

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING\***  
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number
Cheryl Peters	500 Summer St NE, Salem, OR 97301
Rules Coordinator	Address
	503-945-6527
	Telephone

**RULE CAPTION**

Add definitions, Change in coverage to Part D Medicare for certain drugs

**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

6/17/2013	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
Hearing Date	Time	Location	Hearings Officer

*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.  
**ADOPT:**

**AMEND:** OAR 410-120-1210

**REPEAL:**

Stat. Auth. : ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065, 414.329, <sup>414,705 05/13</sup> 414.706, 414.707, 414.708, 414.710

**RULE SUMMARY**

The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-1210 to implement changes made by the Centers for Medicare and Medicaid Services (CMS). January 1, 2013 Medicare Part D will start covering barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines. Currently, barbiturates and benzodiazepines are among the excluded drugs that the Division covers for its Medicaid beneficiaries. Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, Division will continue to cover barbiturates to the extent it covers that drug for a condition other than the three covered by Part D.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

6/19/2013 by 5:00 p.m.

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)

*Rhonda Bussek*

Signature

*Rhonda Bussek*

Printed name

*5-3-13*

Date

\*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State  
**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410  
Agency and Division Administrative Rules Chapter Number

Add definitions, Change in coverage to Part D Medicare for certain drugs  
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of rule 410-120-1210

Statutory Authority: ORS 413.042

Other Authority:

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.705, 414.706, 414.707, 414.708, 414.710

Need for the Rule(s): The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-1210 to implement changes made by Centers for Medicare and Medicaid Services (CMS). January 1, 2013 Medicare Part D will start covering barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines. Currently, barbiturates and benzodiazepines are among the excluded drugs that the Division covers for its Medicaid beneficiaries. Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, Division will continue to cover barbiturates to the extent it covers that drug for a condition other than the three covered by Part D. The Division will permanently amend the temporary rule 410-120-1210 (T).

Documents Relied Upon, and where they are available: Medicare Improvement for Patients and Providers Act of 2008(MIPPA) section 175  
<http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>

Fiscal and Economic Impact: None

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):  
Amending this rule will have no fiscal impact on other state agencies, local government, clients, the public, or businesses, including small businesses. It will be a savings to the Authority as Medicare Part d will become the primary payer for these drugs.

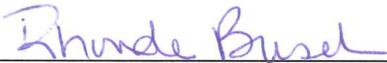
2. Cost of compliance effect on small business (ORS 183.336):  
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:  
The Division has approximately 700 enrolled pharmacy providers. These enrolled providers range from large chains to individually owned pharmacy's. The Division's fee-for-services providers serve approximately 10% of the total OHP population. The Division does not have available information to estimate the percentage of these pharmacy's that are small businesses, but it is likely that there is a several of them.

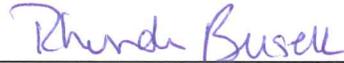
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:  
Amending this rule will not add additional reporting, record keeping or other administrative activities.

c. Equipment, supplies, labor and increased administration required for compliance:  
Amending this rule will not impose any new equipment, supplies, labor and increased administration requirements on small or large businesses.

How were small businesses involved in the development of this rule?  
Approximately two weeks prior to the rules advisory committee meeting a public notice was posted on the agency website, an invitation was emailed to more than 250 people that had expressed interest in the rule making process n meetings referenced above. Those invited are made up of large and small providers groups and associations.

Administrative Rule Advisory Committee consulted?: Yes, a RAC was held on April 4, 2013, details are as outlined in the question above. If not, why?:

  
Signature

  
Printed name

5-3-13  
Date

## **410-120-1210**

### **Medical Assistance Benefit Packages and Delivery System**

(1) The services clients are eligible to receive are based upon the benefit package for which they are eligible. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in each of the Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Chemical dependency services provided through local alcohol and drug treatment providers;

(iv) Mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services;

(B) Limitations: The following services have limited coverage for non pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(b) OHP Standard:

(A) Benefit Package identifier code: KIT;

(B) Eligibility criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;

(C) Coverage includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Outpatient chemical dependency services provided through local alcohol and drug treatment providers;

(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP.

(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Other limitations as identified in individual Division program administrative rules.

(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for chemical dependency treatment (OAR chapter 410, division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency medical transportation (OAR chapter 410, division 136);

(vi) Occupational therapy services (OAR chapter 410, division 131);

(vii) Physical therapy services (OAR chapter 410, division 131);

(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and language therapy services (OAR chapter 410, division 129);

(x) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.

(c) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes:

(i) Services covered by Medicare and OHP Plus as described in section (4) of these rules;

(D) Limitations:

(i) The same as OHP Plus, as described in section (4) of these rules;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

~~(I) Benzodiazepines;~~

~~(II) Over-the-counter (OTC) drugs;~~

~~(III) Barbiturates (Except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).~~

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(d) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED:

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage.

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(e) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clients are non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered, even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(f) CAWEM Plus-CHIP Prenatal coverage for CAWEM (benefit code CWX) - refer to OAR 410-120-0030 for coverage.

(4) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, chemical dependency, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Fee-for-Service Hospital Services Program rule (OAR 410 Division 125).

(d) Primary Care Managers (PCM):

(A) These clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.

(c) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP, PCO or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider will bill the Division directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.[329705](#), 414.706, 414.707, 414.708, 414.710