



**State of Vermont**  
**Department of Vermont Health Access**  
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*Agency of Human Services*

Providers,

Please review the following Physician Administered Drug fee schedule change summary and proposal. With this communication, the Reimbursement Unit is inviting comments and feedback on the frequency of updates, the benchmarks, and/or impacts to this fee schedule you may have.

Any comments should be submitted to the DVHA Reimbursement Unit by the due date specified. Your comments must be received by the due date to be considered before the final policy is released.

Send Comments to: DVHA Reimbursement Unit  
312 Hurricane Lane, Suite 102  
Williston, VT 05495  
[AHS.DVHAReimbursement@state.vt.us](mailto:AHS.DVHAReimbursement@state.vt.us)

Thank you for your consideration

A handwritten signature in black ink, appearing to read "Tom Boyd", written over a horizontal line.

Tom Boyd, Deputy Commissioner for Health Reform



Comments Due: 12/15/2015

Proposed Effective Date: 01/01/2016

**Policy Subject:** Physician Administered Drug Fee Schedule Update

**Explanation of Fee Schedule:**

This fee schedule includes medications administered by a health care professional and excludes any self-administered drugs. For a complete list of all codes included in this proposed update, please refer to <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>

Please note, there are individual drug codes that are covered on Vermont Medicaid's Physician Administered Drug fee schedule that are not included in Medicare's Average Sales Price (ASP) plus six percent (+6%) methodology.

**Background:**

To date, the DVHA has not formally updated the rates associated with the physician administered drug benefit, nor has it formally used a benchmarking methodology.

Current pricing of these drugs is estimated, in the aggregate, to be 93% of Medicare pricing (Medicare Average Sales Price (ASP) plus six percent (+6%) methodology.)

**Proposal:**

The DVHA proposes, starting 01/01/2016, to update all Physician Administered Drug prices to be at 93% of Medicare ASP+6% (per October 2015 release of the ASP data). We propose to update these prices annually beginning January 2017 using the latest version of Medicare's ASP pricing file. The percentage of Medicare will be estimated to ensure payment neutrality between updates; said another way, if pricing increases in the aggregate across all Physician Administered Drugs or utilization increases amongst different types of drugs, the percentage may be decreased to account for these changes. The only exception to this method is consideration for intentional increases in spending or allocations for this category of service. In summary, this proposal reallocates payments within this code set while maintaining payment neutrality in the aggregate for this category of service.

The individual drug codes not included in Medicare's Average Sales Price (ASP) plus six percent (+6%) methodology will continue under periodic review in conjunction with the proposed annual regular updates of this fee schedule.

