Virginia's State-Sponsored Health Insurance Programs

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 individuals, children, elderly people, and people with disabilities and provides medical coverage for about 19% of the total US population.

Medicaid Expansion for Adults

What Is Medicaid Expansion for Adults?

Passed by the General Assembly on May 30, 2018 and signed into law by Governor Northam on June 7, 2018, this is 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).

For every $1.00 Virginia spends on Medicaid Expansion (MedEx), the Commonwealth receives $0.90 in federal funding.

What Medical Services Are Covered?

MedEx enrollees are eligible for the full Medicaid benefit package, including non-emergency medical transportation. Benefits are comprehensive and include some preventive services that haven't been covered in the Medicaid benefit package before. Dental care was added as a covered benefit in July 2021.

The health services are delivered via five Managed Care Organizations (MCOs). Enrollees may select the MCO that will deliver their care from among the five.

Can this Coverage Pay For Recent Medical Bills?

When a person is determined to be eligible for MedEx, coverage 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.

Does It Matter If The Person Already Has Health Insurance?

The person may already have health insurance and they can still be covered by MedEx. 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 qualified legal immigrants ages 19 to 64 with qualifying incomes (≤ 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 $1,732 a month and be financially eligible for MedEx.)**

**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 Virginia's Insurance Marketplace. Losing Medicaid coverage, opens a 90-day "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). 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 Virginia's Insurance Marketplace (Marketplace.virginia.gov).

Via Paper Application: The person can mail or take the "Application for Health Coverage & Help Paying Costs" paper application to his/her LDSS.

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 individuals. "Medically Indigent" or "MI Medicaid" is the largest category of Medicaid providing coverage to children and pregnant individuals in Virginia. The income eligibility levels for children and pregnant individuals are higher than for most other types of Medicaid.

For every $1.00 Virginia spends on Medicaid for children and pregnant individuals, 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 pregnant individuals. 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. Doula services were added in 2022. *(*Pregnant individuals 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) benefit. 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 five Managed Care Organizations (MCOs). Enrollees may select the MCO that will deliver their care from among the five.

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

When a child/pregnant individual 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.

Who is Eligible For FAMIS Plus or 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 $2,521 a month or a family of 4 could earn $3,848 a month and the child(ren) under age 19 would qualify financially for FAMIS Plus)*

Medicaid for Pregnant Women is for pregnant individuals of any age who are US Citizens or lawfully residing non-citizens, 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 individual counts as two people (or more if multiple children are expected) when determining household size.

> *(Example – A pregnant single mom applying is considered a family of 2. She could earn up to $2,521 a month 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/pregnant individual's private insurance plan (i.e. if the child's plan doesn't cover dental or vision services, or if the pregnant individual'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/Individual?

There are no costs for covered services in FAMIS Plus or 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 Medicaid Expansion for Adults on Pages 1.2-1.3. People can apply by phone, online, or via a paper application mailed or taken to the local department of social services.

How Long Does Someone Enrolled in FAMIS Plus/Medicaid for Pregnant Women Remain Eligible?

Starting January 1, 2024, once a child is found eligible for FAMIS Plus, s/he is entitled to 12 month's continuous coverage, except in a limited number of instances (e.g. moving out of state, turning 19.)

Once enrolled in Medicaid for Pregnant Women, the pregnant individual is enrolled for the duration of the pregnancy and for 12 months postpartum regardless of any changes in income.

The family/enrollee is responsible for reporting any change in circumstance that may affect the eligibility within 10 days of the change. 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 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.

A child's eligibility must be renewed every 12 months. DSS may contact the family prior to his/her renewal date and request current income information, if it cannot be verified electronically. Many children are terminated from FAMIS Plus because of the family's failure to complete the annual renewal process.

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

Once a Medicaid enrollee's baby is born, the child will be deemed eligible and enrolled in FAMIS Plus for one year once the birth is reported 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 12 month postpartum period, a Medicaid for Pregnant Women enrollee will be evaluated for eligibility for Low Income Families with Children (LIFC) program or Medicaid Expansion for Adults. If over income for those programs, the individual may be eligible for financial assistance toward

purchasing private health insurance on Virginia's Insurance Marketplace. Losing Medicaid coverage allows for a 90-day "Special Enrollment Period" to explore coverage options there, even if it is outside of the normal open enrollment. If the family income is still under 205% FPL, she could receive limited family planning coverage through Plan First, Virginia's family planning program.

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 $100 Virginia spends on FAMIS, the Commonwealth receives $0.66 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 five 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 lawfully residing non-citizens. 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 $3,492 a month or below or a family of 4 earning $5,330 a month 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.

How Does a Family Apply for FAMIS for their children?

The application process for FAMIS is the same as that outlined under the Medicaid Expansion for Adults on Pages 1.2-1.3. 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 Remain Eligible?

Starting January 1, 2024, once a child is found eligible for FAMIS, s/he is entitled to 12 month's continuous coverage, except in a limited number of instances (e.g. moving out of state, turning 19.) The family is responsible for reporting changes to the local DSS or the Cover Virginia Call Center. The child's eligibility must be renewed every 12 months. The state may contact the family prior to the child's 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 s/he turns 19. At this time, the child will also be evaluated for ongoing coverage under Medicaid Expansion for Adults.

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 call (888) 802-5437 to apply 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 ever 12 months.

FAMIS MOMS

What is FAMIS MOMS?

Started on August 1, 2005, FAMIS MOMS provides health insurance coverage for uninsured pregnant individuals in low to moderate-income families, who are not eligible for Medicaid due to excess income. Like FAMIS, for every $1.00 Virginia spends on FAMIS MOMS, the Commonwealth receives $0.66 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?

FAMIS MOMS enrollees receive the same benefits as those enrolled in Medicaid for Pregnant Women. Routine dental care was added in March 2015 and coverage for breast pumps and breast-feeding consultants was added in January 2016. Doula services were added in 2022. FAMIS MOMS enrollees who are age 21 or over are not eligible for eyeglasses or braces.

FAMIS MOMS services are delivered through five Managed Care Organizations (MCOs). FAMIS MOMS enrollees may select the MCO that will deliver their care from among the five by calling 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.

Who is Eligible for FAMIS MOMS?

An uninsured pregnant individual living in a family with an eligible income that meets the nonfinancial eligibility criteria (including being a US citizen or a lawfully residing noncitizen) are eligible for FAMIS MOMS. The application will be screened for Medicaid for Pregnant Women eligibility first, and the pregnant individual must be enrolled in Medicaid for Pregnant Women if found eligible for that program.

The income guidelines for FAMIS MOMS are 149% FPL to 205% FPL. It is important to note that a pregnant individual counts as two people (or more if multiple children are expected) when determining household size.

*(Example – A single pregnant woman, a family of 2, earning $3,492 a month 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.*

Can a Pregnant Individual Who Already Has Health Insurance Qualify?

FAMIS MOMS is designed for **uninsured** pregnant individuals. Therefore, individuals currently covered by a "creditable" health insurance policy is NOT eligible for FAMIS MOMS.

How Long Does FAMIS MOMS Coverage Last?

Once a pregnant individual is enrolled in FAMIS MOMS, coverage continues for the duration of her pregnancy and 12 months postpartum regardless of any changes in income or insurance status.

A FAMIS MOMS enrollee should be evaluated for family planning services through Virginia's Plan First Program after the 12 month postpartum period and for financial assistance toward purchasing private health insurance through Virginia's Insurance Marketplace. Losing state-sponsored health insurance opens a 90-day "Special Enrollment Period" to shop for coverage on the Marketplace.

Enrollment of the FAMIS MOMS Newborn

Once a FAMIS MOMS enrollee's baby is born, the child will be deemed eligible and enrolled in coverage for one year once the birth is reported to the state (via phone or fax with the Local DSS, online via CommonHelp, or phone via the Cover Virginia Call Center). 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.

How Does A Pregnant Individual Apply for FAMIS MOMS?

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

FAMIS Prenatal Coverage

What is FAMIS Prenatal Coverage?

Started on July 1, 2021, FAMIS Prenatal Coverage is the newest addition to Virginia's CHIP program. It provides health insurance coverage for uninsured pregnant individuals in low to moderate-income families, who do not meet immigration status rules for other Medicaid coverage.

Eligibility for FAMIS Prenatal Coverage 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?

FAMIS Prenatal Coverage enrollees receive the same benefits as individuals enrolled in FAMIS MOMS, including routine dental care and coverage for breast pumps and breast-feeding consultants. Enrollees who are over age 21 are not eligible for eyeglasses or braces.

FAMIS Prenatal Coverage services are delivered through five Managed Care Organizations (MCOs). A FAMIS Prenatal Coverage recipient must choose an MCO from among the five by contacting the Cover Virginia Call Center.

Can FAMIS Prenatal Coverage Pay For Recent Medical Bills?

FAMIS Prenatal Coverage is effective the first day of the month of application. Any unpaid medical bills during that month can be retroactively paid by FAMIS Prenatal Coverage. It is possible that bills for emergency medical services up to three months prior to application may be covered by Emergency Medicaid but only if the pregnant individual had an income below 148% of the Federal Poverty Level at the time.

Who is Eligible For FAMIS Prenatal Coverage?

Any uninsured pregnant individuals living in families with eligible incomes that meet the financial and nonfinancial eligibility criteria (excluding immigration status and the need for a Social Security Number) are eligible for FAMIS Prenatal Coverage.

The income guidelines for FAMIS Prenatal Coverage are between 0% FPL to 205% FPL. It is important to note that a pregnant individual counts as a two people (or more if multiple children are expected) when determining household size.

> *(Example – A single pregnant woman without lawful immigrant status, a family of 2, earning $3,492 a year or below may be eligible for FAMIS PC)**

**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.*

Can a Pregnant Individual Who Already Has Health Insurance Qualify?

FAMIS Prenatal Coverage is designed for **uninsured** expectant individuals. Therefore, a pregnant person currently covered by a "creditable" health insurance policy is NOT eligible for FAMIS Prenatal Coverage.

How Long Does FAMIS Prenatal Coverage Last?

Once a pregnant individual is enrolled in FAMIS Prenatal Coverage, that coverage continues for the duration of the pregnancy and to the end of the month in which the 60th day following the end of the pregnancy occurs, regardless of changes in income or insurance status.

Enrollment of the FAMIS Prenatal Coverage Newborn

An infant born to a FAMIS Prenatal Coverage enrollee will receive ongoing coverage beginning at birth. The coverage will be in FAMIS Plus (children's Medicaid) or FAMIS and is based on the mother's income at the time of application. An application does not need to be submitted for the baby, the family just needs to report the birth to the Cover Virginia Call Center, their Local Department of Social Services, or report it online via CommonHelp.

How Does A Pregnant Individual Apply for FAMIS Prenatal Coverage?

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

Low Income Families with Children

What Is Low Income Families with Children?

Low Income Families with Children (LIFC) 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 $1.00 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. Though vision exams are covered, there is no coverage for eyeglasses unless provided as an extra benefit by their MCO. Routine dental care was 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 Medicaid Expansion for Adults, FAMIS Plus, and Medicaid for Pregnant Women.

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 qualified 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 $891 a month and be financially eligible for LIFC. That same parent living in Accomack County [Group I] could only make $553 or less per month to be eligible.)**

If a parent or caretaker relative's household income exceeds these limits, s/he may still be eligible for Medicaid Expansion.

**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 Medicaid Expansion for Adults. If over 138% FPL at renewal, he/she can be evaluated for Plan First, Virginia's family planning coverage, and for financial assistance toward purchasing private health insurance through Virginia's Insurance Marketplace. Losing LIFC Medicaid coverage, opens a 90-day "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 Medicaid Expansion for Adults, FAMIS Plus, FAMIS, Medicaid for Pregnant Women, FAMIS MOMS, FAMIS Prenatal Coverage, and Plan First.

Medicaid for Former Foster Care Youth

What Is Medicaid for Former Foster Care Youth?

Medicaid for Former Foster Care Youth (FFC) 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 $1.00 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 medical transportation. EPSDT benefits are available to enrollees under age 21. Routine dental care was added as a benefit in July 2021.

Can FFC Pay For Recent Medical Bills?

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

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 Medicaid Expansion for Adults 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 Medicaid Expansion for Adults, FAMIS Plus, FAMIS, Medicaid for Pregnant Women, FAMIS MOMS, FAMIS Prenatal Coverage, and Plan First.