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Medicaid Managed Care Roundtable

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Mr. Chairman, Senator Kohl, and Members of the Committee,

Good morning. I am Jeffrey Crowley, a Senior Research Scholar at the Georgetown University Health Policy Institute. Thank you for inviting me to provide a disability perspective as the Aging Committee considers issues related to Medicaid managed care. I am reminded of a series of forums conducted by the Aging Committee related to Medicaid managed care more than nine years ago that led to critical leadership by members of the Committee when managed care reforms were enacted through the Balanced Budget Act of 1997 (BBA). I hope that this series of roundtables proves to be equally as valuable.

I would like to offer a pragmatic and responsible framework for how to approach managed care recognizing the significant improvements that better management of care can bring to Medicaid beneficiaries with disabilities. I must start, however, by reminding the Committee of the experience of many Medicaid beneficiaries with disabilities, not all of which have been positive. Indeed, ten years ago, if asked, I would have said that in ten or fifteen years, managed care could lead to improved care for Medicaid beneficiaries, but that a lot of vulnerable individuals could get hurt until we resolved some of the challenges of applying managed care models to people with disabilities. Looking back on the past decade, I can say that, through hard work, many states have made great progress and managed care has strengthened some states' efforts to manage services for people with disabilities, but progress has been uneven and not all state experiments with managed care have been successful. I would also say that a lot of people have been hurt by the way in which some federal and state officials embraced managed care as a magic bullet for controlling Medicaid costs—and in some cases pushed managed care reforms forward in a rushed way, ignoring prominent pleas for a careful, well-planned approach to implementing such a major change.

Background on Medicaid Beneficiaries with Disabilities

Medicaid beneficiaries with disabilities have diverse and extensive needs that create unique challenges for managed care organizations (MCOs).

According to the Kaiser Commission on Medicaid and the Uninsured, 14% — or 7.7 million — of Medicaid's 55 million beneficiaries were non-elderly people with disabilities in 2003.[1] They are disproportionately costly, responsible for 43% of benefits spending in that same year.[2] On a per person basis, an average of $11,659 was spent on services for beneficiaries with disabilities in 2003, compared to $10,147 for seniors (who are generally people with disabilities over age 65), and this was significantly more than the $1,410 spent on children or the $1,799 spent on non-disabled adults.[3] Even among Medicaid beneficiaries with disabilities, there are large differences in average costs. Indeed, in 2001, the highest cost beneficiaries with disabilities that comprised just 2% of overall Medicaid enrollment were responsible for 25% of overall Medicaid spending.[4] Large differences in costs reflect large differences in the level of need for services and the complexity of their needs. Therefore, any evaluation of managed care must take into consideration its ability to respond to different needs and different issues among beneficiaries with disabilities.

In the early and mid-1990s, there was a level of excitement about the promise of managed care as a tool to assist states in managing cost increases in Medicaid.[5] Further, many policymakers looked to the experience of commercial managed care in the private market and believed that capitated managed care was a proven model that simply needed to be applied to Medicaid's high cost groups—seniors and people with disabilities. While managed care models still hold potential to improve the management of care for Medicaid beneficiaries, and management techniques that were first widely employed by managed care are still being implemented (even if not necessarily in conjunction with capitation), states' embrace of managed care and commercial insurers has diminished somewhat. The number of states with Medicaid managed care programs for people with disabilities rose about ten years ago, but has receded recently. From 1995 to 2002, the number of states with managed care programs focused on people with disabilities declined from 31 to 22.[6] Further, there has been a retrenchment in the role of commercial managed care plans in managing care of Medicaid beneficiaries. Writing in *Health Affairs* in 2003, Hurley and Somers report that a profitability downturn in the managed care industry has altered interest in public-sector lines of business, and commercial plans began to withdraw from Medicaid as they purged low- and no-margin business lines.[7]

Therefore, while commercial managed care plans may have pushed to enter the Medicaid market in the 1990s, the role of these plans appears to have diminished in Medicaid.

Challenges in Implementing Managed Care for People with Disabilities

Caring for beneficiaries who have a broad range of disabling conditions and large variations in the types of and scope of necessary services can be difficult. The shortcomings of efforts by states and MCOs to adapt managed care to serving people with disabilities have been documented. In a 2001 report, the Kaiser Commission on Medicaid and the Uninsured stated,

> "Enrollment of elderly and disabled populations into managed care is increasing, but is complicated by difficulties in setting appropriate capitation rates, limited plan experience in providing specialized services, and lack of systems to coordinate Medicare and Medicaid benefits for those covered by both programs. The future success of Medicaid managed care depends on the adequacy of capitation rates and the ability of state and federal governments to monitor access and quality."[8]

In a study of 36 states with Medicaid managed care programs for people with disabilities, researchers at the Economic and Social Research Institute found that most managed care programs for people with disabilities are mainstream programs.[9] These programs include Medicaid beneficiaries with disabilities in the same design that is used to serve people with occasional or acute needs. Generally, states have not designed special features to account for the special challenges facing children and adults with disabilities. The study also found that MCOs are paid through capitation rates that frequently do not reflect the varying risk profiles of different categories of enrollees, or are not adequately increased over time to account for rising costs. Further, states have generally not held managed care plans strictly accountable for implementing basic features of a good managed care model such as requiring MCOs to identify

enrollees with special health care needs and provide such people with a comprehensive health care assessment within a reasonable period.

Researchers at Lake Snell Perry and Associates conducted a series of focus groups with Medicaid beneficiaries with disabilities in two states in 1999. Beneficiary concerns in these states were consistent with findings of other research.[10] Focus group participants observed that:[11]

- **Nobody is managing their care**
  Many indicated that they would welcome the assistance of their primary care providers, but that they do not believe that they have the time.

- **Case managers are not helping much**
  Some complain that there is too much turnover among case managers to form a relationship with them.

- **Too few providers participate in their plans**
  This leads to long waiting times for appointments, or because of their special health care needs, requires them to go out of network for care.

- **The referral process is confusing**
  Many say they do not understand when and why they need referrals. They also feel strongly that persons with chronic conditions should not be required to continually obtain referrals to see specialists.

- **Important benefits are hard to obtain or coverage is insufficient**
  Beneficiary participants cited problems accessing pharmaceuticals that included inconsistent policies for whether specific drugs were on a formulary and problems tied to 30-day supply limits on medications; they indicate that they cannot get enough speech, occupational, or physical therapy and they are frustrated that they must "show progress" in order to continue therapy; they believe that MCOs create barriers to obtaining durable medical equipment; they indicate that dental care is inadequate and hard to find providers who accept Medicaid; home health needs go unmet; and they say that transportation services are inconsistent and this causes missed appointments and problems getting prescriptions filled.

Managed Care Consumer Protections for Medicaid Beneficiaries with Disabilities

When Congress enacted the BBA, it considered the challenges of appropriately serving Medicaid beneficiaries with disabilities and other special health care needs in managed care programs. Congress demonstrated its concern through BBA requirements that:

- Exempt dual eligibles and children with special health care needs from mandatory enrollment in managed care (unless a state receives a waiver to mandate this enrollment);

- Established new statutory provisions to protect Medicaid beneficiaries in managed care; and
- Instructed the Secretary of Health and Human Services to conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled in Medicaid MCOs are adequately met.[12]

These provisions resulted in a significant updating of the Medicaid law and provided important new consumer protections for Medicaid beneficiaries. I should note, however, that the Bush Administration retracted Clinton Administration regulations implementing the managed care provisions in the BBA and issued new regulations in 2001. Beneficiary advocates were disappointed by this change because a major area of difference in the rules was the elimination of regulatory protections recommended in the BBA's Report to Congress for people with disabilities and other special health care needs.[13] Nonetheless, BBA regulations that are currently in force guarantee that Medicaid beneficiaries have a choice of MCOs, require MCOs to provide enrollees and prospective enrollees specific information to make an informed choice of plans, provide for emergency room coverage using a "prudent layperson" standard, and require MCOs to demonstrate adequate capacity to provide contracted services, among other protections.

Learning from Past Experience with Medicaid Managed Care

Much has been learned over the last decade about how and how-not to implement Medicaid managed care programs for people with disabilities. In my view, the following are key lessons from recent experience with Medicaid managed care for people with disabilities:

- **Go slowly**

Some of the worst experiences with managed care have come when states have tried to implement wholesale managed care transformation. Instead, I think the most promising managed care programs have been those that have developed slowly. Often, successful programs were tested first as small pilot programs, and after careful evaluation, they have been gradually expanded. For example, New York's Medicaid program entered into a contract with Independence Care System (ICS), which serves people with disabilities in three boroughs of New York City, starting in 2000. ICS is committed to growing at a modest pace that allows them to develop an adequate provider network and hire and retain staff that are committed to developing a greater understand of members unique needs. Their membership has grown to 700 members now and they plan to grow to serve 900–1000 individuals over the next 3 years. This assumes that ICS is able to attracted additional members to participate in this voluntary program.[14]

I understand that the Committee heard from Governor Napolitano over the summer about Arizona's Health Care Cost Containment System (AHCCCS). I agree with the Governor that Arizona can provide some important lessons for how to use managed care to deliver quality care to Medicaid beneficiaries, including beneficiaries with disabilities. I would note, however, that the program is not perfect, and it has evolved and improved over time. The AHCCCS program

was established in 1982 and its long-term care program was added in 1989. It took more than two decades for the program to get to where it is today. I do not believe it would be possible for another state to quickly adopt the "Arizona model" without a long-term planning and implementation process that takes into account the health care system as it currently exists in a specific state. We have experience with states that have tried rapid, massive transformations, but these experiments have often ended badly.

- **Payments to MCOs and providers must be adequate**

A key requirement for managed care to work well is to ensure that MCOs and providers are paid sufficiently to provide the level of services that Medicaid beneficiaries need. Given that many states have embraced managed care primarily to save money, this lesson cannot be overemphasized. While it is possible that MCOs and providers can fall short on delivering quality care when they are paid sufficiently, it is not reasonable to expect MCOs or providers to sustain a high quality delivery system to Medicaid beneficiaries with disabilities who are potentially costly, and with highly variable costs, unless Medicaid programs provide adequate payment. Mental health professionals and advocates have stated that the Medicaid managed care experience with the competing approaches of integrating mental health services with physical health services and carving out mental health services to be provided in a separate behavioral health system have both produced many circumstances where managed care programs provided grossly inadequate access to services. A common denominator, however, has been that many states appear to have underpaid for mental health services and this has lead to serious access constraints for pharmaceuticals and psychiatric services.

A key federal policy that has been particularly important in this regard is the concept of actuarially sound payment rates. In 2001, a key beneficiary protection in the Bush Administration's BBA managed care regulations was the requirement that all payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.[15] I understand that some states have advocated for new flexibility to not comply with this straightforward requirement that requires states to pay MCOs rates that are established using generally accepted standards and that take into account the populations being served and the services to be covered. I urge the Congress to resist making any changes in this regard.

- **States must maintain a sufficient Medicaid administrative infrastructure**

In the mid 1990s, I believe that part of the allure of Medicaid managed care for some governors or other state policymakers was the idea that they could hand off responsibility for Medicaid to private entities who would then be responsible for all of the headaches of managing a Medicaid program. One thing that has become clear is that, as a matter of law, states cannot contract away their responsibilities to comply with the Medicaid Act…and this is as it should be. What this means, however, is that no matter what promises the managed care industry makes to states, at the end of the day, states remain accountable for operating their Medicaid programs according to the law and providing high quality services to their beneficiaries. Another lesson for states has been that to effectively operate Medicaid managed care programs takes a considerable administrative investment. Moving to managed care should not provide an excuse for states to cut state employees. I believe that states such as Arizona that have made long-term investments

in managed care would concur with this view. Further, federal officials at CMS should be prodded to collect and publicly report more detailed information about the experience of specific populations with Medicaid managed care.

- **Adequate provider networks, including specialty care, are essential and often neglected**

One of the most promising aspects of managed care for Medicaid beneficiaries is the idea that MCOs will be legally responsible for managing the care of beneficiaries—and ensuring access to providers. This is viewed by some as a way to address problems associated with limited access to providers caused by historically low Medicaid payment rates. For people with disabilities, however, the key issue is not having access to any provider; it is ensuring access to appropriate specialty care. In many instances, the critical challenge is not finding a primary care provider, or even a specific type of specialist; it is finding the right type of specialist with experience treating a specific condition. So, for example, for a person with HIV/AIDS, the challenge is not ensuring access to a primary care provider, or even an infectious disease specialist, but rather, ensuring access to an infectious disease physician who has experience treating people living with HIV/AIDS and with whom the individual can form a productive treatment relationship. By moving people with disabilities to a service delivery model that permits restrictive networks, even with strict numerical targets for the number or types of providers in a network, too many beneficiaries have found existing treatment relationships interrupted without having access of comparably experienced in-network providers. As another example, for a person with epilepsy who may have spent 5 years working with a neurologist to manage their condition, being forced to switch providers—even if their health plan makes available other neurologists—is not acceptable.

Given the current environment where Medicaid beneficiaries can be forced to participate in managed care, federal policymakers may wish to examine the issue of access to specialty care and may need to consider new protections to give individuals the ability to maintain access to existing providers or to receive services from non-network providers if it is necessary to maintain access to treating providers with current experience treating their specific conditions.

- **Well written and clear contracts can improve accountability**

The relationships between states and MCOs are subject to legally enforceable contracts. This means that if a state clearly defines its expectations for its contractors, it can improve the quality of care provided and improve accountability for the large amount of public funds invested in managed care. Over the past decade, states have grown increasingly sophisticated in their contracting with MCOs. The George Washington University Center for Health Services Research and Policy, with extensive public and private financial support, has contributed greatly to states' ability to develop well-written and clear contracts. For many years, they have conducted an extensive review of state managed care contracts and developed a broad array of model purchasing specifications for states around a number of different populations and issues. For example, the Center developed model purchasing specifications for specific disability populations such as people with epilepsy and people with HIV/AIDS, as well as specifications related to topics such as pharmaceuticals and also behavioral health services.[16] As managed care

approaches are applied to new issues, such as serving dual eligibles or providing managed long-term care services, federal policymakers should ensure that ongoing investments are made in developing purchasing specifications so that states retain the capacity to develop clear and enforceable contracts with MCOs.

- **Managed care can be used to improve care coordination for people with disabilities**

One of the most promising features of Medicaid managed care for people with disabilities is the concept of disability care coordination organizations (DCCOs). Earlier this year, the Center for Health Care Strategies published a synthesis of key lessons from seven of these organizations.[17] This report provides a framework for states that are considering promoting care coordination as part of their managed care strategy. These programs coordinate publicly-funded medical and social services and they blend attributes of social service and health care organizations. As a general rule, these programs coordinate most or all of an individual's benefits and for some people may provide non-Medicaid supplemental benefits, such as in-home wheelchair repair services. Key aspects of what makes these programs work effectively is that they are integrated into the disability community, they work with their clients in developing a person-centered plan of care, and they collaborate with a variety of agencies, providers and vendors to meet an individual's needs. Financing for these programs varies. Some of these programs receive capitated payments, and this gives these organizations the flexibility to offer supplemental benefits out of cost savings, but some programs operate on fee-for-service and primary care case management models. Another notable feature of these organizations is that they are relatively small, and none are owned or operated by commercial MCOs.

With the reduced interest in Medicaid managed care by some commercial MCOs and the unique challenges—and cultural competencies—needed to serve a diverse population of seniors and people with disabilities, DCCOs may be a way for states to apply the benefits of managed care approaches while minimizing the drawbacks and sometimes negative experiences of trying to meet the needs of people with disabilities in large statewide efforts developed for the general Medicaid population.

- **Strengthened consumer protections are needed**

As I mentioned at the beginning, Medicaid managed care has come a long way, but many individuals with disabilities have been hurt by rushed efforts to implement managed care. While Congress enacted significant beneficiary protections in the BBA, the issue of consumer protection remains critical.

A key area for federal policy attention should be to examine the past decade's experience with Medicaid managed care and consider additional consumer protections that are needed at this time. I recommend that Congress consider new protections related to topics such as ensuring that people with disabilities and others have appropriate access to care coordination services, requiring states to meet administrative readiness standards before they expand managed care to new areas such as managed long-term care, requiring states and MCOs to consider services medically necessary when they maintain, improve, or prevent the deterioration of functioning, and requiring states and MCOs to adhere to national performance measures for people with

disabilities and others in managed care programs. The early experience with managed behavioral health services has been particularly distressing, and federal policymakers should engage in a comprehensive review of state efforts to manage mental health services and consider establishing new protections to ensure access to current standards of care, including access to latest generation pharmaceuticals.

In any care delivery system that attempts to prevent unnecessary access to services, disagreements will arise between beneficiaries and their MCOs. One area of contention in the past has been the level of protection to afford beneficiaries in appealing denials of services. In my view, the Congress needs to re-visit this essential issue and consider giving beneficiaries greater grievance and appeal rights. In particular, beneficiaries may need new rights that guarantee that a failure by an MCO to provide services in a timely manner is eligible for an appeal; that ensure that MCOs clearly communicate to beneficiaries their appeal rights, including how to meet specific procedural requirements, such as how to request an appeal or fair hearing or how to request a copy of an enrollee's own records; and that create stricter time standards by which MCOs must resolve both standard and expedited appeals.

Current Opportunities for Using Managed Care to Strengthen Medicaid

I would like to turn to issues that may be at the center of the current policy discussion related to Medicaid managed care and this is the role of managed care in managing long-term services and supports and efforts to integrate the delivery of acute and long-term services for dual eligibles. There is no doubt that these issues hold great promise to improve the delivery of Medicaid services—and potentially to save Medicaid program resources. But, with the promise comes great risk. Dual eligibles and Medicaid beneficiaries that use long-term services are very vulnerable populations. And the federal and state governments spend a great deal of resources in providing services to these beneficiaries. I approach greater managed long-term care and efforts to integrate care for dual eligibles with great trepidation.

- **Increasing access to community-based long-term services**

The defining issue of Medicaid advocacy for the disability community is to end the institutional bias, the Medicaid policy that requires states to provide nursing home care to individuals, while permitting, but not requiring states to provide comparable community-based services. In 1999, the United States Supreme Court issued a decision in the case of *Olmstead v L.C.*, finding that the unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act of 1990 (ADA).[18, 19] The Court ruled that states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals determine that community placement is appropriate; when the person does not oppose such placement; and, when the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services. Despite the *Olmstead* decision, however, the size of Medicaid waiver waiting lists for community-based services has grown from 156,000 in 2002 to 206,000 in 2004.[20]

Managed long-term care creates opportunities for increasing compliance with the *Olmstead* decision because, on a per person basis, community-based services are generally significantly cheaper than institutional services. Better management of long-term services and supports could eliminate cases of unnecessary institutionalization.

I have great concerns, however, because we do not have proven, large-scale models for delivering long-term services and supports in a managed care environment. Arizona remains the only Medicaid managed long-term care program that operates both statewide and on a mandatory basis.[21] While a number of states have been able to start managed long-term care programs, the overall penetration rate for such programs in small, 1.7% in 2004.[22] Another significant challenge is that most MCOs do not have long-term care experience and most of the providers who are experienced in delivering long-term services do not have managed care experience.[23]

Recommendations: Federal policymakers should encourage further experimentation with managed long-term care. However, since this field is in its infancy and the seniors and people with disabilities are so vulnerable, states should not be permitted, through waivers or other initiatives, to mandate participation in these new programs. Further, federal policy should encourage states to reflect the principles of the independent living movement of choice and control. This means that states should be required to engage the senior and disability communities in meaningful partnerships to conceive and implement new experimental designs for managing long-term services. Further, states should be required to conduct person-centered individualized planning processes that maximize individual autonomy and consumer control. Additionally, Congress should insist upon an invigorated evaluation and monitoring component of any pilot or demonstration programs so that federal policymakers, other states, beneficiaries, and the public can learn from state efforts to innovate in this area.

- **Streamlining and improving care and services for dual eligibles**

More than seven million individuals are dual eligibles—individuals who receive both Medicaid and Medicare.[24] Dual eligibles account for one in seven Medicaid enrollees, including virtually all seniors who receive Medicaid and about one-third of non-elderly beneficiaries with disabilities.[25] Most dual eligibles are very low-income individuals with substantial health needs. Nearly one-quarter of dual eligibles are in nursing homes, compared to 2% of other Medicare beneficiaries.[26] Their health costs are nearly double those for other adults covered by Medicare and nearly eight times higher than what Medicaid spends on non-disabled children.[27] The absence of coordination between Medicaid and Medicare in providing overlapping services to these high need individuals—and associated complications arising from conflicting delivery systems, financing structures, and administrative policies—leads to missed opportunities to provide high quality care and potentially wastes billions in federal and state resources. This lack of coordination also likely permits cost shifting to Medicaid for services that may be legitimate Medicare expenses. If ways could be devised to bridge and integrate the Medicaid and Medicare delivery systems, there is significant potential to improve quality of care and save public resources. Managed care programs—which often include financing systems that pay MCOs a per person per month or a per case fee in return for delivering a specified set of services—may

offer flexibility to operate outside traditional fee-for-service regulatory structures that could contribute to integration programs.

For many people with disabilities, protecting access to the specialty services they need to manage their disabilities is so all encompassing that other health needs are neglected. I have heard of numerous stories of people with mental retardation and their families who focus so much on essential long-term services that enable them to live in the community, that more basic needs such as dental care are ignored. Or, I have heard of people with spinal cord injuries who focus all of their energy on protecting access to personal care that they neglect other needs that we must all address as we age such as cardiac health. Integrated care—that involves active management, and individualized care plans could address many of these concerns and lead to a major improvement in the lives of many people with disabilities.

At the current time, however, model programs do not exist. Implementing integrated care programs for dual eligibles has proven difficult for states, and many states have been unable to move from program design to implementation.[28] In 1996, the Robert Wood Johnson Foundation and the George Mason Center for Health Policy Research and Ethics established the Medicare/Medicaid Integration Project. The project has awarded grants to 14 states to develop integrated care programs for dual eligibles. To date, only 3 of these states have been able to implement these programs.[29] The Center for Health Care Strategies reports that challenges with implementing these programs include difficulties in obtaining federal approval, developing plan capacity to integrate care, and navigating operational differences between Medicare and Medicaid.

Recommendations: As with my recommendations related to managed long-term care, I believe that Federal policymakers should encourage further experimentation with integrated care programs for dual eligibles. At the same time, I strongly encourage the Congress to reject pleas for more flexibility to waive or disregard federal rules and beneficiary protections. From the perspective of states or MCOs, any federal requirement could be seen as unnecessarily burdensome. From a beneficiary perspective, however, federal requirements generally provide essential protections. As already stated, dual eligibles are an extremely vulnerable group of individuals. While the federal policymakers may believe it is desirable to move toward greater integration, we do not yet know where were are trying to move. It is completely premature to be considering flexibility for states to require dual eligibles to participate in integrated care programs or to give states even more flexibility in managing their Medicaid programs. Further, since there are so many obvious benefits for improved quality of care, if states develop voluntary demonstrations that address the real concerns of dual eligibles, attracting enough participants to test new experimental models should not be overly burdensome.

- **Holding service providers accountable for providing quality long-term services**

One of the features of managed care that is attractive to states is the ability to use managed care to eliminate waste and maximize the benefits from a very significant federal and state financial investment. Over time, in the realm of managed acute care services, a number of tools have evolved to help achieve this accountability. This includes the development of various clinical practice standards, adoption of consumer protection systems (including statutory and regulatory

protections and state oversight), the development of specific and clear contracts, and the development of performance measures by which MCOs, states, federal administrators, and the public can measure how well MCOs are meeting their obligations.

Comparable tools to measure the performance of MCOs and hold them accountable for delivering long-term services and supports do not exist. The driving force in MCO performance measurement is the National Committee on Quality Assurance's (NCQA) HEDIS measures, which are used to evaluate commercial, Medicaid, and Medicare manage care organizations nationally.[30] Key criteria for these measures are that they are broadly applicable, actionable, and measurable. While helpful, these measures only address a portion of the needs beneficiaries, particularly their acute care needs.[31] Further, there are some performance measures for specific populations such as frail elderly participants in PACE programs or persons with developmental disabilities, but no current measures are broadly applicable to all long-term services populations and none take a broad holistic approach to measuring MCO performance. The Center for Health Care Strategies has convened a work group of states and MCOs to begin the process of developing some of these measures. Importantly, a key goal of this process is the minimize reporting burdens on MCOs, states, providers, and beneficiaries.[32]

Recommendations: The Congress should consider specific steps it can take to spur the development of broadly applicable performance measures for long-term services and supports. Such an effort may be most properly conducted by the Agency for Healthcare Research and Quality (AHRQ), and while building on and collaborating with the Center for Health Care Strategies, would broaden the participation of additional stakeholders to ensure broader participation of a variety of beneficiary representatives and providers and lead to national acceptance of the new measures.

Conclusion

In conclusion, I am encouraged that the Aging Committee is giving its attention to critical issues related to Medicaid managed care and the challenges posed by using managed care to serve seniors and people with disabilities. There are many reasons why states may seek to use managed care programs to strengthen the delivery of Medicaid services—and there is an important role for the Aging Committee and the Congress in encouraging responsible uses of managed care. Nevertheless, managed care does not offer any magic bullets or quick fixes, and experience has shown that it also involves risks. I encourage the Committee to look for managed care opportunities while ensuring that the very vulnerable seniors and people with disabilities served by Medicaid are not placed at risk. I also encourage the Committee to protect the federal financial investment in Medicaid from rushed, irresponsible, or wasteful managed care initiatives that ignore the lessons from the past decade or that promise more than they can deliver.

Thank you very much for providing me the opportunity to participate in today's roundtable.

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