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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 16-0030 PHARM

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

Mrs. Rebecca Pasternik-Ikard
Chief Executive Officer
Oklahoma Health Care Authority
2401 N.W. 23rd Suite 1A
Oklahoma City, OK 73107

JUN 23 2017

Dear Mrs. Pasternik-Ikard:

We have reviewed Oklahoma's State Plan Amendment (SPA) 16-0030, Prescribed Drugs, received in the Dallas Regional Office on December 30, 2016. This SPA proposes to bring Oklahoma into compliance with the reimbursement requirements in the Covered Outpatient Drug final rule with comment.

Based on the information provided, we are pleased to inform you that, consistent with the regulations at 42 CFR 430.20, SPA 16-0030 is approved with an effective date of January 1, 2017. A copy of the signed CMS-179 form, as revised, as well as the pages approved for incorporation into the Oklahoma state plan will be forwarded by the Dallas Regional Office.

If you have any questions regarding this amendment, please contact Mickey Morgan at (410) 786-4048 or Mickey.Morgan@cms.hhs.gov .

Sincerely,

[redacted]

Meagan T. Khau
Deputy Director
Division of Pharmacy

CC: Nancy Nesser, Pharmacy Director, Oklahoma Health Care Authority
Keri Wade, Oklahoma Health Care Authority
Bill Brooks, ARA, CMS, Dallas Regional Office
Stacey Shuman, CMS, Dallas Regional Office

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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16-30
2. STATE: Oklahoma
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.120 42 CFR 447 Subpart I

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $0
b. FFY 2018 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Page 5a-1	Same Page, Revised 01-01-12, TN # 11-07
Attachment 3.1-A Page 5a-1a	No superseded TN; new page
Attachment 4.19-B Page 7	Same Page, Revised 03-01-12, TN # 12-01
Attachment 4.19-B Page 7a	Same Page, Revised 04-01-10, TN # 10-07

10. SUBJECT OF AMENDMENT

Covered Outpatient Drug Reimbursement

11. 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 does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Rebecca Pasternik-Ikard

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
December 30, 2016

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
2401 N.W. 23rd. Suite 1A
Oklahoma City, OK 73107

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
30 December, 2016

18. DATE APPROVED
23 June, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
1 January, 2017

20. SIGN
[redacted]

21. TYPED NAME
Bill Brooks

22. TITLE
Associate Regional Administrator, Division of Medicaid and Children's Health

23. REMARKS
c: Becky Pasternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

12a. **Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

Prescription Drugs

Payment:
Payment is made from Title XIX funds to pharmacies with whom the Agency has a contract on behalf of categorically needy recipients up to a maximum of six (6) prescriptions (new or refill) with a limit of two (2) brand name per month per eligible recipient. A brand limit override is available for one additional brand prescription based on medical necessity and established criteria. The policy regarding the monthly two (2) brand name limitation and the one (1) brand limit override is effective January 1, 2012.

Exceptions:
(1) For persons served by a 1915(c) home and community based services waiver, payment is made from Title XIX funds for up to a maximum of six (6) prescriptions (new or refill) with a limit of three (3) brand name per month per eligible recipient.

(2) Prescription drugs under EPSDT, birth control drugs, antineoplastics, antiretroviral agents for persons diagnosed with acquired immune deficiency syndrome (AIDS), certain prescriptions which require frequent laboratory monitoring, and hemophilia drugs are not limited to either the six (6) prescriptions per month or the two (2) brand name drugs per month limit.

Limitations:
(1) Prescription quantities are limited to a 34 day supply unless (1) the medication is included in the Maintenance Drug List, in which case, 100 dosage units may be dispensed or (2) the drug has a recommended dispensing quantity less than either of those limits. Drug classes listed on the Maintenance Drug List include anticoagulation, asthma, diabetic, hormone, cardiovascular, thyroid, and seizure. A complete list of the selected drugs included on the Maintenance Drug List can be viewed on the agency's website at www.okhca.org.

(2) Some prescription drugs may require prior authorization as determined by the Drug Utilization Review Board (DUR).

(3) Only prescription drugs whose manufacturers have a rebate agreement with CMS are covered.

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

Prior Authorization

The prior authorization process provides for a response by telephone or other telecommunications device within 24 hours of receipt of a completed prior authorization request. In emergency situations, providers may be reimbursed for a 72 hour supply of medication.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

12a. **Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (continued).**

Tiered Drug List

The DUR Board will determine medical necessity for drugs covered under the Oklahoma tiered drug list and establish criteria for any prior authorization process. A preferred product, tiered drug list is utilized for certain categories of drugs. Drugs included in Tier One are generally available without additional documentation. A prior authorization process is available for drugs not included in Tier One.

Supplemental Drug Rebate

Pursuant to Section 1927 of the Act, the State has the following policies for Medicaid supplemental rebates:

A model agreement between the State and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on January 2, 2004, and entitled "State of Oklahoma, Oklahoma Health Care Authority Supplemental Rebate Agreement" and subsequent revisions have been authorized by CMS.

Supplemental rebates received by the State in excess of those required under the national rebate agreement are shared with CMS on the same percentage basis as applied under the national rebate agreement.

Beginning January 1, 2017, Oklahoma is part of the Sovereign States Drug Consortium (SSDC). SSCC will negotiate supplemental rebates for Oklahoma. The state retains all options to accept or reject offers. Drugs of manufacturers who do not participate in the supplemental rebate program will still be available to Medicaid recipients.

Products for which a signed Medicaid State Supplemental Rebate Agreement is on file will have preferred status. This status may be reflected in the product's placement in lower tiers of the Tiered Drug List, inclusion on a Preferred Drug List, or by removing a prior authorization requirement from the product.

State: Oklahoma
Date Received: 30 December, 2016
Date Approved: 23 June, 2017
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Transmittal Number: 16-30

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for Prescribed Drugs

(a) Reimbursement – Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a $10.55 professional dispensing fee. If the provider's usual and customary charge to the general public is lower than the calculated allowable ingredient cost, the reimbursement will be equal to the provider's usual and customary charge to the general public.

(b) Ingredient Cost Methodology and Professional Dispensing fee of $10.55 – The ingredient cost is set by one of the following methods:

(1) **Brand Name Drugs** – Ingredient cost based on Actual Acquisition Cost shall be set as the lower of National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC), plus professional dispensing fee of $10.55.

(2) **Generic Drugs** – Ingredient cost based on Actual Acquisition Cost shall be set as the lower of the State Maximum Allowable Cost (SMAC), NADAC, or WAC plus professional dispensing fee of $10.55.

(3) **State Maximum Allowable Cost** (SMAC) – is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC is calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing a current invoice that reflects a net cost higher than the calculated SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(4) **340B-Purchased Drugs** – For both, covered entity pharmacies and contract pharmacies, the reimbursement to the pharmacy will be the 340B ceiling price plus professional dispensing fee of $10.55.

(5) **Federal Supply Schedule Drugs** – For drugs purchased under the Federal Supply Schedule, other than by Indian Health Service/Tribal/Urban Indian Clinic pharmacies, the provider will submit and be reimbursed their actual acquisition cost plus professional dispensing fee of $10.55.

(6) **Drugs Acquired at Nominal Price (Outside of 340B or Federal Supply Schedule)** – For drugs acquired at nominal price outside of the 340B program or the Federal Supply Schedule, the provider will submit and be reimbursed their actual acquisition cost plus professional dispensing fee of $10.55.

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Revised 01-01-17

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, (Average Sales Price plus 6%), WAC, and NADAC plus professional dispensing fee of $10.55.

(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 $10.55.

(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 $10.55 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 $10.55 per prescription.

(c) Physician Administered Drugs – are reimbursed at a price equivalent to Medicare Part B, ASP + 6%. When ASP 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.

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