

Arizona Health Care Cost Containment System

Manual: Office of Managed Care
Policy and Procedures

Effective Date:10/1/97
Revision Date:6/1/01

Subject: Medicare Cost Sharing for Members in
Medicare HMO's

Authorized Signature:

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I. Purpose

Because there is a difference in the rules for Medicare cost sharing depending on whether the recipient is enrolled in a Medicare Risk HMO or uses the FFS Medicare system, the policy is separated into two policies. The purpose of this policy is to define cost sharing responsibilities of AHCCCS Contractors for their members who are enrolled in Medicare Risk HMO's.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a reimbursement methodology that provides continuity of care for AHCCCS members.

II. Definitions

Contractor -Contractor refers to an AHCCCS acute care health plan, Arizona Long Term Care System (ALTCS) program contractor and the Arizona Department of Health Services (ADHS) for Title XIX behavioral health services.

Cost Sharing -Refers to AHCCCS Contractors' obligation for payment of applicable Medicare coinsurance and deductibles, and copayments.

Dual Eligible - Refers to an AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of dual eligible members: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB Dual), and Medicare beneficiaries not eligible for QMB benefits (Non-QMB Dual).

QMB Dual - An individual who is eligible for QMB benefits as well as Medicaid benefits. QMB duals are entitled to AHCCCS and Medicare Part A and B services.

Non-QMB Dual - An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB.

In-Network Provider - A provider that is contracted with the Contractor to provide services. However, at its discretion, a Contractor may authorize services to be provided by a non-contracted provider, such as a hospital.

Out of Network Provider - An out of network provider is a provider that is neither contracted with nor authorized by the Contractor to provide services to AHCCCS members.

Medicare Risk HMO - A managed care entity that has a Medicare contract with HCFA to provide services to Medicare beneficiaries.

III. Policy

A. Payor of Last Resort

AHCCCS is the payor of last resort. Therefore, if a member is enrolled with a Medicare Risk HMO, the member shall be directed to their Medicare Risk HMO for services. However, if the Medicare Risk HMO does not authorize a Medicaid covered service, the Contractor may review the requested service for medical necessity, and elect to authorize it.

B. Covered Services

1. QMB Dual

QMB Duals are entitled to all AHCCCS and Medicare part A and B covered services. In addition to AHCCCS covered services, QMB Duals may receive Medicare services that are not covered by AHCCCS, or differ in scope or duration. When a member is enrolled in a Medicare Risk HMO, the Contractor is responsible for cost sharing for Medicare services that are not covered by AHCCCS, or differ in scope or duration. These services include:

Chiropractic services for adults

Inpatient and outpatient occupational therapy coverage for adults

Inpatient psychiatric services (Medicare has a lifetime benefit maximum)

Other behavioral health services such as partial hospitalization

Any services covered by or added to the Medicare program not covered by AHCCCS

Please refer to the AHCCCS Medical Policy Manual (AMPM) for Medicare only covered services that are specific to the acute care and ALTCS programs.

2. Non- QMB Dual

Contractors are responsible for cost sharing for *AHCCCS-only covered services* for Non-QMB’s. Contractors are not responsible for the services listed in III. B. 1 above.

3. Cost Sharing Matrix

Covered Services—	Contractor Responsibility	In Network	Out of Network*	Prior Authorization Required
Medicare Only Covered Services**	Cost Sharing responsibility for QMB Duals Only.	N/A	N/A	NO
AHCCCS Only—not covered by Medicare	Reimbursement for all medically necessary services	YES	NO	YES
AHCCCS and Medicare covered Service (except for emergent and pharmacy services)	Cost sharing responsibility only	YES	NO	YES
Emergency Services	Cost sharing responsibility only	YES	YES	NO
Pharmacy and Other Physician Ordered Services (see E. below for more details)	Cost sharing responsibility until member reaches HMO cap, then full reimbursement	YES	NO	YES/NO (See E. below for more details.)

*Unless prior authorized

** AHCCCS contractors are not responsible for cost sharing for Medicare Only Services for Non-QMBs.

C. Limits on Cost Sharing

Contractors have cost sharing responsibility for all AHCCCS covered services provided to members by a Medicare Risk HMO. For those services that have benefit limits, the Contractor shall reimburse providers for all AHCCCS and Medicare covered services when the member reaches the Medicare Risk HMO’s benefit limits.

For those Medicare services which are also covered by AHCCCS, there is no cost sharing obligation if the Contractor has a contract with the Medicare provider, and the provider’s contracted rate includes Medicare cost sharing as specified in the contract.

Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. With respect to copayments, the Contractor may pay the lesser of the copayment, or their contracted rate.

D. Prior Authorization

If the Contractor's contract with a provider requires the provider to obtain prior authorization before rendering services, and the provider does not obtain prior authorization, the Contractor is not obligated to pay the Medicare cost sharing for AHCCCS covered services, except for emergent care. See F below for exceptions for pharmacy and other physician ordered services.

If the Medicare Risk HMO determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If the Medicare Risk HMO denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity, and may not use the Medicare Risk HMO's decision as the basis for denial.

E. Out of Network Services

1. Provider

If an out of network referral is made by a contracted provider, and the Contractor specifically prohibits out of network referrals in the provider contract, then the provider may be considered to be in violation of the contract. In this instance, the Contractor has no cost sharing obligation. The provider who referred the member to an out of network provider is obligated to pay any cost sharing. The member shall not be responsible for the Medicare cost sharing except as stipulated in E.2. of this policy.

2. Member

If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the member is responsible for paying the Medicare cost sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the Contractor's member handbook.

F. Pharmacy and Other Physician Ordered Services

Contractors shall cover pharmacy copayments for prescriptions prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. For purposes of this section, "in network" refers to the provider who supplies the prescription, not the prescribing provider. However, if a provider prescribes a non-formulary prescription, then the Contractor may opt to not reimburse for the prescription copayment. If a Contractor requires prior authorization for formulary medications, then the Contractor may choose not to cover the copayment if prior authorization is not obtained.

If a member exceeds their pharmacy benefit limit, the Contractor shall cover all prescription costs for the member. These prescriptions are subject to the Contractor's formulary, prior authorization and pharmacy network requirements.

If the Medicare Risk HMO does not offer a pharmacy benefit, then the Contractor may require that the prescribing physician be in the Contractor's network for prescription benefit coverage.

This requirement extends to all "prescribed services" such as laboratory and DME.

IV. References

AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing

ARS 36-2946 A

ARS 36-2972 C

AAC R9-29-302B

AAC R9-29-401

1905(p)(3) of the Social Security Act