201 MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

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REFERENCES: ~~ACOM 201, A.A.C. R9-22-201 et seq;, A.A.C. R9-22-702, R9-22-705, R9-28-201 et seq, A.A.C. R9-29-101, A.A.C. R9-29-301 et seq;, A.A.C. R9-29-302,; A.A.C. R9-29-303;~~ 42 § U.S.C. 1396a(a)(25)(A); 42 § C.F.R. 433.136; A.A.C. Title 9, Chapter 29, Article 3; A.A.C. R9-29-302; A.A.C. R9-29-303; A.A.C. R9-29-301 et seq; A.A.C. R9-29-101; A.A.C R9-28-201 et seq; A.A.C. R9-22-1001; A.A.C. R9-22-705; A.A.C. R9-22-702; A.A.C. R9-22-201 et seq; ACOM 434; ACOM 414;ACOM 201
~~DELIVERABLES: AHCCCS Notification to Waive Medicare Part D Co-Payments~~

PURPOSE

~~This policy applies to the Division's Administrative Services Subcontractors (AdSS).~~ The purpose of this policy is to~~:~~

- ~~D~~define the AdSS's cost sharing responsibilities for M~~m~~embers who are Qualified Medicare Beneficiary Duals~~Dual-Eligible Medicare Beneficiaries (Duals)~~ receiving Medicare Parts A and/or B through traditional ~~Original~~ ~~F~~fee f~~F~~or-s~~S~~ervice ~~(FFS)~~ Medicare or a Medicare Advantage Plan in order to~~.~~
- ~~m~~M~~m~~aximize C~~c~~ost A~~a~~voidance efforts by the AdSS and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

DEFINITIONS

~~A.~~1. "Centers for Medicare and Medicaid Services" or "CMS" means the Federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs and the State Children's Health Insurance Program (Title XXI).

2. "Coordination of Benefits" means the activities involved in determining Medicaid benefits when a Member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

3. "Cost Avoidance" means to deny a claim and return the claim to the provider for a determination of the amount of Third Party Liability as defined in A.A.C. R9-22 -1001 et seq.

4. "Cost Sharing" means the AdSS's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

5. "Creditable Drug Coverage" means other insurance sources that a Medicare beneficiary may have to pay for prescription drugs

that equals or exceeds the standard Medicare drug benefit, as specified in 42 § C.F.R. 423.56(a)(b).

~~2. Cost Sharing - The AdSS's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.~~

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

7. "Non-Qualified Medicare Beneficiary Dual" or "Non-QMB Duals" means an individual who qualifies to receive both Medicare and Medicaid services, but does not qualify for the Qualified Medicare Beneficiary program as specified in A.A.C. R9-29-101.

8. "Pay and Chase" means a Post Payment Recovery method in which the Division pays the full amount of a claim according to the AHCCCS Capped-FFS Schedule or the contracted rate, even when a Third Party is liable, and then recoups the payment from the liable Third Party.

9. "Post Payment Recovery" means subsequent to payment of a service by the AdSS, efforts by the AdSS, to retrieve payment from a liable Third Party.
10. "Prior Authorization" or "PA" means approval from a health plan that may be required before the Member receives a service. This is not a promise that the health plan will cover the cost of the service.
11. "Provider" means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.
12. "Qualified Medicare Beneficiary" or "QMB" means an individual who qualifies to receive Medicare services only and cost-sharing assistance, known as QMB Program as specified in A.A.C. R9-29-101.B.
13. "Qualified Medicare Beneficiary Dual" or "QMB Dual" means an individual who qualifies to receive all Medicare Part A and B and Medicaid covered services. QMB Dual Members are identified by

a Medicare Part C entry in the AHCCCS recipient record and typically by the number "two" in the third digit of the rate code. A QMB Dual who receives covered services under A.A.C. R9-22 Article 2 or A.A.C. R9-28 Article 2 from an AHCCCS-registered Provider is not liable for any Medicare deductible, coinsurance, or copayment amounts associated with those covered services, and is not liable for any balance of billed charges as specified by A.A.C. R9-29-302.

14. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

15. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan as defined in 42 § C.F.R. 433.136.

16. "Third Party Liability" or "TPL" means the legal obligation of Third Parties (e.g., certain individuals, entities, insurers, or programs)

to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

~~B. Dual Eligible Medicare Beneficiaries (Duals) – A member who is eligible for the Division and both Medicaid and Medicare services. There are two types of Dual Eligible members: Qualified Medicare Beneficiary (QMB) Duals and Non-QMB Duals (Full Benefit Dual Eligible [FBDE], Specified Low Income Medicare Beneficiary [SLMB], QMB)~~

~~C. Full Benefit Dual Eligible (FBDE) - An AHCCCS member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.~~

~~D. In-Network Provider - A provider that is contracted with the AdSS to provide services.~~

~~E. Medicare Advantage Plan – A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include~~

~~prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and local and Regional Preferred Provider Organizations (RPPOs).~~

~~F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.~~

~~G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.~~

~~H. Medicare Part D - Medicare prescription drug coverage.~~

~~I. Non-Qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in A.A.C. R9-29-101.~~

~~J. Out of Network Provider - A provider that is neither contracted with nor authorized by the AdSS to provide services to its members.~~

~~K. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided~~

~~for in A.A.C. R9-28-201 et seq. A QMB Dual person receiving both Medicare and Medicaid services and cost sharing assistance.~~

~~L. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.~~

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall issue service authorizations in accordance with ACOM 414 in addition to coordinating benefits and identifying Third Party payor resources.
2. The AdSS shall evaluate the medical necessity and coverage of a requested service even when a potential Third Party has not yet determined responsibility for all or part of the cost of the service.
3. The AdSS shall not use a denial of the service request by Medicare as a basis for the AdSS's determination of medical necessity or coverage.

4. The AdSS shall independently evaluate the Member's service request using its own criteria according to the timeframes specified in Division Medical Policy 1610, when Medicare denies a service request.

5. The AdSS shall not apply a secondary Prior Authorization (PA) and shall coordinate payment as specified in this policy when Medicare has approved a service request as medically necessary.

6. The AdSS shall recover payment from Medicare or other liable Third Parties as specified in A.A.C. R9-22-1001 et seq., Federal and State law, and AHCCCS policy by using the following methods:

   a. Cost Avoidance of claims;

   b. Post Payment Recovery; and

   c. Pay and Chase.

7. The AdSS shall adhere to the Third Party Liability Cost Avoidance requirements in accordance with ACOM 434.

B. MEDICARE COST SHARING RESPONSIBILITIES

1. ~~M. For QMB Duals and Non-QMB Duals, t~~The AdSS~~'s~~ shall evaluate the following factors when determining the AdSS's Medicare cost sharing ~~payment~~ responsibilities ~~are dependent upon whether~~:

   a~~1~~. Whether the ~~S~~service is covered by Medicare only, by Medicaid only, or by both Medicare and Medicaid~~;~~.

   b~~2~~. Whether the ~~S~~services are received in- or out-~~-~~of-network; ~~(the AdSS only has responsibility to make payments to AHCCCS registered providers).~~

   c~~3~~. Whether the ~~S~~services are emergency services~~;~~. and

   d~~4~~. Whether the AdSS refers the dual eligible ~~m~~Member out of network.

2. The AdSS shall make Medicare cost sharing payments to AHCCCS registered Providers only.

3. As an exception to the AdSS's cost sharing payment requirement, the AdSS shall pay 100% of the Member cost sharing amount for any Medicare Part A skilled nursing facility (SNF) stays from days 21 through 100 even if the AdSS has a

Medicaid nursing facility (NF) rate less than the amount paid by Medicare for a Part A SNF day.

~~Refer to sections A-B of this policy and to A.A.C. R9-29-301 et seq.~~

~~An exception to the AdSS's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the AdSS must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.~~

~~For AdSS responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division's Operations Manual, Policy 434.~~

C. COST SHARING FOR QUALIFIED MEDICARE BENEFICIARY (QMB) DUALS ~~**QMB Duals**~~

1. The AdSS shall pay Medicare cost sharing amounts for deductibles, coinsurance, and copayments for the following:

a. Medicare Parts A and B covered services; and

b. Services covered by Medicare, but not covered by AHCCCS as specified in this policy.

2. The AdSS shall not use the 09 coverage code to deny payment of claims, including Medicare cost sharing claims for medically necessary services provided to a QMB Dual.

3. The AdSS shall pay Medicare cost sharing amounts for QMB Duals regardless of:

a. Whether or not the Provider is subcontracted in the AdSS's Provider network; or

b. Whether or not Prior Authorization has been obtained.

4. The AdSS shall not pay Medicare cost share amounts if the Medicare payment exceeds the AdSS's contracted reimbursement rate for the covered service.

5. The AdSS shall ensure liability for Medicare cost sharing amounts, plus the amount of Medicare's payment, does not exceed the AdSS's subcontracted

reimbursement rate for the service.

6. The AdSS shall not be liable for Medicare cost sharing payments if:

a. The AdSS has a subcontract with the Provider; and

b. The Provider's subcontracted reimbursement rate. includes Medicare cost sharing amounts.

7. The AdSS shall adhere to the following exception to the limits in this Section on Medicare cost sharing reimbursement:

a. Pay 100% of a QMB Duals Medicare cost sharing amount for any Medicare Part A SNF stay days 21 through 100, even if the AdSS has a Medicaid NF rate less than the amount paid by Medicare for a Medicare Part A SNF day, and

b. In accordance with A.A.C. R9-29-302, unless the AdSS's subcontract with a Provider sets forth different terms, when a QMB Dual receives

covered services from an AHCCCS- registered Provider, whether or not the Provider is in-network or out-of- network, the following apply:

i. When the service is covered by Medicare only, the AdSS shall pay, subject to limits specified in this policy:

1) Medicare deductible;

2) Coinsurance; and

3) Copayment amounts.

ii. When the service is covered by Medicaid only, the AdSS shall pay the Provider in accordance with the AdSS's subcontract.

iii. When the service is covered by both Medicare and Medicaid, the lesser of:

1) The Medicare deductible, coinsurance, and copayment amounts; or

2) The difference between the AdSS's subcontracted payment rate and the

Medicare payment amount.

~~QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their AHCCCS Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C. 9-22 or A.A.C. 9-28 from a registered provider is not liable for any Medicare copayment, coinsurance, or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)~~

~~AdSS Payment Responsibilities~~

~~A. The AdSS is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this policy (see Division Medical Policy Manual Chapter 300). These services include:~~

~~1. Chiropractic services for adults~~

~~2. Outpatient occupational and speech therapy coverage for adults~~

~~3. Orthotic devices for adults~~

~~4. Cochlear implants for adults~~

~~5. Services by a podiatrist~~

~~6. Any services covered by or added to the Medicare program not covered by Medicaid.~~

~~B. The AdSS only has responsibility to make payments to AHCCCS-registered providers.~~

~~C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the AdSS's network or prior authorization has been obtained.~~

~~D. The AdSS must have no cost sharing obligation if the Medicare payment exceeds the AdSS's contracted rate for the services. The AdSS's liability for cost sharing plus the amount of Medicare's payment must not exceed the AdSS's contracted rate for the service. There is no cost sharing obligation if the AdSS has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the AdSS must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.~~

~~E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS-registered provider in or out of network the following applies (Table 1 and Figure 1):~~

~~Table 1: QMB DUALS~~

~~QMB DUALS~~	
~~WHEN THE SERVICE IS COVERED BY:~~	**~~THE AdSS MUST PAY:~~** *~~(Subject to the limits outlined in this policy)~~*
~~Medicare Only~~	~~Medicare copayments, coinsurance and deductible~~
~~Medicaid Only~~	~~The provider in accordance with the contract~~
~~By both Medicare and Medicaid (See Examples Below)~~	~~The lesser of:~~ ~~a. The Medicare copay, coinsurance or deductible,~~ **~~or~~** ~~b.~~a. ~~The difference between the AdSS's contracted rate and the Medicare paid amount.~~

~~Figure 1 – QMB DUAL Cost Sharing - Examples~~

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *Subject to the limits outlined in this policy*			
	Example 1	**Example 2**	**Example 3**
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100
Medicaid rate for Medicare service (AdSS's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
AdSS PAYS	**$20**	**$10**	**$50**

D. COST SHARING FOR NON-QMB DUALSNon-QMB DUALS

1. The AdSS shall not hold Non-QMB Duals who receive covered services under A.A.C. R9-22 Article 2 or A.A.C. R9-28 Article 2 liable for the following:

a. Any applicable Medicare Cost Sharing deductible, coinsurance, or copayment amounts associated with covered services; or

b. For any balance of billed charges, unless services have reached the limitations specified within A.A.C. R9-22 Article 2.

2. The AdSS shall hold Non-QMB Duals who elect to receive services that are covered by both Medicare and Medicaid, from an out-of-network Provider, liable for:

a. **Any Medicare deductible, coinsurance, or copayment amounts unless the service is emergent; or**

b. **For non-emergency services, if the Provider has obtained a signed document from the Member to pay for the services as required in A.A.C. R9-22-**

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3. AdSS Payment Responsibilities for Non-QMB Duals Receiving In-Network Covered Services

a. The AdSS, when a Non-QMB Dual receives covered services from an in-network Provider, and the covered service is provided up to the limitations as specified in A.A.C. R9-22 Article 2, shall not hold the Member liable for any balance of billed charges.

b. When the service is covered by Medicare only, the AdSS shall not pay:

i. Medicare deductibles;

ii. Coinsurance; or

iii. Copayment amounts.

c. When the service is covered by Medicaid only, the AdSS shall pay the Provider in accordance with the AdSS's subcontract.

d. When the services is covered by both Medicare

and Medicaid, the AdSS shall, unless the AdSS's subcontract with the Provider sets forth different terms, pay the lesser of the following:

i. The Medicare deductible, coinsurance, and copayment amounts; or

ii. Any remaining Medicare cost sharing amount after the Medicare payment amount is deducted from the Provider's subcontracted rate.

4. AdSS Payment Responsibilities for Non-QMB Duals Receiving Out-of-Network Covered Services

a. **The AdSS shall not pay for the service when:**

i. The service is covered by Medicare only.

ii. The service is covered by Medicaid only, and

1) The AdSS has not referred the Member to the Provider; or

2) The AdSS has not authorized the Provider to render services and the services are not emergent.

iii. The service is covered by both Medicare and Medicaid, and

1) The AdSS has not referred the Member to the Provider; or

2) The AdSS has not authorized the Provider to render services; and

3) The services are not emergent.

b. The AdSS shall pay for the service(s) in accordance with the requirements of A.A.C. R9-22-705 when the service is covered by Medicaid only, and

i. The AdSS has referred the Member to the Provider; or

ii. The AdSS has authorized the Provider to render services; or

iii. The services are emergent.

c. The AdSS shall pay the lesser of the Medicare deductible, coinsurance, or copayment amounts, or any remaining Medicare cost sharing amount after the Medicare payment amount is deducted from any amount otherwise payable under A.A.C. R9-22-705 when the service is covered by both Medicare and Medicaid, and

i. The AdSS has referred the Member to the Provider; or

ii. The AdSS has authorized the Provider to render services; or

iii. The services are emergent.

~~A Non-QMB Dual eligible member who receives covered services under A.A.C. R9-22-201 et seq or A.A.C. R9-28-201 et seq from a provider within the AdSS's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22-201 et seq. When the Non-QMB Dual Member elects to receive~~

~~services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.~~

~~AdSS Payment Responsibilities (In Network)~~

~~In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-201 et seq, the member is not liable for any balance of billed charges and the following applies (Table 2):~~

~~Table 2: Non-QMB Duals (In Network)~~

~~NON-QMB DUALS (IN NETWORK)~~	
~~WHEN THE SERVICE IS COVERED BY:~~	~~THE AdSS MUST NOT PAY:~~
~~Medicare Only~~	~~Medicare copay, coinsurance or deductible~~
~~WHEN THE SERVICE IS COVERED BY:~~	~~THE AdSS MUST PAY:~~ ~~*Subject to the limits outlined in this Policy*~~

~~Medicaid Only~~	~~The provider in accordance with the contract~~
~~Both Medicare and Medicaid~~	~~The lesser of the following (unless the subcontract with the provider sets forth different terms):~~ ~~a. The Medicare copay, coinsurance or deductible,~~ ~~**or**~~ ~~b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (AdSS's contracted rate).~~

~~**AdSS Payment Responsibilites (Out of Network)**~~

~~In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracting provider the following applies (Table 3):~~

~~**Table 3: NON-QMB Duals (Out of Network)**~~

~~**NON-QMB DUALS (OUT OF NETWORK)**~~	
~~**WHEN THE SERVICE IS COVERED BY:**~~	~~**THE AdSS**~~ ~~*Subject to the limits outlined in this Policy*~~
~~Medicare Only~~	~~Has no responsibility for payment.~~

~~Medicaid only and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent~~	~~Has no responsibility for payment.~~
~~Medicaid only and the AdSS **has** referred the member to the provider or has authorized the provider to render services or the services are emergent~~	~~Must pay in accordance with A.A.C. R9-22-705.~~
~~By both Medicare and Medicaid and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent~~	~~Has no responsibility for payment.~~
~~By both Medicare and Medicaid and the AdSS has referred the member to the provider or has authorized the provider to render services or the services are emergent~~	~~Must pay the lesser of:~~ ~~a. The Medicare copay, coinsurance or deductible, or~~ ~~b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.~~

~~Prior Authorization~~

~~The AdSS can require prior authorization. If the Medicare provider determines that a service is medically necessary, the AdSS is responsible for~~

~~Medicare cost sharing if the member is a QMB Dual, even if the AdSS determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the AdSS must apply its own criteria to determine medical necessity. If criteria support medical necessity, the AdSS must cover the cost of the service for QMB Duals.~~

~~**Part D Covered Drugs**~~

~~For QMB and Non-QMB Duals, federal and state laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.~~

E. MEDICARE PART D COVERED DRUGS

The AdSS shall not use Title XIX or Title XXI funds to pay Medicare cost sharing amounts related to Medicare Part D prescription drug benefit medications.

F. COORDINATION OF CREDITABLE DRUG COVERAGE

1. The AdSS shall coordinate benefits for medications when a QMB Dual eligible Member has Creditable Drug Coverage as specified in 42 C.F.R. § 423.56.

2. The AdSS shall coordinate Creditable Drug Coverage with the identified commercial payer as a primary or secondary payer

as applicable when all of the following apply:

a. The QMB Dual eligible Member has CreditableDrug Coverage through a commercial payer;

b. The medication is federally and state reimbursable;

c. The QMB Dual eligible Member is:

i. Enrolled in Medicare Part A only and is not enrolled in Medicare Part B and Medicare Part D; and

ii. Enrolled with the AdSS for AHCCCS-covered health benefits.

d. The medication is dispensed by an AHCCCS-registered Provider, regardless of whether that Provider is in the AdSS's Provider network.

3. The AdSS shall evaluate the request for drug coverage by applying its AHCCCS drug coverage criteria when:

a. A primary or secondary Creditable Drug Coverage medication request is denied by a commercial payer; and

b. A QMB Dual eligible Member's appeal of such medication denial has been previously upheld by such Creditable Drug Coverage commercial payer when applicable.

4. The AdSS shall not coordinate Creditable Drug Coverage as specified in this Section when the requesting pharmacy provider is not AHCCCS registered.

5. The AdSS shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for a QMB Dual eligible Member with Creditable Drug Coverage.

6. The AdSS shall identify potentially legally liable Third Party payor sources prior to requesting drug coverage from AHCCCS.

7. The AdSS shall exhaust all other possible primary and secondary drug coverage options and payors prior to evaluating drug coverage requests and adjudicating pharmacy claims.

G. MEDICARE PART D COPAYMENTS AND INSTITUTIONAL STATUS REPORTING

1. The AdSS shall not require a QMB Dual eligible Member to pay Medicare Part D copayments for their Medicare covered prescription medications for the remainder of the calendar year when:
   i. The QMB Dual eligible Member is in a medical institution; and
   ii. The stay in the medical institution is funded by Medicaid for a full calendar month.
2. The AdSS shall not report the institutional status of a QMB Dual eligible Member to AHCCCS.

SUPPLEMENTAL INFORMATION

A. For AdSS responsibilities regarding Coordination of Benefits activities for Members who have Third Party coverage other than Medicare, refer to ACOM 434.

B. As a general rule, AHCCCS is the payor of last resort for most Title XIX and Title XXI services. This means that legally responsible

sources are generally required to pay for Title XIX and Title XXI services before payment by the AHCCCS Program. Federal and State provisions specify various expectations to this general rule and are outlined in this policy.

C. If AHCCCS determines that the AdSS is not performing Coordination of Benefit activities consistent with this policy, the AdSS shall be subject to administrative actions.

D. For information on AHCCCS covered services and limitations, refer to AMPM Chapter 300.

E. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and Medicaid.

F. FIGURE 1 – QUALIFIED MEDICARE BENEFICIARY DUALS MEDICARE COST SHARING - EXAMPLES

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID (Subject to the limits specified in this Policy)			
	EXAMPLE 1	EXAMPLE 2	EXAMPLE 3
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID (Subject to the limits specified in this Policy)			
Medicaid rate for Medicare service (AdSS's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
AdSS PAYS	$20	$10	$50

G. PART D COVERED DRUGS

1. Refer to AMPM Policy 310-V for additional information.

2. For information regarding behavioral health medications for individuals with a Serious Mental Illness (SMI) designation, refer to AMPM Policy 320-T1 and AMPM Policy 320-T2.

H. AHCCCS is already aware of the institutional status of QMB Dual and provides this information to CMS.

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