United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

August 30, 2019

Via Electronic Transmission

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Managed Care and Long-Term Services and Supports

Dear Administrator Verma:

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps have been taken by the Centers for Medicare and Medicaid Services (CMS) in follow up to the Government Accountability Office (GAO) report entitled "Medicaid Managed Care: CMS Should Improve Access and Quality in States' Long-Term Services and Supports Programs (LTSS)".[1]

Historically, Medicaid has been the primary payer for LTSS for people with disabilities and the elderly. LTSS includes services such as nursing and assistance with feeding, dressing, or other activities of daily living. In 1965, many of these services were provided in institutions such as nursing facilities. However, Medicaid beneficiaries are increasingly receiving LTSS through Home and Community Based Services (HCBS).[2] This shift in care from institutional settings to HCBS settings has been driven by beneficiary preferences, concerns about the high cost of institutional care, and a Supreme Court Case, Olmstead v. L.C.[3]

During the same period as the transition from institutional care to HCBS, there has been a move to managed care for LTSS. In 2004, only 8 states had implemented managed care for beneficiaries who required LTSS. By 2017, 27 states had either implemented or were planning to implement managed care for these services.[4]

The move to HCBS and to managed care as a payment model have each brought significant changes to the LTSS program and the people it serves. In order to ensure these changes do not

[1] GAO-17-632
[2] https://www.macpac.gov/subtopic/home-and-community-based-services/
[3] https://www.loc.gov/item/usrep527581/
[4] GAO-17-632

cause disruptions for vulnerable people who tend to have significant health care needs, it is incumbent upon CMS and states to ensure adequate oversight.

In terms of the federal role in oversight of the managed LTSS programs, in 2013, CMS issued guidance for states that sought approval for these arrangements under the 1115 and 1915(b) waiver processes. This guidance identified "universal elements that will increase the likelihood of a high quality MLTSS program".[5] The ten items are listed below:

1. Adequate planning
2. Stakeholder engagement
3. Enhancement of HCBS
4. Alignment of payment structures and goals
5. Support for beneficiaries
6. Person-centered processes
7. Comprehensive, integrated service package
8. Qualified providers
9. Participant protection
10. Quality

Please answer the following questions by September 13 , 2019.

1. Does CMS continue to use these universal elements to review and approve MLTSS programs? If not, why not? If not, what other criteria are being used?

2. States are required to have an external quality review process to assess the quality of care MCOs provide. Often an external quality review organization (EQRO) is used. Please list all of the EQROs that are deemed appropriate by CMS for this purpose. How does CMS use the information collected by the EQROs? How many states use EQROs for managed LTSS?

3. According to the 2017 GAO report, appeals and grievances processes were slated to change beginning July 2017 to reflect changes specified in the CMS May 2016 Medicaid managed care rule. Please explain how those processes changed.

4. GAO recommended that "CMS take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances".[5] HHS concurred with that

[5] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf
[5] GAO-17-632

recommendation. What actions has CMS taken to implement such oversight activities?

Managed care has the potential to improve outcomes and save money by streamlining health care services, and in many cases that has been documented. However, the Medicaid managed care program must be responsive to the unique needs of those beneficiaries with disabilities who depend upon MLTSS.

If you have any questions, please contact Karen Summar of Chairman Grassley's staff at 202-224-4515 and Caitlin Warner of Senator Casey's staff at 202-224-6324.

Sincerely,

Charles E. Grassley
Chairman
U.S. Senate Committee on Finance

Robert P. Casey, Jr.
United States Senator
U.S. Senate Committee on Finance