OHIO DEPARTMENT OF MEDICAID
BUREAU OF LONG-TERM SERVICES AND SUPPORTS
Application of Share of Cost/Patient Liability for Nursing Facilities – 5/11/2022

INTRODUCTION

Purpose of Fact Sheet:

The purpose of this fact sheet is to provide nursing facilities (NFs) with:

- An overview of share of cost (SOC)/patient liability (PL)
- An explanation of the application of SOC/PL in various scenarios
- Answers to frequently asked questions

SHARE OF COST/PATIENT LIABILITY BASICS

What is Share of Cost/Patient Liability?

- Residents in medical institutions, including NFs, are generally subject to post-eligibility treatment of income (PETI) to determine the amount they are required to pay the facility as their contribution toward the Medicaid cost of their care. The local County Department of Job and Family Services (CDJFS) processes the PETI calculation to identify the amount the resident must pay the NF each month. This amount is often referred to as the share of cost (SOC) or patient liability (PL).
- The PETI calculation is performed *after* the resident has been determined to be eligible for Medicaid and is to be recalculated when there is a change in circumstances that affects the SOC/PL.
- Individuals residing in a medical institution who have a base eligibility category which uses modified adjusted gross income (MAGI) budgeting will not have a SOC/PL.
- The resident and his or her authorized representative (AR) are sent an Ohio Benefits Notice of Action (NOA) to inform them of the resident's financial responsibility each time SOC/PL is calculated. The NOA includes the amount of SOC/PL, the date the SOC/PL is effective, and the resident's state hearing rights.
- The resident must pay the SOC/PL amount identified on the NOA to the NF.
- SOC/PL is designated in MITS as long-term care facility (LTCF), waiver, or hospital. These SOC/PL "types" identify the specific SOC/PL budget used in the calculation, which is based on where the individual is residing when the SOC/PL is calculated (see Provider Transfers section for additional detail).
- If the SOC/PL is effective for less than a full month, it will also be identified as "pro-rated".

Options for Identifying Share of Cost/Patient Liability Amounts and Dates:

- On the NOA sent to residents and ARs by the CDJFS.
- Via MITS secure provider portal individual resident eligibility inquiries.
- By submitting a HIPAA-compliant 270 eligibility request, the NF can verify eligibility and SOC/PL for all residents (up to 5000 in a single transaction). A 271 Electronic Data Interface (EDI) file provides the response to the provider's inquiry. More information can be found on ODM's website. See the 270 271 Eligibility Transactions Fact Sheet here.

Notification of Changes that May Impact Share of Cost/Patient Liability Amounts:

- The resident or his or her AR is required to notify the local CDJFS within 10 calendar days of any changes which may impact eligibility including changes in address, income, health insurance, and death of spouse or dependent. Delays in reporting changes in income may negatively impact a resident's Medicaid eligibility.
- Form ***ODM 10203 Report A Change for Medical Assistance*** may be used to report the changes.

Changes Affecting Share of Cost/Patient Liability:

The following can affect a resident's SOC/PL amount and will trigger the CDJFS to recalculate the SOC/PL responsibility:

- Increase in income
- Decrease in income
- Changes in health insurance premiums, coinsurance, insurance deductibles and copayments
- Death of spouse or dependent
- Approval for coverage of incurred medical expenses

Scenario	Impact to SOC/PL
Increase in income	County redetermines SOC/PL. SOC/PL increases are future dated to allow for the issuance of the NOA and state hearing rights.
Decrease in income or increase in allowable expenses	County redetermines SOC/PL back to the month of a decrease in income or increase in allowable expenses. NF must adjust previous claim(s) for retroactive decrease in SOC/PL and refund any overpayment(s) after CDJFS recalculates and decreases SOC/PL.
Discharge or death	SOC/PL will be prorated for the month of discharge or death following the NF reporting the discharge or death via ProviderGateway. NFs are to report such changes within 10 days of the discharge or death. **Overpayments of SOC/PL should be refunded to the resident or their estate**. The NF will submit claims or claims adjustments to reflect the partial month and prorated SOC/PL amount.
Past incurred medical expenses/Unpaid past medical expenses or (UPMEs)	The resident or AR can request the CDJFS reduce a reduction in SOC/PL to pay past incurred expenses for medical care. If the CDJFS approves, the SOC/PL will be temporarily reduced to accommodate the past expenses. The resident/family will be able to repurpose those monies to pay the UPME. The NF will adjust the claims accordingly. If multiple providers are involved, the providers must coordinate the collection of patient liability and billing.

ELIGIBILITY AND SOC/PL

Residents Newly Applying for Medicaid in a Nursing Facility:

Residents newly applying for Medicaid in a NF will have SOC/PL calculated based on the admission date or eligibility date, whichever is later. SOC/PL will be prorated by CDJFS for the initial month if the NF admission date is not the first day of the month.

- **The formula for proration used by CDJFS:**
  Prorated SOC/PL = SOC/PL for a full month divided by the total number of days in the month. This number is then multiplied by the number of institutionalized days in the month (date of admission is counted; date of discharge is not counted) and the resulting amount is rounded down to the nearest dollar.

Scenario	Impact to SOC/PL
Resident qualifies for base Medicaid: Typically, income is less than or equal to the Supplemental Security Income (SSI) Federal Benefit Rate (FBR)	If the non-financial and financial criteria are met, the date of eligibility may be up to three months prior to the application date and will be effective the first day of the month of eligibility. SOC/PL will be made effective on the NF admission date or eligibility date, whichever is later.
Resident qualifies under the Special Income Level (SIL) Note: The SIL standard is 300% of the SSI FBR	For eligibility under the SIL, the resident must be in a medical institution for at least 30 consecutive days. Both hospital and NF days are counted. An institutionalized resident who dies within the first 30 days is considered to have met the continuous period of institutionalization for eligibility. If approved, the Medicaid effective date will go back to the first of the month of the first date of institutionalization as long as the application is submitted within three months. SOC/PL will be effective on the date of Medicaid eligibility or NF admission, whichever is later. For continuous institutionalization, which may include a hospital stay prior to the NF admission, SOC/PL will be effective back to the hospital admission date preceding the NF admission.
Resident has income above the SIL	To qualify for Medicaid long-term services and supports (LTSS) eligibility, the resident must set up and fund a Qualified Income Trust (QIT). The date of Medicaid eligibility will be the first of the month in which the QIT is set up and funded. Residents may elect to fund the QIT with all of their monthly income or only the amount over the SIL. Income placed in a QIT continues to be included in the PETI calculation, and it is likely that all or part of the SOC will be paid out of the QIT.

Residents with Current Base (Community) Medicaid:

Residents with current Medicaid must be sent a (NOA) at least 15 days prior to the initial SOC/PL or anytime there is an increase in SOC/PL. If the SOC/PL amount decreases, a NOA is not required to be issued in advance because the action is favorable to the resident.

Residents on Medicare Premium Assistance Programs (MPAP) who May or May Not Have Full Medicaid:

- Residents on Medicare Premium Assistance Programs (MPAP) include the following:
  - Qualified Medicare Beneficiary (QMB) **only** - does not include full Medicaid
  - Qualified Medicare Beneficiary (QMB) **plus** - does include **full Medicaid**
  - Specified Low-Income Medicare Beneficiary (SLMB) **only** - does not include full Medicaid
  - Specified Low-Income Medicare Beneficiary (SLMB) **plus** - does include **full Medicaid**
  - Qualified Individual (QI-1) - does not include full Medicaid

- MPAP residents without full Medicaid coverage must have their case run for base Medicaid and LTSS eligibility following a NF admission. A new Medicaid application is not required. The admission 9401 submitted via ProviderGateway will result in notification for the CDJFS to run the case to determine Medicaid eligibility.
- If an MPAP resident without full Medicaid is over resources for Medicaid, the resident will be denied eligibility. The resident will need to pay privately for their NF stay until they meet the resource requirement and are found eligible for full Medicaid.

OTHER INCOME SCENARIOS

There are two types of common income that impact PETI calculations. One is income from Supplemental Security Income (SSI) and the other is income from a Veterans Administration (VA) medical pension (Aid and Attendance and/or Housebound Benefits).

Resident Receiving Supplemental Security Income (SSI) Admitted to NF:

- If a resident receiving SSI is expected to be in the NF for over 90 days, the NF and the resident should notify the Social Security Administration (SSA). The SSI will be reduced to $30 per month for personal needs. A resident must notify SSA prior to returning to the community so that their full SSI benefit can restart timely.
- If a resident receiving SSI has an expected length of stay of 90 days or less, the SSA will generally permit the resident to keep the full amount of their SSI for living expenses providing they notify the SSA of their admission and submit all of the following:
  - A physician's written statement that the resident will be in the NF for 90 consecutive days or less.
  - A statement from the resident or someone knowledgeable about the resident's circumstances that they need their SSI benefits to maintain their living arrangement.
  - The expected discharge date so that SSA does not terminate their income.
- Once the individual is a permanent NF resident, or after 90 days in the NF, SSA reduces their SSI to $30 per month for personal needs and they will have a $0 SOC/PL unless they have income from another source.

Resident Receiving a Veterans Administration (VA) Medical Pension (Aid and Attendance and/or Housebound Benefits):

- Both the resident and NF should notify the VA of the resident's admission so the VA can reduce their monthly pension (to $90 for their personal needs) during their stay, if appropriate.
- A NF stay covered by Medicaid for a veteran may still have a SOC/PL if they have income from another source.
- Residents should notify the VA prior to being discharged from the NF so that their benefits can restart timely.
- Individuals approved to move from Medicaid to the VA Benefit for covering their NF stay will no longer have SOC/PL as long as Medicaid is not paying for the NF stay.

PROVIDER TRANSFERS (Fee-for-Service (FFS) only)

- Transfers include the following:
  - Institution/Facility to Institution/Facility (NF or ICF-IID or hospital [includes long-term acute care, rehabilitation, and psychiatric hospitals])
  - NF resident enrollment and disenrollment from Hospice
- The transferring facility should coordinate the process of collecting PL up to the cost of care for that month and report that amount of PL on their fee-for-service claim. If the amount of SOC/PL collected exceeds the Medicaid cost of care, the transferring facility may return the SOC/PL balance to the individual or forward to the admitting NF or ICF-IID provider.
- The receiving facility must report on the FFS claim the amount of SOC/PL they collected for that month.
- Individuals in a hospital stay exceeding 30 days may have a SOC determined prior to the NF admission. Upon transfer to an LTCF, the Patient SOC/PL type will be changed from Hospital to LTCF type, but the amount should not change since the same calculation is used for both types.

Residents Entering a NF while on a Home and Community-Based Services (HCBS) Waiver (including Assisted Living Waiver):

If the stay is expected to be short-term, their waiver eligibility will remain active for approximately 90 days to allow for an individual to return home from a short NF stay without losing their waiver slot.

- The NF should:
  - Report the admission to the resident's waiver case management agency (ODM, ODA, or DODD).
  - Submit the admission information via ProviderGateway.
  - Bill NF LTC claims using the waiver revenue center codes.
  - Collection of SOC/PL – The NF will not be responsible for collecting SOC/PL while an individual remains enrolled in HCBS waiver program.
  - Notify the waiver case management agency of discharge or continued stay approaching 90 days so they can work with the resident and determine if their waiver enrollment should be continued or ended.
  - If the resident is disenrolled from the waiver, the CDJFS will receive an alert to run the case for LTC facility eligibility and will calculate a new "LTCF" SOC/PL, which will be visible via MITS. The NF will be responsible for collecting the new PL going forward.

Share of Cost/Patient Liability During a Medicare Part A Stay:

Scenario	Applied SOC/PL
Dual-Eligible in NF covered under a Medicare Part A Stay	The SOC/PL is to be collected by the facility and must be applied to any Medicaid per diem claims, including those for bed-hold days. SOC/PL is not applied to Medicare crossover claims where the Medicare payment is considered payment in full by Medicaid. For any month where the SOC/PL amount due and collected from the resident exceeds the Medicaid payment for the month, the NF must return the excess to the resident.

Handling of Excess Resources:

The NF must notify the resident and the CDJFS when the resident's resources approach $200 less than the resource limit. When the resident's resources are over the resource limit, the CDJFS will redetermine Medicaid eligibility and determine how the excess resources should be handled. If an individual needs to spend down excess resources, the money must be spent on personal items and services that directly benefit and are owned by the resident. Some examples include:

- Home maintenance costs such as mortgage, rent and utilities
- Burial spaces, funds and contracts
- Electric bed
- Personalized wheelchair or lift chair
- Clothing
- Personal electronics
- Payment of service contracts for cell phone, landline, and Internet

CLAIMS

- **For fee-for-service residents,** a NF must report the amount of SOC/PL displayed in MITS on long-term care claims. ODM will reduce the NF payment based on the amount of SOC/PL reported on the claim.
- **For MyCare and managed care residents,** a NF must follow the billing process identified by the managed care organization (MCO), which will reduce the NF payment based on SOC/PL information provided to the MCO by ODM via the MITS 834 file.

FREQUENTLY ASKED QUESTIONS AND ANSWERS

1. ***What amount of SOC/PL should be collected for a resident with a Restricted Medicaid Coverage Period (RMCP)?***
    - Residents with an RMCP qualify for Medicaid but not for LTSS because they improperly transferred assets. They do not owe a SOC/PL during the RMCP because they must pay the entirety of their NF bill during this time. However, at the end of an RMCP, the individual's SOC/PL is often increased for the first month to offset any remaining funds. The SOC/PL will then be reduced to the ongoing amount after that.

2. ***How should questions or concerns regarding an individual's SOC/PL be addressed?***
    - Questions or concerns regarding an individual's SOC/PL amount or dates should be directed to the CDJFS. If the CDJFS is unable to resolve the issue, the provider may submit an inquiry directly to ODM here (Claims related issues should continue to be directed to Provider Services at 1-800-686-1516.)

3. ***Who can assist with SOC/PL discrepancies for MyCare/managed care residents?***
    - SOC/PL payment issues should be directed to the appropriate MCO. After the MCO responds and if the NF still has concerns, they may submit a managed care provider complaint to ODM.

4. ***Who can assist with claims payment questions regarding SOC/PL?***
    - For fee-for-service, contact Provider Assistance at 1-800-686-1516.
    - For MyCare/managed care, contact the MCO directly.

5. ***For new Medicaid residents, can we collect SOC/PL during the pending period?***
    - A NF is permitted to charge an applicant or resident for services while his or her Medicaid eligibility is pending. This charge may be in the form of a deposit prior to admission and/or payment after admission.
    - Once the CDJFS approves the LTSS case and calculates the SOC/PL, the provider must reconcile any payments with the resident and reflect the newly calculated SOC/PL on their FFS claims.

6. ***Can SOC/PL be recalculated to account for child support, alimony, unpaid student loans, or unpaid taxes?***
    - No. Neither the federal nor state rules regarding PETI permit a deduction for these items; however, residents may wish to request a reconsideration of these payments from the appropriate authority.

7. **What is the process for a resident to request a reduction in SOC/PL in order to pay incurred medical bills including NF bills?**
    - The resident or his or her AR can submit a request in writing to the CDJFS. If approved, the CDJFS will notify the NF and provide detailed information.
    - Bills from an RMCP cannot be used to reduce SOC/PL.

8. **What is the Medicaid program "Medicaid Buy-In for Workers with Disabilities (MBIWD)" and why do these individuals have no SOC/PL?**
    - This program provides Medicaid coverage to working Ohioans with disabilities who are employed part-time or full-time for pay. For example, a resident may write articles or blogs for a magazine or go to a job outside the facility. Under MBIWD, the resident pays a premium for their health care benefits instead of a SOC/PL. These residents have a higher resource limit than residents with Medicaid for the Aged, Blind, or Disabled.

9. **Who should collect the SOC/PL for a resident in a NF receiving Medicaid hospice services?**
    - The hospice provider and NF must coordinate the collection of the SOC/PL. The hospice provider must report the SOC/PL on their room and board claim so that ODM can offset their payment.

10. **Does a claim need to be submitted to ODM if the SOC/PL is greater than the claim total?**
    - Yes - NFs are required to submit claims for all dates of services even if the claim will pay $0.00. This action is important in order for ODM to have a complete accounting of all SOC/PL applied to Medicaid payments for a Medicaid consumer.

11. **How will the SOC/PL changes resulting from COLA updates be communicated?**
    - NOAs are issued to individuals and their Authorized Representatives after the recalculation of SOC/PL resulting from the annual COLA updates.

RULES/REGULATIONS

Relevant Ohio Administrative Code:

- 5160:1-2-08 Medicaid: individual responsibilities
- 5160:1-6-07 Medicaid: post eligibility treatment of income for individuals in medical institutions
- 5160:1-5-03 Medicaid: medicaid buy-in for workers with disabilities (MBIWD)
- 5160:1-6-03 Medicaid: special income rules that may apply when an individual is requesting medicaid payment for long-term care services

- 5160-3-39.1 Nursing facilities (NFs): claim submission
- 5160-3-02 Nursing facilities (NFs): provider agreements
- 5160:1-3-05.8 Medicaid: lump-sum payments
- 5160:1-3-05.6 Medicaid: burial funds and contracts
- 5160:1-6-03.2 Medicaid: use of qualified income trusts (QIT)
- 5160:1-6-03.1 Medicaid: determining financial eligibility for medical assistance using the special income level

Relevant Code of Federal Regulations*:*

- 42 CFR 435.725 Post-eligibility treatment of income of institutionalized residents in SSI states: Application of patient income to the cost of care.
- 42 CFR 483.15(b) Equal access to quality care
- Section PP of the State Operations Manual which specifically addresses permitted charges for pending Medicaid residents (individuals with a submitted application waiting for a Medicaid eligibility determination)

Relevant Section of the Social Security Act for Special Income Level:

- SEC. 1902. [42 U.S.C. 1396a] provides language about individuals being required to have 30 days of continuous institutionalization to be Medicaid eligible under the SIL.

FORMS

- ODM 09401 Facility Communication – for reporting NF admissions, discharges, and deaths. Submit electronically at https://ltcmedicaid.providergateway.com/
- ODM 10203 Report A Change for Medical Assistance