201 MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

EFFECTIVE DATE: Month, Day, Year
REFERENCES: 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; Division Operations Policy 434

PURPOSE

The purpose of this policy is to specify the Division's Medicare cost sharing responsibilities for Members that are Dual Eligible Medicare Beneficiaries receiving Medicare Parts A and/or B through traditional fee-for-service Medicare or a Medicare Advantage Plan in order to maximize Cost Avoidance efforts by the Division, and to provide a consistent reimbursement methodology for Medicare cost sharing.

DEFINITIONS

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 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.
4. "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).
5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
6. "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.

7. "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.
8. "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.
9. "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.
10. "Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.
11. "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.

12. "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.
13. "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.
14. "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.

15. "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.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall issue service authorizations in accordance with ACOM 414 in addition to Coordinating Benefits and identifying Third Party payor resources.
2. The Division 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 Division shall not use a denial of the service request by Medicare as a basis for the Division's determination of medical necessity or coverage.
4. The Division 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 Division 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 Division 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 Division shall adhere to the Third Party Liability Cost Avoidance requirements in accordance with ACOM 434.

B. MEDICARE COST SHARING RESPONSIBILITIES

1. The Division shall evaluate the following factors when determining the Division's Medicare cost sharing responsibilities:
   a. Whether the service is covered by Medicare only, by

Medicaid only, or by both Medicare and Medicaid;

b. Whether the services are received in- or out-of-network;

c. Whether the services are emergency services; and

d. Whether the Division refers the dual eligible Member out-of-network.

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

3. As an exception to the Division's cost sharing payment requirement, the Division 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 Division has a Medicaid nursing facility (NF) rate less than the amount paid by Medicare for a Part A SNF day.

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

1. The Division 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 Division 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 Division shall pay Medicare cost sharing amounts for QMB Duals regardless of:
   a. Whether or not the Provider is subcontracted in the Division's Provider network; or
   b. Whether or not Prior Authorization has been obtained.
4. The Division shall not pay Medicare cost share amounts if the Medicare payment exceeds the Division’s contracted reimbursement rate for the covered service.
5. The Division shall ensure liability for Medicare cost sharing amounts, plus the amount of Medicare’s payment, does not exceed the Division’s subcontracted reimbursement rate for the service.
6. The Division shall not be liable for Medicare cost sharing payments if:

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

b. The Provider's subcontracted reimbursement rate.

includes Medicare cost sharing amounts.

7. The Division 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 Division 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 Division'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 Division 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 Division shall pay the Provider in accordance with the Division'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 Division's subcontracted payment rate and the Medicare payment amount.

D. COST SHARING FOR NON-QMB DUALS

1. The Division 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 Division 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. R9-22-702.

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

a. The Division, 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 Division shall not pay:

   i. Medicare deductibles;

   ii. Coinsurance; or

   iii. Copayment amounts.

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

d. When the services is covered by both Medicare and Medicaid, the Division shall, unless the Division'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 (the

Divisions contracted rate).

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

   a. The Division 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 Division has not referred the Member to the Provider; or

         2) The Division 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 Division has not referred the Member to the Provider; or

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

         3) The services are not emergent.

b. The Division 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 Division has referred the Member to the Provider; or

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

   iii. The services are emergent.

c. The Division 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 Division has referred the Member to the Provider; or

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

   iii. The services are emergent.

E. MEDICARE PART D COVERED DRUGS

The Division 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 Division 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 Division 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 Division for AHCCCS-covered

health benefits.

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

3. The Division 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 Division shall not coordinate Creditable Drug Coverage as specified in this Section when the requesting pharmacy provider is not AHCCCS registered.
5. The Division shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for a QMB Dual eligible Member with Creditable Drug Coverage.

6. The Division shall identify potentially legally liable Third Party payor sources prior to requesting drug coverage from AHCCCS.
7. The Division 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 Division 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 Division shall not report the institutional status of a QMB Dual eligible Member to AHCCCS.

SUPPLEMENTAL INFORMATION

A. 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.

B. If AHCCCS determines that the Division is not performing coordination of benefit activities consistent with this policy, the Division shall be subject to administrative actions.

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

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

E. 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

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *(Subject to the limits specified in this Policy)*			
Medicare rate for service	$100	$100	$100
Medicaid rate for Medicare service (Division'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
DIVISION PAYS	**$20**	**$10**	**$50**

F. 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.

G. AHCCCS is already aware of the institutional status of QMB Dual

and provides this information to CMS.