Understanding Managed Care

Managed care plans are health insurance plans that contract with health care providers and medical facilities to provide care for members at lower costs. These providers are the plan's network. The network's rules decide how much of your care the plan will pay for. Managed care is a way of providing health care that focuses on wellness and preventive care and seeks to reduce costs by coordinating care through a primary care physician, such as a family physician, who serves as a "gatekeeper." Many Medicaid beneficiaries in New York must join a Medicaid managed care plan (Regulations at 18 NYCRR 360-10). Medicaid Managed Care initially mandated enrollment for non-disabled Medicaid recipients, but gradually more disabled and chronically ill populations have been mandated to enroll in MMC.

In regular or fee-for-service Medicaid, beneficiaries would go to any doctor who accepts Medicaid. In managed care, the plan is paid a capitated rate (flat monthly fee) to provide for almost all of the beneficiary's health care needs. In Medicaid managed care, enrollees can only see doctors and health providers that are in their plan's network. Enrollees will be assigned a primary care provider and must go to this provider in order to get a referral for specialty care and prior authorizations for non-emergency hospitalizations and many other services.

To read an article that explains the MRT process, the specific changes and the timeline for their implementation, click here or see the attachment.
Beneficiaries must keep their regular Medicaid card. They will need their card to receive important benefits that are not covered by their Medicaid managed care plan. These are called "carved out" services because they are "carved out" of the Medicaid managed care benefit package and still paid for by fee-for-service Medicaid. Currently, carved out services include Mental Health Services for SSI recipients and SSI related beneficiaries, COBRA Case Management, HIV Adult Day Health Care, Medicaid Service Coordination and other Long-Term Care Services for people with Developmental Disabilities, and Non-Emergency Medical Transportation Services.

Are there different types of managed care plans?

Yes, restrictive plans usually cost less and flexible plans usually cost more. There are three types of managed care plans:

1. Health Maintenance Organizations (HMO) usually only pay for care within the network. HMOs set monthly fees and require members to use specific physicians. Members must choose a primary care physician to coordinate care and refer them to specialists.
2. Preferred Provider Organizations (PPO) usually pay more if you receive care within the network. PPOs still pay a portion if you go outside the network. PPOs make arrangements with physicians, hospitals, and other

care providers to accept lower fees for their services. Plan members can refer themselves to other physicians, including those outside the plan, but members will pay more of the bill.

3. Point of Service (POS) plans allow you to choose between an HMO and a PPO each time you need care. Some HMOs offer indemnity-type options referred to as POS plans whereby primary care physicians make referrals to other providers in the plan. Members can refer themselves outside the plan and still receive some coverage. If a physician refers a member out of network, the plan will pay all or most of the bill. If a member refers to an out-of-network provider, and the service is covered, he will pay the co-insurance.

The difference between exempt and excluded:

If you currently receive Medicaid you may have to join a Medicaid managed care plan unless you are exempt or excluded from Medicaid managed care. If you are "exempt" it means you do not have to enroll unless you want to. If you are "excluded" it means you cannot enroll in a plan.

Exemptions include:

- Native Americans
- People in long-term alcohol or drug residential programs
- People who live in facilities for the developmentally disabled
- People with regular Medicaid and being treated for a chronic medical condition for 6 months or longer, and they are seeing a regular Medicaid specialist who is not in a Medicaid health plan. This exemption is limited to a 6 month period and for one time only.
- People in waivered programs such as Care At Home and Traumatic Brain Injury (TBI)
- Foster care children living in New York City

Exclusions include:

- Children or adults who live in state psychiatric or residential treatment facilities
- People in nursing homes or hospice programs at the time of enrollment
- People who will get Medicaid only after they spend some of their own money for medical needs (spend-down cases)
- People with other full benefit health insurance (including Medicare)
- Infants living with their mothers in jail or prison
- Foster care children in New York City
- All foster care children living in an institutional setting outside of New York City
- Children who are blind or disabled and living apart from their parents for 30 days or more
- People eligible for TB services only
- People eligible for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer (MCTP)

Please note that some populations that were once considered exempt must now enroll in a managed care plan. Visit http://www.nymedicaidchoice.com/ask/who-does-not-have-join-health-plan for more information on managed care exemptions and exclusions.

How to be exempt from Medicaid Managed Care:

To get excused you must ask Medicaid CHOICE for an exemption form. You may contact their Helpline at **1-800-505-5678 (TTY: 1-888-329-1541)** and request to speak with an Exemptions Unit Counselor. If you complete and file the exemption or exclusion request within the 60 day time frame your request will temporarily stop the automatic assignment into a Managed Care Plan until a decision is made on your exemption request. If your request to be exempt or excluded is denied you can appeal the denial by asking the Department of Social Services for a fair hearing. You have 60 days from the date of the denial notice to request a fair hearing. The denial notice will include information about how to make the fair hearing request. If you request the fair hearing within 10 days of the date of the notice you will remain in fee-for-service Medicaid rather than being automatically assigned to an HMO until the case is decided. If you do not request the fair hearing within 10 days you will be automatically assigned to an HMO. You will remain in that HMO unless you win the fair hearing and are found to be exempt.

The Enrollment Process:

New York Medicaid Choice, also known as MAXIMUS, sends mailers to Medicaid recipients including a Mandatory Enrollment Package, a letter with the date a recipient will be automatically enrolled in a managed care plan if he/she does not choose one (referred to as auto-assignment), a brochure describing the managed care program, enrollment forms, and a list of health plans following receipt of the initial enrollment package. Enrollees who do not choose a plan will receive a confirmation notice stating the name of a plan for auto-assignment and their effective date of coverage. Contact New York Medicaid Choice MAXIMUS, with questions about managed care and to enroll in a plan. This is the company hired by New York State to handle managed care enrollment. 1-800-505-5678 (TTY: 1-888-329-1541) or www.nymedicaidchoice.com.

Making changes to your managed care plan:

You may change your managed care plan within the first 90 days of your initial enrollment. After that you must wait one full year before changing plans. Call New York Medicaid Choice to change plans. Counselors will assist you in selecting a plan.

Please visit the following webpages for further information on managed care: http://www.wnylc.com/health/entry/160/

*** Please note that the information in this document is subject to change. Please refer to the websites listed above for updates.