NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per the Governor's Regulatory Review Plan memorandum, January 22, 2009 and the continuations issued April 30, June 29 and October 16, 2009. (See the memoranda in this issue on pages 1985 through 1987.) The Governor's Office authorized the notice to proceed through the rulemaking process on September 16, 2009.

[R09-106]

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: 15 A.A.R. 1668, October 16, 2009

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson St., 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 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 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 447, Subpart A. The results of the analysis will be made 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) 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 39,000 members were eligible for the TMA program. For the state fiscal year 2010, the copayment cost to the TMA member for prescriptions will be $2.30; for outpatient evaluation and management services occurring in any setting other than an emergency room, the copayment amount will be $4.00; and for outpatient therapy services, in-office surgeries, Ambulatory Surgical Center (ASC) surgeries, and outpatient non-emergent surgeries, the copayment amount will be $3.00. The AHCCCS Administration estimates the total annual state/federal savings from the TMA copayments to be $1,000,000. 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 $660,621.00. 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 Legal Assistance
701 E. Jefferson St., 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 web site www.azahcccs.gov the week of November 9th, 2009. Please send written comments to the above address by 5:00 p.m., January 5, 2010. E-mail comments will also be accepted during this time-frame.

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: January 5, 2010
Time: 9:00 a.m.
Location: AHCCCS
701 E. Jefferson St.
Phoenix, AZ 85034
Nature: Public Hearing

Date: January 5, 2010
Time: 9:00 a.m.
Location: ALTCS: Arizona Long-term Care System

1010 N. Finance Center Drive, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: January 5, 2010
Time: 9:00 a.m.
Location: DAHL /Office of Special Investigations
2721 N. 4th St., 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

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 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.

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;~~
3. An American Indian;
~~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.~~4. An individual eligible for the Arizona Long Term Care Program in A.R.S. § 36-2931;
~~9.~~5. An individual eligible for Medicare Cost Sharing in A.R.S. § 36-2972; ~~and~~
~~10.~~6. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E)~~.~~; and
~~11.~~7. An institutionalized person under R9-22-216.

~~**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 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. ~~7.~~6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g); and
8. ~~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~~.

~~Covered Services~~	~~Copayment~~
~~Physician office visit~~	~~$1.00 per office visit~~
~~Nonemergency use of the emergency room.~~	~~$1.00 per visit~~

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)(2), (3), (6), (7), or (C)(1) through (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 (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 the Social Security Act, Title IV, Part B 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 of the Social Security Act, Title IV, Part E, without regard to age.
5. The copayments in subsection (D)(1) do not apply to services identified in the National Standard Code Sets as preventative services provided to children under 19 years of age regardless of family income.
6. The copayments in subsection (D)(1) do not apply to services furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o).
7. With respect to the services exempted by subsections (D)(3) through (6), 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.

Covered Services	Copayment
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

F. A provider is responsible for collecting any copayment.

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)~~ (C).

H. The total aggregate amount of copayments under subsections (C) or (D) may not exceed 5% 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), regardless of whether the provider successfully collects the copayments described in this rule; however, the Administration shall not reduce the amount of any payment due to IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of service to an American Indian.