

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
Office of Vermont Health Access (OVHA)**

**AHS Bulletin No: 09-17**

Secretary of State's ID Number: 09P-035

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

**DATE:** December 21, 2009

**SUBJECT:** State Fiscal Year 2010 Coverage Changes

**CHANGES ADOPTED EFFECTIVE:** 01/15/10

**TYPE OF RULE CHANGE**

**Adopted Rule Changes**

**Final Proposed Rule Change**

**Proposed Rule Change**

**RULE REFERENCE(S):**

5330	5447	5560	7101.3
5351	5450	5640	7304
5441	5552	5650	7501
5444	5555	7101.2	7501.4

This rule is being implemented as a direct result of Act #1 of the 2009 Special Session, An Act Making Appropriations for the Support of Government. **This bulletin supersedes all previously adopted emergency rule changes.**

*Specific Changes to Rule Sections Since Filing Final Proposed Rule on September 9, 2009.*

Section	Description of Changes and reasons, where appropriate.
ALL SECTIONS	Effective date changed from 11/12/09 to 01/15/10. Emergency rule Bulletins 09-23E, 09-25E and 09-27E were made effective 11/12/09 since the final proposed rule had not been approved. LCAR agreed that the 1/15/10 effective was appropriate, in that it gave OVHA time to file in adopted form. These rules supersede all previously filed emergency rules.
5351	A clearer description of the VHAP - Limited and VHAP - Managed Care programs was added. The location of the procedures where VHAP - Managed Care services can be found was corrected (LCAR received a "new" final proposed bulletin at 12/15/09 meeting and these changes were included). In response to issues raised by LCAR, subsection A, language around the exception process was made clearer. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 12/15/09 meeting. The objection was then withdrawn and the current language was approved. The lists in Subsections A, B & C were changed from bullets to numbers.

5444	In response to issues raised by LCAR (and some archaic terms), this section was updated to reflect how the price for ingredients is actually calculated. A sentence was added that directs readers where to go in the Medicaid State Plan to find the detailed reimbursement methodology. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 11/3/09 meeting. The objection was then withdrawn and the current language was approved on 12/1/09.
5552	In response to issues raised by LCAR (and some archaic terms), this section was updated to reflect how the price for ingredients is actually calculated. A sentence was added that directs readers where to go in the Medicaid State Plan to find the detailed reimbursement methodology. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 11/3/09 meeting. The objection was then withdrawn and the current language was approved on 12/1/09.
5560	In response to issues raised by LCAR, language around the exception process was made clearer. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 12/15/09 meeting. The objection was then withdrawn and the current language was approved.
5641	In response to issues raised by LCAR, language around the exception process was made clearer. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 12/15/09 meeting. The objection was then withdrawn and the current language was approved.
7501	In response to issues raised by LCAR, language around the exception process was made clearer. The final proposed language was objected to by LCAR on 10/20/09. OVHA submitted the attached language to LCAR at the 12/15/09 meeting. The objection was then withdrawn and the current language was approved. “Beneficiary” replaced the term “recipient” that was previously missed (LCAR received a “new” final proposed bulletin at 12/15/09 meeting and these changes were included).

***Responses to Public Comments***

A public hearing was held on August 18, 2009 from 9:30 am to 10:30 am and from 1:30 pm to 2:00 pm at the Office of Vermont Health Access, Williston, Vermont. Comments were received at the hearing from Matthew Byrne, Audrey McGregor Reardon, Anthony Otis and Phil O’Neill.

OVHA received written comments from Michael Sirotkin o/b/o the Community of Vermont Elders, PhRMA, AstraZeneca, Lila Richardson of the Office of Health Care Ombudsman, Jill Geiger - Lyndonville Pharmacy, Phil O’Neill, Matthew Byrne from Gravel and Shea, and Madeleine Mongan from the Vermont Medical Society.

Their comments are summarized below along with OVHA’s responses.

There were no comments made, either oral or written, with regards to adding limited chiropractic services for adults or adding co-payments for prescriptions under VScript, VHAP-Pharmacy, VPharm and VHAP.

**Comment:** By removing the percentages and specifying that the calculation for the Price for Ingredients is determined based on the Legislature’s approved budget, OVHA is denying pharmacies the formal protections/federal standards of the APA process, including public notice and public hearings. Specifically, 42 CFR 447.205 states that OVHA has to go through the APA process to make adjustments to rate calculations.

**Response:** The removal of the calculation from Medicaid rule does not remove these protections/standards. The state budgetary process is open and public hearings and comments to legislators are not impacted. 42 CFR 447.205 does not require that rule changes need to be done to change payment rates. It describes the public notice requirements for changing payments rates in the Medicaid State Plan. The notice requirements in the CFR will still be followed. The opportunity to provide written comments is required under both the APA process and State Plan Amendment process, so this protection remains. Public hearings are not required by either process.

**Comment:** The budget reduction instituted a 2% reduction across OVHA services, but the AWP was reduced by 2.3%.

**Response:** Correct. Taking a reduction from AWP was determined to be the most stable way to implement a 2% savings on total estimated drug spending. In order to achieve a 2% savings, OVHA calculated estimated SFY 2010 pharmacy costs by using SFY 2008 costs, applying a 5% annual cost trend, and adjusting for membership estimates and policy decisions such as requiring 90-day refills for maintenance medications. Applying such factors resulted in total estimated SFY 2010 pharmacy costs of \$123,241,398. Two percent of this figure is \$2,464,828. To achieve savings of \$2.4 million, OVHA adjusted the AWP from AWP-11.9% to AWP-14.2%.

**Comment:** Requiring pharmacies to provide a 90-day supply for certain maintenance medications could increase the cost of inventory to small pharmacy businesses.

**Response:** Although there may have been an initial increase in costs to procure inventory following the adoption of Bulletin 09-15E, this should not be a recurring issue because the increased length of time between dispensing medications allows for an extended period before re-stocking.

**Comment:** Commenters were concerned that the emergency rules were being enacted too quickly for a smooth transition for the 90-day fills and the pilot program, and that prescribers were not given enough time to update prescriptions or request exemptions.

**Response:** Prescribers and pharmacies were given notice almost a month (not one week) before the initial effective date of July 15, 2009, then OVHA decided to postpone the implementation to August 1, 2009. In June, prescribers and pharmacies received notice via letters, faxes, and banner pages on their Remittance Advice (RA). Prescribers were given the opportunity to request patient lists before implementation to smoothly transition into the pilot and 90-day fill requirements. In addition, notices were sent to beneficiaries in June.

**Comment:** Section 5450 is not consistent with the intention or letter of the statutory language, threatens to undermine the coherence of care through Medicare Part D, and creates incentives to cost shift from Part D to VPharm.

**Response:** This is incorrect. The language for the pilot program in rule is almost verbatim the statutory language. There is continuity with Part D, as most of the drugs excluded under this pilot require higher copays from beneficiaries and cost beneficiaries in the "donut hole" significantly more in the Part D Plans as a method to encourage use of the less expensive alternatives. These additional costs were previously paid for by OVHA and there was no incentive for beneficiaries and prescribers to select the less expensive alternatives. There is no way to cost shift from Part D to the state, as the state (Medicaid/VPharm) is the payer of last resort, and OVHA will not pay until after Part D pays.

**Comment:** The VPharm pilot limits coverage of Medicare Part D cost sharing for certain drugs unless the prescriber obtains a PA and that the statute is designed to encourage the use of generics and OTC drugs. It is duplicative that the prescriber has to file a PA with both the Part D provider and VPharm. By allowing substitution of an OTC for a generic or brand name there could be a cost shift to the state since federal law does not allow Part D plans to cover OTCs except as administrative costs.

**Response:** Correct, the pilot program limits what VPharm will pay for. When the beneficiary has a PA approval from the Part D plan in effect on July 15, 2009, they do not need a PA or an exception from OVHA. There would be no cost shift for coverage of generics as Part D plans generally cover the generic with a lower co-pay for VPharm to cover, and the pilot does not require the use of OTCs, just that they are an available choice for prescribers and beneficiaries. While it is true that Part D plans generally do not cover OTCs, the net cost to VPharm for the preferred OTC in the pilot is less than the excluded brands when Federal funds for excluded drugs are calculated.

**Comment:** It is bad policy when the state Medicaid agency tries to micromanage the formularies and coverage rules of Medicare drug plans. These plans are regional and not subject to state formularies.

**Response:** The pilot program does not try to limit, micromanage, or try to change the PDPs' formularies. The premise of the pilot is to lower costs by limiting access to name brand drugs, not generic or OTC drugs. OVHA prefers drugs that are preferred by greater than 95% of the Part D plans in Vermont (while the OTC is not covered by the Part D plans OTCs are covered by VPharm without requiring PA from the Part D plan). There is no requirement in the pilot program to have people change their generic drugs.

**Comment:** The rules are contrary to federal coordination of care rules.

**Response:** The new Vermont Medicaid rules do restrict coordination of care between Medicare Part D and Medicaid/VPharm. As indicated above, the legend drugs OVHA prefers are preferred by greater than 95% of the Part D plans of the companies doing business in Vermont. Prescribers and pharmacies were notified almost a month before the rules went into effect. In addition, prior to the pilot going into effect, prescribers were given the opportunity of requesting a patient list from OVHA before implementation.

**Comment:** Treatment decisions and the determination of medical necessity, including therapeutic substitutions of specified drugs and prescription dispensing length, should be the result of discussion between physicians and their patients not left to the discretion of pharmacists or states.

**Response:** All insurance companies, including health insurance programs administered by federal and state governments, have the right to set coverage limits, including drug formularies. Both state and federal courts have ruled that the physician is not "the sole arbiter of medical necessity" and there are "reasonable limits on a physician's discretion in determining what treatments are medically necessary." Treatment decisions are never left up to pharmacists.

**Comment:** The new budget (E.307) includes a provision requiring that certain maintenance drugs be prescribed for a 90 day period rather than allowing a range of prescription length between 30 and 90 days. The prior regulations provided that most drugs could be prescribed for a period between 30 and 90 days. The regulation also provided that there could be a waiver to this prescription period when the prescriber documented a need for a shorter period due to “extenuating circumstances”. The new regulations now provide that prescriptions for any drug which is to be used continuously “for 30 days or more” may be filled for 90 days. It makes no sense to say that a drug that is to be used for more than 30 days but fewer than 90 days may be prescribed and dispensed in a 90 day increment.

**Response:** We agree and the language regarding maintenance drugs has been revised. The new changes provide greater clarity and reinstates language previously removed. The select maintenance drug fill requirements are separate from all other maintenance drug fills.

**Comment:** We are not aware of any legislative discussion that would support regulatory changes in the process by which exceptions to this 90 day prescription can be made, and the proposed regulations are contrary to legislative intent insofar as they change the exception process.

**Response:** E.307 does not specifically include or exclude the possibility of exceptions to the 90-day fill requirement. In this absence, OVHA has acknowledged that there may be extenuating circumstances for specific beneficiaries, and has, therefore, created the option for prescribers to request exceptions.

**Comment:** There is concern that some individuals are not able to manage their prescriptions because of mental health or cognitive issues. Others should not have large prescription doses because of a history of substance abuse or suicidal ideation. When these situations exist it is obvious that the rationale for allowing a shorter prescription period may apply to all or most prescriptions. There should be some provision for one provider to document the reason and ask for the shorter prescribing period for all relevant prescriptions, and that these exception forms are included in the rule.

**Response:** Since Section E.307 of Act 1 does not specifically include the availability of exceptions to the 90-day maintenance fill for specific drugs, OVHA has acknowledged that there may be extenuating circumstances for specific beneficiaries, and has, therefore, created the option for prescribers to request exceptions. This form allows prescribers to list more than one medication on each exemption request. These forms will not be added to the rule so that OVHA can readily accommodate form changes without being subject to the lengthy APA process.

**Comment:** The statute requires the prescriber to explain the reasons for prescribing a brand name statin or proton pump inhibitor instead of an OTC or generic prescription but does not require prior authorization by OVHA. Regulation §5450 states that a prescriber can override a therapeutic substitution under the program “by requesting a prior authorization from OVHA.” We suggest that the regulation be changed to read the prescriber may “override...by providing an override explanation to OVHA.”

**Response:** The language has been revised.

**Comment:** The forms used to implement the override exception do not track the statutory criteria for an override. The forms developed by OVHA are at best unduly burdensome for prescribers and at worst actively misleading about the criteria. They include a requirement for showing different medications which have been tried and which have failed. This suggests a step therapy approach to coverage. This question should be omitted from the form and the prescriber should be able to obtain an override if the statutory criteria, included in the form, are met.

**Response:** We disagree. Section E.309.9 (b)(1) specifies the criteria for an exception to the pilot program drugs. Subsection (A) mentions the PA approval from the Part D plan, which directly links to question #2 on the form. Subsection (B)(i) lists the requirement of showing which other drugs have been tried, which is directly linked to questions #3 and #4. Subsection (B)(i)(I) and (II) and (B)(ii) are the first three check boxes under question #5.

**Comment:** The new rules require drugs to be prescribed and dispensed on increments of 90-day supplies, and include an exception for initial fills. Because the titration process for new drugs may require more than one fill before a drug and dosage that can be prescribed in 90-day amounts is selected, it is recommended that this exception should not be limited to one fill.

**Response:** This has been taken into consideration; the limit does not apply to changes in dosage, because those are considered new prescriptions. After the first fill that determined/set the therapeutic effectiveness and patient tolerance, prescriptions written for those selected maintenance drugs must be rewritten for a minimum of 90 days for the drug to be covered.

**Comment:** The 90-day supply rule completely disrupts the multi-dose packaging system because it creates two different mechanisms for delivering drugs: drugs in the Medicine On Time<sup>®</sup> cassettes and drugs in big jars. The 90-day rule severely inhibits the ability of doctors and other medical professionals to monitor compliance with drug regime.

**Response:** This is incorrect. Only the select maintenance drugs are required to be filled in 90-day increments; other maintenance drugs can be prescribed and dispensed in increments of between 30 and 90 days. Medicaid rule does not preclude prescribers from extending all maintenance drug fills to 90-days so the Medicine On Time<sup>®</sup> cassettes can still be used.

**Comment:** There is uncertainty about what needs to be done for non-maintenance drugs that are prescribed in less than 30-day periods.

**Response:** There are no changes for “acute” care drugs (non-maintenance drugs). Those prescriptions are prescribed and dispensed exactly as they have been.

**Comment:** There should be better communications with pharmacies regarding who has obtained a PA and who has not, and the only way the pharmacy would know would be to bill and see if the claim was paid. Pharmacies should not be forced to provide services without knowing whether they will be paid.

**Response:** Pharmacies were notified in mid-July that they could request the names of all of their customers that will be affected by these changes. Pharmacies are never forced to provide services without knowing whether or not they will be paid.

**Comment:** When beneficiary's services are cut, they have the right to an evidentiary hearing prior to the state taking those benefits away. The process that the Office of Vermont Health Access has established for addressing these concerns fails to meet the minimum requirements of the due process clause because it does not allow beneficiaries to assert their own rights, it does not offer an opportunity for a hearing prior to the benefits being taken away, and fails to allow the beneficiary to have a lawyer represent them at the hearing.

**Response:** This is incorrect. Medicaid Rule 4151 states that: "Any Medicaid applicant or beneficiary has a right to appeal any decision about his or her Medicaid eligibility or amount of coverage, and to request a fair hearing before the Human Services Board..." Rule 4151 goes on to state that "Fair hearings... must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred." Notices were sent to beneficiaries by June 19, 2009 for changes effective July 15, 2009. In addition Rule 4153 states: "Continuation of benefits without change does not apply when the... fair hearing is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice."

**Comment:** Implementing the 90-day fill and pilot program, OVHA is causing irreparable harm to beneficiaries of a specific pharmacy due to a disruption of the provision of benefits.

**Response:** There should be no irreparable harm as there should not have been a disruption in benefits since pharmacies were first notified in mid-June of the changes, and again in mid-July, when implementation was extended to August 1, 2009; pharmacies were informed they could request the names of all of their customers that will be affected by these changes. Since these changes impact beneficiaries statewide and not just those at one pharmacy, there is no basis for stating only the customers of that one pharmacy would be harmed.

**Comment:** Under the OVHA regulation, the disabled must prove not only that it is medically necessary, but they must also prove that there are "extenuating circumstances" to obtain access to pharmacy services. The able bodied need only prove that they are medically necessary to access the same services.

**Response:** This is incorrect. Beneficiaries, either disabled or not, do not have to prove anything to access pharmacy services. Prescribers must submit exception forms to OVHA in order to prescribe the select maintenance drugs in less than 90-day supplies and/or to prescribe the name brands in the pilot program, for any and all beneficiaries.

**Comment:** Most beneficiaries have no idea that they can use the prior authorization process to keep their benefits. The notice that OVHA sent to beneficiaries made no mention of the prior authorization process. Without notice, no beneficiary can participate in the prior authorization process the state has developed. Since only physicians can file prior authorizations, there is no mechanism for beneficiaries to request a prior authorization or for the disabled to ensure that their physician actually made the prior authorization request.

**Response:** This is incorrect. Beneficiaries have not lost benefits. The delivery and scope of these benefits has changed. Beneficiaries were sent notice in mid-June clearly stating that “drugs for certain long-term treatment must be given to you in 90-day supplies”. In addition the notice also stated that if the beneficiary had a “prior authorization from your Medicare Part D plan, you may be able to continue to take that drug. Your prescriber may have to notify us of that prior authorization. If your prescriber asks for an authorization for a brand name drug, he or she must show us that you previously tried the VPharm selected OTC or generic drugs and that they did not work or you had bad side effects to them. If you have not tried the VPharm selected drugs before, he or she must explain in detail why the preferred drugs will not work or will have bad side effects.” Beneficiaries have never been involved with the prior authorization process. A beneficiary’s disability status has no bearing on the whether or not the prescriber follows the prior authorization process (or requests an exemption).

**Comment:** Being put in a position to violate the law, have the patient go without medication, or provide medication at a cost that wouldn’t be reimbursed, none of which works. That’s the position that pharmacists have been put in today.

**Response:** Pharmacy practice is governed by both State and Federal law. None of the programs implemented by the OVHA require nor encourage a pharmacist to break the law. It is unclear why the commenter believes they are being forced to do so. Beneficiaries who come to the pharmacy with a prescription or a refill of an OVHA non-preferred PPI or statin will have the option of switching to a preferred product. If prescribers provide medical reasons why their patient cannot be switched to a preferred product, OVHA will apply an exception for the non-preferred branded product and will pay the VPharm beneficiary’s cost-sharing for that product. This process is no different than many other insurers who have preferred and non-preferred products on their drug formularies; it is common industry practice.

During the 2009-2010 legislative session, the elimination of VPharm was considered. VPharm provides coverage for Medicare Part D cost sharing. In the end, VPharm survived with changes designed to make the program less costly to the state budget. One change in the effort to contain costs is a pilot to limit the drugs covered to generics and OTCs in select classes. The other is that each time a drug is dispensed, a dispensing fee is paid to the pharmacy, so certain maintenance drugs will be filled in 90-day supplies. Medicaid policy currently allows for the dispensing of maintenance medications in 90-day supplies but few prescriptions are written in this manner. The result is that more dispensing fees are paid than are medically necessary.

\*\*\*\*\*

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. [General information, not specific rule content information]

\*\*\*\*\*

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.

01/15/10

Bulletin No.09-17

5330

5330 Cost-Sharing RequirementsA. Premium

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

<b>Income Maximums</b>	<b>Monthly Premium per Beneficiary</b>
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

B. Co-payment

There is a co-payment requirement of \$25 per medically necessary hospital emergency room visit, as defined in 7101.3 A (13) and (37).

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

01/15/10

Bulletin No.09-17

5351

---

**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:

**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.

"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 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.

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

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).

01/15/10

Bulletin No.09-17

5441

5441 Cost-Sharing

A 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 Beneficiary
≤ 150%	\$ 17.00
> 150% but ≤ 175%	\$ 23.00
> 175% but ≤ 225%	\$ 50.00

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

01/15/10

Bulletin No.09-17

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.

01/15/10

Bulletin No. 09-17

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. Up to five refills are permitted if allowed by federal or state pharmacy 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 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. 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 beneficiary does not wish to accept substitution, VPharm will not pay for the prescription.

01/15/10

Bulletin No.09-17

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:

- A. drugs for anorexia, weight loss, or weight gain (7502.3);
- B. prescription vitamins or minerals if the conditions described in 7502.4 are met;
- C. over-the-counter prescriptions if the conditions described in 7502.5 are met;
- D. barbiturates; and
- E. benzodiazepines.

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

For those 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 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 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,

01/15/10

Bulletin No.09-17

5450 p.2

5450 Coverage (Continued)

the Part D coverage gap, and catastrophic co-payments according to Medicare Part D rules. Beneficiaries have co-payments as described in 3505.1.

For those beneficiaries 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 a 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 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 were not covered by Part D. If the beneficiary'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.

At the beginning of coverage under Medicare Part D, when a 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 must have made every reasonable effort with CMS and the PDP, given the beneficiary'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, and "hardship" shall include circumstances where

01/15/10

Bulletin No.09-17

5450 p.3

---

5450 Coverage (continued)

alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the beneficiary. OVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

01/15/10

Bulletin No.09-17

5552

---

**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.

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 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.

01/15/10

Bulletin No.09-17

5555

---

5555 Co-payments

A 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 a beneficiary who does not provide the co-payment.

01/15/10

Bulletin No.09-17

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.

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.

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: American Hospital Formulary Service Drug Information; United States Pharmacopeia-Drug Information (or its successor publications); the DRUGDEX Information System; and the peer-reviewed medical literature. These consist of "legend" drugs for which a prescription is required by State or Federal law.

01/15/10

Bulletin No.09-17

5560 p.2

---

5560      Prescribed Drugs (Continued)

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

01/15/10

Bulletin No.09-17

5641

---

**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 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. 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 federal or state pharmacy 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 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 of Vermont Health Access 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.

01/15/10

Bulletin No.09-17

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 Beneficiary</u>
> 150% ≤ 175% FPL	VScript	\$23.00
> 175% ≤ 225% FPL	VScript Expanded	\$50.00

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

---

## 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 (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 hospital.
- \$3.00 per day per hospital for hospital outpatient services unless the beneficiary is also covered by Medicare. A 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 \$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.

01/15/10

Bulletin No.09-17

7101 p.13

---

## 7101 Medicaid Benefit Delivery

### 7101.3 Primary Care Case Management (PCCM)

#### 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 hospital.
- \$3.00 per day per hospital for hospital outpatient services unless the beneficiary is also covered by Medicare. A beneficiary 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 \$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.

01/15/10

Bulletin No.09-17

7304

---

**7304 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 beneficiary, beneficiary's family, friends or such other community resources as may be available.

Chiropractic services for beneficiaries 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 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 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.

01/15/10

Bulletin No.09-17

7501

---

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

Pharmaceutical items include drugs that can only be dispensed with a prescription, over-the-counter drugs, 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.

"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.

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.

01/15/10

Bulletin No.09-17

7501

---

**7501 Drugs and Pharmaceutical Items, Medical Supplies and Equipment (Continued)**

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

For beneficiaries 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 one prescription for each family member for payment purposes.

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 facilities for payments they may make to a pharmacy or supplier.

01/15/10

Bulletin No.09-17

7501 p.3

---

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.

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 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.