

01/15/10

Bulletin No.09-17

7101.2

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## 7101 Medicaid Benefit Delivery

### 7101.2 Managed Health Care Plan (Continued)

#### B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (7408);
- dental care for children under age 21 (7312) and limited dental services for adults up to the annual benefit maximum (7313);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (7316);
- chiropractic services ~~for children under age 21~~ (7304);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (7406); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (7502).

#### C. Cost Sharing

ANFC-related Medicaid beneficiaries age 21 and older and SSI-related Medicaid beneficiaries age 18 and older enrolled in a managed health care plan are subject to the following co-payment requirements, unless exempt under 4161 (B):

- \$75.00 for the first day of an inpatient hospital stay in a ~~general~~ hospital.
- \$3.00 per day per hospital for hospital outpatient services unless the ~~individual~~ beneficiary is also covered by Medicare. An ~~individual~~ beneficiary covered by Medicare has no co-payment requirement for outpatient services.

Medicaid beneficiaries age 21 and older enrolled in a managed health care plan are subject to the following co-payment requirements, unless exempt under 4161 (B):

- \$3.00 for each dental visit.
- Prescriptions:
  - \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less;
  - \$2.00 for each prescription, original or refill, having a usual and customary charge of ~~more than~~ \$30.00 or more but less than \$50.00;
  - \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.

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7101.3

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## 7101 Benefit Delivery Systems

### 7101.3 Primary Care Case Management Program

#### D. Self-Referral Services (Continued)

- chiropractic services ~~for children under age 21~~ (7304);
- maternity/prenatal (7202, 7301);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (7406).

#### E. Cost Sharing

ANFC-related Medicaid beneficiaries age 21 and older and SSI-related Medicaid beneficiaries age 18 and older enrolled in a PCCM are subject to the following co-payment requirements, unless exempt under 4161 (B):

- \$75.00 for the first day of an inpatient hospital stay in a ~~general~~ hospital.
- \$3.00 per day per hospital for hospital outpatient services unless the ~~individual~~ beneficiary is also covered by Medicare. An individual covered by Medicare has no co-payment requirement for outpatient services.

Medicaid beneficiaries age 21 and older enrolled in a PCCM are subject to the following co-payment requirements, unless exempt under 4161 (B):

- \$3.00 for each dental visit.
- Prescriptions:
  - \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less;
  - \$2.00 for each prescription, original or refill, having a usual and customary charge of ~~more than~~ \$30.00 or more but less than \$50.00;
  - \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.

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7304

7304 Chiropractic Services

Services furnished by a licensed chiropractor certified to meet the standards for participation in Medicare are covered ~~for beneficiaries under age 21 only~~.

Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine.

The existence of the subluxation may be demonstrated by means of:

1. An x-ray taken at a time reasonably proximate to the initiation of the course of treatment, or
2. Adherence to the clinical review criteria developed by the Vermont Chiropractic Association and the Vermont Medicaid Program. A copy of the clinical review record must be kept on file by the chiropractor and be made available upon request.

An x-ray will be considered "reasonably proximate" if:

- In the case of a low grade chronic subluxation complex, it is taken no more than 12 months prior to the initiation of the course of treatment. A re-evaluation x-ray must be performed before the beginning of the third year of continuous care; or
- In the case of an acute subluxation, it is taken no earlier than three months prior to the initiation of care (This would justify a course of treatment for a maximum of three months.)

Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the ~~recipient~~beneficiary, ~~recipient's~~beneficiary's family, friends or such other community resources as may be available.

Chiropractic services for ~~recipients~~beneficiaries under the age of 12 require prior authorization from the ~~Medical Review Unit, Medicaid Division, Waterbury~~ Office of Vermont Health Access. Clinical review data pertinent to the need for treatment must be submitted in writing.

Coverage is limited to ten treatments per ~~patient~~beneficiary per calendar year. Exceptional or unusual circumstances may justify a request by the chiropractor for additional coverage. Requests must contain full clinical data, x-rays or other documentation as may be required by the ~~Medical Review Unit, Medicaid Division, Waterbury~~ Office of Vermont Health Access, to evaluate the medical necessity for continued care.

Payment for chiropractic treatment will be made at the lower of the actual charge or the Medicaid rate on file.

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7501

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## 7501 Pharmaceuticals, Medical Supplies and Equipment - General Information

Pharmaceutical items include drugs, medicine chest supplies, vitamins and related items which are normally obtained through appropriately licensed pharmacies. Medical supplies and equipment include prosthetic devices, durable and non-durable equipment for care of the ill or injured, medical supplies and similar items which may be obtained from a pharmacy, hospital-surgical supply service or home health agency.

Payment for covered items, other than prescribed drugs, is limited to the following providers:

- A Vermont provider approved for participation in Medicare; or
- An out-of-state provider, approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX Program within the state where it is located.

Payment for prescribed drugs is limited to Vermont Medicaid enrolled providers who are:

- Registered Vermont pharmacies, including hospital pharmacies; or
- Pharmacies appropriately licensed in another state; or
- A physician, serving an area without regular pharmacy services, who has been granted special approval to bill these items direct.

Payment is limited to covered items furnished on written prescription of a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid, or on telephoned prescription from a prescriber as previously described and enrolled in Vermont Medicaid processed in compliance with applicable federal and state statutes and regulations.

~~Any drug which is to be used continuously (i.e., daily, twice a day, every other day, etc.) for 30 days or more may shall be prescribed and dispensed in increments of 90-day supplies an amount sufficient to treat the patient for no less than thirty (30) days and no more than ninety (90) days at a time except medications which the patient takes or uses on an "as needed" basis. This limit shall not apply to drugs generally used to treat acute conditions.~~ "Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

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7501

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7501 Pharmaceuticals, Medical Supplies and Equipment - General Information (Continued)

Select drugs used for maintenance treatment are limited to 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form may be filed with the Office of Vermont Health Access.

Up to five refills are permitted if allowed by federal or state pharmacy law. ~~If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, the supply may be for less than 30 days.~~

For recipients in a NF or ICF/MR see 7501.6.

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by Medicaid except in an individual case when the quantity has been changed in consultation with the physician.

When the same drug in the same strength is prescribed for more than one member of a family at one time, the pharmacist must submit ~~shall treat it as~~ one prescription for each family member for payment purposes. ~~Specific examples of drugs which might fall into this category are delousing agents (e.g. Kwell) and de-worming preparation (e.g., Vermox).~~

Claims for vendor payment are submitted to and processed by the fiscal agent only; there is no provision for direct reimbursement to recipients or to nursing ~~homes~~ facilities for payments they may make to a pharmacy or supplier.

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7501.2

7501.2 Payment Conditions

Medicaid payment rates are established for covered services. For certain services, a recipient co-payment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

7501.3 Payments for Prescribed Drugs

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients plus the dispensing fee on file or the provider's actual amount charged which shall be the usual and customary charge to the general public.

7501.4 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs: multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., single-source drugs [brand name] or drugs "other" than multiple-source).

A. For multiple-source drugs, the price for ingredients will be the lowest of:

1. the CMS Federal Upper Limit (FUL), or
2. the state Maximum Allowable Cost (MAC), or
3. the Usual and Customary (U&C) charge, or
4. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

B. For "other" drugs, the price for ingredients shall be the lowest of:

1. the Usual and Customary (U&C) charge, or
2. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

The exact payment methodology can be found in Attachment 4.19-B of the Vermont Medicaid State Plan.

~~Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).~~

~~(a) For multiple-source drugs, the price for ingredients will be the lowest of:~~

~~(i) an amount established as the upper limit derived from a listing issued by the Health Care Financing Administration under the authority of Sec. 1902(a)(30)(A) of the Social Security Act, or~~

~~(ii) an amount established as the upper limit by the Department, or~~

~~(iii) 85.8 percent of the Average Wholesale Price (AWP less 14.2 percent).~~

~~(b) For "other" drugs, the price for ingredients will be 85.8 percent of the Average Wholesale Price (AWP).~~

When a physician certifies in his or her own handwriting that a specific brand of a multiple-source drug is medically necessary for a particular ~~recipient~~beneficiary, the price for ingredients will be calculated as for "other drugs". The physician's handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription.

#### 7501.5 Compounded Prescriptions

Payment for compounded prescriptions is made at the lower of the actual amount charged or the price for ingredients plus the dispensing fee plus the compounding fee on file for each minute directly expended in compounding.

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5640

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#### 5640 Coverage

Individuals are enrolled in this program and receive assistance in purchasing covered maintenance drugs from participating pharmacies after meeting all eligibility criteria and paying the required premium.

The department's payment for covered pharmaceuticals shall be based upon current Medicaid payment and dispensing policies.

#### 5641 Maintenance Drugs

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle. ~~It may not be dispensed unless prescribed by a licensed physician.~~ It may not be dispensed unless prescribed by a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid.

~~Maintenance drugs shall be prescribed and dispensed in increments of 30 to 90 day supplies except medications which the patient takes or uses on an "as needed" basis. Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.~~

Select drugs used for maintenance treatment must be prescribed and dispensed in 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office of Vermont Health Access.

Up to five refills are permitted if allowed by state or federal law.

Physicians and pharmacists are required to conform to Act 127 (18 -VSA- Chapter 91), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest-priced equivalent shall be considered medically necessary. If, in accordance with Act 127, the ~~patient~~beneficiary does not wish to accept substitution, VScript will not pay for the prescription.

Lists of covered drugs classes are maintained and periodically updated by the Office and available upon request.

For beneficiaries whose VScript group income is greater than 175 percent but no greater than 225 percent of the federal poverty level coverage is limited to drugs dispensed by participating pharmacies from manufacturers that as a condition of participation in the program, have signed a rebate agreement with the Office of Vermont

Health Access.

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5650

5650 Cost Sharing Requirements

All VScript beneficiaries must pay monthly premiums as specified in 4160 through 4162 to be enrolled in a VScript coverage group.

The following premium amounts apply to VScript.

<u>(i) VScript Group Income</u>	<u>(ii) Coverage Group</u>	<u>Monthly Premium, Per</u> <u>Individual Beneficiary</u>
> 150% ≤ 175% FPL	VScript	\$23.00
> 175% ≤ 225% FPL	VScript Expanded	\$50.00

In addition, an individual beneficiary shall contribute a co-payment of \$1.00 for prescriptions costing \$29.99 or less and a co-payment of \$2.00 for prescriptions costing \$30.00 or more.

A pharmacy may not refuse to dispense a prescription to an individual beneficiary who does not provide the co-payment.

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5550

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### 5550 Cost Sharing

The department requires all beneficiaries to pay a monthly premium of \$17.00 per person to enroll in the VHAP-Pharmacy program. The premium payment system applicable to VHAP-Pharmacy is described in 4160 through 4162.

### 5551 Payments for Prescribed Drugs

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 5552) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

### 5552 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., single-source drugs [brand name] or drugs "other" than multiple-source).

A. For multiple-source drugs, the price for ingredients will be the lowest of:

1. the CMS Federal Upper Limit (FUL), or
2. the state Maximum Allowable Cost (MAC), or
3. the Usual and Customary (U&C) charge, or
4. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

B. For "other" drugs, the price for ingredients shall be the lowest of:

1. the Usual and Customary (U&C) charge, or
2. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

The exact payment methodology can be found in Attachment 4.19-B of the Vermont Medicaid State Plan.

~~Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source):~~

~~a. — For multiple-source drugs, the price for ingredients will be the lowest of:~~

- ~~1. an amount established as the upper limit derived from a listing issued by CMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or~~
  - ~~2. an amount established as the upper limit by the Office of Vermont Health Access, or~~
  - ~~3. 85.8 percent of the Average Wholesale Price (AWP less 11.9 percent).~~
- ~~b. For "other" drugs, the price for ingredients will be 85.8 percent of the Average Wholesale Price (AWP less 11.9 percent).~~

When a physician certifies in his or her own handwriting that a specific brand of a multiple-source drug is medically necessary for a particular ~~recipient~~beneficiary, the price for ingredients will be calculated as for "other" drugs. The physician's handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription.

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~~5552~~5553

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5553 Compounded Prescriptions

Payment for compounded prescriptions is made at the lower of the actual amount charged or the price for ingredients plus the dispensing fee plus the compounding fee on file for each minute directly expended in compounding.

5554 Participating Pharmacy

"Pharmacy" means a retail or institutional drug outlet licensed by the Vermont State Board of Pharmacy pursuant to chapter 36 of Title 26, or by an equivalent board in another state, in which prescription drugs are sold at retail and which has entered into a written agreement with the state to dispense drugs.

A provider must:

- satisfactorily complete and submit to the Office of Vermont Health Access the standard enrollment form;
- conform to the standards of the Vermont State Board of Pharmacy and other federal and state statutes and regulations applicable to the dispensing of prescription drugs to the general public;
- agree to provide reasonable access to records necessary to comply with the provisions for program review set forth in the Provider Agreement;
- never deny services to, or otherwise discriminate against on the basis of race, color, sex, age, religious preference, national origin, handicap or sexual orientation;
- take appropriate steps to prevent the wrong utilization of prescription drugs, with special concern for the potentially dangerous interaction of two or more prescription drugs from different prescribers.

5555 Co-payments

An individual beneficiary shall contribute a co-payment of \$1.00 for prescriptions costing \$29.99 or less and a co-payment of \$2.00 for prescriptions costing \$30.00 or more.

A pharmacy may not refuse to dispense a prescription to an individual beneficiary who does not provide the co-payment.

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5560

5560 Prescribed Drugs

Pharmaceutical items include drugs that are obtained through appropriately licensed pharmacies. Payment for prescribed drugs is limited to:

- Registered Vermont pharmacies, including hospital pharmacies; or
- Pharmacies appropriately licensed in another state; or
- A physician, serving in areas without regular pharmacy services, who has been granted special approval to bill these items direct.

Payment is limited to covered items furnished on written prescription from a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid, or on telephoned prescription from a prescriber as previously described and enrolled in Vermont Medicaid processed in compliance with applicable federal and state statutes and regulations.

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

~~Any drug which is to be used continuously (i.e., daily, twice a day, every other day, etc.) for 30 days or more shall may be prescribed and dispensed in increments of 90-day supplies an amount sufficient to treat the patient for no less than thirty (30) days and no more than ninety (90) days at a time except medications which the patient takes or uses on an "as needed" basis. This limit shall not apply to drugs generally used to treat acute conditions.~~

Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office of Vermont Health Access.

ANNOTATED TEXT

Up to five refills are permitted if allowed by federal or state pharmacy law. ~~If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, the supply may be for less than 30 days.~~

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by VHAP-Pharmacy, except in an individual case when the quantity has been changed in consultation with the physician.

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5560 Prescribed Drugs [3304]

Payment may be made for any preparation, except those unfavorably evaluated, either included or approved for inclusion in the latest edition of official drug compendia: American Hospital Formulary Service Drug Information; the U.S. United States Pharmacopoeia-Drug Information (or its successor publications); and the DRUGDEX Information System; and the peer-reviewed medical literature; ~~the National Formulary, the U.S. Homeopathic Pharmacopoeia, AMA Drug Evaluations, or Accepted Dental Therapeutics.~~ These consist of "legend" drugs for which a prescription is required by State or Federal law.

Physicians and pharmacists are required to conform to Act 127 (18-VSA-Chapter 91), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest priced equivalent shall be considered medically necessary. If, in accordance with Act 127, the ~~patient~~ beneficiary does not wish to accept substitution, VHAP-Pharmacy will not pay for the prescription.

5440 Payment System

VPharm follows the prospective premium-based payment system described at rule 4161.

5441 Cost-Sharing

An ~~individual~~ beneficiary shall contribute the following base cost-sharing amounts, which shall be indexed to the increases established under 42 C.F.R. § 423.104(d)(5)(iv) and then rounded to the nearest dollar amount:

% FPL	Monthly Premium, per <del>Individual</del> <u>Beneficiary</u>
≤ 150%	\$ 17.00
> 150% but ≤ 175%	\$ 23.00
> 175% but ≤ 225%	\$ 50.00

In addition, an ~~individual~~ beneficiary shall contribute a co-payment of \$1.00 for prescriptions where the cost-sharing amount required by Medicare Part D is \$29.99 or less and a co-payment of \$2.00 for prescriptions where the cost-sharing amount required by Medicare Part D is \$30.00 or more.

A pharmacy may not refuse to dispense a prescription to an ~~individual~~ beneficiary who does not provide the co-payment.

5442 Medicare Advocacy Program

In order to ensure the appropriate payment of claims, OVHA may expand the Medicare advocacy program established under chapter 67 of Title 33 of the V.S.A. to individuals receiving benefits from the VPharm program.

5443 Payments for Prescribed Drugs

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 5551) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

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5444

5444 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs: multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., single-source drugs [brand name] or drugs "other" than multiple-source).

A. For multiple-source drugs, the price for ingredients will be the lowest of:

1. the CMS Federal Upper Limit (FUL), or
2. the state Maximum Allowable Cost (MAC), or
3. the Usual and Customary (U&C) charge, or
4. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

B. For "other" drugs, the price for ingredients shall be the lowest of:

1. the Usual and Customary (U&C) charge, or
2. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

The exact payment methodology can be found in Attachment 4.19-B of the Vermont Medicaid State Plan.

~~Payment for the ingredients in covered prescriptions is made for two groups of drugs: multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).~~

~~A. For multiple-source drugs, the price for ingredients will be the lowest of:~~

- ~~1. an amount established as the upper limit derived from a listing issued by CMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or~~
- ~~2. an amount established as the upper limit by the Office of Vermont Health Access, or~~
- ~~3. the Average Wholesale Price (AWP).~~

~~B. For "other" drugs, the price for ingredients will be 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).~~

5445 Compounded Prescriptions

Payment for compounded prescriptions is made at the lower of the actual amount charged or the price for ingredients plus the dispensing fee plus the compounding fee on file for each minute directly expended in compounding.

5446 Participating Pharmacy

"Pharmacy" means a retail or institutional drug outlet licensed by the Vermont State Board of Pharmacy pursuant to chapter 36 of Title 26, or by an equivalent board in another state, in which prescription drugs are sold at retail and which has entered into a written agreement with the state to dispense drugs.

A pharmacy provider must:

- satisfactorily complete and submit to the Office of Vermont Health Access the standard enrollment form;
- conform to the standards of the Vermont State Board of Pharmacy and other federal and state statutes and regulations applicable to the dispensing of prescription drugs to the general public;
- agree to provide reasonable access to records necessary to comply with the provisions for program review set forth in the Provider Agreement;
- never deny services to, or otherwise discriminate, against any individual on the basis of race, color, sex, age, religious preference, national origin, handicap or sexual orientation;
- take appropriate steps to prevent the wrongful utilization of prescription drugs, with special concern for the potentially dangerous interaction of two or more prescription drugs from different prescribers.

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### 5447 Prescribed Drugs

Pharmaceutical items include drugs that are obtained through appropriately licensed pharmacies. Payment for prescribed drugs is limited to the following providers who are enrolled in Vermont Medicaid:

- Registered Vermont pharmacies, including hospital pharmacies;
- Pharmacies appropriately licensed in another state; or
- A physician, serving in areas without regular pharmacy services, who has been granted special approval to bill these items direct.

Payment is limited to covered items furnished on written prescription from a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid, or on telephoned prescription from a prescriber as previously described and enrolled in Vermont Medicaid processed in compliance with applicable federal and state statutes and regulations. ~~Any drug that is to be used continuously (i.e., daily, twice a day, every other day, etc.) for 30 days or more shall be prescribed and dispensed in an amount sufficient to treat the patient no fewer than 30 days and no more than 90 days at a time. Medications that the patient takes or uses on an "as needed" basis are not considered to be used continuously. Up to five refills are permitted if allowed by federal or state pharmacy law. If there are extenuating circumstances in an individual case that, in the judgment of the physician, dictate a shorter prescribing period, the supply may be for fewer than 30 days.~~

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by VPharm, except in an individual case when the quantity has been changed in consultation with the physician.

Payment may be made for any covered preparation, except those unfavorably evaluated, either included or approved for inclusion in the latest edition of official drug compendia: American Hospital Formulary Service Drug Information; United States Pharmacopoeia-Drug Information (or its successor publications); and the DRUGDEX Information System; and the peer-reviewed medical literature.~~the U.S. Pharmacopoeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, AMA Drug Evaluations, or Accepted Dental Therapeutics.~~ These consist of "legend" drugs for which a prescription is required by State or Federal law.

Physicians and pharmacists are required to conform to Act 127 (18-VSA-Chapter 91), otherwise known as the Generic Drug Bill~~Chapter 91 of Title 18 of the Vermont Statutes Annotated (Generic Drugs)~~. In those cases where the Generic Drug Bill Chapter 91 permits substitution, only the lowest priced equivalent shall be considered medically necessary. If, in accordance with Act 127 Chapter 91, the patient beneficiary does not wish to accept substitution, VPharm will not pay for the prescription.

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## 5450 Coverage

Beneficiaries who are entitled to Medicare benefits under Part A or enrolled in Medicare Part B, and who live in the service area of a Part D plan, are defined under Medicare rules at 42 CFR §423.30 as eligible for Part D. Vermont is included in the service area for several Part D plans. According to 42 CFR §423.906, Medicare is the primary payer for covered drugs for Part D eligible individuals. VPharm does not cover drugs in classes included in the Part D benefit. VPharm provides secondary pharmacy coverage as described below for those eligible for Medicare and VPharm.

VPharm provides secondary pharmacy coverage, as described below for those eligible for Medicare and VPharm, limited to drugs dispensed by participating pharmacies from manufacturers that, as a condition of participation in the program, have signed a rebate or price discount agreement with the Office of Vermont Health Access. These rebate or price discount agreements must be at least as favorable as the rebate or price discount paid in connection with the Medicaid program.

Part D is administered either through a prescription drug plan (PDP) or as a component of Part C, Medicare managed care, in a Medicare Advantage – Prescription Drug benefit (MA-PD).

VPharm will provide supplemental coverage for the following categories of drugs if they are not covered by the PDP/MA-PD:

- 1) drugs for anorexia, weight loss, or weight gain (7502.3);
- 2) single prescription vitamins or minerals if the conditions described in 7502.4 are met;
- 3) over-the-counter prescriptions if the conditions described in 7502.5 are met;
- 4) barbiturates; and
- 5) benzodiazepines.

Payment for the covered pharmaceuticals described above shall be based upon current Medicaid payment and dispensing policies.

For those individuals~~beneficiaries~~ whose household income is not greater than 150 percent of the federal poverty level (FPL), the drugs in the above categories are covered as they are covered under Medicaid. In addition, benefits are provided for one comprehensive visual analysis (including a refraction) and one interim eye exam (including a refraction) within a two-year period, and diagnostic visits and tests related to vision.

For those beneficiaries~~individuals~~ whose household income is greater than 150 percent FPL and no greater than 225 percent FPL, VPharm covers the drugs in the above categories only if they are maintenance drugs. "Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer and includes insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a licensed physician.

For those beneficiaries~~individuals~~ whose household income is greater than 175 percent but no greater than 225 percent of the poverty level, coverage in the classes listed above is limited to drugs dispensed by participating pharmacies from manufacturers that, as a condition of participation in the program, have signed a rebate agreement with the Office of Vermont Health Access.

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5450 Coverage (Continued)

In addition, VPharm covers beneficiary cost-sharing after any federal limited-income subsidy is applied. This may include basic beneficiary premiums for the PDP up to the low-income premium subsidy amount (as determined by the Centers for Medicare and Medicaid Services), Part D deductible, co-payments, coinsurance, the Part D coverage gap, and catastrophic co-payments according to Medicare Part D rules. Beneficiaries have co-payments as described in 5441.

For those ~~beneficiaries~~~~individuals~~ whose household income is greater than 175 percent but no greater than 225 percent of the poverty level, cost-sharing coverage is limited to maintenance drugs. On a case-by-case basis, OVHA may pay or subsidize a higher premium for a Medicare Part D prescription drug plan offering expanded benefits if it is cost-effective to do so.

In the case of the statin lipotropic and proton pump inhibitor drug classes, VPharm requires the use of a select OTC and/or a generic drug in order to receive coverage of the Medicare Part D cost-sharing, or of the prescription when the drug would be paid for entirely by VPharm, except that:

- (A) a beneficiary who is taking a brand name drug on June 30, 2009, under a prior authorization through a Medicare Part D plan, may continue to receive coverage under VPharm for that drug; and
- (B) a prescriber may override the substitution of an OTC or generic drug by requesting an exception override from OVHA. The override will be based on the same criteria provided for under section 4606 of Title 18 (generic substitutions). The prescriber must provide a detailed explanation regarding:
  - (1) the OTC or generic drug or drugs that have been previously tried by the beneficiary and:
    - (a) were ineffective; or
    - (b) resulted in the adverse or harmful side effects to the beneficiary; or
  - (2) the reasons why the provider expects that the OTC or generic drug(s) may be ineffective or result in adverse or harmful side effects to the beneficiary if they have not previously tried the drug(s).

The drug utilization review (DUR) board shall determine the list of OTC and generic drugs that shall be available for coverage in each class and shall ensure that the list of generic drugs includes drugs available on the formularies of 90 percent of the Medicare Part D prescription drug plans available in Vermont. In designing the list, the DUR board shall maximize access to a variety of OTC and generic drugs for beneficiaries.

When an ~~individual~~~~beneficiary~~ appeals a denial of coverage of a drug under a Part D or Part C plan, and has exhausted the plan's appeal process through the Independent Review Entity (IRE) decision level, or the plan's transition processes as approved by the Centers for Medicare and Medicaid Services (CMS), the ~~beneficiary~~~~individual~~ may apply to the Office of Vermont Health Access (OVHA) for coverage of the drug if it would have been included in the corresponding Vermont pharmacy benefit (Medicaid or maintenance level of coverage) if the ~~beneficiary~~~~individual~~ were not covered by Part D. If the ~~beneficiary~~~~individual~~'s prescriber documents medical necessity in a manner established by the director of the OVHA, and the process for documentation conforms with the pharmacy best practice and cost control program established under subchapter 5 of chapter 19 of Title 33, the drug shall be covered.

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5450 Coverage (continued)

At the beginning of coverage under Medicare Part D, when an ~~individual~~ beneficiary has applied for and has attempted to enroll in a Part D plan and has not yet received coverage due to an operational problem with Medicare, or has otherwise not received coverage for the needed pharmaceutical, the necessary drugs will be covered, if OVHA finds that good cause and a hardship exist, until such time as the operational problem, good cause and hardship ends. The beneficiary~~individual~~ must have made every reasonable effort with CMS and the PDP, given the beneficiary~~individual~~'s circumstances, to obtain coverage. The intent of the good cause and hardship exception is remedial in nature and shall be interpreted accordingly. In general "good cause" shall include instances where the lack of coverage can not reasonably be considered the fault of the beneficiary~~individual~~, and "hardship" shall include circumstances where alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the beneficiary~~individual~~. OVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

5330 Cost-Sharing Requirements

~~5331~~A.Premium

~~Individuals~~ Beneficiaries meet this requirement when they have paid any required premium as specified in 4160 - 4162. The amount of the premium for each ~~individual~~ beneficiary increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

Income Maximums	Monthly Premium per <del>Individual</del> <u>Beneficiary</u>
0 - 50% FPL	\$ 0
> 50% but $\leq$ 75% FPL	\$7.00
> 75% but $\leq$ 100% FPL	\$25.00
> 100% but $\leq$ 150% FPL	\$33.00
> 150% but $\leq$ 185% FPL	\$49.00

~~5332~~B.Co-payment

There is a co-payment requirement of \$25 per medically necessary hospital emergency room visit, as defined in 7101.5 A (13) and (37).

In addition, ~~individuals~~ beneficiaries in households with income at or greater than 100% of the federal poverty guideline (see Medicaid Procedures P-2420 B) shall contribute a co-payment of \$1.00 for prescriptions costing \$29.99 or less and a co-payment of \$2.00 for prescriptions costing 30.00 or more.

A pharmacy may not refuse to dispense a prescription to an ~~individual~~ beneficiary who does not provide the co-payment.

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5351 Benefits

VHAP - Limited is an interim fee-for-service benefit package that covers a limited number of VHAP services until the beneficiary is enrolled in VHAP - Managed Care. The VHAP - Limited benefit package is described in procedures found at P-4003.

The VHAP - Managed Care benefit package is described in procedures found at P-4005. VHAP - Managed Care beneficiaries can access services through the following ways:

~~The VHAP-Limited benefit packages (limited and managed care) are described in procedures found at P-4003.~~

~~VHAP beneficiaries enrolled in managed health care plans can access services through the following ways:~~

A. Services Requiring Plan Referral

In VHAP - Managed Care the following services must have a referral from the beneficiary's primary care provider:

1. inpatient hospital care (emergency and urgent admissions only, as determined by the admitting physician);
2. outpatient services in a general hospital or ambulatory surgical center;
3. physician services;
4. maxillofacial surgery;
5. cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;
6. home health care;
7. hospice services by a Medicare-certified hospice provider;
8. outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy);
9. prenatal and maternity care;
10. ambulance services;
11. medical equipment and supplies;
12. skilled nursing facility services for up to 30 days length of stay per episode;
13. mental health and chemical dependency services;  
NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
14. podiatry services;
15. prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;

16. over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

~~Any drug which is to be used continuously (i.e., daily, twice a day, every other day, etc.) for 30 days or more may be prescribed and dispensed in increments of 90-day supplies except medications which the patient takes or uses on an "as needed" basis. This limit shall not apply to drugs generally used to treat acute conditions.~~ "Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office of Vermont Health Access.

Up to five refills are permitted if allowed by state or federal law.

#### B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

1. one routine annual gynecological exam and related diagnostic services (as specified by the plan);
2. one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
3. one routine eye examination every 24 months.
4. chiropractic coverage for manipulation of the spine.

#### C. Wrap-Around Benefits

**ANNOTATED TEXT**

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

1. eyeglasses furnished through OVHA's sole source contractor (coverage of all eyewear is suspended indefinitely);
2. family planning services (defined as those services that either prevent or delay pregnancy).