Florida's
MEDICAID
REDETERMINATION PLAN

BACKGROUND

Medicaid is health coverage option for low-income individuals and families. Due to the federal **Public Health Emergency**, the **Department of Children and Families** (Department), as required by the federal government, implemented processes to maintain Medicaid coverage for individuals, regardless of their financial eligibility. This resulted in the number of Medicaid recipients growing from 3.8 million to 5.5 million. In Florida, the Department determines **eligibility** for Medicaid, while the **Agency for Health Care Administration** administers the **Medicaid program**.

Once the continuous coverage requirement ends, the Department will return to the standard Medicaid review process, which ensures eligible recipients will continue to remain enrolled.

PLAN OBJECTIVES

Ensure continuity of Medicaid coverage for eligible individuals while promoting the availability of alternative health insurance providers.

Prioritize exceptional customer service through strong communication and community collaboration.

Leverage technology and operational efficiencies while being compliant with federal guidance.

FLORIDA'S PLAN SUMMARY

- **Increase efficiency** by **aligning public benefit cases** over a 12-month period.
- **Enhance customer service** by **reducing paperwork**.
- **Meet federal regulatory requirements** while **prioritizing Florida's families**.
- **Maximize technology** and **automation** to **enhance processes** and communication to recipients.
- **Automatic review** for recipients to determine Medicaid eligibility. If Medicaid cannot be automatically renewed, **recipients will receive a notice 45 days prior to their renewal date** with instructions on how to complete the renewal process.

FLORIDA WINS

- Technology enhancements and **automation implemented** to help process cases faster.
- **Utilization of technology** to communicate to recipients via email, text messaging and mail.
- More than **92% of our recipients enroll online.**
- Automatic partner referrals to organizations like **Florida Healthy Kids** and other **subsidized programs**.
- **Clear** and **robust communication** to recipients, partners and stakeholders.

*For more information, visit **myflfamilies.com**, or to check on the status of your benefits go to your **MyACCESS Account.***

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

FLORIDA'S MEDICAID REDETERMINATION PLAN

Florida's Plan to Return to Standard Medicaid Eligibility Processing

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EXECUTIVE SUMMARY

In Florida, the Department of Children and Families (Department) determines eligibility for Medicaid while the Agency for Health Care Administration (AHCA) administers the Medicaid program. Medicaid is health insurance coverage for low-income individuals and families. As required by the Families First Coronavirus Response Act, in March 2020 the Department implemented processes to maintain Medicaid eligibility for individuals no longer eligible during the Public Health Emergency (PHE). Medicaid beneficiaries who failed to recertify during the PHE also continued to be eligible. This resulted in the number of Medicaid recipients growing from 3.8 million in March 2020 to 5.5 million in November 2022. Under the Families First Coronavirus Response Act, Florida is currently receiving a 6.2 percent increase in the Federal Medical Assistance Percentage (FMAP) through the end of March 2023. In return for the increased FMAP rate, the State of Florida was not able to reduce eligibility or make it harder for eligible families to enroll in Medicaid. Additionally, the State of Florida was required to provide “continuous coverage” and not able to disenroll any individuals, with limited exceptions, even if they become ineligible for Medicaid.

In December 2022, Congress passed the Federal Consolidated Appropriations Act for 2023, which ends the continuous coverage provision on March 31, 2023, and is no longer linked to the end of the PHE. In addition, the Enhanced FMAP rate will begin to decrease incrementally each quarter until the end of 2023.

Florida’s economy has rebounded quickly and continues to outperform the nation in economic and labor market metrics. With our robust economic environment, many families have had an increase in income and the ability to obtain insurance through employment. This is welcomed news for many families, and the Department will work with them to ensure a smooth transition. Over the post-continuous coverage transition period, the Department will work to notify and communicate to all current Medicaid individuals their redetermination timeframes and next steps.

After March 31, 2023, the Department will follow federal guidance to redetermine Medicaid eligibility while working to ensure eligible individuals remain enrolled. The Centers for Medicare and Medicaid Services (CMS) allows state agencies up to 12 months to initiate Medicaid reviews once continuous coverage has ended. Florida will schedule and conduct redeterminations in a manner compliant with federal regulatory requirements over a 12-month period. To reduce the impact on families and to create efficiencies for the Department's workforce, the Department will align where possible and appropriate, family reviews for both Medicaid and Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance to Needy Families (TANF). CMS has also instituted a Medicare Special Enrollment Period (SEP) for Medicaid recipients who may qualify for Medicare after their continuous enrollment ends.

FLORIDA'S MEDICAID REDETERMINATION PLAN

Impact of the Public Health Emergency on Floridians enrolled in Medicaid

In Florida, the Department determines eligibility for Medicaid while AHCA administers the Medicaid program. Medicaid is health insurance coverage for low-income individuals and families. As required by the Families First Coronavirus Response Act, in March 2020 the Department implemented processes to preserve Medicaid eligibility for individuals no longer eligible during the PHE. The number of Floridians receiving Medicaid increased dramatically during the PHE from 3.8 million in March 2020 to 5.5 million in November 2022. Of the 5.5 million individuals, the Department determines eligibility for approximately 4.9 million, with the remainder addressed by other state and federal agencies.

Florida's Medicaid Redetermination Plan Objectives

- Ensure continuity of Medicaid coverage for eligible individuals while promoting the availability of alternate health insurance options for those who are no longer eligible.
- Prioritize exceptional customer service through strong communication and community collaboration.
- Leverage technology and operational efficiencies while being compliant with federal guidance.

CURRENT STATE – PROCESSING MEDICAID APPLICATIONS IN FLORIDA

Medicaid Eligibility in Florida

The Department of Children and Families determines Medicaid eligibility for:

- Parents and caretaker relatives of minor children
- Children (up to age 21)
- Pregnant women
- Certain individuals formerly in foster care (up to age 26)
- Aged, blind, or disabled individuals not receiving Supplemental Security Income

Florida has an integrated application that allows individuals to apply for Medicaid, SNAP (food assistance), and/or Temporary Assistance for Needy Families (TANF cash assistance) through a single application. Ninety-two percent of the Department's Medicaid applications and redeterminations are filed through the state's online Self-Service Portal, which is available 24 hours a day. Individuals may file a paper application via fax, mail, or in person at the Department's customer service centers or through community partner sites around the state.

Medicaid eligibility is determined by many factors including family circumstances, assets, and income. These factors are inter-related: for example, children and pregnant women are eligible with a higher family income than other adults. In normal circumstances, if a Medicaid individual's circumstances change, such as an increase in income or a change in household composition, they must report changes that may affect their eligibility.

Where possible, the Department processes Medicaid redeterminations without additional outreach to the recipient. The state approves Medicaid eligibility if it can make the determination based on the information provided by the individual and verifications provided through electronic data. Income is generally verified through the State Wage and Income Collection Agency (SWICA) and the state's Timesaving Innovation Process (TIP) automates case processing where possible. In cases where information cannot be automatically verified,

the Department will request additional documentation or information from individuals before making the determination. Most redeterminations occur without recipient involvement or in conjunction with a SNAP or TANF redetermination. During the continuous coverage period, Florida continued processing applications and redeterminations to keep individuals informed of their potential eligibility for Medicaid.

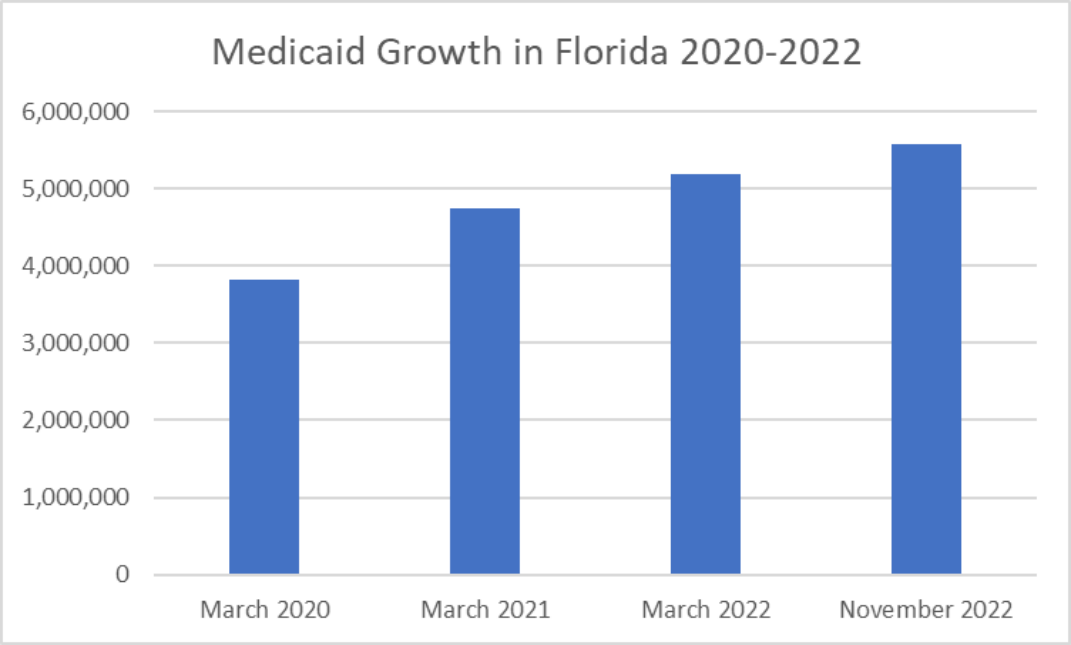
Under Governor DeSantis' leadership, Florida reopened quickly and continues to outperform the nation in key economic metrics. As of November 2022, Florida has experienced 31 consecutive months of job growth. With these economic successes in mind, we encourage all Floridians to contact their employer to see if health coverage options are available to them through their work benefits.

Processing Applications

When individuals are determined ineligible for Medicaid, their application is automatically transferred to Florida KidCare or the subsidized federal programs for review for eligibility for low-cost or subsidized insurance through those programs. In State Fiscal Year 2021, the Department completed an average of 119,217 Medicaid reviews each month and an average of 14 days to process Medicaid applications with 98 percent completed timely. For disability related cases, the average days to process applications is 20, of which 98 percent were completed timely.

By the Numbers

During the PHE, Florida saw an increase in the number of individuals and families seeking Medicaid assistance, from 3.8 million enrolled in March 2020 to 5.5 million in November 2022. Individuals who are determined eligible by the Social Security Administration (SSA) for Supplemental Security Income (SSI) are also enrolled in Medicaid. All others must apply through the Department. On average, the Department processes 220,658 Medicaid applications, redeterminations, or requests for additional assistance each month.



GETTING BACK TO NORMAL – WHEN CONTINUOUS COVERAGE ENDS

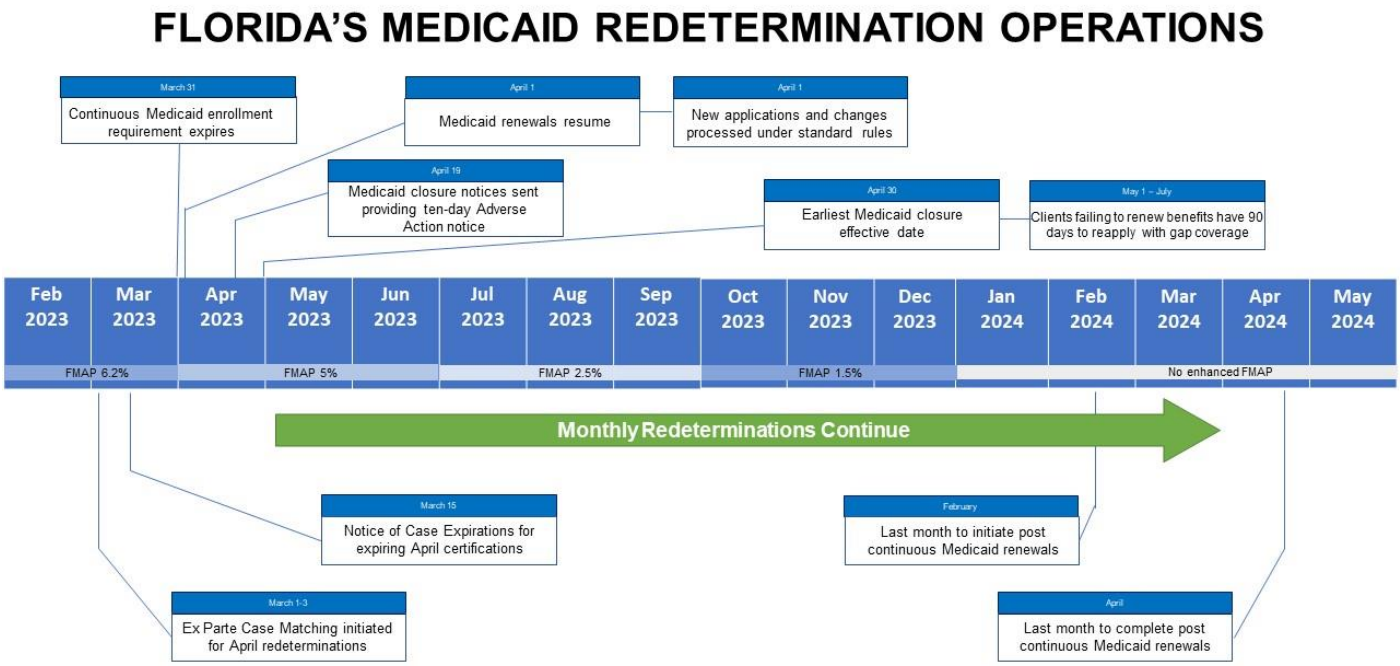
During the PHE, the Families First Coronavirus Response Act provided additional matching funds and required that states continue eligibility for Medicaid for individuals who were covered as of March 2020 or who subsequently became eligible. Individuals receiving Medicaid during this period were removed only if they moved from Florida, requested to be removed from Medicaid, or were deceased.

Federal regulations require that eligibility for Medicaid must be determined "promptly and without undue delay[1]." Eligibility determinations may not exceed 90 days for individuals applying for Medicaid based on a disability or 45 days for all other applicants.

[1] 42 CFR §§ 435.912

Federal Requirements & Guidance

Federal guidance requires states to conduct a full Medicaid redetermination after the continuous coverage period ends, even for individuals who were determined to be ineligible at their last review. States must initiate redeterminations for the total caseload by the last month of the 12-month unwinding period. Simply stated, the state must review all Medicaid cases for eligibility once continuous coverage has ended.



Since the Department continued to complete redeterminations during most of the PHE, the state can identify some approximate numbers of Medicaid households that include one or more individuals that are no longer eligible. During the PHE, an individual that became ineligible remained on Medicaid through continuous coverage, even if the family's income increased above the threshold, the family composition no longer qualified them for eligibility, or the individual or family no longer met another required eligibility factor. These cases were flagged with an indicator identifying that they were ineligible at last review. Because family circumstances may have changed since that determination, the Department will complete another review after continuous coverage ends before determining ineligibility for Medicaid

coverage. The Department estimates that, as of December 2022, there are more than 900,000 Medicaid cases in which one or more individuals in the case are no longer eligible.

In addition to those previously identified as ineligible, there are approximately 850,000 cases wherein Medicaid recipients have not responded to requests from the Department for updated information as a part of their regularly scheduled annual redetermination. In some instances, individuals may have not had their eligibility evaluated for up to three years but have continued to receive continuous coverage. Some individuals may have obtained other coverage or no longer need Medicaid, others may have moved without updating their address and did not receive notification of their redetermination.

Federal guidance allows states to schedule redeterminations at any time for individuals who were ineligible at their last review and those who have not completed a redetermination in the last 12 months. Additionally, federal guidance recommends that states prioritize workload in a manner that "considers the need to prevent inappropriate terminations" and achieves "an evenly-distributed renewal workload that is sustainable in future years."[2]

Florida's Operation Plan for Redeterminations and Eligibility Updates

Based on data available in December 2022, at least 16% of Medicaid households completing their redeterminations included at least one ineligible individual. Some may lose eligibility over the next 12 months, as in any year, due to changes in circumstances, including changes in income, or moving out of state. These individuals generally have a redetermination date already scheduled. Due to external factors, applications and redeterminations have historical peaks in certain months, including November, December, and January. The Department anticipates scheduling redeterminations in a manner that will come closer to equalizing

[2] SHO# 22-001

workload throughout the 12-month period, creating a caseload that aligns more appropriately to staffing, and achieves a greater level of service to individuals.

The Department's plan to conduct redeterminations is designed to return to normal business operations to meet federal regulatory requirements while ensuring eligible individuals continue to receive coverage and ineligible individuals are transitioned to other coverage where possible. The plan also reduces the impact on families and creates efficiencies for the workforce by reducing the number of interactions with recipients by aligning family reviews for both Medicaid and SNAP/TANF. In short, Florida will thoughtfully align benefit review and eligibility processes back to pre-PHE standards in a manner that will provide greater customer service for individuals.

Redetermination Prioritization

Florida has focused on continuity of coverage for eligible households while promoting alternative coverage for those who are no longer eligible. The state has developed a common-sense approach that seeks to prioritize reviews for those that may no longer wish to maintain Medicaid coverage or no longer meet eligibility requirements.

The state has prioritized for first review the group which is anticipated to experience the least negative impact: individuals who have been identified both as ineligible during the most recent redetermination review and have not used Medicaid benefits for at least 12 consecutive months. Individuals who were previously identified as ineligible will constitute the second priority. In addition, SSI recipients who are determined ineligible by SSA and are referred to the Department for an ex parte review will be processed in compliance with federal guidelines.

The Department also recognizes that families who receive multiple benefits, such as SNAP and TANF, may have multiple requirements to complete scheduled, periodic redeterminations. While these requirements are necessary to meet varying certification periods, each presents a risk that failure to complete the process will result in a loss of benefits. Where possible within the monthly processing capacity and existing prioritization, the Department will align Medicaid

redetermination dates to existing SNAP or TANF dates while maintaining any period of Medicaid eligibility that remains. For example, an individual with a Medicaid redetermination date in June and a SNAP recertification in August may, for example, have the Medicaid redetermination occur concurrently in August with the SNAP recertification.

Some Medicaid individuals have not completed a redetermination and will be assigned a redetermination date based on the time since the last redetermination. Similarly, certain Medicaid recipients who do not have an open case in our system, such as Family Planning services recipients determined eligible by the Department of Health, will receive a redetermination as capacity allows and in compliance with federal guidelines.

Finally, the Department coordinated with AHCA to identify Medicaid recipients under the age of 21 diagnosed with a medically complex condition. Similarly, the Department will delay redeterminations for certain other vulnerable groups, including SSI-related institutional care and hospice care with limited income sources. Redeterminations for these group will be postponed until the end of the redetermination period.

ACTIONS TO PROMOTE CONTINUITY OF COVERAGE

Redetermination at SNAP Recertification

Florida provides an integrated application process, allowing individuals to apply for SNAP, Medicaid, and TANF, as well as certain other benefits, on the same application. The integrated application process simplifies the receipt of benefits for Florida's families.

Because Florida is an integrated eligibility state, the state is able to leverage information from the SNAP and TANF program to support Medicaid eligibility determinations. Approximately 42 percent of Medicaid cases also receive SNAP and those recipients are required to recertify every four or six months. When a SNAP recertification is conducted and eligibility factors continue to be met for Medicaid, Medicaid can be extended for 12 months. For example, if an

individual receives both Medicaid and SNAP beginning in January, recertification for SNAP would be due in June to continue receipt of SNAP for July through December. The Medicaid recertification is scheduled for the following January. At the July SNAP review, if eligibility requirements are met, Medicaid can be extended for 12 months. If Medicaid eligibility cannot be established in July, the original 12-month Medicaid eligibility period remains, and a redetermination will occur in January.

Ex Parte Review

Florida's existing processes complete ex parte reviews for Medicaid eligibility for a significant number of cases. At the beginning of the month prior to each redetermination date, the system conducts data matching to evaluate Medicaid recipients for redetermination without contacting individuals. If the data matching does not provide sufficient information to renew Medicaid benefits, a notice is sent to the individual requesting they complete a redetermination.

Technology Enhancements

During the continuous coverage period, the Department implemented new technologies to provide enhanced service to individuals and streamline eligibility processes. Florida has long been a leader in the automation of applications and redeterminations, with more than 92 percent of applications and recertifications submitted electronically.

Enhancements already implemented include:

- Assisted address changes in the Self-Service Portal to facilitate the maintenance of up-to-date addresses.
- Created "How To" videos to assist individuals in updating addresses or making changes to their account.
- Extension of twelve months of continuous Medicaid coverage for postpartum women.
- Automated processes to allow Family Related Medicaid cases to close only after a review has occurred after the end of the continuous coverage period. Existing automation will prevent closure until the review.

- Enhanced returned mail processing that will identify Medicaid redetermination notices that will be referred for special handling/follow-up and to create automatic email or text notifications to individuals.

Additional technology enhancements that we are implementing:

- Changes to Ex Parte processes to increase the number of cases that will allow renewal based on data matching.
- Increased use of email and text messaging to alert customers when redeterminations are due.

Partner Referrals

Some Medicaid recipients who have experienced a change in circumstances that make them ineligible, such as increased income or a change in family composition, may be eligible for coverage through other subsidized state and federal programs. The Department automatically refers certain individuals who are no longer eligible for Medicaid coverage electronically to Florida Healthy Kids, the Medically Needy Program, and other subsidized federal programs.

Workforce

The Department has implemented strategies to maintain its workforce to support the increase in Medicaid redeterminations when the continuous coverage period ends. State strategies include:

- Streamline hiring practices to reduce time to fill positions.
- Provide overtime during the PHE to promote timely case processing.
- Enhance call center performance by:
  - Onboarding additional call center agents to provide support for individuals.
  - Hiring vendor staff to assist with overflow call volume.

- Both Department and vendor staff encourage callers to opt in to receiving case notifications via electronic delivery, ensuring we have accurate electronic contact information.
- Department and vendor staff are actively confirming mailing addresses to ensure the most accurate customer contact information is available to the Department.

- Review for consideration all flexibilities under federal regulations to gain operational capacity and efficiencies.

Fair Hearings

The Department's Office of Appeal Hearings affords due process to individuals who believe actions on their eligibility for benefits were made in error. The Office of Appeal Hearings is poised and ready to process appeal requests that may result from a denial in coverage under this process. However, if the Office of Appeal Hearings identifies that the number of hearing requests exceeds the capacity to respond in a timely manner, the Department may request, through AHCA, authority under section 1902 (e)(14)(A) to temporarily extend the timeframe to take final administrative action on fair hearing requests.

COMMUNICATION AND COMMUNITY OUTREACH

Outreach Goals and Strategies

Medicaid Redetermination Communication Objectives:

- Communicate clearly to recipients, the public, community partners, and stakeholders regarding the ending of continuous coverage and how this may impact their Medicaid enrollment.
- Educate individuals regarding the Department's Medicaid Redetermination Plan and health insurance options to ensure families are prepared and enrolled in health care coverage that meets their individual needs.

In 2022, the Department initiated efforts to ensure Medicaid recipients are aware of upcoming changes. The messaging highlights the urgency for individuals to provide updated contact information. Other key components of the messaging focus on ensuring individuals know it is important to look for and respond to future notices from the Department and understand their coverage options.

Outreach materials will be provided to AHCA for Medicaid health plans to use in assisting individuals in changing their address. Additionally, the Department is encouraging partner organizations, advocacy groups, and other state agencies to remind recipients to update their contact information with the Department. These organizations will have access to a partner packet to assist them in communicating with individuals.

The Department has worked to identify households that have moved and will contact them directly to alert them to change their address. Individuals that have identified a different address with a medical provider, a Medicaid health plan, or the Department's Electronic Benefit Transfer (EBT) provider are sent notifications to all available addresses indicating that they should update their address to ensure they can continue medical coverage.

The Department will leverage various communication channels to provide clear and engaging reminders for individuals to update their address and/or renew their benefits. The Department's Medicaid Redetermination outreach will occur through both direct and indirect messaging. Individuals will receive direct messaging through text messages, email, and mailed notices. Indirect messaging will occur through website, social media platforms, and Interactive Voice Response (IVR).

The Department is exploring additional outreach and customer support avenues that will be implemented before and after the end of continuous coverage.

Key Messaging

For messaging to be effective, it takes repetition. The Department's outreach and communication will focus on providing accurate and clear information to recipients on a

continuous basis through various communication channels. Individual-focused messaging will be available in English, Spanish, and Haitian Creole. Public outreach prior to the end of continuous coverage focuses on education and awareness, while reinforcing the importance of updated contact information and timeliness in responding to redetermination notices. Once continuous coverage ends, messaging will focus on education and awareness, leveraging many of the same communication channels previously engaged.

The Department will roll out direct messaging to Medicaid recipients who must complete the redetermination process which may include postcard mailers, letter notices, text messages, and emails. Redetermination notifications will also be provided to recipients in their Self-Service Portal account. Reminders will align with the recipient's planned redetermination schedule.

Postcard mailer: Individuals who have identified a different address with a medical provider, a Medicaid health plan, or the Department's Electronic Benefit Transfer (EBT) provider will be sent a postcard mailer to all available addresses indicating that they should update their address to ensure they can continue medical coverage. The postcard mailer will have an eye-catching graphic of a moving van encouraging individuals to take action to update their address.

Yellow Stripe Envelope: Medicaid redetermination notices will be identified with a special yellow stripe envelope and a communications campaign will be initiated to encourage individuals to watch for and respond to their notice.

Text Messaging: Redetermination notifications will be sent to Medicaid recipients through a text message campaign. Individuals with returned mail will receive an additional text message notifying them that they were sent a notice from the Department about their Medicaid, but it was returned undeliverable. All Medicaid recipients will receive a text message at the end of the continuous coverage period to let them know they will not lose coverage at this time and to look out for the redetermination notice.

Email Messaging: Individuals who have opted to receive email notifications for updates from their MyAccess account will receive a renewal email sent 45 days before they need to renew. The standard notice will inform individuals to visit their MyAccess account within the next 30 days to renew their benefits. Individuals will also be reminded again to ensure their address and phone number are up to date.

The Department will provide indirect outreach messaging through broad channels including the Department's webpage, social media, Medicaid Health Plans, stakeholders, and community partners. Messaging through indirect communication channels will occur on a continuous basis both before and after the end of continuous coverage.

Website: The Department will establish a webpage to educate and inform Medicaid individuals of what to expect, how to update contact information, and other available health insurance options. Individuals can browse a bank of frequently asked questions about Medicaid Redetermination as well as frequently asked questions about using their MyAccess portal for their renewal. A preview of the Department's notice will be displayed to assist individuals with knowing what to look out for and what they need to do when it is received. This webpage will serve as the state's centralized reference point for up-to-date information regarding Florida's Medicaid redetermination process and next steps. Additional messaging on the Department's webpage will include a continuous scrolling message on the MyAccess homepage and interactive messaging with the Department's virtual assistant.

Social Media: A social media campaign across multiple platforms will amplify the Department's public outreach. Eye-catching phrases and graphics will encourage individuals to update their address and take action to renew their benefits. A link to the MyAccess page and "DCF Virtual Assistant" will be shared in applicable posts to create a seamless path for individuals to update their address or renew their benefits. Short, animated videos will be made available for individuals who need additional assistance with logging into their MyAccess portal or understanding their health coverage options.

Community Partners and Stakeholders

Community partners and key stakeholders are included in the Department's public outreach efforts and will receive electronic fliers for display and distribution to connect individuals to more information on our website in English, Spanish, and Haitian Creole. Many of the Department's community partners support individuals with applying for public benefits or renewing their benefits. The Department sees community partners as a significant resource for message delivery to individuals. Communications to community partners occurs prior to and after the end of continuous coverage.

Partnering with Medicaid Health Plans

The Department will engage in a multi-faceted approach to work with AHCA and the Medicaid health plans to facilitate the maintenance of health coverage.

In anticipation of the end of continuous coverage, the Department provided AHCA with training materials for Medicaid health plans to use in assisting individuals in changing their address through the Department's Self-Service Portal or Call Center. The Department encourages all entities that interact with individuals to ensure individual contact information is current. After the redetermination dates are re-aligned, the Department will provide AHCA current redetermination date information, which will then be shared with the health plans to support individuals in completing their redeterminations.

GLOSSARY

Term/Acronym	Definition
AHCA	Agency for Healthcare Administration, the Florida agency that administers the Medicaid program (DCF determines eligibility for Medicaid).
CMS	Centers for Medicare and Medicaid Services, a federal partner guiding the state's Medicaid Redetermination.
Department of Children and Families' Medically Needy Program	A Medicaid program that allows Medicaid coverage after a monthly "share of cost" is met. The share of cost is determined by household size and family income. Individuals who are not eligible for "full" Medicaid because their income or assets are over the Medicaid program limits may qualify for this program.
Ex Parte Review	Where the Department reviews and renews the customer's Medicaid case automatically.
Federal Marketplace	Also known as the Health Insurance Marketplace, a shopping and enrollment service for medical insurance created by the Affordable Care Act of 2010.
Federally Qualified Health Center	Community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.
Florida KidCare	Florida Kidcare is the umbrella brand for the four government-sponsored health insurance programs – Medicaid, MediKids, Florida Healthy Kids (CHIP), and Children's Medical Services Health Plan, that provide health and dental coverage from birth to age 18.
Healthcare Navigator	Healthcare Navigators are individuals that can help consumers understand new coverage options and find the most affordable coverage that meets their health care needs. In Florida, these individuals must be trained and

	register with the Florida Department of Financial Services.
MAGI	Modified adjusted gross income refers to family-related Medicaid.
Medicaid health plans	Medicaid health plans are a managed care organizations that contract with the Agency for Healthcare Administration to provide healthcare coverage through the Medicaid Program
PHE	Public Health Emergency, declared through the U.S. Department of Health and Human Services, when a disease or disorder presents a public health emergency or that a PHE otherwise exists due to the significant outbreaks of infectious disease. PHE's can last up to 90 days and can be extended at any time by the U.S. Department of Health and Human Services.
SNAP	Supplemental Nutrition Assistance Program (SNAP) provides nutritional support for low-income seniors, people with disabilities living on fixed incomes, and other individuals and families with low incomes.
SSA	Social Security Administration, Federal agency determining aged related and disability benefits.
SSI-Related Medicaid	Individuals who are either aged 65 or older or disabled may be eligible for SSI – Related Medicaid.
TANF	Temporary Assistance for Needy Families, also known as Cash Assistance
TIP	Timesaving Innovation Process is the state's automated case processing program that verifies income with the State Wage and Income Collection Agency.

Medicaid Redetermination Communications Plan

Objective: Communicate clearly to recipients, the public, community partners, and stakeholders regarding the ending of the continuous coverage period and how this may impact the enrollment to the state's Medicaid program. The plan will educate recipients regarding the Department's Medicaid Redetermination Plan and health insurance options, to ensure families are prepared and enrolled in health care coverage that meets their individual needs.

Indirect Outreach

The Department will have an initial campaign of information through broad channels including our website, social media, Medicaid health plans, community partners, and other stakeholders about the continuous coverage period ending and what recipients need to do now.

Direct Messaging

The Department will roll out direct messaging to Medicaid recipients who need to go through the redetermination process. Reminders will align with the recipient's planned redetermination schedule. Medicaid recipients can redetermine benefits within two months of their predetermined redetermination date. Recipients who have an email address and a phone number in their MyACCESS account will receive additional reminders through email and text messaging.

Stakeholders:

- Current Medicaid Recipients
- Medicaid health plans
- Florida KidCare
- Agency for Health Care Administration
- Media
- General Public
- Advocacy Groups
- Community Partners
- Medical Providers
- Legislative Members
- Pharmacies
- DCF Employees & Leadership
- Healthcare Navigators
- Other social service executive agencies

Modes of Communication:

- Department's Website
  - Scrolling messages on MyAccess homepage (continuous)
  - Medicaid redetermination specific page on myflfamilies.com
  - FAQs
  - Virtual Assistant
  - Repackaged 'How To' videos

- Interactive Voice Response – Call Center Message & script
- Social Media
    - Reminders to Medicaid recipients to update information (corresponding graphics)
    - Videos and graphics on what to expect as a current Medicaid recipient
- Direct Messages to Medicaid Recipients
    - Email
    - Text Messages
    - Notices
- Partner Packets
    - Plan summary with QR code to community partners and stakeholders
        - Timeline
        - What to expect
        - How to help our recipients
    - Correspondence to MCOs
        - Letter communicating expectations to share resources outside of the current MCOs' health insurance plans
- Internal Employees
    - ESS training "Tip of the Week"
    - Policy Memos
    - Statewide ESS Operations Call (OCM)
    - Medicaid Redetermination Project Management Meetings

Content

- Florida's Medicaid Redetermination Plan
- Website Content
    - FAQs
    - Timeline (post ending of the continuous coverage period)
    - Chatbot messaging
    - 'How To' videos (repackaged)
    - Sample of the Department's Redetermination Notice
    - Resource flyer
- Social Media Messaging & Graphics
    - Reminder to update contact information

    - Tips for keeping individual's MyAccess account current
    - Medicaid recipient journeys
- Interactive Voice Response Message – Call Center recording
- Talking Points
    - Call Center / Hope Navigator scripts
    - PowerPoint for external meetings/ events
    - External talking points/ statements
- Medicaid Recipient Content
    - Notices – paper and email
    - Text messages
    - Post card regarding duplicate addresses
    - Count down reminders
    - Resource flyer
    - Recipient pathway / next steps

Content Language:

Website Content:

Florida's Medicaid Redetermination Plan

Since the beginning of the Public Health Emergency (PHE), as a requirement to receive additional funding from the federal government, Florida has provided continuous Medicaid coverage and has not disenrolled ineligible recipients. As a result of this policy, Florida saw a significant increase in the number of individuals and families seeking Medicaid assistance, from 3.8 million enrolled in March 2020 to 5.5 million in November 2022. Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients) while the Agency for Health Care Administration (AHCA) administers the Medicaid Program. Each month the Department processes, on average, 220,658 Medicaid applications, redeterminations, or requests for additional assistance.

As a result of legislative changes in the Consolidated Appropriations Act, 2023, the continuous coverage provision will end on March 31, 2023, and is untied from the end of the PHE. The Department will follow federal guidance to restore Medicaid eligibility through normal processing while working to ensure eligible recipients remain enrolled. The Centers for Medicare and Medicaid Services (CMS) allows state agencies up to 12 months to complete Medicaid reviews once the continuous coverage period ends. Florida will undertake this task by scheduling and conducting redeterminations in a manner that will meet federal regulatory requirements while minimizing the impact on families.

Florida's economy has rebounded quickly and continues to outperform the nation in economic and labor market metrics. With our robust economic environment, many families have had an increase in income and the ability to obtain insurance through employment. This is welcome news for many families, and the Department will work with them to ensure a smooth transition. Over the next 12 months, the Department will work to notify and communicate to all current Medicaid recipients their redetermination timeframes and next steps.

LINK FLORIDA'S MEDICAID REDETERMINATION PLAN (post after the ending of the continuous coverage period is announced)

The Florida Medicaid Redetermination Plan Objectives:

- Ensure continuity of Medicaid coverage for eligible individuals while promoting access to alternative health coverage providers.
- Prioritize exceptional customer service through strong communication and community collaboration.
- Leverage technology solutions to enhance operational efficiencies while being compliant with federal guidelines.

LINK FREQUENTLY ASKED QUESTIONS

Don't miss information about your Medicaid coverage – update your contact information here
MOVING GRAPHIC WITH LINK TO Self-Service Portal (SSP)

SSP Posted Scrolling Message: *Have you moved recently or changed your email address? Be sure to update your address with the DCF Virtual Assistant so you can stay up to date on your benefit information.*

FAQs:

What is a federal Public Health Emergency (PHE)?
A PHE is when the United States Department of Health and Human Services (HHS), a federal agency, declares that a disease or disorder presents a public health emergency or that a PHE otherwise exists due to the significant outbreaks of infectious disease. PHEs can last up 90 days and can be extended at any time by U.S. Department of Health and Human Services (HHS). For the COVID-19 pandemic, the federal government declared a PHE on January 31, 2020.

How does the federal PHE affect eligibility for Florida Medicaid?
The Families First Coronavirus Response Act requires that states maintain continuous Medicaid coverage for enrollees during the PHE. Florida has allowed individuals to remain on Medicaid throughout the PHE even though their household situation may have changed. As a result of federal legislative changes in the Consolidated Appropriations Act, 2023, the continuous coverage provision will end on March 31, 2023. Once the continuous coverage ends, some Medicaid recipients may no longer be enrolled in Medicaid.

When will the continuous coverage end for Medicaid?
The continuous coverage provision will end on March 31, 2023.

What will happen when the continuous coverage ends?
Over the course of 12 months the Department will review all Medicaid cases to ensure recipients are eligible for benefits. Many individuals will be the beneficiary of an automatic review and approval to continue Medicaid eligibility (also called passive renewal or ex parte renewal). In this case, individuals will receive a notice that their Medicaid case has been approved and their Medicaid coverage will continue.

If the Department cannot automatically review an individual's Medicaid coverage because additional information is required, the Department will send a notice 45 days prior to the renewal date with instructions on how to complete the renewal process. Individuals will have the opportunity to provide updated information to Department staff who will evaluate their eligibility for Medicaid. Upon receipt of this notice, it is important that individuals act timely to provide requested information to ensure they do not experience a disruption in Medicaid coverage.

For more information on how to sign up for e-mail notifications visit this link: Going Paperless: Email Notifications and Online Notices (myflfamilies.com)

If recipients have questions regarding their MyACCESS Account or about updating their contact information, please check out the 'How To' videos here: Access Florida - Florida Department of Children and Families (myflorida.com).

What should I do when the continuous coverage ends?
You should make sure your address on file is updated by logging in to your MyAccess account. Additionally, be on the lookout for a mailed or emailed notice from the Department to complete your renewal. Upon receipt of that notice, you should renew as quickly as possible by going to https://www.myflorida.com/accessflorida/ to update your Medicaid information. The Department may ask for additional information from you while your case is being reviewed.

What should I do if I am no longer eligible for Medicaid when the continuous coverage ends?
If you are no longer eligible for Medicaid coverage, the Department will send you a notification through your MyACCESS account, and by sending a letter or an email to you. To ensure continuing coverage, applications for individuals not determined eligible for Medicaid, but eligible for a different healthcare coverage program, will automatically be referred to Florida KidCare, the Medically Needy Program, and other subsidized federal healthcare programs. You can check your MyACCESS account to see if your application has been forwarded to one of these agencies.

Florida KidCare provides low-cost health coverage for children based on family income. You can learn more about this program at the following link: www.floridakidcare.org. The Medically Needy Program allows Medicaid coverage after a monthly "share of cost" is met, determined by household size and family income. You can learn more about the Medically Needy program at the following link: Medically Needy Brochure (myflfamilies.com).

If your application is transferred to the Federal Marketplace, you will receive a letter from the United States Department of Health and Human Services with instruction on how to complete an application for healthcare insurance. You can learn more about the Federal Marketplace at the following link: www.healthcare.gov.

What additional information or documentation may the Department need to complete my Medicaid redetermination?
Current Medicaid recipients have already provided verification of some eligibility factors, such as identity, Florida residence, citizenship or eligible immigration status. Example of additional information that may need to be provided includes but is not limited to, information about the members of your household, income and, for certain coverage, asset information.

How long will it take for the Department to review my Medicaid redetermination?
Once all the information needed to make a determination is available, the Department will make a decision on eligibility within 45 days. The Department will review your application to determine if you are eligible for Medicaid and the level of Medicaid coverage you are eligible to receive. If it is determined that you are not eligible for Medicaid, your application will be automatically referred electronically to Florida KidCare, the

Medically Needy Program, and other subsidized federal health programs. You can check your MyACCESS account to see if your application has been forwarded to one of these agencies.

Other Medical Help for Those Not Eligible for Medicaid

Individuals who are not eligible for Medicaid may get help with healthcare in their area through:

- Federally Qualified Health Centers

Individuals who are not eligible for Medicaid may get help with the cost of prescription drugs through:

- Florida Discount Drug Card Program, or
- FloridaRXCard.com

NOTE: These programs are not administered by the Department of Children and Families and are being provided as a potential healthcare resource for you and your family. The Department and its partners, including the Medicaid Health Plans, stand ready to help families secure other options to receive health care coverage including referrals to the Federally Qualified Health Centers, who provide primary care services on a sliding fee scale to individuals without health insurance.

To speak with a **Healthcare Navigator** for guidance on navigating the healthcare system, visit My Florida CFO for a contact list of Florida-registered and federally-certified Navigators. A guide on Health Insurance and HMO Overview is also available at My Florida CFO.

What if I think the determination that I am ineligible is wrong?

If the Department determines that you are not eligible for Medicaid and you think the determination is wrong, you have a right to appeal and should do so within 10 days of the date on the denial letter. You can initiate an appeal by making a request to the Office of Inspector General (OIG). While your appeal is in process, you have the choice to retain your Medicaid coverage.

Talking Points:

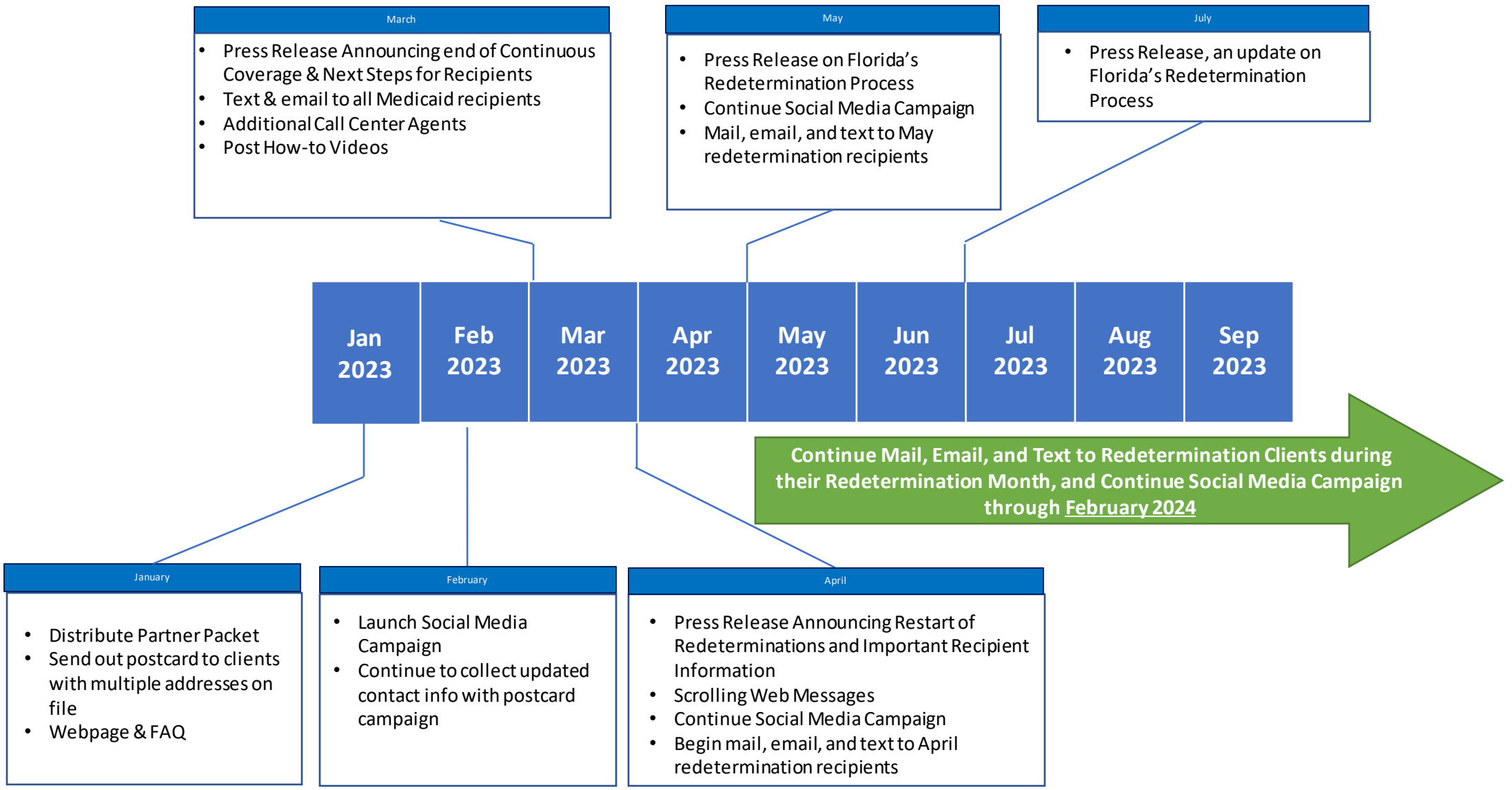
- The Department continues to work diligently for Floridians to ensure that Medicaid coverage remains intact for current enrollees during and throughout the continuous coverage period.
- The Centers for Medicare and Medicaid Services (CMS) allows state agencies up to 12 months to complete Medicaid reviews once the continuous coverage period has ended.
- The Department will follow federal guidance relating to Medicaid eligibility to ensure eligible recipients continue to remain enrolled.
- The Department has already begun outreach to current Medicaid enrollees to communicate the importance of providing updated contact information to ensure that they receive redetermination notices. Due to the duration of the PHE, some current Medicaid enrollees will need to submit additional information or update their information on file to continue their Medicaid coverage.
- The Department has deployed several technology solutions and supports to ensure we will be successful throughout this process.
- Florida's budget this year has funding to expand and supplement our existing call center to provide additional support for recipients. Beginning in March 2021, the Department started working to onboard more than 137 additional call center agents to provide support for recipients who need to update their eligibility information.
- In November 2021, the Department deployed automation and robotics to auto-index returned mail to sort, process and respond quickly to recipients whose notices are not delivered. We are working to deploy an additional bot this spring that will send an automated text message to recipients when a notice returned to the Department.
- These efforts and the extensive work we have done with our partners and key stakeholders across the state are to ensure Florida is poised and ready for the task at hand.
- The Department maintains constant communication with our federal partners, sister state agencies including the Agency for Health Care Administration (AHCA), and stakeholders to work together to ensure Floridians are able to plan for the future.
- Florida has many safety net options for families. In fact, recipients who are determined ineligible for Medicaid based on a change in circumstances are referred automatically to alternatives, including the Florida KidCare, the Medically Needy Program, and other subsidized federal health programs.
- For children in particular, Florida's KidCare program will often provide a low-cost option for medical coverage.
- The Department and its partners, including the Medicaid health plans, stand ready to help families secure other options to receive health care coverage including referrals to the Federally Qualified Health Centers who provide primary care services on a sliding fee scale to individuals without health insurance.

Call Center Script:

If a customer has questions about their Medicaid coverage use these talking points to guide the conversation:

- *It is important to keep your contact information up to date in your MyACCESS account so you will receive notices about your Medicaid coverage.*
- *Once the continuous coverage period ends, the Department will work over the course of 12 months to review all Medicaid cases to ensure recipients are eligible for benefits. Many Medicaid recipients will be automatically redetermined while others may have to provide additional information before the Department can determine their eligibility. If this is the case, the Department will reach out to those recipients with a notice in the mail 45 days prior to their renewal date, as well through email and or text messaging.*
- *Applications for individuals determined ineligible for Medicaid will be automatically referred electronically to Florida KidCare, the Medically Needy Program, and the Federal Marketplace.*
- *You can also log-in to your MyACCESS account and renew online.*
- *For more information about Medicaid or to locate additional resources for you or your family, you can visit the Medicaid Redetermination Frequently Asked Questions page at myflfamilies.com/Medicaid.*

Florida's Medicaid Redetermination Communications



Florida's Response to Common Concerns About the Medicaid Redetermination Process

Item/ Accusation	DCF's Response
Medicaid to Separate CHIP Program	Recipients who are determined to no longer be eligible for Medicaid due to changes in circumstances are referred automatically to alternatives, including Florida KidCare, the Medically Needy program or other subsidized federal health programs.
CHIP Premiums Are a Barrier	For children in particular, Florida's KidCare program will often provide a low-cost option for medical coverage. The Department and its partners, including the Medicaid Health Plans, stand ready to help families secure other options to receive health care coverage including referrals to the Federally Qualified Health Centers who provide primary care services on a sliding fee scale to individuals without health insurance.
Medicaid to Federally Facilitated Marketplace (Federal Marketplace)	Individuals who are determined to no longer be eligible for Medicaid due to changed circumstances are referred automatically to alternatives, including the Florida KidCare, the Medically Needy program, or other subsidized federal health programs. The Department and its partners, including the Medicaid Health Plans, stand ready to help families secure other options to receive health care coverage including referrals to the Federally Qualified Health Centers who provide primary care services on a sliding fee scale to individuals without health insurance.
Notices Frequency, Return Mail & Communication	For more than a year, the Department has been communicating with recipients regarding the importance of updating contact information to ensure we have the most up to date information. Florida's Medicaid Redetermination Plan includes extensive outreach to recipients through multiple communication modes to alert individuals throughout their redetermination period. The Department has shared resources and information with health care and other non-profit stakeholders statewide to provide additional supports to recipients throughout the redetermination process. In November of 2021, the Department deployed automation and robotics to auto-index returned mail to help sort, process and respond quickly to recipients whose notices are not delivered. We have also implemented additional enhancements to facilitate sending automated text messages to recipients when a notice is returned to the Department and when their renewal is due.

Automatic Renewal Rates (using existing data sources)	The Department leverages existing data to automatically renew or redetermine recipients without contacting them when possible. This year, 67 percent of the adult/disabled Medicaid population were renewed without contact. The Department leverages the review process for SNAP and TANF to extend Medicaid where possible and automatically renews recipients when information is received automatically from a variety of data sources integrated within the Department.
12 Months Continual Coverage for Kids	In Florida, children covered by Medicaid under the age of 5 receive 12-month of continuous eligibility while children ages 5 and older receive six months of continuous eligibility.
Boosting Call Center Workforce	To support the needs of our recipients, Governor DeSantis and the Florida Legislature increased funding by more than $22 million to expand our existing call center. We are working now to onboard more additional contracted agents to provide support for recipients who need to update their eligibility information.
Community Based Outreach	The Department has an extensive list of community partners throughout the State. Florida's Medicaid Redetermination Plan includes providing partner packets with information, timelines, and graphics to assist recipients throughout their redetermination process. Additionally, the Department will provide extensive outreach to recipients through multiple communication modes to update recipients throughout their redetermination period.
Application Assistance	The Department has an extensive list of community partners and stakeholders who stand ready to assist recipients in filling out an application for Medicaid or help answer questions regarding their benefits. To locate a community partner in your area, please visit: https://access-web.dcf.state.fl.us/CPSLookup/search.aspx
Redetermination Timeline	The Department will take advantage of the full 12-month timeline.
Improper Determinations	A federal review of the Medicaid eligibility process from 2021 determined that Florida's Medicaid eligibility process has an error rate of only 1.99%. The Department's Office of Appeal Hearings affords due process to individuals who believe actions on their eligibility for benefits were made in error. Within 10 days of receipt of the case action letter from the Department, appeals should be initiated by the recipient through making a request to the Office of Inspector General (OIG).

Press Statement(s):

In coordination with the Agency for Healthcare Administration, the Department has already begun an outreach campaign to current Medicaid enrollees to communicate the importance of providing updated contact information so recipients can receive critical information and notices regarding their Medicaid coverage.

Recipients who are no longer eligible for Medicaid, but are receiving Medicaid coverage due to the continuous coverage period will need to seek additional options for health insurance once their coverage ends. To assist qualifying families in obtaining health care coverage, the Department provides a seamless "account transfer" to other health coverage options. These account transfers allow recipients to be referred to Florida KidCare or other subsidized federal health programs that they may qualify for.

Under Governor DeSantis' leadership Florida reopened quickly, and Florida continues to outperform the nation in key economic metrics. Florida has experienced 31 consecutive months of job growth and its private sector job growth rate has exceeded the nation's for 20 consecutive months. With these economic successes in mind, many recipients have been able to pursue opportunities in Florida and may no longer be eligible for Medicaid.

Statement Operations Back to Normal:

Florida has worked with its partners to develop a robust operational and communication plan to provide information to Medicaid recipients, the public, and key stakeholders. We have developed a strategy to thoughtfully align benefit reviews and eligibility processes in a manner that will provide greater customer service to our recipients.

As Medicaid returns to standard processing, Florida's families should expect an annual review. Some families may see changes in dates as the Department aligns public benefit case reviews where possible, reducing the frequency in which families are required to interact with the Department. We encourage all recipients to contact their employers to see if options for health coverage are available to them through their work benefits.

Florida's plan streamlines processes and reviews, prioritizing recipients first over an annual timeline. Florida families will have their Medicaid case reviewed annually by the Department, which is the normal benefit review and eligibility business processes pre-PHE.

Messaging

IVR Call Center Message:

Have you moved recently or changed your email address? Be sure to let your agent know if you have a change in your contact information so we have the most up to date information on file.

Draft Social Media Messages:

Message 1: *Have you moved within the last 3 years? Make sure your health coverage moves with you. Log in to your MyACCESS account to update your contact information.* (Moving Truck Graphic)

Message 2: *We want to get in touch with you! Medicaid recipients may receive text message reminders from DCF to update your address or renew your benefits application. You can also check for notices from DCF by logging in to your MyACCESS account*. (Mailbox Graphic)

Message 3: A short, animated video on how to update your contact information through MyACCESS account.

Text Message: (Must be under 160 characters)

Message 1: *This is a reminder from DCF to update your address so we can reach you about changes to your Medicaid coverage. To update, log in to your MyACCESS account or chat with the DCF Virtual Assistant.*

Message 2: *This is a reminder from DCF to renew your Medicaid benefits application within 30 days. To renew, log in to your MyACCESS account and click the "Renew My Benefits" button.*

Message 3: *This is a reminder from DCF to renew your Medicaid benefits application within 14 days. To renew, log in to your MyACCESS account and click the "Renew My Benefits" button.*

Message 4: Returned Mail Recipients Only. *DCF has sent you a notice on regarding your Medicaid benefits to your address on file, but the notice was returned undeliverable. Please log in to your MyACCESS account to update or chat with the DCF Virtual Assistant.*

Email:

Message 1: Standard MyACCESS account notices (first notice sent 45 days before customer needs to renew)

Message 2: Additional reminder

It's time to renew your Medicaid benefits application! Visit your MyACCESS account to renew your benefits application within the next 30 days with the Florida Department of Children and Families. Your renewal will be processed to determine if you are still eligible for Medicaid coverage. DCF may ask for additional information while your case information is being reviewed. Please make sure your mailing address and phone number are up to date.

Once we receive your renewal information, DCF will send you a notice to let you know if you are still eligible for Medicaid coverage.

For more information about Medicaid, including other options for health coverage, please visit …INSERT Medicaid RESOURCE LINK

Postcard Mailer

Message 1:
Front: Moving Van Graphic: *Have you moved? Make sure your health coverage moves with you.*
Back: You are receiving this because *the Florida Department of Children and Families (DCF) has multiple addresses on file for you. Please update your mailing address, email address, and phone number with the Department of Children and Families. To update quickly, scan the QR code on the front of this care, or visit: myflorida.com/accessflorida*

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

Make sure your
HEALTH COVERAGE
moves with you!

SCAN FOR
MORE INFO

ACCESS CENTRAL MAIL CENTER
P.O. BOX 1770
Ocala, FL 34478

You are receiving this because Department of Children and Families (DCF) has multiple addresses on file for you. Please update your mailing address, email address, and phone number with DCF. To update quickly, scan the QR code on the front of this card, or visit:

myflorida.com/accessflorida

State of Florida
Department of Children and Families

Ron DeSantis
Governor

Shevaun L. Harris
Secretary

To: Medicaid Health Plans

Re: Florida's Medicaid Redetermination Plan – Recipient Communication

Thank you for your continued partnership in ensuring Floridians have had access to quality healthcare throughout the Public Health Emergency (PHE). I have had discussions with many of you who are interested in supporting the Department as we undergo the Medicaid redetermination process in partnership with the Agency for Health Care Administration (AHCA).

As many of you are aware, under the Families First Coronavirus Response Act, in order to qualify for the enhanced 6.2% FMAP, States were required to provide continuous coverage for Medicaid recipients and to not disenroll any recipients, with limited exceptions, even if they became ineligible for Medicaid. In December 2022, Congress passed the Consolidated Appropriations Act, 2023, which ends the continuous coverage provision on March 31, 2023.

In preparation, and to assist us in this process, we are asking for your support in encouraging your enrollees to update their contact information and report any changes in their circumstance (such as change of mailing or living address, family composition or income) to the Department. As a reminder, recipients can update their information at any time through the virtual assistant/chatbot feature on our website (myflfamilies.com) or through their MyACCESS account.

Our number one priority is to ensure continued coverage for those who remain eligible for Medicaid and to assist those who are no longer eligible with alternative options. When an individual is determined ineligible for Medicaid, the Department will automatically forward their information to agencies such as Florida KidCare, the Medically Needy Program, and other subsidized health coverage options.

We will provide you with the scheduled redetermination dates for your enrollees and the earliest date with which you should begin sending reminders, it is imperative that this schedule be followed to avoid unnecessary confusion and to prevent recipients from submitting documentation too early.

The Department has created a Medicaid Redetermination Partner Packet to assist you in communicating with recipients about their Medicaid coverage. The materials and templates provided in this toolkit include graphics and key messaging. The Medicaid Redetermination Partner Packet is available on our website, myflfamilies.com/Medicaid.

Thank you, again, for your partnership and dedication to serve Florida's families.

Best,

Shevaun L. Harris
Secretary

Florida's
MEDICAID ELIGIBILITY
REDETERMINATION PROCESS

PREGNANT OR NEW MOM

DCF CASE REVIEW

DCF automatically reviews client eligibility based on available data.

ELIGIBLE FOR MEDICAID!

Medicaid is available for expecting mothers and is provided up to 12 months for baby and mom

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ELIGIBLE FAMILY WITH CHILDREN UNDER 18

DCF CASE REVIEW

DCF automatically reviews client eligibility based on available data.

NOTICE

If additional information is needed, DCF will send a notice 45 days before Medicaid ends, asking client to complete a renewal application.

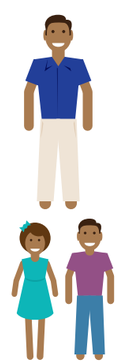
U.S. MAIL & EMAIL

Parent provides info

DCF REVIEWS AND MAKES A DETERMINATION

ELIGIBLE FOR MEDICAID!

INELIGIBLE FAMILY WITH CHILDREN UNDER 18



DCF CASE REVIEW AND NOTICE SENT

DCF reviews client eligibility.

INELIGIBLE FOR MEDICAID

AUTOMATIC REFERRAL

SUBSIDIZED FEDERAL HEALTH PROGRAMS

CLIENT SELECTS A PLAN AND PAYS PREMIUM

ELIGIBLE FOR OTHER HEALTH COVERAGE!

INELIGIBLE FOR MEDICAID

AUTOMATIC REFERRAL

Florida Healthy Kids

HEALTHCARE OPTION PROVIDED

Florida Healthy Kids CONTACTS CLIENT
2-3 days: **NOTICE** (U.S. Mail)
10 days: **PHONE CALL**

CLIENT SELECTS PLAN AND PAYS PREMIUM

ELIGIBLE FOR Florida Healthy Kids!

UPDATE YOUR CONTACT INFO

*To receive important notices about your **HEALTH COVERAGE***

1. **Log in to** your **MyACCESS Account**
2. **Click** the "**Report My Changes**" **button**
3. **Check the box for** Address, Email, or Phone Number **changes**
4. **Enter** your **updated information** and **follow prompts** to **finish** and **submit**

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

If you are no longer eligible for Medicaid...

FLORIDA KidCare

If you do not quality for Medicaid, and you have children under the age of 18, you may be able to purchase low-cost insurance for your children here.

MEDICALLY NEEDY PROGRAM

A program that allows Medicaid coverage after a monthly "share of cost" is met. Those who are not eligible for "full" Medicaid because of income or asset limits, may qualify.

5 OPTIONS* FOR HEALTHCARE

FEDERALLY QUALIFIED HEALTH CENTERS

A healthcare provider who provides medical care for clients with limited or no health insurance. Services are offered on a sliding scale based on income.

FEDERALLY SUBSIDIZED HEALTH PROGRAMS

A national website where you can purchase health insurance, including low-cost income based plans.

COMMERCIAL COVERAGE

Provide health care coverage (including employer sponsored or private) for a monthly fee, and coordinate care for clients through a defined network of physicians and hospitals.

To review your healthcare options, visit:

fqhc.org
healthcare.gov
floridakidcare.org
flmedicaidmanagedcare.com

**Depending on the needs of your family, you may be eligible to benefit from two (or more) healthcare options simultaneously.*

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES