FLORIDA HEALTH JUSTICE PROJECT

How to Change or Opt Out of Your Medicaid Managed Care Plan

All Medicaid enrollees have a right to pick a managed care plan that is best for them.

➔ When will I be assigned to a managed care plan?

Beginning February 1, 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.

➔ What if I want to change my managed care plan?

Once you are assigned, you have 120 days to pick another plan if you do not like the one you are assigned to. You may pick a new plan by contacting AHCA Choice Counseling or selecting the plan through the Choice Counseling online portal.

If you want to switch your plan, you should first confirm with AHCA Choice Counseling that your existing providers are in-network with the new plan.

➔ What do I do if the deadline to change my plan passes?

After 120 days, to switch plans, you must establish a "good cause" reason for switching.
The good cause reasons are below and you can also find them in the "Final" rule at this link.

A *star* next to the reason means you must first file a grievance with your plan before you can switch—unless the enrollee is at immediate risk of permanent damage to their health.
An explanation of how to file a grievance can be found in your plan's Member Handbook which are all accessible online.

- The plan does not cover the service you seek for the enrollee because of moral or religious objections.
- The enrollee's residential or institutional provider changes from in-network to out-of-network under the plan, leaving you in need of changing providers.
- The enrollment is fraudulent.
- The enrollee needs related services to be performed concurrently, but not all related services are available within the plan's network, and the enrollee's primary care provider or another provider has determined that receiving the services separately would subject the enrollee to unnecessary risk.*
- Poor quality of care.*
- Lack of access to services covered under the plan's contract with AHCA, including lack of access to medically-necessary specialty services.*

- There is a lack of access to plan providers experienced in dealing with the enrollee's health care needs.*
- The enrollee experiences an unreasonable delay or denial of service. A delay of service could be considered unreasonable when it exceeds the wait time standards in the contract (*see* the 60 day standard for a specialist below). A denial of service would be unreasonable if, for example, a service that has previously been authorized as medically necessary is denied without a new evaluation. *

Note: if you want to switch into a specialty plan, like CMS, you can make that switch at any time as long as the enrollee meets the eligibility criteria for the specialty plan.

Some enrollees have the right to "opt out" of managed care.

➔ Who must participate in managed care?

Most, but not all, Florida Medicaid enrollees must participate in managed care.

Those who are allowed to opt out of managed care are known as "voluntary" and include the following groups:

- Those enrolled on the iBudget waiver
- Those on the iBudget waitlist
- Those who have Medicaid as secondary health insurance (except Medicare)
- Those living in a group for people with I/DD
- Those who receive Prescribed Pediatric Extended Care (PPEC)

➔ If I do not have to participate in managed care, how do I opt out?

Beginning February 1, 2025, individuals, including those in a "voluntary" group, will be automatically enrolled into a managed care plan.

To opt out of managed care because you are in a "voluntary" group, contact AHCA Choice Counseling or log on to the online portal.

If you are denied the opportunity to opt out by your plan and AHCA, you may request an appeal with the Medicaid Hearing Unit at the Agency for Health Care Administration (AHCA). For guidance on the appeals process, refer to our handout How to File A Medicaid Managed Care Appeal.