

**NOTICE OF PROPOSED RULEMAKING**  
**TITLE 9. HEALTH SERVICES**  
**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**  
**(AHCCCS)**

**PREAMBLE**

**1. Sections Affected**

**Rulemaking Action**

R9-22-711

Amend

**2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2903.01 (B)(7)

Implementing statute: A.R.S. § 36-2903.01 (D)(4)

**3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 16 A.A.R. , , 2010

**4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Mariaelena Ugarte

Address: AHCCCS

Office of Administrative and Legal Services

701 E. Jefferson, Mail Drop 6200

Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The DRA created section 1916A of Title XIX (42 U.S.C. 1396o-1) which permits states to impose higher than nominal copayments on certain populations with incomes over 100% of the Federal Poverty Level (FPL). The AHCCCS Administration plans to move forward using this authority to change the copayment requirements for those members under the

Transitional Medical Assistance (TMA) program with income over 100% of the FPL and any other changes required to conform to 1916A of Title XIX.

**6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The AHCCCS Administration conducted internal analysis of the capped fee-for-service payment amounts associated with the services subject to copayments under this rule. The Administration is relying on this analysis to ensure that the copayment amounts do not exceed maximum amounts established by federal regulations in 42 CFR Part 447 Subpart A. The result of the analysis is available to the public on the AHCCCS Administration public web site. The capped fee-for-service payment amounts used in the study are available for public inspection on the AHCCCS Administration public web site. However, the data underlying the study is not available to the public to the extent that the analysis relied on the use of individually identifiable protected health information which is confidential as a matter of state and federal law.

**7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

None.

**8. The preliminary summary of the economic, small business, and consumer impact:**

The Transitional Medical Assistance (TMA) adult population has been identified as the member population where copayments will be required for prescriptions, outpatient evaluation and management visits, outpatient therapies, and outpatient non-emergent surgeries. In October 2009, approximately 16,400 members of the 39,000 TMA members were estimated to be subject to copayments. For the state fiscal year 2010, the copayment cost to the TMA member for prescriptions is estimated to be \$2.30; for outpatient evaluation and management services occurring in any setting other than an emergency room, the copayment amount is estimated to be \$4.00; and for outpatient therapy services, in-office surgeries, Ambulatory Surgical Center

(ASC) surgeries, and outpatient non-emergent surgeries, the copayment amount is estimated to be \$3.00. The AHCCCS Administration estimates the total annual state/federal savings from the TMA copayments to be \$300,000. For the TMA population, the provider may deny services if the copayment is not paid by the TMA member.

With regard to other AHCCCS populations described in Subsection C of the proposed rule, the \$1.00 copayment amount currently charged will be increased as authorized by State Law. For the state fiscal year 2010, the copayment cost to these members will range from \$2.30 to \$3.40 based on the average Fee-for-Service payment. Although these populations are not required to make copayments, if 2.5% of the proposed copayments were collected, the resulting amount received would approximate \$650,000.00. Providers are prohibited from denying services to these members if they are unable to pay the copayment. Because historical data indicates that copayments from this population are rarely collected by the provider, increases to the current copayment amounts are not anticipated to have an impact on the provider, the member, or the Agency.

Currently, the AHCCCS Administration's annual budget is approximately \$9,400,000,000. The estimated total economic impact resulting from the proposed cost sharing revisions is estimated to be minimal.

- Minimal economic impact = \$0 to \$2,500,000
- Moderate economic impact = \$2,500,001 to \$250,000,000
- Substantial economic impact = \$250,000,001 and above

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: Mariaelena Ugarte  
Address: AHCCCS  
Office of Administrative and Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4693

Fax: (602) 253-9115  
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS website [www.azahcccs.gov](http://www.azahcccs.gov) the week of March 29, 2009. Please send written comments to the above address by 5:00 p.m., May 18, 2010. E-mail comments will also be accepted during this timeframe.

**10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Date: May 18, 2010  
Time: 11:00 a.m.  
Location: AHCCCS  
701 East Jefferson  
Phoenix, AZ 85034  
Nature: Public Hearing

Date: May 18, 2010  
Time: 11:00 a.m.  
Location: ALTCS: Arizona Long-Term Care System  
1010 N. Finance Center Dr, Suite 201  
Tucson, AZ 85710  
Nature: Public Hearing

Date: May 18, 2010  
Time: 11:00 a.m.  
Location: DAHL /Office of Special Investigations  
2721 N. 4th street, Suite 23  
Flagstaff, AZ 86004  
Nature: Public Hearing

**11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

Not applicable.

**12. Incorporations by reference and their location in the rules:**

None.

**13. The full text of the rules follows:**

**TITLE 9. HEALTH SERVICES**  
**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**  
**ADMINISTRATION**  
**ARTICLE 7. STANDARDS FOR PAYMENTS**

Section  
R9-22-711. Copayments

**TITLE 9. HEALTH SERVICES**  
**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**  
**ADMINISTRATION**  
**ARTICLE 7. STANDARDS FOR PAYMENTS**

**R9-22-711. Copayments**

**A.** For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
3. A copayment is assessed prospectively. No refunds shall be made for a retroactive period if there is a change in a person's status altering the amount of a copayment.
4. Family planning services and supplies are exempt from copayments for all members.
5. Services related to a pregnancy or any other medical condition which may complicate the pregnancy are exempt from copayments for all members.
6. Emergency services as described in 42 CFR 447.53 (b)(4) are exempt from copayments for all members.
7. All services paid on a Fee-for-service basis are exempt from copayments for all members.

**B.** The following individuals are exempt from all AHCCCS copayments:

1. An individual under age 19 including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. ~~A Native American eligible under the parent program in A.R.S. § 36-2981.01;~~
4. ~~A Native American enrolled with HHS;~~
5. ~~An eligible individual not enrolled with a contractor and classified as fee for service;~~
6. ~~A pregnant woman eligible for any AHCCCS program;~~
7. ~~An individual eligible for the family planning services program in A.R.S. § 36-2907.~~
- 8.3. An individual eligible for the Arizona Long Term Care Program in A.R.S. § 36-2931;
- 9.4. An individual eligible for Medicare Cost Sharing in A.R.S. § 36-2972; ~~and~~

~~10.5.~~ An individual eligible for the Children’s Rehabilitative Services program under A.R.S. § 36-2906(E);

~~11.6.~~ An institutionalized person under R9-22-216; and

7. An individual receiving hospice care as defined in 42 U.S.C. § 1396d(o).

~~C.~~ Unless otherwise listed in subsection (B), an individual eligible for the parent program in A.R.S. § 36-2981.01 is subject to a \$1.00 per visit copayment for a nonemergency use of the emergency room. A provider shall not deny service because of the member’s inability to pay a copayment.

~~D.C.~~ Unless otherwise listed in subsection (B) ~~or (C)~~, the following individuals are subject to the copayments listed in this subsection. A provider shall not deny a service ~~because of the member’s~~ when a member states their inability to pay a copayment.

1. A family eligible under Section 1931 of the Act;

2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(iii);

3. An individual eligible for State Adoption Assistance in R9-22-1426;

4. An individual eligible for Supplemental Security Income (SSI);

5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in R9-22-1500;

~~6.~~ An individual eligible for the Transitional Medical Assistance (TMA) in A.R.S. § 36-2924;

~~7.6.~~ An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g);  
and

~~8.7.~~ An individual eligible for the Breast and Cervical Cancer Treatment program in A.R.S. § 36-2901.05.

~~9.~~ An individual enrolled for behavioral health services in A.R.S. § 36-2907.

<b>Covered Services</b>	<b>Copayment</b>
<del>Physician office visit</del>	<del>\$1.00 per office visit</del>
<del>Nonemergency use of the emergency room.</del>	<del>\$1.00 per visit</del>

8. Copayment amount per service:

- a. \$2.30 per prescription drug.
- b. \$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. This includes any settings where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
- c. If a copayment is not being imposed under subsection (C)(8)(b), \$2.30 per visit, if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.

**D.** Copayments for individuals eligible for Transitional Medical Assistance.

- 1. Unless otherwise listed in subsection (B)(1), (B)(2), (B)(5), (B)(6), (B)(7) or (C)(1) through (C)(7), an individual eligible for Transitional Medical Assistance (TMA) in A.R.S. § 36-2924 is required to pay the following copayments:
  - a. \$2.30 per prescription drug.
  - b. \$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.
  - c. If a copayment is not being imposed under subsection (D)(1)(b), \$3.00 per visit, if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
  - d. If a copayment is not being imposed under subsection (D)(1)(b) or (D)(1)(c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets when provided in a physician's office, an ASC, or any other outpatient setting, excluding an emergency room, where these services are performed

2. The provider may deny a service if the member does not pay the copayment required by subsection (D)(1), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.
3. The copayments in subsection (D)(1) do not apply to services furnished to individuals with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care without regard to age.
4. The copayments in subsection (D)(1) do not apply to services furnished to individuals with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age.
5. With respect to the services exempted by subsections (D)(3) and (D)(4), an individual eligible for TMA in A.R.S. § 36-2924 is subject to copayments in accordance with subsection (C).

**E.** Unless otherwise listed in subsection (B), (C) or (D) the following individuals are required to pay the copayments listed in this subsection. The provider may deny a service if the member does not pay the required copayment.

1. An individual whose income is ~~under~~ equal to or under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01, or
2. An individual eligible for the Medical Expense Deduction program in A.R.S. § 36-2901.04.

<b>Covered Services</b>	<b>Copayment</b>
Generic prescriptions or brand name prescriptions if generic is not available	\$4.00 per prescription
Brand name prescriptions when generic is available	\$10.00 per prescription

Nonemergency use of the emergency room.	\$30.00 per visit
Physician office visit	\$5.00 per office visit

**G.F.** A provider is responsible for collecting any copayment.

**H.G.** On April 20, 2004, the United States District Court for the District of Arizona issued a preliminary injunction prohibiting enforcement of subsection (E) of this ~~rule~~ section. For so long as the injunction is in effect, persons who would, but for the injunction, be subject to the copayment requirements and other provisions of subsection (E) shall be subject to the copayment requirements and other provisions of subsection ~~(D)~~ (C).

**H.** The total aggregate amount of copayments under subsections (C) or (D) may not exceed 5 percent of the family's income as applied on a quarterly basis. The member shall be responsible for establishing that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. The Administration shall also use claims and encounters information available to the Administration to establish when a member copayment obligation has reached 5% of the family's income.

**I.** Reduction in Payments to Providers. The Administration shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under subsection (D) and (E), regardless of whether the provider successfully collects the copayments described in this section.