

## Managed Care Organizations (MCOs)

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### Overview

Most people eligible for Minnesota Health Care Programs (MHCP) are enrolled in managed care.

DHS contracts with managed care organizations (MCOs) (including counties or groups of counties known as county-based purchasing or CBP) to provide health care services for MHCP members. MHCP members in any of these programs must enroll in a managed care plan (unless excluded from enrollment):

- Medical Assistance (MA) for families and children under age 65
- MinnesotaCare
- Minnesota SeniorCare Plus (MSC+)
- Minnesota Senior Health Option ([MSHO](#))
- Special Needs BasicCare ([SNBC](#))

[Managed care organizations](#) (MCOs) are organizations certified by the Minnesota Department of Health (MDH) to provide all defined health care benefits to people enrolled in an MHCP in return for a capitated payment. MCOs are also known as health plans or prepaid health plans.

Each MCO:

- Determines its provider network.
- Determines how services are delivered.
- Determines which services require authorization or referral.
- Determines its reimbursement rates to providers.
- Determines additional benefits, if any, and alternative services that are cost effective and medically necessary to the needs of the member.
- Pays only for medically necessary services.
- May limit members to services provided through its provider network.
- May refer members to providers outside of its MCO network (the MCO is then responsible for payment of the services).
- Must cover member's urgent or emergency care, including outside of the MCO's network or service area; For out-of-country care, the MCO must not pay 1) for services delivered or items supplied outside of the United States; or 2) a provider, financial institution, or entity (including

subcontractors) located outside of the United States. This includes the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Nonemergency medical services are covered outside of the MCO's service area or network and may require authorization by the MCO. The MCO must be contacted as soon as the provider is aware of the member's participation in an MCO.

- Must cover open access services (family planning, diagnosis of infertility, testing and treatment of sexually transmitted infections, and testing for AIDS or other HIV-related conditions) at any doctor, clinic, pharmacy or family planning agency even if the provider is not in the network.
- Must have procedures for handling member grievances and appeals.

Except as described in this section, MCOs are not obligated to pay for services provided outside their networks. Providers must follow the member's MCO policies and procedures, including for authorizations and referrals, to receive payment for services.

### **Additional Resources**

- [Contact the MCO](#) with provider questions about coverage or contract issues.
- Direct members with questions as follows:
  - MCO coverage or network questions – to their MCO member services
  - Managed care enrollment for adults, families and children – to their [county and tribal human services agency](#)
  - MinnesotaCare eligibility – to the [Health Care Consumer Support \(HCCS\)](#) at 651-297-3862 or 800-657-3672
  - Seniors – to the [Senior Linkage Line \(SLL\)](#) at 800-333-2433
  - People with disabilities – to the [Disability Hub MN™](#) at 866-333-2466
  - Trouble getting services – to the [Managed Care Ombudsperson Office](#) at 800-657-3729 or 651-431-2660

### **Eligible Providers**

The 21<sup>st</sup> Century Cures Act requires states to enroll all Medicaid providers, both those in Medicaid fee for service (FFS) and those in MCO networks.

Each MCO establishes its own provider network. Providers interested in providing medical care to MHCP members through the MCO:

- Must contact the specific MCO directly for information on contracting with them.
- Effective July 17, 2023, MCO in-network providers are required to enroll with MHCP. Refer to the [Enrollment process for managed care organization \(MCO\) network providers](#) section of the DHS website for additional information and the [Enrollment with MHCP](#) Provider Manual page for the enrollment process and list of provider types DHS enrolls.
- Are responsible for all the terms of their MCO contracts.

Providers also have the responsibility to:

- Seek payment from their contracted MCO. MHCP will not pay providers for services provided to members enrolled in an MCO except as noted in the [Carve-out Services](#) section.
- Follow MCO guidelines and requirements for service authorization, referral, admission certification, coordination of benefits, second medical opinion, and more.

### **Eligible Members**

All MHCP MA members must enroll in an MCO, except those who have a basis for exclusion. Some members who are not required to enroll with an MCO may voluntarily enroll. All MinnesotaCare members must enroll in an MCO.

Coverage for members in a prepaid MCO is effective the first day of the next available month. Depending on when a member applies and is eligible, MA members may be on fee-for-service (FFS) coverage for a short time before they are enrolled in an MCO. MinnesotaCare members are enrolled in prepaid MCOs effective the first day of the month after the month eligibility is approved and a first premium payment is received, if a premium is required. They must pay the premium by noon on the last business day of the month preceding enrollment to ensure coverage.

### **Verifying Member Eligibility**

#### **MCO in-network only providers**

Providers who are not enrolled with FFS but are enrolled to provide services with one or more MCO should call the MCO directly with questions about member coverage.

#### **Fee-for-service and MCO in-network providers**

Fee-for-service providers serve members on Medical Assistance who are not enrolled with a managed care organization. Providers who are enrolled with both FFS and are MCO in-network providers must verify member eligibility and their MCO enrollment status through the [MN-ITS Eligibility \(270/271\) transaction](#) prior to performing services.

### **Excluded Members**

MA members who meet certain criteria are excluded from enrollment into an MCO. For example, members in the Refugee Assistance Program and the Emergency MA program are never enrolled into MCOs. Some members have a basis for exclusion but may voluntarily enroll.

### **Member Education and Enrollment**

MA members receive managed care education and enrollment from county staff. MinnesotaCare members receive education and enrollment materials through the mail. Members are:

- Informed of their MCO options when they apply for MA or MinnesotaCare.
- Encouraged to select an MCO (MCOs are assigned when not selected).
- Required to receive their health care services through their MCO network.

For MSHO and SNBC, education is completed by mail, phone or in person. Members are enrolled through the state or MCO. Members may ask for help from the [Senior Linkage Line \(SLL\)](#) or [Disability Hub MN™](#) about the various MCO options available.

### **Identification (ID) Cards**

In addition to their MHCP ID cards, members enrolled in an MCO also receive health plan member ID cards directly from their MCOs. Members must show both ID cards before receiving health care services. Members also must show the cards of any other health coverage they have, such as Medicare or private insurance.

### **Changing MCOs**

Members may change MCOs in the following situations:

- **Once during the first year of initial enrollment**, for any reason: To request this change, MA members must contact the county managed care enrollment office. MinnesotaCare members must contact the MinnesotaCare office. The change is effective for a future month.
- **Within the first 90 days of initial MCO enrollment**: This change option is available to members when they are initially enrolled in a MCO for 90 days or less.
- **During the annual health plan selection (AHPS) period**: Members are notified by mail once a year of the opportunity to change MCOs during AHPS. Members who elect to change MCOs during AHPS are enrolled in the new MCO at a date determined by DHS. Generally, AHPS takes place in the fall and any changes in MCOs are effective January 1 of the following year. Members who do not respond to the mailing remain in their current MCO if it is still available.

- **Following a permanent move outside of the MCO's service area:** The member must request a change within 60 days from the move date.
- **Following an MCO's unavailability in the county:** If an MCO no longer provides services in the member's county of residence, the member must select another MCO.
- **For good cause:** At any time, a member may request a change in MCOs for good cause, including lack of access to services and providers, lack of access to a provider experienced in dealing with member's health care needs, or poor quality of care. Members must contact their [county managed care advocates \(DHS-6666\) \(PDF\)](#) or the [state ombudsperson](#) to request this change.

MSHO and SNBC members may change plans monthly.

### **Transitioning from Fee For Service to MCO**

The following guidelines apply when members transition from FFS coverage to MCO enrollment.

#### **Authorized Services**

MHCP FFS covers both [authorized services](#) and services that do not require authorization **only** through the last day of a member's FFS eligibility.

The MCO:

- Must provide members medically necessary covered services that another MCO or MHCP FFS had authorized before enrollment in the MCO.
- May require the member to receive the services from an MCO network provider if that would not create an undue hardship on the member.

#### **Inpatient Status at MCO Enrollment**

If a member is an inpatient in the hospital on the day the MCO enrollment is effective, the inpatient stay and ancillary services will continue to be covered by the previous coverage (either FFS or the previous MCO). The previous MCO or FFS in effect at the time of admission remains financially responsible for the inpatient hospital stay and for any related ancillary services until discharge from the hospital. The new MCO will be responsible for the services not related to the inpatient hospital stay beginning on the effective date of the enrollment. The same policy applies when a member changes from an MCO to FFS.

#### **Newborn MCO Enrollment**

A newborn whose mother is enrolled in an MCO at the time of delivery is retroactively enrolled for the birth month. Unless the newborn meets an exclusion from managed care (refer to basis of exclusion) the following applies:

- If the managed care enrollment is entered within 90 days of the birth, the newborn is enrolled in the same MCO as the mother for the month of birth and succeeding months unless an MCO change is requested for the succeeding months.
- If the managed care enrollment is entered after 90 days from the date of the birth, the newborn is enrolled in an MCO for the birth month and then re-enrolled in the same MCO for the next available month unless an MCO change is requested for the future months.

A newborn will be enrolled in the same MCO as the mother for MA for families and children if the MCO is available. If the health plan is not available, the baby will be FFS.

This policy also applies to a baby born to a woman enrolled in SNBC.

## Ongoing Services

If a member is receiving ongoing medical services, such as mental health services, and the provider is not in the network of the member's MCO, the provider must contact the member's MCO for authorization to continue the service. Under some circumstances, the MCO may continue to authorize services by the non-participating provider, or may authorize a limited number of visits. Under some circumstances, the MCO will develop a transition plan, which will require the member to change to a provider in the MCO network.

## MCO Covered Services

Unless services are not included in the MCO contract ([Carve-out Services](#)), MCOs are required to provide all medically necessary health services covered under the contract, which include these access services:

- Interpreter services: contact the MCO or their participating clinic to arrange sign or spoken language interpreter services.
- Nonemergency Medical Transportation (NEMT) (bus, cab, volunteer driver): when required by contract, MCOs must provide nonemergency medical transportation for their MSC+, MSHO, Families and Children, MinnesotaCare (pregnant women and children under age 21), and SNBC members who have no other means of transportation to their medical appointments. Members must contact their [MCO](#) to arrange a ride.

MCO members must contact their county or tribal agency for reimbursement of meals, lodging, parking, personal mileage and out-of-state transportation:

- For members living in the 13 counties: Anoka, Benton, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Pine, Ramsey, Sherburne, Stearns, Washington, and Wright, MCO members must contact Minnesota Transportation Management for Minnesota Non-emergency Medical Transportation ([MTM MNET](#)) at 866-467-1724.
- For members living in the following counties: Aitkin, Carlton, Lake, and St. Louis must contact [MTM-MNET](#) at 844-399-9466 for local agency NEMT and related ancillary services.
- For members living in Carver or Scott counties must contact Smart Link 952-496-8341.
- Members in all other counties must contact their [county or tribal agency](#).

Managed care members may access services outside their MCO networks without authorization for the following services:

- Family planning
- Indian Health Services (IHS) facility or tribal provider
- Medical emergency

## Carve-out Services

Some services are "carved out" of MCO coverage based on the population and are covered through FFS MHCP. Bill the following services to MHCP directly:

- Abortion services
- Child Welfare-Targeted Case Management (CW-TCM)
- Developmental Disabilities (DD) case management
- Federally Qualified Health Centers (FQHC), except when the member is enrolled in MinnesotaCare or Medicare
- Home Care Nursing (HCN) services for members aged 64 and younger (this includes SNBC members and Medical Assistance for Families and Children)
- Intermediate Care Facilities/Developmental Disabilities (ICF/DD)
- Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) services provided by school districts
- Nursing facility per diems except for certain MSHO, MSC+ and SNBC members

- Officer-Involved Community-Based Care Coordination Services
- Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) for members aged 64 and younger (this includes SNBC members and Medical Assistance for Families and Children)
- Relocation service coordination (RSC) for SNBC members
- Waiver services under Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Developmental Disability (DD), and Elderly Waiver (EW) except when EW member with an MCO is enrolled in MSC+ or MSHO, then bill EW services to the MCO.

### **Grievance, Appeal and Advocacy Procedures**

For help resolving MCO or provider complaints, MCO members may contact:

- Their county managed care advocates
- The [Office of Ombudsperson for State Managed Health Care Programs](#)
- The [Minnesota Department of Health](#) or the appropriate licensing board (MDH cannot help with appeals having to do with MCO decisions.)

A provider, acting on behalf of the member and with the member's written consent, may file an appeal with the MCO or request a State Appeal (Fair Hearing with the state). The provider does not need written consent if the provider is appealing a prior authorization or payment denial.

### **MCO Notice of Action**

MCOs must notify their enrolled members with a written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice contains the following information:

- The action the MCO is taking
- The reason the MCO is taking this action
- The state and federal laws or MCO policies that support the MCO's action
- The process the member must follow to file an appeal with the MCO or the State

### **MCO and State Appeal Rights**

If the member disagrees with the MCO action, the member must appeal to the MCO before requesting a state appeal (Fair Hearing with the state).

The member:

- Must file the appeal with the MCO within 60 days from the date of notification to deny, terminate or reduce services or deny payment, in whole or part.
- May ask the MCO (in a health plan appeal) or the human services judge (in a State Appeal Hearing) for a fast appeal if the complaint is urgent.
- May have more time if they have a good reason for not appealing within 60 days.
- Must request a state appeal within 120 days of the date of the MCO decision on appeal. May request a state appeal if the MCO is taking more than 30 days to decide their appeal.

If the MCO is stopping or reducing a service, the member can ask to continue getting the service while the MCO appeal is being reviewed. **If a member wants the service to continue during the appeal, the member must ask for an appeal within 10 days** from the date of the notice or before the service is stopped or reduced, whichever is later. The member must ask to keep getting the services. The provider must agree it is medically necessary that the member should continue getting the service. The member can continue getting the service until the appeal is resolved. If the member loses the appeal, they may have to pay for these services, but only if state policy allows this.

Members may also continue benefits during the state appeal if they request a state appeal within 10 days from the date of the MCO appeal decision.

### **Legal References**

[Minnesota Statutes, 256B.69](#) (Prepaid Health Plans)

[Minnesota Statutes, 256D.03](#) (Responsibility to Provide General Assistance)

[Minnesota Statutes, 256L.12](#) (Managed Care)

[Minnesota Statutes, 62D](#) (Health Maintenance Organizations)

[Minnesota Statutes, 62M](#) (Utilization Review of Health Care)

[Minnesota Statutes, 62N](#) (Community Integrated Service Network)

[Minnesota Statutes, 62Q](#) (Health Plan Companies)

[Minnesota Statutes, 62T](#) (Community Purchasing Arrangements)

[Minnesota Rules, 9500.1450 to 9500.1464](#) (Administration of the Prepaid Medical Assistance Program)

[Minnesota Rules, 9505.0285](#) (Health Care Prepayment Plans or Prepaid Health Plans)

[Minnesota Rules, 9506.0200](#) (Prepaid MinnesotaCare Program; General)

[Minnesota Rules, 9506.0300](#) (Health Plan Services; Payment)

[Minnesota Rules, 9506.0400](#) (Other Managed Care Health Plan Obligations)

[Code of Federal Regulations, title 42, section 431](#) (State organization and general administration)

[Code of Federal Regulations, title 42, section 438](#) (Managed care)