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Center for Medicaid and CHIP Services

CMCS Informational Bulletin

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FROM: Cindy Mann, Director
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SUBJECT: Medicaid and CHIP Updates

This Informational Bulletin updates States and other interested parties on three items:

- Publication of the Medicaid Covered Outpatient Drugs NPRM (CMS-2345-P)
- OIG's Report on Medicaid Hospital Outlier Payment Follow-up for Fiscal Years 2004 Through 2006 (A-07-10-04160)
- Updated Information on the Implementation of Medicaid NCCI Methodologies

Medicaid Covered Outpatient Drugs NPRM (CMS-2345-P)

Thursday, February 2, 2012, a Notice of Proposed Rulemaking (NPRM) titled "Covered Outpatient Drugs" (CMS-2345-P) will be published in the Federal Register (www.federalregister.gov.) The NPRM went on display Friday, January 27 and can be viewed at: http://www.ofr.gov/OFRUpload/OFRData/2012-02014_PI.pdf.

This NPRM implements Medicaid drug provisions of the Affordable Care Act and will increase transparency in drug pricing and save States and taxpayers money through a number of improvements, including:

- Aligning reimbursement rates for all drugs closer to the actual price the pharmacy pays for the drug;
- Increasing rebates paid by drug manufacturers that participate in Medicaid;
- Providing rebates for drugs dispensed to individuals enrolled in a Medicaid managed care organization; and
- Lowering reimbursement for certain generic drugs.

The NPRM will be open for public comment through April 2, 2012, and CMS encourages all interested parties and stakeholders to submit comments. Please refer to the Federal Register

publication for instructions about how to submit comments and contact Wendy Tuttle at Wendy.Tuttle@cms.hhs.gov with any questions.

OIG Report "Medicaid Hospital Outlier Payment Follow-up for Fiscal Years 2004 Through 2006 (A-07-10-04160)"

The Office of the Inspector General (OIG) issued a final report on July 21, 2011 that may be useful to States in determining effective ways to make Medicaid hospital outlier payments. The report provides the results of their review of Medicaid hospital outlier payments for fiscal years (FY) 2004 through 2007, a follow-up to earlier audits on outlier payments in eight States. The objective was to determine whether the eight State agencies calculated Medicaid inpatient hospital outlier payments to effectively limit the payments to extraordinarily high-cost cases. The full report can be found at: http://oig.hhs.gov/oas/reports/region7/71004160.pdf

The OIG found that the eight States did not calculate Medicaid outlier payments to effectively limit the payments to extraordinarily high-cost cases. For all hospitals in seven of the eight States, Medicaid outlier payments increased from approximately $913.0 million in FY 2004 to approximately $1.2 billion in FY 2006. During this period, Medicaid outlier payments increased substantially faster than Medicaid diagnosis-related groups (DRG) base payments and Medicare outlier payments. They found that this occurred because the eight State agencies (1) used outdated cost-to-charge ratios to convert charges to estimated costs and (2) did not reconcile Medicaid outlier payments upon cost report settlement.

According to the OIG, if the eight States had used the most recent cost reports to calculate the cost-to-charge ratios for the hospitals reviewed, those State agencies could have, between FYs 2004 and 2006, more effectively limited the payments to extraordinarily high-cost cases, thereby reducing those Medicaid outlier payments by a total of $320.0 million.

Based on the OIG findings, we encourage all States that make Medicaid outlier payments to adjust Medicaid reimbursement for outliers to (1) use the most recent cost-to-charge ratios to calculate Medicaid outlier payments, (2) reconcile Medicaid outlier payments upon cost report settlement or use an alternative method to ensure that outlier payments are more closely aligned with actual costs, and (3) amend their State plans accordingly.

Questions regarding this information may be directed to Robert Weaver at Robert.Weaver@cms.hhs.gov.

Implementation of Medicaid NCCI Methodologies

The National Correct Coding Initiative (NCCI) is a program developed by CMS that uses methodologies to reduce overpayments to providers due to incorrect coding on claims. Section 6507 of the Affordable Care Act directs State use of NCCI methodologies. On September 1, 2010, CMS issued a letter to State Medicaid Directors regarding the implementation of the NCCI, which is available at: http://www.cms.gov/smdl/downloads/SMD10017.pdf.

Updates and additional information addressing the following four topics are now available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/NCCI_FactSheet_Methodologies01262012.pdf:

- Change in the location of the Medicaid NCCI edit files for downloading by State Medicaid agencies;
- Changes in Medically Unlikely Edits (MUEs) for bilateral surgical procedures;
- The claim adjudication algorithms States are required to use in paying Medicaid claims; and
- Reports on changes in the Medicaid NCCI edit files.

For additional information please contact Paul Youket at Paul.Youket@cms.hhs.gov.