



Prospective Data Review 2001 Hospital Care Assurance Program

Final Summary Report

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NOTE: This report is sent to all hospital providers participating in the Hospital Care Assurance Program. Please read the report carefully to ensure that your hospital understands HCAP requirements and the importance of accurate data reporting. Because ODJFS is not required to accept Medicaid cost report revisions received later than thirty days after the provider receives the interim cost settlement, it is very important that each hospital reviews its HCAP data carefully prior to submitting their interim cost report. Please share this report with all relevant persons in your organization, as only one copy is sent to each hospital. A checklist to assist your hospital with data reporting for HCAP is provided at the end of this report.

Ohio Department of Job & Family Services
Bureau of Health Plan Policy
30 East Broad Street, 27th Floor
Columbus, Ohio 43266-0423
(614) 466-6420

Introduction

The 2001 Hospital Care Assurance Program (HCAP) will distribute \$543 million hospitals to offset the costs of providing care to indigent Ohioans. HCAP is the mechanism that the State of Ohio uses to fulfill its federal obligation to provide disproportionate share funding to Ohio general/acute care hospitals which provide indigent care. As part of the program, all general/acute care hospitals in the state are required to provide basic, medically necessary hospital level services without charge to patients whose income is at or below the federal poverty level and to patients enrolled in the Disability Assistance program (DA). Funding for HCAP is derived from an assessment on Ohio hospitals and federal matching funds.

Each year hospitals report the amount of uncompensated care they provided in the previous year on the Ohio Medicaid Cost Report. This is data that the Ohio Department of Job and Family Services (ODJFS) uses as a proxy to measure indigent care services provided by each hospital and to determine how to distribute the limited HCAP funding. Since federal law limits the amount the federal government will match under the HCAP program, a model compares the uncompensated care and Medicaid services provided by each hospital to all other hospitals in Ohio to determine what portion of the total funding available will be distributed to each hospital.

IMPORTANT REMINDER

The amount of uncompensated care reported by one hospital affects the HCAP payment that all other hospitals in Ohio receive. Therefore, it is in the best interest of all the hospitals that participate in the program that the HCAP data is accurate.

In an effort to improve the quality of the data used for HCAP, ODJFS performed data reviews for a sample of hospitals. There were three primary objectives for the reviews:

1. To ensure that uncompensated care data reported by hospitals was accurate and in accordance with HCAP guidelines as stipulated in Ohio Administrative and Revised Codes.
2. To ensure the processes used by the hospital to implement HCAP were in accordance with HCAP guidelines as stipulated in Ohio Administrative and Revised Codes.
3. To prepare and present educational assistance for all of the hospitals in the state based on information gathered during the HCAP data reviews.

Note: This report provides a summary of issues found in the data reviews and is intended to be used as an educational reference only. Please refer to Chapter 5101:3-2 of the Ohio Administrative Code and Chapter 5112 of the Ohio Revised Code for complete HCAP regulations.

Methodology

The reviews were conducted based on hospital compliance with Ohio Revised Code (ORC) and Ohio Administrative Code (OAC) rules in effect at the time of the reviews. The review methodology was conducted in four steps, which are described below.

Step 1: Selection of hospitals

ODJFS selected twenty hospitals for review, including a mix of focused and random selection. In order to conduct the focused selection process, the Bureau of Health Plan Policy (BHPP) completed an analysis of the last three state fiscal years' uncompensated care costs for patients with incomes at or below 100 percent of the federal poverty guidelines (UC<100 %) and patients participating in DA. The four Ohio hospitals with the highest average increase in UC<100 % costs over the last three state fiscal years and the four hospitals with the largest average decrease in UC<100 % costs over the last three state fiscal years were selected for reviews. Five hospitals were selected as a result of issues discovered during the 2000 HCAP program year. Seven hospitals were then randomly selected from the remaining population. All reviews for the 2001 program year were conducted in-house.

Step 2: Review and reconciliation of summary level data

- a. The twenty selected hospitals were instructed to submit three separate chronologically numbered lists, or logs, of patient discharges/visits that supported the total charges reported on the ODHS 2930, Schedule F previously submitted by the hospital. The first list included all uncompensated accounts for patients in the category for DA services, the second list was for UC<100%, and the third list was for uncompensated care services for persons with incomes above poverty without insurance (UC>100%). This was the first year that hospitals were required to submit UC>100% logs, due to the inclusion of these costs in the distribution formula for 2000 HCAP program year. Each log was to contain a patient identification number or account number, the date of service, insurance status, and total net charges written-off.
- b. The hospitals' logs of uncompensated care encounters were compared to their Schedule F by BHPP staff to verify that the totals on the logs matched the amounts reported on Schedule F.
- c. Once the logs of accounts and Schedule F were reconciled, a random sample of thirty-six individual accounts was selected from the log of encounters for each hospital: sixteen accounts from the DA category, sixteen accounts from the UC<100 % category, and four accounts from the UC>100% category for patients without insurance. The list of selected accounts was sent to each hospital, along with a list of documentation to be submitted to ODJFS for the completion of the review.

Step 3: Documentation reviews

Each hospital was required to submit the medical, financial, and eligibility records to substantiate the reported charges on the thirty-six selected accounts. Hospitals were also required to submit their written HCAP policies; copies of billing statements illustrating the required HCAP notices; and the wording, locations, dimensions, and languages of its posted HCAP signs. Staff from BHPP and

registered nurses from the Surveillance and Utilization Review Section (SURS) completed the review process that is outlined below.

a. Medical Record Review

Medical records pertaining to the selected accounts were made available to the SURS member(s) of the review team. SURS staff performed a compliance review to determine if the medical records supported the itemized billing statements for the dates of service in question. SURS staff, with the assistance of the entire review team, verified that only charges for medically necessary hospital level services were written-off to HCAP.

b. Financial Records and Reporting Review

The financial records review was performed by BHPP staff to verify that the amounts reported on Schedule F and the log of accounts matches the amount shown in the itemized list of charges. This included an analysis of accounts which were partially reimbursed by some form of insurance.

c. Eligibility Determination Review

The eligibility documentation review was performed by BHPP staff to verify that hospitals accurately applied eligibility criteria for persons applying for HCAP. This part of the review verified that Disability Assistance eligibility verification (e.g., DA cards) was available for each DA recipient, that the poverty guidelines for patients with incomes at or below the federal poverty level were appropriately applied to each applicant, and that Medicaid consumers were not included. Documentation for patients with incomes above the poverty level without insurance was reviewed to verify that insurance status had been properly reported.

d. Policies and Procedures Review

Health Plan Policy staff reviewed the HCAP policies and procedures of the hospitals to determine whether the hospitals' implementation of the program complies with state law, as specified in the Ohio Administrative Code and Ohio Revised Code. BHPP looked at several aspects of the hospitals' policies including consistency, income and family determination practices, notification of the program, and billing practices.

Step 4: Reviews findings and corrections

ODJFS issued to each of the hospitals a final report detailing the review findings, as well as the required corrective actions and suggestions for improvement. Hospitals were required to make required corrections, including corrections to Schedule F of the cost report, within thirty days of the receipt of the report.

2001 Medicaid Cost Report Data Verification

In addition to the process described above for the HCAP prospective data reviews, ODJFS also completed a separate process to verify the accuracy of Medicaid cost report data. ODJFS selected thirty hospitals based upon significant variances in six different cost report fields: adjusted total facility costs, total Medicaid costs, uncompensated care costs for patients at or below the federal poverty level, uncompensated care costs for patients above the federal poverty level, total facility days, and total Medicaid days. The reported amounts in each of these six categories were compared for State Fiscal Years 1999 and 2000.

First, the hospitals were required to verify the accuracy of the amounts in the six fields and correct any reporting errors. Second, the hospitals were asked to write a brief report on the primary reasons for the significant cost report variances. The following list contains some of the explanations for shifts in costs and inpatient days found in this years verification process:

- S addition of a new program or service
- S additional collections efforts and increased efforts to resolve old accounts receivable
- S year 2000 preparation costs
- S impact of closed hospitals
- S increased Medicaid volume and utilization due to the enrollment of more children in CHIPS
- S increased Medicaid admissions due to a worse than usual influenza season
- S increased Medicaid volume and utilization due to changes in physician referral trends

- S increased Medicaid volume and utilization due to recruitment of new physicians
- S increased Medicaid volume and utilization due to hospital efforts to qualify uninsured patients for Medicaid
- S hiring additional nurses to achieve recommended levels
- S increased costs of employee benefits
- S greater use of technology

This data verification process proved to be a valuable tool to focus the hospitals' attention on the accuracy of their cost report data, and prompted some of the hospitals to submit Medicare and Medicaid cost report revisions to correct inaccuracies.

Findings

Hospitals' logs did not match their Schedule F

- ! Hospitals must maintain a separate log of accounts for each category : DA, UC<100%, and UC>100%.

- ! Logs should be organized to ensure accuracy.
 - S Manual hand-written logs make it difficult to ensure accuracy and correct errors.
 - S Logs should not include duplicate claims.
 - S Subtotals on the logs should be reconciled to the totals on the Schedule F.
 - S There should be no mathematical errors in the calculations of the totals for Schedule F.

- ! Hospitals were required to correct the Schedule F so that the accounts on the logs would substantiate the figures reflected on Schedule F.

- ! Several hospitals did submit well-organized logs, however, and some of these followed the sample format suggested by the department. In general, these logs were easily reconciled to the charges reported on Schedule F.

IMPORTANT NOTE

The Schedule F is not acceptable if the information it contains is not substantiated by the hospital's logs. The logs attest to the

Inaccurate reporting or inappropriate detail on Schedule F

- ! Data for patients with insurance must always be reported separately from data for patients without insurance (for each category: DA, UC<100%, and UC>100%).
 - S Charges for with and without insurance must be supported by documentation and cannot be allocated based on estimated percentages of insured patients.
 - S DA and UC<100% must be written off by date of discharge or visit. Only service dates falling within the reporting period are included on Schedule F.
 - S UC>100% are reported by write-off date, and should not include recoveries made on these write-offs.

- ! Hospitals were required to make corrections so that charges on their Schedule F were in the appropriate categories.

IMPORTANT NOTE

The results from comparing the Schedule F charges to the logs suggest that most Ohio hospitals need to review the reporting requirements in paragraph (E) of OAC rule 5101:3-2-07.17, as well as the cost report instructions in OAC rule 5101:3-2-23. In order to aid hospitals in improving reporting and correctly administering the HCAP program, a sample log is attached.

Incomplete or missing medical records and documentation

- ! Medical records must include documentation for all charges (including radiology reports, documentation of medications, physician orders, and laboratory reports).

- ! In order for charges to be verified, an itemized bill must be submitted for all accounts being reviewed.

- ! The hospitals with unsubstantiated medical charges were required to remove the amounts from the Schedule F charges.

Charges for non-hospital level services

- ! Charges for professional fees, patient convenience items, transportation services, durable medical equipment (DME), and other non-hospital level services should not be reported on the Schedule F.
- ! Hospitals were required to remove the charges for these non-hospital level and non-medically necessary services from Schedule F of the cost report.

Discrepancies between charges listed on itemized bill and logs

- ! For each account, the net charges on the logs must match the net charges written-off from the itemized bill.
- ! Inpatient and outpatient charges should not be included on the same claim.
- ! Insurance payments must be excluded from the write-off amounts.
- ! The service dates on the logs should match the service dates on the medical and financial records.
- ! Payments cannot be received from any patients who qualify for HCAP as DA or UC<100%. Hospitals that received money paid by any patient who qualified for HCAP were required to return the payment to the patient.

A large number of hospitals included Medicaid consumers in HCAP reporting

- ! Medicaid consumers are not to be included in HCAP reporting.
- ! Some hospitals appear to be confusing the DA and Medicaid programs, as a number of hospitals reported Medicaid consumers in this category.
 - S The top of the DA card reads "OHIO DISABILITY ASSISTANCE MEDICAL CARD." The top of the Medicaid card reads "OHIO MEDICAID CARD." As these cards can be easily confused, please pay close attention.
 - S DA verification can also be obtained by calling Medifax, although the Medifax response can also be confusing. Although the Medicaid indicator at the top reads "Y" for DA patients, in the "Medical Information" section the "Case Type" should be "D-DISABLED ASSISTANCE" for DA patients.
- ! Hospitals were required to submit a revised Schedule F to verify the removal of the charges for services provided to Medicaid consumers.

Problems documenting HCAP eligibility

- ! Hospitals must submit appropriate eligibility documentation for DA patients.
 - S DA cards and other DA eligibility documentation must show that the patient was eligible for DA

at the time of service. DA cards are issued on a monthly basis. DA cards for months prior to or after the reported month of service are not acceptable documentation.

- ! Complete eligibility documentation must be submitted for each patient in the UC<100% category. In order for eligibility for this category to be determined correctly, an application with income and family size must be obtained for each patient.

Problems determining of family size

- ! For HCAP purposes a “family shall include the parent(s), their spouse, and all their children, natural or adoptive, under the age of eighteen who live in the home.”
 - S Many errors seem to occur because the hospitals use tax forms to determine family size or ask patients for information regarding “dependents” or “household size,” which may not use the same definition of family as used for HCAP.
 - S Note that step-parents and step-children are counted only if the child has been adopted by the step-parent.
- ! Hospitals must collect and document enough information from patients (e.g., age of family members, relationship of family members to the patient) for the review staff to verify that family size was determined correctly.

Problems calculating income

- ! Each patient’s income should be calculated based on the date of service, rather than the date of application.
- ! All applicable sources of income must be considered when calculating income (e.g., Social Security benefits, pensions, inheritance). Income should be calculated as total salaries, wages, and cash receipts before taxes.
- ! Tax returns and other documentation that do not correspond to the correct time period (defined by date of service) should not be used to calculate income.
- ! Those hospitals with accounts where income was not sufficiently documented or calculated, were required to remove the charges from the UC<100 % lines reported on Schedule F.
- ! Hospitals were not required to collect and submit eligibility documentation for patients reported in the UC>100% category. However, it is important for the hospital to maintain documentation of insurance status for this group of patients.

Eligibility Policies

- ! A good written policy and procedure should include at least the following:
 - S The hospital’s intake/application process
 - S The hospital’s procedure for determining income, with an emphasis on calculating income either for three or twelve months prior to the date of service
 - S The procedure for correctly determining family size
 - S Acceptable income verification documentation (e.g., pay check stubs, letters, tax returns)
 - S The procedure to verify and document DA eligibility

- ! One hospital submitted a flowchart in addition to the written procedure, which appeared to be a useful tool.
- ! HCAP application forms must sufficiently facilitate proper eligibility determinations by requesting all information necessary to calculate income and family size, to screen out Medicaid patients, and to gather other insurance information.

IMPORTANT NOTE

While hospitals are not required to have a written set of policies and procedures to administer HCAP, the findings of the data reviews reinforce that following an established procedure is the best method to ensure correct and consistent implementation of the program. Hospitals should use OAC rule 5101:3-2-07.17 as a guideline for all internal HCAP policies and procedures. In order to aid hospitals in correctly administering the HCAP program, a sample HCAP application is attached, which hospitals can use or adapt for their own purposes.

Billing Requirements

- ! Hospitals are required to print notification about HCAP in at least the first and second bill. The billing statement must provide a notice to accomplish the following:
 - S Explain that individuals with incomes at or below the federal poverty level are eligible for services without charge;
 - S Specify the federal poverty guidelines for individuals and families of various sizes at the time the bill is sent; and
 - S Describe the procedure to apply for HCAP and have charges canceled for services provided.
- ! Hospitals should use wording in their billing notices that can be understood by the population being served. The term “HCAP” may not be easily understood by patients, and therefore hospitals should use wording such as “free care” or “services free of charge” to refer to potential HCAP eligibility.
- ! Effective December 14, 2000 hospitals are now required to reference the notice about HCAP on the front of the bill.

Notice Requirements

- ! Notices/signs regarding HCAP must be posted in the emergency room, admissions areas, and business office (or place patients pay their bills) and must include the following in order to comply with the rule:
 - S The posted notices must specify the rights of eligible individuals to receive without charge, basic, medically necessary hospital level services;
 - S Wording must be clear and in simple terms to be understandable to the population being served;
 - S The notice must be printed in English and other languages that are common to the population

- of the area being served;
 - S The posted notice must be clearly readable at a distance of twenty feet or the expected vantage point of the patrons; and
 - S The facility shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.
- ! Hospitals were informed of any inadequacies regarding their signs and were required to remedy the deficiencies.

Conclusions

In general, most of the hospitals reviewed appear to be operating HCAP with several compliance problems. There were a few areas in which hospitals have demonstrated improvement from the 2000 HCAP program year: fewer instances of inappropriate collection of patient payments were noted, no instances of reporting non-Ohio residents were noted, more hospitals have written procedures regarding the implementation of the HCAP program, and more hospitals reported having posted signs.

The most significant problems revealed during the 2001 data reviews were the inability to produce accurate logs to substantiate reporting on Schedule F of the Medicaid Cost Report, difficulties in reporting charges in the appropriate categories on Schedule F, inclusion of charges for Medicaid consumers, and inadequate or missing documentation. As part of their corrective actions, all twenty hospitals were required to submit a revised Schedule F for the SFY 2000 ODHS Form 2930.

The data reviews continue to be an important tool for ODJFS to not only verify the accuracy of HCAP data, but to also raise hospitals' awareness of how to correctly implement the program.

HCAP Data Review Checklist

By using this checklist as a reference, your hospital can avoid making some of the common errors found in the 2001 HCAP data reviews.

- U Separate logs of accounts are maintained for each reporting category - DA, UC<100%, and UC>100%.
- U Within each log of accounts (DA, UC<100%, and UC>100%), each patient's insurance status is easily identifiable.
- U All of the DA and UC<100% accounts on the logs are for patients with discharge dates which fall within the hospital's cost reporting period.
- U All of the UC>100% accounts on the logs are for patients whose charges were written off during the hospital's cost reporting period.
- U There are no charges for Medicaid consumers on the logs.
- U The total for each log of accounts matches the amounts reported in the respective lines and columns on the Schedule F of the Medicaid cost report.
- U Complete medical records are maintained to substantiate all charges on the Schedule F, and can be made available for data review purposes.
- U Charges for professional fees, patient convenience items, transportation services, durable medical equipment (DME), and other non-hospital level services are not included on the Schedule F.
- U An itemized bill is maintained for each patient with net charges matching the net charges reported on the logs.
- U Insurance payments are not included in net charges reported on the Schedule F.
- U Payments from DA patients and patients with incomes at or below the poverty level are not accepted. If payments are received, the patient is refunded the payment upon proof of eligibility for HCAP.
- U Appropriate eligibility documentation is collected and maintained for HCAP patients, including DA cards, information about family size, and income when necessary.
- U Family size and income determinations are completed properly, using OAC rule 5101:3-2-07.17 as a guide. The HCAP application facilitates a proper eligibility determination by asking for all relevant information needed to determine family size and income properly.
- U A notice about HCAP is printed on at least the first and second bill. The notice is referenced on the front of the bill.
- U Acceptable notices/signs regarding HCAP are posted in at least the emergency room, admissions areas, and business office (or place patients pay their bills).

Note: This checklist provides a summary of issues found in the data reviews and is intended to be used as an educational reference only. Please refer to Chapter 5101:3-2 of the Ohio Administrative Code and Chapter 5112 of the Ohio Revised Code for complete HCAP regulations.

ODJFS Sample Application for HCAP

PATIENT NAME: _____ DATE OF APPLICATION: _____

APPLICANT NAME, IF NOT PATIENT: _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET: _____ CITY: _____

STATE: _____ ZIP CODE: _____

DATE(S) OF HOSPITAL SERVICE: From _____ To _____

U Were you an Ohio resident at the time of your hospital service? Yes ____ No ____

U Were you an active Medicaid recipient at the time of your hospital service? Yes ____ No ____
If yes, Medicaid recipient ID number: _____

U Were you an active recipient of Disability Assistance at the time of your hospital service? Yes ____ No ____
(If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)

U Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes ____ No ____

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, "family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient	Income for 3 months prior to hospital service*	Income for 12 months prior to hospital service*	Type of income verification attached**
(Patient)		self			
Total persons in family		Total family income			

*Income verification must accompany this application, if you reported \$0 income provide a brief explanation on the back of this form or on an attached sheet.

**Income verification may include income tax returns, pay stubs, w-2s, or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

 Applicant Signature

 Date

Please click on link from the HCAP page for the sample logs.