

NOTICE OF FINAL 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 specific 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. The effective date of the rules:**

The rules are effective October 1, 2010, which is more than 60 days after the filing of the rule with the Secretary of State. AHCCCS Administration determined that good cause exists for and the public interest will not be harmed by the later effective date. The effective date will coincide with the providers' and health plans' contract year.

**4. A list of all previous notices appearing in the Register addressing the final rules:**

Notice of Docket Opening: 16 A.A.R. 568, April 9, 2010

Notice of Proposed Rulemaking: 16 A.A.R. 592, April 16, 2010

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

Name: Mariaelena Ugarte

Address: AHCCCS

Office of Administrative Legal Services

701 E. Jefferson, Mail Drop 6200

Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The Deficit Reduction Act (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. TMA provides continued coverage to families with children who were receiving AHCCCS in the "1931" category and become ineligible due to the increased earnings of a parent or specified relative. This category is named after the section 1931 of the Social Security Act. Persons in the TMA program have income over 100% of the Federal Poverty Level. The AHCCCS Administration plans to make other changes required to conform to Section 1916A of Title XIX, such as copayment changes as allowed for the optional copayment group.

**7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not 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 at: <http://www.azahcccs.gov/reporting/state/proposedrules.aspx>. 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.

**8. 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:**

Not applicable

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

The copayment for non-Transitional Medical Assistance (TMA) individuals described in Subsection D of the proposed rule, the \$1.00 nominal copayment amount currently charged will be increased as authorized by federal 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. The copayments for these populations are soft copayments. Although these populations cannot be denied services if unable to pay the copayment, if 2.5% of the proposed copayments were collected, the resulting amount received would be approximately \$650,000.00. Providers are prohibited from denying services to these members if they are unable to pay the copayment. If the provider collects the copayment, then that provider's reimbursement is reduced by the copayment amount. 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.

The copayments for individuals eligible for TMA (adult population) has been identified as the member population where hard copayments will be imposed 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.

Beginning the state fiscal year 2010, TMA members subject to copayments will have hard copayments in the following amounts:

- \$2.30 for prescriptions;
- \$4.00 for outpatient evaluation and management services occurring in any setting other than an emergency room; and
- \$3.00 for outpatient therapy services, in-office surgeries, Ambulatory Surgical Center (ASC) surgeries, and outpatient non-emergent surgeries.

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. The copayment requirements for the TMA population are delineated in Subsection E. If the provider chooses to provide the service without collecting the copayment, the provider will lose the copayment amount since this amount is deducted from the provider's reimbursement of the service.

The copayments for individuals eligible under Section 1115 Waiver., hard copayments will be imposed for prescriptions, non emergency use of the emergency room, and physician office visits. These copayments were approved by CMS as part of the waiver for implementation of copayments, but the enforceability of this subsection of the rule was held due to a litigation matter. An injunction was recently vacated, therefore allowing the enforcement of this rule and application of the already approved copayments. The provider may also deny a service if the member does not pay the required copayment. If the provider chooses to provide the service without collecting the copayment, the provider will lose the copayment amount since this amount is deducted from the provider's reimbursement of the service.

- \$4.00 for prescriptions;
- \$30.00 for non emergency use fo the emergency room; and
- \$5.00 for physician office visits.

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

**10. A description of the changes between the proposed rules, including supplemental notices, and final rules**

**(if applicable):**

In addition to minor technical and grammatical changes, The AHCCCS Administration made the following changes after the proposed rule was filed:

Section 4107(c) and (d) of the Health Care Reform bill states that, effective October 1, 2010, copayments cannot be imposed on tobacco cessation treatment for pregnant women. The Administration has updated R9-22-711 (A)(5) to reflect the change made in Section 4107.

In addition, the United States District Court for the District of Arizona filed an Order as of March 29, 2010 and vacated the proposed Order signed on March 26, 2010 for the case Sharon Newton-Nations vs. Anthony Rodgers succeeded by Thomas J. Betlach, Arizona Health Care Cost Containment (AHCCCS) Director. Therefore, the Order allows the AHCCCS Administration to impose the copayments described in R9-22-711(E) and to strike existing rule R9-22-711(G).

**11. A summary of the comments made regarding the rule and the agency response to them:**

The following matrix lists the public comments received from Ellen Katz, William Morris Institute for Justice as of May 18, 2010, please note that the responses and references to subsections are in reference to how the subsections existed when proposed. The final version of the language will show changes in the subsection numbering:

Item #	Rule Cite Line #	Comment From	Comment	Response
1.		Ellen Katz	The Arizona Health Care Cost Containment System (“AHCCCS”) issued a Notice of Amended Proposed Rulemaking Concerning Administrative Rule R9-22-711. This proposed rulemaking affects class members in <i>Newton-Nations v. Rodgers</i> , CIV 2003-2506 PHX EHC, as well as other low-income Arizonans. The William E. Morris Institute for Justice (“Institute”) is co-counsel for plaintiffs and the class in <i>Newton-Nations</i> .	It is inaccurate that this is <i>amended</i> rulemaking; this is a new rulemaking under the Administrative Procedure Act (APA).
2.		Ellen Katz	AHCCCS proposed rules sometimes speak in terms of exempting individuals and at	We disagree. While the organization of proposed rule is not identical to the federal

			<p>other times in terms of exempting services. This creates confusion and, in some cases, inconsistency with the federal requirements.</p>	<p>regulation, the proposed rule includes all of the necessary content in a manner that is just as clear, if not more clear, than the federal regulation it implements. Here is a summary outline of the rule:  Subsection (A): includes a description of services that are not subject to copayments under any circumstances.  Subsection (B): includes a list of persons who, by virtue of their status, are not subject to copayments for any services.  Subsection (C): describes copayment requirements for persons subject to “nominal” copayments under section 1916 of the Social Security Act.  Subsection (D): describes copayment requirements for persons subject to alternative copayments under section 1916A of the Social Security Act. These individuals are eligible for TMA.  Subsection (E): describes copayment requirements for persons subject to the copayment requirements listed in the Arizona Demonstration Project under section 1115 of the Social Security Act.</p>
3.		Ellen Katz	<p>Moreover, there is no place in the proposed rules where medical services that are exempt and excluded from copayments or from heightened copayments are listed.</p>	<p>All the medical services that are exempt by federal law are listed in this rule. Subsections (A) and (B) are applicable to both nominal and heightened copayments.</p>
4.	R9-22-711 (C)	Ellen Katz	<p>The listed groups of services are exempt from nominal copayments. AHCCCS splits these services between R9-22-711(A) and (B). Then in Section 711(C) for persons for whom only nominal copayments may be charged, AHCCCS only refers to Section 711(B) and omits reference to Section 711(A). Thus, as an example, the way the proposed rule is structured, persons identified in Section C improperly could be charged copayments for an emergency.</p>	<p>Subsection (A) starts with “for purposes of this Article” and it applies to all other subsections within this rule. Moreover, the exemptions from copayments for services described in Subsection (A)(4)-(7) – which include emergency services - clearly state that they apply to “all members.”</p>
5.	R9-22-711 (D)	Ellen Katz	<p>For R9-22-711(D) where AHCCCS proposes to impose heightened copayments, the rule states that “[u]nless otherwise listed in other” subsections the listed copayments can be charged. As noted, pursuant to 42 U.S.C. § 1396o-1(b)(3)(B), no heightened copayments may be imposed on the ten listed services.  Section D does not refer to Section A. it is not clear what services properly can be charged the heightened copayments.</p>	<p>Subsection (A) starts with “for purposes of this Article” and it applies to all other subsections within this rule. Moreover, the exemptions from copayments for services described in subsection (A)(4)-(7) clearly state that they apply to “all members.”</p>
6.	R9-22-	Ellen Katz	<p>The proposed rule allows (or is not clear</p>	<p>Subsection (A) starts with “for purposes of this</p>

	711 (D)		that it is not allowed) family planning services to be subject to the heightened copayment in violation of federal law.	Article” and it applies to all other subsections within this rule. This is covered under (A) (4) which states that “Family planning services and supplies are exempt from copayments for all members.”
7.	R9-22-711 (E)	Ellen Katz	Section E fails to refer to all the exempt services under federal law and to the medical services listed in Section 711 (A) in violation of the federal law.	Subsection (A) starts with “for purposes of this Article” and it applies to all other subsections within this rule. In addition, under the 9 <sup>th</sup> Circuit Court of Appeals decision in <u>Spry v. Thompson</u> , 487 F.3d 1272 (2007), and the District Court decision in <u>Newton-Nations v. Rodgers</u> , 2010 U.S. Dist. LEXIS 29901, (2010), copayments can be imposed on expansion populations consistent with the special terms and conditions imposed by the Secretary of US Department of Health and Human Services as part of a section 1115 demonstration project. The special terms and conditions of Arizona’s approved demonstration project do not require the agency to exclude any particular services from the copayments applicable to the expansion populations described in subsection (E).
8.		Ellen Katz	We request that AHCCCS list in a comprehensive manner all exempt services and all services where non-nominal copayments may not be charged.	This is covered in subsections (A) and (B).
9.	Preamble #5 and #8	Ellen Katz	The preamble states copayments will apply to part of the TMA population but the text of the proposed rules applies to all individuals in the TMA program. See Section D.	There are persons in the TMA population excluded by subsection (B).
10.	R9-22-711 (D)	Ellen Katz	The proposed rules include neither an exclusion of individuals with incomes under the FPL nor a method for determining family income so that individuals in the FPL grouping will have their cost sharing limited. Section D must be clarified to only apply to TMA persons with incomes over 100% of the FPL and the rules must explain how income for this group will be determined.	There is no one in the TMA category who has family income under 100% of FPL. Under 42 USC 1396r-6, TMA refers to persons who lose eligibility under a Title IV-A related Medicaid category due to increased earned income. Under the Arizona State Plan, all of the Title IV-A related Medicaid categories have income limits that are higher than 100% of the FPL. See, A.A.C. R9-22-1428. Thus persons with family income at or below 100% of the FPL are not eligible under the TMA category.
11.		Ellen Katz	The Preamble paragraph 8 and the proposed rules allow the provider to deny services to TMA individuals who are unable to pay the copayment amounts. The Preamble refers to the federal regulations on copayments, 42 C.F.R. § 447 Subpart A. Those regulations require the state to	Federal regulations require that the state plan describe when an individual is unable to pay a nominal copayment. Refer to section R9-22-711 (C); it is based on the member’s statement that s/he is unable to pay.

			<p>specify the basis for determining whether an individual is unable to pay the charge. Our review of the AHCCCS website does not disclose them.</p>	
12.		Ellen Katz	<p>The federal regulations referred to in the Preamble also require the State to specify the procedures for implementing and enforcing the exclusions from cost sharing. 42 C.F.R. § 447.53(d)(5). The proposed regulations fail to do this and are thus inconsistent with the federal law.</p>	<p>Federal regulations require the description in the state plan. Under the Arizona Administrative Procedure Act, internal operations of an agency and the terms of state contracts (such as those AHCCCS has with managed care organization and providers) are not proper subjects for rulemaking. ARS 41-1005(A)(4) and (15).</p>
13.		Ellen Katz	<p>Preamble paragraph 8 states what AHCCCS anticipates the annual state and federal savings total amount to be collected. After returning the percentage of that amount that is due to the federal government, it appears that the State will save only about \$ 222,625. Notably, federal law, 42 C.F.R. § 447.59(a), provides that no federal financial participation (“FFP”) in the State’s expenditures is available for “[a]ny cost sharing amount that recipients should have paid as ... copayments....” Doesn’t this mean, then, that the federal government will refuse FFP in an amount that reflects the copayments that should have been paid by all AHCCCS individuals subject to copayments—in other words, whether or not the individual pays the copayment, the copayment amount should have been paid and, thus, is included into the FFP calculations?</p>	<p>That is an incorrect statement of the effect of copayments on FFP. The agency does not collect the copayment, and, therefore, does not return any amounts to the federal government. AHCCCS will not claim FFP for uncollected copayments.</p>
14.		Ellen Katz	<p>The exceedingly small savings obtained by charging poor people copayments, if it can even be achieved, does not appear to have been netted against the additional administrative costs that will be associated with implementing the copayments as required by federal law (as requested herein). Surely there are other, more suitable sources for these small savings (e.g., nursing homes, managed care companies, other private contractors).</p>	<p>AHCCCS disagrees. AHCCCS has prepared an Economic Impact Statement that addresses the estimated costs and benefits associated with this rule. For the reasons set forth in that EIS, AHCCCS believes that the probable benefits to the public outweigh the probable cost. Furthermore, that there may be other means by which AHCCCS might also achieve program savings is not in and of itself a sufficient justification for forgoing the cost savings opportunities covered by this proposed rule.</p>
15.		Ellen Katz	<p>The R9-22-711(A) and (B) exemptions and exclusions and R9-22-711(C) copayments also violate federal law because they require women with breast and cervical cancer who are receiving Medicaid by virtue of 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa)</p>	<p>Only persons in the TMA category are subject to heightened copayments. Women eligible for the Breast and Cervical cancer treatment program with income at or below 100% of the FPL are not in the TMA category.</p>

			to pay a copayment while federal law excludes them from this requirement. <i>See</i> 42 U.S.C. § 1396o-1(b)(3)(B)(viii).	
16.		Ellen Katz	The exemption for an institutionalized person under R9-22-216 only covers persons in nursing facilities and home and community based services and alternatives. This exemption is not as comprehensive as inpatients covered by 42 U.S.C. § 1396o-1(b)(3)(B)(v), including patients in the listed facilities “or other medical institution.”	The federal requirement only applies to person in institutions who, as a condition of eligibility, are required to “to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.” In Arizona, this is referred to as the “share of cost.” The only populations that are subject to the share of cost requirements are persons in ALTCS. Those persons are exempt from all copayments under subsection (B)(3) of the proposed rule.
17.	R9-22-711 (B)	Ellen Katz	The exemption for disabled children under 42 U.S.C. § 1396o-1(b)(3)(B)(ix) is broader than the subsections for children with disabilities in R9-22-711(B)(2) and (6) unless it is made clear that Section B(1) includes all medical services to all children.	42 U.S.C. § 1396o-1(b)(3)(B)(ix) references an optional eligibility group – certain disabled children described in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIX) and (cc) - that is not covered under Arizona’s State Plan. Therefore, it is not necessary to include in this proposed rule any federal exemption from copayments that relate to this group.
18.		Ellen Katz	Under federal law, no cost sharing may be imposed on individuals to whom welfare services are provided because the child is in foster care and individuals who receive adoption or foster care assistance. 42 U.S.C. § 1396o-1(b)(3)(B)(i). These persons are not listed as exempt in Section B. R9-22-711(C) refers to “[a]n individual eligible for State Adoption Assistance in R9-22-1426 as a person who can be charged copayments. R9-22-1426 applies to exemptions from sponsored deemed income. Thus, that reference is incorrect. R9-22-1433 refers to “Special Groups for Children.” That section only refers to children eligible for Title IV-E adoption subsidy or children eligible for state adoption subsidy under 42 C.F.R. § 435.227. The exemption in 42 U.S.C. § 1396o-1(b)(3)(B)(i) is far broader and includes children in foster care.	The reference to R9-22-1426 is incorrect and will be changed to R9-22-1433. Subsections (C) and (D) provide for exceptions in federal law. Specific to this comment, 42 U.S.C. § 1396o-1(b)(3)(B)(i) prohibits the imposition of alternative (i.e., higher than nominal) copayments on children under age 18 whose eligibility is based upon the receipt of child welfare services under Title IV-B or foster care or adoption assistance payments. Subsections (D)(3) and (D)(4) exempt those children from the higher copayments in subsection (D) of the proposed rule. Technically, subsection (D)(4) is redundant because: (1) only persons in the TMA eligibility group are subject to heightened copayments. No one who is eligible by virtue of the receipt of foster care, or adoption assistance payments is included in the TMA eligibility group; and (2) all children under the age of 19 are exempt from copayment under subsection (B)(1) of the proposed rule. Also, to the extent that there may be individuals 19 years of age and older whose eligibility is based upon receipt of foster care or adoption assistance payments or receipt of child welfare services under Title IV-B, Subsections (D) (3) and (4) exclude those persons from alternative copayments, and Subsection (D) (5) clarifies that they are subject to nominal copayments under Subsection C. However, for purposes of



				clarity, the exceptions in subsections (D)(3) and (D)(4) are being moved to the list of individuals subject to the copayments described in subsection (C).
19.		Ellen Katz	All the copayments in Section C must fall within the limits set by federal law. The revised copayment amount of \$3.40 proposed in R9-22-711C(8)(b) exceeds the maximums currently allowed by federal regulation. The federal regulation caps copayments at \$3.00 for services for which the State pays \$50.01 or more. 42 C.F.R. § 447.54(a)(3). The revised copayment amount of \$3.40 would violate this regulation.	Effective 07/01/10 maximum copayment allowed by federal law for such services will be \$3.40. See 73 Federal Register 71828 (Nov. 25, 2008).
20.		Ellen Katz	Proposed rule, R9-22-711C(8)(a), increases copayments for prescription drugs, and subsection 8(c) increases copayments for physical and other therapies. We were promptly supplied the web site link by counsel for the State; however, the link did not provide access to information concerning the AHCCCS analysis and about the fee-for service amounts that were used to arrive at the proposed copayment amounts for prescription drugs or physical and other therapies. The public had no way to verify whether the copayment amounts reflect the maximums.	A.A.C. R1-1-501 (6) requires the notice of proposed rulemaking to include “a reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or 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 agency is in compliance with that requirement to the extent not inconsistent with federal law. Information regarding increases in copayment amounts for populations other than the TMA population were posted on the agency’s website (as stated in the notice of proposed rule making) at <a href="http://azahcccs.gov/reporting/state/proposedrules.aspx">http://azahcccs.gov/reporting/state/proposedrules.aspx</a> on April 12, 2010 The underlying data on which the analysis was based is protected health information and cannot be made public under 45 CFR Part 164.
21.		Ellen Katz	For the proposed amended rulemaking, AHCCCS only provided data analysis for the TMA eligible persons. The data shows Rx costs for group averaged \$34.76, therefore, the \$2.00 copayment limit would apply.	See the response to comment no.20. The information posted on the AHCCCS website provided the data analysis for the TMA group and for persons subject to the proposed amendments to the copayment in subsection (C). The amount that currently applies to the TMA is as noted in the rule, \$2.30, which is allowed by the latest federal changes.
22.		Ellen Katz	The proposed copayments for TMA individuals do not exclude individuals whose family income does not exceed the FPL, as required by 42 U.S.C. § 1396o-1(a)(2)(A). Thus, the proposal also fails to specify how family income will be determined, as required by 42 U.S.C. § 1396o-1(b)(4).	There is no one in the TMA category (that is, persons subject to higher than nominal copayment amounts) that has a family income under 100% of FPL. See response to comment no. 9. The federal statutory requirement in 42 U.S.C. § 1396o-1(b)(4) is that “family income shall be determined in a manner specified by the State.” It does not require that the manner be specified in state administrative rules.

				AHCCCS has specified the manner of calculating income for purposes of copayments in its Medicaid State Plan. The state plan specifically states that the method for determining income for purposes of copayments is identical to the method for determining income for purposes of eligibility. As the proposed rule does not identify a different method for calculating income, income for purposes of copayments is calculated as described in the existing rules applicable to the various types of eligibility. See, for example, A.A.C. R9-22-1422 and R9-22-1437.
23.		Ellen Katz	Services furnished to children in foster care/adoption assistance and preventive services for children under age 19, will be subject to copayments in accordance with Section C. However, federal law prohibits the imposition of cost sharing on these groups. See 42 U.S.C. § 1396o-1(b)(3)(B)(i), (ii) (“Subject to the succeeding provision of this section, no cost sharing shall be imposed under subsection (a) with respect to the following....”). Also, as noted above, the exclusions from the copayments for TMA persons do not include all the exempted services in the federal law.	42 U.S.C. §1396o-1(b)(3)(B)(i) does not exclude foster care/adoption assistance eligible persons from all copayments, it only excludes them from the imposition of the alternative copayments described in that statute. Subsection (B)(1) excludes all children under age 19 from any copayments. To the extent that there may be individuals 19 years of age or older whose eligibility is based upon the receipt of foster care or adoption assistance payments, subsections (D)(3) and (D)(4) exclude those persons from alternative copayments and subsection (D)(5) clarifies that they are subject to the nominal copayments in subsection (C).
24.		Ellen Katz	In Section E it refers to Section D. Is someone to understand that for those persons covered by Section E, those persons cannot be charged copayments for the medical services listed in Sections D (3) and (4)? The Institute doubts anyone would understand that limitation given the structure and wording of the proposed rule.	There is no one described in subsections (D)(3) and (D)(4) (persons whose eligibility is dependent upon the receipt of child welfare assistance, foster care payments, or adoption assistance payments) who is also described in subsection (E). By excluding persons described in subsections (B), (C), and (D), subsection (E) encompasses only those persons who are considered to be in an “expansion population” under the Arizona section 1115 demonstration project. Copayments for that population are as described in the terms and conditions of the demonstration project. For additional information, see the response to comment no. 6.
25.	R9-22-711 (H)	Ellen Katz	Proposed R9-22-711(H) sets forth an aggregate 5% family income cap; however, it would not apply this cap to individuals who are in Section E and in the <i>Newton-Nations v. Rodgers</i> class. All these persons have incomes below the FPL, with some as low as 40 % of the federal poverty level.	Copayments can be imposed on expansion populations, regardless of income level, consistent with the special terms and conditions imposed by the Secretary of US Department of Health and Human Services, DHS. For additional information, see the response to comment no. 6. The special terms and conditions of Arizona’s approved demonstration project do not require the agency

				to impose a 5% aggregate limitation for persons in the expansion populations described in subsection (E) regardless of income level.
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**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

Not applicable

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

Not applicable

**14. Was this rule previously adopted as an emergency rule?**

No

**15. 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~~ an individual's status ~~altering that alters~~ the amount of a copayment.
4. ~~Family planning services and supplies are exempt from copayments for all members.~~

**B.** The following services are exempt from AHCCCS copayments:

1. Family planning services and supplies are exempt from copayments for all members.
2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman, are exempt from copayments for all members.
3. Emergency services as described in 42 CFR 447.53 (b)(4) are exempt from copayments for all members.
4. All services paid on a fee-for-service basis are exempt from copayments for all members.

**~~B.C.~~** 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 IHS;~~
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~~ A.A.C. Title 9 Chapter 29; ~~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. Copayments for non-Transitional Medical Assistance (TMA) individuals covered under the State Plan. Unless otherwise listed in subsection (B) or (C), ~~the following~~ individuals under subsections (1) thru (8) 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 to the provider an 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~~ R9-22-1433;
  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.
  8. An individual 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 or an individual 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.
  9. ~~An individual enrolled for behavioral health services in A.R.S. § 36-2907.~~

<del>Covered Services</del>	<del>Copayment</del>
<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>

9. 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. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.

- c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(9)(b) 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.

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

1. Unless otherwise listed in subsection (C)(1), (C)(2), (C)(5), (C)(6), (C)(7) or (D)(1) through (D)(8), 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. An outpatient visit includes any setting 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 (E)(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 (E)(1)(b) or (E)(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 (E)(1), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

**E.F.** Copayments for individuals covered under Section 1115 Waiver. Unless otherwise listed in subsection ~~(B), (C), or (D)~~ (C), (D), or (E) 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. However, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

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.

Covered Services	Copayment
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Generic prescriptions or brand name prescriptions if generic is not available	\$4.00 per prescription <u>drug</u>
Brand name prescriptions when generic is available	\$10.00 per prescription <u>drug</u>
Nonemergency use of the emergency room.	\$30.00 per visit
Physician office visit	\$5.00 per office visit

**F.G.** A provider is responsible for collecting any copayment imposed under this Section.

**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. 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).~~

**H.** The total aggregate amount of copayments under subsections (D) or (E) may not exceed five percent of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached five percent 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 subsections (E) and (F), regardless of whether the provider successfully collects the copayments described in this Section.