Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Arizona

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[X] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women. women.

[X] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[X] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[ ]Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

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State/Territory: Arizona

Citation 4.18(b) (Continued)

42 CFR 447.51
through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

[ ] Not applicable. No such charges are imposed.

(i) For any services, no more than one type of charge is imposed

(ii) Charges apply to services furnished to the following age groups:

[ ] 18 or older

[X] 19 or older

[ ] 20 or older

[ ] 21 or older

[ ] Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

A. The following charges are imposed under section 1916 of the Social Security Act and 42 CFR 447.50-.60 with the exceptions specified at Section 1916(a)(2) and (j) of the Act and 42 CFR 447.53(b):

Type of Charge					
Group of Individuals	Item/Service	Ded.	Coins.	Copay	Method of Determining Family Income
All other individuals covered under the State Plan with the exception of those covered under the TMA group under Att. 4.18-F	Prescription drugs	N/A	N/A	$2.30/ drug	Same
	Outpatient visit, excluding emergency room visit if coded as non-emergent surgical procedures or evaluation and management services	N/A	N/A	$3.40/visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$2.30/visit	Same

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

B. The method used to collect cost sharing charges for categorically needy individuals:

_X_ Providers are responsible for collecting the cost sharing charges from individuals.

___ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

By state administrative rule, all providers are required to accept the individual's self-declaration of the inability to pay the charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are able to access and track copayment information from the verification systems used by AHCCCS providers (excluding IVR) such as EVS, the web, and HIPAA transactions 270 and 271. The verification system will identify the member's eligibility category where a specific copay level is assigned by population. It will also identify whether the member is subject to a mandatory or nominal copayment and specify the copayment amount by service level. This system also identifies services which are exempt from copayments. Prior to implementation, AHCCCS provided information all providers and contractors which described the copayment requirements by eligibility category, including descriptions of exempt services and populations. This communication is posted on the website along with the rule, which sets forth the copayment requirements and prohibitions. Contracted health plans receive daily and monthly rosters from AHCCCS that identify each member's cost sharing designation (nominal, mandatory or exempt). In addition, AHCCCS sends the health plans a reference extract table which is used to identify the copay amounts for specific services by the member's cost sharing category.

Interim Plan: October 1, 2010-April 30, 2011: To ensure that American Indians are exempted from cost sharing, fee for service users, who represent the vast majority of American Indian (AI) AHCCCS recipients, will be exempted from cost sharing. Because some AI's choose to receive services through MCO's, the AHCCCS Client Advocate Office will work with managed care enrollees to exempt AI's served under managed care.

Final Plan: Effective no later than May 1, 2011:, As a result of an analysis of FFS claims and encounters, AHCCCS will identify all active and previous users of Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs (I/T/Us) for which AHCCCS has provided reimbursement. All users identified though this analysis will be flagged and exempted from all cost sharing, and this information will be communicated to MCOs' and providers. The AHCCCS Client Advocate office will also work closely with the identified population to ensure that cost sharing is not applied to any American Indian who has ever utilized an I/T/U or received a service through referral by Contract Health Services.

E. Cumulative maximums on charges:

X **State policy does not provide for cumulative maximums.**

__ **Cumulative maximums have been established as described below:**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Alternative Premiums and Cost Sharing Charges

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

A. For groups of individuals with family income at or below 100 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. _X/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

2. Premiums

a. Amount of Premiums

No premiums may be imposed for individuals with family income at or below 100 percent of the FPL.

B. For groups of individuals with family income above 100 percent but at or below 150 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

iii. _X/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including mthly or qtrly period)
		Deductible	Coinsurance	Copayment	
Individuals who receive Transitional Medical Assistance under §1925 of the Social Security Act above 100% FPL and at or below 150% FPL					
	Prescription Drugs	N/A	N/A	$2.30/drug	Same
	Outpatient visit, excluding emergency room visit if coded as evaluation and management services	N/A	N/A	$4.00/outpatient visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$3.00/visit	Same
	If not imposed above, any services rendered during a visit coded as non-emergent surgical procedures when provided in a physician's office, an ASC or any other outpatient setting, excluding an emergency room	N/A	N/A	$3.00	Same

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or X_ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

_X_ / Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Regardless of whether the State elects the above option to permit providers to enforce the collection of cost sharing payments, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost-sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

No premiums may be imposed for individuals with family income above 100 percent of the FPL but at or below 150 percent.

C. For groups of individuals with family income above 150 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

iii. _X/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify amounts by groups and services (see below)):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including mthly or qtrly period)
		Deductible	Coinsurance	Copayment	
Individuals who receive Transitional Medical Assistance under §1925 of the Social Security Act above 150% FPL					
	Prescription Drugs	N/A	N/A	$2.30/drug	Same
	Outpatient visit, excluding emergency room visit if coded as evaluation and management services	N/A	N/A	$4.00/outpatient visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$3.00/visit	Same
	If not imposed above, any services rendered during a visit coded as non-emergent surgical procedures when provided in a physician's office, an ASC or any other outpatient setting, excluding an emergency room	N/A	N/A	$3.00/visit	Same

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or X quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

_X/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, a State's payments to providers must be reduced by the amount of the beneficiary cost-sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

i. _X/ No premiums are imposed.

ii. __/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

b. Limitation:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or __ quarterly basis as specified by the State.
- Premiums may not be imposed for the populations specified at section 1916A(b)(3)(A) of the Act and 42 CFR 447.66(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

i. __/ Prepayment is required for the following groups of applicants when they apply for Medicaid:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

ii. __/ Prepayment is required for the following groups of beneficiaries as a condition for receiving Medicaid services for the premium period:

N/A

iii. __/ Eligibility is terminated for failure to pay after a grace period of __ days after the premium due date (at least 60 days) for the following groups of Medicaid beneficiaries:

N/A

iv. __/ Payment will be waived by the State on a case-by-case basis if payment would create an undue hardship for the individual.

D. Period of determining 5 percent aggregate family limit for premiums and cost sharing:

Specify the period for which the 5 percent maximum will be applied.

_X/ Quarterly

__/ Monthly

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

E. Method for tracking beneficiaries' liability for premiums and cost-sharing:

1. Describe the methodology used by the State to identify beneficiaries who are subject to premiums or to cost sharing for specific items or services.
Alternative cost sharing is only applied to persons determined eligible for Transitional Medical Assistance under section 1925 through the State's normal eligibility redetermination process, which includes reviews initiated by eligible persons who report an increase in income.

   Interim Plan: October 1, 2010- April 30, 2011:To ensure that American Indians are exempted from cost sharing, fee for service users, who represent the vast majority of American Indian (AI) AHCCCS recipients, will be exempted from cost sharing. Because some AI's choose to receive services through MCO's, the AHCCCS Client Advocate Office will work with managed care enrollees to exempt AI's served under managed care.

   Final Plan: Effective no later than May 1, 2011:As a result of an analysis of FFS claims and encounters, AHCCCS will identify all active and previous users of Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs (I/T/Us) for which AHCCCS has provided reimbursement. All users identified though this analysis will be flagged and exempted from all cost sharing, and this information will be communicated to MCOs' and providers. The AHCCCS Client Advocate office will also work closely with the identified population to ensure that cost sharing is not applied to any American Indian who has ever utilized an I/T/U or received a service through referral by Contract Health Services.

2. Describe how the State identifies for providers, ideally through the use of automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.
Contracted health plans will be informed of the services subject to copayments and their corresponding dollar amounts. Health plans will make this information available to their network of providers through the 834- the Benefit Enrollment Maintenance Transaction, a HIPAA required format used as the roster to contracted health plans. Additionally, all providers will be able to access information from the verification systems used by AHCCCS providers (except IVR) such as EVS, the web, and HIPAA transactions 270 and 271. Information regarding whether the member is subject to a mandatory or nominal copayment, when copayments can not be charged and what a member's specific copayment level is by service type.

3. Describe the State's processes (that do not rely on beneficiaries) used for tracking beneficiaries' incurred premiums and cost sharing under sections 1916 and 1916A of the Act if families are at risk of reaching their total aggregate limit for premiums and cost sharing, how the State informs beneficiaries and providers when a beneficiary's family has incurred premiums and cost sharing up to its 5 percent aggregate limit, and how the State assures that the family is no longer subject to further premiums and cost sharing for the remainder of the monthly or quarterly cap period.
The State will use available Health Plan adjudicated encounters to identify beneficiaries reaching the 5% aggregate copayment amount in a quarter by using the lowest possible family income and calculating the applicable copayment amounts for reported services during the quarter. If it is determined that a beneficiary has reached the 5% cap, the State will identify this status in the verification systems described above to inform providers that the member is not be subject to further cost sharing.

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

4. Describe the process through which beneficiaries may request that the State reassess the family's aggregate limit for premiums and cost sharing when the family's income has changed or if a family member's Medicaid enrollment is being terminated due to nonpayment of a premium. Members are informed of applicable cost sharing requirements through the member handbook, the public website, and special copay notices provided to members prior to implementation. Members are advised they can request a reassessment of the family's aggregate limit if they believe the family's income has changed.

F. Public Notice Requirements:

Explain how the State meets the following public notice requirements at 42 CFR 447.76.

1. The requirement at 42 CFR 447.76(a) and (b) for making available certain information about the State's premiums and cost sharing policies and procedures to the general public, applicants, beneficiaries, and providers:
   AHCCCS posted the cost sharing State Plan Amendment on the public website. Additionally, AHCCCS filed the Notice of Proposed rule making and final rule making with the Secretary of State, made this information available on the public website, and conducted a public hearing at the Agency. A matrix of all public comments as well as the Administration's responses to each of the comments were posted to the website. Furthermore, the rulemaking process allowed for public participation at the Governor's Regulatory Review Council prior to the adoption of the rule. Member handbooks were updated to include updated information about cost sharing. Additionally, members subject to the mandatory copayments received advanced notice of the mandatory copayment requirements. AHCCCS updated the member application to describe cost sharing requirements as well as exemptions from cost sharing.

2. The requirement at 42 CFR 447.76(c) to provide the public with advance notice and the opportunity to comment prior to submitting a State plan amendment (SPA) to establish or substantially modify alternative premiums and/or cost sharing under section 1916A of the Act:
   Notice of the proposed rule and the opportunity to provide written or oral comments on the rule were published in the State Administrative Register. Following publication of the proposed rule, the agency allowed a 30 day period for submission of public comments and conducted a public hearing where oral public comments were solicited at the close of the comment period. In addition, a public hearing was conducted by a separate executive branch agency, the Governor's Regulatory Review Council, at which public comment was solicited prior to finalization of the administrative rule. All of this information was published on both the AHCCCS and Secretary of State's websites.