Section 7.2 Medical Institution Reporting of Medicare Part D

7.2.1 Introduction

Medicare eligible recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Medicare Part D coverage includes co-payment requirements of all persons. However, Medicare Part D co-payments are waived when a dual eligible person enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions must notify the Arizona Health Care Cost Containment System (AHCCCS) when a dual eligible person is expected to be in the medical institution for at least a full calendar month to ensure co-payments for Part D are waived. The waiver of co-payments applies for the remainder of the calendar year, regardless of whether the person continues to reside in a medical institution. Given the limited resources of many dual eligible persons and to prevent the unnecessary burden of additional co-pay costs, it is imperative that these individuals are identified as soon as possible.

The objective of this policy is to inform providers designated as medical institutions of reporting and tracking requirements for dual eligible persons to ensure Medicare Part D co-pays are waived.

7.2.2 Terms

Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php and http://www.magellanofaz.com/for-providers/provider-manual/definitions.aspx. The following terms are referenced in this section:

Dual Eligible
Institution for Mental Disease (IMD)
Institutionalized individual
Medical Institution
Medicare Advantage Prescription Drug Plan (MA-PD)
Prescription Drug Plan (PDP)

7.2.3 Procedures

7.2.3-A. Reporting Requirements

To ensure that dual eligible persons' Medicare Part D co-payments are waived when it is expected that dual eligible persons will be in a medical institution, funded by Medicaid, for at least a full calendar month, AHCCCS must be notified immediately upon admittance. Reporting must be done using PM Form 7.2.1, AHCCCS Notification To Waive Medicare Part D Co-Payments For Members In A Medical Institution That Is Funded By Medicaid. Providers

must not wait until the person has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Persons who have Medicare Part "B" only;
- Persons who have used their Medicare Part "A" lifetime inpatient benefit; and
- Persons who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical Institutions
Medical institutions include the following providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – IMD (PT 71)
- Residential Treatment Center – IMD (PT B1, B3)
- Residential Treatment Center – Non IMD (PT 78, B2)
- Nursing Homes – (PT 22)

7.2.4 References

The following citations serve as additional resources for this content area:
42 CFR 400.202
42 CFR 409.62
42 CFR 422.2
42 CFR 422.4
42 CFR 423.4
42 CFR 423.104
9 A.A.C. 20
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DBHS Covered Behavioral Health Services Guide

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PM Form 7.2.1
AHCCCS NOTIFICATION TO WAIVE MEDICARE PART D CO-PAYMENTS FOR MEMBERS IN A MEDICAID FUNDED MEDICAL INSTITUTION

Use this form to notify AHCCCS when a member is expected to reside in a medical institution that is funded by Medicaid for a full calendar month.

Fax to the AHCCCS Member Database Management Administration (MDMA) 602-253-4807

MEMBER INFORMATION

MEMBER NAME_____ AHCCCS ID_____
DATE OF BIRTH ___/___/___

MEDICAL INSTITUTION INFORMATION

NOTIFICATION OF A MEDICAID FUNDED ADMISSION

TYPE OF MEDICAL INSTITUTION	(x)	DATE OF ADMISSION	PROVIDER ID #	NAME OF MEDICAL INSTITUTION
ACUTE HOSPITAL	_____	_____	_____	_____
PSYCHIATRIC HOSPITAL/ IMD	_____	_____	_____	_____
PSYCHIATRIC HOSPITAL/Non-IMD	_____	_____	_____	_____
RTC/IMD	_____	_____	_____	_____
RTC/Non-IMD	_____	_____	_____	_____
SNF	_____	_____	_____	_____
ICF MR	_____	_____	_____	_____

COMMENTS:

SUBMITTED BY: _____ DATE:_____
TITLE:_____

PHONE #:_____

HEALTH PLAN/T/RBHA:_____