I. Overview of Patient Responsibility for Nursing Facility Services

Patient responsibility is the portion of the enrollee’s income the Department of Children and Families (DCF) determines the recipient must pay to the nursing facility and hospice providers, for nursing facility services. SMMC plan reimbursement of institutional care services must be reduced by the amount of the recipient’s patient responsibility, in compliance with Title 42, Sections 435.622 and 435.725, Code of Federal Regulations. DCF must determine the amount of the enrollee’s patient responsibility prior to payments for nursing facility services, even when the enrollee is receiving Supplemental Security Income (SSI). The exceptions to this requirement are:

1. For the reimbursement of nursing facility Medicare deductibles and co-insurance claims when the enrollee receives SSI or is a Qualified Medicare Beneficiary (QMB); Section 1902(n) of the Social Security Act prohibits QMB recipients from being billed for services covered by Medicare;

2. Managed Medical Assistance plan reimbursement of less than 31 consecutive days of nursing facility services as a downward substitution of inpatient hospital care;

3. Long-term Care plan reimbursement of less than 31 consecutive days of nursing facility services for respite; and

4. For the reimbursement of nursing facility Medicare Part B claims, because patient responsibility is not applicable.

Please note:

- DCF must determine the amount of the enrollee’s patient responsibility prior to payment of Medicare deductibles and co-insurances claims when the individual is not SSI or QMB.
- An enrollee may be QMB and have full Medicaid benefits.
- An enrollee with SSI (MS aid category) and Medicare Part A is automatically considered to be QMB, but the QMB may not always show up as a separate category of eligibility.

II. Patient Responsibility Determinations and Adjustments

DCF must determine the monthly amount of the enrollee’s patient responsibility for nursing facility services, even if DCF determines the amount to be a zero dollar value. DCF will determine the amount of the enrollee’s patient responsibility in accordance with federal post-eligibility provisions which take into account the person’s income that is available to help pay for such care after a reasonable allowance for personal needs and other living expenses, allocation of income to a community spouse or dependents, child support deductions, therapeutic wages, and incurred medical expenses that are not subject to payment by a third party, as applicable.

There are a number of reasons that DCF may adjust the monthly amount of an enrollee’s patient responsibility for nursing facility services. If there is an increase or decrease in an enrollee’s
monthly income, DCF will calculate a proportionate increase or decrease in the amount of the enrollee’s patient responsibility. DCF may also approve an institutionalized enrollee’s request for a reduction in the amount of patient responsibility for an uncovered medical expense (UMED), if the enrollee incurs a medical expense for a medically necessary service that is not covered by Medicaid; refer to Title 42, Section 435.725, Code of Federal Regulations. DCF may approve a reduction in institutional patient responsibility for expenses such as health insurance premiums, deductibles, and coinsurance charges.

General information about UMED is available in the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook. Please contact DCF for information about a specific enrollee’s patient responsibility or UMED request. UMED requests must be submitted to DCF either by emailing SR_CCC_Adult@dcf.state.fl.us or faxing (866) 296-9964.

III. Aid Category Requirements for SMMC Plan Reimbursement of Nursing Facility Services

A) Enrollees Without Hospice

If the enrollee has not elected Hospice, DCF calculates patient responsibility for nursing facility services when DCF determines eligibility for the Medicaid Institutional Care Program (ICP). If DCF has approved the recipient eligible for ICP Medicaid, the enrollee will be approved for one of the following the MI aid category codes: MI A, MI I, MI M, MI P, or MI S. The following chart provides a description of these the MI aid category codes.

<table>
<thead>
<tr>
<th>MI A</th>
<th>Institutional Care Medicaid Supplemental to Medicaid for ‘Low Income Families’</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI I</td>
<td>Stand Alone Institutional Care Medicaid</td>
</tr>
<tr>
<td>MI M</td>
<td>Institutional Care Medicaid Supplemental to MEDS for Aged or Disabled (MMS)</td>
</tr>
<tr>
<td>MI P</td>
<td>Institutional Care Medicaid Supplemental to Protected Medicaid</td>
</tr>
<tr>
<td>MI S</td>
<td>Institutional Care Medicaid Supplemental to SSI Medicaid (MS)</td>
</tr>
</tbody>
</table>

Note: Information about verifying an enrollee’s eligibility is accessible on the Agency for Health Care Administration’s website http://ahca.myflorida.com/SMMC. Select News and Events, and then select Event and Training Materials.

Note: SMMC plans may not reimburse nursing facilities for services provided during any month the recipient has a Medicaid benefit code of MI T. The description of the aid category code MI T is: Institutional Care Medicaid Failed Due to Transfer of Assets. An aid category code MI T means DCF has determined a penalty period of ineligibility due to improper transfer of assets.

B) Enrollees With Hospice

If the enrollee has elected Hospice, DCF calculates patient responsibility for Hospice nursing facility services and approves the aid category code MH H. An enrollee who has elected Hospice will also have patient responsibility when residing in the community. Currently there are not separate aid category codes for each living arrangement. When the enrollee has elected Hospice and resides in the community, DCF calculates patient responsibility and approves the MH H aid category code. DCF calculates the amount of patient responsibility differently for each living arrangement. The DCF Notice of Case Action will specify the amount
of patient responsibility for the enrollee’s living arrangement.

IV. Requirements for Reduction in SMMC Plan Reimbursements for Nursing Facility Services

A) Requirements for SMMC Plan Reimbursement of Nursing Facility Services For Stays Not Covered by Medicare Part A or Hospice Benefits

For the enrollee whose nursing facility stay exceeds 30 days and is not covered by Medicare Part A or Hospice benefits, DCF must determine the enrollee’s monthly amount of patient responsibility and approve the enrollee for one of the MI aid category codes: MI A, MI I, MI M, MI P, or MI S. The SMMC plan must either:

1. deduct the appropriate amount of patient responsibility from its payment to the nursing facility, if the nursing facility collects patient responsibility directly from the enrollee; or

2. pay the nursing facility the full per diem rate, if the SMMC plan collects patient responsibility directly from the enrollee.

B) Requirements for SMMC Plan Reimbursement of Nursing Facility Services For Stays Covered by Hospice Benefits

For enrollees whose nursing facility stay exceeds 30 days and is covered by hospice benefits, DCF must determine the enrollee’s monthly amount of patient responsibility and approve the enrollee for the MH H aid category code. The SMMC plan must either:

1. deduct the appropriate amount of patient responsibility from its payment to the hospice for nursing facility services, if the nursing facility or the hospice collects patient responsibility directly from the enrollee; or

2. pay the hospice the full hospice nursing facility per diem rate, if the SMMC plan collects patient responsibility directly from the enrollee.

C) Requirements for SMMC Plan Reimbursement of Nursing Facility Services For Stays Covered by Medicare Part A When Enrollees Are Not QMB or SSI

Medicare Part A benefits cover up to 100 days of nursing facility for rehabilitative care. There is no Medicare Part A coinsurance during the first 20 days of a nursing facility stay. There is Medicare Part A coinsurance due on days 21 through 100 of a nursing facility stay.

For enrollees whose nursing facility stay is covered by Medicare Part A benefits and who are not also QMB or SSI, DCF must determine the enrollee’s monthly amount of patient responsibility during the Medicare coinsurance days and approve the enrollee for one of the MI aid category codes: MI A, MI I, MI M, MI P, or MI S. The SMMC plan must either:

1. deduct the appropriate amount of patient responsibility from its payment to the nursing facility, if the nursing facility collects patient responsibility directly from the enrollee; or

2. pay the nursing facility the full per diem rate, if the SMMC plan collects patient responsibility directly from the enrollee.
D) Requirements for SMMC Plan Reimbursement of Nursing Facility Services For Stays Covered by Medicare Part A When Enrollees Are QMB or SSI

There is no patient responsibility due during a nursing facility stay that is covered by Medicare Part A benefits for enrollees who are QMB or SSI. For enrollees whose nursing facility stay is covered by Medicare Part A benefits and who are also QMB or SSI, DCF does not have to determine the enrollee’s monthly amount of patient responsibility during the Medicare Part A coinsurance days, and DCF does not have to approve the enrollee for one of the MI aid category codes: MI A, MI I, MI M, MI P, or MI S.

Contact DCF: if you have questions about any of the data displayed in DCF Provider View. You may contact DCF Customer Service by calling 1 (866) 762-2237 or emailing SR_CCC_Adult@DCF.state.fl.us.

Contact HP: if you have questions about accessing DCF Provider View on the Medicaid Web portal. You may contact HP by calling 1 (800) 289-7799.

V. Nursing Facility Patient Responsibility During Month of Admission and Discharge

DCF may determine a zero amount of patient responsibility for the month of admission and discharge from a nursing facility, if the individual’s income for that month is obligated to directly pay for their cost of food or shelter outside of the facility (see Chapter 65A-1.7141(1)(f), Florida Administrative Code).

If a nursing facility claim must be reduced by the amount of the recipient’s patient responsibility, then the nursing facility must be billed with the amount of the recipient’s patient responsibility, even if the amount of patient responsibility is a zero dollar value.

VI. Additional Information About Reimbursement of Nursing Facility and Hospice Services

You may refer to the following handbooks for more information about nursing facility reimbursement policies; Florida Medicaid handbooks are accessible on the Public Provider Web Portal at www.mymedicaid-florida.com:

- Florida Medicaid Provider General Handbook;
- Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook;
- Florida Medicaid Provider Reimbursement Handbook, UB-04; and
- Florida Medicaid Hospice Services Coverage and Limitations Services Handbook.

Contact your local Medicaid area office you have any questions about nursing facility reimbursement policies, please. You may access contact information for your local Medicaid area office on the Public Provider Web Portal at www.mymedicaid-florida.com.

VII. Additional Information About Statewide Medicaid Managed Care (SMMC)

There are many different ways to learn about this new program. The Agency has a special website with questions and answers, training events with a live chat feature to ask questions. The website is at http://ahca.myflorida.com/SMMC. The local Medicaid Area Office can also answer questions about the program.
Frequently Asked Questions

1. Are “patient responsibility” and “share of cost” the same thing?
   
   No. While these terms are often used interchangeably, ‘patient responsibility’ and ‘share of cost’ are not the same.

   - The term ‘patient responsibility’ is used to refer to the amount of the individual’s income that the Department of Children and Families (DCF) determines is the amount the recipient must pay towards the cost of Medicaid long-term care services.

   - The term ‘share of cost’ is used to refer to the amount of medical expenses the individual must incur before DCF can determine the individual eligible for the Medicaid ‘Medically Needy’ program. A recipient must submit the appropriate medical bills to the DCF before DCF can determine the individual has met their ‘share of cost’ and is eligible for the Medicaid ‘Medically Needy’ program. A recipient eligible for the Medicaid ‘Medically Needy’ program cannot be determined eligible for Medicaid nursing facility services.

2. Do Managed Medical Assistance (MMA) and Long-term Care (LTC) plans have to use patient responsibility to reduce payments to nursing facilities when enrollees are being admitted to a nursing facility for a short term stay?

   MMA and LTC plans must reduce payments to nursing facilities by the amount of the enrollee’s patient responsibility with the following exceptions:

   1) for the reimbursement of nursing facility Medicare deductibles and co-insurance claims when the enrollee receives SSI or is a Qualified Medicare Beneficiary (QMB);
   2) Managed Medical Assistance (MMA) plan reimbursement of less than 31 consecutive days of nursing facility services as a downward substitution of inpatient hospital care;
   3) Long-term Care (LTC) plan reimbursement of less than 31 consecutive days of nursing facility services for respite; and
   4) for the reimbursement of nursing facility Medicare Part B claims, because patient responsibility is not applicable.

3. When an enrollee is admitted to a nursing facility, how do we get DCF to determine the amount of the enrollee’s patient responsibility to reduce payments to nursing facilities?

   Within ten working days of the Medicaid recipient’s admission to a nursing facility, DCF must receive a completed DCF #2506A Form (Client Referral/Change). The DCF #2506A Form (Client Referral/Change) and its instructions are accessible on this Medicaid Web site [http://ahca.myflorida.com/Medicaid/nursing_fac/index.shtml](http://ahca.myflorida.com/Medicaid/nursing_fac/index.shtml).

   - When the recipient is enrolled in the LTC program, the LTC plan may delegate submission of the DCF #2506A Form (Client Referral/Change) to the nursing facility. However, the LTC plan must obtain a copy of the completed DCF #2506A Form (Client Referral/Change) submitted by the facility to DCF and retain a copy of that completed form in the plan member’s (enrollee’s) file.

   - When the recipient is not enrolled in the LTC program, the nursing facility submits the DCF #2506A Form (Client Referral/Change) to DCF.
Frequently Asked Questions

4. How is DCF notified when an enrollee is discharged from a nursing facility?
   Within ten working days of the Medicaid enrollee’s discharge from a nursing facility, DCF must receive a completed DCF #2506 Form (Client Discharge/Change Notice) or a DCF #2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)). The DCF #2506 Form (Client Discharge/Change Notice), and the DCF #2515 Form (Certification of Enrollment Status (HCBS)) and its instructions are accessible on this Medicaid Web site http://ahca.myflorida.com/Medicaid/nursing_fac/index.shtml.

- When the recipient is enrolled in the LTC program, the LTC plan must submit to DCF a completed DCF #2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)), within ten working days of the Medicaid recipient’s discharge from a nursing facility. The LTC plan may not delegate submission of the DCF #2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)) to the nursing facility.

- When the recipient is not enrolled in the LTC program, the nursing facility submits the DCF #2506 Form (Client Discharge/Change Notice) to DCF.

5. Where is the amount of the enrollee’s patient responsibility in DCF Provider View?
   The following pages explain how to locate an enrollee’s patient responsibility information using the DCF Provider View option on the provider’s secure Florida Medicaid Web Portal. The provider’s secure Florida Medicaid Web Portal is accessible at http://www.mymedicaid-florida.com/.

Step #1: Select DCF Provider View option on the Florida Medicaid Home screen.
Step #2: Complete the search criteria in the DCF Provider View Screen.

Instructions from the DCF ‘Provider View Guide’ related to the ‘Customer Search’ screen:

Reference Type: select one of the following reference types from the dropdown to search by:
- Case Number
- ACCESS Number
- Social Security Number
- Personal Identification Number (PIN)

Reference Number: once reference type has been selected, enter the reference number that coincides with your reference type. Use one of the following combinations:
- Case Number — when Case Number is selected as the ‘Reference Type’, the user then keys in the ten digit Case Number that is assigned to the individual into the ‘Reference Number’ field.
- ACCESS Number — when ACCESS Number is selected as the ‘Reference Type’, the user then keys in the nine digit ACCESS Number that is assigned to the individual into the ‘Reference Number’ field.
- Social Security Number — when SSN is selected as the ‘Reference Type’, the user then keys in the nine digit SSN Number that is assigned to the individual into the ‘Reference Number’ field.
- Personal Identification Number (PIN) — when PIN is selected as the ‘Reference Type’, the user then keys in the ten digit PIN Number that is assigned to the individual into the ‘Reference Number’ field. This is the Medicaid recipient ID number.

Date of Birth: enter the date of birth of the individual that you are searching for. This is a required entry for all reference types of searches.
Step #3: Select Details for Medical Assistance within the My Benefits section.

Instructions from the DCF ‘Provider View Guide’ related to the ‘Benefit Summary’ screen:

Search Results:
- Case Number: if the individual that is being searched for is on more than one case, a list of the cases will be displayed. Click on the case number desired to view.
- Name: the name of the individual that you requested the search for will display here.
- Last Activity Date: this is the last day any activity was done on this case.
- Case Status: One of the following case statuses will display:
  - Open — the case has been approved for some type of benefit.
  - Closed — the case is no longer open.
  - Pending — an eligibility determination has not been made yet.

Coverage Type — this is the type coverage that the customer is currently receiving:
- Medicaid — Medicaid is a program that provides medical coverage to low income individuals and families.
- Medicare Savings Program — this program entitles eligible individuals to receive payments of Medicare premiums, deductibles, and co-insurance.
- Medically Needy (Share of Cost) — individuals enrolled in the Medically Needy program have income or assets that exceed the limits for regular Medicaid, but need help to pay for large medical expenses. The customer's monthly 'Share of Cost' is based on their family's monthly gross income (before taxes) and is similar to a deductible on a health insurance policy. In certain cases, a customer may not have to pay the Share of Cost amount. Additionally, the customer won't become eligible for Medicaid within a month until the date they have incurred medical expenses that are equal to, or exceed their Share of Cost amount, the customer is eligible for Medicaid the rest of that month.
Step #4: The ‘Benefit Summary’ screen provides detailed information about the customer’s public assistance case including scheduled appointments, verifications needed, the status of benefits, and upcoming renewals. To access information about patient responsibility, select History within the section on Medical Assistance.

Step #5: Locate patient responsibility for the dates of service billed and select ‘Print’.
Instructions from the DCF ‘Provider View Guide’ related to the ‘Individual Medicaid Eligibility History’ screen:

Coverage Begin Date — this is the date that assistance began.

Coverage End Date — this is the date that assistance ended (if applicable).

Status – this displays the state of the assistance:

- Processing — this status is displayed when the case is currently being reviewed for eligibility
- Denied — this status is displayed when the case has been reviewed and did not meet eligibility requirements. Click on information to see why it was denied.
- Closed — this status is displayed when the case is no longer open. Click on information to see why it was closed.
- Open — this status is displayed when the case is currently open and is eligible for benefits.
- Enrolled — this status is displayed when individual has a share of cost that they must meet before they are on Medicaid. Click on information to view the amount of share of cost.
- Verification Needed — before eligibility can be determined they must provide the information that the department requested from them.

Coverage Type — this is the type coverage that the customer is currently receiving:

- Medicaid — Medicaid is a program that provides medical coverage to low income individuals and families.
- Medicare Savings Program — this program entitles eligible individuals to receive payments of Medicare premiums, deductibles, and co-insurance.
- Medically Needy (Share of Cost) — individuals enrolled in the Medically Needy program have income or assets that exceed the limits for regular Medicaid, but need help to pay for large medical expenses. The customer's monthly ‘Share of Cost’ is based on their family's monthly gross income (before taxes) and is similar to a deductible on a health insurance policy. In certain cases, a customer may not have to pay the Share of Cost amount. Additionally, the customer won’t become eligible for Medicaid within a month until the date they have incurred medical expenses that are equal to, or exceed their Share of Cost amount; the customer is eligible for Medicaid the rest of that month

Share of Cost — is the amount that is set based on family's monthly gross income. If not shown, the share of cost is $0. Please be aware that this is an estimated amount and may not reflect bills or expenses submitted to ACCESS Florida that have not been processed.

Patient Responsibility — is the total amount of care individual is responsible for paying provider. If not shown, the patient responsibility is $0. Please be aware that this is an estimated amount and may not reflect bills or expenses submitted to ACCESS Florida that have not been processed.