STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88323

RESPONDENT.

_____/

APPEAL NO. 14F-09018

CASE NO. [redacted]

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 10, 2014 at 1:47 p.m.

## APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Ernestine Bethune, Economic Self Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 9, 2014 to enroll her in the Medically Needy (MN) with an estimated share of cost in the amount of $1,135.

## PRELIMINARY STATEMENT

The Department submitted evidence on December 4, 2014 which was entered as Respondent Composite Exhibit 1 (RC1).

## FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. Prior to the appeal, petitioner was covered under the extended Medicaid Program (ME I). On July 30, 2014, the Department extended Medicaid through October 2014.

2. The petitioner submitted an electronic application on September 30, 2014 for Medicaid recertification purposes. On October 9, 2014, the Department terminated the extended full Medicaid coverage and enrolled petitioner in the Medically Needy Program. On October 21, 2014 petitioner requested an appeal due to her extended Medicaid benefits running out in October 2014.

3. The household consists of the petitioner (age 28) and her child (age eight).

4. The petitioner has been taking certain medications since she was age 21. She explained that her full coverage Medicaid was terminated without 30 days notice and she was forced to abruptly stop taking the medications she could not pay for out-of-pocket. Petitioner believes when not on the medications she is hindered from working full time.

5. Petitioner is employed and provided her weekly pay as follows: $397.19 received October 3, 2014, $356.19 received September 26, 2014, $384.38 received September 19, 2014 and $384.38 received September 12, 2014 for a total of $1,522.16. Petitioner was floating at different stores and has now been transferred to a new store

and anticipates her hours to be around 30 per week in the future. Petitioner earns $10.25 per hour.

6. The Department uses a monthly average of the past four weeks, when representative. The Department totaled petitioner's pay listed above, divided by four and then multiplied the result by four for a monthly average of $1522.16. This caused petitioner to exceed the $387 income limit to receive full Medicaid (counting two people).

7. The Department determined the petitioner's MN share of cost amount as follows:

| | |
|---|---|
| Averaged earned income: | $1,522.16 |
| MNIL (Medically Needy Income Limit for two) | -$387.00 |
| Share of cost: | $1,135 |

8. Petitioner believes her medications run about $1000 monthly and her monthly physician's visit is $150.

## CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

11. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner. However, since this was a termination of full coverage Medicaid, that is now corrected to the Department holding the burden of proof.

12. The Family-Related Medicaid income criteria are set forth in Federal Regulations at 42 C.F.R 435.603 and states:

> (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

13. The Department's Program Policy Manual, 165-22, section 2230.0400 Standard Filing Unit (MFAM) states:

> For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

14. The Department's Policy Manual Appendix A-7, "Family-Related Medicaid Income Limits" chart sets forth the standard deduction for two at $146; the income limit for an adult in a household size of two as $241 and the MNIL for two as $387. There is a note for the MNIL which states,

"** MNIL--The Medically Needy Income Limit (MNIL) includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost" and "MAGI--The 5% MAGI disregard is never used in a Medically Needy budget."

15. The Department's Policy Manual, 165-22, section 2630.0108 Budget Computation (MFAM) states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.
In computing the assistance group's eligibility, the general formula is:
Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).
Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.
Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.
Step 4 - Compare the total countable net income to the coverage group's income standard.
If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.
Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).
If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.
Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

16. The Department's Florida Policy Manual section 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.
The following conversion factors based on the frequency of pay are used:
**Weekly income** (once a week): Multiply by 4.
**Biweekly income** (every two weeks): Multiply by 2.
**Semimonthly income** (twice a month): Multiply by 2.

17. In this case, the Department determined the petitioner's eligibility for Medicaid with a standard filing unit that consisted of two persons. The Department also included an average of petitioner's earned income of $1,522.16 monthly. The

undersigned concludes this action was correct. Petitioner's averaged earned income exceeded the income limit for full coverage Medicaid.

18. Petitioner's expected future income of $10.25 per hour for 30 hours per week would result in $307.50 weekly. This converts to a monthly amount of $1230. After the standard disregard of $146 (for two) petitioner's income still exceeds the amount allowed for an adult to have full coverage Family-related Medicaid of both $241 and $387. The undersigned concludes petitioner received the extended Medicaid coverage through October 2014 and the only option after that benefit ran out was the Medically Needy Program.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's actions are affirmed.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 18th day of February, 2015,

in Tallahassee, Florida.

Larry LaBelle

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