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

[redacted]

APPEAL NO. 15F-00176
15F-00177

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 01 Santa Rosa
UNIT: 88630

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 20, 2015 at 10:04am.

## APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Darnella Tucker, ACCESS Supervisor

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 9, 2014 approving Medically Needy for himself and his wife beginning January 2015. The petitioner is requesting full Medicaid.

## PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing. This was entered as Respondent Exhibit #1. The record was held open for additional information from the

Department. This information was received February 27, 2015 and entered as Respondent Exhibit #2.

## 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. The petitioner filed an application for recertification on November 17, 2014. The household consists of the petitioner, his wife and their eight year old daughter. The petitioner's step-daughter is in the household part of the time but she was not included on the application and benefits were not requested for the step-daughter.

2. The petitioner's daughter continues to receive full Medicaid.

3. The household monthly income consists of petitioner's disability insurance benefits of the $2,075. The household does not anticipate filing taxes as they have no taxable income.

4. The Department did not include any income for the household prior to this recertification. Previous budgets for Medicaid reflect that no income was included in the eligibility determination for April 2014 through December 2014.

5. The Department explained for adults in a household of three to receive full Medicaid, they must meet the income limit of $303.

6. The Department explained the Medically Needy (MN) Share of Cost (SOC) calculation process. The Medically Needy Income Level (MNIL) for the household size is subtracted from the gross income amount for the household. In this

case, the MNIL for a household of three is $486. The Department used the gross income of $2,075 less $486 (MNIL) to reach a SOC of $1,589.

7. The Department explained there is a transitional Medicaid category that is utilized when a household begins receiving earned income causing ineligibility. The petitioner's disability payments are considered unearned income. As the loss of full Medicaid was due to receipt of unearned income, the transitional Medicaid category is not appropriate. The Medicaid ended for the parents December 31, 2014.

8. The petitioner received worker's compensation of $2,288.42 per month prior to receiving the disability insurance income of $2,075. The petitioner does not understand how he could be eligible for full Medicaid when they had higher income, but are not eligible for full Medicaid with the lower income amount. The petitioner believes he cannot afford the Share of Cost of $1,589. He understands how the Share of Cost works, but feels it does not take into consideration individuals with health issues.

9. The petitioner explained he and his wife have each applied for Social Security Disability (SSDI). The petitioner was denied by Social Security (SSA) in November 2014. His claim is under appeal. He has presented all of his conditions and worsening conditions to Social Security for review. The petitioner's wife was denied in February 2013. Her claim is also under appeal. All of her conditions and worsening of conditions have been reported to SSA.

10. There was no discussion of an ex parte review prior to determining Medically Needy eligibility.

## CONCLUSIONS OF LAW

11. 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.

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

13. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the respondent.

14. Fla. Admin. Code § 65A-1.702 Special Provisions states in relevant 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.

15. The undersigned concludes prior to making a determination for Family Related Medically Needy, an ex parte determination should be completed for SSI-related as the petitioner and his wife both had applications with Social Security Administration.

16. Federal Medicaid Regulations 42 C.F.R. § 435.541 "Determinations of disability" states in relevant part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
>
> (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
>
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—
> ...
>
> (c)...(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—
> ...
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
>
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
>
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

17. The petitioner and his wife were both denied disability by SSA within the last 12 months. Both individuals have appealed their denial decisions and reported all conditions and changes to those conditions have been reported to SSA. The above controlling authority shows that for SSI-Related Medicaid the respondent must adopt the

SSA decision if the decision has been made within the last 12 months and all conditions and worsening conditions have been reported to SSA and are being considered. The undersigned concludes both the petitioner and his wife have been denied within the last 12 months with all conditions and worsening conditions reported to SSA for consideration. Therefore, there does not appear to be any eligibility for SSI-related Medicaid as the adults have not been found to be disabled.

18. Federal Medicaid Regulations 42 C.F.R. § 435.218 "Individuals with MAGI-based income above 133 percent FPL" states:

> (a) Basis. This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.
>
> (b) Eligibility—(1) Criteria. The agency may provide Medicaid to individuals who:
> (i) Are under age 65;
> (ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;
> (iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and
> (iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.
> (2) Limitations. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.
> (ii) The limitation on eligibility of parents and other caretaker relatives specified in §435.119(c) of this section also applies to eligibility under this section.

19. The Department's Program Policy Manual (165-22) section 1830.0101 Income (MFAM) states:

Taxable Earned income is the receipt of wages, salary, commission, or profit from an individual's performance of work or services or a self-employment enterprise.
Taxable Unearned income is income for which there is no performance of work or services. Taxable unearned income may include:
1. Retirement, disability payments, unemployment/workers' compensation, etc.;
2. Annuities, pensions, and other regular payments;
3. Alimony and spousal support payments;
4. Dividends, interest, and royalties;
5. Prizes and awards;
6. Social Security and Social Security Disability Income.
Excluded income is income (earned or unearned) that is not counted when determining eligibility.

20. The Department's Program Policy Manual (165-22) section 1830.0900 Benefits (MFAM) states in relevant part:

The gross benefit amount received, or anticipated to be received, is considered unearned income. Benefits are owned by the individual for whom they are intended unless the individual is not in the home and the benefits are not redirected.
Benefits excluded as unearned income are:
...
2. Workers' Compensation payments designated for medical expenses paid or deducted at the source and not controlled by the individual.
...
Benefits included as unearned income are:
1. Railroad retirement payments including retirement, survivor, unemployment, sickness and strike benefits
2. Unemployment Compensation Benefit payments
3. Severance pay
4. Social Security Administration Benefits including Title II Social Security benefits
5. Annuities, pensions, retirement or disability payments

21. The findings show the petitioner's income is from disability payments.

According to the above controlling authorities, the income is considered unearned income.

22. The Department's Program Policy Manual 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).
> *Note: Children aged 6-18 do not receive the standard disregard. They do receive the 5% MAGI disregard, if it's needed to determine the assistance group eligible.

23. The ACCESS Florida Program Policy Manual, Appendix A-7 lists the Family-Related Medicaid Income Limits for a household size of three as follows: for adults the Income Standard is $303 and the Standard Disregard $183. The Medically Needy Income Limit (MNIL) is $486. The MAGI Disregard is $83.

24. The petitioner desires to receive full Medicaid instead of Medically Needy Share of Cost. The respondent previously overlooked counting income in the case. However, the undersigned concludes the Department has now correctly counted the

petitioner's income. The petitioner's income of $2,075 exceeds the income standard of $303 for adults in a household of three to receive full coverage under Family-track Medicaid. The gross income of $2,075 less the standard disregard of $183 and the MAGI disregard of $83 is $1,809. The undersigned concludes the income exceeds the income standard of $303 for full Medicaid for the adults. The undersigned concludes the petitioner does not qualify for full Medicaid for himself and his wife in Family-track Medicaid.

25. The undersigned concludes the respondent correctly calculated the Medically Needy Share of Cost and correctly enrolled the petitioner and his wife in the Family-track Medically Needy Program. With the current facts, the undersigned can find no more favorable outcome.

## 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 16th day of April, 2015,

in Tallahassee, Florida.

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Copies Furnished To: [redacted] Petitioner
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