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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
PO Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-2237-IFC (Medicaid Program; Optional State Plan Case Management Services)

These comments on the interim final rule regarding optional state plan case management services published December 4, 2007, at 72 Fed. Reg. 68077. are submitted on behalf of the state agencies and staff responsible for administering Medicaid funded institutional and Home and Community Based Services (HCBS) for people with developmental disabilities.

Background: Impact on HCBS Waiver Programs

While the interim final regulations will have a significant impact on many aspects of delivering Medicaid services to individuals with disabilities, they are especially problematic when applied to HCBS waiver programs. The HCBS waiver program provides services not otherwise available under a state Medicaid plan to individuals who “but for the provision of such services...would require the level of care provided in a skilled nursing facility or intermediate care facility.” The HCBS waiver program is the single most important source of financing for home and community-based services today, serving over one million elderly and disabled citizens.

In order to receive CMS approval to operate a HCBS waiver, states must make a variety of assurances, including the assurance “that necessary safeguards have been taken to protect the health and welfare of recipients of the services.” “A waiver’s design must provide for continuously and effectively assuring the health and welfare of waiver participants. (§1915(c) Home and Community-Based Waiver Application Instructions and Technical Guide.) Processes that are important for assuring participant health and welfare include but are not necessarily limited to: specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications; periodically monitoring the implementation of the service plan and participant health and welfare; identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and, instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights. CMS will not grant – and may terminate – any waiver that does not satisfactorily meet required assurances.

The use of Medicaid funded case management options to meet waiver assurances. In the absence of a function specific to the waiver program, states have defaulted to the use of the one instrument available to carry out its required functions – case management. Case managers routinely perform required assessments, oversee the development of the individual plan and its implementation including access to needed services and monitor to assure individual health, safety and well-being and that individuals are free from neglect or abuse. Since the inception of the HCBS waiver program in 1981, states have used case managers – and all Medicaid funded options for providing case management - as the pivotal vehicle to assure compliance with the health and welfare requirements of the HCBS waiver program

Case management is described in the Interim Final Rule as “commonly understood to be an activity that assists individuals in gaining access to necessary care and services appropriate to their needs.” However, in the HCBS waiver, states are required to do more than assist individuals in gaining access. They must assure there is a plan of care for each participant, that services are delivered, that services meet the participant’s needs, and that changes are made to the plan as the person’s needs change. In addition, state must sign a statement that they will assure the overall health and welfare of waiver participants. States must be able to provide case management activities both on a planned and scheduled basis and at the request of the participant.

Freedom of Choice requirement and the right to refuse case management leads to the use of administrative case management. As the HCBS program has matured, states have discovered that the “freedom of choice” provision in Medicaid challenges the ability of states to build a reliable and accountable system of case management. Freedom of choice, while a strong concept for services, undermines that ability to establish a single point of contact and responsibility. Recognizing the value of a single point of contact, many states have chosen to use **Optional State Plan Case Management Services (TCM)** as it allows the designation of a single point of contact and accountability. While TCM is a viable option for programs serving people with developmental disabilities and mental illness, there is no comparable TCM option for states providing services to the elderly, to people with physical disabilities or brain injury. Unlike case management systems for individuals with developmental disabilities and mental illness, case management systems serving the elderly and individuals with disabilities other than DD cannot create a single point of entry to services in their systems. The alternative for these states has been administrative case management, which allows the state to side step the freedom of choice issue and craft a single point of contact and responsibility. Without this administrative funding option, states lose the ability to create a coordinated single point of entry case management system for seniors and individuals with disabilities.

Administrative case management provides an additional benefit to states building quality oversight systems: the participant cannot reject case management. States can assign case management to each person, affording the participant the choice of a specific case manager who will work with and for them. The participant’s right to refuse a service is sound and right but nevertheless undermines a state’s capacity to assure there is a plan of care, assures that services are delivered and health and welfare are monitored. In the waiver, this function cannot be delivered at the discretion of the participant – it must be a condition of receiving services.

While we have several major concerns regarding the provisions of this Interim Final Rule, perhaps the most significant is that several provisions taken together undermine the ability of states to rely on case management as the bedrock of their capacity to ensure the health and welfare of participants in waiver programs. The Interim Final Rule prohibits funding case management activities as an administrative function, leaving states with the choice of billing for case management as a waiver service – with freedom of choice prohibiting the establishment a single point of contact and responsibility – or TCM – which allows a participant to reject case management and leaves the state without a vehicle to meet its assurances to CMS.

Right of Refusal §441.18(a) (3). The right of refusal and its interaction with assuring service delivery and health and welfare presents states with an irresolvable dilemma. The December 4 interim final rule lays out requirements under §441.18(a) (3), Right of Refusal requiring that states, “not compel an individual to receive case management services, condition the receipt of case management (or targeted case management) services on the receipt of other services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.” We understand that the principle in this requirement is that assuring access to services provided under a HCBS waiver, for example, could not be contingent on receiving case management services. However, the interaction of this right of refusal with the required assurances under HCBS waivers poses a substantial issue for states. Since much of the activities required by CMS to operate HCBS waivers (development of the plan of care, assuring health and welfare) are typically funded and delivered through case management, the right of refusal potentially presents serious concerns about how the state can fulfill the waiver assurances. It is difficult to conceive how individuals will have a plan of care, get coordinated care, how states can assure that the individual plan of care is carried out as written and meet requirements for individual oversight and monitoring without providing case management services. Case managers are the critical source of information to participants and play a pivotal role in assisting individuals to obtain services or make changes to existing services. Case managers are also a fail safe – their monitoring reduces risk, prevents deterioration, and prevents harm.

The likelihood that case management as a service would be rejected is not theoretical. Participants may decide they simply do not want the service, or other family members in the household may determine they do not want case management. This may be most likely to occur in those situations where the protections afforded by case management are most needed—a participant with challenging behaviors who refuses case management in order to be able to continue self-injurious activity, or an elderly participant whose children refuse case management in order to continue abuse or neglect. Again, this right of refusal and its interaction with assuring service delivery and health and welfare presents states with an irresolvable dilemma.

Prohibitions on the Use of Medicaid Administrative Funding

§441.18(c) (5). The proposed regulation under §441.18(c) (5) reads, “Activities that meet the definition of case management services in §440.169 cannot be claimed as administrative activities under §433.15. (b).” (The citation §433.15(b), Rates of FFP for Administration, lays out the basis for states to make claims for payment of Medicaid administration costs.) The new case management regulations effectively place a prohibition on claiming administrative Federal

Financial Participation (FFP) for any activities that are covered under this case management statute. Section III indicates that states can claim FFP as Medicaid administration for certain activities if they are “directly related to the proper and efficient administration of the Medicaid State plan,” and gives examples of the activities claimable as Medicaid administration as: Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; Prior authorization for Medicaid services; Utilization review; and Outreach.

Section III continues, “These examples are not meant to be exhaustive and CMS may make determinations regarding whether these or other activities are necessary for the proper and efficient administration of the State plan.” The coverable activities claimable as targeted case management are described in §440.169(d) (1) and include the following key activities (the full text is found at §440.169(d) (1-4)):

- (1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
- (2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment
- (3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services...
- (4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or individuals and conducted as frequently as necessary, and including at least one annual monitoring.

The prohibition against using Medicaid administrative funding to support activities defined as case management in the Interim Final Rule compounds the problems associated with the right of refusal. The sum of the interaction between the right of refusal and the inability of states to claim these required activities as Medicaid administration, leaves states without a vehicle to provide for the assurances required to operate a Medicaid HCBS waiver. Case management services are the bedrock of states’ capacity to ensure the health and welfare of waiver participants. If the individual refuses case management services AND the state is prohibited from carrying out case management services as an administrative cost, the state is left without a vehicle to meet required assurances under the HCBS waiver regulations.

Of additional concern is the potential interpretation that any single activity that could be construed as case management cannot be claimed as an administrative cost. In a number of states, some case management activities - such as an initial assessment and plan of care development for HCBS waiver participants - are performed by state staff under Medicaid administration. Once the individual is enrolled in the system and receiving initial services, the individual case moves to the “regular,” on-going case manager. State officials other than the case manager also conduct targeted over sight activities, investigations, and get involved in sentinel events in ways that may be regarded as case management activity. These activities assist in effectively and efficiently carrying out the State plan allowing for rapid enrollment of the person into the services needed immediately. States are concerned that these types of effective and

efficient arrangements will no longer be allowable under the new regulations, leading to delays in the implementation of services.

The impact of the combination of the Right of Refusal prohibition and the provision against claiming case management as an Administrative function highlights the need for a structural change to the HCBS waiver program to establish a specific waiver activity - “individual service coordination and quality assurance.” This activity would include assessing the participant’s needs, developing a plan to meet those needs, coordinating services and monitoring. States must be allowed to designate a single point of contact and responsibility to perform “individual service coordination and quality assurance” activities and to restrict choice. The state must be able to require the function as a condition of receiving services. States must be reimbursed at the states’ service federal participation match rate, since the function is person focused and related exclusively to the plan of care for the participant.

Interim Final Rule Scope and Effective Date. CMS’s intention to apply the interim final regulations to all activities that could be defined as case management including case management provided under the HCBS waiver, case management under an 1115 waiver and case management type activities performed as Medicaid administrative function goes well beyond the directive set forth in the DRA. The interim final rule has over written CMS policy, guidance and enforced requirements in place for more than 20 years.

However, it is important to note that even if these new regulations only apply to Optional State Plan Case Management, they pose substantial concerns for states operations of Home and Community Based Services as described above.

This interim final rule was published on December 4, 2007 with an implementation date of March 3, 2008. State must make substantial changes to state practices to comply with the regulations including analyzing current costs, establishing and publishing rates, modifying information technology systems, changing business practices to covert to 15 minute units, modifying collective bargaining agreements, and negotiating the lead case manager that would be responsible for all Medicaid services including behavioral health, acute care, disease management and HCBS services. The implementation date for the rule is impossibly short. States cannot come into compliance with this rule in the time provided, potentially putting federal funds in jeopardy. Even if we concurred with the content of this final rule, the rule makes no provisions for states to develop transition implementation plans over a reasonable timetable in order to come into compliance with the regulations.

§441.10(e) Access to Services – Gate keeping. The regulation states that the purpose of case management is to “gain access to services, not hinder this access.” It further states that permitting case managers to “act as gatekeepers...will allow case managers to restrict access to services. This concept is contrary to the statutory definition of case management services.” The proposed regulations interpret Section 1915(b) (1) as establishing that “providers of case management services (including targeted case management services) furnished under this section are prohibited from serving as gatekeepers under Medicaid.” The rule provides substantial detail regarding the rationale for this requirement, invoking the provision in

§441.10(e) that requires that the authorization of services “must remain within the Medicaid agency.” The background for the regulations indicates that while the State Medicaid agency may “place great weight on the informed recommendation of a case manager, it must not rely solely on case management recommendations in making decisions about the medical necessity of other Medicaid services that the individual may receive.”

The prohibition against case managers serving as gate keepers may have operational implications for states that have vested case managers with the responsibility and authority to authorize services, approve individual plans, and determine individual budgets. It would seem that assessing individual needs and developing the plan fall within accepted activities. It is the actual plan approval and/or service authorization -which imply the authority to deny service- that may be considered gate keeping. Further clarification of this section of the rule is needed for states to understand the scope of what CMS may consider gate keeping, particularly with regard to self-directed services and the development of individual budgets based on services planning.

Section 441.18(a) (5), Single Medicaid Provider. The regulations state that “case management services must be provided by a single Medicaid case management provider.” The regulations note that although an individual may in fact fall within multiple target groups and be eligible for more than one State Plan case management service, “a decision must be made concerning the appropriate target group so that the person will have one case management provider.”

The restriction of case management to a single provider is attractive at the theoretical level but is impractical in application. Many individuals with disabilities have complex needs (multiple diagnoses) that are served in multiple systems. Effective case management is dependent on the case manager having specific expertise and knowledge about the needs of a specific population (elderly/ developmentally disabled/mental illness/substance abuse) and information and working relationships with the provider network (DD service providers/elderly service providers/behavioral health service providers /health care/acute care).

Limiting a developmentally disabled person to one case manager will create new barriers accessing medically necessary services stemming from other diagnoses. For example, if a person with developmental disabilities also has a mental illness, they may have serious difficulty connecting with the appropriate mental health professionals through their DD case manager. Case managers working with individuals with cognitive limitations do not have the expertise to navigate mental health organizations and instead depend on case managers in those systems to assist in obtaining needed services. A person with developmental disabilities who also has serious mental illness requires the involvement of a trained, skilled and knowledgeable case manager in the mental health system as well as the HCBS program to assure access to needed services in both systems. Removing access to the necessary expertise has the impact, in effect, of forcing people to pick their disability rather than addressing their needs holistically. The net result is that it is both inefficient and ineffective, leading to delays in individuals receiving medically necessary services. In a worst case scenario lack of access or timeliness can lead to unnecessary institutionalization as described under the Olmstead Supreme Court Decision

At the program administration level, the limitation to one provider for case management is impractical. It is highly unlikely that one case manager could provide adequate services and oversight in multiple programs such as an HCBS waiver program, managed physical health, disease management, and a managed behavioral health program. No one program could responsibly surrender its oversight and management responsibilities to another program.

§440.169(c) Transition Planning Period. In July 2005, CMS published Olmstead Update No. 3 (July 25, 2005), providing guidelines intended to assist in the transition of individuals from institutional programs to community settings. Among these provisions was a policy permitting payment for case management services needed to assist transition for a period of up to 180 days. Olmstead Letter No. 3 states that, “We [CMS] are revising our guidelines to indicate that Optional State Plan Case Management may be furnished during the last 180 consecutive days of a Medicaid eligible person’s institutional stay, if provided for the purpose of community transition.”

The interim final rule Optional State Plan Case Management regulation establishes that case management may be provided and claimed for institutionalized individuals (with the exception of individuals in an Institute for Mental Disease or inmates of public institutions - prisoners) but significantly shortens the time period during which case management can be claimed. The new rule rolls back the 180 day provision and limits payment to case management services according to the length of time that the individual resided in the institution before transitioning to community services. Under the new regulations “individuals who have been institutionalized for 180 consecutive days or longer” are eligible to receive case management for a period of up to 60 days, while individuals institutionalized for a period shorter than 180 days may only receive Optional State Plan Case Management “during the last 14 days before discharge.” According to the regulations, these provisions reflect concern that separate case management services for institutionalized individuals would, “in general, result in duplicative coverage and payment,” while recognizing that individuals with complex medical needs and individuals with mental retardation have need for “case management that is beyond the scope of work of institutional discharge planners.”

CMS correctly notes that transitioning individuals from institutions to the community is beyond the scope of discharge planners – but the new regulations do not recognize the real world timeframe for making a transition into the community. For individuals who have been institutionalized for a significant period of time, discharge planning is more than just orchestrating a return to the individual’s previous life and home. Many individuals have no home, no family, and no friends – discharge planning means creating an entire new life in the community for and with an individual.

Delivering on the promise of person-centered, individualized planning (again a requirement of the HCBS program) means taking a measured, thoughtful, and intensive approach to planning a new life in the community.

Sixty days is simply not enough time for a person to move to a new home and a new life. In support of the new TCM rules, CMS has asserted that transition from an institution to the community should be completed within 60 days. This assertion, and its reflection in the new

guidelines, fails to account for the realities of setting up complex individualized services. A typical citizen, who has no serious health problems, has many connections in the community, a supportive family, and plenty of financial resources could not initiate and execute a total change in their life in 60 days. It would be unlikely that, from the day of making the decision to moving, any individual could locate and secure a home, buy furniture and arrange for its delivery, locate and secure medical personnel, arrange for the move, and take care of all the details within 60 days. We must remember that people in institutions are moving to a new home and changing the way they will live their life – they are not being moved or transitioned to a new facility.

For those who have spent any time in an institution and are ready to move to the community, planning must factor in time to do a risk assessment and develop a plan, communicate with any family members who may be concerned about, or even oppose, the move, complete the difficult task of finding appropriate housing, secure adequate health professionals prior to the move, deal with whatever unexpected illnesses occur during the process, and allow for transition visits prior to the final move. Some who are anxious about making a move they desire may sabotage their own transition – a violent outburst, a suicide threat or attempt – as an expression of fear. Often illness occurs during the transition process. Without sufficient time to engage in individualized transition planning and service development in preparation for leaving the institution, we must be concerned about a return to the congregate and “cookie-cutter” solutions of past decades - or worse, the lengthening of institutional stays.

Rules restricting reimbursement of case management to either the last 60 or 180 consecutive days of an institutional stay present an unreasonable challenge to waiver management and rate setting for case management activities. In order to accurately align costs based on billable, non-billable but allowable, or non-allowable activities, a case manager must be able to define and report current activities and corresponding costs in one of the three categories. While a case manager can readily “not” bill for units provided to an individual who transitions in a period of time that exceeds the prescribed limit, are the costs of delivering this service non-allowable costs? Are systems required to “delay” reporting of these costs as they are incurred to ensure a person transitions in the allotted time?

Currently, provider agencies have admissions staff that work with prospective service recipients to solicit business but serve to ensure participants are informed and educated to choose a provider. Their work may include exploring housing options, employment services, and other services that a case manager might assist with in preparation for a transition. These services are considered an administrative cost to an agency with few if any restrictions. These costs are allocated to cost centers for waiver services and are computed in generating rates for each of these services. Specifically restricting these activities as provided by case managers will allow providers of other services a more prominent role in directing, and potentially controlling, participant choice.

This shortened timeline has profound implications for states engaged in the Money Follows the Person (MFP) efforts, which rely heavily on the discharge planning option through case management. Many MFP grants were approved with this type of intensive planning for discharge as the cornerstone for moving individuals from institutional to community settings.

Cost Savings. Finally, it should be noted that the fiscal note for the Interim Final Rule does not define the cost savings related to this rule. While services are allowed over 180 days, this does not translate into 180 days of service but rather allows for time spent across 180 day span of time to affect planning and movement. And to compress resources to manage this delicate process is shortsighted and cost inefficient. The typical monthly cost for case management would be less than half the cost of a day of service in an institution.

§441.18(a) (8) (vi) 15 Minute Units. The interim final regulations require that “the unit of service for case management and targeted case management services be 15 minutes or less.”

The 15 minute billing unit negatively affects the quality of case management. We do not agree with the assertion that case management will be a more efficient and effective service if billed in 15 minute units. As the regulations rightly point out, case management is not a direct service and is unlike other professional services that are scheduled and delivered in small increments – services such as private duty nursing services or therapies. Due to the high cost and nature of these other professional services, it is legitimate to pay for only the face-to-face direct service time. Unlike direct services, however, case management is what we might term a “capacity” service. The case manager must be available to conduct routine functions that are required in the HCBS waiver and be able to respond whenever the individual is in need of supports. Case management activities are prescribed for HCBS Waiver programs, e.g. planning, monitoring, and responding to events such as investigation of an incident, assisting in securing medical services for emergencies. States typically plan and budget to support case management/participant ratios based on productivity studies to determine what ratio is adequate to carry out all functions, rather than in terms of billable units. For this reason, funding case management as if it were a direct service delivered in 15 minute units does not provide the necessary stable “platform” of availability and does not recognize the distinction of case management from other direct services.

The regulations characterize case management as a bundled service. The proposed regulations place explicit prohibitions on “bundling.” Citing section 1902(a) (30) (A) of the Social Security Act, the proposed regulations reaffirm the requirement that states have in place “methods and procedures to assure that payments are consistent with efficiency, economy and quality of care.” The language detailing this prohibition reads, “... A State cannot employ a methodology that results in payment for a bundle of services. Per diem rates, weekly rates and monthly rates represent a bundled payment methodology...” A bundle is defined as “when a state pays a single rate for more than one service furnished to an eligible individual during a fixed period of time.” The regulation clearly states that, “We...expect that case management and targeted case management services reimbursed on a fee-for-service basis, as opposed to a capitated basis, will be reimbursed on units of time....we believe that the most efficient and economical unit of service is a unit of 15 minutes or less. Accordingly we are requiring in 441.18(a) (8) (vi) that the unit of service for case management and targeted case management services be 15 minutes or less.”

The DRA and the new regulations clearly indicate that case management is not a direct service and that case management constitutes a constellation of activities including comprehensive assessment and periodic reassessment of individual needs, development (and periodic revision) of a specific care plan based on the information collected through the assessment, referral and related activities and monitoring and follow-up. It is difficult to understand how the definition of case management meets the concept in Medicaid of “bundled” when these are closely related services, performed by the same provider.

Moving to 15 minute increments will require substantial investments and changes for states. Although the regulations indicate that 15 minute units will be more efficient and effective, change to this type of documentation will require significant investments in information technology. As we keep noting, since case management is not a direct service, the variety of activities done by case managers are not easily characterized into discrete units. Case managers, although they document case activities, typically are not tracking their every movement in 15 minute increments. The necessity to keep such detailed notes will detract from the case managers’ ability to maintain their caseloads, which has the ultimate impact of causing individuals not to receive needed supports and services. States will need robust information technology solutions in order that case managers can accurately document their time, without detailing every activity throughout the day. And even if we had no difficulty with the proposed unit of service, the impossibly short timelines of this new regulation do not permit states to get the systems in place needed to support reporting in 15 minute increments.

The new rules fail to identify details necessary for rate setting. And finally, of concern is how states will be permitted to develop rates so they are sufficient to capture the true costs of case management. Within a comprehensive HCBS waiver, case managers are the heart of a service delivery team performing a wide spectrum of functions to plan, coordinate, monitor, and oversee services that assure goal achievement and the health, safety and welfare of the participant. Case managers perform a variety of activities that go far beyond face-to-face contact – activities in support of the very functions described in the regulations such as monitoring, assisting individuals to gain access to services and development of a written plan of care. Under current waiver systems, the case manager’s responsibilities, rather than pressure to produce a billable unit, drive the nature of case management activities.

The rule does not clearly distinguish non-billable but allowable costs from non-allowable costs. Requiring case management providers to distinguish non-billable but allowable costs from billable units within a comprehensive waiver will produce no appreciable costs savings, as units go down but the cost per unit goes up. Unscrupulous providers are then inadvertently rewarded for chasing billable units and neglecting those activities (documentation) that are essential but do not produce revenue.

States will need explicit guidance from CMS on how to craft a rate that fully accounts for the required and necessary time case managers spend on behalf of consumers that is not face-to-face or family contact, particularly those activities that support the health and safety assurances under the HCBS waiver. Of great concern is that any rate structure or guidance CMS provides

regarding the development of case management rates ensures that the true scope of case management activities is allowable.

Summary

As CMS is aware, there are more than 307 HCBS waiver approved to date serving over 1 million individuals throughout the nation, 400,000 of whom are diagnosed with developmental disabilities, who otherwise would qualify for institutional care. The rapid expansion of Home and Community Based Services coupled with the General Accountability Office (GAO) reports on quality of care problems in HCBS programs, it would seem inadvisable to weaken the states' capacity to monitor and assure health and welfare for people who would otherwise be in a nursing home or intermediate facility.

CMS has communicated to this Association its intention to apply the regulations to the HCBS waiver program. The Association recommends that CMS reconsider the decision to apply the same requirements to the HCBS waiver program. We further recommend that CMS develop a function within the HCBS waiver that will enable states to assign a professional to each waiver participant to carry out the functions of developing the required person-centered plan, monitoring the plan's implementation, making modifications to the plan as the person's needs change and effecting those changes, and monitoring incidents and health related sentinel events in the person's life – all of which are the components of assuring health and welfare.

As the March 3rd implementation date approaches, states must begin taking actions to implement the requirements as they are published. Recognizing that significant structural changes will likely be necessary to implement the regulations and that it is unlikely that any state could do so in a short time, the Association recommends that CMS initiate an implementation planning process with each of the states and the District of Columbia that will allow for a thoughtful and responsible implementation.

Nancy Thaler

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