A home health agency which undergoes a change of ownership must notify the DOM in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under DOM policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

The new owner will be reimbursed at the previous owner's rate until the rate is adjusted based on the new owner's initial cost report. This adjusted rate will be effective retroactive to the date of the change of ownership. A prospective rate will also be determined based on this cost report.

The new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division.

2. New Home Health Agencies
When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

Notice of Proposed Rule Adoption

State of Mississippi
Office of the Governor
Division of Medicaid

Economic Impact Statement
For
Home Health Providers

The Executive Director of Medicaid is required by law to recommend expenditure containments when expenditures are expected to exceed funds available for any fiscal year. Medicaid is facing a $90,000,000 shortfall in state revenues for FY2009; therefore, certain cost containment measures have been identified as necessary to balance Medicaid's budget. These measures include reducing certain non-institutional providers an additional 5% reduction in reimbursement in addition to the 5% reduction as outlined in Miss. Code Ann. § 43-13-117 (1972 as amended).

It is estimated that it will cost the Division of Medicaid approximately $5,000 to enforce the increased reduction in payments to providers. This includes system changes and staff time.

An estimate of the total economic impact for home health providers, including small business providers, is noted in the chart below. The total economic impact for providers in State FY 2009 is equal to the sum of federal and state savings noted in the chart below. The Division of Medicaid estimated the impact utilizing the actual and estimated expenditures for the same services for FY2008.

FFY2008 Federal Savings	FFY2008 State Share Savings	FFY2009 Federal Savings	FFY2009 State Share Savings
$ 52,058.09	$ 16,179.02	$ 310,506.12	$ 98,916.51

The Division of Medicaid is facing a $90,000,000 shortfall in state revenues for FY2009. If this cost containment measure is not enacted, there will not be sufficient revenues to reimburse providers for the entire year.

State law limits cost containment measures that may be taken and precludes the Governor from changing eligibility or benefits; therefore, the only option is to reduce expenditures is to reduce payment.