2	3
1.6 C. Individuals Covered – Path 3	3
1.7 C. Individuals Covered – Path 4	4
1.8 C. Individuals Covered – Path 5	4
1.9 C. Individuals Covered – Path 6	4
1.10 D. Income Standard Used – Path 1	5
1.11 D. Income Standard Used – Path 2	5
1.12 D. Income Standard Used – Path 3	6
1.13 D. Income Standard Used – Path 4	6
1.14 E. Basis for Income Standard	7
1.15 F. Additional Information (optional)	7

List of Figures

Figure 1: Package Header	1
Figure 2: Section A and Section B	1
Figure 3: Section C- Path 1– Screenshot 1	2
Figure 4 : Section C – Path 1 – Screenshot 2	2
Figure 5: Section C –Path 2	3
Figure 6: Section C – Path 3	3
Figure 7: Section C – Path 4	4
Figure 8: Section C – Path 5	4
Figure 9: Section C – Path 6	4
Figure 10: Section D – Path 1	5
Figure 11: Section D – Path 2	5
Figure 12 : Section D – Path 3	6
Figure 13: Section D – Path 4	6

Figure 14: Section E..... 7
Figure 15: Section F..... 7

List of Tables

No table of figures entries found.

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

1.1 Package Header

News Tasks Records Reports **Actions** Appian

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21
 MEDICAID | Medicaid State Plan | Eligibility | FL2017M50007D

One or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have 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 FL2017M50007D	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	

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Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

News Tasks Records Reports **Actions** Appian

The state covers the reasonable classifications of individuals under age 21 group in accordance with the following provisions:

A. Characteristics

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

1. Are under age 21, or a lower age, as specified in C.
2. Have household income at or below the standard established by the state, if the state has an income standard.
3. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan.

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](#)

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

News Tasks Records Reports **Actions**

C. Individuals Covered

1. The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes
 No

2. The state covers at least one age group or reasonable classification of children who were not covered prior to January 1, 2014. *

Yes
 No

You must indicate that you cover at least one age group or classification that was not covered prior to January 1, 2014, or that you cover at least one age group or classification that was covered prior to January 1, 2014, or both.

3. The state covers at least one age group or reasonable classification of children who were covered prior to January 1, 2014. *

Yes
 No

You must indicate that you cover at least one age group or classification that was not covered prior to January 1, 2014, or that you cover at least one age group or classification that was covered prior to January 1, 2014, or both.

Figure 5: Section C – Path 2

1.6 C. Individuals Covered – Path 3

C. Individuals Covered

1. The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes
 No

Because the state has elected to cover the Adult Group, it may not choose to cover this optional group since the income standard for this group is lower than that used for mandatory coverage. Please uncheck this group in Optional Eligibility Groups and remove this reviewable unit from the submission package.

Figure 6: Section C – Path 3

1.7 C. Individuals Covered – Path 4

News Tasks Records Reports **Actions** Applan

C. Individuals Covered

1. The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes
 No

2. The state covers at least one age group or reasonable classification of children who were not covered prior to January 1, 2014. *

Yes
 No

a. The state covers all children under a specified age limit who were not covered prior to January 1, 2014.

Yes
 No

b. Reasonable classifications of children not covered prior to January 1, 2014, that are now covered are:

You must add one or more classification(s).

ADD CLASSIFICATIONS

3. The state covers at least one age group or reasonable classification of children who were covered prior to January 1, 2014. *

Yes
 No

a. The state covers all children under a specified age limit who were covered prior to January 1, 2014.

Yes
 No

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

You must add one or more classification(s).

ADD CLASSIFICATIONS

Figure 7: Section C – Path 4

1.8 C. Individuals Covered – Path 5

News Tasks Records Reports **Actions** Applan

C. Individuals Covered

1. The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes
 No

2. The state covers all children of a specified age. *

Yes
 No

a. The age(s) of children covered under this eligibility group is/are:

i. Age 19
 ii. Age 19 and age 20

b. In addition, the state covers reasonable classifications of children.

Yes
 No

3. The reasonable classifications of children that are covered are:

You must add one or more classification(s).

ADD CLASSIFICATIONS

Figure 8: Section C – Path 5

1.9 C. Individuals Covered – Path 6

News Tasks Records Reports **Actions** Applan

C. Individuals Covered

3. The reasonable classifications of children that are covered are:

You must add one or more classification(s).

ADD CLASSIFICATIONS

Figure 9: Section C – Path 6

1.10 D. Income Standard Used – Path 1

Figure 10: Section D – Path 1

1.11 D. Income Standard Used – Path 2

Figure 11: Section D – Path 2

1.12 D. Income Standard Used – Path 3

News Tasks Records Reports **Actions**

1.The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes

No

2. The state covers all children of a specified age. *

Yes

No

D. Income Standard Used

The state's income standard for each age group and reasonable classification 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](#)

Figure 12 : Section D – Path 3

1.13 D. Income Standard Used – Path 4

News Tasks Records Reports **Actions**

1.The state covered all children under a specified age or at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age. *

Yes

No

2. The state covers at least one age group or reasonable classification of children who were not covered prior to January 1, 2014. *

Yes

No

a. The state covers all children under a specified age limit who were not covered prior to January 1, 2014.

Yes

No

3. The state covers at least one age group or reasonable classification of children who were covered prior to January 1, 2014. *

Yes

No

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](#)

Figure 13: Section D – Path 4

1.14 E. Basis for Income Standard

E. Basis for Income Standard

- All children under age 21

1. Minimum income standard
 The minimum income standard for this age group or classification is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in AFDC Income Standards.
[View approved version of MAGI-Based AFDC Payment Income Standard](#)

2. Maximum income Standard

a. The state certifies that it has submitted and received approval for its converted income standards for this age group or classification to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

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

- i. The state's effective income level for this age group or classification 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 this age group or classification 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 this age group or classification 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 this age group or classification 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:

* FPL
- ii. No income test
- iii. 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.
- iv. The maximum income standard for Parents and Other Caretaker relatives.
- v. Other dollar amount

F. Additional Information (Optional)

Figure 14: Section E

1.15 F. Additional Information (optional)

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

Progress bar: 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 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

Table of Contents

- 1. S53 - Children with Non IV-E Adoption Assistance Screenshots..... 1**
- 1.1 Package Header 1
- 1.2 A. Characteristics, B. Financial Methodologies, 1
- 1.3 C. Individuals Covered – Path 1 2
- 1.4 C. Individuals Covered – Path 2 – Screenshot 1 2
- 1.5 C. Individuals Covered – Path 2 – Screenshot 2 3
- 1.6 D. Income Standard Used – Path 1 – Screenshot 1 3
- 1.7 D. Income Standard Used – Path 1 – Screenshot 2 – Path 1 4
- 1.8 D. Income Standard Used – Path 1 – Screenshot 2 – Path 2 4
- 1.9 D. Income Standard Used – Path 2 5
- 1.10 Income Standard Used – Path 3 5
- 1.11 E. Basis for Income Standard - Maximum Income Standard 5
- 1.12 F. Additional Information (optional) 6

List of Figures

- Figure 1: Package Header 1
- Figure 2: Section A and Section B 1
- Figure 3: Section C- Path 1 2
- Figure 4 : Section C – Path 2 – Screenshot 1 2
- Figure 5: Section C – Path 2 – Screenshot 2 3
- Figure 6: Section D – Path 1 – Screenshot 1 3
- Figure 7: Section D – Path 1 – Screenshot 2 – Path 1 4
- Figure 8 : Section D – Path 1 – Screenshot 2 – Path 2 4
- Figure 9: Section D – Path 2 5
- Figure 10: Section D – Path 3 5
- Figure 11: Section E 5
- Figure 12: Section F 6

List of Tables

No table of figures entries found.

1. S53 - Children with Non IV-E Adoption Assistance Screenshots

1.1 Package Header

Records / Submission Packages
NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance
 MEDICAID | Medicaid State Plan | Eligibility | NV2017MS0026D

Children with special needs for medical or rehabilitative care for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid immediately before the adoption agreement was executed, or who had income at that point in time 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 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](#)

Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

The state covers the children with non IV-E adoption assistance group in accordance with the following provisions:

A. Characteristics

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

1. Are under age 21 or a lower age, as specified in C.
2. Have a state adoption assistance agreement in effect between the adoptive parent(s) and a state.
3. The state adoption agency has determined that they cannot be placed for adoption without Medicaid coverage because of special needs for medical or rehabilitative care.
4. Immediately prior to execution of the adoption agreement, were eligible under the Medicaid state plan of the state with the adoption assistance agreement or, at the state's option, immediately prior to execution of the adoption agreement had income no more than the income standard (which could be no income test) specified in Section D.
5. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan.

B. Financial Methodologies

When income is considered, 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](#)

Figure 2: Section A and Section B

1.3 C. Individuals Covered – Path 1

News Tasks **Records** Reports Actions

Applan

C. Individuals Covered

1. The state covers all children under a specified age limit for whom there is an adoption assistance agreement in place from any state.

Yes
 No

a. The age of children covered under this eligibility group is.

- i. Under age 21
- ii. Under age 20
- iii. Under age 19
- iv. Under age 18

b. in addition, the state covers reasonable classifications of children.

Yes
 No

Figure 3: Section C- Path 1

1.4 C. Individuals Covered – Path 2 – Screenshot 1

2. Reasonable classifications of children that are covered are:

a. Children for whom there is an adoption assistance agreement in place with Nevada

- Under age 21
- Under age 20
- Under age 19
- Under age 18

b. Children for whom there is an adoption assistance agreement in place with a state subject to an Interstate Compact on Adoption and Medical Assistance (ICAMA)

- i. All states with which the state has an interstate compact agreement
- ii. Only some of the states with which the state has an interstate compact agreement

Individuals from the following states are covered:

- Under age 21
- Under age 20
- Under age 19
- Under age 18

c. Children for whom there is an adoption assistance agreement in place with specific states

Individuals from the following states are covered:

- Under age 21
- Under age 20
- Under age 19
- Under age 18

Figure 4 : Section C – Path 2 – Screenshot 1

1.5 C. Individuals Covered – Path 2 – Screenshot 2

News Tasks **Records** Reports Actions

Applan

Under age 18
 Under age 19
 Under age 20

d. Other reasonable classifications of children for whom there is an adoption assistance agreement in place.

Name of classification *

Description *

Character count: 0/4000

Under age 21
 Under age 20
 Under age 19
 Under age 18

+Add Classification

Delete

Figure 5: Section C – Path 2 – Screenshot 2

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

News Tasks **Records** Reports Actions

Applan

D. Income Standard Used

1. The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes
 No

2. The state used an income standard or disregarded all income for this group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes
 No

Age Group or Classification	Age	State Elects to Establish an Income Standard	Income Standard Used
Nevada			

Figure 6: Section D – Path 1 – Screenshot 1

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

Records / Submission Packages

NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Request System Help

CMS-10434 OMB 0938-1188

Age Group or Classification : Children in specific states

3. For individuals who were not eligible under the Medicaid state plan immediately prior to execution of the adoption agreement, the state additionally elects to establish an income standard for this age group or classification.

Yes
 No

4. The income standard used for this age group or classification to determine if the child is eligible now, using the child's household income immediately before the execution of the adoption assistance agreement, is:

a. No income test
 b. An income standard

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

Yes
 No

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

* FPL

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

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

Records / Submission Packages

NV - Submission Package - NV2017MS0026D

Summary Reviewable Units News **Related Actions**

Request System Help

CMS-10434 OMB 0938-1188

Age Group or Classification : Children in specific states

3. For individuals who were not eligible under the Medicaid state plan immediately prior to execution of the adoption agreement, the state additionally elects to establish an income standard for this age group or classification.

Yes
 No

4. The income standard used for this age group or classification to determine if the child is eligible now, using the child's household income immediately before the execution of the adoption assistance agreement, is:

a. No income test
 b. An income standard

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

Yes
 No

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

(1) The current income standard used for Parents and Other Caretaker relatives.
 (2) The AFDC payment standard in effect as of July 16, 1996, converted to MAGI-equivalent. This standard is described in AFDC Income Standards.
 (3) Other dollar amount

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 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



**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

Table of Contents

1.	S54 - Optional Targeted Low Income Children Screenshots	1
1.1	Package Header	1
1.2	A. Characteristics, B. Financial Methodologies and C. Individuals Covered-Path 1	2
1.3	C. Individuals Covered-Path 2.....	2
1.4	D. Income Standard Used	3
1.5	E. Basis for Income Standard.....	3
1.6	F. Additional Information (optional)	4

List of Figures

Figure 1: Package Header	1
Figure 2: Section A, Section B and Section C-Path1	2
Figure 3: Section C-Path2	2
Figure 4: Section D.....	3
Figure 5: Section E.....	3

List of Tables

No table of figures entries found.

1. S54 - Optional Targeted Low Income Children Screenshots

1.1 Package Header

The screenshot shows a web application interface for Medicaid State Plan Eligibility. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The user 'Appian' is logged in. The main content area is titled 'NV - Submission Package - NV2017MS0026D' and includes tabs for 'Summary', 'Reviewable Units', 'News', and 'Related Actions'. The 'Medicaid State Plan Eligibility' section is active, showing 'Eligibility Groups - Options for Coverage' and 'Optional Targeted Low Income Children'. A description states: 'Uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state.' A progress bar shows 'Not Started', 'In Progress', and 'Complete' stages. The 'Package Header' section lists: Package ID: NV2017MS0026D, Submission Type: Draft, Approval Date: N/A, Superseded SPA ID: N/A, SPA ID: N/A, Initial Submission Date: N/A, and Effective Date: N/A. There are links for 'Request System Help', 'View Implementation Guide', and a 'VIEW ALL RESPONSES' button. A note at the bottom states: 'The state covers the optional targeted low income children group in accordance with the following provisions: A. Characteristics'.

Figure 1: Package Header

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

The screenshot shows the Appian interface for Path 1. The top navigation bar includes 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Appian' is in the top right. Below the navigation bar, there is a 'View Implementation Guide' link and a 'VIEW ALL RESPONSES' button. The main content area is titled 'The state covers the optional targeted low income children group in accordance with the following provisions:'. It is divided into three sections: A. Characteristics, B. Financial Methodologies, and C. Individuals Covered. Section A lists four criteria for eligibility. Section B mentions MAGI-based methodologies. Section C includes a question about whether the state covers all children under a specified age, with radio buttons for 'Yes' and 'No'. Below this, there is a question about the age of children covered, with radio buttons for 'a. Under age 19', 'b. Under age 18', and 'c. Under other age'. A text input field for 'Under age' is also present.

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

1.3 C. Individuals Covered-Path 2

The screenshot shows the Appian interface for Path 2, specifically section C. The top navigation bar is the same as in Figure 2. The main content area is titled 'C. Individuals Covered'. It includes a question: '1. The state covers all children under a specified age under this eligibility group.' with radio buttons for 'Yes' and 'No'. Below this is another question: '2. The state covers all children within specific age ranges under this eligibility group.' with radio buttons for 'a. Age 1 through age 5, inclusive', 'b. Age 6 through age 18, inclusive', and 'c. Other age range'. Below the 'Other age range' option, there are two text input fields labeled 'Age' and 'Through age'.

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



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

Table of Contents

1. S55-Individuals with Tuberculosis - Screenshots	1
1.1 Section A. “Characteristics”	1
1.2 Section B. “Financial Methodologies”	1
1.3 Section C. “Income Standard Used” – Path 1	1
1.4 Section C. “Income Standard Used” – Path 2	2
1.5 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 1	2
1.6 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 2	2
1.7 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 3	3
1.8 Section D. “Basis for Individuals with Tuberculosis Income Standard - Maximum Income Standard” – Path 4	3
1.9 Section E. “Benefits for Individuals with Tuberculosis” and Section F. “Additional Information”	3

List of Figures

Figure 1: Section A.....	1
Figure 2: Section B.....	1
Figure 3: Section C. - 1	1
Figure 4: Section C. – 2.....	2
Figure 5: Section D – 1.....	2
Figure 6: Section D – 2.....	2
Figure 7: Section D – 3.....	3
Figure 8: Section D – 4.....	3
Figure 9: Sections E & F	3

1. S55-Individuals with Tuberculosis - Screenshots

1.1 Section A. “Characteristics”

Eligibility Groups - Options for Coverage
Individuals with Tuberculosis
 MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D
 Individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. [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 N/A	

[View Implementation Guide](#)
VIEW ALL RESPONSES

A. Characteristics +/-

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

1. Are infected with tuberculosis.
2. Are not eligible for full coverage under the Medicaid state plan.
3. Have household income under a standard established by the state.

Figure 1: Section A

1.2 Section B. “Financial Methodologies”

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](#)

Figure 2: Section B

1.3 Section C. “Income Standard Used” – Path 1

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: * FPL
- b. A dollar amount

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: * FPL
- b. A dollar amount

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

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Table of Contents

- 1. S57 - Independent Foster Care Adolescents Screenshots 1**
- 1.1 Package Header 1
- 1.2 A. Characteristics, B. Financial Methodologies, 1
- 1.3 C. Individuals Covered – Path 1 – Screenshot 1 2
- 1.4 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 2 – Path 1 2
- 1.5 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 3 3
- 1.6 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 2 – Path 2 – Screenshot 1 4
- 1.7 D. Income Standard Used and E. Basis for Income Standard – Path 1 – Screenshot 2 – Path 2- Screenshot 2 4
- 1.8 C. Individuals Covered – Path 2 – Screenshot 1 5
- 1.9 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 2 – Path 1 6
- 1.10 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 3 7
- 1.11 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 2 – Path 2 – Screenshot 1 8
- 1.12 D. Income Standard Used and E. Basis for Income Standard – Path 2 – Screenshot 2 – Path 2 – Screenshot 2 8
- 1.13 C. Individuals Covered– Path 3 – Screenshot 1 9
- 1.14 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 1 10
- 1.15 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 3 11
- 1.16 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 1 12
- 1.17 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 2 13
- 1.18 D. Income Standard Used and E. Basis for Income Standard – Path 3 – Screenshot 2 – Path 2 – Screenshot 3 13
- 1.19 C. Individuals Covered– Path 4 – Screenshot 1 14
- 1.20 D. Income Standard Used and E. Basis for Income Standard – Path 4 – Screenshot 2 – Path 1 14
- 1.21 D. Income Standard Used and E. Basis for Income Standard – Path 4 – Screenshot 2 – Path 2 15
- 1.22 C. Individuals Covered– Path 5 – Screenshot 1 15
- 1.23 D. Income Standard Used and E. Basis for Income Standard – Path 5 – Screenshot 2 – Path 1 16
- 1.24 1.21 D. Income Standard Used and E. Basis for Income Standard – Path 5 – Screenshot 2 – Path 2 16
- 1.25 C. Individuals Covered– Path 6 – Screenshot 1 17

1.26 D. Income Standard Used and E. Basis for Income Standard – Path 6 –
Screenshot 2 – Path 1 17

1.27 1.21 D. Income Standard Used and E. Basis for Income Standard – Path 6 –
Screenshot 2 – Path 2 18

1.28 C. Individuals Covered– Path 7 – Screenshot 1 18

1.29 D. Income Standard Used– Path 7 – Screenshot 2 – Path 1 19

1.30 D. Income Standard Used – Path 7 – Screenshot 2 – Path 2 19

1.31 E. Basis for Income Standard – Path 7 – Screenshot 3 20

1.32 F. Additional Information (optional) 20

List of Figures

Figure 1: Package Header 1

Figure 2: Section A and Section B 1

Figure 3: Section C – Path 1 – Screenshot 1 2

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

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

Figure 6: Section D, Section E – Path 1 – Screenshot 2 – Path 2 – Screenshot 1 4

Figure 7: Section D, Section E – Path 1 – Screenshot 2 – Path 2- Screenshot 2 4

Figure 8: Section C– Path 2 – Screenshot 1 5

Figure 9: Section D, Section E – Path 2 – Screenshot 2 – Path 1 6

Figure 10: Section D, Section E – Path 2 – Screenshot 3 7

Figure 11: Section D, Section E – Path 2 – Screenshot 2 – Path 2 – Screenshot 1 8

Figure 12: Section D, Section E – Path 2 – Screenshot 2 – Path 2 – Screenshot 2 8

Figure 13: 1.13 Section C – Path 3 – Screenshot 1 9

Figure 14: Section D, Section E – Path 3 – Screenshot 2 – Path 1 10

Figure 15: 1.15 Section D, Section E – Path 3 – Screenshot 3 11

Figure 16: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 1 12

Figure 17: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 2 13

Figure 18: Section D, Section E – Path 3 – Screenshot 2 – Path 2 – Screenshot 3 13

Figure 19 : Section C– Path 4 – Screenshot 1 14

Figure 20 : Section D, Section E – Path 4 – Screenshot 2 – Path 1	14
Figure 21: Section D, Section E – Path 4 – Screenshot 2 – Path 2.....	15
Figure 22: Section C – Path 5 – Screenshot 1	15
Figure 23	16
Figure 24 : Section D, Section E – Path 5 – Screenshot 2 - Path 2	16
Figure 25 : Section C– Path 6 – Screenshot 1	17
Figure 26: Section D, Section E – Path 6 – Screenshot 2 - Path 1	17
Figure 27: Section D, Section E – Path 6 – Screenshot 2 - Path 2	18
Figure 28: Section C– Path 7 – Screenshot 1	18
Figure 29: Section D, Section E – Path 7 – Screenshot 2 - Path 1	19
Figure 30: Section D, Section E – Path 7 – Screenshot 2 - Path 2	19
Figure 31: Section E.....	20
Figure 32: Section F	20

List of Tables

No table of figures entries found.

1. S57 - Independent Foster Care Adolescents Screenshots

1.1 Package Header

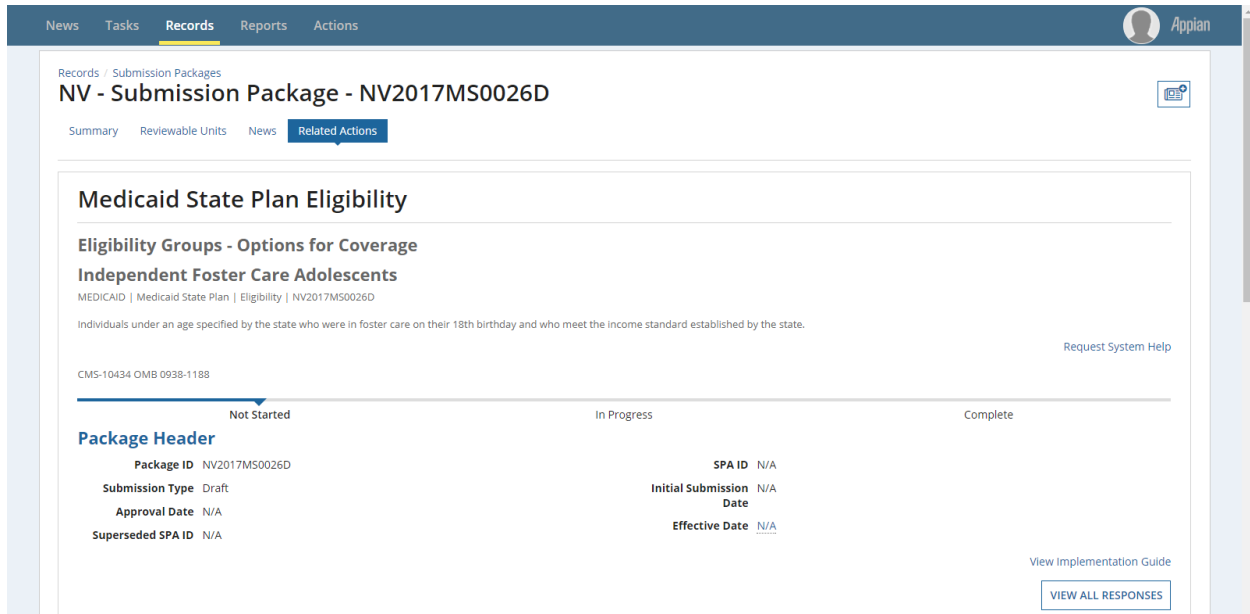


Figure 1: Package Header

1.2 A. Characteristics, B. Financial Methodologies,

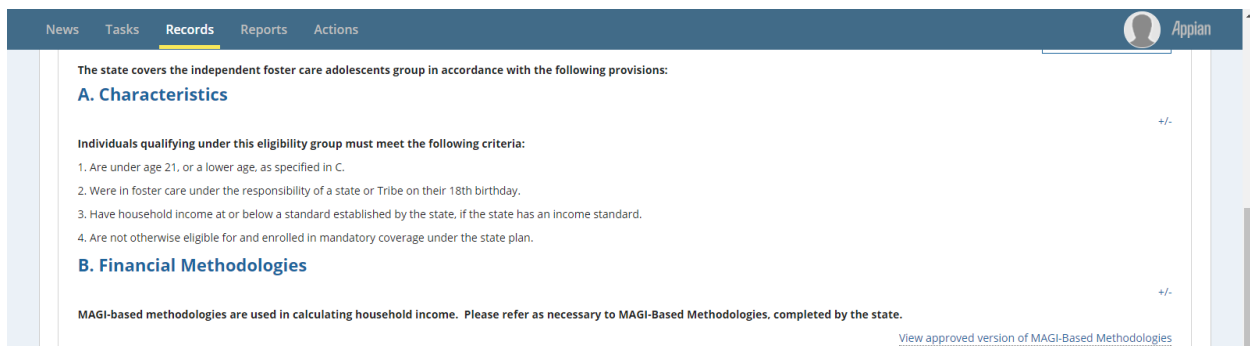


Figure 2: Section A and Section B

1.3 C. Individuals Covered – Path 1 – Screenshot 1

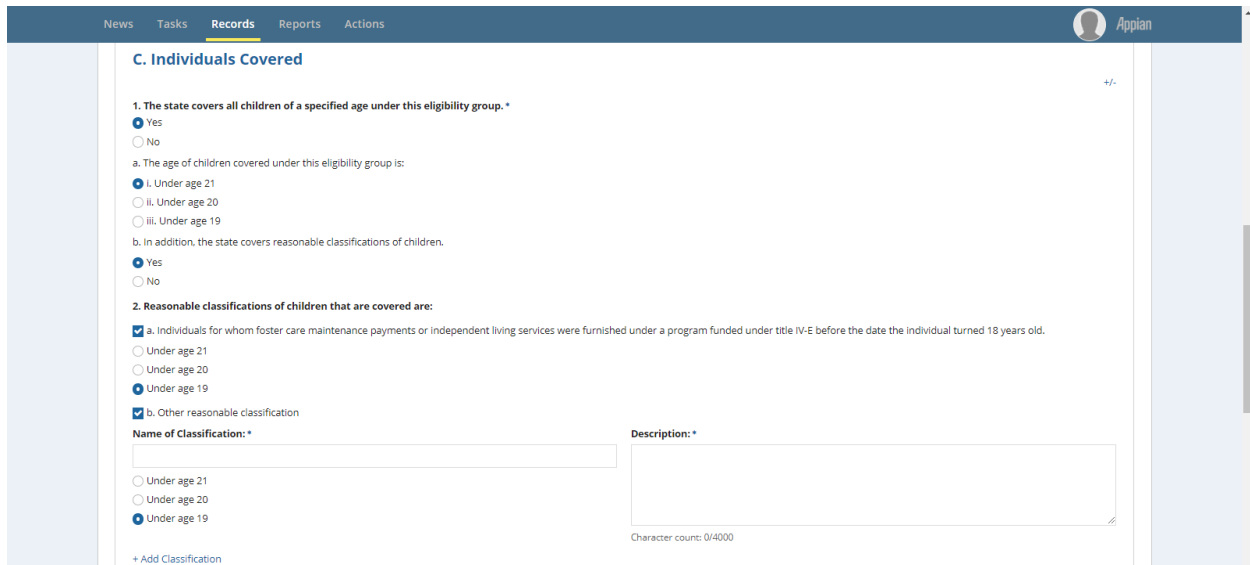


Figure 3: Section C – Path 1 – Screenshot 1

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

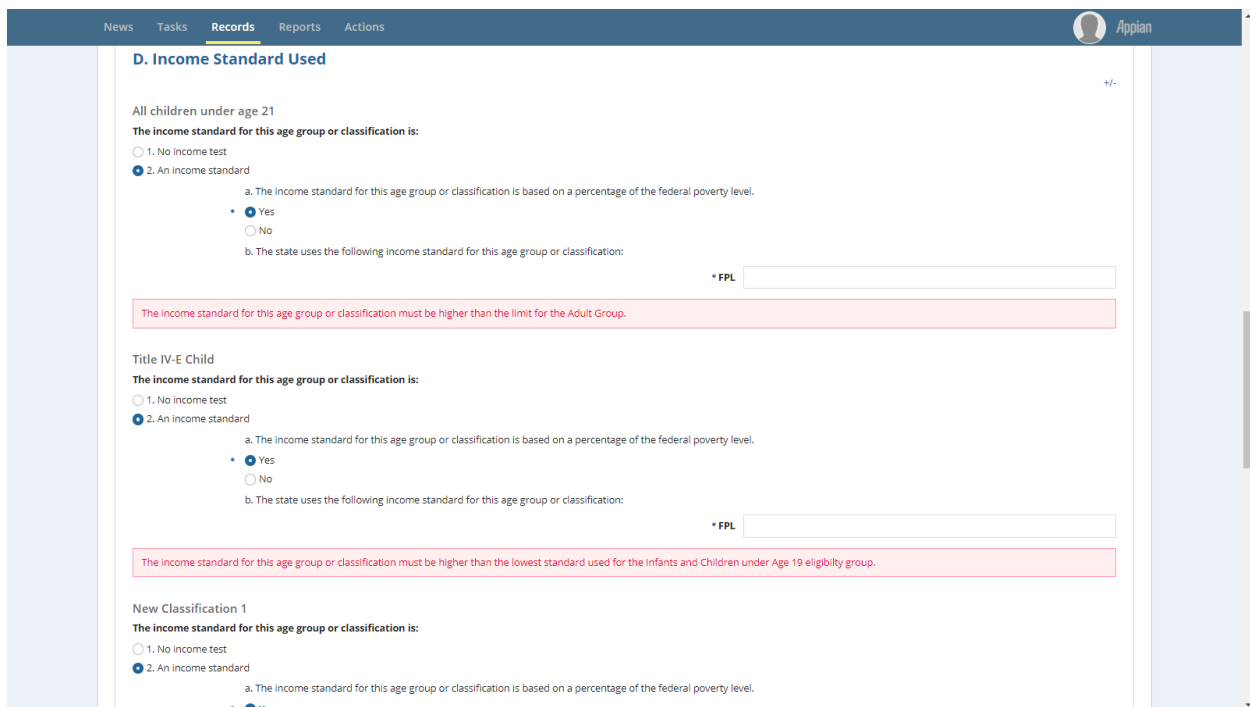


Figure 4: Section D, Section E – Path 1 – Screenshot 2 – Path 1

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

News Tasks **Records** Reports Actions Applan

The income standard for this age group or classification is:

- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the Infants and Children under Age 19 eligibility group.

E. Basis for Income Standard

All children under age 21

- 1. Minimum income standard**
The minimum income standard for this age group or classification is an FPL percent greater than 133%.
- 2. Maximum income standard**
The maximum income standard is no income standard.

Title IV-E Child

- 1. Minimum income standard**
The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.
[View income standard used for Infants and Children under Age 19](#)
- 2. Maximum income standard**
The maximum income standard is no income standard.

New Classification 1

- 1. Minimum income standard**
The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.
[View income standard used for Infants and Children under Age 19](#)
- 2. Maximum income standard**
The maximum income standard is no income standard.

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

1.8 C. Individuals Covered – Path 2 – Screenshot 1

The screenshot shows a web interface for 'C. Individuals Covered'. At the top, there is a navigation bar with 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. The 'Records' tab is active. A user profile for 'Appian' is visible in the top right corner, along with a link to 'View approved version of MACI-Based Methodologies'. The main content area is titled 'C. Individuals Covered' and contains the following sections:

- 1. The state covers all children of a specified age under this eligibility group. ***
 - Yes
 - No
 - a. The age of children covered under this eligibility group is:
 - i. Under age 21
 - ii. Under age 20
 - iii. Under age 19
 - b. In addition, the state covers reasonable classifications of children.
 - Yes
 - No
- 2. Reasonable classifications of children that are covered are:**
 - a. Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.
 - Under age 21
 - Under age 20
 - Under age 19
 - b. Other reasonable classification
 - Name of Classification: ***
 - Description: ***
 - Under age 21
 - Under age 20
 - Under age 19

At the bottom of the form, there is a '+ Add Classification' link and a section titled 'D. Income Standard Used'. A character count '0/4000' is visible below the description field.

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

News Tasks **Records** Reports Actions Appian

D. Income Standard Used

All children under age 20

The income standard for this age group or classification is:

- 1. No Income test
- 2. An Income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
* FPL

The income standard for this age group or classification must be higher than the limit for the Adult Group.

Title IV-E Child

The income standard for this age group or classification is:

- 1. No Income test
- 2. An Income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the Infants and Children under Age 19 eligibility group.

New Classification 1

The income standard for this age group or classification is:

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

The screenshot shows a web application interface with a navigation bar at the top containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is on the right. The main content area is titled 'The income standard for this age group or classification is:' and contains two radio button options: '1. No income test' and '2. An income standard'. Option '2' is selected. Under '2. An income standard', there are two sub-questions: 'a. The income standard for this age group or classification is based on a percentage of the federal poverty level.' with 'Yes' selected, and 'b. The state uses the following income standard for this age group or classification:' with an input field for '* FPL'. A red error message box states: 'The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.' Below this is section 'E. Basis for Income Standard' with a '+' sign. It lists three categories: 'All children under age 20', 'Title IV-E Child', and 'New Classification 1'. Each category has '1. Minimum income standard' and '2. Maximum income standard' sub-sections. For 'All children under age 20', the minimum standard is 'an FPL percent greater than 133%' and the maximum is 'no income standard.' For 'Title IV-E Child', the minimum standard is 'a standard greater than the lowest income standard currently used for children under this age under the infants and Children under Age 19 eligibility group.' and the maximum is 'no income standard.' A link 'View income standard used for Infants and Children under Age 19' is provided. For 'New Classification 1', the minimum standard is 'a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.' and the maximum is 'no income standard.' A link 'View income standard used for Infants and Children under Age 19' is also provided.

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

D. Income Standard Used

All children under age 20

The income standard for this age group or classification is:

- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - Other dollar amount

No Income Standard added

You must add an Income Standard

[ADD INCOME STANDARD](#)

Title IV-E Child

The income standard for this age group or classification is:

- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - Other dollar amount

No Income Standard added

You must add an Income Standard

[ADD INCOME STANDARD](#)

New Classification 1

Figure 11: Section D, Section E – Path 2 – Screenshot 2 – Path 2 – Screenshot 1

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

New Classification 1

The income standard for this age group or classification is:

- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - Other dollar amount

No Income Standard added

You must add an Income Standard

[ADD INCOME STANDARD](#)

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

1.13 C. Individuals Covered– Path 3 – Screenshot 1

The screenshot shows a web application interface with a top navigation bar containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is in the top right. The main content area is titled 'C. Individuals Covered' and contains the following sections:

- 1. The state covers all children of a specified age under this eligibility group. ***
 - Yes
 - No
 - a. The age of children covered under this eligibility group is:
 - I. Under age 21
 - II. Under age 20
 - III. Under age 19
 - b. In addition, the state covers reasonable classifications of children.
 - Yes
 - No
- 2. Reasonable classifications of children that are covered are:**
 - a. Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.
 - Under age 21
 - Under age 20
 - Under age 19
 - b. Other reasonable classification
 - Name of Classification: ***
 - Description: ***
 - Character count: 0/4000

- + Add Classification**
- D. Income Standard Used**
- All children under age 19
- The income standard for this age group or classification is:**
- 1. No income test
- 2. An income standard

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

The screenshot shows a web application interface with a top navigation bar containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is in the top right. The main content area is titled 'D. Income Standard Used' and contains three sections:

- All children under age 19**
The income standard for this age group or classification is:
 1. No income test
 2. An income standard
a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 Yes
 No
b. The state uses the following income standard for this age group or classification:
* FPL
A red error message box states: 'The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.'
- Title IV-E Child**
The income standard for this age group or classification is:
 1. No income test
 2. An income standard
a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 Yes
 No
b. The state uses the following income standard for this age group or classification:
* FPL
A red error message box states: 'The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.'
- New Classification 1**
The income standard for this age group or classification is:
 1. No income test
 2. An income standard
a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 Yes

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

News Tasks **Records** Reports Actions

Applan

2. An income standard

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

Yes
 No

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

* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the Infants and Children under Age 19 eligibility group.

E. Basis for Income Standard +/-

All children under age 19

1. Minimum income standard

The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.

[View income standard used for Infants and Children under Age 19](#)

2. Maximum income standard

The maximum income standard is no income standard.

Title IV-E Child

1. Minimum income standard

The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.

[View income standard used for Infants and Children under Age 19](#)

2. Maximum income standard

The maximum income standard is no income standard.

New Classification 1

1. Minimum income standard

The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.

[View income standard used for Infants and Children under Age 19](#)

2. Maximum income standard

The maximum income standard is no income standard.

Figure 15: 1.15 Section D, Section E – Path 3 – Screenshot 3

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

The screenshot displays a web application interface for configuring income standards. At the top, a navigation bar contains 'News', 'Tasks', 'Records', 'Reports', and 'Actions', with a user profile 'Applan' on the right. The main content area is titled 'D. Income Standard Used' and features a '+/-' icon. It is divided into two sections: 'All children under age 19' and 'Title IV-E Child'. Each section asks for the 'income standard for this age group or classification is:' and provides two main options: '1. No income test' and '2. An income standard'. Under '2. An income standard', there are sub-options: 'a. The income standard for this age group or classification is based on a percentage of the federal poverty level.' with 'Yes' and 'No' radio buttons, and 'b. The state uses the following income standard for this age group or classification:' with 'Other dollar amount' selected. Below each section, a red error message states 'You must add an Income Standard' and a blue 'ADD INCOME STANDARD' button is visible. The bottom of the page shows the start of a 'New Classification 1' section.

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

The screenshot shows a web interface for 'New Classification 1'. At the top, there are navigation tabs: News, Tasks, Records (highlighted), Reports, and Actions. A user profile icon for 'Applan' is in the top right. The main content area is titled 'New Classification 1' and contains the following sections:

- The income standard for this age group or classification is:**
 - 1. No income test
 - 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - Other dollar amount

Below these options, it says 'No Income Standard added'. A red error message box states: 'You must add an Income Standard'. To the right of this message is a blue button labeled 'ADD INCOME STANDARD'.

- E. Basis for Income Standard**
- All children under age 19
- 1. Minimum income standard**
 - The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group. [View income standard used for Infants and Children under Age 19](#)
- 2. Maximum income standard**
 - The maximum income standard is no income standard.
- Title IV-E Child**
 - 1. Minimum income standard**
 - The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group. [View income standard used for Infants and Children under Age 19](#)
 - 2. Maximum income standard**
 - The maximum income standard is no income standard.

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

This screenshot is identical to Figure 17, showing the same web interface for 'New Classification 1'. It displays the same navigation tabs, user profile, and form sections for selecting an income standard and defining its basis. The 'No Income Standard added' message and the 'ADD INCOME STANDARD' button are also present.

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

The screenshot shows a web interface with a navigation bar at the top containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is in the top right. The main content area is titled 'D. Income Standard Used' and includes a sub-header 'All children under age 21'. Below this, it asks 'The income standard for this age group or classification is:' with two main options: '1. No income test' (unselected) and '2. An income standard' (selected). Under option 2, there are sub-questions: 'a. The income standard for this age group or classification is based on a percentage of the federal poverty level.' with 'Yes' (unselected) and 'No' (selected); and 'b. The state uses the following income standard for this age group or classification:' with 'Other dollar amount' (selected). A message states 'No Income Standard added' and a red error box says 'You must add an Income Standard'. An 'ADD INCOME STANDARD' button is visible. Below this is section 'E. Basis for Income Standard', also for 'All children under age 21'. It lists '1. Minimum income standard' (The minimum income standard for this age group or classification is an FPL percent greater than 133%) and '2. Maximum income standard' (The maximum income standard is no income standard.).

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

1.22 C. Individuals Covered– Path 5 – Screenshot 1

The screenshot shows a web interface with a navigation bar at the top containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is in the top right. The main content area is titled 'C. Individuals Covered'. It asks '1. The state covers all children of a specified age under this eligibility group.' with 'Yes' (selected) and 'No' (unselected). Below this, it asks 'a. The age of children covered under this eligibility group is:' with three options: 'i. Under age 21' (unselected), 'ii. Under age 20' (selected), and 'iii. Under age 19' (unselected). It also asks 'b. In addition, the state covers reasonable classifications of children.' with 'Yes' (unselected) and 'No' (selected).

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

The screenshot shows a web interface with a top navigation bar containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Applan' is in the top right. The main content area is divided into two sections:

D. Income Standard Used (with a +/- expand/collapse icon):

- All children under age 20
- The income standard for this age group or classification is:
- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - * FPL

A red error message box states: "The income standard for this age group or classification must be higher than the limit for the Adult Group."

E. Basis for Income Standard (with a +/- expand/collapse icon):

- All children under age 20
- 1. Minimum income standard
 - The minimum income standard for this age group or classification is an FPL percent greater than 133%.
- 2. Maximum income standard
 - The maximum income standard is no income standard.

Figure 23

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

The screenshot shows a web interface similar to Figure 23, but with different selections and a different error message:

D. Income Standard Used (with a +/- expand/collapse icon):

- All children under age 20
- The income standard for this age group or classification is:
- 1. No income test
- 2. An income standard
 - a. The income standard for this age group or classification is based on a percentage of the federal poverty level.
 - Yes
 - No
 - b. The state uses the following income standard for this age group or classification:
 - Other dollar amount

The text "No Income Standard added" is displayed below the options.

A red error message box states: "You must add an Income Standard". A button labeled "ADD INCOME STANDARD" is located to the right of the error message.

E. Basis for Income Standard (with a +/- expand/collapse icon):

- All children under age 20
- 1. Minimum income standard
 - The minimum income standard for this age group or classification is an FPL percent greater than 133%.
- 2. Maximum income standard
 - The maximum income standard is no income standard.

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

1.25 C. Individuals Covered– Path 6 – Screenshot 1

News Tasks **Records** Reports Actions Appian

C. Individuals Covered

1. The state covers all children of a specified age under this eligibility group.*

Yes
 No

a. The age of children covered under this eligibility group is:

i. Under age 21
 ii. Under age 20
 iii. Under age 19

b. In addition, the state covers reasonable classifications of children.

Yes
 No

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

News Tasks **Records** Reports Actions Appian

D. Income Standard Used

All children under age 19

The income standard for this age group or classification is:

1. No income test
 2. An income standard

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

Yes
 No

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

* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.

E. Basis for Income Standard

All children under age 19

1. Minimum income standard

The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.

[View income standard used for Infants and Children under Age 19](#)

2. Maximum income standard

The maximum income standard is no income standard.

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

1.27 1.21 D. Income Standard Used and E. Basis for Income Standard – Path 6 – Screenshot 2 – Path 2

D. Income Standard Used

All children under age 19

The income standard for this age group or classification is:

1. No income test

2. An income standard

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

Yes

No

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

Other dollar amount

No Income Standard added

You must add an Income Standard

ADD INCOME STANDARD

E. Basis for Income Standard

All children under age 19

1. Minimum income standard

The minimum income standard for this age group or classification is a standard greater than the lowest income standard currently used for children under this age under the Infants and Children under Age 19 eligibility group.

[View income standard used for Infants and Children under Age 19](#)

2. Maximum income standard

The maximum income standard is no income standard.

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

1.28 C. Individuals Covered– Path 7 – Screenshot 1

C. Individuals Covered

1. The state covers all children of a specified age under this eligibility group. *

Yes

No

2. Reasonable classifications of children that are covered are:

a. Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.

Under age 21

Under age 20

Under age 19

b. Other reasonable classification

Name of Classification: *

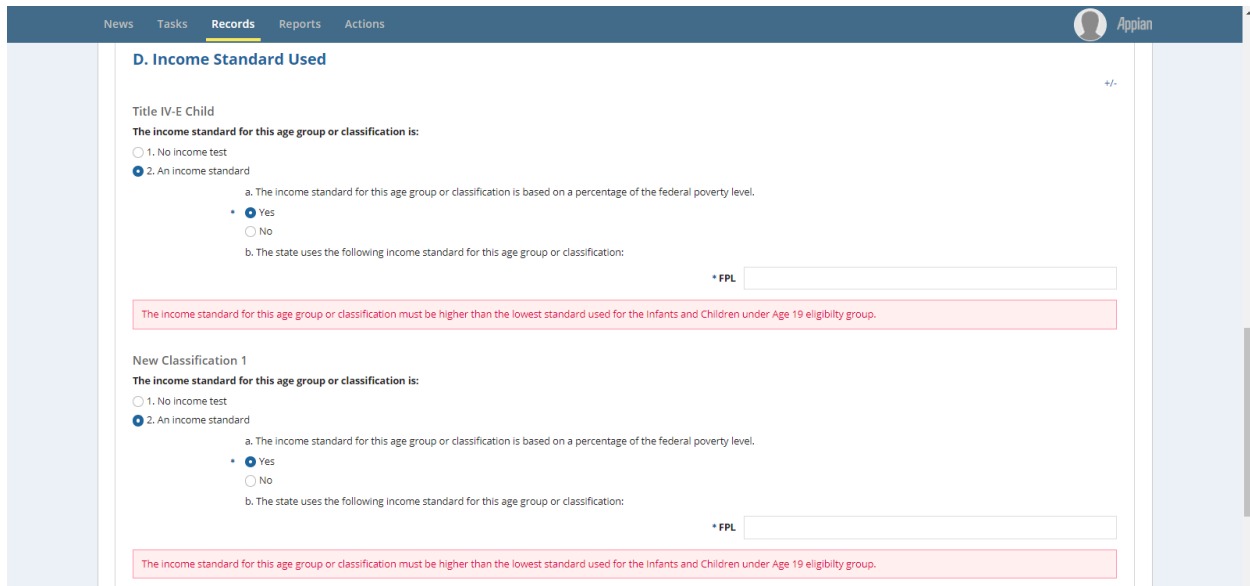
Description: *

Character count: 0/4000

+ Add Classification

Figure 28: Section C– Path 7 – Screenshot 1

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



D. Income Standard Used

Title IV-E Child

The income standard for this age group or classification is:

1. No income test

2. An income standard

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

Yes

No

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

* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.

New Classification 1

The income standard for this age group or classification is:

1. No income test

2. An income standard

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

Yes

No

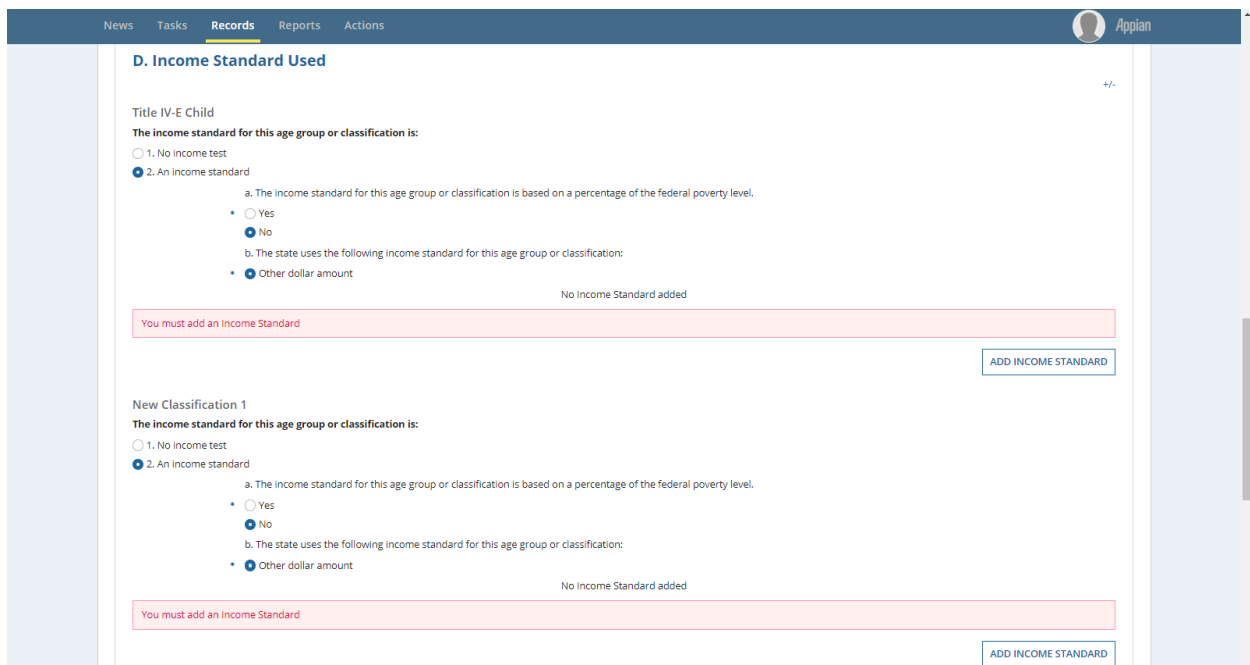
b. The state uses the following income standard for this age group or classification:

* FPL

The income standard for this age group or classification must be higher than the lowest standard used for the infants and Children under Age 19 eligibility group.

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

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



D. Income Standard Used

Title IV-E Child

The income standard for this age group or classification is:

1. No income test

2. An income standard

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

Yes

No

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

Other dollar amount

No Income Standard added

You must add an Income Standard

ADD INCOME STANDARD

New Classification 1

The income standard for this age group or classification is:

1. No income test

2. An income standard

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

Yes

No

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

Other dollar amount

No Income Standard added

You must add an Income Standard

ADD INCOME STANDARD

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

Table of Contents

1.	S59 - Individuals Eligible for Family Planning Services Screenshots.....	1
1.1	Package Header	1
1.2	A. Characteristics, B. Individuals Covered – Path 1	1
1.3	B. Individuals Covered – Path 2	2
1.4	C. Income Standard Used – Path 1.....	2
1.5	C. Income Standard Used – Path 2.....	2
1.6	C. Income Standard Used – Path 3.....	3
1.7	D. Financial Methodologies – Path 1.....	3
1.8	D. Financial Methodologies – Path 2.....	4
1.9	D. Financial Methodologies – Path 3 – Screenshot 1.....	4
1.10	D. Financial Methodologies – Path 3 – Screenshot 2.....	5
1.11	E. Basis for Income Standard - Maximum Income Standard, F. Family Planning Benefits and G. Additional Information (optional)	5

List of Figures

Figure 1:	Package Header	1
Figure 2:	Section A, Section B – Path 1	1
Figure 3:	Section B – Path 2	2
Figure 4:	Section C - Path 1	2
Figure 5:	Section C - Path 2	2
Figure 6:	Section C – Path 3	3
Figure 7:	Section D – Path 1	3
Figure 8:	Section D - Path 2	4
Figure 9 :	Section D - Path 3 - Screenshot 1	4
Figure 10 :	Section D - Path 3 - Screenshot 2.....	5
Figure 11 :	Section E, Section F and Section G	5

List of Tables

No table of figures entries found.

1. S59 - Individuals Eligible for Family Planning Services Screenshots

1.1 Package Header

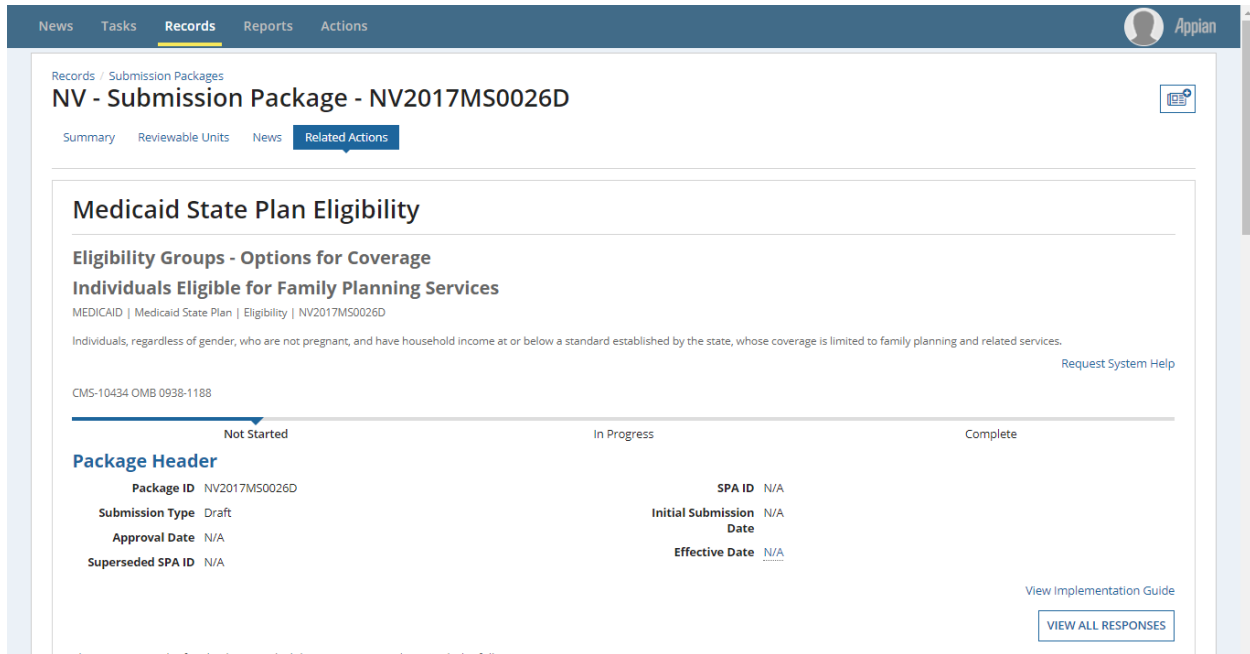


Figure 1: Package Header

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

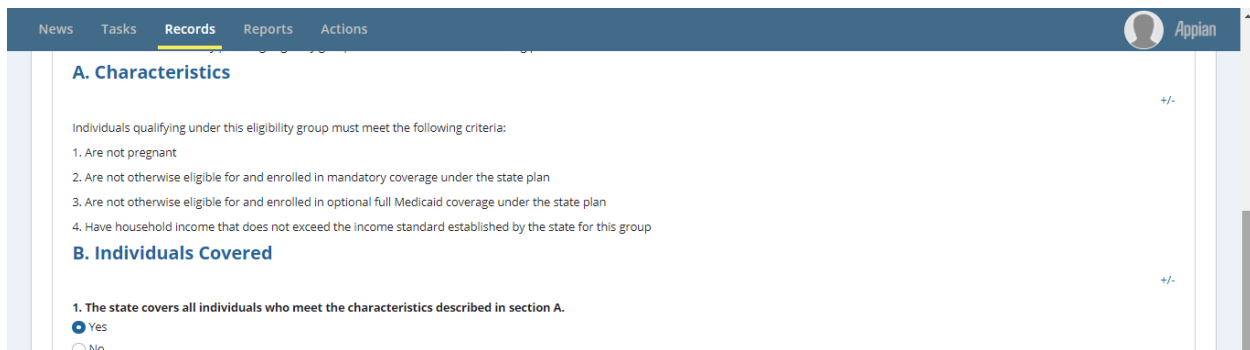


Figure 2: Section A, Section B – Path 1

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

Population	Income Standard (%FPL)
All children under age 18	<input type="text"/>

Figure 5: Section C - Path 2

1.6 C. Income Standard Used – Path 3

C. Income Standard Used

1. The state uses the same income standard for all individuals covered.
 Yes
 No

2. The income standard for all individuals eligible under the group, except for those populations separately identified, is:
 FPL

3. The higher income standards for specific populations are:

a. All children under a specified age limit:
 i. Under age 21
 ii. Under age 20
 iii. Under age 19
 iv. Under age 18

FPL

b. Other:

Name of population *	Description *
<input type="text"/>	<input type="text"/>
	* FPL <input type="text"/>

+ Add population

[VIEW TABLE](#)

Figure 6: Section C – Path 3

1.7 D. Financial Methodologies – Path 1

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

3. In determining eligibility for this group, the state includes the following household members:
 a. All household members
 b. Only the individual

4. In determining eligibility for this group, the state increases the family size by one, counting the individual as two
 Yes
 No

5. In determining eligibility for this group, the state counts the income of:
 a. All household members
 b. Only the individual

Figure 7: Section D – Path 1

1.8 D. Financial Methodologies – Path 2

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

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	<input type="radio"/> All household members <input checked="" type="radio"/> Only the individual	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> All household members <input checked="" type="radio"/> Only the individual

Figure 8: Section D - Path 2

1.9 D. Financial Methodologies – Path 3 – Screenshot 1

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

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

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

Yes
 No

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

i. All household members
 ii. Only the individual

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

a. All children under a specified age limit:

- i. Under age 21
- ii. Under age 20
- iii. Under age 19
- iv. Under age 18

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

All household members
 Only the individual

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

News Tasks **Records** Reports Actions Appian

b. Other:

Name of population *

Description *

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

Yes

No

In determining eligibility for this population, the state counts the income of: *

All household members

Only the individual

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

All household members

Only the individual

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

Yes

No

In determining eligibility for this population, the state counts the income of: *

All household members

Only the individual

+ Add population

VIEW TABLE

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)

News Tasks **Records** Reports Actions Appian

E. Basis for Income Standard - Maximum Income Standard

1. 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 this eligibility group.

2. The state's maximum income standard for this eligibility group is the highest of the following:

- a. The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.
- b. The state's current effective income level for pregnant women under a Medicaid 1115 Demonstration.
- c. The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.
- d. The state's current effective income level for pregnant women under a CHIP 1115 Demonstration.

3. The amount of the maximum income standard is:

FPL

[View Approved Version of Pregnant Women - Income Standard Used Section](#)

F. Family Planning Benefits

Benefits for this eligibility group are limited to family planning and related services described in the Benefit and Payments section of the state plan.

G. 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 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

Table of Contents

1. S59a - Individuals Eligible for Family Planning Services - Presumptive Eligibility Screenshots	1
1.1 Package Header	1
1.2 A. Presumptive Eligibility Period.....	1
1.3 B. Application for Presumptive Eligibility – Screenshot 1.	2
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

List of Figures

Figure 1: Package Header	1
Figure 2: Section A.....	1
Figure 3: Section B – Screenshot 1.....	2
Figure 4: Section B – Screenshot 2.....	2
Figure 5 : Section C and Section D	3
Figure 6 : Section E.....	3

List of Tables

No table of figures entries found.

1. S59a - Individuals Eligible for Family Planning Services - Presumptive Eligibility Screenshots

1.1 Package Header

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

A. Presumptive Eligibility Period

Figure 1: Package Header

1.2 A. Presumptive Eligibility Period

A. Presumptive Eligibility Period

- The presumptive period begins on the date the determination is made.
- The end date of the presumptive period is the earlier of:
 - 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
 - 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.
- 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.

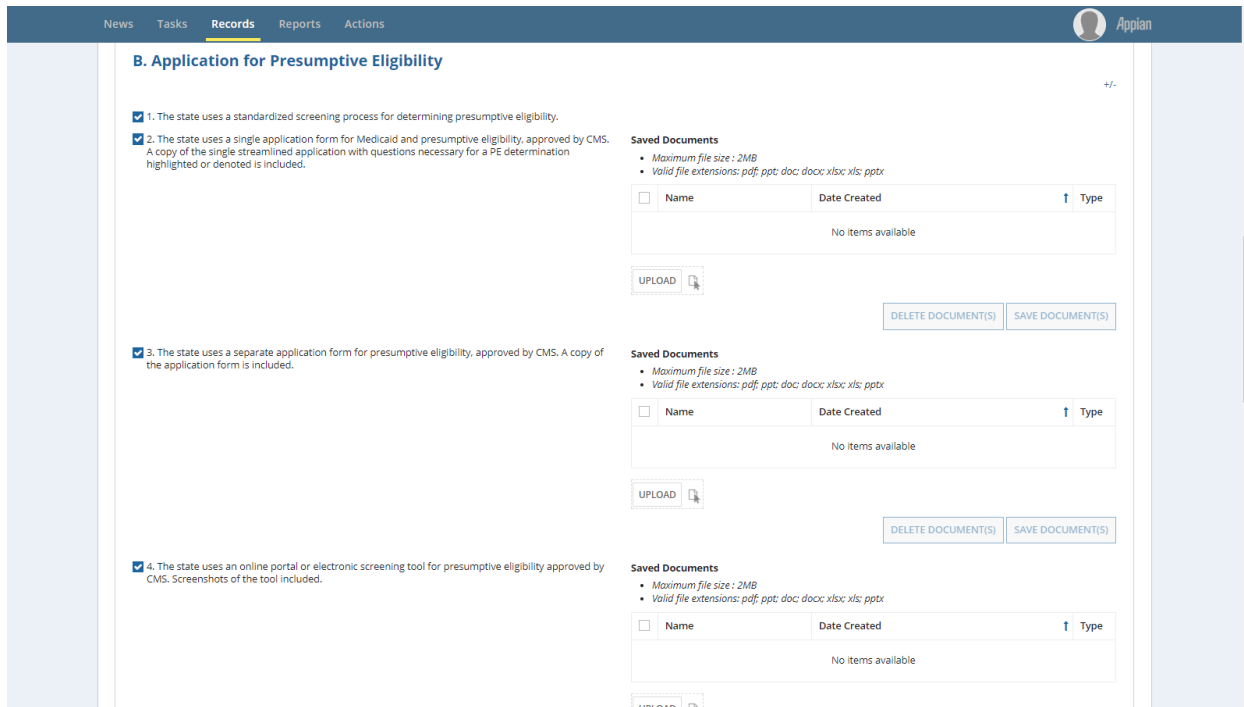


Figure 3: Section B – Screenshot 1

1.4 B. Application for Presumptive Eligibility – Screenshot 2

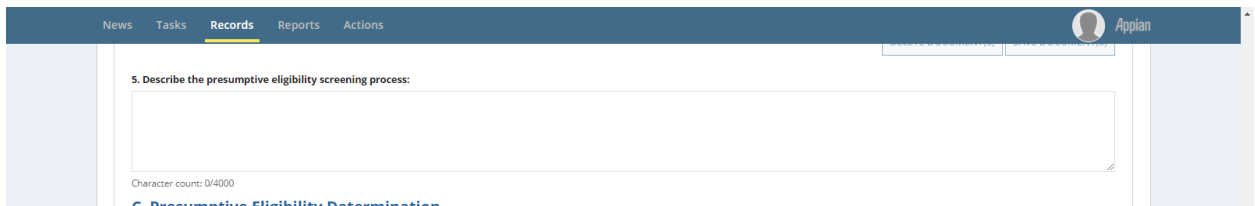


Figure 4: Section B – Screenshot 2

1.5 C. Presumptive Eligibility Determination and D. Qualified Entities

The screenshot shows a web application interface with a top navigation bar containing 'News', 'Tasks', 'Records', 'Reports', and 'Actions'. A user profile icon for 'Appian' is in the top right. The main content area is titled 'C. Presumptive Eligibility Determination' and contains the following text:

The presumptive eligibility determination is based on the following factors:

- The individual must meet the categorical requirements of 42 CFR 435.214.
- Household income must not exceed the applicable income standard described at 42 CFR 435.214.
 - a. A reasonable estimate of MAGI-based income is used to determine household income.
 - b. Gross income is used to determine household size.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

Section D, titled 'D. Qualified Entities', contains:

- The state uses entities, as defined in section 1920C, to determine eligibility presumptively for this eligibility group. These entities must be eligible to receive payment for services under the state's approved Medicaid state plan and determined by the state to be capable of determining presumptive eligibility for this group.
- The following qualified entities are used to determine presumptive eligibility for this eligibility group.

Below the text is an 'ADD/MODIFY QUALIFIED ENTITIES' button. Further down, there are two checked checkboxes:

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

A 'Saved Documents' section follows, with a table:

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

<input checked="" type="checkbox"/>	Name	Date Created	Type
No items available			

Below the table is an 'UPLOAD' button with a file icon. At the bottom right of the section are 'DELETE DOCUMENT(S)' and 'SAVE DOCUMENT(S)' buttons.

Figure 5 : Section C and Section D

1.6 E. Additional Information (optional)

The screenshot shows the 'E. Additional Information (optional)' section. It features a large text input area with a character count of 0/4000. Below the input area is a 'Validation & Navigation' section with the question: 'Would you like to validate the reviewable unit data?' with radio buttons for 'Yes' and 'No' (selected).

To the right is a dropdown menu labeled 'Navigate to Reviewable Unit' with the option '-- Select Reviewable Unit --'. Below this is a progress bar with three stages: 'Not Started', 'In Progress', and 'Complete'. The 'Not Started' stage is currently active.

A PRA Disclosure Statement is provided: '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.'

At the bottom are three buttons: 'EXIT', 'SAVE REVIEWABLE UNIT', and 'GO TO SELECTED REVIEWABLE UNIT'.

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

Table of Contents

1. S88-State Residency - Screenshots.....	1
1.1 State Residency	1

List of Figures

Figure 1: State Residency – 1	1
Figure 2: State Residency – 2	2
Figure 3: State Residency – 3	2
Figure 4: State Residency – 4	3

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.

Other

Name *

Description *

Character count: 0/4000

delete 1

+ Add Other

D. Temporary Absence from the State

+/-

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

Yes
 No

Description of the definition:

Character count: 0/4000

E. Additional Information (optional) +/-

Character count: 0/4000

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

Table of Contents

1. S89-Citizenship and Non-Citizenship – Screenshots	1
1.1 Citizenship and Non-Citizenship	1

List of Figures

Figure 1: Citizenship and Non-Citizenship – 1	1
Figure 2: Citizenship and Non-Citizenship – 2	2
Figure 3: Citizenship and Non-Citizenship – 3	2
Figure 4: Citizenship and Non-Citizenship – 4	3
Figure 5: Citizenship and Non-Citizenship – 5	3

1. S89-Citizenship and Non-Citizenship – Screenshots

1.1 Citizenship and Non-Citizenship

Medicaid State Plan Eligibility

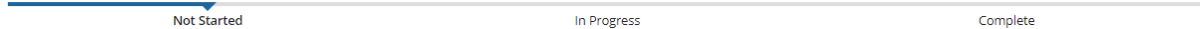
Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D

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CMS-10434 OMB 0938-1188



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
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The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan, consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

+/-

The state provides Medicaid eligibility to otherwise eligible individuals:

1. Who are citizens or nationals of the United States; or
2. Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 U.S.C. §1612(b)(2), and are not restricted by section 403 of PRWORA (8 U.S.C. §1613); or who are non-citizens whose eligibility is required by 8 U.S.C. 1612(b)(2)(E) and (F); and
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.

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



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

Table of Contents

1. S94-Eligibility Process – Screenshots 1
 1.1 Eligibility Process 1

List of Figures

Figure 1: Eligibility Process – 1 1
Figure 2: Eligibility Process – 2 2
Figure 3: Eligibility Process – 3 2
Figure 4: Eligibility Process – 4 3
Figure 5: Eligibility Process – 5 3
Figure 6: Eligibility Process – 6 4
Figure 7: Eligibility Process – 7 4

1. S94-Eligibility Process – Screenshots

1.1 Eligibility Process

Medicaid State Plan Eligibility

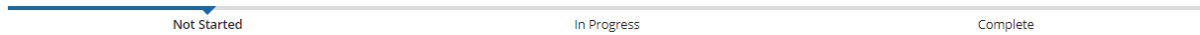
General Eligibility Requirements

Eligibility Process

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0009D

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Package Header

Package ID CA2017MS0009D
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Approval Date N/A
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SPA ID N/A
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Effective Date [N/A](#)

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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 understandable 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

Table of Contents

1.	S94a-Application – Screenshots	1
1.1	Application.....	1

List of Figures

Figure 1:	Application - 1	1
Figure 2:	Application – 2.....	1
Figure 3:	Application – 3.....	2
Figure 4:	Application – 4.....	2
Figure 5:	Application – 5.....	3
Figure 6:	Application – 6.....	3
Figure 7:	Application – 7.....	4
Figure 8:	Application – 8.....	4

1. S94a-Application – Screenshots

1.1 Application

Medicaid State Plan Eligibility

General Eligibility Requirements

Application

MEDICAID | Medicaid State Plan | Eligibility | CA2017MS0013D

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CMS-10434 OMB 0938-1188

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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		

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A. MAGI Paper Application

+/-

The state uses the following paper application(s) for individuals applying for coverage based on the applicable modified adjusted gross income (MAGI) standard.

- 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- 2. One or more alternative single, streamlined applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary

Please click on an application to view, edit or delete.

Figure 1: Application - 1

- 2. One or more alternative single, streamlined applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by 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 alternative applications used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Please click on an application to view, edit or delete.

Name
No items available

Please add at least one application

[ADD APPLICATION](#)

Figure 2: Application – 2

4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Please click on an application to view, edit or delete.

Name	Description
No items available	

Please add at least one application

[ADD APPLICATION](#)

B. MAGI Online Application +/-

The state uses the following online application(s) for individuals applying for coverage based on the applicable MAGI standard.

- 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- 2. One or more alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by 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 alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such programs

Figure 3: Application – 3

3. One or more alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such 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, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Please click on an application to view, edit or delete.

Name	Description
No items available	

Please add at least one application

[ADD APPLICATION](#)

C. Basis Other than MAGI - Paper Application +/-

The state uses the following paper application(s) for individuals applying for coverage on a basis other than the applicable MAGI standard:

- 1. The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

The supplemental form(s) used to collect additional information has been uploaded.

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; xls; xlsx; pptx

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required



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

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

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

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


Screenshots or other documentation of the online form(s) used to collect additional information have been uploaded

Saved Documents

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

<input type="checkbox"/>	Name	Date Created	Type
No items available			

A document is required

UPLOAD 

DELETE DOCUMENT(S) SAVE DOCUMENT(S)

2. One or more application 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 application used to apply for multiple human service programs

Figure 7: Application – 7

3. One or more application 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

E. Additional Information (optional) +/-

Character count: 0/4000

Figure 8: Application – 8