

OMB # 0935-0099
EXPIRES: 09/30/97

SP ID #: _____

PSF ID #: _____

SP NAME: _____

INTERVIEWER NAME: _____

INTERVIEWER ID: _____

DATE OF INTERVIEW: ____/____/____
MONTH DAY YEAR

TIME INTERVIEW BEGAN: _____ am/pm

Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research
and
National Center for Health Statistics

MEDICAL EXPENDITURE PANEL SURVEY

NATIONAL NURSING HOME EXPENDITURE SURVEY

EXPENDITURES

Version 2.3

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1.0 General Structure of Expenditure Instrument

The overall objective of the Expenditures instrument across Rounds 2 and 3 is to collect billing and payment data for all SPs during 1996 for the period of time they were a resident in an eligible LTC part of the facility. In both rounds, insurance missing data is also administered in EX for those SPs who had missing data items in IN or in HA for Medicaid and Medicare, or who had Medicaid pending from the previous round. In Round 3, questions about income from Social Security and pensions and home ownership are asked for all SPs who have expenditure data collected from the facilities in which they were sampled.

Expenditure data are collected in billing period order. The interviewer and the respondent are given the option of collecting all billing data for all billing periods before collecting all payment data for all periods in the reference period or collecting billing data and then payment data for each billing period in the reference period.

1.1 Overview Round 2

Round 2 covers three SP types: CRs continuing in their original SFs, F2s receiving their first SF interview, and CRs receiving their first interviews in another facility, that is a facility other than the one from which they were sampled. (The "transfer" facility could be another SF or an entirely new facility). SPs in this latter category are considered Transfer SPs. For all SP types, Round 2 is the first round that expenditures data are collected. In Round 2, New Facilities (NF) receive the Facility Questionnaire to determine eligibility; eligible Round 2 NFs continue with full data collection as appropriate for the SP; while in ineligible Round 2 NFs, we administer only the RH (i.e., there is no expenditure module).

Expenditures is always administered in eligible facilities for the period of time the SP resided in an eligible LTC part of the facility. When EX is administered for the first SP in the facility, EX5 and EX6 are administered. These questions set up the end date for which the facility has complete billing records, usually the last full month preceding the Round 2 month of interview, and the length of the facility's billing period for all SPs in the facility. In addition, each EX respondent is given the option of collecting all billing data for all billing periods before collecting all payment data for all periods in the reference period or collecting billing data and then payment data for each billing period in the reference period.

For CRs continuing in the facility from which they were sampled, EX is administered in Round 2 from 1/1/96 until the date the facility has complete billing records, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and there is any missing IN data from Round 1, then the INMD questions are administered. All CRs are administered questions about the sources of payment for their care at their Key Admit Date (KAD).

For F2s in the SFs in which they were sampled, EX is administered from their SAD until the date the facility has complete billing records, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and there is any missing IN data from Round 2, then the INMD questions are administered. All F2s are administered questions about the sources of payment for their care at their Key Admit Date (KAD) if their KAD is before their Sampled Admit Date (SAD).

For CRs who had transferred to another eligible facility (according to the Round 1 RH data), EX is administered from the CRs date of admission into an eligible LTC part of the transfer facility until the date the facility has complete billing records, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If there is any missing IN data from Round 1, then the INMD questions are administered.

1.2 Overview of Round 3

Round 3 covers the full range of facility and SP types. For continuing new facilities in Round 3, eligibility was determined in Round 2. All Round 3 NFs receive the FQ to determine eligibility; for eligible Round 3 NFs, full data collection occurs as appropriate for the SP, while for ineligible Round 3 NFs, only RH is administered. Round 3 NFs include those facilities identified for the first time in either Round 2 or Round 3.

As in Round 2, Expenditures in Round 3 is always administered in eligible facilities for the period of time the SP resided in an eligible LTC part of the facility. For continuing SFs and continuing NFs, EX data collection begins by setting up the facility-level data items, and informing the EX respondent that 12/31/96 is the latest date that expenditure data will be collected for the sampled residents. The length of the billing period is automatically set to the same length that it was in

Round 2, i.e., monthly, biweekly, weekly, or quarterly. The respondent and the interviewer are again given the option of selecting the order in which billing and payment data are collected.

For SPs in continuing facilities in Round 3, the EX data collection at the SP-level begins by reviewing any outstanding ancillary charges or payments for basic care or ancillaries for any billing periods that were asked about in Round 2. If there are no outstanding ancillary charges or payment data needing retrieval from Round 2, the EX data collection for the SP begins by asking about charges and payments for basic and ancillary services for the first billing period after the date the facility reported having complete billing records in Round 2.

If there are any outstanding ancillary charges from Round 2 for an SP, those charges are collected for the first billing period expenditure data retrieval is needed. If the interviewer has opted to collect all billing data before payment data in Round 3, then billing data are collected in billing period order for all periods needing ancillary charges retrieved for Round 2 and then all billing data for Round 3 are collected. After all of the billing data is collected, then all payment data is collected, beginning with the first billing period with outstanding payment data from Round 2 and proceeding through the last billing period identified for Round 3. Table 1 below provides an example of the expenditure data collection for this type of scenario.

Table 1, Collect All Billing, Then Collect All Payments

Date of Round 2 Interview: September 9, 1996

C=Completed in Round 2

X=Start of Round 3 Data Collection

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Billing												
Basic Care	C	C	C	C	C	C	C	C	↗	↘	↗	↘
Ancillaries	C	C	C	C	C	C	C	X	↘	↗	↘	↗
Payments												
Basic Care	C	C	C	C	C	C	C	X	↗	↘	↗	↘
Ancillaries	C	C	C	C	C	C	C	↘	↗	↘	↗	↘

If the interviewer opted to collect billing data then payment data for each billing period, then charge and payment data are collected in billing period order for all Round 2 periods needing retrieval before any Round 3 charges and payments are collected. Table 2 below provides an example of the expenditure data collection for this type of scenario.

Table 2, Collect Billing Then Payments for Each Period

Date of Round 2 Interview: September 9, 1996

C=Completed in Round 2

X=Start of Round 3 Data Collection

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Billing												
Basic Care	C	C	C	C	C	C	C	C	↗	↘	↗	↘
Ancillaries	C	C	C	C	C	C	C	X	↘	↗	↘	↗
Payments												
Basic Care	C	C	C	C	C	C	C	↘	↗	↘	↗	↘
Ancillaries	C	C	C	C	C	C	C	↘	↗	↘	↗	↘

New facilities identified for the first time in Round 3 follow the same path through the EX instrument as SFs and NFs followed in Round 2.

For **CRs continuing in the facility in which they were sampled**, EX is administered in Round 3 starting with expenditure data retrieval from Round 2 (if there are any), followed by billing and payment data for any periods the SP was in an eligible LTC part of the facility since the date the facility had complete billing records in Round 2 until 12/31/96, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and Medicaid was pending in Round 2 then the INMD question about Medicaid is asked. For all CRs eligible for EX data collection in Round 3, questions about income from Social Security and pensions and home ownership are administered.

For **F2s in the SFs in which they were sampled**, EX is administered in Round 3 starting with expenditure data retrieval from Round 2 (if there are any), followed by billing and payment data for any periods the SP was in an eligible LTC part of the facility since the date the facility had complete billing records in Round 2 until 12/31/96, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and there is any missing IN data from Round 2, then the INMD questions are administered. For all F2s eligible for EX data collection in Round 3, questions about income from Social Security and pensions and home ownership are administered.

For **F3s sampled in this facility**, EX is administered from their SAD until the 12/31/96, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and there is any missing IN data, then the INMD questions are administered. For all F3s, questions about income from Social Security, pensions, and home ownership are administered.

For **CRs who are continuing residents of an eligible LTC part of a transfer facility**, EX is administered in Round 3 starting with expenditure data retrieval from Round 2 (if there are any), followed by billing and payment data for any periods the SP was in an eligible LTC part of the facility since the date the facility had complete billing records in Round 2 until 12/31/96, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If the EX respondent is different from the IN respondent and Medicaid was pending in Round 2, then the INMD questions are administered.

For **F2s and F3s who are transfers to a new facility eligible facility** (according to the Round 2 or Round 3 RH data), EX is administered for the F2s and F3s from the date of admission into an eligible LTC part of the facility until 12/31/96, the date of death, or the most recent date of discharge from an eligible LTC part of the facility, whichever date is the earliest. If there is any missing IN data, then the INMD questions are administered.

OVERALL PROGRAMMING SPECIFICATIONS FOR FACILITY EXPENDITURES QUESTIONNAIRE

A. Format

1. There are three potential elements to any question: instructions before the question, the question itself (including answer categories), and instructions following the question. The first two are identified by the question number, and the last one is specified by "Programmer Specifications."

2. In addition to questions, there are also double-lined boxes (labelled BOX EX1, BOX EX2, etc.) that contain instructions which do not include a question.

B. Flow

1. If no flow instructions are specified, default to the next question box.

2. Flow may be specified in one of two ways. Simple flow -- which depends only on the question currently being asked -- may be expressed in parentheses after the question categories. Anything more than simple flow (including flow instructions that involve missing data such as DK or RF, or that involve answers to previous questions) is expressed in the double-lined boxes, as described above.

C. Displays

1. Gender. We know the gender of the SP, either from sampling or from question RH6 in Residence History. If the gender is male, display "he" wherever a "{she/he}" is encountered; if female, display "she"; otherwise, display "he or she". Follow the same rules for "{her/him}" and "{her/his}". If SP gender is male, display "husband" wherever a "{wife/husband/spouse}" is encountered; if gender is female, display "wife"; otherwise, display "spouse".

2. Tense. We know whether the SP is alive or deceased, either from sampling or from question RH6 in Residence History. If the SP is alive, use the present tense; otherwise, use the past tense. Relevant word choices include "{is/was}", "{Is/Was}", "{lives/lived}", and "{today/Date of Death}".

3. Facility/READ FACILITY/UNITS LISTED ABOVE]. There are no place headers in Residence History. All other SP-level sections feature a header that includes the eligible LTC places in this facility (i.e., places with NNHES status = eligible) where the SP resided during the reference period. The only exceptions are screens that include the Place Roster; these screens have no places in the header.

For screens that don't include the Place Roster in HS, PM, BQ, IN, IA, USE, EX, and CRR, the eligible unit where the SP lived during the reference period is displayed right-justified on the second line of the screen. If the SP lived in two or three eligible units during the reference period, they are right-justified on the third and fourth lines. If the SP lived in more than three eligible units, the fourth line reads: "MORE UNITS - USE F2" and is right-justified.

4. Dates. If "MO" (month) is missing, display just "YR" (year). Otherwise, display "MO" "YR".

5. DK/RF. Unless otherwise specified, do not display DK and RF.

6. Reference Start Date for Billing Periods (EX2, EX4, EX7PRE)

Set the Round 2 REFERENCE START DATE to "January 1, 1996" for CRs, {SAD} for F2s, and {THE FIRST REPORTED DATE THE SP RESIDED IN AN ELIGIBLE LTC PART OF THE FACILITY ON OR AFTER {TAD}} for TRs.

Set the Round 3 REFERENCE START DATE to either the {FIRST REPORTED DATE THE SP RESIDED IN AN ELIGIBLE LTC PART OF THE FACILITY AFTER THE DATE THROUGH WHICH THE FACILITY REPORTED COMPLETE BILLING RECORDS IN ROUND 2 (EX5 in Round 2)} or the {RD2 EX END REF DATE +1} for CRs, F2s, and TRs in continuing facilities; {SAD} for F3s; and {THE FIRST REPORTED DATE THE SP RESIDED IN AN ELIGIBLE LTC PART OF THE FACILITY ON OR AFTER {TAD}} for TRs in new facilities identified in Round 2 or Round 3.

7. Reference End Date for Billing Periods.

If the SP is alive and in the SF/eligible unit on the date of interview, set the REFERENCE END DATE to the date through which the facility has complete billing records {EX5} or "December 31, 1996", whichever is earliest; else

If the SP has been discharged alive from the SF/eligible unit, display {{EX5}/{MOST RECENT DATE OF DISCHARGE}/December 31, 1996}, whichever is earliest; else

If the SP is deceased, and date of death is on or before the Round 2 date of interview, display {{EX5}/{DATE OF DEATH}/December 31, 1996} whichever is earliest; else

If the SP is deceased, and date of death is after the Round 2 date of interview, display {{EX5}/{DATE OF DEATH}/December 31, 1996}, whichever is earliest.

8. Round 3 EX Retrieval

If any Round 2 billing periods need retrieval in Round 3, a flag (EXRETRV=1) is set at the SP-level in rollover to indicate that data retrieval is needed for the SP. The first billing period needing data retrieval sets the starting reference date for EX, which is displayed at the NAVIGATE screen.

Specific skips for the order for collecting Round 2 billing periods needing data retrieval in Round 3 are specified in BOX EX1, BOX EX7A, BOX EX7B, and BOX EX19.

9. Medicaid Display.

In IN1 and IN6, display {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} by matching the state of the facility's address with a state in the table of State Medicaid Names included in the Round 1 Facility Questionnaire specifications.

10. Date of Interview in Round 2.

In EX17, EX20, and EX28, display the dates of interview that EX was administered for each SP.

MGMT SYSTEM SPEC. for all of EXPENDITURES:

1. Unless otherwise specified, allow DK and RF.
2. The following questions, which reference specified billing periods, should display the following header, centered:

{BP START EX8} - {BP END EX8}

EX10, EX10a, EX11, EX13, EX16, EX17, EX18, EX20, EX20a, EX20b, EX21b, EX22, EX23, EX24, EX25, EX26, EX28, EX28a, EX28b, EX31, EX32, EX33.

IN MISSING DATA MODULE

BOX INMD1	<p>IN missing data is defined as: IN1 = 2 (PENDING) in the preceding round from either Health Insurance or Expenditures; or IN1 = -8 or -7 and HA47 = -8, -7 or -5; or IN6 = -8 or -7; or IN12 = -8 or -7 and (HA44A = -8 or -7 or HA44B = -8 or -7); or IN13 = -8 or -7; or IN14A = -8 or -7 and (HA44A = -8 or -7, or HA44B = -8 or -7); or IN15 = -8 or -7, and (HA44A = -8 or -7 or HA44B = -8 or -7).</p> <p>If the EX respondent is the same as the IN respondent, go to BOX FEX1; else</p> <p>If this is RD2 and the SP is a CR and there is any IN missing data, including IN1 = 2 from RD1 Health Insurance, go to INMD1PRE; else</p> <p>If this is RD3 and the SP is a CR and IN1 = 2 from the RD2 IN Missing Data module in EX go to INMD1PRE; else</p> <p>If this is RD2 and the SP is an FA2 and IN has been completed before EX and there is any IN missing data in RD2, go to INMD1PRE; else</p> <p>If this is RD3 and the SP is an F2 and the IN Missing Data module in EX was not invoked for this SP in RD2 and there is any IN missing data from Health Insurance (RD2), go to INMD1PRE; else</p> <p>If this is RD3 and the SP is an F2 and IN1 = 2 from RD2 in either Health Insurance or IN Missing Data in EX, go to INMD1PRE; else</p> <p>If this is RD3 and the SP is an FA2 and there is any IN missing data from RD2 Health Insurance or IN1 = 2 from either RD2 Health Insurance or IN Missing Data module in EX, go to INMD1PRE; else</p> <p>If this is RD3 and the SP is an FA3 and IN has been completed before EX and there is any IN missing data in RD3, go to INMD1PRE; else</p> <p>Go to BOX FEX1.</p>
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INMD1PRE

If the EX respondent has never been the IN respondent and this is the first time through IN missing data and this respondent has never been through EX23A, display "In asking this information...Health Service Act (42 U.S.C. 299a-1(c))"; else do not display.

INMD1PRE

I'd like to begin by asking about {SP}'s health insurance. {In asking this information, I may need to collect Medicare and/or {"PREFERRED" NAME FOR MEDICAID} {or "ALLOWED FOR" NAME FOR MEDICAID)} ID numbers. This information is voluntary and is collected under the authority of Title IX, Section 902(a) of the Public Health Service Act (42 U.S.C.299a). There will be no effect on {SP}'s benefits and no information will be given to any government or nongovernment agency other than the sponsoring agencies. We need this information to supplement data we will gather about {her/his} insurance coverage, particularly under Medicare and {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} and to determine {her/his} vital status after 1996. Information will be used for research purposes only; it will be held in the strictest confidence and will not be released to anyone without written consent in accordance with Sections 903(c) and 308(d) of the Public Health Service Act (42 U.S.C. 299a-1(c) and 242m(d)).}

PRESS ENTER TO CONTINUE.

BOX INMD2	<p>If IN1 = 2 (PENDING) in the preceding round from either Health Insurance or Expenditures IN missing data module, or</p> <p>If in IN, IN1 = -8 or -7 and HA47 = -8, -7, or -5, go to IN1; else</p> <p>Go to BOX INMD3.</p>
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IN1
Medicaid Display.

IN1
Has {SP} ever been covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)}?
ENTER SHIFT/5 IF RESPONDENT NEVER WILL KNOW.
YES 1 (IN6)
NO 0 (BOX INMD4)
PENDING 2 (BOX INMD4)
RF -7 (BOX INMD4)
DK -8 (BOX INMD4)

PROGRAMMER SPECS:
Disallow DK.
If pending and this is Round 2, flag this item for Round 3 retrieval.

BOX INMD3	If in IN, IN6 = -8 or -7, go to IN6; else Go to BOX INMD4.
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IN6
Medicaid Display.
If SP is CR, display "on January 1, 1996"; else
If KAD is known, display {KAD}: If facility has no special care or affiliated units, display {FACILITY}; else display {KAD UNIT}; else
If KAD is unknown, display {SAD}: If facility has no special care or affiliated units, display {FACILITY}; else display {SAD UNIT}.

IN6
Was {SP} covered by {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} {on January 1, 1996/when {she/he} was admitted to {FACILITY/KAD UNIT/SAD UNIT} on {KAD/SAD}}?
ENTER SHIFT/5 IF RESPONDENT NEVER WILL KNOW.
YES 1
NO 0
RF -7

PROGRAMMER SPECS:
Disallow DK.

BOX INMD4	If in IN, IN12 = -8 or -7 and (HA44A = -8 or -7 OR HA44B = -8 or -7), go to IN12; else If in IN, IN13 = -8 or -7, go to IN13; else go to BOX INMD5.
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IN12-13

SAMPLE LAYOUT

If SP is CR, display "January 1, 1996; else display {KAD}.

Display "Medicare Part A" or "Medicare Part B" for "VARIABLE TEXT".

IN12-13	
Was {SP} covered by {VARIABLE TEXT} of Medicare on {January 1, 1996/{KAD}}?	
ENTER SHIFT/5 IF RESPONDENT NEVER WILL KNOW.	
IN12	YES = 1, NO = 0
Part A?	()
IN13	
Part B?	()
PRESS F1 FOR {VARIABLE TEXT} DEFINITION.	

PROGRAMMER SPECS:

Disallow DK.

BOX INMD5	If in INMD and both IN12 and IN13 = 0, go to BOX FEX1; else If in IN (IN14a = -8 or -7 or IN15 = -8 or -7) and IN12 or IN13 = 1 or -8 go to IN14; else Go to BOX FEX1.
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IN14	
Do you have a document that shows {SP}'s Medicare ID number?	
YES	1
NO	0

BOX FEX1	<p>If this is the first round that EX is administered in this facility, go to EX1PRE; Else if this is the second round that EX is administered in this facility: If FEX2 has not been asked in this facility in this round for this respondent, go to FEX1PRE; Else go to BOX FEX2.</p>
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FEX1PRE

The next series of questions ask about expenditures for room and board and ancillary charges for residents. We will need complete billing records for services provided to residents through December 31, 1996.

PRESS ENTER TO CONTINUE.

PROGRAMMER SPECS:

Set the Round 3 date the facility has complete billing records (EX5) to 12/31/96.

Set the Round 3 billing period length to the Round 2 billing period length (EX6).

BOX FEX2	<p>If this is the first SP in this round and this is the first respondent for this SP, go to FEX2; Else if this is not the first SP in this round and this is the first respondent for this SP and this is the first time this round the respondent has been asked EX, for any SP, go to FEX2; Else, go to EX1PRE.</p>
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FEX2

DO YOU WANT TO...

()

1. COLLECT BILLING INFORMATION FOR ALL BILLING PERIODS, BEFORE COLLECTING ANY PAYMENT INFORMATION?

OR

2. COLLECT BILLING AND THEN PAYMENT INFORMATION FOR A BILLING PERIOD, THEN BILLING AND PAYMENT INFORMATION IN SEQUENCE FOR ALL REMAINING BILLING PERIODS?

A. CHARGES AND SOURCE OF PAYMENT MODULE

EX1PRE

Display "The first few... on KAD" if SP is a CR, sampled in this facility, and this is Round 2 or if the SP is an FA, sampled in this Facility and KAD < SAD and this is the first time expenditures are being collected for this SP; else do not display.
 If Round = 2, display "this year, 1996."
 If Round = 3, display "during 1996."

EX1PRE

This series of questions asks about {SP}'s expenditures for room and board and ancillary charges while a resident of {FACILITY/[READ FACILITY/UNITS ABOVE]} {this year, 1996./during 1996.}

{The first few questions are about billing and sources of payment when {s/he} first became a resident here on {KAD}}.

PRESS ENTER TO CONTINUE.

BOX EX0	If SP is a CR sampled in this facility or an F2 or F3 sampled in this facility whose KAD < SAD and this is the first time expenditures are being collected for this SP, go to KEX1; else Go to BOX EX1.
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BOX EX1	<ol style="list-style-type: none"> 1. If this is Round 3 and Round 2 data are missing for any of the Round 2 billing periods for this SP in this facility (EXRETRV=1), go to step 2 and follow the steps starting with the first Round 2 billing period needing retrieval; else go to step 4. 2. If EX16 (have <u>ancillary</u> charges been posted for SP) = NO (0) or DK (-8) in Round 2, go to EX15PRE; else go to step 3. 3. If EX17 (any <u>ancillary</u> charges for SP) = DK (-8) in Round 2, go to EX15PRE; else go to step 4. 4. If FEX2 = 1 (COLLECT ALL BILLING FIRST) and if SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected, go to EX2; else, go to step 5. 5. If EX20 (receipt of expected payments for basic care) = NO (0) in Round 2, go to EX20; else go to step 6. 6. If EX28 (receipt of expected payments for ancillaries) = NO (0) in Round 2, go to EX28; else go to step 7. 7. If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected, go to EX2; else, go to EXEND.
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KEX1

Display name of facility or unit in which the SP resided on KAD for fill for {FACILITY/[READ FACILITY/UNITS ABOVE]}.

KEX1

When {SP} was first admitted to {FACILITY/[READ FACILITY/UNITS ABOVE]} on {KAD}, what were all of the sources of payment for {her/his} room and board and basic care?

SELECT ALL THAT APPLY.

NO CHARGES
MEDICAID
PRIVATE PAY
SOCIAL SECURITY
SP OR SPOUSE'S OWN INCOME/ASSETS
OTHER FAMILY INCOME/ASSETS
PRIVATE INSURANCE, INCLUDING LTC INSURANCE, BC/BS
PENSION
OTHER PRIVATE PAY (SPECIFY: _____)
MEDICARE, PART A
VA CONTRACT
HMO CONTRACT
OTHER (SPECIFY: _____)
DON'T KNOW

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

PROGRAMMER SPECS:

If "NO CHARGES" or "DON'T KNOW" is selected, do not allow any other item to be selected.

Display error message, "{NO CHARGES/DON'T KNOW} CANNOT BE SELECTED IF ANOTHER ITEM IS SELECTED."

BOX KEX1	If "NO CHARGES" was selected in KEX1, go to KEX2; else If more than one source of payment was selected in KEX1, go to KEX3; else go to EX2.
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KEX2

Why were there no charges?

IF ANSWER IS "MEDICAID PAID," BACK UP TO KEX1 AND SELECT "MEDICAID."

RECORD VERBATIM.

(EX2)

KEX3

Display sources selected in KEX1 for answer categories.

KEX3

Which of these sources was the primary source?

SELECT ONE.

USE ARROW KEYS. TO SELECT OR DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

EX2

(The following questions are about {SP's} basic care between {REFERENCE START DATE} and {REFERENCE END DATE}.) Was there a charge for {her/his} room and board and basic care between {REFERENCE START DATE} and {REFERENCE END DATE}? Please include any charges to {SP}, {her/his} family, or a third party, such as Medicaid, Medicare, or a legal guardian.

YES	1	(EX4)
NO	0	(EX3)
DK	-8	(EX2a)
RF	-7	(EXEND)

EX2A
Display Facility Respondent Roster.

EX2A

Please tell me the name and title of someone in {FACILITY [READ FACILITY/UNITS ABOVE]} who could give me that information.

RECORD RESPONDENT INFORMATION ON PAPER FROG.

Thank you for your time, I will need to continue with [NAME FROM FROG] to complete these questions.

PRESS ENTER TO CONTINUE.

PROGRAMMER SPECS:

Terminate Expenditures with this respondent and return to navigation screen. If Round 3 and data retrieval for any Round 2 billing periods have been collected, set EX status on the navigate screen to BRK; else display RDY. The next time enter is struck on this cell, begin EX at EX1PRE.

EX3

Why were there no charges?

IF ANSWER IS "MEDICAID PAID," BACK UP TO EX2 AND ENTER "1."

RECORD VERBATIM.

BOX EX1A	If there are any Round 2 billing periods missing payment data, go to BOX EX7B; Else, go to EXEND.
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EX4

Between {REFERENCE START DATE} and {REFERENCE END DATE}, was {SP} billed separately for health-related ancillary services? (That is, were there charges for ancillary services that were not included in the basic rate?)

IF FACILITY NEVER BILLS SEPARATELY FOR ANCILLARIES, ENTER SHIFT/5.

YES 1
NO 0

PRESS F1 FOR DEFINITION OF ANCILLARY SERVICES.

PROGRAMMER SPECS:

Disallow DK or RF.

MANAGEMENT SYSTEM SPECS:

If "Shift/5" is entered, set a Flag to indicate that questions about billing and payment of ancillaries (EX15PRE-EX18 and EX28-EX33) should not be asked for any SP in this Facility in this round.

BOX EX2	If this is the first round EX is administered in this facility and if EX5 has not been asked in this facility in this round, go to EX5; else go to BOX EX2A.
---------	--

EX5

If Round = 2, display "Through what date...residents?" and date fields to collect the date the facility has complete billing records. If Round = 3, display "We will need...December 31, 1996." and "PRESS ENTER TO CONTINUE."

EX5

{Through what date do you have complete billing records for the services provided to residents?/We will need complete billing records for services provided to residents through December 31, 1996.}

{MONTH () DAY () 1996}

{PRESS ENTER TO CONTINUE.}

PROGRAMMER SPECS:

Disallow DK or RF.

If Round = 3, set the R3 date the facility has complete billing records to 12/31/96.

EX6

What is the length of the facility's billing period? Is it...

monthly, 1
every two weeks, 2
every week, or 3
quarterly? 4
OTHER (SPECIFY: _____) ... 91

BOX EX2A	If Round = 2 and if the SP's SAD > {DATE FROM EX5}, go to EXEND; else Go to EX7PRE.
-------------	--

EX7PRE

If Round = 2:

If facility bills monthly, and date from EX5 includes the last day of the month specified, display the {DATE FROM EX5}; else

If facility bills monthly and date from EX5 does not include the last day of the month specified, display the month and last day of the month preceding the month specified in EX5; else

Display {DATE FROM EX5}.

Else, if Round = 3, display "December 31, 1996."

<p>*CTRL/E OK*</p> <p>EX7PRE</p> <p style="text-align: center;">BILLING INFORMATION</p> <p>FACILITY HAS UP-TO-DATE RECORDS THROUGH {DATE FROM EX5/December 31, 1996} LENGTH OF BILLING PERIOD: {RESPONSE CODE FROM EX6.} START WITH EARLIEST BILLING PERIOD. COLLECT BILLING INFORMATION FROM {REFERENCE START DATE} THROUGH {REFERENCE END DATE}.</p> <p style="text-align: center;">PRESS ENTER TO CONTINUE.</p>

EX8

Display prefilled start date and end date if EX6 = "monthly"; else do not prefill.

<p>*CTRL/E OK*</p> <p>EX8</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">VERIFY THE START AND END</td> <td style="width: 50%;">BP START DATE: ()/()/96</td> </tr> <tr> <td>DATES FOR EACH BILLING PERIOD</td> <td>BP END DATE: ()/()/96</td> </tr> <tr> <td colspan="2">NUMBER OF DAYS IN BILLING PERIOD ()</td> </tr> </table>	VERIFY THE START AND END	BP START DATE: ()/()/96	DATES FOR EACH BILLING PERIOD	BP END DATE: ()/()/96	NUMBER OF DAYS IN BILLING PERIOD ()	
VERIFY THE START AND END	BP START DATE: ()/()/96					
DATES FOR EACH BILLING PERIOD	BP END DATE: ()/()/96					
NUMBER OF DAYS IN BILLING PERIOD ()						

PROGRAMMER SPECS:

Disallow 0, DK or RF in # OF DAYS IN BILLING PERIOD.

EX9

Display EX9 as an overlay of EX8.

<p>EX9</p> <p style="text-align: center;">Between {BP START DATE} and {BP END DATE}, how many days was {SP} billed for care?</p> <p style="text-align: center;">NUMBER OF BILLED DAYS: ()</p>
--

PROGRAMMER SPECS:

Range -- EX9 ≤ EX8

If "NUMBER OF BILLED DAYS" > "NUMBER OF DAYS IN BILLING PERIOD," display the following message: "NUMBER OF BILLED DAYS, {EX9} CANNOT EXCEED NUMBER OF DAYS IN BILLING PERIOD, {EX8}."

BOX EX3	<p>If there are any DKs or RFs in the Billing Period Start and End Date, the number of billed days (EX9) is missing or days in eligible LTC from {BP START DATE} to {BP END DATE} cannot be calculated from Residence History, go to EX11; else</p> <p>If the number of billed days (EX9) is not missing and the days in the billing period (EX8) = number of billed days (EX9) and number of billed days = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to BOX EX3B; else</p> <p>If the number of billed days (EX9) = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, and the days in eligible LTC < the number of days in the billing period (EX8), go to BOX EX3B; else</p> <p>If the number of days in the billing period (EX8) = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History and the days in eligible LTC > number of billed days (EX9), go to EX10; else</p> <p>If the number of days in the billing period (EX8) > number of billed days (EX9) and number of billed days > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to EX10A; else</p> <p>If the number of days in the billing period (EX8) > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History and the days in eligible LTC > number of billed days (EX9), go to EX10A; else</p> <p>If the number of days in the billing period (EX8) = number of billed days (EX9) and number of billed days > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to EX10A; else</p> <p>Go to EX10.</p>
---------	---

EX10

Can you tell me why I have a discrepancy between the number of days in this billing period, that is, {EX8} and the number of days for which {SP} was billed, that is, {EX9}?

SELECT ALL THAT APPLY.

- | | |
|---------------------------------|------------|
| SP DISCHARGED TO COMMUNITY | (BOX EX3B) |
| SP SENT TO HOSPITAL | (BOX EX3B) |
| SP DECEASED | (BOX EX3B) |
| SP ADMITTED AFTER BP START DATE | (BOX EX3B) |
| SP DISCHARGED TO ANOTHER NH | (BOX EX3B) |
| OTHER (SPECIFY: _____) | (BOX EX3B) |
| DK | (BOX EX3B) |
| RF | (BOX EX3B) |

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

PROGRAMMER SPECS:

If DK or RF is selected, do not allow any other item to be selected. Display error message "CANNOT SELECT {DON'T KNOW/REFUSED} CATEGORY IF OTHERS ARE SELECTED."

EX10A

Earlier, I collected information that {SP} was a resident of this {nursing home/facility} for {NUMBER OF DAYS DURING BILLING PERIOD IN WHICH RH INDICATES SP WAS A RESIDENT IN ELIGIBLE LTC PLACE IN SF OR NF} days during this billing period. Yet, {s/he} was billed for {EX9} days. Can you tell me why I have this discrepancy?

SELECT ALL THAT APPLY.

- SP SENT TO HOSPITAL, BED HELD
- SP NOT BILLED ON ADMISSION DAY
- SP NOT BILLED ON DISCHARGE DAY
- SP NOT BILLED ON DATE OF DEATH
- OTHER (SPECIFY: _____)
- DK
- RF

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

PROGRAMMER SPECS:

If DK or RF is selected, do not allow any other item to be selected. Display error message, "CANNOT SELECT {DON'T KNOW/REFUSED} IF OTHERS ARE SELECTED."

BOX EX3B	If EX9 ("Number of days billed for care") = 0, go to BOX EX5; else Go to EX11.
-------------	---

EX11

PROGRAMMER SPECS:

Display EX11 through EX14 as a three-column matrix, with EX11 and EX13 representing the first column, EX12 in the second column, and EX14 in the third column. Each row on the matrix collects one rate.

Column 1: on the first row, use the question text for EX11, and on subsequent rows use the question text for EX13. Use "ATM style" input, with the decimal point already in place.

The interviewers must completely fill out the rate they are on before adding a new rate, but they can fill the columns out in any order within that rate. They may also arrow back to previous rates and delete the row or modify columns in the row. Interviewers add new rows by pressing Enter in the third column; they will not be allowed to enter a new rate until all three columns have valid data for the current rate.

Interviewers may use control/D to delete a rate. They may not delete a rate if it is the only rate on the matrix.

Static displays. Each billing period is assigned a sequential number (if the facility bills monthly, January will be Billing Period 1, etc.). This billing period number is displayed just after the question text. The billing period start and end dates are displayed on the next line, followed by the number of billed days from EX9.

Dynamic displays. As soon as the number of days for which a rate applies has been entered in column 3, two other displays on the matrix will be dynamically updated. The first is the number of days yet to be accounted for, which is defined as the number of billed days (EX9) minus the sum of the days entered in column 3 for all rates. If column 3 is DK or RF for any rate, the number of days yet to be accounted for will be "DK." The second is the total amount billed, which is defined as the sum of the daily equivalent for each rate multiplied by the number of days for which that rate was charged. [Note that the daily equivalent is calculated using the number of days in the current month for "monthly," or 91 days for "quarterly."] If the total amount billed cannot be calculated (if some component of the rate is DK/RF, or any rate has "Other" selected in column 2), the total amount billed will be displayed as "Unknown".

Leaving the matrix. The interviewer may use Escape to leave the matrix. However, Escape will only be allowed if the number of days to be accounted for is equal to 0 (i.e., all days have been accounted for) or DK. If Escape is pressed and the number of days to be accounted for is not equal to 0 or DK, display the following message at the bottom of the matrix: "The number of days to be accounted for must equal 0 or DK."

Previous billing period displays. After the first billing period, use the right side of the screen to display the billing period number, start and end dates, and number of billed days of the PREVIOUS billing period. Also, if the previous billing period had only one rate, then display the rate (on the same line as the first row in the rate matrix) and allow the interviewer to press control-A to "ditto" the previous billing period's rate into the current billing period, adjusting for the number of days. For instance, if January was billed at \$100.00 per day for 31 days (total charge: \$3,100.00), and the interviewer uses control-A, the "ditto" action is to copy the previous rate into the current billing period and adjust the days from 31 to 28 (total charge for February: \$2,800.00).

EX11

If EX4 = 1 (YES), display {(I'll ask...services later)}; else do not display.
Display F6 only after data has been collected for first billing period.
Display "CTRL/A=ADD" only after the data has been collected for first rate.

EX11

Between {BP START DATE} and {BP END DATE}, what rate was billed for {SP's} care? {(I'll ask about billing for ancillary services later.)}

PROBE: If more than one rate was billed, please give me the first rate within the billing period.

{BP START DATE} - {BP END DATE}
OF BILLED DAYS {EX9}

{ } DAYS YET TO BE ACCOUNTED FOR
[{EX9} - (EX12+ EX14)]

TOTAL AMOUNT BILLED \$ {_. _}

RATE	UNIT	DAYS
[EX11 & EX13]	[EX12 & EX14]	
\$.		
\$.		
\$.		
\$.		
	PER	1. DAY
		2. MONTH
		3. QUARTER
		91. OTHER

USE ARROW KEYS. {F6=DITTO.} {CTRL/A=ADD} CTRL/D=DELETE. TO EXIT, PRESS ESC.

PROGRAMMER SPECS:

Hard range, 0.00-99,999.99. When EX11 (BRAT.BRATRATE) and BRAT.BRATUNIT have been entered, apply the following soft range checks: BRAT.BRATUNIT=1 (DAY), Soft range = 60.00-800.00; BRAT.BRATUNIT=2 (MONTH), soft range = 1,680.00-24,800.00; BRAT.BRATUNIT=3 (QUARTER), soft range = 5,000.00-74,400.00.

For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

EX12

Display EX12 as an overlay of EX11 after the rate has been entered in EX11.

EX12

How many days were billed at that rate?

()
NUMBER OF BILLED DAYS

PROGRAMMER SPECS:

Hard range, 1-366, Soft range, 1-31

If NUMBER OF BILLED DAYS IN EX12 is greater than NUMBER OF BILLED DAYS in BILLING PERIOD (EX9), display message: "DAYS BILLED AT THAT RATE, {EX12}, CANNOT BE GREATER THAN DAYS BILLED IN BILLING PERIOD, {EX9}. PLEASE RE-ENTER."

BOX EX4

If all billed days in the billing period have been accounted for (EX9 - EX12 = 0), go to BOX EX5; else go to EX13.

EX13

Display EX13 as an overlay of EX12 if EX9 - EX12 ≠ 0.

EX13

Between {BP START DATE} and {BP END DATE}, what other rate was billed for {SP's} care?

EX14

Display EX14 as an overlay of EX13 after the rate has been entered in EX13.

If number of days billed (EX14) > number of billed days (EX9), display error message, "DAYS BILLED AT THAT RATE {EX14}, CAN NOT BE GREATER THAN DAYS BILLED IN BILLING PERIOD, {EX9}. PLEASE RE-ENTER."

EX14

How many days were billed at that rate?

PROGRAMMER SPECS:

Repeat EX13 and EX14 until all billed days in the billing period have been accounted for.

BOX EX5

If EX4 = 1 (SP billed separately for ancillaries) and billed days (EX9) > 0, go to EX15PRE; else Go to BOX EX6.

EX15PRE

If this is the first time asking this question for this respondent, this round, display ",that is, your facility's...or telephone"; else do not display.

EX15PRE

The next questions are about health-related services received by {SP} for which there was a separate charge {, that is, your facility's ancillary services. Please do not include non-health-related services such as hairdressing, television, or telephone}.

PRESS F1 FOR EXAMPLES OF NON-HEALTH-RELATED ANCILLARIES.

PRESS ENTER TO CONTINUE.

BOX EX5a	If Round = 2, go to EX16; else Go to EX17.
-------------	---

EX16

Have all charges for ancillaries been posted for the period from {BP START DATE} to {BP END DATE}?

- YES 1 (EX17)
- NO 0 (BOX EX6)
- DK -8 (BOX EX6)
- RF -7 (BOX EX6)

PROGRAMMER SPECS:

If Round = 2 and if EX16 = "NO", flag for data retrieval in next round.

EX17

If Round = 3 and if EX16 or EX17 was flagged for data retrieval in Round 2, display "When I was...now." and "health-related", and for every billing period of data retrieval after the first, display "(When I was...now.)" and "health-related"; else do not display.

If Round = 3, display help instruction.

EX17

{(When I was last here on {DATE OF ROUND 2 INTERVIEW}, I did not collect ancillary charges for some of {SP}'s billing periods. I'd like to ask about that information now.)} Does {SP} have any {health-related} ancillary charges between {BP START DATE} and {BP END DATE}?

- YES 1 (EX18)
- NO 0 (BOX EX6)
- DK -8 (BOX EX6)
- RF -7 (BOX EX6)

{PRESS F1 FOR DEFINITION OF ANCILLARY SERVICES.}

EX18

Altogether, what was the total charge for those health-related ancillary services?

RECORD AMOUNT BELOW.

\$ _____

PROGRAMMER SPECS:

Round 2: Hard range, \$1.00-\$10,000.00; soft range, \$20.00-\$2,500.00.

Round 3: Hard range, \$1.00-\$99,999.99; soft range, \$1.00-\$26,000.00.

BOX EX6	If this is the first round that EX is administered in this facility: If this is the first SP in this round and this is the first respondent for this SP, go to EX19; else If this is not the first SP in this round and this is the first respondent for this SP and this is the first time this round the respondent has been asked EX, for any SP, go to Ex19; else Go to BOX EX7. Else, if this is the second round that EX is administered in this facility, go to BOX EX7A.
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EX19

DO YOU WANT TO ...

()

1. COLLECT BILLING INFORMATION FOR ALL BILLING PERIODS, BEFORE COLLECTING ANY PAYMENT INFORMATION?

OR

2. COLLECT BILLING AND PAYMENT INFORMATION FOR THIS BILLING PERIOD, THEN BILLING AND PAYMENT INFORMATION IN SEQUENCE FOR ALL REMAINING BILLING PERIODS?

PROGRAMMER SPECS:

Do not allow DK or RF.

BOX EX7	If EX19 = 1, "COLLECT ALL BILLING FIRST", loop EX8 through EX18 until all billing periods have been collected; then go to EX20; else If EX19 = 2, "COLLECT BILLING, THEN PAYMENT FOR EACH BP", go to EX20, then loop EX8 through BOX EX14 until all billing periods for which billed days > 0 have been accounted for.
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BOX EX7A	<p>If FEX2 = 1 (COLLECT ALL BILLING FIRST):</p> <p>If in retrieval mode for Round 2 ancillary charges and there are additional periods to collect ancillary charges for, go to EX17; else</p> <p>If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the first billing period for which expenditures data has not already been collected, go to EX2; else</p> <p>If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the second or subsequent billing periods for which expenditures data has not already been collected, loop through EX8 through EX18 until all billing periods have been collected; then go to BOX EX7B; else</p> <p>Go to BOX EX7B.</p> <p>Else, if FEX2=2 (COLLECT BILLING, THEN PAYMENT FOR EACH BP), go to BOX EX7B.</p>
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BOX EX7B	<ol style="list-style-type: none"> 1. If EX20 for this billing period (receipt of expected payments for basic care) = NO (0) in Round 2, go to EX20; else go to step 2. 2. If EX28 for this billing period (receipt of expected payments for ancillaries) = NO (0) in Round 2 or EX17 = YES (1) and ancillary payments have not been collected for this billing period, go to EX28; else 3. For any additional billing periods for which billed days > 0 and for which payment data has not already been collected; go to EX20; else 4. Go to BOX EX21.
-------------	--

EX20

If EX20 has been flagged for data retrieval in Round 2 and this is Round 3, for the first billing period of data retrieval display "when I was last...with you now.", and for every billing period of data retrieval after the first, display "(When I was last...with you now.)"; else do not display.

	CTRL/E OK	{BP START DATE}-{BP END DATE}
EX20		
<p>{{(When I was last here on {DATE OF ROUND 2 INTERVIEW}, you had not yet received expected payments for {SP}'s care for some of the billing periods. I'd like to review that information with you now.)}}</p>		
<p>Have you received all the payments for <u>basic care</u> you expect to receive for {SP} during the [READ BILLING PERIOD ABOVE] billing period?</p>		
	YES	1 (EX21)
	NO	0 (BOX EX7C)

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX7C	If Round = 2, then go to BOX EX14; Else, if Round = 3, then go to EX20A.
-------------	---

EX20A

Do you expect to receive any payment for basic care for {SP} for the [READ BILLING PERIOD ABOVE]?

- YES 1 (EX21)
- NO 0 (EX20B)
- DK -8 (BOX EX14)
- RF -7 (BOX EX14)

EX20B

Why don't you expect to receive any payment for basic care for {SP} for the [READ BILLING PERIOD ABOVE]?

RECORD VERBATIM BELOW.

(BOX EX14)

EX21

Recalculate the "amount remaining" every time a source of payment is entered by subtracting the sum of payments from the total billed, as calculated in EX11.

If amount remaining <0, set amount remaining to "UNKNOWN".

If amount remaining <0, display error message, "Amount paid exceeds amount billed. Verify and reenter."

If EX20 = YES (1), display "paid".

If EX20A = YES (1), display "you expect" and "will pay".

EX21

Please tell me the sources of payment for {SP}'s basic care for this billing period and the total amount {you expect} each source {paid/will pay}.

{BP START DATE} - {BP END DATE}

OF BILLED DAYS {EX9}

TOTAL BILLED: \${ . }

AMOUNT REMAINING: \${ . }

MEDICAID .....	\$	.
PRIVATE PAY .....	\$	.
SOCIAL SECURITY .....	\$	.
SP/FAMILY INCOME .....	\$	.
PRIVATE INSURANCE (SEE BELOW) .....	\$	.
PENSION .....	\$	.
MEDICARE, PART A .....	\$	.
VA CONTRACT .....	\$	.
HMO CONTRACT TEXT .....	\$	.
OTHER SPECIFY TEXT .....	\$	.

USE ARROW KEYS. CTRL/A=ADD, CTRL/D=DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}

{NAME OF INSURANCE COMPANY - PRV HLTH INS}

{NAME OF INSURANCE COMPANY - LTC POLICY}

{NAME OF INSURANCE COMPANY}

PROGRAMMER SPECS:

Hard range, 0.00-99.999.99; soft range, 60.00-26,000.00.

If EX20A = YES (1), set flag to indicate that payment is expected, not actual.

For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

PROGRAMMER SPECS:

SPECIFICATIONS FOR DISPLAYING CATEGORIES ON THE SOURCE OF PAYMENT ROSTER (EX21 AND EX29)

The SP source of payment roster will be built in Expenditures at questions EX21 and EX29. The roster will be dynamic and fully integrated with other CAPI applications including the Facility Questionnaire, Health Status, Background, Insurance, and Income and Assets. The link with the other applications will be a two-way link so that conducting Expenditures will not be dependent on first completing these other instruments. Formatting the source of payment questions as a dynamic roster takes advantage of the CAPI, sharing data across instruments, and will be useful when applying within and across round edit checks.

Display both EX21 and EX29 as a two-column matrix. The first column is the source of payment. The second column is the amount each source paid. Collect dollar amounts ATM style in the format \$X,XXX.XX. Display four rows on the screen.

If private insurance is a source of payment, the text "PRIVATE INS (SEE BELOW)" will appear on the matrix. The verbatim text collected for the insurance company name and type of policy is displayed at the bottom of the screen, as described in the display specifications that follow.

After source(s) of payments have been collected for the first billing period, those sources selected in billing period 1 should be displayed in the billing period that follows. The pattern of payment, including any added sources, will be carried forward from each billing period into the next billing period, including across rounds.

For example, if in Round 2, payment data was collected in January and February, not collected in March, and collected in April and May, then data retrieval in Round 3 will attempt to collect payment information for the "gap", that is, March. The display for the March billing period will carry forward whatever sources of payment were entered on the source of payment roster in February, the billing period that precedes March.

Across rounds, if collection of payment data in Round 2 stopped in April, then Round 3 Expenditures data collection will begin with the billing period that follows April, that is, May. The source of payment roster for May will display sources of payment entered in April.

Following is an example of how sources of payment will be carried forward from one billing period to the next billing period, including across rounds:

(An asterisk indicates selection)

Billing Period 1

PRIVATE PAY

*SOCIAL SECURITY

*SP OR SPOUSE'S OWN INCOME/ASSETS

OTHER FAMILY INCOME/ASSETS

PRIVATE INSURANCE

*MEDICARE

Billing Period 2

SOCIAL SECURITY

SP OR SPOUSE'S OWN INCOME/ASSETS

MEDICARE

F1 for Source of Payment Codes

- | | | | |
|---|---------------------------------------|----|-------------------------------------|
| 1 | MEDICAID | 7 | MEDICARE, PART A ("PART B" AT EX29) |
| 2 | PRIVATE PAY | 8 | VA CONTRACT |
| 3 | SOCIAL SECURITY | 9 | HMO CONTRACT (SPECIFY: _____) |
| 4 | SP/FAMILY INCOME | 91 | OTHER (SPECIFY: _____) |
| 5 | PRIVATE INSURANCE
(SPECIFY: _____) | | |
| 6 | PENSION | | |

CTRL/A to add a source of payment

In effect, using CTRL/A to add a source of payment to the SP SOP roster presents an "unfolding" payment roster for each SP. In any billing period, CTRL/A can be used to open a line to add a source of payment to the SP source of payment roster. Rather than keying in the alpha name, the interviewer will use the codes associated with sources of payment as displayed on the F1 screen (see above). If "5", "9", or "91" is selected, an overlay screen will appear for the interviewer to key in the policy name of the insurance, HMO contract, or the other source of payment.

When "PRIVATE INSURANCE" is selected, the interviewer will key in the name of the policy as given, (e.g., "Blue Cross/Blue Shield"). In both EX21 and EX29, if insurance is added, after the name of the private insurance has been specified, display either EX21a or EX29a, as appropriate, as an overlay of EX21 or EX29, respectively.

As with all SOPs selected, SOPs added to the roster should be carried forward across billing periods. For any source of payment that already appears on the SP level SOP roster, if that source is selected to be added using CTRL/A, display the following error message: "THIS SOURCE IS ALREADY ON PAYMENT ROSTER. SELECT ANOTHER SOURCE."

Example Matrix for Adding a Source of Payment

EX21

Please tell me the sources of payment for {SP}'s basic care for this billing period and the total amount each source paid.

{BP START DATE} - {BP END DATE}		What is the source of payment? ()
# OF BILLED DAYS {EX9}		
TOTAL BILLED:	#{ . }	PRESS F1 TO SEE SOURCE OF PAYMENT CODES.
AMOUNT REMAINING:	#{ . }	
		SPECIFY SOURCE OF PAYMENT:
PRIVATE PAY	\$.	
SOCIAL SECURITY	\$.	
PRIVATE INSURANCE (SEE BELOW)	\$.	
OTHER SPECIFY TEXT	\$.	
		What kind of plan is that? ()
		1. MEDIGAP PLAN
		2. LONG-TERM CARE PLAN
		3. SOMETHING ELSE

USE ARROW KEYS. CTRL/A=ADD. CTRL/D=DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}
{NAME OF INSURANCE COMPANY - PRV HLTH INS}
{NAME OF INSURANCE COMPANY - LTC POLICY}
{NAME OF INSURANCE COMPANY} - OTHER

The overlays are blanked out upon return to the matrix. The new source of payment appears on the matrix, and the cursor is positioned to collect the amount billed for the new source of payment. If "HMO Contract" or "Other Specify" is a source of payment, display the verbatim text on the matrix. If Code 5 was entered, the name of the insurance company entered verbatim appears on the list at the bottom of the screen. If the kind of plan is DK or "3", "SOMETHING ELSE", display "OTHER" next to the name of the plan.

For each SP, for the first billing period reported, EX21 and EX29 will be formatted as SP source of payment rosters according to the specifications below.

MEDICAID

If HA47 (Medicaid #) is complete (that is, ≠ SHIFT/5, DK or RF), display "MEDICAID"; else

If IN1 (ever covered by Medicaid) = "1", display "MEDICAID"; else

Do not display "MEDICAID".

PRIVATE PAY

Always display.

SOCIAL SECURITY

Do not display.

SP OR FAMILY'S OWN INCOME/ASSETS

Do not display.

PRIVATE INSURANCE, INCLUDING LONG-TERM CARE INSURANCE

If IN18 (Medigap/private insurance policy) = "1" display {NAME OF INSURANCE COMPANY}--PRIVATE INSURANCE

If IN20 (Long-term care insurance) = "1" display {NAME OF INSURANCE COMPANY} -- LTC POLICY; else

Do not display.

PENSION

Do not display.

MEDICARE - PART A, MEDICARE - PART B

If HA44B (Medicare #) is complete (that is, ≠ DK or RF), display "MEDICARE - PART A" on EX21 SOP roster; else

If IN12 (covered by Medicare Part A) = "1", display "MEDICARE - PART A" on EX21 SOP roster; else do not display.

If IN13 (covered by Medicare Part B) = "1", display "MEDICARE - PART B" on EX29 SOP roster; else do not display.

VA CONTRACT

If BQ12 (active duty in Armed Forces) = "1", display "VA CONTRACT"; else

Do not display.

HMO CONTRACT

Do not display.

EX21A
 Display as an overlay of EX21.

EX21A	
What kind of plan is that?	
MEDIGAP PLAN	1
LONG-TERM CARE PLAN	2
SOMETHING ELSE	3
DK	-8
RF	-7

PROGRAMMER SPECS:

If EX21A = -8 (DK), -7 (RF), or 3 (SOMETHING ELSE), display {NAME OF INSURANCE COMPANY} "- OTHER" at bottom of the billing matrix screen.

BOX EX7D	<p>If Residence History is complete for the SP and this is the first time this round that Medicare Part A is identified as a payment source for this SP, review the Residence History timeline for a stay, of at least one day, in which place type is HOSPITAL: For CRs, review from January 1, 1996 to the billing period in which Medicare Part A was selected/added; for F2s and F3s, review from SAD-90 days/January 1, 1996, whichever is later, through the billing period in which Medicare Part A was selected/added; for transfer SPs, review from TAD-90 days/January 1, 1996, whichever is later, through the billing period in which Medicare Part A was selected/added; and If there is no HOSPITAL stay reported, go to EX21b; else do not display.</p>
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EX21B
 If EX20A = YES (1), display "would pay"; else display "paid".

EX21B	{BP START DATE} - {BP END DATE}
<p>Medicare Part A has been reported as a payment source for basic care for {SP} for [READ BILLING PERIOD ABOVE], but I have not recorded any preceding hospital stays for {him/her}.</p> <p>Please tell me why Medicare {paid/would pay} for {SP} during this billing period.</p> <p>RECORD VERBATIM BELOW. IF NECESSARY, BACK UP TO CORRECT.</p> <p>IF HOSPITAL STAY IS REPORTED, RECORD DATES OF STAY BELOW.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

BOX EX8	<p>After collecting all payment information for the billing period,</p> <p>If this is the first time this round coming to BOX EX8 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%,</p> <p style="padding-left: 40px;">If Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9;</p> <p style="padding-left: 40px;">Else, if the difference between the "total amount billed" and "total amount paid" is greater than 10%, go to EX22;</p> <p style="padding-left: 40px;">Else, go to BOX EX9;</p> <p>Else, if this is the second time (or greater) this round coming to BOX EX8 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%,</p> <p style="padding-left: 40px;">If EX22 = 1 (MEDICAID WRITE-OFF) or 2 (OTHER WRITE-OFF) for any previous billing period and if the "total amount paid" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9;</p> <p style="padding-left: 40px;">Else, if Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9;</p> <p style="padding-left: 40px;">Else, if the difference between the "total amount billed" and "total amount paid" is greater than 10%, go to EX22;</p> <p style="padding-left: 40px;">Else, go to BOX EX9.</p> <p>Else, go to BOX EX9.</p>
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EX22

If EX20A = YES (1), display "expected payments"; else, display "payments received".

EX22

There seems to be a difference between what {FACILITY/[READ FACILITY/UNITS ABOVE]} billed between {BP START DATE} and {BP END DATE} and the {payments received/expected payments}. The total amount billed I have entered for this billing period is {EX11} and the total payments for the period are {SUM OF EX21 PAYMENTS}. Why is that?

MEDICAID WRITE-OFF/ADJUSTMENT	1
OTHER WRITE-OFF/ADJUSTMENT	2
OTHER (SPECIFY: _____)	91
DK	-8
RF	-7

PRESS F1 FOR DEFINITION OF "MEDICAID WRITE-OFF".

BOX EX9	<p>The <u>first</u> time Medicaid is identified as a payment source for this SP, check January 1, 1996 for CRs, SAD for F2s and F3s, and the start date of the first stay in an eligible LTC after the TAD for transfer SPs and determine from Residence History where the SP was residing at that time (i.e., in which eligible LTC place) and whether that place was certified for Medicaid (Facility Questionnaire), Rd1 for CRs, Rd2 for F2s, F3s, and TRs in new facilities in Round 2 and continuing new facilities in Round 3; and Round 3 for TRs in new facilities in Round 3.</p> <p>If the place is <u>not</u> certified for Medicaid, go to EX23; and</p> <p>The <u>first</u> time Medicare is identified as a payment source for this SP, check January 1, 1996 for CRs, SAD for F2s and F3s, and the start date of the first stay in an eligible LTC after the TAD for transfer SPs and determine from Residence History where the SP was residing at that time and whether that place was certified for Medicare (Facility Questionnaire), Rd1 for CRs, Rd2 for F2s, F3s, and TRs in new facilities in Round 2 and continuing new facilities in Round 3; and Round 3 for TRs in new facilities in Round 3.</p> <p>If the place is <u>not</u> certified for Medicare, go to EX23; else Go to BOX EX9A.</p>
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EX23

I seem to have recorded some discrepant information. Earlier, I recorded that {FACILITY/UNITS NOT CERTIFIED BY MEDICAID/MEDICARE} is not certified by {Medicaid/Medicare} but I have identified {Medicaid/Medicare} as a payment source. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX9A	<p>If EX20A = YES (1), go to BOX EX10, step 1; else</p> <p>For an SP whose Medicaid status in this round is "PENDING" (IN1=2), or whose Medicaid number is unknown (IN3 = -1, -8 or -7 and HA47 = -8, -7, or -5) the <u>first</u> time Medicaid is identified as a payment source and EX20 = YES (1), go to EX23A; else</p> <p>Go to BOX EX10, STEP 2.</p>
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EX23A

If the EX respondent has never been the IN respondent and this is the first time through EX23A and this respondent has never been through IN missing data, display "This information...Health Service Act (42 U.S.C. 299a-1(c))"; else do not display.

Medicaid Display.

EX23A

Please tell me {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number. {This information is voluntary and is collected under the authority of Title IX, Section 902(a) of the Public Health Service Act (42 U.S.C.299a). There will be no effect on {SP}'s benefits and no information will be given to any government or nongovernment agency other than the sponsoring agencies. We need this information to supplement data we will gather about {her/his} insurance coverage, particularly under Medicare and {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} and to determine {her/his} vital status after 1996. Information will be used for research purposes only; it will be held in the strictest confidence and will not be released to anyone without written consent in accordance with Sections 903(c) and 308(d) of the Public Health Service Act (42 U.S.C. 299a-1(c) and 242m(d)).}

MEDICAID ID NUMBER

- DK -8 (BOX EX10 STEP 1)
RF -7 (BOX EX10 STEP 1)

EX23B

Medicaid Display.

EX23B

I'd like to verify the {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number that I have recorded. I have entered {MEDICAID ID NUMBER}. Is this correct?

- YES 1 (BOX EX10, STEP 2)
NO 0
DK -8 (BOX EX10, STEP 1)
RF -7 (BOX EX10, STEP 1)

EX23C
Medicaid Display.

EX23C

Let me enter it again. (What {is/was} {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?)

_____ (EX23B)
MEDICAID ID NUMBER

DK -8 (BOX EX10, STEP 1)
RF -7 (BOX EX10, STEP 1)

BOX EX10	<ol style="list-style-type: none">1. The <u>first</u> time Medicaid is identified as a payment source for an SP, go to EX24 to attempt resolution; and2. The <u>first</u> time Medicare is identified as a payment source for an SP who has not been identified in Health Insurance (IN12 = 0, -8 or -7) and Health Status (HA44A = 3 (SP HAS NO MEDICARE NUMBER), -8 or -7) as a beneficiary of Medicare, go to EX24 to attempt resolution; else Go to BOX EX11.
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EX24
If asking about "Medicaid" display "recipient"; else display "beneficiary".

EX24

Earlier, I recorded that {SP} was not a {Medicaid/Medicare} {recipient/beneficiary} but I have identified {Medicaid/Medicare} as a source of payment. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX11	If Medicaid is not identified as a payment source for the current billing period but appears in the preceding billing period (including if the billing period occurred in the previous round), go to EX25 to attempt resolution; else Go to BOX EX12.
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EX25

It seems that I might have made a mistake in identifying the various sources of payment for {SP's} care. Earlier, I recorded that {her/his} basic charges from {FIRST BP START DATE WITH MEDICAID AS PAYER} through {LAST BP END DATE WITH MEDICAID AS PAYER} were paid by Medicaid, and in this billing period, Medicaid is no longer a payment source. Why didn't Medicaid continue to pay for {her/his} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:

Do not allow DK or RF.

BOX EX12	If Medicare is identified as a payment source on the billing matrix, and the amount paid by Medicare represents less than 10 percent of the total payments received for the billing period, go to EX26 to attempt resolution; else Go to BOX EX14.
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EX26

Display a header, the total amount paid from all sources for the billing period, and beneath it, the amount paid by Medicare. These figures are from EX21.

EX26

TOTAL PAYMENTS: {TOTAL PAYMENTS}
MEDICARE PAYMENTS: {MEDICARE PAYMENTS}

Medicare's payment for this billing period represents less than 10 percent of the total payments for basic care. Is this Medicare payment a Part B payment?

IF NECESSARY, BACK UP TO EX21 TO CORRECT PAYMENTS.

- YES 1 (BOX EX14)
- NO 0 (EX27)
- DK -8 (EX27)
- RF -7 (BOX EX14)

EX27

If EX20A = YES (1), display "would be", else display "is".

EX27

TOTAL PAYMENTS: {TOTAL PAYMENTS}
MEDICARE PAYMENTS: {MEDICARE PAYMENTS}

Can you tell me why the Medicare payment {is/would be} so small?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT PAYMENTS.

BOX EX14	If EX17 = "YES", and ancillary payments for this billing period have not already been collected, go to EX28; else Go to BOX EX19.
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EX28

If EX28 was flagged for data retrieval in Round 2 and this is Round 3, display "health-related"; and for the first billing period of data retrieval, display "When I was...now."; and for every billing period of data retrieval after the first, display "(When I was...now.)"; else do not display.

If Round = 3, display help instruction.

EX28

{When I was last here on {DATE OF ROUND 2 INTERVIEW}, you had not yet received expected payments for {SP}'s health-related ancillary services for some of the billing periods. I'd like to ask you about that information now.} Have you received all the payments you expect to receive for {SP's} {health-related} ancillary services during the [READ BILLING PERIOD ABOVE] billing period?

- YES 1 (EX29)
- NO 0 (BOX EX14A)

{PRESS F1 FOR DEFINITION OF ANCILLARY SERVICES.}

PROGRAMMER SPECS:

Disallow DK and RF.

BOX EX14A	If Round = 2, then go to BOX EX19; Else, if Round = 3, then go to EX28A.
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EX28A

Do you expect to receive any payment for {SP}'s ancillary services during the [READ BILLING PERIOD ABOVE]?

- YES 1 (EX29)
- NO 0 (EX28B)
- DK -8 (BOX EX19)
- RF -7 (BOX EX19)

EX28B

Why don't you expect to receive any payment for {SP's} ancillary services during the [READ BILLING PERIOD ABOVE]?

RECORD VERBATIM BELOW.

(BOX EX19)

EX29

Recalculate the "amount remaining" every time a source of payment is entered by subtracting the sum of payments from the total charge (EX18).

If amount remaining <0, set amount remaining to "UNKNOWN".

If amount remaining <0, display error message: "Amount paid exceeds amount billed. Verify and re-enter."

If EX28 = YES (1), display "paid".

If EX28A = YES (1), display "you expect" and "will pay".

EX29

Please tell me the sources of payment for {SP}'s ancillary services for this billing period and the total amount {you expect} each source {paid/will pay}.

{BP START DATE} - {BP END DATE}

OF BILLED DAYS {EX9}

TOTAL CHARGE: \${ . }

AMOUNT REMAINING: \${ . }

MEDICAID .....	\$	.
PRIVATE PAY .....	\$	.
SOCIAL SECURITY .....	\$	.
SP/FAMILY INCOME .....	\$	.
PRIVATE INSURANCE (SEE BELOW) .....	\$	.
PENSION .....	\$	.
MEDICARE-PART B .....	\$	.
VA CONTRACT .....	\$	.
HMO CONTRACT .....	\$	.
OTHER SPECIFY TEXT .....	\$	.

USE ARROW KEYS. CTRL/A = ADD, CTRL/D = DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}
 {NAME OF INSURANCE COMPANY - PRV HLTH INS}
 {NAME OF INSURANCE COMPANY - LTC POLICY}
 {NAME OF INSURANCE COMPANY}

PROGRAMMER SPECS:

See EX21.

Hard range, 0.00-99,999.99; soft range, \$1.00-15,000.00.

If EX28A = YES (1), set flag to indicate that payment is expected, not actual.

For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

EX29A
 Display as an overlay of EX29.

EX29A	
What kind of plan is that?	
MEDIGAP PLAN	1
LONG-TERM CARE PLAN	2
SOMETHING ELSE	3
DK	-8
RF	-7

PROGRAMMER SPECS:

If EX29A = -8 (DK), -7 (RF), or 3 (SOMETHING ELSE), display {NAME OF INSURANCE COMPANY} "- OTHER" at bottom of billing matrix screen.

BOX EX15	<p>After collecting all payment information for the billing period,</p> <p>If this is the first time this round coming to BOX EX15 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%,</p> <p style="padding-left: 40px;">If Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16;</p> <p style="padding-left: 40px;">Else, if the difference between the "total amount billed" and "total amount paid" is greater than 10%, go to EX30;</p> <p style="padding-left: 40px;">Else, go to BOX EX16;</p> <p>Else, if this is the second time (or greater) this round coming to BOX EX15 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%,</p> <p style="padding-left: 40px;">If EX30 = 1 (MEDICAID WRITE-OFF) or 2 (OTHER WRITE-OFF) for any previous billing period and if the "total amount paid" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16;</p> <p style="padding-left: 40px;">Else, if Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16;</p> <p style="padding-left: 40px;">Else, if the difference between the "total amount billed" and "total amount paid" is greater than 10%, go to EX30;</p> <p style="padding-left: 40px;">Else, go to BOX EX16.</p> <p>Else, go to BOX EX16.</p>
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EX30

If EX28A = YES (1), display "expected payments"; else display "payment received".

EX30

There seems to be a difference between what {FACILITY/[READ FACILITY/UNITS ABOVE]} billed for ancillary services between {BP START DATE} and {BP END DATE} and the {payments received/expected payments}. The total amount billed I have entered for [READ BILLING PERIOD ABOVE] is {EX18} and the total payments for the period are {SUM OF EX29 PAYMENTS}. Why is that?

MEDICAID WRITE-OFF/ADJUSTMENT	1
OTHER WRITE-OFF/ADJUSTMENT	2
OTHER (SPECIFY:_____)	.. 91
DK	-8
RF	-7

PRESS F1 FOR DEFINITION OF "MEDICAID WRITE-OFF".

<p>BOX EX16</p>	<p>The <u>first</u> time ever Medicaid is identified as a payment source for this SP, check January 1, 1996 for CRs, SAD for F2s and F3s, and the start date of the first stay in an eligible LTC after the TAD for transfer SPs and determine from Residence History where the SP was residing at that time (i.e., in which eligible LTC place) and whether that place was certified for Medicaid (Facility Questionnaire), Rd1 for CRs, Rd2 for F2s, F3s, and TRs in new facilities in Round 2 and continuing new facilities in Round 3; and Round 3 for TRs in new facilities in Round 3.</p> <p>If the place is <u>not</u> certified for Medicaid, go to EX31; and</p> <p>The <u>first</u> time ever Medicare is identified as a payment source for this SP, check January 1, 1996 for CRs, SAD for F2s and F3s, and the start date of the first stay in an eligible LTC after the TAD for transfer SPs and determine from Residence History where the SP was residing at that time and whether that place was certified for Medicare (Facility Questionnaire), Rd1 for CRs, Rd2 for F2s, F3s, and TRs in new facilities in Round 2 and continuing new facilities in Round 3; and Round 3 for TRs in new facilities in Round 3.</p> <p>If the place is <u>not</u> certified for Medicare, go to EX31; else Go to BOX EX17.</p>
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EX31

I seem to have recorded some discrepant information. Earlier, I recorded that {FACILITY/UNITS NOT CERTIFIED BY MEDICAID/MEDICARE} is not certified by {Medicaid/Medicare} but I have identified {Medicaid/Medicare} as a payment source. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX16A	If EX28A = YES (1), go to BOX EX17, step 1; else For an SP whose Medicaid status in this round is "PENDING" (IN1=2), or whose Medicaid number is unknown (IN3 = -1, -8, -7 and HA47 = -8, -7, or -5) the <u>first</u> time Medicaid is identified as a payment source and EX28 = YES (1), go to EX31A; else Go to BOX EX17, STEP 2.
--------------	--

EX31A

If the EX respondent has never been the IN respondent and this respondent has never been through IN missing data, and has never been through EX23A, and this is the first time through EX31A, display "This information...Health Service Act (42 U.S.C. 299a-1(c))"; else do not display.

EX31A

Please tell me {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number. {This information is voluntary and is collected under the authority of Title IX, Section 902(a) of the Public Health Service Act (42 U.S.C.299a). There will be no effect on {SP}'s benefits and no information will be given to any government or nongovernment agency other than the sponsoring agencies. We need this information to supplement data we will gather about {her/his} insurance coverage, particularly under Medicare and {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} and to determine {her/his} vital status after 1996. Information will be used for research purposes only; it will be held in the strictest confidence and will not be released to anyone without written consent in accordance with Sections 903(c) and 308(d) of the Public Health Service Act (42 U.S.C. 299a-1(c) and 242m(d)).}

MEDICAID ID NUMBER

DK -8 (BOX EX17, STEP 1)
RF -7 (BOX EX17, STEP 1)

EX31B

Medicaid Display.

EX31B

I'd like to verify the {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number that I have recorded. I have entered {MEDICAID ID NUMBER}. Is this correct?

YES 1 (BOX EX17, STEP 2)
NO 0
DK -8 (BOX EX17, STEP 1)
RF -7 (BOX EX17, STEP 1)

EX31C
Medicaid Display.

EX31C

Let me enter it again. (What {is/was} {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?)

_____ (EX31B)
MEDICAID ID NUMBER

DK -8 (BOX EX17, STEP 1)
RF -7 (BOX EX17, STEP 1)

BOX EX17	<ol style="list-style-type: none">1. The <u>first</u> time ever Medicaid is identified as a payment source for an SP, go to EX32 to attempt resolution, and2. The <u>first</u> time ever Medicare is identified as a payment source for an SP who has not been identified in Health Insurance (IN13 = 0, -8, -7) and Health Status (HA44A = 3 (SP HAS NO MEDICARE NUMBER), -8 or -7) as a beneficiary of Medicare, go to EX32; else Go to BOX EX18.
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EX32
If asking about "Medicaid," display "recipient"; else display "beneficiary".

EX32

Earlier, I recorded that {SP} was not a {Medicaid/Medicare} {recipient/beneficiary} but I have identified {Medicaid/Medicare} as a source of payment.

Why would {Medicaid/Medicare} be paying for {SP}'s ancillaries?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX18	<p>If edit EX25 has not been triggered in BOX EX11 for the current billing period, and If Medicaid is not identified as payment source for ancillaries for the current billing period but appears in preceding period (including if the billing period occurred in the previous round), go to EX33 to attempt resolution; else Go to BOX EX19.</p>
-------------	--

EX33

It seems that I might have made a mistake in identifying the various sources of payment for {SP's} care. Earlier, I recorded that {her/his} charges for ancillaries from {FIRST BP START DATE WITH MEDICAID AS PAYOR} through {LAST BP END DATE WITH MEDICAID AS PAYOR} were paid by Medicaid, and in this billing period, Medicaid is no longer a payment source. Why didn't Medicaid continue to pay for {her/his} ancillary services?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

PROGRAMMER SPECS:
 Do not allow DK or RF.

BOX EX19	<p>If this is Round 3 and Round 2 data retrieval for ancillary charges for the next billing period are needed, go to EX17; else If this is Round 3 and Round 2 data retrieval for payments for basic care or ancillary services for the next billing period are needed, go to BOX EX7B; else Go to BOX EX20.</p>
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BOX EX20	<p>If amounts billed for all BPs have been collected but sources of payment for all BPs in which days billed (EX9) > 0 have not, loop EX20 through BOX EX20 until all those BPs have been collected, then go to BOX EX21; else If amounts billed for all BPs have not been collected, loop EX8 through BOX EX20 until all BPs in which days billed (EX9) > 0 have been accounted for, then go to BOX EX21; else Go to BOX EX21.</p>
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BOX EX21	<p>If private pay (Private Pay, Social Security, SP or Spouse's Own Income/Assets, Other Family Income/Assets, Private Insurance, Pension, Other Private Pay) has <u>never</u> been reported as a source of payment and IN20 = "YES", go to EX34; else Go to BOX EX21A.</p>
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EX34

Display "from 'NAME OF INSURANCE COMPANY FROM IN28'" if it is known; else do not display.

EX34

Earlier I was told that {SP} had long-term care insurance {from {NAME OF INSURANCE COMPANY FROM IN28}}. Is it correct that this policy paid for none of {her/his} care?

YES	1	(BOX EX21A)
NO	0	(EX35)
DK	-8	(BOX EX21A)
RF	-7	(BOX EX21A)

EX35

Can you explain this to me?

RECORD VERBATIM BELOW.

BOX EX21A	<p>If EX (including INMD) respondent is the same as the IN respondent in this round, go to BOX IAR1; else If ((Round 2 and SP is CR) or (Round 3 and SP is F2 or CR)) and IN1 = Pending (2) and Medicaid has <u>never</u> been reported as a payment source, go to EX35A; else Go to BOX IAR1.</p>
--------------	--

EX35A
 Medicaid Display.

EX35A

The last time I was here, I collected information that {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} eligibility status was pending. Is it still pending or has {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} been denied?

STILL PENDING 1
 DENIED 2
 DK -8
 RF -7

BOX IAR1	If SP was sampled in this facility, go to IAR1PRE; Else, go to BOX EX22.
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IAR1PRE

The next questions are about {SP}'s income from Social Security, pensions, and home ownership. This information will be used for research purposes only; it will be held in the strictest confidence.

PRESS ENTER TO CONTINUE.

BOX IAR2	If Social Security ever reported as a source of payment in EX21 or EX29, set IAR2 to 1 and go to IAR3; Else, go to IAR2.
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IAR2

In 1996, did {SP} receive any income from Social Security?

YES 1 (IAR3)
 NO 0 (BOX IAR3)
 DK -8 (BOX IAR3)
 RF -7 (BOX IAR3)

IAR3

In the last month for which you have records available, how much income did {SP} receive from Social Security?

\$ _____

PROGRAMMER SPECS:

Soft range, \$25-\$1,000; Hard range, \$1-\$999,999.

BOX IAR3	If Pension ever reported as a source of payment in EX21 or EX29, set IAR4 to 1 and go to IAR5; Else, go to IAR4.
----------	---

IAR4

In 1996, did {SP} receive any income from private, government, or military pensions?

YES 1
 NO 0

IAR5

In 1996, did {SP} own a home?

YES 1
 NO 0

BOX EX22	<ol style="list-style-type: none"> 1. Determine SP eligibility for CRR: If this SP is a CR sampled in this facility and Rd = 2, or an FA sampled in this facility this round, go to step 2. Else, go to EXEND. 2. Determine facility CRR status: If facility refused to furnish SP names or if facility refused to identify community contacts (FG4 = -7 (REFUSED)), go to EXEND. Else, go to EX36.
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EX36

If EX36 = "YES", display "RECORD THE...ROSTER (CRR)"; else do not display.

EX36

Is someone in the community responsible for handling {SP's} bills?

YES	1
NO	0
DK	-8
RF	-7

{RECORD THE NAME AND OTHER IDENTIFYING INFORMATION OF THE PERSON ON THE PAPER
COMMUNITY RESPONDENT ROSTER (CRR).}

PRESS ENTER TO CONTINUE.

EXEND

YOU HAVE COMPLETED THE EXPENDITURES SECTION FOR THIS SP.

PRESS ENTER TO RETURN TO NAVIGATION SCREEN.

EXPENDITURES QUESTIONNAIRE HELP SCREENS

EX4

ANCILLARY SERVICES

Ancillary services are services provided by the nursing home that are not included in the rates that cover basic care and room and board. These services may be health-related, such as radiology, drugs, therapy (physical, speech, occupational) or lab work, or non-health-related, such as beautician services, laundry, television, and so on.

The study collects expenditure data only for ancillary services that are health-related.

EX21
EX29

SOURCE OF PAYMENT CODES

- | | | | |
|---|--------------------------------------|----|------------------------------|
| 1 | MEDICAID | 7 | MEDICARE, PART (A/B) |
| 2 | PRIVATE PAY | 8 | VA CONTRACT |
| 3 | SOCIAL SECURITY | 9 | HMO CONTRACT (SPECIFY:_____) |
| 4 | SP/FAMILY INCOME | 91 | OTHER (SPECIFY:_____) |
| 5 | PRIVATE INSURANCE
(SPECIFY:_____) | | |
| 6 | PENSION | | |

EX15PRE

NON-HEALTH-RELATED ANCILLARIES

- Beautician services
- Haircuts
- Laundry
- Manicures
- Telephone
- Television
- Therapeutic massages

EX17
EX28

Ancillary services are services provided by the nursing home that are not included in the rates that cover basic care and room and board. These services may be health-related, such as radiology, drugs, therapy (physical, speech, occupational) or lab work, or non-health-related, such as beautician services, laundry, television, and so on.

This study collects expenditure data only for ancillary services that are health-related NOT non-health-related services such as the following:

- Beautician services
- Haircuts
- Laundry
- Manicures
- Telephone
- Television
- Therapeutic massages

EX22

EX30

MEDICAID WRITE-OFF

The allowable Medicaid rate for nursing home care is a figure that is set by the state, and it varies from state to state. Sometimes, a facility that is Medicaid certified may post charges for a resident that are above the allowable Medicaid rate. The difference between what the facility bills and what Medicaid pays is sometimes called a "write-off" as it is money that the facility never expects to see.