

LSA NUMBER: #10-250(F)

TITLE: Medicaid Providers and Services—Reimbursement for Services Performed by Physicians, Limited License Practitioners, and Nonphysician Practitioners

DIVISION: Office of Medicaid Policy and Planning

PREPARED BY: Program Staff: Yvonne Burke Legal Staff: Joy Heim

OVERVIEW OF RULE: This rule amendment revises reimbursement for physician-administered drugs by basing the rates paid to providers of physician administered drugs under 405 IAC 1-11.5 on one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For NDCs without a published WAC, the reimbursement will be the average sales price (ASP) payment amount as published by the Centers for Medicare and Medicaid Services (CMS). For any physician-administered drug product where no WAC cost or Medicare average sales price payment amount is available, other pricing metrics may be used as determined by the office. This policy does not apply to parenteral nutrition and blood factor products. This change in Medicaid reimbursement began on May 1, 2010, via an emergency rule promulgation.

FISCAL IMPACT:

The estimated decrease in Medicaid expenditures for this rule amendment is as follows:

	SFY 2010 (\$ in millions)	SFY 2011 (\$ in millions)
Estimated Decrease in Medicaid Payments	<u>(\$1.1)</u>	<u>(\$6.4)</u>
Estimated Federal Share ¹	<u>(\$0.8)</u>	<u>(\$4.5)</u>
Estimated State Share ¹	<u>(\$0.3)</u>	<u>(\$1.9)</u>

To calculate the fiscal impact, HP, the FSSA fiscal agent contractor compared physician administered drug reimbursement under the existing rates to the estimated reimbursement under the proposed rates based on the applicable WAC or Medicare ASP payment amount. The difference between the existing rates and the proposed rates becomes the estimated annual fiscal impact.

ECONOMIC IMPACT:

In the aggregate, this reimbursement change will reduce overall reimbursement for the technical component of radiology services submitted on the UB-04 claim form by \$1.2 million in SFY 2010 and \$4.8 million in SFY 2011. However, since this change aligns the outpatient radiology rates with the physician fee schedule rates, the reimbursement rate for each radiology procedure code may increase or decrease. Thus, the actual fiscal impact to individual providers will vary, depending on the specific radiology services provided.

OPPONENTS: Providers of physician-administered drugs

PROPOSERS: OMPP

RECOMMENDATIONS: None.

PUBLIC HEARING COMMENTS: The public hearing was held on Thursday, August 5, 2010. There were no public comments.

¹ For the period 5/1/2010 through 12/31/2010, the Federal Medical Assistance Percentage (FMAP) rate used is the enhanced FMAP rate determined under the American Recovery and Reinvestment Act (ARRA) of 2009 that applies for the period 1/1/2010 through 3/31/2010. The enhanced FMAP rate may change on a quarterly basis through 12/31/2010 as a result of this legislation. For the period from 1/1/2011 through 6/30/2011, the FMAP rate used is the FFY 2011 FMAP rate published in the Federal Register, volume 74, No. 227, dated November 27, 2009.