Managed care is a system for providing health care benefits through health plans. In Minnesota, managed care is one way most Medical Assistance (MA) enrollees receive their health care services. The Minnesota Department of Human Services oversees publicly-funded health care programs and contracts with different Managed Care Organizations (MCOs) across the state. The state requires certain groups of MA enrollees, like children age 2-18 or adults without children, be covered under managed care plans, also called Prepaid Medical Assistance Plans (PMAPs). Examples of MCOs that have contracts with the state include Health Partners, UCare, Blue Cross Blue Shield and Medica. Providers vary by county.

Managed care allows MA enrollees access to services that would not otherwise be available through “Fee-for-Service” Medical Assistance, such as gym membership discounts or wellness incentive programs. This is a cost-saving measure that allows some basic MA services to be covered while others are not. If you have Managed Care MA, contact your health plan to get a complete list of covered services and network providers.

What’s the difference between Managed Care MA and “Fee-for-Service” or “straight” MA? The main differences are who provides health care services and availability of services for enrollees. “Enrollees” are people who have applied and been approved for Medical Assistance and are currently enrolled in the program.

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Managed Care</th>
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<td>- State billed directly by providers</td>
<td>- MCO pays for covered services</td>
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<tr>
<td>- Enrollees must find providers that accept MA</td>
<td>- Enrollees go to MCO’s doctors,</td>
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<td></td>
<td>clinics, hospitals, pharmacies &amp;</td>
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<tr>
<td></td>
<td>specialists</td>
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<tr>
<td>- Enrollees may have cost sharing</td>
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*Cost sharing* means the enrollee pays some of the cost for their medical services.

How do I apply for Medical Assistance? Applicants apply for Medical Assistance on MNsure, Minnesota’s health insurance exchange. Applicants may apply online at [www.mnsure.org](http://www.mnsure.org) or by using the paper MNsure application, Application for Health Coverage and Help Paying Costs (DHS 6696). MA program eligibility is determined by a number of factors, including income, household size, citizenship and age. The applicant’s county of residence may request proofs (like paystubs) before approving the Medical Assistance. The applicant will receive an approval notice with managed care information in the mail within a few weeks of submitting their application.

Why does this matter for people with disabilities? The type of Medical Assistance that a person with a disability has impacts services they can access and how they use them. For many people with disabilities, it is important to qualify for MA based on their disability so they have access to waivered services and consumer-directed...
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programs through the county where they live. For example, Fee-for-Service MA funds Personal Care Attendant (PCA) services and allows enrollees to choose the Consumer Support Grant (CSG) option, which gives the consumer more flexibility and choice in how they use their budget to meet their needs. Managed Care MA covers basic MA services including PCA services. Instead of a traditional PCA assessment—done by a county worker or Public Health Nurse—the Managed Care Organization administers it and determines if the enrollee qualifies. Managed Care MA does not allow access to waivers and consumer-directed services, like the Consumer Support Grant (CSG). Some people with disabilities do not need or want waivered services, and Managed Care may be a better option.

How does someone qualify for Fee-for-Service MA?
Applicants qualify on the basis of their disability. The applicant tells the county and state about their disability on the application and goes through a “disability certification” process. The group that determines disability, the State Medical Review Team (SMRT), will request copies of documents, reports, assessments and progress notes from the applicant’s doctor, therapists, medical providers and specialists. A SMRT case worker will tell the applicant what paperwork is needed.

If the applicant already receives Social Security benefits due to their disability, they do not need to go through another disability review; they have already been certified. In this situation, the person may apply for MA and may qualify for Fee-for-Service MA. The county will ask for a copy of the Social Security award letter that certifies the disability.

How do I switch from Managed Care to Fee-for-Service?
There are a few ways current Managed Care enrollees can switch to Fee-for-Service.

- Talk with a county managed care advocate and ask to go through the State Medical Review Team process
- Apply for Social Security benefits on the basis of disability
- Apply for Developmental Disabilities (DD) case management at the county and meet eligibility criteria to qualify.

Being “excluded” from managed care can be difficult. There are advocates and county workers who can help explain what you need to do to switch to Fee-for-Service MA.

Help is available! The Arc Greater Twin Cities has certified navigators who may be able to:

- Assist you in completing the online or paper MNsure application
- Provide forms that you, doctors and other providers must complete
- Send proofs and documents to the county and state on your behalf
- Track the status of the application as it moves through the process
- Provide information about access to disability services and supports once enrolled in a health care program

For further information or advocacy services, contact The Arc Greater Twin Cities at 952-920-0855 or visit [www.arcgreatertwincities.org](http://www.arcgreatertwincities.org). Thank you!

*This document is not legal advice, and should not be construed as such. Thus, no information herein should replace the sound advice of an attorney.*