TABLE OF CONTENTS

VHAP Pharmacy

5500 VHAP Pharmacy (01/01/2007, 06-48)

Legislative Act 14, authorizing and supporting the Vermont Health Access Plan, was adopted by the Vermont General Assembly and signed into law by the Governor on April 12, 1995. The Vermont Health Access Plan extends a pharmacy benefit and vision care services to low-income disabled and elderly Vermonters to assist them to purchase the prescription medicines that maintain their health and prevent unnecessary health problems. Vision care services do not include eyewear.

The policies which follow describe this coverage group called VHAP-Pharmacy.

Beneficiary Fraud

5501 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 VHAP-Pharmacy 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.

Eligibility

5510 Eligibility (01/01/2007, 06-48)

An individual must meet all of the following requirements (rules 5511 - 5524) to be found eligible for this program.

Age

5511 Age (01/01/2007, 06-48)

An individual qualifying on the basis of age must be at least 65 years of age on the date the application is filed.

Disability

5512 Disability (01/01/2007, 06-48)

An individual qualifying on the basis of disability must be receiving disability benefits from Social Security (OASDI) to be considered disabled.

Uninsured

5513 Uninsured (01/01/2007, 06-48)

Individuals meet the uninsured requirement if they do not have any plan, including VHAP-Limited and Medicare, which pays or reimburses, either in whole or in part, with the exception of VScript, or Healthy Vermonters, their prescription drug expenses.

Citizenship and Identity

5514 Citizenship and Identity (01/01/2007, 06-48)

The rules for citizenship and identity are in rule 4170.

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5515 **Date of this Memo** 05/17/1999 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Must an individual reside in Vermont for 12 months before applying for benefits from the VHAP-Pharmacy Program?

ANSWER: No. We have changed the eligibility criteria for state residence in response to the United States Supreme Court decision, Saenz v. Roe (May 17, 1999). Applicants applying for benefits from VHAP-Pharmacy must reside in Vermont at the time of application. This change eliminates the former 12-month residency requirement.

Residence

5515 Residence (05/15/1996, 96-4)

An individual is a state resident if he/she has lived in Vermont during the entire 12–month period immediately preceding application for the VHAP-Pharmacy program and is living in Vermont at the time of such application.

A. with intent to remain permanently or for an indefinite period of time: or

B. while incapable of stating intent.

Temporary absences from Vermont for any of the following purposes does not interrupt or end Vermont residence: visiting, obtaining necessary medical care, or obtaining education or training under a program of vocational rehabilitation or higher education.

Living Arrangement

5516 Living Arrangement (05/15/1996, 96-4)

An individual meets the living arrangement requirement unless he/she is living in a correctional facility including a juvenile facility.

An individual living in a psychiatric facility, an alcohol treatment facility, or a drug treatment facility is eligible for VHAP-Pharmacy.

5520 Financial Need (05/15/1996, 96-4)

An individual must be a member of a VHAP-Pharmacy group with countable income under the applicable income test to meet this requirement.

A VHAP-Pharmacy group includes all of the following individuals if living in the same home:

A. the VHAP-Pharmacy applicant and his or her spouse, and

B. children under age 21 of the applicant or spouse, and

C. siblings under age 21, including half siblings and step siblings, of B and

D. parents, including a stepparent and adoptive parents of C, and

E. children of any children in B and C, and

F. unborn children of any of the above.

The VHAP-Pharmacy group shall not include any individual eligible for and receiving SSI/AABD benefits. In addition, the income of all SSI\AABD recipients living in the household shall not be considered in determining whether the VHAP-Pharmacy group passes the income test for VHAP-Pharmacy.

The VHAP-Pharmacy group shall not include any individual eligible for and receiving Reach Up benefits. In addition, the income (including the Reach Up assistance payment) of all Reach Up recipients living in the household shall not be considered in determining whether the VHAP-Pharmacy group passes the income test for VHAP-Pharmacy.

Countable Income

5521 Countable Income (05/15/1996, 96-4)

Countable income is all earned and unearned income, defined in this section, less all allowed deductions. Income in the month of application (or review) and future months is estimated based on income in the calendar month prior to the month of application (or review) unless changes have occurred or are expected to occur and this income does not accurately reflect ongoing income. If changes are expected to occur, an estimate of income based on current information should be used.

To determine countable monthly income, average weekly income is multiplied by 4.3 and average bi-weekly income is multiplied by 2.15.

A. Lump Sum Receipts

Lump sum benefits that would have been counted as income if received on time, such as Social Security benefits and Unemployment Compensation, shall be added to all other countable income received or expected by an applicant for or recipient of VHAP-Pharmacy and counted only in the month of receipt.

Windfall lump sums, such as insurance payments and money received from the sale of a resource, are not counted.

An insurance payment or similar third party payment which is received for a specific purpose, for example, the payment of medical bills or funeral costs, and is used for the stated purpose is excluded. Payments not used for the stated purpose are counted as income in the month received.

B. Unearned Income

Unearned income includes, but is not limited to, the following:

- Income from benefit and pension programs, such as Social Security, Railroad Retirement, veterans' pensions or compensation, unemployment compensation and employer or individual private pension plans or annuities.
- Interest and dividends.
- Child support payments (rule 5522 W for the exclusion of the first $50) and alimony payments.
- Income from capital investments in which the individual is not actively engaged in managerial effort.
- Time payments on mortgages or notes resulting from a casual sale [i.e., a sale not related to self-employment] of real (stationary or fixed property) or personal property.
- Voluntary contributions from others.

Unearned income does not include the following

- Infrequent or irregular voluntary cash contributions or gifts received from friends or relatives.
- In-kind income that is unearned.
- Five percent of a VA monthly award that is retained by a guardian.

C. Earned Income

Earned income includes all salary, wages, commissions or profit from activities in which an individual is engaged as an employee or a self-employed person, including but not limited to active management of capital investments (e.g., rental property).

Earned income is defined as income prior to any deductions for income taxes, FICA, insurance or any other deductions voluntary or involuntary except that, in determining earned income for self-employed individuals, business expenses are deducted first.

Earnings over a period of time, for which settlement is made at one given time, are also included; i.e., sale of farm crops, livestock, poultry, etc. Monthly income is determined by dividing the settlement by the number of months in which it was earned.

Earned income does not include in-kind income that is earned.

The following items are deducted from gross earned income in the sequence listed:

1. Business expenses (self-employment only)
2. Standard employment expense deduction
3. Dependent care expenses

D. Business Expenses

Business expenses, which are deducted from gross receipts to determine adjusted gross unearned income, are limited to operating costs necessary to produce cash receipts, such as:

1. Office or shop rental; taxes on farm or business property; and
2. Hired help; and
3. Interest on business loans; and
4. Cost of materials, stock, and inventory, livestock for resale required for the production of this income.

Items such as personal business and entertainment expenses, personal transportation, purchase of capital equipment, depreciation and payment on the principal of loans for capital assets or durable goods are not allowable business expenses.

Tax returns and business records are considered appropriate sources of accurate figures for farm and business receipts and expenses.

The income of a VHAP-Pharmacy group owning or operating a commercial boarding house shall be treated as any other business income. A commercial boarding house is defined as an establishment licensed as a commercial enterprise that offers meals and lodging for compensation. In areas without licensing requirements, a commercial boarding house shall be defined as a commercial establishment that offers meals and lodging with the intention of making a profit.

No computation is required for foster homes furnishing boarding care to children in custody of and placed by the Family Services Division. Department board rates are established to cover expenses only with no profit available; therefore, no earned income is considered available from this source.

For a VHAP-Pharmacy group that is not a commercial boarding house, the business expense of furnishing room and board, alone or as part of custodial care, shall be allowed provided that the amount shall not exceed the payment the VHAP-Pharmacy group receives from the roomer/boarder for lodging/meals. (See the Procedures Manual for the table of standard business expense deductions for homes providing room or board on a non-commercial basis.)

E. Standard Employment Expense Deduction

The standard employment expense deduction is the first $90.00 earned per month after deduction of business expenses, where applicable.

The standard employment expense deduction is applied separately to the gross earned income of each individual in the VHAP-Pharmacy group (rule 5520) who is employed or self-employed.

F. Dependent Care Expenses

Dependent care expenses necessary to enable the individual to retain his or her employment will be deducted up to a maximum of $175.00 per month for the care of each member of the VHAP-Pharmacy group who is an incapacitated adult or a child age two years or older, and up to a maximum of $200 per month for the care of each child under two years of age who is a member of the VHAP-Pharmacy group.

Dependent care expenses for the care of a child are not deducted unless the child requiring care is a member of the VHAP-Pharmacy group or is not a member of the VHAP-Pharmacy group solely because he/she is a SSI/AABD or a Reach Up recipient and is:

1. under age 13; or

2. age 13 or older and physically or mentally incapable of caring for himself/herself, as verified by the written report of a physician or licensed psychologist; or

3. age 13 or older and under court supervision.

Dependent care expenses will be allowed as paid up to the maximum. If a recipient's dependent care expenses are below the maximum, transportation to and from the dependent care facility may be deducted as part of the expense up to the maximum for both dependent care and transportation.

Payments for dependent care provided by a member of the same VHAP-Pharmacy group, by the child's parent (biological, adoptive, or stepparent) or legal guardian, or by the incapacitated adult's spouse do not qualify as necessary dependent care expenses under this policy.

The provider of care must be at least 16 years of age. A deduction for dependent care expenses for care of a child can be allowed only when neither parent is available and able to provide necessary care. A deduction for dependent care expenses for care of an incapacitated adult can only be allowed when the incapacitated adult's spouse (where applicable) is either unavailable or available but unable to provide the necessary care because he or she is incapacitated. A spouse shall be considered unavailable if he/she is employed during the time care is required. Incapacity shall be determined in accordance with the process used to determine whether a parent applying for or receiving Reach Up is incapacitated (see rule 2235.3). This process shall give appropriate consideration to the treating physician's opinion.

If dependent care is required for reasons other than employment (e.g., protective services child care or care for training purposes), the client shall be referred to the Family Services Division.

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5522 Date of this Memo 01/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Wages paid by the Census Bureau for temporary employment are excluded.

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5522 Date of this Memo 02/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Any income received from a home equity conversion plan is excluded in the month of receipt. If the income is retained after the month of receipt, count it as a resource beginning the month after receipt.

5522 Excluded Income (05/15/1996, 96-4)

A. Any income received by a recipient of SSI/AABD or Reach Up living in the VHAP Pharmacy household.

B. All income to an undergraduate student (including parents as well as children in the VHAP-Pharmacy group) from student grants, loans, or work/study if:

1. such loans or grants are made under a program administered or insured by the U.S. Commissioner of Education; or

2. the sponsor of the grant or loan precludes its use for maintenance purposes; or

3. the work/study program is administered by a college or university recognized by educational authorities and the undergraduate student is enrolled half time or more than half time, as defined in relation to the definition of full time used by the school.

Examples of excludable income sources are: Basic Educational Opportunity Grants, Vermont Student Assistance Corporation grants or loans, Senatorial Scholarships, Supplemental Educational Opportunity Grants (SEOG), and College Work-Study Programs (CWSP).

That portion of any Veterans Administration Educational Assistance Program payment that is for the student and is actually used for tuition, books, fees, child care services or other expenses necessary for enrollment is also excluded.

C. Student financial assistance provided under Title IV of the Higher Education Act or Bureau of Indian Affairs Student Assistance programs.

Examples of programs in Title IV of the Higher Education Act include:

1. Pell Grants.

2. Supplemental Educational Opportunity Grants (SEOG)

3. State Student Incentive Grants (SSIG)

4. College Work Study (CWSP)

5. Perkins Loans (formerly National Direct Student Loans). These are different from loans under the Carl D. Perkins Vocational and Applied Technology Education Act, which are not totally disregarded see D below.

6. Guaranteed Student Loans (GSLP), including PLUS loans and Supplemental Loans for students.

D. Student financial assistance provided under the Carl D. Perkins Vocational and Applied Technology Education Act when the assistance is made available to meet attendance costs. Attendance costs include:

1. tuition and fees normally assessed a student carrying the same academic workload as the applicant/recipient, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study as the applicant/recipient; and

2. an allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

Excluded Income

E. Reimbursements for expenses (such as child or dependent care, transportation, purchase or maintenance of clothing, and meals) attributable to participation in unpaid voluntary activities, including the value of meals provided during the course of these activities.

F. Payments made pursuant to a court order for support or alimony, an Administrative Order for support issued by the Human Services Board, or a contract between the Office of Child Support and noncustodial parent requiring the payment of support. This income exclusion is limited to payments actually made by a member of the VHAP-Pharmacy group toward the support of a person(s) outside the group. The payment amount is deducted first from the VHAP-Pharmacy group's countable earned income, with any balance deducted from unearned income.

G. The value of 3SquaresVT benefits under the Food Stamp Act of l977.

H. The value of foods donated by the U. S. Department of Agriculture (surplus commodities).

I. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of l970.

J. Earned income of a child under the age of 19 if the child is a full-time student or a part-time student who works less than full time. A child is a student if he or she is enrolled in a school, college, university, or a course of vocational or technical training designed to prepare him or her for gainful employment. Such educational institution shall determine whether the student is enrolled full time or part time. Full-time employment is work that involves 100 or more hours per month; less than full-time employment is work that involves fewer than 100 hours per month.

K. Monthly income of any child (see definition of child at 10. above) from any program carried out under the Job Training Partnership Act (JTPA). This applies to earned or unearned income, except that, in the case of earned income, this disregard may not exceed six months per calendar year.

This income cannot be disregarded for adults.

The $10 per day allowance given to individuals in JTPA training is also always disregarded as income for both children and adults.

L. Payments for support services and/or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions and to persons serving in the Service Corps of Retired Executives and Active Corps of Executives or any other program under Titles II and III pursuant to Section 418 of P.L. 93 133.

M. Payments to individual volunteers under Title I of P.L. 93 133 Section 404(g), University Year For Action payments under P.L. 93-113, and PL 96-143, Section 9 (VISTA) payments, unless determined by the Director of ACTION to be equivalent to or greater than the federal or state minimum wage.

N. The tax exempt portions of payments made pursuant to P.L. 92 203 (Alaska Native Claims Settlement Act of l973).

O. Payments distributed per capita to or held in trust for members of any Indian Tribe under P.L. 92 254 or P.L. 93 134, or P.L. 94 540.

P. Payments received for the care of foster children in the custody of, and placed by, the Family Services Division. The rate of payment is established to cover expenses only with no profit available; therefore, no income is considered available from this source.

Q. Experimental Housing Allowance Program payments made under Annual Contributions Contracts entered into prior to January l, l975, under the U.S. Housing Act of l937, as amended.

Excluded Income

R. Reach Up support services, either as reimbursements or advance payments to the individual for child care, transportation, work related expenses, work related supportive services, education, or training related supportive services.

S. Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older American Act of l965, as amended.

T. The value of supplemental food assistance received under the Child Nutrition Act of l966, as amended, and the Special Food Service Program for children under the National School Lunch Act, as amended (P.L. 92 433 and P.L. 93 l50).

U. Receipts distributed to members of certain Indian tribes referred to in Section 5 of P.L. 94 ll4, which became effective October l7, l975.

V. Any income received from an emergency fuel supplement or energy allowance to assist with the cost of heating.

W. The first $50 in child support payments made by an noncustodial parent on behalf of a VHAP-Pharmacy group member within each calendar month. When more than one noncustodial parent makes child support payments on behalf of a single VHAP-Pharmacy group in the same calendar month, the maximum amount of child support to be disregarded in determining the VHAP-Pharmacy group's eligibility is $50.

X. Payments to persons of Japanese or Aleut ancestry as restitution for injustices suffered during the Second World War.

Y. Federal Earned Income Tax Credit (EITC), whether received with each paycheck or as a refund (lump sum).

Z. Payments made from the Agent Orange Settlement Fund or any other fund established because of the Agent Orange product liability litigation.

AA. Payments made pursuant to the Radiation Exposure Compensation Act (Public Law 101-426).

AB. Payments made under Indian Trust Funds Acts (Public Laws 97-458 and 98-64) and initial purchases made with such funds by the original recipient of the funds.

AC. Interest held in a trust or in restricted lands pursuant to section 8 of Public Law 93-134 and up to $2,000 annual income received from the lease or other uses of the individually owned trust or restricted lands.

AD. Distributions made under Public Law 100-241, which amended the Alaska Native Claims Settlement Act:

1. cash, including cash dividends on stock received from a Native Corporation, to the extent that it does not, in the aggregate, exceed $2000 per individual per calendar year; or

2. stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; or

3. a partnership interest; or

4. land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; or

5. an interest in a settlement trust.

AE. Payments made pursuant to the Maine Indian Claims Settlement Act of 1980 to a member of the Passamaquoddy Indian Tribe, the Penobscot Nation, or the Houlton Band of Maliseet Indians.

Excluded Income

AF. Payments made to a member of the Aroostook Band of Micmacs pursuant to the Aroostook Band of Micmacs Settlement Act.

AG. Financial assistance paid through the Disaster Relief Act of 1974 as amended by Public Law 100-707 in 1988 and provided as major disaster and emergency assistance. This disaster coverage is intended to provide relief to people living or working in an area severely struck by natural or man-made disaster. The disaster must have been so severe as to cause the President to designate a Federal Disaster Zone. Additional relief provided under these circumstances by states, local governments and disaster assistance organizations is also excluded.

AH. Bona fide loans.

5523 Determining Countable Income (07/01/2001, 01-07)

Complete the following steps to determine countable income:

A. Constitute the VHAP-Pharmacy group according to the definition included in the Financial Need of a VHAP-Pharmacy Group (rule 5520)

B. Determine the combined countable income for the VHAP-Pharmacy group as constituted in step A above.

C. Compare the result to the applicable income test for the VHAP-Pharmacy group size as constituted in step A above.

All otherwise eligible individuals in a VHAP-Pharmacy group who pass the income test are income-eligible for the VHAP-Pharmacy program

Individuals potentially eligible for traditional Medicaid, such as pregnant women or children, have their eligibility determined under those rules but are considered members of the VHAP-Pharmacy group for purposes of determining the VHAP-Pharmacy group size and countable income.

5524 Income Test (07/01/2001, 01-07)

The income test, which is based on a percentage of the federal poverty line (FPL), is anticipated to follow the schedule below. However, enrollment may be suspended without further rule-making if this is required to remain within the state appropriation.

Enrollment Limits

Date	Income Test
05/15/96	Less than 100% FPL
07/01/97	Less than 125% FPL
07/01/98	Less than 150% FPL

The income maximums (P-2420) are updated annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds ESD's income maximum, ESD will issue a second increase on April 1.

5530 Application (12/01/2003, 03-17)

An application submitted through the Vermont state income tax process within the usual January 1 to June 15 application period shall be considered a valid application for VHAP-Pharmacy. Applicants determined eligible for VHAP-Pharmacy shall be offered enrollment.

Individuals who did not file through the state income tax process must file an application for VHAP-Pharmacy with ESD and provide information about his/her situation relevant to the tests for eligibility (rule 5510). Applications are date-stamped to assure that earlier applications are acted upon first.

An applicant must furnish his/her social security number or apply for a social security number unless he/she substantiates he/she is 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 the applicant or beneficiary unless it is questionable, verification is outstanding for another benefit program, or the applicant or beneficiary has refused to provide a social security number because of a religious objection. Social security numbers are used to verify information through tape matches. Clients are notified on the application form of the verification actions the department may take, including the use of verification obtained for other department programs, randomly selected quality control reviews, and the penalties for fraudulent reporting of their situation.

Individuals who are found eligible for VHAP-Pharmacy and subsequently become ineligible for that program, due to a change in their circumstances or other program changes, shall be considered for eligibility in the VScript or Healthy Vermonters program.

Application Decision

5531 Application Decision (12/01/2003, 03-17)

An eligibility decision must be made within 30 days of the date the application is received by ESD. An applicant with countable income over the income test shall be denied and may reapply at any time.

An applicant will be sent a notice regarding the action being taken on his/her 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.

Individuals offered VHAP-Pharmacy coverage may apply for any other health care assistance offered by the department at any time.

5532 Eligibility Period and Enrollment (04/01/2005, 05-09)

A. Eligibility

Eligibility criteria are described in rules 5511 – 5524.

If VHAP-Pharmacy eligibility begins on or after July 1 but no later than December 31, eligibility continues through June 30 of the next year. If VHAP-Pharmacy eligibility begins on or after January 1 but no later than June 30, eligibility continues through June 30 of the following year.

A review of eligibility will be completed before the end of each certification period to assure 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 VHAP-Pharmacy is determined and required premiums are received by the department, according to the rules specified at rules 4160-4162, beneficiaries are enrolled beginning on the first day of the month following receipt of full premium payment through June 30 unless they are disenrolled at the end of the month following a notice mailed at least 11 days before the disenrollment date. Disenrollment shall occur whenever beneficiaries:

1. fail to pay the required premium;
2. are incarcerated;
3. become eligible for another plan of assistance or insurance that provides any payment or reimbursement of prescription costs;
4. move out-of-state;
5. voluntarily withdraw;
6. are found to have been ineligible on the date coverage began;
7. are no longer in contact with the Department and has no known address;
8. die.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in rule 4161(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The department 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 the department receives the required verification and premium amounts due.

If the health condition related to this medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.

Identification Document

5533 Identification Document (04/01/2005, 05-09)

Each individual in the household enrolled in VHAP-Pharmacy is provided with an identification card which includes the name and identification number.

Application for Other Benefits

5534 Application for Other Benefits (12/01/2003, 03-17)

Individuals who wish to apply for traditional Medicaid or other benefits available through DCF must file an application as required under those programs.

5540 Right to Appeal (07/01/2007, 06-05)

The Department shall provide individuals with notice whenever they are found ineligible for the VHAP-Pharmacy program or when the services they may receive under the VHAP-Pharmacy program are 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.

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 VHAP-Pharmacy coverage, they have the right, under certain conditions, 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 in full any required premiums (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 appeal the amount of their premium and win 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.

VHAP-Pharmacy beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 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] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5550 **Date of this Memo** 06/10/1996 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Are VHAP-Pharmacy recipient who are pregnant or in a long-term care facility required to pay a co-payment, as indicated at rule 5550?

ANSWER: No, these recipients have no cost-sharing requirements.

Cost Sharing

5550 Cost Sharing (07/03/2008, 08-22)

The department requires all beneficiaries to pay a monthly premium of $17.00 per person to enroll in the VHAP-Pharmacy program. The premium payment system applicable to VHAP-Pharmacy is described in rules 4160–4162.

5551 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.

5552 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 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.

Compounded Prescriptions

5553 Compounded Prescriptions (07/01/2006, 06-18)

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.

5554 Participating Pharmacy (07/01/2006, 06-18)

"Pharmacy" means a retail or institutional drug outlet licensed by the Vermont State Board of Pharmacy pursuant to chapter 36 of Title 26, or by an equivalent board in another state, in which prescription drugs are sold at retail and which has entered into a written agreement with the state to dispense drugs.

A provider must:

A. satisfactorily complete and submit to the Office 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 on the basis of race, color, sex, age, religious preference, national origin, handicap or sexual orientation;

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

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5555 **Date of this Memo** 07/15/2009 **Page** 1 of 1

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

QUESTION: Who is affected by the rule as it related to a 90–day supply?

ANSWER: The rule applies to persons using the selected maintenance drug classes when they are eligible under Medicaid, VHAP-Pharmacy, VScript or VScript Expanded when Medicaid, VHAP-Pharmacy, VScript or VScript Expanded is their primary coverage. This means that the rule does not apply to persons who are on Medicare or covered by private insurance. the list of maintenance drugs requiring a 90–day fill is on the OVHA webpage: http://ovha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts.

QUESTION: What happens when a physician or medical professional licenses to prescribe drugs in Vermont wants to request an exception to the 90–day supply policy?

ANSWER: When a pharmacy submits a claim for payment for a drug in a selected 90 day supply class, the claim will deny unless there is an exception authorization on file. The prescriber should request an exception when he/she believes in his/her clinical and professional judgement there is an extenuating circumstance to justify an exception. A request must be patient and drug specific. To facilitate the request, the prescriber should submit the Exception to Required 90 Day Maintenance Medication Fill form found on the web page of the Office of Vermont Health Access at: http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms using the instructions found on the form.

QUESTION: Will the prescriber have to do anything to request a lesser day supply for the initial fill?

ANSWER: The prescriber does not have to do anything to request the initial supply. When the prescriber writes the new script the pharmacy will indicate it is a new script when submitting the claim for payment. That indication will exclude that first script from the requirement.

Co-Payments

5555 Co-Payments (08/01/2012, 12-05)

A beneficiary shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, 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.

5560 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:

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); 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.

Prescribed Drugs

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.

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5570 **Date of this Memo** 07/29/2002 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is there a change in rule regarding coverage of refraction exams?

ANSWER: Yes. All refraction exams are now covered when provided by a participating Ophthalmologist or Optometrist. No prior authorization is required.

INTERPRETIVE MEMO

[X] VHAP Pharmacy Rule Interpretation [ ] VHAP Pharmacy 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 5570 **Date of this Memo** 07/01/1999 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Does the VHAP-Pharmacy program provide coverage for smoking cessation products?

ANSWER: Yes. The VHAP-Pharmacy program only provides coverage for prescription smoking cessation products; it does not cover any over-the-counter smoking cessation products. A beneficiary may obtain up to two regimens of prescription smoking cessation products per calendar year.

5570 Benefit Coverage (01/01/2006, 05-24)

Benefits are provided for:

- the same pharmaceutical coverage as Medicaid,
- 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.