

Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: February 18, 2020

The proposed policy changes are currently in effect as Emergency Rules and must be promulgated as Permanent Rules. The proposed policy was presented at the May 7, June 8, and November 5, 2019 Tribal Consultation and to the Medical Advisory Committee on November 7, 2019. Additionally, this proposal will be presented at a Public Hearing on February 19, 2020 and to the OHCA Board of Directors on March 18, 2020.

Reference: APA WF # 19-20

SUMMARY:

Pharmacy revisions and American Indians/Alaska Natives (AI/AN) cost sharing exemptions - The proposed rule changes will remove prescription limits on certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed rule changes will also remove co-payments for MAT drugs. Additional rule changes will amend prescription quantity limits when a product is on the maintenance drug list. Other revisions will align administrative rules regarding cost sharing exemptions for AI/AN members with Oklahoma's Medicaid State Plan language and federal regulation at Title 42 of the Code of Federal Regulations (C.F.R.) § 447.56(a)(x). Lastly, revisions will align policy with current practice and correct grammatical errors.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 C.F.R. § 447.56(a)(1)(x)

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Maria Maule
Legal Services

FROM: Vanessa Andrade
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 19-20

A. Brief description of the purpose of the rule:

The proposed rule changes will remove prescription limits of certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed rule changes will also remove co-payments for MAT drugs.

Additional rule changes will amend prescription quantity limits when a product is on the maintenance drug list. The proposed rule changes will allow certain products to be dispensed in quantities of up to a ninety (90) day supply.

Other revisions will align administrative rules regarding cost sharing exemptions for American Indians/Alaska Natives (AI/AN) members with Oklahoma's Medicaid State Plan language and federal regulation at Title 42 of the Code of Federal Regulations (C.F.R.) § 447.56(a)(x).

Lastly, revisions will align policy with current practice and correct grammatical errors.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare members who need access to MAT medications and other prescription drugs on the maintenance drug list will most likely be affected by the proposed rule changes.

SoonerCare members who are AI/AN will most likely be affected by the proposed rule changes.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes to remove prescription limits and co-payments for MAT drugs will benefit SoonerCare members by ensuring members have prompt access to life-saving medications.

The proposed rule changes to allow more flexibility for maintenance drug list prescriptions will benefit SoonerCare members by increasing the allowable dispensing quantity from one-hundred (100) units to a ninety (90) day supply. This will help improve adherence rates while also lowering the cost of care through the decreased number of dispensing fees.

The proposed rule changes to clarify co-payment requirements will benefit SoonerCare members who are AI/AN because the rules will align with the Oklahoma's Medicaid State Plan and federal regulation at 42 C.F.R. § 447.56(a)(x).

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable impact of the proposed rule upon any classes of persons or political subdivisions.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rule, was approved during promulgation of the emergency rule on November 20, 2019.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

- I. A determination of the effect of the proposed rule on the public

health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have no adverse effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: October 7, 2019

Modified: January 6, 2020

RULE TEXT:

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and ~~Cost-Sharing~~cost sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service contract"** means the provider agreement specified in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare ~~Program~~program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare ~~Program~~program.

(b) **Assignment in fee-for-service.** ~~The OHCA's~~Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no

additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a ~~fee-for-service~~fee-for-service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare ~~Contract~~contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the ~~Oklahoma Health Care Authority~~OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost ~~Sharing~~ Copayments**sharing/co-payment. Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the ~~fee-for-service~~fee-for-service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to

collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age ~~21~~twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) ~~Home and Community-Based Service~~Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) ~~Native Americans providing documentation of ethnicity in accordance with OAC 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services~~American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins.

(D) Smoking and ~~Tobacco Cessation~~tobacco cessation counseling and products.

(E) ~~Diabetic supplies.~~Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians~~;~~;

(ii) ~~Advanced Practice Nurses,~~practice registered nurses;

(iii) Physician ~~Assistants,~~assistants;

(iv) Optometrists~~;~~;

(v) ~~Home Health Agencies,~~health agencies;

- (vi) ~~Certified Registered Nurse Anesthetists~~, registered nurse anesthetists;
 - (vii) ~~Anesthesiologist Assistants~~, assistants;
 - (viii) ~~Durable Medical Equipment~~ medical equipment providers~~;~~ and
 - (ix) Outpatient behavioral health providers.
- (E) Prescription drugs.
- (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.
- (4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) ~~unlimited~~ Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or ~~ICF/IID~~ intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) ~~seven~~ Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan ~~(including three (3) brand name prescriptions)~~ [including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) ~~HCBS Waivers~~ Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

~~(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, naloxone for use in opioid overdose, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. For purposes of this Section, "exempt from the prescription limit" means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:~~

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking and tobacco cessation products;

(H) Naloxone for use in opioid overdose;

(I) Certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

317:30-5-77.1. Dispensing ~~Quantity~~quantity

(a) Prescription quantities ~~are to~~ shall be limited to a ~~34~~thirty-four (34) day supply, except in the following situations:

(1) The Drug Utilization Review (DUR) Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert, ~~provided the Chief Executive Officer of the OHCA has approved the recommendation;~~

(2) The product is included on the Maintenance List of medications, which are ~~exempt~~exempted from this limit, and may be dispensed up to ~~100 units~~a ninety (90) day supply;

(3) The manufacturer of the drug recommends a dispensing quantity less than a ~~34~~thirty-four (34) day supply~~+~~.

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the ~~best~~current medical and pharmacological practices. A provider may not generate automated refills unless the member has specifically requested such service. Documentation of this request must be available for review by OHCA auditors.

(c) The ~~Drug Utilization Review~~DUR Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the ~~vendor drug program~~Vendor Drug Program in quantities up to ~~100 units~~a ninety (90) day supply when approved by the prescriber. The ~~Drug Utilization Review~~DUR Board shall review the Maintenance List at least annually. ~~The Maintenance List shall be approved by the Chief Executive Officer of OHCA.~~ When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to SoonerCare members who do not reside in a ~~long term~~long-term care facility. For members residing in a ~~long term~~long-term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a ~~28~~twenty-eight (28) day supply.

(d) For products covered by the Oklahoma Vendor Drug Program, the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific

~~NDC~~National Drug Code (NDC). Only numeric characters should be entered. Designations, such as the form of drug, i.e., ~~Tabs, Caps, Suppositories,~~ tabs, caps, suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

DRAFT