Glossary of managed health care terms

- **Appeal:** A formal request by a member or provider for reconsideration of a determination issued as part of a filed grievance or a Utilization Review recommendation.
- **Drug Formulary:** A listing of prescription medication preferred by the health plan.
- **Medical Necessity:** An evaluation of health services to determine if they are medically appropriate and necessary.
- **Participating Provider:** Health care provider who has contracted with a health plan to deliver medical services to members.
- **Health Maintenance Organization (HMO):** A type of managed care organization providing a range of coverage in a group setting for a flat monthly rate.
- **Preferred Provider Organization (PPO):** A health plan that contracts with medical care providers for a discounted fee.
- **Point-of-Service (POS):** Known as open-ended HMOs or PPOs, these plans encourage using network providers, but allow members to choose providers outside the plan.
- **Prior Authorization:** Obtaining prior approval as to the appropriateness of a certain service or medication.
- **Quality Assurance:** A formal set of activities to review and positively affect the quality of services provided by a plan.
- **Utilization Review (UR):** A formal assessment of the medical necessity, efficiency and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

Your Managed Health Care Rights

Protections for New Yorkers in managed care programs

www.assembly.state.ny.us

Dear Friend,

Millions of New Yorkers are currently enrolled in managed care health programs.

To ensure cost-effective managed care programs don't hurt the quality of care, the state Legislature passed the Consumer Managed Care Reform Act, providing managed care members in New York State with more protections than anywhere else in the nation.

Managed care consumers also have an important protection — the External Appeal Law. This law guarantees consumers the opportunity to a review by an independent panel of medical experts if they are denied services or treatments by their providers.

As always, if you have any questions or comments on this or any other matter, please feel free to contact my office.

Sincerely,

John T. McDonald III
Member of Assembly

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Important phone numbers

Department of Health

Managed Care Hotline
800-206-8125
For additional information:
www.health.ny.gov

Department of Financial Services

Consumer Hotline
800-342-3736

External Appeal Information Line
800-400-8882

Albany County Dept. of Social Services
518-447-7300

Rensselaer County Dept. of Social Services
518-270-8638

Saratoga County Dept. of Social Services
518-884-4140

Updated 4/13

Protections under the Managed Care Reform Act

Managed care insurance plans

Residents of New York State have been joining managed care plans with increasing frequency. Statewide, enrollment in these plans totals over six million members.

The Managed Care Reform Act provides consumers with the most far-reaching protections in the nation. The following are explanations of some of these protections available to consumers in New York State. Greater details are provided in each member's contract and handbook.

Sources: NY Health Plan Association, NYS Health Insurance Program

Disclosure requirements

Every health plan must provide written disclosure to subscribers in their contracts or handbooks and (upon request) to potential subscribers, including the following:

- Plan benefits and coverage
- Definition of "medical necessity"
- Prior authorization requirements
- Methods used for provider reimbursement
- Member financial responsibilities
- Grievance procedures and appeals
- Members' ability to access a provider outside a particular managed plan network
- Procedures to select and change primary care and specialty care physician
- Participating providers and facilities in network, listed by specialty
- Coverage for emergency services

Upon request, a plan must:

- Provide consumer complaint information
- List procedures for protection of confidential information
- Allow members to inspect their health plan's prescription drug formulary
- Describe procedures used to evaluate requests for experimental procedures
- Provide physicians' hospital affiliations
- Provide specific written treatment protocols for a particular disease or condition

Grievance procedures: Non-medical/ Contractual

Every plan must have a grievance and appeals procedure to handle non-medical issues. This includes complaints related to billing problems, coverage issues and issues regarding dissatisfaction with providers or quality of care provided. Every plan's grievance procedure must include:

- Multilingual, accessible toll-free phone line
- Standard form for filing grievances and appeals
- Written description of appropriate appeal procedures if coverage is denied
- Time frame for responding to members after receiving all necessary information:
  - 48 hours when delay would significantly increase the risk to an enrollee's health
  - 30 days in cases regarding referrals or determinations regarding coverage
  - 45 days in all other instances
- Designation of qualified reviewers, including at least one medical professional for each grievance and the right to have a representative in the grievance process

Appeal of grievance determination:

- Members have at least 60 business days to appeal a grievance decision
- Clinical determinations must be made by qualified personnel not involved in original decision
- Non-clinical matters require qualified personnel at a higher level than those who made the initial determination
- Formal notice of an appeal determination detailing reasons for the determination and the clinical rationale

Utilization Review standards: A medical necessity

Utilization Review (UR) is done by the health plan to assess the medical necessity or appropriateness of health care treatments. These reviews can be done before, during or after treatment. All plans performing UR must:

- Allow members or their physicians to appeal adverse decisions
- Provide toll-free access to reviewers
- Establish UR time frames for member notification and appeals
- Have duly licensed and trained personnel conducting UR
- Provide notice of adverse determination in writing, including reasons and how to appeal
- Have a minimum of 45 days to file an appeal
- Provide standard appeal decisions within 60 days

New York's External Appeal Law

Health care consumers are entitled to an independent external review if services are denied for certain reasons. Every health plan must provide an external review application whenever they issue such denials. Consumers can also request copies of external review applications from their health plans, or call the New York State Department of Financial Services' External Appeal Information Line at 800-400-8882. Visit www.dfs.ny.gov or email externalappealquestions@dfs.ny.gov for additional information.