



House of Representatives

General Assembly

File No. 434

February Session, 2002

Substitute House Bill No. 5555

House of Representatives, April 10, 2002

The Committee on Appropriations reported through REP. DYSON of the 94th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT PROVIDING FULL PAYMENT TO PHYSICIANS FOR SERVICES PROVIDED TO DUALY-ELIGIBLE PATIENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (b) of section 17b-265 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2002*):

4 (b) When a recipient of medical assistance has personal health
5 insurance in force covering care or other benefits provided under such
6 program, payment or part-payment of the premium for such insurance
7 may be made when deemed appropriate by the Commissioner of
8 Social Services. Effective January 1, 1992, the commissioner shall limit
9 reimbursement to medical assistance providers, except those providers
10 whose rates are established by the Commissioner of Public Health
11 pursuant to chapter 368d, and physicians licensed pursuant to chapter
12 370, for coinsurance and deductible payments under Title XVIII of the
13 Social Security Act to assure that the combined Medicare and Medicaid

14 payment to the provider shall not exceed the maximum allowable
 15 under the Medicaid program fee schedules. Physicians licensed
 16 pursuant to chapter 370 shall receive the full deductible and
 17 coinsurance payments from the Department of Social Services for
 18 medical assistance covered under Title XVIII of the Social Security Act.

This act shall take effect as follows:	
Section 1	July 1, 2002

HS *Joint Favorable Subst. C/R* APP
APP *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Fund-Type	Agency Affected	Current FY \$	FY 03 \$	FY 04 \$
GF - Cost	Dept of Social Services	-	Significant	Significant

Municipal Impact: None

Explanation

This bill exempts physicians from the requirement that the Department of Social Services (DSS) limit reimbursement to medical providers for coinsurance and deductible payments for individuals eligible for both Medicaid and Medicare. The state began limiting this reimbursement during FY00, and it is estimated that this effort for all providers reduces Medicaid expenditures by \$25 million to \$30 million annually. Allowing DSS to give full reimbursement to physicians is expected to cost \$5.2 million annually. sHB 5019 (the budget bill, as favorable approved by the Appropriations Committee) includes \$3.9 million to implement this provision, effective October 1, 2002. It is likely that DSS will incur additional administrative expenses due to billing physicians differently than other Medicaid providers. The extent of these additional expenses is unclear.

OLR Bill Analysis

sHB 5555

AN ACT PROVIDING FULL PAYMENT TO PHYSICIANS FOR SERVICES PROVIDED TO DUALY-ELIGIBLE PATIENTS**SUMMARY:**

The state helps people who are eligible for both Medicare and Medicaid ("dually-eligible") by paying providers a portion of the people's Medicare cost-sharing (e.g., premiums) requirements. This bill exempts licensed physicians serving these patients from the law's payment limits. Under current law, the amount the Department of Social Services (DSS) may pay these providers, when combined with the Medicaid payment, cannot exceed the amount that Medicaid alone would pay for the same service. (Providers whose rates the Department of Public Health sets are already exempt from these limits.) The bill requires physicians to be paid the patient's full deductible and coinsurance.

EFFECTIVE DATE: July 1, 2002

BACKGROUND***Medicaid-Dually Eligible***

The federal Medicaid program establishes a category or coverage group called "dually-eligible," which consists of several subcategories. State Medicaid programs can pay the Medicare Part A and B premiums, deductibles, and co-payments as a means to help certain Medicare beneficiaries avoid needing full Medicaid coverage.

DSS provides assistance with coinsurance and deductibles to qualified medicare beneficiaries (QMB). These individuals cannot have income greater than 100% of the federal poverty level (currently \$8,860 per year for one person), and their assets cannot exceed more than twice the asset limit in the Supplemental Security Income program (currently \$4,000 for a single person). For QMBs, Medicaid (which provides most states with a 50% federal match) generally pays the Medicare Part A

and B premiums and cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers.

Congress passed the cost-sharing requirement in 1988. The federal State Medicaid Manual, which guides state agencies administering Medicaid, gave states the option to pay Medicare cost-sharing in an amount based either on (1) the full Medicare-approved amount for a particular service or (2) the amount that the state pays for the same service for a Medicaid recipient who was not entitled to Medicare. Connecticut adopted the second option in 1991, but it was not immediately implemented because between 1991 and 1997, courts in some jurisdictions held that states could not limit cost-sharing amounts to those in the Medicaid fee schedule. (Thus, the state's providers during that time, indeed until 1999, continued to be paid the full Medicare co-payment.) In 1997, Congress made it clear that states had this flexibility. The FY 1999-00 DSS budget included a \$54 million reduction to reflect the statute's implementation.

Implementation led to providers in many cases no longer getting co-payments. (DSS never stopped paying the \$100 Medicare deductible.)

Here's an example of what occurred. Before the state began implementing the law in 1999, a provider would bill Medicare \$120 for a QMB's medical procedure. Medicare determined the "allowable" or approved amount for that procedure (\$100) and paid the provider 80% of that amount (\$80). Medicaid then paid the remaining 20% (co-payment) of the approved amount, or \$20.

With the implementation of the statutory limits on coinsurance, DSS now compares the Medicare payment to the amount that Medicaid pays a provider for the same service. If the Medicaid fee is lower or the same, DSS pays the provider nothing. If it is higher, Medicaid pays the difference. (In most cases, the Medicare-approved amount is higher than the amount in the Medicaid fee schedule.)

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute Change of Reference

Yea 18 Nay 0

Appropriations Committee

Joint Favorable Report

Yea 49 Nay 0