Ohio Administrative Code

Rule 5160-26-12 Managed health care programs: member co-payments.

Effective: July 19, 2020

(A) Managed care organizations (MCOs) may elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for dental services, vision services, non-emergency emergency department services, or prescription drugs as provided for in this rule. MCOs must receive prior approval from the Ohio department of medicaid (ODM) before notifying members that a co-payment program will be implemented. This rule does not apply to "MyCare Ohio" plans pursuant to Chapter 5160-58 of the Administrative Code.

(B) MCOs that elect to implement member co-payment amounts must:

(1) Exclude the populations and services set forth in paragraph (C) of this rule;

(2) Not deny services to members as specified in paragraph (D) of this rule;

(3) Not impose co-payment amounts in excess of the maximum amounts specified in 42 C.F.R. 447.54 (October 1, 2019);

(4) Specify in provider subcontracts governed by rule 5160-26-05 of the Administrative Code the circumstances under which member co-payment amounts can be requested. For MCOs that elect to implement a co-payment program, no provider can waive a member's obligation to pay the provider a co-payment except as described in paragraph (G) of this rule;

(5) Ensure that the member is not billed for any difference between the MCO's payment and the provider's charge or request that the member share in the cost through co-payment or other similar charge, other than medicaid co-payments as defined in this rule;

(6) Ensure that member co-payment amounts are requested by providers in accordance with this rule; and

(7) Ensure that no provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent shall pay any co-payment on behalf of the member.

(C) Exclusions to the member co-payment program for dental, vision, non-emergency emergency department services, and prescription medications include the following:

(1) Children. Members who are under the age of twenty-one are excluded from medicaid co-payment obligations.

(2) Pregnant women. With the exception of routine eye examinations and the dispensation of eyeglasses during a member's pregnancy or post-partum period, all services provided to pregnant women during their pregnancy and the post-partum period are excluded from a medicaid co-payment obligation. The post-partum period is the period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends.

(3) Institutionalized members. Services or medications provided to members who reside in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) are excluded from medicaid co-payment obligations.

(4) Emergency. An MCO shall not impose a co-payment obligation for emergency services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily part or organ.

(5) Family planning (pregnancy prevention or contraceptive management). An MCO shall not impose a medicaid co-payment obligation on any service identified by ODM as a pregnancy prevention/contraceptive management service in accordance with rules 5160-21-02 and 5160-1-09 of the Administrative Code and provided to an individual of child-bearing age.

(6) Hospice. Members receiving services for hospice care are excluded from medicaid co-payment obligation.

(7) Medicare cross-over claims. Medicare cross-over claims defined in accordance with rule 5160-1-05 of the Administrative Code will not be subject to medicaid co-payment obligations.

(8) Medications administered to a member during a medical encounter provided in a hospital, clinic, office or other facility, when the medication is part of the evaluation and treatment of the condition, are not subject to a member co-payment.

(D) No provider may deny services to a member who is eligible for services due to the member's inability to pay the member co-payment. Members who are unable to pay their member co-payment may declare their inability to pay for services or medication and receive their services or medications without paying their member co-payment amount. This provision does not relieve the member from the obligation to pay a member co-payment or prohibit the provider from attempting to collect an unpaid member co-payment. If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid medicaid co-payment as an outstanding debt and may refuse service to a member who owes the provider an outstanding debt. If the provider intends to refuse service to a member who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In such situations, MCOs must still ensure that the member has access to needed services.

(E) MCOs may elect to impose member co-payments as follows:

(1) For dental services, the member co-payment amount may not exceed the amount set forth in Chapter 5160-5 of the Administrative Code. Services provided to a member on the same date of service by the same provider are subject to only one co-payment.

(2) For non-emergency emergency department services, the member co-payment amount must not exceed the amount set forth in Chapter 5160-2 of the Administrative Code. For purposes of this rule, the hospital provider shall determine if services rendered are non-emergency emergency department services and will report, through claim submission, the applicable co-payment to the MCO in accordance with medicaid hospital billing instructions.

(3) For vision services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-6 of the Administrative Code.

(4) For pharmacy services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-9 of the Administrative Code.

(F) Prescriptions for medications are subject to the applicable member co-payment for medications if they are given to a member during a medical encounter provided in the emergency department or other hospital setting, clinic, office, or other facility as a result of the evaluation and treatment of the condition, regardless of whether they are filled at a pharmacy located at the facility or at an outside location.

(G) If an MCO has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph (E)(2) of this rule, a hospital may take action to collect a co-payment by providing, at the time services are rendered to a managed care member, notice that a co-payment may be owed. If the hospital provides the notice and chooses not to take further action to pursue collection of the co-payment, the prohibition against waiving co-payments, as described in paragraph (B)(4) of this rule, does not apply.

(H) If an MCO elects not to impose a co-payment amount for dental services, vision services, non-emergency emergency department services or prescription drugs and the MCO reimburses contracting or non-contracting providers for these services using the medicaid provider reimbursement rate, the MCO must not reduce its provider payments by the applicable co-payment amount set forth in this rule.