



**State of Florida  
Department of Children and Families**

**Rick Scott**  
*Governor*

**Mike Carroll**  
*Secretary*

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**TO:** Economic Self-Sufficiency Operations Managers  
Economic Self-Sufficiency Program Offices

**FROM:** Tonyaleah Veltkamp, Chief, Program Policy  
Suzanne Poirier, Chief, Technology and Project Management  
**(Signatures on File)**

**SUBJECT:** Continuous Medicaid Policy Clarification

**EFFECTIVE:** Upon Receipt

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This memorandum provides staff with policy clarification about Continuous Medicaid periods for children under age 19. It also provides case processing guidance about when a child is removed from one case and added to another, the child is not reported on an additional benefit request or renewal, or the Primary Information Person (PIP) is deceased or out of the household.

**Current Policy**

There has been no change in the application of Continuous Medicaid periods. When a change in eligibility results in the loss of Medicaid coverage for a child under age 19, staff must continue Medicaid coverage for the child(ren) during the Continuous Medicaid period, including children receiving Child In Care (CIC) coverage. The Continuous Medicaid period is determined from the last application, renewal or addition to Medicaid coverage and automatically displays on the Individual Eligibility History (IQEL) screen.

- Children up to age 5 receive twelve months of Continuous Medicaid coverage
- Children age 5 up to 19 receive six months of Continuous Medicaid coverage

At the end of the continuous period, staff must complete an ex-parte if applicable, to explore eligibility in another category, which may include Transitional Medical Assistance (ME I).

Continuous Medicaid does not apply to a child determined eligible for regular Medicaid in error, presumptive eligibility, or Medically Needy coverage.

### **Child Moved to Another Case**

Staff must continue Medicaid coverage for a child(ren) during the Continuous Medicaid period, including when a child is removed from one case and added to another case. Staff must document the Running Record Comments (CLRC) screen, in both cases, about the removal from the original case in which Continuous Medicaid eligibility was established.

### **Child Not Reported in Household**

If a child is not reported on an additional benefit request or renewal submitted during their Continuous Medicaid period and there is no ongoing coverage for the child in another case, staff must contact the household to discuss the child's location. Staff must:

- Determine eligibility and continue coverage if the child remains in the household
- If the child is no longer in the home, determine if continuous coverage policy applies, and either apply continuous coverage or terminate coverage using a valid reason code (provided below) and document in CLRC the child's location, if known, and action taken.
- If the child is no longer in the home, staff is unable contact and the reason for removal is not a valid reason to close Continuous Medicaid eligibility, staff must ensure continuous coverage is provided for the remainder of the period. Staff must:
  - Screen print the IQEL screen showing the Continuous Medicaid Period.
  - Document CLRC with the case action and screen print the CLRC notes.
  - Remove the child from the case, and terminate Medicaid coverage using reason code Child(ren) no longer live with you (reason code "379").
  - Complete the Florida Medicaid Management Information System (FLMMIS) Recipient File Problem Resolution Request (Agency for Health Care Administration (AHCA) 5240-0006) form for the remaining continuous eligibility period and attach the IQEL and CLRC screen prints.
  - Follow regional procedures to notify the region's Medicaid File Coordinator (MFC) of the need for coverage via the AHCA 5240-0006 form.
  - The MFC must sign and forward the AHCA 5240-0006 form to the AHCA to add coverage to FLMMIS.
  - The MFC must send the 5240-0006 form to AHCA for the initial continuous period and check eligibility on FLMMIS each month after coverage posts on FLMMIS. FLMMIS reconciliation (recon) will close any coverage in FLMMIS the second month after IQEL is closed. If the coverage in FLMMIS ends during the continuous period, the MFC should resend the 5240-0006 and attach IQEL and CLRC screen prints to AHCA to update eligibility in FLMMIS. This process should be repeated until the continuous eligibility period has ended.
  - Note: If coverage is re-opened on IQEL, the 5240-0006 is no longer needed.

### **PIP Reported as Deceased or Out of the Household**

If the Primary Information Person (PIP) is reported as deceased or no longer in the household (i.e. incarceration) staff must confirm this information and address the child's location.

- If able to contact another adult household member, staff must:
  - Close the current case, since the PIP cannot be changed on a case, and establish a new case to provide the remainder of the Continuous Medicaid eligibility period for the child(ren) and eligibility for the remaining household members. When there is another adult household member, a new application is not required to continue the current coverage.
- If unable to contact, or there are no other adult household members, staff must ensure continuous coverage is provided for the remainder of the period. Staff must:
  - Screen print the IQEL screen showing the Continuous Period.
  - Document CLRC with the case action and screen print the CLRC notes.
  - Terminate Medicaid coverage for the child using reason code Child(ren) no longer live with you (reason code "379").
  - Complete the FLMMIS Recipient File Problem Resolution Request (AHCA 5240-0006) form for the remaining continuous eligibility period and attach the IQEL and CLRC screen prints.
  - Follow regional procedures to notify the region's Medicaid File Coordinator of the need for coverage via the AHCA 5240-0006 form.
  - The MFC must sign and forward the AHCA 5240-0006 form to AHCA to add coverage to FLMMIS.
  - The MFC must send the 5240-0006 form to AHCA for the initial continuous period and check eligibility on FLMMIS each month after coverage posts on FLMMIS. FLMMIS reconciliation (recon) will close any coverage in FLMMIS the second month after IQEL is closed. If the coverage in FLMMIS ends during the continuous period, the MFC should resend the 5240-0006 and attach IQEL and CLRC screen prints to AHCA to update eligibility in FLMMIS. This process should be repeated until the continuous eligibility period has ended.
  - Note: If coverage is re-opened on IQEL, the 5240-0006 is no longer needed.

### **FLORIDA System Instructions**

When a change is reported during the Continuous Medicaid period that would result in the loss of Medicaid coverage, the Medicaid coverage cannot be terminated unless a valid reason exists.

To ensure only the remainder of the continuous period is provided and a new period is not created in error, do not change the entry in the "Rev AG" field on the Assistance Group Names (AGPY) screen during the continuous period.

Valid reasons to terminate Medicaid on the Assistance Group Authorization (AWAA) screen during the Continuous Medicaid period are limited to:

- No longer a Florida Resident
  - You are not a resident of Florida (reason code “169”)
  - You do not meet the Florida residency requirement for this program (reason code “358”)
- Death
  - We received information that a member of your household died and will no longer be covered by this program (reason code “347”)
  - We received information that all the people covered by this program have died (reason code “369”)
- Request for Case/Assistance Group Closure
  - We received your written request to end this benefit (reason code “383”)
  - We received your verbal request to remove an individual from this program (reason code “385”)
  - We received your written request to remove an individual from this program (reason code “386”)
- Error in Initial Determination
  - Your case was opened in error and has now closed (reason code “530”)

Valid reasons to change/close Medicaid on the AWAA screen during the Continuous Medicaid period are limited to:

- Change in Coverage Category
  - We reviewed your case, you are still eligible for Medicaid, but in a different Medicaid coverage type (reason code “227”)
  - You are receiving the same type of assistance from another program (reason code “249”)
  - You are not eligible for DCF Medicaid because SSA found you to be eligible for SSI Medicaid (reason code “255”)
  - An individual is in the same case but a different category (reason code “350”)

If there are policy questions, region offices may email Nathan Lewis at [Nathan.Lewis@myflfamilies.com](mailto:Nathan.Lewis@myflfamilies.com). If there are system questions, region offices may email Ron Hardcastle at [Ron.Hardcastle@myflfamilies.com](mailto:Ron.Hardcastle@myflfamilies.com).

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