

Division of Medicaid State of Mississippi Provider Policy Manual	New: <input checked="" type="checkbox"/> Revised: <input checked="" type="checkbox"/> Current:	Date: 04/01/08 Date: 08/06/08
Section: Benefits	Section: 2.05 Pages: 1	Cross Reference:
Subject: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles		

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 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.

Laboratory and Radiology Services

All outpatient laboratory services shall be reimbursed on a fee-for-service basis.
All outpatient radiology services shall be reimbursed on a fee-for-service basis.

Hospital-Based Clinics

Hospital-based clinics may not bill facility fees on the UB-92 unless they are a teaching hospital with a resident-to-bed ratio of .25 or greater.

Medicaid Upper Payment Limit

In addition to the reimbursement methodology described above, hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each specified class of hospital (State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities), the amount that Medicare would have paid for the previous year will be calculated and compared to the payments actually made by Medicaid during that same time period. This calculation may then be used to make payments for the current year to hospitals eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to 100 percent of the difference between Medicaid payments and what Medicare would have paid may be paid to State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities, in accordance with applicable State and Federal laws and regulations, including any provision specified in appropriations by the Mississippi Legislature. This provision will sunset as of December 31, 2007. ~~Any payment made under this provision will be made bi-monthly.~~

5% Reduction

Notwithstanding any other provision of this section, the Division of Medicaid, as required by State law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. Effective August 6, 2008, the Division of Medicaid shall reduce the rate of reimbursement to all hospital providers, with the exception of state owned and operated and Medicare designated critical access hospitals, for any service by an additional thirty-three and one-half percent (33.5%) of the allowed amount for that service. Hospitals that are owned and operated by the State of Mississippi (State hospitals) and hospitals designated as critical access hospitals (CAHs) by Medicare will not be subject to the reimbursement reductions described above. These facilities will be paid based on 100% of allowable costs. State hospitals and CAHs may request that the outpatient rate be adjusted during the year based on changes in their costs. After the State hospital and CAH files their cost report during the rate year, total outpatient payments for each cost report period will be adjusted to the actual allowable cost for that period.

 TN NO 2005-013

Supersedes

TN NO 2002-22

Date Received _____

Date Approved _____

Date Effective August 6, 2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: MISSISSIPPI

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Outpatient Hospital Services –Prior to October 1, 2008

~~Outpatient hospital services shall be reimbursed at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is the lower of 75% of charges or the cost to charge ratio, as computed by Medicaid using the hospital's cost report. The cost to charge ratio shall be computed each year for use in the following rate year's payments. Adjustments to outpatient services claims may be made if the cost to charge ratio is adjusted as a result of an amended cost report, audit, or Medicare settlement. The cost to charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different rate methodology (i.e., Rural Health Clinic services and Federally Qualified Health Center services). Out of state hospitals shall be reimbursed at the lower of 75% of charges or the average cost to charge ratio of hospitals located in Mississippi for their classification, as computed by Medicaid.~~

Outpatient Hospital Services –Effective Beginning October 1, 2008

Outpatient hospital services shall be reimbursed on a prospective basis at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is equal to the Medicaid cost to charge ratio, as computed by Medicaid, based on the hospital's Medicare cost report, using the attached protocol. The percentage paid will be computed annually, unless this plan requires a rate being calculated at another time, for the period October 1 through September 30. Cost reports used to calculate the percentage will be the cost report filed by the provider for a cost reporting period ending in the preceding calendar year. For example, the percentage effective October 1, 2008, will be based on the most recent cost report filed with a reporting year end as of or prior to December 31, 2007, unless a short period cost report is required for a new provider.

Percentages for new providers, including changes of ownership, will be set at the average outpatient percentage of hospitals located in Mississippi, as determined by the Division. The outpatient percentage computed based on the hospital's initial Medicare cost report, using the attached protocol, will be effective retroactive to the effective date of enrollment.

Out-of-state hospitals shall be reimbursed at the average outpatient reimbursement rate of hospitals located in Mississippi, as determined by the Division.

TN NO 2005-013
Supersedes
TN NO 2002-22

Date Received _____
Date Approved _____
Date Effective August 6, 2008

II. Cost Findings and Cost Reporting – For Rate Years Prior to October 1, 2005

A. Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. No routine extensions will be granted. All other filing requirements shall be the same as those for Title XVIII. Extraordinary circumstances will be considered on a case-by-case basis. One (1) complete copy of the cost report shall be submitted to the Division of Medicaid (DOM). The cost reports for periods ending in the prior calendar year will be used to calculate the per diem rates for the following October 1 – September 30 fiscal year. For example, the cost report of a hospital with a June 30, 1996 year end would be used to set the rate effective October 1, 1997 through September 30, 1998.

B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

C. Cost reports used to initiate this plan will be for reporting periods beginning April 1, 1980, or earlier.

D. All hospitals are required to detail their cost reports for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to all requirements of Section 25, Provider Policy Manual.

TN NO 2008-008

Supersedes

TN NO 2005-012

Date Received _____

Date Approved _____

Date Effective 8/6/08

