What is Managed Care?

Managed care is a complex system that involves the active coordination of, and the arrangement for, the provision of health services and coverage of health benefits.

The most common types of Managed Care Organizations (MCOs) include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs.)

Managed care usually involves three key components: oversight of the medical care given; contractual relationships and organization of the providers giving care; and the covered benefits tied to managed care rules.

In contrast, what is traditional health care?

Traditional health care is most identified with freedom of choice for patients and physicians. Patients can choose whatever physician they want to see, physicians can choose to order whatever services they feel are necessary.

Health Plans are mostly passive third parties, paying for all the services a physician orders, at the provider's usual charges.

A Health Plan’s costs and premiums are based on prior experience and covered benefits of the population insured. There is no way to fix medical costs or know exactly what they’ll be in the future.

After medical services are rendered by providers, the health plan is billed, and patients must pay the difference between provider’s charges and what their health plan pays.

Managed Care Glossary

Access
The extent to which an individual who needs care and services is able to receive them. Access is more than having insurance coverage or the ability to pay for services. It is also determined by the availability of services, acceptability of services, cultural appropriateness, location, hours of operation, transportation needs, and cost.

Accreditation
An official decision made by a recognized organization that a health care plan, network, or other delivery system complies with applicable standards.

Administrative Costs
Costs not linked directly to the provision of medical care. Includes marketing, claims processing, billing, and medical record keeping, among others.

Appropriateness
The extent to which a particular procedure, treatment, test, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to a patient’s or member’s needs. (See also, medically necessary)

Auto-enrollment
The automatic assignment of a person to a health insurance plan (typically done under Medicaid plans).

Behavioral Healthcare
Continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.
Behavioral Healthcare Firm
Specialized (for-profit) managed care organizations focusing on mental health and substance abuse benefits, which they term "behavioral healthcare." These firms offer employers and public agencies a managed mental health and substance abuse benefit.

Beneficiary
A person certified as eligible for health care services. A beneficiary may be a dependent or a subscriber.

Benefit Package
Services covered by a health insurance plan and the financial terms of such coverage. These include cost, limitation on the amounts of services, and annual or lifetime spending limits.

Capitation
A fixed amount of money paid per person for covered services for a specific time; usually expressed in units of per member per month (pmpm).

Carve-in
A generic term that refers to any of a continuum of joint efforts between clinicians and service providers; also used specifically to refer to health care delivery and financing arrangements in which all covered benefits (e.g., behavioral and general health care) are administered and funded by an integrated system.

Carve-out
A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g., behavioral health care) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting or sub-contracting for services to the special population.

Case Management
A system requiring that a single individual in the provider organization is responsible for arranging and approving all devices needed under the contract embraced by employers, mental health authorities, and insurance companies to ensure that individuals receive appropriate, reasonable health care services.

Claim
A request by an individual (or his or her provider) to that individual's insurance company to pay for services obtained from a health care professional.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily (Department of Labor, 2002).

Consumer
Any individual who does or could receive health care or services. Includes other more specialized terms, such as beneficiary, client, customer, eligible member, recipient, or patient.

Cost-sharing
A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, coinsurance, and co-payment are types of cost sharing.

Deductible
The amount an individual must pay for health care expenses before insurance (or a self-insured company) begins to pay its contract share. Often insurance plans are based on yearly deductible amounts.

Drug Formulary
The list of prescription drugs for which a particular employer or State Medicaid program will pay. Formularies are either "closed," including only certain drugs or "open," including all drugs. Both types of formularies typically impose a cost scale requiring consumers to pay more for certain brands or types of drugs.

Emergency Medical Treatment and Labor Act (EMTALA), also referred to as the Federal Anti-patient Dumping Law
An act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay (EMTALA, 2002).

Enrollee
A person eligible for services from a managed care plan.

Enrollment
The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

Fee for Service
A type of health care plan under which health care providers are paid for individual medical services rendered.

Gatekeeper
Primary care physician or local agency responsible for coordinating and managing the health care needs of members. Generally, in order for specialty services such as mental health and hospital care to be covered, the gatekeeper must first approve the referral.

Group-model Health Maintenance Organization (HMO)
A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

Health Insurance Portability and Accountability Act (HIPAA)
This 1996 act provides protections for consumers in group health insurance plans. HIPAA prevents health plans from...
excluding health coverage of pre-existing conditions and discriminating on the basis of health status (Department of Labor, 2002).

**Health Maintenance Organization (HMO)**
A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.

**Horizontal Consolidation**
When local health plans (or local hospitals) merge. This practice was popular in the late 1990s and was used to expand regional business presence (Academy for Health Services Research and Policy, 2001).

**Indemnity Plan**
Indemnity insurance plans are an alternative to managed care plans. These plans charge consumers a set amount for coverage and reimburse (fully or partially) consumers for most medical services (InsuranceFinder, 2001).

**Intensive Case Management**
Intensive community services for individuals with severe and persistent mental illness that are designed to improve planning for their service needs. Services include outreach, evaluation, and support.

**Length of Stay**
The duration of an episode of care for a covered person. The number of days an individual stays in a hospital or inpatient facility.

**Local Mental Health Authority**
Local organizational entity (usually with some statutory authority) that centrally maintains administrative, clinical, and fiscal authority for a geographically specific and organized system of health care.

**Managed Care**
An organized system for delivering comprehensive mental health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment. Generally, managed care controls health care costs and discourages unnecessary hospitalization and overuse of specialists, and the health plan operates under contract to a payer.

**Medical Group Practice**
A number of physicians working in a systematic association with the joint use of equipment and technical personnel and with centralized administration and financial organization.

**Medical Review Criteria**
Screening criteria used by third-party payers and review organizations as the underlying basis for reviewing the quality and appropriateness of care provided to selected cases.

**Medically Necessary**
Health insurers often specify that, in order to be covered, a treatment or drug must be medically necessary for the consumer. Anything that falls outside of the realm of medical necessity is usually not covered. The plan will use prior authorization and utilization management procedures to determine whether or not the term "medically necessary" is applicable (Bazelon Center for Mental Health Law, 1997).

**Medicaid**
Medicaid is a health insurance assistance program funded by Federal, State, and local monies. It is run by State guidelines and assists low-income persons by paying for most medical expenses (Centers for Medicare and Medicaid Services, 2002).

**Medicare**
Medicare is a Federal insurance program serving the disabled and persons over the age of 65. Most costs are paid via trust funds that beneficiaries have paid into throughout the courses of their lives; small deductibles and some co-payments are required (Centers for Medicare and Medicaid Services, 2002).

**MediGap**
MediGap plans are supplements to Medicare insurance. MediGap plans vary from State to State; standardized MediGap plans also may be known as Medicare Select plans (Centers for Medicare and Medicaid Services, 2002).

**Member**
Used synonymously with the terms enrollee and insured. A member is any individual or dependent who is enrolled in and covered by a managed health care plan.

**Mental Health Parity (Act)**
Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments. The Mental Health Parity Act was passed in 1996 and established parity in lifetime benefit limits and annual limits (Department of Labor, 2002).

**Network**
The system of participating providers and institutions in a managed care plan.

**Network Adequacy**
Many States have laws defining network adequacy, the number and distribution of health care providers required to operate a health plan. Also known as provider adequacy of a network.

**Outcomes**
The results of a specific health care service or benefit package.

**Payer**
The public or private organization that is responsible for payment for health care expenses.

**Pharmacy Benefit Manager (PBM)**
PBMs are third party administrators of prescription drug benefits.

**Point-Of-Service Plan (POS)**
A modified managed care plan under which members do not have to choose how to receive services until they need them. Members receive coverage at a reduced level if they choose to use a non-network provider.
Pre-existing Condition
A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the insurance company. Many insurance companies now impose waiting periods for coverage of pre-existing conditions. Insurers will cover the condition after the waiting period (of no more than 12 months) has expired. (See also, HIPAA)

Preferred Provider Organization (PPO)
A health plan in which consumers may use any health care provider on a fee-for-service basis. Consumers will be charged more for visiting providers outside of the PPO network than for visiting providers in the network (American Association of Preferred Provider Organizations).

Primary Care Physician (PCP)
Physicians with the following specialties: group practice, family practice, internal medicine, obstetrics/gynecology, and pediatrics. The PCP is usually responsible for monitoring an individual's overall medical care and referring the individual to more specialized physicians for additional care.

Risk Adjustment
The adjustment of premiums to compensate health plans for the risks associated with individuals who are more likely to require costly treatment. Risk adjustment takes into account the health status and risk profile of patients.

Section 1115 Waiver
A statutory provision that allows a State to operate its system of care for Medicaid enrollees in a manner different from that prescribed by the Centers for Medicare and Medicaid Services (CMS), in an attempt to demonstrate the efficacy and cost-effectiveness of an alternative delivery system through research and evaluation.

Section 1915(b) Waiver
A statutory provision that allows a State to partially limit the choice of providers for Medicaid enrollees; for example, under the waiver, a State can limit the number of times per year that enrollees can choose to drop out of an HMO.

State Children’s Health Insurance Plan (SCHIP)
Under Title XXI of the Balanced Budget Act of 1997, the availability of health insurance for children with no insurance or for children from low-income families was expanded by the creation of SCHIP. SCHIPs operate as part of a State's Medicaid program (Centers for Medicare and Medicaid Services, 2002).

State Mental Health Authority or Agency
State government agency charged with administering and funding its State’s public mental health services.

Subcapitation
An arrangement whereby a capitated health plan pays its contracted providers on a capitated basis.

Third Party Payer
A public or private organization that is responsible for the health care expenses of another entity.

Underwriting
The review of prospective or renewing cases to determine their risk and their potential costs.

Utilization
The level of use of a particular service over time.

Utilization Management (UM)
A system of procedures designed to ensure that the services provided to a specific client at a given time are cost-effective, appropriate, and least restrictive.

Utilization Review
Retrospective analysis of the patterns of service usage in order to determine means for optimizing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

Utilization Risk
The risk that actual service utilization might differ from utilization projections.

Vertical Disintegration
A practice of selling off health plan subsidiaries or provider activities. Vertical disintegration was a trend in the late 1990s (Academy for Health Services Research and Health Policy, 2001).

Glossary Bibliography
Blueprints for Managed Care, Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS) (1995).


Continuation of Health Care Coverage - COBRA, Department of Labor (2002).


The Costs and Effects of Parity for Mental Health and Substance Abuse Benefits, SAMHSA/Center for Substance Abuse Treatment (CSAT) (1998).


Managed Mental Health Care for Publicly Financed Mental Health Services, Bazelon Center for Mental Health Law (1995).


Mental Health Benefits (Mental Health Parity Act), Department of Labor (2002).

Partners in Planning Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services, Bazelon Center for Mental Health Law and the Legal Action Center (1998).


A Primer for Families and Consumers, National Alliance for the Mentally Ill (1995).


The Cornerstone of HMO Care

A man walks into a Doctor's office. He has a cucumber up his nose, a carrot in his left ear and a banana in his right ear.

"What's the matter with me?" he asks.

"You're not eating properly," replies the Doctor.
Managed Care Web Sites

The following list of Web sites does not imply endorsement by CMHS or the U.S. Department of Health and Human Services of the external Web site's content or the views and opinions of the external Web site's sponsoring organization.

AHRQ. Established in December 1989 (Public Law 101-239) is the Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research, AHCPR) is the lead agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. (www.ahrq.gov)

Association for Behavioral Health and Wellness (ABHW, formerly the American Managed Behavioral Healthcare Association, AMBHA) was founded in 1994 to enable the leading organizations in the behavioral healthcare industry to work together on key issues of public accountability, quality, public policy, and communication. (www.abhw.org)

Center for Health Care Strategies, Inc. Established in 1995 as a non-profit, non-partisan policy and resource center affiliated with Princeton University. The Center serves as the National Program Office for two national initiatives of the Robert Wood Johnson Foundation: Medicaid and Managed Care Program and Building Health Systems for People with Chronic Illnesses. (www.chcs.org)

Centers for Medicare and Medicaid Services (CMS). The federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs. (www.cms.hhs.gov)

Netsmart. A combination of its former Creative-Socio Medics subsidiary and several acquisitions, including CMHC Systems, Continued Learning, Addiction Management Systems, QS Technologies and Therapist Helper. It is a leading provider of comprehensive information systems, including UNIX-based management information systems (MIS) and hardware configurations, serving the mental health and addiction treatment community for over 18 years. (www.ntst.com)

Compare Medicare Plans at www.medicare.gov and get easy access to information about Medicare managed care plans, including costs, premiums, and types of services provided.

Substance Abuse Mental Health Services Administration (SAMHSA). Their mission is to assure that quality substance abuse and mental health services are available to the people who need them and to ensure that prevention and treatment knowledge is used more effectively in the general health care system. (www.samhsa.gov)

Partners in Planning

In 1998 NAMA was a stakeholder for “Partners in Planning” about managed care and mental health and addiction treatment services. The book is free and available from the Clearinghouse for Alcohol and Drug Abuse Information (ncadi.samhsa.gov) or the Bazelon Center for Mental Health Law (www.bazelon.org). The book “Partners in Planning: Consumers’ Role in Contracting for Public-Sector Managed Mental Health and Addiction Services” is free and contains excellent information. However some of the material may be dated because of the fast changes that are occurring in public-funded managed care for behavioral health. Consumers and families are guided through the process of identifying and advocating for the best possible managed care contracting practices. Chapters explore the contracting process, the contract content and services, consumer rights, and quality assurance.

Series: SAMHSA Managed Care Technical Assistance Series Volume 10.
Date: 8/25/1998
Your Price: $0
NCADI No: BKD293
Education Series  
Cost per each $2


Number 6. (Not available).

Number 7. Managed Care (August, 2003 Revised).


NAMA Manuals  
Cost per each $10

Number 1. Starting a Methadone Advocacy Group (NAMA Chapter or Affiliate). The basics of starting a methadone advocacy group including history of methadone advocacy, forming a Board of Directors, meeting planning, first projects, politics of methadone, listing of state agencies and other resources.

Number 2. Setting Up a 12 Step Group. A manual to help patients and professionals start a 12 step group. Includes organizing the group, meeting planning, the basics of starting a 12 step group, a generic version of 12 steps and other resources.

The price of the Education Series and Manuals are to cover the cost of duplicating and mailing.

NAMA is a not-for-profit organization.

For membership please complete & mail the coupon below with your dues.

**Coupon**

Name: ____________________________

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Membership

Membership in NAMA is $25 a year for Individual and $40 for International Membership. Additional family members may join at the cost of $10 each a year. Institutional Membership is $110 a year for U.S. and International. If you cannot afford membership dues, or can only afford a part of it, NAMA will still accept your membership request.

National Alliance of Methadone Advocates

435 Second Avenue, New York, NY 10010