



SMD # 16-011

RE: Community First Choice State Plan Option

December 30, 2016

Dear State Medicaid Director:

This letter provides guidance on the implementation of the Community First Choice State Plan Option, a home and community-based benefit package available to states to promote community integration. Section 2401 of the Affordable Care Act amended section 1915 of the Social Security Act (the Act) to add 1915(k) as a new subsection, the benefit known as Community First Choice (CFC). Under section 1915(k) of the Act, states have the option to amend their state plan to provide home and community-based attendant services and related supports. CFC final regulations¹ were published May 7, 2012, and the final regulations for home and community-based setting requirements for CFC² were published January 16, 2014. CMS is committed to helping support states interested in adding the CFC option to their Medicaid state plan, and to aid in that effort we are providing a [state plan amendment \(SPA\) pre-print and CFC technical guide](#).

Background

The purpose of the CFC option is to provide individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting. The CFC option expands Medicaid opportunities for the provision of home and community-based long-term services and supports (LTSS) and is an additional tool that states can use to facilitate community integration while receiving enhanced Federal match of six (6) additional percentage points for CFC services and supports. There is a growing trend towards home and community-based services instead of institutional care. In 2013, 51.3 percent of the dollars spent nationally on Medicaid LTSS was for community-based supports, signifying the first time Medicaid expenditures for these services exceeded institutional care. In 2014, the percentage grew to 53.1 percent.³ It is clear that CMS and states are committed to making additional progress, and the CFC benefit can be used to expand the availability and scope of LTSS. This can include reinvesting the additional Federal Medical Assistance Percentage (FMAP) to provide new PAS, increase the comprehensiveness of existing PAS, and enhance the state's overall LTSS program.

¹ <http://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/cfc-final-regulation.pdf>

² <https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

³ Wenzlow, Audra, Steve Eiken, and Kate Sredl. 2016. *Improving the balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014*. Prepared for CMS by Truven Health. Retrieved from <https://www.medicare.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf>

As states continue to engage stakeholders in the development of home and community-based services, CMS encourages consideration of CFC as a meaningful option to rebalance long-term care expenditures and increase the availability of home and community-based options.

CFC can help reduce the administrative complexity that results from having multiple authorities to provide similar types of services across different populations. While different benefit authorities, such as 1915(c) Home and community-based waivers and 1915(i) Home and community-based state plan services, may provide states the flexibility to target services and populations, this may result in inconsistency in the levels and types of services available across populations. It may also make it difficult to manage and coordinate services across programs with different eligibility criteria and different assessment tools in use. The CFC option allows services to be available across populations for people who meet the institutional level of care, in accordance with need and regardless of the type, nature or severity of disability, thus making it possible to standardize eligibility and needs assessments while better coordinating services.

PAS are utilized by individuals across all conditions and disabilities, and there is not one population with an institutional level of care need that would benefit from PAS more than another. Making services available to individuals across all institutional levels allows states to streamline access to PAS, by focusing on an individual's functional needs, rather than type of disability. CFC offers states the opportunity to provide personal assistance and related services in a coordinated manner that highlights self-direction, person-centered planning, and flexible service delivery.

Individuals receiving CFC services are not precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant, or demonstration authorities. The CFC benefit should be used in conjunction with other services (Medicaid funded and non-Medicaid funded) to support an individual's opportunity for full community integration.

Enhanced Federal Medicaid Assistance Percentage (FMAP)

States will receive a six percentage point increase to the FMAP calculated under 1905(b), not to exceed 100 percent, for the provision of CFC services and supports. For example, a state that regularly receives 50 percent FMAP would receive a six percentage point increase resulting in 56 percent FMAP for services authorized through the CFC state plan option. The enhanced FMAP is only applicable for the provision of CFC supports and services provided directly to individuals who meet the eligibility requirements described in 42 CFR 441.510 (such as attendant care services, person-centered planning, and financial management services). States must adhere to the free choice of provider requirements at 42 CFR 431.51, unless provided through a managed care arrangement or authorized under selective contracting authority.

There are various activities that are performed for the proper and efficient administration of the Medicaid state plan, including for activities related to CFC services, such as level of care determinations, quality management, data collection, implementation of the Development and Implementation Council required under CFC and administrative costs related to implementation of a fiscal agent structure. The state expenditures for these activities will be matched at the 50 percent administrative claiming rate, rather than the CFC enhanced match.

To the extent a state seeks administrative match for the above mentioned activities, and the activities have not been documented within either a state's Public Assistance Cost Allocation Plan (PACAP) or a Medicaid Administrative Claiming (MAC) Plan, the state will have to amend its PACAP or MAC Plan to document these activities and receive administrative match. CMS is available to provide technical assistance on any needed amendments.

Program Eligibility

Section 1915(k) of the Act did not create a new eligibility category for the CFC state plan option. Therefore, coverage for 1915(k), like other state plan services, is dependent on an individual meeting all of the requirements for a Medicaid eligibility category covered under the state plan to which the 1915(k) benefit is made available.

Individuals who are eligible for medical assistance under the HCBS waiver-related category described in §435.217 (“Individuals receiving home and community-based services”) must meet all the 1915(c) waiver requirements, including the receipt of the minimum number of waiver services identified in the waiver, to maintain eligibility for medical assistance and access the CFC state plan option. Receipt of state plan 1915(k) services is not a basis for maintaining Medicaid eligibility for this category.

The CFC benefit includes specific program eligibility criteria that states must adhere to when determining who can receive the CFC benefit. These requirements are summarized as follows:

Level of Care Requirement (42 CFR 441.510)

Individuals receiving CFC benefits must meet one of the following institutional levels of care: (long-term) hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. States must include all levels of care required by the CFC statute and implementing regulations that are covered in their state. States may not develop a CFC benefit that is targeted to a specific population. For example, a CFC benefit could not only be available to individuals who meet a nursing facility level of care. States must have a process to determine CFC eligibility for individuals based on the level of care for the setting in which the individuals would have received institutional services.

Financial Eligibility

In addition to being eligible for Medicaid under the state plan authority, individuals must meet one of two eligibility requirements specific to the CFC benefit. If an individual is in an eligibility category covered under the Medicaid state plan to which coverage for nursing facility services is available, no separate income test is applied to determine the individual’s eligibility for coverage of CFC (§441.510(b)(1)). However, if an individual is not in such an eligibility category, the individual not only must meet any income test applicable to the Medicaid eligibility group, but must have income that is at or below 150 percent of the federal poverty level (FPL) in order to be eligible to receive coverage of CFC (§441.510(b)(2)). The determination of whether an individual’s income is at or below 150% of the FPL must be based on the same methodologies as would apply to the category under the Medicaid state plan in which the individual is enrolled, including application of any disregards approved under the state plan in accordance with section 1902(r)(2) of the Act.

Additionally, section 2404 of the Affordable Care Act mandates that, for the five-year period beginning January 1, 2014, the definition of an “institutionalized spouse” in section 1924(h)(1) of the Social Security Act (the spousal impoverishment statute) includes married individuals who are eligible for, among other things, “medical assistance for home and community-based attendant services and supports under section 1915(k). . . .” The Centers for Medicare & Medicaid Services (CMS) issued 2015 guidance to states on how this provision should be applied (“Affordable Care Act’s Amendments to the Spousal Impoverishment Statute”). CMS reminds states that are interested in adopting, or have adopted, the 1915(k) benefit that Medicaid

eligibility for married individuals should be determined in a manner consistent with our May 2015 guidance, which can be found at: <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf>

CFC Services (42 CFR 441.520)

There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option. There is no requirement that every service that is included in the CFC benefit will be provided to every individual receiving the benefit. States are required to complete an assessment of each individual, and to identify and provide those CFC services and supports that are determined to be necessary and appropriate. All services and items must be linked to an assessed need and identified in the person-centered plan (described in more detail below).

States electing CFC are required to cover the following services, subject to the conditions described above: (1) activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanism to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants.

The optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month's rent and utilities or bedding, basic kitchen supplies, etc.) necessary for an individual transitioning from an institutional setting to a home and community-based setting and (2) expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance. For example, an attendant assisting an individual with transferring from sitting to standing would be considered an ADL, and therefore, considered a covered CFC activity. In lieu of having an attendant on "stand-by" to assist with this activity, the individual may indicate through the person-centered service plan that he would like an electric seat lift so that he can get out of his chair independently. Under this activity, the state could cover the cost of the seat lift, so an individual can get up and sit down independently, instead of needing to have an attendant to provide that type of assistance.

States have a degree of flexibility to determine the scope of what to include in transitional costs and items that increase independence or substitute for human assistance. It is not necessary for the state to list every service or support that would be covered for this purpose; however, in accordance with general Medicaid requirements found at 42 CFR 440.230(a), a state must describe any limitations on the amount, duration or scope of any of the required and optional services. The attached CFC technical guide provides additional information regarding the scope of the benefit and the examples of the optional services that may be included.

Service Models (42 CFR 441.540)

There are three service delivery models available to states to include in their CFC benefit. While each model will have varying levels of responsibilities afforded to the individual, all models must offer a consumer controlled method of selecting and obtaining services that allows the individual the maximum control possible.

Services may be provided through (1) an agency-provider model, (2) a self-directed model with a service budget (utilizing a financial management entity and/or direct cash payments or vouchers), or (3) a state defined model that is approved by the Secretary. The state determines service delivery model(s) to include in its CFC benefit.

Person-Centered Planning Process and Service Plan (42 CFR 441.540)

The person-centered planning process identifies a person’s strengths, goals, preferences, service needs and desired outcomes. It is a process that is driven by the individual⁴ receiving services and must allow for the participation of people freely chosen by the individual. These people can be family members, friends, caregivers, and others the individual or his/her representative wishes to include. The process must involve the individual receiving services and supports to the maximum extent possible, even if the individual has a legal representative.

The person-centered service plan reflects the services and supports (paid and unpaid) that are important for the individual. These services are to assist the individual to address the needs identified through an individual assessment of functional need and the goals identified by the individual. The services must also reflect the individual’s preferences for the delivery of CFC services and supports. Like the person-centered planning process, the development of the person-centered service plan must be driven by the individual receiving CFC services. In order to accomplish this, a support system must be available as part of the CFC benefit and provided in accordance with the requirements described in §441.555. In summary, the support system must provide individuals with counseling, information, training, skills and supports they need to make informed choices and decisions. Counseling would include providing information on the range of service options and choices available, grievance and appeal rights, and information on freedom of choice of providers and service models. Training would include training individuals on the rights and responsibilities of directing the provision of services, such as how to communicate effectively with attendants and how to supervise attendants. The role of individuals providing support activities (e.g., options counselors, support brokers, social workers and others) in the person-centered planning process is to enable and assist individuals to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during the planning process.

In addition to the services and supports available through the CFC benefit, natural supports provided by unpaid caregivers play a critical role in assisting individuals with remaining in the community. As noted in the response to the comment in the preamble of the CFC final regulation (CMS-2337-F), the identification of natural supports in the assessment is an important aspect in determining an individual’s needs. 42 CFR 441.540(b)(6) states that “Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of the attendant.” CMS is clarifying that this language is to set forth the requirement that informal caregivers, family members and friends cannot be required to provide unpaid supports as a condition of an individual receiving CFC services, nor can the beneficiary be required to accept such services. Informal caregivers, family members and friends should only provide unpaid supports if they and the individual determine it is their preferred option based on the assessment, the person-centered planning process, the approved levels of paid support in the plan and in accordance with the service delivery model(s) selected by the state. This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.

Lastly, to prevent conflicts that may arise when an individual’s representative could also provide paid services, CFC regulations prohibit an individual’s representative, as defined in 42 CFR 441.505, from also being paid to provide CFC services to the individual. In circumstances where it has been determined that the representative is the most appropriate person to provide services, an alternative person must be identified to act as the individual’s representative for the purposes of participating in the person-centered planning process and provision of CFC services and supports.

⁴ In accordance with §441.505 *individual* means the eligible individual and, if applicable, the individual’s representative.

Home and Community-Based Settings (42 CFR 441.530)

Section 1915(k)(1)(A)(ii) of the Act states that CFC services and supports must be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities. Implementing regulations found at 42 CFR 441.530 define and set forth requirements for CFC settings.

The home and community-based settings requirements are designed to establish a more experiential definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The requirements apply to residential settings where individuals reside (irrespective of receiving CFC services in that setting) and non-residential home and community-based settings where CFC services are provided.

Prior to submitting a CFC state plan amendment, under 42 CFR 441.575 (b), states are required to consult and collaborate with a Development and Implementation Council, throughout the development and implementation of the CFC benefit. The requirements related to the Development and Implementation Council are described in a separate section of this letter, below. The state should also review its assessment of compliance with home and community-based settings requirements with the Council prior to SPA submission. This includes the Council's prior review of any intended settings the state intends to submit to CMS for heightened scrutiny review. Additional information on the heightened scrutiny review process is available on www.medicaid.gov/hcbs. CMS also strongly encourages states to seek public input on their processes for assessment of settings. These additional efforts will be of great assistance during the SPA review process in which CMS determines if the settings meet the regulatory requirements.

The first step in CMS's review of a CFC SPA will be the determination that all CFC settings comply with the regulation. Medicaid requirements found at 42 CFR 430.20 specify that a SPA may be approved with an effective date that is retroactive to the first day of the quarter in which an approvable plan is submitted to CMS. However, because a SPA cannot be approved if it would result in the provision of services in non-compliant settings, it may be necessary to amend an effective date of a CFC SPA to coincide with the date settings were determined compliant. Under such circumstances, CMS will work with states to determine the adjusted effective date.

As part of the CFC SPA review process, states must submit adequate information to CMS showing that the settings where individuals receiving CFC services reside or receive CFC services, meet the requirements found at 42 CFR 441.530. To assist states with providing adequate information, states should answer the Standard Review Questions related to Home and Community-Based Settings Criteria for 1915(k) Community First Choice (CFC) SPA submissions. Additionally, CMS has issued guidance to assist states in assessing settings and determining compliance with the regulation⁵. The questions and additional information about the home and community-based settings requirements are included in the attached CFC Technical Guide.

Since the home and community-based settings regulation contains new requirements for settings, CMS expects that states will need to revisit and possibly revise their state regulations or issue sub-regulatory guidance to ensure compliance. Training provided by the states on these new requirements is vital for beneficiaries, their families, case managers, providers, and other stakeholders. States should ensure they have developed strong oversight and quality mechanisms to ensure continued compliance, as well as grievance and appeal systems to address any concerns or potential violations.

⁵ www.medicaid.gov/hcbs

The Quality Assurance System (42 CFR 441.585)

The CFC SPA must include a description of a quality assurance system. The system must include a quality improvement strategy that addresses both individual and systemic issues. Among other requirements, the system must also continuously monitor the health and welfare of each CFC recipient, include a process for mandatory reporting, investigation, and resolution of allegations of neglect, abuse or exploitation in connection with CFC services and supports, and a method of measuring individual outcomes associated with an individual's receipt of CFC services. The quality assurance system must include standards for all service delivery models, including how and when an individual can appeal service denials (e.g. type of services requested or the number of assessed service hours), as well as reconsideration procedures for an individual's person-centered service plan. Reconsideration procedures are less formal than the appeals process. They provide the opportunity for the individual receiving CFC services, the individual's representative (if applicable), the person responsible for facilitating the person-centered process and other individuals chosen by the individual to explore an informal resolution to the individual's concerns. With regards to appeals, the fair hearing requirements set forth in part 431, Subpart E, apply to CFC in the same manner as they apply to other Medicaid State plan services. A reconsideration process does not replace the fair hearing process, nor should it delay an individual's right to a fair hearing.

As discussed in our January 16, 2014 regulation, the quality improvement system must also include performance and outcome measures for the home and community setting requirements. In its SPA, the state should include a description of the state's process and content for ongoing monitoring of the compliance for home and community-based settings requirements described in 42 CFR 441.530.

The state's quality assurance system must also include a way to elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of people with disabilities or elderly individuals, members of the community and others to improve the quality of the community-based attendant services and supports benefit.

States may consider utilizing existing components of current quality assurance systems used to evaluate other programs to meet this requirement, as long as all of the specific requirements of 42 CFR 441.585 are addressed.

Maintenance of Existing Expenditures (42 CFR 441.570(b)) and Data Collection (42 CFR 441.580)

For the first full twelve month period in which the state plan amendment is implemented, the state must maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding twelve month period.

Additionally, 42 CFR 441.580 specifies the annual data collection requirements for CFC benefits. Guidance on how to meet the maintenance of existing expenditures and the data collection requirements are provided in the attached CFC technical guide.

Concurrent Use of Other Medicaid Authorities with the Section 1915(k) Benefit

1) Managed Care Authorities

Several states have been approved to include CFC as part of a service package available in a managed care arrangement. For a state to receive enhanced FMAP for CFC services, a state plan amendment is still required even when services are provided through a managed care arrangement. States providing CFC services in a managed care arrangement are required to comply with all of 42 CFR 438.

Specifically, when a state is including a CFC payment in a health plan capitation rate must include a

separate CFC section in their capitated rate Actuarial Certification that is submitted to the Regional Office. The state must use only CFC services in calculating that portion of the entire capitation payment attributable to CFC in the separate section of the actuarial certification in order to be able to claim expenditures for that portion at the enhanced FMAP under this provision. The required information is outlined in the CFC technical guide. CMS will provide technical assistance to any state interested in adding CFC services to a managed care arrangement.

2) Section 1915(b)(4) Authority

A state may use the section 1915(b)(4) authority to request a waiver of section 1902(a)(23) of the Act, the free choice of providers requirement, to selectively contract with entities that furnish CFC services eligible for the enhanced FMAP.

In order to operate sections 1915(b)/1915(k) concurrently, a state must complete and submit a separate section 1915(b) waiver application and section 1915(k) state plan amendment. Both applications are subject to a 90-day review period (clock). CMS internally coordinates the review of both applications. Because a 1915(b) waiver must be approved on a prospective basis, we encourage a state to submit a request to operate sections 1915(b)/1915(k) concurrently at least six months in advance of the proposed CFC effective date to facilitate a smooth implementation.

3) Section 1115 Medicaid Demonstration Authority

States may make CFC services available to individuals enrolled in an 1115 Medicaid demonstration. As required by section 1915(k)(1) of the Act, to receive the enhanced FMAP associated with the provision of CFC services, the state must have an approved CFC state plan amendment and the individuals must meet all of the CFC program requirements described in 42 CFR 441.510, including meeting eligibility requirements under the state plan. CMS has provided states authority through Section 1115 demonstrations to extend Medicaid eligibility to individuals not otherwise eligible under the state plan. In these cases, states provide a “CFC –like” benefit package to those individuals; however, states may only claim the normal FMAP rate for the provision of those services.

State flexibility in developing approaches to benefits and service delivery

States have flexibility to design a CFC program. For example, states could design a program that is limited to only mandatory services and one service delivery model (i.e., self-directed model with service budget) as an approach to establishing the program in the state. Over time, the state could add multiple optional services and service delivery models to expand the choices available to beneficiaries. Alternatively, the state could design a program that provides maximum choice at the outset.

Comprehensiveness of Reimbursement Methodologies and Submission of 4.19 B pages

Regulations at 42 CFR 430.10 require the state plan to contain a comprehensive description of the state’s Medicaid program, including the methods for reimbursing covered services. Therefore, states must submit corresponding 4.19 B pages to describe reimbursement methodologies for CFC services when submitting a state plan amendment to implement the CFC state plan option.

Incorporating the CFC benefit into a state’s current long-term services and supports system

As states contemplate adding CFC services to their LTSS system, it is important to consider the impact on existing components of their state LTSS design. While there is not a requirement that states modify existing authorities to implement CFC, states are required to design their systems in a manner that prevents duplicate payment for the same services and clearly articulates the services and delivery of the program.

CMS is committed to providing technical assistance in this and other aspects of CFC, and strongly urges states to discuss their plans with CMS as early as possible. This will allow the state to obtain technical assistance in determining the types of services that can be delivered within CFC, assessing time frames for desired design decisions and implementation, evaluating options for achieving the outcomes desired by the state in expanding their LTSS design, and ensuring a smooth and seamless transition for recipients of services.

Because some states have chosen to move or modify services from existing 1915(c) HCBS waivers as they add the CFC benefit to their Medicaid state plan, it is critical that states work early and closely with the combined CMS state plan and waiver teams to ensure that the state understands its options and designs a system that is compliant with both state plan and waiver requirements.

Consultation Requirements

Prior to submitting a SPA pre-print to CMS, states must consult and collaborate with a state established Development and Implementation Council when developing and implementing a SPA to provide CFC services and supports. The regulations at 42 CFR 441.575 specifically require the majority of the Development and Implementation Council members be individuals with disabilities, elderly individuals, and their representatives. States may use existing Medicaid advisory committees to serve the purpose of the Development and Implementation Council, as long as the membership and purpose of the committee meet the CFC regulatory requirements.

States with federally recognized Indian Tribes and Indian health care providers must consult with Tribes and solicit advice from Indian health care providers, consistent with their Tribal Consultation SPAs, the transparency regulations at 42 CFR section 431.400 if the state is choosing to implement the program through an 1115 Medicaid demonstration, and Section 8 of the CMS Tribal Consultation Policy.⁶ We encourage states to work collaboratively with Tribes and Indian health providers in their state to assure inclusion of providers that have the expertise to address the unique cultural needs of American Indians/ Alaska Natives (AI/ANs) and provide culturally competent care in LTSS settings.

SPA Submission Requirements

States must use the attached SPA pre-print to describe the CFC benefit. States must also submit a reimbursement page (attachment 4.19-B) identifying the payment rates for the CFC activities eligible for claiming at the Federal Medical Assistance Percentage (FMAP). In submitting the plan amendments, States must comply with the public notice requirements of 42 CFR 447.205. Additionally, the CFC benefit may be part of a service package available in a managed care arrangement. For a state to receive enhanced FMAP for CFC services, a state plan amendment is still required even when services are provided through a managed care arrangement.

SPAs may be approved with effective dates retroactive to the first day of the quarter in which they are submitted as long as all regulatory requirements are met. SPAs are subject to the traditional State plan review process. Please submit your SPA electronically to your regional office in order to implement these provisions.

We look forward to working with states to implement this Medicaid state plan option. CMS is available to provide technical assistance to states as they consider making CFC a part of a state's strategy for

⁶ <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf>

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advancing access to home and community-based services, and hopes that the attached tools are helpful to that end.

If you have any questions, please contact Kirsten Jensen, Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, at 410-786-8146.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

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