201 - MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors. The purpose of this Policy is to specify a Contractor's Medicare cost sharing responsibilities for members that are Dual Eligible Medicare Beneficiaries (Dual Eligible Members) receiving Medicare Parts A and/or B through Traditional Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan in order to maximize cost avoidance efforts by the Contractor, and to provide a consistent reimbursement methodology for Medicare cost sharing.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

COORDINATION OF BENEFITS (COB)	**CONTRACTOR**	**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)	**INSTITUTION FOR MENTAL DISEASE (IMD)**	**INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)**
MEMBER	**NON-QUALIFIED MEDICARE BENEFICIARY (NON-QMB) DUAL**	**PRIOR AUTHORIZATION (PA)**
QUALIFIED MEDICARE BENEFICIARY (QMB)	**SERIOUS MENTAL ILLNESS (SMI)**	**SKILLED NURSING FACILITY (SNF)**
THIRD-PARTY LIABILITY (TPL)		

III. POLICY

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.

Third Party Liability (TPL) and Coordination of Benefits (COB) issues are independent from the Contractor's responsibility to timely issue an authorization determination as specified in State and Federal provisions and as specified in ACOM Policy 414.

Regardless of presence of an individual's Medicare coverage, the Contractor is obligated to timely evaluate the medical necessity and coverage of a requested service, even when the potential third party has not yet issued a determination. A denial of the service request by Medicare is not to be used as a basis for the Contractor's determination of medical necessity or coverage; in these instances, the Contractor shall independently and timely evaluate the member's service request using its own criteria. When Medicare has approved a service request as medically necessary, the Contractor shall not apply a secondary Prior Authorization (PA) and shall coordinate payment as specified in this policy.

The two methods used for COB are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as specified in A.A.C. R9-22-1001 et seq., Federal and State law, and AHCCCS Policy.

1. Cost Avoidance: The Contractor shall cost avoid a claim when it has established the probable existence of liability and receives confirmation that Medicare is responsible for the payment of a claim for a healthcare item or service delivered to a member.

2. Post-Payment Recovery, Pay and Chase: In certain circumstances, the Contractor shall pay a claim even when a third party is liable, and then recoup that payment from the liable third party. This practice is referred to as pay and chase. The Contractor shall pay the full amount of the claim according to the AHCCCS capped-FFS Schedule or the contracted rate and then seek reimbursement from Medicare for the following pay and chase cases:
    a. When the Contractor is unable to confirm the liability of Medicare,
    b. Claims for preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program,
        i. Preventive pediatric care, including EPSDT covered services, refers to screening and diagnostic services to identify congenital, physical, mental health routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under age 21. This includes, but is not limited to:
            1) Immunizations,
            2) Screening tests for congenital disorders,
            3) Well child visits,
            4) Preventive medicine visits,
            5) Preventive dental care,
            6) Screening and preventive treatment for infectious and communicable diseases, therapies,
            7) Behavioral health exams, or
    c. Services covered by Medicare that are derived from an absent parent whose obligation to pay support is being enforced by the Arizona Department of Economic Security DES, Division of Child Support Services (DCSS).

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

For Contractor responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to ACOM Policy 434.

A. CONTRACTOR MEDICARE COST SHARING PAYMENT RESPONSIBILITIES

For Qualified Medicare Beneficiary (QMB) duals and Non-QMB duals, the Contractor's Medicare cost sharing payment responsibilities are dependent upon the following factors:

1. Whether the service is covered by Medicare only, by Medicaid only, or by both Medicare and Medicaid.

2. Whether the services are received in- or out-of-network (the Contractor only has responsibility to make Medicare cost sharing payments to AHCCCS registered providers).

3. Whether the services are emergency services, and/or

4. Whether the Contractor refers the dual eligible member out-of-network.

The Contractor's Medicare cost sharing responsibilities are specified in this Policy and in A.A.C. Title 9, Chapter 29, Article 3: Benefits and Services.

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

B. QUALIFIED MEDICARE BENEFICIARY DUALS

QMB Duals are entitled to all Medicare Part A and B and Medicaid covered services. These members are identified by a Medicare Part C entry in their 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 (A.A.C. R9-29-302).

1. Contractor Payment Responsibilities:
   a. The Contractor is responsible for payment of Medicare cost sharing amounts (deductibles, coinsurance, and copayments) for Medicare Parts A and B covered services, including services covered by the Medicare Program but not covered by AHCCCS as specified in this Policy. For information on AHCCCS covered services and limitations, refer to AMPM Chapter 300, and
   b. The Contractor is prohibited from using the 09 coverage code to deny payment for medically necessary services provided to a QMB Dual. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and Medicaid and shall not be used by the Contractor to deny payment of claims, including Medicare cost sharing claims.

2. The Contractor only has responsibility to make payments to AHCCCS registered providers.
   a. The payment of Medicare cost sharing amounts for QMB Duals shall be provided regardless of whether or not the provider is subcontracted in the Contractor's provider network, or whether or not prior authorization has been obtained (refer to the PA section in this Policy for further information),
   b. The Contractor shall have no Medicare cost sharing obligation if the Medicare payment exceeds the Contractor's contracted reimbursement rate for the covered service. The Contractor's liability for Medicare cost sharing amounts, plus the amount of Medicare's payment, shall not exceed the Contractor's subcontracted reimbursement rate for the service. There is no separate Medicare cost sharing obligation if the Contractor has a subcontract with the provider and the provider's subcontracted reimbursement rate includes Medicare cost sharing amounts,
   c. Exception to the above limits on Medicare cost sharing reimbursement, the Contractor shall pay 100% of a QMB Duals Medicare cost sharing amount for any Medicare Part A SNF stay days 21 through 100, even if the Contractor has a Medicaid NF rate less than the amount paid by Medicare for a Medicare Part A SNF day, and
   d. In accordance with A.A.C. R9-29-302, unless the Contractor'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 (Table 1 and Figure 1) apply:

TABLE 1: QUALIFIED MEDICARE BENEFICIARY DUALS

QUALIFIED MEDICARE BENEFICIARY DUALS MEDICARE COST SHARING REQUIREMENTS	
WHEN THE SERVICE IS COVERED BY:	**THE CONTRACTOR SHALL PAY:** (Subject to the limits specified in this Policy)
Medicare Only	Medicare deductible, coinsurance, and copayment amounts
Medicaid Only	The provider in accordance with the Contractor's subcontract
By both Medicare and Medicaid (Refer to Examples Below)	The lesser of: a. The Medicare deductible, coinsurance and/or copayment amounts **or** b. The difference between the Contractor's subcontracted payment rate and the Medicare payment amount.

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 (b. In Table 1 above)	**EXAMPLE 2** (b. In Table 1 above)	**EXAMPLE 3** (b. In Table 1 above)
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100
Medicaid rate for Medicare service (Contractor'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
CONTRACTOR PAYS	**$20**	**$10**	**$50**

C. NON-QUALIFIED MEDICARE BENEFICIARY DUALS

A Non-QMB dual who receives covered services under A.A.C. R9-22 Article 2 or A.A.C. R9-28 Article 2 from an in-network provider is not liable for:

1. Any applicable Medicare Cost Sharing (deductible, coinsurance, or copayment) amounts associated with those services, or

2. For any balance of billed charges, unless services have reached the limitations specified within A.A.C. R9-22 Article 2.
   a. When a Non-QMB Dual elects to receive services that are covered by both Medicare and Medicaid, from an out-of-network provider, the individual is responsible for any Medicare deductible, coinsurance, or copayment amounts unless the service is emergent, or, for non-emergency services, 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. Contractor Payment Responsibilities (In Network)
   a. In accordance with A.A.C. R9-29-303, 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, the individual is not liable for any balance of billed charges, and Table 2 applies:

TABLE 2: NON-QUALIFIED MEDICARE BENEFICIARY DUALS (IN NETWORK)

NON-QUALIFIED MEDICARE BENEFICIARY DUALS (IN NETWORK) MEDICARE COST SHARING REQUIREMENTS	
WHEN THE SERVICE IS COVERED BY:	**THE CONTRACTOR SHALL NOT PAY:**
Medicare Only	Any Medicare deductible, coinsurance, or copayment amounts
WHEN THE SERVICE IS COVERED BY:	**THE CONTRACTOR SHALL PAY:** (Subject to the limits specified in this Policy)
Medicaid Only	The provider in accordance with the Contractor's subcontract
By both Medicare and Medicaid	The lesser of the following (unless the Contractor's subcontract with the provider sets forth different terms): a. The Medicare deductible, coinsurance and/or copayment amounts, **or** b. Any remaining Medicare cost sharing amount after the Medicare payment amount is deducted from the provider's subcontracted rate (The Contractor's contracted rate).

4. Contractor Payment Responsibilities (Out-of-Network)
   a. In accordance with A.A.C. R9-29-303, when a Non-QMB Dual receives covered services from an out of network provider, the following applies (Table 3):

TABLE 3: NON-QUALIFIED MEDICARE BENEFICIARY DUALS (OUT-OF-NETWORK)

NON-QUALIFIED MEDICARE BENEFICIARY DUALS (OUT-OF-NETWORK) MEDICARE COST SHARING REQUIREMENTS	
WHEN THE SERVICE IS COVERED BY:	**THE CONTRACTOR SHALL PAY:** (Subject to the limits specified in this Policy)
Medicare Only	Has no responsibility for payment
Medicaid only AND the Contractor **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 Contractor **has** referred the member to the provider, or has authorized the provider to render services, or the services are emergent	Shall pay in accordance with the requirements of A.A.C. R9-22-705.
By both Medicare and Medicaid AND the Contractor **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 Contractor **has** referred the member to the provider, or has authorized the provider to render services, or the services are emergent	Shall pay the lesser of: a. The Medicare deductible, coinsurance or copayment amounts, **or** b. 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.

D. PART D COVERED DRUGS

For a QMB Dual and a Non-QMB Dual Federal and State laws prohibit the use of Title XIX or Title XXI funds to pay Medicare cost sharing amounts related to Medicare Part D prescription drug benefit medications. Refer to AMPM Policy 310-V for additional information.

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.

E. COORDINATION OF CREDITABLE DRUG COVERAGE

1. The Contractor is responsible for coordinating the benefit for medications when a dual eligible member has creditable drug coverage as specified in 42 CFR 423.56.

2. If a dual eligible member also has creditable drug coverage through a commercial payer, then the Contractor is required to coordinate such creditable drug coverage with the identified commercial payer (as a primary or secondary payer as applicable) when all of the following apply:
   a. The medication is Federally and State reimbursable,
   b. The dual eligible member is enrolled in Medicare Part A only (and not enrolled in Medicare Part B and/or Medicare Part D), and is enrolled with the Contractor for AHCCCS-covered health benefits, and
   c. The medication is dispensed by an AHCCCS-registered provider, regardless of whether that provider is in the Contractor's provider network.

3. When a primary or secondary creditable drug coverage medication request is denied by a commercial payer, and a dual eligible member's appeal of such medication denial has been previously upheld by such creditable drug coverage commercial payer (when applicable), the Contractor shall evaluate the request for drug coverage by applying its AHCCCS drug coverage criteria.

4. The Contractor does not have the responsibility for coordination of creditable drug coverage as specified in this section when the requesting pharmacy provider is not AHCCCS registered.

5. The Contractor shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for a dual eligible member with creditable drug coverage.

6. The Contractor's AHCCCS drug coverage is the payer of last resort. All other possible primary and secondary drug coverage options and payers shall be exhausted prior to the Contractor evaluating such creditable drug coverage requests and adjudicating such pharmacy claims.

F. MEDICARE PART D COPAYMENTS AND INSTITUTIONAL STATUS REPORTING

1. Medicare Part D Copayments
   When a dual eligible member is in a medical institution and, that stay is funded by Medicaid for a full calendar month, the dual eligible member is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year.

2. Institutional Status Reporting
   To ensure appropriate information is communicated for these members to Centers for Medicare and Medicaid Services (CMS), the Contractor shall submit AHCCCS Notification to Waive Medicare Part D Co-Payments, utilizing Attachment A, and submit as specified in Contract.
   a. This includes those dual eligible members who:
      i. Have exhausted their Medicare Part "A" lifetime inpatient benefit,
      ii. Have Medicare Part "B" benefits only,
      iii. Have Medicare Part "D" benefits only, and
      iv. Are in a continuous placement at a single medical institution, or any combination of continuous placements in more than one medical institution.
   b. The types of medical institutions notifying the Contractor of institutionalized dual eligible members, and as reported to AHCCCS by the Contractor using Attachment A, are defined by 42 CFR 435.1010, 42 CFR 440.140 and 42 CFR 440.150 to include:
      i. Acute hospitals,
      ii. Residential treatment center – Non-Institution for Mental Disease (IMD),
      iii. SNF, and
      iv. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

   ALTCS E/PD and DDD are not required to provide this information as AHCCCS is already aware of the institutional status of these members and provides this information to CMS.