DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
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San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 11, 2015

Mari Cantwell, Chief Deputy Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

The state of California has requested a new Section 1915(c) home and community-based services (HCBS) waiver entitled *California Self Determination Program Waiver for Individuals with Developmental Disabilities*, CMS control number 1166.00. The proposed waiver seeks to provide home and community-based services to individuals who would otherwise require care at an intermediate care facility (ICF), and to allow participants the opportunity to accept greater control and responsibility regarding the delivery of needed services through enhanced self-direction.

Based on our review of the application and substantive correspondence over the past year between CMS and the state, we have concluded that we need the following additional information and edits made to the proposed waiver before the request can be approved.

CRITICAL RESOLUTION ISSUES

Appendix B: Participant Access and Eligibility

1. **B-3-f. Selection of Entrants to the waiver -** Please clarify if all eligible individuals are granted entrance into the waiver or indicate the process for the selection of entrants that is based on objective criteria and applied consistently in all geographic areas served by the waiver.

Appendix B: Evaluation/Reevaluation of Level of Care

2. **B-QIS, Sub-assurance (a) -** The proposed performance measure (PM) addresses only the percentage of enrollees who had a level of care determination before enrolling in the program; whereas the sub-assurance requires that all "applicants" be evaluated who have a reasonable indication that waiver services may be needed. Please revise or add a second PM to fully address the sub-assurance's requirement.

3. **B-QIS, Sub-assurance (c) -** The second proposed measure states "Number and percent of level of care determinations that were completed accurately" Please define "completed accurately" and revise the performance measure to reflect this.

4. **B-QIS, Remediation** - Are there any escalating consequences if issues occur repeatedly?

Appendix C-3: Waiver Services

5. For the following services, please add a statement to the service definition specifying that children under age 21 who need these services will receive them through the state plan per EPSDT requirements: home health aide services, Dental Services, Prescription Lens/Frames, Optometric/Optician Services, Psychology Services, Skilled Nursing, Speech, hearing and language, Integrative therapies.

6. Waiver service qualifications - For all provider types please clearly define the qualification. If a specific regulation or code applies, please include pertinent information regarding that particular citation or the areas the citation covers. If there is a license required please be more specific regarding the type of license needed.

7. Verification entity - FMS is not described in Appendix A as a contracted entity. Please explain why the state has specified the FMS as the verifying entity since this appears to be inconsistent with what is in Appendix A for this Medicaid administrative function.

8. Frequency of Verification - Please verify how each entity responsible for verification will do so "ongoing thereafter through the IPP process." Please define "ongoing" under frequency of verification. Please also spell out IPP in this instance.

9. Behavioral Intervention Services - Habilitation Services - This service should be categorized as an "other" service as it provides services outside the scope of Habilitation services.

10. Home Health Aide Services - Specify the additional services that are provided when the state plan benefit is exhausted. Please also specify the state plan service limit.

11. Respite - The state's service definition includes "regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver(s) are out of the home." Please clarify as to how this service will include activities that are beyond the scope of child care, and how this service is necessary to avoid institutionalization. Additionally, the state needs to specify the limits on these services since respite is a temporary service.

12. Advocacy Services - Is generic legal counsel provided in the state and if so by which entities? If the services are specific to legal counsel please indicate how this does not overlap with independent advocacy listed in Appendix E-1-k of the waiver application. If it is not specific to legal counsel please explain how this service is different than case management/service coordination or the Independent Facilitator services and how duplicate billing will not occur.

13. Communication Support - Please indicate how this is service is different than technology services and specialized medical equipment and supplies and how duplicate billing will not occur.

14. Community Integration and Employment Supports

a. Please separate these services into two separate waiver services. Please indicate how the community integration is different than community living supports services and how duplicate billing will not occur.
b. Please remove “College, including financial assistance with tuition, books, and other related fees” as the state cannot claim FFP for these services, and also subtract any estimated costs associated with this expense from the Factor D cost estimates in Appendix J.

15. **Community Living Supports -** Please describe how this service is different than other similar services such as homemaker services and community integration services, and what mechanisms the state will put in place to prevent duplicate billing.

16. **Crisis intervention and Support**
    a. Please describe how these services are different and not duplicative of the behavioral intervention services.
    b. Crisis Facility, Other standard- Please include in this section all types of 24 hour care services and not a reference to another service section.

17. **Dental Services -** Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

18. **Family Assistance and Supports -** Please further define the types of services and supports that would be provided under this service and how this service is different than Training and Counseling Services for Unpaid Caregivers and how duplicate billing will not occur.

19. **Financial Management Services**
    a. Please indicate why this service is listed as “other” instead of Supports for Participant Direction.
    b. Please define "as appropriate" under the provider qualification, license, business license**.**
    c. Are individuals who provide FMS allowed to provide any other (additional) waiver services to an individual participant?
    d. How many providers do you expect to enroll for this service and please explain how the state will oversee the performance of the FMS providers?

20. **Housing Access Supports -** Please indicate how this service will not duplicate case management, community integration, and advocacy services.

21. **Independent Facilitator**
    a. Please more clearly define this service. Please further explain how this service does not duplicate services provided by the service coordinator, advocacy services, or financial management services.
    b. How will these individuals be trained? How is the training different from that of service providers and/or financial management service coordinators?

c. 700 participants are estimated to use the service starting WY1, is there a workforce of already trained Independent Facilitators to provide services starting WY1?

22. **Individual Training and Education -** How will the state ensure this service is not duplicative of other waiver services? For example, employment related training appears duplicative of the employment supports waiver service. In addition, community integration, advocacy, and community living supports all have similar components.

23. **Integrative Therapies**
    a. Each service will need to be a separate service within the waiver.
    b. Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit. For massage therapy, please specify when this service would be needed and necessary for a waiver participant to live in the community.

24. **Prescription Lens/Frames -** Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

25. **Optometric/Optician Services -** Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

26. **Psychology Services -** Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

27. **Skilled Nursing -** Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

28. **Specialized Therapeutic Services** - Please remove this service from the waiver. This service is not available through a 1915(c) waiver.

29. **Speech, hearing and language** - Please describe the extent of the extended coverage of services. Also please include the provider qualifications directly and not by reference to the state plan. Please also specify the state plan service limit.

30. **Technology Services -** This service appears to overlap with PERS, communication support, specialized medical equipment and supplies. Please clarify how they are different and how duplicate billing will not occur. The state needs to also remove "but not limited to" from this waiver service definition and specify what can be covered since it is not permissible for the waiver service definition to be open-ended.

31. **Training and Counseling Services for Unpaid Caregivers** - Please explain how this service is not duplicative of family assistance and supports services.

32. C-2-c-i: Types of facilities subject to 1616(e) - Per the instructions in the Technical Guide please remove the information from this section.

33. C-2-f: Open Enrollment of Providers - Please describe the enrollment process that assures all willing and qualified providers have the opportunity to enroll.

34. Qualified Providers, Sub-assurance (a)

a. Please explain why bi-annual reviews by DSS are of sufficient frequency to ensure licensed providers initially meet all required standards prior to furnishing waiver services.
b. Regarding the second proposed PM, Please clarify what the review consists of. How will it help the state to ensure that providers are meeting required licensure and/or certification standards and adhering to other applicable standards?

35. Qualified Providers-Sub-assurance (a) and Sub-assurance (b) - Please clarify what is meant by "Representative Sample – 5."

36. Qualified Providers-Sub-assurance (b)

a. The proposed PM only addresses providers who initially meet all required standards; however, the sub-assurance is not limited to initial adherence. Please either revise the proposed PM to indicate how providers continually meet all required standards, or add an additional PM that measures continuous monitoring of providers who do not require licensing or certification.
b. Please explain why bi-annual reviews by DDS are of sufficient frequency to ensure non-licensed providers initially meet all required standards prior to furnishing waiver.

37. Qualified Providers-Sub-assurance (c)

a. How does the State monitor the successful completion of 70 hours of competency based training?
b. Are direct support professionals (DSPs) the only providers that must meet a training requirement? If not, please either revise the proposed PM to measure all provider training requirements or add an additional PM.
c. A provider could potentially provide services for an extended period of time without having met training requirements. Please explain why 70 hours of competency based training within two years of hire is sufficient to assure that the provider training is conducted in accordance with state requirements and the approved waiver. How did the state arrive at 70 hours given training can vary for each participant?

38. C-5: Home and Community-Based Settings

a. Please include a list of the specific settings where individuals will reside.
b. Please include a list of specific settings where individuals will receive services.
c. Please include a detailed description of the process the state Medicaid agency used to assess and determine that all waiver settings meet the HCB settings requirements.

d. Please include the process that the state Medicaid agency will use to ensure all settings will continue to meet the HCB settings requirements in the future.

Appendix D: Participant-Centered Planning and Service Delivery

39. D-1-d: Service Plan Development Process

a. Please describe as part of the planning process how participants are informed of services available under the waiver.
b. Please describe how responsibilities are assigned for implementing the plan.
c. Please describe how waiver and other services such as state plan services are coordinated.
d. Please identify who is assigned the responsibility to monitor and oversee the implementation of the service plan.

40. D-1-g: Process for Making Service Plan Subject to the Approval of the Medicaid Agency

a. Please provide the basis for the sample size of plans reviewed, how it is representative of the total population, and the review methodology.
b. Please include the frequency with which DHCS or DDS completes reviews of the plans.

41. D-2-a: Service Plan Implementation and Monitoring

a. Please clarify how monitoring methods address services furnished in accordance with the service plan, participant access to waiver services is identified in the plan, participants exercise free choice of provider, services meet the participants need, effectiveness of back up plans, participants health and welfare, and participants access to non-wavier services in service plan including health services.
b. Please clarify the method for prompt follow-up and remediation of identified problems.
c. Please clarify the methods used to compile systemic collection of information about monitoring results, and how problems identified during monitoring are reported to the state.

42. D-QIS, Service Plan

a. Please explain why bi-annual reviews by DDS are of sufficient frequency to ensure the service plans address all the participants' assessed needs and personal goals in sub-assurance a,c,d, and e.
b. Please clarify what is meant by "Representative Sample – 5 for sub-assurance a, c, d, and e.

43. D-QIS, Sub-assurance (a)

a. For each PM, please add the words "all of" after the word "addressed" in all instances.
b. How is it determined that the consumers' assessed needs are "adequately" addressed? Who makes this determination?

44. D-QIS, Sub-assurance (c) - Please clarify that the term "required intervals" means that service plans were updated/revised when warranted by changes in the waiver participant's needs.

45. D-QIS, Sub-assurance (d)

a. How will the state determine whether participants have received the appropriate type, scope, amount, duration and frequency of services specified in the IPP?
b. How does the state monitor/ensure that participants with similar needs (similar service plans) do not have drastically different budgets? How will the state monitor whether individual budgets are equitable?

46. D-QIS, Sub-assurance (e) - The proposed PM does not specifically measure whether participants are afforded a choice among services and providers. Please revise this PM to specifically address these issues.

Appendix E: Participant Direction of Services

47. E-1-c: Availability of Participant Direction by Type of Living Arrangement - Please specify/define "community living arrangement" where the state indicated participant direction is supported, including the size of the living arrangement.

48. E-1-f: Participant Direction by a Representative - Please describe the safeguards that ensure a non-legal representative functions in the best interest of the participant.

49. E-1-i-i: Payment for FMS - Please specify how the state will compensate the entities that provide FMS services. Per the HCBS Waiver Technical Guide examples could be a per transaction fee, a monthly fee per participant, a combination of both types of fees, or another method. The state indicates in response to this item in the waiver that FMS costs will be paid from the individual budget but that the individual budget will not be increased to include these costs. This is not permissible. The state may include the FMS waiver service costs in an individual budget but then must reflect and account for this is the individual budget methodology as described in Appendix E-2-b-ii.

50. E-2-b-ii: Participant, Budget Authority - Please specify and define "budget categories." Are there limits to and/or within budget categories? Per the previous comment, if the state intends to pay for waiver FMS costs from the individual budget, then the state needs to revise the budget methodology.

51. E-2-b-ii: Participant Directed Budget - Please describe how the budget methodology is made available to the public.

52. E-2-a: Participant Employer Status - What mechanism does the state have in place to ensure that individuals maintain authority and control over employees when co-employment is occurring.

53. E-2-b-v: Expenditure Safeguards

a. Please describe the safeguards to address potential service delivery problems that may be associated with budget underutilization or premature depletion of the participant budget.

b. What is the state Medicaid agency's role in ensuring that potential budget problems are identified on a timely basis, including over-expenditures or underutilization?

Appendix F: Participant Rights

54. F-1-a: Opportunity to Request a Fair Hearing

a. Please specify who provides Fair Hearing information to the participant?
b. Please specify this information is also given to a participant at the time of their entrance into the waiver.
c. Please specify how notice is made and who is responsible for issuing the notice.
d. Please clarify what assistance, if any, is provided to the individual pursuing a fair hearing.
e. Please indicate where notices of adverse action and the opportunity to request fair hearings are kept.

Appendix G: Participant Safeguards

55. G-1-c: Participant Training and Education

a. What is the frequency of providing training and information?
b. Do the trainings provided by the regional centers to participants and informal caregivers include how to notify the appropriate authorities when the participant may have experienced abuse, neglect, or exploitation?

56. G-1-d: Responsibility for Review of and Response to Critical Events or Incidents

a. How do regional centers monitor special incident reporting for non-vendored providers?
b. Please specify who is responsible for an investigation, how investigations are conducted, and the timeframe for conducting and completing the investigation.
c. Please also indicate the timeframes for informing the participant, applicable representative, and other relevant parties, such as providers, of the investigation results.
d. What is the timeframe for reporting for non- vendored providers?
e. How are non vendored providers notified of SIR requirements?

57. G-2-a: Safeguards Concerning Restraints: Applicability: **Restraints -** The state selected that they will not permit the use of restraints but then indicated in the response that there are certain circumstances in which restraints may be used. Therefore, the state needs to revise the selected response that currently indicates that they do not permit the use of restraints, to "the use of restraints is permitted" and complete the required information for this section.

58. G-2-c: Seclusion - The state selected that they will not permit the use of seclusion but then indicated in the response that there are certain circumstances in which seclusion may be used. Therefore, the state needs to revise the selected response that currently indicates that they do not permit the use of seclusion, to "the use of seclusion is permitted" and complete the required information for this section. CMS notes that the use of seclusion must comport with the home and community-based setting requirements at Section 42 CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR 44.301(c)(1) and (c)(2).

59. **G-3-b: Medication Management and Follow-up -** Please indicate the methods for conducting monitoring, how monitoring has been designed to detect potentially harmful practices, and follow-up to address such practices?

60. **G-3-b-ii: State Oversight and Follow-up** - What is the process to communicate information and findings from monitoring to the Medicaid Agency and operating agency regularly? What is the frequency state monitoring is performed?

61. **G-3-c-iii: Medication Error Reporting** - Please specify the types of medications errors that must be recorded and also those which must be reported.

62. **G-3-c-iv: State Oversight Responsibility** - Please specify the requested information in this section.

63. **QIS-G: Health and Welfare, Sub-assurance (a) -** This PM measures the timeliness of special incident reports and does not measure that the state, on an ongoing basis, addresses and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death. The state needs to develop additional PMs to measure all aspects of this sub-assurance. Also, special incident reports are not the only means of determining whether instances of abuse, neglect, etc. have occurred, as it is possible that some of these instances could go unreported. The state must develop other metrics by which to measure that all instances of abuse, neglect, exploitation and unexplained death are being identified, even if a special incident report has not been filed.

64. **QIS-G, Sub-assurance (b) -** What is the timeframe for appropriate actions to be taken? Please either modify or add PMs to measure that an incident management system is in place that effectively prevents further similar incidents to the extent possible.

65. **QIS-G, Sub-assurance (d) -** How is it determined that a consumer's special health care requirements or safety needs are met? One or more PMs should be added to measure compliance with the state's overall health care standards. The sub-assurance ties the monitoring of health care standards to the responsibilities of the service provider. Please add one or more PMs to measure provider adherence to the health care standards.

66. **Appendix H: Quality Improvement Strategy -** Please include how the QIS stratifies information for each respective waiver, include the control numbers of the other waivers, and provide the other long term care services addressed in the QIS.

Appendix I: Financial Accountability

67. **I-1: Financial Integrity and Accountability**
    a. What are the differences, if any, between the DDS fiscal audits every two years and their follow-up audits in alternate years or more frequently as needed?
    b. What determines if a follow-up audit is needed more frequently than in alternate years?
    c. Are all providers subject to annual onsite audits? If not, what percentage of individual and agency providers are audited on an annual basis and are they chosen by random sample?

d. Are some providers audited more frequently than others? If yes, why and how often are they audited?
e. How does the state recognize whether a provider is a certified biller or not?

68. I-2-a: Rate Methodology - Please describe how information about payment rates is made available to waiver participants.

69. I-2-a: Rate Methodology - Regarding the negotiation of rates between the waiver participant and the selected provider:

a. Please confirm that all waiver service rates are negotiated by participants. If any services are not negotiated by participants, please explain how rates for those services were developed.
    i. Would rates for expanded state plan services also be negotiated?
b. Are participants and providers given any guidance as to what an appropriate rate may be?
c. Is there any limit for what a participant can spend per unit of service?
d. Please describe state's oversight process of rate determination.
e. How does the state ensure that the negotiated rates are consistent with economy, efficiency and quality of care?
f. What role, if any, would the regional center play in setting the rate?
g. Please describe the parameters that would prevent a participant from varying from a reasonable rate.

70. I-2-d: Billing Validation Process

a. Does the state use patient surveys to validate post payment billings? If yes, please describe those methods. If not, describe what processes are in place to assure only proper payments are being made and that any payments for inappropriate billings are recouped.
b. How does DDS ensure that the services were provided?
c. How does DDS ensure that payments are not made for services when a participant is in a nursing facility?

71. QIS – I: Financial Accountability, Sub-assurance (a)

a. How does the State ensure that claims are paid only for services rendered?
b. How does the State ensure that claims are coded correctly?
c. How does the State ensure that services have been actually rendered before they are paid?
d. Please explain why bi-annual reviews are of sufficient frequency to assure the service plans address all the participants' assessed needs and personal goals. Please clarify what the sampling approach is, since the state indicated that less than 100% of the claims will be reviewed.

72. QIS-I, Sub-assurance (b)

a. Please clarify how the approved service rate is assured to be developed consistent with the approved rate methodology.
b. Please clarify what the sampling approach is, since the state indicated that less than 100% of the claims will be reviewed.

Appendix J: Cost Neutrality Demonstration

73. J-2-c: Development of Factor D

a. Please describe how the per capita cost, by service, was trended forward to the number of persons who will be served during years 1 through 3.
b. What is the basis for the estimates of 1,000 and 2,500 for the number of eligible recipients?
c. Please clarify whether the Average Length of Stay units noted in each waiver year represent months or days. If the units are months, please update the waiver to have the Average Length of Stay measured in days.
d. Please confirm the source of the data used to create the Factor D estimates.
e. What analysis was done to ensure that this data was appropriate to use for the projections of this waiver?
f. Were any adjustments made to the data before developing projections for this waiver?
g. Please clarify why Therapeutic/Activity-Based Day Services (Hour) rate is $40 while Therapeutic/Activity-Based Day Services (Month) rate is $50.
h. What history led to the estimate for Technology services?

74. J-2-c: Development of Factors D', G and G'

a. Please confirm that the state has accounted for and removed the costs of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.
b. Please confirm the source of the data used to create the estimates for each of these factors.
c. What analysis was done to ensure that this data was appropriate to use for the projections of this waiver?
d. Were any adjustments made to the data before developing projections for this waiver?

ISSUES THAT NEED FURTHER CLARIFICATION OR CORRECTION

1. **Overall Questions about the Waiver**
   a. What is the anticipated impact of this new waiver on DD waiver enrollment?
   b. A number of services are not available in the current DD waiver; will the DD waiver be updated at renewal or through amendment to mirror services under the SDP?
   c. How will the Waiver Monitoring Process for the SDP waiver be integrated into the existing HCBS Biennial Collaborative Review Process?

2. **Main 6-I: Public Input -** We note that individuals and organizations made comment during the public input period. Please include in this section all the methods and details of how people were able to make public comment.

3. **Appendix A-2-b** - When was the Interagency Agreement (IA) between the State Medicaid Agency and DDS last updated? How frequently is the IA updated? Please provide CMS with the link or a copy of the IA.

4. **B-1-b: Additional Criteria -** When selecting the first option in E-1-d: Election of Participant Direction, this section must specify that the waiver is limited to individuals who want to direct some or all of their services.

5. **B-3-f: Selection of Entrants to the waiver**
    a. How are informational meetings about the SDP being publicized?
    b. How often will the SDP orientation be offered?
    c. How does an individual let their regional center know that they are interested in enrollment?
    d. How is this documented at the regional center?
    e. If there is going to be an interest list or wait list please describe this process?

6. **B-4-b: Medicaid Eligibility Groups Served in the Waiver -** Since the 1931 group has been separated into three distinct eligibility groups; other caretaker relative specified at 435.110, pregnant women specified at 435.116 and children specified at 435.118, the state should remove the check mark from the 1931 group in Appendix B-4-b. No other changes are necessary, since the state has included all other mandatory and optional groups covered under its state pan under the waiver request.

7. **B-6-i: Procedures to Ensure Timely Re-Evaluations -** Please include all pertinent information regarding the procedures used to ensure that re-evaluation will be performed on a timely basis.

C-1- Waiver services

8. **Taxonomy code**- CMS would encourage the state to use the taxonomy codes for the services section.

9. **Participant- Directed Goods and Services -** Please indicate in the definition that the participant directed goods and services must be documented in the service plan and are purchased from the participant directed budget. Also please include that experimental or prohibited treatments are excluded.

10. **Transition/ Set up Expenses -** Please indicate the amount in the amount section if there is a limit for these services.

11. **Transportation -** How will the state determine when the use of natural supports, such as family, neighbors, friends, have been exhausted and services begin?

12. **Vehicle Modifications -** Please add the assurance in the waiver service definition that the vehicle may be owned by the individual or family member with whom the individual lives or has consistent and ongoing contact, who provides primary long term support to the individual and is not a paid provider of such services.
    Please also include any cost limits in the limits sections associated with this service.

13. **C-2-a: Criminal History/Background Investigations**
    a. Please define "other services and supports" in reference to providers who may need to obtain a criminal background check.

b. What is the state's process to ensure that mandatory background investigations have been conducted?
c. Please describe the scope of the investigation.
d. How will the state ensure that they have been conducted in accordance with the state's policies?

14. **C-2-c-ii: Larger Facilities -** Please remove N/A and insert "required information is contained in response to C-5."

15. **I-2-a: Rate Methodology -** Please describe the process used for public input in this section.

Under Section 1915(f)(2) of the Social Security Act, a waiver request must be approved, denied, or additional information requested within 90 days of receipt, or the request will be deemed granted. The 90-day period for this waiver request ends on December 28, 2015. These questions constitute a formal RAI, after which a new 90-day period will begin upon the State's re-submission of a revised waiver application, via the web-based Waiver Management System (https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp). Please refer to CMS control number CA 1166.00 in all future correspondence regarding this waiver.

In addition to re-submitting the waiver application, the state should also send a formal written response to these questions to Amanda Hill in Central Office with a copy to Adrienne Hall in the San Francisco Regional Office (Amanda.Hill@cms.hhs.gov; Adrienne.Hall@cms.hhs.gov). For assistance or information regarding this RAI, please contact Amanda Hill at (410) 786-2457 or Adrienne Hall at (415) 744-3674. Thank you for your prompt attention. We look forward to continuing to work with the state officials to move towards implementation of this new waiver.

Sincerely,

/s/

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

cc: Rebecca Schupp, Chief, Long-Term Care Division, DHCS
Jalal Haddad, Long-Term Care Division, DHCS
Amanda Hill, CMS, CMCS