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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-06318

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.

_________________________________/

## FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on December 8, 2009, at 9:28 a.m., in Lakeland, Florida. The petitioner appeared. petitioner's mother and representative, appeared. David Beaven, medical health care program analyst with the Agency for Health Care Administration (AHCA), appeared and represented the respondent-Agency.

## ISSUE

At issue is the respondent's action denying the petitioner's claim for reimbursement for payment of Medicaid services. The petitioner bears the burden of proof in this appeal.

## FINDINGS OF FACT

1. The petitioner was determined eligible for protected Medicaid for the months of October 2006 through the current month. This determination

was made as the result of a prior final hearing in which the hearing officer found the Department of Children and Families (DCF) had denied the petitioner's Medicaid benefits in error.

2. DCF posted the petitioner's Medicaid coverage for these months by placing them into the FLORIDA system which communicates eligibility to the respondent's Medicaid Management Information System (MMIS).
3. DCF sent a request to the respondent on September 8, 2009, to reimburse the petitioner for prescription expenses he paid for out-of-pocket for the period beginning March 2007. The DCF representative attached a pharmacy printout from CVS (one of petitioner's pharmacies) showing the prescriptions that were filled. The total amount requested for reimbursement at this time was $2,213.14.
4. On September 24, 2009, the respondent completed a reimbursement determination on the expenses received. It determined the petitioner was eligible for $2,146.18. A total of $66.96 was not eligible for reimbursement because that portion was a total of copayment amounts for prescriptions covered by Medicare Part D. That portion remained the responsibility of the petitioner and was not reimbursable under Medicaid guidelines.
5. The petitioner appeals.
6. At the hearing, the petitioner requested the hearing officer review his prescription reimbursement eligibility retroactive to the year 2000. The hearing officer denied this motion as it was deemed a motion for rehearing or reconsideration because that issue directly involved eligibility and was

ruled on in the prior final hearing involving DCF. The petitioner currently has this, as well as other issues, under appeal and review by the District Court of Appeals.

7. The petitioner challenged that the respondent should have reimbursed him the remaining $66.96 ($67.00) as well as all other prescription expenses dating back to October 2006. He also specifically asked about coverage of his prescription for Allegra D.

8. The respondent stated that it would need to submit additional evidence to support why that amount ($66.96) remained unpaid to the petitioner. The record was held open until December 15, 2009, for submission of this evidence. The evidence was received. Also at the hearing, the respondent stated that it is processing all of the petitioner's claims for reimbursement as the petitioner submits them. The respondent has no dispute paying these claims but the petitioner must submit the expenses first before they can be paid out in reimbursement to him.

## CONCLUSIONS OF LAW

42 C.F.R. section 423.906 establishes:

**General payment provisions.** [emphasis original]. ...(b) Medicare as primary payer. Medicare is the primary payer for covered drugs for part D eligible individuals. ...(c) Noncovered drugs. States may elect to provide coverage for outpatient drugs other than Part D drugs in the same manner as provided for non-full benefit dual eligible individuals or through an arrangement with a prescription drug plan or a MA-PD plan.

Fla. Stat. ch. 409.9066 establishes:

**Medicare prescription discount program.**—[emphasis original]

(1) As a condition of participation in the Florida Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to charge any individual who is a Medicare beneficiary and who is a Florida resident showing a Medicare card when he or she presents a prescription, a price no greater than the cost of ingredients equal to the average wholesale price minus 9 percent, and a dispensing fee of $4.50.

(2) In lieu of the provisions of subsection (1), and as a condition of participation in the Florida Medicaid program or the pharmaceutical expense assistance program, a pharmacy must agree to:

(a) Provide a private voluntary prescription discount program to state residents who are Medicare beneficiaries; or

(b) Accept a private voluntary discount prescription program from state residents who are Medicare beneficiaries.

Discounts under this subsection must be at least as great as discounts under subsection (1). ...

Fla. Stat. ch. 409.9081 states in relevant part:

**Copayments.** [emphasis original] (1) The agency shall require, subject to federal regulations and limitations, each Medicaid recipient to pay at the time of service a nominal copayment for the following Medicaid services: ...(d) Prescription drugs: a coinsurance equal to 2.5 percent of the Medicaid cost of the prescription drug at the time of purchase. The maximum coinsurance shall be $7.50 per prescription drug purchased.

The federal regulation above and these Florida statutes show how prescriptions are billed to a recipient who receives both Medicare Part D and Medicaid. When a pharmacy dispenses certain types of drugs to a recipient, he is required to pay a copayment as part of the Medicare Part D program which is not reimbursable by the state of Florida under Medicaid guidelines. In this case, the drug at issue causing the $66.96 difference was the petitioner's Allegra D, which he inquired about at the hearing.

Fla. Admin. Code 59G-5.110 states in relevant part:

> (1)(a)...Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility and a successful appeal or an agency determination in a recipient's favor. The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any goods or services the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.

The above-cited authority provides that the Agency may reimburse a recipient for Medicaid-covered services that the recipient paid for out of pocket provided that the individual is later found to have actually been eligible for Medicaid. The petitioner meets this requirement as he was found eligible for protected Medicaid beginning October 2006. He did pay for many of his prescriptions from that time through the month until he was able to use his Medicaid card.

Based on the evidence and testimony presented, the hearing officer concludes that the petitioner is eligible for direct reimbursement but only for those expenses covered under Medicaid, at the Medicaid rate, and not subsidized by the third party payor Medicare Part D. As a result, as of the date of the hearing the Agency has correctly determined that the petitioner is eligible for $2,146.18 in expenses and has reimbursed him for such. The Agency is currently processing recently submitted prescription bills for reimbursement to the petitioner.

The petitioner is encouraged to continue to submit to the respondent any bills from October 2006 through the current month that are unpaid and for which he wishes to seek reimbursement.

**DECISION**

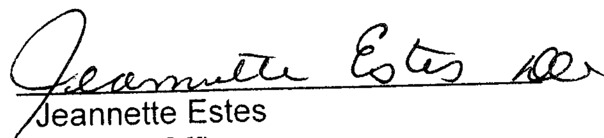
The appeal is denied. The respondent's action is affirmed.

**NOTICE OF RIGHT TO APPEAL**

This decision is final and binding on the part of the agency. 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, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 28th day of December 2009,

in Tallahassee, Florida.



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