

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 Individual <u>Beneficiary</u>
0 - 50% FPL	\$ 0
> 50% but ≤ 75% FPL	\$7.00
> 75% but ≤ 100% FPL	\$25.00
> 100% but ≤ 150% FPL	\$33.00
> 150% but ≤ 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.

11/12/09

Bulletin No. 09-23E

5351

5351 Benefits (Continued)B. Self-Referral Services

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

- one routine annual gynecological exam and related diagnostic services (as specified by the plan);
- 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
- one routine eye examination every 24 months
- chiropractic coverage for manipulation of the spine.

C. Wrap-Around Benefits

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:

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

11/12/09

Bulletin No. 09-23E

5441

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 Individual Beneficiary
≤ 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.

11/12/09

Bulletin No. 09-23E

5447

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.

11/12/09

Bulletin No. 09-23E

5450

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.

11/12/09

Bulletin No. 09-23E

5450

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~~ approval through a Medicare Part D ~~prior authorization~~ 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 ~~a an exception~~ ~~override~~~~prior authorization~~ 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.

11/12/09

Bulletin No. 09-23E

5450

5450 Coverage (continued)

At the beginning of coverage under Medicare Part D, when an ~~n-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.

ANNOTATED TEXT

[the changed names/numbers due to Bulletin 08-20 ARE NOT annotated here]

Office of Vermont Health Access

VHAP-Pharmacy Rules

11/12/09

Bulletin No. 09-23E

5555

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.

11/12/09

Bulletin No. 09-23E

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.

11/12/09

Bulletin No. 09-23E

7101.2

7101 Medicaid Benefit Delivery7101.2 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.

11/12/09

Bulletin No. 09-23E

7101.3

7101 Benefit Delivery Systems7101.3 Primary Care Case Management ProgramD. 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.

11/12/09

Bulletin No. 09-23E

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.