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TEMPORARY ADMINISTRATIVE RULES

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Upon filing.	
Adopted on	
04/01/2014 thru 09/28/2014	
Effective dates	

RULE CAPTION

Allow for CCOs to Pay for Outpatient and Physician Administered Medications

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND: 410-141-3070

SUSPEND:

Stat.Auth.:ORS 413.042, 414.615, 414.625, 414.635, 414.651

Other Audi.: None

Stats. Implemented: ORS 414.610 through 414.685

RULE SUMMARY

The Division needs to amend these rules to modify the allowance for Coordinated Care Organizations (CCO) to pay for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements with the Centers for Medicare and Medicaid (CMS). This change will align with federal regulations as stated in the State Medicaid Director Letter that allows CCOs flexibility with pharmacy payments.

STATEMENT OF NEED AND JUSTIFICATION

The temporary amending of OAR 410-141-3070

In the Matter of

State Medicaid Director Letter (SMDL 9-28-10)

Documents Relied Upon, and where they are available

The Division needs to amend these rules to modify the allowance for Coordinated Care Organizations (CCO) to pay for outpatient and physician administered drugs produced by manufacturers that have valid rebate agreements with the Centers for Medicare and Medicaid (CMS). This change will align with federal regulations as stated in the State Medicaid Director Letter that allows CCOs flexibility with pharmacy payments.

Need for the Temporary Rule(s)

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, providers, CCOs and recipients of Medicaid benefits. These rules need to be adopted promptly so that Coordinated Care Organizations will be compliant with federal regulations. This rule revision is needed immediately to assist these organizations with facilitation of payments made for pharmacy benefits.

Justification of Temporary Rules



Judy Mohr Peterson

3/28/14

Authorized Signer

Printed Name

Date

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Secretary of State
STATEMENT OF NEED AND JUSTIFICATION
A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division) 410
Agency and Division Administrative Rules Chapter Number

In the Matter of: The temporary amending of OAR 410-141-3070

Rule Caption: Allow for CCOs to Pay for Outpatient and Physician Administered Medications

Statutory Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651

Other Authority: None

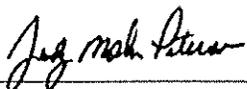
Stats. Implemented: ORS 414.610 through 414.685

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 Judy Mohr-Peterson 3/28/14
Authorized Signer Printed name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

410-141-3070

Pharmaceutical Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. CCOs shall pay for prescription drugs, except:

(a) As otherwise provided, mental health drugs that are in Class 7 & 11 (based on the National Drug Code (NDC)) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal, and those drugs that the Authority specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is fully dual eligible.

(2) CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337. CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list ~~must~~ shall:

(a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) CCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include but are not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 72-hour time requirement for prior authorization and the medical need for the drug is immediate, CCOs must provide, within 24 hours of receipt of the drug prior authorization request, for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.

(5) CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring provider; if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded. Payment is governed by OAR 410-121-0150.

(7) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs which have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. The DESI LTE drug list is available at:
<http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12 LTEIRSDrugs.asp>.

(8) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all of the following information:

(a) The drug name;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Authority should consider this drug for carve out.

(9) If a CCO request-s that a drug not be paid within the global budget, the Authority shall exclude the drug from the global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders.

(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services Program rules (chapter 410, division 121). A CCO may not reimburse providers for carved-out drugs.

(11) CCOs shall submit quarterly utilization data, within 60 days of the date of service, as part of the CMS Medicaid Drug Rebate Program requirements pursuant to Section 2501 of the Affordable Care Act.

(12) CCOs are encouraged to may not provide payment only for outpatient and physician administered drugs produced made-by manufacturers that do not have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. CCOs may continue to have some flexibility in maintaining formularies of drugs regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635, 414.651

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