Coordinated Care: Bringing Key Components Together

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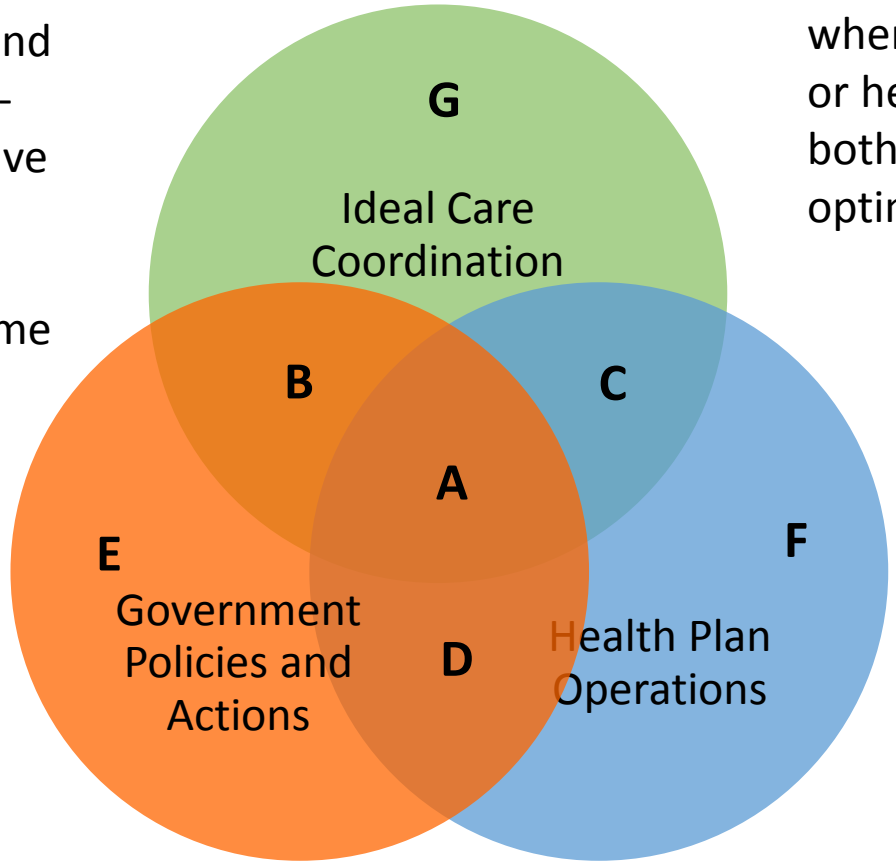
Achieving Optimal Care Coordination in Medicaid and Medicare is Challenging, Important Work

Objectives of an Ideal Program	Complications in Achieving the Objective
Ensuring and facilitating access to all needed services	A blurry line exists regarding what is needed versus what is wanted -- with "wants" being limitless (and often morphing into perceived needs). Financial resources are, of course, far from limitless.
Giving providers latitude and information to efficiently deliver needed care	"Nobody should come between you and your doctor" is good public policy when patient is willing to pay the full bill. However, when taxpayers' Medicaid and Medicare funds are used, the appropriateness and cost-effectiveness of what is being paid for must be assessed. MCOs need to be constructively involved without being overly intrusive, and this can be a challenging balance.
Providing cost-effective outreach and education to support persons during the 99% of their lives when they are not receiving medical care	Sorting out which outreach/education efforts are most effective, using which communication mechanisms, and for which persons is an important work in progress. We need to connect better with high-need beneficiaries during the course of their daily lives with tools to enable them to self-manage their conditions and engage in healthier behaviors – within the boundaries of cost effectiveness.
Identifying and eliminating excess costs and fraud	Avoiding unnecessarily high-cost treatments/therapies and finding and eliminating fraud can be unpleasant endeavors. Nonetheless, good coordinated care programs need to have these components and need them to be done well.

Government Policies and Health Plan Operations Often Fall Short of Delivering an Ideal Program

Area A: represents situations where government policies and actions -- and health plan operations and actions -- are yielding an optimally cost-effective care coordination program in the Medicaid or Medicare arena. While the graphic under-portrays the volume of highly effective partnerships currently in place, substantial improvement opportunities exist.

Areas D, E and F: Situations where a non-optimal program is in place, due to either government design issues, health plan performance issues, or both.



Areas B and C: Situations where either government or health plans (but not both) are facilitating an optimal program.

Area G: Programs and techniques that are needed for optimal care coordination but which are not in use. Minimizing size of this sector requires testing new innovative program models, such as mandatory MCO enrollment for Medicare beneficiaries and dual eligibles.

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Examples of Issues That Occur in Sectors B and C on Previous Chart

Area B: Optimal approaches are promoted by government but are not reflected in health plan actions

- Example Behaviors: Health plans hiding favorable operating margins in other line items -- or not implementing a cost-saving initiative -- because "government will just lower our capitation rate"

Area C: Optimal approaches are used by health plans but not promoted by government policies

- Example Behaviors: Benefits carve-out policies that prevent health plans from delivering whole-person focused approach; Medicaid federal revenue maximization programs tied to fee-for-service model which inhibit use of capitated/integrated model of care coordination

In Sectors D, E and F, Activities Fall Entirely Outside of Optimal Care Coordination

Area D: Government requirements are in place – and health plans are in compliance with them – but the design and implementation are ineffective

- Example Behaviors: Health plans often paying providers full charges for out-of-network care or specialty provider care, with government failing to put reasonable boundaries on unit prices and health plans unable to negotiate more appropriate amounts

Area E: Government policies are sub-optimal and health plans are not involved

- Example Behaviors: High-need persons are kept in traditional fee-for-service coverage setting – or in weaker/ineffective models of care coordination

Area F: Health plan actions are sub-optimal through no fault of government entities

- Example Behaviors: Plan leadership neglect investing in needed operational performance improvements

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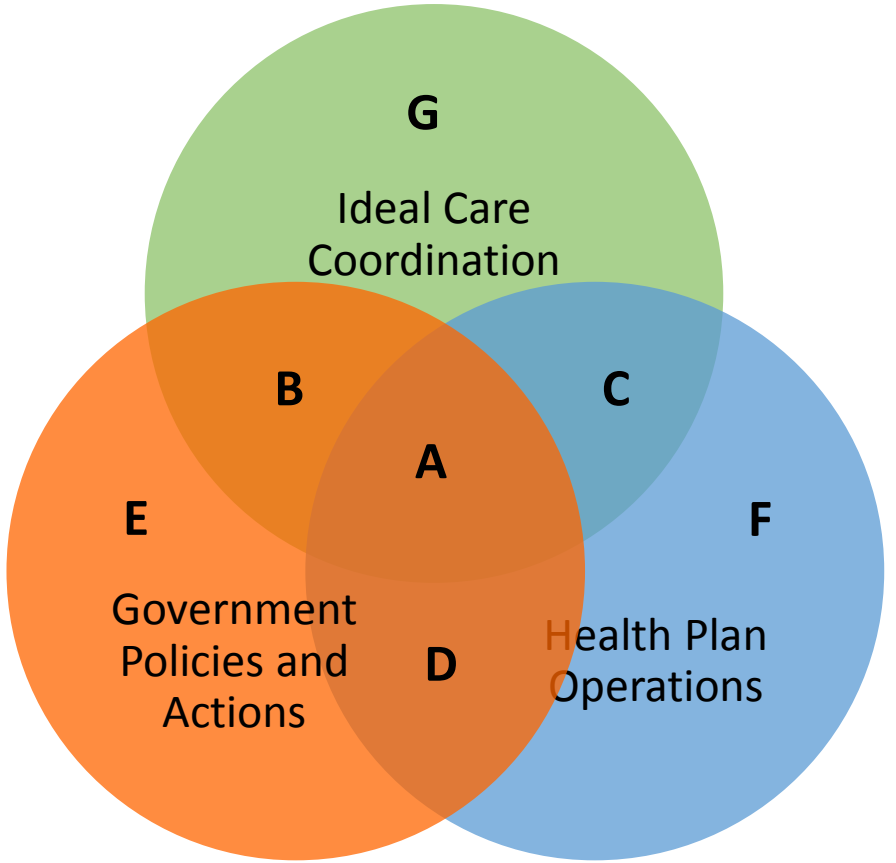
The Years Ahead Offer Tremendous Opportunities for Government and MCOs to Work Together More Often and More Optimally

A key challenge involves ascertaining where a given program is operating within the A-G spectrum

- policy by policy
- MCO by MCO

Outside of segment A, opportunities for improvement exist

As the existing problems and limitations are accurately identified, solutions which bring the three circles together will emerge



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