1. Will the inpatient accumulation as well as the ED visit accumulation be on the ETI report? If not how will days/visits be counted/communicated to the plans? - All the limits will be incorporated into the ETI reporting. And as noted this information will be available on the encounter limits tracking screen in PMMIS and reporting to the plans, although with an acknowledged lag.

2. How will we ensure that the member has received 25 inpatient days or 12 ED visits (not resulting in an inpatient stay) if the encounters have not yet been submitted to AHCCCS at the time a member is transitioned to PHP. - See above, should be included in ETI.

3. Can the hospital bill the member after the 25 inpatient days or the 12 ED visit limits have been met? - Consistent with rule guidelines, yes. Would this apply to out of state? - Yes, out of state is not a noted exception to the limits.

4. Can a contracted hospital refuse an elective admission if the member is over their 25 day limit? - Yes.

5. Is PPC included in the 25 day inpatient and 12 ED visit limit? - Yes, PPC is not a noted exception to the limits.

6. Is Urgent Care counted against this ER visit limitation when billed from a hospital based urgent care facility? - All claims which meet the outlined criteria should be included.

7. How do the benefit limits affect TPL/Reinsurance? - Should not impact. Service is either covered or it is not. Please clarify if I've misunderstood the question.

8. If there was an overpayment of units (25 inpatient days or 12 ED visits) can the plan recoup? - If necessary yes, although preference is always to try to catch pre-payment if possible.

9. Does AHCCCS have a timeline for providing member/provider communication material to the plans? - Timing for these materials is TBD. However, an initial Fact Sheet and FAQ's will be posted to website next week.

Confirm understanding, Observation will have a max of 23 hours, anything greater should be paid IP per diem. – No, the inclusion of Observation hours in 24 hour increments towards the 24 day limit does not impact the OP Observation valuation or payment methodologies. Below are a few examples, let me know if they help. I'm working on specific examples for each of the benefit limits as well as the OPFS changes for us to walkthrough at the 7/19 meeting.

For purposes of the 25 Day Inpatient benefit limit, our processing rules say count each 24 hours of (paid not bundled) observation billed on an Outpatient claim as one unit. If an Outpatient claim has less than 24 units of observation it doesn't even get into this limit evaluation.

So if the following situations occurred here's what we would do -

Member A - has not met their 25 day limit

Outpatient claim for 30 units of paid Observation - Apply 24 of the billed hours as 1 day to limit and pay all hours under OPFS.

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, paid under OPFS.

Member B - has met their 25 day limit

Outpatient claim for 30 units of Observation - Pay 23 hours of OBS under OPFS and disallow 7 hours

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, pay under OPFS

Member C - has accumulated 24 days toward their 25 day limit

Outpatient claim for 30 units of Observation - Apply 24 of the billed hours as 1 day to limit and pay all hours under OPFS

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, pay under OPFS

Outpatient claim for 52 units of Observation - Apply 24 hours of the billed hours as 1 day to limit, pay those 24 hours and 23 of the additional hours under OPFS, and disallow the remaining 5 hours.

IP day limit – will transplants be carved-out of the 25 day limit? – Transplant related days are listed as an exception in the matrix for this limit.

Would the limitation of 25 day IP be per type of admission? i.e. med/surg, maternity, icu – No this limit is 25 Inpatient days per adult member be benefit period (10/1 through 9/30 of each year) regardless of the type of Inpatient admission.

For the IP 25 days limit and contract year split, assume the days calculation starts over on 10/1, even if patient in the middle of a hospital stay? – Correct, days are allocated to the benefit year in which the dates of service fall.

What affect, if any does the limitations have on reinsurance? – No specific impacts to reinsurance, although the payment of less Inpatient days may result in less need for related reinsurance also.

Is the accrual of bed days based on approved/paid days paid? Should days are denied for not meeting medical necessity, delay in care or treatment, etc. not be applied to the accrual of hospital days for the member? – As noted in the matrix, only paid days should be evaluated towards the limit.

Do admissions that do not meet IP criteria, are denied and then negotiated with an observation rate to the facility, count as an IP day? – Lets discuss further and if possible please provide me with an example or two, so I can verify my response.

Since there is no limit on SNF days, can health plans negotiate a lower level of care in acute facilities (SNF, ICF/ECF)? Would days at this level contribute to the member's hospital limit? – Lets discuss further and if possible please provide me with an example or two, so I can verify my response.

If hospital days that are denied do not contribute to the member's bed day limitation, what happens if they are overturned in claim's disputes, appeals or State Hearing process? How will those days be reconciled? – As outlined in the matrix, claims are applied to towards the limit in the order in which they adjudicated as paid/approved. In the event a denial is overturned any days in excess of the limit for that member and benefit period would be disallowed.

IP and ER limits. RE: Adult Recipients age 21 and >. Will there be any additional criteria (beyond QMB) applied to adults? i.e. transplants, maternity, SOBRA, TWG, DD adults, etc? – No additional criteria or exceptions have been defined for this type of limit at this time.

1	Does observation limit include maternity observation (rev code 762)	Observation is identified by HCPCS/CPT procedure code G0378 or G0379, there is currently no criteria that looks at the revenue code in this situation.
2	We are figuring that AHCCCS will be adding space for inpatient days and ED visits to ETI Form. What do you think the timing of the updated form will be	In progress. Will be distributed as soon as possible.
3	Regarding the requirement that Non QMB claims/encounters should count and allow entire stay in which 25th day occurs regardless of length of that stay – I want to confirm that this requirement applies to NonQMB duals only, not regular AHCCCS adults that are not duals	This criteria applies to Medicare Non-QMB Dual claims only.
4	It's anal of us but it would be helpful if in the next update of the grid if AHCCCS could add confirmation that the 25th limit and ED visit limit does not apply to QMB duals and that the standard guidance applies to QMB duals regarding coinsurance and deductible regardless of # days or ED visits	Documentation updated to further emphasize this in the documentation.
5	What do you see/estimate is the timeline for ETA on office visit and transportation benefit reductions? And is the office visit reduction related to copays or no show penalty or both?	At this time Office Visits are not being addressed, any future evaluation will provide for appropriate timeframes. Transportation is still under evaluation, but if addressed will not be prior to 1/1/2012.
6	Follow-up on timing of fee schedules and tier sheets - are we still on track for 8/15 and 8/30 - any way we can obtain earlier. The earlier the better as the resources we use for the benefit changes are the same that complete all of the fee schedule updates	Per the Rate Setting unit these fee schedules are still on target for the communicated timeframes.
7	Potential exists for outliers to increase as a result of the 25 day inpatient limit. A stay that hits the limit with some days covered and some not covered b/c of hitting the limit could end up in outlier status as a result of noncovered days on the end of the stay (majority of expense on front end of stay). Was this discussed?	Yes, this was discussed and noted a possible concern. I will again share this concern with the policy group for any additional feedback. In general disallowance of days should also result in the disallowance for ancillary charges associated with those days prior to outlier consideration.