
MinnesotaCare:

Once enrolled in a health plan, households may change to a new plan:

- > Once during the 1st year of enrollment. This is known as the 1st year change option. This option is available for 12 months beginning with the initial date of enrollment. The 12 months continues to run regardless of whether the household remains continuously enrolled in MinnesotaCare during that time. Apply the 1st year change option to households, not individuals.
- > Annually during open enrollment. MinnesotaCare enrollees receive open enrollment materials approximately 90 days before the due date for returning enrollment forms. If enrollees choose a different plan, enrollment in the new plan will begin on January 1 of the following year.
- > If they move to another county and the plan they are enrolled in is not available in the new county. MMIS will generate a new enrollment form and assign a new default plan.

If a household moves to another county and the plan they are enrolled in is available, they may choose a new plan within 60 days of the move date. However, MMIS will not automatically generate an enrollment form.

- > A health plan terminates its contract with DHS.
- > The primary care provider is inaccessible. The DHS Managed Care Ombudsman decides inaccessibility on a case-by-case basis.
- > Within the 1st 90 days of health plan enrollment. This change option will be available to households each time they are enrolled in a new health plan for 90 days or less. **This change option is not available to enrollees of the MinnesotaCare Limited Benefit Set.**
- > After a break in **eligibility** of more than 2 full calendar months. The household must request the change within 90 days of being re-enrolled.

When a household changes plans, the change is effective the 1st day of the next available month after receipt of the new enrollment form. For changes completed before capitation, the next available month is the month after capitation. For changes completed after capitation, the next available month is the 2nd month after capitation.

EXAMPLE:

The Browns exercise their 1st year change option. They return their enrollment form for the plan they wish to select on August 10. All information is entered before capitation in August. The Browns will be enrolled in the new plan effective September 1.

EXAMPLE:

The Greens move to a new county where their health plan is not available. They return their enrollment form on August 26 after capitation. They will be enrolled in the new plan effective October 1. If MinnesotaCare has paid a capitation to their previous health plan for September, they must receive medical services through the previous health plan or make arrangements with their old health plan to receive services elsewhere.

M.S. 256L.12 subd. 3

Minnesota Rule 9506.0200 subp. 5

MA/GAMC:

At the time of the annual recertification, review each person's circumstances to determine whether or not the person should be excluded from managed care. See §0914.03.03 (Managed Care Exclusions). Track known future changes and process changes in exclusion status when you become aware of changes in circumstances.

If an excluded person is now a mandatory managed care enrollee, refer the person to a managed care presentation or assist the person in choosing a health plan. See §0914.03.05 (Managed Care Enrollment Process) and §0914.03.13 (Adding/Removing People From Managed Care). If a managed care enrollee is now in an excluded group, disenroll the person for the next available month on MMIS. See §0914.03.11 (Managed Care Disenrollment).

People enrolled in managed care may voluntarily change health plans at the following times:

- > Once during the 1st year after initial enrollment in managed care. The first day of enrollment is the initial effective date of health plan enrollment. The 12 months runs continuously from that date regardless of whether the enrollee remains eligible during that time.
- > During the annual open enrollment period.
- > When the client's health plan ends its contract with DHS.

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- > Within 60 days of enrollment into a new health plan when the enrollment is a result of the contract termination of the previous health plan.
 - > The enrollee is permitted to change health plans because of problems with access, service delivery, or other good cause. The following changes can be made without a hearing.
 - An enrollee may change a primary care provider if the travel time to the primary care provider is over 30 minutes from the enrollee's residence.
 - If the local agency incorrectly designated a health plan or primary physician or dentist.
 - > When transferring between counties, if the client requests a change within 60 days of the move date. See §0914.03.17 (Managed Care County Transfers).
 - > After a break of more than 2 full calendar months in MA or GAMC eligibility. The enrollee must request the change within 90 days of being re-enrolled. See §0914.03.09 (Managed Care Re-Enrollments & Reinstatements).
 - > When changing programs between MA, GAMC and MinnesotaCare. Follow these procedures for enrollment when there is a change in health care program:
 - If the same health plan is available with the new program, MMIS will re-assign the enrollee to the same plan with the new product ID.
 - If the same health plan is not available for the new program, code RPPH with exclusion code YY (Delayed Decision) and an exclusion begin date. Code a closing date for the previous enrollment span. Begin tracking on the MMIS RTRK screen. Refer the client to a managed care presentation or mail the information. Medical services may be covered by fee-for-service until the client is enrolled in a new health plan.
- If there is a change in basis of eligibility with no change in medical program, do not allow a change in health plan.
- > Within the 1st 90 days of **initial** health plan enrollment. This change option will be available to enrollees each time they are enrolled in a new health plan for 90 days or less. **For counties where the health plan is the only choice, the enrollee can not disenroll but may change their primary care provider. This**

section does not apply to enrollees who are under a health plan administrative sanction.

Do not change the enrollment status or health plan of a recipient who is hospitalized in an acute care facility on the effective date of the change. Follow these procedures:

- > Delay initial enrollment of a hospitalized enrollee into managed care until the 1st of the next available month after discharge.

EXCEPTION:

Enroll hospitalized MSHO enrollees for the 1st available month. The health plan is not responsible for hospital charges before the effective date of enrollment.

- > Delay changing health plans for a hospitalized MA or GAMC managed care enrollee who is eligible to change until the 1st of the next available month after discharge.
- > Disenroll a hospitalized GAMC managed care enrollee who becomes excluded from managed care for the next available month.

If you discover after an enrollment change that a household member was in the hospital on the effective date, refer the case to your managed care unit or DHS for an adjustment. See §0914.03.15 (Managed Care Adjustments).

Document dates the person went into and out of the hospital and how you verified the dates in MMIS case notes. Explain the delay in changing the health plan or enrollment status in MMIS case notes.