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June 6, 2012

By Electronic Mail

Ms. Melanie Bella
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare-Medicaid Integration Initiatives & Recommended Protections Strategy

Dear Ms. ~~Bella~~ Melanie:

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) supports the overarching goal of offering persons who are Medicare-Medicaid eligible high quality, seamless and cost effective care through integrated, person-centered services. We greatly respect the hard work and focus of the Centers for Medicare & Medicaid Services (CMS) in this area. However, we have a number of concerns regarding the state Medicare-Medicaid integration proposals.

First, we believe the Medicare-Medicaid initiatives must be treated as demonstration projects, consistent with Congressional intent in enacting the law authorizing these projects, and serve to inform any national, federal initiative related to integrating Medicare and Medicaid for people eligible for both programs. We recognize that the demonstrations are currently envisioned to be conducted over the span of three years. However, we are concerned that the state-by-state demonstrations could evolve into a permanent patchwork of state-specific Medicare-Medicaid integration approaches with unclear outcomes and overly burdensome operational and oversight challenges for the federal government.

To address this concern, we ask that CMS broadly embrace the Center for Medicare and Medicaid Innovation's(CMMI's) evaluation and reporting requirements by making available all state evaluation information, not just information "the Secretary determines is necessary to monitor and evaluate such models."[1] The state-by-state evaluation findings should be synthesized into a meta-analysis combining the state-by-state evaluations into a complete set of findings for Congress and stakeholders before taking steps towards any national, permanent effort.[2]

Second, we request that CMS' annual reports to Congress include evaluation findings to support any Medicare-Medicaid integration legislative recommendations based upon Medicare-Medicaid Coordination Office activities.[3][4] Such evaluation findings and related legislative recommendations should be made publicly available and vetted through health care stakeholders.

Third, we recognize that CMS is moving forward with the state-by-state demonstrations. In the remainder of this letter, we highlight our key concerns with the state proposals and offer recommendations for how CMS could address our issues within its demonstration guidance to the states. Our concerns include:

- State and plan experience are not well positioned to support rapid program proliferation and expansion;
- People should have ample opportunity to make educated choices about how they will receive their services and supports; and
- Provider reimbursement must ensure access and overall provider network operational and financial stability.

AHCA/NCAL greatly appreciates our positive working relationship with CMS and offers these observations and recommendations in the spirit of collaboration. We look forward to a dialogue with CMS staff on the ideas below.

Background

AHCA/NCAL represents nearly 11,000 members including profit and not-for-profit skilled nursing facilities (SNF), nursing facilities (NF), assisted living residences, post-acute centers, and homes for persons with intellectual and developmental disabilities. Our members are dedicated to continuous improvement in the quality of long term services and supports (LTSS) provided daily to more than 1.5 million of our nation's older adults, persons who are medically fragile, and persons with disabilities.

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3021; codified at 42 U.S.C. § 1315a(b)(4)(B).
[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3021; codified at 42 U.S.C. § 1315a(g) requires that the Secretary submit a report to Congress at least once every other year to report on the activities of CMMI.
[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2602(e); codified at 42 U.S.C. § 1315b(e).
[4] 42 U.S.C. § 1315a(g) requires that the Secretary submit a report to Congress at least once every other year. Additionally, 42 U.S.C. § 1315b(e) requires the Secretary to submit an annual report as part of its budget with legislative recommendations that would improve care for persons who are Medicare-Medicaid eligible. AHCA requests that both reports address our concerns above.

According to CMS data, close to 65 percent of Medicare-Medicaid eligible persons age 65 or older and approximately 70 percent of Medicaid spending on behalf of these individuals is for LTSS. Of the $84 billion spent on LTSS, roughly 56 percent is used to purchase NF services while most of the balance is spent on home and community-based services (HCBS).

Furthermore, LTSS appears to be the fastest growing segment of Medicaid spending for Medicare-Medicaid eligibles, rising from 59 percent in 2005 to about 70 percent in 2007. For these reasons, AHCA/NCAL has deep interest in ensuring these populations receive the services and supports they need as well as ensuring a stable and high quality LTSS array, both facility-based services and HCBS.

Like many other provider and advocacy organizations, AHCA/NCAL has a number of notable concerns about the state Medicare-Medicaid integration proposals. However, we recognize that CMS is attempting to navigate a vast sea change both in the delivery and financing of public health care. Federal and State officials already have completed considerable work with the Medicare-Medicaid integration efforts. At the federal level, CMS has issued an array of guidance materials including Standards and Conditions (S&C), template Memoranda of Understanding (MOU), and plan guidance for the capitated, risk-based financial alignment option. And to ensure balanced use of both alignment models (e.g., capitated risk-based and managed fee-for-service (MFFS), we urge CMS to expeditiously release equally detailed guidance on MFFS program design.

CMS has indicated that the documents listed above are subject to change while others, such as the S&C checklist, either have not been developed or have not been released such as the MFFS materials. While we remain concerned about several provisions, including passive enrollment, we believe our concerns and issues could be addressed by adding additional elements and detail to the S&Cs and related checklist as well as the CMS-State MOU template.[5]

For purposes of this transmittal, our concerns and suggestions, below, focus primarily on the capitated, risk-based model. How states address our recommended elements may vary and AHCA/NCAL recognizes and respects state flexibility and variation. In addition to the recommended elements, we urge CMS to fully embrace its transparency efforts by broadening and expanding the current Medicare-Medicaid integration public comment and meaningful engagement requirements.

Recommended Principles and Discussion

In the following section, AHCA/NCAL describes its broad areas of concern, specific components of the concern area we believe can be reasonably addressed, and recommended required elements intended to target the concern area.

[5] In its January 2012 Medicare-Medicaid Financial Alignment Demonstration Standards and Conditions (S&C), CMS indicates that once the state proposal has met the S&Cs, CMS will begin working with states to develop the MOUs based on the July 8, 2011 templates.

1. **State and Plan Experience Will Not Support Rapid Program Proliferation and Expansion.** Only about four percent of older adults are enrolled in Medicaid managed care.[6] Outside of a handful of states, the managed care marketplace has limited LTSS experience. When focusing on NF services, of the ten states with some form of managed LTSS currently in operation, half (Arizona, Hawaii, Massachusetts, New Mexico, and Tennessee) include long-stay NF. Minnesota and Texas include what roughly equates to a post-acute care stay. Others do not include NF at all.

    a. The majority of states pursuing integration demonstrations have little to no experience with enrolling older adults in Medicaid managed care plans;
    b. Medicaid managed care plans have very limited experience with LTSS, particularly at the NF level of care;
    c. Currently, CMS and states are struggling with quality measurement in Medicaid fee-for-service LTSS. Since last October, a state-federal work group has been focusing on HCBS quality challenges in Medicaid fee-for-service. Less is understood about how to best measure quality in managed LTSS. Measure Applications Partnership documents offer some ideas for Medicare-Medicaid eligibles but little exists on managed LTSS quality measurement approaches. CMS is launching an MMLTSS web-based state technical assistance platform but the analytic framework appears to be lacking.

Recommended Required Elements

- Other Affordable Care Act (ACA) LTSS programs require states to show evidence of capacity benchmarks before they are awarded funding or authority to move forward. One such example is the Balancing Incentives Payments Program (BIPP). CMS should add analogous benchmark requirements in the CMS-State MOU to ensure appropriate state infrastructure and capacity before implementation (see below for more detail) and expansion;
- We recognize that the S&Cs require states to demonstrate their infrastructure and capacity to implement and oversee the proposed model. Furthermore, CMS notes in the template MOU that States must have undergone "necessary planning activities consistent with the CMS checklist of standards and conditions." Related to the item, above, CMS should: 1) expand upon the state checklist and the plan readiness review provisions and establish a CMS readiness review of states of the states as well as the plans rather than rely on state attestation; and 2) stakeholders should have the opportunity to comment upon CMS' state capacity review process and findings;
- CMS should require a phased demonstration approach under which states and plans meet capacity and infrastructure benchmarks before implementing or expanding; and

[6] MACPAC (June 2011) Report to Congress: The Evolution of Managed Care in Medicaid.

- States and plans should have robust quality monitoring strategies appropriate for LTSS and that are transparent with or leverage – but do not duplicate – existing CMS and state survey and certification oversight requirements for LTSS providers, particularly heavily regulated NFs.[7]

2. **People Should Have Meaningful Opportunities to Make Educated Decisions.** Choice is at the core of the Medicare program. Ensuring that Medicare-Medicaid dual eligibles are able to make informed decisions about enrollment and plan choice is critical.

   a. Passive enrollment on a statewide level would appear to leave little room for such informed decisions by individuals in the Medicare-Medicaid eligible population who by definition have low health literacy levels and the older adult population almost a quarter of whom have some form of dementia. Family members must also be educated and actively engaged;
   b. People and providers struggled with Part D passive enrollment;
   c. Proponents of passive enrollment have indicated that states will use intelligent assignment algorithms to ensure people are enrolled in the most appropriate plan. Considering the dearth of experience with older adults, Medicare-Medicaid eligibles, and NF in managed care, we question whether state technology is sufficient for such plan matching; and
   d. Lock-In periods likely would only exacerbate poor matches. Offering plans the option to lock-in enrollees (in some states for up to six months) represents a drastic change to Medicare-Medicaid eligibles' current enrollment rights in Medicare. These rights exist out of recognition that Medicare-Medicaid eligible are a particularly vulnerable population with changing health needs that may require disenrollment from a managed care plan that is not able to meet an individual's needs. The current demonstration proposals do not appear to contain new benefits or protections sufficient to justify the loss of these enrollment protections. Adopting passive or lock-in enrollment policies, without protections, would leave people who are Medicare-Medicaid eligible with fewer rights and options than they have today.

Recommended Required Elements

Passive enrollment proposals should be assessed against specified standards or criteria, including the following:

- At least 90 day advance notice including evidence of direct contact with beneficiaries, written materials at a 6th grade or lower reading level, evidence that the

[7] Recently, CMS launched preliminary discussions on regulatory streamlining concepts for skilled nursing facilities and nursing facilities. The Medicare-Medicaid efforts are intended to eliminate barriers and reduce administrative barriers to supports for Medicare-Medicaid eligibles. Oversight and regulation among CMS, States, and the Plans must be coordinated and streamlined to ensure efficient and high quality service delivery rather than the production of potentially duplicative materials that do little for the people we serve.

opt-out materials are presented with notification of passive enrollment via beneficiary or legal representative signature;

- An entity independent of the plans and the state, possibly the State's Enrollment Broker, must present the Medicare-Medicaid information and the opt-out materials at the same time. This should not be at the option of the State. During Part D implementation, State Health Insurance Assistance Programs (SHIPs) played a key role in supporting beneficiary decision making. Similar non-traditional programs which already exist in the state might be considered to provide a similar service now. Possibilities include Centers for Independent Living, the Long-Term Care Ombudsman, and Area Agencies on Aging.
- States maintain fee-for-service arrangements that offer equivalent benefits and services so people have something to opt into; otherwise, the notion of choice and the opt out concept is meaningless.
- In the template MOU, CMS indicates that beneficiaries must be allowed to dis-enroll and/or change plans on month-to-month basis connoting maximum 30 day lock-in period. CMS should emphasize this point and require that such information be conveyed by the independent enrollment broker or "choice counselor." CMS also should clarify that special enrollment/dis-enrollment must be available when people change levels of care and/or institutional status.

Finally, AHCA/NCAL urges CMS to carefully consider the detailed passive enrollment protections outlined by the National Health Law Project.

3. **People Should be Able to Access Services a Provider of Their Choice and When They Need Them.** People who are Medicare-Medicaid eligible and have been able to access services either through fee-for-service or a managed Medicare arrangement likely already have strong relationships with acute care providers and their LTSS providers. Additionally, their LTSS needs likely will change over time, particularly for the large proportion of Medicare-Medicaid eligibles who are age 65 or older.

   a. The absence of or limited out-of-network provisions would present serious challenges particularly for those LTSS in which people develop close ties with their caregivers;
   b. States and plans have strong incentives to deliver LTSS in the least restrictive and most efficient setting in accordance with people's preferences. AHCA fully supports such a framework. However, as noted, older adults' LTSS needs are likely to change over time and, little CMS guidance exists on how states or plans must ensure people are able to quickly and efficiently move among LTSS settings as their circumstances change (i.e., health status, functional ability, family caregiver status);
   c. Similar concerns arise with post-acute care. Financial incentives may drive plans to prior authorize shorter post-acute stays or discharge directly to home using home

health care following a hospital stay. While appropriate for some people, such strategies could produce negative results for people and dampen hospital interest in participating due to the ACA penalties for potentially avoidable readmissions; and

d. Some states have proposed as much as 50 miles away for access to services from a provider of choice.

Recommended Required Elements

- In the Capitated Financial Alignment guidance, CMS indicates that demonstration plans will be able to use an exceptions process in areas where Medicare network standards may not reflect the number of individuals dually eligible for Medicare and Medicaid. CMS should clarify that the same exceptions process apply to Medicaid LTSS providers;
- CMS should ensure as part of the readiness review that both states and plans have processes to ensure people are able to move among post-acute and LTSS settings as their needs change and that people are able to do so without unduly cumbersome prior authorization requirements;
- We appreciate CMS' attention to ensuring plans do not create barriers to beneficiary receipt of medically necessary services and offering guidance to plans on medical necessity.[8] However, due to the dearth of plan experience with older adults as well as with LTSS, we believe CMS should develop specific guidance for states and plans on how state Medicaid definitions of "medical necessity" should be modified to ensure access to such Medicaid-financed services; and
- CMS should place limits on the distance a beneficiary could be required to travel for a provider of choice. AHCA/NCAL recommends no more than 20 miles.

4. **Care Coordination Should Produce Efficiencies and Improve People's Experiences.** At the core of integration approaches is care coordination. And, such activities are critical for people who use a variety of acute care specialists, multiple medications, and LTSS. We recognize that CMS, in part, addresses care coordination in the "Care Model" section of the S&Cs. However, unclear care coordination roles and responsibilities at the plan-provider interface level will continue to create confusion and potentially impact quality and efficiency.

   a. In states with heavy Medicare Advantage Prescription Drug Plan (MA-PD) penetration rates, such as Arizona and Rhode Island, already NFs struggle with varied approaches to care coordination, differing reporting requirements as well as differing health record formats. Efforts have been made to eliminate Medicare-Medicaid barriers at the federal-state and state-plan levels. However, AHCA/NCAL

[8] SMDL # 11-008 (July 8, 2011). Attachment: Draft Template MOU for Capitated Model. Page 4; CMS (January 25, 2012) Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans. Page 23.

believes that Medicare-Medicaid and managed care interface issues remain at the plan-provider level. Such barriers will impact quality and efficiency;

b. NF and other LTSS providers already deliver care coordination depending on the service setting – typically more care coordination activities occur in facility-based and residential settings than in home-based settings. Questions arise about how different vehicles and venues for care coordination will interface and how CMS will ensure efficiency in such arrangements.

c. CMS' cost driver report indicates higher hospitalization rates when looking at all chronic conditions among HCBS participants than among NF residents.[9]

Recommended Required Elements

- In the S&Cs "Care Model" checklist section, CMS should include the plan readiness review and suggested state readiness review and require evidence of strategies to ensure effective and efficient interaction among various forms of care coordination;
- States should include in their ongoing stakeholder engagement process discussion, as well as related problem solving, an analysis of how care coordination is functioning;[10]
- CMS should include in its evaluations an analysis of how care coordination is functioning at the plan-provider level focusing on outcomes for people, impacts on providers, and efficiency;
- CMS should examine strategies proposed in the Avoidable Hospitalizations for Nursing Facility Residents Initiative for models which might address these challenges; and
- CMS should place additional emphasis on care coordination in HCBS particularly when changes in health status or level of support change.

5. **Provider Reimbursement and Timely Payment Must Meet Standards that Ensure Access and Overall Network Operational and Financial Stability.** Since 2007, most NF and other LTSS providers have not received rate increases while, at the same time, a notable number have experienced Medicaid rate cuts. AHCA/NCAL is concerned about current challenges with plan payments in the small group of states currently engaged in integration and/or managed LTSS. We are equally concerned about the potential negative implications for people's access to services.

   a. Many providers are concerned that the demonstrations will focus more on savings targets rather than quality and care coordination. And, the likely target for savings will be provider rates. Further rate reductions could impact access and quality;

[9] RTI for CMS (August 2010) Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs. Page 159.

[10] CMS (October 2011) Financial Models to Support State Efforts to Integrate care for Medicare-Medicaid Enrollees Standards and Conditions. Page 2.

b. Blended capitation at the plan level coupled with plan negotiated rates raises serious questions about how providers will be reimbursed particularly in the NF and LTSS sector where providers have considerably less experience negotiating with plans much less on blended payment rates; and

c. Sustained cash flow is a key concern for LTSS providers. In Medicaid managed care states and with MA-PDs, providers already struggle with eligibility verification issues, prior authorizations, and timely payment.

Recommended Required Elements

- CMS should require providers be paid no less under capitated arrangements than they were receiving under Medicare fee for service on an ongoing basis;
- When setting capitation rates, key reimbursement elements must be considered including Medicare Bad Debt, Medicaid provider tax, and, where appropriate, patient liability amounts (e.g., Third Party Liability and Post-Eligibility Treatment of Income). Specifically, plans should be responsible for collecting these amounts and/or covering related payments to providers;
- Savings should come from preventive services, quality initiatives, and care coordination, not provider rates and unnecessary utilization controls;
- States should ensure plans have the ability to make timely payment on claims, or provide for advance payment on claims submitted, consistent with Medicaid timely payment requirements; and
- CMS should apply the Interim Final Rule with Comments entitled, Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions implementing section 1104(b)(2) of the Affordable Care Act to the Medicare-Medicaid integration plans.

6. **Stakeholders Should Have Meaningful Opportunities to Shape the Demonstrations.** AHCA applauds CMS' efforts to implement section 10201(i) of the ACA and its implementing rule, "Review and Approval Process for Section 1115 Demonstrations.[11] And, we appreciate the 30-day federal comment period on the Medicare-Medicaid integration proposals. However, most AHCA affiliates, sister industry groups, and partner advocacy groups have expressed deep concern about the lack of transparency at the state level in the development of the Medicare-Medicaid efforts.

   a. Some public stakeholder meetings were convened by the state with minimal notice and no information was shared before the meetings. Such practices allowed for little meaningful input;

[11] 42 C.F.R. Part 431

b. In still other instances, stakeholder input was received but states transmitted no responses and/or no state attempt at reshaping the proposal based on stakeholder input was observed; and
c. AHCA/NCAL is deeply concerned that opportunities for meaningful, ongoing stakeholder input and impact on the finalization, implementation and operation of the demonstrations will remain limited.

Recommended Required Elements

- AHCA/NCAL recognizes that the transparency requirements do not apply to demonstrations that do not include new Section 1115 waivers. However, we strongly encourage CMS to use its broad authority under Section 1115A of the ACA and fully embrace the transparency guidelines codified at 42 C.F.R. 431 for the Medicare-Medicaid demonstrations considering the vulnerable nature of the population impacted and scale of the proposals;
- Building on our recommendation above, we recognize that the final rule and the April 27, 2012 State Medicaid Directors' Letter indicate that Section 1115 amendments have not yet been addressed by CMS. However, amendments to Section 1115 waivers for purposes of the Medicare-Medicaid integration demonstrations should be considered to have a significant impact and, therefore, should be addressed with additional rigor and vetted thoroughly with stakeholders;
- State responses and changes to proposals made due to comments submitted during the federal 30-day comment period should be made public and posted at CMS' website as well as state websites; and
- Public comment should be solicited on the following: a) a draft of the S&Cs checklist; b) draft of a state readiness review tool (see above); c) completed state S&Cs checklists; d) completed state readiness reviews; and e) interim final MOUs with the opportunity to comment.

7. **Safeguards Should be Implemented to Prevent Maximization of Federal Medicare and Medicaid Funds and Ensure Limited Safety Net Funds are Used to Enhance Quality. Under** the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Congress directed the General Accountability Office (GAO) to conduct an analysis of CMS' oversight of state managed care capitation rate setting. In 2010, GAO found notable problems with CMS' oversight and states' application of the managed care rules for capitated rate setting. Currently, Congressional leaders again are raising serious questions about CMS' capacity to ensure adequate oversight and have alleged that state are padding capitation rates to increase federal matching (e.g., another federal maximization strategy). Of note, the state receiving the most scrutiny is Minnesota, which has long operated a Medicare-Medicaid integration program.

a. If such concerns already exist in Medicaid managed care, CMS and Congressional leaders also should be concerned about blended capitation rates which include

Medicare and Medicaid funds. Such managed care capitation rates would be at least 80 percent federal dollars;

b. Plan failure could present significant problems including service interruption for beneficiaries and negative health outcomes; and
c. Little is understood about how managed care plan payment rates might foster quality in LTSS and, in particular, SNF/NF.

Recommended Required Elements

- CMS should expand its S&Cs checklist, state readiness review, audit of process to ascertain whether rates are actuarially sound;
- CMS should establish guidelines for ensuring providers are paid no less under blended capitation than they were paid in fee for service prior to implementation of managed care. Savings should be generated from preventive services, avoidable admissions, and quality efforts; and
- CMS should offer technical assistance to states on how plans can reimburse for quality in SNF/NF including facility-based person-centered services. We particularly encourage CMS to provide technical support on how nursing home culture change could be fostered in Medicare-Medicaid demonstration participating plans.

8. **CMS Should Consider Changes to Regulatory and Survey to Accommodate Integration Efforts.** One of the primary objectives of the integrated delivery and payment systems CMS and states are proposing is to secure savings through reduced hospitalizations and rehospitalizations. AHCA/NCAL is concerned about state survey agencies' lack an adequate understanding of Medicare-Medicaid Integration efforts that include changes in practice – specifically, delivering more and more intensive skilled care in a SNF/NF than typically seen SNF/NF. Also, AHCA/NCAL is concerned about state survey agencies' reactions when, despite following clinical best practice and in keeping with the Medicare-Medicaid Integration program design parameters, a resident experiences a negative health event.

a. The majority of existing financial, legal, and state/federal regulatory incentives favor hospitalization, rather than assuming the additional risk and cost of managing acute illnesses in the nursing facility;
b. Absent an analysis of the current regulatory and legal system, initiatives to reduce hospitalizations will expose facilities to greater regulatory and legal risk without federal and state survey and certification engagement; and
c. Increased risk of negative survey and certification findings due to programmatic changes outside of the industry's control could dampen NF interest in demonstration participation.

Recommended Required Elements

- In no way is AHCA/NCAL asking for absolution. Rather, we request that the CMS Medicare-Medicaid Coordination Office (MMCO) open a dialogue with CMS Survey ad Certification Group (SCG) on possible challenges. The approach could mirror CMS' approach to nursing home culture change efforts. In the latter, CMS worked diligently with beneficiaries and providers to develop interpretive guidelines explaining how culture change efforts "fit" within the existing regulatory requirements.

- We urge MMCO and SCG to undertake an analysis and subsequent discussion before the demonstrations and alignment initiatives go live. Possible outputs might include:
  - Guidance letter and attachments to State Survey and Certification Agencies;
  - Language in the State-CMS Medicare-Medicaid Alignment MOU assuring CMS that the State Survey and Certification Agency understands the changes and has trained its surveyors on the new practices; and
  - CMS educational events (webinars, etc.) for State Survey and Certification Agencies.
  - Finally, we believe State Long-Term Care Ombudsman entities might also require analogous training.

- State agencies and CMS need to modify their respective survey and enforcement protocols to ensure they are administered in a manner that is consistent with the vision of quality reflected in the new wave of federal and state initiatives targeting reduced hospitalizations.

Conclusion

The ACA is seen as heralding the advent of significant change, but we think that change was long in coming. We believe that CMS, in part, was and is responding to the Congressional vision of ACA but we say, "in part," because we also believe CMS was and is responding to its own inner mandate to improve the state of health care in America. CMS does not exist solely to pay claims. It is the key implementer and guardian of health care in this country. This is not an easy challenge by any means and how this would impact beneficiaries and their access to care.

AHCA/NCAL continues to have notable concerns about the scope, scale, rate of expansion and specific demonstration elements. We are fearful that rapid, statewide implementation will have serious negative impacts on people and the LTSS system. Stated another way, if the demonstrations fail, AHCA/NCAL is concerned about what fee-for-service infrastructure will remain if limited state resources are heavily invested managed care arrangements.

However, we recognize the importance of fomenting change in a long-dysfunctional arrangement between two critical programs delivering services to our nation's most vulnerable citizens. We urge CMS to consider the recommendations provided above, and stand willing to provide additional detail or assistance. If you have questions, suggestions, or concerns, we would be pleased to meet with CMS officials to discuss our ideas in more detail.

Sincerely,

Michael W. Cheek
Vice President, Medicaid & Long Term Care Policy