STATE OF OKLAHOMA

2nd Session of the 53rd Legislature (2012)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2273 By: Cox

COMMITTEE SUBSTITUTE

An Act relating to public health and safety; amending 63 O.S. 2011, Section 5006, which relates to the Oklahoma Health Care Authority; authorizing Authority to pay professional expenses of administrator and full-time physicians employed by the Authority; amending 63 O.S. 2011, Section 5030.5, which relates to a drug prior authorization program; permitting prior authorization of certain drugs; permitting prior authorization of certain new medications pending Board review; providing for inapplicability; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2011, Section 5006, is amended to read as follows:

Section 5006. A. There is hereby created the Oklahoma Health Care Authority. The Authority shall have the power and duty to:

1. Purchase health care benefits for Medicaid recipients, and others who are dependent on the state for necessary medical care, as specifically authorized by law;

2. Enter into contracts for the delivery of state-purchased health care and establish standards and criteria which must be met by entities to be eligible to contract with the Authority for the delivery of state-purchased health care;

3. Develop a proposed standard basic health care benefits package or packages to be offered by health services providers, for Medicaid recipients;

4. Study all matters connected with the provision of state-purchased and state-subsidized health care coverage;

5. Develop and submit plans, reports and proposals, provide information and analyze areas of public and private health care interaction pursuant to the provisions of the Oklahoma Health Care Authority Act;

6. Serve as a resource for information on state-purchased and state-subsidized health care access, cost containment and related health issues;

7. Administer programs and enforce laws placed under the jurisdiction of the Authority pursuant to the Oklahoma Health Care Authority Act, and such other duties prescribed by law;

8. Collaborate with and assist the Insurance Commissioner in the development of a Uniform Claim Processing System for use by third-party payors and health care providers;

9. Collaborate with and assist the State Department of Health with the development of licensure standards and criteria for pre-paid health plans; and

10. Exercise all incidental powers which are necessary and proper to carry out the purposes of the Oklahoma Health Care Authority Act.

B. All positions within the Authority shall be unclassified until approval of the annual business and personnel plan submitted by January 1, 1995, by the Governor and the Legislature. In the annual business plan submitted January 1, 1995, the Board shall include a personnel plan which shall list, describe and justify all unclassified positions within the Authority and their compensation. All other employees and positions shall be classified and subject to the provisions of the Merit System of Personnel Administration as provided in the Oklahoma Personnel Act.

C. 1. The Authority is authorized to:

a. pay professional expenses of the administrator of the Authority, including dues, licenses, professional memberships and continuing education classes conducted in the State of Oklahoma, and

b. pay professional expenses of any Oklahoma-licensed physician, including dues, licenses, professional memberships and continuing medical education classes conducted in the State of Oklahoma, provided the

physician is a full-time employee of the Authority in accordance with subsection B of this section or paragraph 1 of subsection B of Section 840-5.5 of Title 74 of the Oklahoma Statutes and is utilizing those professional skills in the performance of his or her job duties.

SECTION 2. AMENDATORY 63 O.S. 2011, Section 5030.5, is amended to read as follows:

Section 5030.5 A. Except as provided in subsection F of this section, any drug prior authorization program approved or implemented by the Medicaid Drug Utilization Review Board shall meet the following conditions:

1. The Medicaid Drug Utilization Review Board shall make note of and consider information provided by interested parties, including, but not limited to, physicians, pharmacists, patients, and pharmaceutical manufacturers, related to the placement of a drug or drugs on prior authorization;

2. Any drug or drug class placed on prior authorization shall be reconsidered no later than twelve (12) months after such placement;

3. The program shall provide either telephone or fax approval or denial within twenty-four (24) hours after receipt of the prior authorization request; and

4. In an emergency situation, including a situation in which an answer to a prior authorization request is unavailable, a seventy-two-hour supply shall be dispensed, or, at the discretion of the Medicaid Drug Utilization Review Board, a greater amount that will assure a minimum effective duration of therapy for an acute intervention.

B. In formulating its recommendations for placement of a drug or drug class on prior authorization to the Oklahoma Health Care Authority Board, the Medicaid Drug Utilization Review Board shall:

1. Consider the potential impact of any administrative delay on patient care and the potential fiscal impact of such prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any recommendation making a drug subject to placement on prior authorization shall be accompanied by a statement of the cost and clinical efficacy of such placement;

2. Provide a period for public comment on each meeting agenda. Prior to making any recommendations, the Medicaid Drug Utilization Review Board shall solicit public comment regarding proposed changes in the prior authorization program in accordance with the provisions of the Oklahoma Open Meeting Act and the Administrative Procedures Act; and

3. Review Oklahoma Medicaid specific data related to utilization criterion standards as provided in division (1) of subparagraph b of paragraph 2 of Section 5030.4 of this title.

C. The Oklahoma Health Care Authority Board may accept or reject the recommendations of the Medicaid Drug Utilization Review Board in whole or in part, and may amend or add to such recommendations.

D. The Oklahoma Health Care Authority shall immediately provide coverage under prior authorization for any new drug approved by the United States Food and Drug Administration if the drug falls within a drug class that the Authority has already placed under prior authorization.

E. 1. Prior to a vote by the Medicaid Drug Utilization Review Board to consider expansion of product-based prior authorization, the Authority shall:

a. develop a written estimate of savings expected to accrue from the proposed expansion, and

b. make the estimate of savings available, on request of interested persons, no later than the day following the first scheduled discussion of the estimate by the Medicaid Drug Utilization Review Board at a regularly scheduled meeting.

2. The written savings estimate based upon savings estimate assumptions specified by paragraph 3 of this subsection prepared by the Authority shall include as a minimum:

a. a summary of all paid prescription claims for patients with a product in the therapeutic category under

consideration during the most recent month with complete data, plus a breakdown, as available, of these patients according to whether the patients are residents of a long-term care facility or are receiving Advantage Waiver program services,

b. current number of prescriptions, amount reimbursed and trend for each product within the category under consideration,

c. average active ingredient cost reimbursed per day of therapy for each product and strength within the category under consideration,

d. for each product and strength within the category under consideration, where applicable, the prevailing State Maximum Allowable Cost reimbursed per dosage unit,

e. the anticipated impact of any patent expiration of any product within the category under consideration scheduled to occur within two (2) years from the anticipated implementation date of the proposed prior authorization expansion, and

f. a detailed estimate of administrative costs involved in the prior authorization expansion including, but not limited to, the anticipated increase in petition volume.

3. Savings estimate assumptions shall include, at a minimum:

a. the prescription conversion rate of products requiring prior authorization (Tier II) to products not requiring prior authorization (Tier I) and to other alternative products,

b. aggregated rebate amount for the proposed Tier I and Tier II products within the category under consideration,

c. market shift of Tier II products due to other causes including, but not limited to, patent expiration,

d. Tier I to Tier II prescription conversion rate, and

e. nature of medical benefits and complications typically seen with products in this class when therapy is switched from one product to another.

4. The Medicaid Drug Utilization Review Board shall consider prior authorization expansion in accordance with the following Medicaid Drug Utilization Review Board meeting sequence:

a. first meeting: publish the category or categories to be considered for prior authorization expansion in the future business section of the Medicaid Drug Utilization Review Board agenda,

b. second meeting: presentation and discussion of the written estimate of savings,

c. third meeting: make formal notice in the agenda of intent to vote on the proposed prior authorization expansion, and

d. fourth meeting: vote on prior authorization expansion.

F. The Medicaid Drug Utilization Review Board may establish protocols and standards, including prior authorization, for the use of any prescription drug determined to be medically necessary, proven to be effective and approved by the United States Food and Drug Administration (FDA) ~~for the treatment and prevention of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and Hepatitis C without prior authorization, except when there is a generic equivalent drug available~~. Newly approved medications may be prior authorized upon market entry, utilizing the FDA-approved labeling as the authorization criteria pending review by the Medicaid Drug Utilization Review Board. Provided, however, that nothing in this subsection shall apply to prescription drugs used for the treatment and prevention of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).

SECTION 3. This act shall become effective November 1, 2012.

53-2-9838 CJB 02/28/12