

**AHCCCS Benefit Changes**  
**Frequently Asked Questions**  
**Update: 3/15/13**

**GENERAL QUESTIONS**

**Q1. What benefits are being changed and who will be affected?**

A1.

Effective October 1, 2011, the following benefit changes impact **all** adults<sup>1</sup> (21 years and older) in the Acute and ALTCS programs regardless of whether they receive services through managed care or fee for service<sup>2</sup>. The respite change also impacts children in addition to adults who receive ALTCS and/or behavioral health services.

- A 25-day inpatient hospital limit within a one-year time period<sup>3</sup>. Some exclusions will apply such as days in a governmentally operated burn unit, days that are part of a transplant stay, or days in the hospital for behavioral health reasons. Refer to the [final rule](#) for more detail.
- A decrease in the number of respite hours from 720 to 600 hours within a one-year time period for adults and children receiving ALTCS Services and or Behavioral Health Services. Refer to the [final rule](#) for more detail.

**Q2. When will members see a change in these benefits?**

A2. Benefit changes will start for all AHCCCS members October 1, 2011, unless otherwise indicated.

**Q3. Why is AHCCCS limiting these benefits?**

A3. On March 15, 2011, Governor Brewer presented her [plan](#) to preserve Arizona's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State's General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and includes changes to the AHCCCS member benefits. By law, AHCCCS must not spend more monies than have been provided to the program.

**Q4. Will members be notified about the benefit limits?**

A4. All members were notified with a direct mailing about the benefit limits. Member handbooks will also be updated with information about the benefit changes.

**Q5. What happens when a member turns 21 after October 1, 2011?**

A5. The benefit changes begin on the member's 21<sup>st</sup> birthday, except for the respite benefit changes. Respite benefit changes apply to all adults and children who receive ALTCS and/or behavioral health services.

**Q6. Will benefit changes affect adult AHCCCS members who are also on Medicare?**

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<sup>1</sup> AHCCCS will continue to pay Medicare co-pays and deductibles for Qualified Medicare Beneficiaries (QMB) who are duals also enrolled in AHCCCS, with income at or under 100% FPL, even after the benefit limit is reached. For people with Medicare who don't have QMB, members will be responsible for co-pays after the benefit limit is reached.

<sup>2</sup> At this time, these limits also apply to American Indians regardless of where they receive services. AHCCCS will provide notice if there are any changes.

<sup>3</sup> The one year time period runs from October 1 through September 30 each year.

A6. AHCCCS will continue to pay Medicare co-pays and deductibles for Qualified Medicare Beneficiaries (QMB) who are duals also enrolled in AHCCCS, with income at or under 100% FPL, even after the benefit limit is reached. For people with Medicare who are not QMB, members will be responsible for co-pays after the benefit limit is reached. Members should contact their Contractors for more information.

**Q7. How will the provider know that the member is QMB dual?**

A7. PMMIS identifies QMB duals as Medicare Type C and/or with a Rate code of 2 in the 3rd digit.

**Q8. Will there be changes to non-emergency medical transportation (NEMT)?**

A8. Beginning April 1, 2012 some **AHCCCS Care members** (19 years of age or older) (childless adults) who lives in Maricopa or Pima county will be charged a mandatory \$2 co-pay **each way** (or \$4 round trip) for medically necessary taxi rides for services such as going to and from the doctor. Keep checking the website for more information as it becomes available.

**Q9. Can members be billed for services that exceed the limit covered by AHCCCS?**

A9. Providers may charge AHCCCS members for services that are excluded from AHCCCS coverage or which are provided in excess of AHCCCS limits if the provider obtains the member's written agreement to pay for the services in advance.

Providers are prohibited from charging members for services when a claim is denied or reduced due to the provider's failure to comply with billing requirements such as timely claim filing, lack of authorization, or lack of clean claim status.

AHCCCS rule [R9-22-702](#) has been revised to clarify the circumstances when registered providers may bill AHCCCS members.

**Q10. Will the doctor and Contractor (Health Plan or Program Contractor) know about the benefit changes?**

A10. Yes. AHCCCS will send information about the benefit changes to all AHCCCS registered providers (such as doctors) and contracted health plans. Contractors can answer any questions about the benefit changes.

**Q11. Where can I get more information about the benefit changes?**

A11. Continue to check the AHCCCS website [www.azahcccs.gov](http://www.azahcccs.gov) for updated information.

## 25 DAY INPATIENT LIMIT QUESTIONS

**Q12. What if inpatient services were prior authorized before the benefit has been limited?**

A12. When an inpatient admission is prior authorized, it is the medically necessary reason for the admission that is being prior authorized, not the length of stay (number of days in the hospital). A prior authorization does not guarantee payment. When a procedure was authorized before October 1, but not completed until on or after October 1, 2011, the member's days in the hospital from October 1<sup>st</sup> forward will count toward the 25 day limit, except in limited circumstances as described in response #15 below.

**Q13. How are hospitals to obtain information on how many inpatient days have been used by an AHCCCS member in a benefit year?**

A13. Due to member confidentiality considerations, it was determined that broad distribution of this type of data (e.g. posting to the AHCCCS website) is not feasible. Hospitals will need to work with the Managed Care Contractors regarding the number of days utilized by a member.

**Q14. How will the hospital know when the member is approaching the 25<sup>th</sup> inpatient day to advise them of potential responsibility for hospital charges beyond the 25<sup>th</sup> day?**

A14. AHCCCS understands the difficulties providers face in identifying when the 25 day inpatient limit is reached due to the variables in billing and payment of claims. Although a member may be in the best position to know how many days s/he has been in the hospital, this number may not coincide with the number of days that have been billed and paid by AHCCCS at any point in time. Please note that inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim.

It is critical for providers to explain to members before/at the time of admission that certain services may not be reimbursed by AHCCCS either because they are excluded or because they are subject to a limit. Providers should identify what specific services are excluded by AHCCCS or are subject to a limit. The provider must further explain to the member that by signing the document, the member is agreeing to pay for the service in the event it is excluded by AHCCCS or if the AHCCCS limit for the service is exceeded.

**Q15. What are the exclusions to the 25 day inpatient limit?**

- A15.
- Inpatient days related to burn treatment rendered in a governmentally operated Burn Unit.
  - Days reimbursed in accordance with the component pricing specified in specialty contracts between the Administration and a transplant facility.
  - Inpatient days related to behavioral health including:
    - Inpatient days reimbursed at the Psychiatric Tier;
    - Inpatient days when payment is made by ADHS/BHS (includes behavioral health hospitals and the Arizona State Hospital);
    - Inpatient days with certain primary Psychiatric diagnosis codes;
    - Outpatient observation episodes of care lasting less than 24 hours;
  - Same Day Admit Discharge services; and
  - Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities

Refer to the [final rule](#) for more information

**Q16. Is Prior Period Coverage (PPC)<sup>4</sup> included in the 25 day inpatient limit?**

A16. Yes as PPC is not part of the exclusion list in #15.

**Q17. What happens if a pregnant member exhausts her inpatient coverage (for any reason) prior to a delivery or c-section?**

**Does federal law require that the Medicaid health plans cover 48/96 hours following a birth?**

A17. The Newborns' and Mothers' Health Protection Act of 1996 does not apply to Medicaid. AHCCCS coverage of 48/96 hours of a hospital stay following childbirth was adopted from, but not required by, The Newborns' and Mothers' Health Protection Act of 1996.

Therefore, these hospital stays are subject to the AHCCCS 25 day inpatient limit. AHCCCS will cover such hospital stays to the extent that they *do not exceed the 25 day inpatient limit* specified in AHCCCS Rules.

**Q18. Does the observation limit include maternity observation (rev code 762)?**

A18. There is currently no criteria that looks at the revenue code in this situation. Observation is identified by HCPCS/CPT procedure code G0378 or G0379

**Q19. Will observation services at a hospital count toward the 25 day inpatient limit?**

A19. For purposes of calculating the annual 25 day inpatient limit, each 24 hours of paid *outpatient* observation units of care is counted as one inpatient day. Outpatient observation episodes of care lasting less than 24 hours are not counted as part of the 25 day inpatient limit. If a member is admitted to the hospital from observation, the 24 observation units of care will not count toward the inpatient hospital limit. Link to final rule

**Q20. What happens to observation services if the 25 day inpatient limit has already been reached?**

A20.

- Observation services that are directly followed by an inpatient admission to the same hospital are not covered.
- Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
- Twenty-three hours of observation services are covered for continuous periods of observation services of 24 hours or more which are not directly followed by an inpatient admission to the same hospital.

**Q21. How are Outpatient Observation services counted towards and/or impacted by the Inpatient 25 day limit?**

A21. Outpatient Observation hours are considered towards the 25 day limit.

For purposes of the 25 Day Inpatient benefit limit, the processing rules 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 is not considered under this limit evaluation.

Examples are as follows:

**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 the outpatient hospital fee schedule (OPFS).

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<sup>4</sup> Refer to R9-22-701

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 observation 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.

**Q22. Is it necessary for hospitals to split claims into covered and non-covered days when the 25 day benefit is reached?**

A22. Hospitals should bill the full stay for which the member is AHCCCS eligible. The AHCCCS Administration for FFS or the Managed Care Contractor is responsible for determining, and reimbursing based on the covered days.