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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/27/2026 2:35 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
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HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
There is no expected economic impact.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-121-0000, 410-121-0021, 410-121-0033, 410-121-0060, 410-121-0100, 410-121-0135, 410-121-0143, 410-121-0145, 410-121-0146, 410-121-0148, 410-121-0155, 410-121-0190, 410-121-0220

AMEND: 410-121-0000

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0000
Foreword and Definition of Terms ¶

(1) The ~~Health Systems~~ Division (Division) chapter 410 Oregon Administrative Rules (OAR) are designed to assist ~~p~~Providers in preparing claims for services provided to the Division's ~~fee-for-service client~~Open Card Members. Providers must use Pharmaceutical OARs in conjunction with the ~~G~~general ~~R~~rules OARs (chapter 410, division 120) for Oregon Medical Assistance Programs.¶
(2) Pharmaceutical ~~s~~Services delivered through a managed care plan or a Coordinated Care Organization (CCO) contracted with the Division under the Oregon Health Plan (OHP) are subject to the policies and procedures established in the OHP administrative rules (chapter 410, division 141) and by the specific managed care plan or CCO.¶
(3) Definition of Terms:¶
(a) "Actively Practicing" means the active practice of medicine as described in ORS chapter 689 or the active practice of pharmacy as described in ORS chapter 677.¶
(b) "Authority" means the Oregon Health Authority. See the Oregon Health Authority definition in General Rules (chapter 410, division 120);¶
(c) "Average Manufacturer's Price (AMP)" means the average price that manufacturers sell medication to wholesalers and retail pharmacies, as further clarified in 42 CFR 447;¶
(d) "Bulk Dispensing" means multiple doses of medication packaged in one container labeled as required by pertinent federal and state laws and rules;¶
(e) "Centers for Medicare and Medicaid Services (CMS) Basic Rebate" means the quarterly payment by the manufacturer of a drug pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c) of the Social Security Act (42 U.S.C. 1396r-8(c)). See 410-121-0157;¶
(f) "CMS Consumer Price Index (CPI) Rebate" means the quarterly payment by the manufacturer pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r-8(c));¶
(g) "Compendia" means those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:¶
(A) The American Hospital Formulary Service Drug information;¶
(B) The United States Pharmacopeia Drug Information (or its successor publications);¶
(C) The American Medical Association drug evaluations;¶
(D) Peer-reviewed medical literature;¶
(E) Drug therapy information provided by manufacturers of drug products consistent with the federal Food and Drug Administration requirements.¶
(h) "Community Based Care Living Facility" means for the purposes of the Division's Pharmacy Program, a home, facility, or supervised living environment licensed or certified by the State of Oregon that provides 24-hour care, supervision, and assistance with medication administration. These include but are not limited to:¶
(A) Supportive living facilities;¶
(B) Twenty-four hour residential services;¶
(C) Adult foster care;¶
(D) Semi-independent living programs;¶
(E) Assisted living and residential care facilities;¶
(F) Group homes and other residential services for people with developmental disabilities or needing mental health treatment; and¶
(G) Inpatient ~~h~~Hospice.¶
(i) "Compounded Prescription" means the following:¶
(A) A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid

ingredient that must be a reimbursable item or a legend drug in a therapeutic amount;¶
(B) Compounded prescription further defined to include the Oregon Board of Pharmacy definition of compounding (see OAR 855-006-0005).¶
(j) "Dispensing" means issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist;¶
(k) "Director" means the director of the Authority;¶
(~~l~~l) "Drug Order/Prescription" means the following:¶
(A) A medical ~~p~~Practitioner's written or verbal instructions for a patient's medications; or¶
(B) A medical ~~p~~Practitioner's written order on a medical chart for a ~~client~~Member in a ~~n~~Nursing ~~f~~Facility.¶
(m) "Durable Medical Equipment and Supplies (DME)" means equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS);¶
(n) "Intermediate Care Facility" means a facility providing regular health-related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels as defined in ORS 442.015;¶
(o) "Legend Drug" means a drug limited by Section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act to being dispensed by or upon a medical ~~p~~Practitioner's prescription because the drug is:¶
(A) Habit-forming;¶
(B) Toxic or having potential for harm; or¶
(C) Limited in its use to being used under a ~~p~~Practitioner's supervision by the new drug application for the drug:¶
(i) The product label of a legend drug is required to contain the statement: "CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION;"¶
(ii) A legend drug includes prescription drugs subject to the requirement of Section 503(b)(1) of the federal Food, Drug, and Cosmetic Act that shall be exempt from Section 502(F)(1) if certain specified conditions are met.¶
(p) "Long Term Care Facility" means skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455;¶
(q) "Maintenance Medication" means drugs that have a common indication for treatment of a chronic disease, and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "Y" or "1;"¶
(r) "Mental Health Drug" means a type of legend drug defined by the Oregon Health Authority (Authority) by rule that includes but is not limited to those drugs classified by First DataBank in the following Standard Therapeutic Classes:¶
(A) Therapeutic Class 7 ataractics-tranquilizers and Therapeutic Class 11 psychostimulants-antidepressants;¶
(B) Depakote, Lamictal, and their generic equivalents and other drugs that the Division specifically carved out from capitation from CCOs as specified in OAR 410-141-3855.¶
(s) "Narrow Therapeutic Index (NTI) Drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring;¶
(t) "National Average Drug Acquisition Cost (NADAC)" means the rate that is established by CMS or its contractor by rolling surveys of pharmacies nationwide to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product. The NADAC is the average of invoice amounts for individual drug products based on the Generic Sequence Number (GSN);¶
(u) "Net Price" means the amount a drug costs the Division and is calculated using the following formula: OR-AAAC, minus CMS Basic Rebate, minus CMS CPI Rebate, minus State Supplemental Rebate;¶
(v) "Nominal Price" means sales at less than 10 percent of the Average Manufacturer's Price (AMP);¶
(w) "Non-Preferred Products" means any medication in a class that has been evaluated and that is not listed on the Practitioner-Managed Prescription Drug Plan Preferred Drug List in OAR 410-121-0030;¶
(x) "Nursing Facility" means an establishment that is licensed and certified by the Department's office of Aging and People with Disabilities ~~Division~~ (APD) as a Nursing Facility;¶
(y) "Oregon Average Actual Acquisition Cost (OR-AAAC)" means the rate that is established by the Division or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy or corporate entity to wholesalers, manufacturers, or distribution centers for the product. The AAAC is the average of invoice amounts for individual drug products based on the Generic Sequence Number (GSN);¶
(z) "Pharmacist" means an individual who is licensed as a pharmacist under ORS chapter 689;¶
(aa) "Physical Health Drug" means all other drugs not included in the definition of a "mental health drug" according to this rule;¶
(bb) "Point-of-Sale (POS)" means a computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication;¶
(cc) "Preferred Drug List (PDL)" means the list of prescription drugs in selected classes that the Authority in consultation with the Pharmacy & Therapeutics Committee (P & T) has determined represent the most effective drugs available at the best possible price. (See details for the Division's PMPDP PDL in OAR 410-121-0030.) The following are two types of preferred drug lists:¶
(A) "Enforceable Physical Health Preferred Drug List" means the list of "preferred" drug products used to treat

physical health conditions. The "preferred" drugs may nevertheless require ~~p~~Prior ~~a~~Authorization (PA) for clinical reasons. Drugs prescribed that do not appear on the PDL (non-preferred products) shall be subject to PA;¶
(B) "Voluntary Mental Health Preferred Drug List" means the list of "preferred" drug products used to treat mental health conditions. Any drug prescribed for the treatment of mental health diagnosis shall be exempt from non-clinical PA requirements by the Division.¶
(dd) "Preferred Products" means products in classes that have been evaluated and placed on the Practitioner Managed Prescription Drug Plan (PMPDP) PDL in OAR 410-121-0030;¶
(ee) "Prescriber" means any person authorized by law to prescribe drugs;¶
(ff) "Prescription Splitting" means any one or a combination of the following actions:¶
(A) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than 34 days, except as needed for Prescription Synchronization (see OAR 410-121-0146);¶
(B) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing fee for the quantity billed, except as needed for Prescription Synchronization (see OAR 410-121-0146);¶
(C) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or¶
(D) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.¶
(gg) "Prescription Synchronization" means the process of, at the ~~client~~Member's direction, aligning the refill dates of a ~~client~~Member's prescription drugs so drugs that are refilled at the same frequency may be refilled concurrently;¶
(hh) "Prior Authorization Program (PA)" means the prior authorization program is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing:¶
(A) OAR 410-121-0040 lists the drugs or categories of drugs requiring PA;¶
(B) The ~~p~~Practitioner or ~~p~~Practitioner's licensed medical personnel listed in OAR 410-121-0060 may request a PA.¶
(ii) "State Supplemental Rebates" means the Division and CMS approved discounts paid by manufacturers per unit of drug. These rebates are authorized by the Social Security Act section 42 USC 1396r-8(a)(1) and are in addition to federal rebates mandated by the Omnibus Budget Rehabilitation Act (OBRA 90) and the federal rebate program;¶
(jj) "Unit Dose" means a sealed, single unit container of medication so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for the unit dose dispensing system established by the Oregon Board of Pharmacy;¶
(kk) "Urgent Medical Condition" means a medical condition that arises suddenly, is not life-threatening, and requires prompt treatment to avoid the development of more serious medical problems;¶
(~~LL~~ll) "Usual and Customary Price" means a pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs including membership based discounts initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers;¶
(mm) "Wholesale Acquisition Cost (WAC)" means the price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. WAC is the price of a covered product by the National Drug Code (NDC) as published by First DataBank, MediSpan, or Red Book;¶
(nn) "340B Pharmacy" means a federally designated community health center or other federally qualified covered entity that is listed on the Health Resources and Services Administration (HRSA) website.¶
NOTE: Publications referenced are available from the agency.
Statutory/Other Authority: ORS 413.042, 414.065, 414.325
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0021

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0021
Organizations Authorized to Provide Pharmaceutical Prescription Services ¶

(1) Pharmacies, and Medicare certified independent rural health clinics providing urgent medical services for ~~client~~Members as defined in ORS 414.325(7) may provide drug prescription services for ~~fee-for-service Division of Medical Assistance Programs (Division) client~~Open Card Members and receive reimbursement from Division by complying with all the following requirements:¶
(a) Comply with all applicable ~~F~~federal and ~~S~~state statutes, regulations and rules;¶
(b) Meet all current licensing and regulatory requirements;¶
(c) Be enrolled as a pharmacy ~~p~~Provider with Division;¶
(d) Pharmacies must have a current National Association of the Board of Pharmacy (NABP) number to bill Division;¶
(e) Medicare certified independent rural health clinics must have a ~~p~~Pharmacist, ~~p~~Physician, or ~~n~~Nurse ~~p~~Practitioner, licensed to dispense and bill drug prescriptions; and¶
(f) Comply with Division pharmacy billing requirements.¶
(2) Refer to OAR 410-120-1260 for enrollment details.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0033

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0033
Polypharmacy Profiling ¶

(1) The Division ~~of Medical Assistance Programs~~ may impose prescription drug payment limitations on ~~client~~Members with more than 15 unique fee-for-service drug prescriptions in a six-month period.¶
(2) The Division will review the ~~client~~Member's drug therapy in coordination with the ~~client~~Member's prescribing ~~p~~Practitioner to evaluate for appropriate drug therapy.¶
(3) Appropriate drug therapy criteria will include, but is not limited to, the following:¶
(a) Overuse of selected drug classes;¶
(b) Under-use of generic drugs;¶
(c) Therapeutic drug duplication;¶
(d) Drug to disease interactions;¶
(e) Drug to drug interactions;¶
(f) Inappropriate drug dosage;¶
(g) Drug selection for age;¶
(h) Duration of treatment;¶
(i) Clinical abuse or misuse.¶
(4) The Division Medical Director in conjunction with the Drug Use Review/Pharmacy & Therapeutics Committee will make final determinations on imposed drug prescription payment limitations relating to this policy.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0060

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0060
How to Get Prior Authorization for Drugs ¶

(1) A prescriber electing to order a drug requiring P~~A~~rior Authorization (PA) may have any licensed medical personnel in their office request the PA. The PA request may be transmitted to the Oregon Pharmacy Help Desk by any of the following methods:¶
(a) Call the Oregon Pharmacy Help Desk;¶
(b) ~~FAX~~Send a facsimile of the request form shown in the Pharmaceutical Services Supplemental Information on the Oregon Health Authority's website to the Oregon Pharmacy Help Desk; or¶
(c) Transmit the request electronically via the secure MMIS web portal.¶
(2) The status of a PA request received from prescribers or their licensed medical personnel will be reported on the secure MMIS web portal, or by calling the Automated Voice Recognition (AVR) System, within 24 hours of receipt by the Oregon Pharmacy Help Desk.¶
(3) PA approval:¶
(a) It is the pharmacy personnel's responsibility to check whether the drugs are covered, whether the ~~client~~Member is eligible, and to note restrictions such as date ranges and quantities before dispensing any medications that require PA.¶
(b) The pharmacy personnel must also check whether the ~~client~~Member's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the ~~client~~Member is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy ~~p~~Provider in the managed care plan's network, the pharmacy must inform the ~~client~~Member that it is not a ~~p~~Participating ~~p~~Provider in the managed care plan's network and must also recommend that the ~~client~~Member contact ~~his or he~~their managed care plan for a list of pharmacies participating in its network.¶
(c) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy ~~p~~Provider, if consistent with all other applicable administrative rules.¶
(4) If the PA request has been denied, notification to ~~client~~Member and prescriber will occur in accordance with O~~HP General Rules~~AR 410-120-1860.¶
(5) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from the Pharmacy Benefits Manager (PBM) when the ~~client~~Member is eligible for covered fee-for-service drug prescriptions.¶
(a) ~~Client~~Members who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.¶
(b) ~~Client~~Members who do have a PA pending may receive an emergency dispensing up to a seven-day supply.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0100

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0100
Drug Use Review ¶

(1) Drug Use Review (DUR) in ~~Division of Medical Assistance Programs (~~the Division~~)~~ is a program designed to measure and assess the proper utilization, quality, therapy, ~~m~~Medical ~~a~~Appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse:¶
(a) Information collected in a DUR program that identifies an individual is confidential;¶
(b) Staff of the Drug Use Review (DUR)/Pharmacy & Therapeutics (P&T) Committee and contractors may have access to identifying information to carry out intervention activities approved by the Division. The Division, DUR/P&T Committee or contractors shall adhere to all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and all Division policies relating to confidential ~~client~~Member information.¶
(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing ~~p~~Pharmacist:¶
(a) Dispensing ~~p~~Pharmacists must offer to counsel each Division ~~client~~Member receiving benefits who presents a new prescription, unless the ~~client~~Member refuses such counsel. Pharmacists must document these refusals;¶
(A) Dispensing ~~p~~Pharmacists may offer to counsel the ~~client~~Member's caregiver rather than the ~~client~~Member presenting the new prescription if the dispensing ~~p~~Pharmacist determines that it is appropriate in the particular instance;¶
(B) Counseling must be done in-~~-~~person whenever practicable;¶
(C) If it is not practicable to counsel in-~~-~~person, ~~p~~Providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance ~~client~~Member calls in relation to prescription counseling;¶
(b) Prospective DUR is not required for drugs dispensed by Fully Capitated Health Plans (FCHPs);¶
(c) Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.¶
(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. The Division provides a professional drug therapy review for Medicaid ~~client~~Members through this program:¶
(a)The criteria used in retrospective DUR are compatible with those used in prospective DUR. Retrospective DUR criteria may include Pharmacy Management (Lock-In), Polypharmacy, and Psychotropic Use in Children. Drug therapy review is carried out by ~~p~~Pharmacists with the Oregon State University College of Pharmacy, Drug Use Research and Management Program.¶
(b) If therapy problems are identified, an educational letter is sent to the prescribing ~~p~~Provider, the dispensing ~~p~~Provider, or both. Other forms of education are carried out under this program with Division approval.¶
(4) The DUR/P&T Committee is designed to develop policy recommendations in the following areas in relation to Drug Use Review:¶
(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical appropriateness, and appropriateness of health care service may be compared.¶
(b) The use of different types of education and interventions to be carried out or delegated by the DUR/P&T Committee and the evaluation of the results of this portion of the program; and¶
(c) The preparation of an annual report on Oregon Medicaid DUR Program which describes:¶
(A) DUR/P&T Committee Activities;¶
(i) A description of how pharmacies comply with prospective DUR;¶
(ii) Detailed information on new criteria and standards in use; and¶
(iii) Changes in state policy in relation to DUR requirements for residents in nursing homes;¶
(B) A summary of the education/intervention strategies developed; and¶
(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of medical

visits and hospitalizations.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0135

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0135
Pharmacy Management Program ¶

(1) The Pharmacy Management Program promotes the appropriate use of quality ~~p~~Pharmaceutical ~~s~~Services by identifying and correcting overutilization of services.¶
(2) The Pharmacy Management Program limits some ~~fee-for-service client~~Open Card Members to receiving their prescription drugs through the following sources:¶
(a) A single retail pharmacy to pick up prescriptions;¶
(b) The Division~~of Medical Assistance Program (Division)~~ mail order pharmacy contractor; and¶
(c) A specialty pharmacy.¶
(3) The Division ~~will~~may not include the following ~~client~~Members in the Pharmacy Management Program:¶
(a) CCO Members~~enrolled in a Coordinated Care Organization;¶~~
~~(b) Client;¶~~
(b) Members with Medicare drug coverage in addition to OHP;¶
(c) Children in the care and custody of the Oregon Department of Human Services; or¶
(d) Inpatients or residents in a ~~h~~Hospital, ~~n~~Nursing ~~f~~Facility, other medical institution or ~~l~~Long~~t~~-Term ~~c~~Care facility.¶
(4) The Division ~~will~~may consider referrals of potential Pharmacy Management Program ~~client~~Members from the following sources:¶
(a) Providers;¶
(b) Division staff; and¶
(c) Division contractors.¶
(5) Reasons for referring a ~~client~~Member to the Division for potential enrollment in the Pharmacy Management Program shall be limited to factors that indicate possible overutilization or drug misuse, or that raise concern for patient safety. Those factors are:¶
(a) Use of three or more pharmacies during the prior six months;¶
(b) Fills prescriptions from more than one prescriber for the same or comparable medications; or¶
(c) Evidence that the ~~client~~Member altered a prescription; or¶
(d) Exhibits behaviors or patterns of behavior that the Pharmacy and Therapeutics Committee has identified as indicative of intentional overutilization or misuse.¶
(6) ~~C~~lient~~client~~Members referred to the Division for potential enrollment in the Pharmacy Management Program shall be enrolled in the program only when a licensed ~~p~~Pharmacist appointed by the Division conducts a review and concludes the individual utilized pharmaceutical items or services at a frequency or amount that is not ~~m~~Medically ~~n~~Necessary based on factors including, but not limited to, those described in ~~sub~~section (5) of this rule.¶
(7) When the Division concludes enrollment in the Pharmacy Management Program is appropriate as described in ~~sub~~section (6), the Division shall send the ~~client~~Member a notice that provides the following information:¶
(a) The Division plans to require that the ~~client~~Member use a designated pharmacy for a 12-month period;¶
(b) The specific date when the requirement will begin;¶
(c) An explanation of the reason for enrollment in the Pharmacy Management Program, and the benefits of enrollment in the Pharmacy Management Program; and¶
(d) The ~~client~~Member's right to request the following, within 45 days of the date of the notice:¶
(A) A different designated pharmacy; and¶
(B) An administrative hearing to ~~a~~Appeal the Division's decision to enroll the ~~client~~Member into the Pharmacy Management Program.¶
(8) Changing the Pharmacy Management Program ~~client~~Member's enrolled pharmacy:¶
(a) ~~C~~lient~~client~~Members may change their enrolled pharmacy if they:¶
(A) Move out of area;¶
(B) Are reapplying for OHP benefits; or¶
(C) Are denied access to pharmacy services by their selected pharmacy for reasons other than the Pharmacy Management Program factors identified by the Division;¶
(b) ~~C~~lient~~client~~Members cannot change their choice of pharmacy more than once every ~~3~~three months.¶
(9) Pharmacy Management Program ~~client~~Members may receive drugs from a different pharmacy if the

~~client~~Member urgently needs to fill a prescription and the enrolled pharmacy:¶
(a) Is not available;¶
(b) Does not have the prescribed drug in stock; or¶
(c) Is more than 50 miles away from the ~~client~~Member's location at the time the prescription needs to be filled. However, ~~DMAP~~the Division may deny coverage if the ~~client~~Member frequently fills prescriptions out of the area of the enrolled pharmacy.¶
(10) Call the Oregon Pharmacy Help Desk for authorization to fill a prescription in the situations described in subsections (9)(a)-(c) above.¶
(11) The ~~client~~Member's ~~a~~Appeal rights and the process for appealing a Division decision to enroll a ~~client~~Member in the Pharmacy Management Program are found in OAR 410-120-1860. If the ~~client~~Member requests an administrative hearing before the effective date of the ~~client~~Member notice and requests that the services be continued, the Authority shall continue the services pursuant to OAR 410-120-1865.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065, OL 2013 Ch. 467 Sec. 2

AMEND: 410-121-0143

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0143
~~Client~~Member Confidentiality ¶

Pharmacists are responsible for maintaining the confidentiality of ~~client~~Member information in compliance with HIPAA standards. Facilities shall provide adequate privacy for patient consultations.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0145

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0145
Prescription Requirements ¶

(1) ~~Division of Medical Assistance Programs (~~The Division~~) will~~ may make payment for covered drugs supplied on drug order or prescription of a licensed ~~p~~Practitioner and dispensed by a ~~p~~Pharmacist. Dispensings include new prescriptions, refills of existing prescriptions, and over-the-counter (OTC) medications.¶
(2) Each drug order or prescription filled for a Division ~~client~~Member must:¶
(a) Be retained in the pharmacy's file at the pharmacy's place of business; and~~,~~¶
(b) ~~All drug orders or prescriptions must c~~Comply with the Oregon State Board of Pharmacy rules and regulations as listed in OAR 855 Division 041.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0146

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0146
Dispensing Limitations ¶

(1) The ~~Authority~~Division shall reimburse the pharmacy for dispensed medication the lesser of:~~-~~¶
(a) The quantity indicated by the prescriber on the prescription;~~-~~¶
(b) The quantity indicated by the ~~Authority's~~Division dispensing limitations as outlined in this rule; or~~-~~¶
(c) The quantity needed for Prescription Synchronization.~~-~~¶
(2) The pharmacy may only dispense less than the prescribed quantity when the prescribed quantity exceeds the ~~Authority~~Division's dispensing limitations, or when a lesser quantity is needed for Prescription Synchronization.~~-~~¶
(3) The pharmacy may, at the ~~m~~Member's direction, dispense less than the prescribed quantity of a maintenance medication in order to align the refill dates if the ~~m~~Member has received the same dose for two months or more.~~-~~¶
(4) Unless otherwise specified in this rule, the ~~Authority shall~~Division may not reimburse claims for medications exceeding a 34-day supply.~~-~~¶
(5) A~~ll~~ny pharmacy ~~p~~Provider~~s~~ shall be reimbursed for up to a 100-day supply of preferred drugs in the following Standard Therapeutic Classes of medications:~~-~~¶
(a) Ataractics, Tranquilizers - 07;~~-~~¶
(b) Psychostimulants, Antidepressants - 11;~~-~~¶
(6) Exceptions to the 34-day supply do not apply to claims for the following Standard Therapeutic Classes of medications. Claims exceeding a 34-day supply for these medications shall not be reimbursed under any circumstances:~~-~~¶
(a) Muscle Relaxants - 08;~~-~~¶
(b) CNS Stimulants - 10;~~-~~¶
(c) Amphetamine Preps - 12;~~-~~¶
(d) Narcotic Analgesics - 40;~~-~~¶
(e) Sedative Barbiturate - 46;~~-~~¶
(f) Sedative Non-Barbiturate - 47.~~-~~¶
(7) The ~~Authority may~~Division shall allow reimburse~~ment~~ for more than a 34-day supply if the medication's original package size cannot be divided or when primary insurance (~~t~~Third ~~p~~-Party ~~l~~Liability) pays for a larger day supply.~~-~~¶
(8) Except for medications listed in ~~sub~~sections (5) and (6)~~ of this rule~~, claims for up to a 100-day supply of the following types of medications may be reimbursed to the ~~Authority~~Division's mail order pharmacy contractor, Indian Health Services mail order pharmacy ~~p~~Providers, and 340B ~~p~~Providers:~~-~~¶
(a) A PDL generic; and~~-~~¶
(b) A generic drug not on the PDL, costing $10 per month or less.~~-~~¶
(9) A~~ll~~ny pharmacy ~~p~~Provider~~s~~ shall be reimbursed for up to a 365-day supply of family planning drugs.~~-~~¶
(10) ~~Notwithstanding subsection (4) and subsection (11) of this rule, the Authority shall reimburse all pharmacy providers for up to a 365-day supply of preferred drugs within the following Standard Therapeutic Classes, provided that the specific drug dispensed can be stored at room temperature. This subsection is a standalone exception to the day supply limitations in subsections (5), (7), and (8). If the medication is a controlled substance, reimbursement is limited to the maximum day supply permitted under state and federal law. The applicable Standard Therapeutic Classes are: ¶~~
~~(a) Estrogen - Standard Therapeutic Class 61 ¶~~
~~(b) Progesterone - Standard Therapeutic Class 62 ¶~~
~~(c) Aldosterone antagonists - Standard Therapeutic Class 53 ¶~~
~~(d) Androgens - Standard Therapeutic Class 60 ¶~~
~~(e) Gonadotropin-releasing hormone (GNRH) agonists - Specific Therapeutic Classes P1M, P1P, V1O. ¶~~
~~(11) Selected medications identified by the Authority shall be limited to a 15-day supply for initial fills. The Authority has identified these medications~~Selected medications identified by the Division shall be limited to a 15-day supply for initial fills. These medications have been identified as having high side effect profiles, high discontinuation rates, or ~~requir~~needing frequent dose adjustments.~~-~~¶
(1~~2~~1) The pharmacy should provide a minimum of a one-month supply of insulin per dispensing once diabetes management has been stabilized.~~-~~¶
(1~~3~~2) For vaccines available in multiple dose packaging, the Division shall allow a dispensing fee for each multiple

dose. When vaccines are administered at the pharmacy, refer to Oregon Administrative Rule (OAR) 410-121-0185.~~-~~¶
(1~~4~~3) Splitting prescriptions:~~-~~¶
(a) For compounded prescriptions,~~ pharmacy providers must~~ bill components of the prescription separately. ¶
~~(b) When a pharmacy provider receives t~~Third ~~p~~-Party ~~p~~Payments for compounded prescriptions~~, the payments~~ must be split and applied equally to each component;~~-~~¶
(~~c~~b) The ~~Authority~~Division shall consider any other form of prescription splitting as a billing offense and take appropriate action as described in the General Rules (OAR 410 division 120).
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0148

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0148
Dispensing in a Nursing Facility or Community Based Care Living Facility ¶

A pharmacy serving Division ~~of Medical Assistance Program's (Division) client~~Members in a ~~n~~Nursing ~~f~~Facility or a Community Based Care Living Facility must dispense medication in a manner consistent with Board of Pharmacy rules as set out in OAR 855-041.¶
(1) For the purposes of this rule, "Long~~-~~-Term ~~c~~Care facility" includes skilled nursing facilities and intermediate care facilities consistent with the definitions in ORS 443.400 to 443.455.¶
(2) An intermediate care facility is a facility providing regular health related care and services to individuals at a level above room and board, but less than ~~h~~Hospital or skilled nursing levels ORS 442.015.
Statutory/Other Authority: 404.110, 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0155

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0155
Reimbursement ¶

(1) The Division shall pay the lesser of the ~~p~~Provider's billed amount or the ingredient cost plus a professional dispensing fee.¶
(2) The ingredient cost is established by the Division as follows:¶
(a) The Oregon Average Actual Acquisition Cost (OR-AAAC) of the drug;¶
(b) In cases where no OR-AAAC is available, the National Average Drug Acquisition Cost (NADAC);¶
(c) In cases where no OR-AAAC and no NADAC is available, the Wholesale Acquisition Cost (WAC).¶
(3) For ingredient cost for trade name forms of multiple source products:¶
(a) Except as provided in (3)(b) of this rule, the Division shall apply the OR-AAAC or NADAC of the generic form when a trade name form of a multiple source product is dispensed;¶
(b) The Division shall pay the OR-AAAC or NADAC of the trade name form only when the prescribing ~~p~~Practitioner certifies the trade version is required or when the brand drug is listed on the Division's Preferred Drug List.¶
(4) The Division shall revise its OR-AAAC weekly. Pharmacies must make available to the Division or its contractor any information necessary to determine the pharmacy's actual ~~a~~Acquisition ~~c~~Cost of drug products dispensed to the Division's ~~client~~Members.¶
(5) The OR-AAAC shall serve as the basis for reimbursement. Individual pharmacies, other than Indian Health Service, Tribal 638 or Urban Indian Health Program pharmacies, are required to participate in an OR-AAAC survey conducted by the Division or its contractor not more than one time per every 18 to 24-month period. Pharmacies that do not respond to OR-AAAC survey requests may be subject to disenrollment as ~~p~~Providers for the Oregon Health Plan.¶
(6) If a ~~p~~Provider is unable to purchase a particular drug product at the OR-AAAC, the ~~p~~Provider shall report this to the Division or its contractor for further review through a dispute resolution process. Providers may submit inquiries via telephone, facsimile, via electronic mail, or the contractor's secure web site: https://myersandstauffer.com/client-portal/oregon/:¶
(a) The Division or its contractor shall respond to all inquiries or complaints within 24 hours and resolve the issue within five business days;¶
(b) The pricing dispute resolution process shall include the Division or its contractor verifying the accuracy of pricing to ensure consistency with marketplace pricing and drug availability;¶
(c) Price adjustments shall be made during the next weekly pricing update.¶
(7) The Division restricts claims for hemophilia blood factors to Federally Supported Hemophilia Treatment Centers that are a Center of Excellence, as provided in OAR 410-120-0000. This restriction does not apply to ~~client~~Members with other insurances or Medicare in addition to OHP. The Federally Approved provider of factors, non-factor or gene therapy for people with bleed disorders is the Hemophilia Center at OHSU. Questions concerning bleeding disorder case management shall be directed to this provider by calling: 877-346-0640.¶
(8) No professional dispensing fee is allowed for dispensing pill splitters/cutters or diabetic supplies and glucose monitors.¶
(9) Payment for pill splitters/cutters with a National Drug Code (NDC) number shall be reimbursed at the lesser of the billed amount or the ingredient cost and:¶
(a) A ~~p~~Practitioner prescription is required; and¶
(b) The Division shall pay only for one pill splitter/cutter per ~~client in a twelve~~Member in a 12-month period.¶
(10) A prescription is required for glucose monitors and related diabetic supplies.¶
(11) Payment for glucose monitors and related diabetic supplies billed with an NDC shall be reimbursed at a percentage of Medicare's rate for the HCPCS procedure code. The Division's reimbursement rates are listed in the Division's fee schedule located at: http://www.oregon.gov/OHA/healthplan/pages/feeschedule.aspx.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0190

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0190
Medication Therapy Management Services and Clozapine Therapy Monitoring ¶

(1) Clozapine monitoring protocol requires enhanced record keeping and reporting to the drug manufacturer's registry in order to dispense the medication. Dispensing pharmacy must meet all drug manufacturers requirements including data reporting.¶
(2) Clozapine monitoring includes documentation of ~~client~~Member's diagnosis, dosage, dosage changes, appropriate laboratory reports (e.g. white blood cell counts), evaluation intervals, and submission of appropriate information to drug manufacturer to allow dispensing of medication;¶
(3) Clozapine monitoring is to be billed using appropriate Medication Therapy Management Services (MTMS) Current Procedural Terminology (CPT) code with the modifier TC appended. This is limited to no more than ~~5~~five units in 30-day time period per ~~client~~Member, including the 30-day period from the date of discontinuation of clozapine therapy;¶
(4) Clozapine monitoring must be billed by a pharmacy;¶
(5) MTMS rendered outside of clozapine management must be performed by a licensed ~~p~~Pharmacist and must be billed to appropriately reflect the performing ~~p~~Provider. These encounters must be billed using the appropriate MTMS CPT code without the TC modifier.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-121-0220

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-121-0220
Instructions for Completion of the Prescription Drug Invoice ¶

(1) The 1.2 Universal Claim Form is the required billing form for pharmacies billing on a paper claim. Use the standard instructions for completion of the 1.2 Universal Claim Form.¶
(2) Enter all applicable information for billing of prescription drug claims for ~~client~~Members on the Oregon Health Plan.
Statutory/Other Authority: ORS 413.042, 414.034, 414.065
Statutes/Other Implemented: ORS 414.065