Managed Care 101

What is Managed Care?

Managed care is a system to provide health care that controls how health care services are delivered and paid. Managed care has grown quickly because it offers a way of predicting and controlling health care costs. There are different types of managed care organizations, such as health maintenance organizations (HMOs), and preferred provider organizations (PPOs). HMO and PPO plans are different because they pay for and control health care services in different ways. In general, the term managed care organization (MCO) is used to describe all of these different types of managed care. MCO is a broad generic term for organizations involved in managed care.

Managed care organizations (MCOs) do what health insurers did in the past--collect premiums to pay for your health care. However, MCOs add additional steps in the process of obtaining health care. These steps are intended to reduce the cost of providing health care by eliminating unnecessary or ineffective procedures.

Positive Features

- ✓ generally covers preventive services,
- ✓ eliminates paperwork to file insurance claims,
- ✓ eliminates or reduces out-of-pocket expenses,
- ✓ secures access to medical care through a PCP.

Possible Problems

- ✓ limits providers you can use to those in plan network,
- ✓ services not determined "medically necessary" will be denied,
- ✓ can take longer to get referred to specialty care,
- ✓ lack of experienced providers serving people with disabilities.

Who Uses Managed Care?

Managed care now affects almost everyone who has health insurance and many employers and publicly-funded programs are using it as a way to provide health services. People who are likely to use managed care include:

- ✓ employees who get their health insurance through their employer
- ✓ people who are insured through the government (either through Medicare or Medicaid) *NOTE: MEDICAID INFORMATON BELOW.*
- ✓ people who may purchase their own individual insurance.

Learning to Speak the Language

Managed care has created new words, terms, meanings and acronyms. Learning the language of this field can feel like wading through an alphabet soup, but you must do it to make the system work for you.

Managed Care Organization (MCO) is a broad, general term used to describe many different types of managed care arrangements, such as health maintenance organizations, preferred provider organizations, behavioral health organizations, and point of service organizations.

Following are some of the words and acronyms you are most likely to hear and see when using managed care:

Benefits. Health and related services guaranteed to be provided in a health plan.
BHO ~ Behavioral Health Organization. An organization that delivers mental health and/or substance abuse services. Many managed care plans will contract with BHOs to deliver mental health or substance abuse services to the plan's members. If you think you or your family may need mental health or substance abuse services, find out which behavioral health organization your managed care plan uses. (See "carve-out".)
Carve-out. Specialty care within a managed care organization is often separated (carved-out) from a benefit package. In a carve-out, entire segments of a health plan's benefits, such as mental health, are delivered through a separate program. Carve-outs affect consumers in managed care because consumers often assume that the MCO with whom they enroll will cover all their health needs. However, in many cases, particularly in the area of mental health, a MCO will arrange with another specialty MCO to provide those services. Consumers who need special services, such as mental health or substance abuse care, should find out prior to selecting a plan if these services are provided by their MCO or by another organization, such as a BHO.
Case Management / Care Coordination. A system used by insurers to monitor and coordinate treatment for specific enrollees, particularly those involving high cost or long-term care. Case managers are usually nurses or social workers who work for the MCO, and who know what services the plan covers. In some plans, case managers may authorize benefits not usually covered, if they believe it will help the individual and be more practical for the plan. This is usually called "flexing" or "negotiating" benefits.
Complaint/Appeal/Grievance. These terms are sometimes used interchangeably. All refer to processes that allow consumers to identify problems or barriers to care and challenge the MCO's decisions.
Co-payment. A set fee that an individual pays for health care services in addition to what the insurance covers. (If you have Medicaid managed care, you do not have to pay a co-payment.)
DME ~ Durable Medical Equipment. Necessary medical equipment that is not disposable; for example, wheelchairs, walkers, ventilators, commodes.
Enrollee. A term used to describe a consumer within an HMO health plan.
Enrollment Broker. A private company under contract with a state to advise people on Medicaid about their choices among MCOs or choices between managed care and traditional fee-for-services Medicaid and to assist with enrollment. The enrollment broker in Texas is Maximus, Inc.
ERISA ~ Employee Retirement Insurance Security Act. Federal act that allows businesses to develop self-funded health insurance programs. Such programs can limit benefits packages because they are not under the jurisdiction of state insurance regulations.
FFS ~ fee-for-service. Traditional health insurance, allowing consumer to choose providers and services, often with a deductible and co-payment. Also known as indemnity coverage.
Formulary. A list of prescription drugs that a managed care plan will pay for. Generally, drugs that are not on the formulary will not be paid for by the managed care company unless the requirement is waived.
Gatekeeper. Person, usually a primary care physician, designated by the health plan to decide what services will be provided and paid for; approves all referrals, sometimes coordinates care.

HMO ~ Health Maintenance Organization. An organization that delivers and manages health services under a pre-paid arrangement such as capitation. The HMO usually receives a monthly premium or capitation payment for each person enrolled in the plan, based on a projection of what the typical patient will cost. HMOs vary in design, although the common element is that members are restricted to using only providers who are part of the HMO.

Life Time Maximum. The amount of money after which a health insurer will stop paying for your care. This is especially important if you or someone in your family has an illness that requires expensive treatment.

MCO ~ Managed Care Organization. A broad term that describes any health plan that finances or delivers health care by controlling the use of services through limiting the number of providers and the cost of services. HMOs and PPOs are examples of managed care organizations.

Medically Necessary. A health service that is considered important for the treatment or diagnosis of a disease, illness or injury. The definition of medical necessity varies from plan to plan with each MCO using its own definition and interpretation of medical necessity. There is one definition of medical necessity for Medicaid managed care.

PCP ~ Primary Care Provider. The health care provider who is responsible for overseeing all of an individual's health care needs. In most managed care plans, the PCP is considered the "gatekeeper" because the PCP must approve referrals to specialty care. PCPs are usually physicians (such as a family practitioner or pediatrician,) but may also be a nurse practitioner or a physician assistant.

POS ~ Point of Service Option. This option (also called an open-ended HMO) is sometimes included in an HMO's plan. A POS allows HMO plan members to pay more to use providers that are not in an HMO's provider network. Enrollees who use this option usually pay more for those services provided out of the network.

PPO ~ Preferred Provider Organization. A health care plan that pays for more of its members' health care costs if they use providers from a pre-selected group (i.e., the "preferred provider"). PPO members are not required to use the preferred providers, but the members usually pay much less if they do. PPOs are usually more flexible with services than HMOs.

Pre-existing Condition. A health condition or problem that was diagnosed before your insurance policy went into effect. Some insurance companies will not cover pre-existing conditions, while others will establish a waiting period, during which the plan pays for all other covered services except the pre-existing condition.

Provider. A general term used to mean people or facilities delivering health care, for example, doctors; other health care professionals such as nurses and physical therapists; health care facilities, such as hospitals.

Provider Network. Any group of physicians or other providers that have contracted with an HMO.

UR ~ Utilization Review. Processes that a managed care organization uses to determine whether the services a member receives are medically necessary, cost-effective, and meet the plan's requirements for care. Generally treatment or services that do not meet the health plan's medical necessity criteria will not be covered.

What are the accessibility and availability requirements for an HMO?

An HMO is required to provide an adequate network which would consist of contracted physicians and providers for its entire geographical service area.* All covered health care services must be accessible and available to enrollees within certain travel distances. The distance from any point in the HMOs service area to a point of service can be no greater than:

- 30 miles for primary care and general hospital care; and
- 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.

An HMO must arrange and make available urgent care within:

- 24 hours for medical and dental conditions; and

- 24 hours for behavioral health conditions.

An HMO must arrange and make available routine care within:
- 3 weeks for medical conditions;
- 8 weeks for non-emergent dental conditions; and
- 2 weeks for behavioral health conditions

An HMO must arrange and make available preventive care within:
- 2 months for a child;
- 3 months for an adult; and
- 4 months for dental services.

*Geographic Service Area is defined as a geographic area within which direct service benefits are available and accessible to HMO enrollees who live, reside, or work within that geographic area.

You need to know:

Start by calling the Member Services Department within the MCO. Ask for the Member Handbook, and Evidence of Coverage, both provide information about basic covered services offered by the plan. You should also ask for a copy of the Provider Directory, which lists the providers that are available through that particular managed care plan. (*The Member Services telephone number is on all MCO member's identification card.)*

The list must indicate which doctors are not taking any new patients. Managed care organizations have member service representatives who can help you with any questions as you read the information provided in the written material. Whenever you need clarification, the best strategy is to ask for written responses to your questions. Make sure you ask about special services you may need.

Emergency Care

All MCOs must pay for emergency care. "Emergency care is defined as treatment, tests, or services that would lead you to believe that not receiving this care would place your health at risk, cause serious disfigurement, or, if you are pregnant, cause serious risk to your unborn baby."

PPOs must pay for emergency services that you received outside of the PPO network if you could not reasonably be transferred to a provider in the PPO network before receiving the emergency care.

Continuity of Care

If you have a disability or chronic condition, are in the middle of treatment for a sudden, short term condition; have a life-threatening illness; or are past the 24th week of pregnancy, and your provider is terminated from your MCOs network, your MCO must allow you to continue care with that provider for at least 90 days. Your provider must ask the MCO to approve this.

Complaints and Appeals

All managed care organizations are required to have a process for handling members' complaints and are required to resolve those complaints within specific time frames identified in materials provided to enrollees. Non-emergency complaints must be resolved within 30 days.

HMOs and PPOs cannot retaliate against you (by either canceling your coverage, or raising your rates) because you filed a complaint.

If you have a disability that affects your ability to communicate or read, HMOs must accommodate your access to the information in the member handbook and the complaint and appeals process in a format of your choosing. You can select how you want this information to be given to you.

If you believe an HMO denied you medically necessary care, state law requires that you can bring your complaint to an Independent Review Organization, which will review your complaint with the HMO. This process does not cost you anything and should be described in the member handbook. When you are denied care, the written notice you receive should include an explanation of how to get an independent review.

Common Problems and Solutions

The following are situations that you may encounter as you begin using managed care. The term provider is used to mean those individuals or organizations that agree to provide a particular service(s) who are in a network for a specific MCO.

It is easier to resolve problems with your MCO, or to avoid them in the first place, if you... Remember to keep accurate records (e.g., who you talked with, time, date, what you discussed), be firm in your requests, and let your provider know of your particular needs.

You chose a managed care organization (MCO) because your primary doctor is in the plan's network, but later you learn that you don't have access to your longstanding specialists, who may be more important to your health care - *Before selecting a plan, look at the MCO's network of providers. Consider whether the MCO offers you access to your specialists (such as psychiatrists or rehabilitation specialists) as well as your PCP. For people with disabilities, access to a specialist can be more important than access to their regular doctor. If you ask for a list of specialists, the MCO is required to give it to you.*

Special services that you need to manage or treat a medical condition are not covered by your MCO Plan - *Contact your MCO's member services department to request a case manager. Be prepared to explain why you need a case manager. Depending on the MCO, some case managers have the ability to negotiate different benefits for you if they believe that the benefits will improve your medical condition and/or save the MCO money. Send a written request for a case manager to the MCO's medical director after your call.*

Your MCO refuses to pay for a service or piece of equipment that you believe is medically necessary - *The best way to prevent this is to have the MCO confirm, in writing, that it will pay for a service or piece of equipment before you receive the service or purchase the equipment. However, if the MCO doesn't agree to pay for a service or piece of equipment, you have some options to secure the services you need.*

(1) Explain your problem to the MCO's member services department. If your health care coverage is through an employer, contact the benefits manager for that employer. Both of these sources should help you to work through the system.

(2) File a formal complaint with your MCO. The process for filing complaints should be located in your member handbook. If you can't find it, contact the member services department at the MCO. When you file a complaint, be sure to be specific and include copies of any papers the

MCO has given you refusing to pay for a service or equipment and any evidence you have that the services are medically necessary. (See Resources for additional complaint information.)

You did not pick a Primary Care Provider (PCP) when you enrolled with your MCO - *If you do not select a PCP when you enroll with a MCO, the MCO will assign you a PCP. This PCP may not be familiar with your needs or in a location that is convenient. To make sure that you can see a provider in a convenient location, with whom you are comfortable, be sure to select your PCP when you sign up with your MCO. If you do not like the PCP assigned to you, you have the right to pick a different one.*

You are not happy with your Primary Care Provider (PCP)- *If you are dissatisfied with your PCP because he or she does not understand your needs, remember that providers have different levels of experience in working with individuals with disabilities. You may need to share your own expertise to inform your PCP of your needs and expectations. Talk with the PCP about your needs and how you complete daily tasks. Let your provider know what you expect to accomplish in your health care and what equipment, devices or assistance enables you to do so.*

If you want to change your PCP, the law gives you the right to do so. Individual MCOs have different limits on how frequently you may change PCPs and may only allow changes within certain time periods. The law allows MCOs to limit the number of changes to four every 12 months. Obtain an explanation of how to change your PCP in your member handbook or by calling your MCOs member services department.

You want to continue seeing providers/specialists that you saw before joining your MCO - *One of the drawbacks of managed care is that you lose some of your freedom to choose any provider. However, if your former specialist is in your MCOs provider network, you can explain to your PCP that you need these services, and request that your PCP provide you with a pre-authorization to continue receiving these services from the specialist. Most likely, you will only be able to continue seeing providers if they are part of your MCOs network, or if your MCO doesn't have the right kind of providers in their network. You can also encourage your former specialist to contract (join) with your MCO and become a provider within that network.*

You are not satisfied with a final decision by your MCO or are not satisfied with the quality of care - ***All HMOs are required to have internal complaint procedures. You can file a formal complaint with your MCO. Having a written record of denials and communication with the MCO will strengthen your case. In Texas, you can file a complaint either orally or in writing, but you will eventually have to fill out a form.***

You are not able to resolve your problem by using the steps described in this handout and need outside help - ***There are a number of organizations and public agencies that can assist you in resolving problems with a managed care organization****. (See the Resources Section for more information.) While you are ultimately responsible for your own care and your own decisions, you do not have to work alone. These organizations and agencies have experience with managed care and some have the ability to intervene on your behalf. You may also have the right to seek independent review of your situation.*

Medically necessary care that is covered by your plan is not available through a network provider - You should ask your network provider to request approval from the MCO to use an out of network provider. The law requires the MCO to consider this. The MCO must get another similar specialist to look at your case before denying your use of an out of network provider.

Steps to Take if You Are Not Satisfied with Your Health Care Services

How you get help with a managed care problem depends on how you receive your managed care health benefits. Request, read and understand the complaint process in your member handbook.

Take action if you are not getting the services you need.

- Ask your primary care provider (PCP) for help.
- **Tell your MCO you are dissatisfied**.
- File a complaint with your state Department of Insurance or request an independent review of your denial from an HMO. *(See Resources Section below for complaint resources.)*

If you receive your health benefits from Medicaid contact the state agency which administers your Medicaid program. The following information may also apply to you. If you are not a Medicaid recipient, read on....

(1) Discuss your concern with your PCP.

(2) Write a letter or call the member services department of your MCO. If your benefits are covered through an employer, contact the employer's benefits manager--the benefits manager can help you navigate the system.

(3) File a complaint with the MCO, following the MCOs formal complaint procedure outlined in the member handbook. All MCOs are required to have a formal complaint procedure and are bound by state law to resolve members' complaints within a specific period of time.

(4) For Commercial MCO's if you are not satisfied with the outcome of the complaint procedure, write or call your state Department of Insurance.

(5) If you are insured through an HMO, state law requires that you have the option of taking complaints regarding medical necessity before an Independent Review Organization (IRO). An IRO will review your case and decide if the care is medically necessary. You do not have to pay to use an IRO and procedures to follow to access the IRO process should be in the member handbook.

Remember to keep detailed records of your conversations and copies of all correspondence, and ask for written responses to your questions.

RESOURCES

The Texas Department of Insurance (TDI) assists Texans with insurance complaints.
http://www.tdi.state.tx.us/consumer/cpportal.html
TDI has a single complaint form for all types of insurance including health insurance. The forms (in English and Spanish) are available at the above website.

Who handles Medicaid, Medicare, TRICARE (formerly known as CHAMPUS), and CHIP complaints?

Medicaid complaints are handled by the Texas Health and Human Services Commission.

Traditional Medicaid complaints can be sent to:

HHSC Claims Administration and Contract Management
Texas Health and Human Services Commission
Mail Code 91-X
P.O. Box 204077
Austin, TX 78720-4077
(512) 506-7020

Medicaid Star or Star-Plus Plans complaints can be sent to:

Resolution Consultant
Health Service Operations
Texas Health and Human Services Commission
Mail Code H-320
1100 West 49 Street
Austin, TX 78756
(512) 491-1876

Medicare complaints are handled by the Centers for Medicaid and Medicare Services. Medicare complaints can be sent to:

Centers for Medicare and Medicaid Services
Dallas Regional Office
1301 Young Street, Room 833
Dallas, TX 75202
(214) 767-4463

TRICARE (military) complaints for the South Region, which includes Texas, are handled by Humana. TRICARE complaints can be sent to:

Regional Grievance Coordinator
Humana Military Healthcare Services
8123 Datapoint Drive
Suite 400
San Antonio, TX 78229

CHIP complaints concerning enrollment or eligibility issues are handled by the Texas Department of Health. These types of CHIP complaints can be sent to:

CHIP Administrative Liaison
Texas Department of Health
Mail Code Y993
1100 W. 49th Street
Austin, TX 78756