	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	**2550**	**Effective Date:**	**December 2022**
	Policy Title:	**Patient Liability/Cost Share Overview**		
	Policy Number:	**2551**	**Previous Policy Update:**	**MT 58**

REQUIREMENTS

A patient liability/cost share is determined for certain Medicaid recipients in long-term care (LA-D).

BASIC CONSIDERATIONS

A patient liability/cost share (PL/CS) amount is determined for the following ABD Medicaid recipients:

- a Medicaid recipient in a nursing home whose eligibility is determined under the nursing home or Institutionalized Hospice class of assistance (COA)
- a Medicaid recipient who is receiving Community Care Services Program (CCSP/EDWP) services at home
- a Medicaid recipient who is receiving New Options Waiver or Comprehensive Supports Waiver Program (NOW/COMP) Services at home
- a Medicaid recipient who is receiving Independent Care Waiver Program (ICWP) services at home.

A patient liability/cost share amount is determined at the following times:

- at application
- at each review
- when a change in income occurs
- when a change in incurred medical expenses (IME) occurs
- at the beginning of each new averaging period.

NOTE: The monthly PL/CS for a LA-D individual should never exceed the monthly Medicaid billing rate for the facility.

A CCSP/EDWP A/R who enters a nursing home will have a zero-patient liability for the month of admission to the nursing home. The A/R is responsible for paying their regular CCSP/EDWP cost share for the month of admission to the nursing home.

BASIC CONSIDERATIONS (cont.)

A nursing home A/R who enters CCSP/EDWP will have a zero-cost share for the month of admission to CCSP/EDWP. The nursing home patient liability should be recalculated for the month of discharge using the FBR as the PNA.

When an A/R transfers directly from an out of state nursing home to a nursing home in Georgia, calculate the patient liability for the month of admission using the actual payment made to the out of state nursing home as an IME.

Effective September 1, 2004, LA-D A/Rs whose income exceeds the Medicaid Cap and who have not established a Qualified Income Trust (QIT) may have eligibility determined as AMN (S99), but no vendor payment will be made to the LA-D provider on their behalf.

PROCEDURES

Follow the steps below to complete the patient liability/cost share determination process:

Step 1 Determine the average income and IME to use in the patient liability budget(s). Refer to Section 2557, Averaging Income and IME, Section 2558, Significant Change in Income or IME, and Section 2418, VA Income, for treatment of VA income.

Step 2 Complete a patient liability budget(s). Refer to Section 2559, Patient Liability/Cost Share Budgeting, for information on completion of the patient liability budget.

SPECIAL CONSIDERATIONS

Effective Month of Change in Patient Liability

If the A/R or PR reports a change that causes a decrease in patient liability, make the change in patient liability effective no earlier than the month the change is reported. Include the change in the reconciliation process if income and IME are being averaged. Refer to Section 2557, Averaging Income and Incurred Medical Expenses.

If a decrease in patient liability is not issued in a timely manner, the decrease may be handled by making the appropriate system changes to correct the patient liability amount(s) for the month of change and ongoing.

Refer to Section 2557, Averaging Income and Incurred Medical Expenses and Section 2558, Significant Change in Income or IME, for instructions on how to handle a reported change that causes an increase in patient liability.