

**MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER**

August 27, 2019

TO: CUSTODIANS OF MEDICAID OPERATIONS MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 900 – COST AVOIDANCE PROGRAMS

BACKGROUND AND EXPLANATION

Medicaid Operations Manual (MOM) Chapter 900 – Cost Avoidance Programs is being proposed to encompass the following categories; Health Insurance Premium Program (HIPP), incarcerations, Medicare Advantage Plan, Medicare Premium Buy-In and Public Assistance Reporting Information System (PARIS). These changes are being made to improve the organization of content in the MOM and to place contents regarding internal Division of Health Care Financing and Policy operations into the Medicaid Operations Manual.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective: August 28, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL N/A MEDICAID OPERATIONS MANUAL CHAPTER 900 – COST AVOIDANCE PROGRAMS	MTL N/A N/A

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 900	INTRODUCTION	Overview of Cost Avoidance Programs encompassed in Third-Party Liability (TPL); HIPP, incarcerations, Medicare Advantage Plans, Medicare Premium Buy-In and Public Reporting Information System (PARIS).
Section 901	AUTHORITY	Outlined governing authority for cost avoidance programs.
Section 902	DEFINITIONS	Definition of language used throughout the chapter.

Section 903	HEALTH INSURANCE PREMIUM PAYMENT	Section title.
Section 903.1	HIPP POLICY	HIPP policy, determined using cost-effectiveness determinations.
Section 903.2	HIPP ELIGIBILITY DETERMINATION	Explanation of HIPP applicants are determined. Reference HIPP Application and LEP services number.
Section 903.3	HIPP COST-EFFECTIVENESS	Explanation of HIPP methodology used when determining cost-effectiveness. Reference State Medicaid Manual (SMM) Chapter 3, Section 3910 – Medicaid Payments for Recipients Under Group Health Plans.
Section 903.4	RECIPIENT RESPONSIBILITY	Outlines recipient responsibilities to the operating teams.
Section 903.5	HIPP PAYMENT PROCESS	Explains the process on how HIPP enrollees are paid.
Section 903.6	HIPP OVERPAYMENT	Explanation of steps to be taken by the TPL team if an overpayment occurs.
Section 903.7	LIMITATIONS	HIPP restrictions.
Section 903.8	HIPP ELIGIBILITY REDETERMINATION	Explains the limited ability to request a redetermination.
Section 903.9	HIPP PROGRAM DISQUALIFIERS	Outlines circumstances that will automatically disqualify from HIPP.
Section 903.10	HIPP TERMINATION	Explanation of annual recertification and compliance.
Section 903.11	HIPP REINSTATEMENT	Defines HIPP requires a new application with a few exceptions.
Section 904	INCARCERATIONS	Defines incarceration criteria.
Section 904.1	ELIGIBILITY EXCEPTION	References the Division of Welfare and Supportive Services (DWSS) Medical Assistance Manual (MAM) Section C-800 for eligibility criteria.

Section 905	MEDICARE ADVANTAGE (MA) PLANS	Introduction of Medicare Advantage (MA) Plans.
Section 905.1	BENEFITS FOR MEDCARE ADVANTAGE PLANS	Explains fiscal coverage.
Section 905.2	MEDICARE ADVANTAGE PLAN BILLING PROTECTIONS	Defines recipient protection from provider collection.
Section 905.3	MEDICARE ADVANTAGE PLAN PATIENT LIABILITY	Addresses healthcare facility and the number of days for coverage.
Section 906	MEDICARE PREMIUM BUY-IN PROGRAM	Explains the Medicare Premium Buy-In Program.
Section 906.1	MEDICARE PREMIUM BUY-IN ELIGIBILITY	Outlines eligibility.
906.2	EFFECTIVE DATES FOR MEDICARE PREMIUM BUY-IN	Explains the accretion effective date.
906.3	MEDICARE PREMIUM BUY-IN PROGRAM EXCEPTIONS	Explains the exceptions to the program.

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MEDICAID OPERATIONAL MANUAL	Subject: INTRODUCTION

900 INTRODUCTION

Third Party Liability (TPL) is any individual, entity or program that is, or may be, liable to pay all or part of the medical cost for medical assistance furnished to a Medicaid recipient. Medicaid is generally the payer of last resort whenever there are any other responsible resources for payment of health care services. TPL includes, but is not limited to: Medicare, worker's compensation, private or group insurance and any self-insured plans.

Cost Avoidance Programs consist of: Health Insurance Premium Program (HIPP), incarcerations, Medicare Advantage Plan, Medicare Premium Buy-In and Public Assistance Reporting Information System (PARIS).

HIPP is the State's cost-avoidance program, which identifies Medicaid recipients with other health care insurance (OHI) available through another health insurance carrier other than Medicaid or another entity. The program is funded by Medicaid Section 1906 of the Social Security Act (SSA) under Title XIX and Section 4741 of the Balanced Budget Act (BBA) of 1997. Language was amended in Sections 1902(a)(25) and 1906(a)(1) of the SSA making cost avoidance programs optional for the states. The program has been in place since 1992. Nevada Medicaid may pay medical insurance premiums, co-insurance and deductibles for eligible individuals and families when it is determined cost-effective. State of Nevada and taxpayer monies are saved by purchasing health insurance available to eligible Medicaid recipients when found to be cost effective. The program also assists recipients in paying the policy premiums they otherwise may not be able to afford. High health care costs are deferred to the private insurance, thus making Medicaid the payer of last resort in most cases.

An individual who becomes incarcerated is not eligible for Medicaid. An incarcerated individual may become eligible if transported and admitted to a qualifying medical treatment facility.

Individuals who receive their Medicare Part A and Part B coverage through private health plans are considered to be enrolled in a Medicare Advantage plan. Medicare Advantage plans may also include prescription drug coverage offered under Part D. In addition to the standard Part A and Part B benefits or Part D coverage, Medicare Advantage plans may cover supplemental benefits, such as coverage for dental care, vision care, acupuncture or health club memberships. If the supplemental benefits are covered for all enrollees in the Medicare Advantage plan, the benefits are referred to as mandatory supplemental benefits. If the enrollee elects whether to receive these benefits, then they are referred to as optional supplemental benefits. The Center for Medicare and Medicaid Services (CMS) sets rules for and approves Medicare Advantage plans, plan benefits and cost sharing for enrollees.

Under a Medicare Premium Buy-In agreement, states may enroll Medicaid recipients in Medicare Part A, Part B and/or Part D and pay their premiums. The purpose of these arrangements is to permit the state, as part of its total assistance plan, to provide Medicare protection to certain groups of needy individuals. This arrangement also has the effect of transferring some medical costs for

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this population from the title XIX Medicaid program, which is partially state financed to title XVIII Medicare program (guarantees access to health insurance for all Americans aged 65 and older, younger people with disabilities and individuals with end stage renal disease), which is funded by the Federal government and by the payment of individual premiums. Federal Financial Participation (FFP) is available through the Medicaid program to assist the states with the premium payment for certain groups of recipients.

Attachment 4.32 of the Nevada Medicaid State Plan outlines the state government entity's ability to use the PARIS as a tool for cost avoidance. The State has established an eligibility determination system that provides for data matching through the PARIS, or any successor system, including matching with medical assistance programs operated by other states. The information that is requested will be exchanged with states and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements. The state will transmit and receive data quarterly (February, May, August and November).

Nevada has participated every quarter since 1996. In 2007, the PARIS matching system was automated. Once the PARIS file is received, it is then matched against the Division of Welfare and Supportive Services (DWSS) system. The purpose of the PARIS project is to assist in locating veterans and family members enrolled in the state Medicaid program that are seeking assistance through local governments and connect them to services and resources available to them through the Veterans Administration.

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901 AUTHORITY

Section 1906 of the SSA under Title XIX allows states to provide a methodology to determine the likely cost effectiveness of an individual's enrollment in a group health plan (4402 of Omnibus Budget Reconciliation Act 1990).

State Medicaid Manual (SMM) 3909.1 and 3910.

Nevada Medicaid State Plan Section 4.22.

Sections 1902 and 1902(a)(25) of the SSA; 42 Code of Federal Regulation (CFR), Part 433, Subpart D, and 42 CFR 433.139(b)(1).

SSA Title XVIII, Medicare Program.

Medicare Premium Buy-In Program, §1843 of the SSA.

Authority Waivers 1915(c) and 1915(i).

7 CFR 273.18, Overpayment.

42 CFR 431.625.

42 CFR 435.940-435.960 and 42 CFR 455.103 pursuant to SSA 1903(r).

42 CFR Part 455.12, provision under the Program Integrity.

Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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902 **DEFINITIONS**

ADMINISTRATIVE COST

The total monthly Medicaid expenditures for premiums paid by the State on behalf of the recipient to Medicare, commercial or other health carriers, another State or Federal program or service.

COST EFFECTIVENESS

The amount paid for premiums, coinsurance, deductibles or other cost sharing obligations under a group health plan, and additional administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

EMPLOYER-BASED GROUP HEALTH PLANS

This is a plan which provides that a group health plan is any plan of, or contributed to, by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer’s employees, former employees or the families of such employees or former employees.

FEDERAL MATCH

The Federal match, which matches state data with information from the Department of Defense (DoD) and the Office of Personnel Management (OPM) to determine if clients are receiving income from any of these sources or are eligible for Federal health care coverage. In addition, the file contains information that can be used to determine the potential for third-party insurance coverage from Federal sources for Medicaid clients.

INTERSTATE MATCH

Interstate match is when the social security number of public assistance enrollees are submitted by participating PARIS states and matched with data from all other participating states to determine if participants are enrolled in two or more states.

PATIENT LIABILITY

Patient liability is the amount a Medicaid enrollee must pay for long-term care services in a medical institution such as long-term facility or intermediate care facility.

Example: Income (Monthly Social Security Income) minus Deductions (Personal Needs/Medicare Premium) = Patient Liability.

PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS)

PARIS is a computer data matching and information exchange system administered by the

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Administration for Children and Families (ACF) to provide states with a tool to improve program integrity in administering public and medical assistance programs.

MEMORANDUM OF AGREEMENT (MOA)

A signed PARIS MOA commits the state to a minimum participation level and requires that data be submitted in a standardized format.

THIRD-PARTY LIABILITY (TPL)

If a client is eligible for other health care coverage, state Medicaid can update the enrollees TPL information so that Medicaid will become the payer of last resort. This coordination results in cost savings to state Medicaid programs allowing for cost avoidance in shifting the cost of health care services.

VETERAN AFFAIRS (VA) PARIS MATCH

The VA match provides states with information on clients' eligibility for veterans' benefits and allows States to confirm if their clients are receiving income and medical assistance payments from the Department of Veteran Affairs.

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903 HEALTH INSURANCE PREMIUM PROGRAM (HIPP)

903.1 HIPP POLICY

HIPP is a program that uses cost effectiveness determinations to allow access for eligible Nevadans to keep their group health plan and save taxpayer dollars by purchasing health insurance to defer high cost to the group health insurance. HIPP is a Fee-for-Service (FFS) program. Nevada Medicaid may pay medical insurance premiums, co-insurance and deductibles for eligible individuals and families when it is determined cost-effective, thus making Medicaid the payer of last resort.

- A. Non-Medicaid household members do not qualify for the HIPP Program. If medical coverage cannot be separated by family member, and does not increase the premium amounts, then other household members may be eligible for insurance services. The HIPP Program only pays the premiums for non-Medicaid members and not co-insurance and deductibles.
- B. Applications are either given to recipients by the DWSS or can be located on the Division of Health Care Financing and Policy (DHCFP) website at: <http://dhcfp.nv.gov/Pgms/CPT/HIPP/>

903.2 HIPP ELIGIBILITY DETERMINATION

Applicants or Medicaid participants must meet and maintain all Medicaid eligibility criteria during the period of time the participant is determined eligible for HIPP and receives services.

- A. All individuals eligible for Nevada Medicaid with private insurance available through an employer, or persons acting on a recipient’s behalf, are required to complete the HIPP Program Application (Form NMO 5000E English or NMO 5000S Spanish). Please contact our TPL vendor HIPP representative for additional services for persons with Limited English Proficiency (LEP) at (888) 346-1380.

If it is determined that paying the group health insurance is cost effective, recipients are expected to enroll in their group health insurance and HIPP program. Non-cooperation may result in being ineligible for Medicaid.

To qualify for HIPP the following criteria must be met:

- 1. Eligible for full Nevada Medicaid;
- 2. Be enrolled in or have access to private insurance known as TPL or OHI;

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3. Have a catastrophic illness or a medical condition necessitating ongoing care; or
 4. Be determined cost effective.
- B. Eligibility determinations are made by the TPL team. The determination is from a combined analysis of the DWSS, the DHC FP and the Fiscal Agent data. Any HIPP applications collected through the DWSS or the DHC FP are forwarded to the TPL team to determine cost-effectiveness. Applications are to be acknowledged and handled within 14 business days of receipt.
1. The TPL team evaluates the application and determines cost-effectiveness.
 - a. Incomplete applications will be denied at the end of the processing timeframe. Any request to extend the processing timeframe past the 14 business days must be submitted by the TPL team to the DHC FP Chief for an extension request.

903.3 HIPP COST-EFFECTIVENESS

The State HIPP methodology on determining cost-effectiveness of the recipient's group health plan, cost to Medicaid, follows the guideline located in the SMM Chapter 3, Section 3910 "MEDICAID PAYMENTS FOR RECIPIENTS UNDER GROUP HEALTH PLANS" and Medicaid State Plan Section 4.22 Attachment 4.2-C.

- A. The administering TPL team will be required to gather the required documentation, conduct a case analysis and determine cost-effectiveness for eligibility through:
1. Policy Information: Obtain information on the group health plan available to the recipient; policy effective date, exclusions to enrollment, the covered services and premiums paid by the employee along with who it covers.
 2. Average Medicaid Cost: Using the Medicaid Management Information System (MMIS), obtain the average total annual Medicaid costs of the applicants (age, gender, category and geographic data.)
 3. Medicaid Cost for Included Services: Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy. Medicaid expenditures are when states use the average Medicaid cost for the services covered under the group health plan. Primary Medicaid benefits would include inpatient and outpatient services, hospital services, physician, dental, pharmacy and ambulatory surgery services.

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4. **Group Health Plan Costs for Included Services:** Adjust the Medicaid average covered expense amount (amount from Step 3) for the higher prices employer plans typically pay. Alternatively, a national average factor may be used.
5. **Adjustment for co-insurance and deductible amounts:** The health plan cost (amount from Step 4) is multiplied by an average employer health insurance payment rate to obtain the employer recognized covered expense amount. The average payment rate number varies by how large the average employer recognized covered expense.
6. **Administrative Costs:** Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.
7. **Cost-Effectiveness Calculation:** Compare the cost under the group health plan to those costs under Medicaid.

B. Applicant must be on Medicaid FFS for a minimum of six months or present with a medical condition established to be cost effective.

The average of monthly Medicaid payments is greater than the amount of the monthly insurance premium and 50% of patient liability, e.g. coinsurance and deductibles outlined in Step 5 above.

1. Other Medicaid services would be included if covered as an insurance benefit and indicated by recipient’s medical condition. Additional services could include home health services, nursing facility care and durable medical equipment.

903.4 RECIPIENT RESPONSIBILITY

HIPP recipients must cooperate with the State’s TPL team in providing information related to insurance policy and employment information or any other facts pertinent to eligibility.

Recipients must notify the state’s TPL team of any changes regarding insurance premiums or employment information within five working days. Failure to do so can result in administrative actions, including but not limited to, disenrollment from the HIPP Program. Recoupment of premium payment received by the recipient or said guardian of recipient on HIPP. Overpayment recoupments will follow 7 CFR 273.18(a)(1)(i) and 7 CFR 273.18(a)(2).

903.5 HIPP PAYMENT PROCESS

Premiums are effective the first month the recipient becomes eligible.

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- A. Payment will be paid directly to employers unless the premium is a payroll deduction. In that instance, the participant can be reimbursed when they provide verification of the deduction.
- B. Co-insurance and deductibles, up to the Medicaid maximum amount, for Medicaid covered services will be reimbursed through the normal claims processing system.

903.6 HIPP OVERPAYMENT

An overpayment of HIPP payments occurs when the check amount exceeds the actual premium amount due. This may occur for unreported employee/employer premiums, employment terminations, the family losing their eligibility for medical assistance programs or various reasons concerning HIPP eligibility. Pursuant to 7 CFR 273.18(a)(1)(i) & (2) Claims against households, the state must notify and pursue overpayments as outlined below.

A. OVERPAYMENT – FIRST WARNING

When an overpayment occurs, a notification is generated to notify the payee of the overpayment and provides the timeframes for repayment. The notification instructs the payee that repayment is due within 60 days. The notification will include the following:

1. Medicaid ID number of the enrollee in, or who was in, the HIPP Program.
2. Time period of overpayment.
3. Amount of the overpayment.
4. Type and reason for the overpayment (e.g. HIPP overpayment due to termination of employment resulting in termination of insurance.).
5. Instructions on how to return the payment or original check to the address on the notification letter and a contact number for any questions.
6. Due date or timeframe for repayment.

B. OVERPAYMENT – SECOND WARNING

Repayments not received by the 60th day will generate a Second Warning notifying the payee that they have 30 days to repay the overpayment.

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C. REPAYMENT METHODS

The payee may mail a check or money order to the HIPP Program to cover the amount of the overpayment. The check or money order is made payable to the DHCFP c/o DXC Technology (DXC) (State’s Fiscal Agent) and mailed to:

DHCFP c/o DXC
HIPP Repayment Program
P.O. Box 30042
Reno, Nevada 89520

The payee may also return the original HIPP premium check to the HIPP Program when they know they have received the check in error. This check can be mailed to the above address.

A written repayment plan encompassing three or more months requires an approval through the DHCFP Fiscal Service Team.

903.7 LIMITATIONS

Changes to employer health premiums or policy may result in a reassessment to determine if cost-effectiveness is still viable. Disenrollment from the HIPP program will occur if the reassessment no longer results in cost savings.

Recipients cannot appeal HIPP denials; there is no reduction in services, it is a cost-avoidance program only.

903.8 HIPP ELIGIBILITY REDETERMINATION

To ensure that applicants or participants maintain cost effectiveness for the State of Nevada and the taxpayers, eligibility redetermination will occur at minimum on an annual basis. Eligibility redeterminations will be made by the State’s TPL vendor. Annual redeterminations supersede the previous eligibility determination.

If at any point Medicaid eligibility terminates and the recipient is disenrolled from HIPP, they must reapply for the HIPP program after Medicaid eligibility is re-established.

903.9 HIPP PROGRAM DISQUALIFIERS

While applicants or participants may have met all eligibility requirements, if at any point during Medicaid eligibility the below circumstances exist, or become of existence, it is an automatic disqualifier from HIPP:

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- A. Managed Care Organization (MCO) Enrollment: If the applicant becomes enrolled into a Medicaid or Children’s Health Insurance Program (CHIP), known as Nevada Check Up (NCU) MCO, they are no longer qualified.
- B. Employer health plan or private health insurance does not include Major Medical through a Health Maintenance Organization (HMO) or OHI.
- C. Employer health plan or private health insurance that is Medicare, such as Medicare Advantage Plan or Consolidated Omnibus Budget Reconciliation Act (COBRA) is an automatic disqualification.
- D. Base HIPP calculation determines not to be cost-effective to the state.
- E. Loss of employer health insurance.
- F. Loss of Medicaid eligibility.

903.10 HIPP TERMINATION

Annual recertification consists of an assessment via verification of active commercial insurance policy, premium amount validation and cost effectiveness review to verify if the recipient’s premium increased, as outlined in the HIPP cost analysis for eligibility. The TPL team will attempt to contact the recipient three times to obtain the required updated information. If the parent/guardian is non-responsive to the TPL team outreach, the TPL team will mail a Notice of Termination to the recipient indicating they are denied HIPP eligibility due to non-compliance.

903.11 HIPP REINSTATEMENT

In most HIPP cases, previous enrollees cannot be reinstated. A new HIPP application must be completed and submitted with current required documentation.

A. REINSTATEMENT EXCEPTIONS

There are situations where HIPP reinstatement can be considered if they meet the following criteria and receive the DHCFP’s approval. To be considered for reinstatement, a request must be submitted to the TPL vendor explaining the circumstance(s). The state will evaluate and submit for final approval or denial. Examples of requests for reinstatement may include but are not limited to:

- 1. Medicaid eligibility was never terminated (e.g. eligibility aid category changed, or Medicaid case closed in error); or

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2. request is within a 30-day time period of the HIPP denial and termination was not recipient error or a result of non-compliance.

Once a case has been denied or terminated, the applicant can reapply at any time.

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904 **INCARCERATIONS**

An inmate of a public institution is ineligible for the Medicare Beneficiary program unless the institution is a medical institution. The Qualified Medicare Beneficiary program (QMB) helps Medicare beneficiaries of modest means pay all or some of Medicare’s cost sharing amounts (ie. premiums, deductibles and copayments).

904.1 **ELIGIBILITY EXCEPTION**

An inmate of a penal institution is never eligible for Medicaid or the Medicare Beneficiary Program while in the custody of law enforcement officials unless admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. This individual is eligible for Medicaid and any Medicaid covered services provided to them while an inpatient in these facilities. If the individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible for Medicaid services.

See State of Nevada DWSS, Medical Assistance Manual (MAM) Section C-800.

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905 MEDICARE ADVANTAGE PLANS

A Medicare Advantage plan is a type of health plan offered by a private company that contracts with Medicare to provide recipients with all their Medicare Parts A and B benefits. Medicare Advantage plans include health maintenance organizations, preferred provider organizations, private FFS plans and special needs plans. Medicare Advantage plans are considered as a TPL with low to zero monthly premiums.

Medicare Advantage plans may also include prescription drug coverage offered under Part D. In addition to the standard Part A and Part B benefits or Part D coverage, Medicare Advantage plans may cover supplemental benefits, such as coverage for dental care, vision care, acupuncture or health club memberships. If the supplemental benefits are covered for all enrollees in the Medicare Advantage plan, the benefits are referred to as mandatory supplemental benefits. If the enrollee can elect whether to receive the benefits, they are referred to as optional supplemental benefits.

- A. **Mandatory Supplemental Benefits:** Non-drug benefits that are not covered by Medicare but are covered by the plan for every enrollee of the plan. Mandatory supplemental benefits are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums, cost sharing or through application of rebate dollars.
- B. **Optional Supplemental Benefits:** Non-drug benefits that are not covered by Medicare. However, plan enrollees may choose whether to elect and pay for optional supplemental benefits. These services may be grouped or offered individually.

CMS sets rules for and approves Medicare Advantage plans, plan benefits and cost sharing for enrollees.

905.1 BENEFITS FOR MEDICARE ADVANTAGE PLAN

When an individual is enrolled in a Medicare Advantage Plan or Medicare Part C, coverage of Medicare deductibles and coinsurance are required for QMBs under Section 1902(a)(10)(E)(i) and Section 109(p)(3) of the SSA.

905.2 MEDICARE ADVANTAGE PLAN BILLING PROTECTIONS

Providers are strictly prohibited under Section 1902(n)(3) of the SSA from seeking to collect any additional amount from a QMB for Medicare deductibles or coinsurance (other than nominal Medicaid copayments), even if the Medicaid program’s payment is less than the total amount of the Medicare deductibles and coinsurance.

- A. Not all providers or physicians accept Medicare Advantage plans.

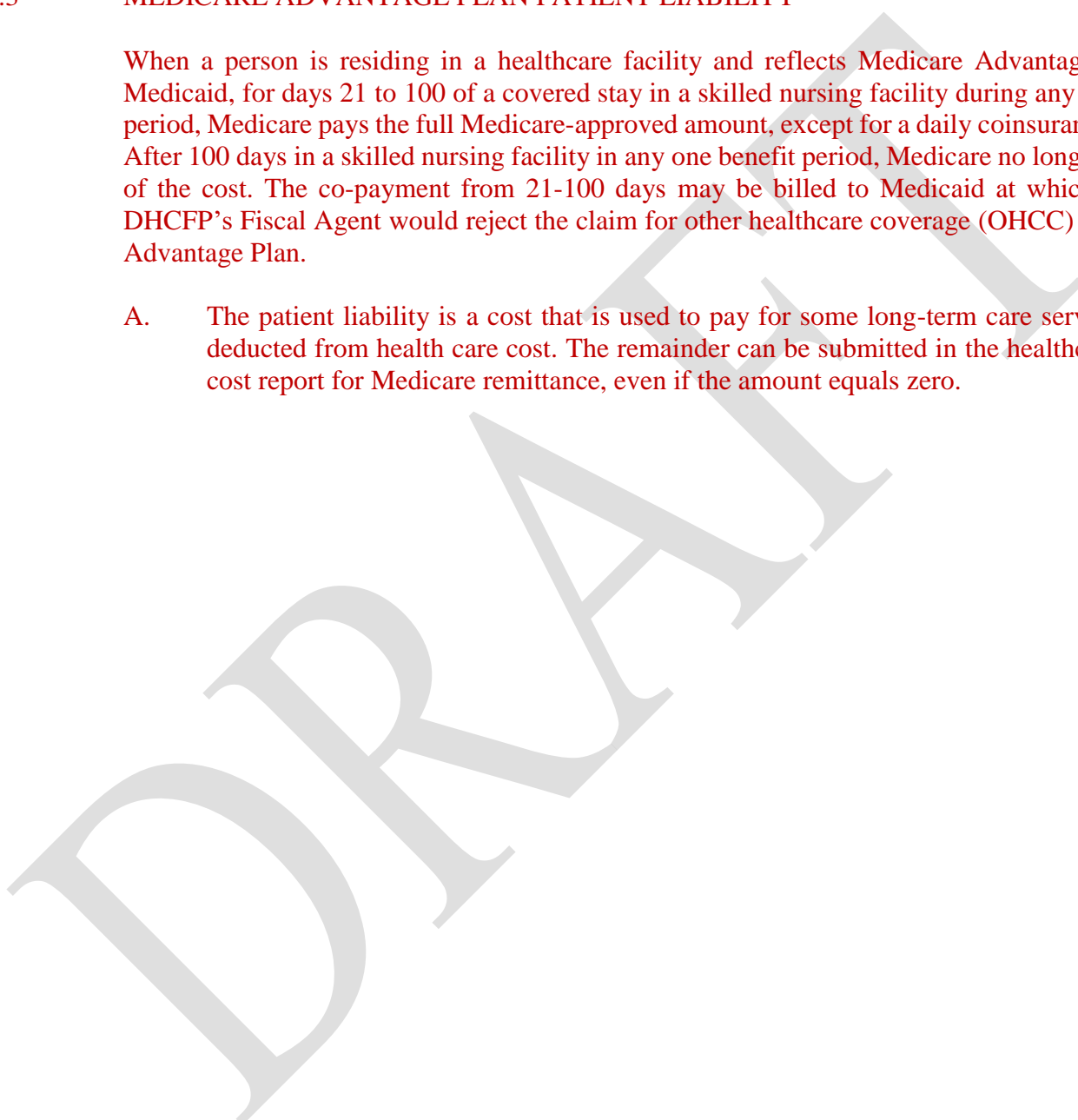
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- B. Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties do not have access to Medicare Advantage Plans.

905.3 MEDICARE ADVANTAGE PLAN PATIENT LIABILITY

When a person is residing in a healthcare facility and reflects Medicare Advantage Plan and Medicaid, for days 21 to 100 of a covered stay in a skilled nursing facility during any one benefit period, Medicare pays the full Medicare-approved amount, except for a daily coinsurance amount. After 100 days in a skilled nursing facility in any one benefit period, Medicare no longer pays any of the cost. The co-payment from 21-100 days may be billed to Medicaid at which point the DHCFP’s Fiscal Agent would reject the claim for other healthcare coverage (OHCC) – Medicare Advantage Plan.

- A. The patient liability is a cost that is used to pay for some long-term care services and is deducted from health care cost. The remainder can be submitted in the healthcare facility cost report for Medicare remittance, even if the amount equals zero.



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906 **MEDICARE PREMIUM BUY-IN PROGRAM**

The Medicare Premium Buy-In program is the process within the state system that allows the state to pay Medicare Parts A, B and D premiums directly to Medicare for eligible individuals. When a Medicaid recipient is enrolled in Medicare Part A but is not enrolled in Part B or Part D, Parts B and D can be initiated by accretion to the Buy-In. When the recipient is enrolled in Part B but is not enrolled in Part A, the DWSS will update the eligibility system to generate an accretion request to initiate Part A at no cost to the recipient.

Medicare is always primary insurance coverage and Medicaid secondary when recipients are dual eligible. Maintaining Medicare enrollment for Medicaid recipients reduces Medicaid costs. Due to cost savings realized, the Division has elected to pay the Part B and Part D Medicare premium for all Medicaid recipients enrolled in Medicare.

906.1 **MEDICARE PREMIUM BUY-IN ELIGIBILITY**

- A. All persons over age 65 who are either a U.S. citizen or an alien lawfully admitted for permanent residency who has resided in the U.S. continuously and meet the 5 years bar.
- B. All persons under age 65 who have received monthly Social Security/Railroad Retirement disability benefits for 24 months.
- C. Persons with End-Stage Renal Disease (ESRD).
- D. Persons with Amyotrophic Lateral Sclerosis (ALS).

A Medicaid applicant or recipient must cooperate in pursuing Medicare Part B & D, if available, as a condition of continuing eligibility, since it would be available at no cost as a result of the state Buy-In process.

906.2 **EFFECTIVE DATES FOR MEDICARE PREMIUM BUY-IN**

The accretion effective date is based on the category of medical assistance of which the person is enrolled. The following are the guidelines for when a person must be accreted:

- A. QMB only:
Part A, Part B and Part D buy-in effective the month after the month of approval.
- B. Full Medicaid and QMB:
Part A buy-in effective the month after the month of approval.

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Parts B and D buy-in effective the first month of Medicaid eligibility.

C. QUALIFYING INDIVIDUAL (QI):

Part B and D buy-in effective the application month and up to three months prior to the application month (prior med).

D. QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI):

Covers ONLY special Medicare Part A hospital insurance premiums for disabled individuals who lost their free hospital coverage due to earnings which exceed the Substantial Gainful Activity (SGA) limits.

Part A hospital insurance premiums can begin the month of application including three months prior to the month of application.

E. SPECIFIC LOW-INCOME MEDICARE BENEFICIARY (SLMB) only:

Parts B and D buy-in effective the application month and up to three months prior to the application month (prior med).

F. Full Medicaid and SLMB:

Parts B and D buy-in effective the first month of Medicaid eligibility.

G. Ongoing Institutional and HOME & COMMUNITY BASED WAIVER (HCBW) with Full Medicaid not eligible for QMB and above the SLMB Limit:

Parts B and D buy-in effective the first month of full Medicaid eligibility in which the client is entitled to Medicare.

H. New Application Institutional and HCBW not eligible for QMB and above the SLMB Limit:

Parts B and D buy-in effective the second month after the approval month.

I. New Application Institutional and HCBW eligible for QMB:

Parts B and D buy-in effective the month after the approval month.

906.3 MEDICARE PREMIUM BUY-IN PROGRAM EXCEPTIONS

Services offered under Provider Types 38, 39, 55, 57, 58 and 59 are non-medical services and

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covered under the 1915(c) and 1915(i) waiver authority that are above and beyond what is offered under the State Plan. The outlined services are non-covered services by Medicare and other commercial insurance carriers. Claims for these provider types are not subject to recoupment from the State's TPL team.

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907 PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS)

PARIS is a federal-state partnership that ensures the integrity of public assistance programs through detecting and deterring improper payments. The PARIS report establishes the ability to conduct searches on improper Temporary Assistance to Needy Families (TANF), Medicaid or Food Stamp payments in more than one state. PARIS matches help minimizes fraud and abuse. The PARIS reports are also used as a resource tool helping community veterans who were unaware of services available to them.

Effective October 2009, based on the provisions of the QI Program Supplemental Funding Act of 2008, all states are required to sign an agreement to participate in accessing PARIS as a condition of receiving Medicaid funding for the automated data system, currently MMIS.

Nevada has a MOA in place for State participation in the use of the PARIS files.

The three separate MOAs in place to support data sharing are reinforced by the Department of Health and Human Service’s Administration for Children and Families (ACF) for participation. The DWSS acts on behalf of the State of Nevada for receivers of the three PARIS data files:

- A. Department of Defense – Federal;
- B. Department of Veteran Affairs – Veterans; and
- C. State Public Assistance Agencies – Interstate.

907.1 FEDERAL MATCH

The Federal file allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management. The Federal file is matched against federal, civilian and military wage and benefit payments.

- A. It is the role of the DWSS FSS case workers to use the Federal Match at new application or at redetermination to identify who are receiving Federal benefits. If recipients are receiving Federal benefits, then DWSS can request additional information from the recipient or the representing agency.
- B. It is the role of the DHCFP or the state’s TPL team to review and conduct analysis for TPL claims and services covered under a separate entity. If recipients are receiving Federal benefits and TPL is discovered, then the DHCFP or the TPL team can request additional information from the recipient or the representing agency.

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907.2 VETERANS MATCH

The veterans file allows states to compare their beneficiary information with the U.S. Department of Veteran Affairs. The veterans file is matched against the Department of Veterans Affairs.

- A. It is the role of the DWSS FSS case workers to use the veterans match at new application or at redetermination to identify who are receiving veteran benefits. If recipients are receiving Veterans Administration benefits, then DWSS can request additional information from the recipient or the representing agency.
- B. It is the role of the DHCFP to review and conduct analysis for TPL claims and services covered under a separate entity. If recipients are receiving Veterans Administration benefits and TPL is discovered, then the DHCFP or the TPL team can request additional information from the recipient or the agency.

907.3 INTERSTATE MATCH

The interstate match allows states to compare their beneficiary information with other states and has become the most used report.

It is the role of the DWSS FSS case workers to contact the other states to obtain their state’s information to pursue intentional program violations (IPV) of duplicate assistance. The DWSS FSS case worker can also use the interstate report to other available resources in another state.

907.4 TRANSMIT

The state will transmit and receive data quarterly (February, May, August and November) from DWSS.

Nevada Medicaid State Plan 4.32, “Income and Eligibility Verification System” has been amended to support MOAs in place and the utilization of each PARIS file.

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908 MEDICAID HEARINGS

For State of Nevada Medicaid Fair Hearing Procedures, refer to Medicaid Services Manual (MSM) Chapter 3100, Hearings.

908.1 HIPP HEARINGS

Section 1902(a)(3) of the SSA provides for a fair hearing when medical assistance is denied. Federal regulation 42 CFR 431.201 specifies that hearing rights are applicable when there is a “termination, suspension or reduction of Medicaid eligibility or covered services.” Therefore, since an individual’s eligibility for Medicaid or Medicaid services is not affected by this decision, HIPP enrollees are not subject to the state fair hearing process.

908.2 INCARCERATION HEARINGS

Nevada Medicaid eligibility is terminated upon incarceration. Incarcerated termination reason is not subject to the state fair hearing process.

908.3 MEDICARE ADVANTAGE PLAN HEARINGS

Medicare Advantage Plans are separate from the state insurance health plans and are not subject to the state fair hearing process.

908.4 MEDICARE PREMIUM BUY-IN HEARINGS

For Medicaid Hearing Procedures, refer to MSM Chapter 3100, Hearings.

908.5 PARIS HEARINGS

PARIS is a data match action and is not subject to the state fair hearing process.