

### **59G-8.600 Disenrollment from Managed Care Plans.**

(1) Purpose. A Florida Medicaid recipient (herein referred to as an enrollee) who is required to enroll in the Statewide Medicaid Managed Care (SMMC) program, may request to change managed care plans. Requests must be submitted via telephone or in writing to the Agency for Health Care Administration (AHCA) or its enrollment broker. Enrollees required to enroll in SMMC programs should not interpret this rule as an exemption from participation in Florida Medicaid's SMMC program. This rule applies to the process and reasons that SMMC managed care plan enrollees may change plans.

(2) Requests for disenrollment must be completed in accordance with sections 409.969(2)(a), (b), and (d), Florida Statutes (F.S.), and Title 42, Code of Federal Regulations (CFR), section 438.56 (42 CFR 438.56).

(3) Good Cause Reasons.

(a) The following reasons per 42 CFR 438.56(d)(2) and section 409.969(2), F.S., constitute good cause for disenrollment from a managed care plan:

1. The enrollee is receiving a medically necessary, active and continuing course of treatment from a provider that is not in the managed care plan's network, but is in the network of the managed care plan requested by the enrollee.

2. The managed care plan does not cover the service the enrollee seeks because of moral or religious objections.

3. The enrollee would have to change his or her residential or institutional provider based on the provider's change in status from an in-network to an out-of-network provider with the managed care plan.

4. Fraudulent enrollment.

(b) The following reasons, per 42 CFR 438.56(d)(2) and section 409.969(2), F.S., as confirmed by AHCA, constitute good cause for disenrollment from a managed care plan when the enrollee first seeks resolution through the managed care plan's grievance process in accordance with 42 CFR Section 438.56(d)(5), except when immediate risk of permanent damage to the enrollee's health is alleged.

1. The enrollee needs related services to be performed concurrently, but not all related services are available within the managed care 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.

2. Poor quality of care.

3. Lack of access to services covered under the managed care plan's contract with AHCA, including lack of access to medically-necessary specialty services.

4. There is a lack of access to managed care plan providers experienced in dealing with the enrollee's health care needs.

5. The enrollee experienced an unreasonable delay or denial of service pursuant to section 409.969(2), F.S.

(4) The Agency for Health Care Administration, or its designee, will review any relevant documentation submitted by the enrollee or the managed care plan regarding the disenrollment request and make a final determination about whether to grant the disenrollment request. The Agency for Health Care Administration will send written correspondence to the enrollee of any disenrollment decision. Enrollees dissatisfied with AHCA's determination may request a Florida Medicaid fair hearing, pursuant to 42 CFR Part 431, Subpart E.

*Rulemaking Authority 409.961 FS. Law Implemented 409.969 FS. History—New 2-26-09, Amended 11-8-16, 1-30-19.*