

ALABAMA MEDICAID AGENCY

NOTICE OF INTENDED ACTION

RULE NO. & TITLE: 560-X-1-.14 Medicaid payments for Medicare/Medicaid and/or Qualified Medicare Beneficiaries (QMB) Eligible Recipients.

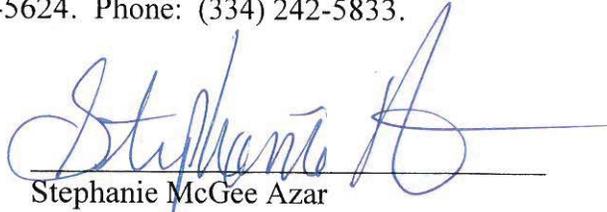
INTENDED ACTION: Amend 560-X-1-.14

SUBSTANCE OF PROPOSED ACTION: The above referenced rule is being amended to remove the outpatient and inpatient hospital reimbursement limitation in accordance with State Plan Amendment 13-016.

TIME, PLACE, MANNER OF PRESENTING VIEWS: Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than June 4, 2015.

CONTACT PERSON AT AGENCY: Stephanie Lindsay, Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Phone: (334) 242-5833.



Stephanie McGee Azar

Acting Commissioner

Rule No. 560-X-1-14 Medicaid payments for Medicare/Medicaid and/or Qualified Medicare Beneficiaries (QMB) Eligible Recipients

Medicaid pays the monthly premiums for Medicare insurance for an eligible Medicare/Medicaid and/or QMB recipient to the Social Security Administration. Medicaid also pays the applicable Medicare Part A and Part B deductibles and/or coinsurance for an eligible Medicare/Medicaid and/or QMB recipient, as specified below.

(1) Definitions

- (a) "QMB" recipient is a Part A Medicare beneficiary whose verified income and resources do not exceed certain levels.
- (b) "Deductible" is the dollar amount a Medicare eligible must pay for his/her own health care services.
- (c) "Coinsurance" is the percentage of each bill a Medicare eligible must pay under certain conditions, in addition to the deductible amount.

(2) Part A

- (a) ~~Medicaid inpatient hospital days run concurrently with Medicare days.~~ The Part A deductible less any applicable copay or coinsurance days are covered Medicaid services, ~~provided the Medicaid covered days for the calendar year have not been exhausted unless the recipient is a QMB.~~ For QMB recipients, the inpatient hospital deductible less any applicable copay, coinsurance days and lifetime reserve days are covered services for any inpatient admission.
- (b) Medicaid may pay the Part A coinsurance for the 21st day through the 100th day for Medicare/Medicaid and/or QMB eligible recipients who qualify under Medicare rules for skilled level of care. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. No payment will be made by Medicaid (Title XIX) for skilled nursing care in a dual certified nursing facility for the first 20 days of care for recipients qualified under Medicare rules.
- (c) Medicare pays in full for Medicare-approved home health services, therefore, Medicaid has no liability for these services.
- (d) Medicare pays in full for Medicare-approved hospice services, therefore, Medicaid has no liability for these services.
- (e) Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate, will be paid.
- (f) Medicaid will pay Part A claims in accordance with Medicaid reimbursement methodology for Medicare recipients who have exhausted their life-time Medicare benefits. Those claims must be filed directly to Medicaid in accordance with instructions in Chapter 19 of the Alabama Medicaid Provider Manual.

(3) Part B

- (a) Except as provided in this subsection, Medicaid pays the Medicare Part B deductible and coinsurance to the extent of the lesser of the level of reimbursement under

Medicare rules and allowances or total reimbursement allowed by Medicaid less Medicare payment.

(b) Medicare related claims for QMB recipients shall be reimbursed in accordance with the coverage determination made by Medicare. Medicare related claims for recipients not categorized as QMB recipients shall be paid only if the services are covered under the Medicaid program.

~~(c) — Hospital outpatient claims are subject to Medicaid reimbursement methodology but are not subject to the outpatient limitation of three visits a calendar year.~~

~~(cd)~~ Medicare claims for rented durable medical equipment shall be considered for payment if the equipment is covered as a purchase item under the Medicaid Program. Rental payments and purchases on non-covered Medicaid items for QMB recipients shall also be considered for payment.

(4) When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/Medicaid eligibles and QMB eligibles must be sent first to the Medicare contracted intermediary. Claims paid by the Medicare contracted intermediary will be electronically forwarded to Medicaid's fiscal agent for payment of the Medicare cost-sharing charges. Claims denied by the Medicare intermediary are not forwarded to the Medicaid fiscal agent. Chapter 20 of this Code contains additional health insurance information.

(a) Providers will complete the appropriate Medicare claim forms ensuring that the recipient's 13 digit Medicaid ID number is on the form. The completed claim shall be forwarded to an Alabama Medicare carrier for payment.

(b) If the provider's claim for service is rejected by the Medicare carrier as "Medicare non-covered service" but is a covered Medicaid service, a Medicaid claim form, completed in accordance with instructions in the Alabama Medicaid Provider Manual, with a copy of the Medicare rejection statement, should be sent to the Medicaid fiscal agent for payment. QMB-Only recipients are not entitled to Medicaid coverage for Medicare non-covered services.

(c) Providers in other states who render Medicare services to Alabama Medicare/Medicaid eligibles and QMB eligibles should file claims first with the Medicare carrier in the state where the service was performed.

Author: Solomon Williams, Associate Director, Institutional Services.

Statutory Authority: State Plan, Attachment 3.2-A and 3.5-A; 42 C.F.R. § 431.625; Social Security Act of 1988 (Public Law 100-360); Balanced Budget Act of 1997.

History: Rule effective October 1, 1982. Amended November 10, 1983; March 13, 1984; June 21, 1984; January 8, 1985; April 11, 1986; January 1, 1988; February 1, 1989; May 12, 1989; January 1, 1990; June 14, 1990; February 1, 1996; April 12, 1996; November 10, 1997.

Emergency rule filed and effective October 1, 1999. Amended: Filed October 13, 1999; effective January 12, 2000. Amended: Filed February 19, 2010; effective May 14, 2010.

Amended: Filed September 11, 2013; effective October 16, 2013. **Amended:** Filed April 20, 2015.