Ohio Administrative Code

Rule 5160-1-09 Co-payments.

Effective: July 3, 2017

This rule sets forth requirements regarding co-payments by individuals for medicaid-covered services.

(A) Certain medicaid services are subject to individual co-payments. Information regarding these services and co-payment amounts can be found in the following Administrative Code rules:

(1) Co-payments for dental services are described in rule 5160-5-01 of the Administrative Code.

(2) Co-payments for vision services are described in rule 5160-6-01 of the Administrative Code.

(3) Co-payments for non-emergency emergency department services are described in rule 5160-2-21.1 of the Administrative Code.

(4) Co-payments for pharmacy services are described in rule 5160-9-09 of the Administrative Code.

(5) Co-payment requirements for services provided through a medicaid managed care plan are described in Chapter 5160-26-12 of the Administrative Code.

(B) With regard to the application of individual payments, the following apply:

(1) No provider may deny services to an individual who is eligible for the services on account of the individual's inability to pay the medicaid co-payment. Individuals who are not able to pay their medicaid co-payment may declare their inability to pay for services or medication and receive their services or medication without paying their medicaid co-payment amount. With regard to an individual who is unable to pay a required medicaid co-payment in accordance with this paragraph, this does not:

(a) Relieve the individual from the obligation to pay a medicaid co-payment; or

(b) Prohibit the provider from attempting to collect an unpaid medicaid co-payment.

(2) No provider shall waive an individual's obligation to pay a provider a medicaid co-payment except when paragraph (A)(5) of this rule applies.

(3) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any co-payment on behalf of an individual.

(4) 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 refuse service to an individual who owes the provider an outstanding debt. If the provider intends to refuse service to an individual who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In determining outstanding debt of an individual, the following apply:

(a) A provider's decision to continue rendering services to an individual who has an unpaid co-payment shall not be considered an outstanding debt of an individual.

(b) Charges which are prohibited in accordance with paragraph (A) of rule 5160-1-60 of the Administrative Code may not be considered an outstanding debt of an individual.

(C) The following individuals are excluded from the co-payment requirement for dental, vision, non-emergency emergency department services and pharmacy services:

(1) Children and youth under the age of twenty-one.

(a) The provider may use the individual's date of birth to identify if this exclusion applies; or

(b) The provider may submit the claim to the Ohio department of medicaid (department). During adjudication of the claim, if the department identifies the individual as a child or youth under the age of twenty-one, the department will not reduce the medicaid payment by the co-payment amount.

(2) Pregnant women during pregnancy and women with post-partum coverage as defined in rule 5160-4-04 of the Administrative Code. The following also apply:

(a) Routine eye examinations and the dispensation of eyeglasses during an individual's pregnancy are subject to co-payment.

(b) For all other claims, the provider may accept the individual's self-declaration of her pregnancy if the pregnancy/ post-partum co-payment exclusion applies. If the provider reports this exclusion applies, the medicaid payment will not be reduced by the co-payment amount.

(3) Residents of a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(a) The provider may use the individual's address to validate whether the individual resides in a NF or ICF/IID; or

(b) The provider may submit the claim to the department. During the adjudication of the claim, if the department identifies the individual as a resident of a NF or ICF/IID, the department will not reduce the medicaid payment by the co-payment amount.

(4) Individuals receiving emergency services are excluded from co-payment when they are 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;

(5) Individuals receiving family planning services defined as pregnancy/contraception management services in rule 5160-21-02 of the Administrative Code are excluded from co-payment when these services are provided to an individual of child-bearing age. The provider may determine on the basis of his or her professional judgment that the individual is receiving pregnancy prevention/ contraceptive services and the co-payment exclusion applies.

(6) Individuals receiving hospice services are excluded from co-payment obligations. The provider

may accept the individual's self-declaration that he or she is enrolled in hospice. If the provider reports that the individual is enrolled in hospice, the medicaid payment will not be reduced by the co-payment amount.

(7) Individuals receiving medicaid because of the state's election to provide coverage under the breast and cervical cancer option pursuant to 42 CFR 447.56(a)(1)(xi).

(D) Medicare cross-over claims as defined in rule 5160-1-05 of the Administrative Code are not subject to medicaid co-payments.