



## **Prospective Data Review 2002 Hospital Care Assurance Program Final Summary Report**

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. A copy of this report can be found on the ODJFS web site at <http://www.state.oh.us/odjfs/ohp/bhpp/hcap.stm>.

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## Introduction

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The 2002 Hospital Care Assurance Program (HCAP) will distribute \$562 million to hospitals to help 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 (Medicaid consumers, people with incomes below poverty, and people without health insurance). 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 data is used by the Ohio Department of Job and Family Services (ODJFS) 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 performs data reviews for a sample of hospitals. There are three primary objectives for the reviews:

1. To ensure that uncompensated care data reported by hospitals is accurate and reported 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 are 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

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The HCAP 2002 data 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. There are five components to the data review: log review (summary level), medical, financial, eligibility, and policy. The review methodology was conducted in four steps, which are described below.

### Step 1: Selection of hospitals

ODJFS selected forty hospitals for the HCAP 2002 data review. Two-stage sampling with simple random sample selection of clusters (hospitals) and simple random sample selection of elements within the clusters (patient visits) was utilized to select hospitals for data review and the accounts of patient visits and discharges within each hospital selected for review. The sample of forty hospitals was proportionally allocated based on the volume of visits for services provided in State Fiscal Year (SFY) 2000 Medicaid cost reporting periods for the hospital type (i.e. Rural, Urban, Children's, Teaching, and DRG exempt). The following table demonstrates the number of hospitals included in the sample by type of hospital. For example, Rural hospitals represented 13.03% of total HCAP visits reported in SFY 2000 and therefore represented 13.03% (or 5 out of 40) of the hospitals selected for data review.

Hospital Type	Number of Hospitals	Total Discharges and Visits (based on SFY 2000 data)		Hospitals in Sample
		#	%	
Rural	50	219,455.00	13.03%	5
Urban	98	968,377.00	57.49%	23
Children's	9	154,662.00	9.18%	4
Teaching	6	337,166.00	20.02%	6
DRG exempt	11	4,677.00	0.28%	2
<b>Total</b>	174	1,684,337.00	100.0%	40

### Step 2: Review and reconciliation of logs (summary level data)

- A. The forty 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 JFS 02930, 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 uncompensated care services for persons with incomes below the poverty level (UC<100%), and the third list was for uncompensated care services for persons with incomes above poverty without insurance (UC>100%). Each log was to contain the following data elements for each account on the log: name of the patient, a patient identification number or account number, the date of service, insurance status, gross charges for services provided, net charges written-off to HCAP, and a grand total of net

charges for each category.

- B. The hospitals' logs of uncompensated care encounters were compared to their Schedule F to verify that the totals on the logs matched the amounts reported on Schedule F and to verify that all data elements were included for each account on the log.
- 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: twelve accounts from the DA category, twelve accounts from the UC<100 % category, and twelve accounts from the UC>100% without insurance category. 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; a copy of their HCAP application; copies of billing statements illustrating the required HCAP notices; and the wording, locations, dimensions, and languages of its posted HCAP signs.

- a. Medical Record Review  
Permedion, the department's Medicaid hospital utilization review contractor, performed a compliance review to determine if the medical records supported the itemized billing statements for the dates of service in question. In addition, Permedion verified that only charges for hospital-level services were written-off to HCAP.
- b. Financial Records and Reporting Review  
The financial records review was performed to verify that the amounts reported on Schedule F and the log of accounts match 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 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. Each claim was also reviewed to verify that insurance status had been properly reported.
- d. Policies and Procedures Review  
HCAP policies and procedures of the hospitals were reviewed to determine whether the hospitals' implementation of the program complies with state law, as specified in the Ohio Administrative Code and Ohio Revised Code. ODJFS looked at several aspects of the hospitals' policies including consistency, DA, income and family determination practices, notification of the program, billing practices, and the hospitals' HCAP application.

#### **Step 4: Review 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 the required corrections, including corrections to Schedule F of the cost report, within twenty-one 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 nineteen 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 2000 and 2001.

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 year's verification process:

- S addition of a new program or service, or expansion of an existing program
- S additional collections efforts and increased efforts to resolve old accounts receivable
- S impact of closed hospitals
- S increased Medicaid volume and utilization
- S increased hospital efforts to qualify uninsured patients for Medicaid
- S health care inflationary increases, particularly in drug costs
- S improved recording of patients above poverty
- S closure of a psychiatric program
- S increase in salaries
- S improved HCAP qualification process
- S census building efforts

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

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Several compliance issues with the HCAP data and the processes used by hospitals to implement HCAP were identified in the data review. The most frequent issues identified include:

- S UC>100% accounts were not reported with write-off dates to ensure accounts were written -off during the appropriate fiscal year
- S Incorrect classification of accounts on the logs based on insurance status
- S Inclusion of Medicaid recipients on Schedule F
- S Services written-off to HCAP were not supported by medical records
- S Non-hospital level services were written-off to HCAP
- S Insufficient documentation to determine HCAP eligibility
- S HCAP applications did not facilitate an appropriate determination of eligibility
- S Policies did not adequately address DA eligibility
- S Policies did not adequately address family size determinations
- S References to HCAP not on the front of hospitals' bills

The following sections describe in detail the findings of the data review. **Please read this section carefully as it describes the issues identified in the data review and advises hospitals on the resolution of these issues in compliance with the Ohio Revised Code and the Ohio Administrative Code rules.**

### **Part I: Reconciliation of logs (summary level data)**

#### **Inaccurate reporting or inappropriate detail on hospital logs**

- ! 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%). **Charges for with and without insurance must be supported by documentation and cannot be allocated based on estimated percentages of insured patients.**
- ! DA and UC<100% must be written-off based on the date of discharge or visit. Only service dates falling within the hospital's cost reporting period should be included on Schedule F.
- ! UC>100% are reported based on write-off date, should account for all recoveries made on these write-offs, should not include collection fees on these accounts, and should have been written-off within the reporting period.
- ! The net charges written-off to HCAP should not be greater than the gross charges on the account. Hospitals who submitted logs with net charges equal to gross charges were required to verify to the department that the net charges listed on the HCAP logs did not include non-hospital level services, collection fees, or any payments received on these accounts.

**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 accuracy of the cost report.**

**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%. Each account on the logs should contain the following information:
  - S name of patient
  - S patient identification number or account number
  - S the date of service
  - S the date of write-off for UC>100%
  - S insurance status
  - S gross charges for services provided
  - S net charges written off to HCAP
  
- ! Subtotals on the logs should be reconciled to the totals on Schedule F.
  - S The DA log should include subtotals for:
    - S DA, inpatient, with insurance
    - S DA, inpatient, without insurance
    - S DA, outpatient, with insurance
    - S DA, outpatient, without insurance
  - S The UC<100% log should include subtotals for:
    - S UC<100%, inpatient, with insurance
    - S UC<100%, inpatient, without insurance
    - S UC<100%, outpatient, with insurance
    - S UC<100%, outpatient, without insurance
  - S The UC>100% log should include subtotals for:
    - S UC>100%, inpatient, without insurance
    - S UC>100%, outpatient, without insurance
  
- ! Logs should be organized to ensure accuracy.
  - S Manual hand-written logs or hand-written portions of the logs make it difficult to ensure accuracy and correct errors.
  - S Logs should not include duplicate claims.
  - S There should be no mathematical errors in the calculations of the totals for Schedule F.
  
- ! Several hospitals did submit well-organized logs, which 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 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 can be found on the department's web site at <http://www.state.oh.us/odjfs/ohp/bhpp/hcap.stm>.

## **Part II Medical Review**

### **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.

### **Charges for non-hospital level services**

- ! Charges for professional fees, patient convenience items, transportation services, durable medical equipment (DME), take home drugs, and other non-hospital level services should not be reported on the Schedule F.

## **Part III: Financial Records and Reporting Review**

### **Discrepancies between charges listed on itemized bill and logs**

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

## **Part IV: Eligibility Determination Review**

### **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 must be interpreted carefully. Even though 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.

### **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.
- ! Outdated eligibility determinations should not be used. A new eligibility determination must be made for:
  - S Outpatient services delivered ninety days after the initial date of service
  - S All inpatient admissions unless the patient is admitted within forty-five days of discharge for the same underlying condition.
  - S DA patients on a monthly basis

### **Problems determining 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) to calculate family size correctly.

## Problems calculating income

- ! Each patient's income should be calculated based on income three months or twelve months prior to the date of service, rather than the date of application. 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.
- ! 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.
- ! 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.

## PART V: Policy and Procedures Review

### 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
  - ! HCAP application forms must sufficiently facilitate proper eligibility determinations by requesting the following information:
    - S Family size according to OAC definitions (family members, age, relationship to applicant)
    - S Family income according to OAC definitions for the date of services
    - S Medicaid or DA eligibility information
    - S Other insurance information
- While hospitals are not required to adopt the ODJFS sample application, the use of this application is strongly recommended.

#### **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 medically necessary hospital-level 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 if the patient qualifies.
  
- ! 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 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.

## Conclusions

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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 2001 HCAP program year. No instances of inappropriate collection of patient payments were noted, no instances of reporting non-Ohio residents were noted, most hospitals have written procedures regarding the implementation of the HCAP program, and most hospitals reported having posted signs.

The most significant problems revealed during the 2002 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, inadequate or missing documentation, and the utilization of HCAP applications that do not facilitate an appropriate determination of eligibility. As part of their corrective actions, all forty hospitals were required to submit a revised Schedule F for the SFY 2001 Medicaid cost report.

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 2002 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			
<b>Total persons in family</b>		<b>Total family income</b>			

\*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