

1 ENGROSSED SENATE AMENDMENT
TO

2 ENGROSSED HOUSE
BILL NO. 1628

By: Derby of the House

and

Griffin of the Senate

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7 An Act relating to the Oklahoma Health Care
8 Authority; prohibiting SoonerCare program from
9 routinely paying for quantitative drug screening;
10 requiring SoonerCare program to pay for confirmatory
11 quantitative drug testing if initial screen is
12 positive under certain circumstances; permitting
13 SoonerCare to pay for quantitative drug screening if
14 certain knowledge will have impact on clinical
15 decision-making; providing requirements for
16 reimbursement; authorizing SoonerCare to implement
17 certain agreements; providing monetary limitation on
18 agreements; providing for noncodification; and
19 providing an effective date.

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24 AMENDMENT NO. 1. Page 1, strike the title, enacting clause and
entire bill and insert

"An Act relating to the Oklahoma Health Care
Authority; amending 63 O.S. 2011, Section 5030.5, as
amended by Section 1, Chapter 341, O.S.L. 2014 (63
O.S. Supp. 2014, Section 5030.5), which relates to
prior authorization; requiring certain review under
certain circumstances; providing an effective date;
and declaring an emergency.

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

1 SECTION 1. AMENDATORY 63 O.S. 2011, Section 5030.5, as
2 amended by Section 1, Chapter 341, O.S.L. 2014 (63 O.S. Supp. 2014,
3 Section 5030.5), is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

23 D. The Oklahoma Health Care Authority shall immediately provide
24 coverage under prior authorization for any new drug approved by the

1 United States Food and Drug Administration ~~if the drug falls within~~
2 ~~a drug class that the Authority has already placed under prior~~
3 ~~authorization.~~ If a new drug does not fall in a class that is
4 already placed under prior authorization, that drug must be reviewed
5 by the Drug Utilization Review Board within one hundred (100) days
6 of approval by the United States Food and Drug Administration to
7 determine whether to continue the prior authorization criteria.

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

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

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

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

21 a. a summary of all paid prescription claims for patients
22 with a product in the therapeutic category under
23 consideration during the most recent month with
24 complete data, plus a breakdown, as available, of

1 these patients according to whether the patients are
2 residents of a long-term care facility or are
3 receiving Advantage Waiver program services,

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

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

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

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

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

23 3. Savings estimate assumptions shall include, at a minimum:
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- 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 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) without prior authorization, except when there is a generic equivalent drug available.

SECTION 2. This act shall become effective July 1, 2015.

SECTION 3. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval."

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

SECTION 1. NEW LAW A new section of law not to be
codified in the Oklahoma Statutes reads as follows:

A. The SoonerCare program shall not routinely pay for
quantitative drug screening but shall pay for confirmatory
quantitative drug testing if there is an initial qualitative urine
drug test screen which is positive. Confirmatory quantitative urine
drug testing is considered reasonable and necessary, following a
qualitative screen, under the following circumstances:

- 1 1. Cocaine confirmation to identify a chronic cocaine user;
 - 2 2. THC (tetrahydrocannabinoids) confirmation to document the
3 patient's discontinuation of THC use according to the treatment
4 plan;
 - 5 3. Negative screen inconsistent with the patient's medical
6 history or currently prescribed pain medications;
 - 7 4. Suspicion of a specific drug use, such as but not limited to
8 Fentanyl and Meperidine, or "designer drugs"; or
 - 9 5. A confirmation drug screen is indicated when the result of
10 the drug screen is different from that suggested by the patient's
11 medical history, clinical presentation or a patient's own statement.
- 12 B. The SoonerCare program may also pay for quantitative drug
13 screening if the knowledge of the absolute level of a drug will have
14 an impact on clinical decision-making.
- 15 C. To be eligible for reimbursement from SoonerCare,
16 participating clinical laboratories performing definitive
17 quantitative testing shall be licensed as a high-complexity
18 laboratory as defined under the Clinical Laboratory Improvement
19 Amendments of 1988 (CLIA) and shall be accredited by the College of
20 American Pathologists (CAP).
- 21 D. To ensure responsible testing and fiscal efficiency,
22 SoonerCare is authorized to implement agreements with laboratory
23 providers that include, but are not limited to, comprehensive
24 testing. Comprehensive testing is defined as unlimited testing

