NOTICE OF FINAL RULEMAKING

TITLE 9 HEALTH SERVICES

CHAPTER 22 ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS &

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

PREAMBLE

1.	**Article, Part, or Section Affected (as applicable)**	**Rulemaking Action**
	R9-22-711	Amend
	R9-22-1428	New

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

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

Implementing statute: Laws 2022, Chapter 314

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

AHCCCS selects the effective date of this rule to be immediate in order to, (4) "provide a benefit to the public and a penalty is not associated with a violation of the rule."

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 22, January 6, 2023

Notice of Proposed Rulemaking: 29 A.A.R. 5, January 6, 2023

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Certain AHCCCS members receiving postpartum care are currently eligible for 60-days postpartum coverage through AHCCCS. As a result of Arizona's decision to opt-in to a 12-months postpartum coverage option through Laws 2022, Chapter 314, AHCCCS submitted a State Plan Amendment for CMS's approval. If the State Plan Amendment is approved, individuals who meet the requirements specified in rule, will be eligible for the 12months of postpartum coverage while some individuals will still qualify only for the 60days of postpartum coverage. Proposed AHCCCS rule R9-22-1428 specifies the different eligibility requirements for the two different postpartum coverage categories.

In addition, modifications to A.A.C. R9-22-711 as well as language added to R9-22-1428 clarify that individuals who are more than 60days postpartum are subject to copays. The previous language regarding copays specified that postpartum individuals (in general) were not subject to copays, because the only postpartum eligibility available was for the 60 days. In the 12-month postpartum coverage option, individuals who are more than 60-days postpartum are subject to copays.

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:

A study was not referenced or relied upon when revising these 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. A summary of the economic, small business, and consumer impact:

The Administration anticipates this will have a general fund impact, however the legislature envisioned this when

they passed House Bill 2863. However, the Administration does not envision any additional fiscal impact in order to implement this eligibility category as part of the Administration.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

There was a zero missing in R9-22-1428(B) which means that the postpartum period was described as 6 days instead of 60 days. Due to the references throughout the rulemaking regarding a 60-day postpartum period this technical change will not prejudice eligible individuals since it clarifies the postpartum eligibility period is 2 months instead of 6 days.

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

Not applicable.

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:

Not applicable.

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

Not applicable.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the

emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-711. Copayments

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

Section

R9-22-1428. ~~Reserved~~Postpartum Extended Eligibility

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. 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 for all members:

1. Family planning services and supplies,
2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
3. Emergency services as described in 42 CFR 447.56(2)(i),
4. All services paid on a fee-for-service basis,
5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
6. Provider preventable services.

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 QMB under Chapter 29;
5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
6. An 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~~including the postpartum period ~~following the pregnancy~~which is the last day of the month in which the 60th day following the date the pregnancy ends;

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), with income at or below 106% of the FPL.

D. Non-mandatory copayments. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (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 caretaker relative 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 Article 15; and

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

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)(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.

1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
    a. $2.30 per prescription drug.
    b. $4.00 per outpatient 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 (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.
2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
    a. $4.00 per prescription drug.
    b. $5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from $50 to less than $100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
    c. $10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of $100 or greater, if any of the services rendered during the visit are coded as evaluation and management

services according to the National Standard Code Sets.

d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as physical, occupational or speech therapy services according to the National Standard Code Sets.

i. $2.00 if the rate on the fee schedule is $20 to $39.99,

ii. $4.00 if the rate on the fee schedule is $40 to $49.99, or

iii. $5.00 if the rate on the fee schedule is $50 and above per visit.

e. If a copayment is not being imposed under subsection (E)(2)(b) –(E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,

i. $30.00 if the rate on the fee schedule is $300 to $499.99, or

ii. $50.00 if the rate on the fee schedule is $500 and above per visit.

f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay $2.00 per trip for non-emergency transportation in an urban area.

g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay $8.00 for non-emergency use of the emergency room.

h. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B)the individual is required to pay $75 for an Inpatient stay.

3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

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

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.

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 subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

R9-22-1428. ~~Reserved~~Postpartum Extended Eligibility

A. Eligibility for 12-months postpartum coverage. Individuals who applied and were determined eligible while pregnant, including prior quarter months under R9-22-303(A), remain eligible through the last day of the month in which a 12-month postpartum period, beginning on the last day of the pregnancy, ends.

B. Copayments during the Postpartum Extended Eligibility period. Individuals eligible under this section are subject to copayments after the end of the 60-day postpartum period described in R9-22-1427.