

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

OVHA

Office of Vermont Health Access

Bulletin No: 09-15 E

FROM: Susan Besio, Ph.D., Director *Susan Besio*
Office of Vermont Health Access

DATE: 6/19/09

SUBJECT: State Fiscal Year 2010 Coverage Changes

CHANGES ADOPTED EFFECTIVE 7/15/09

INSTRUCTIONS

Maintain Manual - See instructions below.

Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin

Information or Instructions - Retain until

MANUAL REFERENCE(S):

M103.2	3304
M103.3	3505
M640	3506
M880-M889	4001.92
3202	4003.1
3203	
3303.6	

This emergency rule is being implemented as a direct result of H. 441, An Act making Appropriations for the Support of Government. This Act instructed OVHA to make these changes using the emergency rule process because of the fiscal crisis in the state.

The changes include:

- the addition of co-payments of \$1 or \$2 to VHAP-Pharmacy, VScript, VScript Expanded, VPharm and beneficiaries at or above 100 percent of the federal poverty guideline (FPL) in the Vermont Health Access Plan (VHAP), with the proviso that pharmacies may not refuse to dispense the prescription if the individual does not provide the co-payment;
- requiring that certain maintenance drug classes identified by the Drug Utilization Review Board be dispensed in 90-day supplies in Medicaid, VHAP, VHAP-Pharmacy, VScript, and VScript Expanded;
- reinstating coverage for chiropractic manipulation of the spine for adults in Medicaid and VHAP;
- a pilot program in VPharm to encourage the use of over-the-counter and/or generic drugs in the classes of statin lipotropics (used to treat high cholesterol) and proton pump inhibitors (used to treat excess stomach acid).

Specific Changes

M103.2	Chiropractic care as described in M640 is added to the list of managed care wraparound services.
M103.3 D	Chiropractic care as described in M640 is included as a self-referral service.
M640	The sentence limiting chiropractic care to children under 21 is removed. References to the Medicaid Division are changed to Office of Vermont Health Access.
M800-M889	The requirement for a 90-day supply of maintenance drugs is added.
3202.1	The VScript requirement for a 90-day supply of maintenance drugs is added.
3203	VScript co-payments of \$1 or \$2 are added
TOC	The VHAP-Pharmacy Table of Contents is updated for the new co-payment section
3303.6	VHAP-Pharmacy co-payments of \$1 or \$2 are added.
3304	The VHAP-Pharmacy requirement for a 90-day supply of maintenance drugs is added.
3505.1	VPharm co-payments of \$1 or \$2 are added.
3506	A reference to the VPharm copayment section is added. The pilot program to promote over-the-counter and/or generic drug use of select statin lipotropic and proton pump inhibitor classes is added.
4001.92	Co-payments of \$1 or \$2 are added for VHAP members at or above 100 percent FPL.
4003.1	The VHAP requirement for a 90-day supply of maintenance drugs is added.
	Chiropractic coverage for manipulation of the spine is added.

Comment Period

Written comments will be accepted until July 8, 2009 and should be addressed to Keri Andersen, Health Programs Administrator, Office of Vermont Health Access, 312 Hurricane Lane, Williston, VT. 05495.

To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863

For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

Manual Maintenance

<u>Remove</u>		<u>Insert</u>
<u>Medicaid Rules</u>		
M103.2 P.3	(03-17)	M103.2 P.3 (09-15 E)
M103.3 P.7	(03-17)	M103.3 P.7 (09-15 E)
M640	(02-35)	M640 (09-15 E)
M800-M889	(05-24)	M800-M889 (09-15 E)
Nothing		M800-M889 P.2 (09-15 E)
<u>VScript Rules</u>		
3202	(05-24)	3202 (09-15 E)
3203	(08-22)	3203 (09-15 E)
<u>VHAP-Pharmacy Rules</u>		
Table of Contents	(06-48)	Table of Contents (09-15-E)
3303.3 P.2	(96-4F)	3303.3 P.2 (09-15 E)
3304 P.2	(05-24)	3304 (09-15 E)
<u>VPharm Rules</u>		
3505	(08-22)	3505 (09-15 E)
3506	(05-24)	3506 (09-15 E)
3506 P.2	(05-24)	3506 P.2 (09-15 E)
Nothing		3506 P.3 (09-15 E)
<u>VHAP Rules</u>		
4001.91	(07-24)	4001.91 (09-15 E)
4003.1	(03-17)	4003.1 (09-15 E)
Nothing		4003.1 P.2 (09-15 E)

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M103.2 P.3

M103 Benefit Delivery Systems**M103.2** Managed Health Care Plan System (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 (M755);
- dental care for children under age 21 (M620) and limited dental services for adults up to the annual benefit maximum (M621);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (M670);
- chiropractic services (M640);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (M740); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (M810-M812).

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 M150.1(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 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 managed health care plan are subject to the following co-payment requirements, unless exempt under M150.1(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 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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M103.3 P.7

M103 Benefit Delivery SystemsM103.3 Primary Care Case Management ProgramD. Self-Referral Services (Continued)

- chiropractic services (M640);
- maternity/prenatal (M510, M600);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (M740).

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 M150.1(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 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 M150.1(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 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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M640

M640 Chiropractic Services

Services furnished by a licensed chiropractor certified to meet the standards for participation in Medicare are covered.

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, recipient's family, friends or such other community resources as may be available.

Chiropractic services for recipients under the age of 12 require prior authorization from the 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 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 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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M800-M889

M800-M889 Drugs and Pharmaceutical Items, Medical Supplies and Equipment

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 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.

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 patient initially fills the prescription in order to provide an opportunity for the patient to try the medication and for the prescriber to determine that it is appropriate for the patient's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, a prior authorization request may be made to the Office.

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

For recipients in a NF or ICF/MR see M813.4.

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M800-M889 P. 2

M800-M889 Drugs and Pharmaceutical Items, Medical Supplies and Equipment (Continued)

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 shall treat it as one prescription 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 for payments they may make to a pharmacy or supplier.

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3202

3202 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.

3202.1 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.

Maintenance drugs may be prescribed and dispensed in increments of 90-day supplies except medications which the patient takes or uses on an "as needed" basis.

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 patient initially fills the prescription in order to provide an opportunity for the patient to try the medication and for the prescriber to determine that it is appropriate for the patient's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, a prior authorization request may be made to the Office.

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 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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3203

3203 Cost Sharing Requirements

All VScript beneficiaries must pay monthly premiums as specified in M150 through M150.2 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 Individual</u>
> 150% ≤ 175% FPL	VScript	\$23.00
> 175% ≤ 225% FPL	VScript Expanded	\$50.00

In addition, an individual 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 who does not provide the co-payment.

3300	Introduction
3301	Eligibility
3301.1	Age
3301.2	Disability
3301.3	Uninsured
3301.4	Citizenship and Identity
3301.5	State Residence
3301.6	Living Arrangement
3301.7	Financial Need
3301.71	Countable Income
3301.72	Excluded Income
3301.73	Determining Countable Income
3301.74	Income Test
3302	Eligibility Process
3302.1	Application
3302.2	Application Decision
3302.3	Period of Eligibility and Enrollment
3302.4	Identification Document
3302.5	Application for Other Benefits
3302.6	Right to Appeal
3302.7	Beneficiary Fraud Investigation
3303	Payment Conditions
3303.1	Cost Sharing
3303.2	Lower of Price for Ingredients Plus Dispensing Fee or Charge
3303.3	Price for Ingredients
3303.4	Compounded Prescriptions
3303.5	Participating Pharmacy
3303.6	Co-payments
3304	Prescribed Drugs
3305	Benefit Coverage

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3303.3 P.2

3303 Payment Conditions3303.3 Price for Ingredients (Continued)

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, 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.

3303.4 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.

3303.5 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.

3303.6 Co-payments

An individual 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 who does not provide the co-payment.

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3304 P. 2

3304 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.

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.

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 patient initially fills the prescription in order to provide an opportunity for the patient to try the medication and for the prescriber to determine that it is appropriate for the patient's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, a prior authorization request may be made to the Office.

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

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.

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: 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. 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 does not wish to accept substitution, VHAP-Pharmacy will not pay for the prescription.

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3505

3505 Payment System

VPharm follows the prospective premium-based payment system described at rule M150.

3505.1 Cost-Sharing

An individual 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
≤ 150%	\$ 17.00
> 150% but ≤ 175%	\$ 23.00
> 175% but ≤ 225%	\$ 50.00

In addition, an individual 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 who does not provide the co-payment.

3505.2 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.

3505.3 Lower of Price for Ingredients Plus Dispensing Fee or Charge

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 3303.3) 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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3506

3506 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.

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 (M811.2);
- 2) single vitamins or minerals if the conditions described in M811.3 are met;
- 3) over-the-counter prescriptions if the conditions described in M811.4 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 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 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 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.

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 3505.1.

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3506 P. 2

3506 Coverage (Continued)

For those 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 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 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 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 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 individual were not covered by Part D. If the 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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3506 P. 3

3506 Coverage (continued)

At the beginning of coverage under Medicare Part D, when an individual 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 individual must have made every reasonable effort with CMS and the PDP, given the 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 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 individual. OVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

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4001.91

4001.9 Cost-Sharing Requirements4001.91 Premium

Individuals meet this requirement when they have paid any required premium as specified in M150 - M150.2. The amount of the premium for each individual 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
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

4001.92 Co-payment

There is a co-payment requirement of \$25 per medically necessary hospital emergency room visit, as defined in M103.3 (13) and (37).

In addition, individuals 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 who does not provide the co-payment.

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4003.1

4003 Benefit Delivery Systems4003.1 BenefitsA. Services Requiring Plan Referral (Continued)

- 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.

- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- 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.

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 patient initially fills the prescription in order to provide an opportunity for the patient to try the medication and for the prescriber to determine that it is appropriate for the patient's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the physician, dictate a shorter prescribing period, a prior authorization request may be made to the Office.

Up to five refills are permitted if allowed by state and 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.

- 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.

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4003.1 Benefits (Continued)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).