Changing Managed Care Organizations (MCOs)

First Year Change Option

Enrollees may change to a new MCO during the first 12 months after initial enrollment in managed care. The first day of enrollment is defined as the initial effective date of MCO enrollment. Prepaid Medical Assistance Program (PMAP) and MinnesotaCare enrollees must contact their worker before the end of the first year after initial enrollment to change MCOs.

In Itasca County and with county based purchasing, enrollees have the right to select a new primary care physician or dentist at any time. To request a change, enrollees must contact their MCO.

The following is a list of reasons for health plan changes.

- AP Appeal
- FY First Year
- HP Health Plan Ended
- MV Move
- NT Ninety-Day
- OE Open Enrollment
- OT Other (updated at the Department of Human Services [DHS])
- SE Service Ended (updated at DHS)
- VL Voluntary (updated at DHS)

The change enrollment form will be processed as other forms are processed, keying in the new MCO for the next available month.

Suggested procedures for processing first year change forms are as follows:

- The first year change enrollment form must be received by the end of the 12th month after the initial enrollment date. If the form is received after cut-off, but still within the 12th month.
- The effective month is dependent on the date of receipt of the change requests. Requests received before managed care enrollment cut-off will be effective the following month.
- Verify the enrollee is eligible for a first year change.
- Verify that all persons listed on the request are eligible. Also determine if anyone else on the case should be added to the MCO. If an enrollee's family members are enrolled in a different MCO (Medical Assistance only), do not change their MCO, unless indicated on the change request. MinnesotaCare family members must all be enrolled in the same MCO.
- Change requests may be taken over the phone. Document the date and time of call, caller's name, phone number and all affected individuals. Enter in MMIS case notes.
- File paper requests.

Annual Health Plan Selection (AHPS)

The Department offers an annual enrollment period during which enrollees may change MCOs. Currently, AHPS takes place in the fall of the year. Enrollment in the new plan is effective January 1 of the following year.

The household is sent a notice about AHPS. Follow-up with the enrollee is not required with AHPS because switching MCOs is an option rather than a requirement.

Enrollees in counties with one MCO choice are notified of the opportunity to change primary care physicians, dentist and/or pharmacy. DHS sends the annual notice at the same time AHPS materials are mailed. Enrollees are directed to contact their MCO to change providers.

The following is a list of the 2023 AHPS notices:

- PMAP AHPS Multi-Plan Notice
- MinnesotaCare (MCRE) AHPS Multi-Plan Notice
- Senior and Special Needs BasicCare (SNBC) AHPS Multi-Plan Notice

- One-Plan Notice

AHPS Notification

Enrollees must be notified of the option to change MCOs or primary care providers before the AHPS enrollment period. The AHPS enrollment period is during the fall of each year. Recipients that were not eligible during the time of AHPS may be eligible to change health plans per managed care regulation 42 C.F.R. 438.56 (c)(2)(iii).

DHS will send an AHPS notice to all enrollees each year. The notice will inform enrollees of the opportunity to change MCOs. It will also give them a list of available MCOs.

Enrollees will be instructed to return the letter in the postpaid envelope if they want to change MCOs. DHS forwards the AHPS change requests for Medical Assistance (MA) cases to the appropriate county. All enrollment changes should be keyed before managed care enrollment cut-off in December.

AHPS Denials

Requests to change MCO, received after managed care cut-off in December should be reviewed to determine if the enrollee is eligible to change MCO's for a different reason. If the case is not eligible for a change the county, or DHS must send Annual Health Plan Selection – managed care letter (DHS-3354F) (PDF) along with a Notice about Your Rights and Responsibilities for Minnesota Managed Health Care Programs – MA and MinnesotaCare (DHS-3214) (PDF). This informs the enrollee they failed to request an enrollment change timely and lists the number to the Minnesota Managed Health Care Ombudsman. The forms are available on eDocs.

MCO Changes outside Regular Enrollment Periods

Termination of MCO Contract

A MCO must notify the State 150 days prior to terminating its contract. When a MCO terminates its contract with DHS, the Department will notify the county and/or MinnesotaCare enrollees. The MCO must notify its enrollees at least 60 days prior to termination in the PMHCP program. Enrollees will be notified of the need to choose a new MCO. Follow the same notification time frame as the AHPS process. The notice will include information about the enrollee's right to a 60 day MCO change option.

Other Change Options

An enrollee may change MCOs outside the regular enrollment periods (first year change option and open enrollment) in the following circumstances:

- The first 90 days of initial MCO enrollment. This change option is available each time of new MCO for 90 days or less.
- Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the AHPS period. Contact your enrollment coordinator to request this change.
- If there is a change in major medical program and the enrollee requests a change, i.e. MinnesotaCare to MA.
- An enrollee may change MCO's if the travel time to the enrollee's primary care provider is over 30 minutes from the enrollee's residence. Minnesota Rule 9500.1453, subp. 7.
- Agency error. Upon an enrollee's request, the county shall change an enrollee's MCO or primary care physician/dentist without a hearing when the enrollee's MCO or primary care physician/dentist choice was incorrectly designated due to local agency error. The county must contact their DHS Enrollment Coordinator for approval of this change. The county should also identify and report to their DHS Enrollment Coordinator if the error has caused any retroactive billing or access issues.
- Good cause. In addition to the specific instances above, federal law allows an enrollee to change MCOs at anytime for "good cause" 42 C.F.R. 438.56(d). This is a highly subjective exception and decisions are determined on a case by case basis. Issues involved could be, but are not limited to
  - The enrollee moves out of the MCO's service area.
  - The plan does not, because of moral or religions 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 with the 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 reason, included 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.
- The state agency must make a determination and take final action on the recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made 42 C.F.R. 438.56(e)(1). If the request to change is denied the managed care operations unit will send a written notice of denial to the enrollee, along with the enrollee's right to a State fair hearing.
- Continuity of Care - to assist you in recommending a continuity of care change below is a list of questions you could review with the recipient:

What doctor/clinic is the enrollee requesting to go to? Review if the physician/clinic is available in the enrollee's current MCO.

Has the MCO been contacted for assistance or was a referral requested from the MCO 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/doctor they are requesting and how much longer is it estimated that the treatment course will need to continue?

The effective month of the change will depend on the date of receipt of the change form or verbal request. Enroll the recipient in the new MCO for the next available month based on managed care cut-off dates.

Twelve Month Lock-In

Enrollees who have been in one MCO for over 12 months, without notification of their chance to change MCO during AHPS, will be allowed to change their MCO upon verification by the Department.

Relocation of Enrollees

A change in the county of residence for Prepaid Managed Health Care Programs (PMHCP) is defined as follows:

- Permanent change in county of residence; the enrollee's address is updated on the MAXIS/METS/MMIS system by the county financial worker or MinnesotaCare representative per eligibility policy.
- Temporary change in county of residence; the county financial worker or MinnesotaCare rep. does not update the MAXIS/METS/MMIS system with an address change per eligibility policy. For temporary changes of residence as defined above, or until MCO enrollment can be terminated, the MCO is responsible for providing emergency or other medically necessary services outside of their network when service authorization has been obtained from the MCO. A service area is defined as a county in which the prepaid MCO has contracted with DHS to provide services.

Denying a MCO Change Request

County financial workers, managed care advocates, and MinnesotaCare reps must send the recipient or their authorized representative a written denial notice and a Rights and Responsibilities brochure anytime a request to change MCO is denied (42 C.F.R. 438.56[f]). The denial notice should be sent within 10 days after receiving the request. Use the Health Plan Change Request Denied – Managed Care (DHS-7192) (PDF) available through eDocs. The worker must add the following information to the notice: the date of denial, case number, and recipient information. If the county or MinnesotaCare are unable to make a determination, refer the request to your DHS Enrollment Coordinator. DHS will then send a denial notice, if required. If the State fails to make a determination by the end of the month after the month the request was received the request will be considered approved.