



Ohio HCAP and Hospital Free Care Requirements

Frequently Asked Questions *(Updated Feb. 2024)*

The OHA member resource for answers to the most frequently asked questions regarding the Ohio Hospital Care Assurance Program (HCAP), its related hospital free care requirement and Ohio Medicaid DSH program audits.

These FAQs reflect requirements in Ohio Administrative Code (OAC) [OAC 5160-2-17](#), established by the Ohio Department of Medicaid (ODM) on the allowance and documentation of free and uninsured hospital services related to the Hospital Care Assurance Program (HCAP).

They are designed to provide guidance to hospitals, but they do not reflect any particular legal interpretation on the part of OHA or ODM and are not intended to provide counsel to consumers about the requirements of [OAC 5160-2-17](#). OHA recommends hospitals review their HCAP and other charity care policies and procedures with legal counsel to ensure they comply with all state and federal laws and rules.

OHA reminds hospitals that Ohio Medicaid eligibility guidelines should allow most Ohio residents who qualify for free hospital care to also qualify for full Medicaid benefits. OHA encourages hospitals to ensure that each patient has applied for Medicaid as part of the free care application process, as outlined in [OAC 5160-2-17\(C\)\(8\)](#). Additional information and an online application for Medicaid benefits is available [here](#).

Additional resources regarding the HCAP program can be found on OHA's website [here](#).

PUBLIC RULES AND INCOME GUIDELINES

1.1 Which rule explains how hospitals must manage public notices and applications for free care, and where can I get a copy of it?

- The rule number is [OAC 5160-2-17](#).

1.2 Which rule explains how a hospital's auditor must conduct an annual review of the data on Medicaid Cost Report Schedule F and where can I get a copy of it?

- The Medicaid Cost Report rule number is [OAC 5160-2-23](#).

1.3 Where can I get the federal poverty level (FPL) guidelines?

- Current federal poverty income guidelines are available from the US Dept. of Health & Human Services [here](#). They go into effect each year on the date they were published in the Federal Register. Eligibility for inpatient admissions or outpatient services under [OAC 5160-2-17](#) delivered on or after that publication date should be judged by the new guidelines. Admissions or services delivered prior to the publication date should be judged by the guidelines in place on the date of admission or service.

APPLICATIONS AND ELIGIBILITY FOR FREE CARE

2.0 I am an Ohio resident and have a bill from an Ohio hospital that I cannot pay. How do I apply for free or discounted care?

- Contact the hospital’s business office and ask for an HCAP application. The hospital will review your application and may ask for income documentation. If your documented family income is below the federal poverty level guidelines in place on the date of service or admission, the hospital will write off its portion of the bill. Please keep in mind that the state’s “free care rule” does not apply to bills from doctors or other medical care providers, nor does it apply to residents of other states or out-of-state hospitals. Also remember that most hospitals have discounted payment programs for patients whose incomes are above the federal poverty levels, so if you are not eligible for free care be sure to inquire about other charity care policies or programs the hospital may offer.

Ohio residents should remember that current Ohio Medicaid eligibility guidelines would allow most Ohio residents who qualify for free hospital care to also qualify for full Medicaid benefits, and to obtain medical coverage far beyond what is available under [OAC 5160-2-17](#). OHA encourages patients to apply for Medicaid before considering a request for free care. Additional information and an online application for Medicaid benefits is available [here](#).

2.1 Is there a standard application for free care?

- There is not a standard application for free care, however OHA and ODM recommend the sample application found [here](#).

2.2a Is there a limit to the amount of time a hospital must take applications for free care?

- [OAC 5160-2-17](#) permits a hospital to adopt a three-year limit on applications. Note that the three-year limit starts on the date of the first follow-up notice sent to a patient, not the date of service. It is expected each hospital that adopts a three-year limit must clearly state this in its written HCAP/free care policy (see FAQ 3.2a) and be consistent in its application.

2.2b Are electronic or e-signatures on an application for free care permitted.

[OAC 5160-2-17\(C\)\(4\)](#) allows a hospital to create policies, in accordance with paragraph (F), that allow for the completion and signature of an application electronically provided there is reasonable assurance that it is the patient or the patient's legal representative who signs the application.

2.2c Can an application for free care be taken over the telephone or the internet?

- In most cases no. Hospitals are permitted to take an application over the phone or the internet only as a last resort, because an application taken by phone cannot be signed by the patient or an authorized applicant.

If an application is taken over the telephone, the interviewer is expected to ask the questions exactly as they are listed on the recommended free care application (see FAQ 2.1) and to mail a copy of the completed application to the patient or authorized applicant to sign and return to the hospital for its records. If there is some reason the patient/applicant cannot sign the application, the interviewer is expected to sign the form and document why the patient/applicant was not able to sign.

2.2d Are free care applications distributed by or completed with the help of community legal aid or patient advocacy groups acceptable?

- The issue is not where a patient gets an application or who helps him/her complete it, but rather how the hospital validates the data against the requirements of [OAC 5160-2-17](#) and the hospital's internal policy on documentation. The hospital also must confirm the signature is the patient's, or that of someone legally able to speak for the patient. As such, if a patient presents a completed application, the hospital should ensure the data on the application conforms to the elements outlined in FAQ 2.1. The hospital then must confirm the data was correct as of the date of service and request the patient, or someone legally able to speak for the patient, sign (or re-sign) and date (or re-date) the application.

2.3 May a hospital require an uninsured patient to apply for Medicaid before it accepts an application for free care?

- Yes. Hospitals should remember, however, that current Ohio Medicaid eligibility guidelines would allow most Ohio residents who qualify for free hospital care to also qualify for full Medicaid benefits, and to obtain medical coverage far beyond what is available under [OAC 5160-2-17](#). OHA encourages patients to apply for Medicaid before considering a request for free care, as outlined in [OAC 5160-2-17\(C\)\(8\)](#). Additional information and an online application for Medicaid benefits is available [here](#).

2.3a May a hospital require a patient to seek commercial health insurance coverage under the Ohio and federal health insurance exchanges before it accepts an application for free care?

- No.

2.5 If a patient account has been sent to collection, can the patient still apply for free care?

- Yes. While the application time limits outlined in FAQ 2.2a apply, if a patient is retroactively found to have been eligible for free care on the date of admission or service the account must be recalled from collection and written off (see FAQ 7.2 for additional information on collection fees and court costs).

2.6a. Is a separate application required for a patient with multiple outpatient encounters or inpatient admissions?

- [OAC 5160-2-17\(C\)\(3\)](#) permits a hospital to apply an approved free care application to any outpatient service delivered up to 90 days from the date of the initial outpatient service. It is also not necessary to take a new application for an inpatient re-admission as long as the re-admission occurs within 45 days of a discharge that was approved for free care and the readmission is for the same underlying condition. Eligibility for all other inpatient admissions must be judged separately and require new free care applications.

2.6b Can an application for an inpatient hospital admission also be used to cover any outpatient care that is required post-discharge?

- Yes, an inpatient application can also be used to cover related outpatient services for the patient in the 90-day period immediately following the first day of the covered inpatient admission.

2.6c Does an approved free care application apply to services delivered by other hospitals during the 90- and 45-day periods immediately following an outpatient encounter or inpatient admission?

- No, unless the two hospitals are part of one system and their internal policies permit a shared application for follow-up care related to the initial outpatient encounter or inpatient admission.

2.7a Who can sign a free care application and attest to the accuracy of the information it contains?

- The application should be signed by the patient or someone who has a legal right to represent the patient, such as a parent or spouse. If there is some reason the patient/applicant cannot sign the application, the registrar is expected to sign the form and document why the patient/applicant was not able to sign.

2.7b Can a parent sign a free care application for an un-emancipated adult (18 or older)?

- No, unless the parent has been appointed by the Court as the un-emancipated adult's legal representative or guardian.

2.7c Who can apply for a deceased patient?

- An application for free care must always be attested to by someone who is legally able to speak for the patient, so the executor of the estate should submit an application on behalf

of the deceased patient. If there is no estate the patient's next of kin could sign and attest to the validity of the information on the application.

2.8 Does a signed application for free care have to be notarized?

- No.

2.9 Occasionally a Medicaid managed care patient will go to an out-of-panel hospital for elective care. If the out-of-panel hospital puts the patient on notice that (s)he will be responsible for the charges, as required by [OAC 5160-26-11](#), can the patient later apply for free care?

- No. If a patient is eligible for Medicaid, including Medicaid managed care, (s)he cannot apply for free care and the hospital cannot include the charges for that admission or service in any field on Schedule F of the Medicaid Cost Report.

2.9a If a patient is only eligible for the Medicaid Family Planning Benefit, as outlined in [OAC 5160-21-02](#), can (s)he apply for free care for services not covered by the FPB program?

- Yes, because his/her Medicaid eligibility is limited to the specific services covered by the FPB program. Note that non-covered FPB charges would be logged for the purposes of reporting Medicaid DSH charges as "without insurance." Do not include charges that are covered by the Medicaid FPB program.

2.10 Can a patient with health care coverage other than Medicaid who has self-pay charges arising from an out-of-panel encounter apply for free care?

- Yes. Note that, if approved, the charges should be logged as "with insurance."

2.11 [OAC 5160-2-17](#) requires a signed application. Is an electronically stored or faxed copy of the signed original application acceptable for audit, or must the hospital keep the original?

- A faxed or electronically stored copy of the original application is acceptable, providing the electronic document is stored in a PDF file, or in some other manner that is not easily altered after it is created, and the fax or electronically stored application is available as outlined in [OAC 5160-2-17\(G\)\(3\)](#).

Note that a hospital will lose credit for the uninsured account if the hospital is unable to retrieve an electronically stored application for review.

2.12 Can a patient who was eligible for Medicaid via the "spend-down" provision apply for free care? Is a hospital obligated to take into account the patient's spend-down amount in the calculation of eligible free care?

- Every patient eligible for Medicaid via spend-down had a specific period during which Medicaid coverage was in effect and it can be verified on the patient’s Medicaid card, or via the ODM eligibility verification system. Any service or admission not included in that period is considered self-pay and is eligible for free care.

Do not net the spend-down amount from the charges reported for the patient in the period (s)he was not eligible for Medicaid, unless the patient actually paid that spend-down amount to the hospital.

2.12a Is the patient with a spend-down amount that is written off to HCAP considered insured or uninsured?

- Since the amount that is being written off reflects a period during which the patient was not eligible for Medicaid, (s)he is considered to be uninsured.

2.13 Is a “sanctioned” Medicaid enrollee eligible for free care?

- “Sanction” means the individual did not follow through with an *Ohio Works First* activity for three months or more and, as such, lost Medicaid eligibility for a period of up to six months. Since they are not eligible for Medicaid during the sanctioned period, a patient could apply for free care for an admission or service date that falls within the period.

2.14 Is a patient who is under the custody of the county Children’s Services Bureau (CSB) eligible for free care?

- No. The CSB is responsible for medically necessary care the child receives.

2.15 Is a prisoner or detainee eligible for free care?

- No. While the local county sheriff is responsible for county-based prisoners and detainees, it is possible that an inpatient admission lasting more than 24 hours is eligible for Medicaid reimbursement. Hospitals should contact the County Department of Job and Family Services to assist the individual with an application for Medicaid coverage.

Inpatient stays lasting less than 24-hours and outpatient visits are not eligible for free care.

2.15a Is a person who is in a “half-way house” eligible for free care?

- No. Persons in half-way houses remain under the control of the Ohio Department of Rehabilitation and Corrections (DRC) Transitional Control Program and the DRC is responsible for their hospital care. However, recent guidance from CMS indicates that residents in a half-way house may be eligible for Medicaid coverage. It is recommended that hospitals assist these patients in applying for Medicaid.

2.16 Can a hospital system have a single application for all hospitals in the system?

- Yes. [OAC 5160-2-17\(C\)\(5\)](#) allows a hospital system to create policies, in accordance with paragraph (F) of the rule, for all hospitals in the system to use a single approved application provided that the provisions of paragraph (C)(3) of this rule are maintained.

DOCUMENTATION

3.1 What documentation is required to support an application for free care?

- Each hospital must have an internal policy outlining its documentation requirements. At the very least a hospital must require an application that contains all data elements contained in the sample application (see FAQ 2.1), which has been signed by the patient or by someone who has a legal right to represent the patient.

No additional documentation is necessary unless a hospital's internal policy requires it. If a signed application is all a hospital requires, and the patient/applicant reports zero income for the period in question, ODM recommends the hospital document how the applicant and his/her family are surviving at the bottom of the application.

Hospitals have the right to deny a signed application if they can document a reasonable doubt that the applicant is not telling the truth.

If a hospital's policy states additional documentation is required, it is recommended that the hospital adopt a hierarchical approach that includes:

- A completed application, signed by the patient or his/her authorized representative, and hardcopy proof of income, such as pay stubs, or a letter from the applicant's employer.
- If the documentation listed above is not available, the hospital should use a completed application, signed by the patient or his/her authorized representative, or an application completed by a hospital representative that is clearly documented to indicate why the patient or authorized applicant was not able to sign (see FAQ 2.2c).

Note that this recommended approach to documenting an application for free care under [OAC 5160-2-17](#) does not apply to a hospital's internal charity care policy and a hospital may request additional documentation to support an application for charity or reduced-cost care for patients with family incomes above 100% FPL.

3.2a. Must a hospital have a written free care policy?

- Yes. [OAC 5160-2-23](#) requires an auditor to use the hospital's internal policy to judge its compliance with [OAC 5160-2-17](#). As such, each hospital must establish a policy that, at least, outlines the application process and what types of documentation, if any, it requires to verify family size and income.

3.2b If a hospital decides to change its free care policy, when should the policy change be implemented?

- The policy change cannot be implemented retroactively. The hospital must choose a specific date on which to change its policy and all applications for dates of service on or after that implementation date must be judged under the revised documentation standards.

3.3 Is an income tax return acceptable income documentation?

- No. By its nature, an income tax return does not cover the date of service, which [OAC 5160-2-17](#) requires to be the basis for determining eligibility, and a tax return defines family and income differently, so a tax return is not a recommended form of documentation. However, if a hospital requires documentation and a tax return is all a patient can produce to document his/her income, it may be considered backup for the signed, sworn statement of income contained in the application. Just be sure that any decision of eligibility is based on income and family size as defined in [OAC 5160-2-17](#), not the federal tax code.

3.4 For how long should hospital maintain a free care application and documentation?

- [OAC 5160-2-17\(G\)\(4\)](#) requires hospitals to keep all Medicaid billing and Cost Report records for the latter of six years from the date of receipt of payment based on those records, or until any audit initiated within that six-year period is completed.

FAMILY SIZE

4.1 Should a hospital include a spouse who does not live in the same home as his/her spouse and/or children in a patient's "family?"

- Yes. [OAC 5160-2-17\(B\)\(2\)](#) states "a "family" shall include the patient, the patient's spouse, regardless of whether the spouse lives in the home, and all of the patient's children, natural or adopted, under the age of eighteen who live in the home.

If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adopted parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adopted, under the age of eighteen who live in the home."

4.2 Regarding FAQ 4.1: What if a patient or the patient's parent is still married, but the patient or patient's parent cannot locate his/her spouse?

- [OAC 5160-2-17](#) instructs a hospital to include the spouse in the "family" count, regardless of where (s)he lives.

4.3 Does a common-law marriage count?

- No. Ohio law stopped recognizing common-law marriages on Oct. 1, 1991, although any persons who entered into a common-law marriage before that date were grandfathered into the revised law and their marriage is still recognized.

4.4 What if the patient or his/her representative states the spouses are “legally separated?”

- Since a legal separation is a court order in which spouses remain married but may live separately, you should count both parents, as outlined in FAQ 4.1

4.5 Do grandparents, stepparents or “legal guardians” count as part of a minor patient’s HCAP “family?”

- No. While any of the above could be part of a minor patient’s household and may in fact contribute to the patient’s livelihood, [OAC 5160-2-17\(B\)\(2\)](#) states they may not be counted as part of the patient’s “family” unless they have formally adopted the minor patient. Further, in most cases where a child is the ward of the Court and is placed in “legal guardianship,” healthcare is provided by the court or the state.

4.6 A patient’s parent states his/her former spouse was given the responsibility to provide for the minor child’s healthcare in a decree of divorce or separation. Do we count both parents as part of the HCAP “family?”

- Yes. One parent’s support-order has no bearing on the requirements of [OAC 5160-2-17](#).

4.7 Often divorced parents share custody of minor children. If the patient is not residing with his/her natural or adopted siblings on the date of service, do we count the siblings in the patient’s HCAP “family?”

- No. [OAC 5160-2-17](#) indicates only siblings that reside in the patient’s home can be counted in his/her “family.” In the case of joint custody, count only the natural or adopted siblings that actually reside in the patient’s home on the date of service as part of his/her “family.”

4.8 Is an 18-year-old high-school student living in his/her parents’ home considered part of the patient’s family?

- No. Regardless of the living arrangements, any patient 18 years or over is considered the basis for his/her own “family.” Only count his/her spouse, if applicable, and any of his/her natural or adopted children.

4.9 If a patient gives birth during an admission, is the baby counted as part of the “family” for purposes of determining eligibility for free care?

- Keep in mind, that in most cases these new families will be eligible for Ohio Medicaid and **OHA encourages hospitals to assist with these applications.** However, if for any reason a low-income mother and/or baby are not eligible for Ohio Medicaid, then the

hospital should consider both mother and baby to be part of each other's "family" when considering a free care application.

4.10 Are persons of the same sex who are legally married considered part of each other's "family" for the purposes of determining eligibility for free care?

- Yes.

RESIDENCY

5.1 How long must a patient have lived in Ohio to qualify for free care?

- [OAC 5160-2-17](#) does not set a standard for residency, other than to state the patient must be "living in Ohio voluntarily." ODM allows hospitals to include temporary residents, such as students or migrant workers, and patients who are temporarily residing with in-state relatives. What is not permitted is the inclusion of out-of-state patients who are on vacation in Ohio, or any patient who has come to Ohio solely to receive medical care.

5.2 Can an undocumented immigrant qualify for free care?

- Yes, assuming s(he) meets the residency requirement outlined in FAQ 5.1.

5.3 Do the free care residency requirements apply to accounts with family incomes above the federal poverty income limits?

- No.

5.4 Is a prisoner or detainee eligible for free care?

- No.

CALCULATION OF INCOME

6.1 Is there any limit to what can be considered income?

- [OAC 5160-2-17\(B\)\(3\)](#) defines income as including total salaries, wages and all cash receipts before taxes. Reasonable business expenses may be deducted for self-employed patients or their families. However, the rule does not exempt other sources of non-wage income. As such, all sources of income, including but not limited to, alimony, child support, veterans' benefits and social security should be counted as income.

Note that child support must be handled differently than other forms of non-wage income. ODM has advised OHA that child support may be counted as income for a family only when the patient is the intended-recipient of that child support payment. That is, if child support is involved and the patient is the sole intended family member designated to receive that support, the family size would remain the same, but you would not count the child support as income for other family members.

6.2a Are a patient's assets taken into consideration as income?

- No.

6.2b Are withdrawals from a savings account then counted as income? What about interest and dividends?

- Withdrawals from an asset such as a savings account or brokerage account would not be considered income. However, interest and dividends on a non-retirement savings or brokerage account would be considered income. See FAQ 6.2c for treatment of retirement accounts.

6.2c The patient has a retirement account [IRA, 401(k), 403(b)]. How should these be treated?

- Funds in a retirement account would be considered an asset. Any distributions from a retirement account, monthly or lump-sum, should be treated as income, if they were not previously taxed. Interest and dividends paid directly to a retirement account would not be considered income until withdrawn.

6.3 Should a hospital take into account a patient's or his/her family's tax returns to determine income?

- Generally, no. (see FAQ 3.3).

6.4 Are grants, scholarships and/ or housing allowances considered income?

- Yes, if they are paid directly to the student/patient. Do not count any scholarship, or grant or allowance that is paid directly to the school or housing authority/landlord as income.

6.4a Does the income exception in FAQ 6.4 also apply to patients who are residents of nursing facilities when all or a portion of their income is paid directly to the nursing facility?

- Yes, but hospitals are encouraged to ensure these patients are not also eligible for Ohio Medicaid by assisting them to submit an application. Additional information and an online application for Medicaid benefits is available [here](#).

6.5 [OAC 5160-2-17](#) lists two ways to calculate income: three months prior to the date of service multiplied by four and 12 months prior to the date of service multiplied by one. May a hospital choose one or the other methodologies, or must it calculate income both ways? What if calculating income both ways results in conflicting eligibility determinations? What if the patient cannot supply documentation to support both methodologies?

- A hospital must calculate income using both methodologies to support eligibility for free care and use the result that is most beneficial for the patient. As such, if using both

methodologies result in conflicting eligibility determinations, use the one that allows the patient to qualify.

If a hospital's policy demands documentation and the patient can only document one of the methodologies, approve the application based on the available documentation, or consider using a signed application (see FAQ 2.1)

6.6a Should a hospital count the income of a spouse who does not live in the same home as his/her spouse and/or children?

- Yes. (See FAQ 4.1)

6.6b Regarding FAQ 6.6a: What if a patient or the patient's parent is still married, but the patient or patient's parent cannot locate his/her spouse? Similarly, what if the patient or patient's parent can locate his or her spouse, but the spouse does not, or will not, contribute to the "family's" income?

- In both instances, [OAC 5160-2-17](#) instructs a hospital to include the spouse in the "family" count, regardless of where (s)he lives. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information.

6.7 How are "reasonable" business expenses defined for a self-employed applicant?

- [OAC 5160-2-17](#) does not specify which business expenses can be deducted from a self-employed patient's income. Hospitals are advised to use common sense and the applicant's most recent federal income tax return as guidance regarding which business expenses are deductible.

6.8 If a patient has a health savings account (HSA) or a health flexible spending account, is (s)he required to spend down the account before applying for free care?

- [OAC 5160-2-17\(C\)\(7\)](#) gives a hospital rights to compensation or benefits from any person for the hospital goods and services rendered. As such, a hospital can establish a policy that states a patient must exhaust a HSA or health flexible savings account before applying for free care.

6.9 An applicant's pay stub indicates part of his/her "pay" is reimbursement for mileage. Is this portion considered income?

- No, because "mileage" is reimbursement for business-related expenses and is not subject to state or federal income taxes.

6.10 Should the hospital count a Medicare Part B premium that is automatically deducted from a patient's Social Security payment as income?

- Yes.

COVERED MEDICAL SERVICES

7.1 [OAC 5160-2-17](#) allows a hospital to include only medically necessary, “hospital-level” services in HCAP-related accounts. How does a hospital determine which services are considered “hospital level?”

- The most important indicator is whether Medicaid would have covered the service had it been billed on a UB-04 using the hospital’s provider number. ODM maintains a list of Medicaid-covered UB-92 Revenue Codes in Appendix I of the Hospital Billing Guidelines, found [here](#). Hospitals should use the list of Medicaid-covered codes as a general indicator of what is considered covered “hospital-level” services. **Note that this requirement applies to all accounts, under and over 100% FPL that are logged and reported in any field on the Medicaid Cost Report Schedule F.**

7.1a Are unpaid deductible and coinsurance amounts from a covered service or admission permitted under CMS’ definition of an “uninsured” patient?

- No. In its Dec. 3, 2014 Final rule: Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition, CMS states *“In the 2012 DSH proposed rule, we stated that costs associated with unpaid coinsurance and deductibles, bad debts and payer discounts for individuals with a source of third party coverage are excluded when calculating the hospital specific DSH limit. ...we are finalizing those provisions as proposed without change.”* As such, unpaid deductibles and coinsurance amounts must be recorded in Schedule F of the Medicaid Cost Report and the supporting logs as “with insurance.”

7.2 If an account has gone to collection, or the hospital has gone to court to enforce collection, and the patient later is found eligible for free care on the date of service, must the hospital write off the collection fees and court costs?

- No. Collection fees and court costs are not considered hospital-level services and may not be included in an HCAP-related write-off. They remain the patient’s responsibility, regardless of his/her eligibility for free care.

7.3 Are experimental drugs and procedures covered under the free care rule?

- No. If the principal reason for an inpatient admission or outpatient encounter was the experimental drug or procedure, then the entire admission or encounter would not be considered a medically necessary, Medicaid-covered service.

7.4 Are routine-care services delivered in conjunction with a clinical trial covered under the free care rule?

- Per [OAC 5160-2-03\(A\)\(2\)\(g\)](#), services of a research nature, services that are experimental and not in accordance with customary standards of medical practice, or

services that are not commonly used are not covered. However, a patient may apply for routine-care charges delivered during a clinical trial related to:

- Items or services that are typically provided absent a clinical trial (i.e., medically necessary conventional care)
- Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.

7.5 The list of covered and non-covered revenue codes, located in Appendix I of the Hospital Billing Guidelines, indicates that dental services billed under UB92 Revenue Code 0512 (Dental Clinic) are covered. Does this mean all dental services, including routine and preventative dental services, performed in a hospital-based dental clinic are covered under the free care rule?

- Generally speaking, no. [OAC 5160-2-03](#)(A)(2)(h) states that dental services are only covered in a hospital setting when “*the nature of the surgery or the condition of the patient precludes performing the procedure in the dentist’s office or other non-hospital outpatient setting and the inpatient or outpatient service is a Medicaid covered service.*” As such, it would exclude any diagnostic or preventative dental services delivered in a hospital setting.

7.6 How does a hospital determine whether a procedure subject to prior authorization by ODM is covered by the free care rule?

- In general, whether an individual service or procedure is eligible for free care hinges on two factors: if the care is medically necessary per [OAC 5160-1-01](#) and would Medicaid cover the service for its enrollees. When considering a service subject to Medicaid prior authorization, a hospital must make the same assessment ODM would have made, had it been the payer. That is, whether the care is medically necessary, versus being done for cosmetic or aesthetic reasons, or for patient convenience.

PATIENT ACCOUNTING AND MEDICAID COST REPORTING

8.1 How should a hospital’s Medicaid DSH data logs be organized?

- CMS requires Medicaid DSH logs to be formatted as outlined in the Patient Log Templates linked to in the introduction to these FAQs.

8.2a If an inpatient admission or series of outpatient encounter crosses two hospital fiscal years, in which fiscal year should the uninsured charges be recorded in the Medicaid Cost Report Schedule F and the related data logs?

- Uninsured care charges should be recorded in the Cost Report and logs for the fiscal year in which the discharge date or service date occurred. This will require split billing any series of outpatient claims that crosses fiscal years.

8.2b Do hospitals get credit for old patient accounts that are written off to HCAP?

- By “old” we are describing patient accounts with dates of service prior to an open cost reporting period, logs and the corresponding Medicaid Cost Report Schedule F. While a closed Medicaid Cost Report cannot be edited to include additional uninsured charges or payments, these charges and payments can be included with the Schedule F patient level data submitted to the federal auditors for that Cost Report year and will be reflected in the hospital’s DSH audit results. Once that DSH audit is completed, that fiscal year is considered closed and final.

8.4 How would a hospital log the recovery of a bad debt?

- All payments received on any account reported as uninsured in any reporting period must be included in the Cost Report that covers the date the recovery or payment was received.

8.4a How should a hospital report a lump sum, bad debt recovery that cannot be tracked back to individual patient accounts?

- All payments should be included in the Cost Report that covers the date the payment was received. If a lump sum recovery covers both accounts that were claimed as uninsured and accounts that were not claimed as uninsured, a prorated portion of the recovery that corresponds to the charges claimed as uninsured should be reported.

8.5a When is a patient to be considered “with insurance?”

- A patient is considered to be “with insurance” only when the service is within a covered benefit package in a group health plan or other health insurance coverage and is not covered by another legally liable third party.

8.5b Would a self-pay deductible or coinsurance amount be logged as with or without insurance?

- While a deductible or co-insurance amount is the patient’s responsibility, (s)he is nonetheless insured for so the entry and amount would be logged as “with insurance.”

8.5c Are self-pay charges for a managed–care patient who has had services out of network considered to be with or without insurance?

- Assuming the patient is not eligible for Medicaid (see FAQs 2.9 & 2.10) any covered self-pay charges for a managed care patient who went out of network would be considered “with insurance.”

8.5d Is a patient covered by workers’ compensation considered to be “with insurance?”

- Yes, as long as the services provided were covered by workers’ compensation.

8.6 In some cases payers reimburse hospitals on a “global” fee basis, that is, the payment represents both the technical and professional components of a bill. If a patient is applying for free care for an unpaid portion of a bill that was paid globally, how does a hospital determine how much to deduct from the payment to represent the professional portion?

- Calculate how much of the total charges represent professional services and apply the same ratio to the payment.

8.7a Are hospitals permitted to include accounts written off as a result of their internal charity-care programs in the >100% FPL categories of the Schedule F, or are only bad debt accounts allowed to be included?

- For the purposes of Medicaid DSH, CMS does not recognize a difference between “bad debts” and “charity care.” Both are eligible to be included in the >100% FPL categories, assuming the accounts meet the other requirements of [OAC 5160-2-17](#). Log these accounts as “with” or “without insurance” as appropriate.

8.7b Does the answer in 8.7a also apply to charges a hospital discounts because of an internal policy?

- Yes, assuming the discount is granted as part of a policy to assist an uninsured or underinsured patient with family income above the FPL. Employee discounts or prompt-pay discounts are not recognized as uninsured services for Medicaid DSH purposes.

8.10a Does ODM require hospitals to bill an auto liability or “Med-Pay” payer prior to writing an account off to HCAP?

- No. CMS has taken the position that auto-liability and “Med-Pay” is not health insurance. In addition, it is often difficult to determine whether a liability or Med-Pay payment is intended to cover health care services, as outlined in [OAC 5160-2-17\(C\)](#).

However, some hospitals have taken the position that they want to pursue liability or Med-Pay, because they have the potential to collect full billed charges. ODM does not oppose this position, other than to state a hospital must not pursue payment from the patient while an auto liability or Med-Pay insurer is deciding whether to pay. In addition, ODM will not grant an exception to the Cost Report timeliness limits if an auto liability or Med-Pay payer denies the claim after the Cost Report that covers the date of service has closed (FAQ 7.10). Conversely, once a hospital decides to write-off an account to free care it should stop all collection efforts from the patient or the liability or Med-Pay insurer.

OHA recommends that if a hospital decides to pursue a liability or Med-Pay insurer it should complete and pend a free care application. That way if the hospital later decides to write the account off as uninsured it has the paperwork on file to support its decision. Also, OHA recommends the hospital keep these accounts segregated so it can examine them at the point it files its Medicaid Cost Report and decide whether to write off any accounts and abandon the pursuit of a payments for them from the insurance company, or

take the chance it will lose the HCAP write-off while it waits for the liability/Med-Pay insurer to make a final determination.

8.10b If, after a hospital takes an HCAP write-off and ceases collection activities from a liability or Med-Pay insurer the insurer pays the account anyway, can the hospital keep the payment?

- Yes, but if the Medicaid Cost Report that covers the date of service is still open the hospital must reverse the write-off. If the Cost Report is closed, the hospital can still reflect the revised data in the Schedule F logs it submits to the state's federal Medicaid DSH auditor for that year.

8.11 Can Medicare bad debts be written-off to HCAP?

- No.

8.11a Is a Qualified Medicare Beneficiary (QMB) eligible for HCAP?

- No.

8.12 Can an account be considered eligible for both HCAP and the Ohio Victims of Crime Compensation Fund?

- No.

8.13 Should a hospital treat a payment from a local levy that covers indigent patients as a bad debt recovery?

- No. It is not necessary to net local levy payments from the amount claimed as uncompensated on the Medicaid Cost Report.

8.14 Many hospitals automatically write-off small balance, patient-pay accounts. Can these small balance write-offs be claimed as uncompensated care and included in the logs and cost report entries for above 100% FPL?

- Yes, assuming the hospital has ensured that the small balance write-offs do not contain charges for Medicaid recipients, that they represent medically necessary, hospital-level services, and that they are logged appropriately as insured or not-insured.

8.16 Can charges for patients with incomes below 100% of the FPL be included in the Medicaid Cost Report Schedule F entries for patients with incomes above 100% FPL?

- If for any reason a patient with an income below 100% FPL is not eligible for Medicaid and does not meet the eligibility or documentation requirements for free care outlined in [OAC 5160-2-17](#) and the hospital's documentation policy, the charges may be included in Schedule F for over 100% FPL. However, the charges can only be logged as "uninsured" when the hospital can supply documentation to support that entry.

8.17 If an uninsured patient states his injuries were the result of an accident, must the hospital bill a liability insurer before writing the account off to HCAP?

- Hospitals should always pursue payment for medical care from every reasonable source, governmental and private, and it is important to keep in mind a liability insurer may pay a patient's charges in full. However, there is no requirement for a hospital to document that a source of liability coverage does not exist prior to writing an eligible account off to free care.

8.18 If a hospital becomes aware that a patient received a payment from a liability insurer, must it pursue the patient for that payment prior to writing the account off to HCAP?

- A liability insurer is not a health care third-party payer, so [OAC 5160-2-17\(D\)](#) does not require a hospital to pursue a payment from one. However, [OAC 5160-2-17\(C\)\(7\)](#) states that, "applicants will cooperate in supplying information about health insurance or medical benefits available so a hospital may determine any potential third-party resources that may be available." As such, if the hospital is sure the payment from the liability insurer was directly related to the health care delivered in an account written off to HCAP it has the option to pursue the liability insurance payment if it wishes.

8.19 Can a hospital write off charges to HCAP for a self-pay patient who does not respond to repeated requests for information?

- No.

8.20 If another payer declares a non-cooperative patient to be self-pay, can the patient apply for free care?

- No.

8.21 If a patient is only eligible for the Medicaid Family Planning Benefit (FPB) program, as outlined in [OAC 5160-21-02](#) how does the hospital log the uninsured charges for services not covered by the FPB program?

- Non-covered FPB charges must be logged for the purposes of reporting Medicaid DSH charges as "without insurance." Do not include Medicaid-covered FPB program charges.

8.22 Medicaid Cost Report OBRA Survey Section B instructions for calculating Fraction 2 indicate hospitals should include gross charges attributable to charity care. Should the hospital include charges for Medicaid recipients from other states for which the hospital has no provider agreement?

- Yes, however, these charges should also be reported on the appropriate Medicaid Cost Report J-Series Schedule and the hospital should keep track of them on their J-Series logs. Out-of-state Medicaid charges do not count in the calculation of the Ohio HCAP, but they would count toward the hospital's OBRA cap, as calculated by the DSH auditor.

PATIENT PAYMENTS

9.1 If a patient is found to be eligible for free care and has already made payments on an account, must the payments be returned?

- Yes. The hospital must return any patient payments for hospital-level services. Any payment(s) for non-hospital services, e.g., physician, take home drugs, or home health services, do not have to be returned, since they were not eligible for free care.

9.2 Can a hospital apply a patient's refund from an account that is found to be retrospectively eligible for free care to another account for the same patient or his/her family that is not eligible?

- No, as long as the payment which caused the refund can be linked to an account that is covered by [OAC 5160-2-17](#). However, if a patient has multiple open accounts, some of which are not eligible for free care, and the hospital can document a payment was not specifically intended for an eligible account, the payment can be applied or re-applied to the other, ineligible account(s).

Notification indicating the account to which the payment was applied must be provided to the patient.

9.3 If a patient's religious or cultural community makes a partial payment on his/her account and the patient wants to apply for free care for the balance, can the hospital accept the partial payment?

- In general, all payments on accounts found to be eligible for free care must be refunded. However, ODM recognizes the situation outlined in FAQ 9.3, and will permit the hospital to accept a partial payment only under the following, documented circumstances:
 - The payment cannot be accepted directly from the patient. It must come from the religious or community group.
 - The payment must be voluntary, with the understanding that the patient's charges are eligible in full for free care and that no payment for hospital services is necessary.
 - The partial payment must be reported in Medicaid Cost Report Schedule F.

HOSPITAL-BASED DATA REVIEW REQUIREMENTS

10.1 Is an independent audit by a CPA of the data on Medicaid Cost Report Schedule F required prior to a hospital's initial submission of a Cost Report to ODM?

- Yes.

10.2 If there are no accounts, or an insufficient number of accounts in any category that is required to be sampled by the Medicaid Cost Report Instructions, how should an auditor proceed?

- ODM requires a specific number of accounts, in specific categories, to be examined by each hospital, depending on the total amount of uninsured care the hospital is reporting. If a hospital has an insufficient number of accounts in any uninsured care category, it should increase the number of accounts randomly selected in other categories until it reaches the total number of accounts it is required to examine.

10.2b Is it necessary to separately review the data in Cost Report Sub-schedules F1, F2 & F3?

- No. Since the totals of sub-schedules F1, F2 & F3 should foot to the total in Schedule F, there should be no reason to re-review the data in the sub-schedules.

10.3 If a hospital changes the amount reported in the Medicaid Cost Report Schedule F after the report is reviewed and initially submitted, does the entire Schedule F have to be re-reviewed by the hospital's CPA?

- The answer depends on the nature and the degree of changes to Schedule F after the initial submission.

If the only change is the addition of some accounts to the <100% FPL categories for patients who have applied for free care after the report was initially submitted, the CPA only has to review a small random sample of the newly approved accounts for compliance with [OAC 5160-2-17](#).

However, if the hospital has made wholesale changes to Schedule F entries after the initial submission, it is recommended the entire data review be repeated, in accordance with [OAC 5160-2-23](#).

10.3a Regarding FAQ 10.3, if the additional patient accounts in the <100% FPL categories are so few that the percent of change is a fraction of one percent, is it necessary to re-review any records?

- Yes. If the fractional increase of accounts to the <100% FPL categories is less than one percent, the hospital should round up and review at least one of the additional account records.

10.3d What is the time limit for changes to the data submitted in Schedules F and Sub-schedules F1, F2 & F3?

- [OAC 5160-2-08\(D\)](#)(1) states: “*For each program year, thirty-days after the expiration of all hospitals' thirty-day data correction periods, the department shall consider the data correction period closed and all data final, subject to review and acceptance by the department.*”

That is, for each hospital's cost report year ODM permits a formal, 30-day opportunity for the hospital to correct the data used to calculate disproportionate share and indigent care program payments. After **all** hospitals have exhausted that initial 30-day period, ODM will for an additional 30 days permit any hospital to, for a fee, request its data be reopened for additional changes, per [OAC 5160-2-08\(D\)\(2\)](#). After that point ODM considers the data to be final.

Regardless, if at any time a hospital realizes its data has resulted in inappropriate Medicaid DSH payments, the hospital is obligated to inform ODM so the overpayment can be corrected.

10.4 Hospital Cost Report Instructions state the external reviewer shall issue a report to the hospital that includes required corrective actions. How should a hospital respond? Should this report be submitted to ODM with the Medicaid Cost Report?

- Each hospital is expected to correct any material errors in the Medicaid Cost Report Schedule F data prior to the Cost Report being submitted. OHA further recommends hospitals prepare a formal response to the report describing any corrective action being undertaken as a result of problems identified in the report.

ODM does not require a hospital to submit the auditor's report with the Medicaid Cost Report, but a copy of it must be kept for at least three years. If a hospital has fewer accounts in total than is required by Hospital Cost Report Instructions, all accounts reported in Schedule F must be included in the auditor's review.