



## **Section 3.4** Co-payments

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### **3.4.1 Introduction**

The purpose of this policy is to describe copayment requirements for health care services provided by Tribal and Regional Behavioral Health Authorities (T/RBHAs). A copayment is a monetary amount that a member pays directly to a provider at the time covered services are rendered. This policy covers Arizona Health Care Cost Containment System (AHCCCS) copayments for the Title XIX (Medicaid)/XXI (KidsCare) population and also covers the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) copayments for the Non-Title XIX /XXI population. Although persons may be exempt from AHCCCS copayments, these individuals may still be subject to Medicare copayments.

### **3.4.2 Terms**

Definitions for terms are located online at <http://www.azdhs.gov/bhs/definitions/index.php> or <http://www.narbha.org/for-providers/provider-resources/provider-policy-manual/definitions>. The following terms are referenced in this section:

[Copayment](#)

[AHCCCS Adult Group](#)

[Provider Preventable Conditions](#)

[Serious Mental Illness \(SMI\)](#)

[Transitional Medical Assistance \(TMA\)](#)

### **3.4.3 Procedures**

- a. ADHS/DBHS Copayments for Non-Title XIX/XXI eligible persons who are determined to have a Serious Mental Illness (SMI).
  - i. For individuals who are Non-Title XIX/XXI eligible persons determined to have a SMI, ADHS/DBHS has established a copayment to be charged to these members for covered services (A.R.S. 36-3409).
  - ii. Copayment requirements in this policy are not applicable to services funded by the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG) or Project for Assistance in Transition from Homelessness (PATH) federal block grant.
  - iii. Copayments are not assessed for crisis services or collected at the time crisis services are provided.



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- iv. Persons determined to have SMI must be informed prior to the provision of services of any fees associated with the services (R9-21-202(A)(8)), and providers must document such notification to the person in his/her comprehensive clinical record.
  - v. Copayments assessed for Non-Title XIX/XXI persons determined to have SMI are intended to be payments by the member for all covered behavioral health services, but copayments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments.
  - vi. Copayments are:
    1. A fixed dollar amount of \$3;
    2. Applied to in network services; and
    3. Collected at the time services are rendered.
  - vii. Providers will be responsible for collecting copayments. Any copayments collected are reported in the encounter.
  - viii. Providers will:
    1. Assess the fixed dollar amount per service received, regardless of the number of units encountered. Collect the \$3 copayment at the time of the psychiatric assessment or the psychiatric follow up appointment.
    2. Take reasonable steps to collect on delinquent accounts, as necessary.
    3. Collect copayments as an administrative process, and not in conjunction with a person's behavioral health treatment.
    4. Clearly document in the person's comprehensive clinical record all efforts to resolve non-payment issues, as they occur.
    5. Not refuse to provide or terminate services when an individual states he or she is unable to pay copayments described in this section. RBHAs must establish methods to encourage a collaborative approach to resolve non-payment issues, which may include the following:
      - a. Engage in informal discussions and avoid confrontational situations;
      - b. Re-screen the person for AHCCCS eligibility; and
      - c. Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person.
- b. AHCCCS Copayments for Title XIX/XXI Members
- i. Persons who are Title XIX/XXI eligible will be assessed a copayment in accordance with [A.A.C. R9-22-711](#). Certain populations and certain services are exempt from copayments. This means that copayments will not be charged to anyone if they are in a population or category listed in section 3.b.ii or if the service is listed in section 3.b.iii.
  - ii. AHCCCS copayments are not charged to the following persons for any service:
    1. Persons under age 19;
    2. Persons determined to have a SMI by ADHS;
    3. Individuals up through age 20 eligible for the Children's Rehabilitative Services Program (CRS);
    4. People who are acute care AHCCCS Members who reside in nursing homes or who receive Home and Community Based Services (HCBS). The exemption from copayments for these acute care members is limited to 90 days in a contract year;
    5. Persons who are enrolled in the Arizona Long Term Care System (ALTCS);



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6. Persons who are eligible for Medicare Cost Sharing in 9 A.A.C. 29 Copayment
  7. Persons receiving hospice care;
  8. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under a tribal 638 facility, or urban Indian health programs;
  9. Individuals in the Breast and Cervical Cancer Treatment Program;
  10. Adults eligible under A.A.C. R9-22-1427(E). These individuals are known as the Adult Group. Persons in the Adult Group are individuals 19-64, who are not pregnant, do not have Medicare, and are not eligible in any other eligibility category and whose income does not exceed 133% of the federal poverty level (FPL). The adult group includes individuals who were previously eligible under the AHCCCS Care program with income that did not exceed 100% of the FPL, as well as other adults described in R9-22-1427(E) with income above 100% FPL but not greater than 133% FPL;
  11. Individuals receiving child welfare services under Part B Title IV of the Social Security Act, on the basis of being a child in foster care without regard to age;
  12. Individuals receiving adoption or foster care assistance under Part E of Title IV of the Social Security Act without regard to age;
  13. Individuals who are pregnant through the postpartum period.
- iii. AHCCCS copayments are not charged for the following services for anyone:
1. Inpatient hospital services and services in the Emergency Department;
  2. Emergency services;
  3. Family Planning services and supplies;
  4. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women;
  5. Preventative services such as well visits, immunizations, pap smears, colonoscopies, and mammograms;
  6. Services paid on a fee-for-service basis; and
  7. Provider Preventable Conditions as described in the AHCCCS Medical Policy Manual, Chapter 1000.
- c. Nominal (optional) copayments for certain AHCCCS members
- i. Individuals eligible for AHCCCS through any of the populations listed below may have nominal (optional) copayments for certain services. Nominal copayments are also referred to as optional copayments. Individuals with nominal (optional) copayments are not charged copayments if they are in a population or category listed in section 3.b.ii. or for a service listed in section 3.b.iii.
  - ii. Providers are prohibited from refusing services to members who have nominal (optional) copayments if the member states he or she is unable to pay the copayment.
  - iii. Persons with nominal (optional) copayments are:
    1. Caretaker relatives eligible under R9-22-1427(A) (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);
    2. Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;



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- 3. Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
  - 4. Individuals receiving Supplemental Security Income (SSI) through Social Security Administration for people who are age 65 or older, blind or disabled;
  - 5. Individuals receiving SSI Medical Assistance Only (SSI MAO) who are age 65 or older, blind or disabled;
  - 6. Individuals in the Freedom to Work (FTW) program.
- iv. Nominal (optional) copayments are listed in Table 1:

Table 1

<b>Nominal (Optional) Copayments</b>	
<b>Service</b>	<b>Copayment</b>
Prescriptions	\$2.30
Out-patient services for physical, occupational and speech therapy	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits	\$3.40

- d. Mandatory copayments for certain AHCCCS Members
- i. Persons with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services. TMA members are described in AHCCCS rule R9-22-1427(B).
  - ii. When a member has a mandatory copayment, a provider can refuse to provide a service to a member who does not pay the mandatory copayment. A provider may choose to waive or reduce any copayment under this section.
  - iii. TMA members are not charged copayments if they are in a population or category listed in section 3.b.ii or for a service listed in section 3.b.iii.
  - iv. Mandatory copayments for TMA members are listed in Table 2:

Table 2

<b>Mandatory Copayments</b>	
<b>Service</b>	<b>Copayment</b>
Prescriptions	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits.	\$4.00
Physical, Occupational and Speech Therapies	\$3.00
Outpatient Non-emergency or voluntary surgical procedures. This excludes emergency room/emergency department visits.	\$3.00



- e. 5% Aggregate limit for nominal (optional) and mandatory copayments
  - i. The total aggregate amount of copayments for persons who have nominal (optional) and/or mandatory copayments cannot exceed 5% of the family's income on a quarterly basis. The AHCCCS Administration will review claims and encounters information to establish when a member's copayment obligation has reached 5% of the family's income and will communicate this information to providers. The member may also establish that the aggregate limit has been met on a quarterly basis by providing the AHCCCS Administration with records of copayments incurred during the quarter.
- f. Financial Reporting
  - i. Any co-payments collected are retained by the provider and reported to ADHS/DBHS in the encounter.
  - ii. Providers shall maintain a process where co-payment collections are reported on the Monthly Program Income Statement.

#### **3.4.4 References**

The following citations can serve as additional resources for this content area:

[A.R.S. 36-3409](#)

[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](#)

[A.A.C. R9-22-1427](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[ADHS/TRBHA IGAs](#)

[AHCCCS Eligibility Policy Manual](#)

[ADHS/DBHS Covered Behavioral Health Services Guide](#)

#### **3.4.5 PM Forms**

None

#### **3.4.6 PM Attachments**

None



Signature on file 10/01/14

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Mary Jo Gregory Date  
President and Chief Executive Officer

Signature on file 10/01/14

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Teresa Bertsch, MD Date  
Chief Medical Officer

[Reference ADHS/DBHS Policy 601](#)