Section 3.4 Copayments

3.4.1 Introduction
A copayment is a fixed amount, which does not exceed the actual cost of services that a person pays directly to a provider at the time covered services are rendered. There are mandatory and “nominal” copayment requirements that apply to AHCCCS eligible members.

3.4.2 Scope
This applies to all AHCCCS eligible members and Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI).

Providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.

3.4.3 Definitions
Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php. The following terms are referenced in this section:

Copayment
Out of network services
Serious Mental Illness
Third Party Liability
Title XIX Waiver Group (AHCCCS Care)

3.4.4 Objectives
Identify when and how providers must assess copayments, address the collection of copayments and address the actions to take for nonpayment of copayments.
3.4.5 Procedures
Copayments must be assessed and collected consistent with state law and Arizona Administrative Code requirements.

3.4.5-A. Collecting Copayments
Providers are responsible for collecting copayments. Providers may take reasonable steps to collect on delinquent accounts.

Any copayments collected are retained by the provider, but the provider must report that information to Mercy Maricopa when submitting the encounter/claims data. All providers must report in their annual audited financial statements the separately identified amounts for copayments received from eligible recipients for covered behavioral health services and reported to ADHS/DBHS in the encounter.

The collection of copayments is an administrative process, and as such, copayments must not be collected in conjunction with a person’s treatment. All efforts to resolve non-payment issues, as they occur, must be clearly documented in the person’s comprehensive clinical record.

3.4.6-B. Copayments
Copayments are specified dollar amounts members pay directly to a provider for each item or service they receive. There are federal limits for certain services and populations.

Copayments are never charged to the following persons:

- Children under age 19;
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program;
- People who are acute care members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member’s medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year;
- People who are enrolled in the Arizona Long Term Care System;
- People who are eligible for Medicare Savings Programs only*;
- People who receive hospice care;
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs;
- Women in the Breast & Cervical Cancer Treatment Program; and
- Receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E.
NOTE: Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

**Copayments are never charged for the following services for anyone:**
- Hospitalizations;
- Emergency services;
- Family Planning services and supplies;
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women;
- Well visits and preventive services;
- Services paid on a fee-for-service basis;
- Provider preventable services.

**Nominal (Low) Copays for Some AHCCCS Programs**
Individuals eligible for AHCCCS through any of the following programs are subject to nominal copayments. The copays apply unless copays are not charged for the above reasons:
- AHCCCS for Families with Children (1931);
- Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
- State Adoption Assistance for Special Needs Children who are being adopted;
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled;
- SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled;
- Freedom to Work (FTW).

Provider needs to look up the member’s eligibility to find out what copays they may have by going to [Mercy Maricopa’s Secure Web Portal](https://secureweb.mercymaricopa.org).

Most people who get AHCCCS benefits are asked to pay the following nominal copayments for medical services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$3.40</td>
</tr>
</tbody>
</table>
Medical providers can ask members to pay these amounts but **CANNOT** refuse services if the member is unable to pay. If the member tells the provider they are unable to pay these amounts, the member cannot be refused services.

**Mandatory Copayments**
Individuals eligible for AHCCCS through any of the following programs are subject to mandatory copayments. The copays apply unless a copay is **not** charged for the above reasons:
- Childless Adults, also known as AHCCCS Care; or
- Families with Children that is no Longer Eligible Due to Earnings - Transitional Medical Assistance (TMA).

Transitional Medical Assistance and Continuous Coverage programs are extensions of the Caretaker Relative program. Caretaker relatives and the children they live with may become ineligible for Medical Assistance due to excess income. These programs allow customers to have up to 12 months of additional coverage.

<table>
<thead>
<tr>
<th>Service</th>
<th>Populations and Copayment Amounts</th>
<th>MANDATORY COPAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AHCCCS Care (Childless Adults)</td>
<td>TMA</td>
</tr>
<tr>
<td>Pharmacy - Generic and brand name when</td>
<td>$4.00</td>
<td>$2.30</td>
</tr>
<tr>
<td>generic not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy - brand name when generic</td>
<td>$10.00</td>
<td>$2.30</td>
</tr>
<tr>
<td>available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits(^1)</td>
<td>$5.00</td>
<td>$4.00</td>
</tr>
<tr>
<td>Outpatient professional therapies</td>
<td>N/A</td>
<td>$3.00</td>
</tr>
<tr>
<td>Non-emergency use of the ER</td>
<td>$30.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Non-emergency surgery(^2)</td>
<td>N/A</td>
<td>$3.00</td>
</tr>
<tr>
<td>Taxis for non-emergency medical transportation(^3)</td>
<td>$2.00 per one way trip</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^1\) Visits to a primary care physician, specialist, or other health care provider, except not in a hospital or outpatient setting. Effective 1/1/14, well exams are exempt from copays.

\(^2\) Applies to surgeries performed in office, outpatient non-emergent, and ambulatory surgical centers.

\(^3\) Effective 4/1/12 and applies to childless adults who reside in Maricopa or Pima County.

Pharmacists and Medical Providers can refuse services if the copayments are not made.
Copayments for Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI)

Copayments assessed for Non-Title XIX/XXI persons determined SMI are intended to be payment by the member for all covered services. The $3.00 copayment, however, is only collected at the time of the psychiatric assessment and psychiatric follow up appointments. Copayments are not assessed for crisis services or collected at the time crisis services are provided.

Non-Payment of Copayments

The following methods may be utilized to encourage a collaborative approach to resolve non-payment issues:

- Engage in informal discussions and avoid confrontational situations;
- Re-screen the person for AHCCCS eligibility; and
- Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person.

3.4.5-C. Member CoPay Matrix

A detailed Member Copay Matrix Table can be located on the AHCCCS website at: http://www.azahcccs.gov/commercial/providerbilling/copayments.aspx.

3.4.5-D. Other Payment Sources

If a person has third party liability coverage, Mercy Maricopa and their providers must follow the requirements set forth in Section 3.5 Third Party Liability and Coordination of Benefits.

Medicare Part D Prescription Drug Coverage

All persons eligible for Medicare Part A or enrolled in Medicare Part B are for Medicare Part D Prescription Drug coverage. Dual eligible persons (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare Part D coverage, persons must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing responsibilities for persons in a Medicare Part D PDP or MA-PD

The Medicare Part D Prescription Drug standard coverage includes substantial cost sharing requirements, which include monthly premiums; an annual deductible and co-insurance (see the Part D Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare).

Persons with limited income and resources may be eligible for the Limited Income Subsidy (LIS) or “extra help” program (see the Social Security Administration for income and
resource requirements). With this “extra help”, all or a portion of the persons’ cost sharing requirements are paid for by the federal government. Dual eligibles and behavioral health recipients on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. T/RBHAs may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D copayments for Non-Title XIX/XXI persons determined to have SMI.

3.4.3 References
The following citations can serve as additional resources for this content area:
A.R.S. 36-3409
A.A.C. R9-20-201(E) (1) and (2)
A.A.C. R9-21-202(A)
(8) A.A.C. R9-21-208
A.A.C. R9-21-401
A.A.C. R9-22-711
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Eligibility Policy Manual
ADHS/DBHS Covered Behavioral Health Services Guide
Section 3.5, Third Party Liability and Coordination of Benefits