Medicaid Premiums and Cost Sharing

State Name: Arizona

OMB Control Number: 0938-1148

Transmittal Number: ___ - __ - ____

Expiration date: 10/31/2014

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☒ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Hospitals will perform the required EMTALA screening on the patient to determine if the condition is non-emergent as determined by a medical professional at the hospital. Non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possession an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. If it is determined that the condition is non-emergent and the individual still opts to be treated in the emergency room, they will be required to pay the copay.

Cost Sharing for Drugs

The state charges cost sharing for drugs.	Yes
The state has established differential cost sharing for preferred and non-preferred drugs.	No

- ■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

AHCCCS posted information on its website with a public notice comment period consistent with 42 CFR 447.57. The link to the website can be found at: http://www.azahcccs.gov/commercial/providerbilling/copayments.aspx.

Medicaid Premiums and Cost Sharing

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Arizona

OMB Control Number: 0938-1148

Transmittal Number: ___ - __ - ____

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals — G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+						X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Prescription Drugs — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	4.00	$	Prescription	The following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group	X
+	106% FPL	185% FPL	2.30	$	Prescription	The following groups are subject to Mandatory Copays under Section 1916A: Transitional Medical Assistance	X
+	0% FPL	Range	2.30	$	Prescription	The following groups are subject to Nominal Copays under Section 1916: SSI Cash (100% FBR), SSI-MAO (100% FPL), Parent Caretaker Relatives (106%FPL), YATI (N/A), State Adoption Subsidy (N/A), Freedom to Work (250% FPL)	X

Service or Item: Office Visits — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	10.00	$	Visit	The following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group $5.00 when AHCCCS pays $50.00-$99.99; $10.00 when AHCCCS pays $100.00 or more.	X

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	185% FPL	4.00	$	Visit	The following groups are subject to Mandatory Copays under Section 1916A: Transitional Medical Assistance	X
+	0% FPL	Range	3.40	$	Visit	The following groups are subject to Nominal Copays under Section 1916: SSI Cash (100% FBR), SSI-MAO (100% FPL), Parent Caretaker Relatives (106%FPL), YATI (N/A), State Adoption Subsidy (N/A), Freedom to Work (250% FPL)	X

Service or Item: Outpatient Professional Therapies

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	5.00	$	Visit	he following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group as follows: $2.00 when AHCCCS pays $20.00-$39.99; $4.00 when AHCCCS pays $40.00-$49.99; $5.00 when AHCCCS pays $50.00 or more.	X
+	106% FPL	185% FPL	3.00	$	Visit	The following groups are subject to Mandatory Copays under Section 1916A: Transitional Medical Assistance	X
+	0% FPL	Range	2.30	$	Visit	The following groups are subject to Nominal Copays under Section 1916: SSI Cash (100% FBR), SSI-MAO (100% FPL), Parent Caretaker Relatives (106%FPL), YATI (N/A), State Adoption Subsidy (N/A), Freedom to Work (250% FPL)	X

Service or Item: Non-emergency Surgery

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	50.00	$	Procedure	The following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group as follows: Applies to non-emergent surgeries performed in office, outpatient non-emergency room settings, and ambulatory surgical centers. $30.00 when AHCCCS pays $300.00-$499.99; $50.00 when AHCCCS pays $500.00 or more.	X

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	185% FPL	3.00	$	Procedure	The following groups are subject to Mandatory Copays under Section 1916A: Transitional Medical Assistance	X

Service or Item: Non-emergency use of the Emergency Room

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	8.00	$	Visit	The following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group	X

Service or Item: Taxis for Non-emergency medical transportation in Pima and Maricopa Counties

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	106% FPL	133% FPL	2.00	$	Trip	The following groups are subject to Mandatory Copays under Section 1916A: Individuals in the Adult group	X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

PRA Disclosure Statement

Medicaid Premiums and Cost Sharing

State Name: Arizona

OMB Control Number: 0938-1148

Transmittal Number: ___ - __ - ____

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional): Adults over 106% FPL

Eligibility Group(s) Included: Individuals in the Adult Group

Incomes Greater than 106 % FPL TO Incomes Less than or Equal to 133% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Inpatient Stay	75.00	$	Visit		X
+	Non-emergency use of the Emergency Room	8.00	$	Visit		X
+	Taxis for Non-emergency Medical Transportation in Pima and Maricopa counties	2.00	$	Trip		X
+	Non-emergency surgery	50.00	$	Visit	Applies to non-emergent surgeries performed in-office, outpatient non-emergency room settings, and ambulatory surgical centers; $30.00 when AHCCCS pays $300.00-499.99 $50.00 when AHCCCS pays $500.00 or more	X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

Medicaid Premiums and Cost Sharing

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Population Name (optional): TMA

Eligibility Group(s) Included: Individuals in Temporary Medical Assistance

Incomes Greater than 106% FPL TO Incomes Less than or Equal to 185% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Non-emergency surgery	3.00	$	Procedure		X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

Medicaid Premiums and Cost Sharing

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V.20140415

Medicaid Premiums and Cost Sharing

State Name: Arizona

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Expiration date: 10/31/2014

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ■ 133% FPL; and
- ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ■ SSI Beneficiaries (42 CFR 435.120).
- ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

■ An individual receiving hospice care, as defined in section 1905(o) of the Act.

■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.	No
The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.	Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☒ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

  Additional description of procedures used is provided below (optional):

- ■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☒ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

◉ 5%

○ 4%

○ 3%

○ 2%

○ 1%

○ Other: %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

◉ Quarterly

○ Monthly

Medicaid Premiums and Cost Sharing

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☐ Other process:

■ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Information about copays will be sent to beneficiaries subject to cost sharing and will include the household's aggregate family limit as part of an approval, change or redetermination notice. Beneficiaries currently enrolled will receive notice of copay requirements, including the aggregate limit. Information about copays will also be included in the Member Handbook.
If the limit is reached, another notice will be sent to the household informing them that they have reached the aggregate family limit and will not be subject to copays for the remainder of the quarter.
Also, when a beneficiary has reached their aggregate family limit, the provider look-up portal will be updated to show the beneficiary has a $0 copay.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

Families who believe they have incurred cost sharing over the aggregate limit within a quarter that has not been captured by the automated tracking system, can send documentation that supports this claim to a special mailbox. AHCCCS will review each claim and adjust copay requirements as needed. Information about this process, as well as the documentation needed to support such a claim will be included in the notice to members about their copays. Note, Arizona is not imposing premiums.

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The system will automatically exempt beneficiaries from copay requirements as soon as they hit a threshold of 3.5% of their household aggregate limit. This triggers a notice informing the beneficiary to stop paying copays for the remainder of the quarter. It also triggers an update to the provider look-up portal that will tell the provider a zero copay is due.

■ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries must report a change in income, household composition or other circumstance. If it results in a change in their aggregate limit, the system would be updated accordingly. The beneficiary will receive a change notice explaining their new aggregate limit. Beneficiaries can also request a reassessment of their family aggregate limit any time there is a change. Changes can be reported to the Agency by phone, mail or online. Information about this process will be included

in the notice to members about their copays.	
The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).	No

PRA Disclosure Statement

V.20140415