



## How to properly report Cost of Care for Medicaid Waiver beneficiaries residing in Assisted Living Homes

This document will explain cost of care and how to properly bill 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 regulation.

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

### 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 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 1 below.*

When billing, the provider must reduce their claims to the Department of Health and Social Services (department) by the amount the provider received from the recipient as payment towards the recipient's cost of care liability.

I. CMS – 1500 Claim Form

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PICA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (DNDiD) (Member ID) (ID#) (ID#) (ID#)</small>		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 <input type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)  7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	
9. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR PICA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (IMP) FROM MM DD YY TO MM DD YY QUAL.		15. OTHER DATE QUAL. MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NP		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-C to service line below (IME)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____		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. DROB OR UNITS H. ICD-9-CM ICD-10 ICD-9-CM ICD-10 J. RENDERING PROVIDER ID #	
25. FEDERAL TAX I.D. NUMBER SBN EIN <input type="checkbox"/> <input type="checkbox"/>		26. TOTAL CHARGE \$	
27. PATIENT'S ACCOUNT NO.		28. AMOUNT PAID \$	
28. ACCEPT ASSIGNMENT? (For bill, attach 28-100) <input type="checkbox"/> YES <input type="checkbox"/> NO		29. Billing Provider Info & PH # ( )	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.)		31. SERVICE FACILITY LOCATION INFORMATION	
SIGNED DATE		32. BILLING PROVIDER INFO & PH # ( )	
a. NPI b.		a. NPI b.	

NUCC Instruction Manual available at: [www.nucc.org](http://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

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$	
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.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
Signature		a.		a.		
DATE		b.		b.		

## 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>