

The following is the Ohio Department of Job and Family Services' (ODJFS's) response to the comments presented at the Federal Fiscal Year (FFY) 2001 Hospital Care Assurance Program (HCAP) forums held in Toledo on March 19, Cleveland on March 21, Cincinnati on March 22, and Columbus on April 2, 2001. ODJFS held these forums prior to proposing the rule so that the comments could be included in the rule that will be proposed in May.

Overall, attendants who provided comments had suggestions for improvements to the program. Many stressed how important the program is to the indigent population and to the medical community that serves them. Some forum attendants thought the existing model worked well or appreciated the challenges involved in determining how to distribute the limited HCAP funding.

THE FOLLOWING COMMENTS WERE MADE BY SEVERAL PEOPLE:

Money should follow the patient.

Comment: The primary goal of the HCAP program is that money should follow the patients.

Response: This has and continues to be a priority for ODJFS when determining the distribution policy. Distributions are based on the cost of care the hospital provided to indigent patients, including Medicaid consumers.

Managed care.

Comment: Managed care shortfalls should be included in the calculation of the HCAP distribution.

Response: ODJFS is proposing to include the managed care shortfall in the HCAP calculation. The proposed methodology uses a proxy formula to calculate the shortfall. For each hospital, the inpatient and outpatient managed care shortfall would be calculated separately using the following formula:

$$\text{Medicaid managed care shortfall} = (\text{Medicaid managed care costs}) \\ - (\text{proxy for Medicaid managed care payment})$$

$$\text{Proxy for Medicaid managed care payment} = [(\text{Medicaid payments under FFS}) \div (\text{Medicaid costs under FFS})] \\ * (\text{Medicaid managed care costs})$$

One person suggested that the formula adjust for case mix. That method was proposed last year but was rejected by interested parties.

Compliance with and access to the HCAP program.

Comments: Hospitals do not adequately inform consumers by posting signs and informing inquirers about the availability of free care under the HCAP program. It would be helpful if hospitals provided advertising about HCAP. One organization is working with hospitals located in its area to improve the efforts they make to inform patients about HCAP and has found those hospitals to be responsive.

ODJFS should enforce the prompt processing of consumers' applications by hospitals. Hospitals should have data that can be audited. There should be further financial audits and physical inspections to ensure the integrity of the data, access to the HCAP program, and a fair distribution of the HCAP dollars.

One hospital at the HCAP forums responded that sometimes it is the patients that are negligent in complying with HCAP. Hospitals follow up with patients to get an HCAP application that is filled out correctly by the patient, but patients are not always responsive. Hospitals then bear the cost of providing the care to the indigent patient but are unable to count those costs toward their HCAP claim because the patient was delinquent in applying.

Response: Under the HCAP rule, hospitals are required to post signs in certain areas, include information on bills sent to consumers, and take any additional steps necessary to inform patients that come to the hospital for treatment about the availability of care free of charge through HCAP. In addition, the hospitals may not bill patients at or below poverty or on disability assistance.

To help ensure the integrity of the HCAP program, ODJFS performs data reviews on a sample of hospitals. Those reviews verify that the hospitals are informing the eligible consumers (e.g., required signs are posted and information is clearly provided on bills) and that the claims are reported correctly (e.g., consumers either do not have insurance or are at or below the poverty level and only appropriate hospital costs are included). In addition, ODJFS is currently talking with the hospital industry about improving data collection and about expanding data reviews.

It is important to note that the federal disproportionate share hospital (DSH) program and Ohio's version, HCAP, are not entitlement programs. Although there is no limit to the amount of uncompensated care qualified consumers may receive, the federal government does limit the amount of funding the state has to reimburse hospitals for that care. The HCAP program is an assistance program for hospitals to help them afford the uncompensated indigent care they provide. Under current federal funding levels, hospitals are not fully compensated for the uncompensated care they provide to the uninsured.

Closed single site and multiple campus hospitals.

Comments: HCAP dollars should not go to closed hospitals. Instead, the HCAP money should go to the hospitals that are picking up the care of the displaced patients.

Response: Because of data limitations, hospital closings provide a challenge to ODJFS in distributing HCAP money. The hospital cost report is the most current and accurate source available for uncompensated indigent care costs incurred by a hospital. ODJFS bases its distribution of HCAP funds to hospitals on that report. In addition, there is one cost report filed for each hospital provider number. In cases where there is one hospital system with multiple campus sites, one provider number and therefore, one cost report, can account for several hospital facilities.

If a hospital facility with a unique provider number closes or discontinues being a hospital provider, ODJFS is proposing to calculate the portion of the current year the provider was open and only provide that proportion of a full year's payment. The remainder of the payment would then be distributed to open hospitals within the same geographic location.

A more challenging scenario is when one hospital within a multi-campus health care system closes and data on the closed hospital's uncompensated care costs is provided in aggregate with the other hospital facilities in the cost report. ODJFS is still working on a solution for the future HCAP distributions. Adding to that challenge is that ODJFS must choose a method that is consistent statewide across a diverse hospital population as well as consistent for situations created in the future.

Input from interested parties regarding procedure.

Comments: ODJFS should allow enough time for input from interested public parties before the HCAP rule is finalized. The association for hospitals and health systems should not set the HCAP policy. Thank you to ODJFS for traveling to different regions of the state for the FFY2001 HCAP forums. ODJFS should travel for the formal public hearings in June as well.

Response: The regional forums were conducted to ensure the opportunity for interested parties to have input in the HCAP program. The forums are a part of the process of preparing the rule and the comments will be used in creating the new formula. Aside from these forums, ODJFS does talk with other interested groups including hospitals and their associations throughout the year. The final formula is created by ODJFS using input from all those who expressed opinions.

ODJFS will again seek input through a hearing process in June after the rule is proposed. The rule hearing process is administered by the Joint Committee on Accreditation and Rule Review (JCARR). Because of travel costs and budget constraints, it is unlikely that ODJFS will travel for the hearings. However, ODJFS does accept written comments.

Income.

Comments: Some people who provided comments at the forum said HCAP payments should focus first on the indigent and place uncompensated care provided to those above poverty as a secondary priority of the formula. Many wanted those costs allowable for persons above poverty to be capped at 200 percent of the federal poverty level. Others said that ODJFS should not cap care above poverty because the U.S. Congress did not set an income limit in the enacting legislation and because it is difficult to determine where to draw the line as families above poverty without health care insurance can face large hospital bills that they cannot afford.

Response: The single largest pool in the HCAP formula is distributed based on the amount of uncompensated care provided to patients on disability assistance or with incomes below the federal poverty level. In addition, the federal government requires that high DSH hospitals (federally defined as those providing a relatively high proportion of Medicaid care) receive DSH payments. These two populations are the primary focus of HCAP payments.

Beginning with last year's program, the HCAP formula has included 30 percent of the costs incurred from providing uncompensated care to uninsured patients above 100 percent of poverty. The formula does not include income limits for uninsured patients above poverty for several reasons. First, uncompensated care provided to patients above poverty has been a growing cost for hospitals. Second, as many people recognized in their comments, at this time hospital cost report data does not distinguish patients with incomes between 100 and 200 percent of poverty from those whose incomes are above 200 percent of poverty. Third, the Ohio Department of Health found in its 1998 Family Health Survey, that 50 percent of uninsured Ohioans above the poverty level are from families near poverty or from families with incomes between 100 and 200 percent of poverty. Therefore, since the HCAP formula only includes 30 percent of the costs of care provided to the uninsured above poverty, a significant majority of the HCAP money provided to hospitals for that care is already for patients between 100 and 200 percent of poverty. Fourth, as was mentioned in the comments above, federal law does not provide a distinction for uninsured persons above poverty and drawing that line could likely cause unintended consequences for uninsured families who face large hospital bills and for the hospitals who treat them.

Disproportionate share limit pool.

Comments: Some commented that the HCAP distribution formula should not reimburse hospitals for their assessment as that is not the purpose of the HCAP program. The focus should be on uncompensated care provided to indigent patients. Others said that the assessment paid by hospitals should be a factor in the distribution.

Response: It is important to point out that when people are commenting about the assessment pool they are referring to what was called the disproportionate share limit pool in last year's rule. Like all the other pools in the HCAP formula, the disproportionate share limit pool never

provides funding to a hospital in excess of their disproportionate share limit. A hospital's disproportionate share limit is the amount of uncompensated costs a hospital incurred while caring for indigent patients. In addition, the money in this pool is distributed based on the hospitals that provided the largest amount of uncompensated care.

The HCAP formula includes the disproportionate share limit pool to compensate small hospitals who provide less indigent care relative to large hospitals in the state, but for whom uncompensated indigent care costs are a large portion of their total costs.

No HCAP dollars for bad debt.

Comments: Hospitals should provide documentation that they did not charge patients above poverty. Such documentation is already required for patients below poverty.

Response: Hospitals participating in HCAP are required by state law to treat patients below the federal poverty level or on disability assistance free of charge. ODJFS does not have similar legal authority regarding charging uninsured patients above poverty.

Evaluating the HCAP program.

Comment: Continually re-evaluate the HCAP program and verify that it is achieving its mission.

Response: The HCAP program exists to help offset the cost of providing care to indigent persons. Each year ODJFS works with hospitals, patient advocates, and other interested parties to re-evaluate the program and see how it can be improved or adjusted to deal with recent changes in the market.

Eligibility.

Comments: Make the application process simple and make forms easy to understand. Hospitals should include information about HCAP clearly on the bills they send their patients. Standardize the HCAP applications.

Response: In promulgating the HCAP eligibility rule effective December 14, 2000, ODJFS worked with hospitals and patient advocacy groups to facilitate easier administration of HCAP in hospitals and greater awareness of HCAP and ease of application for patients. Hospitals are required to follow specific procedures to inform the patients they treat about the availability of the HCAP program. As part of the HCAP data review performed every year, ODJFS checks a sample of hospitals to verify that the information they provide, including the information they are required to include on their bills to patients, is written clearly. If the information is not written clearly, ODJFS requires them to reword it.

ODJFS gives hospitals a sample HCAP application, but does not require hospitals to use the sample format. Many hospitals simplify the process of providing charity care to patients by including several charity care programs on the same form. HCAP would be one of the programs while others may be unique to that hospital. If we were to require a uniform application, this would create additional paperwork for hospitals and for the indigent patients they serve.

THE FOLLOWING COMMENTS WERE MADE BY ONE OR TWO PEOPLE:

Comment: Get more current data and provide more current payment.

Response: Currently the hospital cost report is the only accurate and most current source of data on uncompensated care that is verifiable.

Comment: Legislators should be more involved.

Response: The General Assembly legislated that ODJFS administer the HCAP program (see ORC section 5112.03). However, the legislature maintains involvement in HCAP through the formal administrative rule making process, through JCARR (the entity that administers the rule making process and is composed of legislators from both houses of the General Assembly), and by bringing concerns to and working with ODJFS's Office of Legislation.

Comment: Include non-hospital care (e.g. take home drugs, services provided by community health clinics when the only hospital in the area closes) in the HCAP distribution calculation.

Response: Federal limits in Section 1923(g) (U.S.C. 1396r-4) of the Social Security Act prohibit us from including care beyond hospital care. Therefore, we would receive no federal match for that spending.

Comment: HCAP funding should not be reduced if the hospital receives an allocation from the county.

Response: The HCAP formula does not reduce the cost of uncompensated indigent care provided by a hospital by the financial assistance the hospital received from county levies or other similar sources.

Comment: Maximize the amount drawn down from the federal government.

Response: The state of Ohio is currently drawing down the maximum amount it is able to from the federal government.

Comment: HCAP funds are falling and the federal DSH limit is too low.

Response: The federal Balanced Budget Act of 1997 (BBA) imposed a limit on the total amount the federal government would provide through the matching rate. The limit decreased each year such that, for Ohio, the federal funding level in 2002 would be equal to 85 percent of the federal funding in 1995. The Benefits Improvement and Protection Act of 2000 increased the federal contribution for Ohio, but those limits are still lower than their pre-BBA levels. Therefore, for the past several years the amount available for distribution under HCAP has decreased.

Comment: In the federal high DSH calculation, eliminate non-Ohio days from the total facility days in the denominator if the numerator is restricted to Ohio Medicaid.

Response: Federal law (Section 1923 of the Social Security Act, 42 U.S.C. 1396r-4) requires states to include all facility days in the denominator when calculating high DSH hospitals.

Comment: Rule making should be prospective so hospitals can plan.

Response: The state does use a prospective rule process. This has been improved this year to include an earlier filing date and public forums.

Comment: Allow providers to move patient care costs to schedule D or I if a patient enrolls in Medicaid after he or she leaves the hospital. Currently if a patient's Medicaid application is pending and they seek care at a hospital that does not know this, that hospital will include that consumer under their schedule F. When that consumer becomes eligible, their eligibility date will be retroactive to the date they applied. Since the schedule F prohibits any Medicaid costs from being included, the hospital will be required to remove the charges for that consumer. The cost of caring for that consumer will not be eligible for HCAP. If the hospital missed the allowed Medicaid billing time frame the hospital will not be able to receive Medicaid payments either.

Response: Based on the claims we have reviewed, this is not a common occurrence. Please let us know when this happens.

Comment: What's the difference between critical access hospitals and safety net hospitals? Why is ODJFS proposing to include a separate pool for critical access hospitals in the HCAP distribution?

Response: Critical access hospital (CAH) is a federal designation. A CAH provides care in a health care shortage area and is a safety net provider. The proposed HCAP distribution will include a separate calculation for CAHs because these hospitals are often small and therefore, provide a small amount of indigent care relative to larger indigent care providers. However, their existence is crucial to the communities they serve and their uncompensated indigent care costs are often a large proportion of their total facility costs.

Comment: If a hospital mostly provides specialty non-hospital level care, allow them to remove the non-applicable portion of hospital ancillary costs from the basis of the HCAP assessment.

Response: To preserve the integrity of the data used to determine hospitals' HCAP assessment and distribution, ODJFS uses only standardized reporting formats. Currently there is no standard format available to all hospitals for distinguishing between hospital and non-hospital ancillary costs.