



# Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

## Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

Yes

The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

### 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 5 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.20131219

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

**Alternative Premiums and Cost Sharing Charges**

The following alternative premiums and cost sharing charges are imposed under section 1916A of the Social Security Act and 42 CFR 447.50 and 447.62 - 447.82. A State may select one or more options for cost-sharing (including copayments, coinsurance, and deductibles) and premiums.

**C. For individuals in the new adult group between the ages of 19-64, without Medicare, not pregnant and with family income at or above 106 percent of the FPL:**

1. Cost Sharing
  - a. Amount of Cost Sharing
    - i.   / No cost sharing is imposed.
    - ii.   / Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).
    - iii.   X/ Alternative cost sharing is imposed under section 1916A of the Act as follows:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Arizona

Individuals who are in the new adult group with income above 106% FPL				
Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including mthly or qtrly period)
	Deductible	Coinsurance	Copayment	
Prescription Drugs	N/A	N/A	\$4.00/drug	Same
Outpatient visit, excluding emergency room visit if coded as evaluation and management services	N/A	N/A	\$5.00 or \$10.00/visit <sup>1</sup>	Same
If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	\$2.00 or \$4.00 or \$5.00/visit <sup>2</sup>	Same
If not imposed above, any services rendered during a visit coded as non-emergent surgical procedures when provided in a physician's office, an ASC or any other outpatient setting, excluding an emergency room <sup>3</sup>	N/A	N/A	\$30.00 or \$50.00/surgery <sup>4</sup>	Same
Inpatient hospital stay	N/A	N/A	\$75.00/visit	
Non-emergency use of the emergency room	N/A	N/A	\$8.00/visit	Same
Taxis for Non-emergency medical transportation in Pima and Maricopa Counties	N/A	N/A	\$2.00/trip	Same

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Supersedes  
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Effective Date January 1, 2015

<sup>1</sup> \$5.00 when AHCCCS pays \$50.00-\$99.99; \$10.00 when AHCCCS pays \$100.00 or more

<sup>2</sup> \$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

<sup>3</sup> Applies to non-emergent surgeries performed in office, outpatient non-emergency room settings and ambulatory surgical centers

<sup>4</sup> \$30.00 when AHCCCS pays \$300.00-\$499.99; \$50.00 when AHCCCS pays \$500.00 or more



# Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

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## 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 specifically 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):



# Medicaid Premiums and Cost Sharing

- 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



# Medicaid Premiums and Cost Sharing

in the notice to members about their copays.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

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