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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88326

RESPONDENT.
_____/

APPEAL NO. 15F-03845

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 28, 2015 at 11:00 a.m. and September 15, 2015 at 8:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se.

For the respondent: Christine McKee, Economic Self Sufficiency Specialist II, and Ed Poutre, Economic Self Sufficiency Specialist II.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to terminate her full Medicaid benefits effective February 28, 2015 and enroll her in the Medically Needy (MN) Program with a Share of Cost (SOC) effective March 1, 2015. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On February 13, 2015, the Department sent a Notice of Case Action (NOCA) informing the petitioner that her Medicaid would end effective February 28, 2015 and that she would be enrolled in the MN Program with a $1,038 estimated SOC effective March 2015. The petitioner timely appealed the Department's actions on April 28, 2015.

The hearing was originally scheduled for June 12, 2015. The petitioner failed to appear. The hearing was rescheduled for July 28, 2015 at the petitioner's request. The Department requested a continuance to further evaluate new information that developed during the hearing. The petitioner had no objection to continuing the hearing, so the undersigned rescheduled the hearing for August 12, 2015. The petitioner requested a continuance on August 12, 2015; the undersigned granted her request and rescheduled the hearing for September 1, 2015 at 9:00 a.m. The petitioner requested an earlier hearing to accommodate her work schedule. The hearing was rescheduled for September 2, 2015 at 8:00 a.m. On September 2, 2015, the parties requested a continuance. The undersigned granted the request for continuance until September 15, 2015.

The petitioner indicated she also had an issue regarding payment of a prescription bill. The respondent submitted a Motion for Dismissal explaining this issue was not within the scope of Department of Children and Families (DCF), as it only determines eligibility. The Agency for Healthcare Administration (AHCA) is responsible for issues concerning Medicaid payments; therefore, another appeal was set up to address this issue as the respondent on that appeal will be AHCA. Since the petitioner

also has an issue with the Department's actions, the respondent's Motion for Dismissal is denied.

The petitioner presented no evidence during the hearing for the undersigned to consider. The Department presented a total of 82 pages of evidence for the undersigned to consider, which was admitted into evidence as Respondent's Composite Exhibits 1 and 2. The record was held open until September 22, 2015 for the petitioner to submit additional evidence. The petitioner submitted 2 pages of evidence on September 16, 2015, which was admitted into evidence as Petitioner's Exhibit 1. The record was closed on September 22, 2015.

FINDINGS OF FACT

1. On February 11, 2015, the petitioner submitted an application to recertify for FAP and Medicaid benefits for herself and her child. She reported earned income from Global Prospects. She also reported rent of $400 and electric with heating and cooling.

2. On February 11, 2015, the petitioner sent the following paystubs to verify her gross income: January 16, 2015 $337.95; January 23, 2015 $348.89; January 30, 2015 $396.88, and February 6, 2015 $342.00. The Department added these paystubs to calculate the petitioner's total gross earned income of $1,425.72 per month. The income limit for a parent in a two person household to receive full Medicaid is $241. As the petitioner's income was over this limit, the Department closed her full Medicaid benefits and enrolled her in the MN program with a SOC of $1,038 effective March 1, 2015.

3. The Department calculated the SOC by subtracting the Medically Needy Income Limit (MNIL) of $387 for a two person household from the total gross income of $1,425.72. This resulted in a monthly SOC of $1,038 for the petitioner.

4. The Department explained that she had full Medicaid prior to receiving earned income and met the eligibility criteria at that time. When the petitioner started working, the Department determined she was eligible to receive twelve months of Transitional Medicaid benefits (full Medicaid) through January2015. The petitioner received an extra month of full Medicaid coverage over the guaranteed one year.

5. The petitioner's income varies and her employer changed during the hearing process. As such, the Department agreed to consider the change in income and recalculate her SOC amount. The petitioner returned the following paystubs: May 5, 2015 $696.20; May 20, 2015 $589.92; July 3, 2015 $601.53 and August 5, 2015 $209.38. The Department used the Year to Date (YTD) to determine the gross amounts of the missing paystubs. The Department enrolled the petitioner with the following SOC amounts:

Month	Income	MNIL	SOC
May 2015	$1,285.12	$387	$898
June 2015	$1,011.84	$387	$624
July 2015	$1,244.67	$387	$857

The same methodology used previously was used to calculate each month's SOC.

6. The petitioner does not believe that she should be in the MN program with a SOC. The petitioner will file a tax return this year with her daughter as her tax dependent.

CONCLUSIONS OF LAW

7. 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 Fla. Stat. § 409.285.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The Department publishes a policy manual to interpret the state and federal laws. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2030.0203 Transitional Coverage (MFAM) states in part:

> Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.
> Conditions that must be met:
> 1. The parents and other caretaker relatives' assistance group must be ineligible for Medicaid based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.
> 2. At least one member of the assistance group was eligible for and received Medicaid in at least three of the preceding six months. The three months can include one month in which Medicaid was received in another state, or a retroactive month. All SFU members are eligible, even if they were not a part of the original assistance group.

10. The Fla. Admin. Code R. 65A-1.702 Special Provisions states in part:

> (4) Ex Parte Process.
> (a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage. Both Family-related Medicaid and SSI-

> related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.
> (b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal.

11. The above policies show that an individual who loses his/her full Medicaid eligibility, due to receipt or increase in earned income, is eligible for Transitional Medicaid benefits for up to one year. It further states that an Ex Parte process must be completed. The Department gave the petitioner 12 months of Transitional Medicaid and completed the required Ex Parte determination which afforded the petitioner an additional month of Transitional Medicaid benefits. As the petitioner received over twelve months of Transitional Medicaid benefits, the undersigned concludes that the Department followed rule in terminating the petitioner's Transitional Medicaid benefits effective February 28, 2015.

12. The Code of Federal Regulations 42 C.F.R. § 435.110 defines Medicaid Mandatory Coverage of Families and Children:

> ...
> (c) Income standard. The agency must establish in its Sate plan the income standard as follows:
> (1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act...

13. The Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria states in part:

> (1) (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources…For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

14. The above authority defines earned income and states that it must be used to determine Medicaid eligilibility. The undersigned concludes that the Department was correct to include the petitioner's gross earned income in the determination process.

15. The Federal Regulations at 42 C.F.R. § 435.603 "Application of modified gross income (MAGI)" states in relevant part:

> (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…
> (b) Definitions. For purposes of this section—
> Child means a natural or biological, adopted or step child.
> Code means the Internal Revenue Code.
> Family size means the number of persons counted as members of an individual's household…
> Parent means a natural or biological, adopted or step parent…
> (c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) 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.
(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.
(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.
(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
(e) MAGI-based income. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code,
(f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent....

16. The Policy Manual, CFOP 165-22, passage 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.

17. The above policy explains that Family-Related Medicaid is determined by how the family files federal taxes. The family's eligibility is determined by grouping certain individuals together and counting those members' income; this is called the Standard Filing Unit or SFU. Eligibility is determined for each individual using the tax filing group's income. According to the above policy, all persons filing taxes together are included in the SFU. The undersigned concludes that the Department was correct to include the petitioner and her child in the SFU.

18. The Policy Manual, CFOP 165-22, passage 2630.0108, Budget Computation (MFAM) sets forth the budgeting process and 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).

19. The Policy Manual at Appendix A-7 indicates that for a household size of two, the income limit for a parent to receive full Medicaid is $241 per month and the MNIL is $387. It also indicates "the Medically Needy Income Limit (MNIL) includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost."

20. The undersigned completed a manual budget to determine if the Department's calculations were correct. For the month of July 2015 and ongoing, a standard disregard of $146 was subtracted from the gross income of $1,244.67, to result in a countable income of $1,098.67. The MAGI disregard (5% of federal poverty limit) deduction for a household size of two is $66. The adjusted income would be $1,032.67 after the MAGI disregard was subtracted. As the petitioner's countable income of $1,032.67 is over the income limit of $241 per month, the undersigned concludes that the Department was correct in its action to remove her from full Medicaid and enroll her in the MN program with a SOC. The same methodology was used for all months calculated and the petitioner is over the income limit for full Medicaid for each month.

21. The above-cited authorities state that the MN SOC is determined by the amount by which the gross income exceeds the MNIL for the household size. In this instant case, the petitioner's gross income is $1,244.67 for July 2015 and ongoing, and the MNIL for a household size of two is $387. Therefore, the Department was correct in its calculation of a SOC amount of $857 for the petitioner. The undersigned completed manual budgets for each month at issue

using the above methodology and found no error in the Department's calculation of the petitioner's MN SOC amount.

22. The above-cited authorities were used by the Department in determining the petitioner's eligibility for full Medicaid and the Medically Needy Program. As the petitioner's countable income exceeded the income limit for full Medicaid, the undersigned concludes that the respondent correctly evaluated the petitioner for the Medically Needy Program with a SOC effective March 2015. The undersigned cannot conclude a more favorable outcome for the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is 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 30 day of November, 2015,

in Tallahassee, Florida.

BrandyRicklefs

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