

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**03-14**

2. STATE  
Oregon

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
~~October 1, 2003~~ (P+I)  
**November**

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:  
1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:  
a. FFY 10/1/03 - 9/30/04 \$ - 0 - \$45.76 (P+I)  
b. FFY 10/1/04 - 9/30/05 \$ - 0 - \$49.92 (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, page 3-b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, page 3-b  
*Oregon (03-14)*  
*Approved: 12/02/03*  
*Effective: 11/01/03*

10. SUBJECT OF AMENDMENT:

This transmittal is being submitted to change the method of reimbursement to compound drugs.

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:

Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Lynn Read*      *Jean Thorne*

13. TYPED NAME: Lynn Read

Jean Thorne

14. TITLE: Administrator, OMAP      Director, DHS

16. RETURN TO:

Office of Medical Assistance Programs  
Department of Human Services  
500 Summer Street NE, 3<sup>rd</sup> Floor, E35  
Salem, OR 97301

15. DATE SUBMITTED: **8-21-03**

ATTN: Carole Van Eck

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **AUG 28 2003**

18. DATE APPROVED: **DEC - 2 2003**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
**NOV - 1 2003**

20. SIGNATURE OF REGIONAL OFFICIAL:

*LSI*

21. TYPED NAME: **Karen S. O'Connor**

22. TITLE: **Associate Regional Administrator**

**Division of Medicaid &**

23. REMARKS: **pen + ink changes authorized by the state on 10/1/03**

AUG 28 2003

D. Dispensing or Professional Fees

- (1) The DHS establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies and other Medicaid programs, and by approval of the State Legislature.
- (2) The present dispensing fee payment mechanism is two tiered. The base fee is \$3.50 for retail pharmacies, \$3.91 for institutional or pharmacies dispensing with a true or modified unit dose dispensing system. The pharmacy must provide documentation substantiating annual, Medicaid dispensing volume and unit dose dispensing system employed.
- (3) Pharmacies dispensing through a unit dose or 30-day card system must bill the DHS only one dispensing fee per medication dispensed in a 30-day period.
- (4) Compound prescription fee allowances are made for preparation time and dispensing. A prescription is considered a compound prescription when it is prepared in the pharmacy by combining two or more ingredients and involves the weighing of at least one solid ingredient or a legend drug in a therapeutic amount. Pharmacies will receive a dispensing fee of \$7.50 for a compound, which contains two, or more ingredients listed in the compound. Pharmacies must list all applicable NDC numbers included in the compound

TN #03-14  
Supersedes TN #02-16

Date Approved:  
DEC - 2 2003

Effective Date: 10/1/03  
NOV - 1 2003