

2000 HCAP Data Reviews

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Office of Ohio Health Plans
Bureau of Health Plan Policy

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2000 HCAP Data Reviews

Outline of Discussion

- Prospective Data Review Methodology
- Review Findings and Recommendations
 - General findings
 - Reporting Issues and Requirements
 - Documentation Issues and Requirements
- Changes to 2001 Data Reviews
- Cost Report Data Verification
 - Methodology
 - Findings

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HCAP Review Methodology

Initial Summary Level Review

- Selected 30 hospitals
 - 10 randomly selected
 - 8 selected on variances in uncompensated care
 - 4 selected due to HCAP 1999 issues
- Hospitals provided a summary log of accounts for DA and UC<100
- ODJFS reconciled log and Schedule F of cost report
- Random selection of 36 claims (18 each of DA and UC<100)

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HCAP Review Methodology

Documentation Review

- Medical Records Review
- Financial Records and Reporting Review
- Eligibility Review
- Policy Review

All reviews were in-house reviews.



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Review Findings

Summary Level Review

- Purpose
 - Verify that claims are logged correctly
 - Verify that charges on logs match the charges on Schedule F of the cost report (ODHS 2930)
- Findings
 - Submissions up to 4 or 5 weeks late
 - Hospitals submitted revised Schedule F
 - Logs did not match Schedule F (11 hospitals)
 - Obvious errors on logs and Schedule F (16 hospitals)

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Review Findings - Reporting

Summary Level Review

Lack of organization of the logs has contributed to serious problems for some hospitals.

- Manual logs compromise accuracy
- Confusion leading to inaccurate transfer of data to Schedule E/F

(See examples)



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Review Findings - Reporting

Summary Level Review

Lack of attention to reporting in the appropriate categories on Schedule F has contributed to problems for some hospitals.

- With insurance vs. Without insurance
- DA vs. UC<100 %

(See examples)



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Review Findings - Reporting

Summary Level Review

Be sure that DA and UC<100 accounts are written off by date of service and that only service dates falling within the reporting period are included on Schedule F.

(See examples)



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Review Findings - Reporting

Summary Level Review

Recording of insurance information has been problematic.

- Source of large remitted amounts unknown
- Medicaid enrollment (or pending status) noted on logs

(See examples)



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Review Findings - Reporting

Summary Level Review

Reporting on logs and Schedule F was so problematic that some hospitals had to submit up to 6 versions of logs and Schedule F before they were acceptable.



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Review Findings - Reporting

Summary Level Review - Recommendations

Warning!

If your logs do not substantiate your Schedule F, then your Schedule F is not acceptable!

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Review Findings - Reporting

Summary Level Review - Recommendations

- Remember that you are attesting to the accuracy of your cost report!
- Be sure that you can produce accurate logs that report accounts in the appropriate categories!
- Be sure that your Schedule F is substantiated by your logs!

(See examples)



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Review Findings - Reporting

Summary Level Review

Warning!

ODJFS received 74 cost report changes from hospitals involving data used for HCAP this year. Opportunities to make multiple revisions will no longer be available, so please be certain your reporting is accurate upon interim-settlement.

(See example letter)



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Review Findings

Medical Records Review

- Purpose
 - Verify that billed services were provided
 - Verify that all services were medically necessary hospital level services



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Review Findings

Medical Records Review

- Findings
 - Difficulty producing records and reports (20 hospitals)
 - Medical records submitted for wrong service dates
 - Missing itemized billing statements
 - Undocumented charges and/or duplicate billings
 - Non-medically necessary services (e.g., infertility services, patient convenience items)
 - Non-hospital level services (e.g., professional fees, DME, transportation services)

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Review Findings

Financial Records and Reporting Review



- Purpose
 - Verify charges were accurately reported and transferred to logs
- Findings
 - Charge amounts on itemized bills did not match charges reported on logs (8 hospitals)
 - Problems with service dates (11 hospitals)
 - Poor documentation of insurance (11 hospitals)
 - Patient payments (5 hospitals)
 - Medicaid adjustments and payments

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Review Findings

Eligibility Review

- Purpose
 - Verify eligibility criteria is accurately applied
- Findings
 - No documentation submitted
 - 16 hospitals missing DA documentation
 - 18 hospitals missing UC<100 documentation
 - Documentation not appropriate
 - Documentation indicates Medicaid eligibility (15 hospitals and up to 28 % of sample)

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Review Findings

Eligibility Review

- Findings (continued)
 - Non-Ohio residents
 - Incorrect determination of family size (16 hospitals)
 - Incorrect determination of income (17 hospitals)
 - Inclusion of patients above the poverty level in UC<100

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Review Findings - Documentation

Eligibility Review

Warning!

If you do not have proper documentation, you cannot include the claim on your logs and in your reporting on Schedule F of the cost report. No second opportunities to submit documentation will be granted during the data review process.

(See examples)



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Review Findings

Eligibility Review

OAC rule 5101:3-2-0717 states that hospitals "shall provide, without charge to the individual, basic medically necessary hospital-level services to the individual who... *is not a recipient of the medicaid program.*"

(See examples)



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Review Findings

Policy Review

- Purpose
 - Determine if hospitals were operating the HCAP program in compliance with OAC rules
- Areas Reviewed
 - Eligibility Requirements
 - Billing Requirements
 - Notice Requirements

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Review Findings

Policy Review - Eligibility

HCAP covers services for patients who are:

- Recipients of the DA program at the time of service
- At or below the federal poverty level (family income for 3 months or 12 months prior to the date of service)
- Ohio residents
- Not Medicaid consumers

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Review Findings

Policy Review - Eligibility

Findings:

- Most hospitals have written policies and procedures (all but 5 hospitals)
- Some written policies are incomplete or incorrect
 - Did not correctly address determination of family size (9 hospitals)
 - Did not correctly address income determination (8 hospitals)

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Review Findings

Policy Review - Eligibility

Findings (continued):

- Some hospitals don't follow their written procedures consistently
- Some applications do not facilitate correct determinations (10 hospitals)

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Review Findings

Policy Review - Billing Requirements

- Hospitals must notify patients about the availability of HCAP in at least the first 2 bills
- Notification must include a statement that:
 - Explains that patients at or below the poverty level are eligible for services at no charge
 - Specifies the federal poverty guidelines for individuals and families of various sizes
 - Describes the procedure to apply and cancel charges

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Review Findings

Policy Review - Billing Requirements

Findings:

- Failure to include notification in billing statements (3 hospitals)
- Omission of federal poverty guidelines
- Omission of description of procedure to qualify (e.g., telephone number)
- Notice difficult to find on bill

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Review Findings

Policy Review - Notice Requirements



- Must post notices in at least the ER, admissions, and business/cashier's office
- Posted notices (signs) must:
 - Specify the rights of individuals to receive hospital services without charge
 - Have simple and easy to understand language
 - Be in English and other languages common in the area
 - Be readable at 20 feet or the expected vantage point

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Review Findings

Policy Review - Notice Requirements

Findings:

- No signs (7 hospitals)
- Signs missing in one or more required location
- Wording on signs does not comply with OAC rule
- Only 2 hospitals noted having signs in other languages (Spanish)

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Review Findings

Conclusion

Most significant problems in 2000 review:

- Inability to produce accurate logs to substantiate reporting on Schedule F
- Inclusion of charges for Medicaid consumers
- Inadequate documentation

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Changes for 2001 HCAP Data Reviews

There are plans to begin looking at logs and claims from the UC>100 % category, so please be sure your records are in order!



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Cost Report Data Verification

Methodology

Selected 30 hospitals based on significant variances in cost report fields between SFY 1998 and 1999:

- Adjusted total facility costs
- Total Medicaid costs
- UC>100 costs
- Total facility days
- Total Medicaid days

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Cost Report Data Verification

Methodology

Selected hospitals were required to:

- Verify the accuracy of the cost report data
- Write a brief report or letter on the primary reasons for the significant cost report variances



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Cost Report Data Verification

Results

Reasons cited for significant shifts included:

- Mergers
- Opening of satellites, etc.
- Increased utilization in some departments
- Staffing changes
- Overtime costs due to nursing shortage
- Changes in average length of stay

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Cost Report Data Verification

Results

Reasons for shifts (continued):

- More thorough HCAP procedures implemented
- Hospital had made significant reporting errors

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HCAP Data Reviews and Data Verification

Reminder

Check your data now!



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HCAP Data Reviews

Questions?

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