PTO Form 1957 (Rev 9/2005)
OMB No. 0651-0050 (Exp. 07/31/2017)

Response to Office Action

The table below presents the data as entered.

Input Field	Entered
SERIAL NUMBER	85851818
LAW OFFICE ASSIGNED	LAW OFFICE 111
MARK SECTION	
MARK	http://tess2.uspto.gov/ImageAgent/ImageAgentProxy?getImage=85851818
LITERAL ELEMENT	GATEWAY HEALTH
STANDARD CHARACTERS	YES
USPTO-GENERATED IMAGE	YES
MARK STATEMENT	The mark consists of standard characters, without claim to any particular font style, size or color.
ARGUMENT(S)	

Applicant notes the Examining Attorney has indicated that, despite the Examining Attorney's refusal to register, the Applicant is permitted to submit arguments in support of registration. Applicant respectfully requests reconsideration of the Examining Attorney's refusal to register on the basis of an allegedly improper specimen for the reasons stated below.

Applicant's specimen is "substantially exact" in its depiction of the mark as used in commerce.

The Examining Attorney has refused registration on the grounds that the submitted specimen does not agree with the applied-for mark due to the use of the word "plan" on the specimen. Because the word "plan" is generic for Applicant's services, Applicant respectfully contends that the specimen meets the requirements of 37 C.F.R. § 2.51(a) and the drawing need not be amended.

A. The additional word cited by the Examining Attorney from the specimen is generic for the services provided by Applicant, and need not be included in the mark.

Generic terms are "terms that the relevant purchasing public understands primarily as the common or class name for the goods or services." *In re Dial-A-Mattress Operating Corp.*, 57 U.S.P.Q. 2d 1807, 1811 (Fed. Cir. 2001). It is a well-established principle of trademark law that generic terms cannot serve as source-indicators, and, accordingly, are ineligible for registration with the United States Patent and Trademark Office. TMEP § 1209.01(c).

In the present case, the Examining Attorney argues that the use of "plan" on Applicant's specimen changes the commercial impression of the applied-for mark such that the specimen should be rejected. However, "plan" is merely the generic word for the service offered by health care service providers, including managed health care service providers. As the U.S. National Library of Medicine at the National Institutes of Health explains:

> Managed care *plans* are a type of health insurance. They have contracts with heath care providers and medical facilities to provide care for members at reduced costs. These providers make up the *plan's* network. How much of your care the *plan* will pay for depends on the network's rules.

> *Plans* that restrict your choices usually cost you less. If you want a flexible *plan*, it will probably cost more. There are three types of managed care *plans*…

Exhibit A (emphasis added); *see also* Exhibit B (internet printouts showing generic use of "plan" in context of managed care services). In other words, the word "plan" does not impart any trademark significance. It is simply the generic word for Applicant's services. It does not modify the commercial impression of the mark or provide any additional information that warrants its inclusion in the mark. In fact, because it is generic, it should not be included in Applicant's mark, and, if included, would need to be disclaimed. *See* TMEP § 1209.01(c).

B. The presence of a generic word on Applicant's specimen does not render the specimen less than "substantially exact."

The Trademark Trial and Appeal Board has considered the extent to which the presence of additional wording on a specimen renders the specimen something less than "substantially exact." In *In re Raychem Corp*., 12 U.S.P.Q. 2d 1399 (TTAB 1989), the TTAB considered whether the Applicant's mark "TINEL-LOCK" failed to agree with the mark used on the specimen, "TR06AI-TINEL-LOCK-RING." The examining attorney required applicant to provide new specimens because she contended that "the application [wa]s seeking to register only part of the designation used as a mark on the specimen label." *Id.* at 1399. In reversing the examining attorney's refusal to register on the grounds of improper specimen, the TTAB agreed with the applicant that "'TR06AI' [wa]s merely a part designation number and 'RING' [wa]s the name of the goods, and that these elements shown on the specimens d[id] not form part of its mark." *Id.* The TTAB explained further:

> [T]he generic term "RING," although connected to the model number and the source-identifying term, "TINEL-LOCK," by a hyphen, nonetheless plays no integral role in forming the portion of applicant's mark which distinguishes applicant's goods from those of others. Applicant therefore need not include either the part number or the generic term in the drawing, because neither is essential to the commercial impression created by the mark as shown in the specimens.

Id. As the TTAB notes, "[o]rdinarily, even if it is used with a trademark, the generic name of a product need not be included as part of the words applicant seeks to register unless it forms a part of a unitary mark." *Id.*

The Federal Circuit has also found that the addition of words without trademark significance on a specimen does not warrant rejection of the specimen. *The Institut National des Appelations d'Origine v. Vintners Int'l Co* ., 22 U.S.P.Q. 2d 1190, 1197 (Fed. Cir. 1992). In *Institut National*, the opposer challenged registration of the mark "CHABLIS WITH A TWIST" on the grounds that the mark suffered from trademark mutilation. *Id.* at 1192. Specifically, because the label under which the product was sold contained the wording "CALIFORNIA CHABLIS WITH A TWIST," the opposer argued that the true mark included the word "CALIFORNIA" as shown on the specimen and, accordingly, the applied-for mark should not be registered. *Id.* The TTAB found that the mark was registrable, without substitute specimens, because "the merely descriptive word 'California' [wa]s not an integral part of [applicant's] mark." *Id.* at 1194. In affirming the TTAB's decision in favor of the applicant, the Federal Circuit found that "California is a geographically descriptive word wholly devoid of trademark significance because it cannot distinguish [applicant's] product from others." *Id.* at 1197. As a result, the Federal Circuit "conclude[d] that there [wa]s no genuine dispute as to whether there has been any 'mutilation.'" *Id.*

Much like the applicants in *Raychem* and *Institut National*, Applicant has provided a specimen which includes, in addition to the applied-for mark, a word wholly devoid of trademark significance, namely, the generic term for Applicant's services. As shown in the attached Exhibits, "plan" has a well-established meaning in the context of managed health care services: it is the name of the service provided. Accordingly, as the TTAB found in *Raychem* and the Federal Circuit found in *Institut National*, the addition of this generic term

on the submitted specimen should not render it inadequate or the mark unregistrable in its present form.

Moreover, in the present case, the Examining Attorney has not argued that the inclusion of "plan" on Applicant's specimen creates a unitary mark. To the contrary, the Examining Attorney has requested, and Applicant has agreed to, a disclaimer of a portion of Applicant's mark, namely "HEALTH." This tends to show that the Examining Attorney does not consider the mark to be unitary. *See Dena Corp. v. Belvedere Int'l, Inc* ., 21 U.S.P.Q. 2d 1047, 1051 (Fed. Cir. 1991) (finding that no disclaimer can be required of an element of a unitary mark because a unitary mark is, by definition, an inseparable whole, for which there can be no unregistrable component to disclaim). Under the reasoning of *Raychem*, then, Applicant need not provide a specimen devoid of the word "plan," because the generic word is not "essential to the commercial impression created by the mark as shown in the specimens." *Raychem*, 12 U.S.P.Q. 2d at 1399.

Based on the above, the Applicant respectfully requests that the Examining Attorney reconsider her refusal and allow the application to proceed to registration. Applicant believes that it has responded to all issues raised by the Examining Attorney. If any unresolved issues remain, or if the Examining Attorney requires anything further, she is invited to contact the undersigned attorney at (412) 394-7767.

EVIDENCE SECTION	
EVIDENCE FILE NAME(S)	
ORIGINAL PDF FILE	evi_3810714635-140148307_._response_to_office_action_for_GATEWAY_HEALTH_mark__01505001_.PDF
CONVERTED PDF FILE(S) (20 pages)	\\TICRS\EXPORT16\IMAGEOUT16\858\518\85851818\xml4\ROA0002.JPG
	\\TICRS\EXPORT16\IMAGEOUT16\858\518\85851818\xml4\ROA0003.JPG
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DESCRIPTION OF EVIDENCE FILE	Exhibits "A" and "B" to Applicant's arguments in response to the refusal of registration.
ADDITIONAL STATEMENTS SECTION	
DISCLAIMER	No claim is made to the exclusive right to use HEALTH apart from the mark as shown.
SIGNATURE SECTION	
RESPONSE SIGNATURE	/Paul D. Bangor, Jr./
SIGNATORY'S NAME	Paul D. Bangor, Jr.
SIGNATORY'S POSITION	Attorney of record, PA bar member
SIGNATORY'S PHONE NUMBER	4123947767
DATE SIGNED	12/02/2013
AUTHORIZED SIGNATORY	YES
FILING INFORMATION SECTION	
SUBMIT DATE	Mon Dec 02 14:16:34 EST 2013
TEAS STAMP	USPTO/ROA-XX.XXX.XXX.XX-2 0131202141634096913-85851 818-5007efc22eb42b84a1f9c eafad88c0da144dfe754870d7 cfbdf731b9bca74bf88d-N/A- N/A-20131202140148307407

PTO Form 1957 (Rev 9/2005)
OMB No. 0651-0050 (Exp. 07/31/2017)

Response to Office Action

To the Commissioner for Trademarks:

Application serial no. **85851818** GATEWAY HEALTH(Standard Characters, see http://tess2.uspto.gov/ImageAgent/ImageAgentProxy?getImage=85851818) has been amended as follows:

ARGUMENT(S)
In response to the substantive refusal(s), please note the following:

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EVIDENCE
Evidence in the nature of Exhibits "A" and "B" to Applicant's arguments in response to the refusal of registration. has been attached.
Original PDF file:
evi_3810714635-140148307_._response_to_office_action_for_GATEWAY_HEALTH_mark__01505001_.PDF
Converted PDF file(s) (20 pages)
Evidence-1
Evidence-2
Evidence-3
Evidence-4
Evidence-5
Evidence-6
Evidence-7
Evidence-8
Evidence-9
Evidence-10
Evidence-11
Evidence-12
Evidence-13
Evidence-14
Evidence-15
Evidence-16
Evidence-17
Evidence-18

Evidence-19
Evidence-20

ADDITIONAL STATEMENTS
Disclaimer
No claim is made to the exclusive right to use HEALTH apart from the mark as shown.

SIGNATURE(S)
Response Signature
Signature: /Paul D. Bangor, Jr./ Date: 12/02/2013
Signatory's Name: Paul D. Bangor, Jr.
Signatory's Position: Attorney of record, PA bar member

Signatory's Phone Number: 4123947767

The signatory has confirmed that he/she is an attorney who is a member in good standing of the bar of the highest court of a U.S. state, which includes the District of Columbia, Puerto Rico, and other federal territories and possessions; and he/she is currently the applicant's attorney or an associate thereof; and to the best of his/her knowledge, if prior to his/her appointment another U.S. attorney or a Canadian attorney/agent not currently associated with his/her company/firm previously represented the applicant in this matter: (1) the applicant has filed or is concurrently filing a signed revocation of or substitute power of attorney with the USPTO; (2) the USPTO has granted the request of the prior representative to withdraw; (3) the applicant has filed a power of attorney appointing him/her in this matter; or (4) the applicant's appointed U.S. attorney or Canadian attorney/agent has filed a power of attorney appointing him/her as an associate attorney in this matter.

Serial Number: 85851818
Internet Transmission Date: Mon Dec 02 14:16:34 EST 2013
TEAS Stamp: USPTO/ROA-XX.XXX.XXX.XX-2013120214163409
6913-85851818-5007efc22eb42b84a1f9ceafad
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-N/A-N/A-20131202140148307407

Exhibit A

MedlinePlus®
Trusted Health Information for You

U.S. National Library of Medicine
NIH National Institutes of Health

Managed Care

URL of this page: http://www.nlm.nih.gov/medlineplus/managedcare.html

Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of your care the plan will pay for depends on the network's rules.

Plans that restrict your choices usually cost you less. If you want a flexible plan, it will probably cost more. There are three types of managed care plans:

- Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care.
- Preferred Provider Organizations (PPO) usually pay more if you get care within the network. They still pay part of the cost if you go outside the network.
- Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care.

Overviews

- Health Insurance: Understanding Your Health Plan's Rules [http://familydoctor.org/familydoctor/en/healthcare-management/insurance-bills/health-insurance-understanding-your-health-plans-rules.printerview.all.html] (American Academy of Family Physicians)
  Also available in Spanish [http://familydoctor.org/familydoctor/es/healthcare-management/insurance-bills/health-insurance-understanding-your-health-plans-rules.printerview.all.html]

Related Issues

- About Emergencies (and Managed Care) [http://www.emergencycareforyou.org/YourHealth/AboutEmergencies/Default.aspx?id=26094] (American College of Emergency Physicians)

Clinical Trials

- ClinicalTrials.gov: Health Maintenance Organizations [http://clinicaltrials.gov/search/open/condition=%22Health+Maintenance+Organizations%22] *NIH* (National Institutes of Health)

Journal Articles

References and abstracts from MEDLINE/PubMed (National Library of Medicine)

- Article: A personal journey towards any qualified provider in the NHS. [http://www.ncbi.nlm.nih.gov/pubmed/23638482?tool=MedlinePlus]
- Article: A population-based cohort study of undervaccination in 8 managed care... [http://www.ncbi.nlm.nih.gov/pubmed/23338829?tool=MedlinePlus]
- Article: Early treatment of Parkinson's disease: opportunities for managed care. [http://www.ncbi.nlm.nih.gov/pubmed/23039867?tool=MedlinePlus]
- Managed Care -- see more articles [http://www.ncbi.nlm.nih.gov/pubmed?term=(managed+care+programs[majr]+NOT+insurance,health[majr:noexp])+AND+english[la]+AND+humans[mh]+AND+(jsubsetk[text]+OR+review[pt]+OR+guideline[pt]+OR+patient+education+handout[pt]+OR+jsubsetaim[text]

+OR+jsubsetn[text])+NOT+(letter[pt]+OR+editorial[pt])+AND+%22last+1+Year%22[edat]&tool=MedlinePlus]

Dictionaries/Glossaries

- Glossary of Managed Care Definitions [http://www.patientadvocate.org/index.php?p=384] (Patient Advocate Foundation)

Organizations

- Centers for Medicare & Medicaid Services [http://www.cms.gov/]

Statistics

- Medicaid and Managed Care: Key Data, Trends, and Issues [http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf] (Henry J. Kaiser Family Foundation) - PDF

Children

- How to Find Affordable Healthcare [http://kidshealth.org/parent/system/doctor/find_care.html] (Nemours Foundation)
  Also available in Spanish [http://kidshealth.org/parent/en_espanol/general/find_care_esp.html]
- Managed Care Plans: Getting Good Care for Your Child [http://www.healthychildren.org/English/family-life/health-management/Pages/Managed-Care-Plans-Getting-Good-Care-for-Your-Child.aspx] (American Academy of Pediatrics)

Women

- Women's Preventive Services Guidelines Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being [http://www.hrsa.gov/womensguidelines/] (Health Resources and Services Administration)

Seniors

- Health Maintenance Organization (HMO) Plan [http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/hmo-plans.html] (Centers for Medicare & Medicaid Services)
  Also available in Spanish [http://es.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/hmo-plans.html]
- Medicare Advantage Plans [http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html] (Centers for Medicare & Medicaid Services)
  Also available in Spanish [http://es.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html]
- Medicare Special Needs Plan (SNP) [http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/special-needs-plans.html] (Centers for Medicare & Medicaid Services)
- Preferred Provider Organization (PPO) Plans [http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/preferred-provider-organization-plans.html] (Centers for Medicare & Medicaid Services)
  Also available in Spanish [http://es.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/preferred-provider-organization-plans.html]

You may also be interested in these related MedlinePlus topics:

- Health Insurance [http://www.nlm.nih.gov/medlineplus/healthinsurance.html]
- Health System [http://www.nlm.nih.gov/medlineplus/healthsystem.html]

Date last updated: 23 September 2013

Topic last reviewed: 23 September 2013

Exhibit B

Managed Care Plans

There are three categories of managed care plans: health management organizations (HMO), preferred provider organizations (PPO) and point of service (POS).

- HMO
- PPO
- POS

Health Management Organizations (HMO)

HMOs provide medical treatment on a prepaid basis, which means that HMO members pay a fixed monthly fee, regardless of how much medical care is needed in a given month. In return for this fee, most HMOs provide a wide variety of medical services, from office visits to hospitalization and surgery. With a few exceptions, HMO members must receive their medical treatment from physicians and facilities within the HMO network.

When you join an HMO, you choose a primary care physician who is your first contact for all medical care needs. The primary care physician provides your general medical care and must be consulted before you can see a specialist. Because of this control system, HMO costs tend to increase less rapidly than other insurance plans.

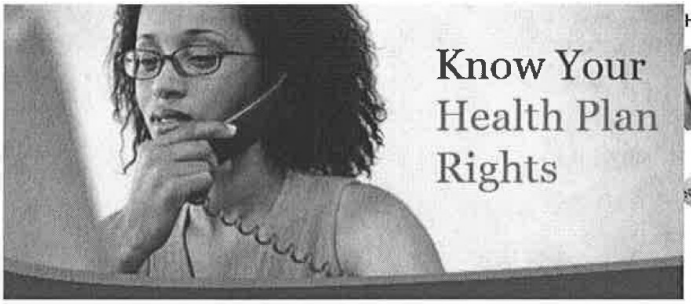
Preferred Provider Organizations (PPO)

A PPO is a group of doctors or hospitals that offer medical services at discounted rates as part of a specific network. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization, such as a union or association. PPO physicians provide medical services to the policyholders, employees or members at discounted rates. In return, the sponsor creates incentives for employees or policyholders to use the physicians and facilities within the PPO network.

Rather than paying in advance for medical care, PPO members pay for services as they occur. The PPO sponsor (the employer or insurance company) generally reimburses the member for the cost of the treatment, minus any out of pocket costs such as co-payments. In some cases, the doctor submits the bill directly to the insurance company for payment. The insurance company then pays the covered amount directly to the doctor and the member pays his or her co-payment amount. The doctors and the PPO sponsor are the ones who negotiate the price for each type of service in advance.

Point of Service (POS)

A Point of Service (POS) plan is a type of managed healthcare system that combines characteristics of the HMO and the PPO. Like an HMO, you pay no deductible and usually only a minimal co-payment when you use a healthcare provider within your network. You choose a primary care physician who is responsible for all referrals within the POS network. If you choose to go outside the network for care, POS coverage functions more like a PPO. You will likely have to pay a deductible and your co-payment will probably include a certain percentage of the total cost.



1 2 3 4 5 6 7

Highlights

Quick Links

- Timely Access Report
- Complaint / Independent Medical Review (IMR) Application form
- Network Adequacy Report for Healthy Families Transition to Medi-Cal
- Premium Rate Review
- California Health Care Reform
- Job Opportunities
- Events / Meetings
- Public Information & Reports
- How to Participate in Regulatory Actions
- Right Care Initiative
- Financial Solvency Standards Board

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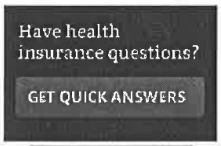

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Managed Care

States have traditionally provided people Medicaid benefits using a fee-for-service system. However, in the past 15 years, states have more frequently implemented a managed care delivery system for Medicaid benefits. In a managed care delivery system, people get most or all of their Medicaid services from an organization under contract with the state. Almost 50 million people receive benefits through some form of managed care, either on a voluntary or mandatory basis.

States can allow people to voluntarily enroll in a managed care program, but more frequently, states require people to enroll in a managed care program. Increasing numbers of States are using Managed Long Term Services and Supports (MLTSS) (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html) as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency.When states implement a managed care program, it can use any one of the following types of entities:

- **Managed Care Organizations (MCOs)** – like HMOs, these companies agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state.
- **Limited benefit plans** – these companies may look like HMOs but only provide one or two Medicaid benefits (like mental health or dental services).
- **Primary Care Case Managers** – these individual providers (or groups of providers) agree to act as an individual's primary care provider, and receive a small monthly payment for helping to coordinate referrals and other medical services.

Federal Authorities

States can implement a managed care delivery system using three basic types of federal authorities:

- State plan authority [Section 1932(a)]
- Waiver authority [Section 1915 (a) and (b)]
- Waiver authority [Section 1115]

Regardless of the authority, states must comply with the federal regulations that govern managed care delivery systems. These regulations include requirements for a managed care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed care plans, among others.

All three types of authorities give states the flexibility to not comply with the following requirements of Medicaid law outlined in Section 1902:

- Statewideness: Lets states implement a managed care delivery system in specific areas of the state (generally counties/parishes) rather than the whole state.
- Comparability of Services: Lets states provide different benefits to people enrolled in a managed care delivery system.
- Freedom of Choice: Lets States require people to their Medicaid services from a managed care plan or primary care provider.

1932(a) State Plan Basics

States can use a managed care delivery system by getting a state plan amendment approved by CMS. The state plan preprint includes information such as the types of entities that will be used and what groups of people will be enrolled. Once a state plan amendment is approved, the state can run its managed care program without needing to get CMS approval again.

This authority does not allow states to require dual eligibles, American Indians, or children with special health care needs to enroll in a managed care program.

21 states are operating 28 managed care programs using the authority of 1932(a).

1915(a) Waiver Basics

States can implement a voluntary managed care program simply by executing a contract with companies that the state has procured using a competitive procurement process. CMS must approve the state in order to make payment.

13 states (and Puerto Rico) use 1915(a) contracts to administer 24 voluntary

Delivery Systems Content

- Fee for Service (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html)
- Managed Care (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html)
- Managed Long Term Services and Supports (MLTSS) (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html)
- Institutional Care (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Institutional-Care.html)
- Other Integrated Health Systems (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Integrating-Care.html)
- Grant Programs (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Grant-Programs.html)
- Self Direction (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html)
- Telemedicine (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html)
- Request Managed Care Technical Assistance (/Medicaid-CHIP-Program-Information/By-Topics

Medicaid and Managed Care

Breast Cancer Surgery

- Breast Cancer Surgery Facilities for Medicaid Recipients

Enrolling in a Medicaid Managed Care Plan

Medicaid Managed Care offers many New Yorkers a chance to choose a Medicaid health plan. Managed Care plans focus on preventive health care and provide enrollees with a medical home for themselves and their families. In many counties, once you are eligible for Medicaid, you can join a plan if there is one available and you want to join. However, there are some counties where families will have to join a plan. In these counties there are some individuals who don't have to join. Enrollment in Medicaid managed care is available at any local Department of Social Services.

To find out more about Medicaid managed care where you live, choose a county from the map or list below.

- Map by County
- List of Counties in New York State

An HIV SNP is a health plan that covers special services for people living with HIV/AIDS. If you live in Metropolitan New York there is a choice of HIV SNPs available.

- HIV Special Needs Plan(SNP)
- HIV/SNPs Questions and Answers

Medicaid managed care provides comprehensive health care services to enrollees. Find out if you can apply by contacting your local Department of Social Services.

- Medicaid Managed Care and Family Health Plus Enrollment Form (PDF 62KB, 2pg.)

Family Planning

Medicaid managed care enrollees may obtain family planning and reproductive health services in or out of network from any Medicaid provider who offers these services without prior approval from the health plan or primary care provider. Enrollees will need to present their Medicaid benefit card to receive services outside their plan.

- Medicaid Family Planning 10 Most Common Questions

Model Contracts:

Information in the model contracts is presented here to provide general guidance on the benefits provided in New York's Medicaid managed care program.

- Primary Care Partial Capitation Provider (PCPCP) Model Contract (PDF, 667KB, 203pg.)
- Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (PDF, 4,455KB, 365pg.)
- Medicaid Advantage Model Contract (PDF, 1.57MB, 223pg.)

Questions or comments: omcmail@health.state.ny.us
Revised: April 2013

Managed Care

Managed Care

Choosing A Managed Care Health Plan

Choosing A Managed Care Health Plan

It used to be that selecting a health plan was a relatively simple process. Your employer offered to enroll you in the company plan, and once you signed on the dotted line, most of your health care expenses were covered.

But times have changed. For many people, choosing health insurance feels like a high-wire act, where even a single misstep might send them into a free fall if illness strikes.

Managed care is still the name of the game for many consumers, forcing them to make sense of the alphabet soup of health care delivery systems, most commonly HMOs (health maintenance organizations) and PPOs (preferred provider organizations).

What is Managed Care?

Managed care is a way to ensure that the patient receives the right care, in the right place at the right time. There are two basic types.

An HMO offers a kind of one-stop shopping for health care. HMOs provide a comprehensive health care services on a pre-paid basis to its members. An HMO member selects a primary care physician as his or her personal doctor and agrees to use only doctors and hospitals affiliated with the HMO. In return, an HMO minimizes out-of-pocket expenses members have to pay when they see doctors. There are usually no deductibles and very small co-payments. PPOs do not require members to select a primary care physician. However, the PPO members receive financial incentives to use doctors and hospitals affiliated with the PPO. Generally, there are no deductibles and small co-payments. A PPO may pay 50 to 70% of the cost of services provided by a non-PPO affiliated doctor or hospitals.

Being in a managed care plan is different from traditional health insurance. Traditional health insurance pays doctors from each service provided, known as fee-for-service. There are fewer restrictions on what doctors and hospitals you may choose. However, you will pay more in premiums, deductibles and other expenses that with a managed care plan. Preventative services are usually not covered.

"Managed care health plans emphasize preventative health care and a strong

relationship with your primary care physician," says Dr. Joseph Hindo, internal medicine physician member of the Silver Cross Managed Care Organization for over 15 years. "With HMO plans, a primary care physician, like myself, manages your referrals to specialists and other health services." -- *Back to top*

Choosing Wisely

Even if you're among the majority of Americans who obtain your health insurance through your employer, you'll need to choose from among the plans being offered, and make sense of the scope of the coverage and how much you'll be paying out-of-pocket.

"As a result, you need to practice your own "planned patienthood," says Dr. Hindo. "Comparison-shop to make sure you're selecting the right coverage for you and your family. The average person spends only about 16 minutes looking at health-plan materials before he or she makes a decision. It would be worth spending more time than that." -- *Back to top*

Guidelines for Optimal Coverage

To help you navigate successfully through the health-plan obstacle course, Dr. Hindo suggests some key issues to examine: -- *Back to top*

Is your own doctor part of the plan, and does she expect to stay on the plan? Before selecting your coverage, choose your physician, and find out what plans she participates in. If you don't already have a primary care physician, you may want to contact the Silver Cross Physician Referral Service at 1-888-660-HEAL (4325). Here you can find information on a doctor's philosophy of practice, where the he received his training and also his office hours. If you already have a doctor who you want to keep seeing, ask her (or her office staff), "I'm thinking of committing myself for the next year to a plan that you're on; is it safe to assume that you're going to continue participating in it for the entire year?" -- *Back to top*

Do you need to see specialists? If you have a chronic health problem—like diabetes or allergies—or if you develop a serious condition that should be treated by a cardiologist or gastroenterologist, for example, make sure that you can receive care from such a specialist. Because your choice of doctors is limited to those who participate in the plan, you want to choose a managed care organization that gives you an abundance of physicians to choose from-like the Silver Cross Managed Care Organization, which offers a choice of over 200 primary and specialty physicians." -- *Back to top.*

Is medical care available close to home? Check the locations of physicians' offices and hospitals that are part of the plan, and make sure they're as convenient as possible. The Silver Cross Managed Care Organization offers physicians in 25 locations throughout the southwest suburbs and is affiliated with Silver Cross Hospital-one of the top 100 hospitals in the nation according to Thomson Reuters, the leading source of health care business intelligence. -- *Back to top.*

Is prescription drug coverage adequate? There can be big differences among plans in their medication benefits. Check on co-payments, the pharmacies you can use, and the maximum amounts that the plan pays per year. On many plans, you will have much smaller co-payments when you choose lower-cost generic drugs. -- *Back to top.*

Does the plan offer preventive and other specialized services? Look for plans that cover vaccinations, preventive screenings (such as mammograms), and "well visits" to the doctor. Also check for coverage for dental and eye care. -- *Back to top.*

How extensive is mental-health coverage? Services by a psychologist or psychiatrist may be limited in the number of office visits and/or the amount of reimbursement per session. There may also be caps on the number of inpatient hospital days for covered psychiatric disorders and substance abuse. -- *Back to top.*

Are "complementary" or "alternative" services part of the plan? Check whether the plan pays for treatment by chiropractors or acupuncturists, for example. -- *Back to top.*

Does the plan have a "lifetime maximum"? There may be a limit to the total health care benefits available to you over a lifetime—typically, $1 million. This may seem like a lot of money, but if you develop a catastrophic illness or have a major operation (an organ transplant, for example), you could be well on your way to reaching the maximum level. For that reason, the higher the cap, the better. -- *Back to top.*

What do your co-workers think of their plan? If you get your health coverage at work, ask your fellow employees whether they're satisfied with the plans offered by your employer. If you are new to the company or the community, co-workers are also a good referral source for choosing a physician and hospital provider. -- *Back to top.*

Located at 1900 Silver Cross Blvd., New Lenox, IL 60451 **Main Phone** (815) 300-1100

SEARCH

Managed Care

The term "managed care" has become a buzzword -- and not everyone knows what it means. Simply stated, managed care refers to health care insurance plans designed to provide care at the lowest possible cost. In order to make coverage affordable, managed care plans require that patients follow certain rules. (We'll get to those rules shortly.) The three major types of managed care plans are:

- Preferred Provider Organizations (PPOs)
- Health Maintenance Organizations (HMOs)
- Point-of-Service (POS) plans.

What do each of these plans offer? Take a look ...

Preferred Provider Organizations (PPOs)

This plan type closely resembles a Fee-for-Service plan. A PPO has arrangements with a network of doctors, hospitals and other providers who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan. This makes it a best-of-both-worlds option for many patients: lower costs in the network, but flexibility to leave the network if necessary.

- If you go to a doctor within the PPO network, you will probably pay a copay (a set amount for certain services -- like $15 for a doctor visit or $10 for a prescription). Your coinsurance will be based on lower charges for PPO members.
- If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. You might also have to pay the difference between what the provider charges and what the plan will pay.

Health Maintenance Organizations (HMOs)

HMOs offer members an array of health benefits -- usually including preventive care -- for a set monthly premium. The rule? You must use the health care providers and facilities within the HMO network in order to receive coverage, unless it's an emergency. Most HMOs require a small copay for each visit to a doctor or plan facility. Some require no payment when you visit doctors. (These plans usually have slightly higher monthly premiums.) HMOs generally provide preventive care like annual check-ups, flu shots, hearing tests, etc., at lower out-of-pocket costs to you. This makes them highly preferred for many people who don't want to pay huge fees for an annual physical, a cholesterol check or other necessary tests.

There are several types of HMOs:

- **The Staff Model HMO** - Here the doctors are actual employees of the health plan, and you see them at a central medical center or office.
- **Individual Practice Associations (IPAs)** - This type of HMO contracts with outside physician groups or individual doctors who have private practices, and you see them in their own offices.

Primary Care Physicians:

A partnership with your doctor

An HMO will typically provide you with a list of physicians. From that list, you choose a "primary care physician." This doctor will serve as your chief medical officer. He or she will coordinate your care, see you when you are sick and make any decisions about whether you should see a specialist.

What kind of doctors are primary care physicians?

Usually, they fall into one of the following specialties:

- **Family practice doctors or general practitioners**: These doctors are trained to diagnose and treat a variety of health conditions. If you are young and in good health, a general practitioner is your best bet. Many HMO members select the same general practitioner for their entire family.
- **Internists**: Specializing in internal medicine, these physicians are trained to treat health conditions like diabetes and cardiovascular disease. If you are managing high blood pressure, heart disease or diabetes, an internist is a wise choice.
- **Pediatricians**: These doctors only treat children, usually under the age of 12.
- **OB/GYN**: Some plans allow women of childbearing age to select an OB/GYN as their primary care physician.
- **Other types of doctors**: Some plans may allow a specialist to be selected as a primary care physician. For example, a diabetic may elect to have an endocrinologist (in the HMO plan, of course) as his primary care physician.

How do you pick a primary care physician?

Most HMOs only offer a list of doctors' names. How can you find out more about them?

- If you know others in the plan, ask for recommendations.
- Make appointments to meet with doctors in your area to find one who is right for you.
- If the plan's doctors are located in the same facility, ask the staff nurse for recommendations.

Can you use your current doctor?

If he or she does not belong to the HMO, you will have to switch to a doctor who does. But don't worry that once you pick a primary care physician, it will be set in stone. Most plans allow you to switch your primary care doctor several times a year. If you don't like one, select another.

Blurring the lines of Fee-for-Service and managed care

While Fee-for-Service and managed care are different, the differences can get a little fuzzy. Many managed care plans now contain Fee-for-Service elements. Conversely, almost all Fee-for-Service plans apply managed care techniques to contain costs and guarantee suitable patient care. What does this tell you? Read the different plan descriptions carefully! You may find that you get Fee-for-Service options through your local HMO at a substantial savings. Or you may discover that with all the caveats, your Fee-for-Service plan walks and talks more like a restrictive managed care plan and is not worth the extra out-of-pocket expense.

Guidelines in every plan

Whether you choose a Fee-for-Service plan, a PPO or an HMO, you will find that your plan has certain rules you have to follow.

Let's say you fall and break your leg while rock-climbing on vacation, and you are rushed to a hospital that is not part of your HMO network. Your emergency medical coverage is most likely included in your plan. After you've been patched up, however, the medical team feels you would be best served by tricky follow-up knee surgery. Chances are, either you or your doctor will have to call your insurance provider to get the go-ahead for the non-emergency treatment. This is known as "pre-authorization." It occurs when your insurer must approve a procedure before you actually have it.

Utilization review

Utilization review is a fancy term for the process used by plans to determine whether a specific medical or surgical service is appropriate or medically warranted. For example: You believe your severe neck pain will be alleviated by a new cervical disk surgery you read about on the Internet. You've talked to your physician about it, and he's familiar with the procedure, but the practice is not regarded as absolutely necessary for your condition. The Medical Review Specialist may be brought in to make the final decision about whether or not your insurance will cover the cost of the operation.

MassResources.org

MASSHEALTH

MassHealth MCO Managed Care Health Plans

NOTE: Glossary words are highlighted. Click on any glossary word to see its definition.

What is an MCO managed care health plan?

An MCO (Managed Care Organization) health plan is a group of doctors and other health care providers who work together to provide health care for their members. The doctors and other health care providers agree to follow certain rules about how they provide services. When you enroll in an MCO, you select a primary care provider who is part of that MCO to do your checkups, provide basic care, and make referrals. If you need to see a specialist, you see a specialist who is approved by your MCO.

Most MassHealth members must choose a either a a primary care clinician (PCC) plan, or a MassHealth MCO managed care plan. See What health plan choices do I have?

For MassHealth members who choose to enroll in an MCO managed care plan:

- there are five plan choices:
  - Boston Medical Center (BMC) HealthNet Plan
  - Fallon Community Health Plan (FCHP)
  - Health New England (HNE)
  - Neighborhood Health Plan (NHP)
  - Network Health
- each MassHealth MCO offers MassHealth Basic, Standard/CommonHealth, Family Assistance and Essential plans
- not all plans are available in all areas of Massachusetts. Your MassHealth enrollment package will include information about the plans available in your area.
- each MassHealth MCO offers all of the benefits of MassHealth, plus some extra benefits
- if you enroll in an MCO, you agree to get your MassHealth benefits from your MCO and will get a health insurance card from your MCO

You can learn more about MassHealth MCOs by calling their customer service numbers, visiting their web sites, or speaking to a MassHealth Benefits Advisor at 1-800-841-2900 (TTY: 1-800-497-4648).

How do MassHealth MCOs provide mental health and substance abuse services?

MassHealth MCO (Managed Care Organization) health plans cover treatment of mental health and substance use disorders as well as treatment of physical health conditions. Most MassHealth MCO health plans have a behavioral health partner to manage these services. If you need mental health or substance abuse services, you should contact a provider in your plan's behavioral health network, or you may call customer service for assistance. You do not need a referral from your primary care provider.

MassHealth MCO Mental Health / Substance Abuse Contact information:

- **Behavioral health emergency**:

  If you are experiencing a mental health or substance abuse crisis, call 1-877-382-1609 and enter your zip code (or see the ESP Statewide Directory) to find the Emergency Services Program (ESP) / Mobile Crisis Intervention (MCI) team that serves your area.

- **Non-emergency:** See MCO plan information (below) for behavioral health contact information and web links
  Note: Behavioral health phone numbers are available 24 hours a day, 7 days a week

Massachusetts and federal mental health "parity" laws require MassHealth MCOs to cover biologically-based mental health disorders on a par with physical disorders. Substance abuse, eating disorders, post traumatic stress disorder, and autism are also included. "Parity" means that any coverage limits (such as number of visits) or other restrictions must be the same for mental health disorders as they are for physical health disorders. See Mental Health Parity and parity disorders from MassLegalHelp for more information.

Also see Emergency Adoption of Mental Health Parity Regulations for information about how the mental health parity laws apply to MassHealth MCOs.

MCO plan information:

Boston Medical Center (BMC) HealthNet Plan

Boston Medical Center (BMC) HealthNet Plan is a not-for-profit managed care plan that serves MassHealth members throughout Massachusetts. The plan was started in 1997 by the Boston Medical Center. BMC HealthNet's behavioral health services are managed by Beacon Health Strategies.

BMC HealthNet Plan - MassHealth:

- Member services: 1-888-566-0010 (TTY: 866-765-0055)
- BMC HealthNet Plan MassHealth
- BMC HealthNet Plan MassHealth Member Handbook
- Find a Medical Provider
- Member Pharmacy Information

BMC behavioral health partner - Beacon Health Strategies:

- Mental health / substance abuse services: 1-888-217-3501 (TTY: 1-888-727-9441)
- Locate a Behavioral Health Provider (enter plan code BMC)

Fallon Community Health Plan (FCHP)

Fallon Community Health Plan is a non-profit health maintenance organization that was started in 1977. Fallon health care providers and hospitals are located throughout Massachusetts. Beacon Health Strategies is the FCHP behavioral health partner.

FCHP - MassHealth:

- Member services: 1-800-341-4848 (TTY: call MassRelay 711)
- FCHP MassHealth
- FCHP MassHealth Member Handbook
- FCHP: Find a Health Care Provider
- Pharmacy and prescription drugs

FCHP behavioral health partner - Beacon Health Strategies:

- Mental health / substance abuse services: 1-888-421-8661 (TTY: 1-781-994-7660)

- Locate a Behavioral Health Provider (enter plan code FCHP)

Health New England (HNE)

Health New England (HNE) is a managed care organization that has served western Massachusetts since 1985. HNE's parent company is Baystate Health. HNE's service area includes Franklin, Berkshire, Hampden, and Hampshire counties. HNE's behavioral health services are managed by the Massachusetts Behavioral Health Partnership.

HNE Be Healthy - MassHealth:

- Member services: 413-788-0123 or 1-800-786-9999 (TTY: 1-800-439-2370)
- HNE Be Healthy! (MassHealth)
- HNE Be Healthy Member Handbook
- Find a Doctor or Other Healthcare Provider
- Pharmacy and Drug Formulary

HNE behavioral health partner - Massachusetts Behavioral Health Partnership (MBHP):

- Mental health / substance abuse services: 1-800-495-0086 (TTY: 1-617-790-4130)
- Search for Behavioral Health Provider Information

Neighborhood Health Plan (NHP)

Neighborhood Health Plan is a non-profit health maintenance organization that serves MassHealth members throughout Massachusetts. NHP is a member of Partners HealthCare which was founded by Brigham and Women's Hospital and Massachusetts General Hospital. Behavioral health services for NHP are managed by Beacon Health Strategies.

Neighborhood Health Plan (NHP) - MassHealth:

- Member services: 1-800-462-5449 (TTY: 1-800-655-1761)
- NHP - MassHealth
- NHP MassHealth Member Handbook
- Find a Provider
- Pharmacy Benefits

NHP behavioral health partner - Beacon Health Strategies:

- Mental health / substance abuse services: 1-800-414-2820
- NHP Behavioral Health Benefits
- Locate a Behavioral Health Provider (enter plan code NHP and select state=MA)

Network Health

Network Health is a managed care plan that was started by the Cambridge Health Alliance in 1997 and is now a subsidiary of Tufts Health Plan. Network Health's service area includes all or part of Barnstable, Berkshire, Bristol, Dukes, Essex, Franklin, Hampden, Hampshire, Middlesex, Nantucket, Norfolk, Plymouth, Suffolk, and Worcester counties.

Network Health - MassHealth:

- Member services: 1-888-257-1985 (TTY: 1-888-391-5535)
- Network Health Together - MassHealth
- Network Health Together Member Handbook
- Find a Doctor or Specialist
- Pharmacy

Network Health behavioral health services:

- Mental health / substance abuse services: 1-888-257-1986
- Find a mental health and substance abuse facility and doctor