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State/Territory Name: Northern Mariana Islands (CNMI)

State Plan Amendment (SPA) #: 26-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

August 4, 2026

George Cruz
Director
Commonwealth Medicaid Agency
Office of the Governor
Caller Box 10007
Saipan, MP 96950

Re: CNMI Disaster Relief State Plan Amendment (SPA) 26-0004

Dear Director Cruz:

The Centers for Medicare & Medicaid Services (CMS) reviewed the proposed disaster relief Medicaid State Plan Amendment (SPA) submitted on July 24, 2026, under transmittal number (TN) 26-0004. This amendment was submitted in response to the Super Typhoon Bavi public health emergency (PHE). The Disaster Relief State Plan Amendment (DR SPA) proposes to:

- Disregard all resources for applicants and beneficiaries' eligibility determinations processed on or after July 2, 2026.
- Replace one pair of lost or broken eyeglasses with self-attestation.
- Replace Durable Medical Equipment limited to one item per equipment type per beneficiary with medical necessity and prior authorization.
- Replace or refill medical supplies for up to 90 days.
- Allow early emergency prescription refills and replacements of maintenance medications for up to 90 days, excluding controlled substances.
- Allow pharmacies to accept self-attestation for lost, damaged, or inaccessible medications.
- Allow medication renewals without clinical review or time/quantity extensions.
- Allow deviations from the preferred drug list in case of shortages.
- Allow advanced interim certified public expenditure (CPE) payments for inpatient and outpatient hospital services using approved interim payment rates methodologies authorized under the state plan with approved reconciliation.
- Add on-island coverage for disaster-related behavioral and mental health services in various settings provided by qualified practitioners enrolled with the Commonwealth Medicaid Agency (CMA) who are reimbursed at the lower of billed charges or the Hawaii Fee Schedule while services provided by the Commonwealth Health Corporation (CHSS) will be reimbursed at cost.

- Implement a prospective/interim payment methodology for enrolled Medicaid providers, excluding CHCC, experiencing disruptions in operation and billing or cash flow as a result of the disaster.
- Clarify that advanced interim CPE payments will be made for three (3) months from the effective date of the Typhoon Bavi PHE.
- Clarify that providers cannot make duplicate claims for payments under Typhoon Sinlaku and Typhoon Bavi disaster relief state plans. Upon reconciliation, providers must return any overpayments. CMA may establish repayment schedules to minimize provider burden while ensuring timely recovery of overpayments in accordance with State and Federal guidelines.

On July 3, 2026, the President of the United States issued a proclamation that the Super Typhoon Bavi constitutes an emergency by the authorities vested in the President by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (the Act). On July 9, 2026, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services (HHS) declared a PHE, invoking the authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act. During a PHE, CMS may approve the use of section 1135 authority to help ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in CMS programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of July 9, 2026, with a retroactive effective date of July 2, 2026. The emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the PHE, including any extensions.

CMS conducted our review of your submittal according to statutory requirements in Title XIX of the Act and implementing regulations. This letter is to inform you that Commonwealth of the Northern Mariana Islands (CNMI) Medicaid SPA Transmittal Number MP-26-0004 is approved effective July 2, 2026.

If you have any questions, please contact Maria Garza at (206) 615-2542 or via email at maria.garza@cms.hhs.gov.

Sincerely,

[redacted]

Barbara K. Richards,
Deputy Director, Medicaid & CHIP Operations Group

Enclosures

cc: Vicenta Rosario, vicenta.rosario@cnmimedicaid.org
Roman Tudela, roman.tudela@cnmimedicaid.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26-0004

2. STATE: MP

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 2, 2026

5. FEDERAL STATUTE/REGULATION CITATION
TITLE XIX of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 5,840,000
b. FFY 2027 $

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
7.4, pages 1-14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
N/A

9. SUBJECT OF AMENDMENT
MEDICAID DISASTER RELIEF FOR SUPER TYPHOON BAVI PRESIDENTIAL DISASTER DECLARATION & PUBLIC HEALTH EMERGENCY

10. GOVERNOR'S REVIEW *(Check One)*
- (●) GOVERNOR'S OFFICE REPORTED NO COMMENT
- ( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
GEORGE J. CRUZ

13. TITLE
MEDICAID DIRECTOR

14. DATE SUBMITTED
7/31/26

15. RETURN TO
GEORGE J. CRUZ
MEDICAID DIRECTOR
OFFICE OF THE GOVERNOR
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
CALLER BOX 10007
SAIPAN, MP 96950

FOR CMS USE ONLY

16. DATE RECEIVED
July 24, 2026

17. DATE APPROVED
August 4, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 2, 2026

19. SIGNATURE
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Barbara Richards

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

Instructions on Back

Section 7 – General Provisions
7.4 Disaster Relief During a Public Health Emergency or Disaster Period

General Information

1. This Disaster Relief state plan amendment (SPA) is in response to: Super Typhoon Bavi – declared an emergency on July 3, 2026 by the President, retroactive to July 2, 2026, and a PHE on July 2, 2026, by the Secretary of Health and Human Services, pursuant to Section 1135(b) of the Social Security Act.

2. ☒ This SPA is adding to a previously approved Disaster Relief SPA in effect.

   MP-26-0001, MP-26-0002, MP-26-0003

3. ☐ This SPA is superseding a previously approved Disaster Relief SPA.

4. The State Medicaid agency (the agency) implements the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the following period:

   This amendment is effective July 2, 2026, and shall remain in effect through the last day of the PHE declared for Typhoon Bavi, including any extensions or renewals.

   NOTE: If a section 1135 waiver is requested with this SPA submission, the SPA period must comply with the limitations applicable to section 1135 waivers.

5. The agency modifies the following sections during the period of the public health emergency or disaster:

   ☒ A – Eligibility

   ☐ B - Enrollment

   ☐ C - Cost Sharing and Premiums

   ☒ D - Benefits

   ☒ E – Payment

   ☐ F - Post Eligibility Treatment of Income

   ☐ G - Other Policies and Procedures Differing from Approved Medicaid State Plan/Additional Information

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. __X__ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

Disregard all resources for applicants and beneficiaries for eligibility determinations processed on or after July 2, 2026.

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. [Reserved]

5. [Reserved]

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. __X__ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

Disaster-Related Behavioral Health and Support Services

The Commonwealth Medicaid Agency (CMA) adds on-island coverage for Disaster-Related Behavioral and Mental Health, and Support Services under the Rehabilitative Services benefit (1905 (a)(13), 42 CFR 440.130(d)).

These services are added to address the increased mental health, substance use, and psychosocial needs of Medicaid beneficiaries arising from the Public Health Emergency (PHE) and disaster declaration associated with this disaster.

These services are intended to support stabilization, recovery, and continuity of behavioral health care access for Medicaid beneficiaries during and following the declared disaster period.

Medically necessary services may include, but are not limited to:

- Behavioral health assessments and screenings
- Individual, group, and family counseling and therapy
- Crisis intervention and stabilization services
- Trauma-informed care and stress-related intervention
- Substance use disorder screening, brief intervention, and referral to treatment (SBIRT)
- Care coordination, including resource material, referrals, and outreach to facilitate connections to non-Medicaid services through community-based resources
- Psychosocial rehabilitation and skill-building services
- Supportive counseling for caregivers and families for the direct benefit of the beneficiary
- Behavioral Health Therapy (BHT) services utilizing evidence-based therapeutic and behavioral interventions to improve or restore behavioral, emotional, cognitive, developmental, or adaptive functioning.

Services may be provided in clinic settings, community-based settings, temporary sites, shelters, schools, homes, or via telehealth, as clinically appropriate to meet beneficiary needs during the disaster recovery period.

Provider Qualifications
Behavioral health and support services may be delivered by licensed, certified, or otherwise qualified practitioners operating within their scope of practice and enrolled with the Commonwealth Medicaid Agency (CMA) through the applicable provider enrollment process.

Unless otherwise specified, behavioral health and supportive service providers must be age 18 or older; possess a bachelor's degree from an accredited U.S. college or university in psychology, counseling, social work, behavioral science, or a related field; complete a minimum of 40 hours

of related training; and possess at least two (2) years of relevant experience within their field of work recognized and approved by the CMA.

Associate-level, paraprofessional, or otherwise unlicensed personnel may furnish services under the supervision of a licensed, certified, or otherwise qualified provider recognized and approved by the CMA and practicing within their authorized scope of practice.

Qualified providers include:

- Licensed Clinical Social Workers (LCSWs) licensed under applicable Commonwealth Law
- Medical Social Workers possessing a master's degree in social work from an accredited institution.
- Bachelor-level Social Workers possessing a bachelor's degree in social work or related behavioral health field.
- Licensed Professional Counselors licensed under applicable Commonwealth law.
- Certified Counselors possessing certification issued by a Commonwealth or national certifying body recognized and accepted by the CMA, as outlined in Commonwealth provider policy, and practicing within the scope of such certification.
- Behavioral Health Specialist
- Board Certified Behavior Analysts (BCBAs) possessing active certification through the Behavior Analyst Certification Board (BACB) and practicing within their authorized scope of practice.
- Behavioral Health Technicians, Case Managers/Care Coordinators, Peer Support Specialists, and other behavioral health personnel

Amount, Duration, and Scope
There are no arbitrary limits on the amount, duration, or scope of services; however, services must be medically necessary.

2. __X__ The agency makes the following adjustments to benefits currently covered in the state plan:

a. **Eyeglasses.** Eyeglasses services include lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist (42 CFR 440.120(d)).

Under this authority the CMA will allow for the replacement of one pair of lost or broken eyeglasses during the PHE. The provider is required to document and accept self-attestation of lost or broken eyeglasses.

b. **Durable Medical Equipment.** Home health services include medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place (42 CFR 440.70(b)(3)).

Under this authority the CMA, with prior authorization, will limit replacement to one item per equipment type per beneficiary during the PHE. CMA does not cover multiple items that are functionally equivalent or serve overlapping medical purposes, regardless of difference in design, portability, or setting of use, unless medically necessary and

approved through prior authorization.

Medical supplies will be replaced for up to 90 days unless medically necessary and approved through prior authorization.

3. __X__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the state wideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. __X__ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Pursuant to Section 1135 of the Act, the CMA request authority to allow early and emergency prescription refills and replacements of maintenance medications for up to 90 days, to exclude any controlled substance prescription. Permit pharmacies to document and accept self-attestations of lost, damaged or inaccessible medications.

7. __X__ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. __X__ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _X__ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. __X__ Other:

Payment will be the lower of the billed charges or the Hawaii Fee Schedule in effect at time of service. All services which are provided by the Commonwealth Healthcare Corporation (CHCC) must be reimbursed at cost. https://medquest.hawaii.gov/content/dam/formsanddocuments/plans-and-providers/Fee_Schedule_20250228.pdf

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

   b. Payments are increased through:

      i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

      ii. ____ An increase to rates as described below.

      Rates are increased:

      _____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X__ Other payment changes:

a) Advanced Interim CPE Payments for Hospital Services

CMA will make advanced interim Certified Public Expenditure (CPE) payments for the following Medicaid services:

- Inpatient Hospital Services, consistent with the approved payment methodology described in

Attachment 4.19-A (SPA MP-12-003); and
- Outpatient Hospital Services, consistent with the approved payment methodology described in Attachment 4.19-B (SPA MP-12-004A).

Advanced interim CPE payments will be paid using the approved interim payment rate methodologies currently authorized under the CNMI Medicaid State Plan. Advanced interim CPE payments will be made for three (3) months from the effective date of Typhoon Bavi PHE.

For outpatient hospital services, final Medicaid outpatient hospital CPE payments will be reconciled following finalization of the applicable Medicare CMS-2552 cost report by the Medicare contractor for the respective cost reporting period. Final Medicaid outpatient hospital costs will be computed using the same approved methodology described in Attachment 4.19-B.

For inpatient hospital services, advanced interim CPE payments will be reconciled to actual allowable Medicaid inpatient hospital costs and claims data in accordance with the approved payment methodology described in Attachment 4.19-A.

Advanced interim CPE payments made during the disaster relief period will be compared to final reconciled allowable Medicaid costs and claims data. Any underpayment identified through the reconciliation process will be paid to the provider. Any overpayment identified through reconciliation must be returned to CMA, and CMA will return the federal share of overpayments in accordance with 42 CFR Part 433 Subpart F.

The final reconciliation will be performed and completed within six (6) months following the Medicare contactor's finalization of the applicable Medicare CMS-2552 cost report and issuance of the Notice of Program Reimbursement.

b) Payment Methodology Description

In response to the Public Health Emergency (PHE) and disaster declaration associated with Super Typhoon Bavi, effective July 2, 2026, the Commonwealth Medicaid Agency (CMA) will implement a temporary prospective/interim payment methodology to ensure provider stability and continued access to care for Medicaid beneficiaries.

Under this methodology, the CMA will issue advance prospective payments to enrolled Medicaid providers experiencing disruptions in operations, billing, or cash flow as a direct result of the disaster.

These payments are intended to:
- Maintain provider capacity and access to services
- Stabilize healthcare delivery systems during the emergency
- Ensure continuity of medically necessary services

Eligibility for Interim Payments

Providers may request interim payments if they:

- Are enrolled and in good standing with the CMA
- Have billed Medicaid for covered services within a reasonable prior period (as determined by the CMA)

- Demonstrate disruption due to the disaster or PHE (e.g., service interruption, displacement, billing delays)
- Are not under active program integrity investigation or subject to payment suspension

Amount of Payment

- Interim payments will be based on historical utilization, prior adjudicated payments, or other reasonable estimates as determined by CMA
- Interim payments will represent up to three (3) months of estimated Medicaid payments for covered services during the PHE, as determined by CMA
- Final payment for services is based on adjudicated claims in accordance with the approved payment methodology described in Attachment 4.19B of the State Plan
- All payments are subject to the reimbursement methodologies and fee schedule limits established in Attachment 4.19B of the State Plan
- Payment amounts are determined by CMA and are subject to reconciliation

Reconciliation and Recoupment

All interim payments are subject to reconciliation and recoupment and are not considered final payments.

- Providers must continue to submit claims for services rendered in accordance with applicable Medicaid requirements.
- CMA will reconcile interim payments to allowable Medicaid payments based on adjudicated claims in accordance with the State Plan.
- Upon reconciliation, providers must return any overpayments to the CMA, which will return any overpayments to CMS.
- In accordance with 42 CFR Part 433 Subpart F, the CMA will return the applicable federal share of any identified overpayments.
- The CMA may establish repayment timeframes and terms to minimize provider burden while ensuring timely recovery of overpayments in accordance with State and Federal guidelines.

Conditions and Safeguards

- Payments are contingent upon medical necessity and covered services under the State Plan
- The CMA will implement program integrity safeguards, including monitoring, reconciliation, and audit authority
- Interim payments will not exceed allowable Medicaid payments for services furnished
- Providers must maintain documentation sufficient to support services billed
- Providers cannot make duplicate claims for payments already made under the authority of DR SPAs 26-0001, 26-0002, or 26-0003 in response to Typhoon Sinlaku. The territory provides assurance that there will be no duplication of payments made under the authority of DR SPAs 26-0001, 26-0002, or 26-0003 in response to Typhoon Bavi."

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information
