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CONSUMER HANDBOOK



Learning to Manage MANAGED CARE

 **Healthcare Matters!**

Your Name: _____

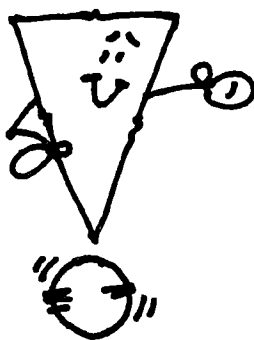
Your Primary Care Physician (PCP): _____

Your PCP's Telephone Number: _____

Name of Your Managed Care Organization (MCO): _____

MCO Member Services Telephone Number: _____

Other Telephone Numbers: _____



Welcome to the world of managed care for people with disabilities! My name is "Tipper" and I am here to give you "tips" to help you understand this new world!

These training materials have been developed to help you understand managed care so that you can get the best possible health and support services.

Information and resources in these training materials are accurate at the time of publication, although some information may change over time.

☆Healthcare Matters!

7800 Shoal Creek Boulevard, Suite 171-E

Austin, Texas 78757

email: healthcarematters@advocacyinc.org

512.454.4816 • 512.453.5734 Fax

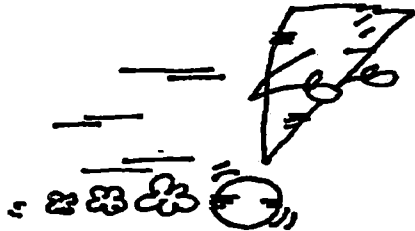
March 1998

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MANAGED CARE 101

WHAT IS MANAGED CARE?



MOVING IN A NEW DIRECTION!

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.

Managed care is a type of health care system that:

- **delivers health care through a network of providers**
- **determines the prices for services**
- **coordinates services**
- **controls how patients use services.**

MCOs use the premiums to pay doctors and hospitals a fixed amount *before* they provide you with any care or services. Because MCOs must pay for your care within that fixed amount, they should have an incentive to make sure you get basic health care for problems before they become serious. As a result, if you get your health care from a managed care plan, the way you arrange for and receive your care is likely to be different than before you joined a PPO or HMO.

BEFORE managed care:

- you were responsible for where and how you got your care;
- you went directly to your doctor or a specialist for various tests or procedures;
- you paid for services out of your own pocket and were paid back by your health insurer;
- you sent in the paperwork to get paid by your insurer; and
- your provider got paid a fee every time they saw a patient/ consumer.

Now, in managed care organizations:

- you pick a primary care provider (PCP) who coordinates your health care;
- you must get a referral from your PCP before getting special tests or procedures or seeing a specialist;
- you are not responsible for paying for care (you may have to pay a small co-payment at each visit);
- you do not have to send in paperwork, (your providers are paid by the MCO); and
- your PCPs and some other providers are paid a "capitation" (see definition) for each patient/consumer.

IS MANAGED CARE AN IMPROVEMENT?

Depending on your situation, and how much control and responsibility you want in your health care, managed care can offer both positive features and possible problems.

POSITIVE FEATURES	POSSIBLE PROBLEMS
• 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.	• 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)
- people who may purchase their own individual insurance.

WHAT ABOUT PEOPLE WITH DISABILITIES AND OTHER SPECIAL HEALTH CARE NEEDS?

For people with disabilities, who often have varying levels of need and multiple health care needs, managed care offers the potential to allow for greater flexibility in services and better coordination of care. However, most managed care organizations have little hands-on experience in serving individuals with disabilities. Many of the systems and providers MCOs use may need to be adapted to ensure that individuals with a disability have equal access to quality health care. Efforts must be made by MCOs to identify and accommodate the needs of people with disabilities and their family members in this new system. Many managed care plans will not pay for or will only pay a small portion of the bill for certain types of services, such as mental health care, physical therapy or long term care.

WHAT'S NEXT?

The current challenge for MCOs is to successfully include individuals with disabilities and special health care needs into a system created for individuals with typical health needs. The challenge to you, as a health care consumer, is to find health care that meets your needs. You already understand your own needs. The next step is to understand how the managed care system works and use it for you and your family members.

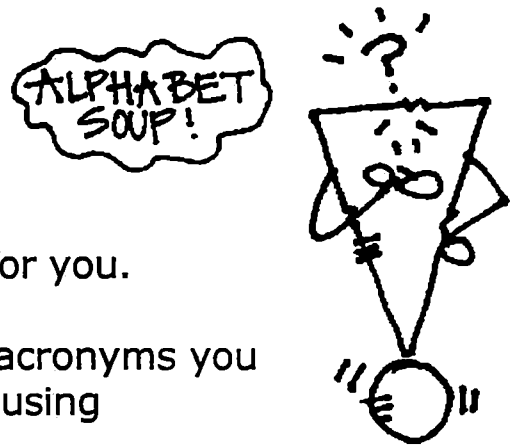


**EVERYONE NEEDS
HELP & SUPPORT
SOMETIME!**

Everybody needs help to understand the new health care system. The best advice is to learn all you can and ask questions.

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.



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

Access. Ability to receive services from a health care system or provider.

Acute Care. Medical services provided after an accident or for a disease, usually for a short time.

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".)

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.

When you are reading this information, just remember that:

MCO = HMO, PPO, BHO, POS

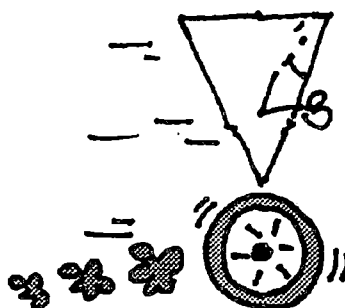
Capitation. Way of pre-paying a health plan, provider, or hospital for health services based on a fixed monthly or yearly amount per person, no matter how few or many services a consumer uses.

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. For example, many HMOs require a \$10 co-pay for each office visit. (If you have Medicaid managed care, you do not have to pay a co-payment.)



**KEEP
GOING...**

DME ~ Durable Medical Equipment. Necessary medical equipment that is not disposable; for example, wheelchairs, walkers, ventilators, commodes.

Dual-Eligibles. People who are eligible for both Medicaid and Medicare.

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.

*KEEP
GOING...*

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.

IPA ~ Individual (or Independent) Practice Association. Association of physicians and other providers, including hospitals, who contract with an HMO to provide services to enrollees, but usually still see non-HMO patients and patients from other HMOs.

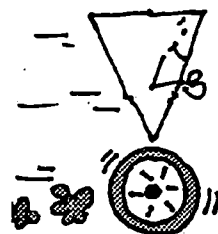
Life Time Maximum. The amount of money after which a health insurer will stop paying for your care. This is especially important if you or someone in your family has an illness that requires expensive treatment.

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.

PCCM ~ Primary Care Case Management. Physicians coordinate a patient's care for a monthly fee, while they continue to be reimbursed on a fee-for-service basis.

*KEEP
GOING...*



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.

Risk. Refers to the change that a health plan or a provider takes when they agree to deliver health services to a group of people for a certain payment rate, even if costs for the services exceed the payments.

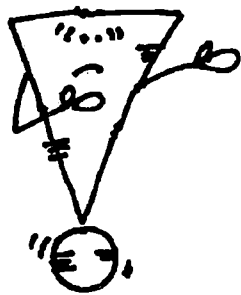
Risk Adjustment. The higher capitation rate paid to providers or health plans for services to a group of enrollees whose medical care is known to be more costly than average.

Risk-Sharing. Occurs when two parties, usually Medicaid and an MCO, agree through a formula to share any losses that result when medical costs exceed payment.

SSI ~ Supplemental Security Income. Monthly cash assistance for people, including children, who have low incomes, and who meet certain age or disability guidelines. In most states, SSI also includes access to Medicaid.

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.

Waivers. The result of a process that allows state Medicaid agencies to apply for and receive permission from HCFA to provide services not otherwise covered by Medicaid and/or to do so in ways not described by the Social Security Act. Most Medicaid managed care programs require waivers. The waivers, which can differ greatly, are known by their numbers (1115, 1119) or as home- and community-based, or as Katie Beckett Waivers.



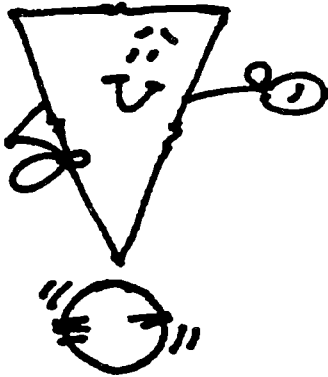
IT'S EASY
TO GET
CONFUSED
WITH A
NEW
LANGUAGE!

The new managed care language can be confusing and difficult. Don't give up. Keep studying the language to understand more about your health care.

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COMMON PROBLEMS AND SOLUTIONS



WHAT DO I
DO NOW?

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.

- ♦ ***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.

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.**

♦ ***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.

- ◆ ***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.



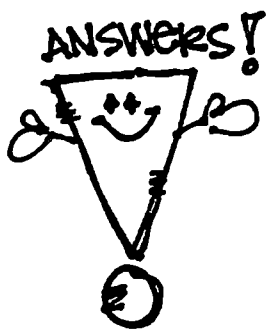
- ◆ ***You are not happy with your Primary Care Provider (PCP)*** - If you are dissatisfied with your PCP because he or she does not understand your needs, remember that providers have different levels of experience in working with individuals with disabilities. You may need to share your own expertise 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. 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. (See the listing of outside agencies included in the "Resources" section of this folder.) You 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.



Every situation in managed care is different. Make sure you get satisfactory answers to best meet your health care needs.

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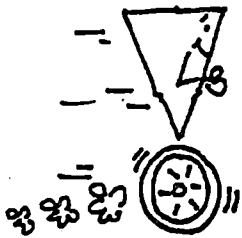


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UNDERSTANDING MEDICAID MANAGED CARE

WHAT IS HAPPENING TO MEDICAID IN TEXAS?



MOVING IN
A NEW DIRECTION!

Medicaid in Texas, like many states, is beginning to move to a managed care delivery system. If you are a Medicaid recipient and not enrolled in a managed care plan now, managed care may be coming to your area in the near future. Many Medicaid recipients are required to use managed care once it comes to their area.

MEDICAID IS CHANGING — MANAGED CARE IS COMING.

Be prepared:

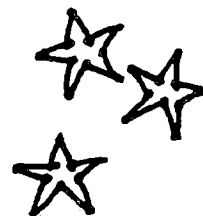
- Look for information from the State Medicaid Office on Medicaid managed care in your mail.
- Read that information carefully.
- **Call the STAR Hotline at 1-800-964-2777, if you have questions about Medicaid managed care.**

If you live in Harris County and are enrolled in STAR or STAR+PLUS, call the **STARLINE** number at **713-767-3919** or **1-800-411-9929**.

- Attend enrollment activities to learn about your choices and responsibilities in managed care.
-

In most communities, people with disabilities are given a choice between managed care and the traditional (fee-for-service) Medicaid, but in Harris County many people with disabilities will be included in managed care through the STAR+PLUS program.

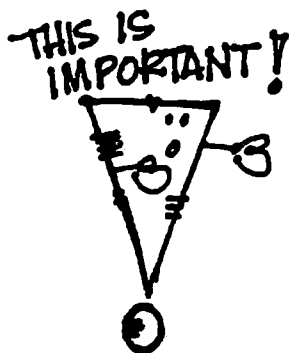
There are two Medicaid managed care programs in Texas: **STAR** (which stands for State of Texas Access Reform) and **STAR+PLUS**.



The STAR program already serves many Medicaid clients in Texas. STAR provides health care services such as visits to a doctor, clinic or hospital, lab work, and x-rays.

FACTS ABOUT STAR

- Connects you with a doctor as your primary care provider (PCP).
- Has been used mostly by mothers and children who qualify for Temporary Assistance for Needy Families (TANF) and other low income pregnant women.
- Is in other parts of the state, including Austin, Fort Worth, Lubbock, San Antonio, Beaumont and Galveston areas and will expand into the Harris County and Dallas areas in the near future.
- Does not have a three prescription limit.
- Includes value-added services beyond traditional Medicaid services.
- Covers annual adult physical examinations (not previously covered in fee-for-service Medicaid).
- Includes behavioral health services for those individuals with mental illness or substance dependency.



The STAR pilot sites, in numerous locations within the state, have minor differences. These differences will be discussed when Healthcare Matters! visits your area.

The STAR+PLUS program is new, and will begin in Harris County. STAR+PLUS is different from STAR because it will also provide members with long-term care services: for example, help in your home with daily activities, home modifications, personal assistance services, respite, attendant care, and more. This means that many people with disabilities, will change from a fee-for-service program to a managed care program for health and long term care services and support.

FACTS ABOUT STAR+PLUS

- Includes additional services available in STAR beyond traditional Medicaid such as:
 - unlimited prescriptions
 - annual physical examinations
 - behavioral health services for individuals with mental illness or substance dependency
 - value added services

- Is a new Medicaid managed care program for Texans living in Harris County who receive Supplemental Security Income (SSI), the federal assistance program for low-income individuals who are elderly or have a disability.
 - Combines medical and long term care services and supports.
 - Currently includes only Medicaid recipients who live in Harris County.
 - Is mandatory for people on SSI who are over 21 and not living in a nursing home.
 - Provides a choice for children on SSI between HMO services or state administered Primary Care Case Management (PCCM) services.
 - Excludes from managed care persons living in ICF-MR facilities or people receiving HCS, HCS-O or CLASS long-term waiver services.
 - Provides a choice for people with mental illness currently receiving services through the Harris County MHMR Center between
 - (1) HMO services for acute and long-term care needs OR
 - (2) state administered Primary Care Case Management (PCCM) services for acute services in conjunction with long-term care services through the Harris County MHMR Center.
-

WILL ALL MEDICAID RECIPIENTS JOIN EITHER STAR OR STAR+PLUS IN THE FUTURE?

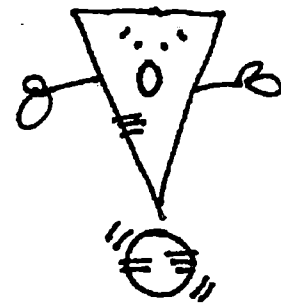
The intent of the STAR pilot studies in the cities and counties in Texas is to determine if Medicaid recipients receive better services without increasing the costs to the state. As results of the pilot studies are reviewed, the state will determine how to make services better and/or to expand the number of managed care pilot sites. At this time, the State Medicaid Office, at the direction of the State Legislature, has plans to expand Medicaid managed care services to other cities and counties.

WHAT IS THE DIFFERENCE BETWEEN TRADITIONAL MEDICAID AND MEDICAID MANAGED CARE?

Traditional Medicaid (Called Fee-For-Service)

- Allows you to use any provider that accepts Medicaid.
- Requires you to locate and coordinate the health services you need.
- Limits adult recipients to three prescriptions a month.
- Limits services to those covered in the State Medicaid Plan.
- Will not pay for annual physical examinations for adults.
- Covers medically necessary services for children.

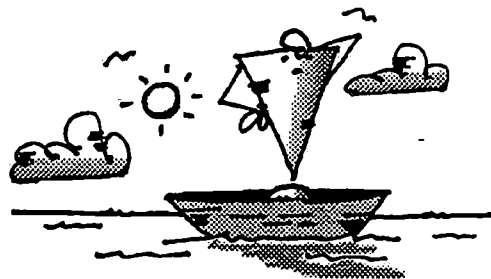
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d^r it was...
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Medicaid Managed Care (STAR)

- Requires you to use providers within the network of the health plan you choose.
- Connects you to your PCP who works with you to identify your health needs and make referrals to specialty services.
- Does not have a three prescription limit for adults.
- Allows HMOs to provide extra "value-added" and preventive services in their plans.
- Covers annual physical examinations for adults.
- Covers medically necessary services for children.

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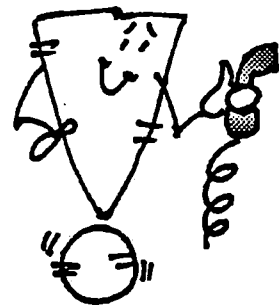
WHAT ADDITIONAL RIGHTS EXIST IN MEDICAID MANAGED CARE?

In addition to the rights that all health care consumers have in managed care, in Medicaid managed care you have additional rights and protections. These include the right to:

- have access to any "value-added service" that the HMO agrees to provide;
- change your primary care provider when you need to;
- change your managed care plan when you need to (as often as every 30 days); and
- have a Medicaid fair hearing if you feel your managed care plan has not settled a complaint to your satisfaction.

WHAT DO I DO IF I HAVE A PROBLEM WITH MY MEDICAID MANAGED CARE PLAN?

- (1) Discuss your problem with your PCP. Explain your needs and what is happening that is not working for you. Your PCP may be able to help you solve your problem.
- (2) If your PCP is not able to solve your problem, contact your managed care organization and ask to speak with a member/customer services representative. You can also contact 1-800-964-2777 (Maximus help-line) for help. If you live in Harris County, call the Texas Department of Human Services **STARLINE** at 713-767-3919 or toll-free at 1-800-411-9929 for assistance or to request a Medicaid fair hearing. Ask what the procedure is for filing a complaint. All HMOs are required to have a process for handling their members' complaints. The HMO must respond within 30 days for non-emergency care or sooner if your complaint is about emergency care.
- (3) If you are not satisfied with your HMO's decision or the state administered PCCM model, you can request a Medicaid fair hearing. Call the Texas Department of Health hotline at 1-800-252-8263 to request a Medicaid fair hearing. To prepare for your fair hearing, you will need to gather medical documentation (such as letters from your doctor or the results of tests) to support your claim.
- (4) You can also use an Independent Review Organization (IRO) to help mediate disputes with your HMO that involve the determination of medical necessity. If your HMO says that the care which you requested does not meet their definition of medical necessity, you will be given an option to use an IRO or to appeal the HMO's decision using the HMO's internal appeal process. The HMO must tell you about this process.



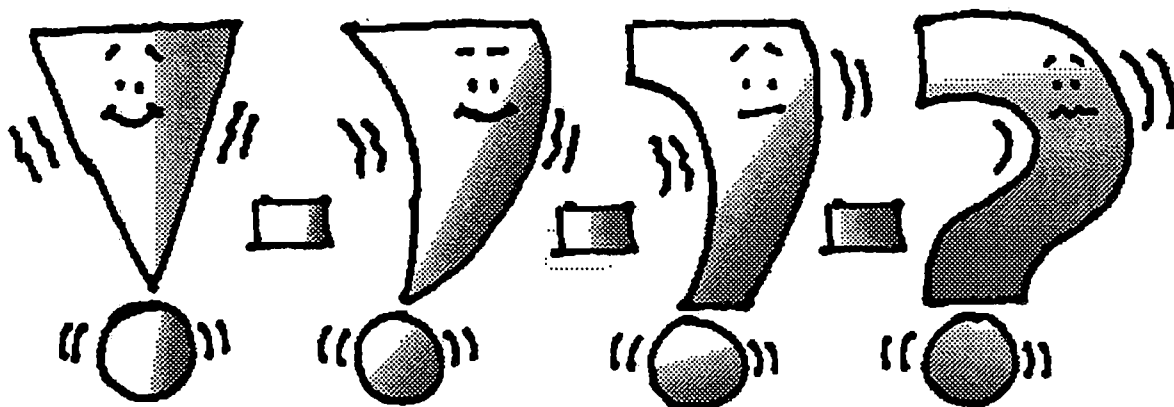
- (5) Contact one of the organizations listed in the "Resources for Additional Help" section of this handbook to help you with your problem.
 - (6) Consult with an attorney on further legal action.
-



There are many agencies and groups willing to help you understand Medicaid managed care. Be persistent and keep asking questions so that your health care needs are addressed.

NOTES:

WHAT QUESTIONS DO I ASK?



Where you get your health care matters to you! Getting answers to important questions can help you to make a decision about whether to enroll in a managed care plan or which plan to choose.

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 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.

MCOs Are Different — ask questions to find out which one is right for you. You need to know:

- what type of plans are available
- what services are available with each plan
- which providers will offer those services
- the process for receiving health care services

Knowing the right questions to ask will help you to find the health care plan that best fits your needs. Please note that the questions listed below are only sample questions. They are not intended to be complete for your personal use. There may be other questions that you need to ask. (You may want to make copies, so that you will have one for each plan available to you.) Every MCO in Texas is required to give you the answer to these questions.

ASK THESE QUESTIONS FOR EACH PLAN AVAILABLE TO YOU

Are the providers I want to use part of the plan's network?

Will the plan pay for the prescription drugs I need?

Will I have to pay a co-payment for visits to my provider? How much?

What preventive services are covered?

What limitations / exclusions exist for specialty services (i.e. is there a limit on the number of outpatient visits or the amount that the MCO will pay for a certain service?)

Is there a dollar limit or "cap" on how much the managed care plan will pay for my care on a yearly basis, or over the course of my lifetime?

Will medical conditions or problems that I am currently being treated for, or have recently been treated for, be covered? If not, how long will I have to wait before they are covered?

How does the plan handle after-hours care or emergencies? Where would I go for care? Who provides it?

If I need care in a hospital, to which hospital will the plan send me?

Does the plan cover home health care services? What services are covered? What are the limits on these services?

Does the plan cover transportation? What services are included?

If I have a problem with the managed care plan, what is the plan's process for handling my complaint?

How do I change my primary care provider (PCP)? Is there a limit to how often I can change my PCP?

ASK THESE QUESTIONS FOR EACH PLAN AVAILABLE TO YOU

Can I use a specialist as my PCP? How do I do this?

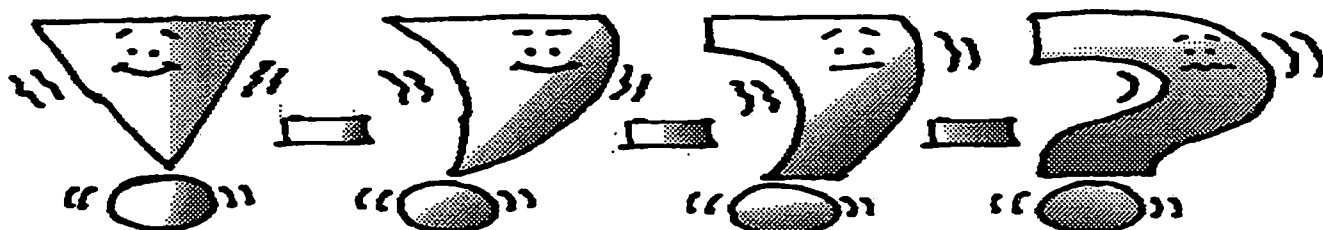
(If you are considering a Preferred Provider Organization....) What percentage of the charges will I be responsible for if I go "out-of-the-network"?

Does the HMO offer a point of service option (POS)? If so, what percentage of the charges will I be responsible for if I use that option? What is the added cost?

Is the material provided by the HMO available in the format I need?

What is the plan's definition of medical necessity?
(Medical Necessity drives most of what the plan will pay for. How a plan defines this term may have a lot to do with the type and amount of care they offer.)

Under what circumstances can I leave (disenroll) from the plan?



ASK THE NETWORK PROVIDERS (DOCTORS) THE FOLLOWING QUESTIONS

Is the provider that I want to choose as my primary care provider accepting new patients?

Can the provider that I currently see continue to care for me under the managed care plan that I am considering?

What are the provider's office hours?

How far in advance must routine visits be scheduled?

**ASK THE NETWORK PROVIDERS (DOCTORS)
THE FOLLOWING QUESTIONS**

Is the office close to a bus stop?

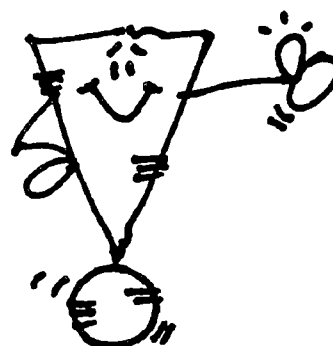
Is the office accessible? Does the office have elevators, ramps, and room for wheelchairs?

Is the office convenient to my home or work?

Are the examining tables and other equipment in the office accessible (adapted for people with disabilities)?

If you have received answers to these questions that are satisfactory to you, you are on the right road to good health care.

If not, ask more questions!



**THIS
WORKED
FOR ME!**

NOTES:

YOUR RIGHTS IN MANAGED CARE

As a health care consumer, you have some basic rights in accessing health services. These rights are yours regardless of your managed care plan or whether you receive your health insurance through the government or an employer. **If you are in Medicaid managed care, there are additional rights to protect you. Please read the section in this handbook called "Understanding Medicaid Managed Care."**

THE LAW
IS ON YOUR
SIDE!



BASIC RIGHTS:

You have the right to:

- make your own decisions about your health care,
- be treated with respect and dignity by your health care providers,
- receive appropriate and relevant information about your medical care,
- keep your health care needs and information private,
- obtain copies of your medical records,
- receive emergency care from the emergency room that is nearest to you, and

YOU HAVE RIGHTS IN MANAGED CARE —

Some of these rights will depend on the type of managed care plan you use. For example, your rights will be different under an HMO than they will be under a PPO.

Whatever type of managed care plan you use, take the time to know and understand your rights.

- be free from discrimination based on actual or perceived disability, race or origin.

ADDITIONAL RIGHTS UNDER FEDERAL AND STATE LAW

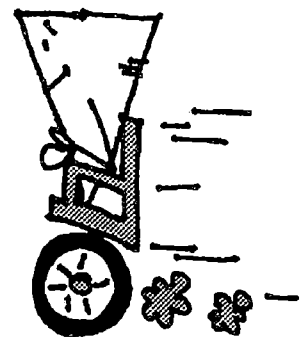
You also have rights that are enforced by federal and state laws governing managed care. Because HMOs and PPOs are subject to different types of regulations, your rights will depend on which type of managed care organization you chose. Your rights may also vary depending on how you get your health insurance. If you are insured through an employer who uses a "self-funded" insurance plan governed by a federal law called ERISA , you may not have all of these rights.

You have the right to:

■ PHYSICAL ACCESS / COMMUNICATION

The federal Americans with Disabilities Act (ADA) requires:

- ✓ that people with disabilities are able to enter and use new buildings, new additions to old buildings, buildings paid with United States government funding, and buildings meant to serve the entire population;
- ✓ that information be available to people with disabilities in Braille and other accessible formats, as needed, including Telecommunication Devices for the Deaf (TDD) in provider offices and use and understanding of Texas Relay (1-800-RelayTX).



Additional resources include the **Texas Commission for the Blind and Visually Impaired**, 4800 North Lamar Boulevard, Austin, Texas 78756 — 512/459-2500 or 1/800-252-5204 and **Texas Commission for the Deaf and Hard of Hearing**, 4800 North Lamar Boulevard, Suite 310, Austin, Texas 78756, 512/451-8494 or 512/407-3251 (TDD).

■ CHOICE OF PRIMARY CARE PROVIDER (PCP)/ MANAGED CARE ORGANIZATION (MCO)

- ✓ Your HMO must allow you to change your PCP. An HMO must allow you to change your PCP at least four times in a 12 month period. Medicaid enrollees can change PCPs as often as needed.
- ✓ HMOs must allow individuals with a disability, or with a chronic or life-threatening condition, to apply to the HMO medical director to use a specialist as their primary care provider.

■ ENROLLMENT IN MANAGED CARE WITHOUT DISCRIMINATION

- ✓ MCOs must accept all eligible applicants during open enrollment periods, and they cannot discriminate based on health status, disability or ethnicity. This is also a federal Medicaid marketing regulation.

■ 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.

HELP + SUPPORT
ARE AVAILABLE
IF YOU NEED
THEM!

■ FREEDOM OF INFORMATION

- ✓ You are entitled to full information from your medical providers. Managed care companies cannot force your provider to withhold medical information from you.

■ LEGAL RECOURSE

- ✓ In Texas, you have the right to sue your HMO for medical malpractice if you believe you were harmed because "medically necessary" services were denied.

The following agencies can help you with legal concerns with your HMO.

Advocacy, Incorporated

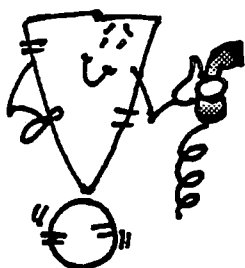
7800 Shoal Creek Boulevard, Suite 171-E
Austin, Texas 78757
512/454-4816 • 1-800-252-9108

Texas Legal Services Center

815 Brazos Street, Suite 1100
Austin, Texas 78701
512/477-6000 (Referral Services)

Texas Lawyers Care

c/o Texas State Bar
1414 Colorado Street, Suite 604
Austin, Texas 78701
1-800-204-2222 x 2155 (Referral Services)

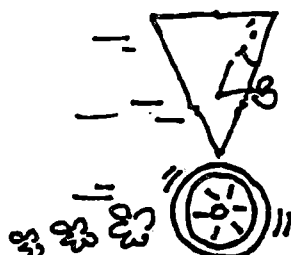


**JUST
CALL!**

**Never be afraid to ask for
help when your health
services are concerned.
Know your rights and know
the answers.**

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STEPS TO TAKE IF YOU ARE NOT SATISFIED WITH YOUR HEALTH CARE SERVICES



*KEEP
GOING...*

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. **If you receive your health benefits from Medicaid, read the section in this handbook called "Understanding Medicaid Managed Care."** 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.

Your health care matters!

Take action if you are not getting the services you need. There are steps you can take to get the health services you deserve:

- Ask your primary care provider (PCP) for help.
- Tell your MCO you are dissatisfied.
- File a complaint with the Texas Department of Insurance or request an independent review of your denial from an HMO.
- Contact advocacy groups for assistance.
- Consult a lawyer, if necessary.

- (4) If you are not satisfied with the outcome of the complaint procedure, write or call the Texas Department of Insurance. There are two divisions that can help you.

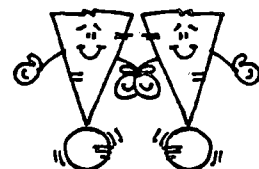
**TEXAS DEPARTMENT OF INSURANCE
Consumer Protection Program
(111-1A)
Post Office Box 149091
Austin, Texas 78714-9091
1/800-252-3439
512/463-6515**

**TEXAS DEPARTMENT OF INSURANCE
HMO Division
Post Office Box 149091
Austin, Texas 78714-9091
512/322-4266 HMO Division
512/305-6745 HMO Complaint**

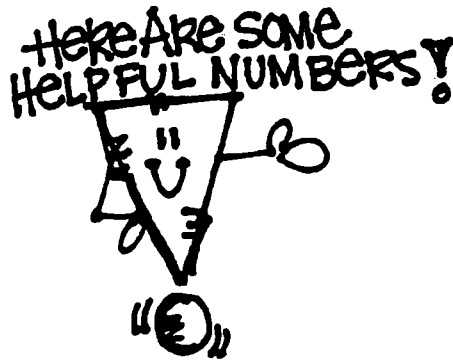
- (5) Contact disability related organizations and consumer advocacy groups with which you are familiar. They often have staff members who are experts on state and national rules/ regulations and can assist you with your problem. (See the "Resources" section.)
- (6) If you are insured through an HMO, 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.
- (7) You always have the option of consulting with a lawyer. If finances are an obstacle, contact your local Legal Aid office or Advocacy, Incorporated, a statewide disability rights organization at 512/454-4816 or 1-800/252-9108.

★ **REMEMBER TO KEEP DETAILED RECORDS OF YOUR CONVERSATIONS AND COPIES OF ALL CORRESPONDENCE, AND ASK FOR WRITTEN RESPONSES TO YOUR QUESTIONS.**

Don't feel like you are all alone in dealing with your health needs. All of us need help when we have problems or concerns.



RESOURCES FOR ADDITIONAL HELP



As consumers, you may encounter difficulties or problems in adjusting to the new managed care delivery system. You may also encounter problems that require assistance from others who know the system better, know specific information about disabilities or specific types of services you need.

The following organizations and agencies are resources to you in the area of information and referral. Call them for information and/or assistance to start learning more about the new managed care world, disabilities and services utilized by persons with disabilities.

STATEWIDE ENROLLMENT BROKER FOR MEDICAID MANAGED CARE (STAR AND STAR+PLUS PROGRAMS):

MAXIMUS
1212 East Anderson Lane, Suite 200
Austin, Texas 78752
512/491-5450
Toll-free Help-Line: 1/800-964-2777

STATE AGENCIES INVOLVED IN MEDICAID MANAGED CARE:

The following state agencies can connect you with their regional/local offices in your area of the state.

TEXAS INTERAGENCY COUNCIL ON EARLY CHILDHOOD INTERVENTION
4900 North Lamar Boulevard, Austin, Texas 78751
512/424-6759 Medicaid Division

TEXAS DEPARTMENT OF HEALTH

1100 West 49th Street, Austin, Texas 78756
512/794-6862 Bureau of Managed Care

TEXAS DEPARTMENT OF HUMAN SERVICES

701 West 51st Street, Austin, Texas 78751
512/438-3224 Managed Care Division

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

909 West 45th Street, Austin, Texas 78751
512/206-4537 Long Term Care Services
512/206-4549 Behavioral Health Services

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

- STATE MEDICAID OFFICE

4900 North Lamar Boulevard, Austin, Texas 78751
512/424-6517 Managed Care Unit

The following agencies can help you with all managed care complaints, including Medicaid managed care.

OFFICE OF THE TEXAS ATTORNEY GENERAL

Post Office Box 12548, Austin, Texas 78711
512/463-2185 Consumer Division

TEXAS DEPARTMENT OF INSURANCE

- HMO OR CONSUMER COMPLAINT DIVISION

Post Office Box 149091, Austin, Texas 78714
512/322-4266 HMO Division
512/305-6745 HMO Complaint

512/463-6500 Consumer Division
800/252-3439 Consumer Complaint

DISABILITY CONSUMER ORGANIZATIONS:

These organizations have affiliate offices / chapters or contacts in many areas of the state. Call them to locate the chapters / offices near you.

ADAPT/Institute for Disability Access

1319 Lamar Square Drive, Suite 101, Austin, Texas 78704
512/442-0252

Advocacy, Incorporated

7800 Shoal Creek Boulevard, Suite 171-E, Austin, Texas 78757
512/454-4816 or 1/800-252-9108

Any Baby Can

3423 Guadalupe Street, Suite 300, Austin, Texas 78705
512/454-3743 (Austin Office)
210/737-9119 (San Antonio Office)

The Arc of Texas

(formerly Association of Retarded Citizens)
1600 West 38th Street, Suite 200, Austin, Texas 78731
512/454-6694 or 1/800-252-9729

Brain Injury Association of Texas

1704 Parkside Lane, Austin, Texas 78745
512/445-2194 or 1/800-927-9199

Coalition of Texans with Disabilities

316 West 12th Street, Suite 405, Austin, Texas 78701
512/478-3366 or 1/800-998-3363

Directors Association of Texas Centers for Independent Living

5555 North Lamar Boulevard, Suite J-125, Austin, Texas 78751
512/467-0744

Epilepsy Coalition of Texas

2650 Fountain View, Suite 316, Houston, Texas 77057
713/789-6295

Mental Health Association in Texas

8401 Shoal Creek Boulevard, Austin, Texas 78757
512/454-3706

Texas Alliance for the Mentally Ill

1000 East 7th Street, Suite 208, Austin, Texas 78702
512/474-2225

Texas Mental Health Consumers

7701 North Lamar Boulevard, Suite 501, Austin, Texas 78752
512/451-3191 or 1/800-860-6057

Texas Planning Council for Developmental Disabilities

4900 North Lamar Boulevard, Austin, Texas 78751-2399
512/424-4080

Texas Respite Resource Network

519 West Houston Street, San Antonio, Texas 78207
210/704-2794

**Texas University Affiliated Program's
Assistive Technology Partnership**

University of Texas at Austin, University Affiliated Program
SZB 252-D5100, Austin, Texas 78712
512/471-7621 or 1-800-828-7839

United Cerebral Palsy of Texas

900 Congress Avenue, Suite 220, Austin, Texas 78701
512/472-8696

**CONSUMER ORGANIZATIONS WORKING ON
MANAGED CARE ISSUES:**

Center for Public Policy Priorities

900 Lydia Street, Austin, Texas 78702
512/320-0222

Consumers Union

1300 Guadalupe, Suite 100, Austin, Texas 78701
512/477-4431

LEGAL ORGANIZATIONS:

Advocacy, Incorporated

7800 Shoal Creek Boulevard, Suite 171-E, Austin, Texas 78757
512/454-4816 or 1/800-252-9108

Texas Lawyers Care

c/o Texas State Bar
1414 Colorado Street, Suite 604, Austin, Texas 78701
1/800-204-2222 x 2155 (Referral Services)

Texas Legal Services Center

815 Brazos Street, Suite 1100, Austin, Texas 78701
512/477-6000 (Referral Services)

Other Helpful Telephone Numbers:

STAR Hotline **1/800-964-2777**

STARLINE (Harris County) **1/800-411-9929**
713/767-3919

Texas Relay **1/800-RELAYTX**
