AHCCCS Copayment Requirements in Proposed Rule R9-22-711
As of 4/21/2010

As a result of the Deficit Reduction Act, the AHCCCS Administration has filed proposed rule A.A.C. R9-22-711 "Copayments" which amends cost sharing requirements for the AHCCCS Program to comport with changes in federal law. AHCCCS anticipates that the amended rule will become effective October 1, 2010 after both a public hearing and the hearing conducted by the Governor's Regulatory Review Council.

The proposed changes to the current regulation include: 1) increasing the copayment amounts currently in AHCCCS rule to correspond with the updated nominal amounts permitted by federal law, 2) authorizing the imposition of "hard" copays for certain services for Transitional Medical Assistance (TMA) members, and 3) clarifying the exemptions from cost sharing for certain populations and services. Most of the revisions to the rule pertain to the cost sharing requirements for the TMA population where providers are permitted to deny services if the member fails to pay the copayment. These changes are described in Subsection D of the proposed regulation. The proposed rule may be found on the AHCCCS internet website at: http://www.azahcccs.gov/reporting/state/proposedrules.aspx

To assist in the review of the proposed rule, below is a high level overview of the major cost sharing provisions in proposed R9-22-711. It includes a description of the general cost sharing requirements for the mandatory and optional **non-TMA** Medicaid population (also referred to as non-TMA non-TWG members) as well as a cost sharing summary specific to TMA members. There is also a brief discussion of the copayment requirements for AHCCCS members known as the “Childless Adults” and the MED population; these two groups are also referred to collectively as the “AHCCCS Expansion Population” or the “TWG Population.”

When reviewing the proposed rule, keep in mind that it is organized in various subsections. Subsection A describes the *services* for which NO copayments may ever be imposed for **any** AHCCCS eligible member, including TMA’s and TWG’s. Subsection B sets forth the populations which are exempt from copayments. Subsection C pertains generally to the **non- TMA non-TWG** members who are subject to “soft,” nominal copayments while Subsection D describes the cost sharing requirements for the TMA population. With respect to TMA members, subsection D specifies the limited circumstances when “hard” copayments are to be charged for certain services. Subsection E sets forth the copayment requirements for the TWG population. “Hard” copays are also authorized for these members, including “hard” copays for non emergency use of the emergency room.

No changes to the rule have been proposed for the TWG population described in Subsection E. Although an injunction has been in place for several years prohibiting imposition of “hard” copays for TWG members (see Subsection G), the federal district court has recently upheld the AHCCCS copayment scheme delineated in Subsection E. Therefore, the AHCCCS Administration will be implementing the "hard" co-pays described in Subsection E (which are also found in the current rule) when proposed rule R9-22-711 goes into effect scheduled for October 1, 2010. Until such time, only the "soft" copays may be imposed for this population consistent with Subsection C.

I. Copayment Requirements for Non-TMA Non-TWG Members

The following are the copayment amounts per service found in the proposed rule. These are “soft" co-pays which means that if a member is unable to pay the copayment, the provider is prohibited from denying the service.

1) $2.30 per prescription drug

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2) $3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non emergent surgical procedures according to the National Standard Code Sets (NSCS).
3) $2.30 if no copayment is imposed for an outpatient visit above *and* any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets (NSCS).

No copayments for any members (including TMA and TWG members) are permitted for the following services:

1) Family planning services and supplies
2) Emergency services
3) Services related to a pregnancy or any other medical condition which may complicate the pregnancy

4) Services paid on a fee-for-service basis

In addition, no copayments are permitted for the following members-irrespective of the service provided:

1) Individuals under age 19, including KidsCare members
2) Individuals determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
3) ALTCS Members
4) Individuals eligible for Medicare Cost Sharing (including QMB's and SLMB's)
5) Individuals eligible for Children's Rehabilitative Services (CRS)
6) Individuals who are institutionalized including individuals who qualify for ALTCS (including HCBS members)
7) Individuals who are receiving hospice care

Also, the proposed rule eliminates the existing $1.00 "soft" copayment for nonemergency use of the emergency room for certain non-TWG members.

II. TMA Copayment Requirements

In most instances, members who are eligible for TMA are **required** to pay copayments for services. These copayments are referred to as "hard" co-pays, and providers are permitted to deny the service if the member fails to pay the copayment. There are exceptions for specific services as well as for specific classes of TMA members which are listed below. Unlike copayments for the non-TMA non-TWG populations, providers *are* permitted to deny a service if the TMA member does not pay the copayment. However, providers may choose to reduce or waive copayments on a case by case basis. Total aggregate cost sharing in a quarter for all individuals in the family cannot exceed 5% of the family's household income. Under the proposed rule, TMA members are responsible to track their copayments and to provide the AHCCCS Administration with records of copayments made during the quarter.

The proposed rule authorizes providers to charge TMA members the following co-pay amounts:

1) $2.30 per prescription drug
2) $4.00 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets (NSCS)
3) if no copayment is imposed under 2 above, $3.00 per visit if any of the services are coded as physical, occupational, or speech therapy visits by the NSCS

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4) if no copayment is imposed under 2 or 3 above, $3.00 per visit if any of the services are coded as non-emergent surgical procedures according to the NSCS when provided in a physician's office, an ambulatory surgical center, or any other outpatient setting, excluding an emergency room

Exceptions

The following *services* are exempt from copayments, and, therefore, providers are prohibited from imposing any copays on TMA members for:
1) Family planning services and supplies
2) Services related to a pregnancy or any other medical condition which may complicate the pregnancy
3) Emergency services

4) Services paid on a fee-for-service basis

In addition, no copayments will be imposed on TMA members for non emergency use of the emergency room.
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Furthermore, the following TMA *members* cannot be charged copayments, and therefore, providers are prohibited from collecting copays-irrespective of the services provided to:
1) TMA children under 19 years of age
2) Individuals eligible for CRS
3) Individuals determined to be SMI
4) Institutionalized persons including individuals who qualify for ALTCS (including HCBS members)
5) Individuals who are receiving hospice care

Note: The proposed rule R9-22-711 D.5. also states that copayments may be imposed for certain services received by TMA members (as described below), but a provider is prohibited from denying the service if the TMA member fails to pay the copayment amount (These copays are referred to as "soft" copays)

Services for individuals 19 years or older who are receiving child welfare services under Title IV Part B of the Social Security Act or adoption/ foster care assistance under Title IV Part E of the Social Security Act.

AHCCCS is currently reviewing this matter with CMS to determine whether any TMA members qualify for the soft copay exception described above. If no TMA members fall within this category, AHCCCS plans to delete Subsection D.5 of the TMA rule. Updates to this issue will be provided.

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