

Virginia's State-Sponsored Health Insurance Programs

New Health Coverage for Adults

What Is New Health Care Coverage for Adults?

Passed by the General Assembly on May 30, 2018 and signed into law by the Governor on June 7, 2018, this is new Medicaid coverage for adults that went into effect on January 1, 2019. This category of Medicaid provides coverage for low-income adults ages 19 to 64 with incomes less than or equal to 138% of the Federal Poverty Level (FPL).

Established in 1965 as Title XIX of the Social Security Act, Medicaid is a joint federal and state program that provides essential health and related services to the most vulnerable populations in society. The program is the third largest source of health insurance in the United States after employer-based coverage and Medicare. The Medicaid program covers millions of low-income women, children, elderly people, and individuals with disabilities and provides medical coverage for about 19% of the total US population.

For every \$0.10 Virginia spends on the New Health Coverage for Adults, the Commonwealth receives \$0.90 in federal funding.

What Medical Services Are Covered?

New Health Coverage for Adults enrollees are eligible for the full Medicaid benefit package, including non-emergency transportation. Benefits are comprehensive and include some preventive services that haven't been covered in the Medicaid benefit package before.

While routine dental care is not covered for adults 21 and over as part of the package of benefits at this time, some of the Managed Care Organizations offer some limited dental services as "added benefits" to their members. Routine dental care will be added as a benefit in July 2021.

The health services are delivered via six Managed Care Organizations (MCOs), called the Medallion 4.0 program by the Virginia Department of Medical Assistance Services. Enrollees may select the MCO that will deliver their care from among the six.

Can this Coverage Pay For Recent Medical Bills?

When a person is determined to be eligible for the New Health Coverage for Adults, it may retroactively pay any outstanding medical bills for the three months prior to the application date. For example, if a signed application is received in April and ultimately results in enrollment, outstanding medical bills may be covered for January, February, and March if the enrollee would have been eligible for coverage during that time. This retroactive coverage

can be requested by answering the appropriate question on the application for coverage.

What Are The Costs?

While in the recipient is in the initial fee-for-service period after enrollment, small copayments apply (\$1 for a clinic visit or generic medicine, \$75 for a hospitalization). Participants in the program who receive services through a Managed Care Organization (MCO) have no copayments.

Does It Matter If The Person Already Has Health Insurance?

The person may already have health insurance and they can still be covered by the New Health Coverage for Adults. The other insurance plan would be billed first and Medicaid would be the second payer. The state coverage may cover some things the private insurance does not (i.e. non-emergency transportation).

Who Is Eligible?

US Citizens or legal immigrants ages 19 to 64 with qualifying incomes (\leq 138% FPL) are generally eligible for this coverage. While most of the non-financial rules are similar to those of other Medicaid categories, one difference is immigration status. A Lawful Permanent Resident (LPR) may be eligible for coverage only after the first five years of residence in the US. Refugees and asylees from certain countries are eligible for only the first seven years in the US. Qualified immigrants who are US military veterans or active duty military are also eligible.

*(Example – A single person can make up to \$1,482 a month and be financially eligible for new health coverage for adults.)**

**The figures given as examples here are based on the current Federal Poverty Guidelines, which are updated each year in late January/early February. They include the additional 5% FPL "standard disregard" allowed to applicants.*

How Long Does A Person Remain Eligible?

Coverage goes back to the first day of the month in which an approved application was received. If requested, coverage may also be retroactive for up to three-months prior to application.

Once approved, coverage will continue for 12 months, as long as no changes are reported. Changes in circumstances, like a pay raise or change in household size must be reported to the state within 10 days and will result in a reevaluation of ongoing eligibility.

It is especially important to inform the local Department of Social Services (LDSS) or Cover Virginia Call Center of a change in address; mail from DSS and the Department of Medical Assistance services (DMAS) is not forwarded, even if the individual has a change of address card on file with the Post Office. If DMAS or the LDSS gets returned mail, coverage may be cancelled.

Coverage must be reviewed at least once every 12 months to determine continued eligibility for coverage. If this annual renewal is not completed, coverage may be cancelled.

If the enrollee is over 138% FPL at renewal, he/she can be evaluated for Plan First, Virginia's family planning coverage. The individual may also be eligible to receive financial assistance toward purchasing private health insurance through the Health Insurance Marketplace. Losing Medicaid coverage, opens a "Special Enrollment Period" to shop for coverage in the Marketplace.

How Does A Person Apply for this Coverage?

Via Telephone: The person can apply over the phone with the Cover Virginia Call Center (855-242-8282) or the Federal Marketplace (800-318-2596). This is a good option if the individual's primary language is something other than English as both numbers have access to language translation services.

Via the Web: The person can apply online via Virginia's CommonHelp website (commonhelp.virginia.gov) or via the Marketplace (healthcare.gov).

Via Paper Application: The person can mail or take the "Application for Health Coverage & Help Paying Costs" paper application to his/her LDSS. This paper application could also be mailed to the Health Insurance Marketplace ("Marketplace.")

FAMIS Plus and Medicaid for Pregnant Women

What are FAMIS Plus and Medicaid for Pregnant Women?

FAMIS Plus is Medicaid for children in low-income families. Medicaid for Pregnant Women is the category of Medicaid for low-income pregnant women. "Medically Indigent" or "MI Medicaid" is the largest category of Medicaid providing coverage to children and pregnant women in Virginia. The income eligibility levels for children and pregnant women are higher than for most other types of Medicaid.

For every \$0.50 Virginia spends on Medicaid for children and pregnant women, the Commonwealth receives \$0.50 in federal funding.

What Medical Services Are Covered?

FAMIS Plus and Medicaid for Pregnant Women provide a comprehensive package of benefits uniquely designed to meet the needs of lower income children and expectant mothers. In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, these programs also cover services such as: behavioral health and substance abuse services, transportation to medical appointments, case management and health education for new mothers and babies with potential health risks, eye exams and glasses*, dental care*, and other services not often covered by

private health insurance plans. (**Pregnant women over the age of 21 are not eligible for eyeglasses or braces.*)

Of special note, children covered by FAMIS Plus are entitled to the EPSDT (Early Periodic Screening, Diagnosis and Treatment) program. This valuable component of Virginia's FAMIS Plus program provides comprehensive health screenings for children up to age 21. A medical condition diagnosed through an EPSDT screening must be treated at no cost to the family.

FAMIS Plus and Medicaid for Pregnant Women health services are delivered via six Managed Care Organizations (MCOs), called the Medallion 4.0 program. Enrollees may select the MCO that will deliver their care from among the six.

Can FAMIS Plus or Medicaid for Pregnant Women Pay for Recent Medical Bills?

When a child/pregnant woman is determined to be eligible, these programs may retroactively pay any outstanding medical bills for the three months prior to the application date. For example, if a signed application is received in March and ultimately results in enrollment, outstanding medical bills may be covered for December, January, and February, if the enrollee would have been eligible for FAMIS Plus/Medicaid for Pregnant Women during that time. This retroactive coverage can be requested by answering the appropriate question on the application for coverage.

Which Children Are Eligible For FAMIS Plus and Which Women are Eligible for Medicaid for Pregnant Women?

US Citizen or legal immigrant children under the age of 19 living in families with qualifying incomes are generally eligible for FAMIS Plus. In Virginia, income eligibility for FAMIS Plus is up to 148% FPL.

(Example – A family of 2 could earn \$25,782 a year or a family of 4 could earn \$39,220 a year and the child(ren) under age 19 would qualify financially for FAMIS Plus)

Medicaid for Pregnant Women is for pregnant women of any age who are US Citizens, or in certain legal immigrant categories, living in families with qualifying incomes. In Virginia, income eligibility for Medicaid for Pregnant Women is up to 148% FPL. It is important to note that a pregnant woman counts as two people (or more if multiple children are expected) when determining household size.

*(Example – A pregnant single mom applying is a family of 2 and she could earn up to \$25,782 a year and qualify financially for Medicaid for Pregnant Women)**

**The figures given as examples are based on the current Federal Poverty Guidelines, which are updated each year in late January/early February and include the 5% FPL disregard.*

Does It Matter If An Applicant Already Has Health Insurance?

Eligibility for FAMIS Plus and Medicaid for Pregnant Women is not affected by whether or not the applicant currently has any other health insurance or had it any time in the past. In the case of other current insurance, the Medicaid/FAMIS Plus benefits “wrap around” the other services providing supplemental benefits to a child’s/expectant woman’s private insurance plan (i.e. if the child’s plan doesn’t cover dental or vision services, or if the pregnant woman’s plan does not cover the pregnancy). The private/work-based health plan is the first payer and Medicaid/FAMIS Plus will pay last.

What Are The Costs For A Family?

There are no costs for covered services for children in FAMIS Plus or pregnant women in Medicaid for Pregnant Women.

How Does a Family Apply for Medicaid for Pregnant Women or FAMIS Plus?

The application process for FAMIS Plus and Medicaid for Pregnant Women is the same as that outlined under the New Coverage for Adults. You can apply by phone, online, or via a paper application mailed or taken to the local department of social services.

How Long Does A Child/Pregnant Woman Remain Eligible?

The family is responsible for reporting any change in circumstance that may affect the child’s eligibility for FAMIS Plus within 10 days of the change. This is generally a change in income or household size. Even if no changes occur, the child’s eligibility must be renewed every 12 months. DSS may contact the family prior to their renewal date and request current income information, if they cannot verify it electronically. Many children are terminated from FAMIS Plus because of the family’s failure to complete the annual renewal process.

Once a pregnant woman is enrolled in Medicaid for Pregnant Women, she is enrolled for the duration of her pregnancy and the 60 days postpartum regardless of any changes in income. This will increase to 12 months postpartum some time in 2021.

It is especially important to inform the local Department of Social Services (LDSS) or Cover Virginia Call Center of a change in address for a covered child or pregnant woman; mail from DSS and DMAS is not forwarded, even if the family has a change of address card on file with the Post Office. If either place gets returned mail, coverage may be cancelled.

Enrollment of the Medicaid for Pregnant Woman’s Newborn and Coverage Options for after the Pregnancy

Once a Medicaid recipient’s baby is born, her child will be deemed eligible and enrolled in FAMIS Plus for one year once she reports the birth to the state (via phone or fax with the Local DSS, online via CommonHelp, or phone via

the Cover Virginia Call Center). If birth-related expenses need to be paid, the family needs to call and report the birth within 3 months of the child's birth to ensure that these bills are covered.

After the 60 day postpartum period, a Medicaid for Pregnant Women recipient will be evaluated for eligibility for Low Income Families with Children (LIFC) Medicaid or the New Health Coverage for Adults. If she is over income for those programs, and the family income is still under 205% FPL, she could receive limited family planning coverage through Plan First, Virginia's family planning program.

Also, if the woman is over income for the New Health Coverage for Adults, she may be eligible for financial assistance toward purchasing private health insurance on the Health Insurance Marketplace. Ending Medicaid coverage allows for a "Special Enrollment Period" to explore coverage options there, even if it is outside of the normal open enrollment.

FAMIS

What Is FAMIS?

The state Children's Health Insurance Program (CHIP) was created by Congress as part of the Balanced Budget Act of 1997. States were given broad discretion to design CHIP programs to provide health insurance coverage for uninsured children in low to moderate-income families with incomes above the Medicaid/FAMIS Plus limit. Enacted as Title XXI of the Social Security Act, CHIP is also a partnership between the federal and state government, but a higher proportion of the cost is paid by federal tax dollars. For every \$0.35 Virginia spends on FAMIS, the Commonwealth receives \$0.65 in federal funding.

In October 1998, Virginia introduced its first CHIP program. In 2000, the Virginia General Assembly authorized a revamped program, the Family Access to Medical Insurance Security plan or "FAMIS" (pronounced like "famous"). FAMIS covers children up to 205% FPL and is designed to function like a private health insurance plan. Since that time the program has undergone many positive changes that have made it easier for children to get enrolled.

All 50 states, the District of Columbia, and some US territories now have approved CHIP programs. In February 2018, funding for the CHIP program was reauthorized by the US Congress for an additional 10 years.

What Medical Services Are Covered?

In Virginia, a FAMIS enrolled child receives benefits through Managed Care Organizations (MCOs). FAMIS benefits are similar to those generally available in comprehensive private health insurance plans. In fact, the benefit package is modeled after the health insurance plan provided to Virginia's state employees. While many medical services are covered by FAMIS, some have annual or lifetime "caps" or limits on the amount of service. There are two

FAMIS Plus benefits that are not available to FAMIS enrollees on an ongoing basis once the child is enrolled in an MCO: non-emergency transportation and EPSDT (though FAMIS does have “well-child” examinations for enrollees.) There are six MCOs that deliver FAMIS covered services in Virginia. Families choose their child’s FAMIS MCO by calling the Cover Virginia Call Center soon after their application has been approved.

Can FAMIS Pay For Recent Medical Bills?

FAMIS coverage is effective the first day of the month of application. Any unpaid medical bills during that month can be retroactively paid by FAMIS. In the case of a newborn, FAMIS may be retroactive to the baby’s date of birth if the date of application is within 3 months of that date and the baby would have been otherwise eligible for FAMIS during that time. An evaluation of eligibility for this period of coverage is required and is requested by answering a question on the application.

Which Children Are Eligible For FAMIS?

Uninsured children under the age of 19 living in families with qualifying incomes may be eligible for FAMIS. They must be US citizens or in certain legal immigrant categories. A child’s application must first be screened for FAMIS Plus eligibility and the child must be enrolled in FAMIS Plus if eligible for that program. The income limit for FAMIS is 205% FPL.

*(Example – A family of 2 earning \$35,711 a year or below or a family of 4 earning \$54,325 a year or below may have children eligible for FAMIS)**

**The figures given as examples are based on the current Federal Poverty Guidelines, which are updated each year in late January/early February and include the 5% FPL disregard.*

Does It Matter If The Child Already Has Health Insurance?

FAMIS is designed for **uninsured** children. Therefore, children currently covered by “creditable” health insurance policies are not eligible for FAMIS.

What Are The Costs For A Family?

There are costs for some services in the FAMIS program, but preventive health care services (well-child checkups, dental services, etc.) are free. Families with children enrolled in FAMIS are required to pay copayments for sick-care services (doctor visits, prescriptions, etc.) Depending on family income, these copayments are generally \$2 or \$5. Families are informed of their copayment levels on the Notice of Action and this information is also listed on the managed care card they receive for their children. Children of Alaska Native or American Indian descent do not pay copayments for any services.

There is, however, a limit set on the amount of cost-sharing a family will have in an enrollment year. For families with incomes at or below 150% FPL it is a family maximum of \$180. For families above 151% FPL, the maximum out-of-pocket cost is \$350.

How Long Does A Child Remain Eligible?

A child in FAMIS is guaranteed 12 months of continuous coverage in the program unless the child moves out of state, the household income rises above 205% FPL, or the child turns 19. The family is responsible for reporting the two changes listed above to the local DSS or the Cover Virginia Call Center. Otherwise, the child's eligibility must be renewed every 12 months. The state may contact the family prior to their renewal date and request updated information to determine if the child is still eligible for FAMIS. A child's coverage will automatically end at the end of the month in which he/she turns 19. At this time, the child will also be evaluated for ongoing coverage under the new Health Coverage for Adults Medicaid category.

Can A Family Use Their Employer's Health Insurance Instead?

There is a component of the FAMIS program, entitled "FAMIS *Select*," that allows the family to enroll in their employer-sponsored health insurance plan (or a private plan) and have FAMIS pay for a portion of the family coverage. The family would enroll their child in FAMIS first, then complete an online application for FAMIS *Select* coverage.

If at any time a family in FAMIS *Select* drops the private/employer coverage, the eligible children will revert to "regular" FAMIS coverage. Like regular FAMIS enrollees, a child must renew their coverage every 12 months.

FAMIS MOMS

What Is FAMIS MOMS?

Started on August 1, 2005, FAMIS MOMS is the newest addition to Virginia's CHIP program. It provides health insurance coverage for uninsured pregnant women in low to moderate-income families, who are not eligible for Medicaid due to excess income. Like FAMIS, for every \$0.35 Virginia spends on FAMIS, the Commonwealth receives \$0.65 in federal funding.

Eligibility for FAMIS MOMS is determined either at the LDSS or the Cover Virginia Central Processing Unit. Once enrolled, case management and ongoing case maintenance will be handled by the LDSS.

What Medical Services Are Covered?

Pregnant women found eligible for FAMIS MOMS receive the same benefits as women enrolled in Medicaid for Pregnant Women. Routine dental care was added in March 2015 and coverage for breast pumps and breastfeeding consultants was added in January 2016. Women enrolled in FAMIS MOMS who are over age 21 are not eligible for eyeglasses or braces.

FAMIS MOMS services are delivered through six Managed Care Organizations (MCOs). A FAMIS MOMS recipient must choose her MCO from among the six by contacting the Cover Virginia Call Center.

Can FAMIS MOMS Pay For Recent Medical Bills?

FAMIS MOMS coverage is effective the first day of the month of application. Any unpaid medical bills during that month can be retroactively paid by FAMIS MOMS.

What Are The Costs For A Pregnant Woman On FAMIS MOMS?

There are no costs for covered services for pregnant women enrolled in FAMIS MOMS.

Which Pregnant Women Are Eligible For FAMIS MOMS?

Any uninsured pregnant women living in families with eligible incomes that meet the nonfinancial eligibility criteria (including being a US citizen or in an eligible legal immigrant category) are eligible for FAMIS MOMS. A pregnant woman's application will be screened for Medicaid for Pregnant Women eligibility first and the pregnant woman must be enrolled in Medicaid for Pregnant Women if found eligible for that program. An applicant under age 19 will be screened for FAMIS Plus/FAMIS first and enrolled in the appropriate program, if eligible.

The income guidelines for FAMIS MOMS are 149% FPL to 205% FPL. If a pregnant woman is ineligible for Medicaid for Pregnant Women due to being over income, she is financially eligible for FAMIS MOMS if her income is under 205% FPL. It is important to note that a pregnant woman counts as a two people (or more if multiple children are expected) when determining household size.

*(Example – A single pregnant woman, a family of 2, earning \$35,711 a year or below may be eligible for FAMIS MOMS)**

**The figure given as an example is based on the current Federal Poverty Guidelines, which are updated each year in late January/early February and includes the 5% FPL disregard.*

Does It Matter If The Pregnant Woman Already Has Health Insurance?

FAMIS MOMS is designed for **uninsured** expectant mothers. Therefore, pregnant women currently covered by "creditable" health insurance policies are NOT eligible for FAMIS MOMS.

How Long Does A Pregnant Woman Remain Eligible?

Once a pregnant woman is enrolled in FAMIS MOMS, she is enrolled for the duration of her pregnancy and 60 days postpartum regardless of any changes in income or insurance status. Coverage will be extended to 12 months postpartum some time in 2021.

A FAMIS MOMS recipient may be eligible for family planning services through Virginia's "Plan First" Program after the 60-day postpartum period and she will be evaluated for this coverage. She may also be eligible for financial assistance toward purchasing private health insurance through the Health

Insurance Marketplace. Coming off of state-sponsored health insurance opens a "Special Enrollment Period" for the woman, and her family, to shop for coverage on the Marketplace.

Enrollment of the FAMIS MOMS Newborn

Once a FAMIS MOMS recipient's baby is born, her child will be deemed eligible and enrolled in coverage for one year once she contacts her local DSS or the Cover Virginia Call Center to report the birth (via phone or online at www.coverva.org). The child will be enrolled in the appropriate program (either FAMIS or FAMIS Plus) and the child's case will be managed at the LDSS. If birth-related expenses need to be covered, the family needs to call and report the birth to the state within 3 months of the child's birth to ensure that these bills are covered.

Low Income Families with Children

What Is Low Income Families with Children?

Another one of the Medicaid covered groups is Low Income Families with Children (LIFC). This category of Medicaid provides coverage for low-income parents or a relative caretaker of a dependent child. A dependent child is defined as a child under the age of 18, or age 18 who is a full-time student in a secondary school or equivalent level of vocational or technical training or GED program who is reasonably expected to complete this schooling/training before or in the month he/she attains age 19. The parents or caretaker relative must be living with the dependent child. It is important to note that the child does not have to be covered by Medicaid for the parents/caretaker to be eligible for coverage.

A caretaker relative is an individual who is not a parent, but who is a relative (blood relative or by marriage) who is living with and assuming continuous responsibility for day to day care of the dependent child. Only **one** caretaker relative can be covered on a case.

For every \$0.50 Virginia spends on a LIFC recipient, the Commonwealth receives \$0.50 in federal funding.

What Medical Services Are Covered?

LIFC enrollees are eligible for the full Medicaid benefit package, including non-emergency transportation. Routine dental care is not covered for adults 21 and over at this time, unless offered as an added benefit by the Managed Care Organization delivering their care. Though vision exams are covered, there is no coverage for eyeglasses. Routine dental care will be added as a benefit in July 2021.

Can LIFC Pay For Recent Medical Bills?

Up to three months retroactive coverage is available in LIFC, just like in the new Health Coverage for Adults, FAMIS Plus, and Medicaid for Pregnant Women.

What Are The Costs For A Parent/Caretaker On LIFC?

While the LIFC recipient is in Fee-For-Service, small copayments are required for services (\$1 for a clinic visit; \$75 for an inpatient hospital admission). Once a LIFC recipients is enrolled with a Managed Care Organization they will no longer have copayments.

Does It Matter If The Person Already Has Health Insurance?

Parents or the caretaker relative may already have health insurance and can still be covered by LIFC. The other insurance plan would be billed first. LIFC may cover some things the private insurance does not (i.e. non-emergency transportation).

Who Is Eligible For LIFC?

US Citizen or legal immigrant parents, or a caretaker relative, living in families with qualifying incomes are generally eligible for LIFC. While most of the non-financial rules are similar to those of the Medicaid for Pregnant Women and FAMIS Plus programs, one difference is immigration status. A Lawful Permanent Resident (LPR) may be eligible for coverage only after the first five years of residence in the US. Refugees and asylees from certain countries are eligible for only the first seven years in the US. Qualified immigrants who are US military veterans or active duty military are also eligible.

The LIFC income guidelines, which change every year on July 1st, are not based on the Federal Poverty Level. They are based on the Consumer Price Index instead. Where a person lives also matters. For this program there are three income groups and DSS divided Virginia's localities amongst them. Group III has the highest allowable monthly income and Group I the lowest.


*(Example – A parent living in a family of two in Alexandria [locality Group III] can make up to \$761 a month and be financially eligible for LIFC. That same parent living in Accomack County [Group I] could only make \$471 or less per month to be eligible.)**

**These figures include the allowed 5% FPL disregard.*

How Long Does A Parent/Caretaker Remain Eligible?

Coverage goes back to the first day of the month in which an approved application was received. If requested, coverage may also be retroactive for up to three-months prior to application.

Once approved for Medicaid in the LIFC category, coverage will continue for 12 months, as long as no changes are reported. Coverage must be reviewed at least once every 12 months. If this annual review is not completed, coverage may be cancelled.



An additional period of coverage (four to twelve months) may be awarded to a LIFC recipient whose income goes up. Once that additional period ends, if the household income exceeds the LIFC limit but is still under 138% FPL, the person can be evaluated for ongoing coverage through the New Health Coverage for Adults. If over 138% FPL at renewal, he/she can be evaluated for Plan First, Virginia's family planning coverage. The individual may also be eligible to receive financial assistance toward purchasing private health insurance through the Health Insurance Marketplace. Losing LIFC Medicaid coverage, opens a "Special Enrollment Period" to shop for coverage in the Marketplace.

How Does A Parent or Caretaker Relative Apply for LIFC?

The application process for LIFC is the same as for the New Health Coverage for Adults, FAMIS Plus, FAMIS, Medicaid for Pregnant Women, FAMIS MOMS, and Plan First.

Medicaid for Former Foster Care Youth

What Is Medicaid for Former Foster Care Youth?

Another one of the Medicaid covered groups is Medicaid for Former Foster Care Youth (FFC). This category of Medicaid provides coverage for young adults who have aged out of state foster care (in Virginia or another state) and Medicaid at age 18. They are eligible for coverage, **regardless of income**, until age 26. One of the changes made possible by the Affordable Care Act was the ability of kids stay on their parent's health insurance plans until age 26. The federal government wanted to give former foster care youth a similar benefit, so they allowed states to extend Medicaid to these individuals.

For every \$0.50 Virginia spends on a Medicaid for Former Foster Care Youth recipient, the Commonwealth receives \$0.50 in federal funding.

What Medical Services Are Covered?

FFC enrollees are eligible for the full Medicaid benefit package, including non-emergency transportation. EPSDT benefits and routine dental care are available to enrollees under age 21. Routine dental care is not covered for adults 21 and over at this time, unless offered as an added benefit by the Managed Care Organization delivering their care. Routine dental care will be added as a benefit in July 2021.

Can FFC Pay For Recent Medical Bills?

Up to three months retroactive coverage is available to FFC recipients. This coverage can be requested on the Application.

What Are The Costs For A FFC Recipient?

While the recipient is in Fee-For-Service, small copayments are charged for services (\$1 for a clinic visit; \$75 for an inpatient hospital admission). FFC recipients receiving services through a Managed Care Organization have no copayments.

Does It Matter If The Person Already Has Health Insurance?

Individuals may already have health insurance and can still be covered by FFC. The other insurance plan would be billed first. FFC may cover some things the private insurance does not (i.e. non-emergency transportation).

Who Is Eligible For FFC?

While most of the non-financial rules are similar to those of the Medicaid for Pregnant Women and FAMIS Plus programs, one difference is immigration status. A Lawful Permanent Resident (LPR) may be eligible for coverage only after the first five years of residence in the US.

These individuals are eligible for coverage **regardless of their income.**

How Long Does A FFC Enrollee Remain Eligible?

Coverage goes back to the first day of the month in which an approved application was received. If requested, coverage may also be retroactive for up to three-months prior to application.

Once approved for Medicaid in the FFC category, coverage will continue for 12 months, as long as no changes are reported. Coverage must be reviewed at least once every 12 months. If this annual review is not completed, coverage may be cancelled. Coverage in this category will also end when the person turns 26. At that time, the individual also be evaluated for ongoing coverage under the new Health Coverage for Adults Medicaid category and income will count toward eligibility.

How Does A Person Apply for Medicaid for Former Foster Care Youth?

The application process for FFC is the same as for the New Health Coverage for Adults, FAMIS Plus, FAMIS, Medicaid for Pregnant Women, FAMIS MOMS, and Plan First.