Understanding Managed Care
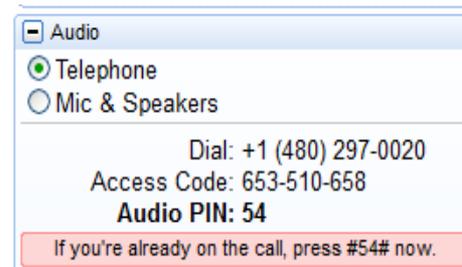
Melena Thompson, DSHS, Division of Behavioral Health Services and Recovery
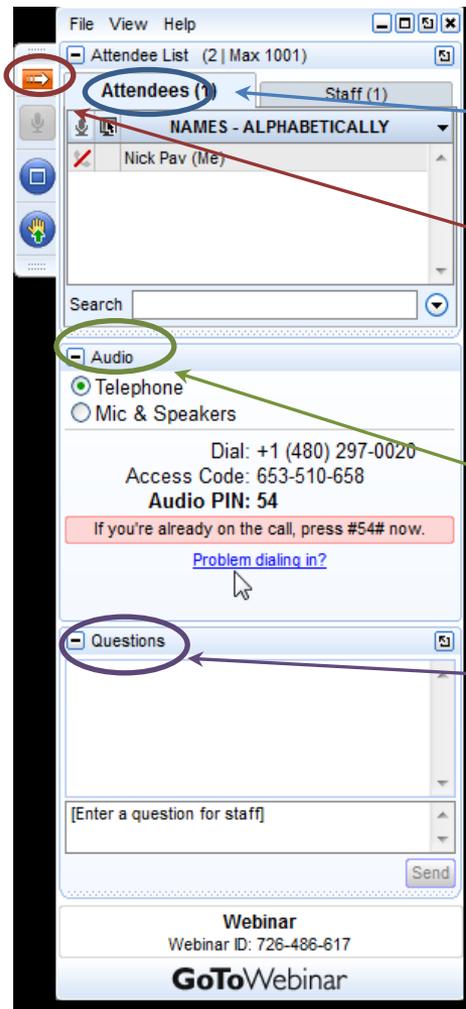Alison Robbins, Health Care Authority

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- It is always a good idea to close other windows while viewing the webinar.

- Be sure to enter the telephone code, if you haven't already.

- For problems during the webinar, please contact Scott McCarty via email at scott.mccarty@dshs.wa.gov

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Webinar Controls

- **Attendee List** - Displays all the participants in-session

- **Grab Tab** –Allows you to open/close the Control Panel, mute/unmute your audio (if the organizer has enabled this feature) and raise your hand

- **Audio pane** – Displays audio format. Click Settings to select telephone devices.

- **Questions panel** – Allows attendees to submit questions and review answers (if enabled by the organizer). Broadcast messages from the organizer will also appear here.

Topics to be covered

- Overview of Managed Care

- Funding

- Managed Care Structure

- Network Adequacy

- Financial Risk

- Benefits/Challenges

Managed Care System

- A system designed to provide quality health care in a cost effective way

- Paid a per member per month premium (PM/PM) to provide and/or purchase covered services.

- PM/PM is considered full payment for all medically necessary services

Managed Care Entities

– Managed Care Organization (MC0)
  - Comprehensive benefit package
  - Payment is risk bearing/capitation

– Prepaid Inpatient Health Plan (PIHP)
  - Limited benefit package that includes outpatient, inpatient hospital or institutional services
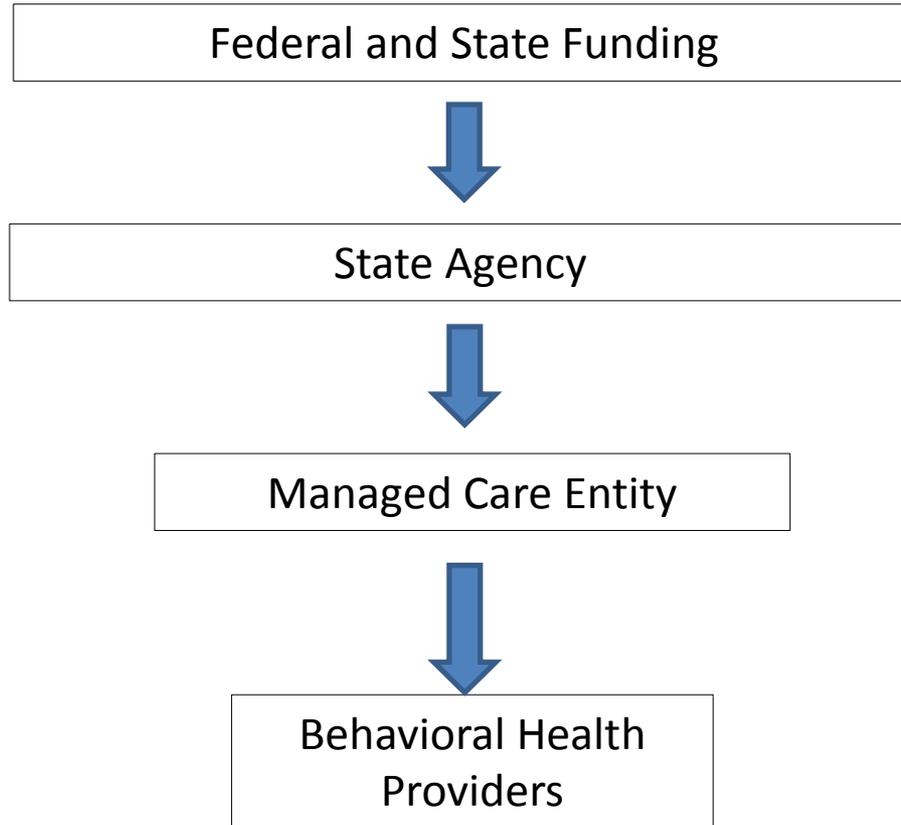 - Payment is risk bearing/capitation

Behavioral Health and Service Integration Administration

Managed Care Programs

– Apple Health plans (formerly Healthy Options) are Managed Care Organization

– Regional Support Networks are PIHPs

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Managed Care Relationships

Federal and State Funding

⬇

State Agency

⬇

Managed Care Entity

⬇

Behavioral Health Providers

Fee-for-Service vs. Managed Care

Fee-for-Service (FFS)	Managed Care (MC)
• Provider agrees to accept rates as payment in full	• Managed care entity accepts a per member per month capitation payment in full
• Enrollees choose their own doctors, hospitals and other providers from a pool of willing providers.	• Assume financial risk for providing all services in the defined benefit package
• State reimburses providers at an established fee for each service rendered	• Must have adequate network to provide timely access to all medically necessary services

Required Elements of Managed Care

✓ Quality Review - Implementation of quality programs

✓ Network adequacy – Sufficient number of in-network providers to meet the need

✓ Eligibility - Acceptance of all enrollees regardless of health condition, gender, ethnicity

✓ Grievance/Appeals – Protections for enrollees

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Quality Review

- Required to have a quality strategy for continuous review and oversight.

- External Quality Review Organization(EQRO) reviews compliance with federal requirements for quality standards.

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Network Adequacy

- Networks must have enough providers to access for all enrollees

- There are no wait lists, there are required timely access standards

- Provide all medically necessary services

Eligibility

– Once determined Medicaid eligible, the enrolled is entitled to services in the defined benefit package

– The service type, scope and duration of services is based on medical necessity

– Specialty services may have standardized medical necessity criteria

Grievance and Appeals

- A check and balance system to protect enrollee's rights

- Provides procedures for timely resolutions to enrollees concerns and requests related to access to care, provision of services and choice of providers

Challenges

- Maintaining a network of providers to meet the demand.

- Determining medical necessity, to ensure the right scope, duration and intensity of services are provided

- At financial risk to manage within the resources provided without regard to demand

Benefits

- Ensures access to all medically necessary services for enrollees.

- Provides protections such as appeals that allow an enrollee to have decision made about services provided reviewed.

- Requires quality improvement processes to decrease inefficiency and maximize outcomes for enrollees.

Review of Questions

Next Webinar

- October 2014
- Topics to include, but not limited to:
  - Adequate funding
  - Contractual Relationships, Current & Future
  - Quality measures
  - Utilization Management and Tools
  - Use of Terms; i.e. enrollee, individual, consumer, patient, client

Email questions to BHOTransitions@dshs.wa.gov

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