Under provisions of the Balanced Budget Act of 1997, a state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full, and the dually eligible cannot be billed the difference between the provider's charge ~~of~~ **and** the Medicare and Medicaid payment.

The Medicaid reimbursement for Medicare ~~Part A~~ crossover claims for dually eligible beneficiaries is restructured as follows:

(1) The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a beneficiary who is not dually eligible;

(2) All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.

(3) All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.

This reimbursement methodology became effective for Medicare part A crossover claims on April 1, 2008. The effective date for Medicare Part B crossover claims is August 6, 2008.

Notice of Proposed Rule Adoption

State of Mississippi
Office of the Governor
Division of Medicaid

Economic Impact Statement
For
Implementation of Lower-of-Logic for Medicare Part B Claims

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. A cost containment measure being pursued by the Division of Medicaid is the "lower of" logic for Medicare Part B crossover claims. The Division of Medicaid will pay the co-pay and deductible amount only up to the Medicaid rate on file. Any crossover claim in excess of the Medicaid rate on file will be reduced to the Medicaid rate on file. If the co-pay and deductible amount is less than the Medicaid rate on file, the co-pay and deductible amount will be paid only up to the amount due the provider for the co-pay and deductible amount.

It is estimated that it will cost the Division of Medicaid approximately $10,000 to enforce the increased reduction in payments to providers. This includes system changes and staff time.

An estimate of the total economic impact for affected 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
Hospitals for Outpatient Services	$ 4,101,855	$ 1,274,806	$ 24,465,958	$ 7,794,008
Physicians	$ 2,537,993	$ 788,777	$ 15,138,137	$ 4,822,487
Durable Medical Equipment/Medical Suppliers	$ 1,520,465	$ 472,542	$ 9,068,978	$ 2,889,063
Ambulance Providers	$ 454,103	$ 141,130	$ 2,708,544	$ 862,848
Dialysis Providers	$1,288,107	$ 400,328	$ 7,683,054	$ 2,447,555

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

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