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 FINAL EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

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

Editor's Note: The following Notice of Final Exempt Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2772.) The Governor's Office authorized the notice to proceed through the rulemaking process on August 14, 2013.

[R14-152]

PREAMBLE

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

R9-22-701	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

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

January 1, 2015

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: 20 A.A.R. 2256, August 22, 2014

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

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
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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 An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking: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, rulemaking to establish cost sharing provisions consistent with federal law and the Federal regulations which became effective January 1, 2014, in 42 CFR part 447.50, et seq. In this rulemaking, the Agency revised the current cost sharing rules to delineate the mandatory copayment requirements for the new adult group described in R9-22-1427(E) with income above106% of the federal poverty guidelines (FPL) subject to CMS approval. In addition, this rulemaking clarifies that members in the new adult group with incomes at or below 106% FPL are exempt from any copayments. These proposed rules also clarify existing language, update cross-references, and include various non-substantive changes.

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

It is estimated that the mandatory copayments that will be collected for the newly eligible adults with incomes above 106% FPL will be less than 5% of the family's income as applied on a quarterly basis. The income limits for individuals subject to mandatory copayments range from above 106% to 133% of FPL. We estimate there will be approximately 54,000 newly eligible adults by July 2015 that will be subject to mandatory copayments.

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 rulemaking and the final exempt rulemaking.

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 public comments were received as of the close of the comment period on September 1, 2014.

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:

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 and its location in the rule:

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 (AHCCCS) ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-701. Standard for Payments Related Definitions
R9-22-711. Copayments

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

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

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the GSA.

"AHCCCS inpatient hospital day or days of care" means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

"APC" means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

"Billed charges" means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

"Business agent" means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

"Capital costs" means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-to-charge ratio" (CCR) means a hospital's costs for providing covered services divided by the hospital's charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

"CPT" means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

"Critical Access Hospital" is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

"Direct graduate medical education costs" or "direct program costs" means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

"Eligibility posting" means the date a member's eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

"Encounter" means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

"Factor" means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

"Fiscal intermediary" means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

"Freestanding Children's Hospital" means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital's services to children.

"GME program approved by the Administration" or "approved GME program" means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

"Graduate medical education (GME) program" means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student

who has completed a recognized undergraduate medical education program.

"HCAC" means a health care acquired condition described under 42 U.S.C.1395ww(d)(4)(D)(iv) but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

"HCPCS" means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"ICU" means the intensive care unit of a hospital.

"Indirect program costs" means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital's direct program costs.

"Intern and Resident Information System" means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

"Medical review" means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Medicare Urban or Rural Cost-to-Charge Ratio (CCR)" means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

"National Standard code sets" means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

"New hospital" means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Non-IHS Acute Hospital" means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

"Observation day" means a physician-ordered evaluation period to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

"Operating costs" means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

"OPPC" means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

"Organized health care delivery system" means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

"Participating institution" means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member

is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

"PPS bed" means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

"Procedure code" means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Public hospital" means a hospital that is owned and operated by county, state, or hospital health care district.

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

"Reinsurance" means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

"Specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

"Sponsoring institution" means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

"Tiered per diem" means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

"Trip" means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

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 ~~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 447.56(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.~~
6.5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms ~~are exempt from copayments for all members.~~
7.6. 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~~ 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 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), 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. ~~Copayments for individuals eligible for Transitional Medical Assistance.~~

1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C)~~(1), (2), (5), (6), (7), (8)~~, an individual ~~eligible for Transitional Medical Assistance (TMA) under R9-22-1427~~ is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided ~~not otherwise exempt under subsection (B)~~ 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, ~~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. 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.

~~2.~~3. 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. 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.