P-2441 Health Insurance (continued)

D. Medicare Part D

Medicaid beneficiaries who are also Medicare beneficiaries receive their primary prescription drug benefits through a Medicare Part D prescription drug plan (see M801). At the beginning of coverage under Medicare Part D, if a beneficiary has difficulty enrolling in a plan due to an operational problem with Medicare, or has otherwise not been able to obtain coverage for a needed prescription, the Office of Vermont Health Access (OVHA) may be asked to cover the drug under a good cause and hardship provision.

OVHA has identified two operational problems: no prescription drug plan in the federal eligibility system and incorrect low-income subsidy information being reported. For both of these situations, OVHA has instituted a point-of-sale fix. Therefore, these procedures will not be applicable.

These are the steps involved in determining good cause and hardship:

1. A beneficiary or advocate contacts member services and explains why the person cannot get a prescription filled, describing what steps have been taken to obtain the prescription and the obstacles that are present. A step-by-step description will serve as documentation. An advocate who works for an organization that contracts with OVHA may contact the appropriate OVHA contract manager directly.

2. Member services sends the request to OVHA.

3. OVHA determines good cause according to rule at M801. If a prudent layperson would determine that every reasonable effort has been made to attempt to resolve the problem (such as calling the prescription drug plan), and OVHA cannot work with the prescription drug plan to have them cover the drug, OVHA will make an entry in the pharmacy benefits management system to allow this immediate prescription to be billed following the general assistance (GA) program protocol, and will notify the benefits program specialist. The decision will be made within three workdays, or less if the situation is urgent.

   When GA coverage is authorized, it means that any prescription will be considered according to GA coverage rules. This process applies the hardship test (described in M801) since GA covers drugs only in classes that could be used to meet an emergency medical need, where serious harm could come to the individual if the drug were not supplied. If a drug does get denied at the pharmacy, GA procedures for an exception will be followed.

4. If OVHA allows the drug to be billed for coverage, no written notice will be sent.

5. OVHA explains the resolution to member services, who contacts the beneficiary or advocate who made the request.

P-2441 Health Insurance (continued)

D. Medicare Part D (continued)

6. If OVHA denies the request, a formal denial letter (including appeal rights) will be sent in addition to the verbal notification.

7. After the decision has been made, depending on the individual situation, OVHA may take other actions. These include continuing to try to resolve the underlying situation (reporting any results to the beneficiary), referring the beneficiary to the office of health care ombudsman (for example, to assist with an appeal), or referring the beneficiary to the State Health Insurance Assistance Program (SHIP) (for example, when the individual needs help in choosing another plan).