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VPharm

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).

Beneficiary Fraud

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.

Eligibility

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.

Age

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.

Disability

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.

Income

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.

PDP Enrollment

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.

Limited Income Subsidy

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.

Citizenship and Identity

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

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

Application

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.

Identification Document

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 beneficiary who does not provide the co-payment.

Medicare Advocacy Program

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.

Compounded Prescriptions

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 (11/1/2019, GCR 19-021)

Pharmaceutical items include drugs that are obtained through appropriately licensed pharmacies. Payment for prescribed drugs is limited to the following qualified providers who are enrolled in Vermont Medicaid:

Licensed Vermont pharmacies, including hospital pharmacies, operating within their scope of practice;

Pharmacies appropriately licensed in another state, operating within their scope of practice; or

A licensed physician, serving in a rural area without an available pharmacy, who has been granted special approval prior to July 1, 2019 to bill these items directly and is operating within their scope of practice.

Payment is limited to covered items with a valid prescription from a medical professional licensed by the state of Vermont to prescribe within the scope of their practice and enrolled in Vermont Medicaid. The prescription must be dispensed by a qualified provider in accordance with applicable federal and state statutes and regulations and must be for the member only.

Up to eleven refills are permitted if allowed by federal and state statutes and regulations.

A pharmacist shall not fill a prescription in a quantity greater than that prescribed if payment is to be made by VPharm, except in an individual case when the quantity has been changed on the prescription in consultation with the prescriber.

Coverage for prescribed drugs is provided in accordance with section 1927 of the Social Security Act, Covered Outpatient Drugs. Coverage of all drugs is subject to the requirements of the Preferred Drug List (PDL), which is available on the DVHA website.

5450 Coverage (06/15/2024, GCR 23-144)

(a) VPharm provides the following supplemental pharmacy coverage:

(1) VPharm covers beneficiary Medicare prescription drug plan cost-sharing after any federal low-income subsidy (LIS) is applied. This may include:

(A) Deductible,
(B) Co-payments,
(C) Coinsurance,
(D) The coverage gap, and
(E) Catastrophic copayments according to Medicare prescription drug plan rules.

(2) VPharm covers the Medicare prescription drug plan premium up to the low-income premium subsidy (LIS) amount (as determined by the Centers for Medicare and Medicaid Services).

(b) VPharm also provides coverage for certain categories of drugs if they are not covered by the Medicare prescription drug plan. These categories of drugs are covered as they are under Medicaid and can be found in the Medicaid State Plan on the Agency of Human Services website.

(1) Coverage is subject to the requirements of the preferred drug list (PDL), which is available on the Department of Vermont Health Access website.

(2) Coverage for the pharmaceuticals described above shall be based upon current Medicaid payment and dispensing policies.

(c) The following additional benefits are available for VPharm 1 beneficiaries only:

(1) One comprehensive visual analysis (including a refraction) and one interim eye exam (including a refraction) within a two-year period, and

(2) Diagnostic visits and tests related to vision.

(d) Beneficiaries have co-payments as described in statute at 33 V.S.A. § 2073(d).

(e) Beneficiaries may request coverage of a prescribed drug when an individual has exhausted the appeal process under the Medicare prescription drug benefit.

(f) For VPharm beneficiaries who are eligible for and have applied for the Medicare prescription drug benefit but have not yet received coverage due to an operational problem with Medicare, or who otherwise have not received coverage for a needed drug: Vermont Medicaid will cover the drug if medically necessary and if it finds that good cause and hardship exist. Coverage will continue until the operational problem and good cause and hardship ends. The individual must have made every reasonable effort with Medicare, given the individual’s circumstances, to obtain coverage.

5450.1 Non-Drug Items (06/15/2024, GCR 23-144)

(a) VPharm covers beneficiary cost-sharing for insulin and other diabetic supplies, including test strips, needles and syringes.