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5400 VPharm (01/01/2006, 05-24)

Act 71, an Act making appropriations for the support of Government authorized and established VPharm. It was adopted by the Vermont General Assembly and signed into law by the Governor on June 21, 2005. 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. Medicaid beneficiaries receive their secondary pharmacy coverage through Medicaid (rule 7501.1).

The rules which follow apply to the coverage group called VPharm.

5401 Definitions (01/01/2006, 05-24)

For purposes of this section concerning VPharm:

A. “ESD” means the Economic Services Division of the Department for Children and Families.

B. “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.

C. “Medicare Advantage – Prescription Drug Plan” or “MA-PD” means a Medicare Advantage plan that is certified by Centers for Medicare and Medicaid Services (CMS) as meeting contract requirements as specified in 42 C. F. R. § 422.2 that provides qualified prescription drug coverage under Part D of the Social Security Act.

D. “Medicare Part D” means the prescription drug program established under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, P. L. 108-173, including the prescription drug plans offered pursuant to the act.

E. “DVHA” means the Department of Vermont Health Access.

F. “Pharmaceutical” means a drug that may not be dispensed unless prescribed by a health care provider as defined by subdivision 9402(8) of Title 18 of the Vermont Statutes Annotated (V. S. A.) acting within the scope of the providers license. The term excludes a drug determined less than effective under the federal Food, Drug and Cosmetics Act.

G. “Pharmacy” means a retail or institutional drug outlet licensed by the Vermont state board of pharmacy pursuant to chapter 36 of Title 26 of the Vermont Statutes Annotated (V. S. A.), or by an equivalent board in another state, in which pharmaceuticals are sold at retail and which has entered into a written agreement with the state to dispense pharmaceuticals in accordance with the provisions of this chapter.

H. “Prescription Drug Plan” or “PDP” means prescription drug coverage that is offered under a policy, contract, or plan that has been approved, as specified in 42 C. F. R. § 423.272, and that is offered by a sponsor that has a contract with the Centers for Medicare and Medicaid Services (CMS).

5402 Beneficiary Fraud (07/01/2007, 06-05)

A person who knowingly gives false or misleading information or holds back needed information in order to obtain VPharm benefits, may be prosecuted for fraud under Vermont law or federal law or both; if convicted, the individual may be fined or imprisoned or both.

When ESD learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

5410 Eligibility (01/01/2007, 06-48)

An individual must meet the following requirements (rule 5411 or 5412 and rules 5413 - 5416) to be found eligible for the VPharm program.

5411 Age (01/01/2007, 06-48)

To qualify on the basis of age, an individual must be at least 65 years of age as of the effective date of coverage under VPharm and entitled to Medicare benefits under Part A or enrolled in Medicare Part B and enrolled in Medicare Parts C or D.

5412 Disability (01/01/2007, 06-48)

To qualify on the basis of disability, an individual must be under 65 years of age as of the effective date of coverage under VPharm and entitled to Medicare benefits under Part A or enrolled in Medicare Part B and enrolled in Medicare Parts C or D.

5413 Residence (01/01/2007, 06-48)

An individual must be a resident of Vermont at the time of application.

5414 Income (01/01/2007, 06-48)

Household income, when calculated in accordance with the rules adopted for the Vermont Health Access Plan (rules 5321- 5323), must be no greater than 225 percent of the federal poverty level.

INTERPRETIVE MEMO

[X] VPharm Rule Interpretation **[ ] VPharm Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5415 **Date of this Memo 03/01/2006** **Page 1 of 1**

This Memo: [X] is New [ ] Replaces one dated ______

Clarification

This eligibility requirement is met only when the individual has signed up for a PDP or a MA-PD that is licensed to do business in the State of Vermont.

5415 PDP Enrollment (01/01/2007, 06-48)

An individual must be enrolled in a PDP or a MA-PD and may not have other private insurance for prescription drugs.

5416 Limited Income Subsidy (01/01/2007, 06-48)

Individuals eligible for the federal limited income subsidy described in 42 C. F. R. §§ 423.771-423.800 must secure it.

5417 Citizenship and Identity (01/01/2007, 06-48)

An individual must meet the citizenship and identity criteria in rule 4170.

5420 Application (09/01/2016, 16-10)

Individuals must file an application for VPharm with the Economic Services Division (ESD) of the Vermont Department for Children and Families and provide information about the individual's situation relevant to the tests for eligibility (rule 5410). Applications are date-stamped to ensure that earlier applications are acted upon first.

Applications may be filed at any time and shall be reviewed annually as set forth in rule 5430.

Individuals must furnish their social security number or apply for a social security number unless they substantiate that they are a member of a religious organization that objects to the use of a social security number. An applicant who substantiates membership in such an organization shall be given an alternate identification number.

Verification of the information provided is not generally required of individuals unless it is questionable, verification is outstanding for another ESD benefit program, or the individual has refused to provide a social security number because of a religious objection. Social security numbers are used to verify information through tape matches. Individuals are notified on the application form of the verification actions the department may take, including the use of verification obtained for other ESD programs, randomly selected quality control reviews, and the penalties for fraudulent reporting of their situation.

5421 Application Decision (01/01/2006, 05-24)

ESD shall make an eligibility decision within 30 days of the date the application is received. An applicant not meeting the eligibility requirements shall be denied and may reapply at any time.

ESD will send the applicant a notice regarding the action being taken on the application. An applicant who is denied will be sent a denial notice that includes the reason for the denial and the applicant's appeal rights.

5430 Eligibility Period and Enrollment (09/01/2016, 16-10)

A. Period of Eligibility

VPharm eligibility will be renewed on an annual basis.

A review of eligibility will be completed before the end of the beneficiary's annual certification period to ensure uninterrupted coverage if the individual remains eligible, pays all required premiums, and complies in a timely manner with review requirements. An individual who fails to pay required premiums or fails to comply in a timely manner with review requirements shall receive a termination notice mailed at least 11 days before the termination date.

B. Enrollment

Once eligibility for VPharm is approved and required premiums are received by ESD, beneficiaries will be enrolled on the first day of the month following receipt and processing of the full premium payment. Each month the department shall prospectively pay PDP or MA-PD premiums on behalf of all beneficiaries enrolled in VPharm as described in rule 5450.

Termination shall occur whenever a beneficiary becomes ineligible pursuant to Economic Services Division Rules 5410 to 5421, 5430, 5440, 5441, 2000, 2010, or 2011 or to Health Benefits Eligibility and Enrollment Rule 20.02.

Individuals are required to report any changes that may affect eligibility, and any change of address within 10 days of the change. A beneficiary may be terminated at the end of the month following a notice mailed at least 11 days before the termination date.

If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in Health Benefits Eligibility and Enrollment Rule 64.09, the beneficiary or the beneficiary's representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. ESD will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until ESD receives the required verification and premium amounts due.

If the health condition related to this medical incapacity is expected to continue or recur, ESD will encourage beneficiaries to sign up for automatic withdrawal of their premium or designate an authorized representative to receive and pay future premiums for as long as the anticipated duration of the condition.

5431 Identification Document (07/01/2007, 06-05)

Each individual in the household enrolled in VPharm is provided with an identification card which includes the individuals name and identification number.

5432 Notice and Appeal (07/01/2007, 06-05)

ESD shall provide individuals with notice whenever they are found ineligible for the VPharm program or when the coverage they may receive under the VPharm program is denied, reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request an internal managed care organization (“MCO”) appeal and a fair hearing before the Human Services Board. Appeals regarding denials of eligibility will not be entitled to an internal MCO appeal.

Regarding eligibility issues, a request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (see rule 7110.2) while a fair hearing is pending or before a fair hearing is requested (see rule 7110.3). Fair hearings or MCO appeals 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. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VPharm coverage, they have the right to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid and continues to pay any required premiums in full (see rule 7110.2). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who successfully appeal the amount of their premium will be reimbursed by ESD for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal 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 (see rule 4150).

Beneficiaries who waive their right to continued benefits will be reimbursed for out-of-pocket expenses for covered services provided during the appeal period in any case in which the MCO or Human Services Board reverses the decision.

VPharm beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115(a) waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at rule 7110.5.

INTERPRETIVE MEMO

[X] VPharm Rule Interpretation **[ ] VPharm Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference **5440** **Date of this Memo** **06/01/2009** **Page** **1 of 1**

This Memo: [ ] is New [X] **Replaces one dated** 06/01/2009

The premium for those with household income ≤ 150% FPL is $15.00 per individual per month. The premium for those with household income >150% but ≤ 175% FPL is $20.00 per individual per month.

This is a temporary suspension of the premium increases that were effective 7/1/08. The suspension continues through 12/31/10, at which time the 7/1/08 premium amounts are reinstated.

5440 Payment System (07/01/2006, 06-18)

VPharm follows the prospective premium-based payment system described at rule 4160.

5441 Cost-Sharing (01/15/2010, 09-17)

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:

VPharm Premiums

% 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 beneficiarywho does not provide the co-payment.

5442 Medicare Advocacy Program (07/01/2006, 06-18)

In order to ensure the appropriate payment of claims, DVHA 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.

5443 Payments for Prescribed Drugs (07/01/2006, 06-18)

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see rule 5552) 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.

5444 Price for Ingredients (01/15/2010, 09-17)

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 Department 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 Department 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.

5445 Compounded Prescriptions (01/01/2006, 05-24)

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.

5446 Participating Pharmacy (01/01/2006, 05-24)

"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 pharmacy provider must:

A. satisfactorily complete and submit to the Department of Vermont Health Access the standard enrollment form;

B. 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;

C. agree to provide reasonable access to records necessary to comply with the provisions for program review set forth in the Provider Agreement;

D. never deny services to, or otherwise discriminate, against any individual on the basis of race, color, sex, age, religious preference, national origin, handicap or sexual orientation;

E. take appropriate steps to prevent the wrongful utilization of prescription drugs, with special concern for the potentially dangerous interaction of two or more prescription drugs from different prescribers.

5447 Prescribed Drugs (01/15/2010, 09-17)

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.

5450 Coverage (02/25/2012, 11-13)

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. Coverage of these drugs is subject to the requirements of the preferred drug list (PDL):

A. drugs for anorexia, weight loss, or weight gain (rule 7502.3);

B. vitamins or minerals if the conditions described in rule 7502.4 are met;

C. over-the-counter prescriptions if the conditions described in rule 7502.5 are met;

D. barbiturates; and

E. benzodiazepines.

Coverage for the 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.

In addition, VPharm covers beneficiary cost-sharing after any federal limited-income subsidy (LIS) 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 rule 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, DVHA 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 select generic drugs 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 a generic drug by requesting an exception override from DVHA. 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 drug(s) that have been previously tried by the beneficiary and:

   - were ineffective; or
   - resulted in the adverse or harmful side effects to the beneficiary; or

   (2) the reasons why the provider expects that the 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 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 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 Department of Vermont Health Access (DVHA) 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 DVHA, 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 DVHA 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 alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the beneficiary. DVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

5450.1 Non-Drug Items (02/25/2012, 11-13)

VPharm covers beneficiary cost-sharing (after a Medicare Part B or Part D payment) for insulin and other diabetic supplies, including test strips, needles and syringes.

5450.2 Rebate or Price Discount (02/25/2012, 11-13)

VPharm provides secondary pharmacy coverage as described in section 5450 for those eligible for Medicare and VPharm. Manufacturers shall pay to the DVHA a rebate on all pharmaceuticals paid by the State for VPharm beneficiaries in an amount at least as favorable as the rebate or price discount paid in connection with the Medicaid program.