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

EFFECTIVE DATES: 10/01/97, 02/01/13, 07/01/13, 12/01/14, 07/01/16, 09/20/17

REVISION DATES: 06/01/01, 03/11/10, 01/03/13, 06/06/13, 07/18/13, 11/20/14, 05/19/16, 09/07/17

I. PURPOSE

This Policy applies to Acute, ALTCS/EPD, CRS, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. The purpose of this Policy is to define Contractor cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this Policy is also to maximize cost avoidance efforts by Managed Care Contractors and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

II. DEFINITIONS

**COST SHARING**

The Contractors’ obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

**DUAL ELIGIBLE MEDICARE BENEFICIARIES (DUALS)**

An AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+).

**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.

**IN-NETWORK PROVIDER**

A provider that is contracted with the Contractor to provide services.

**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).
MEDICARE PART A  Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

MEDICARE PART B  Coverage for medically-necessary services like doctors' services, outpatient care, home health services, and other medical services.

MEDICARE PART D  Medicare prescription drug coverage.

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.

OUT OF NETWORK PROVIDER  A provider that is neither contracted with nor authorized by the Contractor to provide services to its members.

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.

QUALIFIED MEDICARE BENEFICIARY ONLY (QMB ONLY)  A person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB)  Persons entitled to Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary’s Part B premium costs.

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.

III. POLICY

For QMB Duals and Non-QMB Duals, the Contractor’s cost sharing payment responsibilities are dependent upon various factors:

- Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid,
- Whether the services are received in or out of network (the Contractor only has responsibility to make payments to AHCCCS registered providers),
- Whether the services are emergency services, and/or
- Whether the Contractor refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. Title 9, Chapter 29, Article 3.
An exception to the Contractor’s cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the Contractor shall pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

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

A. QMB Duals

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.R9-22-2 or A.A.C. R9-28-2 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)

**Contractor Payment Responsibilities**

1. The Contractor 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 also AMPM Chapter 300, Section 310. These services include:
   a. Chiropractic services for adults,
   b. Outpatient occupational and speech therapy coverage for adults,
   c. Orthotic devices for adults,
   d. Cochlear implants for adults,
   e. Services by a podiatrist, and
   f. Any services covered by or added to the Medicare program not covered by Medicaid.

2. The Contractor is prohibited from using the 09 coverage code to deny payment for medically necessary services to members who are both Medicare and Medicaid eligible. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and Medicaid, and shall not be used to deny payment of claims.

3. The Contractor only has responsibility to make payments to AHCCCS registered providers.

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

5. The Contractor 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. There is no cost sharing obligation if the Contractor 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 Contractor shall pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

6. 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**

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE CONTRACTOR SHALL PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copayments, coinsurance and deductible</td>
</tr>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
<tr>
<td>By both Medicare and Medicaid (See Examples Below)</td>
<td>The lesser of:</td>
</tr>
<tr>
<td></td>
<td>a. The Medicare copay, coinsurance or deductible, or</td>
</tr>
<tr>
<td></td>
<td>b. The difference between the Contractor’s contracted rate and the Medicare paid amount.</td>
</tr>
</tbody>
</table>

**FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES**

<table>
<thead>
<tr>
<th>SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID</th>
<th>EXAMPLE 1 (b. In Table 1 above)</th>
<th>EXAMPLE 2 (b. In Table 1 above)</th>
<th>EXAMPLE 3 (b. In Table 1 above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider charges</td>
<td>$125</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Medicare rate for service</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Medicaid rate for Medicare service (Contractor’s contracted rate)</td>
<td>$100</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td>Medicare deductible</td>
<td>$0</td>
<td>$0</td>
<td>$40</td>
</tr>
<tr>
<td>Medicare paid amount (80% of Medicare rate less deductible)</td>
<td>$80</td>
<td>$80</td>
<td>$40</td>
</tr>
</tbody>
</table>
Medicare coinsurance (20% of Medicare rate)  | $20 | $20 | $20

**CONTRACTOR PAYS**  | $20 | $10 | $50

### B. NON-QMB DUALS

A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9, 9 A.A.C. 28, Article 2 from a provider within the Contractor'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, Article 2. 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.

**CONTRACTOR PAYMENT RESPONSIBILITIES (IN NETWORK)**

1. 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. R9-22-2, the member is not liable for any balance of billed charges and the following applies (Table 2):

**TABLE 2: NON-QMB DUALS (IN NETWORK)**

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE CONTRACTOR SHALL NOT PAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copay, coinsurance or deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE CONTRACTOR SHALL PAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By both Medicare and Medicaid</th>
<th>The lesser of the following (unless the subcontract with the provider sets forth different terms):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. The Medicare copay, coinsurance or deductible, or</td>
</tr>
<tr>
<td></td>
<td>b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (Contractor’s contracted rate).</td>
</tr>
</tbody>
</table>
**CONTRACTOR PAYMENT RESPONSIBILITIES (OUT OF NETWORK)**

2. 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)**

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE CONTRACTOR Subject to the limits outlined in this Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>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</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>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</td>
<td>Shall pay in accordance with A.A.C. R9-22-705.</td>
</tr>
<tr>
<td>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</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>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</td>
<td>Shall 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.</td>
</tr>
</tbody>
</table>
C. PRIOR AUTHORIZATION

The Contractor can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing if the member is a QMB dual, even if the Contractor determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service for QMB Duals.

D. 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.

RBHAs must utilize available Non-Title XIX/XXI funds to cover Medicare Part D copayments for Title XIX/XXI and Non-Title XIX/XXI persons determined to have SMI, with the following limitations:

- Coverage of co-payments are to be used for medications on the AHCCCS Behavioral Health Drug List,
- Co-payments are to be covered for medications prescribed by RBHA in-network providers,
- RBHAs shall utilize Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap, and
- If a request for an exception has been submitted and denied by the Medicare Part D plan and the coverage determination appeals process has been completed, the RBHA may utilize Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons determined SMI, regardless of Title XIX/XXI eligibility.

E. INSTITUTIONAL STATUS REPORTING – PART D COPAYS

1. Acute, RBHA, CMDP and CRS -- When a dual eligible member is inpatient in a medical institution or nursing facility and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. (See Chapter 16b, Section 80.4.3 of the Medicare Managed Care Manual and Medicare Prescription Drug Benefit Manual, Chapter 13, Section 60).

To ensure appropriate information is communicated for these members to CMS, the Contractor must notify the AHCCCS, Member Database Management Administration (MDMA), using the form provided in Attachment A of this Policy, as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person’s Medicare lifetime or annual benefits. Notification is to be submitted as specified in Contract. This includes:

a. Members who have Medicare Part “D” only,
b. Members who have Medicare Part “B” only,
c. Members who have used their Medicare Part “A” lifetime inpatient benefit, and
d. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.

2. **Types of Medical Institutions** -- For purposes of the medical institution notification, medical institutions are defined as:
   a. Acute hospitals,
   b. Psychiatric hospital – Non IMD,
   c. Psychiatric hospital – IMD,
   d. Residential treatment center – Non IMD,
   e. Residential treatment center – IMD,
   f. Skilled nursing facilities, and
   g. Intermediate Care Facilities for the Intellectually Disabled.

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