Understanding Managed Care

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

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

– Regional Support Networks are PIHPs
Managed Care Relationships

- Federal and State Funding
  - State Agency
    - Managed Care Entity
      - Behavioral Health Providers
# Fee-for-Service vs. Managed Care

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

Behavioral Health and Service Integration Administration
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
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.
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