FROM: **Maureen M. Corcoran, Director**

To: **Ohio Department of Medicaid Clearance Reviewers**

SUBJECT: **Next Generation MyCare Ohio – Chapter 5160-26 Five Year Rule Review**

Summary

Attached for your review and comment are the Ohio Administrative Code (OAC) rules in Chapter 5160-26 that will be proposed for five-year rule review (FYRR). These rules are being updated to align with Chapter 5160-58 updates being made as part of the Next Generation MyCare Program launch planned for January 1, 2026.

OAC Rule 5160-26-02, entitled "Managed care: eligibility and enrollment." This rule describes the criteria for recipient enrollment into the Medicaid Managed Care program and explains criteria which excludes recipients from the Medicaid Managed Care program. This rule is being amended and filed as a five-year rule review. Changes include removal of duplicative requirements already contained in the Managed Care Provider Agreement and updates to Code of Federal Regulations (CFR) citations.

OAC Rule 5160-26-02.1, entitled "Managed care: termination of enrollment" is retitled as "Managed care: disenrollment." The rule describes circumstances which could result in removal from the Medicaid managed care program or changes in an individual's Medicaid managed care enrollment, including options to change plans outside the annual open enrollment period. This rule is amended and filed as a five-year rule review. Changes to this rule include a new title with updated terminology (changed from "terminate" to "disenroll") and additional clarification to member-initiated disenrollment requirements.

OAC Rule 5160-26-09.1, entitled "Managed care: third party liability and recovery." This rule describes Managed Care Entity (MCE) requirements regarding third party liability and recovery. This rule is being amended and filed as a five-year rule review. A clarification is being added stating that MCEs are expected to follow overpaid claims policy outlined in OAC rule 5160-1-19.

OAC Rule 5160-26-12, entitled "Managed care: member co-payments." This rule describes MCE requirements regarding member co-payments. This rule is amended and filed as a five-year rule review. A correction to the rule is being made to apply the member co-payments policy to MyCare Ohio Plans, making this rule consistent with OAC Chapter 5160-58 and the MyCare Provider Agreement. The definition of "post-partum period" for eligibility purposes is being clarified.

Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

To receive notification when ODM posts draft rules for public comment please register via the Common Sense Initiative eNotifications Sign-up: eNotifications Sign Up | Governor Mike DeWine (ohio.gov). The Ohio Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.

To receive notification when ODM original, revise, refile, or final files a rule package please register for Joint Committee on Agency Rules Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov.

DRAFT - NOT FOR FILING

5160-26-02 Managed care: eligibility and enrollment.

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

(B) Eligibility for managed care organization (MCO) enrollment.

(1) Except as specified in paragraphs (B)(3) to (B)(5) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 (October 1, ~~2021~~2025), an individual must be enrolled in an MCO if he or she has been determined medicaid eligible in accordance with division 5160:1 of the Administrative Code.

(2) MCO enrollment is mandatory for the following individuals:

(a) Children receiving Title IV-E federal foster care maintenance;

(b) Children receiving Title IV-E adoption assistance:

(c) Children in foster care or other out-of-home placement; and

(d) Children receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMH) or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act, 42 U.S.C. 701(a)(1)(D) (~~July 1, 2022~~January 1, 2025) and is defined by the state in terms of either program participation or special health care needs.

(e) Individuals who meet the criteria specified in rule 5160-59-04 of the Administrative Code and receive services through the OhioRISE home and community based services (HCBS) waiver administered by the Ohio department of medicaid (ODM).

(3) Medicaid eligible individuals may voluntarily choose to enroll in an MCO if they are:

(a) Indians who are members of federally recognized tribes; or

(b) Individuals diagnosed with a developmental disability who have a level of care that meets the criteria specified in rule 5123-8-01 of the Administrative Code and receive services through a HCBS waiver administered by the Ohio department of developmental disabilities (DODD).

(4) Except for individuals receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (~~July 1, 2022~~January 1, 2025), and individuals who meet the criteria in paragraphs (B)(2)(e) and (B)(3)(b) of this rule, medicaid eligible individuals are excluded from MCO enrollment if they:

(a) Reside in a nursing facility; or

(b) Receive medicaid services through a medicaid waiver component, as defined in section 5166.02 of the Revised Code.

(5) The following individuals are excluded from MCO enrollment.

(a) Inmates of public institutions as defined in 42 C.F.R. 435.1010 (October 1, ~~2021~~2025) unless otherwise specified by ODM;

(b) Dually eligible individuals enrolled in both the medicaid and medicare programs;

(c) Individuals receiving services in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or a developmental center as defined in rule 5123-9-30 of the Administrative Code;

(d) Individuals enrolled in the program of all-inclusive care for the elderly (PACE);

(e) Individuals who are determined to be presumptively eligible and receive temporary, time-limited medical assistance as described in rule 5160:1-2-13 of the Administrative Code;

(f) Individuals who receive ~~alien emergency medical assistance~~non-citizen emergency medical assistance in accordance with rule 5160:1-5-06 of the Administrative Code;

(g) Individuals who receive refugee medical assistance in accordance with rule 5160:1-5-05 of the Administrative Code; and

(h) Non-citizen victims of trafficking as set forth in rule 5160:1-5-08 of the Administrative Code.

(6) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medicaid benefits to which he or she may be entitled.

(C) ~~Upon implementation of the single pharmacy benefit manager (SPBM), any~~Any individual enrolled in an MCO as specified in paragraph (B) of this rule will be mandatorily enrolled in the SPBM.

~~(D)~~ (D) ~~Enrollment and commencement of coverage in an MCO or the SPBM.~~

~~(1)~~ (1) ~~The MCO and the SPBM must accept eligible individuals without regard to race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The MCO and the SPBM will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) (October 1, 2021).~~

~~(2)~~ (2) ~~The MCO and the SPBM must accept eligible individuals who request MCO enrollment without restriction.~~

~~(3)~~ (3) ~~If a member loses managed care eligibility and is disenrolled from the MCO and the SPBM, and subsequently regains eligibility, his or her enrollment in the same MCO and the SPBM may be reinstated back to the date eligibility was regained in accordance with procedures established by ODM.~~

~~(4)~~ (4) ~~ODM shall confirm the eligible individual's MCO and SPBM enrollment via the ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily and monthly enrollment files of new members, continuing members and terminating members.~~

~~(5)~~ (5) ~~The MCO and SPBM shall not be required to provide coverage until MCO or SPBM enrollment is confirmed via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files except as provided in paragraph (D)(6) of this rule or upon mutual agreement between ODM and the MCO.~~

~~(6)~~ (6) ~~Infants born to mothers enrolled in an MCO are enrolled in an MCO from their date of birth through~~

~~at least the end of the month of the child's first birthday, or until such time that the MCO is notified of the child's disenrollment via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files. This does not include infants placed for adoption or legally placed in the custody of an Ohio county public children's serivces agency (PCSA).~~

~~(7)~~ (7) ~~Coverage of MCO and SPBM members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily and monthly enrollment files to the MCO and SPBM, except as specified in paragraph (D) of this rule.~~

DRAFT - NOT FOR FILING

5160-26-02.1 Managed care:~~termination of enrollment~~disenrollment.

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

(B) The Ohio department of medicaid (ODM) will ~~terminate~~disenroll a member from ~~enrollment in~~ a managed care organization (MCO) for any of the following reasons:

(1) The member's permanent place of residence is moved outside the MCO service area. When this occurs, ~~termination of~~ MCO ~~enrollment~~disenrollment takes effect on the last day of the month in which the member moved from the service area.

(2) The member becomes ineligible for medicaid. When this occurs, ~~termination of~~ MCO ~~enrollment~~disenrollment takes effect on the last day of the month in which the member became ineligible.

(3) The member dies, in which case MCO enrollment ends on the date of death.

(4) The member is not receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (~~July 1, 2022~~January 1, 2025), is authorized for nursing facility services, and the following criteria are met:

(a) The MCO has authorized nursing facility services for no less than the month of nursing facility admission and for two complete consecutive calendar months thereafter;

(b) For the entire period in paragraph (B)(4)(a) of this rule, the member has remained in the nursing facility without any admission to an inpatient hospital or long-term acute care facility;

(c) The member's discharge plan documents that nursing facility discharge is not expected in the foreseeable future and the member has a need for long-term nursing facility care;

(d) For the entire period in paragraph (B)(4)(a) of this rule, the member is not using hospice services; and

(e) The MCO has requested disenrollment, and ODM has approved the request.

(f) The member is found by ODM to meet the criteria for the developmental disabilities level of care as specified in rule 5123-8-01 of the Administrative Code and resides in an intermediate care facility for individuals with intellectual disabilities (ICF-IID). Following MCO notification to ODM and written approval by ODM, ~~termination of~~ MCO ~~membership~~disenrollment takes effect on the last day of the month preceding the individual's stay in the ICF-IID.

(5) The member has third party coverage, and ODM determines that continuing MCO enrollment may not be in the best interest of the member. This determination may be based on the type of coverage the member has, the existence of conflicts between provider networks, or access requirements. When this occurs, the effective date of ~~termination of~~ MCO ~~enrollment~~disenrollment shall be determined by ODM but in no event shall the ~~termination~~disenrollment date be later than the last day of the month in which ODM

approves the ~~termination~~disenrollment.

(6) The member is not eligible for MCO enrollment for one of the reasons set forth in rule 5160-26-02 of the Administrative Code.

(7) The provider agreement between ODM and the MCO is terminated.

(C) ~~Upon implementation of the single pharmacy benefit manager (SPBM),~~ ODM will ~~terminate~~disenroll a member ~~from enrollment in~~from the SPBM when a member is ~~terminated from enrollment in~~disenrolled from an MCO as specified in paragraph (B) of this rule or if the contract between ODM and the SPBM is terminated.

(D) All of the following apply when ~~enrollment in an~~a member is disenrolled from an MCO or the SPBM ~~is terminated~~ for any of the reasons set forth in paragraph (B) or (C) of this rule:

(1) Such ~~terminations~~disenrollments may occur either in a mandatory or voluntary service area.

(2) All such ~~terminations~~disenrollments occur at the individual level.

(3) Such ~~terminations~~disenrollments do not require completion of a consumer contact record (CCR).

(4) If ODM fails to notify the MCO or the SPBM of a member's ~~termination~~disenrollment from an MCO or the SPBM, ODM shall continue to pay the MCO or the SPBM the applicable monthly capitation rate for the member. The MCO or the SPBM shall remain liable for the provision of covered services as set forth in rule 5160-26-03 of the Administrative Code, until such time as ODM provides the MCO or the SPBM with documentation of the member's ~~termination~~disenrollment.

(5) ODM shall recover from the MCO or the SPBM any capitation paid for retroactive ~~enrollment termination~~disenrollment occurring as a result of paragraph (B) or (C) of this rule.

(6) A member may lose medicaid eligibility during an annual open enrollment period, and thus become unable to change to a different MCO. If the member then regains medicaid eligibility, the member may request to change plans within thirty days following reenrollment in the MCO.

(E) Member-initiated MCO ~~terminations~~disenrollment.

(1) An MCO member who qualifies as a mandatory managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO as follows:

(a) From the date of enrollment through the initial three months of MCO enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph (G) of this rule;

(c) At any time, if the member is a child receiving Title IV-E federal foster care maintenance or is in foster care or other out of home placement. The change must be initiated by the local public children's services agency (PCSA) or the local Title IV-E juvenile court; or

(d) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph

~~(E)(3)(f)~~(E)(3)(e) of this rule;

(2) An MCO member who qualifies as a voluntary managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO, if available, or be returned to medicaid fee-for-service (FFS) as follows:

(a) From the date of enrollment through the initial three months of MCO enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph (G) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph ~~(E)(3)(f)~~(E)(3)(e) of this rule;

(3) The following provisions apply when a member either requests a different MCO or, if applicable, requests to be returned to medicaid FFS:

(a) The request may be made by the member, or by the member's authorized representative as long as the authorized representative is not a provider for the member.

(b) All member-initiated changes or ~~terminations~~disenrollments must be voluntary. The MCO is not permitted to encourage members to change ~~or terminate enrollment~~enrollment or disenroll due to a member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, ancestry, genetic information, health status or need for health services. The MCO may not use a policy or practice that has the effect of discrimination on the basis of the criteria listed in this rule.

(c) If a member requests disenrollment because he or she meets the requirements of paragraph (B)(3) of rule 5160-26-02 of the Administrative Code, the member will be disenrolled after the member notifies the Ohio medicaid consumer hotline.

(d) Disenrollment will take effect on the last day of the calendar month in which the request for disenrollment was made.

(e) In accordance with 42 C.F.R. 438.56(d)(2) (October 1, ~~2021~~2025), a change ~~or termination of MCO enrollment~~in enrollment or a disenrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the MCO's service area and a non-emergency service must be provided out of the service area before the effective date of the member's ~~termination~~disenrollment as described in paragraph (B)(1) of this rule;

(ii) The MCO does not, for moral or religious objections, cover the service the member seeks;

(iii) The member needs related services to be performed at the same time; not all related services are available within the MCO's network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;

(iv) The member has experienced poor quality of care and the services are not available from another

provider within the MCO's network;

(v) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;

(vi) The PCP selected by a member leaves the MCO's network and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCO in the member's service area; and

(vii) ODM determines that continued enrollment in the MCO would be harmful to the interests of the member.

(f) The following provisions apply when a member seeks a change ~~or termination in MCO enrollment~~in enrollment or a disenrollment for just cause:

(i) The member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.

(ii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the MCO. ODM shall make a decision within forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

(iii) ODM may establish retroactive ~~termination~~disenrollment dates and recover capitation payments as determined necessary and appropriate.

(iv) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or ~~termination~~disenrollment.

(v) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.

(vi) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.

(vii) If a member submits a request to change enrollment or disenroll ~~terminate enrollment~~ for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall ensure that the member's MCO enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

(F) MCO initiated ~~terminations~~disenrollments.

(1) The MCO may submit a request to ODM for the ~~termination~~disenrollment of a member for the following reasons:

(a) Fraudulent behavior by the member; or

(b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the

extent that such behavior seriously impairs the MCO's ability to provide services to either the member or other MCO members.

(2) The MCO may not request ~~termination~~disenrollment due to the member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, genetic information, ancestry, health status or need for health services.

(3) The MCO must provide medicaid-covered services to a ~~terminated~~disenrolled member through the last day of the month in which the MCO ~~enrollment is terminated~~membership is disenrolled, notwithstanding the date of ODM written approval of the ~~termination~~disenrollment request. Inpatient facility services must be provided in accordance with rule 5160-26-02 of the Administrative Code.

(4) If ODM approves the MCO's request for ~~termination~~disenrollment, ODM shall notify in writing the member, the authorized representative, the Ohio medicaid consumer hotline, and the MCO.

(G) MCO open enrollment.

(1) Open enrollment months will occur at least annually.

(2) At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals ~~by mail~~ of the opportunity to change ~~or terminate MCO enrollment~~enrollment or disenroll and will explain where to obtain further information.

DRAFT - NOT FOR FILING

5160-26-09.1 Managed care: third party liability and recovery.

(A) Tort.

(1) Pursuant to sections 5160.37 and 5160.38 of the Revised Code, the Ohio department of medicaid (ODM) maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services.

(2) A managed care entity (MCE) is prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by a member.

(3) The MCE must notify ODM and/or its designated entity within fourteen calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (ODM 03245) or a method determined by the ODM designated entity, provided ODM approved the designated entity's method and notified the MCE.

(4) The MCE must submit a summary of financial information to ODM and/or its designated entity within thirty calendar days of receiving an original authorization to release a financial claim statement letter from ODM pursuant to a tort action. The MCE must use the "Tort Summary Statement" form (ODM 03246) or a method determined by the ODM designated entity, provided ODM has approved the designated entity's method and notified the MCE. Upon request, the MCE must provide ODM and/or its designated entity with true copies of medical claims.

(B) Fraud, waste, and abuse recovery. ODM assigns to the MCE its rights of recovery against any TPP for costs due to provider fraud, waste, or abuse as defined in rule 5160-26-01 of the Administrative Code related to each member during periods of enrollment in the MCE. In instances when the MCE fails to properly report suspected fraud, waste, or abuse, before the suspected fraud, waste, or abuse is identified by the state of Ohio, any portion of the fraud, waste, or abuse recovered by the state shall be retained by the state.

(C) Coordination of benefits.

(1) ODM assigns its right to third party resources (coordination of benefits) to the MCE for services rendered to each member during periods of enrollment. ODM reserves the right to identify, pursue, and retain any recovery of third party resources assigned to the MCE but not collected by the MCE after one year from date of claim payment.

(2) Except as specified in paragraph (C)(3) of this rule, the MCE must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary medicaid-covered services. Such expenses will be paid in accordance with this rule and sections 5160.37 and 5160.38 of the Revised Code.

(3) Children that have been legally placed in the custody of an Ohio county public children's services agency (PCSA) or related entity are excluded from third party liability cooperation and are exempt from post-payment recovery unless it is confirmed that the child will not be put at risk for doing so (e.g. medical support order).

(4) The MCE is the payer of last resort when a member has third party resources available for payment of medical expenses for medicaid-covered services, except:

(a) The MCE pays after any TPP including medicare but before:

(i) Resources provided through the program for children and youth with special health care needs under sections 3701.021 to 3701.0210 of the Revised Code.

(ii) Resources that are exempt from primary payer status under federal medicaid law, 42 U.S.C. 1396 (as in effect ~~July 1, 2022~~January 1, 2025).

(iii) Resources provided through the state sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.

(b) The MCE, except SPBM, pays first for preventive pediatric services before seeking reimbursement from any liable third party.

(5) The MCE will take reasonable measures to ascertain and verify any third party resources available to a member. When the MCE denies a claim due to third party liability (TPL), the MCE must timely share, on the explanation of payment sent to providers, available information regarding the third party resources for the purposes of coordination of benefits, including:

(a) Insurance company name;

(b) Insurance company billing address for claims;

(c) Member's group number;

(d) Member's policy number; and

(e) Policy holder name.

(6) The MCE must require providers who are submitting TPL claims to the MCE to request information regarding third party benefits from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no third party benefits, or the provider is unable to determine that the member has third party benefits, the MCE must permit the provider to submit a claim to the MCE. If, as a result of requesting the information, the provider determines that third party liability exists, the MCE must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain third party payment as set forth in paragraph (C)(7) of this rule.

(7) The MCE must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the MCE. The MCE must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP or received partial payment, to submit a claim to the MCE requesting reimbursement for rendered services.

(a) The MCE must process claims when the provider has complied with one or more of the following reasonable measures:

(i) The provider first submits a claim to the TPP for the rendered services and does not receive a remittance advice or other communication from the TPP within ninety days after the submission date. The MCE may require providers to document the claim and date of the claim submission to the TPP.

(ii) The provider has retained and/or submitted one of the following types of documentation

indicating a valid reason for non-payment for the services not related to provider error:

(a) Documentation from the TPP;

(b) Documentation from the TPP's automated eligibility and claim verification system;

(c) Documentation from the TPP's member benefits reference guide/manual; or

(d) Any other documentation from the TPP showing there is no third party benefit coverage for the rendered services.

(iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.

(b) Valid reasons for non-payment from a TPP to the provider for a third party benefit claim include, but are not limited to:

(i) The service is not covered under the member's third party benefits.

(ii) The member does not have third party benefits through the TPP for the date of service.

(iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the MCE showing the appropriate amount received from the TPP.

(iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits, or was non-compliant with the TPP's requirements in order to maintain coverage.

(v) The member is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the TPP.

(vii) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(8) If the provider receives payment from the TPP after the MCE has made payment, the MCE must require the provider to repay the MCE any amount overpaid by the MCE in accordance with the overpaid claims policy outlined in rule 5160-1-19 of the Administrative Code. The MCE must not allow the provider to reimburse any overpaid amounts to the member.

(9) The MCE must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.

(10) The MCE payment for third party claims will not exceed the MCE allowed amount for the service, less all third party payments for the service.

(11) The MCE's timely filing limits for provider claims shall be at least ninety days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.

(12) The MCE must ensure that providers do not hold liable or bill members in the event that the MCE cannot or will not pay for covered services unless all of the specifications set forth in rule 5160-26-05 and rule 5160-26-11 of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the MCE's payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than MCE co-payments.

(D) The MCE is required to submit information regarding members with third party coverage as directed by ODM.

DRAFT - NOT FOR FILING

5160-26-12 Managed care: member co-payments.

(A) This rule does not apply to ~~MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or~~ the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

(B) The managed care ~~organization (MCO)~~entity (MCE) may elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for dental services, vision services, ~~or~~ non-emergency emergency department services, or ~~until implementation of the single pharmacy benefit manager (SPBM),~~ prescription drugs as provided for in this rule. The ~~MCO~~MCE must receive prior approval from the Ohio department of medicaid (ODM) before notifying members that a co-payment program will be implemented.

(C) ~~Upon implementation of the SPBM, the SPBM~~The single pharmacy benefit manager (SPBM) may only elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for prescription drugs as provided for in this rule if directed to by ODM.

(D) If the ~~MCO or SPBM~~MCE implements a member co-payment program, the ~~MCO and SPBM~~MCE must:

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

(2) Not deny services to members as specified in paragraph (F) 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, ~~2021~~2025);

(4) Specify in provider contracts governed by rule 5160-26-05 of the Administrative Code the circumstances under which member co-payment amounts can be requested. If the ~~MCO or SPBM~~MCE implements a co-payment program, no provider can waive a member's obligation to pay the provider a co-payment except as described in paragraph (I) of this rule;

(5) Ensure that the member is not billed for any difference between the ~~MCO or SPBM's~~MCE'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.

(E) 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 twelve month period following termination of pregnancy ends.~~day of delivery and extends through the last day of the twelfth month following delivery.

(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~~MCE 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). The ~~MCO or SPBM~~MCE 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.

(F) 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, the ~~MCO or SPBM~~MCE must still ensure that the member has access to needed services.

(G) The ~~MCO or SPBM~~MCE may 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~~MCE 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. Medicaid managed care prescription drug co-payments are implemented by the SPBM.

(H) 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.

(I) If the ~~MCO~~MCE has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph (G)(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 (D)(4) of this rule, does not apply.

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