# NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

## NOTICE OF EXEMPT RULEMAKING

### TITLE 9. HEALTH SERVICES

### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

*Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 477.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.*

[R12-08]

### PREAMBLE

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

| | |
|---|---|
| R9-22-101 | Amend |
| R9-22-711 | Amend |

**2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**

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

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

Statute or session law authorizing the exemption: Laws 2011, Ch. 31, § 34

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

April 1, 2012

**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: 17 A.A.R. 2456, December 9, 2011

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

The close of the comment period was December 18, 2011.

Name: Mariaelena Ugarte

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701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034

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 An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**

The AHCCCS Administration has received a waiver from the Centers of Medicare and Medicaid Services allowing the Administration to impose copayments for taxi transportation. The copayment will be in the amount of $2 for each one-way trip for a member who resides in Maricopa or Pima County. This copayment will be charged to AHCCCS members who are adults that fall under the category "AHCCCS Care."

In SB 1619, Arizona Laws 2011, Ch. 31, § 13, the Legislature authorized the agency to adopt rules under A.R.S. § 36-2907(G), to charge members copayments for the provision of non-emergency transportation.

Arizona Laws 2011, Ch. 31, § 34 authorizes the Administration to adopt rules necessary to implement the AHCCCS program within the available appropriations and exempts the Administration from the formal rulemaking requirements of A.R.S. Title 41, Chapter 6. Specifically under subsection (A)(3) of Section 34, the Administration may make changes to rules related to cost sharing responsibilities for eligible members.

Arizona Law 2011, Ch. 31, § 34, subsection (B), requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking was accomplished through publication of this rulemaking on the agency web site on November 18, 2011. A supplemental notice will also appear in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice was directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly under A.R.S. § 36-2903.01(B)(6).

**7. A reference to any study relevant to the rule that the agency reviewed and either relied on 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:**

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of taxi transportation services reported through claims and encounters for dates of service during CY 2010, has assisted the AHCCCS Administration in arriving at the projected impact.

**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 summary of the economic, small business, and consumer impact, if applicable:**

AHCCCS estimates that the proposed copayment amount for taxi services will reduce total expenditures by approximately $614,000 in combined state and federal funds for the state fiscal year 2011. The average cost of non-emergency transportation services is approximately $25 per transportation basis or leg.

There are currently approximately 306,983 taxi rides provided each year to AHCCCS Care members, who will pay $2 copay per taxi ride, with a total estimated cost to the member and savings to the AHCCCS program of $613,966.

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

No changes were made between the proposed rule and the final rule.

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

No comments were received during the proposed rule comment period which closed on December 18, 2011.

**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**

**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 the 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:**

Not applicable

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

**TITLE 9. HEALTH SERVICES**

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

### ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions

### ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-711. Copayments

### ARTICLE 1. DEFINITIONS

**R9-22-101. Location of Definitions**

**A.** Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition Section or Citation

"Accommodation" R9-22-701
"Act" R9-22-101
"ADHS" R9-22-101
"Administration" A.R.S. § 36-2901
"Adverse action" R9-22-101
"Affiliated corporate organization" R9-22-101
"Aged" 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate" R9-22-701
"AHCCCS" R9-22-101
"AHCCCS inpatient hospital day or days of care" R9-22-701
"AHCCCS registered provider" R9-22-101
"Ambulance" A.R.S. § 36-2201
"Ancillary department" R9-22-701
"Ancillary service" R9-22-701
"Anticipatory guidance" R9-22-201
"Annual enrollment choice" R9-22-1701
"APC" R9-22-701
"Appellant" R9-22-101
"Applicant" R9-22-101
"Application" R9-22-101
"Assessment" R9-22-1101
"Assignment" R9-22-101
"Attending physician" R9-22-101
"Authorized representative" R9-22-101
"Authorization" R9-22-201
"Auto-assignment algorithm" R9-22-1701
"AZ-NBCCEDP" R9-22-2001
"Baby Arizona" R9-22-1401
"Behavior management services" R9-22-1201
"Behavioral health adult therapeutic home" R9-22-1201
"Behavioral health therapeutic home care services" R9-22-1201
"Behavioral health evaluation" R9-22-1201
"Behavioral health medical practitioner" R9-22-1201
"Behavioral health professional" A.A.C. R9-20-1201

"Behavioral health recipient" R9-22-201
"Behavioral health service" R9-22-1201
"Behavioral health technician" A.A.C. R9-20-1201
"Benefit year" R9-22-201
"BHS" R9-22-1401
"Billed charges" R9-22-701
"Blind" R9-22-1501
"Burial plot" R9-22-1401
"Business agent" R9-22-701 and R9-22-704
"Calculated inpatient costs" R9-22-712.07
"Capital costs" R9-22-701
"Capped fee-for-service" R9-22-101
"Caretaker relative" R9-22-1401
"Case management" R9-22-1201
"Case record" R9-22-101
"Case review" R9-22-101
"Cash assistance" R9-22-1401
"Categorically eligible" R9-22-101
"CCR" R9-22-712
"Certified psychiatric nurse practitioner" R9-22-1201
"Charge master" R9-22-712
"Child" R9-22-1503 and R9-22-1603
"Children's Rehabilitative Services" or "CRS" R9-22-101
"Claim" R9-22-1101
"Claims paid amount" R9-22-712.07
"Clean claim" A.R.S. § 36-2904
"Clinical supervision" R9-22-201
"CMDP" R9-22-1701
"CMS" R9-22-101
"Continuous stay" R9-22-101
"Contract" R9-22-101
"Contract year" R9-22-101
"Contractor" A.R.S. § 36-2901
"Copayment" R9-22-701, R9-22-711 and R9-22-1603
"Cost avoid" R9-22-1201
"Cost-To-Charge Ratio" R9-22-701
"Covered charges" R9-22-701
"Covered services" R9-22-101
"CPT" R9-22-701
"Creditable coverage" R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital" R9-22-701
"CRS" R9-22-101
"Cryotherapy" R9-22-2001
"Customized DME" R9-22-212
"Day" R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action" R9-22-1441
"DBHS" R9-22-101

"DCSE" R9-22-1401
"De novo hearing" 42 CFR 431.201
"Dentures" and "Denture services" R9-22-201
"Department" A.R.S. § 36-2901
"Dependent child" A.R.S. § 46-101
"DES" R9-22-101
"Diagnostic services" R9-22-101
"Director" R9-22-101
"Disabled" R9-22-1501
"Discussion" R9-22-101
"Disenrollment" R9-22-1701
"DME" R9-22-101
"DRI inflation factor" R9-22-701
"E.P.S.D.T. services" 42 CFR 440.40(b)
"Eligibility posting" R9-22-701
"Eligible person" A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member" R9-22-201
"Emergency behavioral health services for the non-FES member" R9-22-201
"Emergency medical condition for the non-FES member" R9-22-201
"Emergency medical services for the non-FES member" R9-22-201
"Emergency medical or behavioral health condition for a FES member" R9-22-217
"Emergency services costs" A.R.S. § 36-2903.07
"Encounter" R9-22-701
"Enrollment" R9-22-1701
"Enumeration" R9-22-101
"Equity" R9-22-101
"Experimental services" R9-22-203
"Existing outpatient service" R9-22-701
"Expansion funds" R9-22-701
"FAA" R9-22-1401
"Facility" R9-22-101
"Factor" R9-22-701 and 42 CFR 447.10
"FBR" R9-22-101
"Federal financial participation" or "FFP" 42 CFR 400.203
"Federal poverty level" or "FPL" A.R.S. § 36-2981
"Fee-For-Service" or "FFS" R9-22-101
"FES member" R9-22-101
"FESP" R9-22-101
"First-party liability" R9-22-1001
"File" R9-22-1101
"Fiscal agent" R9-22-210
"Fiscal intermediary" R9-22-701
"Foster care maintenance payment" 42 U.S.C. 675(4)(A)
"FQHC" R9-22-101
"Free Standing Children's Hospital" R9-22-701
"Fund" R9-22-712.07
"Graduate medical education (GME) program" R9-22-701

"Grievance" A.A.C. R9-34-202
"GSA" R9-22-101
"HCPCS" R9-22-701
"Health care practitioner" R9-22-1201
"Hearing aid" R9-22-201
"HIPAA" R9-22-701
"Home health services" R9-22-201
"Homebound" R9-22-1401
"Hospital" R9-22-101
"In-kind income" R9-22-1420
"Insured entity" R9-22-720
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" 42 U.S.C. 1396d(d)
"ICU" R9-22-701
"IHS" R9-22-101
"IHS enrolled" or "enrolled with IHS" R9-22-708
"IMD" or "Institution for Mental Diseases" 42 CFR 435.1010 and R9-22-101
"Income" R9-22-1401 and R9-22-1603
"Indigent" R9-22-1401
"Individual" R9-22-211
"Inmate of a public institution" 42 CFR 435.1010
"Inpatient covered charges" R9-22-712.07
"Interested party" R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" 42 U.S.C. 1396d(d)
"Intern and Resident Information System" R9-22-701
"LEEP" R9-22-2001
"Legal representative" R9-22-101
"Level I trauma center" R9-22-2101
"License" or "licensure" R9-22-101
"Licensee" R9-22-1201
"Liquid assets" R9-22-1401
"Mailing date" R9-22-101
"Medical education costs" R9-22-701
"Medical expense deduction" or "MED" R9-22-1401
"Medical record" R9-22-101
"Medical review" R9-22-701
"Medical services" A.R.S. § 36-401
"Medical supplies" R9-22-101
"Medical support" R9-22-1401
"Medically necessary" R9-22-101
"Medicare claim" R9-22-101
"Medicare HMO" R9-22-101
"Member" A.R.S. § 36-2901
"Mental disorder" A.R.S. § 36-501
"Milliman study" R9-22-712.07
"Monthly equivalent" R9-22-1421 and R9-22-1603
"Monthly income" R9-22-1421 and R9-22-1603
"National Standard code sets" R9-22-701

"New hospital" R9-22-701
"NICU" R9-22-701
"Noncontracted Hospital" R9-22-718
"Noncontracting provider" A.R.S. § 36-2901
"Non-FES member" R9-22-101
"Non-IHS Acute Hospital" R9-22-701
"Nonparent caretaker relative" R9-22-1401
"Notice of Findings" R9-22-109
"Nursing facility" or "NF" 42 U.S.C. 1396r(a)
"OBHL" R9-22-1201
"Observation day" R9-22-701
"Occupational therapy" R9-22-201
"Offeror" R9-22-101
"Operating costs" R9-22-701
"Organized health care delivery system" R9-22-701
"Outlier" R9-22-701
"Outpatient hospital service" R9-22-701
"Ownership change" R9-22-701
"Ownership interest" 42 CFR 455.101
"Parent" R9-22-1603
"Partial Care" R9-22-1201
"Participating institution" R9-22-701
"Peer group" R9-22-701
"Peer-reviewed study" R9-22-2001
"Penalty" R9-22-1101
"Pharmaceutical service" R9-22-201
"Physical therapy" R9-22-201
"Physician" R9-22-101
"Physician assistant" R9-22-1201
"Post-stabilization services" R9-22-201 or 42 CFR 422.113
"PPC" R9-22-701
"PPS bed" R9-22-701
"Practitioner" R9-22-101
"Pre-enrollment process" R9-22-1401
"Premium" R9-22-1603
"Prescription" R9-22-101
"Primary care provider" or "PCP" R9-22-101
"Primary care provider services" R9-22-201
"Prior authorization" R9-22-101
"Prior period coverage" or "PPC" R9-22-701
"Procedure code" R9-22-701
"Proposal" R9-22-101
"Prospective rates" R9-22-701
"Psychiatrist" R9-22-1201
"Psychologist" R9-22-1201
"Psychosocial rehabilitation services" R9-22-201
"Public hospital" R9-22-701

"Qualified alien" A.R.S. § 36-2903.03
"Qualified behavioral health service provider" R9-22-1201
"Quality management" R9-22-501
"Radiology" R9-22-101
"RBHA" or "Regional Behavioral Health Authority" R9-22-201
"Reason to know" R9-22-1101
"Rebase" R9-22-701
"Referral" R9-22-101
"Rehabilitation services" R9-22-101
"Reinsurance" R9-22-701
"Remittance advice" R9-22-701
"Resident" R9-22-701
"Residual functional deficit" R9-22-201
"Resources" R9-22-1401
"Respiratory therapy" R9-22-201
"Respite" R9-22-1201
"Responsible offeror" R9-22-101
"Responsive offeror" R9-22-101
"Revenue Code" R9-22-701
"Review" R9-22-101
"Review month" R9-22-101
"RFP" R9-22-101
"Rural Contractor" R9-22-718
"Rural Hospital" R9-22-712.07 and R9-22-718
"Scope of services" R9-22-201
"Section 1115 Waiver" A.R.S. § 36-2901
"Service location" R9-22-101
"Service site" R9-22-101
"SOBRA" R9-22-101
"Specialist" R9-22-101
"Specialty facility" R9-22-701
"Speech therapy" R9-22-201
"Spendthrift restriction" R9-22-1401
"Sponsor" R9-22-1401
"Sponsor deemed income" R9-22-1401
"Sponsoring institution" R9-22-701
"Spouse" R9-22-101
"SSA" 42 CFR 1000.10
"SSDI Temporary Medical Coverage" R9-22-1603
"SSI" 42 CFR 435.4
"SSN" R9-22-101
"Stabilize" 42 U.S.C. 1395dd
"Standard of care" R9-22-101
"Sterilization" R9-22-201
"Subcontract" R9-22-101
"Submitted" A.R.S. § 36-2904
"Substance abuse" R9-22-201

"SVES" R9-22-1401

"Taxi" A.R.S. § 28-2515

"Therapeutic foster care services" R9-22-1201

"Third-party" R9-22-1001

"Third-party liability" R9-22-1001

"Tier" R9-22-701

"Tiered per diem" R9-22-701

"Title IV-D" R9-22-1401

"Title IV-E" R9-22-1401

"Total Inpatient payments" R9-22-712.07

"Trauma and Emergency Services Fund" A.R.S. § 36-2903.07

"TRBHA" or "Tribal Regional Behavioral Health Authority" R9-22-1201

"Treatment" R9-22-2004

"Tribal Facility" A.R.S. § 36-2981

"Unrecovered trauma center readiness costs" R9-22-2101

"Urban Contractor" R9-22-718

"Urban Hospital" R9-22-718

"USCIS" R9-22-1401

"Utilization management" R9-22-501

"WWHP" R9-22-2001

**B.** General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"Children's Rehabilitative Services" or "CRS" means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"IHS" means Indian Health Service.

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law

by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417(L).

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered

services.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

"Taxi" is as defined in A.R.S. § 28-2515.

## 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)~~ (F), 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) are exempt from copayments for all members.
4. All services paid on a fee-for-service basis 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 under R9-22-216; and
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 who has received services through an IHS facility; tribal 638 facility or urban Indian health program.

**D.** Copayments for non-Transitional Medical Assistance (TMA) individuals covered under the State Plan. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (8) 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 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 R9-22-1433;
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 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. 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), (2), (5), (6), (7) or (D)(1) through (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 (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 ~~following~~ 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.
~~1. An individual whose income is 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 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.** A provider is responsible for collecting any copayment imposed under this Section.

**H.** 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.** 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.