January - March 2022 Summary of Changes

Chapter	Passage	Summary
0600	0610.0200	Removed language: Households in all programs must report any changes in the household living and/or mailing address
0800	0810.0200	Removed language: Households in all programs must report any changes in the household living and/or mailing address
	0830.0500	Updated policy on expected/unexpected changes
	0830.0600	Updated ex parte determination for postpartum to 12 months
1830	1830.0000 1830.0101 1830.0122	Updated to include pretax income exclusions
2030	2030.0700	Updated ex parte determination for postpartum to 12 months
2430	2430.0204	Pretax income conversion statement added
2630	2630.0108	Updated Step 2: Deduct any verified pretax income exclusions
3400	3410.0212	Add passage for unclear information

0610.0200 SIMPLIFIED REPORTING CHANGE REQUIREMENTS (FS)

Effective November 1, 2009, all food stamp households are simplified reporting.

Simplified Reporting households must report a change when the total household income exceeds 130% of the federal poverty level for the AG size or when an able-bodied adult subject to time limits has a change in work hours below twenty hours per week. ~~Households in all programs must report any changes in the household living and/or mailing address.~~ The SFU must report the change by the 10th day of the month following the month of change.

Process beneficial changes, sanction actions and data exchange responses that are considered verified upon receipt: Social Security (Bendex), State Data Exchange (SDX), Unemployment Compensation Benefit (DEUC), Vital Statistics Death Match (DEDT), Department of Corrections (DOC), and Numident (DENU).

If a discrepancy exists with Social Security Match (DETH) or Prisoner Match (DEPR) information, which are not verified upon receipt, contact the customer by phone or send a pending notice for verification.

ACCESS Integrity staff will process prison incarceration information received directly from the Department of Corrections.

Review responses from other data exchanges as part of the next review. Food stamp AGs that also receive TCA and/or Medicaid must report changes according to TCA and/or Medicaid Program requirements. Act on changes reported for TCA and/or Medicaid and make the change to affect all three programs. For beneficial changes, if the household fails to verify the information, leave the food stamp benefits the same. Do not act on reported adverse changes in food stamp only cases unless the change is the total household income exceeds 130% of the federal poverty level for the AG size. In combination cases with food stamps, TCA, and/or Medicaid, process adverse changes based on the information provided by the household.

0810.0200 SIMPLIFIED REPORTING (FS)

Effective November 1, 2009 all food stamp households are simplified reporting.

Simplified reporting SFUs, that contain a member disqualified for IPV, fleeing felon, felony drug trafficking, certain felons (aggravated sexual abuse, murder, sexual exploitation and other related abuse of children, or offense involving sexual assault) who are not in compliance with their sentence terms, or employment and training sanction, are not broad-based categorically eligible. Simplified Reporting households must report when income exceeds 130% of the monthly income limit for the AG size or when an able-bodied adult subject to time limits has a change in work hours below twenty hours per week. ~~Households in all programs must be encouraged to report any changes in the household living and/or mailing address.~~ The SFU must report the change by the 10th day of the month following the month of change.

Process beneficial changes, sanction actions and data exchange responses that are considered verified upon receipt: Social Security (Bendex), State Data Exchange (SDX), Unemployment Compensation Benefit (DEUC), Vital Statistics Death Match (DEDT), Florida Department of Corrections (DOC), and Numident (DENU).

If a discrepancy exists with Social Security Match (DETH) or Prisoner Match (DEPR) information, which are not verified upon receipt, contact the customer by phone or send a pending notice for verification.

Review responses from other data exchanges as part of the next review. Food stamp AGs that also receive TCA and/or Medicaid must report changes according to TCA and/or Medicaid Program requirements. Act on changes reported for TCA and/or Medicaid and make the change to affect all three programs. For beneficial changes, if the household fails to verify the information, leave the food stamp benefits the same. Do not act on reported adverse changes in food stamp only cases. In combination cases with food stamps, TCA, and/or Medicaid, process adverse changes based on the information provided by the household.

0830.0500 CHANGES (MFAM)

A change (expected or unexpected) may affect eligibility or level of benefits.

Expected: Expected changes become due on the first day of that month and become overdue on the first day of the following month. Set an expected change in the following situations:

~~1. A child in the AG will reach an age limitation for a coverage group;~~
1.~~2.~~ An individual anticipates receipt of or a change in income, or a return to work;
~~3. A management review is required~~;
2.~~4.~~ A check on approval of Social Security, Unemployment Compensation, or other benefits for which the individual applied is required;
~~5. The birth of a child will occur;~~
3.~~6.~~ To obtain the Social Security number in the second month following the month any member of an AG applies for a Social Security number. If the Social Security number has not been received, reschedule the partial for the following month and each subsequent month until the number is obtained;
4.~~7.~~ To determine the outcome of the petition to the court in the third month following the month the Department becomes aware of a trust that could have an effect on the AG's eligibility. If there is delay in a court decision, schedule a partial every two months thereafter until a decision is reached.~~;~~
~~8. To explore continued eligibility in the second month of postpartum coverage.~~

Unexpected: If the change does not require verification, complete action on the case within 10 calendar days of the date the Department becomes aware of the change. If the change requires verification to process, take action to place the case in pending status within two business days.

If the reported change relates to income, refer to the Reasonable Compatibility Job Aid (Appendix 36). If the amount reported is not compatible, the information is questionable or makes the individual or family ineligible pend for income. Use the electronic verification sources as verification when possible.

Examples of unexpected changes include, but are not limited to:

1. changes in income;
2. a change in composition of the SFU;
3. a change in living situation;
4. application or removal of sanctions;
5. changes in Medicaid coverage groups; or
6. notification of pregnancy.

If delay in reporting the change ~~or acting on the change~~ causes overpayment, complete a referral to BR.

Effective Date of Change: With the exception of the addition of new members, changes that result in a beneficial or adverse change are effective according to the following time frames:

1. Beneficial: the first day of the month the change is reported or becomes known to the Department.
2. Adverse: the first day of the next month the change can be made allowing for 10 days adverse action notice.

0830.0600 EX PARTE DETERMINATIONS (MFAM)

An ex parte determination assesses whether a Medicaid individual who is no longer eligible under one coverage group is eligible under a different coverage group. Continue Medicaid until the ex parte process is completed. This includes the automatic transfer(s) to Florida Healthy Kids and the Federally Facilitated Marketplace.

An ex parte determination does not require a new application. There is no requirement for the individual to contact the Department to initiate the ex parte determination. When the determination is complete, send the individual a notice of case action advising of their eligibility. If no one is eligible or is eligible only for Medically Needy with a SOC, notify the individual, ensuring 10 days advance notice.

Perform ex partes when:

1. An increase in income causes ineligibility.
2. A child turns age 18 and is in a MAGI based coverage group or transitional Medicaid AG.
3. An adult or child receiving MAGI Medicaid coverage claims disability, evaluate eligibility under SSI-Related Medicaid. Continue MAGI Medicaid pending a disability decision from DDD.
4. The transitional Medicaid period expires or ends when the last child turns 18.
5. The PEN coverage ends.
6. Cancellation of an individual's SSI Medicaid.

For Extended Medicaid:

1. An ex parte determination must be completed in the fourth month to determine if coverage under another group exists. An eligibility review must be done if one has not been done within the past 12 months.
2. If loss of income from spousal support is reported at any point during the four months of extended Medicaid, an ex parte review must be completed.

For Postpartum Medicaid:

An ex parte determination must be completed in the last month of the 12 ~~two~~-month period. The recipient must be notified of any changes in Medicaid status following the ex parte determination.

For Presumptively Eligible Newborns (PEN)

An ex parte determination must be completed prior to the end of the child's presumptive eligibility. No verification of U.S. citizenship or identity will be needed for these children, even after the presumptive period ends.

Do not perform an ex parte determination when:

1. an individual fails to return requested information;
2. an individual moves out of state;
3. the Department is unable to locate the individual; or
4. an individual requests voluntary cancellation of Medicaid.

1830.0000 Family-Related Medicaid

This chapter discusses policy for individuals whose income must be considered when completing a Family-Related Medicaid eligibility determination. Modified Adjusted Gross Income (MAGI) is an Internal Revenue Service (IRS) method for counting income that aligns financial eligibility across all Insurance Affordability Programs (IAP). Adjusted Gross Income (AGI) is gross income minus casualty losses, charitable contributions, medical and dental expenses, qualified retirement contributions and other miscellaneous itemized deductions. MAGI is equal to Adjusted Gross Income plus foreign earned income, employer contribution plans, and tax exempt interest accrued during the taxable year. Current point in time income will be used in the eligibility determination process when available.

Income is money received from any source such as wages, benefits, contributions, and rentals. If income is taxable, it is counted.

MAGI-based budget determination requires deduction of income for pretax expenses.

Pretax Income Exclusions
Pretax income is excluded from gross income before taxes are deducted. Examples of "pretax income exclusions" include but not limited to:

- Some retirement plans (IRAs and 401(k) plan types)
- Life insurance
- Health Insurance premiums
- Transportation programs
- Health Savings accounts and Flexible spending accounts

Convert all pretax income exclusion amounts on the paystub/verification to a monthly amount (refer to Appendix A-37 for annual pretax income exclusion limits). Failure to deduct all pretax income exclusions will result in an incorrect calculation of income.

Note: An individual does not have to file a tax return to get pretax income excluded in a MAGI budget.

1830.0101 Income (MFAM)

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 compensation;
2. annuities, pensions, and other regular payments;
3. alimony and spousal support payments with decrees issued prior to January 01, 2019;
4. dividends, interest, and royalties;
5. prizes and awards; or

6. Social Security income.

Excluded income is income (earned or unearned) that is not counted when determining eligibility.

Pretax Income Exclusions
Pretax income is excluded from gross income before taxes are deducted. Examples of "pretax income exclusions" include but not limited to:

1. Some retirement plans (IRAs and 401(k) plan types)
2. Life Insurance
3. Health Insurance Premiums
4. Transportation programs
5. Health Savings accounts and Flexible spending accounts

Convert all pretax income exclusion amounts on the paystub/verification to a monthly amount (refer to Appendix A-37 for annual pretax income exclusion limits). Failure to deduct all pretax income exclusions will result in an incorrect calculation of income.

Note: An individual does not have to file a tax return to get pretax income excluded in a MAGI budget.

1830.0122 Verification of Income (MFAM)

To determine eligibility for Medicaid, verification of income will be performed by data exchange when available. An applicant's or recipient's self attestation of income is accepted if the amount stated on the application or renewal is reasonably compatible with information obtained by the Department through electronic sources. Reasonably compatible means both self attestation and electronic sources are below the applicable income standard or when the difference between both amounts is ten percent (10%) or less without regard to the income standard. If the difference is more than 10%, first ask for a reasonable explanation and, if necessary, paper documentation from the individual.

When income cannot be verified by data exchange, such as for individuals with no SSN or who have self-employment income, income must be verified by other acceptable means such as pay stubs, CF-ES 2620, etc.

A pretax income exclusion must be verified before it can be excluded in the MAGI budget. If the individual fails to provide verification determine eligibility without the exclusion. Proof for these pretax income exclusions vary based on the type of deduction and may include:

1. Bills
2. Business records
3. Receipts
4. Bank account statements
5. Paychecks, pay stubs, or employment verification records
6. Current tax returns if the amount is anticipated to be the same: and
7. Any other documents that support the expense or adjustment.

Pretax exclusions are tied to a specific income source and must be evaluated and verified at each annual review or when a change in circumstance is reported.

2030.0700 PREGNANT WOMEN (MFAM)

Medical assistance for the pregnant woman will be under one coverage group. The coverage group under which the pregnant woman receives benefits is determined by the household composition and income.

The following are coverage groups for pregnant women who:

1. have household ~~SFU~~ income at or below ~~under~~ the applicable income standard ~~limit and may have no other children 185% of the FPL~~ (no asset test),
2. are Medically Needy,
3. are presumptively eligible.

A pregnant woman who is eligible for regular Medicaid for at least one month, including a retroactive month, is eligible to receive Medicaid through her pregnancy and until the end of the 12th ~~second~~ month after the birth (postpartum period), regardless of any changes except for Presumptive Eligibility for Pregnant Women and Emergency Medical Assistance for Noncitizens.

2430.0204 Determining Monthly Income (MFAM)

Several factors are involved in determining a gross amount of monthly income to be budgeted. These are anticipating and projecting income, averaging income, and converting the income to a monthly amount.

When income is received more often than monthly, it will be converted to a monthly amount. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future income.

Convert all pretax income exclusion amounts on the paystub/verification to a monthly amount (refer to Appendix A-37 for annual pretax income exclusion limits).

2630.0108 Budget Computation (MFAM)

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 verified pretax income exclusions. Deduct any allowable income tax deductions (Schedule 1 (form 1040) line 22). 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.

3410.0212 Unclear Information (FS)

During the certification period, the Department may receive unclear information about a household's circumstances which prevents the Department from determining ongoing eligibility or benefit amount. Unclear information is information that is not verified, or information that is verified but the Department needs additional information to act on the change.

The Department must request clarification and verification (if applicable) of household circumstances for any unclear information that appears to significantly conflict with the information that was used by the eligibility specialist at the time of application or recertification.

If a discrepancy exists, the eligibility specialist must contact the household by phone or send a pending notice which clearly advises the household of the verification it must provide or the actions it must take to clarify its circumstances and consequences for failure to respond to the request.

Allow the household at least ten (10) days to respond and to clarify its circumstances either by telephone or providing verification, as directed by the Department.

If the household does not respond to the pending notice or refuses to provide information to clarify the unclear information, the eligibility specialist must take action and issue a notice of adverse action which explains the reason for termination of benefits and advises to submit a new application if the household wishes to continue receiving benefits. If the unclear information does not meet the reporting criteria for Simplified Reporting households, then the Department shall not act on the information or require the household to provide verification until the next recertification is due.

If the household responds and provides requested information, the eligibility specialist must act on the new information. When information results in an increase, the eligibility specialist must act on the change.

If a discrepancy exists with Social Security Match (DETH) or Prisoner Match (DEPR) information, which are not verified upon receipt, contact the customer by phone or send a pending notice for verification. The applicant/recipient must be given at least 10 days to resolve the unclear data exchange match.