The Arc
Greater Twin Cities

Arc Guide to Medical Assistance Managed Care

Managed care is a system for providing health care benefits through health plans. In Minnesota, managed care is one way many Medical Assistance (MA) enrollees receive their health care services. The Minnesota Department of Human Services (DHS) 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). MCOs that have contracts with the state include Health Partners, UCare, Blue Cross Blue Shield and Medica. Counties have contracts with MCOs to provide services. The number of MCOs in a county and which MCOs DHS contracts with vary by county.

Managed care allows MA enrollees access to services that would not otherwise be available through "Fee for Service" Medical Assistance (see below), like 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 the network where services are provided.

There is also a managed care program called Special Needs Basic Care (SNBC). SNBC is a voluntary managed care program for people with disabilities ages 18 through 64 who have MA. With SNBC, members have a care coordinator who can help them get health care and support services. There are only a handful of MCOs that offer SNBC. Refer to DHS's website for more information: SNBC

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.

Managed Care:
- MCO pays for covered services
- Enrollees go to MCO's doctors, clinics, hospitals, specialists & pharmacies
- Enrollees may have some cost sharing

Fee for Service:
- Providers bill the state directly for services provided
- Enrollees must find providers who accept this type of MA
- Enrollees may have cost to pay toward some medical costs

Refer to Minnesota Health Care Programs Summary of Coverage, Cost Sharing and Limits (DHS 3860) for more information.

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 (preferred) or by using the paper MNsure application.
MA program eligibility is determined by a number of factors, including income, household size, citizenship, age and disability. The applicant's county of residence may request proofs (like paystubs) before approving the Medical Assistance. If eligible, 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 what services they can access and how they use them. For many people with disabilities, it can be important to qualify for MA based on their disability so they have access to waivered services and consumer-directed programs through the county where they live (Guide To DD Waiver, Guide to Consumer Directed Community Supports). 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 or MnCHOICES assessment—done by a county worker or Public Health Nurse—the Managed Care Organization does the assessment and determines eligibility and how many hours of PCA the person qualifies for (eligibility criteria for PCA is the same). Managed Care MA **does not** allow access to waivers and consumer-directed services, like the 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 indicates they have a disability on the initial health care application and goes through a "disability certification" process. The group that certifies disabilities for MA program eligibility is called the State Medical Review Team (SMRT). Refer to the Arc Guide for State Medical Review Team for more information, including what documentation the state requests in order to make their determination.

If the applicant already receives Social Security disability benefits, they do not need to go through the SMRT process as they have already been certified as disabled. In this situation, the person may apply for MA and qualify for Fee for Service MA. The county will ask for a copy of the Social Security award letter and other proofs to complete the health care application.

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

- Talk with a county managed care worker and ask to go through the State Medical Review Team process
- Apply for Social Security disability benefits and when approved, report the change to the county (refer to the Arc Guide to Supplemental Security Income (SSI) for more information)

Have questions? Need more information?
If you or a family member has an Intellectual or Developmental disability, contact The Arc Greater Twin Cities. Navigators can answer questions about MA, access to services and how enrollees can be "excluded" from (taken off of) Managed Care MA. Navigators can provide you with tools, tips and coaching to help you understand and use your health care benefits.