

## Changing Health Plans

**Revised:** May 1, 2024

This section of the manual describes health plan change options available to those who are eligible for Prepaid Medical Assistance Program (PMAP), MinnesotaCare, and Minnesota SeniorCare Plus (MSC+) and are enrolled in managed care. Enrollees are entitled to health plan change options by law. If an enrollee is eligible for a change option, the health plan change is generally completed by a processing entity (county, tribal, or DHS staff).

Requests to change health plans may be in writing or taken over the phone. Exceptions apply to Minnesota Senior Health Options (MSHO) and integrated Special Needs BasicCare (I-SNBC) and are outlined in the MSHO and SNBC Change Options section of this page. When completing a change request, document the date of the request, how the request was received, requestor's name, phone number (if by phone) and all enrollees who are requesting the change and the health plan they are requesting to change to in MMIS case notes. Requests to change health plans for MSHO or I-SNBC must be received by DHS with a physical signature.

A complete list of change reason codes (CHG RSN) can be found on the [RPPH screen page](#) in the MMIS User Manual. Use the [Edit Health Plan Enrollment procedure](#) in ONEsource to code these changes in MMIS.

### Annual Change Option

#### Annual Health Plan Selection (AHPS)

The Minnesota Department of Human Services (DHS) offers an annual change option called Annual Health Plan Selection (AHPS) each fall. All enrollees enrolled in managed care have the opportunity during AHPS to change health plans for the following year. Enrollment in a new health plan will be effective January 1.

For more information on key dates, [Add Annual Health Plan Selection in MMIS](#) instructions, and other AHPS resources, refer to the [ONEsource AHPS landing page](#).

AHPS requests may be completed telephonically, verbally, or through a completed health plan enrollment form. Processing entities enter AHPS changes through enrollment cutoff in December. If an enrollee sends an AHPS change to a processing entity and it is received after cutoff but before capitation, workers should submit an HPEN ticket indicating the health plan change requested and DHS managed care enrollment staff will make the change in MMIS. Any changes received after December capitation need to be evaluated for another change option (see the following section, Other Change Options). If no other change option is available, the enrollment request will be denied. Refer to the [Denying a Health Plan Change Request](#) section for more information.

Enrollees who lose Medical Assistance or MinnesotaCare coverage during AHPS are allowed an option to change health plans if they regain coverage. The enrollee must make a request to change health plans. Submit an HPEN ticket for assistance.

### Other Change Options

If you receive a request from an enrollee to change their health plan outside of AHPS:

1. Determine if the enrollee requesting the change is eligible for any of the change options listed.
2. Determine if anyone else on the case would be impacted by the change.
  - a. All MinnesotaCare enrollees in the same household must be enrolled in the same health plan.
  - b. For Medical Assistance cases, enrollees in the same household can be enrolled in different health plans.

3. The effective date of an approved change will be determined by the date the request is received.
  - a. Requests received before managed care enrollment cutoff will be effective the beginning of next month.
  - b. Requests received after managed care cutoff will be effective the following month.

### **First Year Change**

Enrollees may change to a new health plan during the first 12 months of initial enrollment in managed care. A processing entity must receive the change request by the end of the 12th month after the first date of managed care enrollment.

**Example:** An enrollee is enrolled in managed care for the first time on April 1, 2022. They have until March 31, 2023, to request a first year change.

**Example:** An enrollee was enrolled in managed care for the first time on April 1, 2022. The enrollee calls to switch health plans on May 11, 2023. The enrollee is not eligible for a first year change. The initial enrollment date was April 1, 2022. The first year change expires after March 31, 2023.

**Example:** An enrollee was enrolled in managed care for the first time April 1, 2020. Their MA coverage ended on September 30, 2022. They were again enrolled in managed care on January 1, 2023. They would not be eligible for the first year change. The initial enrollment date was April 1, 2020. The first year change expires after March 31, 2021.

### **Move Change**

An enrollee may request a health plan change when they move to a new county of residence.

If the current health plan is available in the new county of residence, the enrollment span on the RPPH screen remains open and there will be one continuous span for both counties. No new enrollment packet is sent. The enrollee would need to contact the processing entity to request a change in health plans within 60 days of moving to a new county.

When the health plan is not available in the new county, the system will close the enrollment span on the RPPH screen at the next capitation following the move. The new county will receive a daily enrollment form to send out with enrollment packet materials to the enrollee.

### **90-Day Change Option**

An enrollee may change their health plan during the first 90 days they are enrolled in a health plan for the first time. If they make another health plan change within 90 days, they must choose a health plan they have never been enrolled in to maintain a 90-day change option. If they change to a health plan they've had in the past it ends their ability to utilize another 90-day change.

### **Agency Error**

An enrollee may change health plans without a hearing when the enrollee's health plan was incorrectly assigned due to an agency error. The enrollee must request this change. Processing entities should work with the enrollee to determine if a change for the next available month is acceptable. If it is, change the health plan for the next available month. If it is not, submit an HPEN ticket to DHS to request an agency error change option.

**Example:** A processing entity enrolls an enrollee into health plan A on Feb. 2, 2023, with an effective date of March 1, 2023. On March 5, 2023, the enrollee contacts the processing entity to report there was an error. The enrollee wanted to be in health plan B. The worker confirms the initial enrollment request was received timely and the enrollee requested health plan B. The enrollee is fine with enrolling into health plan B with an effective date of April 1, 2023. The worker makes the change to health plan B for April 1, 2023.

**Example:** A processing entity enrolls an enrollee into health plan A on Feb. 2, 2023, with an effective date of March 1, 2023. On March 5, 2023, the enrollee contacts the processing entity to report there was an error. The enrollee wanted to be in health plan B. The worker confirms the initial enrollment request was received timely and the enrollee requested health plan B. The enrollee reports they need to be enrolled into health plan B with an effective date of March 1, 2023, for continuity of care reasons. The worker submits an HPEN ticket to DHS to request an agency error change option.

### **Break in Coverage Greater Than Two Months**

Enrollees who lose coverage for more than two months may request to change health plans. DHS must receive the request within 60 days of reenrollment. Changes are effective the next available month based on the managed care cut-off date.

### **Enrollee Has Change in Major Program**

Enrollees who have a change in their major program may request to change health plans. DHS must receive the request within 60 days of the program change. Changes are effective the next available month based on the managed care cut-off date. An enrollee who has a change in eligibility from MinnesotaCare to Medical Assistance, or the other way around, would qualify for this change option.

### **Enrollee Has Change in Disability or Elderly Eligibility Type**

Enrollees who have a change in their disability type that results in losing or gaining disability status may request to change health plans. Enrollees who gain an elderly eligibility type may also request to change health plans. DHS must receive the request within 60 days of the program change. Changes are effective the next available month based on the managed care cut-off date.

**Example:** An enrollee who has a change from MA/AX to MA/DX eligibility type or MA/AX to MA/EX eligibility type would qualify for this change option.

**Example:** An enrollee who has a change from MA/DX to MA/AX eligibility type would qualify for this change option.

### **Disenrollment from Health Plan Greater Than 12 Months**

PMAP enrollees who are disenrolled from managed care for more than 12 consecutive months but otherwise retain their medical coverage may request to change health plans. DHS must receive the request within 60 days of reenrollment.

### **Termination of Health Plan Contract**

The termination of health plan contract option applies when a health plan stops providing services in a given county. If a health plan contract is being terminated, DHS will send a notice to the impacted enrollees asking them to select a new health plan. The health plan must also notify its enrollees at least 60 days prior to termination from the Prepaid Managed Health Care Programs (PMHCP). **A plan can leave a county as part of procurement impacting enrollees during AHPS or outside of procurement at other times of the year.**

**Example:** If a health plan is in a county and its contract is terminated from that county for the next calendar year, enrollees must enroll in a new health plan for the first of the next year or they will be placed in a default health plan. PMHCP enrollees would have the right to change health plans in the first 60 days of enrollment in the new health plan. The 60 days is counted from the first date the person is enrolled in the new health plan.

### **Good Cause Changes**

Federal law allows an enrollee to change health plans at any time for “good cause” (42 C.F.R. 438.56[d]). DHS approves the good cause change option on a case-by-case basis. Possible issues include but are not limited to:

- The health plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee needs related services to be performed at the same time; not all related services are available within the health plan network; and the enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
- Other reasons, including but not limited to: poor quality of care, lack of access to services covered under the contract, or lack of access to provider experienced in dealing with enrollee’s health care needs.

Ensure the enrollee has worked with the health plan to resolve the issue and if they cannot find a resolution, submit an HPEN ticket.

### **Continuity of Care**

Continuity of care changes are determined on a case-by-case basis and DHS reviews the requests. Review the following list of questions with the enrollee when requesting a continuity of care change.

- What doctor or clinic is the enrollee requesting to go to?
- Is the physician or clinic available in the enrollee’s current health plan?
- Has the health plan been contacted to discuss if they will cover the service or location?
- Was a referral requested from the health plan or clinic?
- What service is the enrollee having difficulty obtaining?
- What is the medical problem?
- How long has the enrollee been receiving treatment for this condition with the clinic or doctor they are requesting; and how much longer is it estimated that the treatment course will need to continue?

Some continuity of care issues can be resolved through the ombudsperson office. Refer to [Ombudsman for Prepaid Managed Health Care Programs](#) for information on what they can do and when to call them. If the ombudsperson office is unable to assist, submit an HPEN ticket and include the information gathered from these questions as appropriate.

### **Change for Travel Time and Travel Distance**

An enrollee may change health plans if the travel time to the enrollee’s primary care provider is over 30 minutes or over 30 miles from the enrollee’s residence. An enrollee may change health plans if the travel time to the enrollee’s specialty care provider is over 60 minutes or over 60 miles from the enrollee’s residence. (Minnesota Rules, 9500.1453, Subp. 7).

### **Denying a Health Plan Change Request**

If the enrollee does not have a health plan change option available to them, the request to change plans is denied. Send [Health Plan Change Request Denied – Managed Care \(DHS-7192\) \(PDF\)](#) to the enrollee.

The denial notice should be sent within 10 days of receiving the change request. Case note in MMIS the denial, who the denial is for and the date the notice was sent.

If the processing entity is unable to make a change option determination, submit an HPEN ticket. DHS will assess the case for a change option and send a denial notice, if required. If DHS fails to

make a determination by the end of the month following the month in which the request was received, the request will be considered approved.

### **MSHO and SNBC Change Requests**

- An enrollee may disenroll at any time from their current MSHO plan and they will be enrolled into MSC+ with the same health plan. They do so by contacting their health plan or sending a signed statement requesting disenrollment to DHS. When disenrolling from MSHO, if the enrollee wants to choose a different MSC+ health plan, this request must be sent to DHS to be assessed for a change option. If the enrollee does not have a change option, the request will be denied by DHS. The enrollee can make a new request to change plans during the next AHPS.
- MSC+ enrollment is mandatory unless the enrollee meets exclusion criteria. Refer to the [Exclusions](#) page of this manual for more information on exclusions.
- If an enrollee wishes to disenroll from their current I-SNBC plan, they can only change integrated plans at certain times of the year as outlined by CMS. An enrollee may disenroll from their current I-SNBC plan and enroll into non-integrated SNBC or opt out and return to fee-for-service at any time by contacting their health plan or sending a signed statement requesting disenrollment to DHS.
- Managed care enrollment into non-integrated SNBC is voluntary. An enrollee can change health plans or opt out at any time by completing a [SNBC Choice Form \(DHS-6451\)](#) and sending it to DHS or contact Disability Hub™ at 866-333-2466 (toll free) or use their preferred relay service to assist them with disenrollment.