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Generated on May 22, 2014 5:18PM  
**PERMANENT ADMINISTRATIVE RULES**

Oregon Health Authority, Division of Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
Sandy Cafourek	dmap.rules@state.or.us
Rules Coordinator	Email Address
500 Summer St. NE, Salem, OR 97301	503-945-6430
Address	Telephone
Upon filing.	
Adopted on	
07/01/2014	
Effective date	

**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

**REPEAL:** 410-141-3070(T)

**RENUMBER:**

**AMEND & RENUMBER:**

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

**Other Auth.:**

**Stats. Implemented:** ORS 414.610 through 414.685

**RULE SUMMARY**

The Division needs to amend this rule 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.

*Rhonda Busek*

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*5-30-14*

Authorized Signer

Printed Name

Date

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## 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 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](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 requests 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 provide payment only for outpatient and physician administered drugs produced by manufacturers that 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

Stats. Implemented: ORS 414.610 – 414.685