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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DATE: August 22, 2011

TO: AHCCCS Physician and Other Practitioners Community

FROM: Marc Leib, M.D., Chief Medical Officer

SUBJECT: AHCCCS Benefit Changes Effective October 1, 2011: Annual Limits for Inpatient Days and Respite Services

BACKGROUND

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. The Medicaid Reform Package includes changes to the AHCCCS member benefit package and can be found on our website at the following address:

<http://www.azahcccs.gov/shared/news.aspx?ID=reporting#GovernorBrewersMedicaidReformPackage>

The benefit changes addressed in this memo are the annual limits on the number of hospital inpatient days and the number of hours of respite services available. The inpatient hospital limit will **not** impact AHCCCS members under 21 years of age¹. The change in annual respite hours impacts both adults and children. Benefit changes are effective October 1, 2011.

BENEFIT CHANGES

Inpatient Day Hospital Limit (Adults Only)

The annual inpatient hospital limit impacts individuals 21 years and older and only applies to facility (not professional) services. Members in the acute and long term care programs are subject to the limits, regardless of whether they receive services through managed care or fee for service.² No inpatient limits are placed on persons under 21 years of age.

For persons age 21 and older, AHCCCS will pay hospitals a maximum of 25 days of hospital inpatient care per benefit year (October 1 of each year through September 30 of the following year). Each 24 hours of paid observation services also counts as 1 inpatient day. There are certain exceptions to the annual 25 day inpatient hospital limit such as: inpatient days for behavioral services, transplant services which are reimbursed under component pricing, or certain Medicare beneficiaries for whom AHCCCS is responsible for co-pays and deductibles.

¹ AHCCCS is awaiting final approval from CMS.

² 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.

Physician services provided to inpatients beyond the 25-day limit will continue to be covered as an AHCCCS benefit.

Refer to Attachment A regarding coordination of benefits.

Respite (Adults and Children)

The decrease in the number of hours of annual respite services available to AHCCCS members will impact both adults and children receiving respite services through the Arizona Long Term Care System (ALTCS) or through the Behavioral Health System. Effective October 1, 2011, the number of respite hours paid for by AHCCCS or its Contractors will be reduced to a maximum of 600 hours per benefit year. The benefit year time period is from October 1 through September 30 of the following year. Since respite is not a Medicare covered service, AHCCCS is not responsible for co-pays and deductibles. (Prior to October 1, the annual limit for respite services is 720 hours per benefit year.)

NON-COVERED SERVICES & MEMBER BILLING

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

Providers are still prohibited from charging members for non-excluded services provided within the limits 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. For more information, please review AHCCCS rule R9-22-702 which has been revised to clarify the circumstances when registered providers may bill AHCCCS members. As previously mentioned, medically necessary professional services will continue to be covered even when payments to hospitals for inpatient admissions are not paid by AHCCCS or its Contractors after the limits have been met.

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/reporting/legislation/2011/BenefitChanges.aspx> and

<http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx>

Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

**IN-PATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
(MEDICAID ONLY, QMB DUAL AND NON-QMB DUAL STATUS)**

CONDITION	CONTRACTOR IMPLEMENTATION (Fiscal Implications)
Member is Medicaid only and is not Medicare eligible. (Also known as non-dual)	Contractor is responsible for payment limited to the first 25 inpatient days per contract year. Contractor is not responsible for payment of inpatient days beginning with the 26 th inpatient day in a contract year. The first 25 inpatient days are the first 25 inpatient days (with dates of service during the contract year) that are paid by the Administration or the member's Contractor-irrespective of whether the date of payment was during or after the contract year. For more information about counting the 25 day inpatient limit and exclusions, refer to the "Adult Inpatient limits and member billing rule: http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx
Member is Dual Eligible (Also known as Medicare Primary, non-QMB dual)	Contractor is responsible for Medicare cost sharing (co-pay, coinsurance, and deductible) associated with all admissions through the admission in which the 25 th inpatient day of the contract year occurs. (Example: a non-QMB dual with 23 prior inpatient days during the contract year is admitted and remains in the hospital for 10 days. Since the admission occurs before the 25-day limit is reached, Contractor is responsible for Medicare cost sharing associated with the 10 days even though the member exceeds the 25-day annual limit during that admission.) Contractor is not responsible for Medicare cost sharing (co-pay, coinsurance and deductible) related to admissions occurring after the first 25 inpatient days per contract year.
Member is QMB Dual	Contractor is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.
Member is QMB Only	AHCCCS FFS program is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.

DEFINITIONS:

- **Inpatient Setting** – Acute Care hospital including Specialty Care Hospital and Rehabilitation Hospital (in-state and out of state)
- **Dual Eligible (Non-QMB Dual)** - An individual who is Medicare and Medicaid eligible with income above 100% FPL. The individual does not qualify for QMB.
- **QMB Dual** - An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.
- **QMB Only** – An individual who is Medicare only who qualifies to have Medicare premiums, co-payments, and deductibles paid by the AHCCCS program.

EXCLUSION

The following inpatient days are not included in the inpatient hospital limitation:

- a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract¹;
- b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
- c. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011;
- d. Same Day Admit Discharge services are excluded from the 25 day limit; and
- e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

¹ Examples include the following:

- **Evaluation** (Limited to inpatient days directly associated with the evaluation)
- **Harvest** (Tissue harvesting for autologous bone marrow transplants; The related costs/in-pt days for live donors; Note: if the donor is a Medicaid member this will not be included as part of their 25 day limit)
- **Total Body Irradiation** (Limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)
- **Preparation and transplant** (10 days post transplant care for kidney transplants)
- **Post transplant care** (Up to 60 days for other covered transplants)
- **Placement of Circulatory Assist Devices (CADs)** also known as Ventricular Assistive Devices (VADs) and Total Artificial hearts (TAHs) (Limited to day of surgery; Inpatient days before and after the placement of the CADs are to be counted towards the 25 day limit)

Note: Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a member has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.