

On behalf of the Autistic Self Advocacy Network, I write to comment on the Medicaid and CHIP Managed Care Proposed Rule CMS-2390-P. The Autistic Self Advocacy Network is the leading national advocacy organization run by and for autistic adults, working to increase the representation of autistic people and other people with disabilities in policymaking and throughout society.

ASAN applauds CMS for the inclusion of a number of key consumer protections within the proposed regulation. Most notably, we were pleased to note the following provisions within the rule:

- The modification of the definition of medical necessity to include “the opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living,”
- The development of network adequacy standards for Long Term Services and Supports;
- The requirement that a “State must ensure the views of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of a State’s managed LTSS program”
- The requirement that a state must develop and maintain a beneficiary support system that includes choice counseling, training for network providers, assistance for enrollees in understanding managed care and assistance for enrollees who use or desire to use LTSS, including assistance with complaints, concerns, grievance and appeals rights and review and oversight of systemic issues in Medicaid LTSS programs.
- The requirement of a Medical Loss Ratio of no less than 85%, provided that it is implemented in such a way as not to disincentivize enhanced case management or the provision of goods and services by the MCO that enhance community integration of people with disabilities.
- Reinforcing the applicability of the Supreme Court’s 1999 *Olmstead v. L.C.* decision to Medicaid Managed Care programs;
- The requirement that states must include within its contracts, “as a part of its performance measurement activities under this paragraph and in addition to other measures required of all MCOs, PIHPs, and PAHPs, measures that assess the quality of life of beneficiaries and the outcomes of the MCO, PIHP, or PAHP’s rebalancing and community integration activities for beneficiaries receiving LTSS.”
- The requirement that, if a state does not permit participants enrolled in MLTSS to switch managed care plans (or disenroll to Fee For Service) at any time, it must permit enrollees to disenroll and switch to another managed care plan or Fee for Service (FFS) “when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment;”
- The requirement that states “establish time and distance standards specifically for MLTSS programs”;

At the same time, ASAN’s research and stakeholder engagement on this topic compels us to express concerns regarding other areas of the proposed rule that are inadequate to the needs of people with disabilities receiving services under managed care frameworks. As such, ASAN wishes to articulate the following recommendations:

Recommendations:

- **We recommend that the stakeholder engagement group called for by the regulation must include groups run by people with disabilities across multiple disability categories, including (where present within the state and where said populations are included within the managed care framework) Centers for Independent Living, developmental disability self-advocacy groups, mental health consumer organizations and other relevant stakeholder organizations run by beneficiaries who utilize MLTSS.** To quote the National Council on Disability’s report on this issue, ““States must ensure that key disability stakeholders—including people with disabilities, family members, support agency representatives, and advocates—are fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of Medicaid managed care services and service delivery systems.”
- **We recommend that stakeholder engagement groups should also include representation from the state Protection and Advocacy agency for Protection and Advocacy for Persons with Developmental Disabilities (PADD) and Protection and Advocacy for Individuals with Mental Illness.**
- **We recommend that the stakeholder engagement group be required to meet on a monthly basis and have access to data on plan quality indicators as it is provided to the state as well as information on grievance and appeals, planned modifications to the managed care structure and other relevant data in a timely fashion.**
- We were pleased to see the requirement that states establish time and distance standards for MLTSS programs. **We recommend that these standards be submitted for public comment as part of CMS’ review process prior to the approval of a state’s managed care waiver proposal or plan amendment. We furthermore recommend that the state be required to articulate distinct time and distance standards for network adequacy for different categories of LTSS (i.e: attendant care, respite care services, behavioral health, supported living, supported employment, etc.). Such requirements should specifically ensure that services delivered within the most integrated setting, consistent with the requirements of the new HCBS Settings rule, be available within a reasonable distance to all beneficiaries, and articulate a series of potential remedies (i.e: rate increases, provider subsidies, transportation subsidies, etc.) for failure or inability of an MCO to comply.**
- We were similarly pleased to see the requirement for a minimum Medical Loss Ratio. We do, however note, that many MLTSS beneficiaries will require enhanced case management and may benefit from various non-medical goods and services that may enhance their integration into the community. **We recommend that CMS indicate that enhanced case management for beneficiaries with higher levels of need will not count against an MCO for the purposes of meeting the MLR determination. Furthermore, we recommend that CMS further clarify, either through the regulation or through promptly issued sub-regulatory guidance, determining whether or not a traditionally non-medical good or service that enhances community integration will meet the MLR requirements under the new proposed medical necessity definition.**
- **We recommend that quality measures must include both measures that can be assessed via quantitative analysis of plan data, such as rebalancing measures that reflect shifts away from skilled nursing facility utilization or from sheltered workshop towards competitive, integrated employment outcomes, and qualitative analysis of beneficiary experience with**

LTSS under managed care, such as survey instruments measuring levels of choice, control, autonomy, loneliness or other beneficiary-reported information.

- **We recommend that quality data should be made publicly available, disaggregated by population, region and MCO or other managed care plan provider.**
- ASAN is pleased to note the requirement that states include re-balancing measures within their quality management systems. However, we note that re-balancing incorporates not only the shift away from Intermediate Care Facilities, Skilled Nurse Facilities and Institutions for Mental Diseases towards HCBS, but also shifts between different types of HCBS. **We strongly recommend that required re-balancing measures include not only shifts towards HCBS from ICFs/SNFs/IMDs but also shifts towards less restrictive forms of HCBS from more restrictive HCBS, consistent with the CMS HCBS Settings rule and the Olmstead decision.**
- The rule requires managed care companies to use performance measures, monitor the quality of their long-term services and supports, and states that quality measures must include an effort to “rebalance” toward community integration. Ratings are based on indicators that are used in medical care and do not outline specifics for long-term services and supports. Long-term services and supports are very different from medical care supports. Many HMOs or MCOs lack experience serving people with more complex needs and those who self-direct their services. The rule does not specify any separate ranking system specific to long term services and supports. **We recommend that the rule include a LTSS ranking system, incorporating requirements from nationally established data sets such as the National Core Indicators project.**
- One of the most concerning trends ASAN has discovered in our review of state managed care frameworks has been states which shift home and community based services for a population into managed care while maintaining the corresponding institutional benefit in fee for service Medicaid. Such an approach creates deeply perverse incentives for MCOs, which may financially benefit by shifting high-cost individuals out of their risk pool and into institutional settings. **We recommend that states planning to enroll Medicaid recipients in managed long-term services and supports plans should be required by the Centers for Medicare and Medicaid Services (CMS) to cover both institutional and home and community-based services and supports under their respective plans.**
- A consistent source of concern regarding managed care transitions that has emerged repeatedly in ASAN’s stakeholder engagement is late and bureaucratic payment structures placing the financial solvency of small LTSS providers at risk. **We recommend that CMS require managed care contracts to include minimum interest payments owed for payments transmitted later than 60 days after the submission of a properly filed invoice to an MCO. We also recommend that CMS require that states establish a unified, common billing infrastructure and format for MCOs so as to minimize the administrative burden on small LTSS providers and ensure that the transition to managed care does not adversely impact provider network adequacy.**

We stand ready to assist CMS further in its deliberations at your request. If you would like to pursue further communications on this topic, please contact ASAN’s Director of Public Policy, Samantha Crane, at scrane@autisticadvocacy.org.