

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF SENIOR AND DISABILITIES SERVICES

SARAH PALIN, GOVERNOR

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June 10, 2008

Dear Residential Supported Living Provider and Care Coordinators,

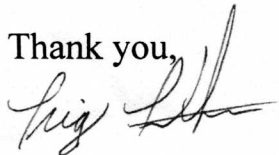
The Quality Assurance unit of Senior and Disabilities Services has been working on a project to improve understanding regarding the Medicaid Cost of Care. The Cost of Care is a recipient obligation determined by Division of Public Assistance. It is communicated through a written notice to a Medicaid recipient. It applies when a person in a nursing home or on a Medicaid Waiver. It is referred to as the "Cost of Care" and defines what amount of Medicaid cost of waiver services the person is responsible to pay. It applies only to the people notified by Division of Public Assistance.

When living in an assisted living home and receiving residential supported living services from Medicaid Waiver, the recipient's Cost of Care payment should go to the assisted living home provider. The provider must then reduce the cost billed to Medicaid by the amount of the Cost of Care.

Enclosed is a pamphlet entitled "Cost of Care." The purpose of this pamphlet is to 1) define and clarify how cost of care affects Residential Supported Living providers, and 2) explain the correct reporting procedure for the cost of care resident.

Please review the pamphlet and contact Trig Fredrickson at 269-5026 with any questions.

Thank you,



Trig Fredrickson
Medical Assistance Administrator

cc: Provider File

Helpful hints

If you receive funds from a resident that exceed the room and board; call to verify if these funds are reportable cost of care.

If you are not sure if your resident has a cost of care you may call the eligibility worker at the long term care waivers unit 269-8950.

**Senior Disability Services
Quality Assurance**



State of Alaska

Dept. of Health & Social Service Senior Disability Services

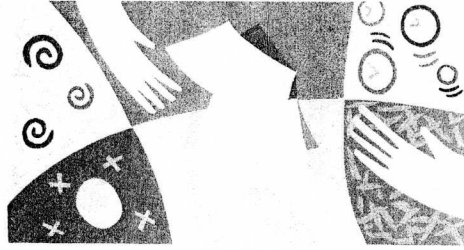
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Cost of Care

State of Alaska



Senior Disability Services QA

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What is Cost of Care

Cost of care is the amount of money the client is responsible to pay to reduce the Medicaid services payment.

Once a client is found to be eligible for Medicaid waivers the eligibility technician then calculate if the client is required to pay cost of care.

How is cost of care determined:

All Medicaid waiver recipients who have a gross income minus eligible deductions greater than the income need standard for their living arrangement will have a cost of care.

Example:

Mr. X is a 70 year old Home and Community base (HCB) waiver recipient on and OA waiver. Mr. X has a monthly income of \$1450.00. The Personal Needs Allowance for a HCB client in an

assisted living home is \$1396.00.

Mr. X has no deductions so his cost of care is determined as follows:

$\$1450.00 - \$1396.00 = \$54.00$

Therefore \$54.00 is designated for cost of care.

Resident has cost of care now what:

Trustees are instructed by the eligibility technician to write two separate checks to the Assisted Living Home provider. One check for room and board another check for cost of care. The amount of the check received for cost of care is to be entered in line 29 of the Health insurance claim form 1500.

Example: In line 28 enter the total amount of Medicaid services being billed for this billing cycle. In line 29 enter the total amount of cost of care paid by resident or trustee. Line 30 will show the amount to be paid by first health. Line 29 and 30 will equal line 28.

Who collects cost of care:

Medicaid regulation 7 AAC 43.1058 (j) reads: If a recipient is receiving residential supported living services (Assisted Living Home) the recipient shall pay the liability first to the recipient's residential supported living service provider and second to other home and community-based service providers if any monthly obligation remains.

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