FAMILY-RELATED MEDICAID PROGRAMS FACT SHEET

April 2016

The Department of Children and Families (DCF) determines eligibility for public assistance programs in Florida. Federal regulations, Florida Statute and Administrative Rule contain specific policies for eligibility. The Family-Related Medicaid Programs Fact Sheet is intended to provide a general description and explanation of the Family-Related Medicaid Programs. Note: Eligibility standards change annually.

The Department of Children and Families determines eligibility for Medicaid. Medicaid may be authorized for up to three months prior to the date of application provided an applicant has unpaid medical bill(s) for one or more of the three months preceding the month of application. This is known as retroactive Medicaid. A notice of case action (NOCA) is mailed to the individual with information about the eligibility determination.

Individuals potentially eligible for Family-Related Medicaid include:

- Pregnant Women
- Parents and other Caretaker Relatives
- Infants under age 1
- Children under age 19
- Children age 19 up to 21
- Former Foster Care Children age 18 up to 26 – There is no income test for this group; however, the individual must have received Florida Medicaid when they aged out of foster care at age 18 in Florida as confirmed by the Office of Child Welfare.

The Family-Related Medicaid Income Limits chart is located at:
http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_07.pdf

Individuals may apply for Medicaid:

- On-line at the DCF/ACCESS Florida website at: http://www.myflorida.com/accessflorida/
- On-site at a DCF/ESS Customer Service Center. To locate a service center, "Select a County" from the "ACCESS Service Center Locations" option at: http://www.dcf.state.fl.us/programs/access/map.shtml
- On-site through a member of the DCF Community Partner Network. Community partners are listed at: http://www.dcf.state.fl.us/access/CPSLookup/search.aspx
- By submitting a paper application, which may be requested by calling 1-866-762-2237, and submitting it in person, by mail or fax. Customer Service Center locations and fax numbers can be found at: http://www.dcf.state.fl.us/programs/access/map.shtml

An individual must create a MyACCESS Account to submit an online application, report a change, submit a renewal or review benefit information at: http://www.myflorida.com/accessflorida/. This website is available 24 hours a day 7 days a week. After registering, customers can:

- Check on the status of an application or renewal
- View a list of items needed to process the application or renewal
- View when the next renewal is scheduled
- Upload and view verification documents
- View the share of cost amount if enrolled in the Medically Needy Program
- Print a temporary Medicaid card

Information may also be accessed by calling the ACCESS Response Unit (ARU) an automated response system available by phone at 1-866-762-2237.

Medicaid coverage is authorized for 12 months and to continue receiving coverage, a renewal must be completed annually. Applicants and recipients are required to report changes that may affect their eligibility for benefits within 10 days. Examples of changes affecting eligibility include:

- Pregnancy
- Birth of a child
- Receipt of new or increased earnings

- Termination of employment
- Arrival or departure of members of the household
- Changes in living arrangement
- Address
- Relocation to another state

Community Partner Network

The Community Partner Network allows coordination and communication between partner and government agencies, community organizations and other entities. Agencies, organizations and entities may contact a Community Partner Liaison to assist with inquiries about the ACCESS Program or to become a community partner. A Community Partner Liaison acts as a point of contact for the ACCESS Program, and provides trainings and other informational program brochures and forms. The Community Partner Liaison for each county can be found at: http://www.dcf.state.fl.us/programs/access/liaisons.shtml.

Overview of General Eligibility Requirements for Family-Related Medicaid

Applicants for Medicaid must be US citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers to facilitate data matching. Most factors of eligibility may be verified electronically via the Federal Data Services Hub (FDSH). Self-attestation is accepted for the majority of eligibility factors; however, a reasonable explanation and/or documentation may be requested to clarify questionable information or resolve inconsistencies.

Applicants for Medicaid must file for all benefits to which they may be entitled including pensions, Social Security and Medicare. Cooperation with Child Support Enforcement must be agreed to during the application process and completed after the eligibility process. Income from wages and self-employment are considered earned income in Medicaid programs. Some examples of unearned income include alimony, Reemployment Assistance (aka Unemployment Compensation), and Social Security benefits. Earned income as well as specific unearned income types are included in the benefit determination. Assets such as bank accounts, mutual funds, vehicles and homestead property will not be counted for Family-Related Medicaid coverage groups.

Family-Related Medicaid eligibility is based on the expected tax filing status for each individual. The household's countable income, after any allowable tax deductions, must be less than or equal to the applicable income limit.

In general, households whose income exceeds the limits for the Family-Related Medicaid will be enrolled in the Medically Needy Program, unless a more beneficial coverage group exists. Individuals enrolled in the Medically Needy Program, who do not qualify for regular Medicaid, may be referred to the Federally Facilitated Marketplace (FFM) or Children's Health Insurance Program (CHIP). See page seven (7) for additional information on the FFM and CHIP.

Descriptions of Family-Related coverage groups that are available and the eligibility requirements specific to each will be addressed on the following pages.

Presumptive Eligibility

Presumptive Eligibility by Hospitals – Florida Medicaid enrolled qualified hospital providers may elect to make presumptive determinations based on federal law and state policy for specific groups of individuals including:

- Pregnant Women
- Parents and other Caretaker Relatives
- Infants under age 1
- Children under age 19
- Former Foster Care Children age 18 up to 26 – There is no income test for this group; however, the individual must have received Florida Medicaid when they aged out of foster care in Florida.

The presumptive period begins with the date the eligibility determination is completed by qualified hospital staff and extends up to one additional month or until an application received for regular Medicaid coverage is approved or denied by the Department of Children and Families.

Hospitals are required to assist individuals determined presumptively eligible in completing an application for regular Medicaid.

Presumptive Eligibility for Pregnant Women (PEPW) – PEPW provides temporary Medicaid to pregnant women and immediate access to prenatal care. County Health Departments, Regional Perinatal Intensive Care Centers (RPICC), Federally Qualified Health Centers, Maternal and Infant Care Projects, Children's Medical Services (CMS) as well as some hospitals and hospital affiliated clinics determine eligibility for PEPW. Pregnant women with household income less than or equal to 185% of the Federal Poverty Level (FPL) may be eligible for coverage. Citizenship and noncitizen status are **not** factors for eligibility. The presumptive period begins with the date the eligibility determination is completed by the Qualified Designated Provider (QDP) and extends up to one additional month or until an application for regular Medicaid coverage is approved or denied by the Department of Children and Families. PEPW covers outpatient prenatal care only.

Presumptive Eligibility for Newborns – A child born to a mother, who is Medicaid eligible, on the date of the infant's birth, remains Medicaid eligible through the month of his or her first birthday, unless born on the first of the month. If the infant was born on the first of the month, eligibility under this coverage group ends on the last day of the month prior to the first birthday.

Family-Related Medicaid Coverage Groups

Coverage for Pregnant Women

Pregnant women may qualify for Medicaid if the household's countable income does not exceed the income limit for the program. Medicaid is provided for the pregnant woman for the duration of her pregnancy and two months post-partum.

Coverage for Parents and Other Caretaker Relatives

Parents and other caretaker relatives may be eligible for Medicaid. Parents and other caretaker relatives must have at least one minor child in the home, or be pregnant, to receive Medicaid if they otherwise meet the program's eligibility criteria. Parents and caretaker relatives, including their spouses, must be within the specified degree of relationship. This includes natural, biological, step or adoptive parents, siblings, first cousins, nephews, nieces, aunts, uncles, grandparents, and individuals of preceding generations as denoted by prefixes of great, and great-great.

Once the last child in the household turns 18 years of age, the parent(s) or other caretaker relative loses eligibility for coverage in Family-Related Medicaid.

Family-Related Medicaid Coverage Groups

Coverage for Children

Infants under age 1 – A newborn child is presumed eligible for Medicaid through the birth month of the following year when born to a mother eligible for Medicaid on the date of the child's birth. If the infant was born on the first of the month, eligibility under this coverage group ends on the last day of the month prior to the first birthday.

Children under age 19 – Medicaid may be provided to individuals under age 19, who are unmarried, not legally emancipated, or whose marriage was annulled.

Children Under 19 Living with Non-relatives – A non-relative may be a representative of an orphanage, a private adoption agency, or group home that is not state funded or may be a relative that is not within the specified degree of relationship to the child. Coverage is for the child only and only the child's income is considered.

Children 19 up to 21 Years Old – Medicaid may be provided to individuals who are 19 and 20 years old who are unmarried or whose marriage was annulled. Household income for the 19 and 20 year old must be below the payment standard and coverage is for the child only.

Former Foster Care Children – Individuals who are under age 26 may receive Medicaid if they were in foster care under the responsibility of the state and receiving Florida Medicaid when they aged out of foster care. There is no income limit for this coverage group.

Continuous Medicaid Eligibility – Children under age five who become ineligible for Medicaid for any reason, may remain on Medicaid for up to twelve months from the last application. Children age five to 19 may receive a minimum of six months of continuous coverage.

Children who do not qualify for Medicaid under any of these coverage groups may be referred to the Children's Health Insurance Program (CHIP) or referred to the Federally Facilitated Marketplace (FFM).

Children's Health Insurance Program (CHIP) – Program provides medical coverage for children under age 19 whose household income is above the Medicaid income limit. The household is responsible to pay a monthly premium for coverage. Additional information regarding CHIP is available at: http://www.floridakidcare.org/

Federally Facilitated Marketplace (FFM) – The Federally Facilitated Marketplace (FFM) is an online marketplace to assist individuals applying for a qualified health insurance plan. Individuals may qualify for Advance Premium Tax Credits (APTCs) to help pay health insurance premiums. Individuals will be referred to the FFM if they are determined over income for Family-Related Medicaid. Additional information regarding the FFM is available at: http://healthcare.gov

Children's Medical Services Network (CMS) – This program will provide case management services to eligible children from birth through age 18 who have special behavioral or physical health needs or have a chronic medical condition. Additional information regarding CMS is available at: http://www.cms-kids.com/families/families.html

Medically Needy

The Medically Needy Program helps individuals and pregnant women who would qualify for Medicaid except for having income that exceeds the program income limit. The Modified Adjusted Gross Income (MAGI) is used to determine an individual's share of cost. Verification of income must be received to accurately determine the amount of an individual's share of cost.

Individuals enrolled in Medically Needy may have a monthly "share of cost", which is similar to an insurance deductible. The share of cost amount varies depending on the household's size and income. Paid and/or unpaid medical bills must be provided to the Department of Children and Families to determine if the share of cost has been met. Once a bill is used to meet share of cost, it cannot be used again to meet the share of cost in another month. The portion of a bill that is paid by Medicare, or other private health insurance, cannot be used to meet the share of cost.

Medicaid cards are not issued to individuals who have a share of cost. Proof of eligibility will be made available on the MyACCESS Account once outstanding medical bills are tracked and the share of cost has been met.

Medical expenses eligible for Medicaid payment may be paid, unpaid and still owed, incurred up to three months prior to date of application, and not subject to third party payment. Paid and unpaid bills are tracked according to the date of service. Medicaid is authorized from the date the share of cost is met through the end of the same month. Any outstanding medical bills must be faxed to the local ACCESS Case Maintenance Unit for tracking. An individual may find contact information for their local ACCESS Case Maintenance Unit at: http://www.dcf.state.fl.us/programs/access/map.shtml.

The Medically Needy Brochure can be found on the Department's Forms and Brochures website at: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/brochures.

Emergency Medical Assistance for Noncitizens

Noncitizens who meet all Medicaid eligibility requirements except for citizenship status may be eligible for Medicaid to cover medical emergencies, including the birth of a child.

The noncitizen must file a complete Medicaid application and provide verifications as requested. A social security number and cooperation with Child Support Enforcement are not required.

Before Medicaid is authorized, applicants must provide proof from a medical professional that the treatment was due to a medical condition of sufficient severity (including severe pain) that could result in placing the individual's health in serious jeopardy and the date(s) of the emergency. In the case of labor and delivery there is no post-partum coverage. Medicaid can be approved only for the date(s) of the emergency. Generally, hospitals forward a Medical Assistance Referral form (CF-ES 2039) to the Department of Children and Families to initiate an Emergency Medical Assistance for Noncitizens (EMA) determination.

Noncitizens in the United States for a temporary reason, such as tourists or those traveling for business or pleasure, are not eligible for Emergency Medical Assistance for Noncitizens (EMA), or any other Medicaid benefits.

Information about your Medicaid Benefits

The Agency for Health Care Administration (AHCA) administers Medicaid services in Florida. To obtain information regarding Medicaid services and providers in your area, or for questions regarding claims or billing, please visit your Area Medicaid Office website at:
http://www.ahca.myflorida.com/MCHQ/Field_Office_Info.shtml

The Agency for Health Care Administration (AHCA) contracts with a fiscal agent to assist Medicaid recipients in choosing a managed care plan, enrolling in a new plan, or changing plans. Specialists assist customers with understanding the differences in plan benefits. Visit the Medicaid Options or Choice Counseling website at:
http://ahca.myflorida.com/Medicaid/medicaid_reform/beneficiary/index.shtml

Beginning January 2016, the Agency for Health Care Administration (AHCA) implemented an Express Enrollment program for individuals applying to receive Medicaid. Individuals receiving/eligible to receive medical services through the Managed Medical Assistance (MMA) program, must enroll in a health plan. The Express Enrollment program allows individuals to choose a health plan when a Medicaid application is submitted through the Department of Children and Families. Plan selection can be completed at: http://www.smmcexpressenrollment.com or by calling 1-877-711-3662. If a plan is not selected, AHCA will automatically assign individuals to a health plan once they are determined to be Medicaid eligible. After enrollment, individuals will have 120 days to choose a different plan in their region.

For more information about express enrollment, please visit the express enrollment website at:
http://ahca.myflorida.com/medicaid/statewide_mc/express_enroll.shtml

The Department of Children and Families (DCF) can process a request to replace a Medicaid card. To report a lost or stolen Medicaid card, SSI recipients may contact **1-866-762-2237**. Customers may request replacement Medicaid cards through their My ACCESS Account at:
http://www.myflorida.com/accessflorida/

The Social Security Administration (SSA) is responsible for specific benefits such as Social Security Retirement and Disability payments, Supplemental Security Income (SSI), Extra Help with Medicare Prescription Drug Plan costs, etc. For information, to apply, or report changes, call the Social Security Administration (SSA) at 1-800-772-1213 or visit the SSA website at: http://www.ssa.gov/

Medicare is a federal health insurance program that includes hospital insurance (Part A), medical insurance (Part B), Medicare HMO plans (Medicare Advantage), and Medicare prescription drug plans (Part D). For information about Medicare coverage, call 1-800-633-4227 or visit the Medicare website at: http://www.medicare.gov

Primary Care Centers provide services to the uninsured on a sliding fee scale. To obtain low cost primary care in your local community, including pharmacy, dental, mental health and substance abuse services, visit the Health Resources and Services Administration website at:
http://www.hrsa.gov/gethealthcare/index.html