THE STATE of ALASKA
GOVERNOR BILL WALKER

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How to Report Cost of Care for Medicaid Waiver Beneficiaries Residing in Assisted Living Homes

This document will explain cost of care and how to properly report cost of care on a CMS-1500 claim form.

What is Cost of Care?

Cost of care is the amount of money the recipient may be responsible to pay to reduce the Medicaid services payment, if their income exceeds applicable disregards and allowances as defined in the Alaska Administrative Code.

Once a recipient is found to be eligible for a Medicaid waiver, the Division of Public Assistance will determine if the recipient is required to pay a cost of care amount (COCA). COCA is also commonly referred to as cost of care liability.

How is COCA determined?

In accordance with 7 AAC 100.554, a recipient's cost of care liability in any given month is the recipient's total monthly income, less the applicable disregards and allowances in 7 AAC 100.554(b) and (c), not to exceed the actual cost of long-term care services paid by the Department of Health and Social Services (Department) on behalf of the recipient.

Who collects COCA?

Per 7 AAC 100.552(b) and (c), a Medicaid provider who renders home and community-based services to a recipient who is eligible under 7 AAC 100.002(d)(4) or (8) must reduce its claim to the Department by the amount the provider actually receives from the recipient as payment toward the recipient's cost of care liability. A recipient with a cost of care liability who does not pay the Medicaid provider is liable to that medical institution or home and community-based waiver services provider for the unpaid amount.

Per 7 AAC 145.520(n), once the Department has determined the recipient's monthly liability under 7 AAC 100.550 - 7 AAC 100.579, the recipient shall pay that liability toward the cost of care for home and community-based waiver services. If a recipient is receiving residential supported living services under 7 AAC 130.255, the recipient shall pay the liability first to the recipient's residential supported-living services provider, and second to other home and community-based waiver services providers if any monthly liability remains.

Including COCA on the CMS-1500 claim form

Home and Community-Based Waiver claims are billed on a CMS-1500 claim form. *See figure I below.*

When billing, the provider must reduce their claims to the Department by the amount the provider received from the recipient as payment towards the recipient's cost of care liability.

CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

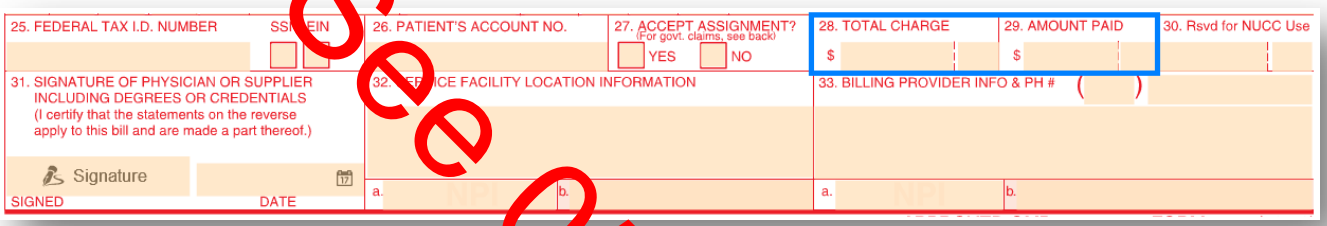
APPROVED OMB-0938-1197 FORM 1500 (02-12)

After entering all necessary information into the claim fields, follow the steps below to enter the cost of care information:

1. In field 28. Total Charge: enter the total amount of Medicaid services being billed.
2. In field 29. Amount Paid: enter the total amount of the cost of care.

See figure II below.

II. CMS-1500 Claim Form Detail



Additional Resources and Training

You can review the most current Home and Community-Based Waiver Rates and Cost Survey Information at: http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx

You may visit the Division of Senior and Disabilities Services website at: http://dhss.alaska.gov/dsds/Pages/default.aspx