NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:

R9-22-711 Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rule and the agency's reason it selected the effective date:

This rulemaking is effective upon filing with the Secretary of State. December 30, 2013

4. A list of all notices published in the Register as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:

Notice of Proposed Exempt Rulemaking: 19 A.A.R. 3983, December 6, 2013

5. The agency's contact person who can answer questions about the rulemaking:

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6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010) specified changes to the AHCCCS Program which require, among other items, rule-making to establish cost sharing provisions consistent with federal law. In this rulemaking, the Agency revised the current cost sharing rules to incorporate exemptions of certain populations from cost sharing requirements specified in final federal regulations which will become effective January 1, 2014. In addition, this rulemaking repeals cost sharing requirements which apply to AHCCCS Waiver populations which will no longer exist beginning January 1, 2014. To clarify cost sharing requirements generally, this rulemaking also includes revision of language, updates to various cross-references, and non substantive changes. In the future, the AHCCCS Administration intends to promulgate other cost sharing provisions in subsequent rulemakings

Section 36 of this Law provides a rulemaking exemption: For a period of one year from the effective date of the Act, the AHCCCS Administration is exempt from the Administrative Procedure Act's rulemaking requirements for rules regarding cost sharing.

7. 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:

A study was not referenced or relied upon when revising the regulations.

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

Not applicable.

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

The Administration will be expending an additional $1.1M per month in capitation payment for the childless adults listed under subsection (F) and the Breast and Cervical Cancer population for the copayment not collected.

10. A description of any changes between the proposed rulemaking, including any supplemental proposedrulemaking, and the final rulemaking package (if applicable):

The Administration has made technical changes as a result of the public comments received.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:

Numb:	Date/ Commentor:	Comment:	Response:
1.	12/20/13 Ellen Katz William Morris Institute	R9-22-711 Section B: Section B pertains to services exempt from copayments. This section does not comply with 42 C.F.R. § 447.56. Services that are exempt include preventative services to children under 18 "regardless of family income …." This includes, at a minimum, well baby and well child care services in the state plan pursuant to 42 C.F.R. § 457.520. Also, the federal law includes as exempt provider preventable services as defined in 42 C.F.R § 447.26(b), which the proposed rule does not include. The proposed rule refers to emergency services as described in 42 C.F.R. § 447.53(b)(4). The correct reference cite is 42 C.F.R. § 447.54.	All preventive and well visits are exempt from copays for all members including adults. See section (B)(5) and (B)(6). The Administration has updated the rulemaking to add provider preventable services and to correct the emergency services reference to 42 CFR 447.56.
2.	12/20/13 Ellen Katz William Morris Institute	R9-22-711 Section C: Section C pertains to persons exempt from copayments. Federal law exempts disabled children. See 42 C.F.R. § 447.56(a)(v). For persons exempt from copayments there is the reference to "An adult eligible under R9-22-1427(E)." We assume this reference is to the proposed rules published in September 2013. The rule should provide a brief description of these persons who the Institute understands are childless adults.	The Administration does not provide coverage to this optional category. The adults eligible under R9-22-1427(E) is correct, final rules will be available early January.
3.	12/20/13 Ellen Katz William Morris Institute	R9-22-711 Section D: In Section R9-22-711(D)(7)(c), there is a reference to subsection (D)(9)(b) which does not exist under the proposed rule.	The Administration has updated the reference.
4.	12/20/13 Ellen Katz William Morris Institute	R9-22-711 Section E: Section E pertains to copayments for Transitional Medical Assistance ("TMA"). The section fails to refer to the services that are exempt from copayments in Section B. That section should be referenced. See 42 U.S.C. § 1396o-1(a)(3)(B). The rule also references TMA eligibility under R9-22-1427. The Institute thinks this must refer to the prior rule which did include a TMA section. The Institute could not find a TMA section in the current rule R9-22-1427 or any other rule proposed	Currently the TMA population is covered under rule R9-22-1427(k) and is covered under the proposed rule language for September 2013 under R9-22-1427(B). The Administration has clarified rule to state that the mandatory copays do not apply to services described under subsection (B).

		in September 2013. The Institute could not find any explanation of TMA eligibility in these rules or the rules proposed in September 2013. That omission should be corrected.	

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:

None

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

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 ~~(F)~~ (E), for the purposes of establishing a copayment amount.
3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.

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)~~ 42 CFR 447.56(2)(i) are exempt from copayments for all members.
4. All services paid on a fee-for-service basis are exempt from copayments for all members.
5. Well visits are exempt from copayments for all members.
6. Preventive services are exempt from copayments for all members.
7. Provider preventable services are exempt from copayments for all members.

C. The following individuals are exempt from 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. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
4. An individual eligible for Medicare Cost Sharing in 9 A.A.C. 29;
5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);

6. An ~~institutionalized person~~ individual receiving nursing facility or HCBS services under R9-22-216;

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

8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;

9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;

10. An individual who is pregnant and through the postpartum period following the pregnancy;

11. 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;

12. 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 ; and

13. An adult eligible under R9-22-1427(E).

D. ~~Copayments for non-Transitional Medical Assistance (TMA) individuals covered under the State Plan.~~ Non-mandatory copayments. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through ~~(8)~~ (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.

1. A ~~family~~ caretaker relative ~~eligible under Section 1931 of the Act~~ eligible under R9-22-1427(A);

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

3. An individual eligible for State Adoption Assistance in 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~~ Article 15; and

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

~~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.~~ 7. 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)~~ (D)(7)(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. Mandatory copayments. Copayments for individuals eligible for Transitional Medical Assistance.

1. Unless otherwise listed in subsection (C)(1), (2), (5), (6), (7), (8), ~~or (D)(1) through (8)~~, an individual eligible for Transitional Medical Assistance (TMA) under R9-22-1427 ~~in A.R.S. § 36-2924~~ is required to pay the following copayments for services not otherwise exempt under subsection (B):

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 or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes in any setting where these outpatient services are performed such as but not limited to a physician's provider's office, HCBS setting, 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 (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.

~~**F.** Copayments for individuals covered under Section 1115 Waiver. Unless otherwise listed in subsection (C), (D), or (E) the individuals whose income is equal to or under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01 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.~~

~~Covered Services~~	~~Copayment~~
~~Generic prescriptions or brand name prescriptions if generic is not available~~	~~$4.00 per prescription drug~~
~~Brand name prescriptions when generic is available~~	~~$10.00 per prescription drug~~
~~Nonemergency use of the emergency room.~~	~~$30.00 per visit~~
~~Physician office visit~~	~~$5.00 per office visit~~
~~Taxi transportation (Maricopa and Pima county residents only)~~	~~$2.00 per one way trip~~

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

~~**H.**~~**G.** The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% 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 5% of the family's income.

~~I.~~**H.** Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under ~~subsections~~ subsection (E) ~~and (F)~~, regardless of whether the provider successfully collects the copayments described in this Section.