

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

August 30, 2019

Via Electronic Transmission

Mr. John Couzins
EQRO Director
Qsource
3340 Players Club Pkwy, Suite 300
Memphis, TN 38125

RE: Medicaid Managed Care and Long-Term Services and Supports (MLTSS)

Dear Mr. Couzins,

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (ML TSS).

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 L TSS through Home and Community Based Services (HCBS).¹ 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.*²

During the same period as the transition from institutional care to HCBS, there has been a move to managed care for L TSS. 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.³

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

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

In terms of the federal role in oversight of the MLTSS 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”.⁴ 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. Do you use these universal elements to review and audit MLTSS programs? If not, why not? If not, what other criteria are being used?
2. How often do you monitor MLTSS services for each MCO you audit?
3. Specifically related to MLTSS, how many MCOs are you currently contracted to audit? Who are these MCOs and if they are subsidiaries, who are the parent companies?
4. Specifically related to MLTSS, what steps are you taking to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances?
5. Specifically related to MLTSS, in the states in which you contract, please outline variations between state Medicaid programs as it relates to coverage decisions, appeals, and beneficiary protections.
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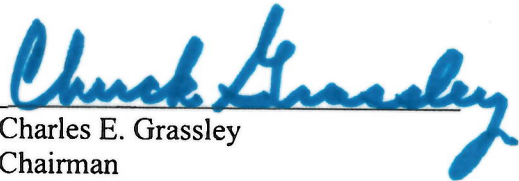
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7. Are any of your audits public? Are the results provided to any entity beyond the MCO?
8. Are you required or allowed to submit audit results to a state Medicaid program?

Managed care has the potential to provide greater independence for beneficiaries, 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.
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Elizabeth A. Shenkman, Ph. D
Director
Institute for Child Health Policy
2004 Mowry Road
Gainesville, FL 32610

RE: Medicaid Managed Care and Long-Term Services and Supports (MLTSS)

Dear Dr. Shenkman,

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (ML TSS).

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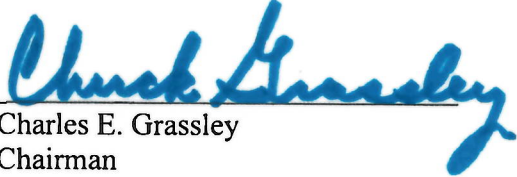
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Via Electronic Transmission

Ms. Dana Green-Bennett
Director, Managed Care
IPRO
1979 Marcus Avenue
Lake Success, NY 11042-1002

RE: Medicaid Managed Care and Long-Term Services and Supports (MLTSS)

Dear Ms. Bennett:

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (MLTSS).

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Mr. Bill Phipps
Vice President, State Medicaid Solutions
Telligen, Inc.
1776 West Lakes Pkwy
West Des Moines, IA 50266

RE: Medicaid Managed Care and Long-Term Services and Supports (ML TSS)

Dear Mr. Phipps,

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (ML TSS).

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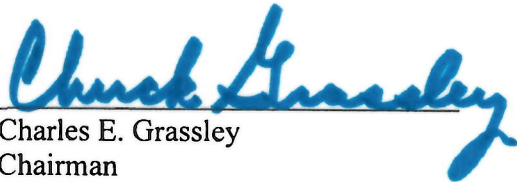
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Via Electronic Transmission

Ms. Sarah Irsik-Good
President and CEO
Kansas Foundation for Medical Care, Inc.
1800 SW Jackson Street Suite 700
Topeka, KS 66612
RE: Medicaid Managed Care and Long-Term Services and Supports (ML TSS)

Dear Ms. Irsik-Good,

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (ML TSS).

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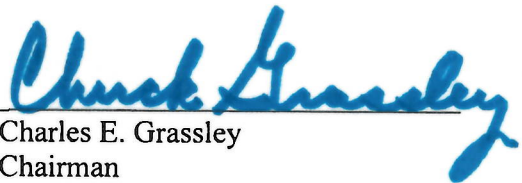
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August 30, 2019

Via Electronic Transmission

Jenny Klink
Vice President of External Quality Review
Metastar
2909 Landmark Place
Madison, WI 53717

RE: Medicaid Managed Care and Long-Term Services and Supports (MLTSS)

Dear Ms. Klink,

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to determine what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (ML TSS).

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 L TSS through Home and Community Based Services (HCBS).¹ 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.*²

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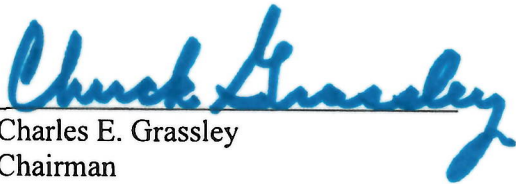
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Ms. Leena Hiilivirta
Principal & Office Business Leader
Mercer Government Human Services Consulting
1255 23rd St NW #500
Washington, DC 20037

RE: Medicaid Managed Care and Long-Term Services and Supports (ML TSS)

Dear Ms. Hiilivirta

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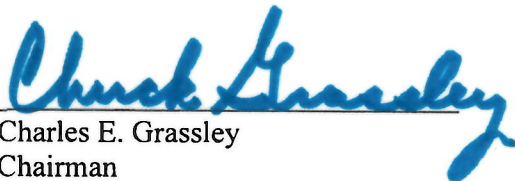
⁴ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>

7. Are any of your audits public? Are the results provided to any entity beyond the MCO?
8. Are you required or allowed to submit audit results to a state Medicaid program?

Managed care has the potential to provide greater independence for beneficiaries, 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

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

August 28, 2019

Via Electronic Transmission

Margaret deHesse
Executive Director
Health Services Advisory Group, Inc. (HSAG)
65 E State St # 1500
Columbus, OH 43215

RE: Medicaid Managed Care and Long-Term Services and Supports (MLTSS)

Dear Ms. deHesse:

As members of the Senate Finance Committee, which has responsibility to oversee the Medicaid program, we write today to ask what steps you are taking to ensure access to needed care for beneficiaries receiving Long-Term Services and Supports in the Medicaid Managed Care Program (MLTSS).

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).¹ 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.*²

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.³

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

¹ <https://www.macpac.gov/subtopic/home-and-community-based-services/>

² <https://www.loc.gov/item/usrep527581/>

³ GAO-17-632

In terms of the federal role in oversight of the MLTSS 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”.⁴ 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 20, 2019.

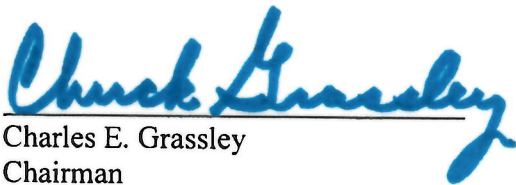
1. Do you use these universal elements to review and audit MLTSS programs? If not, why not? If not, what other criteria are being used?
2. How often do you monitor MLTSS services for each MCO you audit?
3. Specifically related to MLTSS, how many MCOs are you currently contracted to audit? Who are these MCOs and if they are subsidiaries, who are the parent companies?
4. Specifically related to MLTSS, what steps are you taking to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances?
5. Specifically related to MLTSS, in the states in which you contract, please outline variations between state Medicaid programs as it relates to coverage decisions, appeals, and beneficiary protections.
6. Do you have a process whereby you can alert CMS to problems in the MLTSS program? How many times in the past five years has this process been used? What were the outcomes of the specific incidents?
7. Are any of your audits public? Are the results provided to any entity beyond the MCO?
8. Are you required or allowed to submit audit results to a state Medicaid program?

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