STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,159
	)	
Appeal of	)	
	)	

INTRODUCTION

The petitioner appeals a decision by the Office of Vermont Health Access (OVHA) denying her coverage under the VPharm program for insulin supplies. The issue is whether the Department has provided an adequate rationale for non-coverage under the Board's rules and the pertinent regulations.

DISCUSSION

The petitioner is a diabetic who regularly must take insulin. Based on her medical needs she uses a specialized insulin delivery system, which consists of a permanent "insulin pump" and special "syringes" and tubing that attach to the pump and need to be replaced on a regular basis.

The petitioner receives Medicare through Social Security. Prior to January 1, 2006, the petitioner was also eligible for state benefits (either VHAP-Pharmacy or Medicaid) to pay for prescription drugs. According to the

petitioner, before January 1, 2006 all her insulin supplies and medications were covered in full under Medicare and/or her state plan.

On January 1, 2006 Medicare began paying for certain prescription drugs and supplies. On that date the Department instituted its VPharm program, with the following as its stated purpose: "In order to keep Medicare beneficiaries' coverage whole, VPharm provides supplemental pharmaceutical coverage starting January 1, 2006. An individual may not be enrolled in Medicaid." W.A.M. § 3500. There does not appear to be any dispute in this matter that the petitioner was enrolled in the VPharm program on or about January 1, 2006 and was terminated from any other state medical program as of that date.

Sometime in January 2006 the petitioner was unable to obtain full insurance coverage for the syringes and tubing for her insulin pump. She filed an appeal of this decision on January 25, 2006. A hearing was held on February 28, 2006. At the hearing the only explanation offered by the Department for its decision was that VPharm did not cover "insulin pumps". However, the petitioner explained that she already had an insulin pump, and that the items she was seeking were the syringes and tubing used with her pump. The

petitioner further alleged that she has a prescription for regular replacement of these supplies for sanitary reasons, and that since the Department had denied full coverage for their replacement the petitioner was continuing to use old sets at significant risk to her health. The petitioner further alleged that Medicare does not provide full coverage for these items, but that prior to January 1, these items were routinely covered in full under the petitioner's state plan.

At the hearing the hearing officer allowed the Department ten days in which to either reverse its decision or provide the petitioner and the Board with a comprehensible rationale for its decision in the matter. On March 14, 2006, the Department's attorney informed the Board that it understood that Medicare was covering 80 percent of the cost of the items and that only the remaining 20 percent of the coverage was at issue; but that: "The Department is not able to provide a decision on this issue at this time, but is in the process of reviewing the applicable regulations to make that determination."

ORDER

The Department's decision is reversed. The Department shall provide whatever benefits are necessary for full coverage for the petitioner's insulin supplies unless and until it can provide the petitioner with a comprehensible rationale for non-coverage, subject to the petitioner's right to appeal that decision. The matter is remanded to the hearing officer for further consideration of any rationale provided by the Department. The petitioner shall continue to receive continuing benefits to ensure full coverage of these items pending a final decision by the Board.

REASONS

Fair Hearing Rule No. 5 provides as follows:

> Agency Review. Prior to the hearing the commissioner or director of the department or agency involved in the appeal, or his or her designee, shall review the appellant's complaint and determine whether or not the appellant is entitled to relief.
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> If the commissioner or director does not grant that relief, prior to the hearing the agency shall provide the appellant and the hearing officer with a rationale for its decision and, unless prohibited by statute or the compelling confidentiality rights of others, shall make available to them all documents and records relied upon by the agency in reaching its decision.
>
> Upon good cause shown the hearing officer may grant an extension of time for completing this review.

In this case, as noted above, the only rationale offered by the Department to date for its decision is not even accurate in terms of identifying the medical items at issue.

3 V.S.A. § 3091(d) empowers the Board to grant "appropriate relief". In this case all the Board can ascertain at this time regarding the facts is based on the petitioner's representations (not disputed by the Department) that prior to January 1, 2006, the Department had provided full coverage of the items in question. Despite the stated intent of the VPharm program to "keep Medicare beneficiaries' coverage whole", it appears that neither the Department nor Medicare is providing full coverage for those items as of January 1, 2006. Absent a rationale by the Department for this decision, in order to fashion "appropriate relief" the Board must rely on a preliminary "plain reading" of regulations for a brand new program.

It is noted that the VPharm regulations include "secondary coverage" coverage for "maintenance drugs" (§ 3506). The regulations define a "maintenance drug" as specifically including "insulin, an insulin syringe, and an insulin needle" (§3500[2]). There is no indication so far that the Department's denial in this matter is based on any alleged definitional distinction between the above provisions

and the items sought by the petitioner. As noted above, there is no dispute that these items were covered in full previously under Medicaid and/or VHAP-Pharmacy.

The Department represents that Medicare will approve at least part, if not most, of the cost of the items in question. Hopefully, that is the case. Although VPharm is clearly a program of "secondary" coverage, the regulations for that program appear to specifically allow for *full* coverage for "the needed pharmaceutical" when "good cause and a hardship exist" (§ 3506). As noted above, whether or not Medicare is providing any partial coverage, the petitioner alleges (and the Department does not specifically dispute) that she has been unable to afford any of the necessary items, at considerable risk to her health. If it turns out that Medicare coverage is also an issue in this matter, unless and until the Department specifically addresses this, the Board can only conclude that *full* coverage of these items by the Department under VPharm constitutes "appropriate" relief at this time, at least temporarily.

In light of the above, as a matter of law, if not conscience, the Board cannot allow the petitioner to go without needed medical supplies any longer while the

Department sorts out its position pending the petitioner's appeal.

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