

**Date:** January 29, 2016

**Re:** SPA 16-007: Physician Administered Drug Fee Schedule

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### **Access and Reimbursement:**

**Comment:** The new policy will significantly reduce the ability of independent physicians to care for Medicaid patients who rely on physician administered drugs for treatment of their conditions.

**Comment:** This could significantly impede access to care for patients in rural communities and in fact may leave practices in a position of no longer able to accept Medicaid patient.

**Comment:** The proposed reimbursement rate will make it difficult for community-based practices in particular to continue to administer drugs to their Medicaid patients and may result in decreased access to care for these patients.

**Comment:** In many cases independent practices are not able to purchase drugs at the Medicare ASP payment rate and must pay more than that price to obtain the drug.

**Comment:** Independent physician offices do not charge additional facility fees to cover more of the total costs to inventory, stock, refrigerate, insure, and replace drugs in instances of inadvertent expiration and/or other loss

**Comment:** You cannot provide chemotherapy to patients in an outpatient setting if the cost of the drug is greater than the reimbursement of those drugs. This policy does that.

**Comment:** Drugs routinely go up in price every few months but CMS ASP drug fee schedule typically lags 6 months behinds those cost increases. Of note, we have information that there will be significant price increases after January 1 this year coming up which will further dilute the VT Medicaid rates set to date. The VT proposal to adjust this only annually would exacerbate this issue as well.

**Comment:** ASP reflects prior year markets data and are not necessarily reflective of the specific price that practitioners in Vermont will have to pay to purchase the drug. Medication manufactures and suppliers ratchet prices up constantly, and we are completely at their mercy. The Physician Administered Drug fee schedule update does not reduce overall spend, in fact the net impact of these changes results in a slight increase in reimbursement of .12%. This fee



schedule has not been updated in approximately 8 years and while Medicare's rates have tracked industry changes Medicaid's fee schedule has not, thus there are some sizeable increases and decreases to specific drugs. There are 376 rates on file of which 197 are increasing, 175 decreasing and 4 remain unchanged. This update aligns the reimbursement rate relativity with Medicare and in order to be budget neutral the rates reflect 93% of Medicare.

**Response:** In response to concerns that annual updates may result in rates not keeping up with industry changes, DVHA is currently evaluating the impact of performing an update every 6 months. DVHA can move to updates every 6 months; however it should be noted that when updates are done there will likely be both increases and decreases to reimbursement rates for specific drugs. As an example, when comparing Medicare's fee schedule for the 2<sup>nd</sup> quarter of 2015 to the 4<sup>th</sup> quarter of 2015, approximately 60% of the rates increased while 30% decreased. Furthermore, it should be noted the as with any fee schedule updates the final rates are developed to maintain budget neutrality.

### **Other Concerns:**

**Comment:** Concerns this proposal was not reviewed by DVHA's Clinical Utilization Review Board (CURB) or DVHA's Drug Utilization Review Board (DURB)

**Response:** These changes reflect a budget neutral redistribution of reimbursement rates to be in line with Medicare's rate relativity. Unlike some policy changes, this change does not impact clinical aspects of health care delivery and therefore was not introduced to the Clinical Utilization Review Board or Drug Utilization Review Board.