Virginia Department of Medical Assistance Services
Patient Pay
Fact Sheet 2015

Determining the Amount of Patient Pay

Patient Pay is defined as the amount of a member's income that must be paid toward the cost of his or her Medicaid Long-term Care (LTC) Services.

All members must have a patient pay calculated, but not all members have a contribution to pay to the LTC provider. Whether an amount is due to be paid depends upon the type and amount of a member's income and allowable deductions.

The local Departments of Social Services (LDSS) are responsible for determining the amount of the patient pay contribution, if any, the member must make.

Nursing Facility members may have a maximum of $40.00 per month deducted for their basic allowance each month. Members whose only source of income is Supplemental Security Income will only receive $30.00 per month from the Social Security Administration.

Home and Community Based Services members may have a maximum of $1,209 per month deducted from their income for their basic allowance each month.

Adjustments to the amount of patient pay may only be completed prospectively by the LDSS. For adjustments involving non-covered medical expenses, the deduction may only be made after delivery of the service for which the deduction was requested.

Adjustments for non-covered medical expenses that exceed the amount of the member's contribution continue to be deducted until the bill amount has been exhausted.

If the total amount of a medical service or durable medical equipment exceeds $500, the adjustment must be approved by DMAS prior to the service being rendered. However, in no case may the adjustment be allowed prior to the member receiving the services or equipment for which the request was submitted. After a request is approved if a change is required, a new request must be submitted for authorization. The amounts of these adjustments are limited to the Medicare rate if available or the Medicaid rate if no rate was established by Medicare for that particular service or item.

The cost of a health or dental insurance premium may only be deducted after the member has paid the premium amount.

All requests for deduction whether evaluated by the LDSS or DMAS must meet Medicaid policy requirements in order for the deduction to be allowed.

Patient Pay is paid directly to the provider of LTC Services by the member or their representative.

Patient Pay Communication

The DMAS-225 is the approved communication form between LTC providers and the LDSS. This form is only used to communicate initial eligibility, change in eligibility status, penalty period information and changes in insurance. Prompt submission of this form is necessary to insure that patient pay will be revised timely. This form is not used for communicating the amount of patient pay.

The Notice of Obligation of LTC Costs is utilized by the local Departments of Social Services (LDSS) to advise the member/their representative of the amount of the member's patient pay.

Providers must use the ARS or Medicall real-time systems to obtain verification of patient pay amounts. Institutional LTC providers may also use the ASO-317 report in addition to the real-time verification sources.

Patient Pay and Claim Payments

Effective October 1, 2015, DMAS determines the allowed amount for each LTC claim and deducts any copays, third party payments and patient pay to determine the amount paid on the claim. DMAS will automatically enter the patient pay on the claims from its records submitted by the LDSS. If there are multiple claims from LTC providers (the same provider or multiple providers), DMAS will track the amount of patient pay allocated to each claim on a first adjudicated basis. Patient pay will not be deducted for members with authorizations for consumer directed services. The Fiscal Employer Agent for consumer directed services, Public Partnerships LLC, will deduct the patient pay from any payments made for consumer-directed services.

This will apply to all LTC services except for services furnished to individuals in the Intellectual Disability waiver, the Individual and Family Developmental Disabilities Support waiver and the Day Support waiver. For these waivers, it continues to be the responsibility of the case manager or support coordinator to assign a provider to collect patient pay. These providers continue to submit patient pay on the claims. DMAS may audit these claims for the correct patient pay amounts.

Patient Pay and Commonwealth Coordinated Care (CCC) Program

Capitation payments to Medicare-Medicaid Plans (MMPs) do not include patient pay amounts. Please direct any questions to the MMPs about how they handle patient pay in claim payments.

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