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State/Territory Name: OK

State Plan Amendment (SPA) #: 20-0014

This file contains the following documents in the order listed:

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

June 5, 2020

Ms. Melody Anthony
State Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Ms. Anthony:

The CMS Division of Pharmacy team has reviewed Oklahoma State Plan Amendment (SPA) 20-0014 received in the CMS Division of Program Operations on March 20, 2020. This SPA proposes to establish the reimbursement methodology for high-investment drugs.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 20-0014 is approved with an effective date of April 1, 2020. A copy of the signed CMS-179 form, as well as the pages approved for incorporation into Oklahoma's state plan, will be forwarded by the CMS Division of Program Operations.

If you have any questions regarding this request, please contact Whitney Swears at (410) 786-6543 or Whitney.Swears@cms.hhs.gov.

Sincerely,

Cynthia R. Denemark, R.Ph.
Deputy Director
Division of Pharmacy
DEHPG/CMCS/CMS

cc: Sandra Puebla Oklahoma Health Care Authority
Bert Bailey, Oklahoma Health Care Authority
James G. Scott, Division Director, CMS Division of Program Operations
Deborah Read, CMS Division of Program Operations

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: 20 — 0014

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
April 1, 2020

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS 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 §447.520

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 0
b. FFY 2021 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Page 10
Attachment 4.19-B, Page 1b
Attachment 4.19-B, Page 7a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Page 10; TN # 14-10
Attachment 4.19-B, Page 1b; TN # 19-0013
Attachment 4.19-B, Page 7a; TN # 19-0037

10. SUBJECT OF AMENDMENT
Clarify methodology for reimbursement of high investment drugs and allow hospitals to bill for high-investment drugs on a separate outpatient hospital claim

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Melody Anthony

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
March 20, 2020

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 20, 2020

18. DATE APPROVED
June 5, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS
(continued)

A. Services Included in or Excluded from the Prospective Rate *(continued)*

3. Services which may be billed separately include:
   a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient in the second hospital
   b. Physician services furnished to individual patients
   c. Long Acting Reversible Contraception (LARC)
   d. High-investment drugs
      i. High-investment drugs are reimbursed under the methodology described in Attachment 4.19-B, Page 7a. A list of high-investment drugs is found on www.okhca.org.

The agency's fee schedule rate is updated annually in July. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

B. Computation of DRG Relative Weights

1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from Oklahoma hospital claim data. All such claims are included in the relative weight computation, except as described below.

2. Hospital fee-for-service (FFS) claims and adjusted managed care encounter data for discharges occurring from July 1, 2000, through June 30, 2003, are included in the computation and prepared as follows:

   a. All interim and final claims for single inpatient stay were combined into a single record per discharge.

   b. All Medicaid inpatient discharges were classified using the Diagnostic Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient resources. Input files were created for the Medicare Version 22 grouper software. Lines containing detail ICD-9 procedure codes were transposed and attached to the claim header record to produce a single claim record per line. Historical diagnosis and procedure codes that are no longer valid and not recognized by the CMS Medicare Version 22 grouper were updated to reflect their placement codes.

   c. Claims that were grouped into Major Diagnostic Category 15 "Newborns and other Neonates with Conditions Originating in the Perinatal Period" were further grouped using enhanced neonate logic. The enhanced neonate logic creates 20 groupings. The groupings are hierarchical based on discharge state, transfer status, neonate weight, major operating room procedure performed, and the existence of a major or minor diagnosis.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement *(continued)*

E. Therapeutic Services

1. Payment is made for drugs and supplies for outpatient chemotherapy. A separately billable facility fee payment is made for administration based on Medicare APC group 0117. Claims cannot be filed for an observation room, clinic, or ER visits on the same day.

2. For each therapeutic radiology service or procedure, payment will be the technical component of the Medicare RBRVS.

3. High-investment drugs are reimbursed under the methodology described in Attachment 4.19-B, Page 7a. A list of high-investment drugs is found on www.okhca.org.

F. Clinic Services and Observation/Treatment Room

A fee will be established for clinic visits and certain observation room visits. Reimbursement is limited to one unit per day per patient, per provider. The payment rates are based on APC groups 601 and 0339, respectively. Separate payment will not be made for observation room following outpatient surgery.

G. Hospital-based Community Mental Health Centers (CMHCs) Operated by Units of Government

1. CMHCs will be paid on the basis of cost in accordance with the following methodology: An overall outpatient cost-to-charge ratio (CCR) for each hospital will be calculated using the most recently available cost reports, with data taken from Worksheet C, Part 1. The overall CCR for each hospital will be applied to the Medicaid charges for the state fiscal year to determine the Medicaid costs for the year.

2. The agency's fee schedule rates are set as of July 1, 2006 and in effect for services provided on or after that date. All rates are published on the agency's website located at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%

H. Partial Hospitalization Program (PHP) Services

PHP services are provided in accordance with 42 CFR 410.43

Any child 0-20 that is an eligible member and who meets the medical necessity and programmatic criteria for behavioral health services qualifies for PHP. Treatment is time limited and must be offered a minimum of 3 hours per day, 5 days a week. Services are prior authorized for 1-3 months based on medical necessity criteria.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse vendor. An initial prior authorization will be required by OHCA or its designated agent. This initial prior authorization will ensure that the level of service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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 $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 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.

(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 ASP + 6% Medicare Part B; or, (4) billed charges. A list of high-investment drugs is found on www.okhca.org.