1. How is the patient liability applied between room and board, leave days and Medicare coinsurance that is paid by Medicaid?

For non-QMB eligible Medicaid consumers, the entire amount of patient liability, as determined by the County DJFS for the month in which services are provided, should be reported on the direct bill claim for room and board services. This claim will account for all Medicaid covered days, including leave days. For the month in which services are provided, patient liability shall first be applied to these claims for room and board services and leave days. If applicable, any patient liability not applied can then be applied to Medicare coinsurance that has been paid by Medicaid by submitting adjustments to Medicare crossover claims.

2. Can a nursing facility apply excess patient liability to Medicare coinsurance that is not paid by Medicaid under the new Part A crossover payment logic?

No. According to Ohio Administrative Code 5101:3-1-05, “the department’s payment and Medicare’s payment constitute payment-in-full and no additional payment may be sought from the consumer.” This includes cases where the department’s payment toward crossover claims is determined to be $0. Patient liability, as determined for the Medicaid program, may only be applied to Medicaid payments. Any patient liability not applied must be returned to the consumer or, in the case of death, the consumer’s estate.

3. How/When should patient liability be prorated?

Patient liability is prorated by the County DJFS caseworker, when appropriate, according to Ohio Administrative Code 5101:1-39-24. The provider is responsible for reporting the entire monthly amount of patient liability as determined by the county. No further prorating is required by the provider. ODJFS is working with the counties to insure that patient liability is calculated consistently as required by the rule.

4. Why is the date of discharge counted for prorating when Medicaid does not pay for the date of discharge?

Patient liability must be calculated according to Ohio Administrative Code 5101:1-39-24. Report the entire amount on the claim. This issue is under review by ODJFS. Suggestions for rule changes are always welcome and will be considered for future rule revisions.
5. How does the answer to Question 4 affect the collection of unpaid coinsurance as bad debt from Medicare?

Questions regarding providers’ relationship with Medicare must be addressed to Medicare or the fiscal intermediary. Determination of patient liability for the Medicaid program relates only to Medicaid payments and can only be applied to Medicaid payments.

6. What should be done with patient liability not applied in a month when there are no more Medicaid payments to apply it to?

Any patient liability not applied must be returned to the consumer or, in the case of death, the consumer’s estate.

7. What is the provider’s responsibility regarding SSI recipients who may get to keep their SSI for 90 days?

Nothing has changed regarding SSI recipients. It is the facility's responsibility to report to SSA whenever a SSI recipient is admitted to their facility. SSA determines if the individual will continue to receive their full SSI benefit for the first 90 days in the facility. That determination is based on an expected stay in a long term care facility of 90 days or less. If a short term stay is determined, the first three months of full SSI benefits are excluded as income for the purpose of determining patient liability.

8. How is patient liability determined for waiver consumers that are admitted from, or discharged to, the community?

Patient liability is calculated by the County DJFS caseworker and communicated to the provider. The provider is responsible for reporting the entire monthly amount of patient liability as determined by the county. ODJFS will work with the counties to insure that the calculation is consistent among the counties.