FLORIDA HEALTH JUSTICE PROJECT

Important Change to Medicaid Managed Care in Florida and Continuity of Care Requirements

Beginning February 2025, all individuals in Florida Medicaid, except for a small group, will be automatically assigned by the Agency for Health Care Administration (AHCA) to a managed care plan, even if they are not required to be enrolled in a plan. Under the contracts, plans will be required to ensure continuity of care (COC) while you transition into your new plan.

You have a right to continuity of care.

➔ What is continuity of care?

Continuity of care is the right for Medicaid beneficiaries receiving services through managed care health plans to maintain their previously authorized benefits and services without interruption when the individual changes to a new plan or provider.

➔ What rights do I have with my new health plan under continuity of care?

Your new statewide Medicaid managed care plan or long-term care (LTC) plan is required to honor ongoing health care services or routine appointments that were previously authorized through a different plan or directly from Medicaid (fee-for-service) prior to enrollment in the new plan.

➔ Will my doctor need to stop providing treatment?

Your current health care provider should not cancel his or her appointment with you. Your new plan is responsible for the costs of continuation of your treatment for at least **90 days** after the effective date of enrollment, without any form of authorization and regardless of whether these services are being provided by participating or non-participating providers.

➔ What if my doctor refuses to provide treatment because he is not being paid enough or isn't being paid on time by the plan?

Your provider is entitled to the same level of reimbursement for **60 days** after the effective date of enrollment, even if they are not in-network, unless your doctor agrees to an alternative rate. In addition, your new plan is required to pay the doctor promptly, just as it is with in-network health care providers.

You have a right to a health care provider without a lengthy wait.

➔ After my last authorization for services expires and the current provider discharges us, how long will I have to wait for a new provider?

Your managed care plan is required to contract with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to you within 90 days. If an in-network provider is not available, the plan is required to adequately and timely cover these services out of network for you or be subject to a fine.

Continuity of Care for Dental Plans

➔ Does my Dental Plan have the same Continuity of Care Requirements as my Health Plan?

Your new dental plan is required to honor any ongoing previously authorized course of treatment or routine appointments for **at least 90 days** after the effective date of enrollment. Dental plans are required to reimburse your dental provider, even if they are not in network, at the rate they received prior to enrollment in the new plan **for a minimum of 30 days**, unless the provider agrees to an alternative rate.

Exceptions to Continuity of Care Requirements

➔ Will my treatment be covered for more than 60 days after my enrollment in the new plan?

Your current provider can be paid by your new plan for **more than 60 days** in the following circumstances:

- If you are pregnant, your new health plan is required to continue to pay for services provided by your current doctor for the entire course of your pregnancy, including the completion of your postpartum care (six (6) weeks after birth), regardless of whether your provider is in your new plan's network.
- If you have had a transplant, your new health plan is required to pay for services provided by your current doctor for one year post transplant, regardless of whether your doctor is in the plan's network.
- If you are a cancer patient receiving Radiation and/or Chemotherapy services, your new health plan is required to continue to pay for services provided by your current doctor for the duration of the current round of treatment, regardless of whether your doctor is in the new plan's network.
- If you are receiving Hepatitis C treatment, you are entitled to the full course of treatment.
- If you are enrolled in a LTC plan, your new plan is required to provide services according to the plan of care in order to address your LTC needs.

- If you are receiving active orthodontic care, it may extend past the standard COC period.

You have the right to complain if your rights are violated.

If the rights discussed herein are violated, then you have the right to complain. There is an AHCA homepage for Florida Medicaid Complaints where you can submit a Complaint against your managed care plan.

Once completed, you will be given a Complaint # which you can use to check the status of your complaint after 24-48 hours. Refer to FHJP's handout on How to File a Managed Care Complaint for more information.

If you need legal assistance because you were denied services, you can contact Florida Health Justice Project via our website at: Online Intake (legalserver.org)