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State/Territory Name:Oklahoma

State Plan Amendment (SPA) OK: 23-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

October 11, 2023

Traylor Rains
State Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

RE: TN OK-23-0011

Dear Director Rains:

We have reviewed the proposed Missouri State Plan Amendment (SPA) to Attachment 4.19-B OK-23-0011, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 31st, 2023. This state plan amendment aligns payment for certain prescription drugs with Medicare Part B.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410)-786-5914 or Robert.Bromwell@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0011

2. STATE: OK

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2023

5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 440.120
Inflation Reduction Act section 11403 (42 USC 1395w)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 258,048.00
b. FFY 2024 $ 408,082.00

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Page 3
Attachment 4.19-B, Page 4a
Attachment 4.19-B, Page 7a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Page 3 ; TN # 18-26
Attachment 4.19-B, Page 4a ; TN # 20-0017
Attachment 4.19-B, Page 7a ; TN # 20-0014

9. SUBJECT OF AMENDMENT
State Plan Amendment to align payment for certain prescription drugs with the rate paid by Medicare Part B.

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED: The governor's office does not review state plan material.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Traylor Rains

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
7/31/23

15. RETURN TO
Oklahoma Health Care Authority
Attn: Traylor Rains
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

cc: Kasie McCarty; Heather Cox

FOR CMS USE ONLY

16. DATE RECEIVED
7/31/2023

17. DATE APPROVED
October 11, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS
Pen and ink changed authorized via email on 9/5/2023 to box 5 from Inflation Reduction Act section 11403 (42 USC 1395w to 42 CFR 440.120.

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services)

Payment for physician's services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

Effective February 1, 2010, payment will not be made to physicians or other practitioners for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

Vaccines are paid the equivalent to the Medicare Part B allowed charge. When the Medicare Part B allowed charge is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children's program.

METHODS AND STANDARDS OF REIMBURSEMENTFOR INPATIENT HOSPITAL SERVICES

Payment for Durable Medical Equipment, Supplies, and Appliances (continued):

For durable medical equipment, supplies, and appliances purchased at the pharmacy point of sale, providers will be reimbursed the equivalent of the Medicare Part B allowed charge. When the Medicare Part B allowed charge is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare or WAC pricing is available, then the price will be calculated based on invoice cost.

Payment is not made for durable medical equipment, supplies, and appliances that are not deemed as medically necessary or considered over-the-counter.

The Agency does not pay durable medical equipment providers separately for services that are included as part of the payment for another treatment program. For example, all items required at a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities are paid through those corresponding institutional rate methodologies.

For any item subject to the DME FFP demonstration, these items will be priced at or under 100% of Medicare rural/non-rural pricing.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Prescribed Drugs *(continued)*

(b) Ingredient Cost Methodology *(continued)*:

(7) Indian Health Service/Tribal/Urban Indian Clinic Facilities are reimbursed at the OMB encounter rate. This is limited to one pharmacy encounter fee per member per facility per day.

(8) Specialty drugs are reimbursed at the lower of NADAC, WAC, or Specialty Pharmaceutical Allowable Cost (SPAC). The factors included in the SPAC calculation are Medicare Part B pricing, WAC, and NADAC plus professional dispensing fee of $11.41.

(9) Prescriptions for members residing in long-term care facilities are reimbursed as the lower of NADAC, WAC, SPAC, or SMAC plus the Professional Dispensing Fee of $11.41.

(10) Clotting factor from specialty pharmacies, Hemophilia Treatment Centers (HTCs), and Centers of Excellence – Is reimbursed at the SPAC rate plus the professional dispensing fee of $11.41 for hemophilia clotting factors.

When a Hemophilia Treatment Center which is a 340B covered entity provides clotting factor to Medicaid members whether the pharmacy is owned by the covered entity or has a contract pharmacy arrangement, the procedure for 340B pharmacies listed on Attachment 4.19-B, page 7, section (b)(4) will apply.

(11) Investigational drugs are not covered; including FDA approved drugs being used in post-marketing studies.

(12) The Professional Dispensing Fee is $11.41 per prescription.

(c) Physician Administered Drugs – are reimbursed at a price equivalent to the Medicare Part B allowed charge. When the Medicare Part B allowed charge is not available, an equivalent price is calculated using WAC.

340B covered entities are allowed to submit their usual and customary cost and are paid at the regular Medicaid allowable rate. At the end of the quarter, the URA is recouped from the covered entity to keep the state whole based on net cost after rebate.

(d) Meeting the Federal Upper Limits (FUL) in the aggregate – By using the lower of NADAC, WAC or SMAC, the FUL will always be met since NADAC is the floor for the FUL.

(e) High-investment drugs – Payment to hospitals for high-investment drugs used to treat members during an inpatient admission or outpatient hospital visit will be the lower of: (1) the Hospital's Actual Acquisition Cost; (2) the WAC; (3) if available, the Medicare Part B allowed charge; or, (4) billed charges. A list of high-investment drugs is found on www.okhca.org.