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**State/Territory Name: Hawaii**

**State Plan Amendment (SPA) #: 17-001**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
San Francisco Regional Office  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

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June 15, 2017

Dr. Judy Mohr Peterson  
Med-QUEST Division Administrator  
MQD/Admin  
P.O. Box 700190  
Kapolei, HI 96709-0190

Dear Dr. Peterson,

Enclosed is an approved copy of Hawaii's State Plan Amendment (SPA) No. 17-0001, which was submitted to the Centers for Medicare and Medicaid Services on March 23, 2017. This SPA updates the income standard for supplemental payments. The approval of this SPA is effective January 1, 2017.

Attached is a copy of the new State Plan page to be incorporated into Hawaii's approved State Plan at Supplement 6 to Attachment 2.6-A.


If you have any questions, please contact Carolyn Kenline at (415) 744-3591 or [carolyn.kenline@cms.hhs.gov](mailto:carolyn.kenline@cms.hhs.gov).

Sincerely,

A black rectangular redaction box covering the signature of Henrietta Sam-Louie.

Henrietta Sam-Louie  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Tom Duran, CMS Pacific Area Representative  
Evelyn Yamamoto, Med-QUEST Program and Policy Development Office  
Aileen Befitel, Med-QUEST Program and Policy Development Office  
Jeri Kiddo, Secretary  
Carla Turla, Secretary  
Emelina Mauricio, Office Assistant

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER  1    7    —    0001	2. STATE  <b>Hawaii</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  <b>January 1, 2017</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> )  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION <b>42 C.F.R. 435.234 and 42 C.F.R. 435.1006</b>		7. FEDERAL BUDGET IMPACT a. FFY <del>2015</del> — 2017      \$ 0.00 b. FFY <del>2016</del> — 2018      \$ 0.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Supplement 6 to Attachment 2.6-A</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )  <b>Supplement 6 to Attachment 2.6-A</b>	
10. SUBJECT OF AMENDMENT  <b>Standards for optional state supplementary payments.</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> )  <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO <b>State of Hawaii Department of Human Services Office of the Director P.O. Box 339 Honolulu, Hawaii 96809-0339</b>	
13. TYPED NAME <b>Judy Mohr Peterson, PhD</b>			
14. TITLE <b>Med-QUEST Administrator</b>			
15. DATE SUBMITTED      03/23/17			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED      March 23, 2017		18. DATE APPROVED      June 15, 2017	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL  January 1, 2017		20. SIGNATURE OF REGIONAL ADMINISTRATOR 	
21. TYPED NAME <b>Hye Sun Lee</b> Henrietta Sam-Louie		22. TITLE <b>Associate Regional Administrator</b>	
23. REMARKS  CMS made revisions to boxes 7 & 21 confirmed by DHS via 6/7/17 email.			

State: Hawaii

## Standards for Optional State Supplementary Payments

Payment Category	Administered by		Income Level				Income Disregards Employed
(Reasonable Classification)	Federal	State	<u>Gross*</u>		<u>Net**</u>		
			1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X						
LEVEL I	\$735.00	\$651.90	\$2,205.00	N/A	\$1,386.90	N/A	
LEVEL II	\$735.00	\$759.90	\$2,205.00	N/A	\$1,494.90	N/A	

NOTE: \*Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR.

\*\*Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit

TN No. 17-0001

Supersedes

TN No. 15-001

Approval Date:

June 15, 2017

Effective Date:

01/01/2017